FACTORS INFLUENCING FEMALE PARENTAL APPROVAL OF CONTRACEPTIVE USE AMONG ADOLESCENT GIRLS IN KINONDONI DISTRICT, DAR ES SALAAM, TANZANIA

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Masters of Public Health Dissertation
Muhimbili University of Health and Allied Sciences

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Muhimbili University of Health and Allied Sciences

School of Public Health and Social Sciences



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By

Esteria Kisoka

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

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~~**Muhimbili University of Health and Allied Sciences**~~

~~**October, 2017**~~

CERTIFICATION

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The undersigned certifies that he has read and hereby recommends for ~~examination~~ acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***"Factors Influencing Female Parental Approval of Contraceptive Use among Adolescent Girls in Kinondoni District, Dar es salaam"*** 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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Prof. M.T. Leshabari

(Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

I, –**Esteria Kisoka,** 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.

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Signature…… **Date**……..

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My heartfelt gratitude go to my husband, Syriacus Kimenyi, my lovely daughters Daniella and Dellene, and my mother Paulina Kisoka, for their patience, support and encouragement during the time of development and production of this dissertation.

Last but not least, I would like to thank the entire district and ward executive officers, research assistants and respondents whose approval and acceptance to participate in this study made this work possible.

DEDICATION

To my daughters Daniella Syriacus and Dellene Syriacus

ABSTRACT

Background

Use of modern contraceptive methods among women of reproductive age in Tanzania is low. This contributes to the increase of unintended pregnancy in the country. The impact is significantly demonstrable in the form unintended adolescent pregnancy which has increased in number from 23% in 2010 to 27% in 2015. Parental approval of contraceptive use by adolescent girls is among the strategies proposed for reducing unwanted pregnancies among girls. However, little is known about the extent of female parents' approval of contraceptive use among adolescent girls in Tanzania.

Aim of the study

The aim of the study was to determine factors influencing parental approval of contraceptive use among adolescent girls.

Materials and methods

A quantitative approach utilizing cross-sectional study design involving 202 female parents and guardians living with adolescent girls aged 10-19 years was conducted in Kinondoni District in Dar es Salaam. Analysis of quantitative data was conducted using SPSS version 20 through descriptive, Pearson chi square test and regression analysis methods. In descriptive analysis, frequency measures were used to provide descriptive characteristics of the study population. The degree of association between the variables was tested by using Pearson chi square test with the value of $p>0.05$ at 95% confidence interval was considered to be statistically significant.

Results

A total of 202 female parents were interviewed where only 25.7% reported to approve contraceptive use among adolescent girls. Parents aged $\leq$ 35 years ($p=0.04$) were less likely to approve contraceptive use among adolescent girls than other age categories. Parental communication on sexual and reproductive health issues with adolescents is a significantly related to parental approval whereby one-third (31.2%) of respondents reported to have

discussed sexual and reproductive health related issues with their adolescent daughter covering topics such as HIV/AIDS, STI, sexual relationships, and teenage pregnancy. Very few participants talked with their adolescent girls about abortion and family planning. Parents' level of education was also a significant factor for parental approval of contraceptive use among adolescent girls (p=0.04).

Conclusion: This study revealed, female parental approval on contraceptive among adolescents was relatively low and condom was the contraceptive method recommended by the respondent who approved contraceptive use among adolescents.

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CPR	Contraceptive Prevalence Rate
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
mCPR	Modern Contraceptive Prevalence Rate
MOHCDGEC	Ministry of Health, Community Development, Gender, Elders and Children
MUHAS	Muhimbili University of Health and Allied Sciences
OCP	Oral Contraceptive Pills
PI	Principal Investigator
RA	Research Assistant
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infection
TDHS	Tanzania Demographic and Health survey
TDHS/MIS	Tanzania Demographic and Health survey and Malaria Indicator Survey
WHO	World Health Organization

DEFINITIONS OF KEY TERMS

Adolescence is the period in human growth and development that occurs after childhood and before childhood, from age 10 to 19 years

Contraceptive Prevalence Rate - is the proportional of women of reproductive age who are using (whose partner is using) a contraceptive method at a given point in time

Modern Contraception - the deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse

Unwanted Pregnancy- Not or no longer desired pregnancy

Unsafe abortion - is a procedure for terminating an unintended pregnancy, either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards or both

Female Parent – in this study is regarded as a woman (parent/guardian) who lives with an adolescent girl in her household.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

The World Organization defines an adolescent as an individual between 10 and 19 years of age (WHO, 2008). Globally, the adolescent population is estimated to be 1.25 billion (WHO, 2008). Among these, 513 million are between 15–19 years old [1] and 85% of the total adolescent population lives in developing countries (Belachew et al., 2003). Adolescence is a period of transition, growth, exploration and opportunities. During this phase of life adolescents tend to develop an increased interest in sex with attendant risks of unintended and unwanted pregnancies, other health risks associated with early childbearing, abortion outcomes and sexually transmitted infections (STI) including HIV/AIDS (Oringanje et al., 2010). The use of modern contraceptive methods among sexually active adolescents could help in reducing their health risks such as unwanted pregnancy which may lead to unsafe abortion.

In Tanzania, 23% of the total population is made of adolescents aged 10-19 years, among them 10% are adolescents aged 15-19 years. The mean age for first sex for girls is 17.2 years and for boys is 18.2 years (TDHS, 2015). Among married women of reproductive age, the current modern contraceptive prevalence rate (mCPR) is 32% while sexually active unmarried women age 15-29 years 46% are reportedly using a modern contraceptive method. Contraceptive use among married adolescents is only 13% (TDHS, 2015) where unmet need for family planning among married adolescents is 23% (TDHS, 2015). Despite the knowledge of contraceptive methods among the unmarried adolescents being at 99.8%, contraceptive use is still low.

Low use of modern contraceptive methods among women of reproductive age contributes to the increase of unintended pregnancy in the country. Adolescent pregnancies have increased from 23% in 2010 (THDS 2010) to 27% in 2015 (TDHS, 2015). Most of the adolescent pregnancies are unwanted and may lead to unsafe abortions.

Statistics on unsafe abortion though limited by the lack of openness because of the illegality of the termination of pregnancy, majority of the data available are obtained in hospital settings.

High number of adolescents with self reported induced abortion has been recorded among patients admitted due to incomplete abortion (Rasch, 2000). Similar study conducted in Tanzania found that about a third of the women admitted with complications from an illegal abortion were teenagers (Mpangile et al, 1993).

In many African setting, adolescents are influenced by contraceptive information from the parents, family, schools, peers, healthcare workers, and the media. However, these and other sources of sexually-related information materials have been found to be inaccurate, ambiguous, misleading and causing negative impact on sexual behavior and contraceptive use (Kinaro et al, 2008). Similarly, these materials lacked guidance on the methods or language to use when discussing sexuality issues with adolescents, leaving messages passed, to individual interpretations (Kinaro et al., 2008).

In a study conducted in Nigeria, it was reported that there was a difference opinions between parents and teachers on the use of contraceptives by adolescent girls. In this study it was reported that majority of the women did not encourage girls to use contraceptives. Contrary to these findings, more teachers reported to encourage adolescent girls to use contraceptives due to the chance of them getting pregnant and abandon school which then affects their efforts at attaining one's intended goals in life.

Although contraceptive use among adolescent girls is low in the Tanzanian context, little is known and documented about parents' approval regarding access to and use of modern contraceptives among adolescents.

1.2 Statement of the problem

Despite the availability of a free range of modern contraceptive methods in Tanzania, use rate among women of reproductive age (15-49 years) is relatively low (32%), and for adolescents, the rate is only 13.3%. This situation contributes to high rates of unwanted pregnancy and unsafe abortions. In Tanzania, 27% of women in the age range 15-19 years have begun childbearing, 21% have given birth, and an additional 6% are pregnant with their first child (Tanzania Demeographic Health Survey, 2015). Unmet needs for family planning among married adolescents is 23%. Pregnancies among adolescents have increased from 23% in 2010 to 27% in 2015 (Tanzania Demeographic Health Survey, 2015). The Low use of modern contraceptives among adolescent girls is a major contributor to high rate of reproductive health risks in this group, including unwanted and unsafe abortions. Adolescents contribute 50% out of all abortions in the country.

A study conducted in Nigeria revealed that 69.3% of parents had negative attitudes toward the provision of contraception education to adolescents (Olufeni et.al., 2013). This finding deviates from WHO recommendations which say that adolescent fertility regulation and pregnancy prevention is one of the most important health-care issues of the twenty-first century (WHO, 2008). A study by Widman et al. (2015) revealed that maternal communication is more strongly associated with safe sex behaviors among adolescents relative to parental communication among adolescents. It was noted that adolescents with positive feelings about their mothers were more receptive to communication and to share messages about use of contraceptives, including and condom.

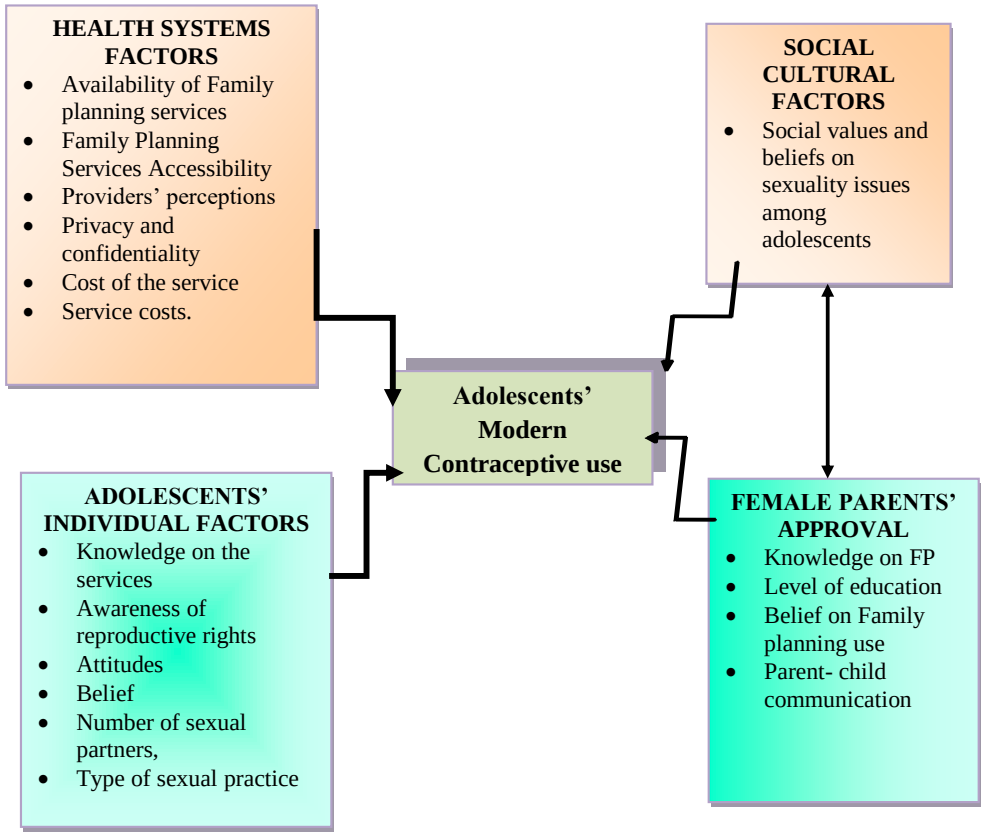
A number of studies (Brody et al., 1978, Shah et al., 1981) indicate that parents are the best source of information about sexuality education among adolescents. Children whose main source of sexuality education is parents tend to be less sexually active before marriage and have fewer sexual partners. A study by Kinaro(2015) revealed that the majority of parents never discussed sexuality issues with their adolescent children. Two-thirds (65%) of them did not approve contraceptive use by unmarried adolescents. Existing reproductive health policies, guidelines and standards advocate for the rights for adolescents to access

contraceptive knowledge, information and use (Tanzania Guideline Policy on Adolescent reproductive rights, 2010). In addition, different programs in the country have been focusing on enabling environment for adolescents to access reproductive health services, including contraceptive information and free use of services (Tanzania Guideline Policy on Adolescent reproductive rights., 2010).

