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Access to Reproductive Health Services and Factors Contributing to Teenage Pregnancy in Mtwara Region, Tanzania

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Abstract
Generally, adolescents/teenagers sexual and reproductive health (SRH) needs are largely unmet in developing countries despite this group's size. This paper examines teenage girls' accessibility to reproductive health services and factors contributing to teenage pregnancy. The study on which the paper is based adopted a cross-sectional explanatory design and was conducted in Mtwara Region, Tanzania covering four secondary schools. Teenage girls in the four secondary schools were randomly selected to participate in the study. Data was collected using questionnaires, focus groups discussions and key informant interviews. A total of 156 people participated in the study. Quantitative data was analyzed using SPPS while qualitative data was analyzed using content analysis. Generally, results show that teenage pregnancy is a major problem in Mtwara and the attributing factors include poverty, culture, desire for money, peer pressure, lack of education on reproductive health issues and poor parental support. Results also show that teenagers in Mtwara lack access to youth friendly reproductive health services. Additionally, the findings show a disparity in terms of access to reproductive health services (RHS) between rural and urban teenage girls: those in the urban area had relatively more access compared with their rural counterparts. It is therefore concluded that access to reproductive health services for teenage girls is a serious challenge in Mtwara region. It is hereby recommended it is recommended that households be empowered to earn sufficient income to provide for their families, particular emphasis should be put on non-farm income generating activities. It is also recommended that youth friendly SRH services be established in the study areas; doing so will improve youth's access to the same.
Keywords: Teenage, Teenage pregnancy, Youth friendly services

1.0 Introduction

Teenage pregnancy is a major threat to Sub-Saharan Africa's (SSA) socio-economic development. According to Madeni et al. (2011) 10% of girls in SSA become mothers by the age of 16 years. The SSA's trend is also manifested in Tanzania where teenage pregnancy is a problem facing adolescent girls leading to most girls dropping out from school. Further to the above, teenage pregnancy and childbirth related complications are the number one killers of teenage girls worldwide (UNFPA, 2007). According to UNFPA (2013a), the issue of teenage pregnancy is not just considered as a health issue; but also a development issue that is deeply rooted in poverty, gender inequality, violence, forced marriage, lack of education etc. In the world today, there are approximately 600 million girls and more than 500 million of these girls live in developing countries. Additionally, (UNFPA, 2013b) points out that about 16 million teenage girls aged 15-19 give birth each year worldwide. According to UNFPA (2013b) 95 % of the world's births to adolescent girls occur in developing countries, nine in 10 of these births occur within marriage or a union. Moreover, about 19% of young women in developing countries become pregnant before the age of 18. Girls below 15 years account for 2 million of the 7.3 million births that occur to adolescent girls under 18 every year in developing countries (UNFPA, 2013b). UNFPA further points out that every day, 20 000 girls below the age of 18 give birth in developing countries, while 70 000 adolescent girls die every year due to pregnancy complications and child bearing. The Population Reference Bureau (2013) argues that, adolescent girls in Sub-Saharan Africa (SSA) have the highest rate of pregnancy in the world. In Tanzania, rates of teenage pregnancy differ between regions with Mtwara being among those regions with a high prevalence (Bangser, 2010; URT, 2010). Based on Tanzania's 2010 Demographic and Health Survey (TDHS) About, 23% of women aged 15-19 in Tanzania have started bearing children while 44% of them are either mothers or pregnant with their first child by 19 years (URT, 2010).

Generally, adolescents/teenagers sexual and reproductive health (SRH) needs are largely unmet in developing countries despite this group's size in the same (Save the Children and UNFPA, 2009). However, adolescent sexual and reproductive health (ASRH) is an important component of a healthy youth population. And despite the multitude of challenges involved in provision of ASRH, Bearinger et al. (2007) argues that it is important that the youth have access to the same in a friendly environment. In particular, sex education programmes should offer accurate, comprehensive information while building skills for negotiating sexual behaviours. Bearinger et al. further argues that both boys and girls need equal knowledge concerning reproductive health to reduce risk behaviours and to promote sexual health. Moreover, Madeni et al. (2011)

citing Andrew et al. (1999) and Grant (2006) points out that adolescent pregnancy is a top concern among public health problems and is a challenging issue because pregnancy at a young age will include high rates of school dropout and poverty.

