EXAMINING THE UTILIZATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS IN NYAMAGANA DISTRICT, TANZANIA

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SOCIAL WORK

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK OF THE OPEN UNIVERSITY OF TANZANIA

2025

CERTIFICATION

The undersigned certifies that he has read and here by recommends for acceptance by the Open University of Tanzania a dissertation entitled; "**Examining the Utilization of Sexual and Reproductive Health Services among Adolescents in Nyamagana District, Tanzania"** in partial fulfillment of the requirements for the award of Master of Social Work.

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DECLARATION

I, **Adroph Rutechura Gration,** declare that the work presented in this report is original. It has never been presented to any other University or Institution. Where other people's works have been used, references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfillment of the requirement for the master's degree of Social Work

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Signature

…….……

Date

DEDICATION

In heartfelt dedication, this research is dedicated to my family in particular my wife Victoria Malugu and my children Alvin Gration and Ivan Gration

ACKNOWLEDGEMENTS

I outspread my sincerest gratitude to all who sacrificed their time to support this research on the accessibility of sexual and reproductive health services among adolescents. First and foremost, I truly thank and appreciate Dr. Johnas Buhori and Prof. Emmanuel Patroba Mhache, my supervisors, for their unwavering support and constructive feedback throughout the entire period of this study. Their knowledge and encouragement have contributed to making this work a success. I am also deeply indebted to Ms. Dorice Rutahimiwa and Dr. Epimark Masawe for their insightful feedback and constructive criticism. Their contribution has significantly enhanced the quality and rigor of this study. I recognize the perseverance and resilience that fueled me to work hard and commit to learning and completing this work.

I am also deeply indebted to my classmates, whose readiness to share their knowledge and perceptions provided the foundation upon which this study was built. Their contributions have enhanced this study of the accessibility of sexual and reproductive health services among adolescents to be done effectively.

I acknowledge the Mabatini Police Medical for providing the necessary resources and infrastructure to support this research. Their support has been essential in creating a conducive environment for academic inquiry. Additionally, I recognize the support of my family and friends, whose unwavering encouragement and understanding helped sustain me throughout the research process. Without the contributions of these individuals, this research would not have been possible.

ABSTRACT

This study aimed at assessing the utilization of sexual and reproductive health (SRH) services among adolescents in Nyamagana district as a case study. Specifically, the study assessed: the level of awareness of adolescents in accessing SRH services; accessibility of SRH services by adolescents; and challenge facing the adolescents in accessing SRH services. The study was guided by Social Cognitive Theory developed by Albert Bandura. Interprevitism philosophy and cross-sectional design. Qualitative approach was employed whereby 30 participants were involved. In addition, a non-probability sampling strategy specifically purposive sampling was used to select parents/guardians, and healthcare providers. Data were collected by using a semi-structured interview. Data analysis involved thematic analysis. Results indicated that utilization to SRH services by adolescents was influenced by the level of awareness such as awareness of the right to information and education on SRH service, freedom of thoughts on SRH, and right to decide number and spacing of children, and free from violence. The study also found the access to SRH services depended on availability of healthcare providers, adolescent-friendly SRH service, life skills and education programmes, and stock-out commodities. Results also indicated the challenges that hindered access to SRH among adolescents to include intrapersonal, interpersonal, and institutional level. The study concludes that utilization to SRH services in Nyamagana district was influenced by adolescent's level of awareness of SRHS services, and access to SRH service. The study recommends that the government under the Ministry of Health of Tanzania and other health practitioners in Nyamagana district should inform adolescents about the importance of getting SRH services.

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LIST OF ABBREVIATIONS AND ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
CBOs	Community Based Organizations
HIV	Human Immunodeficiency Virus
SCT	Social Cognitive Theory
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
STIs	Sexual Transmission Infections
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 Chapter Overview

This study aimed to assess the accessibility of sexual reproductive health (SRH) services among adolescents in Nyamagana District. The study was developed to include three specific objectives. First, the study assessed adolescents' awareness of accessing SRH services. Second, the study assessed adolescents' utilization of SRH services. Third, the study assessed the challenges adolescents face in accessing SRH services. In addition, this chapter describes the background information, problem statement, research objectives, research questions, the study's significance, the study's scope, and the study's organization.

1.2 Background of the Problem

Globally, adolescents are a significant demographic group; the statistics estimate adolescents to be 1.3 billion (United Nations, 2023). Moreover, even though the comprehensive knowledge of Sexual and Reproductive Health (SRH) problems is increasing around the world, many adolescents do not get a chance to obtain information or means of protecting themselves from these problems (Chandra & Akwara, 2020). Of course, adolescents contribute to many health problems. For instance, globally, each year, nearly 21 million adolescents aged 15 to 19 years become pregnant, approximately 12 million of these adolescents give birth, and 5.6 million are shown to undergo abortion (World Health Organization, 2023a).

The concepts of sexual and reproductive health (SRH) were adopted for the first time by governments under the aegis of the United Nations at the International Conference on Population and Development (ICPD) in Cairo (Sidamo, 2022). ICPD laid out a bold, clear, and comprehensive definition of reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (WHO, 2019). The ICPD Programme of Action (PoA) was forward-looking in many areas of sexual reproductive health and rights, particularly about adolescents and young people. The ICPD program provides ways of dealing with youth health by promoting reproductive health services that are effective and accessible to all youth, especially in developing countries (Chiumia et al., 2021).

Besides, it is also known globally that utilization of health care is the extent to which the health system adjusts, inhibits, or initiates the individuals' willingness and ability to use, receive, and benefit from and achieve satisfaction with health services (Levesque et al., 2023). In this case, this is getting to know, searching, entering, and traversing, as well as satisfaction with the care and benefit from the outcomes of the health services. In addition, it is not also limited to consulting healthcare providers and/or getting prescriptions (Yakob & Ncama, 2020). It is well known that improvement in access to sexual and reproductive health services is a critical component of universal health coverage. It is one of the components of Sustainable Development Goals (SDGs) targets (targets 3.7, 3.8, and 5.6) (World Health Organization, 2023b). It is also essential to the

World Health Organization (WHO) adolescent-reproductive health services (Envuladu et al., 2023).

In Sub-Saharan Africa (SSA), statistics indicate that adolescents comprise about 25% of the population (Sidamo et al., 2024). However, SRH-related problems remain a significant health concern for adolescents aged 10-19 years (World Health Organization, 2023a). Adolescents in African countries are engaging in health-risk sexual behaviors (Addila, 2020). Moreover, this early engagement in sexual activity has had detrimental effects on adolescents' morbidity, prematurely exposing them to the inevitable consequence of sexually transmitted infections, including HIV/AIDs, unintended pregnancy, unsafe abortion, and premature death (Dadzie et al., 2022). For example, the latest 2023 report from UNICEF indicates that in 2022 alone, 140,000 adolescents between the ages of 10 and 19 were nearly infected with HIV (Abdurahman & Oljira, 2022). In addition, more than a quarter of girls and women in SSA cannot access family planning services, fueling unplanned pregnancies and spreading HIV and other sexually transmitted diseases.

Furthermore, in most countries, adolescents are often denied access to reproductive health services, partly due to societal beliefs about sexual behaviors and contraception and policies and regulations that prevent youth from receiving reproductive health services. Some policies do not permit or expressly guarantee adolescents access to sexual and reproductive health because of some cultures and norms and thus increased unplanned pregnancies, STIs and HIV, and unsafe abortions (Sidamo, 2022).

In Tanzania, adolescents aged 15-24 are sexually active and engage in high-risk sexual behavior. In addition, adolescents comprise 32% of the population in the country. Furthermore, this group is more likely than any other to engage in unplanned and unprotected sex with multiple partners. Moreover, adolescent females lacked the skills to negotiate safer sex practices (Ninsiima et al., 2021). This leads them to face many significant SRH challenges, such as limited access to information on growth, sexuality, and family planning. This leads them to risky sexual behaviors, resulting in high STI and HIV prevalence and early pregnancy. An estimated 16 million girls aged 15-24 give birth every year, representing 11% of all births but almost a quarter of the ill health related to pregnancy and childbirth, including the consequences of unsafe abortion (Keite, 2020).

Furthermore, many Tanzania communities fear providing sexual and reproductive education to youth with the feeling that the education will promote destructive behaviors among adolescents and hence be reluctant to encourage the use (Sidamo, 2022). Moreover, adolescents who live in settings where considerable traditional norms and taboos regarding sexual behavior persist, particularly about premarital sex, face the challenge of accessing reproductive health services. These socio-cultural norms create significant barriers that limit young people's access to information and services (Chiumia et al., 2021).

Besides, sexual and reproductive health rights entail legal rights and freedoms relating to sexual health, reproduction, and reproductive health. SRH services include but are not

limited to the right to access high-quality birth control, freedom from coerced sterilization and contraception, the right to access good quality maternal health care, the right to access safe abortion and post-abortion care, and the right to access education and information on sexual and reproductive health in order to be able to make free and informed reproductive choices (Chandra et al., 2015). In addition, adolescents have the right to access education and information on protection from sexually transmitted infections, sexual violence, and practices such as female genital mutilation (Petroni et al., 2019).

According to Keite (2020), Tanzania has provided reproductive health education and services to adolescents through school education, reproductive health programs, and mass media (television, radio, newspaper, and internet). The programs implemented by Tanzania support adolescents mainly by raising awareness of their entitlements and sexual and reproductive health rights, providing psychosocial support, and referring them to care for adolescents affected by HIV and STIs (Muganyizi, 2021).

Despite the existence of different programs for improving reproductive health services to adolescents, there are still several challenges, such as inadequate knowledge about the utilization of youth and adolescent sexual and reproductive health services, poor effectiveness of reproductive health services, and poor attitude of some health care providers leading to poor quality of services (WHO, 2019). United Nations Children's Fund (UNICEF, 2019) reported that only 8.6 percent of adolescents have access to reproductive health services through school and reproductive health programs, while

24% of the rest of adolescents continue to face obstacles to receiving services. Adolescents are found to be more vulnerable to unplanned pregnancies, HIV, and sexually transmitted diseases (Chiumia et al., 2021). In addition, it is understood that social work plays a vital role in developing adolescent intervention models. This study, therefore, examines the gaps in the utilization and effectiveness of reproductive health services for adolescents in Mwanza.

1.3 Statement of the Problem

The National Adolescents Reproductive Health Strategy (2011-2015) of Tanzania describes the needs of adolescents in accessing Sexual and Reproductive Health (SRH) services. The needs include information, advice, service, rights, provider competence, policies, management systems, and community and parental support (Lutende, 2016). However, the situation in the community does not reflect this strategic plan; adolescents often face numerous barriers to obtaining the necessary information and services related to their sexual and reproductive health. These barriers can be categorized into socio-cultural, economic, legal, and health system-related factors, each contributing to the limited accessibility and utilization of SRH services by this age group.

Further, this situation is associated with a lack of awareness among the community on issues facing adolescents in accessing sexual and reproductive health services. Due to traditional customs, parents are not allowed to discuss sexual and reproductive health with his/her children (Lutende, 2016). These factors often lead to misinformation, fear, and shame, preventing adolescents from seeking the help they need; economic barriers,

such as the cost of services and transportation, disproportionately affect adolescents from low-income backgrounds, limiting their access to essential health care. Addressing adolescents' accessibility to SRH services is critical for promoting their overall health and rights. Moreover, little information exists on the real situation facing adolescents in accessing SRH services. This study, therefore, needs to bridge the gap by developing a bank of information based on adolescents' utilization of SHR services based on awareness and accessibility of SHR services among adolescents.

1.4 Objectives of the Study

1.4.1 General objective of the study

The general objective of this study was to assess the utilization of sexual reproductive health services among Adolescents in Nyamagana District as a case study.

1.4.2 Specific objectives of the study

i. To assess the level of awareness of adolescents in accessing sexual and reproductive services.

ii. To assess the accessibility of sexual and reproductive health services by Adolescent

iii. To examine the challenge facing the Adolescents in accessing the sexual and reproductive health services.

1.5 Research Questions

i. What is the level of awareness of adolescents in accessing sexual and reproductive services?

ii. To what extent is there accessibility of services provided to adolescents about sexual and reproductive health?

iii. What are the challenges facing adolescents in accessing sexual and reproductive health services?

1.6 Significance of the Study

This study is expected to have theoretical and practical significance. In the theoretical significance the study is expected to have a contribution writing thesis about the formulation of methodology especially for research design, procedure of collecting data, and data analysis on the aspect of utilization of SHR services. In the practical significance, the findings of this study are expected to benefit policymakers by informing decision-making in forming/implementing sexual and reproductive health policies targeting the adolescent population and allocating resources. Specifically, policymakers would use the ideas provided in this study to amend policies and implement enforcement mechanisms.

In addition, it is expected that the findings of this study may also benefit other vital stakeholders, such as Community-Based Organizations (CBOs) and the private sector in the sexual and reproductive health sector, to promote these services in a non-discrimination manner to promote sexual and reproductive health rights. In the case of

social work, this study intends to promote sexual and reproductive rights, which are among the tasks of social work professionals responsible for improving the health status of the affected population.

CHAPTER TWO

LITERATURE REVIEW

2.1 Chapter Overview

The current section conceptualizes key terms and theoretical and empirical literature. In the theoretical literature review, the chapter presents the theory guiding the current study and justifies choosing the selection theory. However, in empirical literature, the chapter describes different studies based on the objectives of the current study. Furthermore, this chapter also provides a knowledge gap and conceptual framework for a study.

2.2 Conceptualization of Key Terms

This part describes the definitions of leading research concepts or ideas. The defined concepts/ideas include adolescent, reproductive health, and reproductive health service, as mentioned in the following subheadings.

2.2.1 Adolescent

Mbuh & Kahugu (2020) define an Adolescent as a person 12 to 19 years old who experiences a chronological period that starts with the sexual and psycho-maturation caused by physical and emotional possession in which the individual gains freedom and productivity and ends at an unspecific time, and quick physical, psychological, and social changes characterize it. In this study, whenever the word 'adolescent' is used, it means a rapid phase from 10 to 19 years of human development and biological and physical maturity. It is the phase in which human beings develop different aspects, such as knowledge and skills, and manage relationships between one person and another.

2.2.2 Reproductive health

Adua (2021) defines reproductive health as a state of physical, mental, and social well-being, and not merely the absence of disease or infirmity in all matters related to the reproductive system and its function process. In this study, reproductive health is defined as the human sexuality and reproductive process, functions, and system at all stages of life.

2.2.3 Reproductive health services

Hable (2020) defined reproductive health services as services that contain a broad range of different services, including contraception, screening for cervical abnormalities, childcare, colonoscopy, abortion, menstrual dysfunction, sexually transmitted infection management, psycho-sexual medicine, and family planning, including infertility services, abortion, and STI/HIV services and care, as well as information and counseling. Hardship forces girls into commercial sex work, leading girls to leave their homes and seek out a livelihood in the informal sector, thereby increasing their vulnerability to sexual exploitation. This signifies that the reproductive health services are not effective and there is poor accessibility of the services. In this study, reproductive health services refer to services like high-quality birth control, access to good quality maternal health care, education and information on sexual and reproductive health, education and information on protection from sexually transmitted infection, violence, and practices such as genital mutilation.

2.3 Theoretical Literature Review

This part involves a critical analysis of the social cognitive theory (SCT), aiming to establish a theoretical framework for this study and describe its Relevance.

2.3.1 Social Cognitive Theory

This study was guided by the Social Cognitive Theory (SCT), developed by Albert Bandura in 1974, also known for his work on observation learning, self-efficacy, and reciprocal determinism. The SCT emphasizes learning within a social context; however, learning always emphasizes awareness of any learned social aspect. In this view, people are active agents who can both influence and are influenced by their environment (Lamort, 2019). The SCT shows how the variables (environment, personal characteristics, and social factors) contribute to mold youths' reproductive health; if utilized in the right way, they contribute to the prevention, promotion, access, and management of reproductive health issues, thus resulting in good health (Bandura, 1998).

The SCT integrates behavior and cognitive explanations for human behavior. Central to Social Cognitive Theory is the notion that humans do not passively respond to past or current environmental influences; however, humans can foresee the consequences of our actions. The cognitive outcomes formed by humans allow them to appraise the potential consequences of engaging in any given behavior and thus determine which behavior humans will engage in (Dale & Maria, 2023). Furthermore, the SCT also describes that the same processes, such as modeling and reinforcement, continue to influence sex-

typing in similar ways as children become older. Through such experiences, children develop outcome expectancies and self-efficacy beliefs that serve to motivate and regulate gender role conduct. As children mature, their social worlds expand beyond the home and limited peer contexts, and they are exposed to a greater prevalence of male and female exemplars and social agents who teach and encourage sex-typed behaviors and attributes (Dale & DiBenedetto, 2023).

The theory also explains that exposure and a more remarkable ability to organize and abstract social information increases as children age. As children's cognitive and verbal skills improve, parents are likely to broaden the scope of their gender socialization through their conversations and interactions with their children. At the same time, peers are thought to act as powerful socializing agents through modeling, social sanctions, and serving as cooperative references for approval of personal efficacy (Dale & DiBenedetto, 2023).

2.3.1.1 Relevance of the theory

In reflection of this study, the SCT is valid in determining persons' perceptions (beliefs) or awareness of individuals' accessibility to sexual and reproductive health services among adolescents. The theory highlights the need for change in belief (Lamort, 2019); in this case, the study applied this theory to determine a person's actions regarding access to sexual and reproductive health services among adolescents, which may cause positive or negative outcomes. The theory is also significant to this study because it changes the associated behavior and attitudes as the children age. As children become

older, they need self-efficacy service utilization; this means they also need to make effective utilization of sexual and reproductive health services (Nabavi & Bijandi, 2012). Therefore, this concept from the theory was applied in this study to establish a link between Adolescents and utilization of sexual and reproductive health.

The theory has also described that as children age, parents have challenges conversing with them. Parents tend not to make conversation about sexual and reproductive health with their children. This affects children in the whole process of accessing education and information concerning sexual and reproductive health (Nabavi & Bijandi, 2012). It is through this concept from the theory that the study has examined the challenges that adolescents face in access to sexual and reproductive health services.

2.4 Empirical Literature Review

This part provides a systematic literature review of previous studies to provide detailed information on the topic under study. Therefore, this part is divided into three sections based on the specific objectives of this study. These three sections include the level of awareness of SRH services, utilization of services provided to adolescents about SRH, and Challenges facing adolescents in accessing SRH services.

2.4.1 level of awareness of Adolescents in accessing SRH service

Mulegi et al. (2023) conducted a study to assess the knowledge and awareness of women's sexual reproductive health services (SRH) under decentralization in Uganda. The study came with the assumption that the level of awareness influences SRH among women. Furthermore, it is recognized that women need to be aware that SRH involves

maternal health care, guidance and counseling, family planning, and decision-making on having a manageable number of children, among others.

In the study by Amran (2023) which investigated adolescents' awareness level in acquiring vital Sexual Reproductive knowledge and health services in Dalama, Turkey. The author stipulated that community-based programs and peer-to-peer support networks are necessary for addressing cultural and social barriers to access care and promote awareness and education issues around SRH services. In addition, through the study, the author identified different variables based on adolescents' awareness of SRH services. The identified variables include the right to information and education on SRH, freedom of thought on SRH, the right to consent to marriage, and the right to decide the number and spacing of children.

Iqbal et al. (2017) conducted a study based on perceptions of adolescents' sexual and reproductive health rights in Pakistan. Specifically, the study assessed adolescents' awareness of sexual and reproductive health services. It was highlighted that there are some measurements of adolescents' awareness which include the right to information and education concerning SRH, the right to freedom of thought on SRH, the right to consent to marriage, the right to decide the number and spacing of children, and the right to be free from violence or ill-treatment.

Mutende (2016) has written about adolescents' awareness of youth-friendly reproductive health services in public health facilities that promote health and access. The author argues that many adolescents lack comprehensive knowledge and awareness about

sexual and reproductive health, and most of them are facing significant barriers to accessing quality sexual and reproductive health services. Most adolescents had never heard of family planning, and they lacked knowledge about sexual transmission infections (STIs).

Khanal, (2016).) conducted a study on adolescents' knowledge and perception of sexual and reproductive health and services in Nepal. Moreover, it was mentioned that adolescents are sometimes aware of some common sexual and reproductive health problems like HIV/AIDS, syphilis, and gonorrhea, and some issues like marriage, teenage pregnancy, and gender inequality were also mentioned. Besides, the culture of communicating SRH problems with parents is almost non-existent, except for girls getting information from their mothers during menstruation.

