

Access to Sexual and Reproductive Health and Rights: Youth Experiences in Handeni District, Tanzania

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Abstract

Young people in Tanzania face many problems that affect their access to Sexual and Reproductive Health and Rights (SRHR). This study on which this paper is based explored youth's knowledge, access to, and utilization of SRHR services. The study adopted a cross-sectional descriptive survey using quantitative and qualitative research methods. Simple random and systematic sampling techniques were used to select 390 respondents. A questionnaire based survey, key informant interviews and focus group discussions were the main methods for data collection. Descriptive statistical analyses were used to analyse quantitative data. The study found some knowledge gap on SRHR. Parents and tribal elders had limited communication with youth on SRHR, a thing which hampered youth's adoption of the recommended practices. It is recommended to local government authorities and NGOs involved in promoting SRHR to involve and support local power structures including tribal elders and village councils during training and capacity building on issues related to SRHR for community ownership, acceptance and sustainability of the initiatives. It is recommended to the local government authorities and NGOs to have a focus on dual protection advocating for abstinence and consistent and correct use of condoms.

Keywords: Sexual behaviour, reproductive rights, HIV/AIDS, STIs

Introduction

Worldwide, the terms “youth”, “young people” and “adolescents” are used interchangeably meaning the same thing, although they can be differentiated. A youth is an individual within a period of transition from childhood to adulthood, between the age of 10-24 (UNICEF, 2011). During this period youth undergo many changes including biological and psychological changes. The changes happen to youth who are usually not adequately informed on such changes and developments; hence they are more likely to face challenges associated with their development.

Young people in Tanzania, as it is the case in many developing countries, face many problems that affect their access to sexual and reproductive health rights (SRHR). According to Boldosser-Boesch (2014), SRHR encompass the right of all individuals to make decisions concerning their sexual activities and reproduction free from discrimination, coercion, and violence. Specifically, access to SRHR ensures individuals are able to choose whether, when, and with whom to engage with in sexual activities; to choose whether and when to have children; and to access the information and means to do so. The SRH problems that youth face ranges from unwanted pregnancy, unsafe abortion and sexually transmitted infections including HIV/AIDS (UAFD, 2001). According to UNICEF (2011), adolescents make up about 20 per cent of the population. One out of every five Tanzanians is an adolescent, but only one-third of adolescents are enrolled in secondary schools. By the age of 19, almost half of all girls are pregnant or have already given birth to a child (UNICEF, 2011).

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Adolescent girls aged 18-to-19 are nearly three times more likely to be infected with HIV than girls aged 15 to 17. About one in every three adolescent girls has been sexually abused. Seven out of ten of adolescent boys and girls have experienced physical violence, abuse and exploitation. These problems continue to happen and affect youth development notwithstanding many efforts made by the government and non-governmental organizations in addressing SRRH in promoting their rights. This paper addressed youth access to, and utilization of Sexual Reproductive Health and Rights (SRHR) services and education for youth and women of reproductive age in Handeni District in Tanzania.

Methodology

The study from which this paper is based was conducted in Handeni District located in Tanga Region in Tanzania. The district is dominated by farmers and agro-pastoralists who are predominantly occupied with farming and livestock keeping, hence a good representation of rural Tanzanian context. The study adopted a cross-sectional descriptive survey using quantitative and qualitative research methods. The study involved school and out of school youth from farming and agro-pastoral communities from six villages that were selected from six wards. The wards were purposively selected to represent the diverse socio-economic and socio-cultural backgrounds of the district such as agro-pastoralists, farmers and nomadic communities.

