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PEACE, CONFLICT AND DEVELOPMENT STUDIES

MASTER'S THESIS

The Socio-Political Determinants of Adolescent Pregnancies and Weaknesses of Current Interventions on Adolescent Pregnancies in Tanzania

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ABSTRACT

The goal of the study was to get an in-depth knowledge of the various socio-political factors that influence the occurrence of many pregnancies among adolescent girls in the Kinondoni municipality, located in metropolitan Dar es Salaam, Tanzania; learn about current interventional approaches undertaken in order to alleviate this problem, which is of great socio-political, developmental as well as public health importance; and uncover their weaknesses. The study was specifically concerned with determining the existing disparities and inequalities that lead to the occurrence of adolescent pregnancies, the level of awareness of sexual reproductive health education, the influence of health care workers' attitudes on adolescents' sexual reproductive health, and lastly identified the gaps in legislative and policy frameworks that hindered adolescent mothers and pregnant adolescents.

A sample size of 82 respondents was used in the investigation. According to the study's findings, primary data and secondary data were primarily used as the methods for data collection. In this study it was study found out that the existing inequalities had a significant impact on the prevalence of adolescent pregnancies. As a result, the study rejected the null hypothesis and accepted the alternative hypothesis. Primary data and secondary data were mostly employed as the techniques for data collection. It was discovered that adolescents had little knowledge of sexual reproductive health, and the mean difference in level of awareness provided by healthcare professionals to adolescents was statistically significant. The study's goals demonstrated that the medical professionals' attitudes regarding adolescents were moderate. Since many of the current injustices considerably influenced how frequently adolescent pregnancies occurred, the study concluded that socio-political issues had an impact on adolescent pregnancies. The study suggested that in order to safeguard and promote young people's health, sexuality education is necessary.

Keywords: Adolescent pregnancy (ies), sexual reproductive health, girls, education

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DEDICATION

I dedicate this thesis to my lovely and kindhearted son Jayden, and to all single adolescent mothers out there. All will be well; it is a matter of time…

*‘When you get a seat at the table, bring extra folding chairs for those whose voices are discounted, yet their lives are impacted just the same (or even more) by the decisions made at the table’ -**Shirley Chisholm***

ABBREVIATIONS

AIDS- Acquired Immunodeficiency Syndrome

CFSC- Communication for Social Change

CRC- Convention on the Rights of the Child

HIV- Human Immunodeficiency Virus

SRHR- Sexual Reproductive Health and Rights

UNFPA- United Nations Populations Fund

UNICEF- United Nations Children's Fund

UDHR- Universal Declaration of Human Rights

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CHAPTER ONE

1.0 Prologue

I was 19 years old when I became pregnant and so many things in my life changed. I found myself unprepared for all the changes my body would undergo, and the physical distress was only worsened by the psychological suffering I had to endure when the father of my child rejected my pregnancy and terminated our relationship. I was alone.

I was confused, hurt and, worst of all, the stories I used to hear about adolescent's pregnancies being rejected had suddenly turned out to be my reality… As I struggled to come to terms with my new circumstances, I sought help from a doctor; I told her I would keep the baby even if I could not fully comprehend the possible ramifications of that decision. A part of me was very confident, even optimistic, I trusted that things would turn out well.

I was visiting my clinic regularly and taking all the nutritional supplements she prescribed, but it was a very taxing experience for my health nonetheless. I used to faint, frequently, during my first trimester, up to 4 times a day; I was diagnosed with anemia and I also lost considerable weight as a result of stress interfering with my appetite. I was down to 49kg by the time I was three months pregnant.

One night the already fragile balance I had somehow managed to keep just shattered. I discovered the father of my child was married to

someone else; I had been lied to for the whole time. I felt like crawling into a hole and disappearing, the pain I went through is difficult to put into words, I cried so much. I just could not stop crying... For a second, I hated myself, I blamed myself for so many things that I knew I could not change. The night was so long. I cried and prayed for God to lift the burden I was carrying then; it was just too heavy for me to handle alone.

In spite of all this, I continued attending my classes, even though I later revisited my decision, and chose to take a full year away from my studies; I needed time to deal with the physical and psychological issues I was facing. I also chose to keep this from my parents, I felt scared of how they may react. Instead, I confided in my sister. We decided we would inform my aunt when the time was right, and she could, in turn, approach my parents in an attempt to dampen the inevitable shock this news would produce. I did, however, speak to the Dean of Students and explain my situation, and my decision to take a break until after I had given birth.

Plans rarely go as intended, and my parents found out sooner than I expected. It was dramatic, as I had anticipated. My mother fainted, was taken to the hospital and had to take a few days off work, this kind of news was not what her high blood pressure needed. When she recovered, as mothers do, she tried to convince me that interrupting my studies because of my pregnancy was not really an option.

I felt even my mother could not understand what I was going through; when school closed, I ran away from home to my cousin's place, in a different city. I underestimated my mother's love and resolve though and found her waiting for me there when I arrived. She confronted me. We spoke, she understood I needed some space and time away, just in order to come to terms with everything.

I finally returned home when I was 5 months pregnant, my parents respected my choices, accepted my apologies for my dramatic behavior and have always been very supportive since then. Amongst the many challenges I faced during this time, I remember the stigmatization I felt… not only was I a pregnant adolescent, without the father of my child; I was also made fun of, because I seemed too young to be pregnant. I ended up a recluse in my own home, by choice, only leaving when I really had to, to go to the clinic or for urgent supplies from local shops.

I luckily gave birth to a beautiful and healthy baby boy. I faced some health complications after birth, but the memories of those are insignificant in comparison to the joy I felt when he came into my life.

I returned to school, determined to be an agent of change, feeling the need to use my experience to help others. Sex is generally taboo, not many speak about it. I myself only spoke about it with my mother after birth, and the little information I knew came from the basic notions in primary and high school science classes. The need for and importance of Sexual Reproductive

Health Education among adolescents in my society became incredibly apparent to me.

I tried to deal with my child's father legally, but the inherent nature of our system, its unreliability, and the lack of professionalism in many of the people I had dealings with, made me also realize how much room for improvement there is in our legal framework and ethics code. However, today, I closely work with my community to address adolescent pregnancies and educate adolescents on matters concerning sexual reproductive health and child protection. It is therefore my hope to bring changes in the national policies and laws of my country in the aspect of holding accountable perpetrators and all those who break the law for their personal gain. It is also my hope that I can give back to the community because I got an opportunity to continue with my dreams, but there are millions of girls out there who are suffering with no hope of their future.

1.1 Introduction

This chapter provides the background of the study explaining the situation of, the statement of the problem, study objectives and questions relevance and justification of the study, scope of the study, study limitation and the organization of the dissertation

1.2 Background of the study

In many countries adolescents are regarded as the strength of the nation due to their ability to start working at their early stage of life. However, different nations have their own ways of defining the age range of adolescence. The Government of India, in its National Youth Policy has defined adolescents as those aged between 13 and 19 years (National Youth Policy, 2014), while most countries have adopted the World Health Organization and United Nations Children Fund definition which defines adolescents as those aged between 10 and 19 years (World Health Organization, 2022).

With the day-to-day innovations and ever-changing technology towards the better all over the world, knowledge on sexual reproductive health is spreading. As a result of the improvement of technology and the widespread sexual reproductive health education adolescents have been affected to a great extent, both positively and negatively. The issue of adolescent pregnancy is a negative effect which has become a global crisis with serious socio-economic implications whose determinants range from social, economic and political factors (World Health Organization, 2022). Over the years, adolescent pregnancies have mainly negatively affected the marginalized groups in the society. United Nations Population Fund (2018) asserts that teenage pregnancies are the pregnancies that result when a girl aged between 15 and 19 years receives her first child or has given birth.

Recent demographic study reports have shown that Adolescent Birth Rates (ABR) decreased globally from 64.5 births per 1000 women in 2000 to 42.5 births

per 1000 women in 2021. They have also shown that the rate of adolescent pregnancies in the United States has been declining over the past 20 years, despite being the nation with the highest number of adolescent pregnancies of all developed nations. In 2018, the Adolescent Birth Rate (ABR) in the United States was 17.4 births per 1000 women aged between 15 and 19 years. This rate decreased to 16.9 births per 1000 women in 2018 (World Population Review, 2022). Furthermore, these reports have shown that in the United States higher rates of adolescents giving births are in the states whose residents have more conservative religious beliefs. Eight out of ten most religious and conserved states are among the states with the highest teenage birth rates (Centre for Disease Control and Prevention, 2018).

A similar demographic research study done in the European Union (EU) member countries have also revealed that Eastern Europe has higher rates of adolescent pregnancies in Europe (41.7 per 1000 women) compared to Northern Europe (30.7 per 1000 women), Western Europe (18.2 per 1000 women) and Southern Europe (17.6 per 1000 women). Despite the availability of data on adolescent birth rates across Europe, there are incomplete or unavailable data on teenage abortions in more than one third of these countries. The research also showed that adolescent pregnancy rates are lower in countries where parental consent is not needed for abortion to be conducted, and where there is availability of youth Sexual Reproductive Health (SRH) services compared to countries where this is not the case (Part et. al, 2013).

Complex shifts in gender norms, availability of Sexual Reproductive Health (SRH) services, sexuality education, information dissemination on sexual issues and timing of childbearing are among the contributing factors in the decline of adolescent pregnancies in developed countries (Part et al., 2013). However, a study conducted by Michaud et. al (2020), showed that there is a substantial part of Europe with limited free access to contraception and healthcare and special programmes focusing on adolescent mothers. The same study by Michaud et. al (2020) further notes that, in nearly half of European countries, there are no health facilities providing Sexual Reproductive Health (SRH) services nor adolescent friendly care that also respects the rights of adolescents in terms of confidentiality and autonomy. Michaud *et. al* (2020) points out that, there is a shortage of health professionals who are fully trained to meet the Sexual Reproductive Health needs of adolescents.

On the other hand, there have been unequal changes in the decline of Adolescent Birth Rates (ABR) in various regions of the world with Southern Asia showing a sharp decline while sub-Saharan Africa (SSA), Latin America and Caribbean (LAC) regions have a very slow decline. India for instance, is one of the countries that have recorded a considerable decline in women who begin childbearing in adolescence (Deol Taran, 2022). Despite all regions showing a decline, up until 2021, sub-Saharan Africa and Latin America and Caribbean regions have continued to have the highest rates of Adolescent Birth Rates (ABR) globally at101 and 53.2 births per 1000 women respectively (United Nations Department of Economic and Social Affairs, 2021). Countries like the Democratic Republic of Congo continue to face high rates of adolescent pregnancies at 111 per 1000 women

aged 15-19 years, mainly due to gender disparities between girls and boys in accessing education, early marriages and the impact of armed conflicts in the country (Human Rights Watch, 2022).

As of 2019, low and middle-income countries (LMICS) had an estimate of 21 million pregnancies each year among adolescents aged 15-19 years, of which approximately 50% were not intended pregnancies (Sully et. al, 2020). Approximately 5.7 million (more than a quarter) of those 21 million pregnancies each year end in abortions, most of which occur in unsafe conditions (United Nations Populations Fund, 2022). Moreover, in 2016 out of an estimated 21 million pregnancies among adolescents aged 15-19 years, approximately 2 million pregnancies resulted in births (Darroch et. al., 2016).

Tanzania is ranked 17th among African countries with the highest adolescent birth rates. Comparison between the 2010 and the 2015/2016 Tanzania Demographic Health Surveys (TDHS) shows that, the adolescent birth-rate increased from 116 to 132 per 1000 girls aged 15-19 making a 4 percent increase in five years' time (United Nations Populations Fund, 2018). There are variations in the rate of adolescent childbearing in different regions of Tanzania. Adolescents in urban areas are less likely to begin childbearing compared to those in rural areas who considerably begin childbearing at a much younger age (Ministry of Health et. al, 2016). To cite a few examples, differences in teenage childbearing rates across the regions, ranged from the lowest of 5 per cent in Mjini Magharibi Region in Zanzibar

and 6 per cent in Kilimanjaro Region to the highest of 45 per cent in Katavi and 43 per cent in Tabora Regions (United Nations Populations Fund, 2018).

1.3 Statement of the Problem

Adolescent pregnancies are a worldwide development problem as well as a major public health concern. In Tanzania, there are various disparities and inequalities among people of different habitats, ethnicity, religious sects, and cultural norms and practices which in one way or another have led to inequitable access to basic education and extreme poverty, thus highly contributing to the increase in adolescent pregnancies.

The above-mentioned societal disparities are a result of structural conflicts which with time influence systems and structures in a society. This holds true across ranges from how relationships are conceived, incubated and differentially groomed so as to preferentially select those who should have access to power, from the family level, community level to the society at large (Kassa et. al, 2018). Understanding the root causes of any problem is very crucial to know the correct interventions and solutions that can be applied.

Sexual Reproductive Health (SRH) education remains a challenge as many adolescents and adults are not well informed about the subject as well as their Sexual Reproductive Health and Rights (SRHR). In many communities in Tanzania sex talk remains a taboo which makes it difficult to discuss sex issues among adolescents or with their parents (Ito et. al, 202 2). This is contrary to Sustainable Development

Goal 3, Target 7 (SDG 3.7) which requires that by 2030, universal access to sexual and reproductive health-care services, including for family planning, information & education, and the integration of reproductive health into national strategies should be ensured.

Furthermore, there have been cases of health care workers being implicated in stigmatization of pregnant adolescents and adolescent mothers seeking for professional help or when attending scheduled antenatal and postnatal clinics.

For a very long time to date legislation policies in Tanzania have continued to undermine pregnant adolescents and adolescent mothers despite the International Community's efforts to intervene (Human Rights Watch, 2020). An act of law which dictates expulsion of pregnant girls from school has been in place since colonial time. Tanzania's education regulation permits students to be expelled from school as soon as they are found to be pregnant. It states that the expulsion of a pupil from school may be ordered where a pupil has committed an offence against morality or entered into wedlock. This regulaton was orchestrated and reinforced by the late President John Pombe Magufuli who during almost all his public rally addresses repeatedly emphasized that pregnant adolescents and adolescent mothers should not be allowed to go back to school (Reuters, 2017). It was not until January this year, following a long period of widespread outcries from local and international media beyond our national borders that the current President, Her Excellency Samia Suluhu Hassan, decided to allow those adolescent mothers who had been expelled from school because of pregnancy to go back to school. This has aroused controversial

statements from different schools of thought across Tanzania between people who support the idea of allowing the young mothers to return to school and those who are skeptical about it and tend to stigmatize them. Those who oppose the idea of the girls going back to school argue that their return may have a negative influence on other schoolgirls who may take the idea of getting pregnant while at school as something normal.

1.4 General Objectives

The general objective of this study is to find out the socio- political determinants of adolescent pregnancies and weaknesses of current interventions on adolescent pregnancies in Tanzania.

1.4.1 Specific Objectives

i) To identify the existing disparities and inequalities which contribute to the occurrence of adolescent pregnancies
ii) To identify the awareness level of sexual reproductive health education and the influence of health care workers on adolescents.
iii) To identify the influence of health care workers' attitudes towards adolescents on sexual reproductive health
iv) To identify weaknesses in legislation policies which undermine adolescent mothers and pregnant adolescents.

1.5 General Questions

What are the socio-political determinants of adolescent pregnancies and impact of current intervention on adolescent pregnancies in Tanzania?

1.5.1 Specific Question

i) What are the existing disparities and inequalities that contribute to the occurrence of adolescent pregnancies?

ii) What is the awareness level of sexual reproductive health education and the influence of health care workers on adolescents?

iii) What is the influence of health care workers' attitudes towards adolescents on sexual reproductive health?

iv) What are the weaknesses in legislation policies that undermine adolescent mothers adolescents?

1.6 Relevance and Justification

Since both the incidence and prevalence of adolescent pregnancies and adolescent mothers are current thought to be on the increase it is important to identify the main underlying causative factors, identify interventional approaches in place and explore strengths and weaknesses so as to come up with a way forward in an effort to help the many young girls in Tanzania who need protection from socio-cultural malpractices, such as puberty traditional initiation rituals and forced child marriages that make them fall into the trap of early pregnancies. Additionally, as children are having children, the number of dependent people in

our society who contribute to high poverty levels is increasing, and the vicious cycle continues.

The problem is still prevalent in Tanzania despite efforts in legal and policy interventions at the local and international levels. The Tanzanian government's policy and the law haven't addressed the inequalities in our society enough, even when they are supplemented by some efforts from private organizations; inter alia, the Tanzania Women Lawyers Association (TAWLA) Tanzania Media Women Association (TAMWA) and Tanzania Girl Guides Association. There have also been unaddressed gaps with the existing legal framework whereby these weaknesses in law enforcement and lack of viable policy strategies could be cited as the main reasons for this failure. This dissertation would serve as an input for legislation on policies relating to adolescent mothers and pregnant adolescents, in hopes to address these issues.

Therefore, all these issues hinder the achievement of the Tanzania National Development Plan and Vision 2025 which focus on human capital development. They also impede the full attainment of Sustainable Development Goals (SDGs); number 1 (no poverty), 3 (Good health and well-being), 4 (quality education), 5 (Gender equality), 10 (reduced inequalities), 16 (Peace, justice and strong institutions), and it is within this thesis that these societal problems will be addressed, and pragmatic solutions will be offered.

1.7 Significance of the study

This study is significant because it addresses the gaps in the legislation policies in Tanzania and offers various methods that can be

1.8 Scope of the Study

The study aimed in investigating the socio-political determinants of adolescent pregnancies and impact of current interventions on adolescent pregnancies in Dar es Salaam specifically in Kinondoni municipality Tanzania. Specifically, the study focused in identifying the existing disparities and inequalities that contributed to the occurrence of adolescent pregnancies, the awareness level of sexual reproductive health education and the influence of health care workers on adolescents. Identified the influence of health care workers' attitudes towards adolescents on sexual reproductive health and lastly identified the weaknesses in legislation policies that undermined adolescent mothers and pregnant adolescents. In analyzing the study objectives, descriptive analysis was mainly used in analyzing the study objectives where the results were presented in Tables.

1.9 Study Limitations and Delimitations

The study was limited to time and financial constraints. The time that was needed in collecting information was limited compared to the needed information. Also, it was difficult in locating the lawyers so as to get the information. Some of the lower sand social workers were very occupied. to overcome this the researcher had to focus on single geographical location which is Kinondoni municipality

1.10 Structure of the Study

This thesis is divided into five parts or chapters: Chapter one gives the general introduction beginning with a prologue to better comprehend the issue in relation to the choice of the topic, then it also provides the background of the study, statement of the problem, objectives, research questions, relevance and justification, scope of the study significance of the study, as well as the structure of the thesis.

Chapter two provides an extensive literature review based on the study objectives. It begins with an introduction and the conceptual definition of terms. It then provides the theories used in the study and why they were relevant to this study. The chapter further gives an empirical review of what other researchers have done on the same topic while providing a link with the study objectives and theories of this study and highlighting the study gap. The study gap then provides a direction on what needs to be covered in this research. This is followed by the researcher's contribution of the study, the conceptual framework and the study hypothesis.

Chapter three focused on the research methodology whereby the study used both a quantitative and qualitative analysis. This chapter contains the chapter overview, research approach, research design, study population, research area, sampling technique, sample size, data collection methods, data analysis, data and interpretation, validity and reliability as well as the ethical considerations.

Chapter four focused on data analysis, interpretation and discussions.

findings of the research based on the research questions and objectives. Also, chapter five focused on the summary, conclusion, recommendations and areas for further studies. Lastly, the study contains bibliography, appendix, questionnaire, interview questions and the permit letter by the government for the conduction of the research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter contains conceptual definitions, theories, empirical review, research gap, and the conceptual framework as explained below.

2.2 Conceptual Definitions

This part provides explanations of the words that have appeared most frequently in the study. The researcher used conceptual definitions to assist the reader in understanding the meaning of the concepts used in the literature review, especially on the terms or concepts that may have different meanings or that may be conflicting.

2.2.1 Adolescent

The World Health Organization (2022) refers to an adolescent as an individual aged between 10 and 19 years. Adolescence is referred to as a phase between childhood and adulthood, and an important stage of human development in which foundations of good health need to be laid. Steinberg (2014) asserts that "adolescence" is a dynamically evolving theoretical construct informed through physiologic, psychosocial, temporal, and cultural lenses. He further expounds that it

is an acritical developmental period which is conventionally understood as the years between the onset of puberty and the establishment of social independence.

Adolescence as a phase can be divided into three stages: early adolescence, middle adolescence, and late adolescence, and each stage has its unique characteristics. The early adolescence or pre-adolescence phase begins from age 10 to 14 years. The middle adolescence or adolescence media begins from age 15 to 17 years and the late adolescence phase begins from age 18 to 21 years (World Health Organization, 2022). However, Salmela-Aro (2011) asserts that adolescence is a transitional period from being a child to an adult and is considered to be the period between 11 and19 years of age. She further adds that adolescents do not only experience physical growth and changes but, also, experience social, psychological, emotional and mental changes and growth. Salmela-Aro (2011) conducted a study of the stages of adolescence and highlighted that adolescence can be categorized into the three stages of:- early adolescence (age 11 to 13 years), middle adolescence (age 14 to 17 years), and late adolescence (age 17 to 19 years). Nevertheless, the same study highlighted that there is an emerging stage of adulthood between age 18 and 25 years. which has been considered as a controversial and conditional phase. This study, therefore, agrees with the definition of an adolescent as an individual between ages 10-19 years, and the stages of adolescence as highlighted by the World Health Organization.

This study strongly agrees with the definition by Deane and Wamoyi (2015) whereby transactional sex involves sexual relationships with certain expectations,

primarily material gain in exchange for sex. It is within transactional sex or relationships that inequalities arise as, automatically, one becomes the main provider or dominant in the relationship while the receiver often becomes submissive. This, in turn, can lead to inequalities where one becomes more powerful than the other or authoritative. UNAIDS (2018) asserts that existing gender norms in the society highly dictate such relationships, thus manifesting gender inequalities.

Gender norms as a social construct therefore direct expectations and the role of men as providers in the relationship. This, in turn, guides the power dynamics in the relationship and individual beliefs about women's and men's roles in a transactional relationship. When adolescent girls are involved in such relationships, where a man is the provider and providing material things in exchange for sex, the girls become vulnerable to adolescent pregnancies as well as contracting HIV/ AIDS and other sexually transmitted diseases. Adolescent girls in such relationships also lack the autonomy to make decisions. UNAIDS (2018) adds that interventions that promote gender-equitable relationships have proved a reduction in men's reporting of transactional sex and violence perpetration.