In their study, Rangi and Mwageni (2018) determined students' awareness of sexual and reproductive health matters. Henceforth, the author argued that some adolescents in secondary schools in the Morogoro region in Tanzania were sexually active; they were involved in risky sexual behavior such as having multiple partners, practicing sex at an early age as early as from 10-15 years, lack use of condoms, engaging with sexual and reproductive health matters was average. Additionally, the results revealed that students' awareness of SRH had a positive influence on students' risky behavior; this means students with a high level of awareness were less likely to engage in risky sexual behavior. Dangat and Njau (2013) stipulated that most of adolescents have adequate knowledge of family planning services. However, healthcare facility is the right place to

access and utilize SRH services including family planning. It was also added by Chipako et al. (2024) that access to sexual and reproductive health services is affected by a myriad of factors related to young people's SRH knowledge and awareness of the availability, access, and usage of these services. Several cultural, socioeconomic, and political factors hinder delivering SRH information and services to young people. Failure to provide youth-friendly services, unwelcoming behavior, and negative attitudes toward healthcare workers often hinder young people's access to RTH services.

2.4.2 The accessibility of services provided to adolescents in relation SRH

A study by Addae (2021) mentioned that the accessibility of sexual reproductive health is determined through the number of skilled healthcare workers, stock out of commodities and suppliers, availability of adolescent-friendly services and life skills education programs, and adolescent youths ' clubs. The author confirmed that family planning and HIV prevention is limited mainly by the availability of adolescent-friendly SRH services and the negative attitudes of providers towards young people, especially girls. In that case, adolescents living in rural and out-of-school areas are most affected.

A study by Mwandali et al. (2020) highlights that most of the healthcare facilities have no adolescent sexual and reproductive health (ASRH) services. This is associated with a lack of trained healthcare providers to provide ASRH services; another factor is the attitudes of healthcare providers toward young people. Therefore, most adolescents do not get their right to be educated on sexuality and safe sex; they also do not get their right to obtain counseling on sexual abuse or gender-based violence. Lugoya (2019),

added that the accessibility of services provided to adolescents about SRH is always affected by taboo in some countries despite various transformations. Conversation about sexual and reproductive health continues to be a taboo in the family. As a result, SRH is not openly discussed in the community at home or in school. In addition, the author argued that there is a general reluctance on the part of adults, in particular fathers, to discuss sexual issues with their children. In this case, sexual and reproductive health education is very inadequate SRH services both at school and at home. Few adolescents receive comprehensive SRH services education, and often, teachers do not have sufficient training information.

Embleton et al. (2023) argued that at the intrapersonal (individual) level, obeying to family planning depends on the accessibility and utilization of SRH services among the individuals. In addition, Lumonje (2019) added that the youths knew their SRH needs and however there is always inadequate information on the various SRH services offered by facilities. This makes the utilization of SRH service to become low. Most did not know the types of SRH services offered. Other factors mentioned include affordability, staff attitude in the health facility, and availability of health facilities.

John et al. (2024) conducted a study on using SRH services among youths in Malaysia. The study employed a cross-sectional study with Andersen's Behavioral Model of Health Utilization. The study reported that few youths have a tendency of visiting in health facilities for SRH services in their entire life. Besides, married participants are more likely to utilize SRH services than single participants. Likewise, participants who

get a chance to receive SRH information from governmental agencies are more likely to utilize SRH services.

Ninsiima et al. (2021) studied factors influencing access to and utilization of youth-friendly SRH services in Sub-Saharan Africa. The study employed a systematic review of studies published between January 2009 and April 2019 using PubMed. The study found a structural barrier, which was the negative attitude of health workers and their being unskilled, and individual barriers included a lack of knowledge among youth. Facilitators utilizing the service were primarily structural, including community outreaches, health education, and policy recommendations to improve the quality of health services and clinics for adolescents.

Belay et al. (2021) studied youth-friendly sexual and reproductive health services utilization and its determinants in Ethiopia. The study used a systematic review and meta-analysis to study the utilization of SRH services and its determinants. The study found that grade levels 11-12, 9–10, close-to-home sexual and reproductive health services, male sex, and discussion of SRH services with family, friends, and groups, and ever-experience sexual activity were associated with utilization of youth-friendly sexual and reproductive health services.

2.4.3 Challenges facing adolescents in accessing SRH service

Sidamo (2022) conducted a study on socio-ecological analysis of barriers to access and utilization of adolescent SRH services in Sub-Saharan Africa. The study highlighted the barriers to include: the intrapersonal barriers to accessing SRH services by adolescents

include inadequate information about SRH services, incorrect perception of SRH services, low self-esteem, fear of being noticed by family members, and financial constraints. The interpersonal barriers, including unsupportive families and a lack of open communication between Adolescents and parents about sexuality issues. Other barriers are known as institutional-level barriers, which include lack of provider competency, provider attitude, an unsupportive environment, physical inaccessibility of services, and shortage of medicines.

Dzinoreva (2021) explained that adolescents are embedded within policy, cultural, economic, and social contexts that influence their access to SRH services. Sexuality matters are seen as taboo for adolescents and youths in some primitive cultures. In this case, the study mentioned different barriers, including religious barriers, gender-based violence (GBV), economic barriers to SRH service access, and lack of capacity for health institutions.

Furthermore, in his study, Bwalya (2016) argued that adolescents globally continue to face challenges in accessing SRH services. Most Adolescents access SRH services less frequently than expected and are also more likely to seek services after sexual exposure. Moreover, the author also identified challenges that adolescents undergo, particularly the lack of access to SRH services. The identified challenges include a lack of a consistent source of primary care. Additionally, adolescents are less likely to visit a doctor or have any regular source of medical care than adults. Besides, in most African societies, issues

of sexuality are still considered taboo. They can never be discussed openly between adolescents and their parents, who may be health service providers.

Langat et al. (2024) explained that barriers to accessing adolescent and youth SRH services include individual factors such as feelings of shame, lack of information, and fear of being judged. Other factors include parental factors, healthcare workers and health institution factors, teacher/educators' factors, and broader contextual factors like culture, religion, poverty, and illiteracy. It was added by Mohamed et al. (2020) that three thematic challenges to adolescent's utilization of SRH include; the individual (inadequate knowledge about SRH and poor attitudes of adolescents towards SRH), social (parental influence, community and religious norms, financial constraints, and stigma), and health system challenges (poor attitudes of service providers and inconvenient health facility opening hours).

Kibira (2021) confirmed that challenges to utilization of SRH services include a lack of quality sexual and reproductive health services such as contraceptive services, maternal and neonatal mortality, sexually transmitted infections (STI) including human immunodeficiency virus (HIV), and cervical cancer treatment, violence against women and girls, and addressing sexual and reproductive health needs of adolescents.

In addition, in his study, Nkonde-Bwalya (2016) argues that there are gender variations challenges in SRH services experienced by girls and boys. Girls face more significant reproductive health challenges than boys following puberty. Adolescent girls face more significant risks of contracting STIs, including HIV/AIDS, compared to boys due to

social and physiological factors. The variation is also seen in terms of utilization of sexual and reproductive health services among adolescents. Condom use varies widely, with no apparent pattern by sex—moreover, problems that adolescents undergo, particularly the lack of access to healthcare services.

Kamwine (2022) stipulated that healthcare providers faced two main challenges: client-initiated and healthcare provider weaknesses. The client-initiated challenges were based on clients' negative attitudes towards services, myths, misconceptions about services, and language barriers. Challenges associated with weaknesses of healthcare providers include limited skilled providers and human resources, limited equipment, and limited funds. Furthermore, among the barriers to accessing sexual and reproductive health services for adolescents include legal and policy constraints related to age and marital status. These barriers include also the stigma associated with adolescent pregnancy, cultural taboos about adolescents' sexuality, inconvenient hours of services and locations of health facilities, and high costs of receiving services. (Emmanuel et al. 2014).

Table 2.1: Summary of the Previous Related Studies

S/N	Authors' Name & Year	Aim of The Study	Variables Examined	Data Analysis Methods Used	Main Findings
1	Mulegi et al., (2023)	Level of knowledge and awareness of women SRH service		Descriptive & Content Analysis	Guidance and counselling Family planning Decision making
2	Addae (2021)	Understanding adolescents' SRH needs	Availability of services related to SRH	Descriptive Analysis & Content Analysis	Health care providers Friendly SRH service Life skills-education programs Adolescents' youth clubs
3	Mwandali et al., (2020)	Availability, range and utilization of SRH service		Thematic Analysis	Education Health facilities
7	Sidamo (2022)	Socio-ecological analysis of barriers to access utilization of adolescent SRH service	Challenges facing adolescents in accessing SRH service	Exploratory Factor Analysis	Intrapersonal barriers Interpersonal barriers Institutional-based barriers
8	Dzinoreva (2021)	Obstacles hindering access to SRH service		Literature review	Policies Culture Economic Social contexts

2.5 Research Gap

While general factors affecting the utilization of sexual and reproductive health (SRH) services among adolescents have been widely studied (Addae, 2021; Dzinoreva, 2021; Mulegi et al., 2023; Sidamo, 2022), much of this research has not focused on specific factors within Nyamagana district in Tanzania. This gap is significant because factors influencing utilization can vary greatly based on geographical location. Therefore, this

study aims to assess the level of awareness, accessibility of SRH services, and the challenges adolescents face in accessing these services in the Nyamagana district. Addressing these gaps in the existing knowledge could help mitigate barriers to accessing SRH services among adolescents in the study area.

2.6 Conceptual Framework

The conceptual framework indicates the utilization of SRH service among adolescents in the middle part of the conceptual framework because it seems to be affected by the level of awareness of SRH service among adolescents, the accessibility of SRH service, and challenges facing adolescents in accessing SRH service. (Figure 2.1)

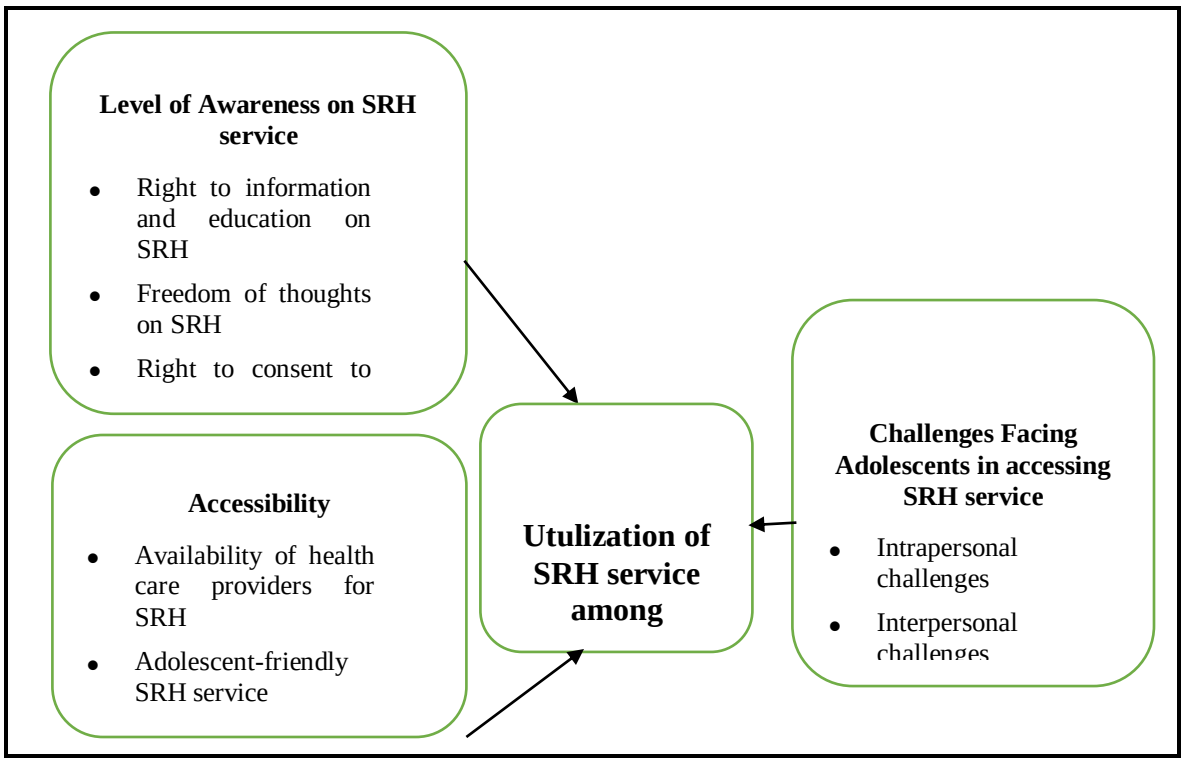


Figure 2.1: Conceptual framework

Source: Constructed by a Researcher (2024)

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Chapter Overview

This chapter is beneficial for identifying and describing the methods used to conduct this research based on what, how, when, and why. Therefore, the chapter elaborates on all the components of different techniques that were applied from the study design and data collection stage to the data analysis stage.

3.2 Research Philosophy

The term research philosophy encompasses how knowledge is developed and the nature of knowledge within a particular research setting (Nickerson, 2024). Research philosophy is essential since it helps the researcher understand how he/she is approaching his/her research study and assists in understanding other researchers' studies (Kaushik & Walsh, 2019).

This study applied a research philosophy, particularly interpretivism, which is fit for qualitative analysis. The interpretivism research philosophy was employed in this study because it assumes that reality is subjective, multiple, and socially constructed. This means a researcher can understand someone's reality through their experience of that reality, which may be different from another person's shaped by individuals' historical and social perspectives (Nickerson, 2024).

3.2.1 Research Design

Research design is a framework for collecting and analyzing data. It keeps the study centered on its purpose while accommodating the inevitable twists and turns occasioned by real-world contingencies as they are met in naturalistic inquiry (Siedlecki, 2020). Furthermore, research design aims to help the researcher organize his ideas to flow well (Ambary, 2017). This study employed a cross-sectional research design, which, according to (Bryman and Bell (2011) the cross-sectional research design is also known as a social survey design. In reflection of the cross-sectional design, this study collected data at once. This research design was employed because it saves time and funds during data collection.

3.2.2 Research Approach

A research approach is a plan and procedure that consists of steps from broad assumptions to detailed methods of data collection, analysis, and interpretation. In addition, the research approach is divided into three categories: quantitative, qualitative, and mixed (Chetty, 2016).

In this study, the qualitative research approach was employed. The qualitative research approach is described as a research approach that allows a researcher to switch his focus to gaining a better understanding of the problem by giving detailed information about the central theme of the study topic (Quinn, 2002). Additionally, the main goal of a qualitative study is to have a complete and detailed description of the study phenomenon by applying reasoning (Ambary, 2017). The qualitative research approach was used to

learn about the accessibility of SRH services in the study area. The motivation for using a qualitative research approach was to generate opinions and insights and collect primary information directly from the target group on the accessibility of SRH.

3.5 Study Area

The study was conducted in the Mwanza Region and focused on the Nyamagana district. Specifically, the Mabatini ward was selected as the area of study from 18 words in Nyamagana. This area was chosen because it has many active reproductive health services. Besides, according to Tanzania Demographic and Health Survey (TDHS) data of 2015/2026, there has been a difference between the childbearing rates along the regions from low 5% to 45%, the highest. Mwanza region stands in the third position with 28%, while Katavi is in the first position with 45%, followed by Tabora with 43% (Mrisho et al., 2022). Therefore, because the Mwanza region is found in the top three regions that show a high rate of childbearing, this study decided to involve the Nyamagana district of the Mwanza region to examine access to SRH services among adolescents.

3.6 Population of the Study

Population is the total population of elements a researcher wishes to reference. It can also be explained as the entire set of people, things, services, elements, events, or objects to be studied (Murry et al., 2022). Furthermore, the target population is explained as a specific population about which information is desired (Ambary, 2017). The targeted population of this study was adolescents aged 15 – 19, parents or guardians, and health

workers, all in the Nyamagana district in the Mwanza region. These individuals were selected and included in the population because they all experienced SRH service through seeking or providing this specific service; valid information was captured in this case. In addition, according to the Ward Officials (2024), the study population in the study area in the Mabatini ward was comprised of 16636 adolescents in 2024.

3.7 Sampling Procedures

In research, sampling is the strategic selection of individuals or a subset of a population, aiming to predict the characteristics of the entire population (Bisht, 2023). In this study, a non-probability sampling procedure was applied to select participants.

3.7.1 Non-Probability Sampling Procedure

In this study, non-probability sampling, in particular purposive sampling, was applied to select adolescents, parents/guardians, and healthcare providers to be involved in the study. Purposive sampling is a type of non-probability sampling where the researcher chooses a person who, in his/her judgment, has some appropriate characteristics required of the sample members (Nikolopoulou, 2022). Thus, in this study, a purposive sampling procedure was used to select adolescents, parents/guardians, and healthcare providers to be involved in the study. Specifically, 20 adolescents, seven parents/guardians, and three healthcare providers were selected purposively and included in the study during data collection.

3.8 Sample Size

Based on an excellent grounded theory, a 30-convenience sample size of individuals was involved in this study, as recommended by Morse (2015); the appropriate and applicable sample size in a qualitative study would be 30 to 50 individuals. However, this depends on the topic understudy and its scope. Moreover, the actual sample size is obtained through saturation point. Therefore, the proposed sample size in this study was 30 participants. However, this sample size was reached due to the saturation point. In addition, the description of the sample size was 20 adolescents (15-19 age), seven parents/guardians, and three health care providers.

3.9 Inclusion and Exclusion Criteria

The study involved inclusion and exclusion criteria, identified and described in the following sub-headings.

3.9.1 Inclusion Criteria

The inclusion criteria in this study involved adolescents 15-19 years of age who were found in Mabatini Ward, Nyamagana districts. The inclusion criteria also considered parents/guardians of the selected adolescents in the Mabatini ward. Lastly, the inclusion criteria in this study focused on healthcare providers who work in the Mabatini ward.

3.9.2 Exclusion

The exclusion criterion involved all adolescents in the Mabatini ward, Nyamagana districts. Another exclusion criterion involved all parents/guardians in the Mabatini

ward. The exclusion criterion also involved all healthcare providers in Nyamagana districts.

3.10 Primary Data Source

Primary data are described as data gathered for specific research topic, using processes that best suit the topic. It is important to note that on every occasion that primary data are collected, new data are added to the existing store of social knowledge (Ambary, 2017). In this study, the primary data source was individuals who provided data. These individuals included adolescents 15-19 years old, parents/guardians, and healthcare providers in the Mabatini ward, Nyamagana district. Moreover, a researcher generated primary data from interviews with all participants in this study.

3.11 Data Collection Method

The study employed in-depth interviews to collect information through the interview guide.

3.11.1 Interview Guide

The interview is a venture in which two individuals exchange and share ideas regarding a specific theme or subject matter (Korstjens & Moser, 2018). This study employed interview as a data collection method because it is the method through which qualitative studies quickly obtain an individual's point of view regarding certain situations or experiences; it also allows a researcher to gain insight into the general perspective of the participants (Maxwell, 2012). This study employed semi-structured interviews as a data collection instrument. It was purposely intended for adolescents, parents/guardians, and

health care providers. Only open-ended questions were designed to gather data on the accessibility of SRH services among adolescents. The logic of using semi-structured interviews was that it is an operational data collection method when investigators want to collect candid information.

3.12 Qualitative Data Rigor

The study employed the rigor of qualitative data, including trustworthiness, dependability, credibility, and conformability.

3.12.1 Trustworthiness

Ensuring trustworthiness is crucial in establishing the credibility and reliability of qualitative findings. This study maintained trustworthiness through its four components: credibility, transferability, dependability, and conformability. Amin et al. (2020) explain that trustworthiness in qualitative research comprises various essential elements, such as credibility, transferability, dependability, and conformability.

3.12.2 Dependability

Dependability in a qualitative study is how research reflects transparency and accurate research procedures, consistency in research methodology, data collection, and data analysis (Tong & Dew, 2016). According to Combs (2017), researchers use different strategies to address the dependability of qualitative research and improve research accuracy, validity, and reliability. The strategies may include methodological triangulation, member checking, audit trails of field notes, and protocol reviews.

In this study, dependability ensured that there was a reviewing interview guide by supervisors, research, and other experts who were asked to review if the questions answered research objectives. In addition, the same questions were used for all study participants to ensure consistency.

3.12.3 Credibility

Credibility refers to the research's trustworthiness and acceptability of the findings. In addition, the credibility of the qualitative study depends on the accuracy, consistency, and interconnections of the concepts with the research findings (Yin, 2018). Furthermore, the research considered building rapport with participants over time, which allowed the researcher to gain insights into participants' experiences, behaviors, and beliefs. Additionally, credibility helped capture rich data that might not be immediately evident during belief interactions.

3.12.4 Transferability

According to Smith (2017), transferability refers to transferring the findings from one context into another. In addition, transferability is also described as the context to which the findings of a qualitative study apply to other contexts, settings, or participants (Devlin, 2018).

This research ensured transferability by providing a detailed description of the research process, including participants, and by ensuring detailed analysis of information from in-depth interviews, data collection process, and analysis. Transferability has been considered to describe the research context, participants, and methods that allow readers

to evaluate the similarities between their context and the study, enabling them to judge the applicability and relevance of findings to their settings. Besides the study, they also described the sampling methods and the criteria for participant selection to determine whether the findings might apply or be transferable to similar populations or settings outside the study context.