According to CRR (2013), between the periods of 2003 and 2011 over 55 000 teenage girls dropped from both primary and secondary schools due to pregnancy in Tanzania. The governments of Tanzania and development partners have made efforts to reducing teenage pregnancy and transmission of sexually transmitted diseases (STI's) through promotion of abstinence, forced pregnancy test, expulsion of pregnant girls from schools (CRR, 2013), and programmes/strategies such as the National Adolescent Reproductive Health Strategy (2010-2015): the above aimed at strengthening the policy, legal and community environment for sexual and reproductive health information, services and life skills (UNICEF, 2011). In addition, there was the Prevention and Awareness in Schools of HIV/AIDS (PASHA). PASHA specifically aimed at providing school students with the correct information on Sexual and Reproductive Health (SRH) and selected quality Reproductive Health Services. *PASHA* Phase I ran from 2003–2006 in Tanga Region by piloting methodologies and activities for addressing issues around SRH and HIV Prevention in 120 secondary schools: Phase II (2007–2009) allowed the above to be extended to Mtwara and Lindi regions whereby it covered both primary and secondary schools. According to the Swiss Centre for International Health (SCIH) (nd) PASHA was a great success in Tanga whereby the proportion of secondary school students with basic knowledge in the areas of HIV/AIDS and reproductive health increased from 37.6% (baseline from UNFPA, Knowledge, Attitudes and Practice Study) to 95% in 2006. Despite Mtwara region being covered under phase II teenage pregnancy rates and school drop outs has remained high relative to other parts of Tanzania. Therefore, based and the above and the importance of teenagers access to SRH the research on which this paper is based was conducted in Mtwara Region to determine teenager's accessibility to reproductive health services and factors contributing to teenage pregnancy.

1.1 Theoretical framework

The study on which the paper is based used the Social Learning Theory (SLT): the theory has been identified to be appropriate for sexuality education as well as many other areas of health education, including substance abuse prevention and violence prevention. Generally, the theory shows how an individual's behaviour could be changed. The SLT is particularly good for pregnancy, STI and HIV prevention programmes because sexual behaviour is influenced by personal knowledge, skills, attitudes, interpersonal relationships, and environmental influences: all of these factors are addressed by the SLT (RECAPP, 2009). The biggest strength of SLT is that real world examples can be applied and can be quickly and easily administered. However, the SLT cannot account for all development behaviour since thoughts and feelings are influenced by many internal and external factors as well as inherited and maturation factors. The SLT despite having important implications in education leading to great discoveries, it still lacks an overall understanding of the complexity of human behaviour, personalities and human differences as well as biological differences (Smith and Berge, 2009). Nevertheless, the strength of the theory allowed its use in the current study in particular to show the connection between specific personal and environmental factors and teenage pregnancy in the study area.

According to a review by Kirby (2007), individual personal factors can lead to teenage pregnancy. Those factors include: teens' own sexual beliefs, values, attitudes, skills, and intentions towards school to mention a few. Kirby further argues that teens are more likely to have sex more frequently and to have more partners, if they have permissive attitudes toward premarital sex. For example, as regards to intention towards school, if a teenager is performing well in school, and has plans for a brighter future, the chances of that teenager becoming pregnant is low compared to a teenager who is falling behind in school and does not have plans for the future. Furthermore, environmental factors could lead a teen becoming a high risk to teenage pregnancy. Generally, environmental factors include interpersonal relationships such as weak family connections and support, peer pressure, community norms and culture that support earlier sexual activities of teenagers.

2.0 Methodology

2.1.1 Description of the study area

The study on which the paper is based employed the cross-sectional research design whereby data were collected at a single point and time (Matthwes and Ross, 2010; IWH, 2015). According to Matthwes and Ross the design allows one to collect information by examining people's history, reporting on their experience and opinions which was the current study's aim. In addition, the design allows comparison of differing characteristics of experiences and the respective outcomes of different populations at a single point in time (IWH, 2015). Further to the above, the design is useful for descriptive purposes as well as for determination of associations between certain variables. In addition, the study used a mixed method approach in data collection whereby both quantitative and qualitative data were collected. According to literature (Creswell, 2003; Kanire, 2012) a mixed methods approach allows one the possibility of triangulation which enables him/her to use various methods to validate and check the results. Of great importance is the fact that use of the different methods allows one to

verify, validate and minimize the weaknesses caused by any of the methods if used alone.

