KNOWLEDGE, ATTITUDE AND PRACTICE OF HEALTH CARE PROVIDERS IN TEMEKE-DAR ES SALAAM REGARDING ADOLESCENT POST ABORTION CARE AND FAMILY PLANNING SERVICES.

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By

Donald Micah Maziku, MD

A dissertation Submitted in (Partial) Fulfilment of the Requirements for the Degree of Master of Medicine (Obstetrics and Gynaecology) of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***"Knowledge, Attitude and Practice of health care providers in Temeke - Dar es salaam regarding adolescent Post abortion care and Family Planning service",*** in (partial) fulfilment of the requirements for the degree of Masters of Medicine (Obstetrics and Gynaecology) of the Muhimbili University of Health and Allied Sciences.

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Dr. Furaha August

(Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

I, **Dr. Donald Micah Maziku**, declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature…….. Date……..

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ABSTRACT

Background: Health care providers have a key role in promotion and provision of adolescents' reproductive health services. Despite that, adolescents still face obstacles in accessing family planning and abortion related services from health providers.

Objectives: The study aimed at assessing Knowledge, Attitude and Practice of Health Care Providers (HCPs) in provision of modern Family Planning (FP) and Post Abortion Care (PAC) services to adolescents.

Methods: This was a descriptive cross sectional study, conducted in public health facilities in Temeke municipal. Selection of health facilities was through stratified random sampling and participants were recruited by random sampling from each facility. Pretested structured questionnaire was used to collect data.The data obtained was entered into EPI-INFO and then analyzed using the Statistical Package for Social Science (SPSS) version 18**.** Descriptive statistics and chi-square test were performed to drive proportions and association.

Results: There was a good knowledge and practice of HCPs on PACs (> 80%). Most components of PACs were well performed except for community participation which was 5.4% among study participants. Nearly half of study participants had poor knowledge on FPs and contraceptives with long term effect were the least provided to adolescents (Intra Uterine Contraceptive Devices (IUCDs) 17.1%, Implants (19.7%). Negative attitude prevailed among study participants towards provision of PACs and FPs to adolescents (43% and 45.7% respectively).

Conclusion: There is limited knowledge on modern family planning services together with a negative attitude on provision of PACs and FPs to adolescents among health providers. This may have negative impact to the provision of both PACs and FPs to adolescent. Therefore efforts to train and alleviate negative attitude on FPs and PACs among HCPs is of paramount importance to improve those services to adolescents as a special group.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS:

AMO	Assistant Medical Officer
ASRH	Adolescent and Sexual Reproductive Health
CMO	Council Medical Officer
CO	Clinical Officer
CPAC	Comprehensive Post Abortion Care
EC	Emergency Contraceptive
FP	Family planning
FPs	Family planning services
HCPs	Health Care Providers
HFs	Health Facilities
HIV/AIDS	Human Immunodeficiency virus/ Acquired Immunodeficiency Syndrome
IUCDs	Intrauterine Contraceptive Devices
MA	Medical attendant
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health.
MO	Medical Officer
MUHAS	Muhimbili University of Health and Allied Sciences
NGOs	Non Government Organizations
PAC	Post Abortion Care
PACs	Post Abortion Care services
PI	Principal Investigator
RAs	Research Assistants
RCH	Reproductive and Child Health
RH	Reproductive Health
SRHS	Sexual Reproductive Health Services
STIs	Sexual Transmitted Infections
USA	United States of America
WHO	World Health Organization

	OPERATION DEFINITION
Adolescent	refers to any young person at the age of 10- 19 years
Health care provider	refers to a health professional working in the study area at the time of data collection, certified to work in health service facilities in direct care of patients including provision of family planning and other health related services.

INTRODUCTION

Adolescence is a transitional stage from puberty to adulthood characterized by significant physiological, psychological and social changes [1]. The World Health Organization (WHO) refers to the term 'adolescent' as any person between the age of 10 and 19 years [2]. It is estimated that one in every five people in the world is an adolescent and developing countries account for 85% of adolescents in the world [3].

Generally it is known that the period of adolescence is a phase in life when young people are particularly vulnerable to many risks especially those in relation to sexuality. This is because adolescents often lack access to adequate information, counselling and services on issues crucial to their developmental needs [4, 5]. A large proportion of adolescents are in their most impressionist years when behaviour and character traits have not been fully formed. They reach sexual maturity before they develop mental or emotional maturity and the social skills needed to appreciate the consequences of their sexual activity [2].

Adolescent pregnancy is a major health concern because it's associated with higher morbidity and mortality for both the mother and the newborn. Child bearing during adolescence frequently has adverse social consequences in particular for education attainment, because adolescent who become mothers their education is likely to be hampered [6]. Despite those consequences faced by adolescent, yet some adolescents still believes that pregnancy cannot occur during the first sexual episode [5]. Such poor knowledge of adolescent on reproductive health puts them at risk of unwanted or unplanned pregnancy.

It is estimated that 14 million adolescents globally give birth each year and more than 90% of these births occur in developing countries [7]. In India 16% of adolescent women are documented to have begun childbearing [8]. The same trend is observed in Tanzania where 23% of adolescent falling in the age 15-19 has started childbearing, 17% have had live birth and 6% are pregnant with their first child. Forty four percent of female adolescents are either mothers or are pregnant with their first child by age 19 [9]. These findings reflect the unmet need of reproductive health services among adolescents.

In Tanzania and around the globe, unsafe abortion is a major contributor to maternal mortality. It is estimated that 23% of all maternal deaths in Tanzania are due to complications of unsafe abortion, with wide variations between districts [10]. Public hospital based studies in Dar es Salaam have shown that 20% of septic abortion cases are adolescents under 15 years old and one-third of patients with abortion complications are adolescents [10].

With recognition of the importance of adolescent health, Tanzania Government since 1980s instated a wide range of policies related to ASRH and young people/s access to information and services. The policies outline a range of services needed by adolescents including; Provision of information and education on adolescent development, sexual and reproductive health. The policy also outline adolescent rights for contraceptive services, maternal health services including PAC, management of STI and HIV related services [10].

Health care providers (HCPs) are important stakeholder in provision and promotion of health services in the community in which adolescents are included. Therefore HCPs in their daily activities are expected to have the capacity to provide basic and quality services to adolescents with different needs related to Sexual and Reproductive Health (SRH). The important components in Adolescent and Sexual Reproductive Health Services (ASRHS) which should be familiar with HCPs include; Sexual maturation, marriage, sexual intercourse, use of condoms with other forms of contraception, pregnancy, childbirth, abortion as well as sexually transmitted diseases [11].

The HCPs are important in provision of information to adolescents about their physical and emotional changes that take place as they proceeds through puberty, and also counselling on sexual intimacy, family planning and contraception. With regard to sexual intercourse, adolescents should be provided with information on how to avoid unprotected intercourse and informed on how to access Reproductive Health Services (RHS) when are in need [11].

The provision of variety of RHS to adolescents by HCPs is not supposed to be judgemental. Additionally, HCPs rendering such services must not have a negative attitude towards adolescents by the time delivering services. Such services include FP, treatment of STIs and Post Abortion Care (PAC). Thus, an adolescent deserves convenient and confidential environments while being provided with those services.

For proper provision of RHS to adolescents, HCPs are required to have good knowledge and skills in management of adolescent pregnancy and associated complications. This will ensure early and consistency antenatal care to adolescent pregnant wherever they are in needs of the services. Thus, it's a role of HCPs to help adolescents suffering from abortion complications which arises from unsafe abortion by providing to them right management and timely.This would enable adolescents to access safe post abortion care timely and without any discrimination.

The underutilization of SRHS among adolescents has been attributed to HCPs who are unwilling or unable to provide age –appropriate RH information to adolescents [12]. In the Sub-Saharan Africa region there are lower FP utilization rates and limited knowledge of RHS to adolescents. This may account for a higher proportion of the region's new HIV infections and maternal mortality [13].

LITERATURE REVIEW

The adolescent RH is an increasingly important component of global health and is both a challenge and an opportunity for HCPs. Despite many people considering HCPs as the best source of information regarding SRHS [14], yet HCPs are frequently unwilling or unable to provide complete, accurate and age-appropriate RH information to adolescents. This may be attributed by their discomfort about the subject or the false belief that, providing such information will encourage sexual activity among adolescents [15]. It is this failure of HCPs to provide relevant information as well as services related to adolescent's reproductive health which raised questions on their knowledge, attitude and practice in delivery of SRHS to adolescents.

KNOWLEDGE

Adolescents being at risk of unplanned or unwanted pregnancy and their related complications are illegible and deserves contraceptive services [16]. Thus HCPs are required to have sound knowledge on contraceptives, available methods and how or when should be issued to respective users in accordance to contraceptives medical illegibility [16]. However, it is documented that HCPs have limited knowledge and training in field of ASRHS [17, 18] of which can be accounted as contributing factors for adolescent barriers to access RH services [19].

The HCPs are also found to lack accurate and consistent knowledge on contraceptives [20], of which has potential effect to their ability in provision of care to adolescents. This in turn may have negative impact in prevention of unplanned pregnancies among adolescents.

There are misinformation and misconceptions on various modern FP among HCPs which, in turn are communicated to their clients. In Philippines (2006) it was found that among HCPs already trained on FP nearly half believed that pills causes weight gain, migraine (35%) and cardiovascular disease (11%). In addition, others believed that modern FP methods causes birth defect, breast and uterine cancer, pelvic infection, abortion and adversely affects fertility [21]. Such misconception among

HCPs may affect provision of FP services particular to adolescents who are adversely affected in accessing and utilizing modern FP methods.

The provision of Intrauterine Contraceptives Devices (IUCDs) to nulliparous women including adolescents in USA was limited because some of HCPs considered IUCDs as unsafe, which accounted for their infrequent provision [22]. The same trend was observed in India where most of HCPs were not ready to issue IUCDs and inject able contraceptives to adolescents. That was because most of them believed that, they adversely affect their fertility [23] and this precluded adolescents from accessing services from HCPs.

The awareness on Emergency Contraceptive (EC) among HCPs is high but their knowledge on how EC works is found to be low. For instance in Nigeria despite over 80% of HCPs being aware of EC, about one third believed that EC can be used to induce abortion [24, 25]. Some of the HCPs associates the use of EC and causation of thromboembolic events, liver diseases and increased risk to transmission of STIs [26]. Low knowledge and misconception among HCPs is likely to hinder the provision of EC to sexually active adolescents hence predisposing them to unwanted pregnancies. In Tanzania there is limited information with regards to knowledge of HCPs in relation to modern family planning methods.

