Barriers to accessing sexual and reproductive health services among adolescent girls and young women living with HIV in Nzega district, Tabora

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BARRIERS TO ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT GIRLS AND YOUNG WOMEN LIVING WITH HIV IN NZEGA DISTRICT

By

Dionis Masanja Shimbi

A Dissertation Submitted in (Partial) Fulfillment of the Requirement for the Degree of Master of Public Health of

Muhimbili University of Health and Allied Sciences
October, 2019

CERTIFICATION

The undersigned certifies that, he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation titled, **"Barriers to accessing sexual and reproductive health services among adolescent girls and young women living with HIV in Nzega district, Tabora",** in (partial) fulfillment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

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Dr. Tumaini Nyamhanga

(Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

I, **Dionis Masanja Shimbi**, 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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Finally yet importantly, I would like to thank my research assistant including Grace Revocatus who assisted me with assisted me throughout the data collection process. Special appreciation are also extended to Martha Yunge for her great contribution in transcribing the recorded interviews and discussions

May almighty God bless you all!

DEDICATION

To my Parents, Thomas J. Shimbi and Devotha Nicholaus for all the sacrifices you made and your endless prayers for me throughout my studies.

To my Daughter- Noreen

May the Almighty God guide you always!

Amen.

ABSTRACT

Background

In most of the Sub-Saharan African countries including Tanzania young people face restricted access to accurate information, appropriate guidance, or comprehensive reproductive health services and they are likely to experience significant unmet needs as they initiate sexual relationships. Previous studies in Tanzania have mainly focused their attention on the general population of Adolescent Girls and Young Women (AGYW). Little research has been conducted on the barriers to accessing sexual and reproductive health (SRH) services targeting AGYW living with HIV who are more vulnerable to contextual impediments.

Objective

The main objective of the study was **to** assess the barriers to accessing SRH services among HIV-positive adolescent girls and young women (aged 15-24 years) in Nzega District.

Methodology

This study employed purposive sampling approach, which utilized Focus Group Discussions (FGDs) and in-depth interviews to collect data. Expedient samples of 24 AGYW from 3 selected health facilities were purposively recruited. Modified and adapted socio-ecological model was used to explore the factors influencing access to SRH services. Data collected were analyzed using the six-phase thematic analysis approach by Braun & Clarke (1).

Findings

The findings of the study indicate that HIV positive AGYW in Nzega DC have limited access to and utilization of SRH services. Informants reported that, individual level factors like fear, lack of confidence, and limited awareness on SRH services among AGYWs negatively influenced their access to and utilization. Moreover, inter-personal level barriers included unfriendly language by the service providers and denial of permission to seek care by the male partner and parent(s). Furthermore, organizational barriers included: unstable availability of SRH medications, lack of comfort space at the clinic set up, and long waiting hours.

Conclusion and recommendations

The study has revealed that AGYW living with HIV are exposed to range of barriers to accessing SRH services across the four levels (individual, interpersonal, community and organizational) listed in the social ecological model. This study has demonstrated that limited awareness on SRH services, limited availability of SRH services, denial to seek ASRH services by male partners or parents, financial constraints and lack of comfortable space in health facility settings creates barriers to accessing adolescent SRHS and rights. Overall, this study has provided useful information for health care workers and other stakeholders working with adolescents and young people in SRH services to addressing barriers as indicated in this study. HIV Positive AGYW should be fully engaged in programming interventions tailored to addressing their own SRH service needs.

TABLE OF CONTENTS

CERTIFICATION i
DECLARATION AND COPYRIGHT ii
ACKNOWLEDGEMENT iii
DEDICATION iv
ABSTRACT v
TABLE OF CONTENTS vii
LIST OF TABLES x
LIST OF FIGURES x
ABBREVIATIONS xi
DEFINITION OF KEY ITEMS xii
CHAPTER ONE 1
1.0 INTRODUCTION 1
1.1 Background to the Problem 1
1.2 Statement of the Problem 3
1.3 Research questions 4
1.3.1General question 4
1.3.2 Specific questions 4
1.4 Objectives 5
1.4.1Broad Objective 5
1.4.2 Specific Objectives 5
1.5 Theoretical framework 6
1.6 Rationale of the study 8
CHAPTER TWO 9
2.0 LITERATURE REVIEW 9
2.1 Introduction 9
2.2 Barriers of SRH services for AGYW living with HIV 9
2.2.1 Individual barriers 9

2.2.2 Interpersonal level barriers....11
2.2.3 Community level barriers:....12
2.2.4 Organizational level barriers....13
CHAPTER THREE....15
3.0 METHODOLOGY....15
3.1 Study Design....15
3.2 Study area....15
3.3 Study Population....15
3.4 Inclusion Criteria....16
3.5 Exclusion Criteria....16
3.6 Sampling and sample size....16
3.6.1Sampling procedure....16
3.6.2 Sample size....17
3.7 Data collection methods and tools....17
3.7.1Data collection methods....17
3.7.2Data collection tools....18
3.8 Data Analysis....19
3.9 Ethical consideration....20
3.10 Plans for Utilization and Dissemination of Information....21
3.11 Trustworthiness....21
CHAPTER FOUR....22
4.0 RESULTS....22
4.1 Socio-demographic Characteristics....22
4.2 Barriers to accessing SRH services among HIV-positive AGYW....23
3.2.1 Individual barriers to accessing SRH services among AGYW living with HIV....24
3.2.2 Interpersonal Barriers to accessing SRH services among AGYW living with HIV..26
3.2.3 Community barriers to accessing SRH services among AGYW living with HIV....28
3.2.4 Organizational barriers to accessing SRH services among AGYW living with HIV.30

CHAPTER FIVE 32
5.0 DISCUSSION 32
5.1 Individual Level Barriers to accessing SRH service among AGYW living with HIV 32
5.2 Limited awareness on SRH services 32
5.3 Preference for female service providers 33
5.4 Interpersonal Barriers to assessing SRH service among AGYW living with HIV 33
5.5 Denial of permission to seek care by the male partners and or parent(s): 34
5.6 Community level barriers 35
5.7 Financial barriers 35
5.8 Organizational level barriers 36
5.9 Lack of comfort space at the clinic set up. 37
5.10 Study limitations and mitigation 38
CHAPTER FIVE 39
5.0 CONCLUSION AND RECCOMENDATION 39
5.1 Conclusion 39
5.2 Recommendations 39
REFERENCES 41
APPENDICES 48
Appendix 1: Informed Consent Form 48
Appendix 2: In-depth interview guide AGYW 51
Appendix 3: Focus Group Discussion Guide for AGYW (English Version). 53
Appendix 4: Consent Letter to Parents/Guardians for the Under 18 years Adolescents (English Version) 55
Appendix 5: Approval for ethical clearance 56
Appendix 6: Introduction Letter 57

LIST OF TABLES

Table 1: Demographic Characteristics 23

Table 2: Summary of main findings on the barriers to accessing ASRH services among AGYW living with HIV 24

LIST OF FIGURES

Figure 1: Conceptual Framework.....6

ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
ASRH	Adolescent and sexual and reproductive Health
CHMT	Council Health Management Team
DH	District Hospital
HC	Health Center
HIV	Human Immunodeficiency Virus
NACP	National AIDS Control Program
RHS	Reproductive Health Services
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
THIS	Tanzania HIV Impact Survey
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
HCWs	Health Care Workers
MoHCDGEC	Ministry of Community Development, Gender, Elderly and Children

DEFINITION OF KEY ITEMS

1. Sexual and reproductive health services

The national standards for adolescent friendly sexual and reproductive health services outline a range of adolescent friendly SRH services to be delivered in line with the Essential Reproductive Health Package developed by the Ministry of Health and Social Welfare. The services include prevention, promotion, curative and rehabilitation activities undertaken at different levels and settings within the health sector (2). For the purpose of this study SRH services does include HIV testing and prevention services, STIs screening and management and access to contraceptives services including emergency contraceptives

2. Adolescent girls and young women

Globally ‘Adolescents’ are defined as individuals in the 10-19 years age group and 'Youth' as the 15-24 year age group, while 'Young People' covers the age range 10-24 years (2). Adolescent girls and young women (AGYW) are classified by WHO as a group of female persons 15–24 years of age, inclusive (3).

Adolescents and young people are not a homogenous population; they are exposed to variety of environments and also have different needs. The development from childhood to adulthood comprises dramatic psychological, physical, and social developmental changes, all taking place at the same time (4). In addition to opportunities for development this transition poses risks to their health and wellbeing and therefore different stakeholders supporting adolescents and young people services have been working tirelessly to strengthen the health services to adolescent and young people by focusing on strategic information and advocating for supportive policies. Increasing young people's access to, and use of appropriate health services and commodities that respond to a number of priority health condition (3).

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Problem

The national Adolescents Reproductive Health strategy advocates for an increase in adolescents' access to and utilization of quality reproductive health services by promoting positive attitudes and behaviors among parents, adolescents and the community (2). Most of the health facilities and communities have not invested significantly in addressing adolescent related challenges especially those focusing on girls and young women, such as early pregnancies and parenthood, difficulties accessing contraception and high rates of HIV and sexually transmitted infections (5). According the most current UNICEF statistics in 2017, about 1.8 million adolescents between the ages of 10 and 19 were living with HIV worldwide (6). Globally Adolescents and young people signifies a growing portion of people living with HIV and accounts for significant percentage of yearly new infection, it is estimated that in 2017 alone 590,000 young people between the ages of 15 to 24 were newly infected with HIV (7).

