FACTORS CONTRIBUTING TO HIGH PREVALENCEOF TEENAGE PREGNANCY IN LINDI MUNICIPALITY - TANZANIA

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR DEGREE OF MASTERS IN ENVIRONMENTAL STUDIES (HEALTH STREAM) OF THE OPEN UNIVERSITY OF TANZANIA

2015

CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by the Open University of Tanzania a dissertation titled: *"**Factors Contributing to High Prevalence of Teenage Pregnancy in Lindi Municipality, Tanzania"*** in partial fulfillment for the requirements of degree of Master of Environmental Studies (Health) of the Open University of Tanzania.

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(Supervisor)

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Date

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DECLARATION

I, **Juvenalis Babilas Mauna** do hereby declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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Signature

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Date

DEDICATION

This dissertation is dedicated to my late farther Mr. Babilas Mafuru Mauna and my Mother Mrs Bernadeda Nyasinde Misango for their highly contributions in my life. My almighty God rest them in peace. Amen

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ACKNOWLEDGEMENTS

I wish to acknowledge with sincere gratitude all those who contributed to the production of this readable dissertation manuscript.

My appreciation should go to my supervisor Dr. Irene Aurelia Tarimo for various supports including constructive suggestions, innovative ideas, argumentative comments and close guidance throughout the dissertation write-up.

Also I would like to wish thanks to all Ward Executive Officers, Mtaa Executive Officers and the community as a whole who were interested in the research for their great support and efficiency in providing vital information.

ABSTRACT

This study was carried out at Lindi Municipality, Lindi Region, Tanzania. Teenage pregnancy continues to be a social, economic and cultural problem due to its continuing rise that has an adverse impact to both teenage and the community as a whole. Teenage mothers are likely to suffer from several complications during delivery that result in higher morbidity and mortality for both mother and child. The study was aiming to determine environmental factors contributing to high prevalence of teenage pregnancy. The research methodology involved a descriptive cross-section study, where a simple random sampling was used to select a study population and sample size. The method used for data collection was interviews, administered questionnaires and focus group discussion (FGD). A total of 207 teenage interviewed, 101(49%) were males and 106 (51%) were females. The study has come out with the findings that majority 108 (52%) respondents have poor knowledge on methods of contraceptives. On other hand the study noted that early attending to initiation rites ceremony have an impact on early sexual practice were majority 95 (86%) of respondents attended initiation rites practiced sexual intercourse early compared to 16 (14%) of respondents who had not attend. This difference is statistically significant ($\chi^2 = 4.38154$; $P < 0.05$; $df = 1$; CI = 95%).It has noticed that the situation of sexual intercourse at the first contact was a coerced act. It is recommended that there is a need to strengthen reproductive health education programs in school and out of school that promote communication skills among males and females. Establishment of approach which is more holistic; equipping teenage with appropriate knowledge on sexuality, access to contraceptives rather than traditional coaching approaches that focus upon improving sexual ability.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Research Problem

Teenage pregnancy is detrimental to the health of both mother and child, is a common public health problem worldwide. It is a problem that affects nearly every society, developed and developing alike. It is one of the key issues concerning reproductive health of women not only in developing but also in developed countries.

A teenage or teen is a person whose age is a number ending in teen, that is to say, someone from the age of ten to the age of nineteen. In practice the operational definition of teenage varies widely from country to country depending on cultural, institutional and political factors. For the purposes of this study the term teenage refers to a person being from the age of 10- 19 years.

Teenage pregnancy is a public concern in both developed and developing world (Acharya et. Al., 2010). Globally 15 million women under the age of 20 give birth each year. In developing world, women under the age of 20 die due to pregnancy related complications. The risk of death due to pregnancy – related cause is doubled among women aged 15 to 19 compare to women in their twenties. Young women are also at risk of unwanted pregnancies, sexual transmitted diseases and unsatisfactory or coerced early relationship (Acharya *et. al.,* 2010).

Early childbearing particularly has negative demographic, socio-economic and socio-cultural consequences. Teenage pregnancy is associated with higher rates of morbidity and mortality for both the mother and infant during and after delivery. Teenage mothers are at

greater risk of socio-economic disadvantage throughout their lives. The younger the mother the greater the likelihood that she and her baby will experience health complications.

The risk of death among infants in the first month of life is particularly high when the mother is under 20 years old. Among adolescent mothers, the rate of death among infants during the first month of life – the neonatal mortality rate - is 41 per 1000 live births, compared with 22 per 1000 when the mother is older (Masanyiwa *et al.,* 2011).

Early sexual activity increases the risk of multiple sex partners, unprotected sex that ends up into sexual transmitted diseases such as Acquired immunodeficiency syndrome (AIDS) and risk of premature rupture of membranes, preterm labor, and postpartum infection. According to WHO (2010) among the teenage mothers, the neo-natal mortality rate is 41 per 1000 live births, compared with 22 per 1000 when the mother is older between 20 to 29 years.

Teenager constitutes a high risk group requiring high priority services. At the onset of menstruation, 12-18 percent of pelvic growth in girls is still not completed. Giving birth at this stage can lead to fatal complications or leave the mother with lifelong morbidities. All these bring the teenager female at high risk of experiencing more adverse reproductive health outcomes.

Pregnancy of a still growing girl means an increase in nutritional requirement, not only for the growth of foetus but also for the mother herself which inevitably leads the teenage mother to malnutrition and she has to suffer from various pregnancy complications like obstructed labour, retardation of foetal growth and premature birth. Slowing the rate of teenage pregnancy will help to reduce the risks.

In Sub-Saharan Africa the average rate of births per 1,000 females 15–19 years of age is 143, and in other countries one in five teenage females gives birth each year. This is very high compared to the world average of 65 (WHO, 2004).

In many societies the age of first sexual intercourse is generally very early for both girls and boys. It is estimated that 23 percent of teenage women have already begun their reproductive life, 20 percent had at least a child and 3 percent are pregnant with their first child at 17 years and nearly 14 percent of the teenage have already begun their childbearing(Sayem and Nury, 2011).

More than half of women age 25–49 (58%) and 41% of men age 25-49 interview during the survey were sexually active by the age of 18. Fifteen percent of women had sex by the age of 15. Women start sexual activity about one year earlier than men, the median age of 17.4 years for women and 18.5 years for men (TNBS, 2011).

In most areas teenage sexual intercourse is not a matter of choice. Studies conducted in rural Malawi, 55 percent of 120 teenage surveyed reported that they were often forced to have sex. Street children boys as well as girls performed "survival sex" which is using as a means of bargaining for money, food or protection from violence (Barnett, 1997). According to (Madise *et al.*, (2007) in a study conducted on poverty as a driver for risky sexual behaviour in Burkina Faso, Ghana, Malawi, and Uganda found that among the sexually experienced 15-19 years old 4% of girls and 15% of boys reported having at least two or more partner within the period of 12 months. Like other countries in the world, Tanzania is also facing the same problem of teenage pregnancy. According to Tanzania Demographic Health Survey (2004-2005), revealed that one-fourth of women aged 15-19 have begun

childbearing, 20 percent are already mothers and 7 percent are pregnant with their first child. The percentage of women aged 15-19 that has begun childbearing has remained constant over the past 15 years. At the age of seventeen, one quarter, and at the age of eighteen 39%, of all females are either pregnant or already mothers. About 0.5 to 1% of primary schoolgirls within the age of fertility, standard 5to7 fall pregnancy every year. At the age of 16, one in ten girls have begun child-bearing; this rises to one in five by 17 years and to more than one in three by 18 years (TNBS, 2011).

Although prevention of teenage pregnancy is one of the national strategies, many teenage continued to become pregnant and this continued has been complex and challenging issue for families, health workers, educators, societies, governments as well as teenagers themselves (Dangal, 2005).

Legal measures to control teenage pregnancy in Tanzania are complicated by contradictions within the existing laws. Laws relating to marriage and permissible sexual relations within marriage are unclear and contradictory both on the mainland and in Zanzibar. On the mainland, for example, the 1971 Marriage Act defines the minimum age of marriage as 18 for males and 15 for females, the law also allows courts to permit marriage of females who have reached 14 years of age (Marriage Act, 1971).

The Penal Code allows for females of “African or Asiatic descent” to be married in accordance with local custom or religion if marriage is not intended to be consummated before a female reaches 15 years of age (Penal Code 138). In the latter case, even when marriage is permitted, sexual intercourse is prohibited until the girl reaches 15 years of age. Islamic law, according to the Tanzanian Government allows marriage and consummation of the marriage from puberty (Rights of The Child, 2000). Legal age of marriage was not

addressed in the Law of the Child Act or in Zanzibar's Children's Act due to fears that the topic might result in a backlash from religious leaders that could delay passage. During debates in Zanzibar around the Children's Bill in 2010 several religious leaders repeatedly stressed that a legislative minimum age of marriage was not appropriate, since religious doctrine states that a girl shall be ready for marriage on reaching puberty. Such views essentially justify child marriage.

Under Mainland law, neither customary law nor Islamic law can override the provisions of the Law of Marriage Act or the Penal Code. While Islamic and customary laws are applied in practice in many communities, this is a violation of statutory law. There is a pressing need to harmonies customary and Islamic law with national statutes and ensure that the law is known and enforced. The decline in child marriage is more likely to have been influenced by changes in attitudes towards girls' education and increased access to secondary school than by an increased understanding of the law. However the same time the sexual offence special provision act of 1998 states that "any person who carnally knows any girl under age of 14 years is guilty of a felony and is liable to imprisonment for life, with or without corporal punishment."

The study conducted by Mbelwa and Isangula (2012) found that in 2006 about 400 schoolgirls became pregnant in Rukwa region, southwest of Tanzania, 200 schoolgirls dropped out of school because of pregnancy. The study therefore was conducted to identify factors contributing to high prevalence of teenage pregnancy in Lindi Municipality.

1.2 Statement of the Problem

Pregnancy in teen is a danger to mothers, as the body is not sufficiently prepared to carry a foetus, this leads to teen mother in a position to become undernourished and suffer premature or prolonged labour which is a risk to a permanent morbidity or death.

Teenage childbearing is associated with many adverse consequences for teen mothers, their family and children. While the disadvantaged backgrounds of most teen mothers account for many of the burdens that these young women carry, byhaving a baby during teenage often restricts economic and educational opportunities and these disadvantages tend to be passed on to the next generation. Children born to teen mothers are often worse off than children born to older mothers. They are at higher risk of poverty, low educational attainment, behaviour problem, early sexual activity, and becoming a teen parent themselves.

InLindi Municipality Teenage pregnancy is a serious problem as the number of teenage increases. Reports collected from Reproductive and Child Health clinics health facilities have shown that in 2011 out of 840 pregnant women attended Reproductive and Child Health clinics 49 (5.8%) were teenage, in 2012 out of 826 pregnant women attended 53 (6.2%) were teenage, while in 2013 out of 940 pregnant women attended 144 (15.3%) were teenage (Lindi Municipal Council reports, 2011, 2012 and 2013). Thus the number keep on increasing year after year.

The factors influencing the increase of teenage pregnancy are not well known, however hypothetical factors assumed to influence this problem are inadequate knowledge about reproductive health, inaccessibility to reproductive health services, poverty, early sexual practice, single parent care which lead to poor upbringing, attending initiation rites at early

age, negative culture and beliefs towards utilization of reproductive health services. This study therefore, identified some environmental factors contributing to high prevalence of teenage pregnancy in Lindi Municipality, Tanzania.

1.3 Objectives

The main objective is to determine the environmental factors contributing to high prevalence of teenage pregnancy in Lindi Municipality, Tanzania.

1.3.1 Specific Objectives

1. To assess the awareness on sexual practices and reproductive health among teenage in Lindi Municipality.
2. To determine the environmental, socio-economic, cultural and beliefs that influence early sexual practices among teenage in Lindi Municipality.

1.3.2 Research Questions

1. What is the awareness on sexual and reproductive health among teenage in Lindi Municipality?
2. What are the environmental, socio economic, cultural and beliefs that influence early sexual practices among teenage in Lindi Municipality?

1.4 Purpose/Rationale of the Study

The rationale of this study comes from the fact that teenage pregnancy is recognized as a serious problem in the society despite of the initiatives done so far. At the moment there is no documented study done in the municipality on this aspect to find the factors contributing to high prevalence of teenage pregnancy. The proposed study aims to investigate the

possible factors contributing to this problem and thereafter recommend intervention measures in order to avert the consequences of teenage pregnancy. Information obtained from this study will help the Municipality and other stakeholders to design and set appropriate interventions that will help to alleviate the problem of high prevalence of teenage pregnancy.

