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Understanding the Role of Stigma and Discrimination in Restricting Adolescents' Access to Sexual and Reproductive Health Services in Tanzania

*Working
Paper
No. 9*

This publication was prepared by Joyce Waymoi, Melissa Stockton, Daniel Nyato, and Laura Nyblade of the Health Policy Project.



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EXECUTIVE SUMMARY

It is widely recognized that young people, particularly in sub-Saharan Africa, are at increased risk for a myriad of sexual and reproductive health (SRH) issues. Constrained access to SRH services and information contributes to adolescents' risk for unplanned pregnancy and sexually transmitted infections (STIs). This risk is shaped in part by sociocultural factors, including stigma and discrimination (S&D). Stigma is a powerful social process known to act as a barrier to prevention, care, and treatment for other health conditions, including HIV, tuberculosis, and mental health. However, S&D has been little explored in relation to adolescent SRH.

In Tanzania, access to family planning (FP) for adolescents—regardless of marital status or parity—has been established policy since 1994, while a focus on provision of youth-friendly services is reflected in national policy guidelines. Nevertheless, access to SRH information and services for adolescents and young people remains restricted. Contraceptive use remains low and nearly one-quarter of girls ages 15–19 are pregnant or already mothers. Many girls who experience unplanned pregnancies resort to unsafe abortions, often leading to further complications and death.

As stigma and discrimination are known barriers to seeking healthcare for conditions that are often linked with transgressing social norms (e.g., HIV), we sought to explore S&D faced by adolescents at the individual, community, and health facility levels, in addition to its role in restricting adolescents' access to SRH services and information. Data were collected in two communities (one urban, one rural) in Mwanza region, Tanzania in August 2014, through an exploratory qualitative study involving 22 participatory focus group discussions (FGDs) and 56 semi-structured in-depth interviews. Study participants (n=191) included young people ages 14–24 (young women who experienced unplanned pregnancy; in-school/out-of school, never-pregnant young women; in-school/out-of school young men), parents of unmarried youth, healthcare providers, teachers, and a coordinator at a local NGO that works with young people on FP/SRH. A policy scan was also conducted to provide insight into the policy environment in which FP/SRH services and information are provided to young people. Interviews were recorded, transcribed, and translated. Thematic analysis was conducted using an open coding approach that combined preconceived theoretical constructs with emerging concepts from the data. NVivo 10 was used to explore, organize, and manage the data. During the course of this iterative process, a framework emerged for exploring and analyzing the drivers of S&D surrounding adolescent SRH in the study communities; the various forms and sources of S&D; the roles of mediating factors (e.g., fear of disclosure, communication) and misconceptions; and S&D's effect on behavioral and, ultimately, other health outcomes.

The presence of S&D surrounding adolescent and young people's premarital sexual activity, as well as family planning across all groups of participants, was strongly evident in both study communities. Social norms—including expectations of appropriate behavior, the pressure to maintain social standing, and the importance of fertility and childbearing—and economic constraints emerged as key drivers of S&D. Stigma and discrimination manifested in the family and community through shaming, name calling, isolation, physical punishment, and withdrawal of emotional and economic support. In health facilities, S&D manifested through shaming, scolding, and excessive questioning from healthcare providers, and sometimes refusal of service. Secondary stigma felt by family members was also strikingly evident, reflecting the central importance of upholding social standing and how violations of social norms governing 'proper' or 'socially acceptable' behavior can undermine the social standing of not only the individual adolescent, but his or her family. While the study did not aim to directly explore HIV stigma, reoccurring HIV-related concerns demonstrated that widespread fears and stigma continue to surround HIV in the study communities and can affect adolescent access to SRH services.

This exploratory study also highlights the prevalence of two key misconceptions related to stigma and SRH behavioral outcomes. The first is the belief that knowing about contraception and access to SRH services would encourage promiscuity. The second misconception is that use of hormonal contraception during one's adolescent years will lead to sterility later in life. Fear of disclosure and severely limited communication between adolescents and adults (parents, teachers, healthcare providers) on SRH topics also emerged as factors that play a mediating role between S&D and SRH outcomes. The power of S&D as a barrier to seeking SRH information and services—particularly anticipated (feared) S&D—emerged as a key theme across all groups. Because of stigma, adolescents struggled to access and use contraception and were reluctant to seek STI treatment or antenatal care services.

The study also demonstrates the pervasiveness of stigma surrounding unmarried adolescents' SRH at multiple levels of society—individual, family, community, school, and health facility—as well as the pathways through which S&D can discourage young people from accessing SRH information and services in two communities in Mwanza region, Tanzania. Furthermore, stigma is a barrier to parents, teachers, and healthcare personnel who provide adolescents with SRH services and information, and to adolescents disclosing their need for SRH information and services. Given the pervasiveness and fear of stigma, it is crucial to explore the integration of more direct stigma-reduction techniques into programs focused on providing youth-friendly services, or to create more enabling environments in general for youth SRH, leading to improved health outcomes for adolescents and young people.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
co-PI	co-principal investigator
FP	family planning
FGD	focus group discussion
HIV	human immunodeficiency virus
IDI	in-depth interview
NGO	nongovernmental organization
NIMR	National Institutes for Medical Research
SRH	sexual and reproductive health
STIs	sexually transmitted infections
S&D	stigma and discrimination
TDHS	Tanzanian Demographic and Health Survey

INTRODUCTION

It is widely recognized that young people—in particular, girls and young women in sub-Saharan Africa—are at increased risk for a myriad of sexual and reproductive health (SRH) issues (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2014; Bearinger et al., 2007). Constrained access to SRH services and information contributes to the risk of unplanned pregnancy, unsafe abortion, and sexually transmitted infections (STIs) (Sidze et al., 2014; Speizer et al., 2000). This risk is shaped in part by sociocultural factors, including stigma (Mbeba et al., 2012; Bearinger et al., 2007). Stigma is a powerful social process that has been documented as a barrier to the prevention, care, and treatment of other health conditions, including HIV, TB, mental health, and cancer (Mahajan et al., 2008; Stangl and Grossman, 2013; Chambers et al., 2012; Chang and Cataldo, 2014; Corrigan, 2004), yet has been little explored with respect to adolescent SRH. This study draws on conceptualizations and frameworks for HIV and mental health stigma (Stangl and Grossman, 2013; Mahajan et al., 2008; Link and Phelan, 2001; Parker and Aggleton, 2003; Stangl, 2010; International Center for Research on Women (ICRW) and Strive, 2013), as well as the socio-ecological framework (Bronfenbrenner, 1979; DiClemente et al., 2005; Zapka et al., 2003), to examine the role of stigma in shaping adolescents and young peoples' access to SRH information and services, in particular for contraception, STIs, and antenatal care (ANC) in two communities in Mwanza region, Tanzania.

Since 1994, Tanzanian policy has granted access to SRH services, including contraception, to adolescents and young people, while policy guidance documents have included a focus on the provision of youth-friendly services. However, access to SRH information and services for adolescents and young people remains restricted (Tylee et al., 2007; Sawyer et al., 2012; Mchome et al., 2015). In exploring the potential role of stigma and access, we seek to understand whether stigma reduction could be a useful approach to improving access to adolescent SRH services. In this study, we refer to adolescents/young people as those individuals ages 14–24. This definition is drawn from the United Nations Population Fund's categorization of adolescents as individuals ages 10–19, and young people as those ages 15–24 (United Nations Population Fund and Save the Children, 2009). We use the words *adolescent* and *young people* interchangeably throughout the document.

BACKGROUND

Adolescent Reproductive Health in Tanzania

As in much of sub-Saharan Africa, sexual activity begins early in Tanzania. By age 15, 9 percent of girls and 10 percent of boys have made their sexual debut (TCAIDS et al., 2013). In rural Mwanza, sexual behavior data indicate that over half of adolescents are sexually active by age 15 (Boerma et al., 2002). Despite high levels of contraceptive knowledge among adolescents in Tanzania, adolescents' use of condoms and other contraceptives remains low (Doyle et al., 2010; TCAIDS et al.; 2013). According to the 2010 Tanzanian Demographic Health Survey (TDHS), almost one in four young women ages 15–19 are pregnant or already mothers. Only 16 percent of all women (married and unmarried) ages 15–24 reported ever having used a contraceptive method (National Bureau of Statistics (NBS) [Tanzania] and ICF Macro, 2011). The 2004–2005 TDHS found that more than one-third of girls ages 15–19 who had ever used a contraceptive only did so after having a child (National Bureau of Statistics (NBS) [Tanzania] and ORC Macro, 2005). In addition, adolescent modern contraceptive users disproportionately reside in urban areas (Chen and Guilkey, 2003). According to the 2011–2012 Tanzanian AIDS Indicator Survey, the self-reported STI prevalence among women and men ages 14–24 was 2.6 percent and 4.0 percent, respectively (TCAIDS et al., 2013). A study conducted in rural Mwanza (Plummer et al., 2008; Plummer et al., 2010) and another conducted in the city of Dar es Salaam (Silberschmidt and Rasch, 2001) revealed that adolescent girls who experienced unplanned pregnancies resorted to unsafe abortions, often endangering their lives. Tanzania's Ministry of Health and Social Welfare has reported that 16 percent of maternal deaths are due to complications from abortion, most of which happen in young women (Ministry of Health and Social Welfare, 2010). Due to early sexual debut and low utilization of contraceptives, adolescents in Tanzania, as elsewhere in sub-Saharan Africa, face unplanned pregnancies, unsafe abortions, and STIs (Doyle et al., 2010; Jewkes et al., 2006; Plummer et al., 2008; Ross, 2010; UNFPA, 2007).

Tanzanian Adolescent Reproductive Health Policy

Until the mid-1990s, adolescents in Tanzania were not recognized as a specific population in need of contraceptive services and information. Instead, the focus was on women of childbearing age, suggesting that contraceptive services and information were meant only for child-spacing purposes (Ministry of Health, 1990). This focus shifted in 1994 with the revised National Policy Guidelines and Standards for Family Planning Service and Training that stated

... all males and females of reproductive age, including adolescents irrespective of their parity and marital status, shall have the right of access to family planning information, education and services. Any woman or man shall be provided with a family planning method of her/his own choice after appropriate and adequate counseling without requiring the consent of the spouse. Adolescents shall be provided with information, education and counseling on family planning methods that are appropriate to them

~ (Ministry of Health, 1994).

Although this recognition of adolescent SRH needs was a key step toward more open access, the emphasis remained on providing **adolescent-appropriate** information, education, and counseling on family planning (FP) methods. This left room for diverse interpretation by service providers as to what constituted “appropriate” services and information for adolescents. Recent policy guidelines and standards for family planning (2013) more clearly define youth-friendly services; standard 5.1 states that relevant information and education materials should be displayed or distributed to young people, and standard 5.2 establishes that young people should be able to obtain preventive, rehabilitative, and curative

services that are appropriate to their needs (Ministry of Health and Social Welfare, 2013). However, the continued lack of specificity or guidance on what defines the provision of **appropriate** services and information leaves these standards open for interpretation. Ultimately, this could lead to the exclusion of adolescents from accessing certain types of SRH services and information at the discretion of providers.

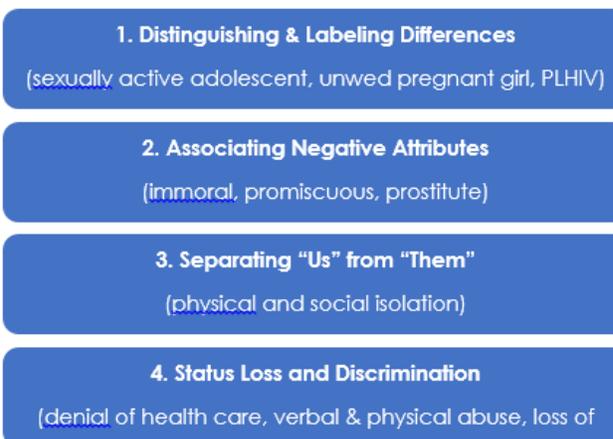
The education sector treats SRH education in a similar fashion. The 1995 National Policy on HIV/AIDS and STIs recognized young people as a key audience in identifying the need to integrate **appropriate** education on reproductive health matters related to HIV/AIDS and STDs into school and training institutions' curriculums (Ministry of Health, 1995). The 2001 National Policy on HIV/AIDS expanded on this, stating, "HIV/AIDS information should be introduced early enough to protect children who are not yet sexually active before they are exposed to sexual practices so as to equip them with knowledge and skills to protect themselves and others from HIV transmission" (The United Republic of Tanzania Prime Minister's Office, 2001). This is further emphasized in the health policies of 2003 (The United Republic of Tanzania Ministry of Health, 2003) and 2007 (Ministry of Health and Social Welfare, 2007b). Despite this progressive trend, the policy documents stress abstinence, fidelity, and condom-use education and raise concerns over whether young people can easily access other contraceptive methods.

To implement these policies, various manuals have been developed to guide service providers. For example, the Trainer's Guide for Management of Sexually Transmitted and Reproductive Tract Infections (2008) encourages contact referral (tracing) or partner notification as an effective means of breaking the transmission chain (Ministry of Health and Social Welfare, 2008). Since many people, particularly young people, do not necessarily seek treatment for STIs, the first antenatal visit is considered an important opportunity for STI screening. The National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections (2007) highlight the healthcare provider's responsibility to assist with partner notification and treatment and to encourage STI patients to test for HIV (Ministry of Health and Social Welfare, 2007a). While contact tracing is an important public health measure, there are insufficient guidelines on ensuring that this does not inhibit young people from accessing services. Persistent questioning about a partner and/or the insistence on partner notification may put up a significant barrier for adolescents, limiting their ability to attend health facilities for STI treatment or antenatal services.