ATTITUDE

The HCPs in the course of their practices are confronted with women suffering from complications associated with induced abortion, who real need immediate care. In such situations HCPs are required to provide the immediate care needed (i.e. treating them as an emergency) in order to rescue their lives. However, some of the HCPs are found to have negative attitude towards these clients of which may accounts for clients delay to receive the right and appropriate services [27, 28]. The HCPs attitude is likely to block the development of better abortion related services of which adolescents are more sufferers. Similar findings was observed in Pakistan where majority of HCPs had unfavourable attitude to clients conducted induced abortion and even suggested amendment of law so as to be more strict to those who commits abortion [29]

In Lusaka (2003) HCPs (nurses) were denying adolescences from receiving services like contraceptives and treatments for STIs considering these services to be only for adults and married couples [30]; similar findings were reported in Nigeria [31]. Such practices expelled adolescents from receiving modern contraceptive, hence decided to seek care from traditional healers [30]. This kept adolescent to increased risks of unwanted and unplanned pregnancies.

The HCPs have been found to be judgemental and apprehensive in addressing sexual and RH among adolescents as well as neglecting adolescent health issues. This may be contributing to failure of health system to meet the unique needs of adolescents [8]. Having information about HCP's attitudes towards ASRH is extremely helpful in eliminating barriers to adolescent from accessing and obtaining their health services from health care system.

PRACTICES

The HCPs while providing PAC to their clients are supposed to provide services in a friendly environment with the assurance of confidentiality, privacy and clients' comfort. However, HCPs are faced with lack of right environment; like big rooms with adequate space to provide services at the same time to maintain confidentiality [27, 32]. Lack of confidentiality among HCPs during services delivery discourages adolescent from attending clinics where the services are provided [33]. This was also reflected in Lithuania where HCPs required adolescent to be accompanied with their parents or guardian before being provided with services [34]. This kind of practice may be one of the contributing factors for adolescent to seek services they need in clandestine environments.

Post abortion care services are intended for comprehensive care to those individual suffering from abortion be it spontaneous or induced. Thus HCPs should provide Comprehensive Post Abortion Care (CPAC) to adolescents wherever they come across with those suffering from abortion related complication. Despite that it has been found that most HCPs provides only clinical management and disapproved adolescents from contraceptives and counselling of which are important part of CPAC service [27, 33].

Adolescents are illegible for all form of contraceptives except when there is medical contraindication for a specific contraceptive [16]. However, HCPs have been prohibiting adolescent from access to some forms of contraceptives. For instance in Zambia HCPs denied adolescent to access contraceptive and issued only to married couple [30].

Little is known about knowledge, attitudes and practise of general HCPs in provision of ASRH services in our country. Therefore the is a need for this study to be conducted and the results findings will be utilized to improve our guideline and training of health care providers with regard to sexual and adolescent reproductive health.

PROBLEM STATEMENT

Women rights include female adolescents to access health care services particularly in the areas of FP, pregnancy and during the postnatal period [35]. However, despite such rights, everyday in every two minutes, somewhere in the world and particularly in developing countries a woman dies from complications related to pregnancy and child birth [36]. Adolescents pregnancy contributes significantly to maternal mortality, accounting for approximately 70,000 deaths each year [37].

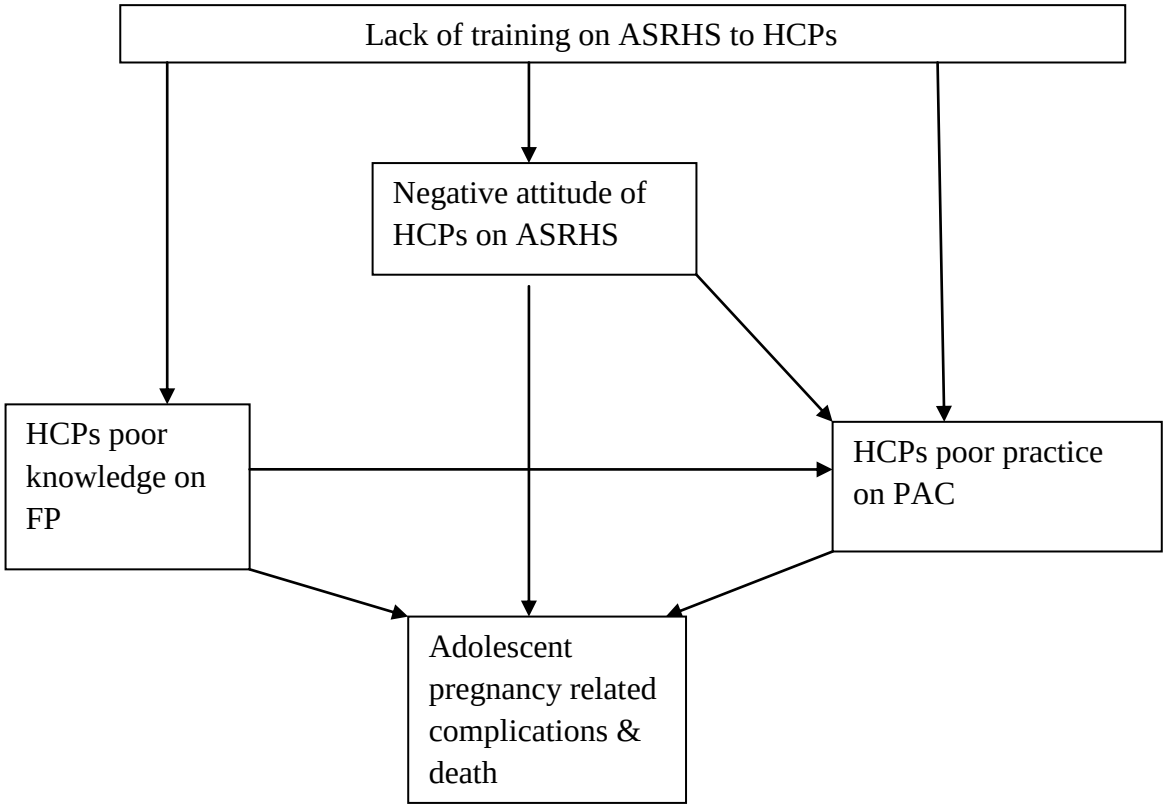
Maternal death contributed by adolescency pregnant can be reduced significantly by provision of FP to adolescents in need and proper provision of post abortion care to adolescents suffering from unsafe abortion complications.

However, several studies have cited HCPs as contributory factor for adolescent not accessing available FP and PAC services. The HCPs are reported to be reluctant in the provision of information regarding RHS including modern FP to adolescents and PAC services to those who underwent unsafe abortion [38]. Such disdain compounds the poor HCPs knowledge, attitude and practices, challenges which hamper delivery of appropriate RHS to adolescents.

Tanzania is one of developing countries with high prevalence of adolescent pregnancy. A quarter of girls aged 17 years are reported to have begun child-bearing and the figure increases to 40% by age 18 years [39]. These unintended pregnancies reflect demands for FP and PAC services among adolescents. Temeke is one of the municipal reported to have high prevalence of dolescents suffered from unsafe induced abortion and seeking help from health facilities [40]. This is a reason led for this study to be conducted in Temeke municipal. There is limited evidence on knowledge, attitude and practice of HCPs in provision of FP and PAC services to adolescents. This if remain unknown then keeps a great challenge in reducing maternal mortality of which adolescent contributes to due to inaccessibility to FP and PAC services.

CONCEPTUAL FRAMEWORK

Figure 1



Adolescent pregnancy related complications and deaths are the results of failure for adolescent to access modern FP and PAC services for those suffering from consequences of unsafe abortion. This may be contributed by poor services provided by HCPs who have been documented to have poor knowledge on modern FP, poor practice in provision of FP and PAC services. Lack of training on ASRHS among HCPs can account for the negative attitude of HCPs in provision of FP and PAC services to adolescent hence becoming an obstacle to adolescent in accessing FP and PAC services from health facilities.

RATIONALE OF THE STUDY

Integrated services delivered through the health care system are identified as one of the most effective ways of delivering ARHS. Health professionals are responsible for promotion and provision of FP and PAC services to adolescents in health facilities.

One of the two targets for assessing the fifth MDG is achieving universal access to reproductive health by 2015. To achieve this target HCPs need to be knowledgeable, with positive attitude and good practice in their delivery of services in particular to adolescents. Little is known regarding the knowledge, attitude and practice of HCPs in their provision of health services particularly towards adolescents.

This study is intended to explore HCPs knowledge and attitudes related to their provision of FP and PAC services to adolescents. Information generated from HCPs will be useful in improving policies which are in place, training of HCPs and serve as a tool in improving adolescent reproductive health services.

RESEARCH QUESTION

What are the knowledge, attitude and practice of HCPs in provision of sexual and reproductive health services among adolescents?

OBJECTIVES

Broad objectives

To assess Knowledge, Attitude and Practice among HCPs in provision of modern FP and PAC services to adolescents.

Specific objectives

1. To determine level of knowledge of health care providers on post abortion care services
2. To determine level of knowledge of HCPs on modern family planning
3. To assess attitude of HCPs towards post abortion care to adolescents
4. To assess attitude of HCPs towards provision of modern family planning services to adolescent
5. To determine the practice of HCPs on provision of post abortion care services to adolescents
6. To determine the practice of HCPs on provision of modern family planning to adolescents

METHODOLOGY

Study design

This was a descriptive cross sectional study

Study duration

The study was conducted for one month, September 2013.

Study setting

The study area was Temeke municipal, which is Southernmost of one of the three districts in Dar es Salaam. The other two being Kinondoni, located to the far North of the city, and Ilala is located in the downtown of Dar es salaam. Temeke municipal population is 1.3 million [41] and occupy an area of 786.5 km^2. Administratively, it is divided into 3 divisions and 24 wards. It has 123 Health Facilities (HFs) of which 39 belongs to the government and 84 are private. Among 123 HFs, hospitals are 5, health centres 3, and dispensaries 115. Of those HFs, the government own 3 hospitals, 1 health centre and 35 dispensaries.