However, little is known about parental acceptance to such suggestions. The extent to which female parents know and use modern contraceptives is not well documented and no one knows if there is any relationship between contraceptive use by parents and how such behavior relates to their will to allow such pregnancy preventive measures to be used by their adolescent girls. It is for this reason this study was designed

1.3 Conceptual Framework

Contraceptive use among adolescent girls is associated with a number of factors. This conceptual framework highlights the relationship of different variables and how they contribute to contraceptive use among adolescent girls.



Female parent approval

The Female parents' approval framework shows that parents knowledge on Family Planning (FP), level of education, parents' family planning use, parent-child communication influence female parental approval to contraceptive use among adolescent girls.

Social and cultural factors

Social and cultural factors framework shows that social values and belief on sexuality education, information, and services among adolescents may affect the parental approval and also the use of modern family planning methods among adolescents.

Health system factors

Framework on health system factors highlights its relationship with contraceptive use among adolescent girls. Availability, affordability and accessibility, providers' perceptions and privacy all contributes to utilization of modern contraceptive methods among adolescent girls.

Adolescent individual factors

Individual factors such as knowledge, perception, belief, type of sex, number of sexual partners, awareness of reproductive health rights, and parental approval have a relationship and may influence of the utilization of modern contraceptive among adolescent girls.

1.4 Rationale of the study

Understanding the factors influencing female parents' approval of modern contraceptive use among adolescent girls can help provide information on the extent of parents' approval contribution to the use of contraceptives among adolescent girls. This study, hence can be useful in informing policy makers and programmers on the importance of involving parents in the process of developing policies, guidelines and programs related to adolescent reproductive health as they contributes to the increase of modern contraceptive use among adolescents.

The study will contribute to the work of a social marketing firm, Population Services International (PSI – TZ), its program staff and other stakeholders on the importance of involving parents fully during the development to execution of reproductive health projects targeting adolescents in the country.

1.5 Research questions

This study intended to address the following questions:

1. What proportion of female parents approves contraceptive use by adolescent girls in Kinondoni district?
2. What proportion of female parents communicates sexual reproductive issues, including family planning with their adolescent girls?
3. What is the level of contraceptive knowledge among female parents of adolescent girls in this district?
4. What type of modern contraceptive methods do female parents approve for use by adolescent girls?

1.6 Objectives

1.6.1 Broad objective

To determine factors influencing female parents' approval of contraceptive use among adolescent girls in Kinondoni district, Dar es Salaam.

1.6.2 Specific objectives

1. -To determine the proportion of female parents who approve contraceptive use among adolescent girls in Kinondoni district.
2. To determine the proportion of female parents who communicates sex related issues with adolescent girls in the district.
3. To determine the level of contraceptive knowledge among mothers of adolescent girls in the district.
4. To identify the type of modern contraceptive methods that female parents would approve for adolescent girls in Kinondoni district.

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CHAPTER TWO

2.0 LITERATURE REVIEW

Proportional of Parents who approves on contraceptive use among adolescent girls

2.1 Parents' attitude towards contraceptive use by adolescents

A few studies have examined parental attitude towards the use of contraceptives by adolescents and concluded differently. Olufemi and colleagues, for instance, examined parental attitude towards the use of contraceptives by adolescent girls in Osun State and found that there was no significant relationship between the use of contraceptives among adolescent and parental knowledge of contraceptives (Olufemi, et al., 2013). Moreover, the study found that parents did not support contraceptive use among their girls believing that it would subsequently increase the rate of teenage pregnancies and associated problems. In another study, Wibbelsman (2014) showed that parental acceptance of teens' autonomy was significantly associated with increased acceptability of all methods of modern contraception. Parental recognition of their teen's autonomy was associated with greater parental acceptability of clinicians providing their adolescents with contraceptives regardless of the specific type of method being offered.

2.2 Parents perceptions on contraceptive use among adolescents

A study conducted in Kenya to explore and identify barriers and perceptions that affect contraceptive use among female and male adolescents in the country made the findings that the overall results of perceptions on contraceptive use among adolescents from the parents, teachers and adolescent were negative with about 65.1% of parents or guardians objecting to

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contraceptive use by unmarried adolescents and 67.6 % of the adolescents disapproving of contraceptive use by unmarried adolescents. Narratives also show that teachers and parents focus on discouraging contraceptive use by unmarried adolescents (Kinaro et al., 2015).

Although the theory of perception formation emphasizes the role of the environment in shaping behavior [14] teachers and parents who are change agents are facing some challenges in their attempts to do so. While teachers experience the lack of adequate skills to teach adolescent girls about sexuality, parents culturally find it difficult to communicate sexuality issues with their adolescent children. A study carried out in Nairobi, the perceptions and factors discussed included parental approval, opinion of unmarried youth to use contraceptives, ability of adolescents to access contraceptives for self, and partner communication regarding contraception (Kimani, et al. 2015). The study indicates that parents and teachers hold negative perceptions about contraception making them focus on communicating the negative effects of contraceptives when delivering sex-related messages to their students. Many parents would also not allow their children to use contraceptives; they would be annoyed and very few parents talked about the advantages of contraceptives with their teenage children while citing the disadvantages of contraceptives as their main focus of discussion. Despite family and school being considered critical socialization institutions [15], teachers and parents' focus on discouraging use of contraceptives among adolescents poses a significant challenge in the designing and implementing of policies and programs aimed at encouraging contraception.

Proportion of parents who communicates sex related issues with adolescent girls

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2.3 Parents communication on sexual reproductive health issues to adolescents

In a study conducted in Ghana, researchers analyzed adolescent girls' views on the factors associated with teenage pregnancies and found that the girls do talk about sexuality with their mothers at home and did receive some form of sexual and reproductive health education, including the use of condom discussions in schools. (Krugu, et al., 2016). Girls reported high awareness of pregnancy, risks related to unprotected sex, were positive about using condoms

and indicated strong self-efficacy beliefs towards negotiating condom use (Krugu, et al., 2016).

Determine the level of contraceptive knowledge among parents

2.4 Inadequate contraceptive knowledge and its contribution to negative perceptions towards contraceptive use

A study on adolescents', parents' and teachers' perceptions and barriers to contraceptive use among adolescents conducted in Kenya suggested that misconceptions about contraceptive use among adolescents, parents and teachers seemed to have contributed to low contraceptive use among adolescents in the country (Kinaro, 2015). Unfavorable perceptions played greater role compared to barriers such as sexual partner communication, opinion on adolescents to use a contraceptive and ability to seek contraceptives. On perceptions, 65% of parents would object to unmarried youth using contraceptives while 23% of adolescents approved unmarried youth to use contraceptive methods. Overall, barriers factors did not seem to influence respondents to use contraceptives. Knowledge of where to get contraceptives was the main barrier factor found to demotivate adolescents to use contraceptives. In addition, this study shows that parental approval of contraceptive use among adolescents was significantly associated with contraceptive use.

2.5 Parental approval on contraceptive use among adolescents

One study on the effects of mandatory parental notification of prescribed contraceptives on use upon seeking sexual health care services by adolescent girls reported that 59% of girls reported that they would stop using all sexual health care services, delay testing or treatment for human immuno-deficiency virus (HIV) or other sexually transmitted diseases (STDs), or discontinue using specific services because of the requirement for mandatory parental notification (Reddy, et al., 2017).

In another study that aimed at determining the extent to which parents were aware of their teenage daughters accessing reproductive health services and how minors would react to parental involvement laws on prescription of birth control revealed that among all adolescents 59% would use the clinic for prescription contraception even if parental notification were mandated (Jones, et al., 2017).

Most adolescent females seeking family planning services reported that their parents were aware of their use of the services and most would continue to use clinic services since parents were aware of such decisions.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

This was a community-based descriptive cross-sectional study.

3.2 Study area

The study was conducted in Kinondoni district as this is the district with more youth compared to other districts in the region. The district is located in the northern part of the city of Dar es Salaam. The area of Kinondoni is 531 km², the latest population census of 2012 showed that population of Kinondoni was 1,775,049: 914,247 female and 860,802 male. There are 446,504 households in Kinondoni with the average of 4 people per household. Administratively, Kinondoni District is broken into 4 divisions, 27 different wards, and 113 sub-wards. (Tanzania Census, 2012).

3.3 Study population

The study population was female parents/guardians of adolescent girl aged 10-19 years in Kinondoni District, Dar-es-Salaam.

3.3.1 Participant inclusion criteria

- Adult Female (biological mother or guardian)
- Living with at least one adolescent girl in the household

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3.3.2 Participant exclusion criteria

- Cognitive impairment

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3.4 Data collection techniques and tools

An interview guide was used to generate data for this study. Questions were first developed in English and then translated into Kiswahili language that is clearly understood by almost all study participants. The interview guide questions focused on demographic characteristics, parent-adolescent communication on sexual and reproductive health (SRH) issues, parents' contraceptive knowledge, practice and use, parent's approval and preferred modern contraceptive methods for the adolescent girls. The data collection tool was pretested to test on a sample of 20 mothers of adolescent girls from a ward in the district which was not involved in the study for clarity of questions. Corrections were made to bring a meaning and logical sequence of the questions before the beginning of data collection. The tool was also shared to peers and colleagues to make sure that the concepts measured reflected what objectives of the study intended to measure from the study participants.

3.5 Research assistants

Through interviews, three research assistants experienced in data collection, particularly in reproductive health studies, were recruited and trained. The research assistants were trained after a brief overview of the purpose of the study. The major purpose of the training was to briefly inform the research assistant on the overview of the study, how to conduct interviews after requesting and signing of consent form by the interviewee and how to establish and maintain rapport with study participants.