Stigma and Discrimination Defined

Stigma is a complex social process that often leads to social and economic exclusion of individuals or groups and impedes access to healthcare and other services. Goffman, writing in the early 1960s, defined stigma as an "attribute that is deeply discrediting" and that reduces the individual or group "from a whole and usual person to a tainted, discounted one" (Goffman, 1963). Recent work has focused more on stigma as a social process that occurs in the context of power (Link and Phelan, 2001; Parker and Aggleton, 2003). Link and Phelan (2001) conceptualize stigma as a process that includes four key phases that occur within this context: 1) distinguishing and labeling differences; 2) associating negative attributes to those identified differences; 3) separation and distancing; culminating in 4) status loss and discrimination (Link and Phelan, 2001). Discrimination refers to any form of arbitrary distinction, exclusion, or restriction typically affecting a person, but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group, irrespective of whether or

Figure 1



Stigmatization Process: Link, B.G. and J.C. Phelan. 2001. "Conceptualizing Stigma." *Annual Review of Sociology*: 363–385.

not justification exists for these measures (UNAIDS, 2011). For adolescents and young persons, the process of stigma surrounding SRH can begin with identifying and labeling a young person as different because they are sexually active—either because of visible marks of sexual activity (e.g., pregnancy, STI, living with HIV) or because of assumptions about their sexual behavior. The process continues via association of negative attributes to the young person through derogatory name calling (e.g., ‘prostitute,’ ‘promiscuous,’ ‘irresponsible’). This feeds a process of separation and isolation, whereby the young person becomes an ‘other,’ and not part of ‘us,’ leading to status loss and fueling and justifying discrimination.

Stigma and discrimination can take many different forms. In its most obvious incarnation, stigma is experienced or enacted through interpersonal acts of discrimination (Steward et al., 2013; Scambler, 1989). For example, a study in Tanzania found that healthcare providers denied women access to contraception by employing eligibility restrictions and unnecessary process hurdles (Speizer et al., 2000). Stigma and discrimination may extend beyond the stigmatized individual to affect those associated with or related to the individual (e.g., family, caregivers); this is referred to as secondary stigma or stigma by association (Ogden and Nyblade, 2005; Deacon et al., 2005). Perceived stigma is the perception of the prevalence of stigmatizing attitudes in the community and among other groups (for example, healthcare providers) (Stewart et al., 2008; Visser et al., 2008; Green, 1995). Stigma can also be anticipated, stemming from a fear or expectation that one will experience S&D from others in the future (Earnshaw and Chaudoir, 2009). For example, an adolescent might fear that seeking services for an STI might expose his or her sexual activity to parents or others, leading to S&D. Anticipated stigma can influence behavior, whether or not the stigma is actually experienced or enacted. Finally, internalized or self-stigma refers to an individual taking on (internalizing) the stigma he or she experiences or perceives, and accepting it as true or just (Goffman, 1963; Harrison, 2008). Self-stigma can manifest in low self-esteem and sense of worth, self-blame, and self-isolation/withdrawal.

Types of Stigma	
Experienced	Stigma that is enacted through interpersonal acts of discrimination
Secondary	Stigma extended to family or other caregivers of stigmatized individual
Perceived	Perception of the prevalence of stigmatizing attitudes in the community or among healthcare providers
Anticipated	Fear of stigma, whether or not it is actually experienced
Internalized	Act of accepting experienced or perceived stigma as true and just

While S&D are cited as major barriers to accessing prevention, care, and treatment services, especially with regards to HIV (Kalichman and Simbayi, 2003; Parker, 2012; Parker and Aggleton, 2003; Stangl and Grossman, 2013), less is known about the S&D that young people face in accessing SRH information and services. In reviewing the literature published between 2000 and 2013, we found that the S&D lens was rarely used to assess adolescent access to SRH services; however, fundamental aspects and forms of S&D—described as social factors—were frequently discussed. At the policy level, legislation on confidentiality, the promotion of SRH services, prevention of early marriages and early or unintended pregnancy, and access to safe abortion and post-abortion care were all noted to be affected by cultural and political taboos, traditional values, and attitudes surrounding adolescent sexuality (Utomo and McDonald, 2009; Obare et al., 2011; Jaruseviciene et al., 2011). Within healthcare facilities, providers’ preconceived notions of appropriate sexual behavior based on age, gender, or marital status affected their ability to provide high-quality information and services (Nalwadda et al., 2011; Wood and Jewkes, 2006). Cultural beliefs or attitudes surrounding premarital sex or pregnancy and taboos surrounding adolescent sexual activity also influenced formal education, as well as familial communication on SRH topics and support

of adolescent access to SRH services (Bastien, 2009; Tavadze et al., 2009; Biddlecom et al., 2007; Biddlecom et al., 2009).

APPROACH AND METHODS

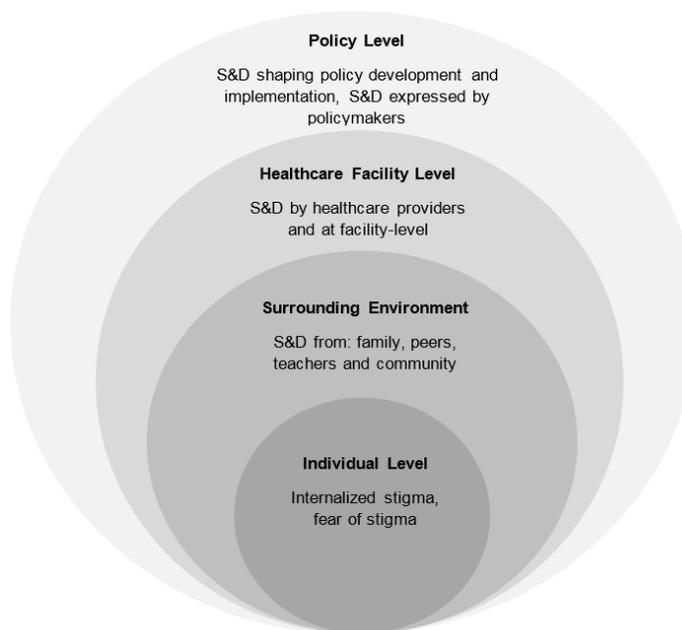
Informed by the socio-ecological framework (Bronfenbrenner, 1979; DiClemente et al., 2005; Zapka et al., 2003) and several HIV-stigma frameworks (Stangl and Grossman, 2013; Mahajan et al., 2008; Link and Phelan, 2001; Parker and Aggleton, 2003; Stangl, 2010; International Center for Research on Women (ICRW) and Strive, 2013), this study employed a qualitative research design involving participatory focus group discussions (FGDs) and semi-structured in-depth interviews (IDIs) to explore S&D faced by adolescents at the individual, community, and health facility levels, along with its role in restricting adolescents' access to SRH services and information. In addition, the research team conducted a literature review and policy scan to support development of the data collection instruments and to frame the study context, particularly regarding implementation of certain practices at the health facility level. Beyond the policy scan, the study was unable to conduct primary data collection at the policy level.

We describe the data collection methods starting with the policy scan, followed by the primary data collection involving participatory FGDs and IDIs. For primary data collection, we describe the study setting, study population and sampling, and the two data collection methods and analysis.

Policy Scan

A policy scan was conducted prior to the fieldwork to provide the policy context in which SRH information and services are provided to adolescents in Tanzania. This included a desk review of existing policy documents on unmarried young people's SRH and access to SRH services and information. The research team mapped the sectors or ministries that had direct links with young people's SRH-related issues. Relevant ministries included health and social welfare; education and vocational training; labor, employment and youth development; planning, economy and empowerment; and community development, gender and children. Online repositories were searched for relevant policy documents, guidelines, and reports that broadly covered youth and health, including the Ifakara Health Institute's digital library, the Tanzania gateway, and individual ministries' websites. Where further information was needed on specific policy documents, the research team contacted relevant authorities, including representatives from the Ministry of Education and Vocational Training and the Ministry of Health and Social Welfare. Relevant documents were identified and retrieved for reference and analysis using a checklist.

Figure 2: The socio-ecological framework



Primary Data Collection

Study setting

Fieldwork took place in two wards (one rural, one urban) in Mwanza region in northwestern Northern Tanzania. The urban site was in Mwanza city while its rural counterpart was in Magu district. The National Institutes for Medical Research (NIMR), Mwanza branch had previously worked in the selected wards on other studies and maintained a good rapport with local communities on which to build this exploratory study.

Study population and sampling

Eligible participants included unmarried young people ages 14–24, parents of unmarried young people (14–24), healthcare providers, teachers, and coordinators of nongovernmental organizations (NGOs) that work with adolescent SRH. These groups were selected to reflect several levels of the socio-ecological framework that are known to shape adolescent access to SRH information and services: individual, family, community, and institutions. At the individual level, never-pregnant girls and boys who were both in and out of school were interviewed, as well as unmarried girls who had delivered a live birth. Parents were interviewed to provide insight on their role in young people's SRH decision making (Poulsen et al., 2010; Vandenhoudt et al., 2010; Wamoyi et al., 2010; Wamoyi et al., 2011) and as adult members of both families and the communities. As teachers influence young people's understanding of SRH issues, science teachers were recruited from three schools (two rural, one urban). Healthcare providers in reproductive and child health departments were also recruited and interviewed from all three existing government health facilities (one rural, two urban). In addition, the research team identified NGOs working on SRH in the selected wards, as these organizations can be key sources of information and services for adolescents in the study community. Unfortunately, finding NGOs willing to participate in the study proved challenging and only one coordinator agreed to be interviewed. Sampling from both rural and urban settings enabled the data to reflect a broad range of experiences and demographic profiles. While the research team was unable to include a policy-level perspective through direct interviews, it did endeavor to recognize policy-level factors. Drawing from the policy scan, this analysis pays close attention to interpretation and implementation of policy as a barrier to SRH services for adolescents.

Participatory focus group discussions

Participatory FGDs are useful for collecting general community perspectives and shared experiences. This method allows the researcher to elicit a wide variety of perspectives related to a particular issue while also allowing him or her to observe the ways in which individuals collectively make sense of a phenomenon and construct meanings around it (Bryman, 2004). The FGD method was particularly instrumental in discussing adolescent access to SRH information and services, as well as any ensuing S&D. A total of 22 participatory FGD sessions were conducted with young people ages 14–24 and parents of young people within this age group (Table 1). Recruitment of FGD participants was done in steps, using a mix of snowball and purposive sampling. Researchers first met with the village chairperson and the village executive officer to introduce the study aim and objectives and to obtain local permission to conduct the study. The researchers used snowball sampling to gain initial access to participants. Village authorities in each site identified two adult women and two adult men to help the study team. Also for each site, the four adults then identified two young men and two young women. These eight individuals per site (16 total) then recruited other individuals that met the inclusion criteria (purposive sampling), with adults recruiting adults and young people recruiting young people. The initial 16 individuals, plus the additional individuals they recruited, were then invited to participate in a FGD. The FGDs ranged in size from six to ten individuals per group. Two researchers of the same sex as participants conducted each FGD; one moderated the discussion while the other observed and took notes on the proceedings. FGDs were conducted in Swahili and were tape recorded with the permission of the respondents.

Table 1: FGDs Completed (n=22)

Participant Category	Rural	Urban
Young women ages 14–24		
In-school	2	1
Out-of-school, never pregnant	1	2
Out-of-school, experienced pregnancy	1	1
Young men ages 14–24		
In-school	2	1
Out-of-school	2	1
Parents		
Mothers	3	1
Fathers	3	1
Total	14	8

More participatory FGDs were conducted in the rural than urban setting as data collection began in the rural site and based on this experience the research team was better able to ascertain data saturation (the point at which no new information is being learned) in the urban setting. A brief profile of FGD participant characteristics can be found in Table 2.

Table 2: Participant Characteristics

Category	Average Age	Average Years of Schooling	Total
Young women ages 14–24			
In-school	16.1	8.7	24
Out-of-school, never pregnant	17.8	6.7	24
Out-of-school, experienced pregnancy	20.0	7.5	17
Young men ages 14–24			
In-school	16.1	8.8	26
Out-of-school	19.0	7.2	21
Total Adolescents	17.6	7.8	112
Parents			
Mothers	42.3	5.7	37
Fathers	47.5	6.2	29
Total Parents	44.6	5.9	66

To start and facilitate the discussion, FGD guides were structured around four hypothetical scenarios about adolescents facing various SRH issues (Roura et al., 2009). Interviewers initiated and prompted continued discussion by presenting these scenarios that involved: 1) unplanned pregnancy; 2) attempts to access contraception; 3) contraction of an STI; and 4) attempts to access SRH information. Prompts for differentiating the experiences and challenges faced by young women and young men were included for the latter three scenarios. For example, participants were asked to imagine that an adolescent (first a girl, then a boy) had an STI. They were next asked to brainstorm and discuss the situation, imagining how the adolescent might be feeling and what he or she might do. Study researchers trained interviewers to utilize

semi-structured topic guides with probes to follow up on key issues that emerged from the discussion around each hypothetical situation. Despite this guidance, the FGDs were loosely structured to ensure that participants could drive the discussion. Probes focused on understanding hypothetical adolescent responses, including potential challenges faced in obtaining services, as well as factors or people who might provide them with support (or not). Participants were encouraged to consider how the adolescent's family, wider community, peers, teachers, and healthcare providers would respond; what fears (if any) the adolescent would face; and the quality of treatment/service he or she would receive at the health facility. Finally, participants were prompted to discuss specific barriers (especially those related to S&D) to accessing a particular SRH service. The guide was designed to focus on generic SRH issues and did not attempt to directly elicit any personal information or experience.