Youth friendly reproductive health services in government owned HFs are provided in only three HFs namely Kigamboni (health centre), Yombo vituka and Kizuiani dispensaries. In other HFs which offers Reproductive and Child Health (RCH) clinics, adolescents are handled as adults with no special care.

This research was conducted in public HFs with an assumption that; most adolescents attend public HFs because of low costs for the services provided in comparison to private health facilities. Temeke was chosen for this study, because it was one of the Municipals reported to be with high rate of induced abortion among adolescent [40].

The total number of HCPs in Temeke government HFs was 992, whereas at hospitals 705, and at H/C 70 HCPs and at each Dispensary there were 6 HCPs in average.

Study population

The study population were HCPs working in the public HFs, involved in care of inpatient, outpatient and RCH services in Temeke Municipality.

Sample size estimation

The sample size was calculated from the formula,

$$N = \frac{z^2 p\,(100-p)}{d^2}$$

Where N = Desired sample size

Z = percentage of standard normal distribution corresponding to 95% of confidence interval which is 1.96

d = Marginal error (absolute precision of P which is 5%

p = Proportion of HCPs with positive attitude towards sexual and reproductive health services for adolescents in Ethiopia 69.3% [28].

Therefore from the above formula

$$N = \frac{1.96^2 \times 69.3 \times (100-69.3)}{0.05^2}$$

N = 327

Taking into accounts of 10%, then the health care providers expected to be interviewed were 360.

Inclusion criteria

- The HCPs involved directly in provision of medical services to both inpatient and outpatients, including provision of FPs and post abortion.
- Medical officers, Assistant Medical Officers, Clinical officers and Nurses.
- Present during data collection in selected health facilities.

Exclusion criteria

- Refusal to participate in the study.

Sampling procedure

Stratified random sampling was applied. The sampling frame was obtained by listing all the public health facilities, and then they were stratified into hospital, health centre and dispensary. The distribution of HCPs in government HFs in Temeke municipality was constituted of 72%, 7% and 21% from hospitals, health centre and Dispensaries respectively. Among HCPs from all hospitals, two-third was from Temeke hospital. Therefore to have representative sample of all HCPs from different HFs, 72% of study sample (participants) was obtained from hospitals, 7% from health centre and 21% from dispensaries. Temeke hospital being the only referral in the municipal was automatically selected with another one hospital. Names of the two remained hospitals were each written on small pieces of paper and one was randomly selected. Fifteen dispensaries were selected so as to reach a desired sample from dispensaries. Names of each dispensary was written on small piece of papers, mixed in a box and one piece of paper was randomly selected repeatedly to reach 15 dispensaries.

The health facilities which were selected were; 2 hospitals (Temeke and Mbagala Rangi tatu), one health centre (Kigamboni) and 15 dispensaries (Yombo vituka, Mbutu, Kizuiani, Mwongozo, Kingugi, Tambukareli, Kibugumo, Mbagala round table, Makangarawe, Mbande, Toangoma, kimchemchem, Majimatitu, Buza and Gezaulole)

The desired number of participants from each facility was obtained as follows;

- Of 72% from all hospitals in 360 required sample = 259, Temeke hospital accounted for 2/3 of hospital sample (173) and Mbagala rangi tatu (86).
- Health centre accounted for 7% of the sample =26
- Dispensaries accounted for 21% of the sample = 76, each dispensary contributed at least 5 HCPs.

Daily attendance register was used to obtain names of HCPs present at each health facility on day of data collection. The propotion of HCPs by cadres was derived, so as to determine the number of HCPs required in each cadre for representation at each facility. Then at each facility, list of names were formulated from the attendance register in accordance with HCPs cadres. Thereafter from each list, names were given specific number. Numbers were written to small pieces of paper, folded, mixed and inserted into the boxes for each cadre. Thereafter one piece of paper was picked randomly repeatedly to reach the required numbers of participant needed from each cadre per facility. Selected HCPs were those working in MNCH/FPs and other section of HFs. This is because at each HF, staffs have rotations whereby they do rotate from one section to another for a given time, thus recruiting only those working at MNCH/FPs would have been bias and missing appropriate sample.The selected HCPs were then traced and asked to participate in study.

Data Collection

The Principal Investigator (PI) and two Research Assistants (RAS) collected data. The investigators explained the purpose of the study to the HCPs and later they were asked to freely participate in the study. Those who accepted they were given consent form and signed to be enrolled in the study.

The data were collected by a structured self-administered Swahili version questionnaire. Data from each health facility was collected on different days after obtaining the permission from the in-charge of the respective health facility. The selected participants were given questionnaire. The questionnaire was filled by each participant for half an hour to 45 minutes for those who had free time to do so. To others who had no time to fill the questionnaire on the same day, it was left and collected the following day. Therefore it took one to two days for each health facility to collect the data. The filled questionnaires were later checked for completeness by the principle investigator. The questionnaire that was used for data collection had mainly four parts so as to obtain relevant information of HCPs on socio-demographic characteristics, knowledge, attitude and practice on PAC and FP services.

Part one

This included HCPs Socio-demographic characteristics. There were 8 questions on this part which included age, level of education, occupation, marital status and working duration in number of years.

Part two

This part included questions to explore knowledge of HCPs on PAC and FP services to adolescent. A set of questions enquired information on knowledge of HCPs on PAC and FP services towards adolescents.

Part three

This included HCPs attitude towards PAC and FP services towards adolescents.

Part four

This included HCPs practices on provision PAC and FP services to adolescents.

Determinant of Knowledge, attitude and Practice

Assessment of knowledge on PACs and FPs

Knowledge was assessed using point scale. There were a total number of 13 questions, but only 5 questions inquired knowledge on PAC and FP services, the remained 7 questions inquired awareness and the source of relevant information of HCPs on PAC and FP services. The 5 questions used to assess knowledge on PAC and FP comprised a total number of 25 right responses, of which every response a score of 1 was awarded and 0 for wrong response. For the 25 responses, only 5 responses were for assessment of knowledge on PAC and the rest 20 responses used to assess knowledge on FP services. Therefore the total point to be scored in PAC was 5 and in FP was 20 and the minimum was 0 in both PAC and FP. The points were awarded as follows; considering Qn.14. The following is one of the components of post abortion care? A) Counselling. Yes (1), No (0) and I don't know (0).

On assessment, Modified Bloom's cut off points was where a score of 50 – 100% of correct responses was regarded as good knowledge and less than 50% of correct responses as poor knowledge in both PAC and FP.

Therefore the scores with their respective knowledge levels were as follows,

i) Knowledge on PAC: ≥ 3 Good knowledge and ≤ 2 Poor knowledge
ii) Knowledge on FP: ≥ 10 Good knowledge and ≤ 9 Poor knowledge

Attitude assessment

Attitude was assessed by 16 questions of which 8 questions were used to assess attitude on PACs and other 8 questions for FPs. The questions were put on Likert's scale. The questions on Likert's scale had positive and negative responses that ranged from strongly disagree, disagree, neutral, agree and strongly agree. The scoring system used with respect to respondent's responses was as follows: strongly disagree score 1, disagree 2, neutral 3, agree 4 and strongly agree 5.

The responses were summed up and a total score obtained for each respondent. Then mean score was calculated. Those who scored equal or above the mean were considered to have positive attitude and those scored below the mean were regarded to have negative attitude towards PAC and FP services.

Assessment for practice

The practice of participants on provision of PAC and FP services were assessed through 9 questions. Of those, 3 questions were used to assess practice on PACs and 6 questions to assess for FPs. The 3 questions (qn 40, 41 & 42) used to assess practice in provision of PACs had 8 right responses, thus with maximum score of 8 points. The score of ≥ 5 and above was considered to have good practice and ≤ 4 as poor practice. On another hand 6 questions were used to assess practice in provision of FPs. There were 10 right responses scoring to 10 points. Those who scored ≥ 5 were regarded as having good practice, and score of ≤ 4 as poor practice in provision of FPs to adolescents.

Data Entry and analysis

All the questionnaires were thoroughly checked to make sure that were filled properly. The data collected was coded, entered into Epi info computer software for cleaning then transferred to Statistical Package for Social Science (SPSS) version 18, computer software for analysis. Univariate analysis was conducted to determine knowledge, attitude and practice of HCPs on provision of FP and PAC services to adolescents. Then cross tabulation were conducted to determine the association between the proportions of knowledge and attitude on provision of FP and PAC services. Chi-square test was conducted to test for the association and *P* value of < 0.05 was considered to be statistically significant.

Pilot study

A pilot study was conducted at Temeke hospital, where 20 HCPs were interviewed to test the appropriateness of the research tools by the principal investigator and research assistants. Necessary corrections were incorporated accordingly before the beginning of data collection.The twenty HCPs interviewed during pilot testing were not included the study sample.

Training of Research assistants

Two RAs underwent a two day training course conducted by the PI, trained on the aim of the study, how to use the questionnaire, data collection techniques, how to treat the respondents and maintenance of confidentiality.They also participated in pilot study.

Ethical issues

Ethical clearance was obtained from MUHAS Institute Review Board. The permission to conduct the study in Temeke municipal was obtained from Temeke Council Medical Officer (CMO) and medical in charges of respective health facilities.

Thorough information about the study was given to every participant before they consent for the study. The participant had right to decline from participating without required explanations. Privacy and confidentiality was assured and maintained throughout.

RESULTS

Health care providers who were present in the selected health facilities on the day of data collection and met the inclusion criteria were 682. After random sampling, 361HCPs agreed to participate in the study. Total of 342 HCPs were included in the analysis (Table 1). Ten questionnaires were not returned and nine were missing important information therefore excluded from data analysis. The mean age of study participants was 39.29± 8.94 years (range 22- 60years), and most (40.6%) were in the 31-40 years group. Most participants were female (78.9%), married (78.7%), Christians (72.8%), and 46.5% had been in practice for less than 10 years. More than half of participants were nurses (52.6%); followed by Clinical officers (25.4), Medical officers (11.7%) and the least were Assistant medical officers (10.2%). Participants from hospitals, health centre and dispensaries were 72.8%, 6.4% and 20.8% respectively.

However, among the respondents seven were not aware of PACs (2%) whilst three were not aware about modern family planning services, so were not included in analysis of PACs and FPs respectively.