3.6 Sample size and sampling procedure

3.6.1 Sample size

The sample size was calculated using the formula

N=$\underline{Z^2P\ (100\text{-}P)}$ (Leslie K et al., 1965)

E^2

$$N = \frac{Z^2}{E^2}(100 - P)1)$$

(Leslie K et al., 1965)

N = Sample size

Z = Standard normal deviation at 95% confidence level, equal to 1.96

P = 13.3%

P was the Adolescent Modern Contraceptive Prevalence Rate (mCPR) (TDHS, 2015)

Margin of error, equal to 5%

$N = (1.96)^2 \times 13.3\ (100-13.3)/5^2$, equal to 177.18

To mitigate errors that may occur in some of the data collected, an additional 13% of the calculated sample size was added to make a total of 202 study participants.

3.7 Sampling technique

The study used multistage sampling technique to select the study sample. In the first stage, a list of wards in Kinondoni district (N=20) was obtained from the district municipal office and four (4) wards were selected randomly (Kigogo, Kawe, Mbezi juu and Tandale). From each selected ward four (4) streets were randomly selected from the list of streets in the wards provided by the ward executive officials, except for Kigogo ward which has only 3 streets and all were included in the sampling frame of streets. The households were the sampling frame. From each selected street, 14 eligible households with female parents living with adolescent girl(s) were randomly selected from the list of households with parents living with adolescent girls. From each selected household only one female parent was interviewed and for households with more than one eligible female parent, one was randomly selected and included in the study sample. For a household with more than one adolescent girl, the selected women were asked to answer questions with focus on the elder adolescent in the household.

3.8 Data management, quality control and analysis

The collected data was checked by the principal investigator on a daily basis for completeness, consistency and accuracy. The level of knowledge of family planning issues (contraceptive) was measured using 14 knowledge questions where the questions were marked and right the answer was given a score of one and a wrong answer was given a score of zero. The overall score of each study participant was obtained by adding all the correct answers and converted into percentage. The scores of the study sample were arranged in an ascending order and respondents who scored 0 to 42.8 percent were classified to have low knowledge, 42 to 64.2 percent moderate knowledge, and scores of above 64.3 were classified as high knowledge. Data was entered and analyzed using the Statistical Package for Social Sciences (SPSS) software version 20.

Descriptive statistics/ cross tabulation was used to determine the description characteristic and proportional of parents approving contraceptive use among adolescent girls.

The degree of association between the variables was tested by using pearson chi square test. A value of $p>0.05$ at 95% confidence interval was considered to be statistically significant.

Regression models were also used to examine the association between parental approval of contraceptive use among adolescent girls and the age of the respondent, marital status, level of education, religion, contraceptive knowledge, and use of contraceptives in communicates with adolescent girls. Binary logistic regression analysis was first conducted to examine the factors associated with parental approval of contraceptive use among adolescent girls. Factors with p-value less than 0.2 were introduced into multiple logistic regression models to examine independent factors associated with parental approval of contraceptive use among adolescents. The level of significance was taken at p-value less than or equal to 0.05 in two tails.

3.9 Variables

3.9.1 Dependent (outcome) variable

Parental approval of contraceptive use among adolescent girls

3.9.2 Independent (determinant) variables

1. Female parents' contraceptive knowledge,
2. Female parent current use of contraceptives,
3. Parent-adolescent communication,
4. Religion.
5. Age of the respondent by range
6. Level of education
7. Marital status
8. Respondent's use of contraceptive during her adolescence period.

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3.10 Ethical Clearance

Ethical clearance was obtained from the research and publication committee of the Muhimbili University of Health and Allied Sciences and it was then was sent to the local authority within the study area – the office of the District Executive Director (DED) in Kinondoni District. A letter permitting to carry out the study in the mentioned wards was then shared to the ward and streets executive officers to approve the principal investigator and research assistants to interview female parents in the households' respective streets. During data collection, the study participants were given information on the study and were assured that all data was confidential and was going to be analyzed as aggregates. Written consent was obtained from individual respondents who agreed to be interviewed. The interviews were conducted in a place where privacy and confidentiality were assured.

CHAPTER FOUR

4.0 RESULTS

4.1 Demographic information

A total of 202 female parents or guardians living with an adolescent girl participated in this study. Their age ranged from 20 to 75 years with a median of 38 years. About one third (35%) were young adults under the age of 35 years and 24% were older adults above the age of 45 years. Two-thirds of the participants (69%) were married, 11% were single and the rest belonged in other marital categories. Almost two-thirds (64%) had primary education, 21% were secondary or post-secondary school graduates while 15% had no formal education. About half (54%) of the respondents were Christian and the rest were Muslim. As indicated in the table 1 below, half (51%) of the respondents were self-employed and a quarter (26%)were unemployed.

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Table ~~1~~1: Demographic characteristics of the study participants

Characteristics	Frequency -(N(%)
Age Groups	
≤35	70 (35%)
36- 44	82(41)%
≥45	50(25)%
Total	202(100%)
Marital Status	
Married	141(70%)
Single	23(11)%
Others (Widow, Divorced, separated)	38(19%)
Total	202 (100%)
Level of education	
Informal Education	31(15%)
Primary Education	129(64%)
Secondary Education +	42(21%)
Total	202(100%)
Religion	
Christian	108(54%)
Muslim	94(46%)
Total	202(100%)
Occupation	
Employed	43 (23%)
Self-employed	95(51%)
Unemployed	48(26%)
Total	202(100%)

Source: Fieldwork, 2017
N=202

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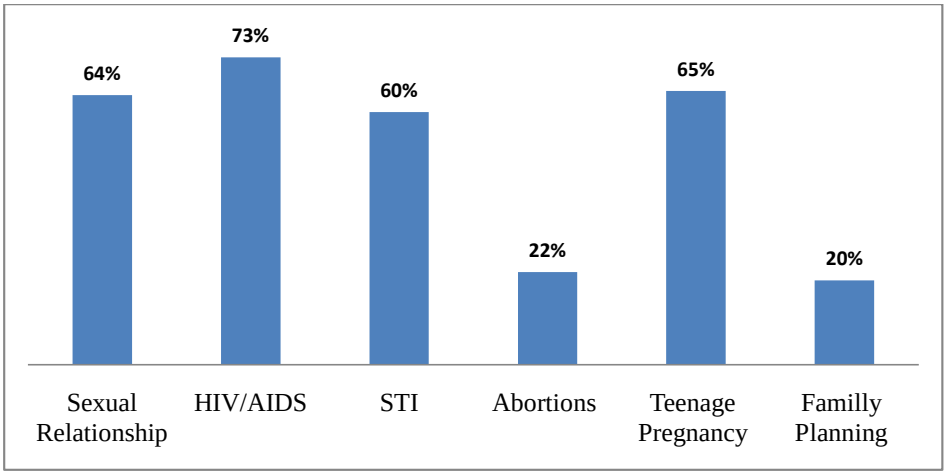
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4.2 Female parents' communication with adolescent girls about sexual and reproductive health issues

Respondents where first asked if they had ever generally discussed/ talked issues related to reproductive health with their adolescents girls. Only one-third (31.2%) of the respondents said they had done so. Specific issues discussed are summarized in figure 1.

HIV/AIDS was the most common topic the mothers discussed with their adolescent daughters followed by teenage pregnancy and sexual relationships. Fairly few (19.8%) talked about family planning issues with their adolescent girls.

Figure ~~1~~1: ~~.~~ Female Parents' Communication about Sexual and Reproductive Health Issues by Topic



The percentage of study participants who discussed about various sex and reproductive health issues with their adolescent girls increased with increasing age except for HIV/AIDS where mothers who were 36 to 44 years were more likely to discuss such issues compared to those in other age groups. These variations were statistically significant for discussions on

HIV/AIDS (χ^2= 9.3, p =0.01), STIs (χ^2 =7.5; p =0.023) and teenage pregnancy (χ^2 =11.7; p =0.003).

The percentage of mothers who discussed issues related to sexual relationships with their daughters increased with increasing level of education. However, the variation of level of education and talking to adolescent girls about sex and reproductive health issues was not statistically significant.

Table 22: Variation of the Extent Mothers Talk about Sexual and Reproductive Health (SRH) Issues to Their Adolescent Girls by Selected Demographic Characteristics

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Variable	Sexual relationship	HIV/AIDS	STI	Abortion	Teenage Pregnancy	Family planning
	Yes (%)	Yes (%)	Yes (%)	Yes (%)	Yes (%)	Yes (%)
Age Range						
≤ 35	37(54%)	43(62%)	33(48%)	13(19%)	34(49%)	11(16%)
36-44	57(70%)	69(84%)	54(66%)	19(23%)	60(73%)	16(20%)
≥45	35(70%)	36(72%)	35(70%	12(24%)	37(74%)	13(26%)
Total	129	148	122	44	131	40
Religion						
Muslim	62(67%)	69(67%)	62(18%)	17(20%)	66(71%)	19(20%)
Christian	67(62%)	79(57%)	60(25%)	27(19%)	65(60%)	21(19%)
Total	129	148	122	44	130	40
Education level						
Informal	18(62%)	23(79%)	18(62%)	4(14%)	21(72%)	5(17%)
Primary	83(64%)	94(72%)	78(60%)	29(22%)	83(64%)	2(620%)
Secondary +	28(67%)	31(74%)	26(62%)	11(26%)	27(64%)	9(21%)
Total	129	148	122	44	131	16

Source: Fieldwork, 2017

4.3 Respondents' awareness of different types of contraceptive methods

Almost all respondents (96%) reported to have heard of family planning methods. Injectables were the most commonly mentioned method (88.1%) followed by oral contraceptive pills (83.7%). Tubal ligation (5.9%) and vasectomy (8.4%) were the least known among the modern methods of contraception.

Table ~~3~~3: ~~.~~Respondents Awareness of Different types of Contraceptives

Variable	Frequency (%)
Type of Family Planning Heard	
Breastfeeding	2(1%)
Withdrawal	8(4%)
Calendar	34(17%)
Male condom	85(42%)
Female Condom	33(16%)
Oral contraceptive pills	169(84%)
Injectable	178(88%)
Implants	158(78%)
IUCD	119(59%)
Female Sterilization (Tubal ligation)	12(6%)
Male Sterilization (Vasectomy)	17(8%)

Given that almost all the mothers were aware of family planning methods, an attempt was made to measure their level of knowledge on these issues. Fourteen questions were used to measure contraceptive knowledge of the study participants. Each correctly answered question scored one point and wrong answers were given a zero score. Overall scores obtained by the study participants varied from 21.4% to100%. All those who scored less than 6 points (0 to 42.8%) were classified to have low contraceptive knowledge while those whose scores varied from 42.9% to 64.3 were classified as having moderate knowledge. Study participants with scores above 64.3% had good contraceptive knowledge.