2.2.2 Transactional sex

Jewkes et. al (2012) define transactional sex' as sexual interactions in which something is exchanged or transferred, in a more informal basis than, and a very different concept from, commercial sex work. Moreover, Deane and Wamoyi (2015) suggest a more formalized definition that refers to transactional sex as a sexual relationship or act(s), outside of wedlock or sex work which is primarily motivated

by certain material expectations and sometimes love, and trust are also at play. Fredlund et. al. (2013) asserts that, unlike commercial prostitution which is viewed as a profession in many countries, transactional is considered informal trading of sex, experimental and of low frequency.

This study strongly agrees with the definition by Deane and Wamoyi (2015) whereby transactional sex involves sexual relationships with certain expectations primarily, material gain in exchange of sex. It is within transactional sex or relationships that inequalities arise as automatically one becomes the main provider or dominant in the relationship while the receiver often becomes submissive. This in turn can lead to inequalities where one becomes more powerful than the other or authoritative. UNAIDS (2018) asserts that, existing gender norms in the society highly dictate such relationships, thus manifesting gender inequalities.

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2.2.3 Gender

John Hopkins University Affiliate (2020) defines 'gender' as the social, political, economic, and cultural attributes and opportunities related to being women and men. Gender is a social construct and what it means to be a man or woman varies across cultures and changes over time. John Hopkins Affiliate (2020) further adds that gender is a sociocultural expression where roles and particular gender characteristics are associated with individuals in relation to their sex and sexuality.

The Canadian Institutes of Health **(2020) defines gender as** the socially constructed roles, behaviors, expressions and identities of girls, women, boys, men, and gender diverse people. They further explain that gender plays a big role in our daily lives, and it influences how people act and interact, how they perceive themselves and each other as well as the distribution of power and resources in society.

This study strongly agrees with the Canadian Institutes of Health (2020) definition of gender. This study also believes that unequal gender relations are the main causes of disempowerment of women and girls as these relations depict the relations of power. It is in gender and social relations where women and girls can be systemically disadvantaged and face challenges in expressing their voices and choices. Gender inequalities have, to a large extent, played a great role in contributing to adolescent pregnancies as a result of cultural norms that do not treat girls and boys equally. The unequal treatment of girls and boys begins in families, in accessing education and the age to marry where, in most cases, girls are forced to

marry earlier than boys.

As a result of gender inequalities, women and men are considered as isolated categories. Therefore, the whole concept of gender escalates how unequal social relations are produced and reproduced (Save the Children, 2022). Moreover, unequal gender relations are mainly grounded in patriarchal societies. Patriarchy is a social system which primarily men hold power in various economic, political and social domains such as leadership, moral authority, control of property and social privileges (Kioko et.al, 2020:5). In patriarchy societies, the father is the head of the family over his wife, children and property. Women and girls face subordination, marginalization and discrimination in patriarchal societies, which in turn their voices and choices are constrained in the sphere of the decisions made by their families, communities and the state.

Therefore, when patriarchy is very strong up to the state level, it ends up shaping the policies and laws within the nation with a foundation of its societal gender norms. In patriarchal societies like Tanzania, policies and laws are also governed by the gender norms. This is why this study has also focused on the weaknesses in legislation policies that undermine adolescent mothers and pregnant adolescents.

2.2.4 Gender-Based Violence

UNHCR (2022) defines Gender Based Violence as harmful acts directed at an individual based on their gender and is rooted in gender inequality. UNHCR

(2022) further points out that GBV is a serious violation of human rights with serious life-threatening health consequences which can even lead to death. With estimates of one in three women experiencing gender-based violence in their lifetime, harm inflicted can be characterized as sexual, mental, physical, and economic. There are various forms of gender-based violence such as child marriages, rape, intimate partner violence, female genital mutilation, and honor crimes.

John Hopkins University Affiliate (2020) defines gender-based violence as violence derived from gender norms and roles with unequal power relations between women and men. The study further explains that gender-based violence is not just limited to physical, sexual, and psychological harm, it also includes violence perpetuated by the state, deprivation of liberty within family or community, suffering, coercion, or intimidation.

This study relates more to the definition by John Hopkins University Affiliate. Looking at what this research focused on: adolescent pregnancies are influenced by factors such as gender-based violence and unequal power relations. All this worsens the situation when it is associated to other factors such as the cultural practices and beliefs that treat girls as predominantly child bearers and home caretakers. While, on the other hand, boys are treated differently and given the priority to access education more than girls. Moreover, this study analyzed the weaknesses in legislation policies that undermine pregnant adolescents, thus showing that gender-based violence does not just end in households but rather

continues up to the state. This is where we see that violence can also be perpetuated by the state.

2.2.5 Sexual Reproductive health

United Nations Populations Fund (2022) has defined good sexual and reproductive health as a state of complete physical, mental, and social well-being in all aspects of the reproductive system. It implies that people can have a fulfilling and safe sexual life, as well as the ability to reproduce and the freedom to choose whether, when, and how frequently they reproduce. People need accurate information and the safe, effective, affordable, and acceptable contraception method of their choice to maintain their sexual and reproductive health (World Health Organization, 2022). They must be educated and provided with the necessary tools to protect themselves from sexually transmitted infections. When women decide to have children, they must also have access to skilled health care providers and services in order to have a healthy pregnancy, safe birth, and healthy child.

2.3 Study Theories

This part explains the theory of stigmatization theory, the theory of change, the socio-ecological model, and the critical discourse analysis.

2.3.1 Stigmatization Theory

Goffman (1963: 3) defined stigma as an “attribute that is deeply discrediting.” He perceived stigma as a general social life aspect that makes

everyday micro-level interactions complicated. Therefore, those often stigmatized (subject to a stigma or marked as an outcast), may be cautious of interacting with those who do not share their stigma, and those without a stigma may denigrate, overcompensate for, or disregard stigmatized individuals (Clair, 2018). On the other hand, social stigma can be defined as "the extreme disapproval of an individual based on social characteristics that are perceived to distinguish them from other members of a society"- (Latalova et. al, 2014). Social stigma may be intense to an extent that it overpowers positive social feedback on the way that the same individuals cohere to other social norms.

Moreover, Goffman (1963:138) argued that most people experience the role of being stigmatized in some connections or life phases. He further presented the fundamentals of stigma as asocial theory, which entails his interpretation of "stigma" as a means of spoiling identity. By this, he referred to the whole notion of the stigmatized trait's ability to "spoil" recognition of the individual's ability to adhere to social norms in other facets of self. Goffman's definition of stigma integrates many contemporary discredited attributes; therefore, he identified three main types of stigma :(1) "blemishes of character"-stigma associated with mental illness, homosexuality, and addiction (2) "physical deformities" - stigma associated with physical deformation; and (3) "tribal stigmas"- stigma attached to identification with a particular race, ethnicity, religion, ideology, etc.

Notably, Link and Phelan (2001), interpret stigma as the convergence of four different factors: (1) differentiation and labeling of various segments of

society; (2) linking the labeling of different social demographics to prejudices about these individuals; (3) the development of an us-versus-them ethic; and (4) disadvantaging the people who are labeled and placed in the "them" category. This depicts that stigma is about social control, and an outcome of this is that stigma is necessarily a social phenomenon. Thus, a society is a prerequisite for stigma; without a society, one cannot have stigma. In order to have stigma, there must be a stigmatizer and the stigmatized. Therefore, this ends up being a dynamic and social relationship. Stigmatization theory then focuses on the perception and indication of certain traits as deviant by a second party as stigma emerges from social relationships.

The researcher chose the stigmatization theory because it is very applicable to the study and explains what stigma is, its causes, the contexts within which stigma occurs, the consequences, and the responses to stigma. Sometimes individuals are unaware of what they do or do not understand that they are stigmatizing an individual and how this impacts the stigmatized persona. There is a lot of stigmatization around adolescent pregnancies and adolescent mothers that is mainly influenced by norms and cultural practices. Moreover, the stigmatization does not just end in families and the community, but it spreads all the way to healthcare services. Adolescents in general face stigmatization in accessing healthcare services by healthcare workers due to religious and cultural beliefs associated with the use of contraceptives and sex before marriage. The governing systems in place are influenced by culture and influence cultures. Governments make policies and laws that are influenced by cultures. When

governments make national policies that stigmatize adolescent pregnancies and adolescent mothers like in Tanzania, so will society. It is then important that the key policies and discourses around stigma are addressed, reviewed, and implemented along with cultural reframing.

Table2.1: Psychological and Sociological Approaches to Stigma along Four Categories

	Micro-level (Psychology)	Meso-level (Social psychology and cultural sociology)	Macro-level (Sociology)
Causes	Physical and mental disorders, sociobiological and instrumental motivations	Intersubjective and symbolic motivations, cultural motivations, stereotypes	Social closure, power, institutional practices, neighborhood and social segregation, discriminatory laws
Contexts	Body, mind, cognitive schema	Individual perceptions and attitudes, interpersonal relationships	Policies/laws, neighborhoods, workplaces, nation-states, built and natural environments
Consequences	Mental illness, stress, physical illness	Self-esteem, identity, symbolic worth, interpersonal (mis)recognition	Group disparities in mental and physical health, in/out-group membership, economic and social inequality
Responses	Grit, physiological coping, individual management	Interpersonal withdrawal, psycho-social resources, cultural reframing	Social movements, institutional/organizational change, policy and legal change

Source: Clair (2018:3)

In addition to that, Parker and Aggleton (2003:17) emphasize that, with all the above, there is then an important recognition that stigma arises, and

stigmatization takes shape in specific contexts of culture and power. Nevertheless, Parker and Aggleton (2003:13) mention that this new emphasis on traditional sociology is concerned with structures, institutions, classifications, and power; and the manner that stigma feeds upon, consolidates, and reproduces existing inequalities of class, race, gender, and sexuality. This has in turn led to grassroots initiatives emerging to combat specific types of social stigma.

2.3.2 Theory of Change

Positive Peace as a term was launched in the 1960s and has been comprehended historically in a qualitative manner based on the idealistic concepts of a peaceful society (Positive Peace Report, 2016). Human beings face conflicts on a daily basis, but a majority of the conflicts do not result in violence. At the same time, conflicts provide a chance to negotiate or renegotiate, to revise mutual outcomes. Nonviolent conflicts can be constructive (Lederach, 2003) and there are certain facets that act as enablers in society, for instance, legal structures devised for the reconciliation of grievance or attitudes and institutions that discourage violence. Thus, positive peace alongside the perspective of ‘peace as freedom’ for social, political, and economic development to address structural violence, can be described as optimal points for human potential to grow (Institute for Economic and Peace,2018)

Tanzania experiences negative peace with the manifestation of the absence of violence, and the fear of violence among its population. However, the prevalence of structural violence is enormous, thus society needs to focus highly

on the creation of positive peace as a theory of change framework. Positive peace is therefore defined as the attitudes, institutions, and structures that create and sustain peaceful societies (Positive Peace Report, 2020)

Theory of Change can be described as a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context (Geiger et. al, 2021: 89). The theory focuses on identifying the gap and filling in what is missing while looking at how the intended change is done (interventions or activities) and how it leads to the desired goal. This is done through identifying the long-term desired goals and the conditions or outcomes that have to be in place for the accomplishment of the goal in a framework known as the Outcomes Framework (Center for Theory of Change,2021)

Thus, the Outcomes Framework lays out the foundation of the type of activity or interventions that will spearhead the outcomes that were previously identified as preconditions to accomplishing the presupposed long-term goals. With this approach, it leads to the comprehension of the connection between activities and the attainment of long-term goals ensuring better organization and planning and understanding in detail how change occurs. Moreover, it creates room for measuring progress toward the attainment of long-term goals, and better evaluation while going beyond the identification of the program's outputs. (Center for Theory of Change, 2021).

This theory is useful in this research because, for peace to be fully attained, there must be preconditions that allow the sustenance of positive peace.

Strong institutions and government systems that value human capital are more likely to achieve this. Adolescents including adolescent mothers and pregnant adolescents are a fundamental part of society that contribute to the human capital of any society and, in turn, bring development. When pregnant adolescents and adolescent mothers are neglected in the legal framework and institutions, it results in a vicious cycle of poverty and infant mortalities. This, to a great extent, again, contributes to the increase in disparities and inequalities in society, in which the latter plays a crucial role in the contribution of adolescent pregnancies.

2.3.3 Socio-Ecological Model

The "socio-ecological model" was developed by psychologist Urie Bronfenbrenner in the late 1970s, to recognize that individuals affect and are affected by a complex range of social influences and nested environmental interactions (Kilanowski, 2017). This model takes into account the complex interplay of individual, relationship, community, and societal factors. It enables us to comprehend the variety of factors that put people at risk of experiencing or perpetrating violence. The model's overlapping rings show how factors at one level influence factors at another (Center for Disease Control, 2022).

In addition to assisting in the clarification of these factors, the model suggests that, in order to prevent violence, it is crucial to act across multiple levels of the model at the same time. This approach has a better chance of sustaining prevention efforts over time and achieving population-level impact. This model is divided into

four levels which are individual, relationship, community and societal level and this study will explain, at each stage, how this model was relevant to this study.

At the Individual level, it identifies biological and personal history factors that increase one's proclivity to become a victim or perpetrator of violence. Age, education, income, substance use, and a history of abuse are some of these factors. At this level, prevention strategies promote anti-violence attitudes, beliefs, and behaviors. Conflict resolution and life skills training, social-emotional learning, and safe dating and healthy relationship skill programs are examples of specific approaches (Liebman et. al, 2017). This level is applicable to the study as it closely looks at the drivers of adolescent pregnancies at an individual level such as rape, peer pressure, lack of education or peer pressure.

At the relationship level, it looks at the close relationships that may accelerate the vulnerability of an individual in experiencing violence as a victim or perpetrator. An individual’s immediate people in his or her social life fall in this category. These can be friends, family members, schoolmates, neighbors who influence and contribute to their experience on a daily basis. Parenting or family-focused prevention programs, as well as mentoring and peer programs, may be used at this level to strengthen parent-child communication, promote positive peer norms, problem-solving skills, and healthy relationships (Caperon et. al, 2022). This level then shows how some of the relationships that an adolescent girl can have with the people around her can either be of positive or negative influence. The relationships around her, either with parents, friends, family members or teachers can be helpful to

her through educating her about sexual reproductive health and risks of early pregnancies or urge the adolescent girl on the importance of education at this age. At the same time, the people around her can either be the ones who influence her to get married at a tender age or friends who want to engage in irresponsible sexual practices. The relationship level plays a great role in the discourses that an individual is exposed to and shape their perceptions.

At the community level, it seeks to understand where an individual engages with other people in different contexts or settings. These are settings such as schools, neighbourhoods, and workplaces and can play a great role in understanding the characteristics of the contexts of one becoming a victim or perpetrator of violence. At this level, the strategies of prevention focus on how to improve the physical and social environment in these contexts. These strategies can be such as ensuring security and safe places to live, work, play or learn. Moreover, further strategies can also include addressing all other factors that can trigger violence including instability, poverty in the neighbourhood, and residential segregation and inequalities (Sobelson et. at al, 2015).

At the society level it investigates the broad societal factors that contribute to a climate that encourages or discourages violence. Social and cultural norms that support violence as an acceptable way to resolve conflicts are among these factors. Other significant societal factors include health, economic, educational, and social policies that contribute to the perpetuation of economic or social inequalities among groups in society. Efforts to promote societal norms that protect against violence, as

well as efforts to strengthen household financial security, education and employment opportunities, and other policies that affect the structural determinants of health, are examples of prevention strategies at this level (Center for Disease Control, 2022).. In many developing countries including Tanzania, the social norms and cultural practices have played a big role in contributing to adolescent pregnancies. The values that individuals adhere to due to religious or traditional beliefs in regard to division of gender roles and the overall societal expectations between men and women lead to very significant inequalities. It is these inequalities that can dictate young girls to fall into the trap of child marriages, gender-based violence, along with the lack of access to education and sexual reproductive health services.

2.3.4 Communication for Social Change Model

The guiding philosophy of communication for social change (CFSC) can be tracked down to the work of Paulo Freire (1970), a Brazilian educator who devised the concept of communication as dialogue and participation with the intention of creating cultural identity, trust, commitment, ownership, and empowerment. He believed that dialogue is a way of learning and knowing in 'an encounter between men mediated by the world in order to name the world' (Freire, 1970, 1993). The pioneers of the communication for social change model who built on this principle and a broad literature on development communication, theories of communication, dialogue, and conflict resolution included scholars, practitioners, and communication activists such as Beltrán, Díaz Bordenave, Calvelo, Shirley White, Prieto Castillo, Everett Rogers, Mata, Simpson, Servaes,

Portales, and Kincaid (Figueroa et.al, 2002).

(Cotton, 2014) emphasizes the importance of bringing an interaction between theory and practice, thus producing indispensable contributions and discernment for the field of development communication unequivocally, and this ought to be done through dialogue among practitioners and scholars. Often communication is simply referred to as the transmission of a message from a sender to a receiver or group of receivers which, in turn, has effects at an individual level, and can have desired or predetermined effects. However, it is not appropriate to base the description of communication for the social change model on such a linear base of the common description of communication, but rather to perceive communication as an engaging and a two-way process (Cotton, 2014).

Therefore, this study has used the Communication for Social Change (CFSC) model to outline the possible ways forward toward addressing the problem of this study. Thus, this model is relevant because, with any problem that affects society and involves people, conversations around the stated problem are needed through dialogue, active participation of the community members, transparency, and the integration of various methods of communication. With the integration of various communication methods, individuals should make sure that the intervention methods are culturally appropriate and do not impose ideas on people. Inclusive methods with the community members are important as, not all the time, certain solutions that worked in a certain context can work the same in another place. Thus, dialogue and the involvement of every key person in society are required. Solutions that work for those affected, provided by themselves

through effective communication are very important in bringing about peace and development.

2.3.5 Critical Discourse Analysis (CDA)

The researcher also conducted the study based on critical discourse analysis. Van Dijk (2001:96), regards critical discourse analysis' emphasis on social problems focusing on the role that discourse plays in the production and reproduction of power abuse or domination. This, therefore, sets up a relationship between language and power. Wodak (2001), also perceives critical discourse analysis as primarily concerned with the analysis of both opaque and transparent structural relationships. These relationships could be relationships of dominance, discrimination, power, and control in our societies as depicted in language. He further expounds that it critically explores social inequality as it is conveyed, signaled, constituted, and legitimized by using language.

Critical discourse analysis explores the interconnection between power and discourse while scrutinizing the approach within which authority, dominance, and social inequality are constructed, sustained, reproduced, and resisted in both written texts and spoken word discourses (Kazemian and Hashemi, 2014). On the other hand, Meyer (2001) asserts that critical discourse analysis aims to expose the discursive aspects of societal disparities and inequalities. As perceived by Van Dijk (2003), critical discourse analysis fundamentally explores how social power abuse,

dominance, and inequality are validated, reproduced, and resisted by both text and talk in social and political settings.

Fairclough (1995) describes the concept of critical discourse analysis as follows:

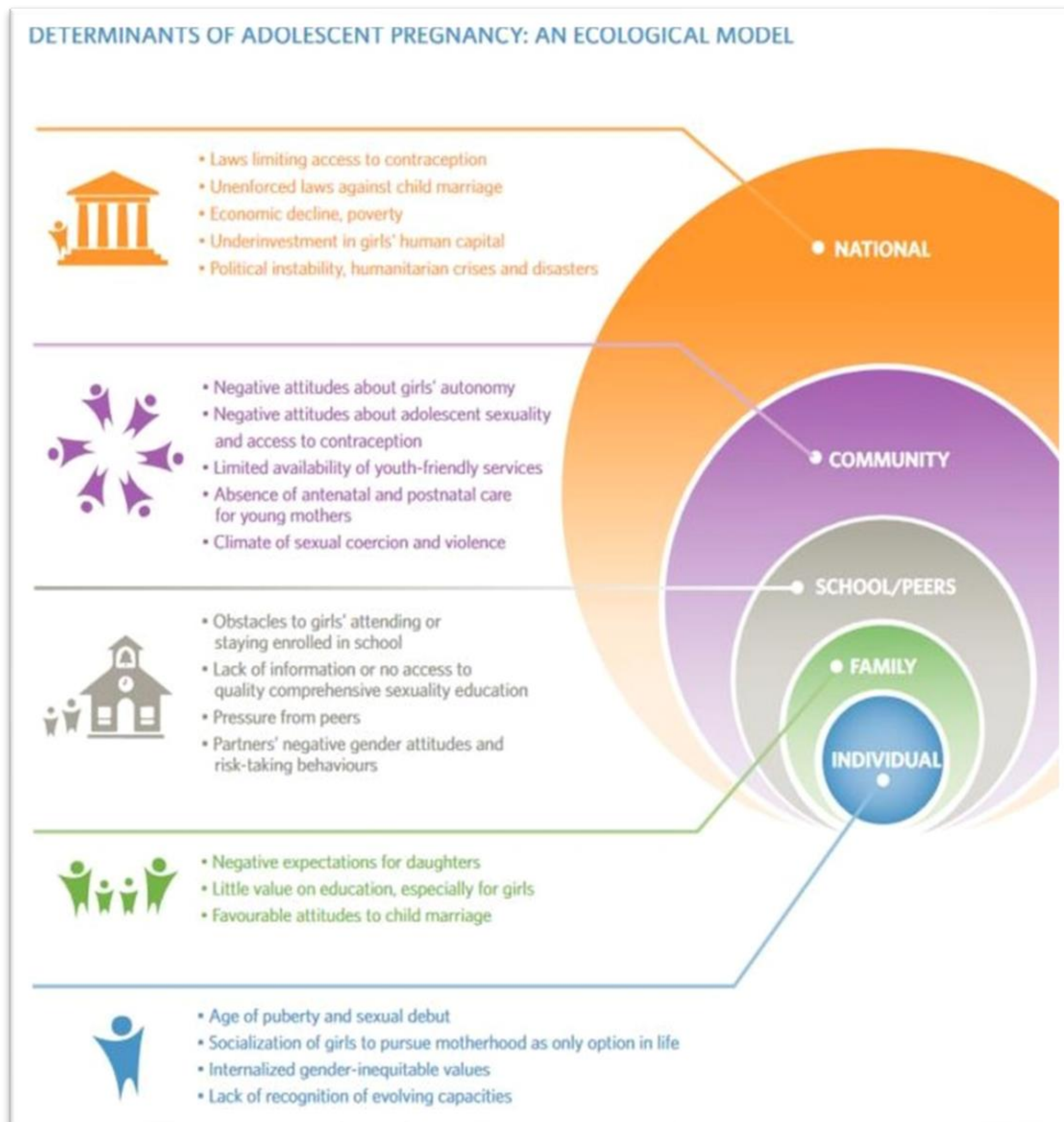
> By critical discourse analysis I mean analysis which aims to systematically explore often opaque relationships of causality and determination between (a)discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power, and to explore how the opacity of these relationships between discourse and society is itself a factor securing power and hegemony (p. 132-133).