Table 1: **Socio-demographic characteristics and profiles of study participants (N=342)**

Variables	N	(%)
Age (yrs)		
≤ 30	67	19.6
31 – 40	139	40.6
41 – 50	100	29.2
≥ 51	36	10.5
Sex		
Female	270	78.9
Male	72	21.1
Marital status		
Single	73	21.3
Married	269	78.7
Cadres		
Clinical officer	87	25.4
Nurse	180	52.6
Assistant medical officer	35	10.2
Medical officer	40	11.7
Trained on PACs [a]	191	57.0
Trained on FPs [b]	241	71.1
Working duration (yrs)		
< 10	159	46.5
10 -19	92	26.9
20 -29	65	19.0
≥ 30	26	7.6
Religion		
Muslim	93	27.2
Christian	249	72.8
Kind of Health facility		
Hospital	249	72.8
Health centre	22	6.4
Dispensary	71	20.8

[a]Seven were not aware of PACs, [b]Three were no aware of FPs

Table 1 shows the majority of study participants were at age between 22 to 60 years, the mean age being 39.29 ± 8.94 years. Female were the majority (78.9%) and nurses comprised about half of participants.

Table 2: **Socio-demographic characteristics and profile of Participants and their knowledge on PACs towards adolescents (N =335)**

Variables	Knowledge		p- value
	Poor N (%)	Good N (%)	
Age (yrs)			
≤ 30	12(17.9)	55(82.1)	
31 -40	12 (8.8)	125(91.2)	0.284
41- 50	13(13.3)	85(86.7)	
≥ 51	5(15.2)	28(84.8)	
Sex			
Female	37(14.0)	227(86.0)	0.115
Male	5 (7.0)	66(93.0)	
Marital status			
Single	10(13.9)	62(86.1)	0.696
Married	32(12.2)	231(87.8)	
Cadres			
Clinical officer	5(5.9)	80(94.1)	
Nurse	32(18.1)	145(81.9)	0.013*
Assistant medical officer	3 (8.8)	31(91.2)	
Medical officer	2 (5.1)	37(94.9)	
Trained on PACs			
Yes	22(11.5)	169(88.5)	0.517
No	20(13.9)	124(86.1)	
Trained on FPs[a]			
Yes	22 (9.2)	216(90.8)	0.006*
No	19(20.2)	75(79.8)	
Working duration (yrs)			
< 10	24(15.3)	133(84.7)	
10 -19	7 (7.7)	84(92.3)	0.385
S20 – 29	8 (12.9)	54(87.1)	
≥ 30	3 (12.0)	22(88.0)	
Religion			
Muslim	10(11.0)	81(89.0)	0.601
Christian	32(13.1)	212(86.9)	
Kind of Health facility			
Hospital	26(10.7)	217(89.3)	
Health centre	5(22.7)	17(77.3)	0.176
Dispensary	11(15.7)	59(84.7)	

***** Statistically significant at $p < 0.05$. The overall good knowledge on PACs among participants was 87.5%. **[a]**Ten participants not included because of those 7 were not aware of PACs and 3 about FPs

Trained on FPs and being clinician had statistically significant relationship with knowledge of respondent's on post abortion care services ($p < 0.01$**)**. However, there was no statistical significant relationship between age, sex, working duration and other socio-demographic characteristics ($p > 0.05$).

Table 3: **Socio-demographic characteristics and profile of Participants and their knowledge on modern FPs towards adolescents (N = 339)**

Variables	Knowledge		*P*- value
	Poor N (%)	Good N (%)	
Age (yrs)			
≤ 30	15(22.4)	52(77.6)	
31- 40	59(43.4)	77(56.6)	0.005*
41- 50	46(46.0)	54(54.0)	
≥ 51	19(52.8)	17(47.2)	
Sex			
Female	122(45.7)	145(54.3)	0.001*
Male	17(23.6)	55(76.4)	
Marital status			
Single	19(26.4)	53(73.6)	0.004*
Married	120(44.9)	147(55.1)	
Cadres			
Clinical officer	35(41.2)	50(58.8)	
Nurse	85(47.5)	94(52.5)	0.005*
Assistant medical officer	12(34.3)	23(65.7)	
Medical officer	7(17.5)	33(82.5)	
Trained on PACs[a]			
Yes	67(35.1)	124(64.9)	0.031*
No	66(46.8)	75(53.2)	
Trained on FPs			
Yes	77(32.0)	164(68.0)	0.000*
No	62(63.3)	36(36.7)	
Working duration (yrs)			
< 10	55(35.0)	102(65.0)	
10 – 19	37(40.7)	54(59.3)	0.048
20 -29	36(55.4)	29(44.6)	
≥ 30	11(42.3)	15(57.7)	
Religion			
Muslim	42(46.2)	49(53.8)	0.243
Christian	97(39.1)	151(60.9)	
Kind of Health Facility			
Hospital	104(42.1)	143(57.9)	
Health centre	10(45.5)	12(54.5)	0.573
Dispensary	25(35.7)	45(64.3)	

*Statistically significant at $p < 0.05$. The overall good knowledge on FPs among participants was 59.0%. [a]Ten participants not included because of those 7 who were not aware of PACs and 3 about FPs

Lower age, clinicians, being single and trained on PACs and FPs was statistically significant associated with good knowledge on FP ($p < 0.05$**)**. But working duration, religion and kind of health facility working at did not show any statistical significant relationship and their knowledge on FPs to adolescents ($p \geq 0.05$).

Table 4: **Performance of participants in provision of PACs to Adolescents (N=167)**

Service provided	N	%
Use D & C	58	34.7
Use MVA	137	80.2
Screening for STIs and HIV/AIDS	132	79.0
Counselling on contraceptives use	146	80.4
Provide contraceptives	106	63.5
Treat other medical condition	148	88.6
Community involvement/participation	9	5.4
Time to initiate contraceptives after abortion(wks)		
Immediately	79	47.3
≥ 2	25	15.0
≥ 3	5	3.0
≥ 4	58	34.7

The overall performance was 85% good practice (142 out of 167 participants)

Most components of PACs were well performed, except for community involvement where only 5.4% of study participants involved community. Over half (63.5%) of study participants provided contraceptives following abortion care but less than half initiated contraceptives in the right time.

Table 5: **Practice of participants in provision of family planning services to adolescents (N=339)**

Variables	N	%
Knew HF have contraceptives	325	95.9
When contraceptives not available at HF		
Patient asked to go home	10	3.1
Patient referred to other HF	298	91.7
Nothing is done	17	5.2
Asked for contraceptives by adolescents	193	56.9
Provide Inject able contraceptive[a]	75	38.9
Provide IUCDs[a]	33	17.1
Provide Implant[a]	38	19.7
Provide Oral contraceptives[a]	125	64.8
Provide Diaphragm[a]	35	18.1
Not at all provided contraceptives to adolescent	67	34.7
Asked consent from guardian/parent	67	34.7
Disclosed information to guardian/parent	77	39.9

[a]The total was 193, because they were the only participants asked for and provided contraceptives out of 339

The overall performance in provision of FPs to adolescent by participants was good (90.5%)

Most study participants' referred their clients to other health facilities if contraceptives were not available to their facility. The least contraceptives provided to adolescents were IUCDs, Diaphragm and Implants.

Table 6: **Socio-demographic characteristics and profileof participants and their attitudes towards PACs (N = 335)**

Variables	Attitude		*P* –value
	Negative N (%)	Positive N (%)	
Age			
≤ 30	31(46.3)	36(53.7)	
31 – 40	61(44.5)	76(55.5)	0.318
41 – 50	35(35.7)	63(64.3)	
≥ 51	17(51.5)	16(48.5)	
Sex			
Female	121(45.8)	143(54.2)	0.042*
Male	23(32.4)	48(67.6)	
Marital status			
Single	29(40.3)	43(59.7)	0.600
Married	115(43.7)	148(56.3)	
Cadres			
Clinical officer	41(48.2)	44(51.8)	
Nurse	78(44.1)	99(55.9)	0.333
Assistant medical officer	11(32.4)	23(67.6)	
Medical officer	14(35.9)	25(64.1)	
Trained on PACs[a]			
Yes	82(42.9)	109(57.1)	0.982
No	62(43.1)	82(56.9)	
Trained on FPs[b]			
Yes	90(37.8)	148(62.2)	0.006*
No	51(54.3)	43(45.7)	
Working duration (Yrs)			
< 10	71(45.2)	86(54.8)	
10 -19	36(39.6)	55(60.4)	0.339
20 – 29	23(37.1)	39(62.9)	
≥ 30	14(56.0)	11(44.0)	
Religion			
Muslim	33(36.3)	58(63.7)	0.129
Christian	111(45.5)	133(54.5)	
Kind of Health facility			
Hospital	108(44.4)	135(55.6)	
Health centre	11(50.0)	11(50.0)	0.339
Dispensary	25(35.7)	45(64.3)	

*statistically significant at $p < 0.05$; [a]Seven participants not included because were not aware of PACs. [b]Ten participants not included because of those 7 were not aware of PACs and 3 about FPs

Of all respondents (335), 43% had negative attitude towards PACs.

Training on FPs and male gender among study participants had a statistically significant relationship with positive attitude toward PACs to adolescents ($p < 0.05$**).**However, participants cadre, age groups, working duration, being trained on PACs, marital status and religion had no any statistically significant association with their attitude towards PACs to adolescents($p > 0.05$).

Table 7: **Socio-demographic characteristics and profile of participants and their attitude towards Provision of FPs to adolescents (N=339)**

Variables	Attitude		*p*- value
	Negative N (%)	Positive N (%)	
Age			
≤ 30	26(38.8)	41(61.2)	
31 – 40	64(47.1)	72(52.9)	0.363
41 – 50	51(51.0)	49(49.0)	
≥ 51	14(38.9)	22(61.1)	
Sex			
Female	133(49.8)	134(50.2)	0.004*
Male	22(30.6)	50(69.4)	
Marital status			
Single	30(41.7)	42(58.3)	0.436
Married	125(46.8)	142(53.2)	
Cadres			
Clinical officer	43(50.6)	42(49.4)	
Nurse	85(47.5)	94(52.5)	0.162
Assistant medical officer	15(42.9)	20(57.1)	
Medical officer	12(30.0)	28(70.0)	
Trained on PACs[a]			
Yes	78(40.8)	113(59.2)	0.064
No	72(51.1)	69(48.9)	
Trained on FPs[b]			
Yes	94(39.0)	147(61.0)	0.000*
No	61(62.2)	37(37.8)	
Working duration (Yrs)			
< 10	69(43.9)	88(56.1)	
10 – 19	42(46.2)	49(53.8)	0.172
20 – 29	36(55.4)	29(44.6)	
≥ 30	8(30.8)	18(69.2)	
Religion			
Muslim	39(42.9)	52(57.1)	0.521
Christian	116(46.8)	132(53.2)	
Kind of Health facility			
Hospital	119(48.2)	128(51.8)	
Health centre	9(40.9)	13(59.1)	0.325
Dispensary	27(38.6)	43(61.4)	

*statistically significant at $p < 0.05$; [a]Ten participants not included because of those 7 were not aware of PACs and 3 about FPs; [b]Three participants not included because were not aware of FPs

Of all respondents (339), 45.7% had negative attitude towards provision of FPs to adolescents.