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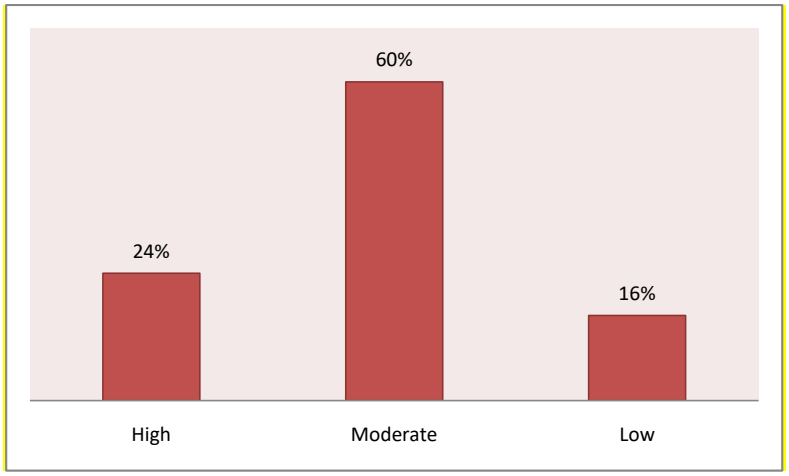
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Figure 22: The Level of Contraceptive Knowledge of Respondents



As summarized in figure 2, 60.4% of the respondent had moderate contraceptive knowledge and 15.8% had low knowledge.

Interpret the figure before getting into how knowledge varies by selected independent variables.

Respondents' Level of Contraceptive Knowledge by Age, religion, Marital status and Education of the Mother

The number of respondents with high contraceptive knowledge scores increased with increasing age while those with low contraceptive knowledge scores decreased with

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increasing age. However, these variations were not statistical significance (χ^2 =3.2; p =0.5). Also, the relationship between the level of knowledge and religion was not statistically significant (χ^2 = 5.7; p = 0.59). Only 17.3% of married respondents had high contraceptive knowledge scores compared to 30.4% of those who were single and 30.6% of those in other marital categories. These variations between knowledge scores and marital status were statistically significant (χ^2=21.7; P=0.016).

Table 44: ~~;~~ Variation on the Respondents' Level of Contraceptive Knowledge by Age, religion, marital status and Education of the Mother

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Variable	Level of Contraceptive Knowledge		
	High Yes (%)	**Moderate Yes (%)**	**Low Yes (%)**
Age, Range			
≤ 35	19	63	19
36 - 44	24	59	17
45+	30	60	10
Religion			
Muslim	18	69	13
Christian	29	53	19
Marital status			
Married	17	64	19
Single	30	52	17
Others	31	63	6
Education level			
Informal Education	40	53	7
Primary Education	23	61	16
Secondary	14	64	21

In terms of education level, the percentage of study participants who had high level of contraceptive knowledge decreased with increasing level of education while that of respondents whose level of contraceptive knowledge is moderate knowledge as well as those

with low knowledge increased with increasing level of education. These variations were however not statistically significant (χ^2 =7.7; p=0.12).

4.4 Approval of Contraceptive Use by ~~the Mothers~~the Mothers/Guardian

-Approval of contraceptive use by female parents of the adolescent girls was generally low. Only 25.7% of participants approved contraceptives use and 26.2% had a similar opinion for their own daughters.

Table 5: Variation of the Respondents' Approval of Contraceptive Use among Adolescent Girls by demographic characteristics and contraceptive knowledge

Variable	Approval to Any Adolescent	Approval to Adolescent Living within the Household	Approval to Respondents' Own Adolescent
	Yes (%)	Yes (%)	Yes (%)
Age, Range			
≤ 35	24(35%)	25(36%)	26(38%)
36-44	21(26%)	21(26%)	21(26%)
≥45	7(14%)	8(16%)	6(12%)
Marital Status			
Married	35(67%)	37(69%)	36(68%)
Single	8(15%)	8(15%)	8(15%)
Others	9(17%)	9(17%)	9(13%)
	52(26%)	54(27%)	53(26%)
Religion			
Muslim	24(46%)	25(46%)	24(45%)
Christian	28(54%)	29(54%)	29(55%)
	52(100%)	54(100%)	53(100%)
Contraceptive knowledge			
High	7(15%)	7(15%)	7(15%)
Moderate	31(26%)	33(27%)	32(26%)
Low	14(44%)	14(44%)	14(44%)
	54(26%)	54(27%)	53(26%)

When approval was examined across different demographic characteristics and contraceptive knowledge of the mothers/guardians, it was noted that approval decreased with increasing age of the mothers. These variations were statistically significant in general (χ^2 =6.2; p=0.046) for adolescent who were not their biological child (χ^2 =6.2; p=0.046) as well as those who were respondents' own children (χ^2 = 9.88; p=0.007).

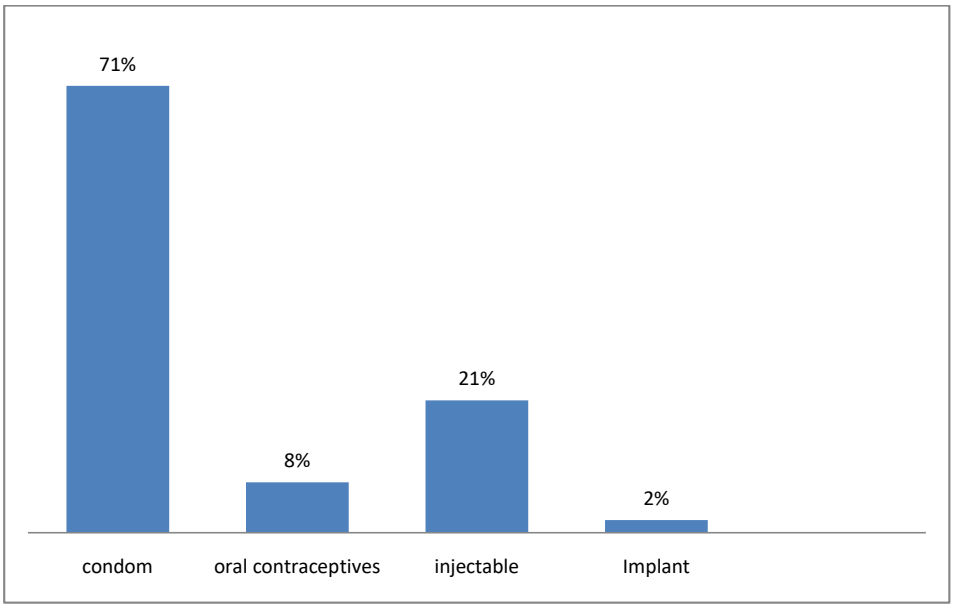
As indicated in table 9, a higher percentage of married mothers were more likely to approve contraceptive use by adolescent girls compared to single mothers as well as those in other marital categories. However, the differences were not statistically significant (χ^2 =5.8; p =0.3). Similarly, religion as well as variations in the level of contraceptive knowledge of the mothers did not have a statistically significant difference regarding approval of contraceptive use by adolescent girls (χ^2=0.03; p=0.9).

When approval was examined across levels of contraceptive knowledge of the study participants it was noted that the percentage of respondents who approved increased with decreasing contraceptive knowledge. The percentage of mothers who approved contraceptive use by adolescent girls decreased from 14.6% among those with high contraceptive knowledge scores to 43.8% of respondents with low scores. These variations were statistically significant (χ^2=8.5; p=0.014).

4.5 Type of contraceptive methods female parents recommended for adolescent girls.

Results presented in Figure 3 shows types of contraceptive methods recommended for adolescent girls by the study participants. Condom was the most common method recommended followed by injectables and oral contraceptive.

Figure 33: ~~:~~ Type of Contraceptive Method Recommended for Adolescent Girls by Their Parents



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Table ~~5~~6: Variation of Approval of type of Contraceptive Methods across Socio-demographic Characteristics of the Respondents

Variable	Condom		Oral Pills		Injectable		Implant	
	N	(%)	N	(%)	N	(%)	N	(%)
Age (years)								
≤ 35	20	27	2	3	7	10	1	1
36-44	19	23	1	1	2	2	1	1
≥45	5	10	2	4	2	4	-	-
Total	**44**	**60**	**5**	**8**	**11**	**16**	**2**	**2**
Religion								
Muslim	23	25	3	3	7	7	-	-
Christian	21	19	2	2	4	4	2	2
Total	**44**	**44**	**5**	**5**	**11**	**11**	**2**	**2**
Marital status								
Married	31	22	2	1	6	4	1	1
Single	5	22	1	4	-	-	1	4
Others	8	20	2	5	5	13	-	-
Total	**44**	**64**	**5**	**10**	**11**	**17**	**2**	**5**
Level of Education								
informal Education	9	30	1	3	5	17	-	-
Primary Education	26	20	3	2	5	4	2	2
Secondary Education	9	21	1	2	1	2	-	-
Total	**44**	**71**	**5**	**7**	**11**	**23**	**2**	**2**

4.6 Type of contraceptive methods female parents recommended for adolescent girls.

The table shows that the approval rate of condom as a contraceptive method of choice was relatively higher as compared to other methods of contraception namely oral pills, injectables and implants. This was the case for all socio-demographic characteristics namely age, religion, marital status and level of education of respondents. The approval of condom use by the respondents decreased with increasing in age. These variations were not statistically significant (χ^2=1.5; p=0.47).

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Table 67: Multiple Logistic Regression; Influencing Factors on Female Parent Approval of Contraceptive Use among Adolescent Girls

	N (%)	Binary Logistic Regression	Multiple Logistic Regression
Risk Factor		**OR(95%CI)**	**AOR(95%CI)**
Age			
≥35Years	30(48%)	0.31(0.12-0.78)	0.26(0.74-0.94)
36-44Years	23(37%)	0.47(0.18 - 1.21)	0.39(0.11-1.37)
≤45+	9 (15%)	1	
Total	62(100%)		
Marital status			
Married	40(65%)	0.85(0.37-1.97)	1.54(0.47-5.06)
Single	7(11%)	0.54(0.17-1.69)	0.88(0.18-4.16)
Others	15(24%)	1	
Total	62(100%)		
Religion			
Muslim	33(53%)	0.99(0.53 - 1.87)	
Christian	29(47%)	1	
Total	62(100%)		
Education level			
Informal education	15(24%)	0.44(0.15-1.27)	0.18(0.04 -0.73)
Primary	36(58%)	0.47(0.18-1.21)	0.71(0.27-1.81)
Secondary+	11(18%)	1	
Total	62(100%)		
Contraceptive Knowledge			
High	45(24%)	4.56(1.57-13.19)	4.67(1.28-16.96)
Moderate	111(60%)	2.25(1.00-5.07)	3.02(1.15-7.88)
Low	30 (16 %)	1	
Total	186(100%)		
Currently Using Contraceptive			
Yes	47 (25%)	1.52(0.72-3.21)	0.97(0.39-2.41)
No	139 (75%)	1	
Total	186(100%)		
Communicates with Adolescents			
Yes	60 (31%)	1.93(1.00-3.72)	3.14(1.38-7.16)
No	126 (69%)	1	
Total	186(100%)		
Used Contraceptive at Adolescent Age			
Yes	44 (24%)	1.44(0.71-2.91)	
No	142 (76%)	1	
Total	186(100%)		

In multiple logistic analyses only factors with less than 0.2 in bivariate analysis were in cooperated in the model. The analysis results several factors to be independent predictors of parental approval of contraceptive use among adolescent.