In-depth interviews

Since group discussions collect views at a general level, it was important to explore individual experiences through in-depth interviews (IDIs) to help differentiate the normative views presented in FGDs from the real practices of individuals. Interviewers selected young people and parents to participate in IDIs based on their participation in FGDs (i.e., based on their provision of interesting insights that required further follow-up, or on their reservation and/or lack of active participation in the group setting). The study team anticipated that both active and passive participants would have personal experiences that they might be willing to share in a setting that was protective of their confidentiality. During the IDIs, interviewers were able to capitalize on the rapport built during the participatory FGDs and could ask more focused questions on individual, personal, and familial experiences related to SRH.

The IDIs were semi-structured, involving the use of topic guides with probes for key issues. Similar to the FGDs, the interviews were meant to be flexible and respondent-driven. This open-ended, discursive approach permitted an iterative process of refinement, whereby lines of thought identified by earlier interviewees were taken up and presented to later interviewees (Mason, 2006).

Table 3: IDIs Completed (n=56)

Participant Category	Rural	Urban
Young women*		
In-school	4	2
Out-of-school, never pregnant	2	2
Out-of-school, experienced pregnancy	4	4
Young men*		
In-school	4	2
Out-of-school	4	2
Parents*		
Mothers	2	3
Fathers	5	1
Professionals		
Teachers	4	2
Healthcare providers	2	4
NGO workers	1	0
Total	34	22

*All parents and adolescents previously participated in FGDs

Data analysis

Interview tapes were transcribed verbatim and transcripts were checked for accuracy prior to undergoing translation. The software NVivo (version 10) was used to explore, organize, and manage the data. Coding began with an open coding approach using participants' language and combining emerging concepts with preconceived theoretical constructs. Constant comparative techniques were used to analyze the data (Strauss and Corbin, 1998).

Initial open codes were inductively developed by three independent coders (including the local co-principal investigator) and the collaborating institution's co-principal investigator (co-PI). The three coders and the co-PI then met to discuss the codes and emerging themes. Eleven transcripts were double-coded and compared to further refine the codes and ensure consistency in application between coders. Thereafter, 32 transcripts were coded by MS, 27 were coded by DN, and eight were coded by JW (all abbreviations refer to names of coders). During this first stage of analysis, open codes were then assigned to transcript segments to portray meaning. After more than half of the coding had been completed, axial coding was used to group open codes into more abstract conceptual categories. As analysis continued, the three researchers responsible for coding met with the co-PI to discuss the codes and determine predominant emerging themes. Queries were executed in NVivo to compare and analyze themes across groups within the study populations.

Ethical considerations

Ethical clearance for the study was granted by the Health Media Labs, who review all research studies for the USAID-funded Health Policy Project, and locally by the Medical Research Coordination Committee of the NIMR, Mwanza branch. Obtaining consent was a multi-step process. It was negotiated at the district and village levels, and then again with individuals at various points throughout the data collection process: at the introduction to the study, during recruitment, and at the beginning of the FGDs and/or IDIs. As is common with studies conducted in Tanzania, researchers first sought permission to work in the communities from the district executive officer. Once this officer issued a letter of permission for the study team to access the selected wards, permission to access villages was sought from the village chairperson and village executive officer. Similarly, before approaching health facility staff or teachers, permission was sought from the head of the health facility or school's headmaster.

When recruiting potential participants, the researchers clearly explained the purpose of the study; that participation was fully voluntary; that declining to participate would not affect a person in any way; and that written and oral consent would be required for participation. All potential participants were encouraged to ask questions and received an information sheet with study details to help guide their decision to participate. Immediately prior to the start of each FGD and IDI, the researchers re-explained study objectives to all participants before collecting both oral and written consent from each participant. In an effort to maintain confidentiality and anonymity for participants, no identifying information was collected during the interviews (e.g., codes were used in place of names, and FGD participants were assigned numbers and instructed to refer to themselves and each other using only that number during the discussion). All possible efforts were made to preserve confidentiality in relation to information disclosed in the FGDs. Participants were asked to maintain confidentiality on the issues discussed, but the study team acknowledged that it cannot control whether participants share information disclosed within their group. In recognition of the difficulty of ensuring confidentiality of sensitive information shared with a group during FGDs, researchers encouraged reflection and discussion on generic SRH issues and community-level values and discouraged discussions about individual experiences.

For participants younger than 18, researchers sought permission to participate from parents/caregivers (in addition to consent from the young person). In accordance with standard practice for non-biomedical research (in previous studies in the region), the researchers also sought consent from headmasters for both student and teacher participation. Headmasters were encouraged to inform students and teachers about the

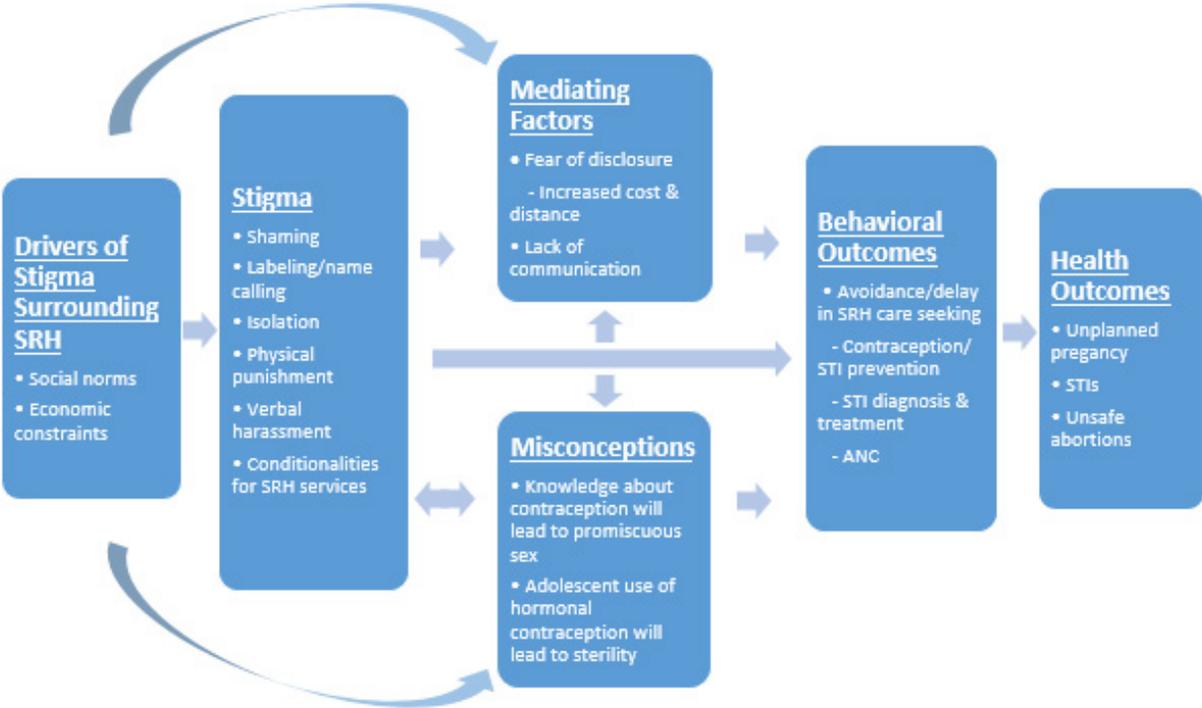
study in advance, assure them that participation was voluntary and non-participation would not affect them in any way, and to allow ample opportunity for potential respondents to share information about the study with parents/guardians prior to data collection.

As is usual practice with most research conducted in the study setting, participants were compensated for their time and transportation (TSh 5,000; \$3) each time they participated in a formal interview.

RESULTS

The following framework (Figure 3), for exploring and analyzing SRH-related S&D among adolescents in the study communities, emerged from the data through an inductive process of data analysis and was informed by a wide variety of existing stigma frameworks (Stangl and Grossman, 2013; Mahajan et al., 2008; Link and Phelan, 2001; Parker and Aggleton, 2003; Stangl, 2010; International Center for Research on Women (ICRW) and Strive, 2013; Kumar et al., 2009). This new framework provides structure for the presentation of study results below. Key themes from the data are presented to describe each part of the framework and illustrate the links and pathways between drivers of stigma, stigma, mediating factors, and adolescent behavioral and health outcomes. Key drivers include social norms and economic constraints that feed directly into the manifestations of S&D faced by young people and their families, as well as misconceptions and mediating factors including fear of disclosure and hindered communication. Stigma influences behavioral outcomes, both directly and through misconceptions and mediating factors, all of which ultimately adversely affect SRH outcomes for adolescents.

Figure 3



Drivers of Stigma

Broadly, social norms and economic constraints emerged from the data as key drivers of adolescent SRH stigma. The overarching social norm driving stigma was the importance of maintaining a respected social status within the community. ‘Proper’ sexual behavior was key to this good social standing, with links to maintaining respect, as well as marriage and childbearing. Breaking with social norms governing ‘proper’ or ‘socially acceptable’ adolescent sexual behavior was perceived to undermine social standing—not only for the individual, but for the family as well—leading to stigma. Marriage and childbearing (proving fertility) were also essential to maintaining social status. Therefore, avoidance or restriction of behaviors

perceived to damage the prospects of either marriage or childbearing was important to maintaining social standing, but also to avoiding stigma related to childlessness or being single. These social norms driving stigma are imbued with fear of the economic consequences of a fall in social status, in addition to the costs of unplanned pregnancy.

Social norms

Appropriate sexual behavior

Adolescents in the study community, particularly girls, are expected to abstain from sex before marriage—or at least before age 18 and while still in school. Abstinence is seen as a means of preserving purity, taking care of oneself (*kujitunza*), maintaining self-respect (*kujiheshimu*), observing religious teachings, and protecting the reputation of oneself and one’s family. Engaging in sex at a socially unacceptable age demonstrates a lack of self-respect (*hujiheshimu*) and bad manners/behavior (*tabia mbaya*). In explaining this norm, respondents stated

When you are living with your parents you are not supposed (to engage in sex), you need to take care of yourself, respect yourself.

~ (IDI 55, healthcare provider, urban)

You tell her that they should not have sex until she reaches the appropriate age of giving birth to a baby.

~ (FGD 4, adult women, rural)

They will advise and tell her that she should do away with sexual matters because she is still a student.

~ (FGD 2, in-school boys, rural)

Participants also underscored that religious teachings reinforced these expectations.

When we go to the church ... youths are advised that we aren't supposed to do some bad things and especially to avoid sex before marriage. You aren't supposed to have sex unless you are married and if you do so you would be committing adultery and when you commit adultery you break the law of God and when you break the law of God it means that you wrong God.

~ (IDI 38, in-school girl, urban)

While the consensus among participants was that both unmarried girls and boys were expected to abstain from sexual behavior, further probing revealed that abstinence was significantly more important for girls than for boys, in part because the latter cannot get pregnant (“*kwasababu mvulana hapati mimba*”). Pregnancy, as visible evidence of transgressing sexual norms, puts unmarried girls at increased risk of loss of respect, shame, and damage to their personal and family social standing. The fear of shame from adolescent premarital sexual activity would be intensified if a girl became pregnant; this theme was both strong and recurrent across all respondents, but of particular concern to parents in the FGDs.

Now if she becomes pregnant while she is still young, what will I do? She will bring shame at home.

~ (FGD 6, adult women, rural)

Maintaining respect and social standing

Heshima, a Swahili word for respect, is a powerful cultural construct that defines an individual’s dignity, integrity, moral standing, and social status within the study communities. An individual’s social standing

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is contingent on whether he or she abides by social norms, but also on whether their family members do so. The consequences of non-conformity can be far reaching, leading to loss of social status, disrespect, shame, reduced marriage prospects, and negative economic consequences for both individuals and families. Therefore, the drive to maintain respect and preserve status is strong. Appropriate adolescent sexual behavior is a key part of maintaining individual and family respect and social standing.

Adult men describe how the family will be viewed by their community and neighbors when others learn of a daughter's unplanned pregnancy:

Respect has generally gone down ... even the grade of her parents has deteriorated ... there is no respect in that family.

~ (FDG 3, adult men, rural)

An out-of-school boy describes why he would caution his peers to always use contraception:

Because once you contract a sexually transmitted disease, you lose respect in the community. Once you get pregnant, as a girl you lose respect from the society and this may affect your chances of marriage. Even if you can get married, you may just be divorced. This is because your respect (heshima) has been eroded. So I would like to advise girls and fellow young men or even adults who are not married or those who have wives to always use protection.

~ (IDI 52, out-of-school boy)

The data consistently show that engaging in premarital sexual activity is considered a moral issue and that upholding social norms around sexual behavior is a central part of maintaining respect and social standing, particularly for adolescents and unmarried young people. A group of out-of-school girls described how the community would view an adolescent girl known to be sexually active.

They build her a bad reputation in the street. For grown-ups who have families, they will see that she has had a moral downfall. That is a moral decline because she is a small child.

~ (FDG 21, out-of-school girls, urban)

In an interview one student describes the consequences of not meeting the expectation of abstinence:

If teachers find out [that you are having sex], you could be expelled from school ... because you spoil discipline, you do not have morals/discipline ... if you are left to stay [in school] you show that the school has bad morals.

