



Evidence on family planning use in young people of Tanzania

Kerina Tull

University of Leeds Nuffield Centre for International Health and Development

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Question

Please provide evidence on the sexual and reproductive health knowledge, family planning use, attitudes and barriers among young people, women with disabilities, and young people with HIV infection in Tanzania.

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The K4D helpdesk service provides brief summaries of current research, evidence, and lessons learned. Helpdesk reports are not rigorous or systematic reviews; they are intended to provide an introduction to the most important evidence related to a research question. They draw on a rapid desk-based review of published literature and consultation with subject specialists.

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1. Summary

Adolescents (aged 10–19 years) and youth (aged 15–24 years) face a multitude of sexual and reproductive health (SRH) risks that, if not managed, will have consequences that follow them into adulthood (Nguyen et al., 2019). The United Republic of Tanzania has the second youngest population in East Africa, with a median age of the population being 18 years.¹

Although most data on family planning available for young people includes the age range under 25 years (i.e. adolescents aged 10–19 years, and youth aged 15–24 years), this rapid review focuses on data for 15-19 year olds. Recent monitoring data is found for both male and female adolescents, although most evidence is from grey literature, which focuses on females. There is a dearth of evidence on barriers to family planning use in young people with HIV infection, as well as adolescents with disabilities. Adolescents are hardly mentioned in documents, but are submerged in broader demographic categories like children and youth (MOHCDGEC, 2018).

Key highlights found in the evidence include:

- Geographical differences were found in sexual health knowledge (SHK): Youth in three municipalities (Ilala, Kinondoni and Iringa) had incomplete information and knowledge on how to protect themselves from STIs and HIV/AIDS (Andersson et al., 2015). In an investigation of SHK in secondary school children from Morogoro, eastern Tanzania, it was found that approximately 1 in 5 (20.2%) teenagers still lack basic knowledge of HIV transmissions in Tanzania (Kaale and Muhanga, 2017).
- Evidence shows that the level of sexual and reproductive health and rights (SRHR) awareness is high among school truants (69%), followed by youth with disabilities (66.4%), and youth living with HIV (64.4%) (Ngilangwa et al., 2016). Most youth with disabilities stated that their main sources of SRHR information were teachers (Ngilangwa et al., 2016).
- Media use is associated with use of contraceptives in youths aged 15-24 years (Sedlander and Rimal, 2019). Results from Olsen et al. (2018) show that m4RH users mostly requested content on contraceptive methods and role model stories. *However, because the m4RH system did not routinely collect demographic data from users, it is unable to disaggregate information-seeking behaviour by age or sex.*
- Younger unmarried men aged 15-19 years are less likely to use a condom during sexual intercourse than unmarried young men aged 20-24 years (MOHCDGEC, 2018). Adolescent girls aged 15-19 years have both the lowest contraceptive use rates and highest unmet need for family planning in East Africa (Izugbara et al., 2018) – reported as 9% in Tanzania (MOHCDGEC, 2018). Among unmarried young women, use of a condom at sexual intercourse is higher among adolescents aged 18-19 years.
- Geographical differences were found in family planning use: Youths in rural areas use condoms at a lower rate compared to their urban counterparts (MOHCDGEC, 2018).
- Little attention is given to SRH needs of young people living with HIV and AIDS, and also among young people who are disabled (Andersson et al., 2015). The limited evidence available shows:

¹ National Bureau of Statistics (2012). The 2012 Population and Housing Census (PHC) for the United Republic of Tanzania.

- Adolescents with HIV have restricted access to accurate information, appropriate guidance, or comprehensive reproductive health services, and are likely to experience significant unmet need as they initiated sexual relationships (Busza et al., 2013); those seeking care with caregivers feared to ask for contraceptives, since this would attract questions from their caregivers about their sexual activity (Kimera et al., 2019).
- Research shows that access to SRHR information is high among youth with mental or physical disabilities (Ngilangwa et al., 2016). However, stigma is still a barrier to accessing SRH services. These barriers can be societal (stigma and discrimination from family, community members and service providers), physical (long distances to health facilities and inaccessible buildings), and economic (financial constraints) (CCBRT, 2018).
- The Ministry of Health and Social Welfare’s 2015-2020 strategic plan (United Republic of Tanzania, 2015) states that although the total fertility rate is reducing, SRH services such as family planning are not performing as hoped in Tanzania, despite continued investment.
- Tanzania Service Provision Assessment survey data shows that clients aged under 20 years of age were more likely to report being satisfied with family planning services, compared to those aged between 20 to 29 years (Bintabara et al., 2018).
- Both cultural barriers and parents’ lack of knowledge/skills are barriers to SRH matters in adolescents (Ngilangwa et al., 2016). Excessive questioning, scolding, and requirements to bring sexual partners or parents to receive services at health facilities were identified as obstacles to accessing care (Nyblade et al., 2017).
- Social cohesion, trust or participation is not associated with young age at sexual debut or intention to use a condom (Kalolo et al., 2019). However, use of short-term methods of contraception are thought of as suitable only in certain groups of ‘young’ women (Sedekia et al., 2017).
- Further wide-scale research from the *Adolescents 360 (A360)* programme aims to understand current attitudes in uptake of modern contraceptives and family planning in adolescents (Atchison et al., 2018).