Factors found to be independent predictors include, age category of respondents where those with ≥ 35 years old were less likely to approve contraceptive use among adolescents compared to other age categories and the different was statistically significant (AOR=0.26,95%CI(0.74-0.94), respondent level of education was another factor all levels of education of respondents were significantly associated with parental approval of contraceptive use among adolescent; no formal education(AOR=0.18,95%(0.04-0.73)) primary education (AOR=0.71(95%CI0.27-1.81))

Despite respondents with high contraceptive knowledge had higher odds ratio than respondent with moderate contraceptive knowledge the difference is statistically significant (AOR=4.67,95%CI(1.28-16.96)). Another factor which was statistically significant associated with parental approval was parents who communicate sexual reproductive health with adolescent (AOR=3.14, 95% CI(1.38-7.16)

CHAPTER FIVE

5.0 1 DISCUSSION

This study assessed factors influencing female parental approval of contraceptive use by adolescent girls in Kinondoni district, Dar es Salaam region.

Many study participants (60.4%) had moderate knowledge on contraceptive methods. This finding was similar to the study conducted in Nigeria on parent's attitudes on the use of contraceptives among adolescents done in Nigeria (Olufemi et al., 2013) where it was found that 69.3% of female parents were aware of contraceptive methods.

In this study, only 19% of respondents with high knowledge of contraceptives reported using contraceptives and 21% of respondents with high contraceptive knowledge reported to have used family planning services during their adolescence period. This is contrary to the findings of a study conducted in Nairobi which revealed that the knowledge of how to use contraceptive methods significantly influences use of contraceptives (Kinaro et al., 2015).

Also, only a third (31.2%) of the study respondents reported communicating sexual reproductive related issues to their adolescent girls. Such discussions mainly focused on HIV/AIDS, STI, sexual relationships and teenage pregnancy. Very few respondents reported having talked with their adolescent girls about abortion and family planning. These findings are similar to a study carried out in Kenya on parents' child communication which indicated that most of the discussions at home and in school did not focus on preventing unplanned pregnancies (Kinaro et al., 2015).

Parents reported to start the reproductive health-related discussion with their adolescent girls once they know or assume they have started menarche. In this study, only 44% of the study respondents reported to know when their adolescent girls had started their menarche. This finding is in line with the findings of a study by Bonafide (2015) which revealed that parent-adolescent communication and parent responsiveness to sexual discussions play an important role in delaying early sexual intercourse and that this is especially true for girls.

Parental approval on adolescent girls' contraceptive use was found to be low. Only a quarter of the respondents reported to approve contraceptive use among adolescent girls regardless of whether or not if the said adolescents were their biological or non-biological daughters. Of the parents who support contraceptive use, about 67.3 percent are married. These findings are similar to that of a study conducted in Nigeria which revealed that 69.5 percent of its respondents had very negative attitude toward provision of contraceptives to adolescents (Olufemi et al., 2013). Again, the findings are similar to that of another study by Kinaro et al., (2015) which discovered that 65 percent of parents would object to unmarried youth using contraceptives.

In this study, it is also revealed that there is a significant relationship between respondents' level of education, age category of ≥35 years old, contraceptive knowledge, communication on reproductive health and parental approval of contraceptive use among adolescent girls. However, there is no significant relationship between female parents' religious belief and their approval of contraceptive use among adolescents.

Regarding the contraceptive methods, most of the female parents recommended condom use (71%) to their adolescent girls. This was followed by injectables (21%), implants (2%) and oral pills (8%).

CHAPTER ~~6~~SIX

6.1 Study limitation

Some of the respondents may have answer the questions that do not reflect to what they are doing to adolescents and also as their knowledge of contraceptive was moderate and majorities knowing condom better than other contraceptive methods, this may have been the reason for approving condom use more than other contraceptive methods.

6.2 Conclusion

This study revealed female parental approval on contraceptive use among adolescent is low. It also highlighted the factors influencing parental approval on contraceptive use among adolescent girls where. educational level, age category of ≥35 years old, contraceptive knowledge, and communication of sexual and reproductive health among adolescents have been found to be among the factors influencing parental approval for contraceptive use among adolescent girls. In addition, the study has found condom use to be the most recommended modern contraceptive method for adolescent girls.

6.3 Recommendations

- The government and other stakeholders such as the United Nations (UN) and its agencies, the United States Agency for international Development (USAID) and the United Kingdom Agency for International Development (UKAid) need to design and implement socio-behavioral change communication interventions to promote parental approval and adolescent uptake of modern contraceptive methods.
- Reasons for parents not being ready to approve contraceptive use to their adolescent girls need to be recognized and adequately addressed. Youth programs should also be

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targeting parents with the aim of explaining to them the importance of contraceptives and about appropriate contraceptive methods for adolescents.

- This study looked at female parents' approval of contraceptive use among adolescent girls. Similarly, another study needs to be conducted to investigate male parents' approval of contraceptive use among adolescent girls.

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APPENDICES

Appendix I: Questionnaire – English Version

Name of interviewer _____

Date of interview _____/_____/_____ (dd/mm/yyyy)

Questionnaire No. _____

Ward: _____

Name of ten-cell leader: _____

Household No: _____

Section 0: SCREENING

I would like to ask you a few questions about yourself and your children,

How old are you? _____

How many children do you have currently, and living under your authority? (whether or not they are your own children) /___/___/

Of these children, how many are girls (whether or not they are your own children)?

☐ Boys /____/

☐ Girls /____/ if 0, STOP the interview

What are the ages of your girls, starting from the oldest to the youngest?

Girl in charge N° 1 (Oldest): Name_____ Age: /____/_____/yrs

Girl in charge N° 2 (Next to oldest): Name_____ Age: /____/_____/yrs

Girl in charge N° 3 (last): Name_____ Age: /____/_____/yrs

Girl in charge N° 4 (last): Name_____ Age: /____/_____/yrs

Girl in charge N° 5 (Oldest): Name_____ Age: /____/_____/yrs

Girl in charge N° 6 (Next to oldest): Name_____ Age: /____/_____/yrs

Girl in charge N° 7 (last): Name_____ Age: /____/_____/yrs

Girl in charge N° 8 (last): Name_____ Age: /____/_____/yrs

How many of the girls are between the age of 10-19 (inclusive)? /____/

*(**Note**: If there is girl/s of age range above but was married but now divorced and lives in the household, do not include)*

STOP the interview, if there are more than one girl of the age above, ask the respondent to answers the questions referring to the elder girl only.)

Is the elder girl your biological or non biological girl?

1. Biological ☐
2. Non- Biological ☐

Section A: Socio-demographic characteristics and family characteristics

Now I would like to ask you few questions regarding yourself

A01. What is your age? _____

A02. What day, month, and year were you born? _____/_____/_____ (dd/mm/yyyy)

A03. What is your marital status?

1. Married ☐
2. Single (never married) ☐
3. Divorced ☐
4. Separated ☐
5. Widowed ☐
6. Cohabiting ☐

A04. Do you know how to read and write? If yes, what is the level of education you attended?

1. Not gone to school ☐
2. Not gone to school but can read and write ☐
3. Incomplete Primary education ☐
4. Complete primary education ☐
5. Incomplete Ordinary Secondary education ☐
6. Complete Ordinary Secondary education ☐
7. Incomplete Advanced Secondary education ☐
8. Complete Advanced Secondary education ☐
9. Incomplete tertiary education ☐
10. Complete tertiary education ☐

A06. What is your Religion?

1. Muslim ☐
2. Christian ☐
3. None ☐
4. Others (please specify) _____

A07. How often do you usually involve yourself in religious services/activities?

1. More than 2 time a day ☐
2. Once a day ☐
3. Once a week ☐
4. At least once a month ☐
5. At least once a year ☐
6. Do not ☐

A08. How important is religion in your life?

1. Very important ☐
2. Important ☐
3. Not important ☐

Section B: Knowledge on Family Planning

Now let us talk about family planning

B1. Have you ever heard of family planning?

1. Yes ☐
2. No ☐ → Q B3

B2: Which of the following family planning methods have you heard of?

1. Breastfeeding ☐
2. Withdrawal ☐
3. Calendar ☐
4. Male Condom ☐
5. Female Condom ☐
6. Oral Contraceptive pills ☐
7. Injectable ☐
8. Implant ☐
9. IUD ☐
10. Female sterilization ☐
11. Male sterilization ☐

B3. Which are correct statements about male condom?

1. Male condom is a plastic sheath worn on a penis ☐
2. Male condom is worn when the penis is erect ☐
3. Male condom can be used more than once ☐
4. Wearing male condom prevents from sexually transmitted infection ☐

B4. Is the use of oral contraceptive pills everyday prevents a woman from becoming pregnant?

1. Yes ☐
2. No ☐
3. Not sure ☐

B5. Can a woman who takes oral contraceptive pills become pregnant in case she forgets to take her pill once?

1. Yes ☐
2. No ☐
3. Not sure ☐

B6. Are Pills more effective than female sterilization?

1. Yes ☐
2. No ☐
3. Not sure ☐

B7. Do oral contraceptive pills cause abortion?

1. Yes ☐
2. No ☐
3. Not sure ☐

B8. Which part of the woman body is an Intra Uterine Contraceptive Device (IUCD) place?

1. Upper side of an arm ☐
2. Stomach ☐
3. Uterus ☐
4. Cervix ☐

B9. Does the use of IUCD interfere with partner's sexual pleasure?

1. Yes ☐
2. No ☐
3. Not sure ☐

B10. Can a woman who has never had a baby use IUCD?

1. Yes ☐
2. No ☐
3. Not sure ☐

B11.For how long is injectable contraceptive effective?

1. ☐ Less than 3 months
2. ☐ 3 months
3. ☐ More than 3 months
4. ☐ Not sure

B12. Can injectable make a woman Infertile?

1. Yes ☐
2. No ☐
3. Not sure ☐

B13. Where does an implant placed in the woman body?

1. Upper side of an arm
2. Stomach
3. Uterus
4. Cervix

B14. Can implants move around within a woman's body?

1. Yes ☐
2. No ☐
3. Not sure ☐

B15. Do Implants protect a woman from HIV infection?

1. Yes ☐
2. No ☐
3. Not sure ☐

B16. Is female sterilization (tubuligation) a reversible method of family planning?