~ (IDI 7, in-school girl, rural)

Marriage and childbearing

Marriage is a key part of maintaining social status, as is childbearing within marriage. Thus, engaging in premarital sex reduces a girl's marriage prospects as she will garnish a poor reputation and lose the favor of her community. However, this is not the case for a boy, whose marriage prospects remain largely unaffected by premarital sexual activity.

People will be thinking that generally this girl does not deserve to get married ... First of all who will marry her? ... People will be talking about her and thinking that she is not good ... So and so daughter's actions are bad in the community.

~ (IDI 41, adult man, urban)

All the time a girl is told that “a female child by the customs should always be settled/disciplined.” That’s why I am telling you that a girl, that’s why she stays a virgin. On the other hand, have you ever seen a boy being asked whether he is virgin or not? ... And a girl [who gets pregnant], you know that later on she won't get married because she is [considered] a prostitute, but for a boy, even if he is promiscuous, it comes that he gets married anyway.

~ (IDI 55, healthcare provider, urban)

Fertility and the importance of bearing children (once married) to upholding social status, while discussed less directly by participants, drove concerns about the effects of adolescent hormonal contraceptive use. The fear of future infertility and the resultant implications for social standing were very strong. In explaining why some adolescents preferred to use condoms over other forms of contraception, one adolescent girl stated

... because they would ruin their future ... if they use some contraceptives/medicines, they might be sterile.

~ (IDI 7, in-school girl, rural)

One adolescent boy explained how using contraceptive pills can lead to sterility and ultimately disrupt marriage.

This is what will happen: you can find that Jeni [fictional adolescent girl] uses some contraceptive pills when she has sex to prevent pregnancy. Therefore, when she gets married she is astonished that she doesn't get any pregnancy, she doesn't give birth, and the results of this are that she is chased away [from her marriage/home] because of sterility.

~ (FDG 15, in-school boy, urban)

Economic implications of unplanned pregnancy

Parents invested in their children’s future by supporting their education, often incurring significant financial hardship as a result—for example, by selling key assets to pay for tuition and other costs. This investment is assumed lost if a girl becomes pregnant, since the likelihood of being able to continue her education is low. This perceived loss of investment was a recurrent theme and also served as a driver of discrimination inflicted on unwed pregnant girls by their families.

Because they have sold some cows and you have gone to school only to bring a pregnancy, that's a great loss.

~ (FDG 7, experienced unplanned pregnancy, rural)

Now the mother, to make things easy, she will tell her [daughter]: “this is what you have to do ... get rid of that pregnancy. All these costs that your father has incurred on you, what will we do about them?”

~ (FDG 17, adult men, urban)

Not only is a daughter’s educational investment deemed lost with pregnancy, but the family is then faced with the additional challenge of providing for another child. This added economic burden can fuel anger and mistreatment during and after pregnancy. Adult women and in-school boys put themselves in the shoes of a parent with a pregnant daughter:

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First they will say she has brought a loss to the family ... If her mother and father have already stopped childbearing, they will now have to start raising an infant again because that child may be known not to have a father ... Or the father is there but does not care. It means those parents of Sara [fictional character] will go into the issue of raising a child again ... Of raising a grandchild ... So that again is a loss to the family. Instead of relaxing for themselves because they are aging, they start again caring for an infant.

~ (FDG 14, adult women, rural)

I am preparing her future life—that she would help the future generation in this family. Now [because she is pregnant] it means that she would depend on me in the future instead of us depending on her. That is what would make the parent expel her.

~ (FDG 15, in-school boys, urban)

Participants, particularly those who had experienced unplanned pregnancy, elaborated on how this financial burden (in addition to the shame of unwed pregnancy) would encourage parents to arrange for their daughter to be married in an effort to shift financial responsibility for their daughter and grandchild to the father.

There will be a fight with the parents because she has been impregnated and she is still in school, that the family have got a loss now ... She would be forced [by her parents] to follow the man who has impregnated her ... So that he could help her with some expenses.

~ (FDG 7, experienced unplanned pregnancy, rural)

I was discriminated at home, I was told: "and right now you are pregnant, where will you get the money for your expenses? Where will you get the money for your expenses? ... Tell whoever impregnated you to give you money for your expenses."

~ (IDI 19, experienced unplanned pregnancy, rural)

The economic implications of an unplanned pregnancy could also adversely impact the young woman's ability to return to school, because of both the finances needed to support her return and hesitancy to invest more money in her education. A group of girls who had experienced unplanned pregnancies discussed their parents' reluctance to support their return to school:

Or they might tell you that: "who will take care of your child if you want to go back to school? You decided to have a child at an early age, sit there and take care of it. I don't have money to pay fees at school."

~ (FDG 7, experienced unplanned pregnancy, rural)

Another girl who had experienced unplanned pregnancy described her despair over the end of her academic career:

I mean, I found that was the end of my dreams. I was praying to God that I complete my studies. Maybe I would get a help, but I have ended up here [did not finish school] ... Because, I mean, when one gets pregnant people say that "this wasn't studying, she wasn't concentrating on her studies" ... So even if a person had been helping you and

saying “let her complete her studies so she can advance,” they now give up completely on you.

~ (IDI 45, girl who has experienced unplanned pregnancy, urban)

Stigma

Pressures to uphold social standing in the community by adhering to social norms, coupled with economic concerns, underpin the S&D surrounding adolescent access to SRH information and services in these two communities. Many forms of adolescent SRH-related S&D emerged from the data, with all groups of respondents describing a range of manifestations of enacted, anticipated, and secondary stigma that group together into negative name calling, shame, social and physical isolation, physical punishment, verbal harassment (scolding, excessive questioning), and imposition of conditionalities for SRH services. These manifestations of stigma broadly map onto the four steps of the stigma process described in **Figure 1**; negative name calling maps onto the first two steps of distinguishing, labeling, and associating negative attributes to a person or group, and the remainder of the manifestations demonstrating the third and fourth steps—separation, social loss, and discrimination. While HIV-related stigma was not explicitly part of the interview guides and was never discussed directly, the fear of this stigma emerged in discussions with implications for adolescent access to SRH information and services; it will be discussed at the end of this section.

Steps 1) Distinguishing and labeling; and 2) Associating negative attributes

The first two steps in the stigmatization process involve identifying or labeling differences in individuals or groups, and attributing negative connotations to these differences (**Figure 1**). These steps manifested in the data through negative name calling.

Negative name calling

All respondents described the commonplace derogatory labeling of adolescents who are sexually active, have experienced unplanned pregnancy, are currently on contraception, or have an STI. Regardless of gender, these derogatory names generally characterize the young person as promiscuous or having poor character.

For young men, labelling denounces extreme promiscuity and immorality, but also almost praises a sense of sexual prowess through names that included ‘sex maniac,’ *jembe* (sex expert), ‘hooligan,’ *shalobalo* (modern person/bling), *fataki* (powerful/explosive), ‘fornicator,’ ‘pretender,’ and ‘naughty.’ For example, one young man described an adolescent boy with an STI being called a ‘bat,’ explaining

Maybe like that name of referring to him as the bat which is neither a bird nor an animal. He goes this way and that way, he does things maybe here and there, he seems to be good and yet he is doing stupid things.

~ (IDI 52, out-of-school boy, urban)

Mhuni was a common term used to describe sexually active boys, and occasionally girls. The term generally refers to someone who has engaged in sexually unacceptable behavior and, in this context, referred to as a “sexually active unmarried person, hooligan, idler, or outcast.” An out-of-school boy describes his fear of being seen as a *mhuni* in explaining why he would be unable to seek care from a doctor.

I mean there is shame [in telling the doctor I have an STI]. Because first of all, I would be regarded as a mhuni [hooligan/sex maniac].

~ (

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A teacher from an urban community explains the use of the term:

I mean, to a certain extent the community perceived the child as a mhuni ... As I told you, judgment is in people's hearts/minds. They question why this child did that [get pregnant] before getting married and the child does not have a father. So they perceived her as a mhuni ... they look at it as something indicative of broken ethics, failed morals. I mean she lacks respect, I mean why has she done something outside the acceptable morals (maadili). That is how they look at it.

~ (IDI 40, teacher, urban)

Labels for young women evoked sexual deviance and included 'spoiled,' 'harlot,' 'sex worker,' 'easy,' *malaya* (prostitute), 'cheap (easygoing),' *shalobalo* (bling), 'fool,' 'undisciplined,' 'unbearable daughter,' *shinge wangumila* (spinster), 'crook,' and 'naughty.' Across all respondents, the most common term used to describe sexually active young women was *malaya*, although it would occasionally be applied to boys. *Malaya* (prostitute) means a woman who has sex indiscriminately to obtain money/gifts. This term was used not only by adults, but also by adolescent peers, as described by these school boys:

They will think that you have gone astray/you are lost ... Also the one who engages in careless sex at a young age, below the age of 18 years ... She will also be called malaya.

~ (IDI 22, in-school boy, urban)

Girls' experience of this name calling is poignantly described by one respondent:

But you are not actually a prostitute, but they are just seeing you that way because you got pregnant, that you are a prostitute. But you are not, and you never expected to become pregnant.

~ (IDI 16, experienced unplanned pregnancy, rural)

While respondents discussed how all adolescents known or assumed to be sexually active, regardless of gender, would experience name calling and labelling, nearly everyone acknowledged that negative labelling is often worse for girls than boys. One young woman described it this way:

The boy can even have sex with them [women] and won't be referred to as a mhuni, but once a girl even if she has not had sex with ten men they will say she is a malaya [prostitute]. This one has sex with somebody, she is a great Malaya, but the boy is never considered as a malaya.

~ (FGD 20, out-of-school girls, urban)

Adult men echoed similar sentiments:

They will say, now these children [girls] are malaya ... those malaya don't get married. They are just used [exploited] ... but when it is a boy, he is praised a lot, that he is sharp with women ... that that boy has impregnated [girls] at place I and K."

~ (IDI 1, adult man, rural)

Another important distinction is that girls who experienced unplanned pregnancy faced more intense name calling through the use of additional derogatory terms like *misimbe* (unmarried mother), *mama katumbo* (mama big stomach), *mjinga* (stupid), *limbwa* (bitch), and *anamapepe* (unsettled/not calm).

The [parent] can change the name they call their child to bitch. They change the name and tell her "you dog, go away."

~ (FGD 12, out-of-school girls, rural)

You see, if we talk about that, they [her friends] would say to her "how can you be so stupid to the point that he impregnates you."

~ (FDG 19, out-of-school boys, urban)

Girls who had experienced unplanned pregnancy reported some of the following language during an FGD:

Respondent 1: *She is a scatterbrain (mapepe).*

Respondent 2: *You are a scatterbrain (mapepe), you are unsettled/not calm (mcharuko).*

Respondent 3: *You prostitute (malaya), come here.*

Respondent 4: *You for all (cha wote), you easy ride/cheap (mteremko).*

Respondent 5: *Vegetables (cheap stuff), if you feel thirsty [feel a desire for sex] you go to so and so, she is our vegetable.*

~ (FGD 22, experienced unplanned pregnancy, urban)

Pejorative labelling was also extended to anyone believed to have contributed to, or to have failed to prevent, the young person's behavior, including parents, family members, peers and, in some cases, even schools. If an adolescent faced unplanned pregnancy or contracted an STI, his or her parents would be accused of poor parenting or having failed to correctly socialize their child. A woman described responses to a girl with an STI, which included bad-mouth and linking her behavior to bad parenting:

It would be like ... "I have heard that so and so's daughter, I have heard that she is suffering from STIs, it is because they leave her free." I mean people bad-mouth you.

~ (IDI 14, adult woman, rural)

A health provider in an urban setting described the community's labeling of sexually active girls as *malaya* (prostitute), and how that label is extended to their families as well:

They say, "so and so's daughter is a malaya ... they also say that that family is very malaya ... you see, even school they have stopped."

~ (IDI 47, healthcare provider, urban)

Not only are parents blamed for the behavior of adolescents, but schools can be as well. One in-school girl revealed that her school reputedly had a sexually active student body and had been nicknamed *Mv Mapenzi*, (*Mv Lover*). She described how students from this school were considered by the community to be promiscuous and to have poor discipline. Some participants reported that fear of damaged reputations caused some schools to expel pregnant girls. As one participant explained, schools expelled girls who became pregnant "because that would portray the school as having bad behavior ... lacking morals/discipline," or in order to preserve the school's reputation.

Teachers will insist that they can't retain a pregnant girl at school ... Because that would portray the school as having bad behavior ... They [pregnant girls] will result in the school being looked at as lacking morals/discipline.

~ (IDI 7, in-school girl, rural)

Steps 3) Separating “us” from “them”; and 4) Status loss and discrimination

The negative differentiating and derogatory labeling of known or assumed sexually active adolescents is closely connected to and feeds into the next steps in the process of stigma: the separation and distancing of those who have been singled out as different, leading to status loss and discrimination (see **Figure 1**). In the data, the third and fourth steps of the stigma process manifested most clearly through a process of shaming, social and physical isolation, physical punishment, and verbal harassment of unmarried adolescents thought to be sexually active. In addition, a particular manifestation of stigma within health facilities is the imposition of conditionalities for SRH services.

Shame

The overarching theme seen throughout the transcripts was the shaming of unmarried adolescents, particularly girls, who were thought to be sexually active—often indicated by contraceptive use, STIs, or pregnancy. Shame was also extended to the adolescent’s family.

And if she gets pregnant, for the parents and society it is a saddening thing and it becomes a shame.