Thus, key concepts in critical discourse analysis are issues like 'discrimination', social order, 'struggle', ideology, 'power', 'dominance', 'resistance', 'hegemony', 'reproduction' etc. With the central approaches to critical discourse analysis, Fairclough's socio-cultural approach and system of discourse analysis have been distinguished into three dimensions, since discourse is portrayed concomitantly as: (i) a text (spoken or written, including visual images), (ii) a discourse practice production, consumption and distribution of the text, and (iii) a socio-cultural practice.

On the other hand, ideological impacts as a result of discursive practices may produce and reproduce unequal and unbalanced power relations between social classes, ethnic and cultural majorities, and minorities as well as gender groups (Amassou and Ayodele, 2018). Thus Fairclough (1989), emphasizes that "the

exercise of power, in modern society is increasingly achieved through ideology and some underlying assumptions behind certain selections of discourse are never value-free and innocent but ideologically driven and motivated.

Figure1: Determinants of Adolescent Pregnancy: An Ecological Model



Source: Women's Hope International (2021)

2.4 Empirical Literature Review

This part contains reviews from different literatures based on the study objectives. This section highlights what has already been done or said by other authors on the same matter while analyzing the gap in the literature. Thus, the study has focused on finding literatures concerning the contribution of existing disparities and inequalities on adolescent's pregnancies, impact of sexual reproductive health on adolescent pregnancies, legislation policies relating to adolescent mothers and pregnant adolescents in Tanzania and the Social Change Model on preventing adolescent pregnancies.

2.4.1 The existing disparities and inequalities that contribute to the occurrence of adolescent pregnancies

The existence of disparities within the community is mentioned to be among the factors that contribute to the occurrence of adolescent pregnancies. Aspects such as poverty within the communities, gender inequality, and financial difficulties are among the other factors that contribute to the occurrence of adolescent pregnancies. Kapileh (2019) carried out a study focusing on the factors that lead to early pregnancies among girls in public secondary schools in Tanzania using a descriptive cross-section design and discovered that financial constraints are among the factors that contribute to the occurrence of adolescent pregnancies. Not only that, but also other factors such as peer pressure, and self-desire were mentioned to be the main cause of adolescent pregnancies. The findings of the study revealed that economic factors contributing to girls' pregnancies included insufficient funds to access family

planning methods. Also, the study showed that participants had education and information about sexual reproductive health, but they still faced challenges in making their own decisions.

The literatures have also reviewed that social-cultural factors were among the factors that contributed to occurrence of adolescent's pregnancies. Danor (2015) mentioned that adolescents exposed themselves to sexual practices at a young age due to peer pressure, self-desire, and not having a boyfriend seemed like not being modernized. Other factors include shame, lack of money and fear of being abandoned where it was concluded that inadequate services to young girls had contributed to early pregnancies. The case of inequalities within the society is seemed to worsen girls violation sexually. A report written by the World Health Organization (2018), which focused on Violence against women prevalence, notes that 24% of adolescents aged 15-19 years have already experienced physical/sexual violence from an intimate partner at least once in their lifetime.

As a result there has been an increase in number of adolescents as reported by the World Health Organization (2020) which reported that one of the contributing factors that lead to increase in adolescent pregnancies is child sexual abuse, and it is estimated that at least 120 million girls aged less than 20 years are sexually abused. As a matter of fact girls are mentioned to be more affected by sexual abuse compared to boy adolescents. The WHO (2020) report explained that child abuse is deeply rooted in gender inequality with more girls being affected than boys. The report further explained that at least 1 in 8 children around the world had been

sexually abused by the time they reach the age of 18 years while 1 in 20 girls between the age of 15-19 years had experienced forced sex. This is mentioned to be very discouraging since it shortens the dreams of some of the adolescents.

Tanzania is among the countries where adolescent girls face challenges in reaching their dreams. At the beginning a child may be so determined to complete her studies and support her parents but all these dreams tend to come to an ending after getting pregnant. Mauna (2015) discussed the factors that contributed to high prevalence of teenage pregnancy in the Lindi Municipality in Tanzania. The study used an ecological perspective that focuses on a person in the environment and a health action model to collect the needed information. As a result both married and unmarried teenagers residing in Lindi were interviewed in the study. And it was discovered that most of the girls started practicing sexual intercourse at a young age. Also, the parents were supporting the initiation ceremony. However, some of the girls were found to be abused by their relatives within the family.

Yakubu and Salisu (2018) conducted a study on the determinants of adolescent pregnancy in Sub-Saharan Africa and found that among the factors that lead to adolescent pregnancy are poverty, religion, lack of parental counseling and guidance, coercive sexual behavior, peer influence, absence of free education, non-use of contraceptives, and inappropriate forms of recreation are some of the factors influencing adolescent pregnancies. These factors were also found to be similar with the study conducted by McCleary-Sills *et al* (2013) that focused on gender norms, sexual exploitation, and adolescent pregnancy in rural Tanzania and discovered that

multiple partnerships, cross-generational and transactional sex, and sexual violence, among others have a negative impact on girls' pregnancies. Ramadhani (2018) found the same results, that poverty and sexual risk as well as rape and coercive sex contribute to early pregnancy. Thus, the study insists on girls and boys to be empowered to make decisions and to have interpersonal and leadership skills.

However, there have been different studies that have tried to explain the causes that lead to early pregnancy, the effects of pregnancies, and the measures taken to reduce them, such as the study conducted by Ramadhani (2018), aimed at identifying the factors that lead to early adolescent pregnancy among secondary school students in Tanzania in the Bahi district, where he discovered that most of the girls got pregnant since they wanted to meet their financial needs such as food, clothes and having accessories. As a result, poverty was mentioned as the main obstacle that caused secondary school girls to drop their studies. If that had not been the case, some societies were pressured to marry and bear children early . The World Health Organization (2022) published a report which investigated the contributing factors to adolescent pregnancies and births in Low- and Middle-Income Countries (LMICs). This report asserted that, in many societies, girls tend to be under pressure to marry and bear children while they are young, and associated with high fertility probability.

So far the World Health Organization (2022) added that there are approximately 650 million child brides globally. Due to a lack of educational and employment prospects, many girls opt to become pregnant or get married. This is

also because, culturally, in such societies, motherhood within wedlock is highly valued and prestigious to parents of the girls and the girls themselves. The report further added that difficulties in accessing contraceptives in many places play a big role in increasing adolescent pregnancies. Sometimes contraceptives are available but the lack of enough funds or knowledge on how to use them correctly becomes a challenge. On top of that, stigmatization from those who provide the contraceptives, changing life circumstances on reproductive intentions, and concerns about the side effects of contraceptives all discourage adolescents to continue using contraceptives. The same report adds that restrictive laws and policies in place make it difficult for the provision of contraceptives to adolescents as they strictly focus on the marital status of those who seek contraceptives. On the other hand, health workers tend to be biased and reluctant to identify the needs of adolescents in terms of their sexual health.

Nevertheless, the literatures have mentioned that there is a need for taking precautionary measures such as education, training, and having the right company, and parental guidance must be taken in order for this problem to be addressed. As the study conducted by the World Health Organization (2020) reported that there are more strategies and interventions that have focused more on pregnancy prevention, and therefore recommended that there was a considerable attention that needed to be paid to improving the access and quality of prenatal and antenatal care to pregnant adolescents and adolescent mothers. However, at the end of the day, access to quality care depends on the geographic location and context as well as the social status of adolescents. Sometimes, access is not a challenge but the quality of care

and interpersonal support that adolescents receive is very different from that adult women receive.

However, the literatures have revealed that there is a great need for providing education on sexual reproductive health to teenage pregnancy due to negative beliefs about the use of reproductive health facilities. The study recommends that all stakeholders should equip adolescents with the necessary knowledge and skills concerning reproductive health and not leave girls to rely on traditional norms and values. Therefore, the study recommends that all stakeholders should ensure that girls get access to reproductive health in order to reduce early pregnancies (Yakubu and Salisu, 2018)

Ramadhani (2018) insisted on the measures to be taken so as reduce poverty and provision education to parents and children. The study also insisted that health education should be given to girls and that parents should be closer to their daughters and should teach them well how to avoid pregnancies.

2.4.2 The awareness level of sexual reproductive health education

The study was also interested in identifying different author's ideas concerning the sexual reproductive health education. The study conducted by Hokororo (2014), focused in identifying the barriers to access reproductive health care for pregnant adolescent girls in Tanzania. Where it was mentioned that the participants were aware of the implications of STIs together with their unborn

babies, however, they never considered themselves at risk of contracting sexually transmitted diseases. Their perceptions of contraceptives, and specifically condoms, were that condoms were unnecessary for people in committed relationships and were not effective for pregnancy and sexually transmitted infections. Moreover, they were discouraged by long waiting times to access the services, lack of privacy in the clinics, and stigmatization in the whole process. The study then concluded that reproductive health care for adolescent girls who are not pregnant does not exist in Tanzania and healthcare access is also limited for pregnant adolescents. It, therefore, recommended increased clinic accessibility to provide reproductive health education to all rather than pregnant women only.

Same to the study conducted by Magwanja *et al* (2021), focused in investigating the factors that were associated with utilization of maternal health care services by Adolescent Mothers in Tanzania. The study used 550 adolescent mothers in the analysis that the majority (53.5%) had less than four antenatal care visits and 68.5% of mothers delivered at a health facility. The study revealed that the level of education had a great role to play among adolescent mothers in utilizing maternal health care services. Adolescent mothers with higher education tend to utilize more antenatal health care services compared to those with no education or less educated. The study recommended that the government should employ more effort in disseminating information on antenatal care services, delivery services, and postnatal services to consolidate easier access to important information by pregnant adolescents and adolescent mothers. Moreover, the study put an emphasis on the government to improve the quality of delivery services and to ensure that there are

enough healthcare centers with strict monitoring of the services, especially in rural areas with a limited number of trained personnel. The study also emphasized more government efforts on information dissemination on the importance of utilization of maternal health services with adolescent mothers and pregnant mothers which, in turn, would also reduce mortality rates for both the mothers and the infants.

Nkata *et al.* (2019) had a different view where he aimed at reviewing what has been written about sexual behaviors and reproductive health among adolescents in Tanzania between the years 2000 and 2017. The findings of the study showed that adolescents in Tanzania are highly exposed to high-risk sexual behaviors such as having multiple sexual partners, limited use of condoms, limited use of contraceptives, and transactional sex. As a result, they get early pregnancies and are at risk of being infected with sexually transmitted diseases (STDs). The study recommended that education should be given priority and that more friendly health services should be given to adolescents.

Some of the adolescents are mentioned to misunderstand the tools that are used in sexual reproductive health. Dunor (2015) aimed at determining factors that contributes to teenage pregnancy, the ability of teenagers to use reproductive health facilities, and the contribution of intervention programs to teenage pregnancy. On the findings he discovered that students had knowledge of reproductive health and knowledge of the impact of adolescent pregnancies. However, some respondents had misconceptions about the use of condoms. The study concluded that girls in the Mtwara region are vulnerable and at risk of

getting pregnant before they complete secondary education; it also concluded that teenagers lack reproductive health support access. It recommended girls' empowerment and access to friendly reproductive health services.

So far the studies keep on reporting that there is scars knowledge concerning the sexual reproductive health. Metta *et al*. (2019) conducted a study on the experiences of girls dropping out of secondary school due to unplanned pregnancies in Southern Tanzania. The study revealed that the adolescents had scarce knowledge about their experiences before, during, and after the pregnancy. Also, it was revealed that the girls were not aware of pregnancy prevention methods before getting pregnant and they had challenges that prompted them to become involved in sexual relations. Lastly the literature concluded that girls incurred a lot of problems before, during, and after they got pregnant while in school thus there is a need of the interventions to focus on sex socialization and the culture of silence and of treating sex as a taboo should be changed.

2.4.3 The influence of healthcare workers' attitudes towards adolescents on sexual reproductive health

Mweteni *et. al* (2021), conducted research on 'Implications of power imbalance in antenatal care seeking among pregnant adolescents in rural Tanzania.' The research was mainly a qualitative thematic analysis study that focused on the experiences of pregnant adolescents with accessing antenatal care (ANC) in Misungwi district, Tanzania. The study revealed that adolescents faced stigmatization within their communities including from health care workers.

Pregnant adolescents were perceived as different from their agemates that in turn affected them emotionally and psychologically. Due to the experienced stigmatization, they preferred not to be seen in the villages and became reluctant to attend their antenatal clinics. The study further showed that pregnant adolescents became hesitant to reveal their pregnancies which deprived them from getting the necessary health care support in the initial stages of their pregnancies. This study, however, did not address the treatment (maternity care) that pregnant adolescents receive while giving birth in labor wards. Lusambili et. al (2020) conducted a study that revealed disrespectful maternity care by health care workers in rural Kenya to an extent that adolescents were told to deliver on their own.

Another study conducted in Ethiopia by Tilahun et.al (2012), focused on 'Health workers' attitudes towards sexual and reproductive health services for unmarried adolescents in Ethiopia'. The study found out that healthcare workers had negative attitudes towards adolescents on the provision of sexual reproductive health services. This was mainly influenced by health workers lower levels of education, the fact that they were married, lack of training on reproductive health and the non-use of family planning methods by healthcare workers themselves. This study concluded that it was true that health care workers had some negative attitude on unmarried adolescents. However, this study only focused on unmarried adolescents but how about married adolescents who were married due to forced early marriages and still face various challenges in accessing sexual reproductive health services? Mauna (2015), highlights that both unmarried and married adolescents face negative attitudes from health care workers as it was seen in Lindi, Tanzania.

Moreover, another study conducted by Jonas et. al (2017), focused on 'Healthcare workers' behaviors and personal determinants associated with providing adequate sexual and reproductive healthcare services in sub-Saharan Africa'. The study showed that a majority of healthcare workers in Kenya (82%) and Zambia (86%) advised adolescents to abstain from sex when they needed contraceptives. The study concluded that health care workers believed that clients were the ones who were reluctant to access sexual reproductive health services as they feared stigmatization. Not only that but also, health care workers believed that clients held strong myths or superstitious and religious beliefs that limited them to access these services. Therefore, healthcare workers recommended dissemination of information among community members to tackle this problem. However, this study had contradicting results as during the study, the health care workers admitted telling unmarried adolescents to abstain from sex which already stigmatizes them. The study then concluded that clients were the ones who feared stigmatization accompanied with strong religious beliefs. As it was highlighted by Tilahun et. al (2012), it is clear that health care workers play a big role towards stigmatizing adolescents thus making it difficult for them to access proper services.

A study conducted by Mesiäislehto et. al (2021), focused on 'Disparities in Accessing Sexual and Reproductive Health Services at the Intersection of Disability and Female Adolescence in Tanzania'. The study revealed that adolescents in general were stigmatized by health care workers. The health care workers required that pregnant adolescents presented written permission from local leaders for them to access antenatal care (ANC) in the absence of their partners. All this

stigmatization contributed to delay in beginning antenatal care (ANC). The study thus concluded on the importance of various interventions such as: focusing on empowering adolescent mothers through normalizing pregnancy and antenatal care, educating the society about stigmatization and the need for authorities and policy makers to restructure and reexamine regulations concerning pregnant adolescents from the individual, community to the system level. However, this study did not address the need of health care workers to be provided with proper training so as to treat adolescent without any form of discrimination as addressed by Kola et. al, (2020).

A study conducted by Ooms et. al (2022) focused on 'Healthcare workers' perspectives on access to sexual and reproductive health services in the public, private and private not-for-profit sectors: insights from Kenya, Tanzania, Uganda and Zambia'. The study aimed at identifying differences and commonalities in the challenges faced while accessing sexual and reproductive health services across the public, private and private not-for profit sectors. The study concluded that healthcare workers highlighted that, poor patient knowledge was the most common barrier to accessing sexual and reproductive health services. Bylund et. al (2020), however, shows that the lack of sexual reproductive health knowledge is a result of poor information dissemination to community members by responsible institutions such as health facilities and governments.

2.4.4 Weaknesses in legislation policies that undermine adolescent mothers and pregnant adolescents

The United Republic of Tanzania ratified the Convention of the Rights of the Child (CRC) in 1991. In the Convention on the Rights of the Child (CRC), under Article 1, a child has been defined as an individual below the age of 18 years (United Nations Human Rights Office of the High Commissioner, 2022). By Tanzania ratifying the convention, that means it agrees to the definition and the fact that a child is one below 18 years of age. It also means it agrees to the four core principles of the convention which are: - non-discrimination, devotion to the best interests of the child, the right to life, survival and development, and the respect of the views of the child (UNICEF,2019). However, there are contradicting issues with what is going on in Tanzania and some of its laws and policies in place that highly contribute to adolescent pregnancies.

As of 2019, the revised edition of the Law of Marriage Act of 1971, Chapter 29 (CAP.29. R.E. 2019) under section 13 on restrictions on marriage and minimum age of marriage entails that:

> (1) No person shall marry who, being male, has not attained the apparent age of eighteen years or, being female, has not attained the apparent age of fifteen years.
>
> (2) Notwithstanding the provisions of subsection (1), the court shall, in its discretion, have power, on application, to give leave for a marriage where the parties are, or either of them is, below the ages prescribed in subsection (1) if-
>
> (a) each party has attained the age of fourteen years; and

> (b) the court is satisfied that there are special circumstances which make the proposed marriage desirable.
>
> (3) A person who has not attained the apparent age of eighteen years or fifteen years, as the case may be, and in respect of whom the leave of the court has not been obtained under subsection (2), shall be said to be below the minimum age for marriage. (CAP.29. R.E,2019)

This Act exposes some contradictions and problems that contribute to child marriages, adolescent pregnancies, and gender inequalities and undermine girls' rights to education. These implications also contribute to poverty, infant mortality, depression, risks of contracting sexually transmitted infections, and emotional abuse. Subsection (1) highlights the minimum age for boys to marry is 18 years old and that for girls is 15 years old (CAP 29. R.E 2019). This Act also consolidates those communities where child marriages are highly practiced in defense that the law in place allows marriage below the age of 15 years for girls. At this age, with the definition of who a child is, children at age 15 years are supposed to be in school.

Again, the Tanzanian Constitution under article 12 says that "all human beings are born free and equal and that every person is entitled to dignity" (Art. 12 TCUT). In the same constitution, under article 13, it states that "all persons are equal before the law and are entitled without discrimination to protection and equality before the law" (Art. 13 TCUT). However, there is no equal treatment of boys and girls under the Law of Marriage Act of 1971 and therefore, this law discriminates adolescent girls while perpetuating child marriages.

Moreover, the same Law of Marriage Act of 1971, Chapter 29 (CAP.29. R.E. 2019) under section 17 on Requirement of Consent Act No. 21 of 2009 s. 163 entails that:

(1) A female who has not attained the apparent age of eighteen years shall be required, before marrying, to obtain the consent-
   (a) of her father;
   (b) if her father is dead, of her mother; or
   (c) if both her father and mother are dead, of the person who is her guardian.

(2) Where the court is satisfied that the consent of any person to a proposed marriage is being withheld unreasonably or that it is impracticable to obtain such consent, the court may, on application, give consent and such consent shall have the same effect as if it had been given by the person whose consent is required by subsection (1).

(3) Where a marriage is contracted in Islamic form on accordance with the rites of any specified religion or in accordance with the customary law rites, it shall be lawful for the*kadhi,* minister of religion or the registrar, as the case may be, to refuse to perform the ceremony if any requirement of the relevant religion or person other than a person mentioned in subsection (1) has not been complied with:
Provided that, nothing in this subsection shall construed as empowering the *kadhi*, minister of religion or registrar to dispense with any requirement of subsection (1) (CAP.29.R.E.2019)

Section 17 of the Law of Marriage Act supports child marriages. Under subsection (3) it condones the facilitation of initiation ceremonies as well as traditional and religious values that support child marriages which highly contribute to adolescent pregnancies. With the nature of these marriages, children tend to be forced to marry. All this violates the principle of the best interest of the child and the respect of the views of the child, in cases where the girls refuse to get married and prefer to continue with their education.

Tanzania proves to not implement the charters it has ratified such as the African Charter on the Rights and Welfare of the Child (1990). Article 2 of the African Charter has also defined a child as an individual under the age of 18 years (Art 2 ACRWC). Furthermore, the same charter has highlighted that child marriages shall be prohibited and effective action including legislation should specify the minimum age, however, Tanzania's minimum age of marriage for girls is still 15

years (CAP.29.R.E 2019). The African Charter on the Rights and Welfare of the Child under Article 21 (2) thus states (Art.2 ACRWC):

> Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

Moreover, Tanzania is a signatory to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2003 (The Maputo Protocol). This charter or protocol is the fundamental legal instrument in the protection of the rights of women and girls in Africa. Article 6 (a) of the protocol states that "no marriage shall take place without the free and full consent of both parties" (Art.6 PRW) and Article 6 (b) states that "the minimum age of marriage for women shall be 18 years" (At. 6 PRW). Therefore, this effectively does not adhere to the practice of child marriage. When one or both parties are under 18 years, the given circumstance may easily dictate their consent, thus asserting child marriages as not free and non-consensual (Art 6. PRW)

Moreover, the Maputo Protocol under Article 14 touches on the right to sexual reproductive health for all girls and women in Africa (Art. 14 ACHPRRWA). However, with all the efforts put forth in this protocol, pregnant adolescents and adolescent mothers in Tanzania still face a lot of challenges in accessing these rights. Healthcare workers, on the other hand, are not competent enough or lack enough training in sexual reproductive health education. Also, there are not enough youth-friendly services and healthcare workers continue to stigmatize adolescents in

general. Article 14 of the Maputo Protocol further expounds on the right to family (Art.14 ACHPRRWA) and entails that:

> State parties are required to provide complete and accurate information which is necessary for the respect, protection, promotion and enjoyment of health, including the choice of contraceptive methods. The measures required of State parties include:
>
> (a) training or upgrading healthcare providers and competent educators regarding complete information to provide to clients, including the causes of the failure of the practiced contraception method and the options that are available, if the said failure results in an unwanted pregnancy;
>
> b) ensuring that available, accessible, acceptable and reliable information on contraceptive methods is provided, in printed form or by other means, such as the Internet, radio and television, mobile phone applications, and other telephone assistance service.
>
> (c) enabling the structures of health facilities, institutions, and teaching programs, as well as civil society organizations that are duly competent, to provide the relevant population with necessary information and education on family planning/contraception;

Tanzania ratified the Convention on the Elimination of All Forms of Discrimination against Women 1979 (CEDAW) in 1985. This convention serves as an instrument to ensure non-discrimination on the basis of gender and to ensure equality in all areas in which women are denied equality with men (United Nations, 2022). According to United Nations Human Rights Office of the High Commissioner (2022) Article 16 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) states that:

> 1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:
>
> (a) The same right to enter into marriage;

(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;

(c) The same rights and responsibilities during marriage and at its dissolution;

(d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

In Tanzania, some laws have raised concerns on the aspect of equality and questioning issues of consent to sex among adolescents. The Education ACT CAP 353 Section 60A.:

(1) It shall be unlawful under any circumstance for:

(a) any person to marry a primary or secondary school girl or a schoolboy; or

(b) a primary or secondary school boy to marry any person.