1.5 Significance of the Study

Teenage childbearing is associated with many adverse consequences for teen mothers, their family, and children. Many of the negative consequences for teen mothers are due to the disadvantaged situations in which many of these girls already lived before having a teen birth. While the disadvantaged backgrounds of most teen mothers account for many of the burdens that these young women carry, by having a baby during teenage often restricts economic and educational opportunities, and these disadvantages tend to be passed on to the next generation. The study aimed to determine factors contributing to high prevalence of teenage pregnancy in Lindi Municipality. The information that will emerge from the study will guide in what need to be done and what need to be improved or changed and to determine the factors contributing to teenage pregnancy.

Furthermore, it is expected that the findings will be used by the Municipality and other stakeholders to design and set appropriate intervention that will help to alleviate the problem of high prevalence of teenage pregnancy. By finding the root cause of the problem, will help to manage the situation that cause teenage to become pregnant hence reduce the consequences associated with. Data collected will be used to further revise the strategies in place

1.6 Conceptual Framework

Teenage pregnancy can be view from an ecological perspective. The ecological perspective looks at person in the environment and the affects it has on its members. The social-economic environment consists of the different types of interactions with individuals, groups, and organizations. Whether its face to face contact, homes people live in, involvement in the community, the different types of income generation activities will affect the outcome of their lives also it looks at the teenager mother in her social-economic environment and how the environment has an adverse impact on her wellbeing if not provided with adequate resources. From that points of view you find that if there is no adequate intervention taken to reduce this problem, there will increase the problems related to early teenage pregnancy that will end up to poverty.

1.7 Theoretical Perspective on Education Inputs regarding to High Prevalence of Teenage Pregnancy

Health education is one of the most important components of health promotion that involves motivation to adopt health promoting behaviour and help people make decisions put into practice. Effective health education may thus produce changes in understanding or in ways of reasoning. It may bring some shift in beliefs and attitude or influence value and facilitate acquisition of skills and effect changes in life style and behaviour.

CONCEPTUAL FRAMEWORK FOR FACTORS CONTRIBUTING TO TEEN PREGNANCY IN LINDI MUNICIPALITY - TANZANIA

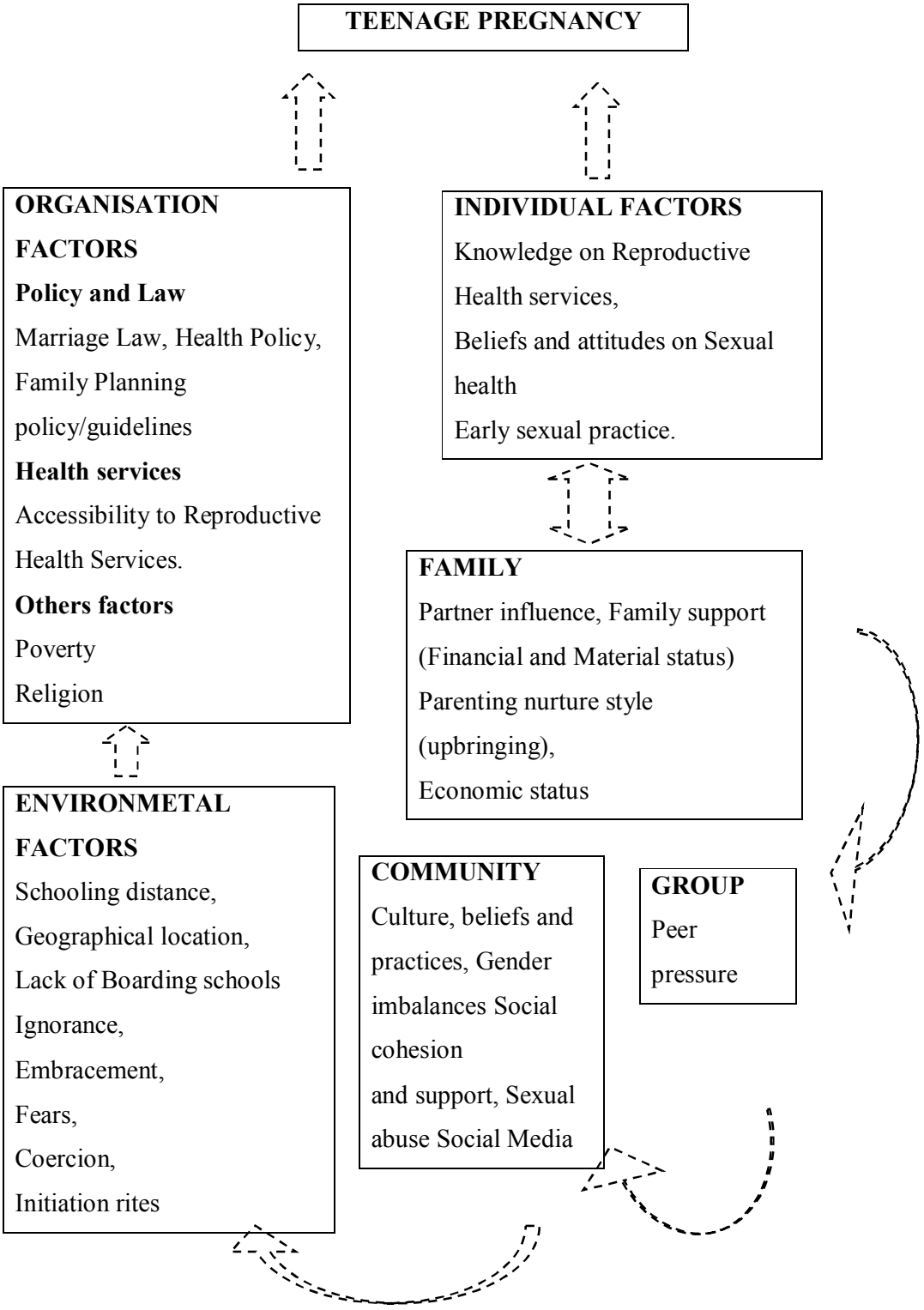

Figure 1.1 : Conceptual framework for factors contributing to teen pregnancy in Lindi Municipality.

(Source: This study, 2015)

1.7.1 Health action model (HAM)

This model provides a comprehensive framework in which major variables influencing health choices and actions and their interrelationship are categorized and described. Health action model consists two major sections that are Individual's intention to act or behavior to intention (BI) and factors determine whether or not an intention is translated in practice.

The model is effective and more powerful tool because of its capability of incorporating other models and other health education related theories (Beal, 1996). To intervene the problem of teenage pregnancy, Health Action Model will be used.

1.7.2 Belief System

A belief is a probability judgment that links some objects or concept to some attribute (Ajazn and Fishbein, 1975). The belief system incorporates three major categories of beliefs namely belief about the particular action, belief about self and normative beliefs.

According to Beal (1996), the good preventive model is that which persuade the individual to take responsible decision i.e. to adopt behaviour that will prevent the problem at primary, secondary and tertiary level.

The study findings revealed that, teenagers do not use contraceptives as they believe that contraceptives have side effects in the future. They believe that using contraceptives might end up with problems such as irregularity of menstrual cycle, 31 percent responded that they might fail to conceive the time wants a baby. To change their beliefs health education is needed so as the community will acquire knowledge that will make them to feel that the problem is serious and impact affects the whole community. Imparting them with sexual and reproductive health knowledge will enable them understand the magnitude of the problem. Health education will enable change their negative beliefs toward use of

contraceptives and ultimately will starts use of contraceptives. The information will make teenagers and the community to believe that use of contraceptives prevents pregnancy.

1.7.3 Motivation system

It describes a complex of affective elements that ultimately determines the individual's attitude to specific action and their intention to adopt it. Part of this is the individual's value system, the attitude and drives (Beal, 1996).

From the study, it have found that there are ways that can be used to increase knowledge of contraceptives use among teenagers such as use of IEC materials that inform the impacts of teenage pregnancy and how uses of sexual and reproductive health can help in reduction of teenage pregnancy and other effects concern with teenage pregnancy. IEC materials will be use as means of promoting the use of sexual and reproductive health is very important to equip knowledge to teenagers and the whole community.

1.7.4 Normative System

The term "norm" describes culture, subculture and group behaviour with various values, beliefs and routines associated with particular behaviour. Health action model (HAM) describes the normative system from an individual's perspectives. It includes the likely reaction of significant others, member or general social norms for decision to seek for particular health action. The influence of norms within a group on its individual members may be powerful provided the individual value membership of the group .The normative system is directly related to both belief and motivation system.

In this study it has revealed that sexual and reproductive health services for teenagers are surrounded by stigma especially among parents, community leaders and religious leaders. As the result of stigma teenagers could not access to services. Although teenagers might have an intention of utilizing the services, they are in a situation that cannot use due to fear of being known by their parents/guardians, members of the community or influential leaders like community and religion leaders who do not want teenagers use sexual and reproductive health services.

These are significant others, they cause teenagers hesitate to utilize the service. These leaders are regarded as the last say in the community whatever they say are taken as customs of the community and no one is supposed to challenge, are the gatekeeper of the community wherever changes to be introduced in the community should be passed to them so as can be accepted to the community. Influential community and religion leaders are the key holders you cannot enter in the community without opening the gate. To remove the stigma on use of sexual and reproductive health among teenagers, community leaders should be educated on the impact of teenage pregnancy and the importance teenagers to utilize sexual and reproductive health. Health education that will introduce change of attitude toward sexual and reproductive health services hence become willing to open the gate that is to inform the community the importance of using sexual and reproductive health services on reduction of teenage pregnancy.

1.7.5 Facilitating and Inhibiting Factors

Facilitating factors are those factors that enable an individual make a positive health action while inhibiting factors are those factors, which prevent an individual from carrying out the intended health action. When an individual is motivated, develops an intention or attitude to

act towards health promotion and then an intention is translated into action /practice. In this case, various facilitating factors have to be made present, while at the same time various inhibiting factors have to be (removed) from the environment.

During the study some inhibiting factors toward utilization of sexual and reproductive health services identified were such as teenagers lack information on methods of contraception due to the fact that they are not accessible to appropriate information on contraceptives, there is no teenager friendly sexual and reproductive health services and unwilling of some services providers to provide service to teenagers. For this reason there is need to involve higher authorities and policy makers to improve primary health care especially on sexual and reproductive health education among teenagers in school and out of school, as having appropriate information about sexuality in early stages of their childhood will enable them to make informed decision about sexual at the time make a decision to sexual practice.

1.7.6 Behaviour outcome

Through introduction of health education as inputs to teenagers, health service providers, community leaders using appropriate facilitating factors, there will be expected behavioural changes on an individual action and practice towards utilization of sexual and reproductive health services. Improve infrastructure of health services that can be improved to deliver sexual and reproductive health service that is friendly to teenager. Train health workers on communication skills that equip them good approaches especially during provision of sexual and reproductive services to teenagers. Involve policy makers to improve primary health care especially on sexual and reproductive health.

Behavioural outcomes are identified through three categories of health actions, namely ***Routine, Quasi-routine*** **and** ***Discrete single time choice***

Routine: are behaviours that have become habitualized often as a result of previous, primary or acquired socialization (parental influences). The main goal of health education is to make sure that, many health practices become familiarized. Actual acquisition of routine behaviour is not limited to early socialization but adult may learn a wide variety of psychomotor skills at any stage in their life. The routine practices of any kind are not under direct conscious and not require conscious decision except when they become well established.

Using health education will enable the community change their behaviour that causes teenager hesitate the use of reproductive services. Teenagers will reduce or stop sexual practice, utilize the services without fear eventually the use of service become a routine practice. Using health education will enable health providers provide service of the good quality.

Quasi-routine: are normative systems comprising of the whole range of norms and interpersonal pressures, which may be so important in affecting individual's decision, making. They are adoption of health related behaviour different from those of routine. Using health education will enable the normative to open up the gate that was holding community as the result cannot utilize the services. Teenagers will utilize the services without fear of being known or isolated from the community.

Discrete Single-Time Choice: Introducing changes require a lot of time and patience due to individual attitude and values. Through using health education the teenagers will be equipped with knowledge that will remove single time choice and become a permanent behaviour.