Male gender and being trained on FPs had a statistically significant relationship with attitude of study participants ($p < 0.05$) on their attitude on providing FPs to adolescents. The age group, working duration, marital status or religion of participants had no any statistically significant relationship ($p > 0.05$) with their attitude.

DISCUSSION

Knowledge on PAC & FP

Majority of HCPs were knowledgeable on post abortion care services for adolescent, whereas over three quarter had good knowledge. Participants who had been received in-service training on PACs services had comparable knowledge with those who were not yet trained on PACs. This could be due to lack of re-fresher training or either, the training they received was not specific for adolescents. However, similar awareness on adolescent PACs among health care providers was also observed in Nigeria [42]. This may reflect the similarity of health services in developing countries.

Majority of respondents (59%) had good knowledge on FPs for adolescents. But it was also reflected in our study, though not significantly that, there was a trend of being less knowledgeable on FPs for those who were in-service for long duration. Again this shows a gap in lack of training on both PACs and FPs among healthcare providers specifically oriented to adolescents. These findings, concurs with other previous studies done in Nigeria and Latin America [17, 20, 31]. It is expected that once someone is trained on a particular subject becomes knowledgeable, but conversely in this study it was found that those HCPs already trained on PACs had comparable knowledge as those not yet received such training. These findings suggest that training provided need to be reviewed. Lack of knowledge and minimal training among HCPs may have contributed to the reason why most of them are not conversant to provide various methods of FPs to adolescents.

Attitudes of HCPs on PACs and FPs

Fifty seven percent of participants had positive attitudes towards provision of PACs to adolescents in this study. Male participants and those who had received training on FPs had more positive attitude on provision of PACs to adolescents. Nearly half of study participants had negative attitude towards provision of PACs to adolescents. These findings concur with other studies done in Ethiopia, Kenya and Zambia [28, 33], where half of participants had positive attitude towards providing PACs to female adolescents who presented to health facilities with signs of induced abortion. In other study done in Nigeria HCPs not only had negative attitude towards PAC to adolescents, but also were reported to withhold services to adolescents found to have

had induced abortion [31] . Negative attitude among HCPs to PACs to adolescents was reported also in Malawi and Dominican Republic [32].Thus it's clear that there is prevailing negative attitude among HCPs towards provision of PACs to adolescents. Therefore this reveals a need to intervene so that new insight with regard to PACs to adolescents among HCPs is achieved. This can be through on job training for those in-services and incorporation of ARHS to curriculum of HCPs in certificate, undergraduate and postgraduate studies.

The HCPs remains as an obstacle for adolescents in accessing of FPs. This was revealed in our study where 45.7% of respondents had negative towards provision of FPs to adolescents. Similar results are reported in Uganda, Ethiopia and Nigeria [28, 31, 43, 44]. This can be accounted by cross-cutting cultural factors in African countries. In China above two third of family planning workers were found to have positive attitude towards provision of FPs to adolescents[45], though they demanded that, for adolescent to be given contraceptives should be 18 years or above and married. The high positive attitude in China it could be attributed to their family policy, again it was an observation from family planning workers who were likely to have positive attitude.

The inaccessibility to contraceptives among adolescents is attributed to contraceptives being out of stock, health providers' negative attitude, lack of confidentiality, limited knowledge and parental pragmatic practice while providing RHs to adolescents [32, 33, 46, 47]. The finding in this study concurs with others studies showing the gap in knowledge and negative attitude among HCPs in adolescent reproductive health services.

Practice on PACs and FPs

The provision of PACs by HCPs was generally good. Most components related to post abortion care were well performed, except one component that requires community participation. Poor community participation may be attributed by patients going to health facilities alone hiding to be recognized in their families and community. In this study most participants reported managing patients with incomplete abortion using MVA (68.2 -95.2%) and few still used D&C. For those

who still use D&C could be due to lack of facilities for MVA. This finding correlated with the study done in Latin America, where the use of MVA in management of incomplete abortion was over 90% [48]. Contrary from this study, in Nigeria use of MVA by HCPs was reported to be 18.2% to 46% and D&C to be 25% to 36.3% [49-51]. The discrepancy can be accounted by training among HCPs as well as expertise in the use of MVA or availability of instruments necessary for MVA procedure. In this study also we assessed practice in other components of PACs and there was generally good performance in counselling, screening and treatment for STIs. The provision of contraceptives following abortion services ranged between 45.5 to 83.3% among providers. Similar results were reported in Nigeria and Ethiopia [49, 52]. This shows that there is still reluctance of HCPs to provide contraceptives to adolescent. The limited knowledge on various methods of modern family planning or pre occupied negative attitude among health provider can be underlying cause. Therefore there is a need of training HCPs on modern family planning, so as to mitigate barriers which could be attributed to less provision of FPs to adolescents.

The provision of contraceptives to adolescents remains being hampered by HCPs who are not willing or ready to issue them to adolescents in needs [33]. In this study majority of participants were not providing most variety of contraceptives to adolescents. The provision of oral contraceptives to adolescents was relatively high compared to other forms of contraceptives for more than half of study participants prescribed them. Hesitancy of providing contraceptives is also reflected in others studies, for instance in South Carolina (USA) less than half (42%) of HCPs inserted IUCDs to adolescents [53]. In Nigeria about quarter of doctors were no recommending provision of contraceptives to adolescents and 11% never prescribed to adolescents contraceptives despite their needs [54]. The WHO recommends the use of all forms of contraceptives to adolescents and those of long terms effects like IUCDs and Implants to be considered first line [16]. However, most HCPs seems either are not aware of this or still pre occupied with misconception with regards to various forms of contraceptives and their use to adolescents.

LIMITATION

In this study a self administered questionnaire was used and this may lack capacity to detect real knowledge, practice and attitude of respondents. This could be due to recall biases and under reporting, and answers may not reflect the real practice of respondents. To minimize this effect, HCPs had privacy during administration of the questionnaires and anonymity was maintained for they were not required to write their names.

CONCLUSION

There is limited knowledge on modern family planning and negative attitude on provision of PACs and FPs to adolescents among health providers. This may have negative impact to the provision of both PACs and FPs to adolescent and hence remaining at risks of unwanted pregnancies and their related complications. Thus health providers should be provided with training on both FPs and PACs in particular to adolescents in efforts to improve those services to adolescents as special group.

RECOMMENDATIONS

There is a need to train HCPs on PACs and FPs which both goes in hand so as to improve RHs to adolescents. The training should include different cadres as they all play part in dealing with adolescents' health at large**.** Furthermore, there is a need to review the training provided to HCPs as quite large number of them already trained had poor knowledge on FPs. Targeted efforts are needed towards alleviating negative attitude towards PACs and FPs to adolescents among HCPs and re-enforcing positive attitude. These efforts should involve not only HCPs but also adolescents, community, parents and policy makers.

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APPENDICES

APPENDIX I: Consent form

KNOWLEDGE, ATTITUDE AND PRACTICE ON POST ABORTION CARE AND FAMILY PLANNING SERVICES TOWARDS ADOLESCENTS AMONG HEALTH CARE PROVIDERS IN TEMEKE-DAR ES SALAAM

Introduction

I am Dr. Maziku Micah Donald, a researcher from Muhimbili University of Health and allied sciences (MUHAS). I am conducting a study on health care providers in Temeke Municipal Health facilities, in Dar es Salaam. The aim of this research is to explore knowledge, attitude and practice of healthcare providers in provision of modern family planning and post abortion care services to adolescents.

Participation in the study

You are kindly requested to participate in this study. If you accept to participate in this study your particulars/information will be taken and used for the purpose of this research and this will certainly not bother you or cause any discomfort to you.

Confidentiality

You are strongly assured of the confidentiality of the information obtained that will only be used for the purpose of this research and anonymity will highly be observed when collecting data and compiling report. To assure you, even your name will not be required to appear in the questionnaire.

Risk to participant

No anticipated risk or harm that may result from participating in this study.

Right of participation in the study

Your participation is absolutely voluntary and there is no penalty for refusing to participate. You are free to ask any question and you may stop to participate in this study any time.

Contact Person

The principal investigator, Dr Maziku Micah Donald (0755-043431) is a key contact person with regard to any queries about this study.

If you have any questions/concerns about your rights as a participant you may contact

Professor Mainen Mushi, the chairman of the university senate research and publications, MUHAS P.O.BOX 65001, Dar es salaam. Telephone; 2150302-6

Signing of the consent

If you agree to participate in this study please sign in this consent form.

I (initials)…… have read and understood the contents of this form and I have been given satisfactory explanation with all my questions answered. I therefore consent to participate in this study.

Signature of interviewee .....…….. Date.....

Signature of interviewer .....Date ……..

FOMU YA RIDHAA KUSHIRIKI KATIKA UTAFITI

Ufahamu, mtazamo na utendaji wa watoa huduma za afya kuhusu huduma mara baada ya mimba kuharibika pamoja na utoaji wa huduma ya uzazi wa mpango kwa vijana wenye umri chini ya miaka ishirini, katika Manispaa ya Temeke – Dar es salaam

Utangulizi

Mimi naitwa Dk. Maziku Micah Donald, mtafiti kutoka Chuo Kikuu cha Sayansi ya Tiba Muhimbili. Ninafanya utafiti kuhusiana na watumishi watoa huduma za afya Manispaa ya Temeke, katika vtuo vya kutolea huduma, Dar es salaam. Lengo la utafiti huu ni kubaini uelewa, mtazamo na utendaji kazi wa watumishi wa afya katka utoaji wa huduma za uzazi wa mpango na matibabu mara baada ya mimba kuharibika kwa vijana chini ya miaka 20.