3.12.5 Conformability

Ibrahim and Edgley (2015) define conformability as the extent to which the study is unbiased and objective. Most qualitative studies apply conformability to ascertain the data, interpretations, transcriptions, and findings sourced from the information collected on the phenomenon of inquiry.

This study engaged with colleagues and experts to review the interpretations and findings. In addition, conformability through feedback from peers and experts helped this study validate interpretations and minimize personal bias because alternative perspectives were introduced. Therefore, it increased objectivity and confirmed the accuracy of the findings.

3.13 Data Analysis and Presentation

This part provides readers with research technicalities applied to data analysis and presentation.

3.13.1 Data Analysis

The study employed thematic analysis to analyze the collected qualitative information. The following steps were considered: each interview was divided into individual meaning units, similar individual meaning units were grouped under a unifying theme, underlying characteristics were identified for each theme, and a summary was built to develop the contents within and across the participants' views.

3.13.2 Data Presentation

Data presentation compares two or more data sets with visual aids, such as graphs, charts, and tables. In addition, data presentation, particularly in qualitative studies, uses words in quotes (Ambary, 2017). In this qualitative study, data were presented in text after developing a theme, and quotes were used to generate the contents of a specific theme.

3.14 Ethical Consideration

The study considered ethical considerations, which include university clearance, confidentiality, anonymity, Consent, and voluntary participation.

3.14.1 University Clearance

University clearance refers to the ethics reviews in the life of research at a university (Beckmann, 2017). Before going to the field for data collection, the Open University of Tanzania reviewed the prepared proposal for ethical issues. On the other hand, permission was obtained from the Mwanza Region. In addition, the current study only considered and included the participants willing to participate by signing the provided

consent form. Furthermore, participants were free to withdraw from the study without facing any consequences. It is also necessary to understand that the current study maintained confidentiality during data collection and analysis and throughout the research's lifetime.

3.14.2 Confidentiality

Confidentiality is defined as an agreement to keep something private or secret. The research follows Consent, which seeks to protect participants' information (Holland & Linvill, 2023). In order to build a strong rapport during data collection, all study participants were assured of confidentiality. The participants were assured that their information could not be shared with anyone. In that case, the researcher considered the obtained Informed Consent from the participants, utilizing appropriate data collection methods (interviews), which offers a chance for maintaining confidentiality. Additionally, data were stored securely using password-protected devices. The justification for considering confidentiality in this study was to encourage participants to share information without any doubt openly.

3.14.3 Anonymity

Holland and Linvill (2023) describe anonymity as the tendency in which research does not collect or identify information about individuals' personalities such as name, address, email address, etc. In this study, in case of anonymity, the participants were assured that this research did not collect or identify information of individuals such as name, address, email address, employers' name, relatives' names or addresses, fingerprints, and other

personally identifiable information. The participants were assured that the research was not to link participants' responses to identities. In that case, the study could not collect identification information of participants. Anonymity was applied in this study because when the participants feel protected for their segments and opinions as influenced by anonymity, they tend to contribute effectively to the provision of data. Furthermore, anonymity ensures that participants deliver actual responses that lead to accurate data. For these reasons, anonymity was beneficial for candid information in this study.

3.14.4 Consent

Consent is one of the founding principles of research ethics. It indicates that human participants can participate in research freely (voluntarily) with complete information about what it means for them to take part and that they give Consent before they do so (Marshall et al., 2014).

In this study, participants were given informed Consent to show their agreement to participate. The Consent comprised information based on the purpose of the study, its significance to the community and participants in general, risks, and benefits. The justification for using informed Consent was to ensure that participants had an informed choice about whether to participate.

3.14.5 Voluntary Participation

Voluntary participation in research refers to the participant's complete voluntary involvement in the study. The participant can be free to decline to participate for any reason. The participant may also stop participating or refuse to answer individual

questions. Even after he/she signs the consent form, he/she can stop (Marshall et al., 2014).

In this study, through an informed consent form, all participants were informed that the agreement to participate in the study was a voluntary agreement of individuals. The participants were assured that no adverse effect could be faced even if they disagreed with participating in the study. The informed consent form was designed to include the statement that participating in this study was a voluntary agreement regarding the role of a person in this research study.

CHAPTER FOUR

FINDINGS PRESENTATION AND DISCUSSION

4.1 Chapter Overview

In this chapter, the results and discussion are presented. The three main themes derived from the data are presented. These themes focused on awareness of adolescents in accessing the SRH services, utilization of SRH services by adolescents, and challenges facing the adolescents in accessing the SRH services. Besides, it is essential to note that the current study was undertaken in the context of the proposal and actual attempts at the accessibility of sexual reproductive health services among adolescents in the Nyamagana district, Mwanza region. Moreover, the chapter starts by presenting the socio-demographic characteristics of all participants.

4.2 Socio-Demographic Characteristics of Participants

The study involved 30 participants from the Mabatini ward, Nyamagana districts. It is also essential to recognize that the sample size was reached at 100% because it was predicted to be 30 participants in a proposal. However, the final sample size was to be made after reaching a saturation point. This means the saturation point was reached at the predicted sample size.

Moreover, it is also essential to recognize that the study considered the demographic profile of participants during data collection because it is believed that in social sciences research, the personal characteristics of participants have a very significant role to play in expressing and giving responses about problems. Furthermore, keeping in mind, this

study examined a set of personnel characteristics, namely age, gender, marital status, education level, and occupation. The results are illustrated in Table 4.1.

Age: The findings of age of respondents indicate more than half 20(66.7%) of respondents their age ranged from 15-19 years old, followed by 4(13.3%) ranged from 40 years and above, 2(6.7%) ranged from 20-24 years, and 2(6.7%) ranged from 35-39 years. These results revealed that most participants in this study were adolescents. Furthermore, the variable age was examined in reflection of Manoti's (2015) views; there are sometimes age disparities in access to SRH services. Sadly, though, adolescents consider health a low to medium priority.

Sex: Results on the sex of participants in this study indicated that out of 30 participants, 18(60.0%) were females, and 12(40.0%) were males. Furthermore, these results revealed that this study involved both genders; as stipulated by (Pan American Health Organization (2016), the gender dimension is critical in sexual and reproductive health services. Gender serves as a foundation for building connections and linkages that should result in marked improvements in a variety of sexual and reproductive health indicators as well as indicators of the general sexual well-being of individuals, families, and communities. Additionally, the service planning process always is to recognize that people, regardless of their sex/gender identity.

Marital status: The results regarding the marital status of participants of this study showed that in a total of 30 participants, 19(63.3%) were single, 8(26.7%) were married, and 3(10.0%) were widows/widowers. Besides, marriage is one of the vital events, and if

adolescents go through marriage, then they will be exposed to various sexual reproductive activities for the long term. Therefore, they need proper knowledge of sexual and reproductive health services. Besides, the variable marital status has been examined because marriage is a gateway that gives exposure to sexual reproductive health as well as pregnancy, abortion, and sexually transmitted infections (Naik et al., 2024).

Education level: Results regarding education level indicated that out of 30 participants, 16(53.3%) had a secondary education level, 5(16.7%) certificates, 4(13.3%) primary, 3(10.0%) diplomas, and 2(6.7%) universities. The findings indicated that the study comprised people with different levels of education; additionally, all of them had gone to school, and it could be straightforward for them to receive sexual and reproductive health services. In line with Coral et al. (2022), education is a critical factor that often leads to social and economic empowerment, positively contributing to individuals' SRH services.

Occupation: The results indicated that of the 30 participants in this study, 21(70.0%) were unemployed, 5(16.7%) were self-employed, and 4(13.3%) were employed. Thus, most of the adolescents who participated in this study were unemployed. In addition, scholars like Misinde et al. (2018) indicated that employment status influences accessing sexual and reproductive health services. The low-wage and unemployed are at a greater risk of exposure to sexually transmitted infections (STIs) because they do not have enough resources to access sexual and reproductive health services. Employment, either

it is by being employed or self-employed, offers females an avenue so that they are better able to access SRH services to reduce their exposure to STIs.

Table 4.1: Socio-demographic characteristics of respondents

Variable		Frequency (n=30)	Percent %
Age	15-19 years	20	66.7
	20-24 years	2	6.7
	25-29 years	1	3.3
	30-34 years	1	3.3
	35-39 years	2	6.7
	40 years and above	4	13.3
Sex	Female	18	60.0
	Male	12	40.0
Marital Status	Single	19	63.3
	Married	8	26.7
	Widow/widower	3	10.0
Education level	Primary	4	13.3
	Secondary	16	53.3
	Certificate	5	16.7
	Diploma	3	10.0
	University	2	6.7
Occupation	Unemployed	21	70.0
	Self-employed	5	16.7
	Employed	4	13.3

Source: Field Data, (2024)

4.3 Level of Awareness of Adolescents in Accessing SRH Service

In the first objective, the study qualitatively explored adolescents' level of awareness in accessing sexual and reproductive health services in the Mabatini ward, Nyamagana district. Furthermore, different themes emerged regarding adolescents' level of awareness. The themes include the right to information on SRH, freedom of thought on SRS, correct consent to marriage, suitability to decide the number and spacing of children, freedom from violence, and family planning.

4.3.1 The Right to Information and Education on SRH

Participants of this study were found to have little awareness of their rights to access information and education on sexual and reproductive health services. In the interview with adolescents who participated in this study, the interviewees stated that the issue of accessing information and education on SRH is always under the parents who guide them not to talk openly about sexual and reproductive health education. Most of the adolescents in this study confirmed that they depended on their parents' instructions on the topic of sexual and reproductive health; it was unknown to them that they had the right to ask for information based on SRH. For example, one of the adolescents with this view stated that:

> *"I live by responding to my parents' instructions, my parents always instructed me not to talk about sexual and reproductive issues because it is like I commit sins. This of course has put me into a position of not knowing more about sexual and reproductive services"* ***(IDI No. 4, Adolescent, Mabatini, August 22, 2024).***

On the other hand, even parents were unaware of their children's right to access SRS. Most of them indicated that when children are left free to talk or to access sexual and reproductive health education, they will become sex workers. As one of the parents stated:

> *"I cannot allow my child to access sexual and reproductive education at the age of either 12 or 14 years old, this is because when they start talking about sexual issues they can become as those with see in bars they have become like sex workers"*
>
> **(IDI No. 27, Parents, Mabatini, August 24, 2024)**

These results revealed that both parents and adolescents in the study area lacked awareness of the right of access to sexual and reproductive health services by adolescents. However, the findings differ from the human rights perspectives; adolescents have the right to access information, skills, and services regarding their sexual and reproductive health (SRH), the right to participate in health and development programs that affect their lives, and the right to grow up in a safe and supportive environment (URT, 2015).

4.3.2 Freedom of Thought on SRH

Most of the participants of this study, especially female adolescents, said that they were not aware of their right to freedom of thought on SRH because of gender inequality at the family and community levels. Boys are given more freedom to express their opinions, suggestions, and attitudes about SRH compared to girls, who are constantly

living under a certain level of restriction, which at times compromises their sexual and reproductive health. One of the participants commented that:

> *" We, girls face many problems, no one is there to listen to our thoughts to understand us, even when I am on monthly periods, I have to do household stuff and my brother might be somewhere playing with his friends, actually it hurts but no one gives me a chance to share my thoughts"*

(IDI No. 12, Adolescent, Mabatini, August 18, 2024).

In addition, other participants shared that adolescents who are boys are given more freedom of thought compared to adolescents who are girls. Boys are given chances to talk about sexual and reproductive issues with friends and parents. However, things go differently for girls. They are restricted from discussing or sharing anything about sexual and reproductive health. The community believes that giving girls, in particular adolescents, the right to share their opinions and thoughts about sexual and reproductive issues is like promoting prostitution. One of the adolescents confirmed that:

> *"I am two years older than my young brother, but I see him discussing sexual and reproductive health issues with my father, and I am restricted from doing so. The reason behind this is my parents think I can be a prostitute if I get a chance to share my thoughts about sexual and reproductive health issues"*

(IDI No. 5, Adolescent, Mabatini, 2024).

Furthermore, healthcare providers shared their experiences; most parents do not give their children the right to freedom of sharing their thoughts concerning sexual and reproductive health. It has been a challenge even to allow their children to participate in clubs designed to provide opportunities to share their thoughts through discussions. One of the healthcare providers stated that:

> "*Sometimes adolescents are aware of the right to share their thoughts, however, they don't get platforms for doing so. Their parents don't like their children to participate even in clubs designed for adolescents. This has been a big challenge in our society"* ***(IDI No. 30, Healthcare Provider, Mabatini, August 25, 2024)***

Moreover, on the side of parents, freedom of thought on sexual and reproductive services is not an issue to consider for adolescents because when adolescents are allowed to talk or discuss sexual and reproductive health, it encourages them to try sexual intercourse, which later causes problems of sexually transmitted infections like HIV/AIDS. In addition, by doing so, the parent may lose the power to control their adolescents against having sexual intercourse. That is why adolescent girls are restricted from being included in discussions of sexual and reproductive health.

> *"It is not right to give all freedom to a girl child, as you know parents use a lot of effort to protect their girl children from having sexual intercourse. To give them a chance to share their opinions about sexual and reproductive health is the same as allowing them to do sexual intercourse, I cannot provide that stuff to my children"*
>
> **(IDI No. 23, Parent, Mabatini, August 16, 2024)**

The results revealed that freedom of thought on sexual and reproductive health among adolescents in the study area was affected by the parents who did not allow their children to participate in clubs to share their thoughts. Moreover, these results collaborate with the results by Tilahun et al. (2023) and Perkins et al. (2019), awareness of adolescents' freedom of thought was affected by different barriers, including SRH services, religious organizations, and parents who do not give their children a chance to share their opinions on SRH.

4.3.3 Right to Consent to Marriage

In the interviews, the researcher understood that in the study area, families always struggle to provide food and clothing for their children, let alone fees or other costs related to keeping their children in school. As a result, many families resort to marrying off their adolescents as a means of protecting them economically. Some adolescents agree to marry because they are unaware of the right to consent to marriage. One of the adolescents of this view argued that:

> *"I am married, my parents saw this as the only means of helping me economically. Through my marriage, they received cash for the bride price which reduced poverty in my family. However, there was no need to consent to that marriage because it was a willing of my parents, no one could oppose their willing"*
>
> **(IDI No. 18, Adolescent, Mabatini, August 22, 2024)**

Furthermore, healthcare providers confirmed that poverty has been a critical driver of adolescent marriage in the study areas. Other factors, such as the right to consent and the

challenges marriage will bring, are not always considered. Most adolescents have been forced to be out of education and into a life of poor prospects, with an increased risk of violence, abuse, ill health, or early death; all these are influenced by early marriage, which is sometimes never considered a right to consent for it. As one of the healthcare providers pointed out:

> *"In this community, the way marriage is done denies adolescent girls their right to make vital decisions about marriage, they are always forced to be married to solve the families' economic challenges. They are not given the right to consent for that marriage, bad enough both adolescents and parents are unaware with this stuff"*

(IDI No. 29, Healthcare Provider, Mabatini August 20, 2024)

Besides, through interviewing the parents in the study area, it was understood that parents force their adolescent girls to be married because those adolescents reach an age that supports marriage. According to parents/guardians who participated in this study, 14 years of age and above is enough for an adolescent girl to be married. It has been difficult for a parent to continue caring for a child of 14 years and above. Moreover, parents/guardians declared the interest that they do not provide a chance for their children to consent to marriage. This is because of the level of poverty they face, which makes marriage not have other alternatives; it is only necessary for a child girl of 14 years and above to get married.

> *"No need to consent to marriage, the age of 14 years and above is enough for a girl child to be in a marriage institution. It is also a good*

way to reduce our level of poverty because we escape from the task of taking care of that child"

(IDI 22, Parent, Mabatini, August 16, 2024)

The results implied that adolescents and their parents/guardians lacked awareness of the right to consent to marriage; they are all driven by economic factors. In line with Kamau (2016) and Naik et al. (2024), marriage and sexual activity among adolescents were always not consented to, and this exposed them to greater risk. Thus, adolescents were more vulnerable to rape, harassment, and sexual exploitation because their right to consent was violated. In addition, many governments worldwide have raised the legal age of marriage to 18 years; some are considering raising the age of sexual consent. Without close-in-age exemptions, arguments to align the legal age of sexual consent with that of marriage would restrict the ability of adolescents to have sex legally. In contrast to international agreements that affirm 18 years as the minimum age for consent to marriage, international human rights standards do not recommend specific age limits for sexual consent but urge recognition of adolescents as rights holders (Petroni et al., 2019).

4.3.4 Right to Decide Number and Spacing of Children

The interview reported that married adolescents understand the issue of deciding the number and spacing of children for their husbands. These participants reported that it is not easy for a woman to have a say on how many children of chooses to have; the husband decides to decide whether to participate in family planning. Before marriage,

adolescent girls learn how to listen to their husbands for all decisions; the husband makes the final decision on all matters in the family. As one of the interviewees stated:

> *"I am married, I know what happens in marriage, it is an institution that puts all final decisions under men. The issues of deciding number of children and time to conceive are for husbands, this is what we learn from parents even before marriage"*
>
> **(IDI No. 8, Adolescent, Mabatini, August 10, 2024)**

Another participant, who was an adolescent boy, argued:

> "*I am not married, but I have learnt from my community that we boys have the power to make final decisions in families. For example, if I am married today, I cannot give to my wife a chance to select number of children to have, this is because to accomplish marriage a man must pay for bride prices, this means a married woman is under control of her man"*
>
> **(IDI No. 15, Adolescent, Mabatini, August 12, 2024)**

The results implied that adolescent girls, especially those who had been married, were not aware of their right to decide freely and responsibly the number, spacing, and timing of their children and to have information to do so. Furthermore, in their study, Iqbal et al. (2017) found that the International Planned Parenthood Federation Charter outlined essential rights of adolescents to include healthcare, information and education, life, liberty, privacy, freedom of thought, equality, choice in marriage and number of children, and freedom from torture.

4.3.5 Freedom from Violence

The researcher understood that violence has become a resource for disempowered adolescents in the study area. It was reported that although adolescents were aware of freedom from all kinds of violence, they experienced a lot of it. Most adolescents reported experiencing corporal punishment at the hands of their parents and by teachers in the case of school-attending adolescents.

> *"We know that we are to be free from violence, however, sometimes violence is done by our parents or teachers. It has been difficult for us to argue on this, we see parents as our second God"*
>
> **(IDI No. 10, Adolescent, Mabatini, August 12, 2024)**

Another adolescent who participated in this study shared:

> *"We experience verbal harassment from our parents or sometimes from our teachers, it is like a taboo not to argue for violence done by parents, what we need to do is only to respect parents for everything they do. So, when we do any kind of mistake, they beat us"* ***(IDI No. 18, Adolescent, Mabatini, August 20, 2024).***

The participants, especially adolescents, also reported various types of punishments. As one of the adolescents, a boy confirmed:

> *"Parents flog us using a stick, pinch us and punch our heads with their fist. I can explain what I experienced; my parents beat me with a cable of cord. It is not because I am not aware of freedom from violence, but it was a level of respect I needed to show to my parents, I was not*

supposed to argue about anything" ***(IDI 17, Adolescent, Mabatini, August 20, 2024).***

The results indicated that although adolescents were aware of freedom from violence, they were challenged by their parents and teachers who did not take care of it. In line with Jones et al. (2019), adolescents experience violence due to social norms, including bullying, sexual violence, and harmful traditional practices. Adolescents experienced violence in the home, with no significant differences between girls and boys. Moreover, Pankhurst et al. (2018) indicated that intra-household violence directed at children and adolescents is nearly universal in Ethiopia essentially because parents share cultural assumptions and beliefs in the necessity of child corporal punishment to ensure proper child upbringing.

4.4 The Access to SRH Services by Adolescent

The second objective of this study needed a researcher to assess the access to sexual and reproductive health services by adolescents. Furthermore, the results come out with some themes on the accessibility of SRH services by adolescents. The emerging themes include the availability of healthcare providers for SRH, adolescent-friendly SRH service, life skills, education programs, stock-out commodities, open discussion on SRH, and guidance and counseling.

4.4.1 Availability of Healthcare Providers for SRH Services

In the case of the availability of healthcare providers to provide sexual and reproductive health services, the participant reported facing an obstacle in utilizing them. This is

because there was an inadequate number of healthcare providers. An inadequate number of healthcare providers has been an obstacle for adolescents to use sexual and reproductive health effectively. Sometimes, adolescents have a problem requiring a high level of confidentiality when presenting to healthcare providers; however, the privacy issue fails due to the inadequate number of healthcare providers. This makes adolescents not attend that stuff. Besides, the insufficient number of healthcare providers also caused inadequate health facilities to provide SHR services to adolescents. As one of the adolescents pointed out:

> *"Not all facilities in our district are allowed to offer SRH services to adolescents. This is due to the inadequate number of healthcare providers with skills to facilitate SRH services to adolescents"*
>
> **(IDI No. 2, Adolescent, Mabatini, August 8, 2024)**

In addition, the parents who participated in this study clarified that sometimes adolescents failed to utilize SRH services effectively due to inadequate healthcare providers in health centers. As one of the parents who participated in this study confirmed:

> *"The needs of adolescents to utilize SRH services are not met at the health center because there are insufficient healthcare providers"*
>
> **(IDI No. 24, Parent, Mabatini, August 16, 2024)**

The results indicated that access and access to sexual and reproductive health services by adolescents in the study area are affected by the shortage of healthcare providers who

could specialize in providing services to adolescents. This caused the sexual and reproductive health services to be underutilize by the adolescents. Moreover, the results concur with those obtained by Mwandali et al. (2020); the adolescents reported adequate healthcare providers to associate inaccessibility of sexual and reproductive health services. This caused a high burden of sexual and reproductive health problems for adolescents, like unsafe abortion, STIs/HIV, and birth complications. Likewise, in Mtwara, Tanzania, Mbeba et al. (2012) found that SRH services were available at all the assessed facilities. However, the services were adult-oriented and did not consider adolescents, so they did not use them.