(2) Any person who contravenes any provision of subsection (1) commits an offence and shall, on conviction, be liable to imprisonment for a term of thirty years.

(3) Any person who impregnates a primary school or a secondary school girl commits an offence and shall, on conviction, be liable to imprisonment for a term of thirty years.

(4) Any person who aids, abates or solicits a primary or secondary school girl or a school boy to marry while pursuing primary or secondary education commits an offence and shall, on conviction, be liable to a fine of not less than five million shillings or to imprisonment for a term of five years or to both.

(5) Every Head of School shall keep record and submit to the Commissioner or his representative a detailed quarterly report of cases of marriages and pregnancies under subsection (1), (3) or (4) and legal actions taken against the offenders. Cap 16 (6) Notwithstanding anything in this section, the provisions of the Penal Code relating to sexual offences against girls or children under eighteen shall, where appropriate, apply mutatis mutandis in relation to primary and secondary school girls and boys under the age of eighteen”

There have been arguments on how biased this law is. For example, in situations where both the girl and boy had consent, spectators question why the girl should be seen as a victim and the boy as the only one to be blamed. Also in situations where a girl is above 18 years of age but still and school and she gets impregnated by a boy below 18 years of age, the law is always in favor of the girl given that she is still in school.

2.5 Study Gap

The study has discovered that most of the authors found in the literatures have not identified the weaknesses in the policies that affect pregnant adolescents. Most of the studies have only focused in explaining the policies that are attached to adolescents such as the study conducted by Mesiäislehto et. al (2021) and Dunor (2015); while laws such as the Law of Marriage Act (CAP. R.E. 2019) perpetuate child marriages which highly contribute to adolescent pregnancies. However, concerning the attitude of health care workers, it was not mentioned directly how the attitude affects pregnant adolescents and adolescent mothers. The studies focused on explaining the beliefs that limit individuals in accessing sexual reproductive health services such as Jonas et. al (2017) and Yakubu and Salisu (2018). It has also been difficult to identify awareness level of health care workers since the level of awareness to adolescents differed according to different locations. Example a study conducted by Hokororo (2014) mentioned that the reproductive health care for adolescent girls who are not pregnant does not exist in Tanzania and healthcare access is also limited for pregnant adolescents. While Magwanja *et. al* (2021),

revealed that the level of education had a great role to play among adolescent mothers in utilizing maternal health care services.

2.6 Researcher's contribution

The researcher hopes that this study will assist in the review and implementation of policies and laws in place (and those ratified internationally to be adhered to) regarding adolescents, pregnant adolescents, and adolescent mothers. The researcher hopes that our systems and institutions will have more inclusive laws and policies, free of bias for access to education, gender inequalities, stigmatization of girls, access to sexual reproductive health services, and the protection rights that support better mechanisms for peace and development.

2.7 Conceptual Framework

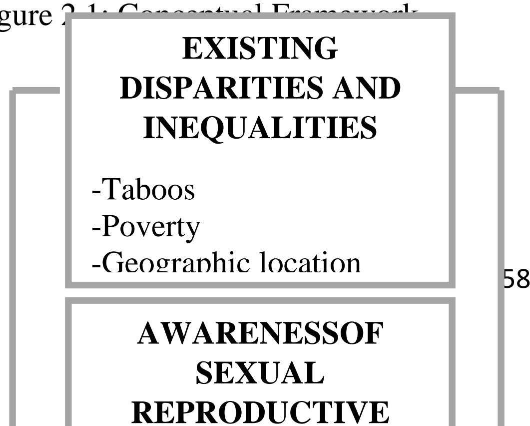
This part will look at the conceptual framework to better comprehend the study orientation and how the study contributes to the body of knowledge on the topic of adolescent pregnancies. Moreover, it will look at how various elements of this study align, and how the study design and methodology meet rigorous research standards.

A conceptual framework is described as a hypothetical suggestion of how the concept and construct interact in the actual settings (Maxwell and Loomis, 2003). The sociopolitical determinants and the weaknesses in current interventions make the independent variable, while adolescent mothers and pregnant adolescents make the dependent variable. The study believes that adolescent mothers and pregnant adolescents are undermined by different factors.

The study figured out that the existing disparities and inequalities have an impact on adolescent mothers and pregnant adolescents. Factors such as the existence of taboos, poverty, geographical location, and education inequality within the Tanzanian society affect adolescent mothers and pregnant adolescents.

The study believed that pregnant adolescents and adolescent mothers needed to be educated on reproductive health. With evidence, most adolescents end up getting pregnant and being mothers at a young age because of lack of awareness on sexual reproductive health issues including unwanted pregnancies, safe abortions, sexual transmitted infections, and postpartum depression.

Figure 2.1: Conceptual Framework



Source: Conceptualized from the literature reviews (2022)

However, the framework portrays that pregnant adolescents and adolescent mothers faced difficulties in obtaining sexual reproductive health due to the attitude of healthcare workers thus facing challenges in obtaining appropriate information concerning sexual reproductive health, contraception and treatment for sexually transmitted diseases, healthcare facilities/ tools, privacy, and confidentiality.

Lastly, the study was interested in knowing the weaknesses in legislation policy that undermined adolescent mothers and pregnant adolescents. Laws that hold accountable the male counterpart for impregnating adolescent girls and laws and policies towards child protection were among the factors that undermined adolescent mothers.

2.8 Study Hypothesis

The study is also based on the following hypothesis: -

H_0: $\mu_{\text{Disparities}}$ = Disparities ("Disparities contribute to the occurrence of adolescent pregnancies")

H_1: $\mu_{\text{Disparities}} \neq$ Disparities ("Disparities do not contribute to the occurrence of adolescent pregnancies ")

H_0: $\mu_{\text{Awareness Level}}$ = Awareness Level ("Health care-workers provide awareness on sexual reproductive health to adolescents")

H_1: $\mu_{\text{Awareness Level}} \neq$ Awareness Level ("Health care-workers do not provide at all awareness on sexual reproductive health to adolescents ")

H_0: μ_{Attitude} = Attitude of health care workers ("health care workers have a positive attitude towards adolescents on sexual reproductive health services")

H_1: $\mu_{\text{Attitude}} \neq$ Attitude of health care workers ("health care workers have a negative attitude towards adolescents on sexual reproductive health services ")

H_0: $\mu_{\text{weakness in legislation}} =$ weakness (" there is weakness in legislation policies that undermine adolescents mothers")

H_1: $\mu_{\text{weakness in legislation}} \neq$ weakness ("there is no weakness in legislation Policies that Undermines adolescents mothers ")

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This chapter focuses on the research methodology that has been adopted by this study. It presents the research area where the population was located. It also presents the research philosophy and research design that the researcher has decided to use. Furthermore, this chapter presents the sampling methods, sample size and

data collection methods. It ends by showing the validity and reliability as well as the ethical considerations.

3.1 Research Approach

This was a cross sectional non-probability descriptive study involving both qualitative and quantitative approaches. The qualitative approach mainly focused on words and meanings. Therefore, it basically dwelt on anthropological issues. The quantitative approach in the study on the other hand was mainly used in obtaining the numeric information and various statistics. This approach was also of great help to the researcher in testing and confirming her research hypotheses and theories made earlier on, hence enabling her in decision making and arriving at a conclusion.

With regard to the study as a whole, it helped in identifying how people in different communities establish relationship with each other at individual and community level in order to maintain acceptance and are able to perform their day to day-to-day activities that support their livelihood. In this case, adolescent pregnancies are essentially a result of opposite gender relations within respective communities in Tanzania. A number of factors such as values, norms and customs play a significant role in influencing the way people relate to each other and the strength of their relation bondage. However, it is very important to take an active participatory role such as making close observation of the norms and values of the community while carrying such studies just as if one were part of that particular community.

Using qualitative approach helped to understand people's perception on adolescent pregnancies. In addition, the phenomenology, that is the branch of philosophy that deals people's feelings, thoughts, and experiences, is said to be useful in anthropological studies, especially ethnographic studies as stated by (Geertz, 1973). This approach was propagated by Paul Ricoeur in line with Phenomenological Investigations by Russerl. The cultural phenomenology looks at the cultural artifacts like communication, public discourse, constituted subjectivity and human consciousness. This approach uses methods, such as semiotics and hermeneutics to understand the culture of a particular community. This approach also involves critical questioning of the cultural conditions that make existence possible. This approach also considered subjective empirical lived experience as part of ethics not just ethics as primordial obligations. This study looked at the cultural conditions that make the existence possible for the adolescent pregnancies, even though it was also aware that there is fragmentation of cultural consciousness.

This study also used the insights of Levinas (1978, 1979, 1987) who said that human beings are moral beings who have obligation to care for each other and communicate organically. They are bound by an ethic which transcends individual culture and embraces universal culture. This philosophy criticizes the instrumental or competitive communication which takes other people as objects that can be manipulated to satisfy a particular instinct. It also criticizes indifference of some people towards suffering of others, ignoring or neglecting them is denying them their humanity. This ethic therefore shows that society has a moral obligation to care for

citizens, including adolescent who became pregnant, and it encourages reciprocity among human beings by acknowledging the shared humanity (Honneth, 1996).

3.2 Research Design

Research design are plans and processes for conducting research that range from making broad assumptions to choosing specific strategies for gathering and analyzing data (John, 2010), descriptive research provides a quantitative or numerical account of trends, attitudes, or opinions within that community by examining a sample of that population (Kothari, 2004). The study used descriptive design, which allowed researcher to acquire data, summarize it, present it, and evaluate it in order to comprehend the study objective. This means that the study bases more on narratives to understand how, why, where, when, what happened that led to adolescent pregnancies. This design helps to fill the gaps in literature and to describe the situation in a more vivid way than it has been done before. This is done due to the fact that scholars have already studied the problem of adolescent pregnancy but there are things which were left behind. That is why this research design went beyond cause-effect relationship to find more on structural and cultural elements such as inequalities, policies, services, and communication systems that influence the adolescent pregnancy.

3.3 Study Population

The study involved different group of people thus it involved the community members, adolescent girls, bar maid, communication experts, health care workers,

lawyers and the social workers living in Dar es Salaam specifically in Kinondoni municipality. The study involved both male and female respondents in collecting information mainly the study focused in collecting views and opinions from people with different opinions.

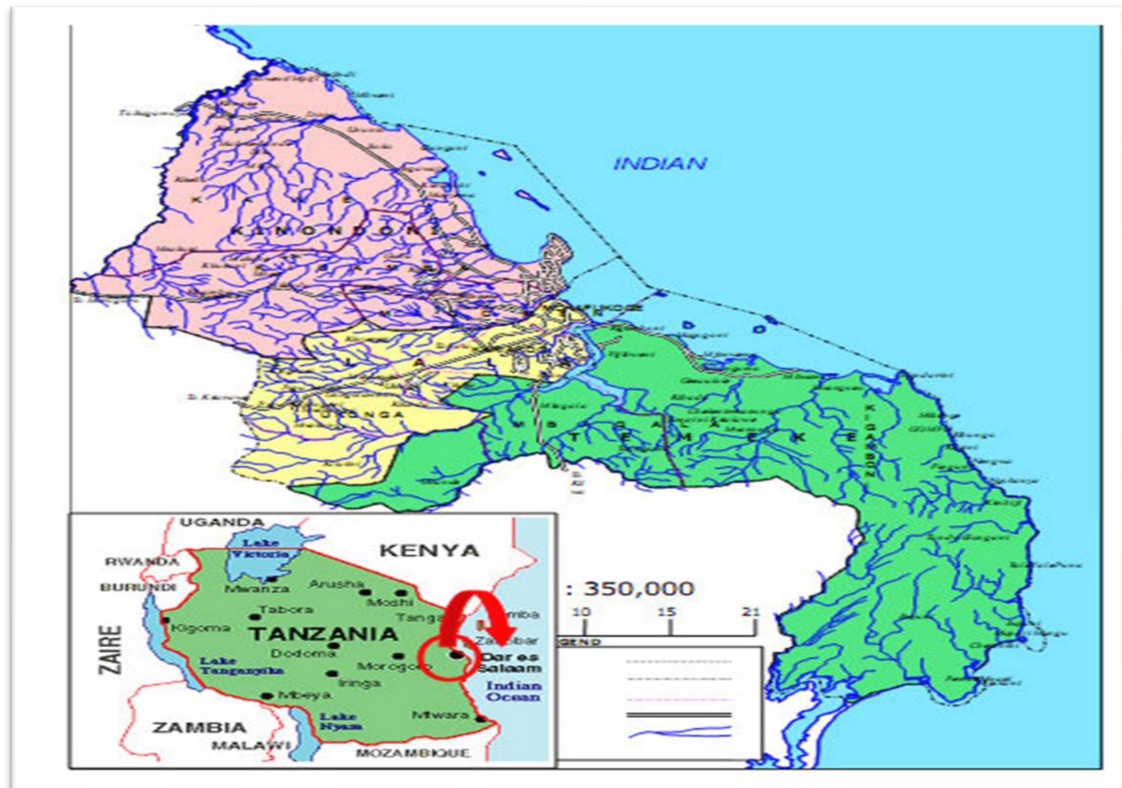
In this study respondents given first priority were pregnant adolescent girls and those who were not pregnant but were involved in the study because they too had history of having conceived and given birth to babies during their adolescence. As already stated above, the study involved respondents who were adolescent girls and barmaids located within Kinondoni municipality. This group was aware of the disparities that they faced within their community, the health workers' attitude towards them and had awareness concerning adolescent pregnancy.

Apart from adolescent girls and barmaids other groups involved in the study were health care workers, social welfare workers and lawyers. The healthcare workers and social welfare workers were important in the study especially in providing information concerning their attitude towards (opinions and feelings they usually had about) the girls that they were duty bound to render service to. The lawyers were very useful to the study in that they were responsible for identifying weaknesses in articles of the legislation act and government policy and regulations. Not only did they do that but also provided some information concerning the existing disparities different geo-administrative regions and various cultural practices and also expressed their views concerning the low level of awareness shown by most of the pregnant adolescent girls and adolescent mothers.

3.4 Study Area

This study was specifically conducted in Kinondoni Municipality, located in Metropolitan Dar es Salaam. This municipality was selected because of its diverse multiethno-cultural human population composition. Dar es Salaam City, a sprawling metropole on the shores of the Indian Ocean in Tanzania, is the largest business hub on the east coast of Africa, is home to more than six million people. Located at 6.9042° South of the Equator and 39.1960° East of the Greenwich Meridian with a land area coverage of about 1,590.5 square kilometers and a total population of about seven million people.

Figure 3.1: Map of Dar es Salaam showing Administrative Municipalities



Source: Saria, (2017)

3.5 Sampling Technique

The study used mainly the nonprobability sampling technique in locating the study respondents as a result snowball technique was used in selecting the participants. Snowball sampling technique was used in identifying the desired population. Snowball sampling is used when it is not easy to identify members of the desired population (Saunders *et al* 2009). This approach helped the researcher to reach the next respondent easily after identifying the first person who then then directed to the next person who was already aware of the study topic. The technique

helped researcher a lot in reaching the respondents and collecting correct information concerning social economic factors that affected the pregnant adolescents.

In the process of data collection, the researcher ensured that all respondents' information provided was kept as very confidential and would not be used for any other reason. This ensured the privacy of the respondent including protecting their names. After information was collected from one respondent then the researcher got an opportunity to ask for information leading to reaching the next respondent who would be willing to respond to the study questions.

3.6 Sample Size

Oso and Onen (2009) define sample size as part of the target population. Since the study population is an unknown sample, Andrew Fisher's Formula was used in calculating the sample size from the unknown population by using the following assumption: -

$$n = \frac{Z^2 P(1-P)}{d^2}$$

Where n = sample size,

Z = Z statistic for a level of confidence is 1.96

P = expected prevalence or proportion (in proportion of one; if 50%, $P = 0.5$),

d = precision (in proportion of one; if 10%, $d = 0.1$).

$$n = \frac{1.96^2 \times 0.5(1 - 0.5)}{0.1^2}$$

$$n = \frac{0.9604}{0.01}$$

$$n = 96$$

Table 3.1: Sample size

Category of Respondent	Expected respondents before field	Obtained Respondent after field
Lawyers	7	5
Community members	22	18
Bar maids	5	2
Communication Experts	4	5
Health Workers	10	7
Social Workers	6	5
Adolescents	42	40
Total	96	82

Source: Field Data (2022)

The initial study plan was to use a sample population size of 96 respondents. However, the results from the field were different in that only 82 respondents were willing to give consent for participation in giving responses as shown in Table 3.1above.

3.7 Data Collection Methods and tools

This part explains the methods that were used in collecting data and the tools that were used in obtaining the study information

3.7.1 Primary Data

The study used primary data and secondary data methods of data collection. Primary data was used to collect the first hand information from the lawyers, community members, bar maids, communication experts, health workers, social workers and adolescents.

3.7.1.1 Questionnaire

Primary data was collected using questionnaire. This tool was selected since it was simple to apply and was not costly. Also the tool helped in reaching the people who were hard contact such as the lawyers and the health workers who were hard to locate physically. This form consisted of a number of questions that had been prepared by researcher focusing on the study objective. Most of the questionnaire was comprised of close ended questions, a fact which helped in focusing on the study questions.

3.7.1.2 Focus Group Discussion (FGD)

Focus group discussion was conducted to some of the social workers from the Tanzania Youth Vision Association and AfriYAN organization. Mainly the study focused on understanding the in-depth information concerning the existing disparities within the community, their attitude towards the health workers and the

weakness in legislation policy. The study involved a group of 5 members hence it gave room to probing questions which were intended to more understanding of issues that are raised through discussions. This method had limitations, since some confidential and personal information could not be expressed in the group; that is why to get in-depth information, the researcher had to combine FGDs and interviews.

3.7.1.3 Key Informants Interviews (KIIs)

This method of data collection was used in order to get in-depth information from adolescent mothers and care takers like parents and other community members. The KIIs helped the researcher to get the views of people who represent the community in order to have information on norms, values, customs, policies, and social services availed to adolescent mothers. These interviewees were selected from different sections of the community and different gender in order to get deep information on how other people view the problem of adolescent pregnancy

3.7.2 Secondary Data

Secondary data was used in obtaining the second hand information from the documented materials. As a result documentary reviews were mainly used in the study as discussed.

3.7.2.1 Documentary Review

The study used literature from different scholars, but also different Legislative Acts were used in the study in regard with issues concerning the weakness that were discovered in the legislative policies.

3.8 Data Analysis

The study used both quantitative and qualitative analysis as explained below

3.8.1 Quantitative analysis

Quantitative analysis was used in analyzing the numeric information that was collected through questionnaire. The Statistical Package for Social Sciences (SPSS) version 26 was used in analyzing the obtained information from the questionnaire. Descriptive analysis and correlation analysis were used, hence Frequencies, percentages, and means were utilized to interpret the study data and lastly sample T test was used to test the hypothesis of the study objectives.

3.8.2 Qualitative analysis

Qualitative analysis was used in analyzing the information that was obtained from the Interviews, focus group discussion and the documentary reviews. Thematic analysis was used in analyzing the information that was obtained from the interviews and the focus group discussions. The researcher had to conduct data reduction, data display, and making conclusion of the obtained results.

3.9 Data Interpretation

Data were interpreted using different theories and models. These theories allowed to make sense of data collected and to understand the meaning, representations, signs, and symbols used by respondents and the community in transmitting the language in a coded way that needs to be decoded in order to find the underlying meaning of words and gestures. This interpretation allowed the researcher to give a clear line to the ideas in accordance with the objectives of the study. This approach allowed the researcher to link theory and practice and to use both deductive and inductive reasoning in analyzing data.

3.10 Validity and Reliability

The concern of validity is about ensuring that the instruments of data collection measure what they are supposed to measure and not something else which is not related to the study. This study ensured validity by tailoring the instruments of data collection to the gap, objectives. It also made sure that the instruments were complete, had required quality, were varied, and addressed all issues of interest. It also used triangulation which consisted of utilizing observation, interviews and focus group discussions to make sure that all means were taken to reach the desired ends.

Reliability consists in addressing variations in data collected. It is expected that data are reliable if they converge on some points and diverge on others and if the same instrument produces similar data with different respondents. The Cronbach alpha indicate the extent to which a set of test items can be treated as measuring a

single latent variable (Amin, 2005) and is more accurate and careful method of establishing the reliability of a measuring instrument. The Cronbach alpha reliability coefficient ranges from 0 to 1, the closer the alpha coefficient is to 1.0, the greater the internal consistency of the items in the scale. A Cronbach alpha coefficient of 0.70 or more is considered ideal. In this study instruments used were pre-tested and piloted to see whether they produced the expected results. Interview guide and FGD guide were polished to avoid ambiguity and vagueness. They were translated in Kiswahili which is the national language used by Tanzanians. This allowed a clear understanding of the questions presented. The reliability was also checked after data were collected to find out whether there was common understanding among respondents. Data were also checked for quality purpose to find whether there were no manipulation of data and misinformation.

3.11 Ethical Consideration

This study took all measures to ensure that the researcher abided by the ethical considerations. To this end, the researcher used consent forms whereby respondents were given the necessary information before participating in the fieldwork. The consent helped to give respondents freedom of participation. Furthermore, the data collected were kept confidential and respondents were allowed to answer the questions anonymously. The information received from respondents was only used for the study purpose and not for any other unauthorized purpose. The researcher also obtained the clearance permit from relevant authorities to conduct the study. The proposal was also presented to the supervisors to find out whether there

was nothing harmful to the people. Finally, the respondents were treated in a respectful manner and were given the necessary support.