Kushiriki katika utafiti huu

Tafadhali unaombwa kushiriki katika utafiti huu, na mara tu utakapo ridhia ,unahakikishiwa kuwa habari zako na maelezo utakayotoa yatatumika kwa makusudio na malengo ya utafiti huu tu na kuwa hii haitakuletea usumbufu wowote.

Usiri wa taarifa za mshiriki

Unahakikishiwa tena kuwa taarifa zozote zitakazopatikana kutoka kwako wakati wa utafiti huu zitapewa usiri mkubwa sana na hazitatumika kwa malengo mengine yeyote tofauti na utafiti husika. Kuhakikisha hilo dodoso litakalo husika halitakuwa na jina lako wakati wote wa utafiti na hata baada ya utafiti.

Athari za utafiti huu kwa mshiriki

Hakuna athari au madhara yeyote yatakayokupata kutokana na kushiriki katika utafiti huu.

Haki ya kushiriki au kutoshiriki katika utafiti huu

Ushiriki wako katika utafiti huu ni wa hiari kabisa.unayohaki ya kushiriki au kutoshiriki bila kulazimika.Pia unayo haki ya kukataa kuendelea kushiriki/kuacha

kujibu maswali wakati wowote utakapojisikia kufanya hivyo na hakutakuwa na hatua yeyote itakayochukuliwa dhidi yako au kulaumiwa kwa kufanya hivyo.

Mawasiliano

Wasiliana na mtafiti mkuu, Dk. Maziku Micah Donald kwa simu namba 0755-043431 wakati wowote utakapokuwa na maswali au jambo lolote lenye kuhitaji ufafanuzi kuhusu utafiti huu.

Hata hivyo endapo utakuwa na maswali kuhusu haki yako kama mshiriki unaweza pia kuwasiliana na **Prof. Mainen Mushi,** Mwenyekiti wa Baraza la Utafiti na Uchapishaji wa Chuo Kikuu cha Sayansi ya Tiba Muhimbili. S.L.P. 65001, Dar es Salaam.Simu namba 2150302-6

Kukubali kushiriki

Ukikubali kushiriki tafadhali thibitisha kwa kujaza na kusaini sehemu ya fomu hii hapa chini.

Mimi …….
Nimesoma/nimesomewa na kuelewa yaliyomo kwenye form hii na maswali yangu yote yamejibiwa vizuri.Hivyo ninakubali mwenyewe kwa hiari yangu bila kushurutishwa au kushawishiwa kushiriki katika utafiti huu.

Sahihi ya mhojiwa……..... Tarehe…….....……..

Sahihi ya mhoji. ……Tarehe ……

APPENDIX II: English version questionnaire

Part one: Socio-demographic characteristics.

1. Age (in years).....
2. Name of health facility.....
3. Sex
    a. male
    b. female
4. Marital status:
    a. single
    b. married
    c. cohabitation
    d. divorced
    e. Separated
    f. Widowed
5. Religion.
    a. Christian
    b. Muslim
    c. Others (specify).....
6. Occupation:
    a. Clinical officer
    b. Nurse assistant
    c. Nurse Midwife/officer
    d. Assistant medical officer
    e. Medical officer
7. Working duration in medical field (in years)
    a. Less than 10 years
    b. Ten to 19 years
    c. Twenty to 29 years
    d. Thirty years and above

8. What kind of health facility are you working at?
    a. Hospital
    b. Health Centre

c. Dispensary
d. Others (mention).....

Part two: Knowledge

Adolescent in this questionnaire refers to any one with the age of 10 to19 years. Therefore as you respond to various questions referring to adolescent consider for those of age mentioned above.

9. Have you ever heard on post abortion care services in adolescents?
    a. Yes
    b. No (go to qn .....14)
10. Where did you get the information?
    a. School
    b. Colleagues/other workers
    c. Others (specify).....
11. Have you ever received any in-service training on post abortion care services in 2 years ago?
    a. Yes
    b. No (go to qn.....14)
12. Where did you receive that training?
    a. Workshop/seminars
    b. On job training
    c. Others (specify).....
13. The following are one of the components of post abortion care? (Respond to all options by selecting the right answer)
    a. Counselling ...Yes /No/I don't know
    b. Treatment of emergencies.....Yes /No/ I don't know
    c. Contraceptive and family planning services.....Yes / No/ I don't know
    d. Reproductive and other health services**.....**Yes / No/ I don't know
    e. Community and health care provider partnership.....Yes / No/ I don't know

14. Have you ever heard on modern family planning methods?
    a. YES
    b. NO (go to qn.....29.)
15. Have you ever received any in-service training on modern family planning methods in 2 years ago?
    a. YES
    b. NO
16. The following modern family planning methods can be safely used with adolescent? (Respond to all options by selecting the right answer)
    a. Combined oral contraceptives.....YES/NO/ I don't know
    b. Intrauterine Contraceptive Device.....YES/NO/ I don't know
    c. Emergency Contraceptives(Morning after pills).....YES/NO/ I don't know
    d. Condoms.....YES/NO/ I don't know
    e. Implant(Norplant).....YES/NO/ I don't know
    f. Tubal ligation.....YES/NO/ I don't know
    g. Inject able (Depo provera).....YES/NO/ I don't know
    h. Coitus interruptus.....YES / NO/ I don't know
17. The following FP methods can be used as Emergency Contraceptives for adolescents? **(** Respond to all options by selecting the right answer)
    a. IUCD.....YES/NO/ I don't know
    b. COCs.....YES/NO/ I don't know
    c. Progesterone only containing pills (Postinar).....YES/NO/ I don't know
    d. Inject able Depo provera.....YES / NO/ I don't know

e. Implant .....YES/NO/ I don’t know

18. The Emergency Contraceptives (morning after pills) works by which of the following mechanism? (Respond to all options by selecting the right answer)
    a. Inhibits or delay ovulation.....YES/NO/ I don’t know
    b. Prevents implantation.....YES/NO/ I don’t know
    c. Abortificient .....YES/NO/ I don’t know
19. Emergency contraceptives are effective if given or administered in which time after someone being exposed to unprotected sexual intercourse? (Respond to all options by selecting the right answer)
    a. In less than 24 hours..... YES/ NO/ I don’t know
    b. In less than 48 hours..... YES/ NO/ I don’t know
    c. In less than 72 hours..... YES/ NO/ I don’t know
    d. In less than 148 hours..... YES/ NO/ I don’t know
20. The following may be consequences of poor utilization of Reproductive health services in particular PAC and FP services to adolescents. (Respond to all options by selecting the right answer)
    a. Infertility.....YES/NO/ I don’t know
    b. STIs and HIV/AIDS.....YES/NO/ I don’t know
    c. Early pregnancy.....YES/NO/ I don’t know
    d. Maternal Death.....YES/NO/ I don’t know

Part three: Attitude

A) Attitude on family planning services (Tick only one response):

21. Would you like modern family planning services for adolescents to be expanded?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
22. Adolescents have harder time to get family planning services than clients aged 20 years or above?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
23. Provision of modern FP services to adolescents is important for female adolescents because they are the victims of pregnancy related problems?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
24. Education on FP services is better to be started at primary school level?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
25. Family planning services expansion towards adolescent is an effective way to prevent unwanted pregnancy and its adverse consequences?
    a. Strongly I disagree
    b. Disagree

c. Neutral
d. Agree
e. Strongly agree

26. Adolescents have right to use FP services as other clients aged 20 years or above?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
27. How would you feel towards your daughter less than 20 years using contraceptives?
    a. Strongly I will be disappointed
    b. Disappointed
    c. Neutral
    d. Good
    e. Very good
28. Are you ready to provide FP services for every adolescent in need?
    a. Strongly I am not ready
    b. Not ready
    c. Neutral
    d. I am ready
    e. Strongly ready

B) Attitude on post abortion care (Tick only one response)

29. Would you like post abortion services for adolescents to be expanded?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
30. Health care providers are important in reducing adolescent pregnancies and related complications?
    a. Strongly I disagree

b. Disagree
c. Neutral
d. Agree
e. Strongly agree

31. Information on post abortion care services should be made available and accessible to all adolescent.
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
32. Discussion between HCPs and adolescents on PAC is mandatory to reduce complications associated with illegal abortion among adolescents?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
33. Adolescents should be provided with post abortion care services wherever they are in needs?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
34. Adolescents have harder time to get post abortion care services than clients aged 20 years or above?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

35. Information on PAC and FP services should be available not only at health facilities but also in schools and youth centres where a large number of adolescents can be addressed?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree
36. Adolescent's unsafe abortion should be blamed as guilt or the responsibility of those who conduct such abortion?
    a. Strongly I disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

Part four: Practice

A) This part should be filled with one who ever heard or provided post abortion care to adolescent

37. Have you ever been consulted by an adolescent suffering from induced abortion related complication?
    a. Yes
    b. No (Move to qn no. .....47)
38. What was the complication she was suffering from?(you may select more than one response)
    a. Incomplete abortion
    b. Haemorrhage
    c. Septic abortion
    d. Intra abdominal injury
    e. Others (mention).....
39. Were you able to manage that complication?
    a. Yes

b. No (what did you do?)

Explain.....

.

40. For those with incomplete abortion of which the gestation age is less than 14 weeks, what technique do you use to treat them?
    a. Dilatation and curettage
    b. Manual vacuum aspiration
    c. Others (mention).....

41. Following the above treatment (refers to qn. No.40 above) what other services do you provide? (Respond to all options by selecting the right answer)
    a. Screening for STIs and HIV/AIDS .....Yes / No
    b. Counselling on contraceptives use .....Yes/ No
    c. Provision of contraceptives .....Yes / No
    d. Treat other medical conditions the patient may be suffering.....Yes /NO
    e. Involve family members or community leader on how to help women suffering from abortion..... Yes / No
42. When do you usually initiate contraceptives following an abortion treatment?
    a. After one month
    b. After three weeks
    c. After two weeks
    d. Immediately after abortion treatment
43. Have you ever been asked by an adolescent for termination of pregnancy which was unwanted?
    a. Yes
    b. No (Move to qn .....47)
44. Have you ever tried to terminate such pregnancy following such request?
    a. Yes (Move to qn.....47)
    b. No
45. What reason prohibited you from performing an abortion to such adolescent? (select one)
    a. It’s against the law

b. It's against my religion
c. It's against medical ethics
d. I don't know how to terminate the pregnancy
e. Others reason (Specify).....