In Tanzania HIV prevalence among 15 to 24 years old is 1.4 percent (2.1 percent among females and 0.6 percent among males) (8). The disparity in HIV prevalence between males and females is most pronounced among younger adults, with women in age groups 15 to 19 and 20 to 24 all having prevalence more than double that of males in the same age groups (4). Youth population (15-24) constitute 19% of Tanzania's population where by adolescents aged (10-19) account for about 5% of all people living with HIV and about 12% of new adult HIV infections (9). Young people engage in risky unprotected sexual behavior and mostly having multiple sexual partners (7). This demonstrates the need of SRH information and access to contraceptive methods and secondary prevention strategies to prevent re-infecting themselves and transmitting the HIV to their children and sexual partners.

Despite existence of these supportive policies, there are still a number of obstacles to young people's access to quality reproductive health services (10–12). According to the 2015-2016 Tanzania Demographic Health Survey, Malaria Indicators Survey, overall 27% of adolescent women age 15-19 are already mothers or are pregnant with their first child (7). The WHO Global Health Sector Strategy on Sexually Transmitted Infections 2016–2021 Sub-Saharan Africa as hardest hit region in context of HIV, STIs and viral hepatitis with disproportionate burden of HIV and STIs among women (13). Worldwide, the highest rates of sexually transmitted infections (STIs) occur among 20-24 year olds, followed by 15-19 year olds (14).

There is an important information gap on the sexual and reproductive health needs for adolescent girls and young women (15-24 years). 12% of adolescents and young women aged 15-24 years report their sexual debut began before the age of 15 years (7). The percentage of teenagers who had a child or who were pregnant was 26% in 2004-05, after which it decreased to 23% in 2010, then increased to 27% in 2015-16 (7). A prospective cohort study of 15–24 year olds from Uganda revealed that condom use is more difficult for adolescents with HIV compared to non HIV-positive adolescents, particularly if they had received counseling messages that did not support or empower them to negotiate with partners (15).

Despite studies conducted on barriers to accessing SRH services among adolescents and strategies implemented by the government to increase access of the services to adolescents and young people, still there is several incidences of sexual and reproductive health problems especially among HIV positive AGYW. This observation suggests that we are lacking a comprehensive understanding of the factors limiting HIV positive AGYW from accessing SRH services which have kept them at high risk of unintended pregnancy, HIV transmission to their sexual partners and their children, transmission and acquiring STIs infection, acquiring new HIV infections from other HIV-infected people. The study applied the ecological model of behavior change (16) to explore individual level, interpersonal level, community level and organizational level barriers that can be addressed.

1.2 Statement of the Problem

Young people globally face remarkable obstacles to satisfy their sexual and reproductive health needs and rights. Insufficient access to SRH education and services leads to lack of awareness about sexuality, puberty and reproductive rights which may results to serious problems among adolescents' sexual and reproductive health (17). In most of the Sub-Saharan African countries including Tanzania young people face restricted access to accurate information, appropriate guidance, or comprehensive reproductive health services and were likely to experience significant unmet need as they initiated sexual relationships (18).

Previous studies in Tanzania have mainly focused their attention on the general population of adolescent girls and young women. limited by cultural barriers, lack of appropriate ASRH information or knowledge, stigma and discrimination, negative attitude by health service providers, economic hardship, social-cultural barriers, poor communication skills, unfriendly clinic settings and restrictive policies (5,19–21). However, little research has been conducted on the barriers to accessing SRH services targeting AGYW living with HIV who are more vulnerable to contextual impediments. Lack of access to SRH education and services increases several risks, including: being re-infected, transmission of HIV to their sexual partners, transmission of HIV to their children, and getting unwanted pregnancy. Therefore, this study systematically explored the barriers – particularly so in the light of socio-ecological model.

1.3 Research questions

1.3.1General question

What are the barriers to accessing SRH services among HIV-positive adolescent girls and young women in Nzega District?

1.3.2 Specific questions

1. What are the individual level barriers to accessing SRH services among HIV-positive AGYW in Nzega District?
2. What are the interpersonal level barriers (family, friends/partners and social networks influences) to accessing SRH services among AGYW living with HIV- Nzega District?
3. What are the community level barriers to accessing SRH services among AGYW living with HIV- Nzega District
4. What are the organizational level barriers to accessing SRH services among AGYW living with HIV- Nzega District

1.4 Objectives

1.4.1 Broad Objective

To explore the barriers to accessing SRH services among HIV-positive AGYW (aged 15-24 years) in Nzega District

1.4.2 Specific Objectives

1. To examine the individual barriers to accessing SRH services among AGYW living with HIV in Nzega District.
2. To assess interpersonal barriers to accessing SRH services among AGYW living with HIV in Nzega District
3. To assess community level barriers to accessing SRH services among AGYW living with HIV in Nzega District
4. To examine organizational barriers to accessing SRH services among AGYW living with HIV in Nzega District

1.5 Theoretical framework

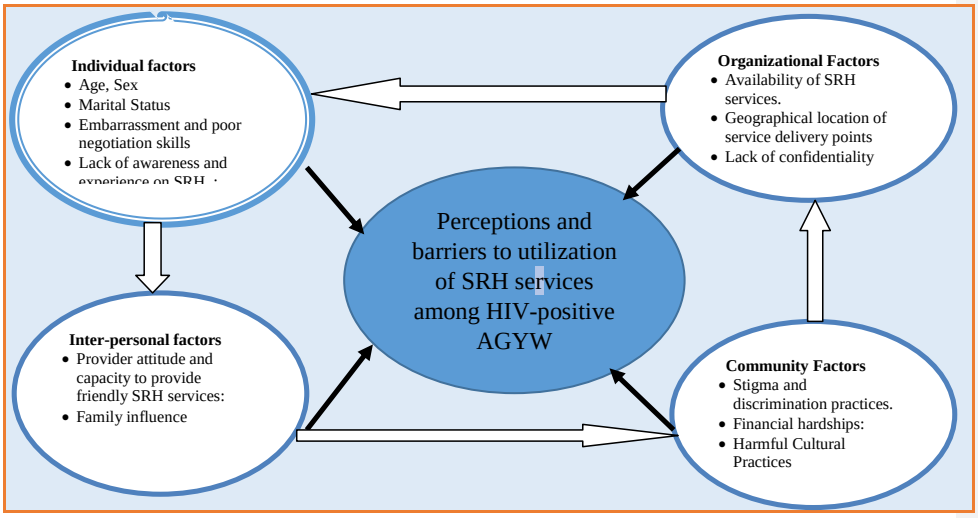
Socio-ecological model (SEM)

The SEM is considered to be comprehensive model as it consists of factors including individual level factors, environmental and societal policies level, organizational level factors, community level factors and interpersonal relationship factors. This model helps to address the complexities and interdependence between the environments, policies incorporating social and psychological influence on the behavior (22). The models provides a framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations (16,23). There are various versions of the socio-ecological model.

This study employed socio-ecological model developed in the year 1988 by Kenneth, McLeroy, and Bibeau et.al (23) to provide a solid understanding of the barriers towards accessing SRH services among AGYW living with HIV.

Figure 1: Conceptual Framework

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In the context of barriers to accessing SRH services among AGYW living with HIV the study applied a combination of factors at four levels of the model. Various studies has widely applied socio-ecological model to create an understanding multifaceted factors influencing behavior. In the most recent reviewed studies the model was used by Belinda et.al to explore the barriers of accessing SRH and services among couples living with HIV in Malawi (21) and also was applied in another study conducted in Nepal to assess the factors that influence adolescents' access to SRH services (24,25).

Individual (intrapersonal) level factors

These includes factors comprising the micro-level psychological and biological aspects, such as fear of embarrassment, poor negotiation skills, lack of knowledge and experience on SRH services (25).

Interpersonal level factors

This level highlight the social networks and social support systems that can influence individual behaviors, these includes family influences through strong traditional and cultural practices, stigma and discrimination and health care worker's relationship with youth (25). When the social groups or traditions influences are supportive, HIV-positive AGYW are more likely to seek for SRH services.

Community level factors

These includes the informal networks and practices that influence health seeking behavior among adolescents (25). Financial hardships among AGYW present harmful cultural practices which can influence accessibility and utilization of SRH services.

Organizational level factors

These are organizations or institutions rules, structures and operational procedures which may constrains or promotes the behavior of adolescents in terms of accessing SRH services. Factors like limited availability of SRH services and lack of privacy and confidentiality settings, in particular, prevents many poor people adolescents and young people to utilize services (25).