In each ward one village was purposefully selected on the basis of the socio-economic and socio-cultural characteristics. The villages involved were Sindeni, Mzeri, Msomera, Kibindu, Kwamatuku and Kang'ata. Thirty-five out of school respondents were selected from each village using the principle of simple random selection. Systematic sampling technique was used to select 30 school based respondents: 10 primary school pupils from standard 6 & 7 and 10 secondary school students from form 2 & 4. Therefore, a total of 390 respondents were selected to participate in the study. However, after data cleaning to remove incompletely filled in questionnaire copies a total of 365 questionnaire copies were used for data analysis. This response rate of 93% was considered adequate for data analysis and drawing inferences to the studied population. The basis for estimation of the sample is based on the guidance by Bailey (1998) who argues that a population sub-sample of 30 respondents is enough to make statistical analysis and inference for a particular population. A structured questionnaire was the main tool for data collection, and key informant interviews (KII) and focus group discussions (FGD) were used to collect data that were used to complement the information collected through the questionnaire.

Qualitative data were analysed using content analysis. Data from the FGDs and KIIs proceedings were recorded and transcribed verbatim. Codes and themes were identified after several reads and reviews of the transcripts. The emerging themes were generated using participants' quotes and perspectives about various aspects of SRHR, which were compared for the discussions in relation to the study objectives.

Quantitative data collected using the questionnaire were analysed with the aid of Statistical Package for Social Sciences (SPSS) version 16. SPSS is a computer software that is commonly used to analyse socio-economic data. Descriptive statistical analyses such as frequency and cross-tabulations analysis were employed to gauge and compare the characteristics and distribution of the socio-economic characteristics and key study variables such as socio-demographic information, source of information and levels of access to information, among other things.

Findings and Discussion

Socio-Demographic Characteristics of Respondents

The socio-demographic characteristics of the respondents who participated in this study are presented in Table 1. The minimum age of the respondents was 9 years, and the maximum age was 44 years, while the median age was 19.1 years. In order to facilitate comparison of the findings in this study and other studies as well as to facilitate the categorization of adolescent stages, the age of the respondents was grouped into the six age brackets seen in Table 1. The largest proportion of the respondents (37%) was in the 16-20 years' age bracket. This age bracket comprises mainly of adolescents who are undergoing many rapid changes, coupled with experimentation of their body changes and sexual behaviour; hence they are at a higher risk of contracting sexually transmitted diseases and unintended pregnancies. The sample had small differences in male and female counts, and the school based respondents were also comparable in terms of numbers to out of school respondents. The majority of out of school respondents (77%) was living as singles and had only attained primary school level of education (59.7%).

Table 1: Social Demographic Characteristics of Respondents (Percent n = 365)

SN	Attribute	Male		Female		All	
		Freq	%	Freq	%	Freq	%
1	Age of respondent						
	5-10 yrs	1	0.5	5	2.8	6	1.6
	11-15 yrs	56	30.4	68	37.6	124	34.0
	16-20 yrs	70	38.0	65	35.9	135	37.0
	21-25 yrs	22	12.0	16	8.8	38	10.4
	26-30 yrs	17	9.2	14	7.7	31	8.5
	30+ yrs	18	9.8	13	7.2	31	8.5
2	Sex of the respondent						
	Male	-	-	-	-	-	50.4
	Female	-	-	-	-	-	49.6
3	Nature of respondent						
	School based	87	47.3	93	51.4	180	49.3
	Out of school	97	52.7	88	48.6	185	50.7
4	Marital status						
	Single	146	79.3	74.6	74.6	281	77.0
	Married	36	19.6	21.0	21.0	74	20.3
	Separated	2	1.1	2.2	2.2	6	1.6
	Widow	0	0	0.6	0.6	1	0.3
	Divorced	0	0	1.7	1.7	3	0.8
5	Education level						
	Primary	103	56.0	115	63.5	218	59.7
	Secondary	73	39.7	52	28.7	125	34.2
	Did not attend	8	4.3	14	7.7	22	6.0
6	Village name						
	Sindeni	32	17.4	27	14.9	59	16.2
	Mzeri	40	21.7	32	17.7	72	19.7
	Msomera	24	13.0	35	19.3	59	16.2
	Kibindu	20	10.9	23	12.7	43	11.8
	Kwamatuku	49	26.6	45	24.9	94	25.8
	Kang'ata	19	10.3	19	10.5	38	10.0
7	Religious affiliation						
	Muslim	138	75.0	120	66.3	258	70.7
	Christian Protestant	31	16.8	51	28.2	82	22.5
	Christian Catholic	15	8.2	10	5.5	25	6.8