46. What did you do to help that adolescent to resolve her problem?
    a. I did advise her to continue with pregnancy
    b. I did advise her to seek help from other HCPs
    c. Others (Mention).....

B) This part should be answered by one who has ever heard on modern family planning services

47. Are you aware that at your health facility there are modern family planning contraceptives?
    a. Yes
    b. No / I don't know (Move to qn.no. .....49)
48. In case when contraceptives are not available at your health facility what do you do with your clients, in particular adolescents?
    a. The client is asked to go home
    b. The client is referred to another health facility
    c. Nothing is done thereafter
49. Have you ever been asked for contraceptives by an adolescent in your practice?
    a. YES
    b. NO (Move to qn .....54)
50. Which of the following family planning commodities have you ever prescribed or provided to an adolescent? (Respond to all options by selecting the right answer)
    a. Inject able.....Yes / NO
    b. IUCDs .....Yes / NO
    c. Implant .....Yes / NO
    d. COC .....Yes / NO
    e. Diaphragm .....Yes / NO
    f. Others (specify).....

51. How often have you provided or issued modern family planning contraceptives to an adolescent in need?
    a. Not at all issued (Move to qn .....54)
    b. Often issued when asked
52. How often have you asked for consent from guardian/parents before you issue contraceptives to an adolescent?
    a. Not at all asked for consent
    b. I often ask for consent
53. How often have you been disclosed the information of the adolescents you attended to their guardians or parents?
    a. Not at all disclosed
    b. Rarely I do disclose
    c. I often disclose when asked
54. At your health facility do you have any guideline for management of sexual and reproductive services to adolescents?
    a. Yes
    b. No

Swahili version questionnaire

Sehemu ya kwanza:

1. Umri (Miaka).....
2. Jina la kituo chako cha kazi.....
3. Jinsia
    a. Mme
    b. Mke
4. Mahusiano
    a. Sijaoa/ sijaolewa
    b. Nimeoa/Nimeolewa
    c. Tunaishi pamoja
    d. Nimetalikiwa
    e. Tumeachana
    f. Mjane
5. Dini
    a. Mkristo
    b. Muislam
    c. Nyingineyo (Itaje).....
6. Kazi yako
    a. Tabibu
    b. Muuduzi msaidizi
    c. Muuguzi Mkunga
    d. Daktari msaidizi
    e. Daktari
7. Muda uliotumika kazini katika idara ya afya kwa taaluma yako (wastani wa miaka mingapi?)
    a. Chini ya miaka 10
    b. Miaka 10 hadi 19
    c. Miaka 20 hadi 29
    d. Miaka thelathini na zaidi

8. Je unafanya kazi katika kituo chenye hadhi ipi?
    a. Hospitali
    b. Kituo cha Afya
    c. Zahanati
    d. Kinginecho (Taja).....

Sehemu ya pili

Katika dodoso hili, kijana uchukuliwa kama mtu yeyote mwenye umri kuanzia miaka 10 hadi miaka 19. Hivyo unapokuwa ukijibu swali lolote kuhusiana na vijana zingatia kuwa ni kwa wale wenye umri uliotajwa hapo juu.

9. Je umewahi kusikia kuhusiana na huduma mara baada ya mimba kuharibika kwa vijana?
    a. Ndiyo
    b. Hapana (Nenda swali no... 14)
10. Je ulipata taarifa hiyo wapi?
    a. Nikiwa katika masomo chuoni
    b. Kutoka kwa watumishi wenzangu
    c. Kwingineko
       (taja).....
11. Je umewahi kupata mafunzo yeyote kuhusiana na huduma mara baada ya mimba kuharibika ukiwa kazini katika kipindi cha miaka miwili iliyopita?
    a. Ndiyo
    b. Hapana (nenda swali no... 14)
12. Je ulipata wapi mafunzo hayo?
    a. Semina
    b. Mafunzo kazini
    c. Kwingineko (taja).....
13. Huduma mara baada ya mimba kuharibika ujumuhisha mambo muhimu yafuatayo?
    a. Ushauri .....Ndiyo/ Hapana/ Sijui
    b. Kutoa matibabu ya dharura .....Ndiyo/ Hapana/ Sijui

c. Uzazi wa mpango na dawa za uzazi wa mpango.....Ndiyo/ Hapana/ Sijui
d. Huduma ya uzazi na maradhi mengineyo.....Ndiyo/ Hapana/ Sijui
e. Ushirikiano kati ya jamii na watoa huduma za afya.....Ndiyo/ Hapana/ Sijui

14. Je umewahi kupata taarifa kuhusiana na dawa za uzazi wa mpango?
    a. Ndiyo
    b. No **(**Nenda swali no.....29)
15. Je umewahi kupata mafunzo ya aina yeyote kuhusiana na dawa za uzazi wa mpango ukiwa kazini katika kipindi cha miaka miwili iliyopita?
    a. Ndiyo
    b. Hapana
16. Njia zifuatazo za uzazi wa mpango ni salama na uweza kutumiwa na vijana chini ya umri wa miaka 20?
    a. Vidonge vya majira(COCs).....Ndiyo/ Hapana/ Sijui
    b. Kitanzi.....Ndiyo/ Hapana/ Sijui
    c. Vidonge vya majira vya dharura.....Ndiyo/ Hapana/ Sijui
    d. Kondomu …… Ndiyo/ Hapana/ Sijui
    e. Vipandikizi.....Ndiyo/ Hapana/ Sijui
    f. Kufunga uzazi.....Ndiyo/ Hapana/ Sijui
    g. Sindano za majira .....Ndiyo/ Hapana/ Sijui
    h. Kutokojolea manii ukeni wakati wa kujamiiana.....Ndiyo/ Hapana/ Sijui
17. Njia zifuatazo uweza kutumika kwa dharura kuzuia ujauzito mara baada ya kujamiiana kwa vijana wenye umri chini ya miaka 20? **(**Jibu vipengele vyote kwa kuchagua jibu sahihi)
    a. Kitanzi.....Ndiyo/ Hapana/ Sijui
    b. Vidonge vya majira.....Ndiyo/ Hapana/ Sijui
    c. Vidonge venye kichocheo cha progesterone(Postinar).....Ndiyo/ Hapana/ Sijui

d. Sindano za majira(Depoprovera).....Ndiyo/ Hapana/ Sijui

e. Vipandikizi.....Ndiyo/ Hapana/ Sijui

18. Vidonge vya majira vya dharura (morning after pills) huzuia mimba kwa njia ipi?
    a. Uzuia kutoka au uchelewesha kutoka kw yai la kike.....Ndiyo/ Hapana/ Sijui
    b. Huzuia kijipandikiza kwa yai tayari lililorutubishwa.....Ndiyo/ Hapana/ Sijui
    c. Uharibu mimba isiendelee kukua.....Ndiyo/ Hapana/ Sijui

19. Je njia za kuzuia mimba za dharura(Emergency contraceptives) uweza kufanya kazi vema ikiwa zitatolewa muda gani mara baada ya tendo la kujamiiana?
    a. Chini ya masaa 24..... Ndiyo/ Hapana/ Sijui
    b. Chini ya masaa 48..... Ndiyo/ Hapana/ Sijui
    c. Chini ya masaa 72..... Ndiyo/ Hapana/ Sijui
    d. Chini ya masaa 148..... Ndiyo/ Hapana/ Sijui
20. Kukosekana kwa huduma sitahiki ya afya ya uzazi kama vile huduma duni mara baada ya mimba kuharibika au njia sahihi za uzazi wa mpango, uweza kusababisha madhar yafuatayo? **(**Jibu vipengele vyote kwa kuchagua jibu sahihi)
    a. Ugumba .....Ndiyo/ Hapana/ Sijui
    b. Magonjwa ya zinaa ikiwemo UKIMWI.....Ndiyo/ Hapana/ Sijui
    c. Mimba za utotoni.....Ndiyo/ Hapana/ Sijui
    d. Vifo vya kina mama.....Ndiyo/Hapana/ Sijui.

Sehemu ya Tatu

A) Mtazamo kuhusiana na huduma za uzazi wa mpango (Chagua jibu moja tu)

21. Je ungependa huduma za uzazi wa mpango kwa vijana chini ya miaka 19 kuenezwa sehemu nyingi zaidi?
    a. Sihafiki kabisa
    b. Sihafiki

c. Kuwepo na kutokuwepo yote sawa
d. Nahafiki
e. Nahafiki kabisa

22. Vijana chini ya miaka 20 upata wakati mgumu kupata huduma za uzazi wa mpango ukilinganisha na wale wenye umri wa miaka 20 au zaidi?
    a. Sihafiki kabisa
    b. Sihafiki
    c. Yote sawa
    d. Nahafiki
    e. Nahafiki kabisa
23. Utoaji wa huduma za uzazi wa mpango kwa vijana wa kike chini ya miaka 20 ni mhimu kwani ndio waathirika wakubwa wa madhara yatokanayo na mimba?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubaliana
    e. Nakubaliana kabisa
24. Elimu kuhusiana na uzazi wa mpango ni vema ikaanza kufundishwa katika shule za msingi?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubali
    e. Nakubaliana kabisa
25. Usambazaji wa huduma za uzazi wa mpango ili kuwafikia vijana chini ya miaka 20 ni njia thabiti ya kuzuia mimba zisizotarajiwa na madhara yake?
    a. Sikubalini kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubaliana

e. Nakubaliana kabisa

26. Vijana chini ya miaka 20 wana haki ya kutumia huduma za uzazi wa mpango kama wenye umri mkubwa pia?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubali
    e. Nakubaliana kabisa
27. Je wewe utajisikiaje ikiwa binti yako mwenye umri chini ya miaka 20 atakuwa anatumia vidonge vya majira (uzazi wa mpaango)?
    a. Nitajisikia vibaya sana
    b. Sitafurahi
    c. Siwezi kufurahi au kusononeka
    d. Nitafurahi
    e. Natajisikia vizuri sana
28. Je uko tayari kutoa huduma ya uzazi wa mpango kwa kila kijana mwenye umri wa miaka chini ya 20 anayehitaji huduma hiyo?
    a. Siko tayari kabisa
    b. Siko tayari
    c. Naweza kukubali au kukataa
    d. Niko tayari
    e. Niko tayari kabisa

B) Mtazamo kuhusiana na huduma mara baada ya mimba kuharibika (Chagua jibu moja tu)