2.1.2 Population of study sampling techniques and sample size

The study's population of interest included all female students in Mtwara secondary schools. Due to time constraints two local government authorities were purposefully selected for the study, these were Mtwara Municipality (Urban) and Mtwara District (Rural), the two were selected to allow for comparison between students in urban areas and those in rural areas based on the assumption that sharing and access to information differs between the two with the urban areas be more accessible. After the above was done two schools were randomly chosen from the two clusters of intervention and none-intervention schools: the intervention schools are those in which Prevention and Awareness in School HIV and AIDS Peer Education (PASHA) programme had been implemented. Therefore, schools involved in the study were four i.e. two intervention ones (Mtwara Girls Secondary School (Urban) and Nanyamba Secondary (Rural) and the two none-intervention ones were Chuno Secondary school (Urban) and Ziwani Secondary School (Rural)).

The sampling frame for the study was students from the above-mentioned secondary schools. The study's sample size was 104 respondents. According to Sunder (2007), a sample size intensity of 30 households could be considered for any research. Additionally, Warren (2002) also suggests that, the minimum requirement for sample size in qualitative studies needs to be between 20 and 30 in order for an interview-based qualitative study to be published. Therefore, based on the above, 52 students were randomly drawn from both the intervention schools and none-intervention ones. Random Sampling was seen to be appropriate as it allows an equal opportunity for all elements in the sampling frame to be included in the final sample. Further to the above, snowball sampling was employed to identify adolescent girls who had dropped out of school because of pregnancy: these served as key informants along with other key informants i.e. teachers, health workers and parents. The later were purposefully selected on assumption they were knowledgeable on the subject. Generally, information collected from the key informants focused on teenage students' pregnancy prevalence rates, causes of teen pregnancy in the study area.

2.1.3 Data Collection

The study on which the paper is based used a mixed methods approach in its collection of primary data: both qualitative and quantitative data were collected. Actual data collection was done between September 2014 and December 2014 in Mtwara Region, Tanzania. Generally, data was collected using a pre-structured questionnaire, focus group discussions (FGDs) and Key Informant Interviews (KIIs), the FGDs and KIIs were guided by an FGD guide and check list of questions respectively. Choice of the mixed methods approach in data collection was done to allow for triangulation of the findings hence increasing the study's credibility (Hussein, 2009). In addition, the FGDs and KIIs can be very useful in validating what is captured through a questionnaire.

Generally, the pre-structured questionnaire was administered to 104 respondents randomly selected form four secondary schools mentioned earlier in the sub-section on population, sampling techniques and sample size. Before the actual survey, a pilot study was conducted in order to ensure that the questionnaire was valid and reliable. Testing of the research tools was done to ensure clarity and familiarity with the tools as well as the study area. The pre-testing was done with 19 students from two secondary schools namely Umoja and Nanguruwe secondary schools found in Mtwara District and Mtwara Municipality (urban) respectively. The two schools were not included in the final survey.

The FGDs and KIIs involved students, teachers of sex education subjects, health workers, school dropouts and other stakeholders associated with the problem under study. The Qualitative information collected through the FGDs and KIIs mainly aimed to complement the data collected through the pre-structured questionnaire. A total of four FGDs were conducted; each session involved nine participants therefore 36 in total. Additionally, for the key informant interviewees, there were five school drop outs, four school teachers, four health workers and three parents making a total of 16. The information collected focused on issues of sexuality, pregnancy, culture and views about teenage pregnancy. Therefore, a total of 156 individuals were involved in the study.

2.1.4 Data Analysis

Primary data collected through the pre-structured questionnaire was coded and analyzed using the Statistical Package for Social Sciences (SPSS) software whereby descriptive statistics i.e. frequencies and percentages were determined in relation to factors contributing to teenage pregnancy in the study area. In addition to the above, cross tabulation was used to show the difference in access to reproductive health support between rural and urban respondents/schools.

Qualitative information collected through the FGDs and KIIs were analyzed using content analysis. This method is useful for identifying intentions, focus of communication trends of an individual, group or organization (Busch *et al.,* 2012).

3.0 Results and discussion

3.1 Social-Demographic Characteristics of Respondents

Respondents socio-demographic factors considered by the study included respondent's age, education level of parents, parent's employment status and whether the respondent were living with both biological parents or with guardians.

3.1.1 Respondents' age

Observations in Table 1 show that most (61.5%) of the respondents were aged between 15 to 16 years, the mean age was 15.45 years. Generally, age has an impact on teens' sexual behaviour. According to Kirby (2007), as teens become older, they are much more likely to engage in sexual activities. Moreover, if they mature physically at an early age, they begin menarche early, and appear older than their age; they are also more likely to initiate sex earlier. Additionally, some of the effects of getting older are strictly physical, including increased sexual maturity and higher testosterone levels, which may lead to a greater desire for intimacy and sex, greater sexual attractiveness, or both. Other effects are social, such as increased pressure from peers to have sex, changes in perceived norms about sexual and contraceptive behaviour, and increased opportunities to have sex, which come with greater freedom and independence. At the same time, teens are increasingly more likely to become pregnant and to parent a child as they grow older. In other words, because more teens have sex more often as they grow older, they are increasingly likely to become pregnant, even though they may also be more likely to use contraception (Kirby, 2007).