1. Yes ☐
2. No ☐
3. Not sure ☐

B17. Are all modern contraceptives methods effective in prevention of pregnancy?

1. Yes ☐
2. No ☐
3. Not sure ☐

B18. Which of the contraceptives methods are best for prevention of pregnancy?

1. Male condom ☐
2. Female Condom ☐
3. Oral contraceptive / Pills ☐
4. Implant ☐
5. Injectables ☐
6. Intrauterine device - IUD ☐
7. Female sterilization ☐

B19. Have you heard of natural methods of contraception?

1. Yes ☐
2. No ☐ → B21
3. Not sure ☐

B20. If yes can you mention what family planning methods do you have?

B21.Have you heard of traditional methods of contraception

1. Yes ☐
2. No ☐ → B23
3. Not sure – ☐

B22. If yes, what are the traditional methods you have heard?

B23: Have you ever used any contraceptive methods?

1. Yes ☐
2. No ☐ → B29

B24: If Yes, Which methods have you ever used? ***Probe***

1. Breastfeeding ☐
2. Withdrawal ☐
3. Calendar methods ☐
4. Condom ☐
5. Oral pills ☐
6. Implant ☐
7. Injectable ☐
8. Intra uterine contraceptive device ☐
9. Female sterilization ☐

B25: Are you currently using any contraceptive method?

1. Yes ☐
2. No ☐ → B29

B26: Which contraceptive method are you currently using?

1. Breastfeeding ☐
2. Withdrawal ☐
3. Calendar methods ☐
4. Condom ☐
5. Oral pills ☐
6. Injectable ☐
7. Intra uterine contraceptive device ☐
8. Female sterilization ☐

B27: Have you encounter any side effect of the method you are currently using?

1. Yes ☐
2. No ☐ → B30
3. Not sure ☐

B28: If yes, what are the side effects?

1. Excessive bleeding ☐
2. Spot bleeding ☐
3. Increase in body weight ☐
4. Frequent headache ☐
5. Nausea ☐
6. Vomiting ☐
7. Excessive vaginal fluid ☐
8. Breast tenderness ☐

9. Lower abdominal pain ☐
10. Loss of libido ☐ Yes No
11. Others.....(Mention)

B29: Are you planning to use any contraceptive method in future?

1. Yes ☐
2. No ☐ → B30

B30: What are your sources of knowledge on contraception?

1. Family member ☐
2. A friend ☐
3. Radio ☐
4. Television ☐
5. Newspapers/magazines ☐
6. Healthcare workers ☐
7. A teacher ☐
8. Do not know ☐

Section C: Female parents' communication with adolescent girls on sexual reproductive health issues

Thanks for your cooperation; we will now discuss issues related to your communication with your adolescent girl regarding sexual reproductive health issues.

C1. An adolescent girl you live with, do you know when your adolescent girl started her menarche?

1. Yes ☐
2. No ☐
3. Not sure ☐

C2.When your adolescent girl got her menarche, who talked to her regarding the body changes

1. Myself ☐
2. Teacher ☐
3. Health care provider ☐
4. Aunty ☐
5. Sister ☐
6. Friend ☐
7. Grandmother ☐

C3. Whom do you recommend to talk to adolescents regarding their menarche and body changes?

1. Myself ☐
2. Teacher ☐
3. Health care provider ☐
4. Aunty ☐
5. Sister ☐
6. Friend ☐
7. Grandmother ☐

C4. Have you ever discuss with the adolescent girl issue related to sexual reproductive health (SRH)?

1. Yes ☐
2. No ☐
3. Not sure ☐

C5. Have you talked to her on the following sexual reproductive related issues? ***Probe***

Topic	**Yes**	**No**
1. Sexual relationship		
2. HIV/AIDS		
3. Sexual transmitted infection		
4. Abortion		
5.		

C6. As a mother how comfortable are you to discuss Sexual Reproductive Health issues with your daughter

1. Very comfortable ☐
2. Comfortable ☐
3. Uncomfortable ☐
4. Very uncomfortable ☐

C7. Do you encounter any challenge when you discuss sexually-related matters with adolescent girl?

1. Yes ☐
2. No ☐ → C 11

C8. If yes, which of the following challenges do you encounter when discussing sexual reproductive health issues with your adolescent girl?

1. Mother to child relationship ☐
2. Time constraints ☐
3. Traditional and cultural values do not allow ☐
4. In my religion this is not allowed ☐

5. It is not my role to discuss with her ☐
6. I know she is taught at school ☐
7. lack of SRH knowledge ☐

C9. Have you ever discussed issue related to teenage pregnancy?

1. Yes ☐
2. No ☐ → C 14

C10. If yes, did you discuss risks associated with teenage pregnancy?

1. Yes ☐
2. No ☐ →C14

C11. If yes, what associated risks did you discuss with your adolescent girl? *Probe*

1. Infected with HIV/AIDS ☐
2. Early teenage pregnancy ☐
3. Unsafe abortion ☐
4. Excessive bleeding during delivery ☐
5. Infected with Sexual Transmitted Infection ☐

C12. Do you think it is important for an adolescent girl to have knowledge on how to prevent her from pregnant?

1. Yes ☐ →C14
2. No ☐ →C13

C13.If No, why is it not important, ***Probe***

1. She is too young to be taught ☐
2. Once knowledgeable she will indulge into sexual relationships ☐
3. As a parent I would be encouraging her to get involved into sexual activities ☐
4. Other (specify) ----------

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C14. If yes, have you discuss with her issues of family planning methods

1. Yes ☐
2. No ☐ →C16

C15. If yes, what family planning methods did you discuss with your adolescent girl?

1. Abstinence ☐
2. Condom ☐
3. Oral contraceptives ☐
4. Injectable ☐
5. Implants ☐
6. IUCD ☐

C16. Have any of your girls leaved or is living with you got pregnant when she was an adolescent (10-19yrs)?

1. Yes ☐
2. No ☐ →D1

C17. If yes, do you believe family planning could have prevent her for the teenage pregnancy?

1. Yes ☐
2. Not sure ☐
3. No ☐

Section D: Approve contraceptive use among adolescent girls

Thank for your continued cooperation, the following few questions will be on your views and readiness to allow adolescent to use family planning.

D1. As a mother, do you remember using any family planning method during your adolescent age (10-19 yrs)

1. Yes ☐
2. No ☐→D4

D2. If yes, which method did you use?

1. Male condom ☐
2. Female condom ☐
3. Oral contraceptive pill ☐
4. Injectable ☐
5. Implant ☐
6. IUCD ☐

D3. What made you use?

1. Being sexually active ☐
2. Because I got married earlier ☐
3. Got my first child at the adolescent age ☐
4. To prevent pregnancy ☐
5. To prevent STI / HIV ☐

D4. As a mother would you approve any adolescent girl to use any family planning?

1. Yes ☐
2. No ☐ →D5

D5. As a mother would you approve your adolescent girl living with you to use any family planning?

1. Yes ☐
2. No ☐ →D6

D6. As a mother would you approve your biological adolescent girl living with you to use any family planning?

1. Yes ☐
2. No ☐ → D8

D7. If yes, which method do you think is most suitable for her? ***probe***

1. Calendar methods ____☐
2. Condom ____☐
3. Oral contraceptive pills ☐
4. Injectable ☐
5. IUD ☐
6. Emergency contraception ____☐
7. Other ----------

D8. If no, when do you endorse as the appropriate period for your adolescent to use family planning?

1. Once she is married ☐
2. After her first child birth ☐
3. Should not use any family planning method at all ☐
4. Above 20 yrs of age ☐

D9. Do you approve boys and girls to have sex provided they use family planning methods to prevent pregnancy?

1. Yes ☐
2. No ☐

Appendix II: Kiambatisho A: Dodoso la lugha ya kiswahili

Jina la Mhojaji_____

Tarehe ya mahojiano_____/_____/_____ (ss/mm/mmmm)

Namba ya Dodoso. _____

Kata:_____

Jina la kiongozi wa nyumba kumi/kiongozi wa mtaa: _____

Namba ya Kaya:_____

Sehemu 0: UCHUNGUZI

Ningependa kukuuliza maswali machache kuhusu wewe na watoto wako

Una watoto wangapi kwa sasa wanaoishi chini ya mamlaka yako? /__/___/

Kati ya watoto hawa, wangapi ni wa kike (Ikiwa ndio au sio watoto wako wa kuwazaa)?

☐ Watoto wa kiume /____/

☐ Watoto wa kike /____/

(kama ni 0, sitisha mahojiano)

Ni upi umri wa watoto wako wa kike, kuanzia mkubwa hadi mdogo?

Msichana anayehusika namba 1 (Mkubwa): Jina_____ Umri:/___/___/ miaka

Msichana anayehusika namba 2 (Anaemfatia mkubwa): Jina_____ Umri: /__/__/ miaka

Msichana anayehusika namba 3 (Anaemfwatia wa 2wa mwisho): Jina_____ Umri: /__/__/ miaka

Msichana anayehusika namba 4 (Anaemfwatia wa 3wa mwisho): Jina_____ Umri: /__/__/ miaka

Msichana anayehusika namba 5 (Anaemfwatia wa 4Mkubwa): Jina_____ Umri: /__/__/ miaka

Msichana anayehusika namba 6 (Anaemfatia5): Jina_____Umri:/__/__/ miaka

Msichana anayehusika namba 7 (Anaemfwatia wa 6): Jina_____ Umri: /__/__/ miaka

Msichana anayehusika namba 8 (Anaemfwatia wa 7): Jina_____Umri: /__/__/ miaka

Ni wasichana wangapi wenye umri kati ya 10-19 (kwa pamoja)? /___/

*(*Kama kuna msichana/wasichana wenye umri tajwa apo juu lakini alikuwa ameolewa na sasa amepewa talaka na anaishi katika kaya, usimjumuishe*.)*

(Sitisha mahojiano, kama hakuna msichana wenye umri tajwa apo juu,

kama yupo muombe mhojiwa ajibu maswali kuhusu msichana mkubwa pekee)

Je Binti mkubwa ni mtoto wa kumzaa au au si wa kumzaa?

1. Wa kumzaa ☐
2. Siyo wa kumzaa ☐

Sehemu A: Tabia za kijamii na idadi ya watu na tabia za familia

Sasa ningependa kukuuliza maswali machache kuhusu wewe

A01. Una umri gani? ___

A02. Ni siku, mwezi na mwaka gani ulizaliwa? ____/_____/_____ (ss/mm/mmmm)

A03. Ni ipi hali yako ya ndoa?

1. Nimeolewa ☐
2. Pekee (sijawahi kuolewa) ☐
3. Talaka ☐
4. Kutengana ☐
5. Mjane ☐
6. Kuishi unyumba ☐

A04. Unajua kusoma na kuandika? Kama ndiyo, umesoma mpaka darasa la ngap?