4.4.2 Adolescent-Friendly SRH Services

In the interview, the interviewees reported that adolescents face a barrier to unfriendly sexual and reproductive services during the utilization of such stuff. Many healthcare providers have not been trained with personnel to provide friendly services to adolescents. One of the adolescents stated:

> *"It was a few months ago that I went to a healthcare facility for service, and the nurse there was so rude to me. She was not so friendly enough when she was providing service to me"*
>
> **(IDI No. 19, Adolescent, August 20, 2024)**

Besides, healthcare providers explained that they fail to provide adolescent-friendly SRH services because of the adequate space needed to ensure counseling. No separate rooms with doors may support privacy and minimal interruptions.

These results revealed that sometimes adolescents fail to utilize sexual and reproductive health services because of unfriendly services in healthcare facilities. Furthermore, the World Health Organization (WHO) considers adolescents-friendly services when every obstacle hindering adolescents from receiving SRH is cleared by ensuring that the main characteristics of adolescent-friendly services are met. In addition, these main characteristics include health services are accessible (adolescents can obtain the available health services), acceptable (when they are willing to get available services), equitable (when all adolescents can obtain the services of their choice), and effective (when services of their choice are provided in the right way) (Mbeba et al., 2012). Other characteristics of adolescent-friendly services are when healthcare providers' attitudes are non-judgmental and consistent when dealing with adolescents and when the community knows where adolescents get the services and supports them (Ministry of Health and Social Welfare, 2011). Moreover, adolescents consider friendly services if treated respectfully and adhere to confidentiality (Mngadi et al., 2018).

4.4.3 Life Skills and Education Programmes

In the interview, the participants stated that adolescents need education and skills to become lifelong learners, secure productive work, make informed decisions, sexual and reproductive health education, and be positive in their communities. Unfortunately, some of the adolescents were not in schools in secondary schools where programs for life skills and education were provided. This resulted in them not utilizing the services provided. One of the participants stated that:

> *"You know, with access to secondary education adolescents are provided with different life skills education which also includes SRH education, unfortunately, some of the adolescents have never attended secondary education this makes them not utilize this kind of service"*
>
> **(IDI 28, Healthcare Provider, Mabatini, August 20, 2024)**

In addition, it was also reported that adolescents need skills education more because they are at the age of transition from childhood to adulthood. It is a time for achievement, deciding on professions, developing personality, and emotional instability, but often end up doing so due to a lack of self-control and lots of societal, parental, and peer pressure. Furthermore, it was also reported that sometimes adolescents need to get life skills education in programs launched on the streets. Unfortunately, there are no these programs in the study area.

> *"You know, as other adolescents do not get an opportunity to attend secondary education, so they need to get this education in the streets unfortunately there is not these programmes in streets"*
>
> **(IDI No. 25, Parent, August 16, 2024)**

The results revealed that adolescents in the study area failed to access effectively sexual and reproductive health services because there were no programs designed in the street to provide life skills education. The results concur with the results found by Mwandali et al. (2020) that if adolescents are empowered with life skills and education, it can help them improve the health and well-being of their families and communities. Besides, from a human rights perspective, adolescents have the right to access information, skills,

and services regarding their sexual and reproductive health, the right to participate in health and development programs that affect their lives, and intervention related to adolescent sexual and reproductive health (URT, 2015).

4.4.4 Stock Out of Commodities

The accessibility of sexual and reproductive health services by adolescents was reported to be affected by the issue of stock out of commodities. It was explained that it reached the time adolescents needed commodities like condoms; however, when they reached the health center, they found a stock of condoms. One of the interviewees, who was an adolescent, confirmed:

> "The male's condoms are available, but there was a stock-out of the female's condoms" ***(IDI No. 8, Adolescent, Mabatini, August 10, 2024)***

Furthermore, through probing, a researcher understood that the female condoms were not available in stock because female adolescents did not show a willingness to use that kind of condoms. The previous females' condoms were underutilized and expired before being utilized, which led to the wastage of scarce health resources. One of the interviewees explained:

> *"The previous females' condoms expired because adolescents did not require them. They say that they do not use such stuff because of the difficulty with the insertion of such stuff during sex"*
>
> **(IDI No. 30, Healthcare Provider, Mabatini, August 25, 2024)**

It was also reported by the interviewees that sometimes adolescents fail to utilize sexual and reproductive health services effectively because some of these services are not available in some health facilities; this is due to the predetermined SRH health care package for health facilities that have been set by the Ministry of Health guidelines. The interviewees feel that if SRH services were allowed in all health facilities, they would have utilized SRH services effectively. One of the interviewees with this view stated:

> *"The private institution provides the tests and treatments of STIs. They also provide HIV counseling. However, for HIV treatments, we are transferred to public health facilities for ART. We also have some contraceptive methods, but when we need family planning, we are also transferred to the hospital or health center where the governmental health facilities provide these services for free"*
>
> **(IDI No. 14, Adolescent, Mabatini, August 15, 2024)**

The results implied that there are obstacles for adolescents to utilize effectively sexual and reproductive health services in the study area. These obstacles include stock out of commodities such as condoms and unavailability of other services in other health facilities. In line with a study by Ndayishimiye (2020), some of the services were not available in health facilities due to being underutilized; such was the case with female condoms. In contrast, Odo et al. (2018) found that female condoms were available in almost all health facilities in Nigeria.

4.4.5 Open Discussion on SRH

In the interview with participants of this study, the researcher understood that at the family level, adolescents can participate in discussions concerning sexual and reproductive health. However, the debate is always limited by cultural norms that treat parent-child conversations on SRH as taboo. Moreover, it was reported that parents are generally uncomfortable having open discussions on sex-related issues with their children and have limited knowledge and skills to communicate effectively on SRH issues. This causes only a few parents to discuss SRH with their children.

> *"Parents would be the people to communicate to their children, but few parents do that. So they play a very small role"*
>
> **(IDI 28, Healthcare Provider, Mabatini, August 20, 2024)**

However, the parents in this study explained that conducting open discussions with adolescents depends on the parent-child relationship. This develops the ability of parents and children to approach each other and discuss any SRH issues openly. Adolescents close to their parents are motivated and can initiate discussions on SRH matters. On the other hand, there is no communication when the relationship is poor.

> *"If the child and parent are free with each other, it is easy for them to discuss. As a parent you may be willing to talk to your child, but she/he is not free with you, she/he will end up seeking advice from the neighbors or friends"*
>
> **(IDI No. 27, Parent, August 20, 2024).**

The findings revealed that sometimes adolescents fail to participate in open discussions with their parents due to cultural barriers, creating a poor relationship with them. In line with Ndugga et al. (2023), cultural norms were the most reported barriers to parent-child SRH discussions. The parents in their setting did not discuss sex matters with their children because it is taboo; it is an abomination to speak about sex with a child.

4.4.6 Guidance and Counseling

The study participants explained that they were not instructed on where to go for guidance and counseling services. This situation forced them to use friendly mediums like WhatsApp to obtain SRH information. Guidance and counseling practitioners could form WhatsApp groups for adolescents in communities to discuss SRH issues. The formulated groups comprised adolescents with similar traits such as age and gender. It was also reported that although adolescents think of seminars as the means to obtain guidance and counseling, there was no tendency to conduct workshops for adolescents in the study area. That is why adolescents decided to seek information guidance and counseling in WhatsApp groups.

> *"It is through seminars where we can get guidance and counselling services, however, we are not given opportunity to get seminars. This has caused us to make a trust on WhatsApp groups"*
>
> **(IDI No. 10, Adolescent, Mabatini, August 12, 2024)**

The results revealed that adolescents in the study area had only one means of getting guidance and counseling: social networks like WhatsApp groups. Moreover, the findings

concur with those obtained by Adzovie (2022) in Ghana, which was that WhatsApp platforms had become commonly used by adolescents to share information and discuss sexual and reproductive health services.

4.5 Challenges Facing Adolescents in Accessing SRH Services

The third objective needed a researcher to examine the challenges facing adolescents in accessing sexual and reproductive health services. Three themes emerged during data collection. The emerging themes include intrapersonal challenges (inadequate information, incorrect perceptions, low self-esteem, and fear of being noticed by family members), interpersonal challenges (unsupportive families, and lack of communication), and institutional-level challenges (provider competency, provider attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines).

4.5.1 Intrapersonal Challenges

The study found that barriers at the intrapersonal (individual) level are among the challenges that adolescents face in accessing sexual and reproductive health services in the study area. The participants reported the lack of information about sexual and reproductive health services to be among the intrapersonal barriers. Some adolescents reported not having any knowledge of SRH issues, in particular contraceptives. However, those who knew it did not know where to get it or which was good for them. One of the interviewees confirmed:

> *"I don't understand which health facilities provide SRH service. No one informs us. Even if I want to know my health status, I don't know where to go for that stuff"*
>
> **(IDI 17, Adolescent, Mabatini, August 20, 2024)**

Moreover, adolescents' low self-esteem was also reported as an intrapersonal (individual) barrier that affects access to SRH services by adolescents. The participants of this study identified that certain behaviors of adolescents, like low self-esteem and lack of confidence to seek adolescent SRH services, were among the barriers to obtaining sexual and reproductive health services. Some adolescents were perceived to be too shy to discuss SRH services openly. One of the interviewees stated:

> *"Before I visited the health facility, I was afraid that healthcare providers would not be comfortable discussing sex-related issues. But after visiting the health facility my negative thinking disappeared. There are adolescents like me in the community who have similar perceptions"*
>
> (**IDI No. 6, Adolescent, Mabatini, August 06, 2024)**

Besides, adolescent perceptions of sexual and reproductive health services were reported as among the intrapersonal barriers. Most of the adolescents were reported to perceive that only adults are supposed to be involved in sexual and reproductive health services.

Moreover, fear of being seen by family or relatives emerged as a sub-theme of intrapersonal (individual) barriers. The participants reported that the fear of adolescents being seen in the health facility for sexual and reproductive health services is among the

barriers to accessing SRH services among adolescents in the study area. Most adolescents prefer not to be seen by family, relatives, other adults, neighbors, or teachers, who would be most likely to inform their parents.

> *"You know, if anyone sees you at the health facility for SRH services he thinks that you have a boyfriend"*
>
> **(IDI No. 11, Adolescent, Mabatini, August 12, 2024)**

Besides, another participant added:

> *"When you go to the health facility and see someone who knows you. So, you must fear going there because that person can find out and inform your parents"*
>
> **(IDI 17, Adolescent, Mabatini, August 20, 2024)**

The findings revealed that access to sexual and reproductive health services is sometimes affected by individual factors. These factors happen due to the perception of adolescents themselves utilizing sexual and reproductive health services. In line with Abuosi & Anaba (2019), Ezenwaka et al. (2020) and Mohamed et al. (2020) found that intrapersonal (individual) such as adolescents' low self-esteem, perception towards SRH services and fear of being seen by family or relatives to the challenges that affect access to sexual and reproductive health services among adolescents.

4.5.2 Interpersonal Challenges

Lack of parental support was mentioned as an interpersonal barrier. The participants reported that parents were to serve as truthful sources of information about sexual and

reproductive health services for adolescents. Parents were needed to play the role of being the primary source of logistical and financial support for adolescents to access sexual and reproductive health services. However, it was reported differently in the study area; there was a lack of support, which also affected access to sexual and reproductive health services by adolescents. The participants explained that parents did not give their adolescents time to access information about SRH services; this is because they thought it was not the right time. One of the participants pointed out:

> *"I needed to go to the health facility for SRH services, but my parents never allowed me to do so.*
>
> **(IDI No. 20, Adolescent, Mabatini, August 20, 2024)**

However, the parents explained that their task is just to advise their children, especially adolescents, on what is right to do. For example, the application of family planning is against God's will, religion, and culture. One of the parents explained that:

> *"We have a task to advise adolescents on what is better for them until they become married, which is the only option to remain healthy for both males and females. The use of family planning is against our religion and culture"*
>
> **(IDI No. 21, Parent, Mabatini, August 20, 2024)**

In addition, poor-parent-to-adolescent communication about SRH issues was also reported as one of the interpersonal barriers to access and use of adolescent sexual and reproductive health services. This means sexual and reproductive issues were rarely

discussed at home due to the social norm of the community and perceived that adolescents are as children, not young adults. One of the participants explained that:

> *"My mother sometimes talks to me about menstrual hygiene, but she has never discussed birth control methods, sexually transmitted disease, and other things that we are talking about now, however, he warns me not to get involved in sexual activity"*
>
> **(IDI No. 14, Adolescent, Mabatini, August 15, 2024)**

The obtained findings imply that access to sexual and reproductive health services in the study area depends on the interpersonal barrier. Moreover, these findings concur with the results obtained by Mutea et al. (2020) and Amankwaa et al. (2018), who found the interpersonal barriers to include unsupportive families and a lack of open communication between adolescent parents about sexuality issues.

4.5.3 Institutional Challenges

The participants of this study identified institutional barriers, including facility-related and provider-related barriers. Moreover, the participants reported that facility-related barriers include an unsupportive environment, shortage of medicines and suppliers, and inaccessibility of services. The participants also identified healthcare providers in the study area, including healthcare provider behaviors, poor provider competency, and attitudes of the healthcare providers for adolescents.

It was also reported that the physical inaccessibility of SRH services had been a barrier to accessing SRH services by adolescents. Most adolescents lived far from healthcare

facilities; it had been challenging to access health facilities for SRH services. One of the interviewees reported that:

> *"The nearest health facility is far from my home, I found it tough to travel a longer distance for SRH services"*
>
> **(IDI No. 9, Adolescent, Mabatini, August 10, 2024)**

Moreover, sometimes, shortages of medicines and suppliers have been causing a challenge for adolescents to access SRH services. In the study area, participants reported finding stock-outs of condoms when they attended health facilities for SRH services. One of the participants stated that:

> *"I visited to health facility for SRH service, the nurse insisted me not to sex without a condom. But sometimes I asked for condoms and the nurses told me that they were not available"*
>
> **(IDI No. 4, Adolescent, Mabatini, August 08, 2024)**

Furthermore, an unsupportive environment was identified as the barrier for adolescents to access SRH services. The participants, especially adolescents, reported that when they visited health facilities, they met with long waiting, inadequate physical space, and a lack of separate rooms.

> *"I went for SRH services at the health facility, I used a long time waiting for the healthcare provider. I am sure most people do not also like it"*
>
> **(IDI No. 1, Adolescent, Mabatini, August 8, 2024)**

Moreover, one of the healthcare providers confirmed that they used a single room for counseling activities. However, sometimes, it becomes overcrowded, with inadequate privacy and poor ventilation. In addition, it was also reported that the lack of separate rooms for delivering SRH services to adolescents is a barrier that negatively influences access to adolescents' SRH services.

In addition, the participants reported unfriendly behaviors of healthcare providers. Healthcare providers were reported to be very rude. One of the participants stated that:

> *"Frankly speaking, some healthcare providers are rude, that is the major complaint of adolescents"*
>
> **(IDI No. 25, Parent, August 16, 2024)**

In addition, one of the adolescents confirmed that:

> *"Most of the healthcare providers are very rude. From my own experience, after I waited for over three hours, the healthcare provider only took three minutes to talk with me and call the next person"*
>
> **(IDI No. 11, Adolescent, Mabatini, August 12, 2024)**

Besides, the participants also reported that sometimes access to SRH services among adolescents is affected by the attitude of healthcare providers toward adolescents who are seeking sexual and reproductive health services. There were healthcare providers who did not provide contraceptive services to adolescents for the reason that they were still young.

> *"My friend went for SRH service specifically to take a modern contraceptive, but the healthcare provider was emotionally unwilling to provide that stuff to her, criticizing that she was too young to have sex by that time"*
>
> **(IDI 16, Adolescent, Mabatini, August 20, 2024)**

The findings imply that access to sexual and reproductive health services among adolescents is sometimes affected by institutional factors, which include an unsupportive environment, shortage of medicines and suppliers, and inaccessibility of services. Moreover, the findings concur with findings obtained by Mutea et al. (2020) and Ahumuza et al. (2014) that sexual and reproductive health services among adolescents are constantly challenged by barriers at an institutional level, which are further classified into facility-related barriers and healthcare providers-related barriers.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Chapter Overview

The chapter summarizes the study findings, presents the study's conclusions based on objectives, and details recommendations based on the obtained findings.

5.2 Summary of the Study Findings

This study aimed at assessing the utilization of sexual and reproductive health (SRH) services among adolescents in Nyamagana district as a case study. Specifically, the study assessed: the level of awareness of adolescents in accessing SRH services; accessibility of SRH services by adolescents; and challenge facing the adolescents in accessing SRH services. The study was guided by Social Cognitive Theory developed by Albert Bandura. Interprevitism philosophy and cross-sectional design. Qualitative approach was employed whereby 30 participants were involved. In addition, a non-probability sampling strategy specifically purposive sampling was used to select parents/guardians, and healthcare providers. Data were collected by using a semi-structured interview. Data analysis involved thematic analysis.

The study indicated that access to sexual and reproductive services by adolescents was influenced by the level of awareness of SRH services by adolescents themselves. The adolescents' understanding of SRH services comprised awareness of the right to information and education on SRH service, freedom of thought on SRH, right to consent

to marriage, suitable to decide the number and spacing of children and freedom from violence.

The study also found that the accessibility of sexual and reproductive health services among adolescents in the study area depended on the availability of healthcare providers for SRH service, adolescent-friendly SRH service, life skills, and education programs, stock-out commodities, and guidance and counseling.

The results also indicated that there are challenges that hinder access to sexual and reproductive health among adolescents. The challenges include intrapersonal (individual) challenges (inadequate information, incorrect perceptions, low self-esteem, and fear of being noticed by family members), interpersonal challenges (unsupportive families, and lack of communication), and institutional-level challenges (provider competency, provider attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines).

5.3 Conclusions

The study concludes that access to SRH services in the study area was influenced by adolescents' level of awareness of SRS services. The adolescents' understanding of SRH services comprised awareness of the right to information and education on SRH services, freedom of thought on SRH, right to consent to marriage, proper to decide the number and spacing of children, and freedom from violence. The study also concludes that SRH service utilization among adolescents in the study area depended on the

availability of healthcare providers, adolescent-friendly SRH services, life skills, education programs, stock-out commodities, and guidance and counseling.

The study also concludes that access to sexual and reproductive health services by adolescents in the study area is faced with a myriad of challenges at the intrapersonal level (inadequate information, incorrect perceptions, low self-esteem, and fear of being noticed by family members), interpersonal level (unsupportive families, and lack of communication), and institutional level (provider competency, provider attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines).

5.4 Theoretical Implication

The current study filled the gap in terms of theoretical contribution. In 1994, Albert Bandura explained in the Social Cognitive Theory that the environment, personal characteristics, and social factors contribute to youths' reproductive health. In addition, if these variables are applied or utilized correctly, they can contribute to the prevention, promotion, access, and management of reproductive health issues, thus resulting in good health (Bandura, 1998).

Therefore, this study has used the ideas of Social Cognitive Theory as a motivation factor for determining the influential factors on access to sexual and reproductive health among adolescents. In terms of personal characteristics, the current study has determined factors like intrapersonal factors, whereas at the community level, the study has come with interpersonal factors; the current research has also explored institutional factors. All

these factors would contribute to the body of knowledge, which means that other researchers in developing countries in Africa other than Tanzania, especially on health, will use the current findings to design their studies.

With the assistance of the Social Cognitive theory, this study has explored the level of awareness and utilization of sexual and reproductive health services among adolescents. Therefore, this study is an addition to studies that have been conducted in the field of sexual and reproductive health services. As it has been highlighted by Emmanuel et al. (2014), about 11% of all births worldwide are by adolescent girls aged 15-19 years. These young mothers are more likely to experience complications and die of pregnancy-related causes. Therefore, this study contributes to a continuum that recognizes the importance of reaching adolescents in all strata with age-specific services that consider the critical developmental milestones in adolescents' development.

5.5 Recommendations

Given the above conclusion about adolescents' awareness of access to SRH services, the study recommends that the government under the Ministry of Health of Tanzania and other health practitioners in Nyamagana district should inform adolescents about the importance of getting SRH services. This can be done through developing seminars and clubs for adolescents.