3.1.2 Respondents' care taker/Person living with respondent

Results in Table 1 show that under half of the respondents were living with both of their biological parents, about a quarter lived with a single parent and the rest lived with guardians or relatives. Generally, the study considered living with both biological parents to be important particular in getting guidance as the girls' mature and enter adulthood hence the possibility of getting pregnant. According to literature (Kirby, 2007; Miller *et al*., 2001; Markham *et al*., 2003), family characteristics are very important in determining risk of teen pregnancy. Normally, the risks of teenage pregnancy are very low for teenagers living with both their biological parents and enjoying a close relationship with them. Teens in this group are less likely to have unprotected sex and become pregnant. Specifically, if teens live with biological parents (instead of only one parent or step-parents), they are less likely to have sex, but if they do, they are likely to have sex less frequently. Miller *et al.* (2001) found that parent/child closeness or connectedness, parental supervision of children's activities, and parents' values against teen intercourse (or unprotected intercourse) decrease the risk of adolescent pregnancy. Generally, the chances of becoming victims of teenage pregnancy are low for those teenagers who live with both biological parents as compared to those who lived with a single parent or guardian. If biological parents divorce or separate, their children are more likely to initiate sex at an early age than if the parents are not divorced or separated (Kirby and Lepore, 2007; Adu-Mireku, 2003; Markham 2003; Miller, 2001).

The study's finding that about a quarter of the respondents lived with single parents is similar to that of an earlier assessment conducted by Munir (2012) in Mtwara Region. According to Munir's study a high percent of children were living with single parents or guardians and that this was partly due to the high rate of divorces in the area (Munir, 2011). In Mtwara Region, there are few matrilineal communities, for such communities whenever there is divorce, the children are left with the mother usually without support and the husband has to leave the house (Erhardt *et al.,* 2011). Although the children are left with the woman, when she enters into a new relationship she moves in leaving the children behind. Thus, leaving the care of the children in the custody of a relative, most often with their grandmothers, this is supported by the quotes below:

> *"In Mtwara divorce is a very common issue. Many women and men do not stay long in marriage. Usually when a woman gets divorced she remarries to ensure her survival and if she already had children in the previous marriage, she leaves them behind with either her mother or other relatives because she can't carry them along into her new husband's home. That is the system here"* (A 47 year old female key informant (KI), Mtwara Municipality, October 20, 2014).
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> *"Many women feel they need to enter into a second marriage childless to avoid burdening their new husband"* (A 45 year old male KI, Mtwara District, October 24, 2014).

3.1.3 Education level of respondents' parents/guardians

Study findings (Table 1) show that more than half of the respondents' parents/guardians had primary school education, under a quarter had secondary school education and very few had tertiary education while the rest lacked formal schooling. According to Phetla *et al.* (2008), education enables a person to acquire skills and knowledge that expands their understanding capacity. It helps individuals to access and become cognizant of different issues in their environment and their daily lives including how to take care and plan for their children. In addition to making one aware of happenings, education is also a key factor in changing individual attitudes towards values unfavourable in respect to culture and other practices such as early marriage. According to Kirby (2007), teens whose parents are more educated are less likely to become pregnant compared to teens whose parents have less education. Furthermore, parents with higher education and income usually emphasize to their

children the importance of education, pursuing a career and avoiding early childbearing. Moreover, in most of the cases they make resources available to support teens in these pursuits. The same author argues that, if parents monitor, supervise and have conversations with their children about sex and contraception well before they become sexually active, the initiation of sex may be delayed and use of condoms or other contraceptives is increased. However, this effect is most likely to occur when the teen is a daughter, when the parent is the mother, when the teens and their parents feel connected to one another, when the parents disapprove of teens having sex or support contraceptive use, and when parents can discuss sexuality in an open and comfortable manner (Kirby, 2007). Generally, for this paper, the primary education obtained by respondents' parents is counted as having low education that cannot enable a person to find a well-paid employment. In turn the above implies that, this category of parents could struggle in provision of a household's basic social needs in particular of their teenage girls if they do not engage in other income generating activities.