CHAPTER FOUR

ANALYSIS, INTERPRETATIONS AND DISCUSSION

4.1 Introduction

This chapter provides the results of the study questions that were collected with different tools of data collection as shown in chapter three above. mainly the study focused in identifying the existing disparities and inequalities that contribute to the occurrence of adolescent pregnancies, the awareness level of sexual reproductive health education and the influence of health care workers on adolescents, The influence of health care workers' attitudes towards adolescents on sexual reproductive health, and the weaknesses in legislation policies that undermine adolescent mothers and pregnant adolescents.

In attending the study questions as explained above the chapter is organized into three sections. The first section provides results of the demographic of respondents who participated in providing the study results; the second section focused in testing the validity and the reliability of the study results and the third part contains the analysis, interpretations and the discussions of the study questions.

4.2 Demographic of Respondents

Demographic of respondents these are the characteristics of respondents whereby the study was more concerned with the gender of respondents, academic level of respondents, age of respondents and the category of respondents. The demographic results were analyzed using SPSS software. Whereby, Descriptive analysis has been

used in providing the demographic results in terms of frequencies and percentages. Descriptive analysis was mainly selected since the study wanted to present participants presentations in terms of their numbers and the extent to which they participated in providing the study results. While cross tabulation was used in analyzing different categories of respondents.

4.2.1 Gender of Respondents

The study was interested in identifying the sexual category of respondents that were involved in answering the study objectives. As results the study involved both male and female respondents in answering the study questions.

Table 4. 3: Descriptive analysis on Gender Respondent

Gender of Respondent	Frequency	Percent
Male	27	32.9
Female	55	67.1
Total	82	100.0

Source: Field Data (2022)

Table 4.1 above reveals that male respondent's presents 32.9% and female respondent's presents 67.1%. These results confirmed that large number of participates who participated in the study were female respondents. This is due to the nature of the study questions that required understanding concerning the adolescent girls.

4.2.2 Academic Level

The study was interested in identifying the academic level of the respondents who were involved in the study. Knowing the academic level of respondents was important especially in knowing awareness of respondents concerning the sexual reproductive health. Thus, the study involved respondents with primary school education, secondary school both Ordinary-level (O-level) and Advanced -level (A-level), undergraduate and postgraduate education

Table 4. 4: Descriptive analysis on Academic Level

Academic Level	Frequency	Percent
Primary Level	8	9.8
O Level	24	29.3
A Level	7	8.5
Undergraduate (Diploma/Degree)	39	47.6
Postgraduate (PHD)	4	4.9
Total	82	100.0

Source: Field Data (2022)

Table 4.2 above reveals that respondents with primary education presents 9.8%, O-level presents 29.3%, A-level presents 8.5%, undergraduate present's 47.6% and postgraduate represented 4.9%. These study results implies that the study results came from people with different levels of understanding.

4.2.3 Age of Respondents

The study was also interested in knowing the age of the respondents who were involved in the study. The aim of selecting age was to identify the experience of respondents concerning the sexual reproductive health. Thus, the study involved respondents who were aged below or equal to 18 years to respondents who were above 55 years.

Table 4.3: Descriptive analysis on Age of Respondent

Age of Respondents	Frequency	Percent
≤18 Years	8	9.8
19-30	25	30.5
31-42	22	26.8
43-54	18	22.0
55 and above	9	11.0
Total	82	100.0

Source: Field Data (2022)

Table 4.3 above involved respondents with different age groups, those who were aged below to 18 years presents 9.8%, those aged 19-30 years presents 30.5%, aged 31-42 years represented 26.8%,aged 43-54 years represented 22%, 55 years and above represented 11%; these results confirm that the collected results came from people with different understanding concerning the sexual reproductive health.

4.2.4 Category of Respondents

The study was also interested in identifying category of respondents in terms of their occupations or activities. Thus the study collected information from the lawyers, communication members, bar maids, communication experts, health workers social workers and adolescents. The aim of selecting respondent category was to collect opinion from people with different professional and understanding concerning the sexual reproductive health.

Table 4.4: Descriptive analysis of Category of Respondents

Category of Respondent	Frequency	Percent
Lawyers	5	6.1
Community members	18	22.0
Bar maids	2	2.4
Communication Experts	5	6.1
Health Workers	7	8.5
Social Workers	5	6.1
Adolescents	40	48.8
Total	82	100.0

Source: Field Data (2022)

Table 4.4 above revels that respondents who are lawyers presents 6.1%, community members presents 22%, bar maids presents 2.4%, Communication Experts presents 6.1%, Health Workers presented 8.5%, Social Workers presents 6.1% and adolescents presents 48.8%. These results prove that the study collected opinions from people with different professional.

4.2.5 Age of Respondents and Category of Respondents

The study was interested in identifying the age of respondents by comparing with their categories. This helped in drafting age of respondents and their activities.

Table 4. 5: Cross tabulation between age of respondents and category of respondents

Age of Respondent	Category of Respondent						
	Communication members	Lawyers	Bar maids	Communication	Health Workers	Social Workers	Adolescents
≤18 Years	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	52%
19-30	5.6%	0.0%	5.6%	16.7%	0.0%	16.7%	81.8%
31-42	12%	0.0%	4.0%	8%	16%	8%	0.0%
43-54	4.5%	100%	0.0%	0.0%	13.6 %	0.0%	0.0%
55 ≤	0.0%	55.6%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: Field Data (2022)

Table 4.5 above revels that adolescents who were aged below18 years presents 52%, respondents who were aged between 19 to 30 years community members presents 5.6%, bar maids presents 5.6%, communication experts presents 16.7% , social workers presents 16.7% and adolescents presents 81.8%. Respondents who were aged 31to42 years community members presents 12%, bar maids presents 4.0%, communication experts present 8%, health workers presents 16% and social workers presents 8% , respondents who were aged 43 to 54 years the community members presents 4.5% lawyers presents 100%, health workers presented 13.6% , respondents who were aged 55 and above were lawyers who represent 55.6%

4.3 Testing validity and reliability of the study results

The study was interested in testing the validity and reliability of the study focusing on the study variables. Thus SPSS software was used in analyzing the validity and reliability of the study results. Person's correlation analysis was used in testing the validity of the study results and cronbach alpha was used in testing the reliability of the study results.

4.3.1 Validity

Pearson's Correlations analysis was used to establish the relationships between the study variables basing on the study questions. Thus, the study accepted the probability values that were below 0.05 and rejects the probability values that are above 0.05.

4.3.1.1 Validity Test on Existing Disparities that Contribute to Occurrence of Adolescents' Pregnancies

The first objective was tested through correlation analysis so as to identify the validity of the existing disparities that contributes to occurrence of adolescents' pregnancies. The relationship between the studies variables are expressed in Table 4.6 below

Table 4. 6: Correlation analysis on existing disparities that contributes to occurrence of adolescents' pregnancies

		Norms and cultural practices	Existing of taboos	Poverty	Geographic location	Education inequalities	Gender inequalities
Norms and cultural	Pearson Correlation	1					
	Sig. (2-tailed)						
Existing of taboos	Pearson Correlation	.689**	1				
	Sig. (2-tailed)	.000					
Poverty	Pearson Correlation	.879**	.690**	1			
	Sig. (2-tailed)	.000	.000				
Geographic location	Pearson Correlation	.718**	.914**	.711**	1		
	Sig. (2-tailed)	.000	.000	.000			
Education inequalities	Pearson Correlation	.855**	.715**	.732**	.687**	1	
	Sig. (2-tailed)	.000	.000	.000	.000		
Gender inequalities:	Pearson Correlation	.707**	.888**	.710**	.849**	.854**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	
**. Correlation is significant at the 0.01 level (2-tailed).							

Source: Field data (2022)

Table 4.6 above revels that there is a significant and positive relationship between existing taboos and norms and cultural practices ($r=.689^{**}$,p=.000). There is a significant and positive relationship between poverty and existing taboos ($r=.690^{**}$, p=.000). There is a significant and positive relationship between geographic location and poverty ($r=.711^{**}$, p=.000), there is significant and positive relationship between education inequalities and geographic location ($r=.687^{**}$, p=.000), there is a significant and positive relationship between gender inequalities and education inequalities ($r=.854^{**}$,p=.000)

4.3.1.2 Validity test on the level of awareness of sexual reproductive health to adolescents on sexual reproductive health

The second objective was tested through correlation analysis so as to identify the validity of the level of awareness of sexual reproductive health to adolescents on sexual reproductive health. The results of the study variables are expressed in Table 4.7 below

Table 4.7: Correlation analysis on the level of awareness of sexual reproductive health to adolescents on sexual reproductive health

		Unwanted pregnancy	Unsafe abortion	Sexually transmitted infections	Health problem like anemia	Postpartum hemorrhage	Mental disorders
Unwanted pregnancy	Pearson Correlation	1					
	Sig. (2-tailed)						
Unsafe abortion	Pearson Correlation	.898**	1				
	Sig. (2-tailed)	.000					
Sexually transmitted infections	Pearson Correlation	.891**	.886**	1			
	Sig. (2-tailed)	.000	.000				
Health problem like anemia	Pearson Correlation	1.000**	.898**	.891**	1		
	Sig. (2-tailed)	.000	.000	.000			
Postpartum hemorrhage	Pearson Correlation	.887**	.975**	.855**	.887**	1	
	Sig. (2-tailed)	.000	.000	.000	.000		
Mental disorders (like depression)	Pearson Correlation	.874**	.865**	.969**	.874**	.832**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	
**. Correlation is significant at the 0.01 level (2-tailed).							

Source: Field Data (2022)

Table 4.7 above revels that there is significant and positive relationship between unsafe abortion and unwanted pregnancy (r=.898**,p=.000), there is significant and positive relationship between transmitted infections and unsafe abortion (r=.886**, p=.000), there is significant and positive relationship between health problem like anemia and sexually transmitted infections (r=.891**p=.000), there is significant and positive relationship between postpartum hemorrhage and health problem like anemia (r=.887**p=.000) there is significant and positive relationship between mental disorders (like depression) and mental disorders postpartum hemorrhage(r=.832**,p.000)

4.3.1.3 Validity test on the Influence of health care workers attitudes towards adolescents on sexual reproductive health services

The third objective was tested through correlation analysis so as to identify the validity of the Influence of health care workers attitudes towards adolescents on sexual reproductive health services. The results of the study variables are expressed in Table 4.8below

Table 4.8: Correlation analysis of Influence of health care workers attitudes towards adolescents on sexual reproductive health services

		Appropriate information	Contraception and treatment	Privacy and confidentiality	Health care facilities/ tools
Providing appropriate information	Pearson Correlation	1			
	Sig. (2-tailed)				
Contraception and treatment	Pearson Correlation	.905**	1		
	Sig. (2-tailed)	.000			
Privacy and confidentiality	Pearson Correlation	.973**	.912**	1	
	Sig. (2-tailed)	.000	.000		
Health care facilities/ tools	Pearson Correlation	.880**	.962**	.906**	1
	Sig. (2-tailed)	.000	.000	.000	
**. Correlation is significant at the 0.01 level (2-tailed).					

Source: Field Data (2022)

Table 4. 8 above reveals that there is a significant and positive relationship between contraception and treatment and appropriate information (r=.905** P=.000). There is a significant and positive relationship between privacy and confidentiality and contraception and treatment (r=.912**P=.000), also there is significant and positive relationship between Health care facilities/ tools and Privacy and confidentiality (r=.906**P=.000)

4.3.1.4 Validity test on the weakness in legislation policies that undermines adolescent's mothers in Tanzania.

The results in the Table 4.9 below were generated using the SPSS software program in order to explore the Pearson's Correlations in order to establish the relationships between the variables of Planning. First correlation was conducted to show the sample characteristics - that means to establish the relationships between the variables

Table 4.9: Correlation analysis on weakness in legislation policies that undermines adolescent mothers in Tanzania

		Laws that hold accountable the male counterpart	laws and policies on child protection	Child protection mechanisms	Awareness of individuals about the existing laws	Lack of information on where to report or access their rights
Laws that hold accountable the male counterpart	Pearson Correlation	1				
	Sig. (2-tailed)					
laws and policies on child protection	Pearson Correlation	.726**	1			
	Sig. (2-tailed)	.000				
Child protection mechanisms	Pearson Correlation	.890**	.736**	1		
	Sig. (2-tailed)	.000	.000			
Awareness of individual on existing laws	Pearson Correlation	.759**	.922**	.746**	1	
	Sig. (2-tailed)	.000	.000	.000		
Lack of information on where to report or access their rights	Pearson Correlation	.861**	.734**	.757**	.707**	1
	Sig. (2-tailed)	.000	.000	.000	.000	

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Field Data (2022)

Table 4.9 revels that there is a positive and significant relationship between laws and policies on child protection and laws and laws that hold accountable the male counterpart (r= .726**,p=.000) there is a positive and significant relationship between child protection mechanisms and laws and policies on child protection (r=.736**,p=.000) there is a positive and significant relationship between awareness of individual on existing laws and child protection mechanisms (r=.746**,p=.000) there is a positive and significant relationship between lack of information on where to report or access their rights and Awareness of individuals about the existing laws (r=.707**,P=.000)

4.3.2 Reliability Test

Reliability of the study is the degree to which research instrument measures the element which is supposed measuring (Taherdoost, 2016). As for the study the researcher used Chronbach's coefficient alpha to measure the internal consistency to all items within the instrument. The closer the Alpha is to 1.0, meaning that the greater the internal consistency of items in the instrument being assumed. Therefore, the measures of the variables were conducted as follow:-

Table 4.10 Reliability of the study objectives

Study Objectives	No of Items	Cronbach's Alpha
Existing disparities that contribute to occurrence of adolescent's pregnancies	6	.973
level of awareness of sexual reproductive health to adolescents on sexual reproductive health	6	.952
Attitudes towards adolescents on sexual reproductive health services	4	.976
Weakness in legislation policies that undermines adolescent mothers in Tanzania.	5	.947

Source: Field Data (2022)

Existing disparities that contribute to occurrence of adolescent's pregnancies had 6 items which are norms and cultural practices, existence of taboos, existence of poverty, geographic location , education inequalities , gender inequalities with Cronbach's Alpha of .973 this implies that there is greater internal consistency of items in the instrument being assumed.

Level of awareness of sexual reproductive health to adolescents on sexual reproductive health had 6 items which are awareness on unwanted pregnancy, awareness on unsafe abortion, awareness on sexually transmitted infections, awareness on health problem like anemia, awareness on postpartum hemorrhage, awareness on mental disorders (like depression) with Cronbach's Alpha of .952 this implies that there is greater internal consistency of items in the instrument being assumed

Attitudes towards adolescents on sexual reproductive health services had 4 items which are providing appropriate information, providing contraception and treatment for sexually transmitted, maintaining privacy and confidentiality, utilization of health care facilities/ tools with Cronbach's Alpha of.976 this implies that there is greater internal consistency of items in the instrument being assumed

Weakness in legislation policies that undermines adolescent mothers in Tanzania. had 5 items which are lack of implementation of laws that hold accountable the male counterpart from impregnating an adolescent girl, lack of implementation and enforcement of laws and policies in place towards child protection specifically related to adolescent pregnancies, lack of enough child protection mechanisms that protect and manage children's rights, awareness of individuals about the existing laws and information by individuals on where to report or access their rights with Cronbach's Alpha of.947 this implies that there is greater internal consistency of items in the instrument being assumed

4.4 Study Objective

The study was interested in identifying the existing disparities that contribute to occurrence of adolescent's pregnancies, identifying the level of awareness of sexual reproductive health to adolescents on sexual reproductive health and lastly the study identifies the weakness in legislation policies that undermines adolescent mothers in Tanzania. The study objectives were analyzed using SPSS software whereby descriptive analysis, cross tabulation and one sampled T- test has been used

expressing the study results. However, the study results are presented frequencies, percentages and mean in form of tables.

4.4.1 Disparities that contribute to occurrence of Adolescent pregnancies

The first objective focused in identifying the existing disparities that contributes to occurrence of adolescent's pregnancies. the study question was attended by all category of respondents (lawyers, communication members, bar maids, communication experts, health workers social workers and adolescents)\

Descriptive analysis was used in analyzing the study results frequencies percentage and mean ware used in interpreting the study results. However in interpretation the mean score 1.00-1.80 presents Very Small disparities that contributes to occurrence of adolescent pregnancies, 1.81-2.60 presents Small disparities that contributes to occurrence of adolescent pregnancies, 2.61-3.40 presents Moderate disparities that contributes to occurrence of adolescent pregnancies, 3.41-4.20 presents High disparities that contributes to occurrence of adolescent pregnancies and 4.21-5.00 presents Very High disparities that contributes to occurrence of adolescent pregnancies

Table 4.11: Descriptive analysis on existing Disparities that Contribute to Occurrence of Adolescent Pregnancies

	SD	D	M	A	SA	N	Mean
Norms and cultural practices	3 (3.7%)	8 (9.8%)	3 (3.7)	28 (34.1%)	34 (41.5%)	82	4.00
Existence of Taboos	5 (6.1%)	8 (9.8%)	3 (3.7%)	33 (40.2%)	33 (40.2%)	82	3.99
Existence of Poverty	3 (3.7%)	7 (8.5%)	14 (17.1%)	30 (36.6%)	28 (34.1%)	82	3.89
Geographic location	5 (6.1%)	9 (11%)	8 (9.8%)	29 (35.4%)	31 (37.8%)	82	3.88
Education inequalities	8 (9.8%)	11 (13.4%)	2 (2.4%)	34 (41.5%)	27 (32.9%)	82	3.74
Gender inequalities	10 (12.2%)	5 (6.1%)	6 (7.3%)	18 (22.0%)	43 (52.4%)	82	3.96
Weighted Mean							3.91
1.00-1.80= Very Small Contribution 1.81-2.60= Small Contribution, 2.61-3.40= Moderate Contribution, 3.41-4.20= High Contribution, 4.21-5.00= Very High Contribution							

Source: Field Data (2022)

Table 4. 11 above revels that respondent who were asked concerning the existing disparities that contributes to accordance of adolescents pregnancies 41.5% strongly agreed on the fact that norms and culture practices are among the disparities that contributes to occurrence of adolescents pregnancies. 34.1% agreed on the fact that norms and culture practices are among the disparities that contributes to occurrence of adolescents pregnancies, 3.7 were moderate on the fact that norms and culture practices are among the disparities that contributes to occurrence of adolescents pregnancies 9.8% degreed on the fact that norms and culture practices are among the disparities that contributes to occurrence of adolescents pregnancies

and 3.7% strongly disagreed that the norms and the cultural practices did not contribute to occurrence of adolescents pregnancies.

Concerning Existence of taboos 80.4% (40.2%, 41.5%) of the respondents agreed that the taboos had a great contribution while 3.7% responded that it was normal and 15.9% (6.1, 9.8) of the respondent disagreed that existence of taboos did not contribute to occurrence of adolescent pregnancies.

Concerning existence of poverty within the society 70.7% (36.6%,34.1%) of the respondents agreed that poverty had a contribution in adolescents pregnancies while 17.1% said it was a normal contribution and the remaining 12.2% (3.7,8.5%)disagreed that existence of poverty within the society did not contribute to occurrence of adolescent pregnancies. Concerning the geographic location 73.2% (35.4%, 37.8%) of the respondent agreed that it was a great contribution while 9.8% reported that it was a normal contribution and 17.1% disagreed that it did not contribute to adolescent pregnancies.

Opinions concerning the education inequality 74.4% (32.9, 41.5%) of the respondent agreed that education inequality contributed adolescents pregnancies while 2.4% reported that it was a normal contribution and 23.2(9.8%, 13.4%)% disagreed that it did not contribute to adolescent pregnancies . lastly the opinions concerning the gender inequality 74.4% (22%, 52.4%) of the respondent agreed that gender inequality contributed adolescents pregnancies while 7.3% reported that it was a normal contribution and 18.3% (12.2%,6.1%) disagreed that gender inequality did not contribute to adolescent pregnancies.

Also it was confirmed that norms and cultural practices had high contribution in occurrence of adolescents pregnancies with mean score of 4.00, existence of taboos had high contribution in occurrence of adolescents pregnancies with mean score of 3.99, existence of poverty had high contribution in occurrence of adolescents pregnancies with mean score of 3.89, geographic location had high contribution in occurrence of adolescents pregnancies with mean score of 3.88,education inequalities had high contribution in occurrence of adolescent's pregnancies with mean score of 3.74, Gender inequalities had high contribution in occurrence of adolescents pregnancies with mean score of 3.96.

Generally the study objective concludes that the existing disparities had high contribution to occurrence of adolescent pregnancies.

4.4.2 One Sample T-test analysis of Disparities and inequalities that contribute to occurrence of Adolescent Pregnancies

Based on 2019 data, 55% of unintended pregnancies among adolescent girls aged 15–19 years end in abortions, which are often unsafe in LMICs (1) (WHO, 2022). The One Sample *t* Test is used to test Statistical difference between hypothesized values of the mean in the population. Which are:-

H_0: $\mu_{\text{Disparities}}$ = Disparities contributes to occurrence of adolescent's pregnancies

H_1: $\mu_{\text{Disparities}} \neq$ Disparities does not contribute to occurrence of adolescent's pregnancies

Therefore the researcher accepts the probability value (P values) that is below 0.05 and rejecting the values that are above 0.05 as assessed by Shapiro-Wilk's test. The t-value measures the size of the difference relative to the variation in the sample data

Table 4.12: One Sample Statistics of Disparities that contribute to occurrence of Adolescent pregnancies

	N	Mean	Std. Deviation	Std. Error Mean
Existing Disparities	82	3.9106	1.09969	.12144

Source Field Data (2022)

The One-Sample Statistics, provides information about the existing disparities that contributes to occurrence of adolescent pregnancies, the mean for existing disparities that contributes to occurrence of adolescent pregnancies (3.9106 ± 1.0996) was lower than the normal score of the occurrence of adolescent pregnancies which is 55% (0.55)

Table 4.13 One Sample Test Disparities that contribute to occurrence of Adolescent Pregnancies

	Test Value = 0.55					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Disparities	27.672	81	.000	3.36057	3.1189	3.6022

Source: Field data (2022)

The existing disparities are statistically significant to the occurrence of adolescent pregnancies since then, t (81) =27.672, P= .000. Also the mean difference of disparities was statistically significant by 3.36057 (95% CI, 3.6022 to 3.1189) as a result the study rejects null hypothesis and accept the alternative hypothesis.

H_0: $\mu_{\text{Disparities}}$ = Existing disparities contributes to occurrence of adolescent's pregnancies

4.4.3 Discussion Disparities that contribute to occurrence of Adolescent pregnancies

This part provides the discussion of the concerning the disparities that contributes to occurrence of adolescent pregnancies. Thus, the study discuses on the norms and cultural practices, existence of taboos, existence of poverty, geographic location, education inequalities and gender inequalities

4.4.3.1 Norms and Cultural Practices and Existence of Taboos that Contributes to Occurrence of Adolescents Pregnancies

This part revels that in Tanzania society there are different norms, cultural practices and taboos that contributes to occurrence of adolescence pregnancies.