2. Sexual and reproductive health knowledge

According to the World Health Organization (WHO), adolescents are persons between 10 and 19 years of age who experience biological, psychological, mental and social changes during this period. As a developmental phase in human life, adolescence is further divided into early adolescence (10-12 years), mid adolescence (13 to 15 years) and late adolescence (16-19 years). This age range falls within WHO’s definition of *young people*, which refers to individuals between ages 10 and 24 years.² Therefore, rather than 10–19 years of age, a definition of 10–24 years corresponds more closely to adolescent growth and popular understandings of this life phase (Sawyer et al., 2018).

Adolescents (aged 10–19 years) and youth (aged 15–24 years) face a multitude of sexual and reproductive health (SRH) risks that, if not managed, will have consequences that follow them

² <https://www.britannica.com/science/adolescence>

into adulthood (Nguyen et al., 2019). The United Republic of Tanzania has the second youngest population in East Africa, with a median age of the population being 18 years.³ It is one of the developing countries where HIV/AIDS, early pregnancies, and school dropouts have been affecting youth in general, as well as secondary school students at large (Kaale and Muhanga, 2017: 120). However, in the legislation space, adolescents are hardly mentioned in documents, but are submerged in broader demographic categories such as children and youth (MOHCDGEC, 2018: 34).

SHK in young people

In the East African region, the percentage of childbearing teenagers is highest in both Uganda and Tanzania (Izugbara et al., 2018: 31). Given that 57% of young women and 48% of young men report having had sex by age 18 years, it is important for adolescents to have access to comprehensive sexual education (MOHCDGEC, 2018: 19). Though information, education and services related to SRH are limited to young people in general, they are further limited to certain marginalised groups – such as orphans, young people in rural areas, as well as young people living with HIV/AIDS, and young people with disabilities (Ngilangwa et al., 2016). Therefore, understanding sexual health knowledge (SHK) in this age group is vital, as it can reduce early pregnancies, unsafe abortions, and school dropouts due to early pregnancies, as well as the spread of HIV/AIDS plus sexually transmitted infections (STIs) among secondary school students (Kaale and Muhanga, 2017: 120).

Knowledge of family planning

Government data reveals that adolescents' (aged 10-19 years) knowledge on family planning is much lower among youths in the country compared to the national average (MOHCDGEC, 2018: 20).

Knowledge of contraceptive types

A recent report on family planning in East Africa found that the proportion of women with correct knowledge of the rhythm (or calendar) method is currently highest in Kenya, Tanzania, and Rwanda (Izugbara et al., 2018: 9).

In a study among female undergraduate university students in Kilimanjaro region in Tanzania, the majority of the respondents were sexually active and started sexual activity at over 18 years of age (Sweya et al., 2016). Most of the participants stated that they had knowledge of both traditional and modern contraception. Nevertheless, the rate of contraceptive use was low. *However, only 1.2% of this sample were aged 16-20 years.*

According to government data, girls who are at (but have not completed) primary school are least likely to use a modern method of contraception at 9% (MOHCDGEC, 2018: 20). Even though

³ National Bureau of Statistics (2012). The 2012 Population and Housing Census (PHC) for the United Republic of Tanzania.

there is a comprehensive sexual education as part of the curriculum in secondary schools in Tanzania, there is limited offering of these courses with teachers not prioritising it.⁴