~ (FGD 14, adult women, rural)

The shame was universally strong and greatly feared across all respondent groups. Respondents were particularly conscious of the shame parents would feel if a daughter became pregnant.

The shame, some parents feel that shame, where will I hide with all this shame ... The shame, that is, you might get when the child becomes pregnant when she is still in school. It is embarrassing to the parent.

~ (FDG 20, out-of-school girls, urban)

...it is not good, a girl shouldn't have a child before marriage. Now maybe that thing, it is what the parent finds that it is a shame in the family, for a girl to have pregnancy while she is still at home [before marriage], you know African customs.

~ (IDI 55, healthcare provider, urban)

Bringing shame to oneself and one’s family through sexual activity leads to loss of respect and, ultimately, social standing, and should be avoided at all costs. A group of adult men explain this belief in the following discussion of what happens when it becomes known that a certain family’s daughter has become pregnant.

Once those neighbors see that child [pregnant], the respect for the family will go way down because she has brought shame to them as she is still very young.

~ (FDG 3, adult men, rural)

Shame is such an overriding theme, and is so embedded in the discourse, that it becomes difficult to disentangle from other forms of stigma and is often used to explain the isolation or physical punishment that occurs. It is also given as an explanation for why adolescents do not seek SRH services or drop out of school.

She drops out of school ... she is afraid of the shame [because] once she gets to the step of testing and finding she is pregnant, then all the teachers find out—that is shameful—you shame yourself.

~ (IDI 27, in-school girl, rural)

So it will be hard to go there [to get treatment] ... We all know that a student is not allowed to be engaged in love affairs ... And you will have proven that now you have engaged in love affairs ... It will be a shame ... Because people know that you are a student.

~ (IDI 22, in-school boy, rural)

Shame could also extend to friends/peers, the community, and potentially the school. During a FGD, one in-school boy explains how shame might motivate a young pregnant girl to have an abortion.

It seems like the child's upbringing wasn't good. Parents were paying more attention to their own affairs than to their child so that she got pregnant ... it means that it was because of their negligence. What would be seen would be like she ... shames the family, clan, environment that surrounds her, even the street in which she lives. Even the teachers in school in which she is studying, they would also be shamed because teachers are also guardians. They would be shamed by that spot [mark] she has caused them.

~ (FDG 15, in-school boys, urban)

Social and physical isolation

Social isolation of sexually active adolescents was imposed by the whole community through a process of separation and shunning, driven in part by a belief that 'immoral' sexual behavior is socially contagious. Respondents described their belief that if one adolescent were to engage in premarital sexual activity (experience unplanned pregnancy, use contraception, or contract an STI), this would increase the likelihood that their siblings or peers would follow suit. For instance, an unmarried girl who gets pregnant is thought to have set a poor example for her siblings and peers. Through association, her peers and siblings are considered more likely to engage in premarital sex and end up in the same condition. A teacher explains:

Maybe, in most cases, [the girl] will be very much isolated by the community ... This is for the purpose of being taught a lesson, so that it can be a lesson to others ... So you have done this, so for us we have been isolating them from the community so that others cannot copy what their elder has done. A girl has been impregnated before marriage, her young sisters are at the same home ... So that they cannot continue with that example, their elder sister has to be expelled from home.

~ (IDI 4, teacher, rural)

This prevalent belief leads to isolation of the affected young person. Participants across groups reported that parents do not like their children to befriend or associate with young people who are sexually active, or who have experienced unplanned pregnancy, for fear that such contact would encourage their child to engage in similar "bad behavior." In discussing what would happen if a 15-year-old primary school girl was discovered to be pregnant, one respondent explained

If the community discovers [a girl is pregnant], some parents will forbid their children to befriend that [girl] ... If the parents see another girl walking with [her] they will say she too has started involving herself in issues of sex.

~ (FGD 16, in-school girls, urban)

Health personnel echoed this sentiment:

They will say this girl has bad behavior ... If your child was walking with her, she [her mother] might tell her to stop, "you shouldn't walk with this girl, she has this and this behavior" ... You start by warning your child, you tell her, "aah! [now] leave that one

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alone. She will teach you bad behavior ... She doesn't have good behavior at all, her character is not good."

~ (IDI 48, health provider, urban)

Unmarried girls who became pregnant could be further isolated and sent away from their homes, sometimes in anger and other times in hopes of hiding the pregnancy from the community.

They [her parents] isolate her, she is told that, "I don't want to see you in this family. I don't want to see you here at home or even at my relatives' homes. I don't want to see you." It is because of that anger.

~ (FDG 4, adult women, rural)

Another parent might understand that his daughter is pregnant and may tell her to go and live with her aunt, so that she may not be seen since it is very shameful for her to give birth while at home.

~ (IDI 48, healthcare provider, urban)

In recounting their reactions to learning of their pregnancies, many adolescent girls' initial response was fear of being expelled from their homes.

I mean I was afraid maybe they would chase me away from home ... That I would be chased away from home and that they wouldn't even know me anymore, but it wasn't like that ... I thought I would be chased away because while I had seen some other girls who were kept at home, some others were chased away. So my heart was paining, as I didn't know whether mom would expel me.

~ (IDI 45, experienced unplanned pregnancy, urban)

Physical punishment

Adolescents reported fear of physical punishment if it became known they were sexually active, using contraception, or pregnant, or if they had an STI. In addition, young people described fear of physical punishment for merely seeking out SRH information. Such fears were not unfounded. A mother described beating her daughter upon discovering that the girl had discussed birth control with her friends.

Then she [daughter] left there. I saw them [daughter and friends] and when she found that I have seen her, she followed me saying "mom, you know my friends are fools, these friends of mine have been discussing using depo. They want to go and use depo, they want to go and have injections so as not to become pregnant." ... To be honest, what I did was to pick up a stick and I started beating her.

~ (FGD 18, adult women, rural)

Nearly all parents believed that it would be disrespectful and insulting for adolescents to talk to them about contraception. In the group discussion with fathers, participants described how parents would beat their children for broaching the subject of contraception.

... In our Sukuma society especially, a parent will swear at (kutukana) her ... [They will swear at her for asking about birth control saying] "You tell me these things? I will report you to your father, you will be beaten." She now fears, that is what it means.

~ (FGD 3, adult men, rural)

Adolescents who do manage to access contraceptives, including condoms, risk serious punishment if their parent(s) find out. While adolescents mainly feared physical punishment from parents, young men also anticipated physical punishment from their teachers if they were caught with condoms, as this would imply that they were coming to school not to study, but to have sex.

They [teachers] punished them not because they brought some condoms to school, but because they brought them [condoms] to show other people that they use condoms ... no, it isn't a good thing ... so he isn't coming to school to study ... he comes to have sex so that's why he is punished.

~ (IDI 37, in-school boy, urban)

Expulsion from school

Participants all agreed that a pregnant adolescent schoolgirl would be expelled from school. However, boys who father a child rarely face the same fate. Generally, participants agreed that, in principle, these expelled girls would be allowed to return to school after giving birth, but disagreed as to whether it would actually happen due to the burdens of unplanned pregnancy. Girls who had experienced pregnancy elaborated on why parents might not support a daughter's return to school:

Some of the parents would say, "No, you have given birth, none would take you to school, stay home, you just stay home," ... They would tell her that, "You have shamed your family."

~ (FGD 7, girls who have experienced unplanned pregnancy, rural)

Outside of unplanned pregnancy, participants highlighted the importance of discipline at schools and the belief that a sexually active student body infringed upon a school's ability to maintain order. One student explains

If teachers notice/find out [that you are having sex], you could be expelled from school because this demonstrates that "this is a school of undisciplined students" that would be branded as "an undisciplined school."

~ (IDI 7, in-school girl, rural)

Verbal harassment

In addition to physical harassment, scolding and excessive questioning were repeatedly described as forms of stigma that restricted access to SRH, particularly when encountered within health facilities.

Participants reported that adolescents, especially those still in school, risked being scolded or verbally harassed if it became known that they were sexually active, pregnant, or on contraception, or that they had contracted an STI. One adolescent girl explained that a girl seeking services for STIs "would be cursed at by the nurse" (FGD 7, experienced pregnancy, rural). In discussing a hypothetical girl with an STI, adult men were adamant that she would be harassed if she sought treatment.

To be honest Jane will be received [get services] ... but at the health center or hospital she will have a difficult time. First, she will be received with harassments. She will be shouted at and bad mouthed that her age is young, yet she is suffering from this disease. Surely she must be harassed.

~ (FDG 5, adult men, rural)

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Verbal harassment doesn't just occur within health facilities, but also in the community. One young woman shared that she had been harassed in the village by her peers and other community members during her pregnancy.

The other people laughed at me when I was pregnant. I had become pregnant while still at home ... They were just talking about me, "The daughter of so and so is pregnant, let her give birth and become old, she will lose her market."

~ (IDI 19, experienced unplanned pregnancy, rural)

Adolescent participants feared that attempts to access contraception and other SRH services would be met with excessive and unnecessary questioning. This fear was both a prominent theme and a key obstacle to obtaining contraception and other SRH information and services. Adolescents reported that asking for contraception or other SRH services would lead to a barrage of questions demanding that they reveal their age, whether or not they had any children, their relationship status or the whereabouts of their partner, their motivation for pursuing contraception, or the source of their STI. Nearly all respondents anticipated that such questions would cause discomfort, embarrassment, and fear, and impede adolescents' ability to seek contraception and other SRH information and services. The belief that contraception was meant only for adults—specifically, only for married adults with the appropriate number of children—seemed to fuel the questioning and verbal harassment from healthcare providers. An adult woman and teacher described the anticipated questioning from healthcare providers:

They will ask you, "how many times have you given birth?" You say, "I haven't given birth ... [They will respond:] So why are you looking for contraception?"

~ (FGD 14, adult women, rural)

Then they will look at her age which is small, and her many needs of pregnancy prevention and so on. Then they will ask her, "how come your age doesn't allow you and why should you do that, you are a child of fifteen years old, you have come for birth control ... What has made you to indulge in sexual relationships and yet you are a young girl?" They will ask her many questions because her age doesn't allow her.

~ (IDI 3, teacher, rural)

Young people believed the excessive questioning and scolding is due to healthcare providers' personal reluctance to provide services related to "promiscuous" behavior to someone so young. Adult men and women described health workers' questioning of young people as a type of stigma, specifically using the term '*kunyanyapaa*' (to stigmatize). One adult man explains what would happen if an adolescent boy tried to get treatment for an STI.

If he had no parent [or went for treatment without an adult] he would encounter unyanyapaa [stigma] with lots of questioning.

~ (IDI 13, adult man, rural)

In my view, the nurse will not admit Sara [hypothetical character] in good manner/way just by looking at her age (15 years). Even if she will give her the service, it will not be the same to the service given to an adult woman. She would look at her ... in fact, she can stigmatize her in giving the service.

~ (FGD 17, adult men, urban)

Conditionalities for SRH services

A key concern among all participants was that health providers would impose certain conditions—specifically, the presence of a husband/male sexual partner or parent—before providing SRH services to adolescents, including ANC or STI treatment. While national policies state that adolescents should have access to SRH services, these policies are less clear about specific conditions for access, while other policy guidelines strongly encourage contact tracing of partners for STIs and involvement of male partners with ANC. The data indicated that health providers in these communities are choosing to interpret these guidelines so as to restrict adolescent access to SRH services.

Many adolescent respondents feared they would be required to bring their sexual partner or parent when accessing STI, contraceptive, or ANC services. Although healthcare providers described inquiries about a sexual partner as a procedural undertaking when treating STIs, it was frequently featured as a challenge for adolescents. One adult man described his own experience:

The doctor, actually he sent me back [when seeking STI treatment], that [he would not treat me] until I come with the person ... Go and bring the one you had sex with ... You have to take her up to the doctor ... now you leave.

~ (FGD 17, adult men, urban)

A group of in-school boys discussed a hypothetical scenario, describing how healthcare providers would contact parents before providing contraception to an adolescent girl.

First of all the doctors that she would find there would ask her, "Which service do you need?" ... If she needs that service [contraception], they would look at her age and ask her, "With whom do you live with in your home?" She would tell them maybe, "I live with my father and mother or with my grandmother." They would say to her, "Give us their phone numbers"

~ (FDG 15 in-school boys, rural)

Similarly, respondents believed that pregnant adolescent girls seeking ANC would be asked to involve a parent or a husband.

[After discovering she is pregnant], she will start going to the clinic. She will be checked to see if she has diseases. She will be told that, "You go home and return here with your husband or with your mother."

~ (FGD 4, adult women, rural)

When asked how ANC healthcare providers responded to her young age, one adolescent girl replied

They were so surprised; they said "your parents!" I just lied to them that I don't have parents, that's it, because if I had told them I had parents they would have asked me to call my mother. Because they asked me to call my husband and I said he is not around ... because if I had told him [father of the child] he wouldn't go, he would be afraid ... I told them I live alone, so they told me "you are lucky we have sympathized with you!"; that's when they tested me.

~ (IDI 44, experienced unplanned pregnancy, urban)

Another young woman recounted her experience in accessing ANC services, including refusal of services for failing to bring her husband. In her second attempt to access ANC, she was obliged to bring her mother to confirm that she could not bring a husband.