In this context, the HAM is proposed to bring about an effective behavioural change regarding causes of high prevalence of teenage pregnancy. It will help to change community to adopt from beliefs and normative system that can cause the problem increase. Using HAM will enable to introduce knowledge that will bring changes of the behaviour in relation to the existing problem of teenage pregnancy. HAM will put in place facilitating factors to achieve the ideal behavioral action which is routine utilization of sexual and reproductive health.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter tries to explore information from different researchers, books, article news and reports on what other authors have done concerning the related topic. Thereafter will find a gap to research on for the purpose of this study.

2.2 Family Planning Policy and Guidelines

Every human has right to access quality and affordable sexual and reproductive health services. No one is allowed to obstruct someone to make choice of these services in any way. For that case every country should make sure that no one lacks quality service of reproductive and sexual health as it is the right that all individual should access regardless of his or her age or gender. This right is recognized in the International Conference on Population and Development in Cairo in 1994.

According to Tanzania National Family Planning Guidelines and Standards (2013) all men and women including young people (10–24 years of age), irrespective of their parity and marital status, are eligible to access accurate and complete family planning information, education and services. Although our policy allows teenager to access reproductive and health services, yet the policy have not effectively implementing in most of areas as teenager are still facing with difficulties when they in need of the services.

2.3 Cultural and briefs on Sexual and Reproductive Health Issues

In most of our societies sexual and reproductive health issues has considered as secret and undisclosed matters that are not allowed to be discussed in public and even at home with

parents or close relatives. In need of transmitting such information to a matured person, parents are supposed to find someone on behalf of parents who is a relative or selected member of the community to instruct a teenager on all matters concern sexual and reproductive health including norms associated with. Such situation has been causing teenager sometimes get inadequate and wrong information. Mostly gets information from unreliable sources i.e. peer groups, friends at school, magazine and radio.

Study by Ruto (1999) in Kenya evidenced that parents and adults do not give teenage information on sex and contraception because it is not considered culturally appropriate, hence they turn to their peers who give them inappropriate and/or inaccurate advice.

2.4 Lack of Knowledge on Reproductive Health

Knowledge about reproductive health among teenagers has an impact to the welfare of both teenage as well as the community as a whole. Lack or inadequate knowledge about reproductive health has a serious problem to their welfare of a teenager. Most of teenager has been exposed to various risks such as unprotected sexual activities and early pregnancy. Teenage pregnancy has an effect to a teen as once conceived she is not allowed to continue with school programs even after delivery where she spend her time taking care of her child.

A study conducted in Philippines by WHO (2003) conceded that there is a clear relationship between knowledge and pregnancy. The findings showed that two out of every 10 young women gave birth before age 20. Among less-educated women that number increased to four out of 10. Less educated women were more likely to become pregnant during their teen years than their better-educated counterparts. Out-of-school youth estimated to be 5.5 million and mostly concentrated in urban areas faced a higher risk of teenage pregnancy.

Research in Latin America has also shown that there is a relation of high proportion of teenage pregnancy due to poor exposure to sexual and reproductive health education and to family planning services among teenagers. In Africa, studies have demonstrated that a large proportion of teenagers in Uganda and Nigeria are exposed to the risk of conception as the result of receive poor sexual and reproductive health education as well contraceptive education (Mfono, 1998).

Survey in Swaziland has also shown that knowledge on use of condoms is high among teenagers, about 97 percent but only 20 percent of young women aged 15-19 and 30 percent of young men aged 15-19 have ever used a condom during sex (Biaye, 2004).

Sex education stands effective if the knowledge of birth control pills and their usage are made clear to teenagers. This is evident from the Youth Risk Behaviour Survey carried out by Centre for Disease Control (CDC) in USA which found that 80 percent of lowered teen pregnancies have been reported to be caused by more effective practice of contraception techniques among them (Dasgupta,2011).

In a study conducted by Mushwana *et al.,* (2015) on Factors influencing the adolescent pregnancy rate in the Greater Giyani Municipality, Limpopo Province–South found that inadequate sexual knowledge (61%), changing attitudes towards sex (58.9%) and peer pressure (56.3%) contribute to high pregnancy rate among teenagers.

2.4 Lack of Information about Reproductive Health Services among Teenagers

The attitude that adults hold about providing information to young people on reproductive health is crucial in shaping the content of messages provided to the youth. A study

conducted in Ghana found that over 90% of adults support for providing young people with the information they need to protect themselves from unwanted pregnancies and sexually transmitted infectious diseases (USAID, 2000).

In a study conducted in Bangladesh by (Bhuiya *et al.,* 2004) to assess reproductive health services for adolescents found that adolescents had limited access to Reproductive health services and the available services are not friendly especially those who were married who could not access family planning methods.

Giving information about reproductive health to teenage has positive impact lather than restricts them. Parents are advised to discuss matters concern reproductive health rather than limiting on cultural issues.

Boys and girls learn about traditions through peer effects, the social process at home and in the community during the initiation rites. Still needs comprehensive sexual and reproductive health education so that they can prepare themselves for healthy adult relationships, increase adolescents' knowledge and help them to explore attitudes, feelings and values about human development, relationships, dating, gender roles, sexual orientation, sexual behavior and informed healthy sexual decision-making.

Studies of young people in other regions have shown a similar lack of accurate information. In India approximately 100 girls who attend to hospital seeking abortion, 80 percent did not know that sexual intercourse can end up to pregnancy and 90 percent did not know about contraception due to lack of reproductive health education in early age (www.fhi.org, 2003).

2.5 Socio -economic Status of the Family Income Inequality

Economic status of the family has an impact on the teenager. At this age teenagerface with different demand to support day to day life thus needs financial assistance to basic needs such as clothes, body makeup, entertainment etc. for that sense need to be supported by parents, guardian or close relatives. The absence of support from the parents has been causing the teenage to find support from outside the trusted person as result are found themselves engaged into sexual activities as return of gifts or assistance received. One of the reasons that came instantly on the question as to why girls get pregnant was poverty. In many cases it was noted that the lack of basic requirements tends to expose girls to risks of pregnancy (Ahikire and Madada, 2011).

According to Chen *et al. (*2013), young people growing up in disadvantaged economic, familial and social circumstances are more likely than those who did not to engage in risky behavior and have a child during their adolescent years. Among teens aged 15–17, income inequality and per capita income were independently associated with birth rate; the mean birth rate was 54 per 1,000 in counties with low income and high income inequality, and 19 per 1,000 in counties with high income and low inequality. Among older teens (aged 18–19) only per capita income was significantly associated with birth rate.

Although teen childbearing is the result of individual behaviors, community-level factors such as income and income inequality may contribute significantly to differences in teen birth rates. In a study conducted on factors contribute to adolescent pregnancy among secondary student in Kinondoni by Peter (2009)it was observed that low socioeconomic status is one of the cause for adolescent pregnancies. Other factors responsible were luxury and deprivation of education to girls (43.5% and 16.5% respectively).

Acharya*et al*. (2010)explained that socio-economic status, educational attainment, cultural factor and family structure were all identified as risk factors for teenage pregnancies in South Asia. Teenage pregnancies are significantly higher in the lower social classes (52%) than in the higher social classes (26%).

Teenage pregnancy is associated with the most deprived and socially excluded of young people. Difficulties in young people's lives such as poor family, relationships, low self-esteem and unhappiness at school also put them at greater risk. These are among the reasons that contribute to school dropout. Once a girl has become pregnant are not allowed to continue with classes and are discriminated by the family as well as the community. The event has great consequences to the overall wellbeing of a teenager, family and the whole community; spoil her future career and threatening their future economic prospects.

2.6 Environmental Factors and External Force from the Community

Teen has been engaging in early sexual active as result of external force from the community they live. Many of the teenagers today live in stressful environments where there is violence, poor housing conditions, and many of the experienced discrimination on a daily basis. All these determinants have impact on how the teenagers perceive their future that also has an impact on their sexual decision-making.

In some of African culture once a girl or a boy matured are supposed to show that he or she is capable of undertaking sexual activities. In a Study of sexual behavior among young people conducted in Kenya found that 21% of females and 11% of males had experienced sex under coercive conditions. Most of the perpetrators were intimate partners including boyfriends and girlfriends (Erulkar, 2004).

A study conducted in Lindi by Tumbo (1994) said that instructions given to boys and girls during the initiation can contribute to the increase of rate of teenage pregnancy as these boys and girls are trained on how to satisfy their partner during sexual intercourse. Girls are trained how to move their waist rhythmically during intercourse, this coaching need more practice before they get masterly. To master they continue on practicing as the result most of them have ended up with pregnancy.

Violence may be related to teenage pregnancy indirectly or directly. Women who have suffered childhood abuse my tend to engage in bad behaviors for example sex risk taking, drug and alcohol abuse that prevent consistent or correct contraceptive use. They may also not use contraceptive due to fear of and culture (Bruyn, 2002). The problem of teenage pregnancy is cyclic in nature because children born to teen mothers are 66% more likely to become teen mothers themselves (Basch, 2011).

2.7 Sexual Behaviour and Religious Commitment

Religious teachings has an important role in shaping behavior of an individual in the formation of individual's attitudes, values and make proper decisions toward sexual practice as fear to commit adultery. A study conducted in Nigeria on relationship between faith and sexual behavior found that there is a correlation between teenager sexual behaviour and religious commitment. Religious values are the source of moral prescriptions for many individuals, and the teachings of the churches are likely to play a role in the formation of individual attitudes, values and decisions. The extent to which religion influences individual attitudes and behaviour, however, depends on the specific doctrines and policies of the churches and on the degree of integration and commitment of individuals to their particular religious institutions (Odimegwu, 2005).

2.8 Parenting Nurture Style

The environment that surrounds the teenagers have strongly correlated to increased rates of teenage pregnancy. For example, there is a strong correlation between teenage pregnancy and the neighborhood in which the teenager live. Teenager who lives in neighborhoods with high levels of poverty, low levels of education and high residential turnover are at higher risk for teenage pregnancy. Teenagers whose mother or sister gave birth as a teen are also more likely to become pregnant during their teenage years. Females who grow up without fathers in the home usually end up having pre-marital sex (Hinckely, 1998). They subconsciously want to make up for the affection that they didn't receive from their fathers. They become too dependent on men because they want someone who can replace their father. These women usually don't know how to relate to other males and they have the wrong idea about what a relationship should be like.

The study conducted by Gyan (2013) at Chorkor in Ghana on the incidence of teenage pregnancy has been reviled that teenage pregnancy has effect on the educational attainment. With respect to factors that lead to teenage pregnancy, it was evident that poor parenting, poverty and peer influence are the major causes of teenage pregnancy.

2.9 Lack of Boarding Schools

Lack of boarding schools has been contributing to the increase of teenage pregnancy in most of communities. On the way and back home from schools teenagers are facing with influence from adult person who tends to provide gifts, food or transport in return of sex.

Most of schools are located very far from many households as result students have to walk between 4 to 8 kilometres from their villages to school. In order to be able to be close to school, many students hired rooms famously known to them as ‘ghetto’. In these ‘ghettos’ a

mixed of ordinary community members, boys and girls live together, which has lead girls to be enticed to immoral behaviours. This has lead to failure in academics, face sexual abuse such as rape, teen pregnancy, and threats of contracting HIV and other Sexually Transmitted Infections (Nyirenda, 2012).

2.10 Research Gap

According to the review of literature of various studies in different places by different researchers that has been exploring different factors contributing teenage pregnancy. However, given the different environment and situation of different socio-economic, law and policies, cultural and beliefs aspects, this study reveals there is of lack of knowledge in issues concern with reproductive health services among the teenagers as well as among members of community. Therefore thestudy conducted to determine the factors contributing to high prevalence of teenage pregnancy in Lindi Municipality Tanzania.

CHAPTER THREE

METHODS AND MATERIALS

3.1 Study Area

The study was conducted in Lindi Municipality that is one of the six Districts in Lindi Region comprising of Kilwa, Lindi rural, Liwale, Nachingwea, Rwangwa and Lindi Municipality. It is located at latitudes 9o45' and 10o45'south of equator and Longitude 39o50' and 39o36' East of Greenwich. Both sides it is surrounded by Lindi District Council except at the eastern side where there is an Indian Ocean. The District has an area of 251sq km, and generally warm, with temperatures ranging between 18.5o to 31.5o. According to the projection from National population census of August 2012. It has a population of 78,841 with 1.4 population growth rate per annual.

Figure 3.1 : Map of Lindi Region showing Administrative Area. Source (www.lindi.go.tz)

3.1.1. Social Economical and Cultural

Lindi Municipality has various social economic groups, which practice their activities according to their nature of interests. The three main groups are youths, women and elder

groups. Most of the residents depend on agriculture, petty trade/business and fishing as their main economic activities.