Knowledge about SRH

The level of knowledge of sexual and reproductive health (SRH) was found to be generally high. Most respondents (83.3%) had heard of information related to SRH such as use of contraceptives and safe delivery issues. The most common means through which youth received such information are radio (63.8%), television (32.1%) and newspapers or magazines (29.6%) whose headlines are read on the radio. However, when asked about the reliable sources of information about SRH, school teachers ranked highest (29.3%), being followed by media and health care providers (21.9% and 16.6%, respectively). Less popular sources of information were community volunteers, peer educators and brothers and sisters (See Table 2). UNICEF (2011) has also reported that the numbers of adolescents who are completing primary and secondary school education levels have improved, although too many adolescents still don't know how to protect themselves against HIV and AIDS and other sexually transmitted diseases.

Other scholars, for example Ngilangwa *et al.*, 2016 in their study on accessibility to sexual and reproductive health and rights education among marginalized youth in Tanzania, found that youth had low level of comprehensive knowledge about sexual and reproductive health rights. Such divergent findings suggest that, generally, youth's access to comprehensive knowledge may still be constrained by several factors. This continues to happen despite several government initiatives to address youth's access to sexual and reproductive health services (URT, 2007; UNICEF, 2011; URT, 2015).

Table 2: Source of SRH information for youth (Percent (n = 365))

SN	Source of information about SRH	Male	Female	School	Out of school	All	Preferred source
1	School teacher	29.9	28.7	41.7	17.3	29.3	2nd
2	Media(radio/news papers)	23.4	20.4	21.1	22.7	21.9	5th
3	Health care provider	14.1	19.3	5.0	28.1	16.7	1 st
4	Parents/guardian	7.6	11.6	12.8	6.5	9.6	3rd
5	Friends	10.3	7.2	1.7	15.7	8.8	4th
6	Films/videos	4.3	2.8	5.6	1.6	3.6	6th
7	Other family members	3.3	2.8	4.4	1.6	3.0	7th
8	Books/magazines	2.2	3.9	3.3	2.7	3.0	8 th
9	Community Volunteers	2.7	1.1	1.1	2.7	1.9	9 th
10	Peer educators	1.6	1.7	2.2	1.1	1.6	10 th
11	Brother/sister	0.5	0.6	1.1	0	0.5	11 th

Furthermore, respondents were asked through which sources they would prefer to receive information on SRHR. The most common/preferred source of information was healthcare providers, being followed by school teachers and parents (Table 2). Furthermore, peer educators and community health volunteers were mentioned to be important sources of knowledge that youth prefer. The youth's preferred sources of knowledge are in line with what are advocated to be the entry points in assisting youth to overcome sexual and reproductive challenges they encounter (TACAIDS *et al.*, 2008). The three important aspects of youth's sexual behaviour were further explored in this study: sexuality, pregnancy and HIV/AIDS.

Youth and Sexuality

The self-reported age when one had started having sexual intercourse was 5 years. This is very low age which implies that most youth start having/trying to have sexual intercourse at very young ages to the extent that they may not even remember the exact time they started engaging in sexual intercourse practices. The mean age for one's engagement in sexual encounters was 15.9 years. Youth who were married (30.6%) were also asked the age at which they first got married. The minimum self-reported age for getting into marriage was 12 years, and the mean age at marriage was 19.9 years. When they were asked to give their opinions on the most preferred age for one to get married, the mean age they stated was 21 years due to the fact that by this age one would be mature enough (67.2%), have the ability to meet family obligations (18.1%), feel secure (5.9%) and conform to customs and traditions (4.1%). The study also found that youth had many sexual partners and were inconsistent in using condoms during sexual intercourse. On average, the respondents had 5.7 lifetime partners. Males reported to have more than doubled the number of lifetime partners than their female counterparts (7.8 and 2.8 for male and female respectively). Similar trends of sexuality among youth have also been widely reported in literature (TACAIDS *et al.*, 2008; HEARD, 2015, Mbeba *et al.*, 2012). These finding indicate that youth are more likely to be affected by sexually transmitted diseases including HIV/AIDS.