1.6 Rationale of the study

Despite existence of supportive policies, there are still a number of obstacles to young people's access to quality sexual and reproductive health services. Data on sexual behavior among HIV-positive AGYW remain limited, and few studies disaggregate their findings by age so that adolescents (10–19) can be compared to older youth (15–24). Thus it is important to understand the perceived barriers of this population in accessing SRH service as they make up a significant portion of the HIV-positive population. Understanding these individual, social-cultural and organizational factors is of paramount importance in improving accessibility of quality SRH services among HIV positive AGYW

The main goal of this qualitative study that targets HIV-positive AGYW was to assess the barriers affecting access to SRH services with much emphasize on HIV transmission secondary preventive services, STIs screening and management, and access to contraceptives. The study contributed evidenced-based information that could be used by Nzega District Council Health Management Team (CHMT) and other stakeholders to strategize and plan and implement interventions which respond positively to AGYW needs. This study adds to existing literature on ways through which access to these services by the HIV positive AGYW can be enhanced.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The literature review describes the concept of adolescent reproductive services, adolescents' use of sexual and reproductive health services, as well as factors affecting adolescents' access and utilization of RHS. It also considers approaches to improve access and utilization of ASRH services and finally describes the theoretical framework of the study.

Adolescent girls and young women (15-24 years)

World Health Organization (WHO) classifies adolescent girls and young women (AGYW) as group of girls aged 15- 24 years (26). Adolescents and young people are considered to be a group people passing through life period of predominantly vulnerable health issues, this is a time when critical behaviors are shaped that will affect health in the future and some already experiencing them (2). New HIV infections among adolescent girls and young women are substantially higher than among males of the same age because HIV is more commonly acquired from male sexual partners who are a few or several years older (4). Majority of adolescents and young people living with HIV reside in sub-Saharan Africa (27).

2.2 Barriers of SRH services for AGYW living with HIV

SRH access is limited in most of the Sub-Saharan African countries, the barriers range from economical barriers, social barriers, religious barriers, moral or other beliefs and norms relating to young people's sexuality (28,29). The below review draws out to understand various individual, social, political and economic barriers constructed to regulate adolescent girls and young people's access to SRH services.

2.2.1 Individual barriers

Embarrassment and poor negotiation skills

Young people feel embarrassed while talking about sexual and reproductive health matters with friends of the opposite sex, family, and even with their sexual partners. In the study

conducted in Nepal showed that the participants thought that girls found it difficult to initiate a discussion about SRH matters with their sexual partners. Boys also argued that it was difficult to keep condoms as they felt embarrassed when caught by family or friends (24).

Another study conducted on understanding barriers to young people's access to SRH Services in Sierra Leone showed that young people are ashamed to seek access to contraception, particularly due to the issue of lack of confidentiality. The study further revealed young people don't trust health workers not to share their secrets, and, in particular in relation to contraception, are worried their parents will find out that they are sexually active (30).

AGYW living with HIV feels embarrassed being served with health care workers while visiting the service delivery facilities. Some young people prefer sharing their sexually problems with younger service providers(5,24,31). In most of the health facilities adolescent girls feel reluctant to be examined by male care providers same applies to the male adolescents who find it difficult to share and discuss their health issues with female health services providers (2).

The study conducted in Nepal further revealed young people especially girls, have poor negotiation and decision-making skills which may lead to unsafe sex. Most of them fail to openly discuss about sexual matters with their boyfriends (24). Young HIV-positive women struggle to negotiate condom use with their partners who are aware of their HIV status but insisted on unprotected sex (32).

Further studies reveal that language differences can induce fear of improper diagnosis among adolescents seeking for SRH services (29,33).

Lack of awareness and experience on SRH services

In the study conducted in Vanuatu a Melanesian country and one of the poorest country in the Pacific adolescents mentioned lack of 'awareness' about SRH as a reason why they didn't access services (34). Inadequate awareness about condoms and contraception is the major reason for not using family planning, lack of awareness about how adolescents could communicate with nurses are mentioned by most of scholars as reasons for not accessing services (29,34).

In another study conducted to assess the barriers to sexual health services for young people in Nepal, it was revealed that young people have poor sexual health awareness and the available services, this leads to failure to utilize the available sexual health-service. Minimal understanding and accessibility of sexual health services normally force young people to engage in unsafe sexual practices (24). Education level of adolescents and young people cancan affect service accessibility (29,34).

2.2.2 Interpersonal level barriers

Young people's behaviors are strongly affected by the attitudes, norms and beliefs of the adults who have power and authority over them (30). Young people often lack the autonomy and life skills of adults to make informed decisions about their own sexual and reproductive health and adopt behaviors that are endorsed by society, either explicitly or implicitly.

Provider attitude and capacity to provide friendly SRH services:

Several studies has indicted that health provider's attitude is often cited by most of the adolescents and youth as a barrier to accessing SRH services. Some of the health care providers feel uncomfortable to manage health problems of adolescents because they lack skills on how to effectively work with adolescents and young people. Moreover health care providers may have their personal bias in providing adolescents some of the recommended SRH services worrying of their readiness to receive the information or services (29,35,36). In the study conducted in DRC, health care workers felt uncomfortable to discuss sex and providing condoms to HIV-positive young people and were confused about whether it was legal to provide family planning counseling to youth under the age of 18 (37).

Family influence

Parents, guardians and partners (sexual partners) have the vital role to play in promoting positive attitudes and practices at the household and community levels regarding adolescent sexual and reproductive health services(2). An important finding from the study conducted in Ilala MC to assess adolescents' awareness on youth friendly SRH services highlighted that parents have a vital role to play in motivating adolescents to access SRH services, the study

found out that parents are too shy to discuss reproductive health issues with their children (39).

2.2.3 Community level barriers

Stigma and discrimination practices

In the study conducted by ATHENA stigma was identified as a major barrier, including stigmatizing beliefs that AGYW living with HIV should not be having sex, this in turn prevented them from accessing services (38). Given the potential for horizontal and vertical transmission and the continuing social stigma of HIV illness and mortality, there is still stigma that surrounds HIV and reproductive health issues in the communities where PLHV comes from (21,40).

Stigma practices poses risk to sexual and reproductive health for many groups, including AGYW living with HIV living with HIV. Persistent stigma adversely distresses access to care, resources and support which play an important part in our health and the health of our communities (41).

Economic hardships

Poverty plays a significant role in determining who can access SRH services in many countries, and may be the greatest barrier to access to SRH services around the world. (29,30)

The 2016 TDHS- MIS also highlights that two-thirds of women in Tanzania report problems related with getting money for advice or treatment by (50%) as a major challenge in accessing health care (7). Some adolescents feel too embarrassed to ask their parents for money to attend SRH services, imposing payments for SRH services and commodities would prevent young people from seeking (30,34)

People living with HIV including AGYW need money for transport or health services which in some cases necessitate payment. Since both required to attend their ART uptake routinely visits and given their low social economic status, ART services remain their main priority for them (21,33).

Young people also face inability to afford travel to clinic or user fees. Young people who are living long distance form their health facilities normally face cost barriers to accessing SRH

services (21,30). Introduction of user fees, in particular, prevents many poor adolescents and young people utilizing health services due to lack of financial independence to cater for their needs (29).

Harmful Cultural Practices

Cultural practices contribute to the utilization level of SRH services among adolescents and young people. A study done in Mtwara DC revealed that initiation ceremonies was singled out as a key cause of early pregnancy that determine sexuality among adolescents in Mtwara (5). Other practices like early marriages, contraceptive use misconceptions among adolescents and young people, FGM resulting to childbirth complications affects effectiveness in SRH services provision (18,42).

Another study conducted in Bangladesh revealed that religious leaders of the mosque, neighbors, and other residences close to health facilities make oppositions from time to time about the services provided to FSWs in drop in centers (41).

Cultural taboos to avoid open discussion about sex and reproduction between parents or guardians have a negative contribution to adolescents' reluctance to discuss SRH with providers. Most do feel anxiety about being asked sensitive questions and also fear of physical examination (34).

2.2.4 Organizational level barriers

Availability of services

Availability of young people SRH health at all health care delivery points assists adolescents and young people to access SRH services (40,43). The commonly available SRH services includes but not limited to family planning, ante-natal care, post-natal care, provision of condoms, health education, sex education, HIV testing services, prevention of mother to child HIV transmission (PMTCT), screening and management of sexual transmitted infections (STIs), abortion services, post abortion care and safe deliveries (2,44,45). A study conducted by UMATI in Tanzania showed that only 30% of the health facilities in Tanzania meets the national standard of adolescents and youth friendly services (28). The study further showed that only 16 percent of the health facilities had designated areas for adolescents and 52% had

no information management system for adolescent health. Access to inclusive and correct information on SRH services means that AGYW are equipped to manage their sexual health and reduce potential health risks.

In the study conducted on the barriers to accessing SRH services among HIV-positive couples on Malawi revealed that inconvenient service hours was a barrier to accessing the sexual and reproductive health services (21). Due to shortage of staff in these health facilities, the services were provided twice a week. Hence male informants who wished to access the services indicated that the times and days coincided with the times when they have to fend for their families (21).

Lack of privacy and confidentiality

The national standard of Adolescents and youth friendly services requires service delivery points to provide a comfortable environment with adequate privacy for adolescents in the waiting and consulting areas. This may require setting secluded waiting and counseling rooms for adolescents and young people (44).