3.1.4 Main occupations of respondents' parents/guardians

Parent's employment is very essential when studying issues of teenage pregnancy because their occupation determines the fulfillment of the students' academic needs as well as other basic needs. Family income is an issue to consider for teen's high risk of pregnancy. According to the study results (Table 1), more than half of respondents' parents had farming as their main occupation; under a quarter were involved in business and very few were engaged in other activities (driving, tailoring teaching and construction respectively). According to literature (Siettou and Sarid, 2011; Kirby, 2011) teens from families with higher incomes are less likely to become pregnant or to bear children early. When the parents are employed and capable of providing basic necessities, it is difficult for their children to easily fall prey to teen pregnancy by not engaging in activities that will lead to pregnancy. As observed from the study, most of the students' parents were farmers. Due to the general poor performance of the agricultural sector in Tanzania, households could be struggling to meet most of their basic needs and of their teen girls due to lack of money. Moreover, agriculture in Tanzania over the past years has not translated into poverty reduction, especially in rural areas. The sector's poor performance, according to Mashindano *et al*. (2011), can be attributed to several factors such as low utilisation of fertilizer and improved seeds and low government budget allocation, among others.

In Mtwara, cashew nut is among the major cash crops produced in the region. However, the cashew nut industry in the world and Tanzania in particular, is facing a major challenge (Rweyemamu, 2002; Baregu and Hoogeveen 2009; Rabobank, 2012). Tanzania unlike other countries such as Mozambique and Kenya who usually process their cashew nut is mostly exporting its cashew nut raw because most of their processing facilities are not functional, only about 20 000 tonnes of the raw cashew nuts are processed out of the 160 000 tonnes produced. It was reported that cashew nut produced from Tanzania is usually left over and unprocessed. For example, it was reported by Rabobank (2012) in April 2012 that, Tanzania had an unsold stock of 90 000 tonnes of raw cashew nuts still lying in the villages. Such a situation might cause most parents not to be able to pay their children's school fees as well as being unable to provide food for their households. Additionally, such a scenario has the potential of enticing more young girls into sexual relationships in prospect of getting their necessities, and as a consequence they could get pregnant (Siettou and Sarid, 2011; Kirby, 2011).

Table 1: Demographic characteristics of respondents (n=104)

Characteristic		Frequency	Percent
Age category	13-14	22	21.2
	15-16	64	61.5
	17-19	18	17.3
Respondent care taker/provider	Both parents	48	46.2
	Single parent	25	24.0
	Guardian	31	29.8
Education level of respondents parents/guardians	Non formal Education	20	19.2
	Primary	56	53.8
	Secondary	23	21.1
	Tertiary	5	4.8
Respondents parent's/guardians main occupation	Farming	59	56.7
	Business	23	22.1
	Teaching	6	5.8
	Others	16	15.4

3.2 Factors Contributing to Teenage Pregnancy in Mtwara

Study findings as summarized in Table 2 show that several factors contribute to teenage pregnancy in the study area. The major ones according to the respondents included poverty culture, and desire for money. Others were peer pressure to engage in relationships, lack of education on reproductive health and related issues and poor parental care.

3.2.1 Poverty and teenage pregnancy

Generally, the majority of respondents argued that poverty was a major cause of the high rates of teenage pregnancy in the study area. High levels of poverty particularly in rural Tanzania and other urban areas other than Dar es Salaam are due to overreliance of the agricultural sector as the major source of livelihood. Tanzania's agricultural has been performing poorly compared to other sectors in the country due to low productivity of most smallholder farmers; most produce at the subsistence level hence low incomes. As a consequence of the above, one can easily be tempted to conclude that those engaged in such agricultural activities are incapable of adequately providing for their household needs, including some specific needs for their teenage girls thus, leading to teenage girls being forced to provide for themselves and as the result end up being pregnant and dropping out of school. As shown in Table 2, more than two thirds of the respondents mentioned the desire for money among young girls as a major factor contributing to teenage pregnancy. The greed for material things, known as *tamaa* in Kiswahili was reinforced during the focus group discussions (FGDs) and key informant interviews (KIIs) as a cause of teenage pregnancy among girls. However, the girls admitted that, desire for money was an issue. Nonetheless, they claimed that it is a strategy to meet up with basic needs such as food, clothing, and school fees which are not met by most parents and guardians. More evidence is provided by the following quotes:

> "*Some girls see the lovers of their friends buy good things such as clothes, phones, cosmetics etc. for them. So they want to have those things too, so they do what their friends do*" (A 40 year old female KI, Mtwara Municipality, October 22, 2014).
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> "*Some girls find lovers who will provide the basic needs they lack at home*" (A 17 year old FGD participant, Mtwara District, October 27, 2014).
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> *"One needs to eat and look good. If my family cannot provide these things, I will surely find someone who will provide for me*" (A 16 year old FGD participant, Mtwara Municipality, October, 22, 2014).