Olsen et al. (2018) studied longitudinal data from users of the Mobile for Reproductive Health (m4RH) intervention.⁵ Among these users, 89.6% accessed specific m4RH content on family planning, contraceptive methods, adolescent-specific and youth-specific information, and clinic locations after first accessing the m4RH main menu. The majority of these users (52.8%) requested information on contraceptive methods; fewer users (5.7%) requested information on clinic locations (Olsen et al., 2018). Past surveys to assess the demographic profile of users repeatedly showed that m4RH is mostly utilised by young people. This could suggest a higher demand for specific contraceptive information compared with general adolescent and youth SRH information that is also offered through other communication channels, for example, through HIV or AIDS health promotion programmes. Results show that m4RH users mostly requested content on contraceptive methods and role model stories. *However, because the m4RH system did not routinely collect demographic data from users, it is unable to disaggregate information-seeking behaviour by age or sex* (Olsen et al., 2018).

Knowledge of HIV/AIDS and STIs

An estimated 4.7% of adolescents (aged 10-19 years) are living with HIV in Tanzania.⁶ However, knowledge of HIV and STIs varies across the country:

- In the Tuitetee⁷ baseline study in 2011, youth in three municipalities (Ilala, Kinondoni and Iringa) had incomplete information and knowledge on how to protect themselves from STIs and HIV/AIDS (Andersson et al., 2015: 20).
- However, in a small study in Morogoro Municipality, which is amongst the regions in Tanzania that is highly exposed to many risks of HIV/AIDS and STIs – partly due to the large number of visitors who pass through the town to other up-country regions and countries – 79.8% of the secondary school respondents had knowledge on STIs (Kaale and Muhanga, 2017).
- The majority of youth in a semi-rural study in Ifakara in Kilombero District had heard about STIs (83.6%), but only 32.7% were able to mention at least one sign, and only 12.2% were able to mention two or more signs (Abdul et al., 2018).

⁴ Human Rights Watch, Barriers to Secondary Education in Tanzania (2017).

⁵ Participants access the m4RH programme by SMS text messaging “m4RH” to short code “15014” to receive a menu of choices for accessing information on a variety of SRH topics including contraceptive methods, family planning clinic locations, role model stories (story installments modelling positive health attitudes, norms, and behaviours), etc.

⁶ UNAIDS ‘AIDS Info.’ 2016.

⁷ Amref Health Africa had been implementing a 3-year project on SRHR called Tuitetee (‘Let’s Fight For It’) project in three municipalities; two in Dar es Salaam (Kinondoni and Ilala Municipal councils) and one in Iringa Region (Iringa Municipal Council) in Tanzania. Its focus was to support reproductive health and rights of young people aged 10-24 years including making pregnancy safer for women. The project targeted approximately 100,000 people including 100 youths with disabilities and those living with HIV.

Sexual and reproductive health and rights (SRHR) awareness

Data from 10-24 year olds taking part in the Tuitetee project showed that access to SRHR information is high, but decreases when it is disaggregated across different age groups (Ngilangwa et al., 2016) – *although specific data for these age groups are not listed*. Results from three municipalities of Iringa, Ilala and Kinondoni in Tanzania shows that parents/guardians are the main source of SRHR information for the majority of young people (Ngilangwa et al., 2016).

Research in selected areas of Tanzania revealed that the level of SRHR awareness was high among school truants (69%), followed by youth with disabilities (66.4%) and youth living with HIV (64.4%) (Ngilangwa et al., 2016).

SHK in young people with disabilities (PWDs)

SRHR issues of youth with disabilities are often ignored in research, programming and policymaking (Ngilangwa et al., 2016). Evidence of SRHR status of marginalised youth in Africa, and especially in Tanzania, is lacking. Adolescents with disability are found to be more vulnerable to sexual abuse, unplanned pregnancy, HIV and STIs. In a study looking at accessibility of SRHR information in marginalised young people, about a third of young PWDs indicated newspapers as their main source of SRHR information (Ngilangwa et al., 2016). In individual sources of SRHR information, it emerged that parents/guardians were the main source of information for the majority of young people, with the exception of youth with disabilities whose main source were teachers (indicated by 53% of the youth with disabilities) (Ngilangwa et al., 2016).

SHK in young people with HIV

Youths living with HIV/AIDS experience innumerable challenges within schools and the larger community (Kimera et al, 2019). Busza et al. (2013) interviewed a small group of adolescents aged 15–19 years who had acquired HIV perinatally. Adolescents expressed unease about their sexuality, fearing that sex and relationships were inappropriate and hazardous, given their HIV status. They worried about having to disclose their status to partners, the risks of infecting others and for their own health. Thus, many anticipated postponing or avoiding sex indefinitely. The adolescents had 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 (Busza et al., 2013).