Adolescents and young people may sometimes provide or require sensitive nature of the information and therefore guaranteeing confidentiality and anonymity is of the highest significance. Recent studies conducted in Mtwara and Mwanza, respondents noted lack of privacy and confidentiality are the key determinant associated with utilization of SRH services among youth (5,40). In another study conducted in Zimbabwe and Kenya to assess the factors which the adolescents considered to be important factors for them to access ASRH services, adolescents among other things exposed out that they prefer short waiting time, friendliness of staff and confidentiality (43).

Young people fear sexual health service providers to be judgmental and lack confidentiality (24,29). Failure to do this may leave young people in a state of uncertainty as to whether confidentiality will be ensured in practice, which in turn will render them less confidence to access services, especially where existing young people's sexuality norms are restrictive and prohibitive (34).

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

This study employed a descriptive qualitative study approach and data were collected through in-depth interviews and focus group discussion.

3.2 Study area

The study was conducted in Nzega District in Tabora region. According to the 2012 national census, the region had a population of 2,291,623 with 1,235,337 being children below 18 years (9). The region is in the central-western part of the country with a size of 76,151 square kilometers. According to National AIDS Control Program report number 23 of 2013, there were 71,694 clients in 2012 enrolled into care in Tabora region, among which 12,653 were current on ART (46). As per the most recent DHIS2- 2018 data report, there are 2517 adolescents and young people currently on ART (565 male and 2517 female) in Nzega DC.

The Demographic Health Information System (DHIS2) also reports that in the year 2018 alone, a total of 28,934 (11,102 Male, 17832 Female) adolescents and young people (15-24years) were tested for HIV, out of which 117 boys and 326 girls were found HIV positive (DHIS2, 2018)

3.3 Study Population

The study population is AGYW living with HIV aged between 15- 24 attending care and treatment clinics in selected health facilities. Respondents were requested to provide their opinion on the common barriers to accessing SRH services and how to improve provision of quality ASRH services to AGYW.

3.4 Inclusion Criteria

AGYW with an ability to assent by using their thumb stamp or written consent and those with detailed information or knowledge on SRH services were included in the study. HIV positive AGYW serving as peer educators, Informants who are aware of their HIV status and or had informed about each other's HIV status, and were in the reproductive age group of 15 to 24 years were recruited for the study.

3.5 Exclusion Criteria

- AGYW living with HIV who were not in a sound state of mind, or who had not disclosed their HIV status, adolescents coming from the same families and those who could not communicate effectively were excluded from the study.

Sampling and sample size

3.6.1 Sampling procedure

Participants were recruited using a purposive sampling technique considering availability of potential participants and need. For FDGs the theoretical sampling method was used and sampling continued until theoretical saturation was achieved. Focus group discussion participants and In-depth interviewees were selected purposely from a specific population of interest to study HIV positive AGYW who attend their monthly care and treatment clinics (CTC).

The In-depth interview was employed to ensure confidential conversations between an interviewer and participants. This method enabled the researcher to gain an insight into individual assessment as it is considered to be appropriate for the issues which were controversial or sensitive. Also, there was time for the participant to further develop and give reasons for his or her individual point of views without being influenced by the opinions of other participants.

Regarding FGDs respondents were subdivided into two age groups of adolescents (15-19) years and young women aged (20 -24) years so as to allow the researcher to study noted traits and characteristics under each group. The researcher conducted 3 FGDs with at least 6 members each, 1 for adolescents aged (15-19) years at Nzega DH, and 2 for young women aged 20-24 from 2 health facilities (Itobo HC and Nzega DH). General information about the study was provided to all clients attending their clinics in the waiting area and those selected or interested were invited in a special room for a private conversation meet the researcher who then assessed them to decide their eligibility. To allow convenience in participation among adolescents some of these FGDs were conducted over the weekends during special clinics for adolescents and youths so as to get a representative number of these informants but also to be able to get enough time that will not interfere with their works or school time during week days.

3.6.2 Sample size

The sample size of this study was based on the saturation principle that, data collection stopped when there was saturation of the collected information. The researcher stopped collecting data when new data no longer bring additional insights to the research questions. A total of 24 AGYW living with HIV participated in the study.

3.7 Data collection methods and tools

3.7.1 Data collection methods

Data were collected through In-depth Interviews (IDI) and Focus Group Discussion (FGD). A combination of in-depth interviews (IDIs) and focus group discussions (FGDs) increased the understanding of complex issues related to adolescent and young people's sexual behaviour, and provided for a detailed understanding of barriers to accessing SRH services. Given the sensitive nature of the research, and the fact that the study involved speaking to young girls and women about their behaviour, choices, perceptions and experiences related to access to sexual and reproductive health services, individual IDIs was used to ensure privacy and confidentiality to the respondents. In IDIs, semi-structured interviews were conducted using

key predetermined questions regarding barriers towards accessing SRH services. This provided room to explore issues deeper by enabling clarification of issues during the interview, the researcher was able to do further probing and modification of interview guides in the course of the study (47)

The study also conducted FGDs with AGYW where by questions asked depended on the nature of the services, and issues surrounding anonymity. Three FGD were conducted at selected health facility with the HIV-positive AGYW, one for the AGYW aged 10-19 years and 2 for AGYW aged 20-24 years. 1 research assistant assisted the researcher to take notes during focus groups and encouraging adolescents to speak out as, it was assumed that the interviewer's gender does have a significant influence on responses to sensitive questions

With consent from participants the research recorded audio of all interviews and FGDs which were later transcribed in Swahili and then translated into English.

3.7.2 Data collection tools

In this study, data collection tools used were research in-depth interview guide for AGYW (Appendix 2) and focus group discussion guide for AGYW (Appendix 3). A research assistant engaged during this study was trained on the respective tools.

The developed IDIs and FGD guides were all developed based on the research objectives. The questions for AGYW were made reflecting four levels of social-ecological model (Individual, interpersonal, community and organizational barriers) specifically the questions covered the following key areas: experience on the available SRH services for AGYW living with HIV, the likely factors influencing access to SRH services, barriers to accessing SRH services among HIV positive AGYW and suggestions to improving accessibility of ASRH services.

Principle investigator pre-tested the tools to ensure elaborations and messages remain appropriate and are clearly understood. Tools review helped to regulate length of each FGD and IDI. Few modifications were made on the questions and probing observed as the result of the pre-test.

3.8 Data Analysis

Qualitative analytical approach was employed to interpret qualitative data from which the researcher provided this analytical narrative study report. After data collection, the researcher and researcher assistant listened to the audios and read the field notes and transcripts several times so as to ensure clarity of the collected data. In each objective, all interesting features of the data from IDI and FGDs were coded systematically across the data set.

Six-phase approach thematic analysis by Braun & Clarke (2006) was applied in transcribing the study data (1). Thematic analysis is a method of identifying, analyzing, and reporting patterns (themes) within data. These are: (i) familiarizing with the data, (ii) generating initial codes (iii) searching for themes (iv) reviewing themes (v) defining and naming themes, and (vi) producing the report.

Step 1: Becoming familiar with the data

In the first step, the researcher familiarized with collected data by reading and reading the transcripts and the interview notes and listening to the recordings several times.

Step 2: Generate Initial Codes

Under second step, data were organized in a more meaningful and systematic manner, open coding were used to develop and modify during coding process. The researcher scrutinized the data in order to identify codes that described the contents of a line or even a paragraph. The researcher coded the chunks of data by using highlighters and inserting comments in the text to identify sections of the data.

Step 3: Search for themes

The third is more about themes searching from the codes that were previously determined from the data. The researcher organized various codes into possible themes by looking for patterns in the coding and categorized them into tentative themes.

Step 4: Reviewing the themes

In the fourth phase, the researcher reviewed the tentative themes by re-reading the entire data set to ascertain whether some possible themes were not really themes or whether other themes

required breaking down into further distinct themes. During this step some themes were abandoned, some were modified or subdivided and new themes were generated.

Step 5: Defining the themes

The researcher identified subthemes which could be defined and labeled. Under this step the researcher considered how each theme could be fitted into the general picture being presented about the data in relation to the research objectives.

Step 6: Writing-up

The final step involved the report writing. Under this phase the researcher described and explained the themes in the form of a dissertation.

3.9 Ethical consideration

Ethical clearance (No. DA.287/298/01A) to conduct this study was obtained from Muhimbili University of Health and Allied Sciences through Institutional review Board. Letters of introduction was sent to council executive director office where the permission was provided to conduct the research. During data collection courtesy call were made to District Medical Officer (DMO) office and Facility Medical Officer in charges in the selected care and treatment facilities.

The selected AGYW and health care workers were assured of their privacy and asked for informed consents before participation. The welfare and best interests of the participants was made a primary consideration in data collection. Written consent were also sought from parents and or legal guardians of adolescents below 18 years before participating in the research.

Conducive settings in health facilities were selected to ensure privacy and free conversations between interviewers and participants. Participation in the study was on a voluntary basis. No incentives were provided.

All participants were informed of the purpose and nature of the study through the information and consent form at the start of all interviews and focus group discussions. Both verbal and written consents were requested from participants to conduct the interview or focus group discussion and then record that permission has been granted. Due to the sensitive nature of the information which were provided by participants, ensuring confidentiality and anonymity was taken with highest importance. The participants were informed their identities will be kept confidential throughout the process of data collection as well as in the analysis and writing up the study findings.