Table 4: Sexuality and condom use during sex (Percent, n = 365)

SN	Variable	Male	Female	School	Out of school	All
1	Ever had sexual intercourse	67.2	50.0	24.2	91.9	58.4
2	Age at first sex (Before 18 yrs)	84.9	78.7	94.9	79.5	82.2
3	Average age at first sex (After 18 yrs)	15.5	16.4	14.3	16.2	15.9
4	Average numbers of life time sexual partners	7.9	2.8	3.0	6.6	5.7
5	Condom use during first sex	37.1	38.2	46.0	34.5	37.6
6	Condom use during last sex last	39.2	33.0	52.5	31.0	36.5
7	General condom use during sex					
	Every time	19.5	19.6	39.2	13.4	19.5
	Almost every time	14.6	13.0	5.9	16.5	14.0
	Sometimes	30.9	19.6	15.7	29.3	26.0
	Don't know	7.3	5.4	21.6	1.8	6.5
	Never	27.6	42.4	17.6	39	34.0
8	Believe partner has/had other partners	13.8	32.3	23.2	21.2	21.7
9	Can say No to have sex when you do not feel like	70.6	64.9	32.8	80.6	71.3

While this study found that respondents had many sexual partners and that condom use during sex was low and inconsistent; very few respondents reported to have contracted sexually transmitted infections. This might be due to the associated stigma that sexually transmitted diseases are an evidence of promiscuity and or extramarital affairs among married couples. The majority of youth knew the symptoms of STDs and were able to describe them such as discharge from penis/vagina (42.7%), pain during urination (20.5%) and ulcers/sores in genital areas (8.8%). Just over a quarter of the respondents (27.1%) were not aware of those symptoms. The majority of the respondents also knew the places where to seek medical attention when one contracts STDs. Relatively higher level of empowerment was also reported; 71.3% were able to refuse to have sexual intercourse when they did not feel like; females were less likely to resist having sexual intercourse than their male counterparts. Such sex differences in one's ability to defend oneself in engaging in sexual intercourse have different implications for the spread of sexually transmitted diseases for boys and girls.

Table 3: Knowledge about pregnancy and its prevention (Percent, n = 365)

SN	Respondents who know/believe	Male	Female	School	Out of school	All
1	There certain days when a woman is more likely to become pregnant in her cycle	83.1	81.2	75.4	88.6	81.9
2	Halfway between two periods is risk period for one to get pregnancy	8.7	11.0	8.8	10.9	9.9
3	A couple can avoid sex on days when pregnancy is most likely to occur	76.5	68.5	68.9	76.1	72.3
4	Women can have an operation to avoid pregnancy	62	50.3	60.6	51.9	56.2
5	Men can have an operation to avoid having any more children	37	26.5	36.1	27.6	31.8
6	loop or coil/IUD) can prevent pregnancy	72.8	71.8	72.2	72.4	72.3
7	Injectables can prevent pregnancy	74.7	81.2	72.4	70.8	77.5
8	Implants can prevent pregnancy	66.1	75.5	70.8	84.9	70.7

9	Pill can prevent pregnancy	82.2	80.7	61.5	80.0	82.2
10	Men can put a rubber sheath on their penis before sexual intercourse (condom)	89.6	77.9	80.6	84.2	83.6
11	Female condom can prevent pregnancy	77.7	68.5	78.9	88.6	73.2
12	Safe days/calendar can prevent one to get pregnancy	67.9	64.4	67.2	78.9	66.0
13	Men can be careful and pull out before climax (withdraw)	68.3	53.6	62.8	69.6	60.8
14	Emergency contraception can prevent pregnancy	40.8	27.2	45.0	23.4	34.0
15	There are other methods that women or men can use to avoid pregnancy (traditional methods)	9.2	8.5	2.3	15.1	8.8