3. Family planning use

Birth rates and need for family planning in young people

Tanzanian teens are having more than three times as many children as their counterparts (Japhet, 2017). Data shows that 23% of women aged 15-19 have started childbearing (Andersson et al., 2015: 11). Research shows that approximately 45% of all 19 year old Tanzanian women are either pregnant or already have a child (CCBRT, 2018). About 37% of

women aged 20-24 were married or were in union before the age of 18.⁸ This implies that the sexual and reproductive health needs of some young people are not being met adequately, particularly for young adolescents below the age of 18 years (Ngilangwa et al., 2016).

It is apparent that pregnant women who are younger than 18 years of age face increased risks of complications for both the mother and the newborn, compared to women 20-24 years old (MOHCDEGEC, 2018: 20).

The relationship between contraceptive prevalence and unintended pregnancy is complex. Unintended pregnancy is rising despite growing contraceptive prevalence (Izugbara et al., 2018: 6-7). The 2015–2016 Tanzania Demographic and Health Survey⁹ shows that Tanzania's unmet need for family planning stands at 22% among married women aged 15–49 years. In East Africa, reporting of unintended pregnancy among women of reproductive age is currently lowest in Ethiopia and Tanzania (Izugbara et al., 2018: 6). The decline in unmet need for family planning is slow in Tanzania (Izugbara et al., 2018: 26). Unmet need is lowest among women aged 15-19 years, and highest among the 30-39 and 20-29 age groups (Izugbara et al., 2018: 27).

Contraceptive prevalence rates (CPRs) in young people

Although there has been a steady increase in contraceptive use in Tanzania, the country's total fertility rate remains high at 5.4 children per woman (Sharan et al., 2011). A recent report on family planning in East Africa found that Uganda and Tanzania have the lowest contraceptive prevalence rates (CPRs)¹⁰ in sub-Saharan Africa (SSA) (Izugbara et al., 2018: 31). Both countries also currently have the highest wanted fertility rates¹¹ (Izugbara et al., 2018: 16).

Overall, adolescents (aged 15-19) have both the lowest CPRs and highest unmet need for family planning in East Africa (Izugbara et al., 2018: iv). The Tanzania Youth and Adolescent Reproductive Health (TAYARH) coalition is concerned that the teenage pregnancy rate has risen from 22% in 2010 to the current rate of 27% among young girls aged 15 to 19 years. While records claim that contraceptive use stands at 32%¹², data from the Ministry of Health shows that the figure is lower at 27.4% (Japhet, 2018). Therefore, use of family planning in this age group is crucial.

⁸ National Bureau of Statistics (2012). The 2012 Population and Housing Census (PHC) for the United Republic of Tanzania.

⁹ Demographic and Health Survey (2016). "Tanzania: 2015-16 Demographic and Health Survey and Malaria Indicator Survey. Key Findings". <https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf>

¹⁰ CPR is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception. *Tanzania Demographic and Health Survey 2010*. <https://dhsprogram.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf>

¹¹ This rate is the number of children who would be born per woman (or per 1,000 women) if she/they were to pass through the reproductive years bearing children according to a current schedule of age-specific fertility rates if only "desired" or "wanted" births occurred. https://www.measureevaluation.org/prh/rh_indicators/family-planning/fertility/wanted-total-fertility-rate

¹² This figure (32%) for the current uptake of any modern contraceptive (that includes: female sterilisation, intra-uterine device, pills, injectable, implants and male condoms) is still low.

Methods of family planning in young people

Modern contraceptive methods approved for use in Tanzania include: implants; male and female sterilisation; oral contraceptive pills; progestogen-only injectables; intrauterine device - copper containing only (IUCD); male and female condoms, and emergency oral contraceptive pills (Sedekia et al., 2017). Short-acting methods remain the most commonly used forms of family planning: currently married women are most likely to use injectables (11%) or pills (7%), whereas sexually active unmarried women prefer male condoms (16%) and injectables (15%).¹³

The Ministry of Health and Social Welfare's 2015-2020 strategic plan (United Republic of Tanzania, 2015: 11) states that although the total fertility rate is reducing, SRH services such as family planning are not performing as hoped in Tanzania, despite continued investment.