Given the utilization of SRH services by adolescents, the government under the Ministry of Health should inform adolescents about the adverse effects of not using SRH services effectively. In addition, the government under the Ministry of Health should ensure that

there are always available healthcare providers, commodities, and open discussions on SRH to enhance the utilization of SRH services among adolescents. To avoid intrapersonal, interpersonal, and institutional challenges regarding adolescents' access to SRH services, the government under the Ministry of Health should educate adolescents, parents, and healthcare providers to change their attitudes about SRH service utilization.

5.6 Limitations and Areas for Further Studies

This study was done in the Mabatini ward, Nyamagana district, in the Mwanza region. However, Tanzania has more than 26 regions and many districts. This means that the sample might not represent the whole population. Therefore, this study recommends that future studies be done in other areas of Tanzania to obtain actual information and generalize findings.

A comparative study between rural and urban areas of Tanzania could help to identify the differences in access to sexual and reproductive health services among adolescents. This can provide more localized data for policymakers to design relevant strategies.

REFERENCES

Abdurahman, C., & Oljira, L. (2022). Sexual and reproductive health services utilization and associated factors among adolescents attending secondary schools. *Reproductive Health*, *19*(1), 161.

Abuosi, A. ., & Anaba, E. . (2019). Barriers on access to and use of adolescent health services in Ghan. *J Health Res*, *33*(3), 197–207.

Addae, N. (2021). *Understanding adolescents' sexual and reproductive health needs in the Cape Coast Metropolis*. University of Cape Coast.

Addila, A. (2020). Premarital sexual practice and its predictors among preparatory school students living with and without parents in Hossana Town Southern Ethiopia. *Science*, *8*(3), 63–71.

Aduah, R. (2021). *Women's experiences with digital health service as a tool for improving awareness perception on sexual reproductive health and contraception. A phenomenography qualitative study*. Dalarna University.

Adzovie, H. . (2022). Exploring Ghanaian Adolescent Sexual and Reproductive Health (SRH) Information Source(s): A Qualitative Approach. *The Qualitative Report*, *27*(3), 648–663.

Ahumuza, S. ., Matovu, J. ., & Ddamulira, J. . (2014). Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. *Reprod Health*, *11*(1), 1–9. https://doi.org/doi:10.1186/1742-4755-11-59

Amankwaa, G., Abass, K., & Gyasi, R. . (2018). In-school adolescents' knowledge, access to and use of sexual and reproductive health services in Metropolitan,

GhanaKumasi. *J Public Health*, *26*(4), 443–451. https://doi.org/doi:10.1007/s10389-017-0883-3

Ambary, S. (2017). *Studying the Roles of Government in Solving Challenges Facing Single Parented Secondary School Students in Tanzania: A Case of Kinondoni Municipality*. Master's Dessertation, University of Science and Technology of China.

Amin, M. ., Nørgaard, A. ., Cavaco, M. ., Witry, L. ., & Cernasev, S. . (2020). Establishing trustworthiness and authenticity in qualitative pharmacy research. *Res. Soc. Adm. Pharm*, *16*, 1472–1482. https://doi.org/10.1016/j.sapharm.2020.02.005

Amran, M. (2023). *Health in Crisis: An Integrative Review of Sexual and Reproductive Health in Humanitarian Settings*. Dalarna University.

Bandura, A. (1998). Health promotion from perspective of social cognitive theory. . . *Psychology and Health Journal*, *13*(3), 623–649.

Beckmann, J. (2017). *University research ethics clearance: Safety nets, or a false sense of legal immunity*. North West University.

Belay, H., Arage, G., Degu, A., Getnet, B., Necho, W., Dagnew, E., Melkie, A., Seid, T., Bezie, M., & Nibret, G. (2021). Youth-friendly sexual and reproductive health services utilization and its determinants in Ethiopia: A systematic review and meta-analysis. *Heliyon*, *7*, e08526.

Bisht, R. (2023). What are Sampling Methods? Techniques, Types, and Examples. *Retrieved from Https://Researcher.Life/Blog/Article/What-Are-Sampling-Methods-Techniques-Types-and-Examples/ on October 27, 2024*.

Bryman, A., & Bell, E. (2011). Research Designs. In: Business Research Methods. *New York. Oxford University Press.*

Bwalya, N. . (2016). *Factors affecting access to and utilization of reproductive health services amomg adolescents in Lusaka District: Case of study Kamanga Compound*. University of Zambia.

Chandra, M., Venkatraman, L., & Wong, S. (2015). What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. *Global Health, Science and Practice*, *3*(3), 333–340.

Chandra-Mouli, V., & Akwara, E. (2020). Improving access to and use of contraception by adolescents: what progress has been made, what lessons have been learnt, and what implications for actions? *Best Pract Res Obstret Gynaecol*, *66*, 107–118.

Chetty, P. (2016). Importance of research approach in a research. *Retrived from: Https://Www.Projectguru.in/Selecting-Research-Approach-Business-Studies/ on October 26, 2024*.

Chipako, I., Singhal, S., & Hollingsworth, B. (2024). *Impact of sexual and reproductive health interventions among young people in sub-Saharan Africa: a scoping review.* Arba Minch University, Ethiopia.

Chiumia, I. ., Ninsiima, L. ., & Ndejjo, R. (2021). It is painful and unpleasant": Experiences of sexual violence among married adolescent girls in Shinyanga, Tanzania. *International Health Journal*, *18*(1), 17.

Combs, K. . (2017). *Strategies for retaining employees for call centers (Unpublished Walden Doctoral dissertation).* Walden University.

Coral, K., Mohosin, A., Amin, A., & Hasan, T. (2022). Influence of education on sexual and reproductive health service utilization for persons with disabilities in

nationwide Bangladesh: an explanatory sequential mixed-methods study. *Reproductive Health*, *19*(46), 1–15.

Dadzie, L. ., Agbaglo, E., & Oyere, J. (2022). Self-reported sexually transmitted infections among adolescents girls and young women in Sub-Saharan Africa. *Int Health*, *14*(6), 545–553.

Dale, H., & DiBenedetto, K. (2023). Leraning, Cognition, and Human Development. *International Encyclopedia of Education (Fourth Edition)*.

Dale, H., & Maria, K. (2023). Learning, Cognition, and Human Development. *International Encyclopedia of Education*, *4*(1), 12–18.

Dangat, C., & Njau, B. (2013). Knowledge, attitude and practices on family planning services among adolescents in secondary schools in Hai District, northern Tanzania. *Tanzania Journal of Health Research*, *15*(1), 1–8.

Devlin, A. (2018). *The role of compensation in clinical study and the ethical considerations (Walden Doctoral dissertation). ProQuest Dissertations and Theses database. (UMI No. 5611539)*.

Dzinoreva, B. (2021). Obstacles hindering access to sexual reproductive health, responsibilities and rights (SRHR) in Zimbabwe: How youths and adolescents can access and utilize services? *Journal of Development Administration*, *6*(2), 71–79.

Embleton, L., Braitstein, P., Ruggiero, E., Oduo, C., & Wad, Y. (2023). Sexual and reproductive health service utilization among adolescent girls in Kenya: A cross-sectional analysis. *PLOS Glob Public Health*, *3*(2), e0001508. https://doi.org/https://doi.org/ 10.1371/journal.pgph.0001508

Emmanuel, G., Williams, A., & Ochonye, G. (2014). Challenges with providing sexual and reproductive health services for adolescents. *Nigerian Journal of Health Sciences*, *14*, 52–56.

Envuladu, E., Massar, K., & Wit, J. (2023). Healthcare workers' delivery of adolescent responsive sexual and reproductive healthcare service an assessment in Plateau state. *Nigeria BMC Women's Health*, *1*(132).

Ezenwaka, U., Mbachu, C., & Ezumah, N. (2020). Exploring factors constraining utilization of contraceptive services among adolescents in Southeast Nigeria: an application of the socio-ecological model. *BMC Public Health*, *20*(1), 1–11.

Haile, B., Shegaze, M., Feleke, T., & Glagn, M. (2019). *Utilization of sexual and reproductive health services and associated factors among adolescents in youthfriendly service implemented and non-implemented high school of South Ari District, South Omo Zone, Southern Ethiopia, 2019.* Arba Minch University.

Holland, H. ., & Linvill, J. . (2023). Important considerations for protecting human research participants, Dimensions of Discovery July–August 2019. *Retrieved from: Https://Www.Purdue.Edu/Research/Dimensions/Important-Considerations-for-Protecting-Human-Research-Participants/ on October 27, 2024*.

Ibrahim, N., & Edgley, A. (2015). Embedding researcher's reflexive accounts within the analysis of a semistructured qualitative interview. *The Qualitative Report*, *20*(10), 1671–1681.

Iqbal, S., Zakar, R., Zakar, Z. ., & Fischer, F. (2017). Perceptions of adolescents' sexual and reproductive health and rights: a crosssectional study in Lahore District, Pakistan. *BMC International Health and Human Rights*, *17*(5), 1–13.

John, R., Salleh, M., & Farid, N. (2024). Utilization of Sexual Reproductive Health Services Among Youths in Malaysia: A Cross- Sectional Study Applying Andersen's Behavioral Model of Healthcare Utilization. *Cureus, 16*(5), e60230. DOI 10.7759/cureus.60230.

Jones, N., Presler-Marshall, E., Baird, S., Hicks, G., Yadete, W., & Alemayehu, Y. (2019). Adolescent bodily integrity and freedom from violence in Ethiopia. *A Report on GAGE Ethiopia Baseline Findings. London: Gender and Adolescence: Global Evidence*.

Kamau, W. . (2016). *Factors influencing access and utilization of preventive reproductive health services by adolescents in Kenya: A case study of Murang'a District*. University of Bielefeld, Germany.

Kamwine, J. (2022). *Challenges faced by providers of sexual and reproductive health services in Kampala*. Makerere University.

Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a research paradigm and its implications for Social Work research. *Social Sciences*. https://doi.org/10.3390/socsci8090255

Keite, M. (2020). *Adolescent Sexual and Reproductive Health Tookit Humanitarian Settings: Acompanion Inter-Agent Field Manual on the Reproductive Health in Humanitarian Settings*. Inter-Agency Working Group Reproductive Health in Crises.

Khanal, P. (2016). *Adolescents knowledge and perception of sexual and reproductive health and services- A study from Nepal*. University of Eastern Finland, Kuopio.

Kibira, D. (2021). *Access to sexual and reproductive health medicines and supplies in Sub-Saharan Africa*. Universiteit Utrecht.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120–124.

Lamort, W. (2019). *The Social Cognitive Theory*. Boston University.

Langat, E., Mohiddin, A., Kidere, F., Omar, O., Akuno, J., Naanyu, V., & Temmerman, M. (2024). Challenges and opportunities for improving access to adolescent and youth sexual and reproductive health services and information in the coastal counties of Kenya: a qualitative study. *BMC Public Health*, *24*(484), 1–11.

Levesque, J., Harris, M., & Russell, G. (2023). Patient-centered access to health care conceptualizing access at the interface of health systems and populations. *Int J Equ Health*, *12*(1), 1–9.

Lugoya, H. (2019). *Factors contributing to high prevalence rate of teenage pregnancy in Uyui District Council*. Institute of Social Work.

Lumonje, I. (2019). *Utilization of the sexual and reproductive healthcare service among youth living on the streets in Nakuru County, Kenya*. Kenyatta University.

Lutende, A. (2016). *Adolescents awareness of youth friendly reproductive health services in public health facilities: The case of Ilala Municipality*. The Open University of Tanzania.

Manoti, M. . (2015). *Factors influencing access to sexual reproductive health services: A case of the University of Nairobi Main Cumpus Undergraduate Students Institute of Anthropology African Studies in Kenya*. University of Nairobi.

Marshall, P., Adebamowo, C., Adeyemo, A., & Zhou, J. (2014). Voluntary participation and comprehension of informed consent in a genetic epidemiological study of breast cancer in Nigeria. *BMC Medical Ethics, 1*(2), 25–34.

Maxwell, J. . (2012). Qualitative Research Design: An Interactive Approach. *Sage*.

Mbeba, R. ., Mkuye, M. ., Magembe, G. ., Yotham, W. ., Mellah, A. ., & Mkuwa, S. . (2012). Barriers to Sexual Reproductive Health Services and Rights among Young People in Mtwara District, Tanzania: A Qualitative Study. *Pan African Medical Journa*, *13*(13).

Mbuh, H., & Kahugu, S. (2020). *Cancer in adolescents, the social developmental challenges in identity formation: A systenatic literature review*. Lapland University of Applied Sciences.

Ministry of Health and Social Welfare. (2011). *National Adolescent's Reproductive Health Strategy. Dar-es-salaam.*

Misinde, C., Nansubuga, E., & Nankinga, O. (2018). Out of school female adolescent employment status and sexually transmitted infections (STIs) risk in Uganda: is it a plausible relationship? *BMC Public Health*, *18*(1173).

Mngadi, P. ., Faxelid, E., Zwane, I. ., Hojer, B., & Ransjo-Arvidson, A. . (2018). Health Provider's Perceptions of Adolescent Sexual and Reproductive Health Care in Swaziland. *International Nursing Review*, *55*, 148–155.

Mohamed, S., Nmadu, A. ., & Usman, N. . (2020). Barriers to adolescents' access and utilisation of reproductive health services in a community in north- western Nigeria: a qualitative exploratory study in primary care. *Afr J Prim Health Care Fam Med*, *12*(8), 1–8.

Morse, J. . (2015). Analytic strategies and sample size. *Qualitative Health Research*, *25*(10), 1317–1318.

Mrisho, M., Mantel, M., Kabanywanyi, A., Fakih, B., Manzi, F., & Mtenga, S. (2022). Understanding Sexual and Reproductive Health Needs of Adolescents:

Evidence from a Formative Study in Three Districts of Lake Regions in Tanzania. *J Gynecol Reprod Med*, *6*(4), 170–179.

Muganyizi, J. (2021). *Assessment on the application of sexual and reproductive health education among Adolescents in Mvomero District. A Dissertation Report*. Sokoine University of Agriculture, Tanzania.

Mulegi, T., Laila, N., Roseanne, M., & Barongo, E. (2023). Assessment of the level of knowledge and awareness of women on sexual and reproductive health services (SRH) under decentralization in Kampala Uganda. *Inosr Arts and Humanities*, *9*(1), 35–47.

Murry, C., Momoh, O., & Rathburn, C. (2022). Population Definition in Statistics and How to Measure It. *Https://Www.Investopedia.Com/Terms/p/Population.Asp*.

Mutea, L., Ontiri, S., Kadiri, F., Michielesen, K., & Gichangi, P. (2020). Access to information and use of adolescent sexual reproductive health services: qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. *PLoS One*, *15*(11), e0241985. https://doi.org/doi:10.1371/journal

Mutende, M. . (2016). *Adolescents' awareness of youth friendly reproductive health services in public health facilities: The case of Ilala Municipality*. The Open University of Tanzania.

Mwandali, K. ., Msuya, E. ., & Mwakanyamale, A. . (2020). Availability, Range and Utilization of Sexual and Reproductive Health (SRH) Services for Adolescents at Kinondoni Municipality, Dar es Salaam—Tanzania. *Open Journal of Nursing*, *10*, 286–307.

Nabavi, R. ., & Bijandi, M. (2012).). Bandura's social learning theory & social cognitive learning theory. *Theories of Developmental Psychology*, 14–15.

Naik, G., Behera, J., Patra, D., & Jena, S. (2024). Adolescent marriage a violation of sexual and reproductive health rights: Trend, spatial variation and covariate analysis from national family health survey. *Clinical Epidemiology and Global Health*.

Ndayishimiye, N. (2020). Availability, Accessibility, and Qualirt of Adolescent Sexual and Reproductive Health (SRH) Services in Urban Health Facilities of Rwanda. A survey among social and health care providers BMC. *Health Services Research*, *20*(1), 1–11.

Ndugga, P., Kwagala, B., Wandera, S., Kisaakye, P., Mbonye, M., & Ngabirano, F. (2023). "If your mother does not teach you, the world will…": a qualitative study of parentadolescent communication on sexual and reproductive health issues in Border districts of eastern Uganda. *BMC Public Health*, *23*(678).

Ngomi, K. (2018). *Utilization of sexual and reproductive health services by secondary school adolecents in Mochudi*. University of South Africa.

Nickerson, C. (2024). Interpretivism Paradigm & Research Philosophy. *Retrieved from Https://Www.Simplypsychology.Org/Interpretivism-Paradigm.Html on September 7, 2024*.

Nikolopoulou, K. (2022). What Is Convenience Sampling? Definition & Examples. *Retrieved from Https://Www.Scribbr.Com/Methodology/Convenience-Sampling/ on March 21, 2024*.

Ninsiima, L., Chiumia, K., & Ndejjo, R. (2021). Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. *Reprod Health*, *18*(135), 1–17. https://doi.org/https://doi.org/10.1186/s12978-021-01183-y

Nkonde-Bwalya, B. (2016). *Factors affecting access to and utilization of reproductive health services among adolescents in Lusaka district: Case of Kamanga Compound*. University of Zambia.

Odo, A. ., Samuel, E. ., Nwagu, E. ., Nnamani, P. ., & Atama, C. . (2018). Sexual and reproductive health services (SRHS) for adolescents in Enugu state, Nigeria: a mixed methods approach. *BMC Health Serv Res*, *18*(1), 1–12.

Pan American Health Organization. (2016). *"Linking Sexual and Reproductive Health and Gender Programs and Services with Prevention of HIV/STI."*

Pankhurst, A., Crivello, G., & Tiumelissan, A. (2018). Children's Work in Family and Community Contexts: Examples from Young Lives Ethiopia. *Oxford: Young Lives, Oxford Department of International Development (ODID), University of Oxford*.

Perkins, J., Rahman, A. E., Mhajabin, S., Siddique, A. B., Mazumder, T., Haider, M. R., & El Arifeen, S. (2019). Humanised childbirth: the status of emotional support of women in rural Bangladesh. *Sexual and Reproductive Health Matters*, *27*(1). https://doi.org/10.1080/26410397.2019.1610277

Petroni, S., Das, M., & Sawyer, S. (2019). Protection versus rights: age of marriage versus age of sexual consent. *The Lancent Child & Adolescent Health*, *3*(4), 274–280.

Quinn, M. (2002). *Qualitative Research & Evaluation Methods* (3rdEd ed.). Sage Publications.

Rangi, W., & Mwageni, E. (2018). *The Role of Sexual Reproductive Health Education in Adolescents: Sexual Behaviours in Secondary Schools in Morogoro Municipality, Tanzania*. The Open University of Tanzania.

Sidamo, N. (2022). Social Ecological Model Analysis of Barriers to Access and Utilization of Adolescents Sexual and Reproductive Health Services in Sub Saharan Africa. *Reproductive Health Journal*, *18*(2), 24–32.

Sidamo, N., Kebo, A., & Dibaba, Y. (2024). Exploring Barriers to Accessing Adolescents Sexual and Reproductive Health Services in South Ethiopia Regional State: A Phenomenological Study Using Levesque's Framework. *Adolescent Health Medicine and Therapeutics*, 45–61. https://doi.org/DOI:10.2147/AHMT.S455517

Siedlecki, S. (2020). Understanding Descriptive Research Designs and Methods. *Clinical Nurse Specialist (CNS)*, *34*(1), 8–12.

Smith, A. (2017). *Communication strategies used during organizational change in a health care organization. Unpublished Walden Doctoral dissertation*. Walden University.

Tilahun, D. ., Yilak, G., Amena, A., Abebe, G., & Ayele, M. (2023). Exploring the perceptions of health service providers and adolescents on the utilization of adolescent sexual and reproductive health services in Tikur, 2023: A qualitative study. *SAGE Open Medicine*, *12*, 1–12.

Tong, A., & Dew, M. (2016). Qualitative study in transplantation: Ensuring relevance and rigor. *Transplantation*, *100*(4), 710–712.

United Nations Children's Fund (UNICEF). (2019). *Adolescents in Tanzania. Communication, Advocacy and Partnerships Section:* UNICEF Tanzania.

United Nations. (2023). Department of economic social affoirs, population dision. Adolescents data. *Retrieved from Https://Www.Researchgate.Net/Deref/Https%3A%2F%2Fdata.Unicef.Org%2Ftopic%2Fadolescents%2Foverview%2F%2F?_tp=eyJjb250ZXh0Ijp7ImZpc*

nN0UGFnZSI6InB1YmxpY2F0aW9uIiwicGFnZSI6InB1YmxpY2F0aW9uIn19 on August 12, 2024.

United Republic of Tanzania (URT). (2015). National Adolescent Reproductive Health Strategy 2011-2015. *Ministry of Health and Social Welfare*.

World Health Organization (WHO). (2019). Adolescent pregnancy. *Retrieved from Http://Www.Who.Int/News-Room/Fact-Sheets/Detail/Adolescent-Pregnancy on 15/07/2024*.