Knowledge about pregnancy

Pregnancy is an indicator of unprotected sex and may be unintended. Pregnancy increases the risk of contracting STIs and HIV. To ascertain such knowledge, respondents were asked if they knew how one gets pregnant and common methods that are used to prevent pregnancy (Table 3). Despite most respondents being aware that there are certain days when a woman is more likely to become pregnant, only a few respondents (9.9%) could correctly say when this was. Generally, the respondents had good knowledge on many methods that can be used to prevent pregnancy from happening. School based candidates had relatively better levels of knowledge with regard to different contraceptives as compared to out of school youths. However, during discussions with youth in focus group discussions (FGDs), many youths revealed that despite widespread level of knowledge of contraceptives the level to which they were used was low.

Knowledge about HIV/AIDS and STIS

The survey on which this paper is based also sought respondents' knowledge on HIV/AIDS as it is closely associated with SRH (Table 5). Generally, 95.1% of the respondents had heard of HIV or AIDS. The level of comprehensive knowledge on HIV/AIDS was generally good. However, limitations in knowledge on how HIV/AIDS is transmitted were also reported. For example, some youth had common misconceptions about HIV/AIDS such as the possibility of people being able to get HIV/AIDS by being bitten by insects e.g. mosquitoes (7.7%), sharing food with a person who has AIDS (12.9%), and due to witchcraft or other supernatural means (5.8%). There was a small difference in level of knowledge about HIV/ADS between men and women and between out of school and in-school youth. Out of school youth and male youth had relatively higher levels of knowledge than schooling youth and female youth respectively, this is probably due to the knowledge that out of school youth have accumulated during schooling as well as the impact different ant HIV/AIDS campaign and sensitization. The level of knowledge also varied with age; knowledge was observed to increase with an increase in age. These findings compare well with those reported by TACAIDS *et al.* (2008).

Table 5: Youth Knowledge about HIV/AIDS and STIs (Percentage, n = 365)

SN	Respondent who/believes	Male	Female	School	Out of school	All
1	Ever heard of HIV or AIDS	92.6	93.9	91.0	98.9	95.1
2	It is possible to cure AIDS	14.4	12.2	18.8	4.9	11.8
3	A person with HIV always looks emaciated or unhealthy in some way	32.2	34.4	38.9	27.7	33.2
4	People can get HIV/AIDS by being bitten by insects e.g. mosquito's	7.1	8.3	11.1	4.3	7.7
5	People can get AIDS by sharing food with a person who has AIDS	12.0	13.8	19.4	6.5	12.9
6	People can get AIDS because of witchcraft or other supernatural means?	2.2	9.4	10.0	1.6	5.8
7	People can reduce their chances of getting AIDS virus by having just one uninfected sex partner who has no other sex partners	59.2	51.9	50.1	61.1	55.6
8	People can reduce their chances of getting AIDS by using condom every time they have sex	62.3	49.7	53.1	58.9	56.0
9	People can get HIV/AIDS by hugging or shaking hands with a person who is infected	9.8	13.9	12.3	11.4	11.8
10	People can the virus that cause AIDS be transmitted from a mother to her baby during pregnancy	55.4	46.4	62.8	39.5	51.0
11	Apart from HIV/AIDS are there other diseases that men and women can catch by having sexual intercourse	76.1	64.1	52.2	87.6	70.1
12	During the last 12 months have you ever been infected with a sexually transmitted disease?	11.0	7.8	5.6	13.0	9.3

The use of Contraceptives

The knowledge about use of contraceptives was relatively high. However, the use of contraceptives was low especially among men. Several factors account for this phenomenon. For example, during FGDs with male young men, it was revealed that a combination of inadequate knowledge and cultural practices are both the reasons for not using the contraceptives. The majority of Maasai youth where the research was done believe that they can prevent themselves from contracting sexually transmitted diseases using their own traditional medications. On the other hand, fear of un-intended pregnancy was a key factor that motivated more females to seek contraceptives. As long as they are assured they cannot get pregnant they would not fear contracting STIs and HIV. One youth emphasized this by saying: *"Condom is for the town people like you [researcher]... we do not need it...We are strong and have our own ways of life and medications. We can't get HIV. We are immune to those diseases. This is your own problem"* (Maasai Youth).