Marriage practices at young age have been the main obstacles to adolescents girls in completing there studies. Girls are forced by parents or guardians to marry a man of the parents' choosing after completing primary education at about the age of 15. One of the health care workers claims that ethnic groups from eastern Tanzania's, the coastal region of Tanzania are the ones most likely to practice the cultural marriages for their daughters. Parents can simply arrange for a daughter to marry a spouse overseas or pressure her to accept so that the marriage will be legitimate under Tanzanian law, despite the fact that the local government intervenes in cases of forced marriages of girls under the age of 18.

Also the study discovered that many females from low-income homes want to marry and have families, according to both male and female interviewers. They imagine a better life with a husband who can provide for them better than their parents can, but they fail to consider the fact that they will be parenting their children at a young age. Girls assume that because they would have freedom to eat and dress whenever they pleased, maybe the living in their husband's house will be different.

"You can force your child to get married, but two or three years later you may learn that she is divorced and has one, two, or three kids. She

will then return to you with her kids. We struggle to care for both our own family and other people's families." (Respondent IV 2022)

Girls who get married and have children find out they are unprepared and are left with children to support; some of them return home and are seen as an economic burden by the same parents who encouraged or allowed them to get married young in the first place. One of the respondents mentioned that this happens to girls who get married at their early aged and have kids:-

4.4.3.2 Existence of Poverty

Existence of poverty is among the factors that contribute to early pregnancies. According to Nkata et al (2019) mentioned that, there are more teenage births outside of marriage within communities with greater rates of poverty.

These girls continue to live in poverty since the majority of them are ostracized by their parents and their community and are subjected to hardships like lack of food, housing, and clothing both before and after birth. One of the most powerful indicators of low birth weight, particularly among adolescent moms, is poverty status (Alan Guttmacher Institute, 1994). In order to prepare the next generation for a nation where poverty has been somewhat reduced, the government and parents as a whole are spending in education costs for this youth of today. However, some parents still allow their daughters to marry wealthy men. Young girls are compelled to marry older, wealthier men for the case of bride price because they believe this is the only option to escape poverty in their neighborhoods.

"*Interviewees claimed that the bride price often ranged from 50,000 to 500,000 Tzs. Because of their families' requests for a cheaper bride price, affluent men allegedly preferred to marry poor girls, but parents reportedly hoped for a son-in-law who could not only support their daughter but also help them financially.*" (Respondent III 2022)

Some teenagers are taken advantage of with simple gifts like phones and delicious food like chips that they are unable to receive at home due to low standard of life. In that situation, it is discovered that the teenagers engage in risky sexual encounters with one another, which leads to an early pregnancy. As a result, the partner always succeeds in fleeing, leaving the girl to carry the child alone. Since the parents are responsible for raising the child and taking care of the newborn baby, this has become a burden to many families. One of the survey participants stated that.

"When I became pregnant at age 17, so many aspects of my life changed, I grew up in a challenging environment with my aunt, where we had to walk a mile every day. Life was very challenging. I considered it a stroke of fate that I had a wealthy partner who had previously lived in the area. At the end of the day, I discovered that I was engaging in sexual activity. As a result, when I became pregnant, I was unprepared for all the physical changes my body would go through. The psychological pain I experienced after the father of my child rejected my pregnancy and ended our relationship only made the physical discomfort worse. Being alone" (Respondent LX 2022)

Steinberg Laurence, (2014) the majority of adolescent pregnancies are rejected as soon as the partner learns of the circumstance, according to reports that young girls become confused when they realize that what they were hoping for

didn't happen. The majority of the girls in this scenario struggle to move on with their lives, and some even endanger their own lives by having abortions where some girls lose their lives since they are unsure of how they would raise the child given the impoverished situation.

All areas of the nation are affected by poverty, which is one of the main causes of child marriage. Even without including in school fees or other expenses, economically disadvantaged families frequently struggle to feed and clothe their kids. As a result, many families turn to the practice of "protecting" their daughters financially by marrying them off. Unaware of the hardships marriage will bring, some girls may decide to be married young in order to escape the challenges at home. Some societies view the bride price, which parents get when their children marry, frequently given in livestock or cash, as a tactic to combat poverty. Child marriage is a significant cause of and a consequence of poverty.

Picture 4.1: Shows the living standards of people in one of places where the research was conducted

Source: Field data (2022)

4.4.3.3 Geographic location

For some students who study distant from their homes or must travel a great distance to get to school, geographic location has been a barrier. On their route to school, some teenagers are tempted. According to the study findings, majority of the pupils who received rides to school developed relationships with motorbike riders. One of the respondents reported that.

I became pregnant with a motorcycle rider who used to transport me to and from school. Regarding myself, I didn't spend much money on transportation.(Respondent VIII, 2022).

It's lucky that Tanzania's government has struggled to build new schools close to residents' neighborhoods. However, some parents continue to think that enrolling their children in older schools will help them score well on their final examinations and get them accepted into reputable government institutions where they won't have to pay much in tuition. Teenagers actually don't comprehend their parents' intentions and believe that studying remotely is a punishment, which leads them to participate in risky relationships because they know their parents won't find it simple.

4.4.3.4 Education and Gender inequalities

The government of Tanzania offers free education to its residents; some girls still are unable to complete their education because of early pregnancies. One of the elements that contribute to early pregnancy is gender disparity. The belief that boys should receive priority since they are the family's head is still present in some

regions of Tanzania. In that circumstance, families tend to place less value on girls. As a result, the girls receive instruction on how to be good wives to their husbands while the boys are transported to school. Regardless of the conditions, girls in primary and secondary schools are not given priority once they are discovered to be pregnant. One of the respondents mentioned that

"In form two when I discovered I was pregnant for the first time, I had no idea what to do. When my teachers found out I was pregnant, they forbade me from continuing with my studies because they thought I may have a negative influence on my other students. I was compelled to remain at home until I was able to give birth to my child, and then I went to continue my studies but found that all of my peers were ahead of me." (Respondent VI, 2022).

The study also found that some females who were 15 years old were made to participate in informal education that prepared them for parenthood at a young age. However, it was stated that girls in Unyago reportedly live in a specifically constructed room being taught in weeks how to be good wives at their young age. Girls received instruction on appropriate behavior and respect for others and themselves from an older woman, typically an older sister, aunt, grandmother, or traditional female instructor, either during or after their time spent. Older interviewees said that in their ethnic group, unyago was viewed as a procedure that turned a girl into an adult lady. Among the respondents, one said;

"I was 'inside 'the room where Unyago was practice for 2 weeks. On the fourth day, they gave me a local drug so I could throw up all the "dirt."By removing all the childish items when we vomit, as is our

custom, we signify the girl's transition into adulthood. I was 15.I now have six children, and never received a formal education (respondent X, 2022)

The study also found that when a girl completed her time 'inside the Unyago place', her family throws a public party for her with food, drink, traditional dance, and gifts to thank them for raising her "in a nice way," which means she hasn't become pregnant before unyago. The most frequently cited justification was that many parents believed their children were already having sex or at least "knew a lot about sex" before they would typically go through unyago. One respondent further stated

When parents are not available some of the adolescent's girls are forced to engage in transactional sex in order to eat. As a result, many parents feel that it is too late to try to teach daughters manners through unyago, and they find no reason to rejoice that their daughter was reared "in a good way." (Respondent II 2022)

The study supports the critical discourse analysis (CDA's) since it draws attention on social issues and plays a great role in creation and perpetuation of power abuse or dominance, establishing a connection between dialogue and power. According to Wodak (2001), the theory further explains that there is a need of examining how dialogues are used in finding justice within the societies so as to bring equivalent within the society.

Picture 4.2: Shows the researcher with some children who belonged to adolescent mothers, and the children did not have the opportunity to go to school

Source: Field data (2022)

4.4.4 Level of Awareness of Sexual Reproductive Health to Adolescents

The second objective focused in identifying the level of awareness of sexual reproductive health to adolescents. Descriptive analysis was used in analyzing the study results frequencies percentage and mean ware used in interpreting the study results. 1.00-1.80= Very Small, 1.81-2.60= Small, 2.61-3.40= Moderate, 3.41-4.20= High, 4.21-5.00= Very High

Table 4.14: Descriptive analysis Level of Awareness of Sexual Reproductive Health to Adolescents

Variables	SD	D	M	A	SA	N	Mean
Awareness on unwanted pregnancy	41 (50%)	15 (18.3%)	1 (1.2%)	13 (15.9%)	12 (14.6%)	82	2.2683
Awareness on unsafe abortion	14 (17.1%)	42 (51.2%)	13 (15.9%)	13 (15.9%)	0 (0%)	82	2.3049
Awareness on sexually transmitted infections	54 (65.9%)	15 (18.3%)	0 (0%)	13 (15.9%)	0 (0%)	82	1.6585
Awareness on Health problem like anemia	41 (50%)	15 (18.3)	1 (1.2%)	13 (15.9%)	12 (14.6)	82	2.2683
Awareness on postpartum hemorrhage	14 (17.1%)	42 (51.2%)	12 (14.6%)	13 (15.9%)	1 (1.2%)	82	2.3293
Awareness on mental disorders (like depression)	53 (64.6%)	14 (17.1%)	2 (2.4%)	10 (12.2%)	3 (3.7%)	82	1.7317
Weighted mean							2.0935
1.00-1.80= Very little Awareness 1.81-2.60= little Awareness 2.61-3.40= Moderate Awareness 3.41-4.20= High Awareness 4.21-5.00= Very High Awareness							

Source: Field Data (2022)

Table 4.14 above reveals that respondent who were asked on concerning the level of awareness of sexual reproductive health to adolescents; as a result table 4.7 above revels that concerning the awareness on unwanted pregnancy 68.3(50%,18.3%) disagreed that awareness concerning unwanted pregnancy was not well taught, 1.2% presented moderate awareness, 15.9% strongly agreed that there was awareness concerning unwanted pregnancy and 14.6% strongly agreed that awareness on unwanted pregnancy was well taught. concerning the awareness on unsafe abortion 17.1% strongly disagreed and 51.2% disagreed that awareness

concerning unsafe abortion was not well taught, while 15.9% presented moderate awareness, 15.9% strongly agreed that there was awareness concerning unwanted pregnancy and 0% strongly agreed that awareness on unsafe abortion was well taught.

Concerning the awareness on sexually transmitted infections 65.9% strongly disagreed and 18.3% disagreed that awareness concerning sexually transmitted infections was not well taught, while 0% presented moderate awareness, 15.9% strongly agreed that there was awareness concerning unwanted pregnancy and 0% strongly agreed that awareness on sexually transmitted infections was well taught. concerning the awareness on health problem like anemia 50% strongly disagreed and 18.3% disagreed that awareness concerning on health problem like anemia was not well taught, while 1.2% presented moderate awareness, 15.9% strongly agreed that there was awareness concerning unwanted pregnancy and14.6% strongly agreed that awareness on health problem like anemia was well taught.

Concerning the awareness on postpartum hemorrhage 17.1% strongly disagreed and 51.2% disagreed that awareness concerning postpartum hemorrhage was not well taught, while 14.6% presented moderate awareness, 15.9% strongly agreed that there was awareness concerning unwanted pregnancy and 14.6% strongly agreed that awareness on postpartum hemorrhage was well taught. concerning the awareness on mental disorders (like depression)17.1% strongly disagreed and 51.2% disagreed that awareness concerning on mental disorders (like depression)was not well taught, while 15.9% presented moderate awareness, 15.9% strongly agreed that

there was awareness concerning unwanted pregnancy and 0% strongly agreed that awareness on mental disorders (like depression)was well taught. Concerning the awareness on mental disorders 64.6% strongly disagreed and 17.1% disagreed that awareness concerning mental disorders was not well taught, while 2.4% presented moderate awareness, 12.2% strongly agreed that there was awareness concerning unwanted pregnancy and 3.7% strongly agreed that awareness on mental disorders was well taught.

Table 4.14 above revels that the adolescents had little awareness on unwanted pregnancy with mean score of 2.2683,the adolescents had little awareness on unsafe abortion with mean score of 2.3049 ,the adolescents had little awareness on sexually transmitted infections with mean score of 1.6585 the adolescents had little awareness on health problem like anemia with mean score of 2.2683 the adolescents had little awareness on postpartum hemorrhage with mean score of 2.3293 the adolescents had little awareness on mental disorders (like depression) with mean score of 1.7317

Generally the study concludes that the adolescents had little awareness on sexual reproductive health to adolescents 2.0935

4.4.5 One sample test

The study revealed that respondents' awareness on sexual and reproductive health issues was 46.8% (0.468) of the respondents had high awareness on sexual and reproductive health matters (Rangi and Mwageni, 2018). The One Sample *t* Test

is used to test Statistical difference between hypothesized values of the mean in the population. Which are:-

H_0: $\mu_{\text{Awareness Level}}$ = Awareness Level ("Health care-workers provide awareness on sexual reproductive heal to adolescents")

H_1: $\mu_{\text{Awareness Level}} \neq$ Awareness Level ("Health care-workers do not provide at all awareness on sexual reproductive heal to adolescents ")

Therefore, the researcher accepts the probability value (P values) that is below 0.05 and rejecting the values that are above 0.05 as assessed by Shapiro-Wilk's test. The t-value measures the size of the difference relative to the variation in the sample data

Table 4.15: One Sample Statistics on the Level of Awareness of Sexual Reproductive Health to Adolescents

	N	Mean	Std. Deviation	Std. Error Mean
Awareness Level	82	2.0935	1.16978	.12918

Source: Field Data (2022)

The One-Sample Statistics, provides information about awareness given by health workers to adolescent, the mean for health care workers that provides awareness to adolescents (2.0935 ± 1.16978) was lower than the normal score of the occurrence of adolescent pregnancies which is 46.8% (0.468).

Table 4.16: One- Sample Test of information about awareness given by health workers to adolescent

	Test Value = 0.468					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Awareness Level	12.583	81	.000	1.62550	1.3685	1.8825

Source: Field Data (2022)

The results revels statistically significant on the level of awareness provided by the health care workers provided to adolescents whereby:- t (81) =12.583, P= .000. Also the mean difference of level of awareness provided by the health care workers provided to adolescents was statistically significantly significant by with mean difference of 1.62550(95% CI, 1.3685 to 1.8825) as a result the study rejects null hypothesis and accept the alternative hypothesis.

H_0: $\mu_{\text{Awareness Level}}$ = Awareness Level ("Health care-workers provide awareness on sexual reproductive heal to adolescents")

4.4.6 Discussion on study objective level of awareness of sexual reproductive health to adolescent

Tanzania's strategic framework of 1998 - 2002 for prevention and control of HIV/AIDS/STDs stated that, the in-school youth are to be provided with HIV/AIDS education at primary and secondary levels, with Ministry of Education and Culture (MOEC) being the key actor (URT, 1998).

4.4.6.1 Awareness on unwanted pregnancy

The study discovered that most of the teenagers frequently quit school, which prevents them from achieving their educational and personal goals. Although a global problem, adolescent pregnancies mostly affect poorer and vulnerable groups. Many females experience intense pressure to get married at young age and have children while at their early age. When girls aren't allowed to make choices about their sexual and reproductive health and well-being, the rate of teenage pregnancy rises. Girls must be empowered to make decisions regarding their bodies and lives, understand the consequences of adolescent pregnancy, and have access to appropriate healthcare services and in-depth sexuality education, according to (Kapileh (2019).

Additionally, factors like family income and the depth of a girl's education have a role. Pregnant girls frequently drop out of school, which reduces their chances of finding job later on and keeps them trapped in a cycle of poverty. Pregnancy is frequently seen by girls as being preferable to continuing their education. In addition, girls' particular dangers during crises raise their chances of becoming pregnant. The desire to make up for the loss of a child, less access to education and contraception, and an increase in sexual violence is some of the contributing factors.

A significant factor in mother and infant mortality continues to be adolescent pregnancy. The main cause of death for girls between the ages of 15 and 19 worldwide is complications associated with pregnancy and childbirth. Due to their undeveloped bodies, pregnant girls and teenagers also face additional health risks

and issues. Babies born to mothers who are younger are likewise more vulnerable. Many adolescent girls and boys do not plan or desire to become pregnant or have children. Teenagers frequently turn to unsafe abortion in nations where it is either outlawed or severely regulated, endangering their health and lives. World Health Organization (2020) Teenage mothers who are not married may experience bullying or rejection from their parents and classmates, as well as threats of physical harm. Violence in a marriage or partnership is also more likely to occur for girls who become pregnant before turning 18 years old.

Picture 4.3: Shows the researcher with adolescent mothers and their children

Source: Field Data (2022)

4.4.6.2 Awareness on Unsafe Abortion

Systematic evaluations on this topic and related contexts are still scarce, despite several attempts to comprehend adolescents' knowledge, attitudes, and practices surrounding contraception and safe abortion. To adequately address their requirements for sexual and reproductive health, one must have a thorough understanding of this topic. The topic matter covered, the amount of knowledge, and the extent/intensity of the risky behaviors being engaged in all influence the impact of sexual reproductive health education on adolescents' hazardous sexual behaviors. Mauna (2015) said that 95 percent of births of adolescent females between the ages of 15 and 19 are believed to occur in low-income nations, which account for 11 percent of births worldwide. Around 210 million women worldwide experience pregnancy each year. Approximately 75 million of themor 36%are unwanted or unexpected pregnancies. One of the main causes of maternal mortality and morbidity in South Asia is unintended or unplanned pregnancy. For instance, 35% of pregnancies in Nepal, 21% in India, and 30% in Bangladesh are unintended.

Twenty-two million unsafe abortions are expected to occur annually worldwide, almost all of which occur in underdeveloped nations, according to the World Health Organization (WHO). According to statistics from poor nations, 14% of unsafe abortions occur on women under the age of 20, (Yakubu and Salisu (2018). While abortion is legal in some nations, others, like Nepal, have made considerable strides in ensuring that women have access to safe medical care by creating comprehensive abortion care at public sector institutions McCleary-Sills *et*

al (2013). However, the majority of young people likely to die because they don't know enough about abortion. It is anticipated that a significant number of abortions are carried out outside of registered facilities by unregistered providers.

> *The adolescent stage is a very important time in life, and because they are going through a transition, they may engage in sexual activity out of love or curiosity. However, because they lack knowledge and awareness of what is inappropriate, this may force them to engage in a variety of risky behaviors. Adolescents who engage in unsafe sex are more likely to experience unexpected pregnancies, unsafe abortions, and difficulties from pregnancy.*" (Respondent XX, 2022)

Adolescent girls are at high risk and face significant physical, psychological, and financial consequences as a result of complications from unsafe abortions, which result in maternal deaths and a number of other morbidity connected to abortion around the world Ramadhani (2018). In terms of accessing reproductive health treatments, adolescents in rural locations are less knowledgeable and experienced. Rural youth frequently lack access to inexpensive, discreet health treatments for reproductive health as well as basic health information and awareness (World Health Organization (2022).

> *"Because they are typically avoided by healthcare professionals and treated poorly because they are not supposed to be engaged in sexual activity at their age, adolescents who are at risk of unsafe abortion do not even have full access to reproductive health information and treatments.*"(Respondent XI 2022)

Since health professionals typically avoid educating adolescents and treat them differently because they are not anticipated to be participating in sexual activity at their age, youths who are at risk of unsafe abortion do not even have full access to reproductive health information and treatments (Hokororo, 2014).

4.4.6.3 Awareness on Sexually Transmitted Infections

In Sub-Saharan Africa, initiation of sexual activity rises gradually between the ages of 15 and 19, with almost 75% of women and nearly 2/3 of men having sex even before age of 20. (UNAIDS, 2006). An essential element of both economic and social growth is sexual and reproductive health education in primary and secondary schools, where the majority of teenagers are found. It is one of the tactics used to combat the negative effects of teenagers' hazardous sexual conduct, such as STDs, abortion, unintended pregnancies, and even HIV/AIDS infections (UNICEF, 1996)

The majority of the teenagers studied had sexual partners who were five or more years their senior. A tragedy has resulted from the youths' lack of knowledge. The majority of adolescents mistakenly believe that they are loved and cared for when taking risks. Young males have no problem having several lovers or having sex with unofficial partners. At Mozambique, 82% of girls in government schools reported being sexually active and likely to have had numerous sexual partners, compared to 52% of girls in private schools who reported having only one partner (Barua and Kurz, 2001).

Lack of understanding causes some adolescents to become alcoholics, and as a result, the majority of them are at danger of obtaining HIV and other STDs. Additionally, the National HIV/AIDS policy emphasized that behavior change at all levels by all sectors is possible through increased awareness created and maintained through information, education, and communication

4.4.6.4 Awareness on Health problem like anemia

The majority of young people are not properly informed about health issues like anemia. Most young women who are pregnant experience exhaustion, weakness, dizziness, and shortness of breath without being aware of the underlying cause. Some pregnant young people don't realize that their lives must change in order to take care of their nutrition, consume foods high in iron, take vitamins, and protect themselves from infectious diseases including malaria, TB, HIV, and parasitic infections. Most young women who become pregnant discover this concept for the first time.

Anemia is a significant global public health issue that primarily affects young children and pregnant women, according to (Magwanjaet. al 2021). According to WHO statistics, anemia affects 40% of pregnant women and 42% of children under the age of five worldwide. Anemia is known to affect more than one-third of all women of childbearing age and young children under the age of five. One of the healthcare professionals that was questioned stated that

"Anemia is a condition where there are fewer red blood cells and less hemoglobin in the blood. Hemoglobin that is aberrant may also exist.

Hemoglobin, a protein found in red blood cells (RBCs), is a specialty cell that is present in our blood. The hemoglobin found in red blood cells (RBCs) binds to the oxygen in the lungs. As a result, all regions of the body receive this oxygen from the lungs through the blood. Any decrease in the quantity of RBCs or hemoglobin and abnormalities in hemoglobin lead to a diminished ability to carry oxygen, which in turn reduces the amount of oxygen delivered to a variety of crucial bodily tissues"(Respondent IV 2022)

Most young women who become pregnant in their early years are unaware that they need take prenatal vitamins containing iron to help prevent and cure iron deficiency anemia during pregnancy. Additionally, teenagers were often unaware that poor diet can help avoid iron deficiency anemia during pregnancy.