29. Je ungependa huduma mara baada ya mimba kuharibika kupatikana sehemu nyingi zaidi kwa vijana?
    a. Siafiki kabisa
    b. Siafiki
    c. Kuwepo na kutokuwepo yote sawa
    d. Naafiki
    e. Naafiki kabisa

30. Watoa huduma za afya ni mhimu katika kupunguza mimba za utotoni kwa vijana chini ya miaka 20 na madhara yake?
    a. Siafiki kabisa
    b. Siafiki
    c. Siwezi kuafiki au kutoafiki
    d. Naafiki
    e. Naafiki kabisa
31. Taarifa kuhusiana na upatikanaji wa huduma mara baada ya mimba kuharibika ni vema ikapatikana na kufahamika kwa vijana wote chini ya miaka 20?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubaliana
    e. Nakubaliana kabisa
32. Majadiliano kati ya watoa huduma za afya na vijana wenye umri chini ya miaka 20, ni mhimu ili kupunguza madhara yatokanayo na utoaji haramu wa mimba miongoni mwao?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubaliana
    e. Nakubaliana kabisa
33. Huduma mara baada ya mimba kuharibika ni mhimu kutolewa kwa vijana chini ya miaka 20 kila inapohitajika?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubali
    e. Nakubali kabisa
34. Vijana chini ya miaka 20 upata wakati mgumu kupata huduma zinazohusiana na uzazi mara baada ya mimba kuharibika?
    a. Sikubaliani kabisa

b. Sikubaliani
c. Siwezi kukubali au kukataa
d. Nakubali
e. Nakubaliana kabisa

35. Taarifa za upatikanaji wa huduma mara baada ya mimba kuharibika na uzazi wa mpango ni mhimu zikapatikana mashuleni na sehemu zenye mikusanyiko ya vijana chini ya miaka 20 na sio katika vituo vya kutolea huduma (afya) pekee?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubali
    e. Nakubali kabisa
36. Utoaji haramu wa mimba miongoni mwa vijana unatakiwa kulaaniwa ikiwa ni pamoja na wahusika kama chanzo cha tatizo?
    a. Sikubaliani kabisa
    b. Sikubaliani
    c. Siwezi kukubali au kukataa
    d. Nakubali
    e. Nakubaliana kabisa

Sehemu ya nne:

A) Sehemu hii ijibiwe na yule ambaye aliwahi kusikia au kutoa huduma mara baada ya mimba kuharibika kwa kijana/vijana chini ya miaka 20.

37. Je umewahi kumhudumia kijana chini ya miaka 20 ambaye ametoa mimba katika mazingira yasiyo salama?
    a. Ndiyo
    b. Hapana (Nenda swali no.....47)
38. Je alikuwa akikabiliwa na tatizo lipi kati ya haya?(unaweza kuchagua zaidi ya jibu moja)
    a. Kutoka kwa mimba kusiko kamilika(incomplete abortion)
    b. Kuvuja damu nyingi

c. Maambukizi ya vijimelea vya magonjwa(septic abortion)
d. Kutobolewa kwa mfuko wa uzazi na au viounngo vya ndani ya tumbo
e. Mara mengineyo **(**taja).....

39. Je uliweza kutoa huduma stahiki iliyohitajika?
    a. Ndiyo
    b. Hapana (Je ulifanya nini?)
       Elezea.....
       .....
40. Kwa wale wenye mimba zilizoharika (umri wa mimba chini ya wiki 14) na kubakia masalia ya ujauzito katika mfuko wa uzazi (Incomplete abortion), Je unatumia njia ipi kutoa huduma?
    a. Kusafisha kwa vyuma(forceps)
    b. Kufyonza mabaki kwa MVA
    c. Nyingineyo (itaje).....
41. Je mara baada ya matibabu hayo (swali no. 40 hapo juu), huduma gani nyingine unazitoa?
    a. Ufanya vipimo kubaini uambukizi wa magonjwa ya zinaa ikiwemo UKIMWI.....Ndiyo / Hapana
    b. Ushauri kuhusu kutumia dawa za majira .....Ndiyo / Hapana
    c. Utoa dawa za majira..... Ndiyo / Hapana
    d. Utibu magonjwa mengine anayoweza kuwanayo mgonjwa.....Ndiyo/ Hapana
    e. Uhusisha baadhi ya wanafamilia au viongozi wa eneo husika jinsi ya kumsaidia mwenye tatizo la mimba iliyoharibika…….Ndiyo/ Hapana
42. Je mara baada ya matibabu ya mimba iliyoharibika huwa unatoa dawa za majira mara baada ya muda upi?
    a. Mwezi mmoja
    b. Wiki tatu
    c. Wiki mbili
    d. Mara baada ya huduma/matibabu

43. Je umewahi kuombwa na kijana chini ya miaka 20 umsaidie kutoa ujauzito ambao hakuutarajia?
    a. Ndiyo
    b. Hapana (Nenda swali la.....47)
44. Je umewahi kujaribu kutoa mimba mara baada ya kuombwa na kijana mwenye ujauzito akiwa na nia ya kutoa mimba?
    a. Ndiyo (nenda swali la..... 47)
    b. Hapana
45. Je sababu ipi ilikuzuia kutoa mimba mara baada ya kuombwa kufanya hivyo? (chagua jibu moja)
    a. Ni kinyume cha sheria
    b. Ni kinyume cha dini yangu
    c. Ni kinyume cha maadili ya uuguzi/ udakitari
    d. Sijui jinsi ya kutoa mimba
    e. Sababu nyingineyo (Taja).....
46. Je ulifanya jitihada gani kwa kijana huyo kutatua tatizo lake?
    a. Nili mshauri kuendelea na ujauzito huo
    b. Nili mshauri atafute msaada kutoka kwa watu wengine
    c. Nyingineyo **(**Itaje).....

B) Sehemu hii ijibiwe na yule ambaye aliwahi kusikia kuhusiana na dawa za uzazi wa mpango

47. Je unafahamu kituo chako unachofanyia kazi kina dawa za uzazi wa mpango?
    a. Ndiyo
    b. Sifahamu/Sielewi (Nenda swali la..... 49)

48. Je kituo chako kinapokuwa hakina dawa za majira unawahudumia vipi wale wenye hitaji la huduma hiyo hasa wale wenye umri chini ya miaka 20?
    a. Uwarudisha nyumbani
    b. Uwaelekeza kwenda vituo vingine kupata huduma
    c. Hakuna ninachokifanya
49. Je umewahi kuombwa dawa za majira na kijana chini ya miaka 20?

a. Ndiyo
b. Hapana (Nenda swali la 54**)**

50. Je ni njia ipi ya uzazi wa mpango kati ya zifuatazo umewahi kuitoa ili kutumiwa na kijana chini ya miaka 20? **(**Jibu vipengele vyote kwa kuchagua jibu sahihi)
    a. Sindano za majira..... Ndiyo / Hapana
    b. Kitanzi..... Ndiyo / Hapana
    c. Kipandikizi..... Ndiyo / Hapana
    d. Vidonge vya majira .....Ndiyo / Hapana
    e. Diaphram .....Ndiyo / Hapana
    f. Nyingineyo (Itaje).....
51. Je ni kwa kiwango gani umewahi kutoa dawa za uzazi wa mpango/majira kwa vijana chini ya miaka 20?
    a. Sijawahi kutoa kabisa (Nenda swali la ...54)
    b. Utoa mara kwa mara kwa ambaye uhitaji
52. Je umewahi kuomba kibali kutoka kwa mlezi au mzazi kabla ya kutoa dawa za uzazi wa mpango /majira kwa kijana chini ya miaka 20?
    a. Sijawai kuomba ruhusa ya walezi/wazazi
    b. Mara nyingi nahitaji ruhusa ya walezi/wazazi
53. Je ni kwa kiasi gani umewahi kutoa taarifa kwa mlezi au mzazi wa kijana uliye mhudumia?
    a. Sijawahi kutoa taarifa kwao.
    b. Utoa taarifa kwao pale wanapohitaji.
54. Je katika kituo chako kuna kitabu cha muongozo jinsi ya kuwahudumia vijana chini ya miaka 20 kuhusiana na masuala ya uzazi?
    a. Ndiyo
    b. Hapana

APPENDIX III

The list of government health facilties in Temeke municipal

NO.	NAME OF HEALTH FACILITY	WARD	FACILITY TYPE
1	Buyuni	Pembamnazi	Dispensary
2	Buza	Buza	Dispensary
3	Chamazi	Chamazi	Dispensary
4	Chekeni mwasonga	Kisarawe II	Dispensary
5	Gezaulole	Somangila	Dispensary
6	Gomvu	Somangila	Dispensary
7	Kimbiji	Kimbiji	Dispensary
8	Kibada	Kibada	Dispensary
9	Kigamboni	Kigamboni	Health centre
10	Kilakala	kilakala	Dispensary
11	Kisarawe II	Kisarawe II	Dispensary
12	Kizuiani	Mbagala	Dispensary
13	Kibugumo	Mjimwema	Dispensary
14	Kichemchem	Mbagala kuu	Dispensary
15	Kingugi	Kiburugwa	Dispensary
16	Keko mwanga	Keko	Dispensary
17	Magala Rangi tatu	Mbagala	Hospital
18	Mtoni	Mtoni	Dispensary
19	Mikwambe	Toangoma	Dispensary
20	Mbutu	Somangila	Dispensary
21	Mbande	Chamazi	Dispensary
22	Mjimwema	Mjimwema	Dispensary
23	Mbagala round table	Mbagala	Dispensary
24	Makangarawe	Makangarawe	Dispensary
25	Maji matitu	Mianzini	Dispensary
26	Mwongozo	Somangila	Dispensary
27	Mzinga	Toangoma	Dispensary

28	Nunge	Vijibweni	Dispensary
29	Tambuka reli	Azimio	Dispensary
30	Temeke	Temeke	Hospital
31	Tundwi songani	Pembamnazi	Dispensary
32	Toangoma	Toangoma	Dispensary
33	Vijibweni	Vijibweni	Hospital
34	Yombo vituka	Yombo vituka	Dispensary
35	Mkamba	Kisarawe II	Dispensary
36	Yaleyale puna	Pembamnazi	Dispensary
37	Sigara	Yombo vituka	Dispensary
38	Sanitas	Changombe	Dispensary
39	Sandali	Sandali	Dispensary