World Health Organization (WHO). (2023a). Adolscent pregnancy. *Retrieved from Https://Www.Researchgate.Net/Deref/Https%3A%2F%2Fwww.Who.Int%2Fnews-Room%2Ffact-Sheets%2Fdetail%2Fadolescent-Pregnancy?_tp=eyJjb250ZXh0Ijp7ImZpcnN0UGFnZSI6InB1YmxpY2F0aW9uIiwicGFnZSI6InB1YmxpY2F0aW9uIn19 on August 12, 2024*.

World Health Organization (WHO). (2023b). *World Health Statistics: Monitoring Health for SDGs, Sustainable Development Goals License:*

Yakob, B., & Ncama, B. (2020). A socio-ecological perspective of access to and acceptability of HIV/AIDS treatment and care services: a qualitative care study research. *BMC Public Health*, *16*(1), 1–15.

Yin, R. (2018). *Case study: Design and methods* (6th ed.). Sage Inc.

APPENDICES

Appendix I: Interview guideline for adolescents

1. Capture the socio-demographic characteristics of respondents (Age, Gender, Marital status, Education level, and Occupation)
2. In your opinion, do you think it is necessary for you to obtain sexual and reproductive health services? Why …….
3. Are you aware on the sexual and reproductive health services that you are supposed to get? Please, can you identify such services? …….. (**Probe on** *right to information and education on SRH, freedom of thoughts on SRH, right to consent to marriage, right to decide number and spacing children, free from violence, and family planning*).
4. Is sexual and reproductive health service available in your area? How do you get it?
5. What kind of sexual and reproductive health services are available in your area? (**Probe on:** *availability of health care providers for SRH, availability of adolescent-friendly SRH service, availability of life skills and education programs, availability of stock out of commodities, open discussion on SRH, and availability of guidance and counselling service*)
6. What are intrapersonal challenges do you/adolescents face in accessing sexual and reproductive health services? Please, explain….. (**Probe on:** *intrapersonal challenges such as: inadequate information about SRH, incorrect perception*

about SRH services, low self-esteem, fear of being noticed by family members, and financial constraints).

7. What are interpersonal challenges do you/adolescents face in accessing SRH service? Please, explain ……. (**Probe on:** *unsupportive families, and lack of open communication between adolescents and parents about sexuality issues*).
8. What are institutional-based challenges do you/adolescents face in accessing SRH service? Please, explain ……. (**Probe on:** *lack of health care providers' competency, health care providers' attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines*).
9. Do you have anything to add about the accessibility of sexual and reproductive health services among adolescents? Please, explain …….

Thank you for your cooperation!

Appendix II: Interview guideline for Parents/Guardians

1. Capture the socio-demographic characteristics of respondents (Age, Gender, Marital status, Education level, and Occupation)
2. In your opinion, do you think it is necessary for adolescents to obtain sexual and reproductive health services? Why …….
3. Do you think adolescents are aware with sexual and reproductive health services that they are supposed to get from level of family to the level of community? Please, can you identify such services in which adolescents are aware of? …….. (**Probe on:** *right to information and education on SRH, freedom of thoughts on SRH, right to consent to marriage, right to decide number and spacing children, free from violence, and family planning*).
4. Do adolescents, including your child get sexual and reproductive service in your area? How do they get it? ……
5. What kind of sexual and reproductive health services are available in your area for adolescents? (**Probe on:** *availability of health care providers for SRH, availability of adolescent-friendly SRH service, availability of life skills and education programs, availability of stock out of commodities, open discussion on SRH, and availability of guidance and counselling service*)
6. What are intrapersonal challenges do adolescents face in accessing sexual and reproductive health services? Please, explain….. (**Probe on:** *intrapersonal challenges such as: inadequate information about SRH, incorrect perception*

about SRH services, low self-esteem, fear of being noticed by family members, and financial constraints).

7. What are interpersonal challenges do adolescents face in accessing SRH service? Please, explain ……. (**Probe on:** *unsupportive families, and lack of open communication between adolescents and parents about sexuality issues*).
8. What are institutional-based challenges do adolescents face in accessing SRH service? Please, explain ……. (**Probe on:** *lack of health care providers' competency, health care providers' attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines*).
9. What efforts do you do in the level of family to make sure that your child receives sexual and reproductive health services? Explain ……..
10. Do you have anything to add about the accessibility of sexual and reproductive health services among adolescents? Please, explain …….

Thank you for your cooperation!

Appendix III: Interview guideline for Health Care Providers

1. Capture the socio-demographic characteristics of respondents (Age, Gender, Marital status, Education level, and Experience of working in years).
2. In your opinion, do you think it is necessary for adolescents to obtain sexual and reproductive health services? Why …….
3. Do think adolescents are aware with sexual and reproductive health services that they are supposed to get from level of family to the level of community? Please, can you identify such services in which adolescents are aware of? …….. (**Probe on:** *right to information and education on SRH, freedom of thoughts on SRH, right to consent to marriage, right to decide number and spacing children, free from violence, and family planning*).
4. Do adolescents, including your child get sexual and reproductive service in your area? How do they get it? ……what is your role as a health care provider in making sure that adolescents get sexual and reproductive health services in your area? ……..
5. What kind of sexual and reproductive health services are available in your area for adolescents? (**Probe on:** *availability of health care providers for SRH, availability of adolescent-friendly SRH service, availability of life skills and education programs, availability of stock out of commodities, open discussion on SRH, and availability of guidance and counselling service*)
6. What are intrapersonal challenges do adolescents face in accessing sexual and reproductive health services? Please, explain….. (**Probe on:** *intrapersonal*

challenges such as: inadequate information about SRH, incorrect perception about SRH services, low self-esteem, fear of being noticed by family members, and financial constraints).

7. What are interpersonal challenges do adolescents face in accessing SRH service? Please, explain ……. (**Probe on:** *unsupportive families, and lack of open communication between adolescents and parents about sexuality issues*).
8. What are institutional-based challenges do adolescents face in accessing SRH service? Please, explain ……. (**Probe on:** *lack of health care providers' competency, health care providers' attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines*).
9. What efforts do you make in the level of institutional you work with to make sure that adolescents are enabled to receive sexual and reproductive health services? Explain ……..
10. Do you have anything to add about the accessibility of sexual and reproductive health services among adolescents? Please, explain …….

Appendix V: CLEARANCE LETTERS

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

THE OPEN UNIVERSITY OF TANZANIA

Ref. No OUT/PG202101699 **2nd October, 2024**

Municipal Director,

Mwanza Municipal Council,

P.O.Box 1333,

MWANZA

Dear Director,

RE: RESEARCH CLEARANCE FOR MR. ADROPH RUTECHURA GRATION, REG NO: PG202101699

2. The Open University of Tanzania was established by an Act of Parliament No. 17 of 1992, which became operational on the 1st March 1993 by public notice No.55 in the official Gazette. The Act was however replaced by the Open University of Tanzania Charter of 2005, which became operational on 1st January 2007.In line with the Charter, the Open University of Tanzania mission is to generate and apply knowledge through research.

3. To facilitate and to simplify research process therefore, the act empowers the Vice Chancellor of the Open University of Tanzania to issue research clearance, on behalf of the Government of Tanzania and Tanzania Commission for Science and Technology, to both its staff and students who are doing research in Tanzania. With this brief background, the purpose of this letter is to introduce to you **Mr. Adroph Rutechura Gration Reg.No: PG202101699),** pursuing **Master of Social Work (MSW).** We here by

grant this clearance to conduct a research titled **"Examining the Accessibility of Sexual and Reproductive Health Services among Adolescents in Nyamagana District, Tanzania.** He will collect his data at your office from 3rd October to 30th November 2024.

4. In case you need any further information, kindly do not hesitate to contact the Deputy Vice Chancellor (Academic) of the Open University of Tanzania, P.O.Box 23409, Dar es Salaam. Tel: 022-2-2668820.We lastly thank you in advance for your assumed cooperation and facilitation of this research academic activity.

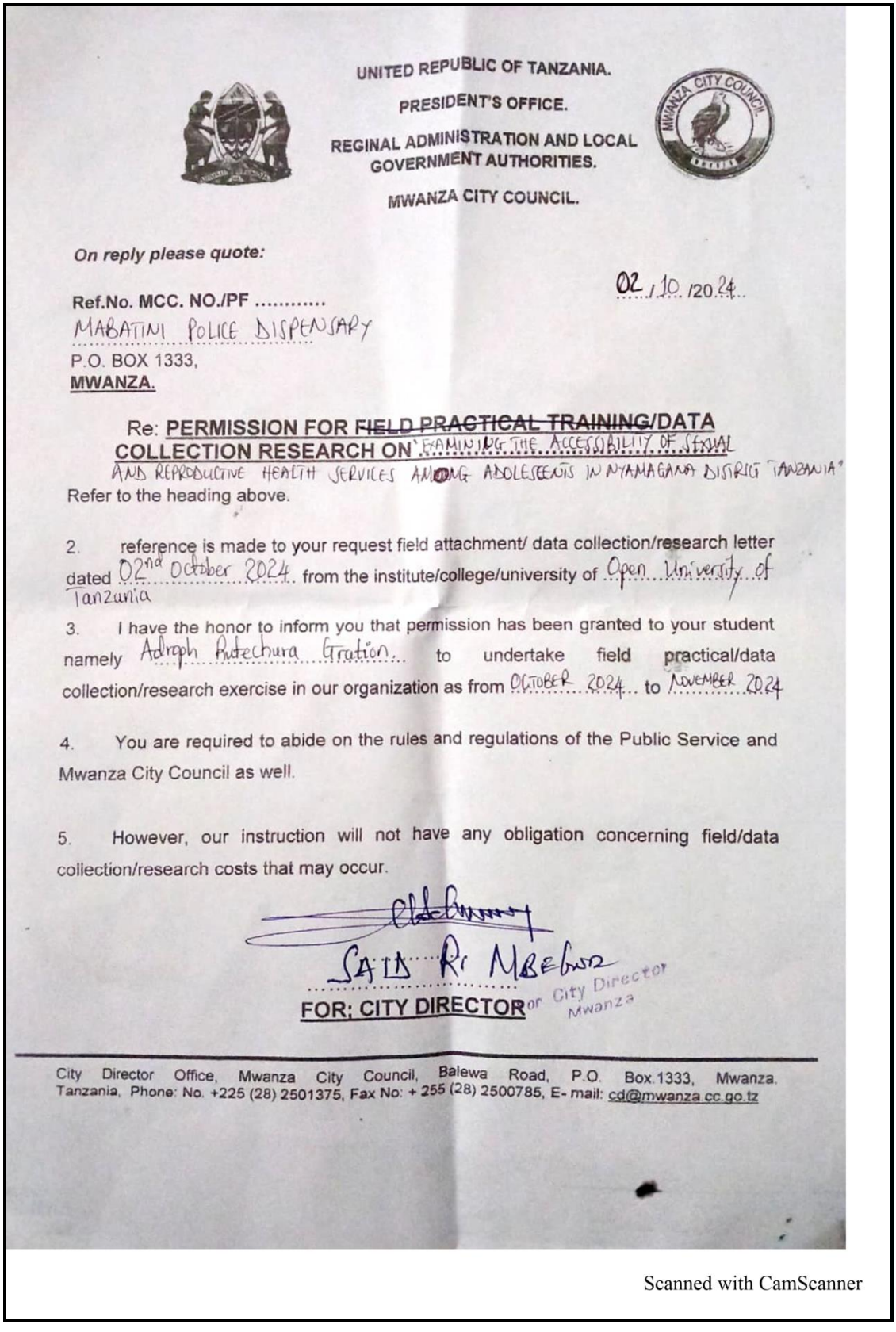
Yours sincerely,

THE OPEN UNIVERSITY OF TANZANIA

Prof.Gwahula Raphael Kimamala

For: VICE CHANCELLOR

Kinondoni Biafra, Kawawa Road; P.O 23409; Dar es Salaam; Tel: +255 22 2668 445;
E-Mail:vc@out.ac.tz|| Website:www.out.ac.tz



UNITED REPUBLIC OF TANZANIA.

PRESIDENT'S OFFICE.

REGINAL ADMINISTRATION AND LOCAL GOVERNMENT AUTHORITIES.

MWANZA CITY COUNCIL.

On reply please quote:

02/10/2024

Ref.No. MCC. NO./PF .....

MABATINI POLICE DISPENSARY

P.O. BOX 1333,

MWANZA.

Re: **PERMISSION FOR ~~FIELD PRACTICAL TRAINING~~/DATA COLLECTION RESEARCH ON** EXAMINING THE ACCESSIBILITY OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS IN NYAMAGANA DISTRICT TANZANIA"

Refer to the heading above.

2. reference is made to your request field attachment/ data collection/research letter dated 02nd October 2024. from the institute/college/university of Open University of Tanzania

3. I have the honor to inform you that permission has been granted to your student namely Adroph Rutechura Gration.. to undertake field practical/data collection/research exercise in our organization as from OCTOBER 2024.. to NOVEMBER 2024

4. You are required to abide on the rules and regulations of the Public Service and Mwanza City Council as well.

5. However, our instruction will not have any obligation concerning field/data collection/research costs that may occur.

SALIM R. MBEGU

FOR: CITY DIRECTOR City Director Mwanza

City Director Office, Mwanza City Council, Balewa Road, P.O. Box 1333, Mwanza. Tanzania, Phone: No. +225 (28) 2501375, Fax No: + 255 (28) 2500785, E- mail: cd@mwanza.cc.go.tz

The Examination the Challenge Facing the Adolescents in Accessing the Sexual and Reproductive Health Services.

Adroph G. Rutechura, Johnas Amon Buhori (PhD), & Emmanuel P. Mhache (Prof)

The Open University of Tanzania, Department of Sociology and Social Work

ABSTRACT

This study assessed the challenges facing adolesecent when accessing of sexual and reproductive health (SRH) services in Nyamagana district. Specifically, the study evaluated adolescents' awareness of SRH services, utilization of SRH services by adolescents, and challenges facing adolescents in accessing SRH services. The study was guided by Social Cognitive Theory, developed by Albert Bandura, an interpretivism philosophy with a cross-sectional design. A qualitative approach was employed, and 30 participants were involved. Data were collected by using an interview. Data analysis involved thematic analysis. Results indicated that access to SRH services by adolescents was influenced by the level of awareness, such as awareness of the right to information and education on SRH service, freedom of thought on SRH, and right to decide the number and spacing of children, and freedom from violence. The study also found the utilization of SRH services among adolescents depended on the availability of healthcare providers for SRH service, adolescent-friendly SRH service, life skills and education programs, and stock-out commodities. Results also indicated the challenges that hindered access to SRH among adolescents to include intrapersonal challenges, interpersonal, and institutional levels. The study concludes that access to SRH services

in the Nyamagana district was influenced by adolescents' level of awareness of SRHS services and utilization of SRH services. The study recommends that the government under the Ministry of Health of Tanzania and other health practitioners in the Nyamagana district should inform adolescents about the importance of SRH services.

Introduction

It is important to note, adolescents are a significant demographic group; the statistics estimate adolescents to be 1.3 billion (United Nations, 2023). Moreover, even though the comprehensive knowledge of Sexual and Reproductive Health (SRH) problems is increasing around the world, many adolescents do not get a chance to obtain information or means of protecting themselves from these problems (Chandra & Akwara, 2020). Of course, adolescents contribute to many health problems. For instance, globally, each year, nearly 21 million adolescents aged 15 to 19 years become pregnant, approximately 12 million of these adolescents give birth, and 5.6 million are shown to undergo abortion (World Health Organization, 2023a).

The concepts of sexual and reproductive health (SRH) were adopted for the first time by governments under the aegis of the United Nations at the International Conference on Population and Development (ICPD) in Cairo (Sidamo, 2022). ICPD laid out a bold, clear, and comprehensive definition of reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (WHO, 2019). The ICPD Programme of Action (PoA) was forward-looking

in many areas of sexual reproductive health and rights, particularly about adolescents and young people. The ICPD program provides ways of dealing with youth health by promoting reproductive health services that are effective and accessible to all youth, especially in developing countries (Chiumia et al., 2021).

Besides, it is also known globally that access to health care is the extent to which the health system adjusts, inhibits, or initiates the individuals' willingness and ability to use, receive, and benefit from and achieve satisfaction with health services (Levesque et al., 2023). In this case, this is getting to know, searching, entering, and traversing, as well as satisfaction with the care and benefit from the outcomes of the health services. In addition, it is not also limited to consulting healthcare providers and/or getting prescriptions (Yakob & Ncama, 2020). It is well known that improvement in access to sexual and reproductive health services is a critical component of universal health coverage. It is one of the components of Sustainable Development Goals (SDGs) targets (targets 3.7, 3.8, and 5.6) (World Health Organization, 2023b). It is also essential to the World Health Organization (WHO) adolescent-reproductive health services (Envuladu et al., 2023).

In Sub-Saharan Africa (SSA), statistics indicate that adolescents comprise about 25% of the population (Sidamo et al., 2024). However, SRH-related problems problems remain a significant health concern for adolescents aged 10-19 years (World Health Organization, 2023a). Adolescents in African countries are engaging in health-risk sexual behaviors (Addila, 2020). Moreover, this early engagement in sexual activity has

had detrimental effects on adolescents' morbidity, prematurely exposing them to the inevitable consequence of sexually transmitted infections, including HIV/AIDs, unintended pregnancy, unsafe abortion, and premature death (Dadzie et al., 2022). For example, the latest 2023 report from UNICEF indicates that in 2022 alone, 140,000 adolescents between the ages of 10 and 19 were nearly infected with HIV (Abdurahman & Oljira, 2022). In addition, more than a quarter of girls and women in SSA cannot access family planning services, fueling unplanned pregnancies and spreading HIV and other sexually transmitted diseases.

Furthermore, in most countries, adolescents are often denied access to reproductive health services, partly due to societal beliefs about sexual behaviors and contraception and policies and regulations that prevent youth from receiving reproductive health services. Some policies do not permit or expressly guarantee adolescents access to sexual and reproductive health because of some cultures and norms and thus increased unplanned pregnancies, STIs and HIV, and unsafe abortions (Sidamo, 2022).

In Tanzania, adolescents aged 15-24 are sexually active and engage in high-risk sexual behavior. In addition, adolescents comprise 32% of the population in the country. Furthermore, this group is more likely than any other to engage in unplanned and unprotected sex with multiple partners. Moreover, adolescent females lacked the skills to negotiate safer sex practices (Ninsiima et al., 2021). This leads them to face many significant SRH challenges, such as limited access to information on growth, sexuality, and family planning. This leads them to risky sexual behaviors, resulting in high STI and

HIV prevalence and early pregnancy. An estimated 16 million girls aged 15-24 give birth every year, representing 11% of all births but almost a quarter of the ill health related to pregnancy and childbirth, including the consequences of unsafe abortion (Keite, 2020).

Furthermore, many Tanzania communities fear providing sexual and reproductive education to youth with the feeling that the education will promote destructive behaviors among adolescents and hence be reluctant to encourage the use (Sidamo, 2022). Moreover, adolescents who live in settings where considerable traditional norms and taboos regarding sexual behavior persist, particularly about premarital sex, face the challenge of accessing reproductive health services. These socio-cultural norms create significant barriers that limit young people's access to information and services (Chiumia et al., 2021).

Besides, sexual and reproductive health rights entail legal rights and freedoms relating to sexual health, reproduction, and reproductive health. SRH services include but are not limited to the right to access high-quality birth control, freedom from coerced sterilization and contraception, the right to access good quality maternal health care, the right to access safe abortion and post-abortion care, and the right to access education and information on sexual and reproductive health in order to be able to make free and informed reproductive choices (Chandra et al., 2015). In addition, adolescents have the right to access education and information on protection from sexually transmitted

infections, sexual violence, and practices such as female genital mutilation (Petroni et al., 2019).

According to Keite (2020), Tanzania has provided reproductive health education and services to adolescents through school education, reproductive health programs, and mass media (television, radio, newspaper, and internet). The programs implemented by Tanzania support adolescents mainly by raising awareness of their entitlements and sexual and reproductive health rights, providing psychosocial support, and referring them to care for adolescents affected by HIV and STIs (Muganyizi, 2021).

Despite the existence of different programs for improving reproductive health services to adolescents, there are still several challenges, such as inadequate knowledge about the availability of youth and adolescent sexual and reproductive health services, poor effectiveness of reproductive health services, and poor attitude of some health care providers leading to poor quality of services (WHO, 2019). United Nations Children's Fund (UNICEF, 2019) reported that only 8.6 percent of adolescents have access to reproductive health services through school and reproductive health programs, while 24% of the rest of adolescents continue to face obstacles to receiving services. Adolescents are found to be more vulnerable to unplanned pregnancies, HIV, and sexually transmitted diseases (Chiumia et al., 2021). In addition, it is understood that social work plays a vital role in developing adolescent intervention models. This study, therefore, examines the gaps in the accessibility and effectiveness of reproductive health services for adolescents in Mwanza.