3.10 Plans for Utilization and Dissemination of Information

Finding from this research will help stakeholders implementing various SRH interventions to plan relevant interventions which focus at addressing the barriers. The dissertation will be disseminated to Muhimbili University of Health and Allied sciences, MoHCDGEC, National AIDS Control Program (NACP), Nzega DC- DMO and in charges of the respective health facilities in Nzega district council. All stakeholders at ranging from national level to health facility level, organisation working with adolescent girls and young women, development and implementing partners providing technical assistance are encouraged to make use of this report.

3.11 Trustworthiness

Qualitative research is based on subjective, interpretive and contextual data making it critical for researchers to ensure the reliability and validity on research findings. Validity and credibility of the results can be secured by applying several mechanisms such as prolonged engagement and peers debriefing (48,49). The IDI and FGD guide were tested and modified accordingly to improve the main and probing questions. Restating and summarizing the responses from informants were used during both in depth interview and group discussion to ensure what was heard was in fact correct. Moreover, the researcher used triangulation of data from interviews and FGDs and by enhancing the truth of the study's findings through clients
The investigator is therefore confident that the findings are valid and grounded in the data

CHAPTER FOUR

4.0 RESULTS

This chapter presents the study findings as per the study objectives. Thus the study is organized under five main sections, as follows: socio-demographic characteritics; individual barriers to accessing SRH services among AGYW living with HIV; interpersonal barriers to accessing SRH services among AGYW living with HIV; community level socio-cultural barriers to accessing SRH services among AGYW living with HIV; and organizational barriers to accessing SRH services among AGYW living with HIV.

4.1 Socio-demographic Characteristics

A total of 24 AGYW living with HIV from three health facilities (Nzega district hospital, Lussu health center (HC) and Itobo HC participated in the interviews. 50% of all AGYW respondent had primary level education, 42% had primary education and 8% never attended any formal education. Majorities (50%) of the respondent were peasants, 33% engaging in small business activities and 8% students and employed respectively.

Table 1: Demographic Characteristics

Background factor	***Total***	***Number (N= 24)***
Age Distribution	**Number**	**Percentage (%)**
15-19	9	37
20-24	15	63
Occupation	N	%
Small businesses	8	34
Student	2	8
Employed	2	8
Peasants	12	50
Grand Total	**24**	**100%**
Education level	**N**	**%**
Primary school education	12	50
Secondary school education	10	42
Not attended school	2	8
Grand Total	**24**	**100%**

4.2 Barriers to accessing SRH services among HIV-positive AGYW

The explored barriers to accessing SRH services **a**re organized in accordance to the analytical themes that emerged from the data, as indicated in **Table 2**

Table 2: Summary of main findings on the barriers to accessing ASRH services among AGYW living with HIV

Individual barriers to accessing SRH services among AGYW living with HIV	*Interpersonal Barriers to accessing SRH services among AGYW living with HIV*	*Community barriers to accessing SRH services among AGYW living with HIV*	*Organizational level barriers to accessing SRH services among AGYW living with HIV*
• Fear and lack of confidence • Service provider's young age • Preference for female service providers • Limited awareness on SRH services	• Use of unfriendly language by the service providers • Denial of permission to seek care by the male partner • Denial of permission to seek care by parent(s)	• Financial hardship • Stigma and discrimination practices.	• Availability of SRH services. • Lack of comfortable space at the clinic set up • Lack of confidentiality

3.2.1 Individual barriers to accessing SRH services among AGYW living with HIV

i) Fear and lack of confidence

Some respondents viewed fear and lack of confidence as barriers to accessing sexual and reproductive health services. HIV positive AGYW coming from rural areas finds themselves lacking confidence to communicate their health needs to health care workers.

"You may find someone who doesn't have the confidence of speaking and self-explanation since he/she comes from the village, his/her physical appearance and the fact that he/she is sick makes him/her think that he/she looks different from other people" [Participant 5, FGD # 2]

Fear and lack of confidence were attributed to low educational achievement. The study revealed that AGYW who didn't attend formal education in schools experience challenges in expressing their health problems to service providers. Some do to even speak Swahili which is commonly used by many service providers, and rather they use their traditional languages (Nyamwezi and Sukuma) that is not understood by some of the service providers, as one interviewee said:

"*Some of the young people fail to express themselves due to lack of education so they are not fluent with the Swahili language that is understood by most of the service providers and eventually making them fails to express their problems" [IDI # 2, 19 year old respondent]*

ii) Service provider's young age

The AGYW also revealed that they find it difficult to communicate their health problems with service providers of their ages.

"I may come with sores in my private parts and I find a senior male Doctor, I will be comfortable to address my problem. But if I find someone of my age, I may not be comfortable to address my problem. A senior Doctor will politely examine me by asking: what is your problem, son? But the junior Doctor will just ask: what's your problem? May be I say my head is aching, and he will say: only that? And if you look for other one, you can find no body" [Participant 3, FGD # 2]

iii) Preference for female service providers

A sizable number of AGYW argued that they would prefer female service providers as they feel free and much more comfortable to share their sexual and reproductive health concerns because they are of the same sex. One of the participants thus said:

"There personal issues like family planning methods I wish to talk only with female. A female health provider makes me feel free to share my concern and she can easily provide me counseling because she is my fellow" [IDI # 5, 23 year old respondent]

iv) Limited awareness on SRH services

Most of the AGYW seemed to have limited awareness of the full range of SRH. Most of them reported to know specific services they came for at the health facility, but lacked understanding of comprehensive SRH services. Majority of informants stated the type of services they normally receive at CTC or RCH without knowing they are generally referred as SRH services. When asked about what is meant by SRH services, one of the participants admitted that.

"I don't know what SRH services are. I just came here (at the health facility) for my child routine clinic, general health checkup and child development assessment. As for me, I checked my body weight and they screened me with sexual transmitted infection and I don't have any" [IDI # 5, 23 year old respondent].

3.2.2 Interpersonal Barriers to accessing SRH services among AGYW living with HIV

i) Use of unfriendly language by the service providers

AGYW revealed that use of unfriendly language by the service provider constituted a deterrent to utilization of SRH services. They claimed that, sometimes service providers use of unfriendly language while communicating with adolescents. Unfriendly language from service providers discourages young people to discuss their health problems with service providers.

One of the respondents during FGD with adolescents aged 15-19 in Nzega stated her view on how unfriendly and harsh language may discourage young people from accessing SRH services.

"You may find a service provider asking you "what are you doing here". What kind of a question is that! Sometimes if someone is asked this question may leave without receiving the service she came to seek and probably won't come back again" [Participant 1, FGD # 2]

Moreover, it was reported that past negative experiences on interaction with service providers among AGYW living with HIV might affect use of the sexual and reproductive health services, majority of the informant discouraged future use of the services:

"For my case, I once came here for drugs refill, I told one of them (service providers) that my child's drugs (ARV) are almost over and I am expecting to ravel, he/she started scolding me like didn't you know that today is a public holiday? And it wasn't a holiday actually, it was a last day of a public holiday. We did not get services, we went back home that way, this really disappointed me" [Participant 5, FGD # 2]

ii) Denial of permission to seek care by the male partner

AGYW informants indicated that at times their partners' negative attitudes and lack of awareness on the importance of early seeking behavior may affect their decision on accessing SRH services. Some respondents depend on partner's approvals to seek health services in health facilities.

"Yes, as for me, my husband was initially restricting me from accessing services. But later the situation started getting worse and since I did not want the infection to continue affecting me, I decided to visit the health facility alone, although he stopped me from going to the health facility, I came and started medication. I was provided with health education that real helped me and I encouraged him also to come for testing and he is currently on medications" [IDI # 6, 22 year old respondent]

Some male partner restricts their wives from opting/taking some of the services like contraception.

"In some cases, there should be a mutual understanding between wife and her husband, because some of the husbands tend to restrict their wives from accessing certain kind of services for example when one need permanent contraception" [IDI # 1, 19 year old respondent]

iii) Denial of permission to seek care by parent(s):

AGYW living with their parents are sometimes restricted from accessing SRH services in health facilities particularly when the girl has not disclosed. Respondents argued that some

parents believe it is immoral for young girls to access family planning services as they associate it with bad behaviors.

"Not every parent is informed about the issue. If you find a family is not informed. Surely, it is a problem, whenever you want to go, you will be asked, what are you going to do? What's so special? You, just stay here and do your business. So you won't go since no body supports you" [Participant 3, FGD# 2]

3.2.3 Community barriers to accessing SRH services among AGYW living with HIV

i) Financial hardship

Majority respondent were found to be financially dependent either to their parents or spouses. Some are living long distances from their nearby health facilities and hence requiring them to have money to cover for their transport costs every time they want to visit these health facilities. Some respondents especially those in urban areas (Nzega town) find it difficult to meet these costs.

"I spend 6,000/ TZS as transport cost every time I visit health facility, sometimes I don't have the money to cover for transport cost, in this situation decide either not to come or lend bicycle from my neighbor or relatives" Respondent- [Participant 4, FGD # 1]

"Some young people live long distances from here and therefore may not afford the transport cost every time they need to visit the facility. We have seen others do give deliver their babies at home, while others do come at facility on the same delivery day so as to minimize cost" [IDI # 1, 19 years old respondent]

Another respondent at Nzega DH during FGD while responding to the question on the individual barriers to accessing ASRH services stated;

"If a person doesn't have money for transport it will be hard to come and access services to centers. Thus, moving from home to center becomes a challenge" [Participant 2, FGD # 2]

ii) Stigma and discrimination practices.