The latest service provision assessment implemented by the Ministry of Health and Social Welfare showed that there is a high level of client satisfaction with family planning services in Tanzania (Bintabara et al., 2018). Clients aged under 20 years of age were more likely to report being satisfied with family planning services compared to those aged between 20 to 29 years.

Access to contraception in young people

Evidence shows that there are limited numbers of health providers that are trained in provision of adolescent SRH, as well as a limited number of health centres that provide safe and confidential services to the youth (Andersson et al., 2015: 12).

Sedlander and Rimal (2019) studied how collective norms and media access affects access to contraception in adolescents (15-24 year olds) from Ethiopia and Tanzania. Demographic and Health Surveys from these two countries from SSA were used as they are similar on many demographics. Overall, the Tanzanian sample used more media: 79% listened to some radio compared with 38% in the Ethiopian sample and 58% watched some television, compared with 40% in Ethiopia. In both samples, approximately 38% of adolescents were married, and contraception use was approximately 14%. In both samples, older adolescents, compared with younger ones, were significantly more likely to use contraceptives. Marital status was positively associated with use of contraceptives in both samples ($\beta = 2.68$, $p < .001$) in the Ethiopian sample and ($\beta = 0.40$, $p < 0.001$) in the Tanzanian sample. Media use was associated with use of contraceptives in the Tanzanian sample only ($\beta = 0.17$, $p < 0.01$).

Geographical differences in access

Youths in rural areas use condoms at a lower rate compared to their urban counterparts (MOHCDGEC, 2018: 20). Among unmarried young women, use of a condom at sexual intercourse is higher among adolescents aged 18-19 years. However, younger unmarried men (aged 15-19 years) are less likely to use a condom during sexual intercourse than older unmarried young men (aged 20-24 years) (MOHCDGEC, 2018: 20).

¹³ <https://www.k4health.org/toolkits/tanzania-capacity-and-communication-project-toolkit/family-planning-tanzania>

Access by young PWDs

Although young PWDs have the same needs for SRH services as everyone else, these needs are often neglected or overlooked. Access to safe, effective and affordable contraception reduces death and injury caused by childbirth, and allows women to pursue education and employment. This is especially crucial for PWDs, as PWDs are more likely to live in poverty, and unplanned or unwanted pregnancies further strain already limited resources (CCBRT, 2018). Women with disabilities are more likely to be subjected to sexual abuse and violence, as well as being refused access to SRHR services.¹⁴ *However, whether adolescents and/or young people are included in these findings is unclear.*

Access by young people with HIV

STIs, including HIV/AIDS, remain a great risk as 40% of new infections occur in adolescents (MOHCDGEC, 2018: 7).

Data shows that the number of visits to Youth Friendly SRH services has increased, which is an indicator of demand for services (Andersson et al., 2015: 7). However, TAYARH notes that access to adolescent friendly SRH and family planning services is still a challenge, with only 30% of service delivery points offering these services.¹⁵

It is also noted that services currently provided to young people are not rights-based, leaving out key populations such as men who have sex with men, intravenous drug users, and commercial sex workers that form an important part in the prevention of new HIV infections leading to high HIV prevalence and high rates of poverty and inequality among young people. This equally applies to other marginalised groups, such as institutionalised young people in juvenile homes, orphanage centres and disabled vocational schools (Andersson et al., 2015: 62).

A recent systematic review on youths with HIV/AIDS in East Africa found that those seeking care with caregivers feared to ask for contraceptives, since this would attract questions from their caregivers about their sexual activity (Kimera et al., 2019).

4. Attitudes and barriers to family planning

Despite the stigma around sexual intercourse among young adolescents and unmarried women in low and middle income countries such as Tanzania (Nyblade et al., 2017), some adolescent girls are sexually active even before the age of 15 years, and sexual intercourse among unmarried women is common.