Table 2: Causes of teenage pregnancy in the study area as per respondents (n=104)

Major factors responsible for teenage pregnancy	Frequency	Percent
Poverty	78	75.0
Culture	77	74.0
Desire for money	71	68.3
Peer Pressure	59	56.7
Lack of Sexual Reproductive Health Education	48	46.2
Poor parental care	38	36.5
Self-interest for sex	5	4.8
Watching pornographic films	4	3.8
Globalization	3	2.9
Rape	3	2.9
Temptation from men	2	1.9
Attending Night Club	2	1.9
Alcohol and drug use	2	1.9
Prostitution	1	1.0

3.2.2 Culture and teenage pregnancy

Study findings (Table 2) further show that about three-quarters of the respondents associated teenage pregnancy with cultural practices ('*Jando'* and '*Uyango'* i.e. boys circumcision and girls initiation ceremonies respectively) in the Region. Generally, the above-mentioned ceremonies attract young children usually those entering their puberty (i.e. nine to twelve years). During the above cultural practices, attendees are taught cultural norms, including respect for elders and gender roles. Other lessons include sexual practices and techniques. Males are circumcised during the '*Jando'* ceremonies and are encouraged to have sex with females of their age thereafter (Munir, 2011). It was observed during the study that '*Jando'* and '*Unyago'* were cultural practices influencing early sexual engagement by teens in the region, thus the possibility of teen pregnancy particularly when contraceptives are not used. The finding is comparable to findings by Dev Raj *et al.* (2010) that socio-economic factors, culture and family structure were consistently identified as risk factors for teenage pregnancy in Asia.

3.2.3 Peer pressure and teenage pregnancy

Generally, peer pressure can cause individuals to do the unprecedented. Results (Table 2) show that more than half of the respondents thought peer pressure contributes to teenage girls' involvement in sexual relationships which at times leads to teenage pregnancy. Similar findings have been reported by Smith and Coleman (2012) and Akella and Jordan (2015) that, peer pressure plays a major role in teenage pregnancy. According to Smith and Coleman teenagers can be particularly vulnerable to external influences, especially the opinions and behaviours of their friends and classmates. According to Akella and Jordan teenage girls tend to learn from their peers and the society around them and they do absorb both acceptable and unacceptable behaviours. Further to the above, a study by Bearman and Brukner (1999) found that larger peer groups, or cliques, exert influences on

sexual debut and pregnancy of teenagers. Bearman and Brukner (1999) further argue that, as the number of high-risk members in a girl's peer group rises, so does her risk of sexual debut.

3.2.4 Lack of Reproductive health and teenage pregnancy

Findings in Table 2 also show that less than half of the respondents thought the lack of reproductive health education among school age girls was a factor contributing to school girls' teenage pregnancy. The respondents stated that they didn't have accurate knowledge on how to prevent themselves from becoming pregnant. According to the WHO (2012), lack of reproductive health education is a major challenge in many developing countries. The organization further asserts that many adolescents do not know how to avoid getting pregnant, or are unable to obtain and use contraceptives correctly and that there is a lack of sexuality education in many developing countries.

3.2.5 Poor Parental Care and Teenage Pregnancy

Parental care according to literature is quite important in prevention of teenage pregnancies. Results from the study show that, in addition to the above-mentioned factors, poor parental support was cited as one of the major causes of teenage pregnancy in the region. According to Whitbeck *et al.* (1993), lack of parental support was related to depression for teen males and females, but the association between depressive symptoms and sexual activity was much stronger for females than for males. The authors argue that low support from parents is associated with a greater propensity for alcohol use, which is more strongly associated with early sexual activity of teens. Both daughters and sons who view their parents as being unsupportive are likely to report depressed moods and use alcohol, whereas depression does influence sexual behaviour for daughters, alcohol use is more strongly related to the sexual behaviour of sons. Moreover, a study conducted by Puja and Kazimoto (1994) also found that poor parental support was a factor for many adolescent girls getting pregnant and dropping out of school. The authors argue that children raised by single parents often get little protection or emotional support and that such a situation may lead children to easily fall prey to teen pregnancy, especially when parents are not providing food, not meeting school requirements and not making proper follow up on their activities. The issue of teenage girls living with single parents (particularly their mothers) getting pregnant has also been reported by Akella and Jordan (2015). Separation from parents due to divorce is very common in Mtwara. Most of the key informants as well as those female teens who had dropped out of school attributed the problem of teenage pregnancy to lack of support and care from their parents. The following quotes assert this:

> "*The reason children are getting pregnant is because of their parents. Some parents leave their children at home alone for a long time without sending the necessary supplies. Therefore, when the little provisions available at home are finished they are forced to enter into sexual relationships just to meet these needs by any means possible, a situation which causes teenage girls to get pregnant*" (A 30 year old female KI, Mtwara Municipality, October 21, 2014).
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> "*These days marriage is not taken seriously. Families break up at any time and parents end up seeing children as a burden and nobody cares for them. They end up begging on the streets. Nobody protects them or provides for them*" (A 54 year old male KI, Mtwara District, October 24, 2014).
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> "*My father used to leave us with our mother and be away for a long time without leaving any money at home. As for me, I had a boyfriend who was selling goods at the market place; he used to give me money. I used to share the money with my mother and my young sister. I got pregnant last year and dropped out of school. I really wanted to study and become a doctor. I am not sure of that dream anymore*" (A 17 year old School dropout, Mtwara Municipality, October 27, 2014).

As regards to factors contributing to teenage pregnancy, the key informant interviewees who were school drop outs revealed a clear picture of how the situation is for girls in Mtwara who have fallen to teenage pregnancy. Although most of the factors were already mentioned by the respondents, but the KIIs conducted with the drop out girls explained more details about the factors and how they have been affected by teenage pregnancy. The dropouts attributed the issues of lack of support from parents, early marriage, poverty and lack of education on pregnancy prevention as the major reasons that led them to becoming pregnant. All the girls pointed out that it was not their plan to get pregnant, but they wanted to complete school and have a career. See some quotes of what the girls said during the interviews.

> *"When my dad and mom separated, my younger brothers and sisters and I were left with our mother. But she had no good paying job to get money and take care of us. So at the age of 15 I had someone helping me. However, in the process I got impregnated by him"* (School dropout aged 16 years, Mtwara District, October 27, 2014).
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> *"I didn't know of when a woman can get pregnant. In addition, I did not know of how to prevent myself from getting pregnant. Moreover, the information I had from my friends was not correct. They said that if one takes antibiotics right after sexual intercourse one cannot get pregnant but it was wrong"* (A 16 year old School dropout, Mtwara District, October 27, 2014).
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> *"It was my family who encouraged me to get married because they told me that I was of age to marry and that I would continue with school. I got married and I was still going to school. However, while still in*

school, I got pregnant. Now I am taking care of my son. I hope to go back to school someday, if possible. School is a good place to be" (An 18 year old School dropout, Mtwara Municipality, November 1, 2014).

"Poverty is the reason why girls get pregnant. Sometimes when you do not have money to buy food, school uniforms and pay school fees lots of temptation can come your way. Even if you reject at first, due to persistent temptation, later on you will agree. I got this baby from someone I didn't love at first, but because he was helping me and my family I decided to agree. Now we are no longer together, and the child is with me" (A 19 year old School dropout, Mtwara Municipality, November 1, 2014).

The quotes from the school dropout generally show that teenage girls in Mtwara are vulnerable to teenage pregnancy, and one can get pregnant at any time and may not be able successfully complete secondary school. If this trend of teenage pregnancy continues, the consequence will be intergenerational cycle of poverty, abuse and oppression of women.

3.2.6 Other Factors Responsible for Teenage Pregnancy in Mtwara Region

In addition to the above-mentioned factors of teenage pregnancy especially secondary school girls a number of other causes were mentioned by a few of the respondents. These included self-interest in sex, watching pornographic movies, failure to resist temptations from the opposite sex, and the influence of globalization (i.e. seeing relationships that involve sex as a common thing contrary to the customs of the area). Others were rape, alcohol use and going to night clubs. Generally, though the above were mentioned by only a small proportion of the respondents literature nonetheless shows that they do contribute to teenage pregnancies. For example, Langham (2015), points out that rape, teenage drinking and glamorization of pregnancy are a major cause of teenage pregnancy. Langham citing ABC's "Good Morning America" points out that the movie industry and the media contribute to teenage pregnancy by glamorizing teen pregnancy in news stories and movies which depict teen pregnancy as something to be desired thus encouraging teens to engage in reckless sexual activity.