3.1.2 Accessibility to Health Services

The residents of Lindi Municipality are getting medical services from 18 health facilities present in the district, only 14 Health facilities which are Government health facilities provide sexual and reproductive health education and family planning services, the remain 6 health facilities do not provide the mentioned services.

Table 3.1 : Distribution of the health facilities type and ownership

H/facility type	Ownership				Total
	Government	Voluntary agency	Private	Parastatal	
Hospital	1	0	0	0	1
H/ centre	1	0	1	0	2
Dispensary	10	0	2	3	15
Total	**12**	**0**	**3**	**3**	**18**

Source: Municipal Director - Lindi Municipality (2015)

3.2 Research Design

The study design was descriptive cross- sectional conducted in Lindi Municipality. The study duration was six months starting from December 2014 to 1st week of May 2015.The study design covered physical characteristics of people, materials or the environment as in prevalence survey or evaluation of coverage social economical characteristics of people such as their age, education, marital status and income the behaviours of people and the knowledge, attitudes,

beliefs and opinions that helped to explain the behaviour and events that occurred in the population in relation to teenage pregnancy.

3.3.0 Sampling procedure

The simple random sampling procedure was employed to obtain respondents of the study.

3.3.1 The study population

The study population was the individuals of both married and single/unmarried teenage who were the residents of Lindi Municipality.

3.3.2 Sample size

The sample size was calculated by using a proportion of 15.3% taken from Town Medical officer report of 2005.Using margin error of 5% at the precision of 95% confidence interval. The following formula was applied to determine the sample size (Goyal, 2013).

. $n = P\ \frac{(100-P)}{e^2}$

Where **n** = Ideal size (Sampling size)

P = Proportion (15.3%)

e = Standard error (2.5)

Therefore $n = \frac{15.3\ (100-15.3)}{(2.5)^2} = \frac{15.3 \times 84.7}{6.25} = 207.3$

n = 207 Respondents.

3.3.3 Study unit

Male and femaleteenage individuals in Lindi Municipality.

3.3.4 Sampling method

Simple random sampling method was used to select 9 wards, from thirteen wards by writing on a piece of paper and each name of the ward was placed in the box and then shaken vigorously. Then the research assistants were asked to pickup 9 pieces of paper from the box. The selected wards were Jamhuri, Mtanda, Msinjahili, Nachingwea, Mwenge, Rasbura, Mitandi, Makonde and Wailes.

In selecting the 38 Mtaa/streets out of 46 streets in the 9 selected wards, the same procedure as above was carried out by writing names of all streets on each piece of paper folded and placed in the box followed by shaking the box vigorously. Then a piece of paper was picked out from the box at a time and recorded without returning the paper in the box the same procedure was done until the required number of the Mtaa/streetsware obtained.

The proportion was used to get the number of teenagers to be involved in this study in each Mtaa/street by using the following formula.

Total number of teenagers in Mtaa streetx sample size (207)
Total number of teenagers in all 38 Mtaa/streets (6,218)

i.e The number of teenagers interviewed from Ghana street were

$$\frac{170}{6,218} \times 207 = 6$$

The same procedure was applied in all Mtaa/streets.

The study interval was obtained by taking the total number of teenage to be studied in a specific Mtaa/street divided by the total number of teenagers in a specific Mtaa/street as follows.

$$\frac{6}{170} = \frac{1}{30}$$

The study interval ratio was 1:30

To obtain a teenage to start to interview was obtained by writing their numbers on papers folded and put into a box and shacked vigorously. There after one piece of paper was picked up once and the number of study teenager to start the interview with was obtained from the study frame prepared. This procedure was applied to all Mtaa/streets.

3.4.0 Data Collection Technique and Tool

3.4.1 Techniques of data collection

Data collection techniques used was interviewing and Focus Group Discussion (FGD). The respondents were given a copy of self-administration questionnaires to fill and collected immediately after have been filled. The FGD involved three groups of 6 – 12 informants selected conveniently from the community.

3.4.2 Tools for data collection

Self- administered questionnaires with open and closed-ended questions were used for data collection. Self-administration was used so as to help the respondents to feel free and to express themselves. This has been so because of the nature of the study. FGD questions interview guide was used for focus group discussion.

3.4.3 Data handling

The questionnaires were labeled with numbers as per the sample size (01- 207). The questionnaires ware kept securely in the folder after being filled correctly. At the end of the day the researcher counter checked if the questionnaires were properly filled and data was

entered into a data master sheet. The FGD results was narrated, verbalism was translated and printed.

3.5 Ethical consideration

Prior to conducting the study, a letter for requesting permission was sent to the Municipal Director's Office, with a copy to Ward executive officers, Mtaa Executive officers of the selected wards and Mtaa. Concert was also sought to the individuals involved in the study.

3.6 Quality control

All activities regarding data collection were done under the monitoring and supervision of the principal investigator. Either, research team met every evening after data collections to review the collected data and cross check the filled questionnaires for correctness and completeness.

Before data collection one research assistant was recruited and trained for three days on data collection. Thus ensured accuracy and validity of the data collected.

3.7 Data Processing and Analysis

The collected data was sorted manually using data master sheet and a calculator. Then the data was entered into a computer using Excel spreadsheet and analyzed using Statistical Package for Social Sciences (SPSS) program version 20.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.0 Findings / Results

This chapter presents the research findings obtained during data collection in nine selected wards out of thirteen wards of Lindi Urban. The respondents, age and sex distribution ranged from 15 - 19 years. A total of 207 teenage respondents interviewed, 101(49%) were males and 106 (51%) were females. Results for respondent's characteristics can be seen in Table 4.1.

Table 4.1 : Distribution of respondents by Age and sex

n= 207

	SEX					
	Male		Female		Total	
Age	No.	%	No.	%	No.	%
11	3	3	7	7	10	5
12	6	6	8	8	14	7
13	7	7	5	5	12	6
14	3	3	2	2	5	2
15	9	9	19	18	28	14
16	16	16	20	19	36	17
17	21	21	12	11	33	16
18	24	24	19	18	43	21
19	12	12	14	13	26	13
Total	**101**		**106**		**207**	

Table 4.1 shows that the highest number of the respondents 43 (21%) were at the age of 18 years, while the lowest number 5(2%) were at the age of 14 years.

4.1 Awareness on Teenage Pregnancy

When assessed if they have ever heard about teenage pregnancy the responses were as illustrated in table 4.2.

Table 4.2 : Respondents awareness of Teenage Pregnancy

n = 207

Awareness of teenage pregnancy	Sex				Total	
	Male	%	Female	%	Male +Female	%
Aware	94	48	101	52	195	94
Not ware	7	58	5	42	12	6
Total	**101**	**48.8**	**106**	**51.2**	**207**	**100**

Results in Table 4.2 indicates that majority 195 (94%) were aware of teenage pregnancy compared to 12 (6%) who were not.

4.2 Source of information on Teenage Pregnancy

Regarding to the source of information on teenage pregnancy the responses were as shown in Table 4.3.

Table 4.3 : Distribution of respondents by source of information about Teenage Pregnancy

n = 195

Source of information	Sex				Total	
	Male	%	Female	%	Male +Female	%
Media(News papers, Poster/Leaflets, Tv and radio)	70	65	83	70	153	68
From family member	28	26	17	14	45	20
Medical personnel	4	4	6	5	10	4
From teachers	5	5	12	10	17	8

Table 4.3 shows that majority of 153 (68%) respondents got the information about teenage pregnancy from various media compared to 10 (4%) from medical personnel.

4.3 Level of awareness on Sexual and Reproductive Health among Teenage

To assess the level of awareness and reproductive health among teenage, respondents were asked which part of the menstrual cycle girls are more fertile and therefore more at risk of getting pregnancy. Details on the key issues can be seen in **Annex 3** and the responses are shown in Table 4.4.

Table 4.4 : Respondents level of knowledge on part of the menstrual cycle, which a girl is more fertile and therefore more at risk of getting pregnancy

n = 207

Respondents level of knowledge	Sex				Total	
	Male	%	Female	%	Male+ Female	%
Good knowledge	23	23	28	26	51	25
Moderate knowledge	21	21	27	25	48	23
Poor knowledge	57	56	51	48	108	52
Total	**101**		**106**		**207**	

Table 4.4 shows that 108 (52%) of respondents have poor knowledge on part of the menstrual cycle a girl is more fertile and more at risk for getting pregnancy compared to 51 (25%) respondents who had good knowledge.

4.4 Responses as to whether Girls can get pregnant during Menstrual Period

Respondents were asked to give their opinions whether girls can get pregnant during menstrual period. Results are portrayed in Figure 4.1.

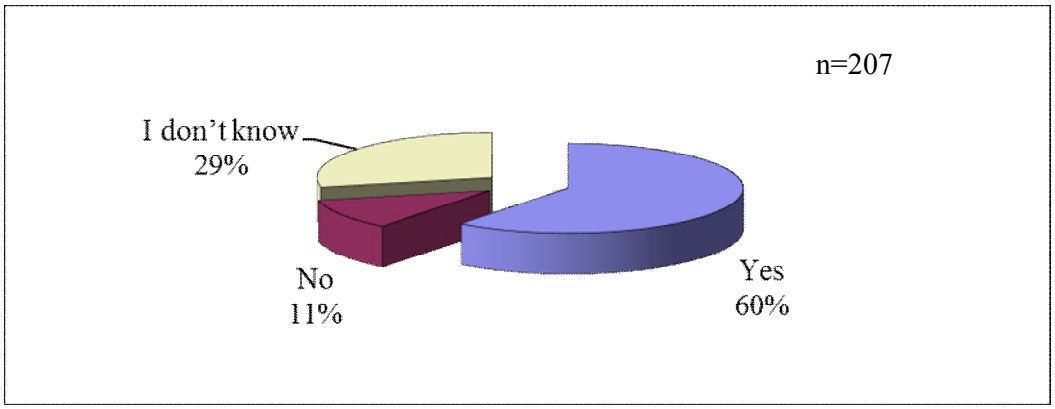

Figure 4.1 : Respondents opinion whether girls can get pregnant during menstrual period

Figure 4.1 shows that 125 (60%) respondents said that a girl can become pregnant during menstrual period compared to 23 (11%) who responded that they do not know.

4.5 Responses on whether Girls can get Pregnant on first Sexual contact with Men

Again respondents were asked whether a girl could get pregnant on first sexual contact with men. Results are in Figure 4.2

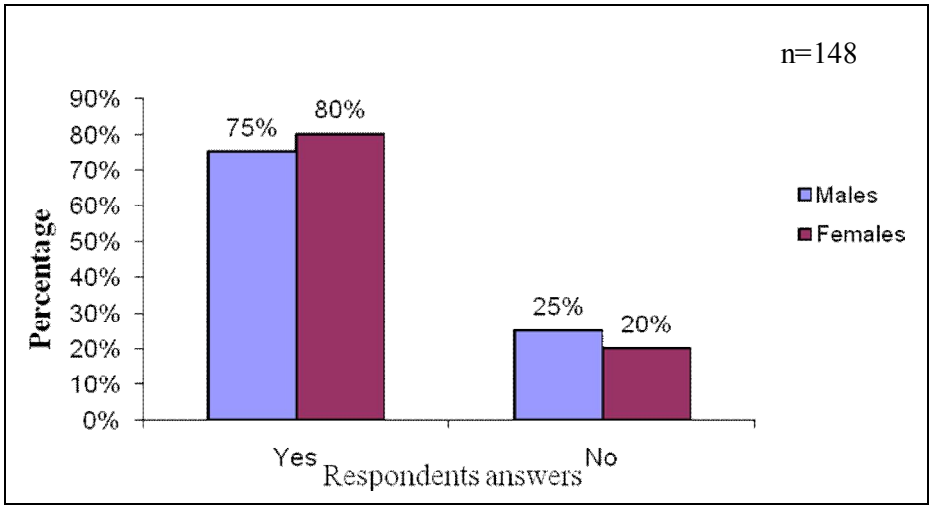

Figure 4.2 : Responses on whether Girls can get Pregnant during their first Sexual Intercourse

Figure 4.2 shows that majority of respondents 60 (80%) and 55 (75%) girls and boys respectively responded that a girl could get pregnant for the first time she had sexual intercourse.