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In my first antenatal care visit I went alone and they told me to come [back] next time with my husband/partner ... When I told my mother, she said "what will you do?" When I went for the second antenatal care visit I was accompanied by mom and she supervised me and said that "she is my daughter." They told her that, "We would like to see her partner." Mom answered them that "he isn't here, he ran away" ... They said that "there is no problem because you as a parent have come here, so she will have all services as needed"

~ (IDI 45, experienced unplanned pregnancy, urban)

Another pregnant adolescent who lied about having a husband for fear of being scolded or turned away described a similar experience:

I had the fear that they [the nurses] might ask me "where is your husband?" ... [and when they asked] I just said that he is at home. Just to stop the conversation and be given the services ... I always hear that the nurses scold people, saying things like "you have been impregnated and don't even have a reliable source [father]." So I told them that he is at home so that they could serve me faster so I can go home to rest.

~ (IDI 19, experienced unplanned pregnancy, rural)

HIV stigma

While the study did not directly explore HIV-related stigma, respondents touched on the topic when discussing barriers to seeking STI and ANC services. Specifically, participants described how the stigma surrounding HIV, combined with routine HIV testing during ANC or STI services, might make adolescents hesitant to seek these services. For example, fear of being required to take an HIV test when seeking STI treatment was often mentioned as a challenge for adolescents. An adult man describes this fear:

In the village, in the society, people talk about something that they fear so much—that if you go to hospital [for an STI] they will ask you if you have been tested for HIV. If not, they will take you first to the room for HIV testing. Only after that, will they give you the services you need. So Shija [hypothetical adolescent girl with STI] ... that same issue [HIV testing] can make her afraid and give her difficulties to go to the health facility.

~ (FGD 3, adult men, rural)

Participants were also cognizant that HIV testing was part of standard ANC services. Adolescent boys discussed how fear of testing could influence a pregnant adolescent's willingness to access ANC services:

For now, they go to test, it means that she is going to test the big test—HIV—they call it blood test, now that one ... many girls are afraid of that ...

~ (FDG 10, out-of-school boys, rural)

In addition to fear of HIV testing when seeking STI treatment or ANC, out-of-school girls in two FGDs discussed how HIV acted as a barrier to contraceptive access. They described how some nurses were hesitant to provide hormonal contraceptives to adolescents, for fear that taking away the risk of pregnancy would mean adolescent girls would not use condoms and therefore be exposed to HIV.

Even from the nurses, there is advice because you can protect yourself against pregnancy but you might get the other diseases ... So even if you go to the nurses they won't accept, they will tell you, "ok you are still young you will protect yourself against pregnancy but will you avoid HIV/AIDS?"

~ (FDG 20, out-of-school girls, urban)

It is because the girls of nowadays go to be given the injection before they get married, they go to get the injection and use contraceptives, they [the nurses] will be saying, "this one doesn't see ... This one doesn't know condoms, she will even get HIV, her behavior is out of control."

~ (FDG 22, out of school girls, urban)

While the study was not designed to capture information on HIV, the concerns that emerged in discussions about STIs and ANC demonstrate the widespread nature of fear and stigma surrounding HIV and how it may affect adolescent access to SRH services and information.

Misconceptions

Respondents consistently raised two key misconceptions related to stigma and SRH behavioral outcomes. The first is the belief that knowledge of contraception and access to SRH services would not only lead adolescents to have sex, but facilitate their promiscuity. The second is that use of hormonal contraception by adolescent girls will lead to sterility. These misconceptions can fuel stigma, while stigma can help reinforce and entrench the misconceptions.

Knowledge and access leads to promiscuity

The data indicated that many adult respondents believe that access to SRH information and services would increase adolescent sexual activity. Generally, parents felt that talking about SRH would appear to legitimize adolescent sexual activity and actually encourage their children to have sex. In addition, there was an underlying assumption that contraception use would remove the risk and fear of pregnancy, which was believed to keep young people from having sex. Parents in FGDs expanded on this theme related to young people's access to information and services:

The first fear that is there, is to fear that if I talk about this [contraception] inside the family ... with the children seated there ... It is like I am teaching them to, or giving them the freedom to go and do this [sex] and just take care to use this and this [contraception], that is why fear comes.

~ (FGD 3, adult men, rural)

It means that if you have taught her about the methods of contraception it means that she will ask herself, "why are they talking about this? It means that if they are teaching me how to use contraception it means that they are telling me to have sex with the men." So that is not a topic to talk about with a girl who hasn't given birth, to teach her about family planning.

~ (IDI 2, adult woman, rural)

Adolescents reflected some of the same views as parents, as explained by out-of-school boys.

... Any girl or boy is not allowed to have sex before marriage. Therefore, when you allow your child to use contraceptive pills, you are allowing them to have sex because pregnancy will not happen. So they become ruined.

~ (FGD 19, out-of-school boys, urban)

Female adolescent contraceptive use leads to sterility

A prominent belief or fear expressed across all groups was that contraception (other than condoms) was harmful to adolescent girls and would lead to infertility, especially for girls who had never given birth.

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Participants vocalized many anticipated side effects of hormonal contraception—destroyed uteri and ovaries, cervical cancer, prolonged periods, vaginal bleeding, giving birth to abnormal or disabled children, miscarriages, and loss of weight—and believed, as a result, that hormonal contraception should never be used by adolescent girls. In-school girls explained their beliefs that contraception is only meant for married women over age 18:

What I know about family planning is that first it is mainly for people who are married. Or for people who are above eighteen years old ... [If an adolescent uses birth control] She may be sterile ... and they [people] say that they dissolve. Now when they dissolve and you are still young, they destroy the uterus.

~ (IDI 27, in-school girls, rural)

One adult woman recommended that mothers never allow their young daughters to use contraception:

If you are a parent never allow your daughter to start using contraception, they are very bad [ni vibaya mno]. First there is the danger of becoming barren, then you give birth to children who have deformities. That does happen, because I have seen my sister. She had a husband, she used contraception without knowing that she had overstepped the days, when she gave birth, the child was strange/unusual.

~ (IDI 53, adult woman, urban)

The fear of hormonal contraception leading to sterility led one girl to use the calendar method of birth control:

Apart from looking at my menstrual cycle—that I am seeing my days on this date so let me protect myself at this period or not. I have never swallowed pills, never injected, no implants or even loops although I am knowledgeable about them because we are taught at school ... [because] I have once seen those who have been affected with them [contraception] ... I have seen people who cannot get pregnant.

~ (IDI 43, out-of-school girl)

Mediating Factors: Pathways Between Stigma and Behavioral Outcomes

Fear of disclosure and lack of communication emerged throughout the transcripts as possible mediating factors between stigma and SRH outcomes. Both adolescent and adult respondents cited fear of disclosure, stemming from the fear of stigma directed at adolescents seeking SRH information or services from family, community, and the health system. Similarly, adolescents described strategies for protecting confidentiality, which have implications for service access. The challenges around SRH communication—whether between parents and children, students and teachers, or adolescents and health providers—represented another recurrent theme.

Fear of disclosure/strategies for protecting confidentiality

Adolescents risk being identified or marked as sexually active when seeking SRH information or services. An out-of-school boy describes this risk in explaining why a 15-year-old girl would be afraid to access information on contraceptives or STIs:

She would be afraid ... First of all, [because of] the views of the people, she would be afraid that they would know that she is engaging in sexual activities.

~ (FDG 10, out-of-school boys, rural)

Respondents described how the potential risk of ‘outing’ led to fear of disclosure and various strategies to protect confidentiality. Adolescents were aware of the need to preserve and safeguard their personal and family social standing, sometimes ignoring their SRH needs or employing a range of measures to preserve anonymity that can ultimately hinder access to effective or timely SRH services. To maintain anonymity, adolescents often sought public health facilities distant from their communities, or visited pharmacies/drug shops or private clinics (rather than public facilities) to obtain Depo-Provera or birth control pills. During a group discussion, adult women talked about these strategies:

They [girls], if it is pills, they can ask an adult woman, a friend, to get them. They can ask for a thousand shillings to go buy something, then they give that to someone to go buy the pills for them. A girl cannot go where she is known—for example if she is from here and she gets down near the police station [to go to the clinic], the women there will know her, so she would go instead to another place farther away. Girls are clever. She avoids hospitals, because she knows that someone there might know her. Instead she goes to a certain pharmacy where she knows she can get depo, she just pays two thousand shillings and gets depo. I hear them [girls] discussing this.

~ (FGD 18, adult women, urban)

Similarly, an out-of-school boy describes his belief that it would be “easiest” to access contraception at a distance from where one is known: “It is easy to go if [the facility] is far away, somewhere where they do not know me at all ... then when I go there, I need this service, I see it is there ... Ah! I just buy” (IDI 51, out-of-school boy, urban). When asked why it would be a problem to obtain contraception where he is known, he laughed and replied, “It might become the news in town ... ‘You see that boy, aah! He is not good.’”

Both male and female adolescents largely agreed that drug shops/pharmacies were the healthcare source of choice for contraception. Shopkeepers were perceived to be more concerned with business than with the morality of young people, and so were less likely to question or scold the adolescents, and more likely to keep confidentiality, than health workers.

“Those who mostly work in the pharmacies don’t scold people because they are doing business.”

~ (IDI 9, in-school boy, rural)

It should be noted, however, that accessing contraception from drug shops was not always free from risk of disclosure. Some young people expressed concern that they would be seen buying contraception, and that community members or the shopkeepers themselves would inform their parents.

For instance, you get close to him; you tell him whisperingly that I want a condom so that they [others] don’t hear you ... Because even if they hear me ... they will be so much surprised that you are asking for a condom yet you are just like that [young] ... At the center, there are some men who like to sit there playing cards ... if they are seated there you can’t go there to request for a condom.

~ (IDI 6, in-school boy, rural)

As a result of this fear, adolescents sometimes either asked an older friend or family member to buy condoms for them, or pretended that they were purchasing the condoms for someone else.

You see due to that shyness, to access it they have to request through someone else. For him to get that salama [brand of condom], they look for an adult person or they could even use [send] a brother, those are the ways they use [to access].

~ (IDI 31, out-of-school boy, rural)

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For young women interested in accessing oral or injectable contraception, the process usually hinged on finding a sympathetic healthcare provider. Even adult men described how such doctors or nurses could be found using an informal network—usually word of mouth between adolescent girl peers.

To prevent pregnancy, Shija [fictional character] must know someone, even if it is her fellow student, who say, "I have once been taken there by someone." It is this person who will direct her to a particular doctor ... because there are certain ways so that you can easily get [contraception] without even parents noticing.

~ (FGD 3, adult men, rural)

Adolescent girls and boys and adult women also discussed how giving a *soda* or bribe to healthcare workers can facilitate access to more confidential care and help avoid excessive questioning.

There is a private room where she will give you the injection [Depo-Provera], so not in public. It means that when you get there you knock and she will ask you, "Why have you decided to use contraception when you are still young?" [And you will respond] "Help me, I will give you soda, mmh!" She will say, "that is my work [agree to provide contraception]."

~ (FGD 22, out-of-school girls, urban)

In the case of unplanned pregnancy, strategies for hiding evidence of premarital sexual activity included abortion, fleeing (or being sent away from) the natal home, being forced to marry the man responsible, and (in some extreme cases) committing suicide. Respondents discussed how girls who do carry their pregnancies to term may try to hide the pregnancy for as long as possible, which can lead to delays in or avoidance of ANC services, as experienced by one respondent.

Interviewer: Why did you wait up to six months and why didn't you go earlier?

Respondent: I was afraid.

Interviewer: Who were you afraid of?

Respondent: Home ... I didn't want them to know I was pregnant, they only noticed when I was five month pregnant.

~ (IDI 18, experienced unplanned pregnancy, rural)

Lack of communication, education, and information

Participants described prevailing values that dictated what and how adolescents should be taught about sexual relationships and health. When probed for reasons why parents do not or cannot discuss these issues with their children, adults mentioned '*aibu*,' or shame. One adult man said

Most of them don't sit with them [their children]. They find it embarrassing a lot and to explain to them about such things [reproductive health], they feel it is like they teach them to do those things [sex].

~ (FGD 3, adult men, rural)

Parents also felt it was impossible (*haiwezekani*) or difficult (*vigumu*) to talk to their children about contraceptive use, often shifting responsibility to school teachers or healthcare professionals. If there was any consideration of parents talking to their children, it was focused on daughters rather than sons, because of the risk of pregnancy. In adult group discussions, men stated that it was the mother's responsibility to talk to the daughter and that it was unheard of for a father to have such a conversation.

On the other hand, mothers thought that health workers could best educate their daughters, and felt that they themselves could only appropriately advise abstinence.

It isn't possible that I sit with my daughters and tell them that issue [pregnancy]. Maybe if health workers note that many unmarried girls get pregnant ... they could generate a seminar for them. Now this health worker, it is normal [to talk about pregnancy], that's her responsibility.

~ (ID 14, adult women, rural)

Of the very few parents who believed that a conversation on contraception was possible, none had held an actual conversation with their adolescent. A few parents mentioned that they would talk to their daughter about contraceptive use *only* after her first pregnancy, and then *only* if they discovered she was continuing to have sex.

I cannot talk to/tell her ... "Use contraception" ... Maybe when I have seen that she has matured ... Or she has given birth/she has a child or I have seen that she has changed and that she is dating men. Then, I can tell her that "you should be settled/calm, use contraception now."

~ (IDI 15, adult woman, rural)

Values surrounding adolescent sexual activity permeate communication and education outside the home as well. The majority of teachers opposed teaching about contraception and preferred to focus on abstinence. However, even teachers who were more proactive in providing contraception education could face significant opposition from parents and the community. One primary school teacher recalled the resistance he faced when informing parents about his SRH education syllabus:

[The parents said,] "Teacher, you teach my child and tell that this is a penis ... Teacher, no!" There are parents who thought about it negatively that "don't you see that you encourage them."