"When I was first pregnant, I didn't understand why I was always fatigued, and I was afraid to visit the hospital for fear that they would mistreat me. I was unsure about whether I should take dietary sources of iron include dried beans, dark-green leafy vegetables, seafood, poultry, and lean red meat. My life used to just be normal eating since it was so challenging."(Respondent LXX 2022)

According to estimates, anemia affects one in three women worldwide of reproductive age (WRA) and manifests as hemoglobin (Hb) levels under 11 g/dl (World Health Organization (2020). Pregnant women are considerably more burdened. According to the 2011 Nutrition Impact Model Study, anemia affects 38% of pregnant women worldwide

4.4.6.5 Awareness on postpartum hemorrhage

The global health system continues to face significant obstacles due to maternal mortality. According to the World Health Organization (WHO), the majority of the 295 000 women who pass away each year as a result of pregnancy-related problems can be prevented or treated. 94% of maternal deaths worldwide occur in low- and lower-middle-income nations. United Nations Populations Funds, (2022) point out that about 20% of all maternal deaths are caused by postpartum hemorrhage, accounting for more than 25% of these deaths (PPH). Most young people are unaware of postpartum hemorrhage PPH, which puts them in danger of losing 500 ml or more of blood within 24 hours of giving birth (World Health Organization, 2022).

According to World Population Review, (2022) the main barrier to high-quality PPH-care identified by patients was a lack of information among adolescents and their partners prior to, during, and after the PPH event. By contrast, health care providers cited a lack of clarity in the guidelines, a lack of knowledge, and poor communication within teams as barriers. Therefore, an in-depth analysis from various perspectives and the identification of influencing factors for the delivery of quality PPH-care will provide the necessary information for implementing a strategy to improve care, and will help to improve the quality of care given to youth for the prevention of PPH. From the viewpoints of patients and families, the community, and health care professionals, little is currently understood in Tanzania

regarding important factors that can influence the early detection of youth at risk of PPH.

4.4.6.6 Awareness on mental disorders (like depression)

A teenage pregnancy can change a young mother's life's direction. She is now in a position where she must take care of another person in addition to herself. Physical changes are simply one aspect of being a mother and carrying a child. Women experience mental changes as well. Young mothers experience additional stress due to restless nights, child care arrangements, doctor's appointments, and trying to complete high school.

The study discovered that postpartum depression affected girls between the ages of 15 and 19 at a rate that was twice as high as that of women over the age of 25. According to (Yakubu *et al* 2018), teen moms experience high levels of stress, which might subsequently cause more mental health issues. Teenage mothers experience increased depression rates in addition to higher postpartum depression rates. Additionally, they have more suicidal thoughts than their friends who aren't mothers. Posttraumatic stress disorder (PTSD) is more common in young mothers than in other teenage girls. This might be the case because teen mothers are more likely to have experienced physical or emotional abuse.

> *One of the people who responded said that she had baby blues symptoms one to two weeks after giving birth. Mood swings, worry, depressed, overwhelm, difficulty concentrating, trouble eating, and difficulties sleeping are some of these symptoms".*(Respondent, IX 2022)

According to the survey, the majority of young people were unaware of postpartum depression. Postpartum depression is twice as common in teen mothers as in mature mothers. Some of the teenagers had trouble bonding with their infants, excruciating exhaustion, a sense of worthlessness, worry, panic attacks, and the desire to hurt themselves or their children. They also had trouble engaging in activities they used to like. Part Kart, (2013) Due to their increased likelihood of exposure to communal and interpersonal violence, teen moms are also at risk for acquiring symptoms of posttraumatic stress disorder. According to one study, young moms had averaged >5 traumatic experiences, such as physical assaults by a partner, parental neglect, abuse, incarceration, and tragic loss.

The study presumes that communication is a tool that could be used for social change. The study believes that communication is the best way of providing awareness to the adolescent's girls since them focuses in bringing about change. However lack of communication might impact communities positively or negatively with an emphasis on adolescent pregnancies. Effective communication for social change involves and engages the local community to fully understand the issues they are facing and the potential solutions that affect people.

4.4.6.7 Influence of health care workers attitudes towards adolescents on sexual reproductive health services

The third objective focused in identifying the influence of health care workers attitude towards adolescents on sexual reproductive health services. Descriptive analysis was used in analyzing the study results frequencies percentage

and mean ware used in interpreting the study results However in interpretation the mean score 1.00-1.80= Very Small, 1.81-2.60= Small, 2.61-3.40= Moderate, 3.41-4.20= High, 4.21-5.00= Very High

Table 4.17: Cross tabulation Influence of health care workers attitudes towards adolescents on sexual reproductive health services

Variables		SD	D	M	A	SA	Mean
Providing appropriate information	Adolescents girls	5 16.7%	8 26.7%	2 6.7%	3 10%	0 0%	2.93
	Health Workers	0 0%	0 0%	1 3.3%	5 16.7%	1 3.3%	
	Social Workers	0 0%	0 0%	1 3.3%	2 6.7%	2 6.7%	
Providing contraception and treatment for sexually transmitted	Adolescents girls	8 26.7%	6 20%	1 3.3%	1 3.3%	2 6.7%	3.00
	Health Workers	0 0%	0 0%	0 0%	4 13.3%	3 10%	
	Social Workers	0 0%	0 0%	0 0%	3 10%	2 6.7%	
Maintaining privacy and confidentiality	Adolescents girls	4 13.3%	9 30%	2 6.7%	3 10%	0 0%	3.03
	Health Workers	0 0%	0 0%	0 0%	5 16.7%	2 6.7%	
	Social Workers	0 0%	0 0%	1 3.3%	2 6.7%	2 6.7%	
utilization of health care facilities/ tools	Adolescents girls	9 30%	5 16.7%	2 6.7%	0 0%	2 6.7%	2.93
	Health Workers	0 0%	0 0%	0 0%	4 13.3%	3 10%	
	Social Workers	0 0%	0 0%	1 3.3%	1 3.3%	3 10%	
Weighted Mean							2.972
1.00-1.80= Very Small Attitude 1.81-2.60= Small Attitude 2.61-3.40= Moderate Attitude 3.41-4.20= High Attitude 4.21-5.00= Very High Attitude							

Source: Field Data (2022)

Table 4.17 above revels that 16.7% of the adolescents strongly disagreed that health care workers provided appropriate information 26.7% disagreed that health care workers provided appropriate information, 6.7% reported on moderate attitude 10% agreed that health care workers provided appropriate information. 3.3% of the health workers reported on moderate attitude 5% agreed that health care workers provided appropriate information and 1% strongly agreed that health care workers provided appropriate information. 3.3% of the social workers reported on moderate attitude 6.7% agreed that health care workers provided appropriate information and 6.7% strongly agreed that health care workers provided appropriate information

26.7% of the adolescents strongly disagreed that health care workers provided contraception and treatment for sexually transmitted 20% disagreed that health care workers Provided contraception and treatment for sexually transmitted, 3.3% reported on moderate attitude 3.3% agreed that health care workers provided contraception and treatment for sexually transmitted 6.7% strongly agreed that health care workers provided contraception and treatment for sexually transmitted. 13.3% of the health workers reported agreed that health care workers provided contraception and treatment for sexually transmitted and 10% strongly agreed that health care workers provided contraception and treatment for sexually transmitted/ 10% of the social workers agreed that health care workers provided contraception and treatment for sexually transmitted and 6.7% strongly agreed that health care workers provided contraception and treatment for sexually transmitted

30% of the adolescents strongly disagreed that health care workers provided Provisions of health care facilities/ tools 16.7% disagreed that health care workers Provided Provisions of health care facilities/ tools, 6.7% reported on moderate attitude 6.7% strongly agreed that health care workers provided contraception and treatment for sexually transmitted. 13.3% of the health workers agreed that health care workers provided awareness on utilization of health care facilities/ tools and 10% strongly agreed that health care workers had good attitude to adolescents in utilization of health care facilities/ tools, 3.3% of the social workers moderately reported that health care workers had good attitude on utilization of health care facilities/ tools and 3.3% of the social workers agreed that health care workers provided good attitude on utilization of health care facilities/ tools and 10% strongly agreed that health care workers provided good attitude of health care facilities/ tools

Health care workers provided moderate attitude on appropriate information concerning sexual reproductive health with mean score of with mean score of 2.93, Health care workers provided moderate attitude on contraception and treatment for sexually transmitted on sexual reproductive health services with mean score of with mean score of 3.00, Health care workers provided moderate attitude on consequences of early pregnancies on sexual reproductive health services with mean score of with mean score of 3.0, Health care workers provided moderate attitude in utilization health care facilities/ tools on sexual reproductive health services with mean score of with mean score of 2.93,

Lastly the study concludes that the health care workers had moderate attitudes towards adolescents on sexual reproductive health services with weighted mean of 2.972.

4.4.5 Attitudes of health care workers towards adolescents on sexual reproductive health services

Proportion of positive attitudes was assumed to be 50%; and r, the margin of error of estimation, was assumed to be 5% or 0.05 (Tilahum *et al* 2012) The One Sample *t* Test is used to test Statistical difference between hypothesized values of the mean in the population. Which are:-H_0: $\mu_{Attitude}$ = Attitude of health care workers ("health care workers have positive attitudes towards adolescents on sexual reproductive health services")

H_1: $\mu_{Attitude} \neq$ Attitude of health care workers ("health care workers have negative attitudes towards adolescents on sexual reproductive health services ")

Therefore, the researcher accepts the probability value (P values) that is below 0.05 and rejecting the values that are above 0.05 as assessed by Shapiro-Wilk's test. The t-value measures the size of the difference relative to the variation in the sample data.

Table 4.18 One Sample Statistics on the Influence of health care workers attitudes towards adolescents on sexual reproductive health services

	N	Mean	Std. Deviation	Std. Error Mean
Attitude of Health care workers	30	2.9750	1.42537	.26024

Source: Field data (2022)

The One-Sample Statistics, provides information about health care workers attitudes towards adolescents on sexual reproductive health services, the mean for health care workers attitudes towards adolescents on sexual reproductive health services (2.9750±1.42537) was lower than the normal score of the occurrence of adolescent pregnancies which is 5% or 0.05

Table 4.19: One Sample T-test on the Influence of health care workers attitudes towards adolescents on sexual reproductive health services

	Test Value = 0.05					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Attitude of Health care workers	11.240	29	.000	2.92500	2.3928	3.4572

Source: Field Data (2022)

The health care workers attitudes towards adolescents on sexual reproductive health services then, t (81) =11.240, P= .000. Also the mean difference of health care workers attitudes towards adolescents on sexual reproductive health services was statistically significantly significant by 2.92500 (95% CI, 2.3928 to 3.4572) as a result the study rejects null hypothesis and accept the alternative hypothesis.

H_0: $\mu_{Attitude}$ = Attitude of health care workers ("health care workers have positive attitudes towards adolescents on sexual reproductive health services")

4.4.5.1 Discussion on the Attitudes of health care workers towards adolescents on sexual reproductive health services

The research demonstrates that adolescents are less at ease than adults in using reproductive and sexual health services because they frequently lack fundamental Blood group information, expertise, and experience. This might be a result of parents, healthcare professionals, and educators frequently being unable or reluctant to give children age-appropriate RH information. Discouragement is frequently attributed to adolescents' embarrassment or discomfort discussing sensitive topics with their health care provider, less favorable attitudes toward the use of health services and providers, dissatisfaction with how questions are handled by healthcare professionals, uncertainty about what providers do with information, and even being treated disrespectfully by their health care providers.

Picture 4.4: Shows Healthcare workers having a discussion on their understanding on provision of sexual reproductive health services to adolescents

Source: Field data (2022)

4.4.5.2 Providing appropriate information

Health care professionals have voiced complaints about the lack of sufficient education regarding sexual and reproductive health. The youth do not show up for meetings when they are call or do not attend sessions when instruction is offered, according to the healthy workers. Some of the healthcare professionals claimed that it was challenging to track down one young person after another; others found them in schools where they hold talks with instructors and pupils. The majority of respondents, however, claimed that the healthcare professionals didn't give a damn,

even though they gave the broad information that was previously well-known. The researcher found a variety of replies from teens. As a result, some young people don't learn the truth.

Some teenagers claimed that the medical staff told them that since globalization has made everything more widely known, there is no need to spend much time elaborating on the truth. According to Saria, Joseph, (2017), adolescents worry about being reprimanded by medical professionals and being exposed. According to other studies, health care professionals lack the requisite training for efficient communication with teenagers. Teenagers were demonstrated to seek assistance from close friends and siblings in these circumstances, as well as from distant medical facilities. They might also be inclined to use illicit medical facilities, such as those that perform illegal abortions, placing their own lives in grave danger.

Picture 4.5: Shows adolescents receiving sexual reproductive health education

Source: Field data 2022

The picture above shows the researcher (fourth from left), with adolescents during a focused group discussion on their awareness of sexual reproductive health.

4.4.5.3 Providing contraception and treatment for sexually transmitted utilization of health care facilities/ tools

The young people claimed that the medical staff did not offer appropriate contraceptive or sexual and reproductive health care. They were informed by some of the healthcare professionals that contraception was only for adults.

One of the teenagers claimed that "*the health care professionals instructed them to concentrate primarily on their grades rather than receiving the correct information, neglecting the fact that the adolescents' entitlement to obtain sexual and reproductive education*".

According to statistics, teens face a number of challenges while attempting to access medical care (and among the young people surveyed, many said they needed condoms). Healthcare professionals' opinions on providing sexual and reproductive health treatments to teenagers are divided, according to (Steinberg Laurence, 2014). They overwhelmingly supported explicit sexuality education and responded favorably to health education (92%) (Part Kart, 2013). Young men and one-third of young women reportedly used a condom during their most recent sex, according to (Nkata, 2019). Teenagers are thus more vulnerable to a range of problems with

reproductive health, such as unplanned pregnancies, unsafe abortions, and sexually transmitted infections like HIV/AIDS.

Picture 4.6: Shows and adolescent mother testifying about her experience with healthcare workers when she was pregnant and after giving birth

Source: Field data (2022)

4.4.5.4 Maintaining privacy and confidentiality

Maintaining the teens' privacy was challenging for the medical staff because of the weakness they disclosed to the medical professionals, some of the pupils even lost their studies or was expelled from school after reporting what they had been taught to the school community. In addition, some students claimed that they found it difficult to interact with medical professionals since they frequently enlisted the help of multiple people when seeking a solution, which made it embarrassing for them.

4.4.6 Weakness in legislation Policies that Undermines Adolescents Mothers

The fourth objective focused in identifying the weakness in legislation policies that undermines Adolescent mothers. Descriptive analysis was used in analyzing the study results frequencies percentage and mean ware used in interpreting the study results However in interpretation the mean score 1.00-1.80= Very Small, 1.81-2.60= Small, 2.61-3.40= Moderate,3.41-4.20= High, 4.21-5.00= Very High. Also the likert scale presents that SD-Strongly disagree, D- Disagree- Moderate, Agree, SA- Strongly Agree.

Table 4.20 below reveals that those who reported that lack of implementation of Laws that hold accountable the male counterpart from impregnating an adolescent girl strongly disagree presented 6.1%, disagree were 11%, moderate presented 8.5%, agree presented 32.9 ,strongly agree presented 41.5% , concerning implementation and enforcement of laws and policies in place towards child protection specifically related to adolescent pregnancies strongly disagree presented 7.3%, disagree were 9.8%, moderate presented 4.9%, agree

presented 37.8%, strongly agree presented 40.2% .

Table 4.20: Descriptive analysis on the weakness in legislation policies that undermines Adolescent mothers

	SD	D	M	A	SA	N	Mean
Lack of implementation of Laws that hold accountable the male counterpart from impregnating an adolescent girl	5 (6.1%)	9 (11%)	7 (8.5%)	27 (32.9)	34 (41.5%)	82	3.93
Lack of implementation and enforcement of laws and policies in place towards child protection specifically related to adolescent pregnancies	6 (7.3%)	8 (9.8%)	4 (4.9%)	31 (37.8%)	33 (40.2%)	82	3.94
Lack of enough child protection mechanisms that protect and manage children's rights	5 (6.1%)	8 (9.8%)	12 (14.6%)	29 (35.4%)	28 (34.1%)	82	3.82
Awareness of individuals about the existing laws	7 (8.5)	8 (9.8%)	8 (9.8%)	28 (34.1%)	31 (37.8%)	82	3.83
Information by individuals on where to report or access their rights	7 (8.5%)	11 (13.4%)	4 (4.9%)	33 (40.2%)	27 (32.9%)	82	3.76
Weighted mean							3.856
1.00-1.80= Very Small Weakness 1.81-2.60= Small Weakness 2.61-3.40= Moderate Weakness 3.41-4.20= High Weakness 4.21-5.00= Very High Weakness							

Source: Field data (2022)

Table 4.20 above reveals concerning Lack of enough child protection mechanisms that protect and manage children's rights strongly disagree presented 6.1%, disagree were 9.8%, moderate presented 14.6%,agree presented 35.4%,

strongly agree presented 34.1% , concerning awareness of individuals about the existing laws strongly disagree presented 8.5%, disagree were 9.8%, moderate presented 9.8%, agree presented 34.1%, strongly agree presented 37.8% , concerning information by individuals on where to report or access their rights strongly disagree presented 8.5%, disagree were 13.4%,moderate presented 4.9%, agree presented 40.2%, strongly agree presented 32.9%

High weakness in Lack of implementation of Laws that hold accountable the male counterpart from impregnating an adolescent girl with mean score of 3.93, High weakness Lack of implementation and enforcement of laws and policies in place towards child protection specifically related to adolescent pregnancies with mean score of 3.94, High weakness Lack of enough child protection mechanisms that protect and manage children's rights with mean score of 3.82, High weakness Awareness of individuals about the existing laws with mean score o 3.83, High weakness Information by individuals on where to report or access their rights with mean score of 3.76.

Generally the objective concludes that there was high weakness in legislation policies that undermines Adolescent mothers with weighted mean of 3.856

The study accepts the facts that stigmatization is among the factors that destroys people lives however the new adolescents mothers get stigmatized once they get pregnant. One of the respondents reported that

"Among the many difficulties I had at the time, I recall the stigmatization I

experienced. In addition to being a pregnant adolescent and raising my child alone, I was also teased because I appeared too young to be pregnant. I chose to become a recluse in my own home, only going when absolutely necessary to see the clinic or get needed necessities from nearby stores My parents accepted my apology for my dramatic behavior, understood my decisions, and welcomed me back when I was five months pregnant. They have been very supportive ever since" (Respondent IX, 2022)

On the other side, teenagers who are pregnant and adolescent moms experience significant stigmatization in society, beginning in their households and among medical professionals when they visit clinics and ending with the general public (Martinez, 2017). Additionally, they frequently receive criticism for putting themselves in such predicaments without holding men responsible for their behavior or understanding the underlying primary issues.

What initially caused them to fall into the trap, according to the experiences of the majority of adolescent mothers and pregnant adolescents, was primarily poverty, with families occasionally pressuring them to bring money for food back home, with the simplest way being to engage in sexual activity in exchange for money. Along with that, they also deal with a lot of stigmatization from society because single girls with children are seen differently than married girls.

Stigma is a "attribute that is severely disparaging," according to Goffman (1963: 3). He considered stigma to be a common element of social life that complicates routine, small-talk exchanges. As a result, those who are frequently

stigmatized (having a stigma or being labeled as an outcast) may be wary of dealing with people who do not share their stigma, and those who do not experience stigma may disparage, overcompensate for, or ignore stigmatized people (Clair, 2018).

Additionally, Parker and Aggleton (2003) underline that it is crucial to recognize that stigma develops and stigmatization takes shape in certain cultural and political contexts as a result of all the aforementioned. However, Parker and Aggleton (2003) point out that this renewed focus on traditional sociology is still concerned with structures, institutions, classifications, and power, as well as how stigma feeds on, solidifies, and perpetuates already-existing inequalities of class, race, gender, and sexuality. In response, grassroots efforts to combat particular types of societal stigma have emerged.

4.4.6.1 Weakness in legislation Policies that Undermines Adolescents Mothers

The One Sample *t* Test is used to test Statistical difference between hypothesized values of the mean in the population. Which are:-

H_0: $\mu_{\text{weakness in legislation}=}$ There is Weakness in legislation Policies that Undermines Adolescents Mothers”

H_1: $\mu_{\text{weakness in legislation}} \neq$ There is no Weakness in legislation Policies that Undermines Adolescents Mothers

Therefore the researcher accepts the probability value (P values) that is below 0.05 and rejecting the values that are above 0.05 as assessed by Shapiro-Wilk's test. The t-value measures the size of the difference relative to the variation in the sample data

Table 4.21: One Sample T- Test on Weakness in legislation policies that undermines Adolescent mothers

	N	Mean	Std. Deviation	Std. Error Mean
Weakness in legislation Policies	82	3.8537	1.12746	.12451

Source: field Data (2022)

The One-Sample Statistics, Weakness in legislation policies, the mean for Weakness in legislation policies (3.8537 ± 1.12746) was lower than the normal score of the occurrence of adolescent pregnancies which is 55% (0.55)

Table 4.22: Weakness in legislation policies that undermines Adolescent mothers

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Weakness in legislation Policies	26.534	81	.000	3.30366	3.0559	3.5514

Source: field Data (2022)

The existing disparities are statistically significant to the occurrence of adolescent pregnancies since Weakness in legislation policies that undermines Adolescent mothers en, t (81) =26.534, P= .000. Also the mean difference of disparities was statistically significantly significant by 3.30366 (95% CI, 3.0559 to 3.5514) as a result the study rejects null hypothesis and accept the alternative hypothesis.

H_0: μ_{Weakness} = There is weakness in legislation policies that undermines Adolescent mothers

4.4.6.2 Discussion of study findings concerning Lack of implementation of Laws that hold accountable the male counterpart from impregnating an adolescent girl

Law of marriage ACT Section 10(2), 13 (1) and 17 allow men to contract polygamous marriages and permit the marriage of 15 years old girls while the minimum age of a boy is 18 years. When parents agrees that their child need to get married then the marriage is allowed or when the doctor confirms that the child is ready to get into marriage. Also when the religious leaders confirm that the child should get married this is stated in governmental proposal as of 28th September 2022 regarding adolescent's pregnancies and child marriages.

However, fifteen respondents who were men urged that most of Tanzania's projects focus more on empowering women and creating awareness on women on

matters that affect them than also involving men. Little attention has been put on programs that focus on men themselves or on programs carried out by men for men as the perpetrators of most gender-related problems including adolescent pregnancies.