4.6 Knowledge on Consequences of Early Pregnancy

On finding out whether teenage knows the consequences of early pregnancy or not they were asked to mention the consequences of early pregnancy. The results were categorized into high knowledge, moderate knowledge and low knowledge and scores were done by using a key. Details on the key can be seen in **Annex 3** and responses are in Table 4.5.

Table 4.5 : Level of knowledge on the consequences of Early Pregnancy

n = 195

	Sex				Total	
Level of knowledge	**Male**	**%**	**Female**	**%**	**Male +Female**	**%**
Good knowledge	36	37.1	44	44.9	80	41
Moderate knowledge	34	35.1	42	42.9	76	39
Poor knowledge	27	27.8	12	12.2	39	20
Total	**97**		**98**		**195**	**100**

Table 4.5 shows that majority 80 (41%) respondents have high knowledge on the consequences of early pregnancy, while 39 (20%) have low knowledge.

4.7 Knowledge on Contraceptive Methods

Specific questions were asked to assess the knowledge on methods of contraceptives they understand. The findings are as shown in Figure4.3.

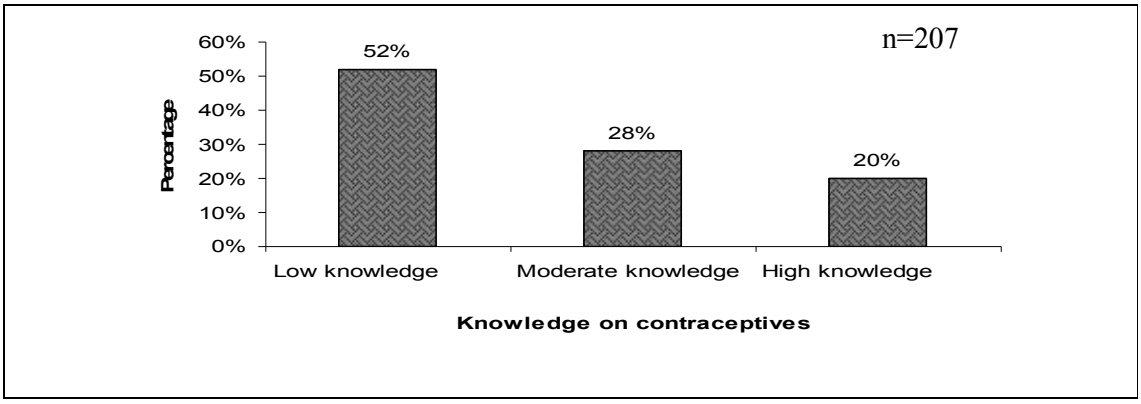

Figure 4 3 : Knowledge of the methods of contraceptives

Figure 4.3 shows that majority 108 (52%) respondents have poor knowledge on methods of contraceptives compared to 41(20%) respondents with good knowledge.

4.8 Knowledge on how to avoid pregnancy

Concerning the knowledge on how teenage can avoid impregnate and being impregnated, the responses are as shown in Table 4.6.

Table 4.6 : Responses on what could a Boy/Girl do to avoid impregnate or pregnancy?

n = 207

Respondents answers	Sex				Total	
	Male	%	Female	%	Male +Female	%
Use a condom	32	31.7	38	35.8	70	33.8
Withdraw the penis before ejaculation	10	9.9	6	5.7	16	7.7
Make sure that the girl takes the pills	11	10.9	27	25.5	38	18.4
Respect the girl's unsafe days for having sex	3	3.0	2	1.9	5	2.4
Do not know	39	38.6	25	23.6	64	30.9
Abstain	6	5.9	8	7.5	14	6.8
Total	**101**		**106**		**207**	**100**

Table 4.6 shows that majority 70 (33.8%) uses condom, followed by pills 38 (18.5%) as a method of prevention from pregnancy while 64 (30.9%) girls and boys do not know.

4.9 Relationship between methods of contraceptives and awareness on teenage pregnancy

It was necessary to test if there is any relationship between knowledge on methods of contraceptives and awareness on teenage pregnancy. Results can be seen in table 4.7.

Table 4.7 : Relationship between knowledge on methods of contraceptives and awareness on teenage pregnancy

n= 207

Knowledge on methods of contraceptives	Awareness on teenage pregnancy					
	Aware		Not aware		Total	
	No.	%	No.	%	No.	%
Poor knowledge	106	54	2	17	108	52
Moderate knowledge	55	28	3	25	58	28
Good knowledge	34	17	7	58	41	20
Total	**195**		**12**		**207**	**100**

Table 4.7 shows that 106 (54%) of respondents have poor knowledge on teenage pregnancy compared to 34 (17%) with good knowledge. This difference is statistically significant ($\chi^2 = 6.044$; $P < 0.05$; $df = 2$; $CI = 95\%$).

To explore cultural beliefs in relation to reproductive health services among teenage, respondents were asked questions about getting contraceptives.

4.10Responses on whether teenage (boys and girls) were allowed to get contraceptives

The interviewers were asked whether boys and girls under 20 get contraceptives from traditional birth attendants (TBA) or health facility. The results are indicated in Figures 4.4.

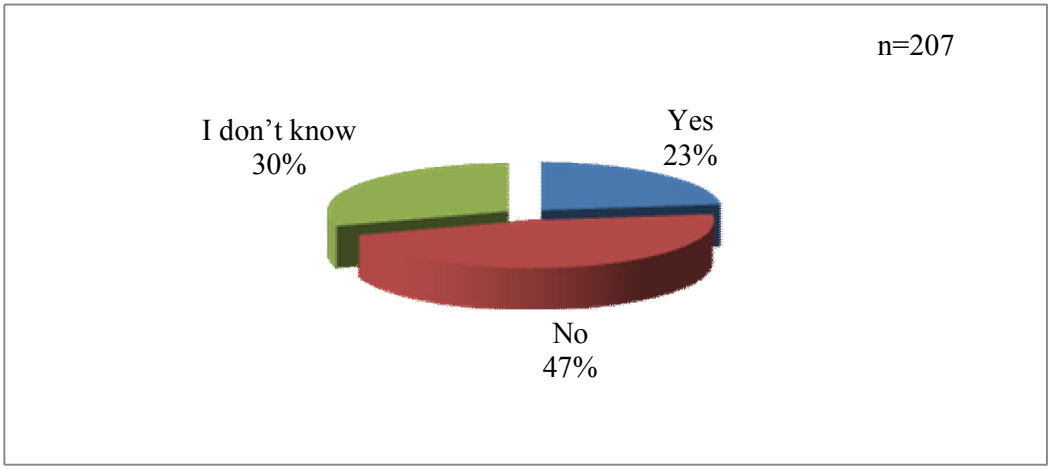

Figure 4.4 : Responses on boys and girls under 20 on whether they get contraceptives

Figure 4.4 shows that majority 98 (47%) of respondents responded that teenagers were not allowed to get contraceptives compared to 48 (23%) of teenagers responded that they could have access to contraceptives.

4.11 Reasons for not getting contraceptives

The research went further more to find the reasons why teenagers were not getting the contraceptives. The results are as indicated in Table 4.8.

Table 4 8 : Reasons for not getting contraceptives

n = 98

Reasons	Frequency	Percentage
Under 20 years	46	47
Contraception have effects in the future	30	31
Cause teenage to engage in prostitution	26	27
Cause school drop out	24	24
Fear of being reported to their parents/guardian	32	33

Respondents responded to more than one option

Table 4.8 shows that majority 46 (47%) responded that under 20 teenagers were not getting compared to 24 (24%) responded that could them to drop out from school.

4.12 Accessibility to reproductive health services among teenage

To assess accessibility of reproductive health services among teenage, questions were asked to assess whether teenagers are accessible to reproductive health services or not. They were asked if a teenage approach to a doctor/Nurse for contraceptive their parents/guardian were being informed about the request. The results are as indicated in Table 4.9.

Table 4.9 : Teenage approach to a doctor/Nurse for contraceptives and Parents/guardians

n = 192

	SEX					
	Male		Female		Total	
Age	No.	%	No.	%	No.	%
Yes	21	30	64	53	85	44
No	11	15	32	26	43	22
I don't know	39	55	25	21	64	33

Table 4.9 shows that majority 85 (44%) responded that once they approach Doctor or Nurse for contraceptives, parents/guardian were informed compared to 43 (22%) responded that they were not told.

4.13 Source of information about contraceptives and reproductive health services

Concerning to where did they get the knowledge about contraceptives and reproductive health services. The responses are in the Table 4.10.

Table 4.10 : Source of information about contraception and reproductive health

n = 207

Source of information	Sex				Total	
	Male	%	Female	%	Male +Female	%
Friends	47	40	50	41	97	38
Health workers	41	35	39	32	80	31
(Media) TV/radio, Posters/leaflets	26	22	29	24	70	27
Family members	4	3	4	3	8	3

Respondents responded to more than one option

Table 4.10 shows that 97 (38%) responded that the source of information about contraception and reproductive health services were from their friends while 8 (3%) from family members.

4.14Teenage preference for advice on sexual and reproductive health services

On asking where they would prefer to go for an advice about reproductive health services, the respondent's results are shown in Table 4.11.

Table 4.11 : Teenage preference for advices about sexual and reproductive health services

n = 207

Preference	Sex				Total	
	Male	%	Female	%	Male +Female	%
Health workers	67	66	56	53	123	59
Friends	35	35	22	21	57	28
Family member	8	8	16	15	24	12
TBA /(CBD)	2	2	1	1	3	1

Respondents responded to more than one options

Table 4.11 shows that majority 123 (59%) prefers to get advice on reproductive health from Health services workers compared to 3 (1%) who prefers TBAs / (CBD).

4.15 Accessibility to advice on sexual reproductive health services

Furthermore the researcher wanted to know whether they feel that they have good access to the advices they need on sexual and reproductive health services, the responses are shown in Figure 4.5.

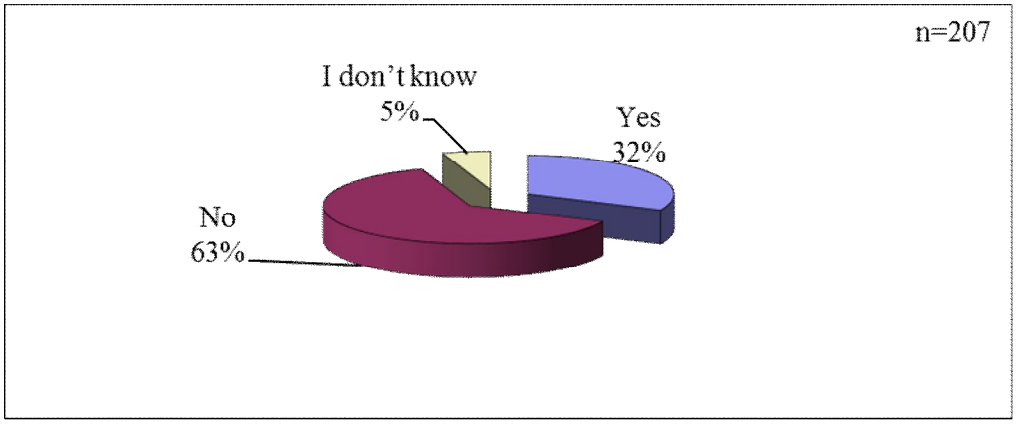

Figure 4.5 : Responses on access to the advices needed on sexual and reproductive health services

Figure 4.5 shows that only 66 (32%) of respondents have access to get advices they need on issues concerning to sexual and reproductive health services, while majority 130 (63%) do not have access.

4.16 Reasons hindering teenager accessibility to the advices

Teenagers were asked to mention the reasons that hinder them from getting the advices or help that they needed concerning to sexual and reproductive health services. The results can be seen in Table 4.12.

Table 4.12 : Reasons for not getting advices or help on sexual and reproductive health services

n = 130

Reason	Frequency	Percentage
Embarrassment from service providers	38	29
Don't know where to go	52	40
Feel ashamed	20	15
Fear of parents/ guardians find out	27	21
Fear religious leaders	15	12

Respondents responded to more than one options.

Table 4.12 shows that majority 52 (40%) of respondents do not know where to go for sexual and reproductive health services, 38 (29%) fear of embarrassment, 27 (21%) fear to be known by their parents/guardians, 20 (15%) feel ashamed, 15 (12%) fear religious leaders.

4.17 Suggestions for improvement

The researcher asked respondents to suggest what should be done to improve the teenage pregnancy situation. The results can be seen in Table 4.13.