Discussions with women, on the other hand, presented more favourable views than those of men. Some of the women in the village had had opportunities to meet with health workers and hence learned from them the importance of using contraceptives such as injectables, implants, pills and condoms. However, they still faced challenges associated with actual uses of the contraceptives, mostly resistance from men as they dislike use of such contraceptives by their wives. They also fear side effects associated with the use of contraceptives, and some have inadequate knowledge of proper use of the contraceptives.

Referring to men as barriers for women wanting to access and use contraceptives, one Maasai women emphasized that: *"We do not use any form of family planning. For example, some government people have come to educate us on family planning ... we have understood it is a good idea ... but men are not ready to accept it ... better talk to them as well so that they can also understand it"*. (Women FGD at Msomera).

On the same tone, some women decide to use some forms of contraceptives without the knowledge of their partners. One married woman revealed this by saying: *"Maasai men want to have many children ... so if you don't take initiatives to protect your own health they will make you a reproduction machine ... having heard of the family planning services from the health clinic, I went for those sticks that were inserted in my upper arm ... I always make sure that my husband doesn't touch it ... it is working perfectly and I plan to space my children as I like..."* (Maasai woman, Msomera village).

Challenges on accessing and utilization of quality SRH services

Utilization of quality Sexual and Reproductive Health (SRH) services in Handeni District faces numerous challenges. Some of the health facilities are located far from where people live. Therefore, people have to travel longer distances to reach health facilities, which is coupled with lack of professionalism and lack of privacy. During focus group discussions with youth many challenges were revealed in relation to delivery of health services, including lack of confidentiality among health workers. One youth from Sindeni village insisted: *"If I contracted STDs I would rather tell my parents than friends, lest they spread the news all over the village and put me to shame"* (Sindeni Youth FGD).

Another youth gave a plea that the SRH programme should also target parents and insisted: *"We will be happier if you talk to our parents and advise them to talk to us about sexual issues ... it is considered a taboo for parents in our village to talk to youth about sexuality ... we depend on our peers for information but we are not sure whether they know many things"* (Sindeni Youth FGD)

Conclusions and Recommendations

The study has revealed the youth's prevailing level of knowledge on access to, and utilization of Sexual Reproductive Health and Rights (SRHR) services and education for youth and women of reproductive age in Handeni District, Tanga Region. On the basis of the empirical findings, pertinent conclusions and recommendations are made. There is limitation in knowledge of youth on SRHR, hence there is a need to involve youths (both in school and out of school) in education campaign to impart knowledge to them and give them practical skills on SRHR. Special consideration should be made for different age groups for both in school and out of school youths to ensure a tailor made education programme which is age and activity specific. Parents, family members and tribal elders may hamper youths' adoption of the recommended practices. It is recommended to local government authorities and NGOs involved in promoting youth health and rights to involve and support local power structures such as tribal elders (*Laiwanan* for the case of the Maasai) and village councils during training and capacity building on issues related to SRHR for community ownership, acceptance and sustainability of the initiatives. Parents, guardians and village elders should be used as important people for conveying educational messages on SRHR education, and they should be encouraged to have open and regular discussions with youth on SRH issues. Local government authorities and NGOs should continue to lobby to the Ministry of Education to incorporate SRHR education in both primary and secondary school curricula. This would in turn help to address inadequate capacity in the primary and secondary schools to deliver on SRH. There is also a need to support the dissemination of the approved certificate of secondary education curriculum on SRHR by the Ministry of Education, Science and Technology to the schools. It is recommended to the local Government Authorities and NGOs to have a focus on dual protection advocating abstinence and consistent and correct use of condoms.

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