Government attitudes and barriers

The government of Tanzania has increased its budget for family planning services: in 2016/2017 TZS5 billion (USD2.2 million) was allocated to the family planning budget; however, in 2017/2018

¹⁴ Sida (2014). Disability Rights in Tanzania. <https://www.sida.se/globalassets/sida/eng/partners/human-rights-based-approach/disability/rights-of-persons-with-disabilities-tanzania.pdf>

¹⁵ <https://www.everywomaneverychild.org/commitment/tanzania-youth-and-adolescent-reproductive-health-tayarh-coalition/>

the government allocated TZS14 billion (USD6 million) – an increase of 180%.¹⁶ It is committed to scaling up the number of health facilities that provide adolescent and youth-friendly SRH services, from its current coverage of 30% to 80% in 2030. However, in September 2018, the government contacted agencies funded by the United States Agency for International Development (USAID) involved in birth control projects and told them to stop running any family planning content in the media, a directive that rights group Amnesty International called “an attack on the sexual and reproductive health of people in the east African country.”¹⁷ The United Nations Population Fund (UNFPA), which supports and advocates for improved access to family planning services in many African countries, said its programmes were guided by the International Conference on Population and Development agreement, which Tanzania has signed.¹⁸ This ban on advertising was lifted in March 2019.¹⁹

Social influences on family planning

Research shows an individual’s social network (e.g. spouse, mother-in-law, and friends) has great influence on his or her fertility desires and SRH. Thus, addressing the overall context in which SRH decisions are made could accelerate the progress towards reducing unmet need that has languished until now.²⁰ Formative research has found that deeply embedded social norms related to gender roles underlie unmet need for family planning in Tanzania, and other similar countries.

Caregivers and home-based care providers reinforced negative views of sexual activity, partly due to prevailing misconceptions about the harmful effects of sex with HIV (Busza et al., 2013).

Social cohesion (social trust and social participation), together with its dynamics, is multidimensional, as explained by the multiplicity of available frameworks and approaches used to study it (Kalolo et al., 2019). Studies that exclusively focus on the link between social cohesion and sexual behaviours among school adolescents are scarce in the SSA settings. Of particular interest are adolescents living in rural areas with limited access to social marketing programs and the media. The finding that adolescents participated more in community-based activities than those at school may imply that more opportunities are created at community level to enhance openness and eagerness of adolescents to participate in safe sex promoting activities (Kalolo et al., 2019).

¹⁶ <https://tanzania.unfpa.org/en/news/family-planning-empowering-people-developing-nations-8>

¹⁷ <https://edition.cnn.com/2018/09/25/africa/tanzania-suspends-family-planning-advert-intl/index.html>

¹⁸ <https://www.everywomaneverychild.org/commitment/tanzania-youth-and-adolescent-reproductive-health-tayarh-coalition/>

¹⁹ <https://www.thecitizen.co.tz/News/Government-lifts-ban-on-family-planning-ads/1840340-5046038-11v9sxb/index.html>

²⁰ http://irh.org/projects/tekponon_jikuagou/

Barriers to family planning

Barriers to young people

A woman's age plays a significant role in her need for family planning. Unmet need for family planning in SSA varies by age, with adolescents aged 15-19 years bearing a considerable burden of it. This demonstrates the unique barriers adolescents may face in contraceptive access and use (Izugbara et al., 2018: 26).

While lack of contraceptive supplies and logistical problems in accessing these services continues to be a challenge in some areas, a 2015 survey by the Population Reference Bureau (2015: 2) showed that only 3% of young Tanzanian women (aged 15 to 24 years) stated that lack of access was their main reason for not using contraception. This indicates a need for more deliberate efforts to increase uptake of these services.

Some of the key barriers to uptake of family planning include fear of side effects, concerns about delayed return to fertility, and disapproval of family planning by influencers, such as sexual partners, and religious institutions.²¹

These are cultural barriers and parents' lack of knowledge/skills about sexual and reproductive health matters. During interviews, respondents explained that it was not in keeping with African culture for parents and their children to discuss issues related to sexuality (Ngilangwa et al., 2016).

Barriers to young PWDs

Despite general awareness of SRH being widespread among PWDs surveyed by CCBRT and Marie Stopes Tanzania, only half report using any family planning methods (CCBRT, 2018). Many PWDs instead report that they face significant barriers to accessing SRH services, including family planning. These barriers can be societal (stigma and discrimination from family, community members and service providers), physical (long distances to health facilities and inaccessible buildings) and economic (financial constraints). Even when PWDs in Tanzania can access health facilities, most service providers do not have the disability-specific knowledge or skills they need to offer disability-inclusive SRH services, and health facilities fail to provide disability-friendly hospital equipment or educational materials. In the worst cases, service providers turn away, ridicule, reject or even sterilise PWDs seeking SRH services (CCBRT, 2018).

Young people with disabilities face several challenges when visiting a health facility for SRH services. Findings from an evaluation from the Swedish International Development Cooperation Agency (Sida) showed that parents, teachers and communities' members at large were not aware of adolescent SRH rights, or the national policy provisions for such (Andersson et al., 2015: 36).