~ (IDI 4, teacher, rural)

Outcomes (Behavioral/Health)

While the sample size of this study was too small to capture a large number of adolescents able to share direct experiences of contraceptive use, pregnancy, and STIs, it is clear from the data that stigma—either directly or through the mediating factors of fear of disclosure—and lack of communication, education, and information contribute to several SRH-related behavioral outcomes. Outcomes include lack of contraceptive use and STI prevention (condoms), as well as avoidance or delay of ANC and treatment for STIs; these, in turn, impact health outcomes such as unplanned pregnancy, high-risk pregnancy, unsafe abortion, and STIs.

Lack of contraceptive use

In the study communities adolescent contraceptive use was restricted due to misconceptions, fear of disclosure, and fear of stigma or discrimination. Participants believed that healthcare providers would not provide contraception to adolescent girls, in part due to the prevailing misconception that contraception use is harmful. When a group of adolescent girls who had experienced pregnancy was asked if adolescents would be given contraception (of any form) upon request from a healthcare provider, they responded in the following way:

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Respondent 1: *They are harmful to young children, it is not allowed.*

Respondent 2: *And she is not allowed.*

~ (FDG 7, experienced unplanned pregnancy, rural)

Adolescent girls in particular discussed frequent reliance on the calendar method, due to fear of the assumed side effects of birth control.

[They believe the calendar method is the best] because it will prevent her from becoming pregnant and she won't be asked questions such as where did you get pregnant from? And you might find out that a person has learned and discovered the side effects of using the pill and injections so she decides that it is better to use the calendar method because it is much safer. She will have no fears of maybe gaining weight and she will be assured of the safety of her health.

~ (FDG 16, in-school girls, urban)

Embarrassment or fear of disclosure prevented some adolescents from acquiring condoms. For example, adolescent boys and young men shared how self-doubt based on anticipated reactions from health providers prevented them from seeking condoms at health facilities. They feared questions from health providers, and how others would perceive them upon finding that they had sought these services.

Already there are questions you will be asking yourself in your head. "Maybe if I go there what will I be asked? And when I am asked, how will I be perceived?" So, she can judge herself and decide on if it is worth getting that information from that health facility.

~ (FGD 9, in-school boys, rural)

So it feels that, the shame that makes me not to be able to get involved in asking for those things [contraception] is because I feel that how am I going to portray myself in front of that woman or in front of that man.

~ (IDI 52, out-of-school boys, urban)

A healthcare provider emphasized that girls' concern over how they would be viewed constituted a barrier to contraception use.

The girls don't come [get birth control services], they fear ... They believe that when the girl takes pills or gets the injection she is perceived to be a prostitute.

~ (IDI 33, healthcare provider, urban)

While drug shops or pharmacies were discussed as a preferred source of condoms because adolescents were less likely to encounter questioning or harassment, embarrassment and fear of disclosure were still common concerns when accessing contraception from such a public place.

You can find that at our village maybe there are some drug shops and it is men who are selling there, you see ... maybe even an elder with his family ... he feels shy, and it is hard for him to go to buy some condoms ... If he won't get a person to send, he cannot buy ... Mm, for a girl, she cannot.

~ (FDG 10, out-of-school boys, rural)

Generally, participants agreed that fear-based barriers would be more easily overcome by boys than by girls, reportedly due to two factors. First, social norms surrounding sexuality are less strict for boys than for girls; as one adolescent girl described it, "Because a boy is allowed to have sex" (FDG 01, adolescent

girls). Second, young men are believed to be inherently more courageous and less timid. This belief is described by adult men as follows:

Because the way a man has been created he is courageous ... A woman the way she has been created she is not courageous. She is shy and she likes advice and being pushed.

~ (FDG 13, adult men, rural)

STI treatment

Respondents were posed a question: How easy do you think it would be for adolescents to access treatment for an STI? Participants generally agreed that it would be very difficult for adolescents, particularly girls, to access treatment due to a myriad of stigma- and non-stigma-related factors. First, stigma associated with being sexually active and having contracted an STI was reported to have prevented and delayed access to treatment for adolescents, because STIs are considered shameful diseases. Adult men discussed how embarrassment, fear of disclosure, and shame would prevent a young girl from accessing timely treatment:

For Jane [fictional character] the difficulty of saying it early or the fear of going to hospital is because her problem [STI] is shameful. She must hide it because that is a secret—that disease is supposed to be a secret, that's why you hear someone is afraid disclosing it even to friends so that they can take her to hospital. That is why she sacrifices herself—because of her secretive disease, she doesn't want others to hear about it. She will be dealing with it herself until when she cannot hide it anymore, that's when she can disclose it saying I feel shame and scared.

~ (FDG 13 adult men, rural)

Shame also prevented male adolescents from accessing services. A father reported in an interview that he knew someone who had died recently from refusing treatment for HIV, and described the likelihood an adolescent boy would go get treatment.

Ah! They might go, but not if they feel that they have just become a worthless person. "I am already like this," he just goes to drink. Some say that when they realize that they are infected [usually referring to HIV] they feel ashamed to take the pills, that is why some just sit back, you just hear that so and so is sick, but they just sit back.

~ (IDI 11, adult man, rural)

Participants across groups noted that adolescents generally needed monetary support and/or permission from their families to seek treatment at a health facility. Participants frequently described how adolescents who had contracted an STI would be so reluctant to reveal their true symptoms that they might lie or feign non-related symptoms in an effort to access care without disclosure. In discussing a young girl who thought she had an STI, adult women agreed she would never tell her mother about her actual symptoms.

Respondent: She might even just say it is a headache or abdominal pain.

Respondent: But she won't say that she has had a sexual intercourse with someone.

Respondent: Yes, she won't tell you [her mother].

Respondent: Maybe the outcome of the test will show, she won't talk about anything.

~ (FDG 6, adult women, rural)

The inability to adequately communicate one's symptoms can impede timely and correct access to treatment. After describing how her mother once accused her of teaching her niece how to get pregnant—when she was actually teaching her how to use sanitary pads—one young woman explained how fear of her mother's reaction prevented her from getting care for a fungal infection.

I had never told my mother that I am suffering with this symptom ... I was educating her [niece], but when my mother came and found me talking to her about that [menstruation], she said I was teaching her how to get pregnant. So that led me to think that if my mother knew about my symptoms she may start to think that maybe her child had started this [sex] and should think that I am a prostitute [Malaya] and she would stop loving me thinking that, "my child's behavior has changed."

~ (IDI 43, out-of-school girl, urban)

Participants across groups reported that adolescent girls would be unable or unwilling to access services alone due to expectations or fears about negative interactions with healthcare providers. In an effort to mitigate these fears, adolescent girls could seek out a confidant, often a close friend or trusted relative, preferably older. However, the strategy of involving a third party still raised concerns over disclosure and embarrassment, which once again hindered timely treatment.

The way I see it, she [hypothetical girl with an STI] will not take any steps, she'll just stay with her illness ... She will be afraid to even go to the hospital, she will even be afraid to tell her friends. Therefore she will just stay that way with her illness.

~ (FGD 11, in-school girls, rural)

Participants also revealed that some adolescents try to bypass the diagnostic stage of accessing treatment, by self-diagnosing and self-treating using traditional medicines or medicines available for purchase from a drugstore or pharmacy.

These STIs, one needs quick advice with them, but in fact many do not even go to hospital. For STIs, they just take just medicines commonly found in the streets, traditional medicine, or someone could get them through the person who sells at the pharmacy.

~ (FDG 21, out-of-school girls, urban)

Use of antenatal care

Participants described barriers to ANC services, both hypothetically and through their experiences. Again, embarrassment, shame, and fear of disclosure featured as major deterrents to accessing timely and continuous ANC services. Adolescent girls who had experienced unplanned pregnancy described how fear prevented them from accessing timely ANC services.

I told her, "mother I can't go, I fear" ... I started going to the clinic when ... [I] was three months (pregnant) ... my mother took me there ... It was by force.

~ (IDI 50, experienced unplanned pregnancy, urban)

First I was afraid going to the clinic, I said, "It has passed all those months without going, if I go now won't they deny me the service?" But I said, "I will just go," and I went.

~ (IDI 44, experienced unplanned pregnancy, urban)

The same adolescent further described how fear of street harassment while walking to the clinic constituted an additional challenge to accessing services.

Ooh, now even at the street they still saw me ... they said a lot of words, until I was scared even to walk ... they were saying things like: "you are pregnant and left school so your mother is also stupid. If it was me I mean I would have kicked you out to go to that man who has given you pregnancy. Your mother still takes care of you so maybe she is the one who was taking you [for sex]."

~ (IDI 44, experienced unplanned pregnancy, urban)

In addition to the fear of being seen going to the ANC clinic and harassment on the street, other fears revolved around how adolescents would be treated by health providers. Even adult men knew about and discussed how fear of humiliation and harassment from the ANC service providers can prevent pregnant adolescents from accessing care.

The kind of humiliation she will get from the nurses because of her being pregnant at a young age, she might leave home with her card and never get to hospital and go back home because of fear ... It is because she will face a lot of humiliation on first day even if she has to go with her mother on the second day ... She will just think of how she was abused by the nurses, she will fear so much she might decide not to go to clinic. She will just decide not to go back again.

~ (FDG 03, adult men, rural)

DISCUSSION

Across all groups of participants, in both study communities, S&D was strongly evident surrounding adolescents' and young people's premarital sexual activity, contraception use, unplanned pregnancy, and STIs. Adolescents, healthcare providers, parents, community members, and teachers from both rural and urban settings all similarly reported these manifestations of stigma. At the familial and community levels, respondents described S&D in the form of pejorative name calling and labelling, social and physical isolation, physical punishment, and withdrawal of economic support. Fear of physical punishment and mistreatment from parents and family members was disturbingly common.

Stigma and discrimination in schools and health facilities was an extension of S&D seen at the community level. Teachers shamed sexually active students and schools expelled girls found to be pregnant. Healthcare providers harassed, scolded, and excessively questioned young people about pregnancy, STI status, and their need for contraception when they sought SRH services. At times, healthcare providers would even deny adolescents care for failing to bring a husband, partner, or parent. However, it should be noted that a few healthcare providers in the study communities were aware that young people needed to be encouraged to access SRH services and information, but also to be treated with dignity and respect.

Participants described the anticipation (or fear) of S&D more frequently than actual experiences. This is unsurprising due to the small sample size and small number of adolescent participants who had experienced unplanned pregnancy, contracted an STI, or used any form of contraception. Anticipated stigma is likely rooted in personal or observed experiences of stigma and can have a powerful influence on behavior. A study in four African countries also found that anticipation of S&D was a barrier to accessing SRH services and information (Biddlecom et al., 2009). Anticipation of beatings or banishment from the home led adolescents in the study communities to resort to secrecy when engaging in sexual activity, obtaining contraception, and accessing SRH services and information; in some cases, they avoided needed services completely. This echoes findings in a study by Sedgh and Hussain, who found that young women are unwilling to risk social disapproval associated with seeking contraceptive services, contributing to unmet need for these services (Sedgh and Hussain, 2014).

While the data did not entirely capture internalized stigma (for this reason, it is not discussed in the results section), it is important to mention that this form of stigma has been shown in other areas to affect depression and health-seeking behaviors (Clement et al., 2014; Simbayi et al., 2007). One qualitative South African study found that adolescents internalized stigmatizing sexual ideologies on "good behavior" and the idea that "sex is wrong," which hindered discourse about healthy sexuality and behavior (Harrison, 2008). A few of the young women who had experienced unplanned pregnancy indicated the presence of self-stigma through acknowledging a degree of responsibility for embarrassing themselves and bringing shame to their families. Young people who have experienced STIs and/or unplanned pregnancies may have lower self-esteem as a result of treatment from their peers, teachers, community members, health providers, and family members. One adolescent boy discussed why an adolescent would feel 'bad' following an STI diagnosis, due to shame and failure to use contraception.

First it is the shame about the disease, and a condition like that ... but you will be feeling shy that you have contracted the disease while protections are there and you never made use of them.

~ (IDI 31, out-of-school boy, urban)

Young people in these situations need to be approached more sensitively, as the consequences of S&D may affect their health and, in the case of unplanned pregnancy, their relationships with their children (Gipson et al., 2008).

The picture painted by the respondents' collective voices shows how the communities are responding to what they perceive as a threat to their social fabric—unmarried young people having sex—and how the social process of stigma is a response to that perceived threat and an attempt to control it. In discussing the issue of unmarried young women having sex, a teacher explained that stigma can be helpful to the community because (through punishment) it teaches adolescents how to behave appropriately.

... One [unmarried girls or young women] shouldn't have sex until you are married. So stigma sometimes helps the community, stigma helps us in one way or another. Because without stigma sometimes the community doesn't learn [how to behave] ... To reprimand something bad that you did in the community, that is what is known as stigma, however it is a stigma that teaches the community to a certain degree [how to behave].

~ (IDI 4, teacher, rural)

Stigma in the study communities was driven by social norms. Moral judgment of adolescents and their behavior, driven by social norms, can have far-reaching consequences on their lives and that of their families. Their fears of being shamed or scolded for their sexual behavior; of being isolated from family, peers, and the community; and of physical punishment help shape adolescents' decisions on whether (and where) to access SRH services or request information. Families' fears of losing social standing in the community led them to engage in stigmatizing actions; hindered SRH education and communication; contributed to low levels of knowledge on contraception, prevention of pregnancy, and STIs; interrupted, stalled, or discontinued school attendance; and encouraged forced marriage. Such findings are not unique to this study. A multi-country African study found that embarrassment and fear, as well as other psychosocial factors, hindered access to care (Biddlecom et al., 2009).