Table 4.13 : Suggestions to improve the teenage pregnancy situation

n = 96

Suggestions	Frequency	Percentage
There should be a specific days for conducting sexual and reproductive health education in schools	16	12
Sexual and reproductive health should be intensively integrated to school curriculum and adult education programmes.	57	44
Prepare and supply Information Education Communication materials i.e. Posters, leaflets etc.	13	10
Contraceptive services should be provided in confidentiality way.	34	26
Parents should support and give advice to their children about sexual and reproductive health education.	10	8

Table 4.13 shows that majority 57 (44%) suggested that sexual and reproductive health education should be intensively integrated to school curriculum and adult education program. While 10 (8%) suggested that parents should support and give advices to their children about sexual and reproductive health education.

4.18 Teenager's home environment

Teenage were asked to mention care/ guardian do they live with. The results can be seen in Table 4.14.

Table 4.14 : Distribution of teenagers by caretakers

n = 207

Caretaker	Frequency	%
Mother and father	77	37
Single parent	61	29
Live with relative/alone	69	33
Alone	0	0
Total	**207**	100

Table 4.15 shows that 77 (37%) of respondents live with both parents and 61(29%) live with a single parent (mother or father).

4.19Participation in initiation rites ceremony

Respondents were asked whether they have undergone initiation rites and the age at the time of the ceremony. Responses can be seen in Figure 4.6 andTable 4.16.

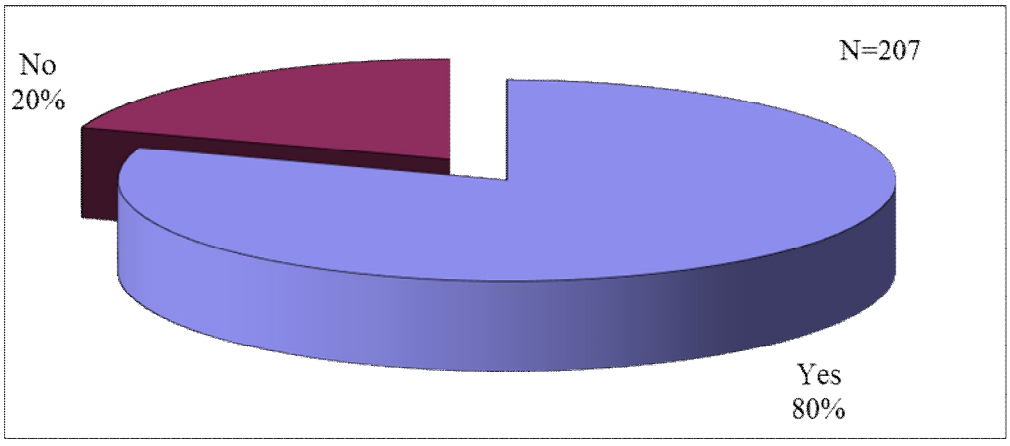

Figure 4.6 : Participation the initiation rites ceremony

Figure 4.6 shows that majority 166 (80%) of the respondents participated in the initiation rites compared to 41 (20%) who did not participate.

Table 4.15 : Responses on the age when they participated in the initiation rites

n = 166

Age	Total	
	Male +Female	%
4-6	6	4
7-10	30	18
11-13	24	14
14 -16	89	54
17-19	17	10
Total	**166**	**100**

Table 4.15 shows that majority 89 (54%) of the respondents participated to initiation rites ceremony at the age between 14 - 16 years old compared to 6 (4%) attended at the age of 4 – 6 years.

4.20 First sexual contact

The respondents who were asked the age when they participated in initiation rites were also asked to mention the age when they had sex for the first time. The result are illustrated in Figure 4.7.

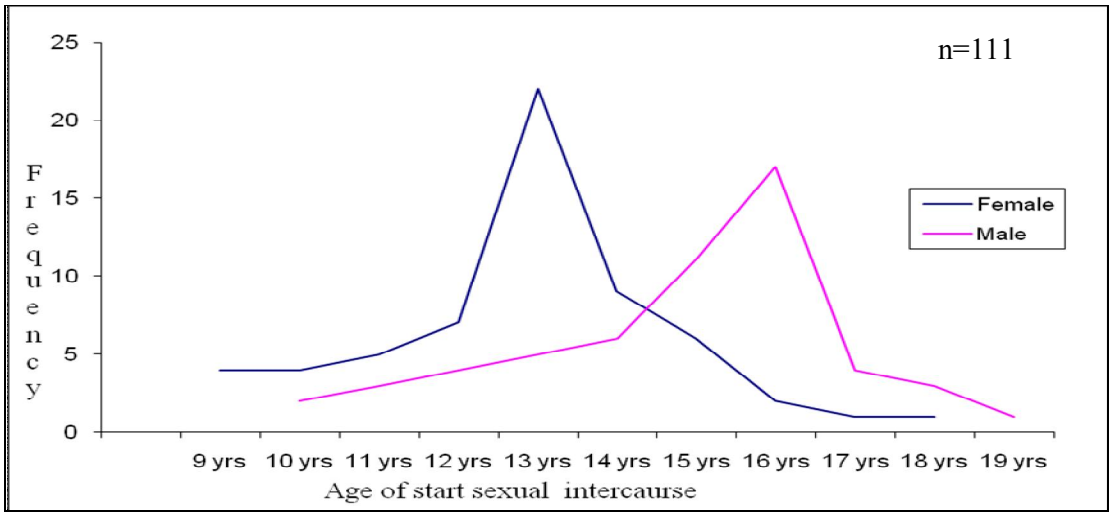

Figure 4.7 : Respondents by age of first sexual intercourse

Figure 4.7 shows that the age of starting sexual intercourse ranged between 9 to 19 years with majority 22 (25%) females started sexual intercourse at the age of 13 years compared to 17 (27%) males started sexual intercourse at the age of 16 years. The mean age (x) of teenage to start sexual intercourse is 13.7 ≈ 14 years.

4.21 Relationship between caretaker/guardian and early sexual practices

The researcher also wanted to find out if there is any relationship between early sexual practices and care taker the teenage living with. The results can be seen in Table 4.16.

Table 4 16 : Relationship between sexual practices and caretaker lives with

n = 207

Caretaker/guardian live with	Practice sexual		Not practice sexual		Total	
	No.	%	No.	%	No.	%
Live with both parents	30	27	47	49	77	37
Live with single parent	31	28	30	31	61	29
Live with relative/alone	50	45	19	20	69	33
Total	**111**		**96**		**207**	**100**

Table 4.16 shows that majority of respondents 50(45%) live with relative/alone practice sexual intercourse compared to 30 (27%) of respondents live with both parents. This difference is statistically significant ($\chi^2 = 16.6979$; $P < 0.05$; df = 2; CI = 95%).

4.22 Situation of sexual intercourse

In order to explore the situation of sexual intercourse at the first contact respondents were asked whether the act was coerced or was done willingly. The responses are shown in Figure 4.8. n = 111

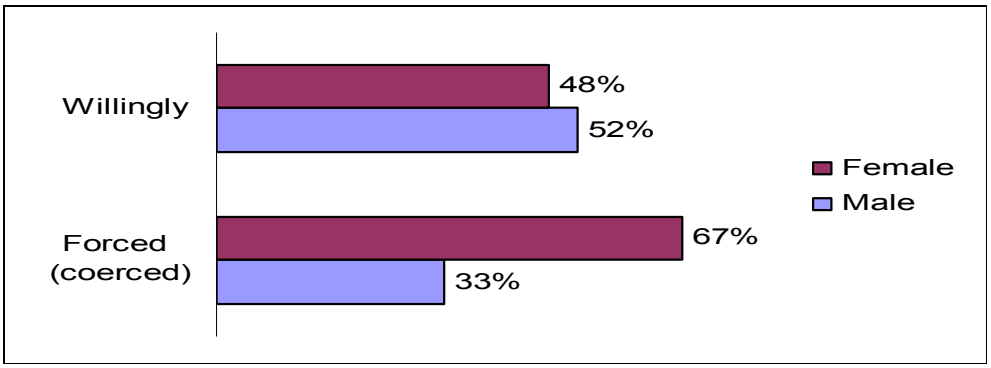

Figure 4.8 : Situation of sexual intercourse for the first time

Figure 4.8 shows that majority of females 32 (67%) had coerced to practice sexual intercourse for the first time compared to 14 (33%) males.

4.23 Relationship between initiation rites ceremony and early sexual practices

However the research explored more to find out whether there is any relationship between early sexual practices and attending initiation rites ceremony. The results can be seen in Table4.17.

Table 4.17 : Relationship between attending initiation rites ceremony and early sexual practices

n = 207

Initiation ceremony	Practice sex		Not practice sex		Total	
	No.	%	No.	%	No.	%
Attended initial rites	95	86	71	74	166	80
Not attended	16	14	25	26	41	20
Total	**111**		**96**		**207**	**100**

Table 4.18 shows that majority 95 (86%) of respondents attended initiation rites practice sexual intercourse early compared to 16 (14%) of respondents who had not attend. This difference is statistically significant ($\chi^2 = 4.38154$; $P < 0.05$; df = 1; CI = 95%).

2.24 Current sexual partner relationship

The researcher also wanted to know whether the respondents are currently having sexual partners. Teenagers were asked to respond whether they have boy/girl friends and their age. Results can be seen in Table 4.18 and Figure 4.9.

Table 4.18 : Distribution by respondents currently having a girl or boy friends

n = 207

	Sex				Total	
Respondents answers	**Male**	**%**	**Female**	**%**	**Male +Female**	**%**
Yes	31	43	41	57	72	35
No	70	52	65	48	135	65
Total	**101**	**49**	**106**	**51.2**	**207**	**100**

Table 4.18 shows that 72 (35%) of the respondent boys and girls who have girl or boyfriends/lovers compared to 135 (65%) who have no girl or boyfriends/lovers.

4.25 Age group and sexual partner relationship

It was further necessary to know what the age of the person he/she is having relationship with. The results can be seen in Figure 4.9.

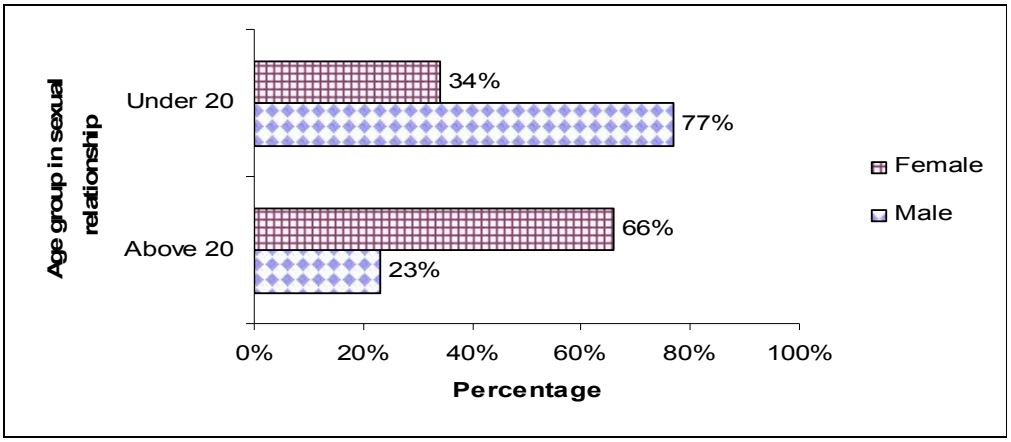

Figure 4.9 : Distribution of partners (boy/girl friends) by age group

Figure 4.9 shows that 24 (77%) male are in relationship with sex partners whose age is under 20 years old compared to 27 (66%) female who are in relationship with sex partners aged above 20 years.

4.2 Findings from focus group discussion (FGD)

Triangulation methods for this matter were used in order to enrich the research findings.

The study units in the Focus Group Discussion (FGD) were purposively selected after consultation made with the Ward Executive Officer (WEO) and Mtaa Executive Officer (MEO) in each of selected Wards and Mtaa respectively.

The group discussion comprised of both males and females teenage. The number for one FGD was between 6 – 12 people. Thus, the total number of people involved in the FGD was 36. As regarding gender aspects among 36 participants 16(44%) were males and 20(56%) were females. The following results were found during FGD.

4.2.1 Understanding on teenage pregnancy

During focus group discussion (FDG) it was learned that teenage felt shy and feared to discuss issues of sexuality. On discussing about what is teenage pregnancy, it was observed

that majority of the respondents do understand about teenage pregnancy. Apart from getting the information from different media about the teenage pregnancy, other responded that they have experienced the problem within the community they live. One participant replied that apart from the information of teenage pregnancy gets from media, I have also experienced the problem from my sister when she became pregnant and terminated from studies.