1. Sikwenda shule ☐
2. Sikwenda shule lakini naweza kusoma na kuandika ☐
3. Sijahitimu elimu ya msingi ☐
4. Nimehitimu elimu ya msingi ☐
5. Sijahitimu elimu ya sekondari ☐
6. Nimehitimu elimu ya sekondari ☐
7. Sijahitimu elimu ya juu ya sekondari ☐
8. Nimehitimu elimu ya juu ya sekondari ☐
9. Sijahitimu elimu ya juu ☐
10. Nimehitimu elimu ya juu ☐

A05. Wewe ni muumini wa dini gani?

1. Muislamu ☐
2. Mkristo ☐
3. Sina dini ☐
4. Mengineyo (tafadhali fafanua) _____

A06. Ni mara ngapi huwa unajihusisha na shughuli za kidini?

1. Zaidi ya mara 2 kwa siku ☐
2. Mara moja kwa siku ☐
3. Mara moja kwa wiki ☐
4. Angalau mara moja kwa mwezi ☐
5. Angalau mara moja kwa mwaka ☐
6. Sijihusishi ☐

A07. Dini ina umuhimu gani katika maisha yako?

1. Muhimu sana ☐
2. Muhimu ☐
3. Sio muhimu ☐

Sehemu B: Elimu na uelewa wako juu ya Uzazi wa Mpango

Sasa naomba tuzungumzee kuhusu uzazi wa mpango.

B1. Umewahi kusikia kuhusu uzazi wa mpango?

1. Ndiyo ☐
2. Hapana ☐→Q B3

B2. Ni aina zipi za uzazi wa mpango umewahi kusikia? [***Dadisi***]

1. Kunyonyesha ☐
2. Kujiondoa ☐
3. Kalenda ☐
4. Kondomu ya kiume ☐
5. Kondomu ya kike ☐
6. Vidonge vya uzazi wa mpango ☐
7. Sindano ☐

8. Kipandikizi ☐
9. Kitanzi ☐
10. Kufunga uzazi kwa mwanamke ☐
11. Kufunga uzazi kwa mwanaume ☐

B3. Ni zipi taarifa sahihi kuhusu kondomu za kiume? (***Msome mhojiwaji***)

1. Ni plastiki inayovaliwa kwenye uume ☐ T
2. Kondomu ya kiume huvaliwa uume unaposimama ☐ T
3. Kondomu ya kiume inaweza kutumika zaidi ya mara moja ☐ F
4. Uvaaji wa kondomu ya kiume unaweza kumzuia mtu kupata magonjwa ya zinaa ☐ T

B4. Je, matumizi ya vidonge vya uzazi wa mpango kila siku vinaweza kumzuia mwanamke kupata ujauzito?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B5. Je mwanamke anaetumia vidonge vya uzazi wa mpango anaweza kupata ujauzito kama akisahau kumeza vidonge vyake siku moja?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B6. Je vidonge vina ubora zaidi kuliko kufunga uzazi kwa mwanamke?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

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B7. Je vidonge vya uzazi wa mpango husababisha mimba kutoka?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B8. Ni sehemu ipi ya mwili wa mwanamke kitanzi huwekwa?

1. Upande wa juu wa mkono ☐
2. Tumbo ☐
3. Mfuko wa uzazi ☐
4. Mlango wa mfuko wa uzazi ☐
5. Sina uhakika ☐

B9. Je, matumizi ya kitanzi yanaweza kuingilia starehe ya mapenzi kwa mwenzi ?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B10. Je, mwanamke ambaye hajawahi kuwa na mtoto anaweza kutumia kitanzi?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B11. Ni kwa muda gani Sindano ya uzazi wa mpango huzuia mimba?

☐ Chini ya miezi mitatu
☐ Miezi mitatu
☐ Zaidi ya miezi mitatu
☐ Sina uhakika

B12. Je, sindano ya uzazi wa mpango huweza kufanya mwanamke kuwa mgumba?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B13. Kipandikizi huwekwa sehemu ipi ya mwili wa mwanamke?

1. Upande wa juu wa mkono ☐
2. Tumboni ☐
3. Mfuko wa uzazi ☐
4. Mlango wa mfuko wa uzazi ☐

B14. Je vipandikizi vinaweza kuzunguka ndani ya mwili wa mwanamke?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B15. Je, vipandikizi humlinda mwanamke kutopata maambukizi ya VVU?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B16. Je ni njia ya uzazi wa mpango ya kufunga uzazi kwa mwanamke (Tubligation) inayomwezesha mama kupata ujauzito baadaye endapo atahitaji ?

1. Ndiyo ☐
2. Hapana ☐

3. Sina uhakika ☐

B17. Je, njia zote za kisasa za uzazi wa mpango ni salama kwa kuzuia ujauzito?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

B18. Ni njia zipi za uzazi wa mpango bora zaidi kuzuia ujauzito?

1. Kondomu ya kiume ☐
2. Kondomu ya kike ☐
3. Vidonge vya uzazi wa mpango ☐
4. Kipandikizi ☐
5. Sindano ☐
6. Kitanzi ☐
7. Kufunga uzazi kwa mwanamke ☐

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B19. Umesikia kuhusu njia za asili za uzazi wa mpango?

1. Ndiyo ☐
2. Hapana ☐ → B21
3. Sina uhakika ☐ → B21

B20. Kama ndiyo, unaweza kutaja ni njia zipi za uzazi wa mpango zilizopo?

_____

B21. Umesikia kuhusu njia za jadi za uzazi wa mpango?

Ndiyo ☐
Hapana ☐ → B23
Sina uhakika ☐→ B23

B22. Kama ndiyo, ni njia zipi za jadi umesikia?

_____

B23. Umewahi kutumia njia yoyote ya uzazi wa mpango?

1. Ndiyo ☐
2. Hapana ☐ → B29

B24. Kama ndiyo, ni njia zipi umewahi kutumia? dodosa

1. Kunyonyesha ☐
2. Kujiondoa ☐
3. Njia za kalenda ☐
4. Kondomu ☐
5. Vidonge vya uzazi wa mpango ☐
6. Sindano ☐
7. Kipandikizi ☐
8. Kitanzi ☐
9. ~~9.~~ Kufunga uzazi kwa mwanamke ☐

9.

B25. Kwa sasa unatumia njia yoyote ya uzazi wa mpango?

1. Ndiyo ☐
2. ~~2.~~ Hapana ☐ → B29

2.

B26. Ni njia ipi ya uzazi wa mpango unatumia kwa sasa?

1. Kunyonyesha ☐
2. Kujiondoa ☐
3. Njia za kalenda ☐
4. Kondomu ☐
5. Vidonge vya uzazi wa mpango ☐
6. Sindano
7. Kipandikizi ☐

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8. Kitanzi ☐
9. Kufunga uzazi kwa mwanamke ☐

B27. Umekutana na madhara/maudhi madogo madogo yoyote ya njia unayotumia sasa?

1. Ndio ☐
2. Hapana ☐ → B30
3. Sina uhakika ☐

B28. Kama ndiyo, ni madhara/maudhi madogo madogo yapi uliyopata ukiwa unatumia njia ya uzazi wa mpango?

1. Kutokwa damu nyingi ☐
2. Kutokwa matone ya damu ☐
3. Kuongezeka uzito ☐
4. Kuumwa kichwa mara kwa mara ☐
5. Kichefuchefu ☐
6. Kutapika ☐
7. Maji mengi ya uke ☐
8. Matiti kusinyaa ☐
9. Maumivu ya chini ya tumbo ☐
10. Kupoteza hamu ya kujamiana ☐
11. Mengineyo.....(Taja)

B29. Unatarajia kutumia njia yoyote ya uzazi wa mpango hapo baadaye?

1. Ndiyo ☐
2. Hapana ☐

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B30. Ni vipi vyanzo vyako vya taarifa juu ya uzazi wa mpango?

1. Mwanafamilia ☐
2. Rafiki ☐
3. Redio _____ ☐
4. Runinga/televisheni ☐
5. Magazeti/majarida ☐
6. Wahudumu wa afya ☐
7. Mwalimu ☐
8. Mitandao ya kijamii ☐
9. Sijui ☐

Sehemu C: Mawasiliano ya wazazi wa kike na wasichana kuhusu masuala ya afya ya uzazi

Asante kwa ushirikiano wako; sasa tutajadili juu ya mawasiliano yako na binti yako kuhusu masuala ya afya ya uzazi.

C1. Binti unayeishi nae, unafahamu ni lini alivunja ungo?

1. Ndiyo ☐
2. Hapana ☐
3. Hajavunja ungo ☐
4. Sina uhakika ☐

C2. Binti yako alipovunja ungo, nani alizungumza nae juu ya mabadiliko ya mwili wake? ***(Changua moja)***

1. Mimi mwenyewe ☐
2. Mwalimu ☐
3. Mtoa huduma ya afya _____ ☐

4. Shangazi ☐
5. Dada ☐
6. Rafiki ☐
7. Bibi ☐

C3. Ni nani ungempendekeza kuchukua jukumu la kujadili kuhusu kuvunja ungo na mabadiliko ya mwili kwa wasichana? ***(Chagua Moja)***

1. Mimi mwenyewe ☐
2. Mwalimu ☐
3. Mtoa huduma ya afya ☐
4. Shangazi ☐
5. Dada ☐
6. Rafiki ☐
7. Bibi ☐

C4. Umewahi kujadili na binti yako kuhusu masuala ya afya ya uzazi?

1. Ndiyo ☐
2. Hapana ☐
3. Sina uhakika ☐

C5. Umezungumza na binti yako kuhusu masuala yafuatayo ya afya ya uzazi? Dadisi

Mada	**Ndio**	**Hapana**
6. Uhusiano ya kimapenzi		
7. VVU/UKIMWI		
8. Magonjwa ya zinaa		
9. Utoaji mimba		

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C6. Kama mama, unajisikiaje kujadili masuala yahusuyo afya ya uzazi na binti yako?

1. Vizuri sana ☐
2. Vizuri ☐
3. Wasiwasi ☐
4. Wasiwasi sana ☐

C7. Je, unakabiliwa na changamoto yoyote unapojadili masuala yanayohusiana na ngono na binti yako?

1. Ndiyo ☐
2. Hapana ☐ → C 9

C8. Kama ndiyo, ni changamoto kuu kati ya hizi uliyokutana nazo unapojadili masuala ya afya ya uzazi na binti yako?

1. Uhusiano kati ya mama na motto ☐
2. Vikwazo vya muda ☐
3. Maadili ya jadi na utamaduni haviruhusu ☐
4. Kwenye dini yangu hii hairuhusiwi ☐
5. Sio jukumu langu kujadili nae ☐
6. Nafahamu anafundishwa shuleni ☐
7. Ukosefu wa elimu na uelewa wa ya afya ya uzazi ☐

C9. Umewahi kujadili kuhusu mimba za utotoni?