Stigma and discrimination practices in the community were identified to be barriers to accessing sexual and reproductive health services among AGYW living with HIV. The responses revealed both self-stigma and social stigma surrounding HIV affects AGYW's decision to attend clinics seeking for SRH services. Most of them do not want to disclose their HIV status or to be seen by others especially people they are familiar with.

One of respondents aptly said:

"I live in the community with youth who are not infected. Do you think I can tell them that I am HIV positive? I can't, I would rather die without letting them know. The problem comes when you attend clinic because you may meet your neighbors. So, how will they regard me if they already know that I'm HIV positive? Certainly you won't feel comfortable to interact with people. They will speak badly about me in the community. They will all point fingers at you and there will be no more privacy" [Participant 3, FGD # 1].

Furthermore, it was reported that because of stigma and discrimination AGYW opt not to disclose the HIV positive status to family members. This results into limited social support among AGYW who are enrolled in the care and treatment clinic (CTCs). Consequently, they may not consistently utilize available HIV care and treatments services.

"SRH services are available in health facilities, but many adolescents don't want to disclose their HIV status, services are being offered but the adolescents don't want to be seen by the in public receiving them, some even don't want to be tested because they are afraid of being known if they will be diagnosed HIV positive" [Participant 2, FGD # 3].

Moreover, most of the respondent also expressed their view that, probably there is significant number of HIV positive AGYW with unknown status, only that they are afraid how the community would perceive them if they will be found HIV positive. This was well expressed by one of the participants:

"Most of the young people don't seek for testing services because of the fear of being diagnosed HIV positive and how the community would perceive them and how they could copy themselves living with HIV. You may find someone remaining at home until he/she is seriously sick before deciding to seek for health checkups at the health center, this shows self-determination is still also a problem" [IDI 6, 22 year old respondent]

3.2.4 Organizational barriers to accessing SRH services among AGYW living with HIV.

i) Availability of SRH services.

Sometimes health facilities experience shortage of medical supplies due to frequent stock out.

"I may come and find some medicines are out of stock, they will tell me to go and come some other day and I did not come due to lack of money for transport. I stopped taking medication during that period" [IDI 3, 24 year old respondent]

Inconvenience hours were indicated by informants as barrier to accessing sexual and reproductive health services. One respondent during focus group discussion for 20-24 AGYW at Itobo stated.

"Yes others are scared of being seen in the afternoon they would rather come in the evening to hide from people. But to us we have used to peoples talking so we come anytime" [Participant 5, FGD # 3].

ii) Lack of comfortable space at the clinic set up

Most of AGYW reported that the health facilities set up does not guarantee them a comfort space for their age category as they seek for health support from service providers. They don't feel comfortable to be mixed with elder people attending SRH service due to bad judgments directed to them like finger pointing and discussing them as ill-mannered children with immoral behavior.

"Space is a problem; young people are scared of being seen near health facilities because they may be seen by adults who could perceive them negatively" [IDI # 2, 23 year old respondent]

Respondents also indicated long waiting hours as a factor that could lead them fail to utilize the services.

"It is very disappointing when you come and then a provider asks you to wait because of other personal things to do like taking breakfast. Unfortunately they spend long time and we remain waiting, sometimes we are told to go home and comeback the following day" [IDI # 7, 19 year old respondent]

iii) Lack of confidentiality

Some AGYW indicated that service provider's capabilities, attitudes towards service users, and skills to offer confidentiality and privacy as the key fundamental determinants that can either promote or hinder adolescents to access SRH services.

"Some of us (AGYW) we are afraid that they (service providers) will spread our medical information to everyone in the community and they will speak badly about him/her and therefore some opt not to visit health facilities" [IDI # 2, 23 year old respondent]

CHAPTER FIVE

5.0 DISCUSSION

This chapter discusses the key findings from the study on the barriers to accessing sexual and reproductive health services among AGYW living with HIV by exploring. As such it is organized as per thematic areas that reflect specific objectives that the study responded to. The study findings accord the existing literature concerning barriers to accessing health services among AGYW living with HIV.

5.1 Individual Level Barriers to accessing SRH service among AGYW living with HIV

Fear and lack of confidence

Informants in this study view fear and lack of confidence to communicate with service providers as barriers to accessing sexual and reproductive health services. This implies that, because of fear and lack of confidence AGYW find it difficult to communicate their health problems with service providers of their ages or different sex. It was argued AGWY lack confidence to discuss their sexual and reproductive needs with service provider and hence they opt to remain silence with their SRH needs. Another study conducted in Nepal indicated that the young people of Nepal fear sexual health service providers to be judgmental and lack confidentiality(24). Training of health care workers on youth friendly services for young people contribute significantly in disseminating sexual health information and services utilization (45).

5.2 Limited awareness on SRH services

Informants in this reported to know specific services they came for, however, this study has shown that there is limited awareness/understanding among AGYW living with HIV with regard to comprehensive SRH services. Majority of informants stated few type of the services they normally receive at CTC or RCH without knowing they are generally referred as SRH services. This shows that AGYW with limited awareness on SRH are more likely to be

affected much with SRH problems and hence they might affected with other problems related to their ART uptake and their desire to bear children.

This is in agreement with the findings of a study conducted in Sri Lanka, where the researcher found out that adolescents' limited awareness on the available reproductive health services created a barrier to their seeking the services (50). Conversely, a study conducted in Ethiopia found out that adolescents with good knowledge on SRH services are more likely to seek and utilize the available services.

The health sector should work to design inclusive programs which could help to empower young people with awareness of the available health services with the purpose of increasing their ability to utilize the services. Health care workers should also prepare programs that focuses on reaching more adolescents in community and those in schools (33,51).

5.3 Preference for female service providers

Informants indicated that they prefer restrict them from visiting heath facilities to seek for health care services and also utilizing some of the services like contraception. Given the fact that not all health facilities have optimal number of female and male service providers, HIV positive AGYW are more likely to miss services should they have sensitive health issues and find no female service provider to share their information with. This is in agreement with another study (52) that pointed in recent years out that sex concordance between patient and physician has increased in recent years, female feel more comfortable being served by their fellow female service providers.

5.4 Interpersonal Barriers to assessing SRH service among AGYW living with HIV

Use of unfriendly language by the service providers

Informants claimed that sometimes service providers use unfriendly language while communicating with adolescents. Use of unfriendly language by service providers discourages HIV positive AGYW to discuss their health problems with service providers. This suggests that service providers must be trained on how to use young people's friendly languages in

order to attract more young people to access health services in health facilities. The finding is similar to another study that was conducted in Kenya that indicated adolescents are discouraged to access and utilize the SRH services as see consider service providers being too judgmental and fail maintain confidentiality (51).

Other studies indicates similar findings that health care providers may have their personal bias in providing adolescents some of the recommended SRH services worrying of their readiness to receive the information or services (29,35,36,51). Effectively implemented SRH programs would contribute positively to utilization of SRH services among AGYW living with HIV. Health programs should be designed to train more service providers at all levels (national, regional, district and health facility lever level to ensure they all provide quality friendly services (53).

5.5 Denial of permission to seek care by the male partners and or parent(s):

The study established that men have a narrow understanding of a comprehensive sexual and reproductive as a result they tend to restrict their wives from taking some of the services like contraception. This finding indicates that feelings of superiority cause some men to deny their partners permission to seek heath care services in health facilities. Denial have kept AGYW under high risk of transmitting HIV to their children and acquiring new infections because of rooted in gender inequality-related, social, cultural, economic, and human rights barriers, which disproportionately affect AGYW. This is largely influenced by presence of powerful social norms and stereotyping attitudes, regarding male involvement in sexual and reproductive health services, in the communities. Health workers' dual loyalty pressures (professional and community member), attitudes and values, could be a possible explanation. It is true that awareness on partners each other's health needs increase their likelihood to access services (54).

Various studies highlights the need to increase male education on SRH and target information for men this includes initiative like community awareness campaign activities including distribution of IEC materials where male spend time on their own premises (54,55).

5.6 Community level barriers

Stigma and discrimination practices

In this study respondent mentioned that stigma and discrimination surrounding HIV affects their decision to attend clinics seeking for SRH services. This suggests that a significant number of AGYW with unknown status miss HIV testing in health facilities worrying how would other people in the community perceive them if they will be found HIV positive. Because of self-stigma practices some AGYW living with HIV become afraid to disclose their HIV status and hence affect effectiveness in ART uptake. This is in agreement with other two recent studies was conducted in Kenya and sub-Saharan Africa which pointed out that adolescents preferred to access services outside the health centers in order to overcome the stigma attached to accessing RHS services (51,56). SRH services programs targeting adolescents and young people should always consider designing education sessions that could help to reduce stigma surrounding SRH and HIV services that hinder the adolescents from accessing (51,57). A study conducted in Uganda reported that HIV stigma in their communities had declined as a result of the collective activities of groups of people living with HIV (57).