4.2.2 Causes of teenage pregnancy

On the cause of teenage pregnancy it was observed that majority of the participants mentioned different reasons that they think can be the cause of teenage pregnancy. One of the participants replied that among the causes of teenage pregnancy is the failure of parents and members of the community to confine teenage those behave against the community's culture and norms.

4.2.3 Any obstacles, which hinder teenage to utilize sexual and reproductive health services

On exploring whether there is any obstacles which hinder teenagers to utilize sexual and reproductive health services, majority of participants commented that the system of providing sexual and reproductive health services make the teenagers to hesitate to use the services. There is no confidentiality as there is no separation of the teenagers and the adults. However some of the service providers do not like to provide the services to the teenagers and do not use polite language. One of the participant replied that clinics that provide reproductive and health services are opened and closed at the time we are at school. It is also very difficult to access the service even if you go early in office hours as you meet with other customers of different age groups among of them are relatives i.e. Mother and sisters

who restrict us to access the service. It becomes very difficult to join the queue wait for the services.

The researchers continue to explore if there are other reasons that hinder teenagers to utilize the available services. Among the reasons mentioned were using contraceptives such as pills or injectables might cause sterility as once you use contraceptives you will never conceive the time you wish. Parents and the community have negative perceptions towards the use of contraceptives especially to the teenagers. They think that those who use contraceptives are prostitutes.

4.2.4 Is there any effect on the presence or absence of boarding schools to the teenager girls?

On exploring whether there is any effect on the presence or absence of boarding schools to the teenager girls**,** majority of participants commented that the absence has been highly contributing to teenage pregnancy as most of them do not leave near the school environment and they are living a long distant from schools. Students are required to walk a long distance to attend school programs. Apart from that there is no food provided in school, everyone is supposed to depend on him or herself. For boys this is not a big issue but for girls it has become a big problem. Some of them have been convinced with mature person who provide them some gifts and food also transport to and from school, obviously hoping to get return of what they know themselves. We have been seeing some of the girls having a lot of money and assert out from their parents or guardians. One of the participant replied that many students have hired houses were no parents or teachers takes of then, in short some of them lives with boyfriends as wife and husband.

4.2.5 Suggestions towards Reduction of Teenage Pregnancy

Some of the participants said that the responsible authority should provide sexual and reproductive health services to the teenagers in a confidentiality manner, the service which allow teenage to be free to get the service any time they think to do so.

Majority said that the there should be clinics that provide such services within the school or few meters from the school, there should be specific posts where there are trained personnel who can provide clear instructions on sexual intercourse and reproductive health services to the teenager.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the findings of the study conducted in thirteen wards in Lindi Municipal Council about Environmental factors contributing to high prevalence of teenage pregnancy. The discussions are based on the findings in relation to the research objectives and other related studies conducted in different areas of the same environments.

5.1 Knowledge on Sexual and Reproductive Health Services among Teenage

Regarding the level of knowledge, the research found that majority of the teenagers have poor knowledge about the time of the menstrual cycle a girl is more fertile and more at risk to become pregnant. This implies that poor knowledge about menstrual cycle might be contributing to the problem as the teenagers don't know physiological changes occurring in the reproductive system, they do not know at what time in the period the menstrual cycle is safe to practice sexual intercourse and free from chances of conceiving.

However on responding to the question if a girl can become pregnant for the first time of having sexual intercourse. Most of teenagers 55 (75%) and 60 (80%) boys and girls respectively understand that a girl can conceive on the first sexual intercourse.

The study has found that almost all teenage interviewed ware aware of teenage pregnancy. Findings of Table 4.2 show that majority 195 (94%) of the respondents were aware about teenage pregnancy only 12 (5.8%) were not aware about teenage pregnancy. Even during the Focus group discussion informants reported they have seen pregnant teenage within the community. This indicates that information about the impact of teenage pregnancy is well understood to most of the teenagers.

Concerning to the source of information Table 4.3 in the results on teenage pregnancy, the study has revealed that majority of respondents 153 (68%) get information from media, 45 (20%) family members, 17(8%) teachers and 10(4%) medical personnel.

The increasing problem of teenage pregnancy in Lindi urban could have been attributed by lack of proper information among teenage. Regardless of the initiatives done by the authority (Municipality) in cooperation with different NGOs to distribute reproductive health materials which provide information to teenage about sexual and reproductive health services still the problem exists.

The study noticed that teenage face multiple barriers to accessing sexual and reproductive health information. Some information obtained from media does not equip them with adequate knowledge on sexual and reproductive health. These are not enough, clear and understandable to most of teenage rather they creating misconceptions.

In the study on Teenage sexual activity conducted in urban provinces of Lusaka-Central and Copperbelt, Zambia by Pillai and Yetes (1993) revealed that a large proportion of teenage females enter into close relationships with males at young ages and a high proportion of young females have engaged in sexual intercourse without being well informed about sexuality.

Inadequate knowledge on sexual and reproductive health lead to the possibility of teenagers to become pregnant if not provided with comprehensive sexual and reproductive health information at earlier ages. This can help the teenagers so that by the time they are initiating sexual activities, they are in a position to make informed decisions. Information can equip

them skills so as to be able to differentiate between accurate and inaccurate information. It can help them to handle situations of unwanted sexual advances and useful relationship skills such as communication, negotiation, listening and decision-making. They can discuss a range of moral and social issues and perspectives on sex and contraception.

This is consistent with study the findings carried out by the Guttmacher Institute (2002) US which found that one of the factors contributing to a high rate of teenage pregnancies is lack of openness about sex in society.

On finding out whether teenage knows the consequences of early pregnancy or not(Table 4.5), the study revealed that majority of teenage 80 (41%) have high knowledge concerning to consequences of early pregnancy. This implies that teenagers do understand well on the impacts of early teenage pregnancy to their health and the all community.

Concerning the knowledge on what teenage can do to avoid getting pregnant and impregnating (Table 4.6) majority 70 (34%) responded that they use condom and more than a quarter 64 (31%) responded that they do not know what to do. These findings imply that teenagers are not well informed with different methods of contraception.

The findings are in consistent to a study by Byamugisha *et al.* (2005) on emergency contraception and Fertility awareness among University Students in Kampala, Uganda. That study revealed that the most common methods used to prevent from pregnancy were condoms (48.9%) and withdrawal (23.4%).

Many sexually active teenagers lack the knowledge needed to avoid unintended pregnancies as they lack timely access to health-care products such as condoms and other contraceptives. Even if they have access to condoms, girls and young women are often unable to negotiate their use with their partners (WHO, 2006).

Concerning the level of knowledge on methods of contraceptives the study findings (Table 4.7) show that majority 108 (52%) of respondents have low level of knowledge compared to 41(20%) with high knowledge.

During the study most of respondents had managed to mention one or two methods and others failed to mention even a single method. This implies low level of knowledge on methods of contraception contributed to the increase of the problem as more than half have low knowledge about contraceptives methods despite being aware of teenage pregnancy.
On relating level of knowledge on methods of contraceptives and awareness of teenage pregnancy the study revealed that 106 (54%) of teenage out of 108 respondents with low knowledge on methods of contraceptives were aware of teenage pregnancy compared to 34 (17%) with high knowledge. This difference is statistically significant with $P< 0.05$ at 95% confidence level.

This implies that regardless of the introduction of sexual and reproductive health education in schools and out of schools still knowledge on methods of contraceptives is low and teenage continued to become pregnant. Thus, there is a need to modify or find new approaches that can equip teenagers with the knowledge and skills on the use of contraceptives so as to reduce the problem of teenage pregnancy.

5.2 Cultural beliefs in relation to Reproductive Health Services

To determine existing cultural beliefs in relation to reproductive health services among teenagers, the study in (Figure 4.4) identified that majority of respondents 98 (47%) have notion that teenagers are not allowed to use contraceptives, only 48 (23%) responded that teenage are allowed.

The findings imply that although sometimes teenagers need to get sexual and reproductive services, there are some beliefs that have been caused teenagers not getting the services. Teenagers do not utilize the service due to the fact that they have been told that under 20 are not allowed to use contraceptives as they are still young. However on other side they fear of being reported to their parents/guardian, they are not clear with the efficiency of contraceptives as most of them have been heard that the use of contraceptives have side effects in the future, such as irregularity of menstrual cycle and failure to conceive the time you want a baby.

The findings are similar to the findings of a study by Wood and Jewkes (2006) undertaken in Limpopo Province on the barriers to adolescent girls accessing clinic services for contraception. They found that majority of girls described that pressure from male partners and family members to have a baby or prove their fertility. Other barriers to contraceptive use include medical inaccurate notions, fears about the effects of contraception on fertility and menstruation, unwillingness and unkind treatment from service providers.

Also in a study conducted by Nzioka (2001) in Makueni District of Eastern Kenya on risks of unwanted pregnancy and sexually transmitted infections among adolescents revealed that both females and males report reticence in communicating about sexual matters and contraception with their partners. At the same time, they are reluctant to seek condoms in

public places for fear of disclosure and reprove. Females face difficulties in negotiating safe sex, in reconciling the desire for condom use with norms demanding submissiveness and lack of assertiveness in contraceptive decision-making.

5.3 Accessibility to Reproductive Health Services among Teenagers

It was established in this study that teenagers are not fully accessible to reproductive health services. Teenagers receive very little sexuality education from their parents and modern institutions. Findings in Table 4.10 show that majority of teenage 97 (38%) got the information about contraception and reproductive health from friends, 80 (31%) from health workers, 70 (27%) from Media (TV/radio, Posters/leaflets, magazine) and 8 (3%) from family members.

Parents and other members of the family do not talk to their children matters concerning to sexual issues and reproductive health services. Information from books, videos and magazines, apart from encouraging sexual freedom does not give appropriate information about the risks of being involved in sexual intercourse. This situation has caused teenagers to practice sex without taking precaution measures to prevent them from unwanted pregnancy.

Parents and other members of the community have a major role to talk with their children in early stage of child-hood so as to acquire knowledge and skills that can enable them to make decision on sexuality. Parents and others members of the community are the key person to shape the behavior of the teenagers. In this era of science and technology where children are accessible to different information on sexual and reproductive health, parents are required to play a big role in talking to their children openly without fear of the culture and traditions

that restrict parents to talk with their child matters concerning sexual and reproductive health to rescue them from the impact of teenage pregnancy.

The study by Ruto (1999)in Kenya evidenced that parents and adults do not give teenage information on sex and contraception because it is not considered culturally appropriate, hence they turn to their peers who give them inappropriate and/or inaccurate advices.
Regarding to where teenagers prefer to seek advice and services on sexual and reproductive health services, findings in (Table 4.11)revealed that majority 123 (59%) prefer to seek advices from medical personnel rather than other sources. This was followed by friends who counted 57(28%) as the second preference.

Despite of inadequate information on sexual and reproductive health services among the teenagers, still those who need the services are not accessible to them. Majority do not know where to go for the services, pressure from the community, family, friends, unwilling of some service providers to provide service to the teenagers, lack of motivation and beliefs. The findings show that majority of the teenagers interviewed do not know where to go for sexual and reproductive health services, embarrassment from service providers, fear to be known by their parents/guardian, fear of being told off and fear religious leaders.

This implies that sexual and reproductive health services for teenagers are surrounded by stigma especially among parents, community leaders and religious leaders as well as the service providers. Such environment has been contributing lack of knowledge and skills about reproductive health hence engage in sexual activity without informed decision. There is no doubt that if this situation continues the problem of teenage pregnancy might persist.

For that reason there is a need to conduct sensitization to the parents, members of the family, influential leaders and the community at large on the impact of teenage pregnancy.

5.4 Factors influencing early Sexual Practice among Teenage

To determine factors influencing early sexual practice among teenage, several factors were evident. The study found that teenagers who live with a relative/alone are likely to practice sexual intercourse early compared to those who live with both parent with (Table 4.17). Statistically has shown that there is an association between the caretaker ora guardian the teenage live with and early sexual practice. Hence: ($\chi^2 = 16.6979$; $P < 0.05$; df = 2; CI = 95%).

The study indicated that attending initiation rites ceremony also have an impact on early sexual practice as the findings indication that more than 89 (54%) of teenagers in (Table 4.16) interviewed had participated in the initiation rites ceremony at the age between 14 – 16 years. It is during this age there is high rate of sexual intercourse practice among teenagers.