The National Adolescents Reproductive Health Strategy (2011-2015) of Tanzania describes the needs of adolescents in accessing Sexual and Reproductive Health (SRH) services. The needs include information, advice, service, rights, provider competence, policies, management systems, and community and parental support (Lutende, 2016). However, the situation in the community does not reflect this strategic plan; adolescents often face numerous barriers to obtaining the necessary information and services related to their sexual and reproductive health. These barriers can be categorized into socio-cultural, economic, legal, and health system-related factors, each contributing to the limited accessibility and utilization of SRH services by this age group. Further, this situation is associated with a lack of awareness among the community on issues facing adolescents in accessing sexual and reproductive health services. Due to traditional customs, it is not allowed for the parents to discuss sexual and reproductive health with his/her children (Lutende, 2016). These factors often lead to misinformation, fear, and shame, preventing adolescents from seeking the help they need; economic barriers, such as the cost of services and transportation, disproportionately affect adolescents from low-income backgrounds, limiting their access to essential health care.

Addressing adolescents' accessibility to SRH services is critical for promoting their overall health and rights. Moreover, little information exists on the real situation facing adolescents in accessing SRH services. This study, therefore, needs to bridge the gap by developing a bank of information based on adolescents' access to SRH services. While general factors affecting the accessibility of sexual and reproductive health services among adolescents have been widely studied (Addae, 2021; Dzinoreva, 2021; Mulegi et

al., 2023; Sidamo, 2022), to mention a few based in different places out of Tanzania, this has led to voids in the body of knowledge concerning specific factors in Nyamagana district in Tanzania. This is because factors may vary due to different geographical locations. Therefore, specifically, this study intends to assess the level of awareness, availability of SRH services, and challenges adolescents face in accessing SRH services in the Nyamagana district. Filling these gaps in the existing knowledge body could help mitigate barriers to accessing SRH services among adolescents, specifically in the study area.

Theoretical Review

This study was guided by the Social Cognitive Theory (SCT), developed by Albert Bandura in 1974, also known for his work on observation learning, self-efficacy, and reciprocal determinism. The SCT emphasizes learning within a social context; however, learning always emphasizes awareness of any learned social aspect. In this view, people are active agents who can both influence and are influenced by their environment (Lamort, 2019). The SCT shows how the variables (environment, personal characteristics, and social factors) contribute to mold youths' reproductive health; if utilized in the right way, they contribute to the prevention, promotion, access, and management of reproductive health issues, thus resulting in good health (Bandura, 1998). The SCT integrates behavior and cognitive explanations for human behavior. Central to Social Cognitive Theory is the notion that humans do not passively respond to past or current environmental influences; however, humans can foresee the

consequences of our actions. The cognitive outcomes formed by humans allow them to appraise the potential consequences of engaging in any given behavior and thus determine which behavior humans will engage in (Dale & Maria, 2023).

Furthermore, the SCT also describes that the same processes, such as modeling and reinforcement, continue to influence sex-typing in similar ways as children become older. Through such experiences, children develop outcome expectancies and self-efficacy beliefs that serve to motivate and regulate gender role conduct. As children mature, their social worlds expand beyond the home and limited peer contexts, and they are exposed to a greater prevalence of male and female exemplars and social agents who teach and encourage sex-typed behaviors and attributes (Dale & DiBenedetto, 2023).

The theory also explains that exposure and a more remarkable ability to organize and abstract social information increases as children age. As children's cognitive and verbal skills improve, parents are likely to broaden the scope of their gender socialization through their conversations and interactions with their children. At the same time, peers are thought to act as powerful socializing agents through modeling, social sanctions, and serving as cooperative references for approval of personal efficacy (Dale & DiBenedetto, 2023).

In reflection of this study, the SCT is valid in determining persons' perceptions (beliefs) or awareness of individuals' accessibility to sexual and reproductive health services among adolescents. The theory highlights the need for change in belief (Lamort, 2019); in this case, the study applied this theory to determine a person's actions regarding

access to sexual and reproductive health services among adolescents, which may cause positive or negative outcomes. The theory is also significant to this study because it changes the associated behavior and attitudes as the children age. As the children become older, they need self-efficacy service utilization; this means they also need to make effective utilization of sexual and reproductive health services (Nabavi & Bijandi, 2012). Therefore, this concept from the theory was applied in this study to establish a link between Adolescents and utilization of sexual and reproductive health. Further, the theory has also described that as children age, parents have challenges conversing with them. Parents tend not to make conversation about sexual and reproductive health with their children. This affects the children in the whole process of accessing education and information concerning sexual and reproductive health (Nabavi & Bijandi, 2012). It is through this concept from the theory that the study has examined the challenges that adolescents face in access to sexual and reproductive health services.

Methods and Materials

This study adopted an **interpretivist research philosophy**, which is suitable for qualitative research as it considers reality as socially constructed and subjective (Kaushik & Walsh, 2019). A **cross-sectional research design** was used, allowing for data collection at a single point in time, making it efficient in terms of time and cost (Bryman and Bell, 2011). The **qualitative research approach** was employed to gain in-depth insights into the accessibility of sexual and reproductive health (SRH) services. The study focused on **Mabatini ward in Nyamagana district, Mwanza region**, an area with high reproductive health service activity and significant childbearing rates. The

target population included adolescents (aged 15-19), parents/guardians, and healthcare providers, totaling 16,636 adolescents. A **sample size of 30 participants** was determined based on the saturation point.

Inclusion criteria encompassed adolescents aged 15-19, parents/guardians, and healthcare providers in Mabatini ward, while all others were excluded. **Semi-structured interviews** were conducted to collect data, as they allow for a flexible and comprehensive exploration of participants' views. Holland and Linvill (2023) to ensure **data credibility and reliability**, trustworthiness was maintained through credibility, transferability, dependability, and confirmability. **Thematic analysis** was used for data interpretation, identifying patterns and themes in participants' responses. Yin (2018) **Ethical considerations** were upheld, including obtaining university clearance, informed consent, confidentiality, anonymity, and voluntary participation. Participants were assured that their identities would remain anonymous, and their responses would not be linked to personal identifiers (Marshall et al., 2014).

Findings Presentation and Discussion

it is essential to note that the current study was undertaken in the context of the proposal and actual attempts at the accessibility of sexual reproductive health services among adolescents in the Nyamagana district, Mwanza region. Moreover, the chapter starts by presenting the socio-demographic characteristics of all participants.

Socio-Demographic Characteristics of Participants

The study involved 30 participants from the Mabatini ward, Nyamagana districts. It is also essential to recognize that the sample size was reached at 100% because it was predicted to be 30 participants in a proposal. However, the final sample size was to be made after reaching a saturation point. This means the saturation point was reached at the predicted sample size. Moreover, it is also essential to recognize that the study considered the demographic profile of participants during data collection because it is believed that in social sciences research, the personal characteristics of participants have a very significant role to play in expressing and giving responses about problems. Furthermore, keeping in mind, this study examined a set of personnel characteristics, namely age, gender, marital status, education level, and occupation. The results are illustrated in Table 4.1.

The findings of age of respondents indicate more than half 20(66.7%) of respondents their age ranged from 15-19 years old, followed by 4(13.3%) ranged from 40 years and above, 2(6.7%) ranged from 20-24 years, and 2(6.7%) ranged from 35-39 years. These results revealed that the majority of participants in this study were adolescents. Furthermore, the variable age was examined in reflection of Manoti's (2015) views; there are sometimes age disparities in access to SRH services. Sadly, though, adolescents consider health a low to medium priority. Results on the sex of participants in this study indicated that out of 30 participants, 18(60.0%) were females, and 12(40.0%) were males. Furthermore, these results revealed that this study involved both genders; as stipulated by (Pan American Health Organization (2016), the gender

dimension is critical in sexual and reproductive health services. Gender serves as a foundation for building connections and linkages that should result in marked improvements in a variety of sexual and reproductive health indicators as well as indicators of the general sexual well-being of individuals, families, and communities. Additionally, the service planning process always is to recognize that people, regardless of their sex/gender identity. Moreover, the results regarding the marital status of participants of this study showed that in a total of 30 participants, 19(63.3%) were single, 8(26.7%) were married, and 3(10.0%) were widows/widowers. Besides, marriage is one of the vital events, and if adolescents go through marriage, then they will be exposed to various sexual reproductive activities for the long term. Therefore, they need proper knowledge of sexual and reproductive health services.

Besides, the variable marital status has been examined because marriage is a gateway that gives exposure to sexual reproductive health as well as pregnancy, abortion, and sexually transmitted infections (Naik et al., 2024). Further, results regarding education level indicated that out of 30 participants, 16(53.3%) had a secondary education level, 5(16.7%) certificates, 4(13.3%) primary, 3(10.0%) diplomas, and 2(6.7%) universities. The findings indicated that the study comprised people with different levels of education; additionally, all of them had gone to school, and it could be straightforward for them to receive sexual and reproductive health services. In line with Coral et al. (2022), education is a critical factor that often leads to social and economic empowerment, positively contributing to individuals' SRH services. In nutshel, the results indicated that of the 30 participants in this study, 21(70.0%) were unemployed,

5(16.7%) were self-employed, and 4(13.3%) were employed. Thus, most of the adolescents who participated in this study were unemployed. In addition, scholars like Misinde et al. (2018) indicated that employment status influences accessing sexual and reproductive health services. The low-wage and unemployed ones are at a greater risk of exposure to sexually transmitted infections (STIs) because they do not have enough resources to access sexual and reproductive health services. Employment, either it is by being employed or self-employed, offers females an avenue so that they are better able to access SRH services to reduce their exposure to STIs.

Table 1.1: Socio-demographic characteristics of respondents

Variable		Frequency (n=30)	Percent %
Age	15-19 years	20	66.7
	20-24 years	2	6.7
	25-29 years	1	3.3
	30-34 years	1	3.3
	35-39 years	2	6.7
	40 years and above	4	13.3
Sex	Female	18	60.0
	Male	12	40.0
Marital Status	Single	19	63.3
	Married	8	26.7
	Widow/widower	3	10.0
Education level	Primary	4	13.3
	Secondary	16	53.3
	Certificate	5	16.7
	Diploma	3	10.0
	University	2	6.7
Occupation	Unemployed	21	70.0
	Self-employed	5	16.7
	Employed	4	13.3

Level of Awareness of Adolescents in Accessing SRH Service

In the first objective, the study qualitatively explored adolescents' level of awareness in accessing sexual and reproductive health services in the Mabatini ward, Nyamagana district. Furthermore, different themes emerged regarding adolescents' level of awareness. The themes include the right to information on SRH, freedom of thought on SRS, correct consent to marriage, suitability to decide the number and spacing of children, freedom from violence, and family planning.

The Right to Information and Education on SRH

Participants of this study were found to have little awareness of their rights to access information and education on sexual and reproductive health services. In the interview with adolescents who participated in this study, the interviewees stated that the issue of accessing information and education on SRH is always under the parents who guide them not to talk openly about sexual and reproductive health education. Most of the adolescents in this study confirmed that they depended on their parents' instructions on the topic of sexual and reproductive health; it was unknown to them that they had the right to ask for information based on SRH. For example, one of the adolescents with this view stated that *"I live by responding to my parents' instructions, my parents always instructed me not to talk about sexual and reproductive issues because it is like I commit sins. This of course has put me into a position of not knowing more about sexual and reproductive services"* (Participant No. 4, Adolescent).

On the other hand, even parents were unaware of their children's right to access SRS. Most of them indicated that when children are left free to talk or to access sexual and reproductive health education, they will become sex workers. As one of the parents stated,*"I cannot allow my child to access sexual and reproductive education at the age of either 12 or 14 years old, this is because when they start talking about sexual issues they can become as those with see in bars they have become like sex workers"* (Participant No. 27, Parents)

These results revealed that both parents and adolescents in the study area lacked awareness of the right of access to sexual and reproductive health services by adolescents. However, the findings differ from the human rights perspectives; adolescents have the right to access information, skills, and services regarding their sexual and reproductive health (SRH), the right to participate in health and development programs that affect their lives, and the right to grow up in a safe and supportive environment (URT, 2015).

Freedom of Thought on SRH

The majority of the participants of this study, especially female adolescents, said that they were not aware of their right to freedom of thought on SRH because of gender inequality at the family and community levels. Boys are given more freedom to express their opinions, suggestions, and attitudes about SRH compared to girls, who are constantly living under a certain level of restriction, which at times compromises their sexual and reproductive health. One of the participants commented that, *"... We, girls*

face many problems, no one is there to listen to our thoughts to understand us, even when I am on monthly periods, I have to do household stuff and my brother might be somewhere playing with his friends, actually it hurts but no one gives me a chance to share my thoughts" (Participant No. 12, Adolescent).

In addition, other participants shared that adolescents who are boys are given more freedom of thought compared to adolescents who are girls. Boys are given chances to talk about sexual and reproductive issues with friends and parents. However, things go differently for girls. They are restricted from discussing or sharing anything about sexual and reproductive health. The community believes that giving girls, in particular adolescents, the right to share their opinions and thoughts about sexual and reproductive issues is like promoting prostitution. One of the adolescents confirmed that, *"…… I am two years older than my young brother, but I see him discussing sexual and reproductive health issues with my father, and I am restricted from doing so. The reason behind this is my parents think I can be a prostitute if I get a chance to share my thoughts about sexual and reproductive health issues"* (Participant No. 5, Adolescent).

Furthermore, healthcare providers shared their experiences; most parents do not give their children the right to freedom of sharing their thoughts concerning sexual and reproductive health. It has been a challenge even to allow their children to participate in clubs designed to provide opportunities to share their thoughts through discussions. One of the healthcare providers stated that, *"Sometimes adolescents are aware of the right to share their thoughts, however, they don't get platforms for doing so. Their parents don't*

like their children to participate even in clubs designed for adolescents. This has been a big challenge in our society" (Participant No. 30, Healthcare Provider)

Moreover, on the side of parents, freedom of thought on sexual and reproductive services is not an issue to consider for adolescents because when adolescents are allowed to talk or discuss sexual and reproductive health, it encourages them to try sexual intercourse, which later causes problems of sexually transmitted infections like HIV/AIDS. In addition, by doing so, the parent may lose the power to control their adolescent against having sexual intercourse. That is why adolescent girls are restricted from being included in discussions of sexual and reproductive health, *"It is not right to give all freedoms to a girl child, as you know parents use a lot of efforts to protect their girl children from having sexual intercourse. To give them a chance to share their opinions about sexual and reproductive health is the same as to allow them doing sexual intercourse, I cannot provide that stuff to my children"* (Participant No. 23, Parent)

The results revealed that freedom of thought on sexual and reproductive health among adolescents in the study area was affected by the parents who did not allow their children to participate in clubs to share their thoughts. Moreover, these results collaborate with the results by Tilahun et al. (2023) and Perkins et al. (2019), awareness of adolescents' freedom of thought was affected by different barriers, including SRH services, religious organizations, and parents who do not give their children a chance to share their opinions on SRH.

Right to Consent to Marriage

In the interviews, the researcher understood that in the study area, families always struggle to provide food and clothing for their children, let alone fees or other costs related to keeping their children in school. As a result, many families resort to marrying off their adolescents as a means of protecting them economically. Some adolescents agree to marry because they are unaware of the right to consent to marriage. One of the adolescents of this view argued that, *"I am married, my parents saw this as the only means of helping me economically. Through my marriage, they received cash for the bride price which reduced poverty in my family. However, there was no need to consent to that marriage because it was a willing of my parents, no one could oppose their willing"* **(**Participant No. 18, Adolescent).

Furthermore, healthcare providers confirmed that poverty has been a critical driver of adolescent marriage in the study areas. Other factors, such as the right to consent and the challenges marriage will bring, are not always considered. Most adolescents have been forced to be out of education and into a life of poor prospects, with an increased risk of violence, abuse, ill health, or early death; all these are influenced by early marriage, which is sometimes never considered a right to consent for it. As one of the healthcare providers pointed out, *"In this community, the way marriage is done denies adolescent girls their right to make vital decisions about marriage, they are always forced to be married to solve the families' economic challenges. They are not given the right to consent for that marriage, bad enough both adolescents and parents are unaware with this stuff"* (Participant 29, Healthcare Provider).

Besides, through interviewing the parents in the study area, it was understood that parents force their adolescent girls to be married because those adolescents reach an age that supports marriage. According to parents/guardians who participated in this study, 14 years of age and above is enough for an adolescent girl to be married. It has been difficult for a parent to continue caring for a child of 14 years and above. Moreover, parents/guardians declared the interest that they do not provide a chance for their children to consent to marriage. This is because of the level of poverty they face, which makes marriage not have other alternatives; it is only necessary for a child girl of 14 years and above to get married, *"No need to consent to marriage, the age of 14 years and above is enough for a girl child to be in a marriage institution. It is also a good way to reduce our level of poverty because we escape from the task of taking care of that child"* (Participant 22, Parent).

The results implied that adolescents and their parents/guardians lacked awareness of the right to consent to marriage; they are all driven by economic factors. In line with Kamau (2016) and Naik et al. (2024), marriage and sexual activity among adolescents were always not consented to, and this exposed them to greater risk. Thus, adolescents were more vulnerable to rape, harassment, and sexual exploitation because their right to consent was violated. In addition, many governments worldwide have raised the legal age of marriage to 18 years; some are considering raising the age of sexual consent. Without close-in-age exemptions, arguments to align the legal age of sexual consent with that of marriage would restrict the ability of adolescents to have sex legally. In contrast to international agreements that affirm 18 years as the minimum age for consent

to marriage, international human rights standards do not recommend specific age limits for sexual consent but urge recognition of adolescents as rights holders (Petroni et al., 2019).

Right to Decide Number and Spacing of Children

The interview reported that married adolescents understand the issue of deciding the number and spacing of children for their husbands. These participants reported that it is not easy for a woman to have a say on how many children of chooses to have; the husband decides to decide whether to participate in family planning. Before marriage, adolescent girls learn how to listen to their husbands for all decisions; the husband makes the final decision on all matters in the family. As one of the interviewees stated, *"I am married, I know what happens in marriage, it is an institution that puts all final decisions under men. The issues of deciding number of children and time to conceive are for husbands, this is what we learn from parents even before marriage"* (Participant No. 8, Adolescent).

Another participant, who was an adolescent boy, argued, *"I am not married, but I have learnt from my community that we boys have power to make final decision in families. For example, if I am married today, I cannot give to my wife a chance to select number of children to have, this is because to accomplish marriage a man must pay for bride prices, this means a married woman is under control of her man"* (Participant 15, Adolescent).

The results implied that adolescent girls, especially those who had been married, were not aware of their right to decide freely and responsibly the number, spacing, and timing of their children and to have information to do so. Furthermore, in their study, Iqbal et al. (2017) found that the International Planned Parenthood Federation Charter outlined essential rights of adolescents to include healthcare, information and education, life, liberty, privacy, freedom of thought, equality, choice in marriage and number of children, and freedom from torture.

Freedom from Violence

The researcher understood that violence has become a resource for disempowered adolescents in the study area. It was reported that although adolescents were aware of freedom from all kinds of violence, they experienced a lot of it. Most adolescents reported experiencing corporal punishment at the hands of their parents and by teachers in the case of school-attending adolescents, *"We know that we are to be free from violence, however, sometimes violence is done by our parents or teachers. It has been difficult for us to argue on this, we see parents as our second God"* (Participant No. 10, Adolescent). Another adolescent who participated in this study shared: *"We experience verbal harassment from our parents or sometimes from our teachers, it is like a taboo not to argue for violence done by parents, what we are needed to do is only to respect parents for everything they do. So, when we do any kind of mistake, they beat us"* (Participant 18, Adolescent).

The participants, especially adolescents, also reported various types of punishments. As one of the adolescents, a boy confirmed: *"Parents flog us using a stick, pinch us and punch our heads with their fist. I can explain of what I experienced; my parent beat me with a cable of cord. It is not because I am not aware of freedom from violence, but it was a matter level of respect I needed to show to my parents, I did not supposed to argue about anything"* (Participant 17, Adolescent). The results indicated that although adolescents were aware of freedom from violence, they were challenged by their parents and teachers who did not take care of it. In line with Jones et al. (2019), adolescents experience violence due to social norms, including bullying, sexual violence, and harmful traditional practices. Adolescents experienced violence in the home, with no significant differences between girls and boys. Moreover, Pankhurst et al. (2018) indicated that intra-household violence directed at children and adolescents is nearly universal in Ethiopia essentially because parents share cultural assumptions and beliefs in the necessity of child corporal punishment to ensure proper child upbringing.

The study concludes that access to SRH services in the study area was influenced by adolescents' level of awareness of SRS services. The adolescents' understanding of SRH services comprised awareness of the right to information and education on SRH services, freedom of thought on SRH, right to consent to marriage, proper to decide the number and spacing of children, and freedom from violence. The study also concludes that SRH service utilization among adolescents in the study area depended on the availability of healthcare providers, adolescent-friendly SRH services, life skills, education programs, stock-out commodities, and guidance and counseling. The study

also concludes that access to sexual and reproductive health services by adolescents in the study area is faced with a myriad of challenges at the intrapersonal level (inadequate information, incorrect perceptions, low self-esteem, and fear of being noticed by family members), interpersonal level (unsupportive families, and lack of communication), and institutional level (provider competency, provider attitude, and unsupportive environment, physical inaccessibility of services, and shortage of medicines).