Consequently, research done in Bangladesh and Uganda by UNFPA and ICOMP (2011), believes that it is important to include men in gender and development because when one goes down to the reality of most developing countries of Asia and Africa, men tend to be predominantly service providers on gender issues law enforcers, health center personnel, lawyers, community leaders the main actors in social behaviors and the existing beliefs that influence the gender needs of women and children. Moreover, they emphasized those men as service

Providers must ideally respond to the perceived and objective needs of women and children in the communities and must be part of the implementation of laws that focus on protecting women and children. Thus, the existence of inclusive programs that promote boys' and men's participation will lead to the achievement of positive roles and a sense of responsibility of men as leaders, husbands, fathers or peers. This will then impact the society differently being aware of men's role in domestic violence, the spread of STIs including HIV/AIDs, family planning and risky lifestyles that significantly affect the lives of girls, women, boys, and men themselves.

When thirty male respondents were asked about their perception on the use of contraceptives, to begin with, most preferred not using condoms, and apart from

condoms they preferred women to be the ones using contraceptives instead. When they were asked why they preferred it the other way round, they said they were more concerned on the impacts of contraceptives on their sexual performance and fertility. There were also strong cultural myths attached to contraception. Other men did not prefer using contraceptives due to religious beliefs that discourage the use of contraceptives, and individuals believe that it is sinful to use them. Nevertheless, for instance, the bible has not mentioned anything specific with population control but the bible verse that most people relate with is Genesis 1:22 – And God blessed them, saying, "Be fruitful and multiply and fill the waters in the seas, and let birds multiply on the earth

4.4.6.3 Lack of implementation and enforcement of laws and policies in place towards child protection

Implementation and enforcement of laws was found to be poor when interviewing one of the respondents reported that my son aged 17 years is charged with an offence of impregnating a schoolgirl who is apparently aged 19 years. I wonder why my son is being charged while the girl consented, and why the girl is not charged for having sexual intercourse with someone below the age of 18 years. Respondents complained that why did the laws protect only female students and not male students below 18 years. Child marriage denies girls their right to make vital decisions about their sexual health and well-being. It forces them out of education and into a life of poor prospects, with an increased risk of violence, abuse, ill health

or early death. Child marriage perpetuates poverty, inequality and insecurity and is an obstacle to global development.

Respondent said that in Tanzania, bottom-up approaches are still not well practiced as most decisions are made by entities or individual people with authority or power. She gave an example of the decision that was made by the late President Magufuli that did not allow adolescent mothers to return to school after giving birth. However, this policy was not supported by many people in society due to the fact that every child has the right to education, and some girls end up in such a situation due to different factors such as rape where you cannot fully blame the girl for getting pregnant.

4.4.6.4 Weakness Related to adolescent pregnancies lack of enough child protection mechanisms that protect and manage children's rights

Tanzania has a variety of regulations pertaining to teenage pregnancy. The Written Laws (Miscellaneous Amendments) Act, No.1 of 2020 revised the Education Act, which states that impregnating a schoolgirl is illegal under section 60 A (3). A schoolgirl's pregnancy carries a minimum sentence of 30 years in jail. However, the Act is deemed to have a flaw in that it enables that a schoolgirl's consent to sexual activity is not an adequate defense against a charge of impregnating a schoolgirl. Additionally, it thinks that a girl's consent can disprove a rape accusation if the victim was at least 18 years old when the crime was committed.

The statute further states that two facts must be proven in order for the crime of impregnating a schoolgirl to be proven: first, that the girl was enrolled in a primary or secondary school at the time of the impregnation, and second, that the accused was the one who did it. Age of the victim and consent are not important factors.

According to section 138C(1)(d) of the Penal Code [Cap.16 R.E 2019] as amended by the Written Laws (Miscellaneous Amendments) Act, No.1 of 2020, a female engaging in sexual activity with a male who is under the age of 18 is guilty of a crime referred to as "severe sexual abuse." Because the schoolgirl had sex with a boy who was underage, she can also be charged with grave sexual abuse. Because the schoolgirl engaged in sexual activity with a boy who was under the age of 18, she may also be charged with the crime of grievous sexual abuse. Whether the boy attends school or not is irrelevant. Regardless of whether a boy is enrolled in school or not, it is against the law to have sexual relations with anyone under the age of 18.

The minimum penalty for having sexual intercourse with a boy under 18 years is also 30 years imprisonment. Although the minimum penalty for impregnating a schoolgirl is 30 years imprisonment, in view of section 60A(6) of the Education Act as amended by Act No.1 of 2020, where the offender is a boy under the age of 18 years, he cannot be sentenced to 30 years imprisonment. Its also claimed that a boy under the age of 18 years is a child so he would be sentenced according to section 119(1) of the Law of the Child Act [Cap 13 R.E 2019] which prohibits the imposition of custodial punishment to a child under the age 18 years.

The minimum sentence for engaging in sexual activity with a boy under the age of 18 is 30 years in prison. Although the minimum term for getting a schoolgirl pregnant is 30 years in prison, section 60A (6) of the Education Act as amended by Act No. 1 of 2020 states that a boy who committed the crime before turning 18 cannot receive a 30-year sentence. In accordance with section 119(1) of the Law of the Child Act [Cap 13 R.E 2019], which forbids the application of prison punishment to a child under the age of 18, a boy under the age of 18 would be condemned.

One of the respondents revealed that he was originally from Maasai settlements in Tanzania's northeast. He underlined that because of their nomadic lifestyles as cattle rustlers, for instance, girls in his village are never ready to attend school (education for females is not valued). He claimed that a girl child is primarily prepared to be a housewife and child-bearer through Maasai cultural traditions. Girls frequently marry young, and occasionally to men who are up to 50 years older than them. A woman can have up to 18 children, and they frequently do so because having offspring is seen as a symbol of supremacy. In addition to these, widow inheritance and female genital mutilation are also common in Maasai tribes. He explained that girls may face psychological trauma and other challenges at an early age that are difficult to handle even as adults.

4.4.6.5 Awareness of individuals about the existing laws Information by individuals on where to report or access their rights

The study found that some people were unaware of the rules that govern adolescents. In addition, the respondent said that due to a lack of openness, there are

additional issues that can be connected to adolescents in general (both boys and girls) in addition to adolescent pregnancies. The majority of parents, she continued, do not communicate with their kids in such a way that it results in a lack of self-awareness. Parenting in general, according to the respondent, should.

A second respondent, a social worker from Victoria in Dar es Salaam who was 18 years old, solidified the idea of shared cultures. He said that social workers who assist with adolescent pregnancies frequently interact with many villages and tribes around Tanzania. Lack of shared cultural traditions and experiences, as well as their inability to always speak the same language, make it difficult for the community to comprehend them or to accept some of the changes they wish to implement. This is one of their largest problems. He did, however, say that it was simpler to listen to someone who was from their community or who spoke a language comparable to their own.

The respondent cited as an example a 24-year-old Sukuma woman with five children that he met in Chato. Less than 3000 Tanzanian shillings were the girl's daily earnings from selling sweets beside the road (about 1.13 Euros). They made an effort to get her to talk about her knowledge of certain issues surrounding adolescent pregnancies, such as the detrimental effects of adolescent pregnancies and how she manages to raise five kids. The girl said she wasn't receiving enough support from the father of her children. She was giggling at one time and attempting to figure out what they were discussing. Because she had always been raised to marry and have

children, she felt as though it was a violation of their cultural customs. In fact, she went on to say that having more children in her society is a privilege.

It is crucial to have dialogues with kids and teenagers that can promote self-awareness and save a lot of difficulties when seen as a component of raising future adults. Additionally, talking to kids about life objectives and what to do if they find themselves in an environment or circumstance that compels them to violate their morals should start at a young age. Another respondent emphasized the importance of starting the conversation at the family level before moving it to the community level. Parents should talk to their kids, and older siblings should talk to their younger siblings when it makes sense. The respondent also stated that in the current digital age, kids and teenagers are exposed to many types of information, including pornographic content on various websites and social media. Children and teenagers therefore have a larger risk of experimenting with what they see and looking for more information in an environment where discourse is not taking place.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

Descriptive analysis was used in analyzing the study results. Frequencies, percentage and mean were used in interpreting the study results. Thus, correlation analysis shows the sample characteristics that mean to establish the relationships between the variables. As for the study, the researcher used Cronbach's coefficient alpha to measure the internal consistency to all items within the instrument.

5.1.1 Disparities that contribute to occurrence of Adolescent pregnancies

The first objective focused on determining the disparities that contribute to the occurrence of adolescent pregnancies. Mainly the study objective focused on norms and cultural practices, existence of taboos, existence of poverty, geographic location, education inequalities and gender inequalities. The study objective discovered that the existing disparities had high contribution to the occurrence of adolescent pregnancies. Also, the existing disparities were found to be statistically significant to the occurrence of adolescent pregnancies. As a result, the study rejected null hypothesis and accepted the alternative hypothesis. H0: $\mu_{\text{Disparities}}$ = Existing Disparities ("Existing disparities contribute to occurrence of adolescent pregnancies")

5.1.2 Level of Awareness of Sexual Reproductive Health to Adolescents

The second objective focused on the level of awareness of sexual reproductive health to adolescents. Mainly the study focused on identifying the level of awareness on unwanted pregnancies, awareness on how their bodies function, awareness on unsafe abortion, awareness on sexually transmitted infections, awareness on health problems like anemia, awareness on postpartum hemorrhage and awareness on mental disorders (like depression). On the results it was found that adolescents had little awareness on sexual reproductive health on adolescents. Also, the mean difference of level of awareness provided by the health care workers to adolescents was statistically significant. As a result, the study rejected null hypothesis and accepted the alternative hypothesis H0: $\mu_{\text{awareness level}}$ = awareness level ("health care-workers provide awareness on sexual reproductive heal to adolescents”).

5.1.3 Influence of health care workers’ attitude towards adolescents on sexual reproductive health services

The third objective focused on identifying the influence of health care workers’ attitude towards adolescents on sexual reproductive health services. The study focused on the following variables which are: providing appropriate information, providing contraception and treatment for sexually transmitted infections, maintaining privacy and confidentiality and utilization of health care facilities/ tools. The study objectives confirmed that the health care workers had moderate attitude towards adolescents on sexual reproductive health services.

However, health care workers' attitudes towards adolescents on sexual reproductive health services were statistically significant. As a result, the study rejected null hypothesis and accepted the alternative hypothesis. H0: μAttitude = Attitude of health care workers ("health care workers have positive attitude towards adolescents on sexual reproductive health services")

5.1.4 Weaknesses in legislation policies that undermine adolescent mothers

The fourth objective focused on identifying the weaknesses in legislation policies that undermine adolescent mothers. Thus, the study focused on the lack of implementation of laws that hold accountable the male counterpart from impregnating an adolescent girl, the lack of implementation and enforcement of laws and policies in place towards child protection specifically related to adolescent pregnancies, the lack of enough child protection mechanisms that protect and manage children's rights, the lack of awareness of individuals about the existing laws and the lack of information by individuals on where to report or access their rights. The study findings revealed that there was high weakness in legislation policies that undermine adolescent mothers. Also, the study found that the existing disparities were significant to the occurrence of adolescent pregnancies because of weaknesses in legislation policies that undermine adolescent mothers. Also, the mean difference of disparities was statistically significant.As a result, the study rejected null hypothesis and accepted the alternative hypothesis. H0: $\mu_{Weakness}$ = Existing Disparities (" There is weakness in legislation policies that undermine adolescent mothers")

5.2 Conclusion

As there are interventions to tackle the problem stated from the international community, regional level and to the national level, it is vital that these interventions depend on how the problem of 'conflict' or 'violence' and the desired goal of 'peace' and 'development are eventually attained. Like any other aspect that requires structural conditions for development to take place, so does peace- with emphasis on positive peace.As we reflect on what our freedoms are, it is vital to rethink peace and restructure our systems.

The reform of institutions does not only require changes in structures and processes but also, altering the incentives and norms that drive behavior in governance systems. The discourses around pregnant adolescents and adolescent mothers do not merely need re-examination but the prioritization of collective action from individuals, families, communities to societal level with those affected while ending the traditional philanthropy of top-down approaches.

The existing disparities and inequalities as well as weak structures and legal frameworks in any society, directly impact those whom the system is not in their favor. Instead of focusing on whom to blame through our daily discourses that stigmatize adolescent girls, pregnant adolescents and adolescent mothers, it is important to reflect in depth in the root of the root of causes of adolescent pregnancies.

While different interventions are in place. This study calls upon African feminism. Why does it do so? Given the context of the study, African feminism directly relates with the lived experiences, voices and realities of African women within their diverse cultures and acknowledging the varying backgrounds. Through fighting for the rights of adolescent mothers by non-violence to overcome discrimination, violence and patriarchal oppression, African feminism calls upon gender equality with oppression of neither gender.

Thus, the study comes to the conclusion that socio-political factors affected adolescent pregnancies since many of the existing inequities significantly influenced how often adolescent pregnancies occurred. Additionally, adolescents had minimal knowledge of sexual and reproductive health, while medical professionals' attitudes on adolescents' access to such services were more moderate. Finally, there was a significant lack of strength in the laws and policies that support teenage moms.

5.3 Recommendation

Communication for development and communication for peace building are highly interconnected. As we look at the issue of adolescent pregnancies and weaknesses in policies as a development and health concern, it is very crucial to consider the new tendencies and trends that are used in the context of peace and development. With a focus on adolescent pregnancies, this study believes that effective communication that focuses on bringing change in the society can impact societies positively and therefore, recommends the following: -

- In the efforts to address the existing inequalities and disparities in the society, it is important to solve problems of those affected 'with' them not 'for' them. This should also ensure the inclusion of those who are 'oppressed' and the 'oppressor' towards addressing the contributing factors such as norms and cultural aspects as well as gender and education inequalities. Coming up with development programs that involve the community to offer their own solutions can help them take active participation and create a sense of ownership in development programs focusing on addressing adolescent pregnancies. Moreover, our African governments should be there for the people and serve the people to reduce the gaps within its societies such as differences in access to education in different regions.
- Emphasis on dialogue is very important as dialogue serves as a fundamental tool for promotion of peace, development, inclusive and just societies. It is important for transparency to exist among family members with their adolescents and the society at large. Specifically, breaking the culture of silence on adolescent matters concerning their sexual reproductive health. Dialogue between health care workers and adolescents is equally important. More information dissemination is required among adolescents and the emphasis of more 'preventive measures' such as the use of contraceptives and condoms instead of 'restrictive measures' alone such as abstinence. In these conversations, questions of 'what', 'why', 'where', 'how', 'which' and

'when' with regards to their sexual reproductive health need to be addressed in a youth-friendly manner with respect, privacy and confidentiality.

- The study further recommends that there is a need of providing sexuality education to young people so as to protect and advocate for their health. Also, there is a need of building well-being and dignity by providing adolescents with a necessary toolkit of knowledge, attitudes and skills. Not only the right to make choices about one's body but also the information to making the right decision on when to engage in sexual reproductive.
- There should be strategies that are culturally appropriate and scientific oriented for improving men's attitudes about family planning services. educate them about reproductive health and family planning. Moreover, the end goal is to maximize the utilization of family planning or contraception services by men, particularly male-based contraception such as condoms and vasectomies, and attain male support for women to practice family planning methods
- There should also be great importance placed on involving men and boys in development agendas concerning women. The education given to boys and men or the discourses around masculinity need to be transformed. The education that boys receive should bring about a change in the gender role patterns instilled in them. Gender roles are socially constructed and differ across cultures. Individuals' perceptions about life and the world around them including their identities is greatly influenced by their cultures which goes to the systems that govern them. Going back to the discourses around

masculinity would enable the creation of systems and structures that are more inclusive and do not undermine girls and women from the family, community to society level

- With a focus on holding individuals accountable, individuals should reflect on what the foundations of accountability are, to whom people are accountable and create a balance between those who they feel accountable to right form the family level.

5.4 Area for Further studies

The study has revealed that there are many studies conducted focusing on adolescent girls everywhere, but there are a few or no studies at all focusing on adolescent boys specifically investigating on the challenges they face, what experiences they face as adolescents, what interventions can be done to assist them, as well as in accessing sexual reproductive health services. As we try to achieve a world of equal gender relations, there should be equal attention paid to adolescent boys and girls to bring a balance instead of creating a situation of 'us' versus 'them.'

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APPENDIX I

QUESTIONNAIRE

My name is **LISA LUKE SIYAME,**a student from Universitat Jaume I in Spain. This questionnaire is purposely designed to collect data for the following topic **THESOCIO-POLITICALDETERMINANTSOFADOLESCENTPREGNANCIESAND THEWEAKNESSES OF CURRENT INTERVENTIONS ON ADOLESCENTPREGNANCIESINTANZANIA.** The provided information shall be used for academic purposes. I kindly need your assistance

A. Information

Please select the correct information

1. Gender of respondent. Please circle on the right box

Male	Female
1	2

2. What is your highest level of academic education? Please circle on the right box

Primary	Certificate	Diploma	Bachelor	Master	PHD
1	2	3	4	5	6

3. What is your age? Please circle on the right box

Below 18 Years	19-25	36-32	33 above
1	2	3	4

4. Category of respondent. Please circle on the right box

Category of Respondent	
Activists	1
Adolescents	2
Bar maids	3
Communication Experts	4
Health Workers	5
Social Workers	6
Lawyers	7

B. Study Objectives

5. The study wants to identify the existing disparities that contribute to the occurrence of adolescent pregnancies. The answers are rated into response rate with a Likert scale of DA-Disagree Agree, D-Disagree, M-Moderate, A-Agree and SA-Strongly Agree. Please tick on the right box.

S/N	Variables	SD	D	M	A	SA

5B1	Existence of Taboos	1	2	3	4	5
5B2	Existence of Poverty	1	2	3	4	5
5B3	Geographic location	1	2	3	4	5
5B4	Education inequalities	1	2	3	4	5
5B5	Gender inequalities	1	2	3	4	5
5B6	Existence of Taboos	1	2	3	4	5

6. The study wants to examine the level of awareness of sexual reproductive health to adolescents. The answers are rated into response rate with a Likert scale of DA-Disagree Agree, D-Disagree, M-Moderate, A- Agree and SA-Strongly Agree. Please circle on the right box.

S/N	Variables	SD	D	M	A	SA
6B1	Awareness on unwanted pregnancies	1	2	3	4	5
6B2	Awareness on unsafe abortion	1	2	3	4	5
6B3	Awareness on sexually transmitted infections	1	2	3	4	5
6B4	Awareness on health problems like anemia	1	2	3	4	5
6B5	Awareness on postpartum hemorrhage	1	2	3	4	5
6B6	Awareness on mental disorders (like depression)	1	2	3	4	5

7. The study is interested in investigating the influence of health care workers'

S/N	Variables	SD	D	M	A	SA
7B1	Providing appropriate information	1	2	3	4	5
7B2	Providing contraception and treatment for sexually transmitted	1	2	3	4	5
7B3	Maintaining privacy and confidentiality	1	2	3	4	5

attitude towards adolescents on sexual reproductive health services. The answers are rated into response rate with a Likert scale of DA-Disagree Agree, D-Disagree, M-Moderate, A- Agree and SA-Strongly Agree. Please circle on the right box.

7B4	Utilization of health care facilities/ tools	1	2	3	4	5

8. The study is interested in knowing and identifying the weaknesses in legislation policies that undermine pregnant adolescents and adolescent mothers. The answers are rated into response rate with a Likert scale of DA-Disagree Agree, D-Disagree, M-Moderate, A- Agree and SA-Strongly Agree. Please circle on the right box.

S/N	Variables	SD	D	M	A	SA
8B1	Lack of implementation of laws that hold accountable the male counterpart from impregnating an adolescent girl	1	2	3	4	5
8B2	Lack of implementation and enforcement of laws and policies in place towards child protection specifically related to adolescent pregnancies	1	2	3	4	5
8B3	Lack of enough child protection mechanisms that protect and manage children's rights	1	2	3	4	5
8B4	Awareness of individuals about the existing laws	1	2	3	4	5
8B5	Information by individuals on where to report or access their rights	1	2	3	4	5

APPENDIX II

Interview Questions

1. Gender of Respondent ____
2. Age of Respondent ____
3. Category/Activity of Respondent_______________________________
4. Education level of Respondent _________________________________
5. What do you understand about norms and cultural practices that affect adolescents?

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6. What do you understand about existence of taboos that affect adolescents?

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7. What do you understand about existence of poverty?

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8. How does geographic location affect adolescent mothers?

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9. How do education inequalities affect adolescent mothers?

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10. How do gender inequalities affect adolescent mothers?

11. Do adolescents have enough awareness on unwanted pregnancies?

12. Do adolescents have enough awareness on unsafe abortion?

13. Do adolescents have enough awareness on sexually transmitted infections?

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14. Do adolescents have enough awareness on health problems like anemia?

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15. Do adolescents have enough awareness on postpartum hemorrhage?

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16. Do adolescents have enough awareness on mental disorders (like depression)?

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17. Do health care workers provide appropriate information on sexual reproductive health education?

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18. Do health care workers provide contraception and treatment for sexually transmitted infections to youth?

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19. Do health care workers maintain privacy and confidentiality to adolescents?

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20. Do health care workers provide health care facilities/ tools to adolescents?

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21. Are there weaknesses in implementation of laws that hold accountable the male counterpart from impregnating an adolescent girl?

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22. What are the weaknesses in implementation and enforcement of laws and policies in place towards children?

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23. Are there weaknesses in child protection mechanisms that protect and manage children's rights?

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24. Do individuals have awareness about the existing laws?

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25. Do individuals know where to report or access their rights

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LETTER OF PERMIT FOR RESEARCH CONDUCTION

UNITED REPUBLIC OF TANZANIA

PRESIDENT'S OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

KINONDONI MUNICIPAL COUNCIL

Reply to:

Ref. No.KMC/HEALTH/RS.09/29 — 2ND March, 2022

To Whom it may concern,

REF: PERMISSION GRANTED TO CONDUCT RESEARCH IN KINONDONI MUNICIPAL COUNCIL FOR THE FULLFILLMENT OF THE INTERNATIONAL MASTER IN PEACE, CONFLICT AND DEVELOPMENT

Refer to the heading above.

2. Reference is made with your letter with no reference number dated 1st March 2022 Concerning the request for the Research Permit concerning adolescent pregnancies and impact of current interventions on adolescent pregnancies in Tanzania.

3.With this letter we inform you that the permission is granted to conduct the stated Research in Kinondoni Municipal Council from 3rd March 2022 up to 31st May 2022.

Your Sincerely,

Kny:MGANGA MKUU WA MANISPAA
HALMASHAURI YA MANISPAA YA KINONDONI

Tawani Selemani
On Behalf of Kinondoni Municipal Medical Officer

All correspondences to be addressed to the Municipal Director, Box. 31902, 2 Morogoro Road, 14883 Dar es Salaam,contact with us through Tel: +255 2170173 Fax: 2172606, Email – info@kinondonimc.go.tz