However study findings show that age of start sexual intercourse range from 9 years to 19, at age of 13 years majority 22 (25%) females and 17 (27%) of male 16 years have already started sexual intercourse with their mean and median ages of about 14 years in Figure 4.7.

During this age of 14 years most of the teenagers are sent to initiation rites ceremony and it is the period when most of them are in primary and secondary school. The study suggest that there is a need to set effective strategies that can enable to equip them knowledge and

skills on sexual and reproductive health services. This knowledge can help them to make appropriate decision about sexuality matters to prevent unwanted pregnancies.

The age to start sexual intercourse is not the same, it differs from one area to another depending on the culture, beliefs and social – economic status of the place. The study noted that early attending to initiation rites ceremony have an impact on early sexual practice. Teenage who attended initiation rites ceremony in (Table 4.18) are likely to practice sexual intercourse early compared to teenagers who had not attended. This is statistically significant that there is an association on early sexual practice and attending initiation rite ceremony. Hence: ($\chi^2 = 4.38154$; $P < 0.05$; $df = 1$; $CI = 95\%$).

The study findings is consistent to a study by Tumbo (1994) in Ruangwa district before known as Lindi (rural) revealed that instructions given to boys and girls during the initiation can contribute to the increase of rate of teenage pregnancy as these boys and girls are trained on how to satisfy their partner during sexual intercourse. Girls are trained how to move their waist rhythmically during intercourse, this coaching need more practice before they master it. To master it, they continue on practicing as the result most of them have ended up with pregnancies.

In this study it is noticed that the situation of sexual intercourse at the first contact was a coerced act, teenagers were committed to practice sexual intercourse without their willing, as the findings show that 32 (67%) females and 14 (33%) males responded that they had been forced or coerced to practice sexual intercourse for the first time had sexual contact. During the study it has revealed that among 207 teenage interviewed 72 (35%) had boy/girlfriend with whom they practice with sexual intercourse. It was further necessary to

know whether they practice with their fellow age group or not. The study in (Figure 4.9) observed that majority 24 (77%) males were in relationship with sex partners whose age was under 20 years old compared to 27 (66%) females whose sexual partners were aged above 20 years.

This implies that some adult males are among the facilitating factors that have been contributing to the increase of teenage pregnancy as they use their opportunities to entice girls to participate in sexual practices. This could have been caused by the pressure teenager get from financial inducement received from adults.

The results of this study is supported by the study on sexual activity and contraceptive use among female adolescents by Okpani (2000) in Port Harcourt, Nigeria found that at the time of the survey, 190 girls (24.7%) were sexually active and 74.2% of their male consorts were older working men receiving financial support as a motive for the girls' sexual activity.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Generally the findings from the study revealed that teenage pregnancy is public health problem despite that majority of respondents were aware of teenage pregnancy and their consequences. Knowledge on contraceptives methods is still low. It shows some of factors contribute to high prevalence of teenage pregnancy which have been identified were negative beliefs on the uses of family planning and reproductive services, inadequate information on sexuality, unavailability of teenagers friendly services, culture that hinder parents to talk with the teenagers about sexuality matters.

6.2 Recommendations

From the research findings and the conclusion above, the following recommendations are crucial.

6.2.1 To Law and Policy Maker

a. Should advocate youth friendly health services and support the introduction of life-skills education for girls and boys both in and out of school.
b. Should ensure girls have the opportunity and are actively encouraged to continue with their education if they become pregnant while still at school. Support implementation of the government guidelines on re-entry to school and provision of training opportunities. Be aware that while schoolgirl pregnancy gets the headlines, in fact girls who are not in school are much more likely to get pregnant early.
c. Should support the National Adolescent Reproductive Health Strategy (2010-2015) which aims to strengthen the policy, legal and community environment for sexual

and reproductive health information, services and life skills that seeks to improve health system responses to teenager and adolescent health needs and to provide a platform for linkages with other sectors dealing with adolescents and young people.

6.2.2 To Local Government Authority

a. Should introduce youth-friendly health services throughout the district.
b. Should ensure that all health facilities provide supportive and quality reproductive health services to teenagers so as feel comfortable and confident about expressing their concerns in relation to reproductive health.
c.

6.2.2 To Nongovernmental and Civil Society Organizations

a. Should support community-based programmes that empower teenage girls to protect themselves and enable them to continue their education if they become pregnant while still at school.
b. Advocate for national and local government investment in life skills and youth-friendly health services.
c. Support the development of community-based early childhood development centers that can provide care to children of young mothers while they continue their education.

6.2.4 To the Ministry of Health and Social Welfare and Ministry Of Education

a. The ministries should establishment approach which is more holistic to equipping the teenagers with appropriate knowledge on sexuality, access to sexual and reproductive health services rather than traditional coaching approaches that focus upon improving sexual ability, attitudes and norms.

b. Ministry of Health in collaboration with Ministry of Education media should strengthen reproductive health education programs in school and out of the schools that promote communication skills among teenagers.

6.2.5 To the Media

Should produce features and editorials on the importance of ensuring all young Tanzanians have access to advice on reproductive health and the means to prevent unwanted pregnancy through life skills education and youth friendly health services.

6.2.6 Further Research

More study should be conducted on environmental factors contributing to high prevalence of teenage pregnancy. Further study with similar nature should be conducted on how foundation of faith and ethics can contribute to the reduction of teenage pregnancy as how solid waste management should be coordinated, developed and implemented.

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TOOLS FOR DATA COLLECTION

Questionnaire for environmental factors contributing to high prevalence of teenage pregnancy in Lindi Municipality, Tanzania

This questionnaire is entirely anonymous and confidential. Please answer as truthfully as possible.

Date of interview……

Ward……

Hamlet…….

About you

Sex (Please tick in box)

Male	
Female	

Are you (Please tick in box)

Married	
Not married	

Age: Years……

Section 1- Awareness on reproductive health

1. Have you ever heard about teenage pregnancy? (Tick correct answer)

Yes	
No	

2. If Yes where did you get the information? (Tick correct answers)

On the newspaper	
Posters/leaflets	
From family member	
From Doctor/CO	

From teachers	
Magazine	
On TV/Radio	

3. Please mention what information you got from the mentioned above sources

……..

…….

4. Which part of the menstrual cycle are girls more fertile and therefore more at risk of pregnancy? (Tick correct answer)

During period	
Mid cycle	
Just before a period	
I don't know	

5. Can a girl get pregnant during menstrual period? (Tick correct answer)

Yes	
No	
I don't know	

6. Can a girl get pregnant for the first time she had sex? (Tick correct answer)

Yes	
No	
I don't know	

7. What are the consequences of early pregnancy teenage?

…….

…….

8. Which methods of contraception have you heard about?

(Write down as many as you can)

…… ……

…… ……

9. What could a girl do to avoid getting pregnant? (Tick correct answers)

Have the man use a condom	

Have the man withdraw before ejaculation	
Take the pill	
Drink very strong tea without sugar after sex	
Choose safe days for having sex	
Do not know	
Abstain	

10. What could a boy do to avoid impregnating a girl? (Tick correct answers)

Use a condom	
Withdraw the penis before ejaculation	
Make sure that the girl takes the pill	
Respect the girl's safe days for having sex	
Do not know	
Not have sex	

Section 2 – Cultural beliefs and socio economic in relation to reproductive health services

11. Can young people of your age allowed to get contraception?

(Tick correct answer)

Yes	
No	
I don't know	

12. If no. what is the reason for not getting contraceptive?

(Write down as many as you can)

……

……

13. If a teen girl goes to a Doctor/Nurse for contraception will they tell her Parents/Guardian about the request? (Tick correct answer).

Yes	
No	
I don't know	

14. Where did you get knowledge about contraception and reproductive health? (Tick correct answers).

Friends	
Posters/leaflets	
Family member	
Doctor/CO	
Nurse	
Magazine	
Family planning Clinic	
TV/Radio	

15. Who/Where would you rather go for an advice about reproductive health? (Tick correct answers).

Doctor/CO	
School	
Friends	
Family planning Clinic	
School teachers	
Family member	
Nurses	
TBA (CBD)	

16. Do you feel you have good access to the advice you need on sexual and reproductive health? ((Tick correct answer).

Yes	
No	
I don't know	

17. If no what hinder you from getting the advice and help you need in sexual and reproductive health? (Tick correct answers).

Embarrassment	
Don't know where to go	
Fear of being told off	
Fear of parents/ guardians find out	
Fear religious leaders	

18. Any other reason? (Write below)

……

……

19. Can you think of any way in which we can improve the situation? (Suggestions please)

……

……

20. Do you think medical personnel should do anything else to improve the situation?(Suggestions please)

……

……

21. Whom do you live with? (Tick correct answer).

Mother and father	
Mother only	
Father only	
With relatives	
Alone	

22. Have you participated in the initiation rites? (Tick correct answer).

Yes	
No	
I don't know	

23. If yes how old were you when you participated in the initiation rites?

Age: yrs……

24. What did you taught?

…… ……

…… ……

25. How old were you when you had sex for the first time? (Tick correct answer).

Years ……	
No yet	
I don't remember	

26. When you had sex for the first time it was? (Tick correct answer).

By force	
Willingly	

27. Do you currently have a lover? (Tick correct answer).

Yes	
No	

28. If yes how old is your lover?

Years

»»»»»»»» **Thank you for your cooperation in filling this questionnaire.** »»»»»»»»

Annex 2

Interview guide for focus group discussion

1. What do you understand by the term teenage pregnancy?
2. What do you think are the causes of teenage pregnancy?
3. Are there any obstacles which hinder teenage to utilize sexual and reproductive health services?
4. What are the environmental factors that contribute to teenager pregnant?
5. Is there any effect on the presence or absence of boarding schools to the teenager girls?
6. What measures do you suggest to be done in order to reduce teenage pregnancy?

»»»»»»»» **Thank you for your cooperation.** »»»»»»»»

Annex. 3

A guide for categories and scales for assessment of teenage awareness on Reproductive Health

List of possible answers on possible consequences of early pregnancy in teenage that will expect to be mentioned by respondents

- Death.
- Chased from home
- Death of child due to improper care
- Psychological effects
- No chance for further education
- Poverty

Key; Category	**Scale**
Poor knowledge	Able to mention 0- 2
Moderate knowledge	Able to mention 3
Good knowledge	Able to mention 4<

List of possible answers on methods of contraception have you heard about

- Condom
- Pills
- Mocrogynon
- Lofemanal
- Depo - provera injection
- Microval
- Norplant
- Implanon
- Vasectomy

Key; Category	**Scale**
Poor knowledge	Able to mention 0- 2
Moderate knowledge	Able to mention 3
Good knowledge	Able to mention 4<

Annex. 4

JAMHURI YA MUUNGANO WATANZANIA

Tawala za Mikoa na Serikali za Mitaa

Halmashauri ya Manispaa ya Lindi

Telegraphic address:
''UkumbiwaManispaa"
Tel: 023-220-2164
Fax: 023-220-2116
E-mail:
lindimunicipal@gmail.co.m
Kwa majibu

Ukumbi wa Manispaa,
S. L. P.1070,
LINDI.

Kumb Na. LMC/M.10/14/77 14/12/2014

Afisa Mtendaji Kata,
Jamhuri,Mtanda,Msinjahili, Nachingwea, Mwenga
Rasbura, Mitandi, Makonde na Wailes.
S. L. P 1070,
LINDI

YAH: KUWATAMBULISHA WAKUSANYA TAKWIMU ZA UTAFITI WA SABABU ZINAZO CHANGIA ONGEZEKO LA MIMBA ZA UTOTONI – MANISPAA YALINDI

Tafadhali rejea kichwa cha habari hapo juu.

Nawatambulisha **Ndg. Eneco Mshana, Anita Mauna, Victor Katunzi, Gella Mwenda na Hamza Lada** kama wakusanya takwimu za utafiti wa sababu zinazo changia ongezeko la mimba za utotoni – Manispaa ya Lindi. Matokeo ya utafiti huu yatasaidia kupanga mikakati ya kupunguza tatizo hili katika eneo letu na maeneo mengine mchini.

Kwa barua hii naambatanisha timu itakayohusika na ukusanyaji wa takwimu katika kata yako ili waweze kukusanya takwimu husika katika maeneo yaliyochaguliwa.

Naomba wapewe ushirikiano wa kutosha.

Nawatakia utekelezaji mwema.

Daniel Kaluse

Kny: Mkurugenzi wa Manispaa

LINDI