5.7 Financial barriers

Financially dependent respondent especially those living long distances from the health facilities lacks money to cover for the transport costs. This implies that while HIV positive AGYW's financial dependency normally cause them to fail to cover transport medication costs when required and hence affect their ability to visit health facilities every time they experience any health problems or when seeking for information and education. HIV positive AGYW are double burdened as they are required to visit health frequently for both SRH services and HIV services (monthly ARV uptake). This as well, accord with study conducted in Sierra Leone to understand the barriers young people face in accessing FP and SRH services cited distance to health services and the cost as barriers to accessing FP and SRH services, the study revealed young people lack financial independence to cover for the travel costs (30).

Since SRH services is provided free to all HIV positive AGYW, Interventions targeting at strengthening of young people's income like village community savings and loan programs should encouraged to equip AGYW with economic independence. In the study conducted in Côte d'Ivoire assessing Microfinance and HIV mitigation among people living with HIV in the era of anti-retroviral therapy showed village savings and loan programs increase HIV-positive clients' access to money and economic self-sufficiency and eventually increasing their ART uptake(58).

5.8 Organizational level barriers

Availability of SRH services

The findings of the study point out that the lack of comprehensive SRH services and unfriendly characters among service providers is considered a barrier to AGYW's access and utilization of RHS. Through interviewed service providers, some mentioned that they regularly lack some key medications and other supplies like contraceptives making it difficult to provide comprehensive services. Unstable availability of SRH services not only amounts to poor utilization of the services by young people but contributes to poor adherence among AGYW users of ART. This concurs with another the study that was conducted in Kenya to assess sexual and reproductive health service provision to young people in Kenya that presented that shortage of essential equipment and supplies contraceptives) as service barriers to provision of SRH services (59).

Service providers also mentioned that shortage of staffs in health facilities is factors hindering efficient provision of sexual and reproductive health services among young people. This suggest staffing in health facilities is potentially likely to cause long queues of clients coming for services, this affect more young people including AGYW as they mostly feel uncomfortable to wait long hours before they are served. A study conducted in Kenya revealed the similar finding as health care workers indicated that staff shortages and lack of space were the barriers that hindered efficient RHS delivery to adolescents (51). Similar study was conducted in South Africa to access barriers and facilitators of the provision of a youth-

friendly health services that indicated shortages of trained staffs to provide youth friendly services hinders young people access to services(60).

Ensuring stable availability of SRH services and presence of trained and skilled service providers who provide youth friendly services creates enabling environment for provision of high quality SRH services. This is also evidenced being a factor that works in increasing accessibility and utilization of SRH services on many other studies (5,28,51).

5.9 Lack of comfort space at the clinic set up

Informants asserted that they are not comfortable when mixed with elder people when seeking SRH service due to bad judgments provided to them like finger pointing and discussing them as ill-mannered children with immoral behavior. This implies that, there are still little awareness on essentialness of young people seeking SRH services as most of the community members tend to misjudge them, this has caused them fail to seek and utilize the available services. These finding are similar to other study conducted to assess barriers to accessing sexual and reproductive health services among adolescents where long waiting hours and lack of comfort spaces were mentioned as barriers to accessing services among young people (21,33,51) .

Facilities should consider setting special rooms or areas to allow youth to feel comfortable visiting the health facilities. Facilities with trained health care workers on youth friendly SRH services are evidenced to be preferred by majority of informants, this was evidenced in a study conducted in Tanzania Mainland to assess availability and accessibility of adolescent sexual and reproductive health services(28).

5.10 Study limitations and mitigation

This study faced the followinmg limitations:

1. Since the study was qualitative in nature and therefore involved purposive selection of the study sample, its findings cannot be generalized. However, being a qualitative study, its goal was not to generalize but rather to provide rich information on barriers to accessing SRH services experienced by AGYW living with HIV in Nzega DC.

2. Considering that the most of the information under this study fall under sensitive topic, some of the participants especially girls aged 15-19 provided responses that could please the interviewer and health care workers, probably they thought giving much negative response would affect their trend of receiving health care services in health facilities. The principle investigator insisted on the objectives of the study, further reassured them on confidentiality, and also asserted on the importance of giving honest answers in order to obtain truthful information that could be used to improve and provide better SRH services.

CHAPTER FIVE

5.0 CONCLUSION AND RECCOMENDATION

5.1 Conclusion

This study revealed that a socio-ecological modal provides an expedient framework to explore the multilevel barriers affecting AGYW living with HIV in accessing and utilizing SRH services. The study provides additional evidence on presence of several barriers to accessing SRH which results to poor access and utilization of the available services. Factors like fear and lack of confidence, preference for female service providers, limited awareness on SRH services, use of unfriendly language by the service providers, denial of permission to seek care by the male partner and parents, financial hardship and stigma and discrimination practices, availability of SRH services and lack of comfort space at the clinic set creates a barriers to accessing SRH services among AGYW. Certainly there is need for improved SRH services/program to offers comprehensive services to AGYW living with HIV and increased interventions focusing on SRH education to the AGYW and the entire community.

5.2 Recommendations

Based on the findings of this study, the following are recommended:

1. Health systems should design and implement HIV positive AGYW's specific and appropriate interventions focusing on awareness creation and building their confidence in health seeking behaviors to improve access and utilization of SRH services.
2. Council health management team and implementing partners should train health care workers on provision of adolescents and young people friendly services to improve AGYW-provider interactions and health services responsiveness.
3. Council health management team and health facilities need to advocate for stable availability of SRH supplies and commodities, set comfortable space at the clinic set up which guarantee privacy and confidentiality to improve AGYW's readiness to utilize the available SRH services.

4. Health care workers need to work with village leaders to integrate SRH education sessions during general village meetings to address challenges on denial of permission by both parent and sexual partners facing AGYW living with HIV to accessing SRH services
5. Health facilities should identify and link HIV positive AGYW facing financial constraints to economic empowerment stakeholders to strengthen their economic status and equip their financial independence.
6. In order to address stigma and discrimination, and to enhance community readiness to support adolescents and young people to accessing SRH services, District health management team need to work with SRH services implementing partners to design and implement community sensitization interventions focusing on SRH services and HIV/AIDS in particular
7. This study did not look at all 5 levels of the socio-ecological modal, societal level barriers were excluded from the study, the factor that would negatively influence access to SRH services among HIV positive AGYW a gap that is recommended for further research.

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APPENDICES

Appendix 1: Informed Consent Form

INFORMED CONSENT FORM FOR A PARTICIPANT

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DEPARTMENT OF DEPERTMENT OF BEHAVIORAL SCIENCES

FORM NO: ☐

Title of the Research: Barriers to Accessing Sexual and reproductive Health Services among Adolescent Girls and Young Women Living with HIV (aged 15-24 years) – Nzega District"

Principal Investigator: Dionis Masanja Shimbi

Institution and address:

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)

P.O Box 65001,

DAR ES SALAAM – TANZANIA

Introduction

This consent form contains information of the above named research. In order to be sure that you are informed about participating in the research, we are asking you to read (or we read to you) this consent form and understand it. You will also be asked to sign it (or make your mark in front of the witness). You will retain a copy of this form. This form might contain words that are unfamiliar to you, please ask us to explain anything you may not understand.

Before contacting you, we have obtained permission to conduct this study from the district authority, the regional Administrative Secretary and Medical Officer of Dodoma municipal.

Purpose of this study

To assess the individual, socio-cultural and organization barriers to accessing SRH services among HIV positive AGYW in Nzega district.

Participation

We will ask you some questions related to accessing and utilizing SRH services provided in health facilities. Feel free to respond according to your experience in proving or accessing SRH services. You will be asked about the kind of SRH services recommended for adolescents girls and young women. You will also be asked to share your experience on what is considered to be the common individual, inter-personal and organizational barriers to accessing SRH services. Please do feel free to participate.

Confidentiality

All issues concerning your participation will be treated as confidential; no any authorized person will have access to this information. We will be compiling a report, which will contain responses from several participants without any reference to individuals. We will not put your name or any identifying information on the records of the information you provide.

Risks

Be assured that no harm or risk will be involved for those who will voluntarily participate in this study.

Right to Withdraw and Alternatives

Taking part in this study is completely your choice. If you choose not to participate in the study or if you decide to stop participating in the study, you will not get harm. You can stop participating in this study at any time, even if you have already given your consent.

Benefits

Participating in this study will give us an opportunity to identify if there are any individual, social factors and organizational factors influencing access to SRH services among HIV positive adolescents and young women. This information will help create awareness to policy and decision makers on various interventions to address the barriers and make improvement

strategies or interventions for improving access to and utilization of SRH services in the district.

Contact

The research has been reviewed and approved by Ethical Research Committee of Muhimbili University of Health and Allied Sciences (MUHAS). Please if you have any question about your rights as a participant, you may contact Chairman of the Senate Research and Publications Committee, P.O Box 65001, Dar es Salaam (Tel 022-21503002-06, 2152489) or Dr. Tumaini Nyamhanga; MUHAS: P.O Box 65001, Dar-es Salaam. (Tel. 0713 254 000) who is the supervisor of this research.

Agreement Part

I therefore request your participation in this study; participation in this study will involve asking some questions and you will be required to respond according to what you know basing on your own experience on the given options.