²¹ <https://www.k4health.org/toolkits/tanzania-capacity-and-communication-project-toolkit/family-planning-tanzania>

Barriers to young people with HIV infection

Approximately 50% of adolescents living with HIV live in just six countries: South Africa, Nigeria, Kenya, India, Mozambique, and Tanzania (UNICEF, 2015).

In 2016, an estimated 4.7% of adolescents (aged 10-19) were living with HIV in Tanzania. Among women aged 15-19 years, HIV prevalence is low at 1%.²² However, stigma and discrimination against youth living with HIV and AIDS deprives them of their basic right to SRHR services (Andersson et al., 2015: 11). Religion shapes everyday beliefs and activities in Tanzania,²³ however, religious advice still does not promote using condoms,²⁴ even though HIV and AIDS are major issues that need to be curtailed.

Attitudes to family planning in young people

Effect of social cohesion

Sexual debut at under 13 years of age was reported by 12% of the respondents from Newala in Mtwara region, rural Tanzania (Kalolo et al., 2019). However, the intention to use a condom was reported by 77% of the respondents. Having multiple sexual partnerships was associated with social trust only (odds ratio: 3.5, 95% CI 1.01–12.3), whereas reported condom use was related with social cohesion (odds ratio 4.8 95% CI 1.66–14.06). Social cohesion, trust or participation was not associated with young age at sexual debut or intention to use a condom. Being a female (odds ratio 2.07 95% CI 1.04–4.12.) was associated with intention to use a condom.

Social stigma on young people's sexual health

The Tanzanian government policy on family planning has made an effort to ensure the availability of free contraceptive services, including family planning education, in its health facilities for men and women who are in need. However, information on contraceptive use is not easily available to young students due to the social stigma of using contraception before marriage, and hence, they may fear disclosing their sexual activity (Sweya et al., 2016).

Nyblade et al. (2017) performed analysis on a qualitative study that explored the micro-level social process of stigma surrounding young people's SRH in two communities in Tanzania. Respondents perceived that stigma (which manifests itself in multiple forms, ranging from verbal harassment and social isolation to physical punishment by families, community members, peers and healthcare providers) was a barrier to young people accessing sexual and reproductive health services. They identified excessive questioning, scolding and requirements to bring sexual partners or parents to receive services at health facilities as obstacles to accessing care.

²² <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/tanzania>

²³ Zou et al (2009). Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. <https://www.ncbi.nlm.nih.gov/pubmed/19261186>

²⁴ <https://www.theguardian.com/global-development/2018/jul/22/hiv-education-tanzania-africa-biker-nun-new-campaign>

Attitude on type of contraception methods

Qualitative data from a study exploring perceptions of modern contraceptives in southern Tanzania found that it was widely acceptable for women who were students, young, unmarried, and women in unstable marriage to use them to delay first birth (Sedekia et al., 2017). However, long-acting reversible methods, such as implants and intrauterine devices, were perceived as inappropriate methods, partly because of fears around delayed return to fecundity, discontinuation once woman's marital status changes, and permanently limiting future fertility (Sedekia et al., 2017).

Urban vs rural attitudes

Qualitative research on individuals, communities and health providers in southern Tanzania revealed that a small number of participants from both rural and urban areas did not approve the use of contraceptive methods before the birth of a first baby at all, not even for students (Sedekia et al., 2017). *This may be due to the lack of clarity and consistency on the definition of 'young' - which had direct implications for access, autonomy in decision-making, confidentiality, and consent for young people* (Sedekia et al., 2017).

Influence of adolescents

A new programme implemented in late 2017, *Adolescents 360 (A360)*, funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation, aims to increase the uptake of modern contraceptives among girls aged 15-19 years across Nigeria, Tanzania and Ethiopia – three countries with some of the highest teen pregnancy rates, and the lowest rates of modern contraceptive use among adolescents (Atchison et al., 2018). A360 flips traditional family planning messaging on its head – building from what girls say they want, to deliver SRH services when and how they need. In Tanzania, both married and unmarried girls aged 15–19 years will be included in the study. After late 2019, findings of this study will be widely disseminated through workshops, conference presentations, reports, briefings, factsheets and academic publications (Atchison et al., 2018).

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Key websites

- Adolescents 360: <https://a360learninghub.org/countries/tanzania/>

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