1. Ndiyo ☐
2. Hapana ☐ → C 12

C10. Kama ndiyo, ulijadili kuhusiana na hatari zitokanazo na mimba za utotoni?

1. Ndiyo ☐

2. Hapana ☐ → C 12

C11. Kama ndiyo, ni hatari zipi ulijadili na binti yako? **(*Dadisi)***

1. Kuambukizwa VVU ☐
2. Mimba za utotoni ☐
3. Utoaji mimba usio salama ☐
4. Kutokwa damu nyingi wakati wa kujifungua ☐
5. Kuambukizwa magonjwa ya zinaa ☐

C12. Unafikiri ni muhimu kwa binti kuwa na elimu ya jinsi ya kujikinga na kutopata ujauzito?

1. Ndiyo ☐ →C14
2. Hapana ☐ →C13

C13. Kama hapana, kwanini sio muhimu? ***Dadisi*** →C116

1. Ni mdogo sana kufundishwa ☐
2. Akishapata Maarifa atajiingiza kwenye mahusiano ya kingono ☐
3. Kama mzazi, nitakuwa nikimuhamasisha kushiriki shughuli za ngono ☐
4. Mengineyo (taja) ----------

C14. Kama ndiyo, umejadili naye masuala yahusuyo njia za uzazi wa mpango?

1. Ndiyo ☐ → C15
2. Hapana ☐ →C16

C15. Kama ndio, ni njia zipi za uzazi wa mpango umejadili na binti yako?

1. Kuacha kujamiana ☐
2. Kondomu ☐
3. Vidonge vya uzazi wa mpango ☐
4. Sindano ☐

5. Vipandikizi ☐
6. Kitanzi ☐

C16. Je, kuna binti/mabinti uliowahi kuishi/unaishi nao kupata ujauzito kabla(miaka 10-19)?

1. Ndiyo ☐
2. Hapana ☐ →D1

~~2.~~

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C17. Kama ndiyo, unaamini uzazi wa mpango ungeweza kumzuia kupata mimba ya utotoni?

1. Ndiyo ☐
2. Sina uhakika ☐
3. Hapana ☐

Sehemu D: Kuhidhinisha matumizi ya uzazi wa mpango kwa wasichana

Asante kwa kuendelea kuwa na ushirikiano. Maswali machache yafuatayo yatatokana na maoni yako na utayari wa kuruhusu binti kutumia uzazi wa mpango.

D1. Kama mama, unakumbuka kutumia njia yoyote ya uzazi wa mpango wakati wa ujana wako (miaka 10 hadi 19)?

1. Ndiyo ☐
2. Hapana ☐→D4

D2. Kama ndiyo, ni njia zipi ulitumia?

1. Kondomu ya kiume ☐
2. Kondomu ya kike ☐
3. Vidonge vya uzazi wa mpango ☐
4. Sindano ☐
5. Kipandikizi ☐
6. Kitanzi ☐

D3. Nini kilikufanya utumie?

1. Kuweza kujamiiana ☐
2. Kwa sababu niliolewa mapema ☐
3. Nilipata mtoto wangu wa kwanza nilipokuwa binti ☐
4. Kuzuia mimba ☐
5. Kuzuia maambukizi ya magonjwa ya zinaa/VVU ☐

D4. Kama mama, unaweza kukubali binti yoyote kutumia njia yoyote ya uzazi wa mpango?

1. Ndiyo ☐
2. Hapana ☐

D5. Kama mama, unaweza kukubali binti unaeishi nae kutumia njia yoyote ya uzazi wa mpango?

1. Ndiyo ☐
2. Hapana ☐

D6. Kama mama, unaweza kukubali binti yako wa kumzaa unaeishi naye kutumia njia yoyote ya uzazi wa mpango?

1. Ndiyo ☐ → D7
2. Hapana ☐ → D8

D7. Kama ndiyo, njia ipi unafikiri inamfaa zaidi? (***Dadisi)***

1. Njia za kalenda ☐
2. Kondomu ☐
3. Vidonge vya uzazi wa mpango ☐
4. Sindano ☐
5. Kipandikizi ☐
6. Kitanzi ☐
7. Uzazi wa mpango wa dharura ☐
8. Mengine ----------

D8. Kama hapana, ni kipindi gani mwafaka kuidhinisha binti yako kutumia uzazi wa mpango?

1. Atakapoolewa ☐
2. Baada ya kujifungua mtoto wake wa kwanza ☐
3. Asitumie njia yoyote ya uzazi wa mpango ——☐
4. Zaidi ya miaka 20 ——☐
5. Baada ya kujifungua mtoto wake wa kwanza hata kama hajaolewa ☐

D9. Unakubali wanaume na wanawake kufanya mapenzi endapo wanatumia njia za uzazi wa mpango kuzuia ujauzito?

1. Ndiyo ☐
2. Hapana ☐

Appendix III: English Consent Form

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS,

INFORMED CONSENT FORM

ID NO: …….

Greetings,

My name is ……working for school of public health and social sciences at Muhimbili University of health and allied sciences in Dar Es Salaam.

Purpose of the study

Dear respondent, I would like to inform you that this is a research study titled "Factors influencing female parental approval of contraceptive use among adolescent girls in Kinondoni municipal council, Dar es salaam, Tanzania"

This study seeks to assess level of compliance of iron folic acid supplements and factors associated.. Kindly be honest and true for good results that could lead to better intervention and recommendations in future.

Confidentiality

We will protect and treat information you will provide with high confidentiality to the best of our knowledge. We will not write your name on the questionnaire or in any reports/documents that might let someone identify you. Your name will not be linked to research information in any way.

The investigator will take care of information to be collected. However, final results after the analysis will be shared with national stakeholders and I will submit the manuscript for publications in scientific journals.

Right and withdraw alternatives

Your participation is voluntary. You may decline from participation from participation to the study at any time even if you have consented to participate. Your decision to participate or not to participate will not be associated with the right to get services in the facility. There is no penalty for refusing to participate in the study. You will not experience loss of your refusal to participate in this study

Benefits

This study may aid in identifying the problems of compliance to IFA supplements that will help in formulating recommendations to improve care of pregnant women. It may also help to see how compliance of IFA supplements by pregnant women is affected by different factors.

Obtained results will be shared with municipal hospitals that will fulfill long-term commitments to the continuous improvement process.

Risks

There is no harm for participating in the study. However, you are free to stop participating as the respondent at any time during the discussion in the event you feel uncomfortable.

Person to contact

If you have any questions about this study you should contact the principal investigator, (Esteria Kisoka Mob: 0754 319545) of MUHAS, Dar es Salaam.

If you have any questions about your participation rights please contact, Supervisor, Prof. M.T. Leshabari Mob: (0783 287 062) MUHAS Dar Es Salaam.

DECLARATION

I have read or being read by the researcher and understood the contents in this form. My questions have been answered. Do you agree?

Participant agreed ☐ Participant disagreed ☐

The above document describing benefits, risks and procedures for research titled "Factors associated with compliance to iron folic acid supplementation by pregnant women attending antenatal clinic in Temeke municipal council, Dar es salaam, Tanzania" I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this study have been explained to me.

Signature or stamp of the respondent……Date…….

Signature of the researcher ……..……Date……...

Appendix IV: Fomu ya Ridhaa

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES

IDARA YA UTAFITI NA MACHAPISHO

FOMU YA RIDHAA

ID NO:……

Salaam,

Jina langu naitwa ……. Ni mwanafunzi kazi na Shule Kuu ya Afya na Umma na Sayansi ya Jamii katika Chuo Kikuu cha Tiba na Sayansi ya Muhimbili Jijini Dar es Salaam.

Madhumuni ya Utafiti

Ndugu mhojiwa napenda kukujulisha kuwa somo hili la utafiti lenye jina " **Mambo mpelekea mzazi wa kike kuruhusu utumihaji wa njia za uzazi wa mpango kwa binti wa kike** manispaa ya Kinondoni.

Usiri

Sisi tutalinda na kuziweka taarifa zako kwa usiri wa hali ya juu na kadri ya uwezo wetu. Sisi hatutaandika jina lako katika ripoti yoyote/nyaraka ambazo zinaweza kuruhusu mtu kukutambua wewe. Jina lako halitakuwa na mahusiano na habari za utafiti kwa njia yoyote.Watafiti watatunza takwimu na taarifa zitakazo kusanywa. Hata hivyo matokeo ya utafiti yatawasiliswa kwa ajili ya uchapishaji katika majarida ya kisayansi.

Haki na uondoaji mbadala

Ushiriki wako ni wa hiari. Unaweza ukajiondoa katika ushiriki katika utafiti wakati wowote, wakati wa mahojiano hata kama ulikuwa umekubali kushiriki.. Hakuna adhabu ya kukataa kushiriki katika utafiti. Hutapata hasara yoyote kama ukikataa kushiriki katika utafiti huu.

Faida:

Utafiti huu utawawezesha kusaidia kugundua kama mama anaweza kuwa chanzo cha kusabasisha matumizi hafifu ya njia za uzazi wa mpango kwa kijana wa kike.. Pia utafiti huu unaweza kusaidia kutoa mapendekezo ya kusaidia kuboresha huduma za afya ya ya uzazi kwa vijana hususuani matumizi ya njia za uzazi wa mpango ili kupunguza mimba zisizotarajiwa.

Hatari:

Hakuna madhara kwa kushiriki katika utafiti. Hata hivyo wewe uko huru katika kuacha kushiriki kwa wakati wowote katika mjadala huu katika tukio unalojihisi kuwa na wasiwasi.

Endapo utapata madhara:Hutegemei kupata madhara yoyote kutokana na ushiriki wako katika utafiti.

Nani wa kuwasiliana naye:Kama una maswali kuhusiana na utafiti huu tafadhali wasiliana na mtafiti mkuu, Esteria Kisoka (0754 319 545) wa Chuo Kikuu cha Tiba na sayansi Muhimbili,S.L.P 65001,Dar es Salaam.

Kama una swali juu ya haki zako za msingi kama mshiriki, unaweza kuwasiliana na Prof. M.T. Leshabari (0783 287 062) ambaye ni msimamizi wa utafiti huu.

Je unakubali

Mshiriki anakubali……Mshiriki hakubali……...

Mimi …… nimesoma maelezo ya fomu hii. Nakubali kushiriki katika utafiti huu.

Saini ya mshiriki……

Saini ya Mtafiti……. Tarehe ya kusaini ……

Appendix V: List of Wards in Kinondoni District

Serial number	Name of the ward
1	BUNJU
2	HANANASIF
3	KAWE
4	KIGOGO
5	KIJITONYAMA
6	KINONDONI
7	KUNDUCHI
8	MABWEPANDE
9	MAKONGO
10	MAKUMBUSHO
11	MBEZI JUU
12	MBWENI
13	MIKOCHENI
14	MSASANI
15	MWANANYAMALA
16	MZIMUNI
17	NDUGUMBI
18	TANDALE
19	WAZO
20	MIKOCHENI