DO YOU AGREE? (Please tick for appropriate response)

( ) YES

( ) NO

If you agree, sign below

Participant's sign…….. Date…….

Investigator's sign…… Date…….

Appendix 2: In-depth interview guide AGYW

Basic Information on the setting

1. Date of Interview:
2. Time:
3. Interviewer Name:

Introduction

Self-introduction, name, general affiliation and the purpose of the study

I appreciate that you have taken the time to participate in this research process which we know will greatly help us to understand the barriers to individual, social cultural and organizational barriers to accessing sexual and reproductive health services among HIV positive adolescent girls and young women. The issues we discuss here are completely confident. At any time during the interview, if you feel you need a brake or you not comfortable answering any question let me know.

Introductory information to put the client at ease:

i. Sex
ii. Education Level
iii. Religion
iv. Occupation
v. Marital status

Interview Guide Questions

1. From your perspective, tell me about availability of SRH for adolescents living with HIV
   Probe: Location/ where do adolescents seek SRH services
   Modality of accessing
2. What are the factors enable you to access SRH services?
3. What are the barriers hindering you from accessing SRH services?
   Probe: 1) Individual's awareness of SRH services

a. Individual perception, awareness and experience on SRH services
b. Capability to communicate and negotiate about SRH services (Open talk with financial capability (transport cost, service fees and other needs like food)
c. HCWs of both sex, embarrassment feeling)

Probe: 2: Interpersonal factors and perception on SRH services for AGYW

a. Family/ Social support (financial, encouragement)
b. Stigma and discrimination at family level
c. Role of a male sexual partner
d. Provider's attitude (Relevant skills and friendly environment in provision of HCWs.

Probe: 3 Health facility factors

a. Availability of SRH services/ type of services/ extended hours
b. Adherence to privacy and confidentiality is adhered by HCWs Cost imposed to SRH services,
c. How do they meet these costs?
d. HCWs are judgmental while offering SRH services

4. What can be done to support you to utilize the available SRH services?

Appendix 3: Focus Group Discussion Guide for AGYW (English Version).

Research question: What are the barriers to accessing SRH services among HIV-positive adolescent girls and young women in Nzega District?

Introduction.

I would like to thank you for taking the time to meet with me today. My name is _____ and I will be facilitating this focus group discussion as part of my study that seeks to understand the individual, interpersonal and organizational barriers to accessing SRH services among HIV positive AGYW in Nzega District, Tanzania.

The discussion should take less than an hour. I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments.

All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time. I encourage you to share your opinions with me, because your contribution is valuable and important. Please note that there are no any right or wrong answers, so feel free to express both positive and negative viewpoints

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Kindly sign the below to confirm your participation

Signature (or thumbprint) of respondents:

Self-introductions:

a) Icebreaker Question: Let me start by introducing myself to you and tell me about your personal life, family life/school and age.

Thank you very much and let us begin

Date of FGD: ……

Health Facility Name: ..... Ward: ……. Council: ……..

Questions:

1. From your perspective, tell me about availability of SRH for adolescents living with HIV

   Probe: Location/ where do adolescents seek SRH services

   Modality of accessing
2. What are the factors which enable **AGYW** to access SRH services?
3. What are the barriers that hinder AGYW from accessing SRH services?

   Probe: 1) Individual's awareness of SRH services

   a. Individual perception, awareness and experience on SRH services
   b. Capability to communicate and negotiate about SRH services (Open talk with HCWs of both sex, embarrassment feeling)

   Probe: 2: Interpersonal factors and perception on SRH services for AGYW

   a. Family/ Social support (financial, encouragement)
   b. Stigma and discrimination at family level
   c. Role of a male sexual partner
   d. Provider's attitude (Relevant skills and friendly environment in provision of HCWs.

   Probe: 3 Health facility factors

   a. Availability of SRH services/ type of services/ extended hours
   b. Adherence to privacy and confidentiality is adhered by HCWs Cost imposed to SRH services,
   c. How do they meet these costs?
   d. HCWs are judgmental while offering SRH services
4. What can be done to support you to utilize the available SRH services?

Thank you for your time.

Appendix 4: Consent Letter to Parents/Guardians for the Under 18 years Adolescents (English Version)

P. O. Box 65001
Dar es Salaam.

Dear Parent / guardian of
Child name:

REF: REQUEST FOR PERMISSION TO ALLOW YOUR CHILD TO PARTICIPATE IN AN ACADEMIC RESEARCH ON BARRIERS TO ACCESSING SRH AMONG HIV POSITIVE ADOLESCENT GIRLS AND YOUNG WOMEN IN NZEGA DC.

Please refer to the heading above.

Students from Muhimbili University of Health and Allied Science are in the process of doing various health researches. I, DIONIS SHIMBI, I am conducting research on barriers to accessing sexual and reproductive health services among adolescent girls and young women living with HIV in Nzega district.

As a parent/guardian of one of a potential respondent you are asked to allow your child to participate in this research. These discussions will be voluntary where by every participant may either accept or refuse to answer a question for any reason. All issues concerning your participation will be treated as confidential; no any authorized person will have access to this information.

With this letter, I request that you allow your child to share his opinion with other adolescents in making changes and improve health services provision in the community, and that his participation is important in helping other young people in Tanzania.

I believe that my request will be accepted.

Thank in advance

Appendix 5: Approval for ethical clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

P.O. Box 65001
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Ref. No. DA.287/298/01A/ 22nd May, 2019

Mr. Dionis Shimbi
MPH-Distance Learning
MUHAS.

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: "BARRIERS TO ACCESSING SEXUAL REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENT GIRLS AND YOUNG WOMEN LIVING WITH HIV-NZEGA DISTRICT"

Reference is made to the above heading.

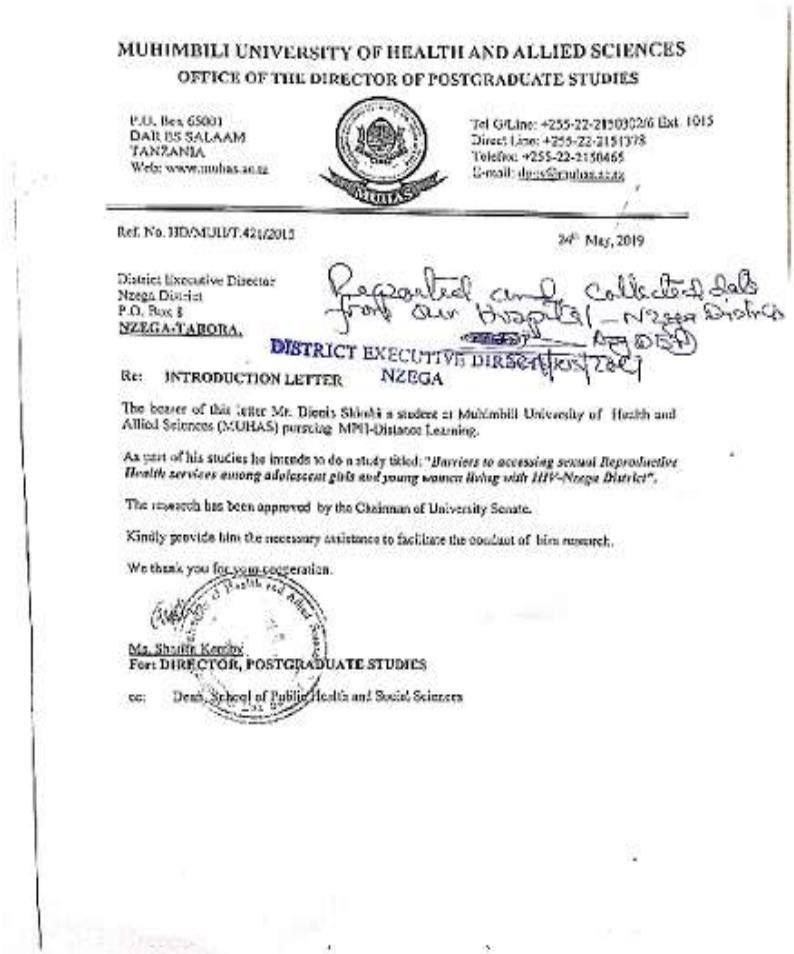
I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from 21st **May, 2019 to 20th May, 2020.** In case you do not complete data analysis and dissertation report writing by **20th May, 2020,** you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Emmanuel Bulandya
ACTING: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
ee: Dean, School of Public Health and Social Sciences, MUHAS

Appendix 6: Introduction Letter



MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
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Ref. No. HD/MUII/T.42/2013

24th May, 2019

District Executive Director
Nzega District
P.O. Box 8
NZEGA-TABORA.

Requested and collected data from our Hospital - Nzega District

DISTRICT EXECUTIVE DIRECTOR
NZEGA

Re: INTRODUCTION LETTER

The bearer of this letter Mr. Dionis Shishi a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing MPH-Distance Learning.

As part of his studies he intends to do a study titled: "*Barriers to accessing sexual Reproductive Health services among adolescent girls and young women living with HIV-Nzega District*".

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of him research.

We thank you for your cooperation.

Ms. Shukia Kambi
For: DIRECTOR, POSTGRADUATE STUDIES

cc: Dean, School of Public Health and Social Sciences