REFERENCES

Abdurahman, C., & Oljira, L. (2022). Sexual and reproductive health services utilization and associated factors among adolescents attending secondary schools. *Reproductive Health*, *19*(1), 161.

Abuosi, A. ., & Anaba, E. . (2019). Barriers on access to and use of adolescent health services in Ghan. *J Health Res*, *33*(3), 197–207.

Addae, N. (2021). *Understanding adolescents' sexual and reproductive health needs in the Cape Coast Metropolis*. University of Cape Coast.

Addila, A. (2020). Premarital sexual practice and its predictors among preparatory school students living with and without parents in Hossana Town Southern Ethiopia. *Science*, *8*(3), 63–71.

Aduah, R. (2021). *Women's experiences with digital health service as a tool for improving awareness perception on sexual reproductive health and contraception. A phenomenography qualitative study*. Dalarna University.

Adzovie, H. . (2022). Exploring Ghanaian Adolescent Sexual and Reproductive Health (SRH) Information Source(s): A Qualitative Approach. *The Qualitative Report*, *27*(3), 648–663.

Ahumuza, S. ., Matovu, J. ., & Ddamulira, J. . (2014). Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. *Reprod Health*, *11*(1), 1–9. https://doi.org/doi:10.1186/1742-4755-11-59

Amankwaa, G., Abass, K., & Gyasi, R. . (2018). In-school adolescents' knowledge, access to and use of sexual and reproductive health services in Metropolitan, GhanaKumasi. *J Public Health*, *26*(4), 443–451. https://doi.org/doi:10.1007/s10389-017-0883-3

Ambary, S. (2017). *Studying the Roles of Government in Solving Challenges Facing Single Parented Secondary School Students in Tanzania: A Case of Kinondoni Municipality*. Master's Dessertation, University of Science and Technology of China.

Amin, M. ., Nørgaard, A. ., Cavaco, M. ., Witry, L. ., & Cernasev, S. . (2020). Establishing trustworthiness and authenticity in qualitative pharmacy research. *Res. Soc. Adm. Pharm*, *16*, 1472–1482. https://doi.org/10.1016/j.sapharm.2020.02.005

Amran, M. (2023). *Health in Crisis: An Integrative Review of Sexual and Reproductive Health in Humanitarian Settings*. Dalarna University.

Bandura, A. (1998). Health promotion from perspective of social cognitive theory. . . *Psychology and Health Journal*, *13*(3), 623–649.

Beckmann, J. (2017). *University research ethics clearance: Safety nets, or a false sense of legal immunity*. North West University.

Belay, H., Arage, G., Degu, A., Getnet, B., Necho, W., Dagnew, E., Melkie, A., Seid, T., Bezie, M., & Nibret, G. (2021). Youth-friendly sexual and reproductive health services utilization and its determinants in Ethiopia: A systematic review and meta-analysis. *Heliyon*, *7*, e08526.

Bisht, R. (2023). What are Sampling Methods? Techniques, Types, and Examples. *Retrieved from Https://Researcher.Life/Blog/Article/What-Are-Sampling-Methods-Techniques-Types-and-Examples/ on October 27, 2024*.

Bryman, A., & Bell, E. (2011). Research Designs. In: Business Research Methods. *New York. Oxford University Press.*

Bwalya, N. . (2016). *Factors affecting access to and utilization of reproductive health services amomg adolescents in Lusaka District: Case of study Kamanga Compound*. University of Zambia.

Chandra, M., Venkatraman, L., & Wong, S. (2015). What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. *Global Health, Science and Practice*, *3*(3), 333–340.

Chandra-Mouli, V., & Akwara, E. (2020). Improving access to and use of contraception by adolescents: what progress has been made, what lessons have been learnt, and what implications for actions? *Best Pract Res Obstret Gynaecol*, *66*, 107–118.

Chetty, P. (2016). Importance of research approach in a research. *Retrived from: Https://Www.Projectguru.in/Selecting-Research-Approach-Business-Studies/ on October 26, 2024*.

Chipako, I., Singhal, S., & Hollingsworth, B. (2024). *Impact of sexual and reproductive health interventions among young people in sub-Saharan Africa: a scoping review.* Arba Minch University, Ethiopia.

Chiumia, I. ., Ninsiima, L. ., & Ndejjo, R. (2021). It is painful and unpleasant": Experiences of sexual violence among married adolescent girls in Shinyanga, Tanzania. *International Health Journal*, *18*(1), 17.

Combs, K. . (2017). *Strategies for retaining employees for call centers (Unpublished Walden Doctoral dissertation).* Walden University.

Coral, K., Mohosin, A., Amin, A., & Hasan, T. (2022). Influence of education on sexual and reproductive health service utilization for persons with disabilities in

nationwide Bangladesh: an explanatory sequential mixed-methods study. *Reproductive Health*, *19*(46), 1–15.

Dadzie, L. ., Agbaglo, E., & Oyere, J. (2022). Self-reported sexually transmitted infections among adolescents girls and young women in Sub-Saharan Africa. *Int Health*, *14*(6), 545–553.

Dale, H., & DiBenedetto, K. (2023). Leraning, Cognition, and Human Development. *International Encyclopedia of Education (Fourth Edition)*.

Dale, H., & Maria, K. (2023). Learning, Cognition, and Human Development. *International Encyclopedia of Education*, *4*(1), 12–18.

Dangat, C., & Njau, B. (2013). Knowledge, attitude and practices on family planning services among adolescents in secondary schools in Hai District, northern Tanzania. *Tanzania Journal of Health Research*, *15*(1), 1–8.

Devlin, A. (2018). *The role of compensation in clinical study and the ethical considerations (Walden Doctoral dissertation). ProQuest Dissertations and Theses database. (UMI No. 5611539)*.

Dzinoreva, B. (2021). Obstacles hindering access to sexual reproductive health, responsibilities and rights (SRHR) in Zimbabwe: How youths and adolescents can access and utilize services? *Journal of Development Administration*, *6*(2), 71–79.

Embleton, L., Braitstein, P., Ruggiero, E., Oduo, C., & Wad, Y. (2023). Sexual and reproductive health service utilization among adolescent girls in Kenya: A cross-sectional analysis. *PLOS Glob Public Health*, *3*(2), e0001508. https://doi.org/https://doi.org/ 10.1371/journal.pgph.0001508

Emmanuel, G., Williams, A., & Ochonye, G. (2014). Challenges with providing sexual and reproductive health services for adolescents. *Nigerian Journal of Health Sciences*, *14*, 52–56.

Envuladu, E., Massar, K., & Wit, J. (2023). Healthcare workers' delivery of adolescent responsive sexual and reproductive healthcare service an assessment in Plateau state. *Nigeria BMC Women's Health*, *1*(132).

Ezenwaka, U., Mbachu, C., & Ezumah, N. (2020). Exploring factors constraining utilization of contraceptive services among adolescents in Southeast Nigeria: an application of the socio-ecological model. *BMC Public Health*, *20*(1), 1–11.

Haile, B., Shegaze, M., Feleke, T., & Glagn, M. (2019). *Utilization of sexual and reproductive health services and associated factors among adolescents in youthfriendly service implemented and non-implemented high school of South Ari District, South Omo Zone, Southern Ethiopia, 2019.* Arba Minch University.

Holland, H. ., & Linvill, J. . (2023). Important considerations for protecting human research participants, Dimensions of Discovery July–August 2019. *Retrieved from: Https://Www.Purdue.Edu/Research/Dimensions/Important-Considerations-for-Protecting-Human-Research-Participants/ on October 27, 2024*.

Ibrahim, N., & Edgley, A. (2015). Embedding researcher's reflexive accounts within the analysis of a semistructured qualitative interview. *The Qualitative Report*, *20*(10), 1671–1681.

Iqbal, S., Zakar, R., Zakar, Z. ., & Fischer, F. (2017). Perceptions of adolescents' sexual and reproductive health and rights: a crosssectional study in Lahore District, Pakistan. *BMC International Health and Human Rights*, *17*(5), 1–13.

John, R., Salleh, M., & Farid, N. (2024). Utilization of Sexual Reproductive Health Services Among Youths in Malaysia: A Cross- Sectional Study Applying Andersen's Behavioral Model of Healthcare Utilization. *Cureus, 16*(5), e60230. DOI 10.7759/cureus.60230.

Jones, N., Presler-Marshall, E., Baird, S., Hicks, G., Yadete, W., & Alemayehu, Y. (2019). Adolescent bodily integrity and freedom from violence in Ethiopia. *A Report on GAGE Ethiopia Baseline Findings. London: Gender and Adolescence: Global Evidence*.

Kamau, W. . (2016). *Factors influencing access and utilization of preventive reproductive health services by adolescents in Kenya: A case study of Murang'a District*. University of Bielefeld, Germany.

Kamwine, J. (2022). *Challenges faced by providers of sexual and reproductive health services in Kampala*. Makerere University.

Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a research paradigm and its implications for Social Work research. *Social Sciences*. https://doi.org/10.3390/socsci8090255

Keite, M. (2020). *Adolescent Sexual and Reproductive Health Tookit Humanitarian Settings: Acompanion Inter-Agent Field Manual on the Reproductive Health in Humanitarian Settings*. Inter-Agency Working Group Reproductive Health in Crises.

Khanal, P. (2016). *Adolescents knowledge and perception of sexual and reproductive health and services- A study from Nepal*. University of Eastern Finland, Kuopio.

Kibira, D. (2021). *Access to sexual and reproductive health medicines and supplies in Sub-Saharan Africa*. Universiteit Utrecht.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120–124.

Lamort, W. (2019). *The Social Cognitive Theory*. Boston University.

Langat, E., Mohiddin, A., Kidere, F., Omar, O., Akuno, J., Naanyu, V., & Temmerman, M. (2024). Challenges and opportunities for improving access to adolescent and youth sexual and reproductive health services and information in the coastal counties of Kenya: a qualitative study. *BMC Public Health*, *24*(484), 1–11.

Levesque, J., Harris, M., & Russell, G. (2023). Patient-centered access to health care conceptualizing access at the interface of health systems and populations. *Int J Equ Health*, *12*(1), 1–9.

Lugoya, H. (2019). *Factors contributing to high prevalence rate of teenage pregnancy in Uyui District Council*. Institute of Social Work.

Lumonje, I. (2019). *Utilization of the sexual and reproductive healthcare service among youth living on the streets in Nakuru County, Kenya*. Kenyatta University.

Lutende, A. (2016). *Adolescents awareness of youth friendly reproductive health services in public health facilities: The case of Ilala Municipality*. The Open University of Tanzania.

Manoti, M. . (2015). *Factors influencing access to sexual reproductive health services: A case of the University of Nairobi Main Cumpus Undergraduate Students Institute of Anthropology African Studies in Kenya*. University of Nairobi.

Marshall, P., Adebamowo, C., Adeyemo, A., & Zhou, J. (2014). Voluntary participation and comprehension of informed consent in a genetic epidemiological study of breast cancer in Nigeria. *BMC Medical Ethics, 1*(2), 25–34.

Maxwell, J. . (2012). Qualitative Research Design: An Interactive Approach. *Sage*.

Mbeba, R. ., Mkuye, M. ., Magembe, G. ., Yotham, W. ., Mellah, A. ., & Mkuwa, S. . (2012). Barriers to Sexual Reproductive Health Services and Rights among Young People in Mtwara District, Tanzania: A Qualitative Study. *Pan African Medical Journa*, *13*(13).

Mbuh, H., & Kahugu, S. (2020). *Cancer in adolescents, the social developmental challenges in identity formation: A systenatic literature review*. Lapland University of Applied Sciences.

Ministry of Health and Social Welfare. (2011). *National Adolescent's Reproductive Health Strategy. Dar-es-salaam.*

Misinde, C., Nansubuga, E., & Nankinga, O. (2018). Out of school female adolescent employment status and sexually transmitted infections (STIs) risk in Uganda: is it a plausible relationship? *BMC Public Health*, *18*(1173).

Mngadi, P. ., Faxelid, E., Zwane, I. ., Hojer, B., & Ransjo-Arvidson, A. . (2018). Health Provider's Perceptions of Adolescent Sexual and Reproductive Health Care in Swaziland. *International Nursing Review*, *55*, 148–155.

Mohamed, S., Nmadu, A. ., & Usman, N. . (2020). Barriers to adolescents' access and utilisation of reproductive health services in a community in north- western Nigeria: a qualitative exploratory study in primary care. *Afr J Prim Health Care Fam Med*, *12*(8), 1–8.

Morse, J. . (2015). Analytic strategies and sample size. *Qualitative Health Research*, *25*(10), 1317–1318.

Mrisho, M., Mantel, M., Kabanywanyi, A., Fakih, B., Manzi, F., & Mtenga, S. (2022). Understanding Sexual and Reproductive Health Needs of Adolescents:

Evidence from a Formative Study in Three Districts of Lake Regions in Tanzania. *J Gynecol Reprod Med*, *6*(4), 170–179.

Muganyizi, J. (2021). *Assessment on the application of sexual and reproductive health education among Adolescents in Mvomero District. A Dissertation Report*. Sokoine University of Agriculture, Tanzania.

Mulegi, T., Laila, N., Roseanne, M., & Barongo, E. (2023). Assessment of the level of knowledge and awareness of women on sexual and reproductive health services (SRH) under decentralization in Kampala Uganda. *Inosr Arts and Humanities*, *9*(1), 35–47.

Murry, C., Momoh, O., & Rathburn, C. (2022). Population Definition in Statistics and How to Measure It. *Https://Www.Investopedia.Com/Terms/p/Population.Asp*.

Mutea, L., Ontiri, S., Kadiri, F., Michielesen, K., & Gichangi, P. (2020). Access to information and use of adolescent sexual reproductive health services: qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. *PLoS One*, *15*(11), e0241985. https://doi.org/doi:10.1371/journal

Mutende, M. . (2016). *Adolescents' awareness of youth friendly reproductive health services in public health facilities: The case of Ilala Municipality*. The Open University of Tanzania.

Mwandali, K. ., Msuya, E. ., & Mwakanyamale, A. . (2020). Availability, Range and Utilization of Sexual and Reproductive Health (SRH) Services for Adolescents at Kinondoni Municipality, Dar es Salaam—Tanzania. *Open Journal of Nursing*, *10*, 286–307.

Nabavi, R. ., & Bijandi, M. (2012).). Bandura's social learning theory & social cognitive learning theory. *Theories of Developmental Psychology*, 14–15.

Naik, G., Behera, J., Patra, D., & Jena, S. (2024). Adolescent marriage a violation of sexual and reproductive health rights: Trend, spatial variation and covariate analysis from national family health survey. *Clinical Epidemiology and Global Health*.

Ndayishimiye, N. (2020). Availability, Accessibility, and Qualirt of Adolescent Sexual and Reproductive Health (SRH) Services in Urban Health Facilities of Rwanda. A survey among social and health care providers BMC. *Health Services Research*, *20*(1), 1–11.

Ndugga, P., Kwagala, B., Wandera, S., Kisaakye, P., Mbonye, M., & Ngabirano, F. (2023). "If your mother does not teach you, the world will…": a qualitative study of parentadolescent communication on sexual and reproductive health issues in Border districts of eastern Uganda. *BMC Public Health*, *23*(678).

Ngomi, K. (2018). *Utilization of sexual and reproductive health services by secondary school adolecents in Mochudi*. University of South Africa.

Nickerson, C. (2024). Interpretivism Paradigm & Research Philosophy. *Retrieved from Https://Www.Simplypsychology.Org/Interpretivism-Paradigm.Html on September 7, 2024*.

Nikolopoulou, K. (2022). What Is Convenience Sampling? Definition & Examples. *Retrieved from Https://Www.Scribbr.Com/Methodology/Convenience-Sampling/ on March 21, 2024*.

Ninsiima, L., Chiumia, K., & Ndejjo, R. (2021). Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. *Reprod Health*, *18*(135), 1–17. https://doi.org/https://doi.org/10.1186/s12978-021-01183-y

Nkonde-Bwalya, B. (2016). *Factors affecting access to and utilization of reproductive health services among adolescents in Lusaka district: Case of Kamanga Compound*. University of Zambia.

Odo, A. ., Samuel, E. ., Nwagu, E. ., Nnamani, P. ., & Atama, C. . (2018). Sexual and reproductive health services (SRHS) for adolescents in Enugu state, Nigeria: a mixed methods approach. *BMC Health Serv Res*, *18*(1), 1–12.

Pan American Health Organization. (2016). *"Linking Sexual and Reproductive Health and Gender Programs and Services with Prevention of HIV/STI."*

Pankhurst, A., Crivello, G., & Tiumelissan, A. (2018). Children's Work in Family and Community Contexts: Examples from Young Lives Ethiopia. *Oxford: Young Lives, Oxford Department of International Development (ODID), University of Oxford*.

Perkins, J., Rahman, A. E., Mhajabin, S., Siddique, A. B., Mazumder, T., Haider, M. R., & El Arifeen, S. (2019). Humanised childbirth: the status of emotional support of women in rural Bangladesh. *Sexual and Reproductive Health Matters*, *27*(1). https://doi.org/10.1080/26410397.2019.1610277

Petroni, S., Das, M., & Sawyer, S. (2019). Protection versus rights: age of marriage versus age of sexual consent. *The Lancent Child & Adolescent Health*, *3*(4), 274–280.

Quinn, M. (2002). *Qualitative Research & Evaluation Methods* (3rdEd ed.). Sage Publications.

Rangi, W., & Mwageni, E. (2018). *The Role of Sexual Reproductive Health Education in Adolescents: Sexual Behaviours in Secondary Schools in Morogoro Municipality, Tanzania*. The Open University of Tanzania.

Sidamo, N. (2022). Social Ecological Model Analysis of Barriers to Access and Utilization of Adolescents Sexual and Reproductive Health Services in Sub Saharan Africa. *Reproductive Health Journal*, *18*(2), 24–32.

Sidamo, N., Kebo, A., & Dibaba, Y. (2024). Exploring Barriers to Accessing Adolescents Sexual and Reproductive Health Services in South Ethiopia Regional State: A Phenomenological Study Using Levesque's Framework. *Adolescent Health Medicine and Therapeutics*, 45–61. https://doi.org/DOI:10.2147/AHMT.S455517

Siedlecki, S. (2020). Understanding Descriptive Research Designs and Methods. *Clinical Nurse Specialist (CNS)*, *34*(1), 8–12.

Smith, A. (2017). *Communication strategies used during organizational change in a health care organization. Unpublished Walden Doctoral dissertation*. Walden University.

Tilahun, D. ., Yilak, G., Amena, A., Abebe, G., & Ayele, M. (2023). Exploring the perceptions of health service providers and adolescents on the utilization of adolescent sexual and reproductive health services in Tikur, 2023: A qualitative study. *SAGE Open Medicine*, *12*, 1–12.

Tong, A., & Dew, M. (2016). Qualitative study in transplantation: Ensuring relevance and rigor. *Transplantation*, *100*(4), 710–712.

United Nations Children's Fund (UNICEF). (2019). *Adolescents in Tanzania. Communication, Advocacy and Partnerships Section:* UNICEF Tanzania.

United Nations. (2023). Department of economic social affoirs, population dision. Adolescents data. *Retrieved from Https://Www.Researchgate.Net/Deref/Https%3A%2F%2Fdata.Unicef.Org%2Ftopic%2Fadolescents%2Foverview%2F%2F?_tp=eyJjb250ZXh0Ijp7ImZpc*

nN0UGFnZSI6InB1YmxpY2F0aW9uIiwicGFnZSI6InB1YmxpY2F0aW9uIn19 on August 12, 2024.

URT. (2015). National Adolescent Reproductive Health Strategy 2011-2015. *Ministry of Health and Social Welfare*.

World Health Organization (WHO). (2019). Adolescent pregnancy. *Retrieved from Http://Www.Who.Int/News-Room/Fact-Sheets/Detail/Adolescent-Pregnancy on 15/07/2024*.

World Health Organization. (2023a). Adolscent pregnancy. *Retrieved from Https://Www.Researchgate.Net/Deref/Https%3A%2F%2Fwww.Who.Int%2Fnews-Room%2Ffact-Sheets%2Fdetail%2Fadolescent-Pregnancy?_tp=eyJjb250ZXh0Ijp7ImZpcnN0UGFnZSI6InB1YmxpY2F0aW9uIiwicGFnZSI6InB1YmxpY2F0aW9uIn19 on August 12, 2024*.

World Health Organization. (2023b). *World Health Statistics: Monitoring Health for SDGs, Sustainable Development Goals License:*

Yakob, B., & Ncama, B. (2020). A socio-ecological perspective of access to and acceptability of HIV/AIDS treatment and care services: a qualitative care study research. *BMC Public Health*, *16*(1), 1–15.

Yin, R. (2018). *Case study: Design and methods* (6th ed.). Sage Inc.