Within health facilities and schools, local interpretation (or misinterpretation) and implementation of national policy and guidelines appeared stigmatizing and ultimately discriminatory. The general community climate of stigma may have influenced health providers' implementation of policies and delivery of care. This study demonstrates that participants may be discouraged from attending health facilities for fear of scolding and questioning by health providers. A recent Tanzanian 'mystery client' evaluation of healthcare providers' reception of adolescents requesting condoms and information on hormonal contraception and STIs found that providers often responded inadequately and with hostility (Mchome et al., 2015). Similarly, a qualitative study conducted in South Africa with adolescent girls found that nurses stigmatized teenage sexuality and harshly treated and scolded their female adolescent clients (Wood and Jewkes, 2006).

In addition, the data indicated that adolescents may avoid seeking care out of fear that they will not meet the criteria to receive SRH services. Our interpretation of the data and policy scan hints that this behavior is shaped by the environment of stigma and may be partially due to health providers' misinterpretation of government policies on SRH—particularly with respect to bringing a husband, partner, or parent when seeking ANC or treatment for STIs. Similar findings were noted in another study conducted in rural Tanzania that found that conditionalities (e.g., attending the health facility with one's partner or parent) imposed on pregnant women seeking ANC services discouraged uptake and attendance (McMahon et al., 2014). Our scan of Tanzanian policies suggests that the 'requirement' of attending a health facility with a spouse is derived from the National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections (2007), which encourage contact tracing and treatment, testing of STI patients for HIV, and reinforcing prevention with all age groups. Although this policy was intended to reduce re-infection (WHO, 2001), it seems to have been misunderstood in practice by some health providers. In addition, reviewed policies are silent regarding parental roles during adolescents' access to SRH services and information. Such silence in policy leaves much to the discretion of health providers, who may act as they feel appropriate based on contextual circumstances. Respondents described how the

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expected questioning and scolding makes adolescents fearful of visiting healthcare providers for services and information. A multi-country African study resulted in similar findings, with youths reporting difficulty in seeking STI treatment from clinics due to being asked to “bring your partner first.” This resulted in a preference for seeking treatment from traditional healers (Jana et al., 2012).

Our scan of relevant national policy documents with a focus on SRH information and services for adolescents revealed important gaps in existing policies and deficiencies in several areas. Although legislation requires the provision of youth-friendly health services in Tanzania, there is a lack of clear guidance on what such services should include. For example, policy guidelines and standards for family planning (2013) under youth-friendly services insist that “*relevant* information and education materials be displayed or distributed to young people,” and that young people should be able to obtain preventive, rehabilitative, and curative services that are *appropriate* to their needs. However, it is not clear as to what service or information is considered relevant or appropriate for adolescents, and interpretation left up to the provider may be informed or shaped by stigma. Encouraging ‘youth friendliness’ without a clear idea regarding implementation and inclusion of services is not unique to Tanzania. Other studies have begun to examine more exact definitions and parameters for youth-friendly services (Erulkar et al., 2005).

Insufficient human resources to provide youth-friendly services were identified as a major issue in Tanzania; however, in the latest costed implementation plan, the budget allocated for youth-friendly services for the period 2010–2016 is limited, and intended only for training of trainers. Mobilization of resources for trainers to train healthcare providers is left to council community health plans (CCHPs). This can be challenging since, as studies have shown, healthcare prioritization in a decentralized health system in Tanzania is political and highly influenced by local contexts and actors (Maluka et al., 2011). In a climate of strong and prevalent community stigma toward adolescent SRH, one can imagine that raising and allocating resources to youth-friendly services is unlikely to occur.

In addition to stigma that directly affects health behaviors, the findings also point to an indirect pathway between stigma and behavioral health outcomes through disclosure (or fear thereof), leading to an urgent need to protect confidentiality, lack of communication, and misconceptions around adolescent promiscuity and the effects of hormonal contraception.

Because of the stigma surrounding adolescent sexual activity, adolescents receive messages that primarily stress abstinence, while parents rarely talk to their children about SRH topics and schools avoid providing adequate information about contraception. Other studies on SRH education and adult-child communication have similarly demonstrated that prevailing values and beliefs on appropriate sexual behavior hinder education and communication (Bastien, 2009; Awusabo-Asare et al., 2008; Kumi-Kyereme et al., 2014; Lindberg and Maddow-Zimet, 2012). However, young people desire to use contraception and make efforts to access these services and information, despite the S&D that they face. Adolescent navigation of S&D may include befriending and bribing health providers, accessing SRH services from distant facilities or shops where no one knows them, and pretending to buy condoms for someone else or having someone else buy condoms for them. These strategies do impose additional costs; as a result, when adolescents can’t afford these costs they may go without the services.

Several key misconceptions surrounding contraceptive use emerged from the data, including a strong belief that knowledge and access to SRH information and services would encourage adolescent promiscuity. Illustrating the strength of this belief, girls who use contraception are believed to be more immoral than girls who merely have ‘occasional’ sex but do not use contraception. This stems from the perception that girls who use contraception are premeditating or planning to have sex, while girls who do not use contraception just make an occasional ‘mistake.’

Participants almost universally expressed a strong fear that adolescent use of hormonal contraceptives will lead to sterility, highlighting the centrality of childbearing to these communities. This fear exposed

what appears to be a challenging conundrum for adolescents and their parents: the risk of more immediate stigma from an unintended pregnancy, versus the risk of stigma from future infertility. Research shows that concern over future infertility-related stigma is not unfounded. A review of the psychosocial consequences of infertility in African communities found that infertility is often met with stigmatization (Dyer, 2007). The prevalence of such fears also indicates the pervasiveness of misconceptions surrounding hormonal contraception. Other literature from sub-Saharan Africa has highlighted similar fears and misconceptions about both contraception and general SRH education being delivered to adolescents (Mchome et al., 2015; Wood and Jewkes, 2006; Dyer, 2007; Williamson et al., 2009).

It is worth noting that some evidence disproves the beliefs that providing education and information on SRH to adolescents would lead to increased sex (Kirby, 2002a, b).

It is also now widely acknowledged that some adolescents become sexually active at an early age. In rural Mwanza, the average adolescent is sexually active by age 15 (Boerma et al., 2002), and accessing SRH information and services is their basic right (Shaw, 2009; Kothari et al., 2012; Lloyd, 2005). Several studies have explored general barriers to adolescent access to SRH services (Tylee et al., 2007; Shaw, 2009), but little had been done to frame, understand, or address the role of S&D. Therefore, this exploratory study's important contribution to the literature is the elucidation of the potential role of stigma as a barrier to adolescent SRH, through an examination of the drivers, consequences, and forms of S&D experienced by adolescents in their endeavor to access SRH services and information. Notwithstanding this contribution, the nature and scope of this study did not allow for an exploration of the extent to which the reported forms of stigma are actually related to low uptake of SRH services and information among adolescents.

CONCLUSION AND RECOMMENDATIONS

This exploratory study demonstrates the pervasiveness of stigma surrounding unmarried adolescents' SRH at multiple levels—individual, family, community, school, and health facility—as well as the pathways through which S&D can discourage young people from accessing SRH information and services in two communities in Mwanza region, Tanzania. Stigma is a barrier to parents, teachers, and health providers providing adolescents with SRH services and information, and to adolescents disclosing their need for SRH information and services. The root causes of adolescent SRH stigma that emerged from the data include both economic constraints and the importance of upholding social standing through compliance with social norms and expectations. Stigma manifested in multiple ways, including the local implementation of some national health guidelines—for example, requiring contact tracing for STIs and male partner involvement in ANC for adolescents. While changing these pervasive drivers is a long-term and perhaps daunting proposition, lessons from the HIV experience have taught us that, in the short-term to intermediate timeframe, there are actionable steps that can be taken to reduce S&D—particularly in health facilities, but also in the broader community. Given the pervasiveness and fear of stigma surrounding adolescent SRH, integration of a more direct stigma-reduction focus into programs focused on provision of youth-friendly services (or, generally, the creation of more enabling environments for youth SRH) could bring another tool to this challenging issue. The following recommendations emerged from the findings of this exploratory study:

1. Strengthen understanding of the gap between policy guidelines specific to protecting the reproductive health needs of young people, and the local implementation of those policies.

Since 1994, Tanzanian policy has clearly stated the right of adolescents—irrespective of parity and marital status—to access contraception, and has included a push to require the provision of youth-friendly health services. Despite this, adolescent access to these services remains severely limited (Mchome et al., 2015). While national policy seems relatively clear, there is a lack of well-defined policy guidelines and detailed information on what such services should include (Ministry of Health, 1994; Ministry of Health and Social Welfare, 2013). There is a general lack of discussion about what services should be provided to adolescents; instead, it is stated only that adolescents have the right to access services that are appropriate or relevant to their needs, leaving the definition of these terms open for interpretation. The policy documents are also silent regarding the role of parents regarding adolescents' access to contraception or treatment of STIs.

It is important to acknowledge that social norms and community values influence the way in which healthcare providers and teachers deliver services, despite their relatively high level of educational attainment. Where policy guidelines leave some room for interpretation (Ministry of Health and Social Welfare, 2013), prevailing community norms will often shape service delivery. In the context of strong, prevalent stigma toward adolescent SRH, this can lead to services delivered with a heavy dose of S&D. Therefore, policy guidance documents must more explicitly reflect specific contraceptive and other SRH service needs of young people, as well as implementation. Because stigma is a social and cultural phenomena linked to the actions of various societal groups, all sectors of society must be engaged in its reduction (Parker and Aggleton, 2003). Young people, parents, community members, teachers, and healthcare providers must be engaged in the creation of such policy guidelines in an effort to ensure that they are appropriate and culturally sensitive.

2. Consider national-level financing of local human resource development for youth-friendly services.

Despite the push for provision of comprehensive/improved youth-friendly services in Tanzania, the lack of knowledgeable human resources is a key stumbling block. Notably, the latest costed implementation

plan, while including a budget for training of trainers on youth-friendly services, does not finance training for health providers at local levels; instead, it directs district councils to raise funds for human resource training to provide youth-friendly services (Ministry of Health and Social Welfare, 2010). This is challenging, considering that raising and allocating resources depend on the districts' priorities. Provision of SRH services to adolescents is imbued with social norms and values, which may restrict prioritization at the district level. Therefore, it is important for the central government to finance human resource training, through various channels, for the success of youth-friendly services and information programs.

3. Engage and train healthcare providers and teachers in stigma reduction.

Stigma and discrimination are often unconscious and can shape delivery of services without the awareness of service providers (Nyblade et al., 2009). Tools and approaches from HIV-stigma reduction efforts could be adapted to include a focus on stigma and adolescents. These approaches use data to begin discussions with stakeholders, and focus on participatory stigma-reduction training coupled with the development of codes of conduct led by service providers. Initial training, and subsequent refresher trainings, should include a focus on the need to maintain confidentiality and meaningfully engage young people in discussions about their sexual health. This could be facilitated, in part, by having a separate service delivery protocol specific to young people that clearly dictates the types of questions that should and should not be asked of unmarried young people. Trainings should also emphasize that, while partner contact tracing is good public health policy in general, it should never be a precondition for service; any insistence on this issue can be damaging to the health-seeking behavior of adolescents.

4. Incorporate stigma-reduction programming at the community and familial levels.

In addition to within the health and educational sectors, incorporation of targeted stigma-reduction initiatives into programs at the community and familial levels is necessary to break the process of stigma. The study findings show that stigma at these levels also impedes access to SRH information and services. Again, tools and approaches used to reduce HIV stigma could be adopted, focusing on a participatory process that engages parents and the general community. Families and community members would be encouraged to reflect on the drivers, manifestations, and consequences of stigma, and on how their actions are stigmatizing and may discourage young people from accessing broadly beneficial information and services. This approach could incorporate sessions to address communication barriers between parents and adolescents. Participatory activities may also include sessions for boosting adolescent girls' self-esteem lost as a consequence of their experiences of unplanned pregnancy.

5. Incorporate messages into ongoing family planning campaigns to address myths and misconceptions surrounding contraception use by adolescents.

Fears and misconceptions surrounding contraceptive use and the adverse side effects of hormonal contraception, particularly for adolescents, were prevalent in the study population. In order to enhance access to contraception information and services, it is important to explore and directly address these fears and concerns. The side effects of hormonal contraception must be clearly defined in magnitude and prevalence, while also highlighting that hormonal contraception is safe for adolescents and will not lead to sterility.

6. Conduct further research with a focus on experienced stigma and links to health outcomes.

This small, exploratory study makes an important contribution by examining stigma as a barrier to adolescent access to SRH, through descriptions of the drivers, forms, and consequences of S&D anticipated by adolescents in their endeavors to access SRH services and information. However, the study was less successful at capturing experienced or enacted stigma and directly linking stigma to health outcomes. This was due, in part, to the small sample of participants—in particular, those who had

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experienced unplanned pregnancy, ever contracted an STI, or ever used hormonal contraception—and the qualitative nature of the study. Therefore, we recommend further research with a larger sample size of adolescents who meet these criteria, combining qualitative and quantitative methods, to explore the extent to which stigma and discrimination is actually experienced or enacted, as well as stigma's relationship to health outcomes.

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