3.3 Respondents Access to Reproductive Health Support and Satisfaction with the Services

3.3.1 Access to reproductive health support

Findings from the study on whether teenage girls had access to reproductive health support are presented in Table 3. According to the results, there was a general challenge facing teenage girls as regards access to SRH. The results show that about two thirds of the respondents admitted having some kind of access to reproductive health services. From the research observation, sexual reproductive health services were a major challenge in the health facilities in Mtwara Municipality and Mtwara District, the study areas. Generally, there existed no specific Youth Friendly Services (YES), for example at the regional hospital, all reproductive services were shared with adults hence there was no separate place for teenagers to access the services in a more private manner. See the following quote below:

"At the moment there is no specific place to serve only youth clients. However, we are hoping that such services will be offered in the near future because I think it would be a good initiative"(A 32 year old Female Health practitioner, Mtwara Municipality, October 25, 2014).

According to WHO (2008), most adolescents often do not seek contraceptive services or neglect it completely because they are afraid of social stigma or being judged by clinic staff. Therefore, many SRH service needs of youth were not met. Moreover, it was discovered that contraception shortage was a common problem. A study conducted in Ethiopia showed that shortage and inaccessibility of contraceptives influenced people especially young people from visiting reproductive health centres (Gizaw and Regassa, 2011). Generally, UNECA et al. (2015) argue that Africa is faced with two challenges, first low contraceptive prevalence rates and second the unmet need for family planning despite the above being necessary for women's needs. Therefore, in order for young people to use sexual and reproductive health services, delivery must be made more responsive and friendly to adolescents for them to adequately utilize the same.

Access to reproductive health (RH) services was found to vary with location. The study found that most of the respondents in Mtwara Municipality admitted having access to RH compared to their rural counterparts in Mtwara District. This observation suggests that students from the rural areas could be more vulnerable and are most likely to fall prey to the incidence of teen pregnancy and other related issues e.g. STI's relative to their urban counterparts. According to the WHO (2008), adolescent pregnancies are more likely to occur among the poor, less educated and rural populations. Furthermore, the finding of disparity in reproductive health services provision between rural and urban dwellers is not a new scenario. Similar studies conducted by Stewart and Kaye (2013) on a study of '*Teen childbearing in rural America'* found that teens in rural America face greater risk of pregnancy than their urban counterparts. Stewart and Kaye (2013) attributed the incidence partly to lack of access to a range of services such as comprehensive contraceptive services opportunities. The authors further stated that there just aren't as many sexual health resources in rural areas, and that teens may have to travel far to access reproductive health services. A study conducted in Myanmar, Asia found that regardless of the availability of RH services there were disparities in access and utilization of RH services among rural and urban youth, with high levels of unmet needs for rural youth (Thin Zaw *et al.,* 2012).

Table 3: Respondents access to reproductive health services (n=104)

Variable		Rural	Urban	Overall
Access to reproductive health services	Yes	28(41%)	40(59%)	68(65%)
	No	24(67%)	12(33%)	36(35%)

3.3.2 Respondents' satisfaction with reproductive health services

Ones satisfaction to any services is mainly determined by his/her uptake. Study results (Table 4) show that respondents were moderately and highly satisfied with staff's confidentiality and friendliness respectively. The above is somehow acceptable because confidentiality and friendliness of the staff are critical issues that young people really care about, especially when it comes to matters of sexuality (WHO, 2008). A study conducted by Erulkar *et al.* (2005) among adolescents in Zimbabwe found that having confidential services, including a nurse that takes her time, short waiting time, 'one-stop shop' approach, and low cost or free services were the most important characteristics youth appreciated. However, Table 4 also shows a majority of the respondents were not satisfied with the level of support that they were receiving from health centres as well as educational materials that were available at the health centres. The quotes below show the FGD participants' mixed feelings in relation to the services:

> *"Though we don't have a separate place to get reproductive services but the nurses are good and they don't share other people's issues"* (An 18 year old FGD Participant, Mtwara District, October 26, 2014).
>
> *"Many of my friends are getting pregnant because first they don't know how to prevent pregnancy. Second, we cannot go to the hospital to ask those questions. If you do so, they will start talking behind your back. I don't feel free going there"* (A 17 year old FGD Participant, Mtwara Municipality, October 21, 2014).
>
> *"I don't go there for contraception because I am a student. I am supposed to abstain"* (A 16 year old FGD Participant, Mtwara District, October 24, 2014).

Table 4: Respondents' level of satisfaction with RH services (n=68)

Respondents level of satisfaction	High	Moderate	Low
Level of satisfaction with access RH services	22	18	28
Easy access to RH Support	12	17	39
Satisfaction with confidentiality	16	28	24
Satisfaction with educational material at health center	14	14	40
Staff are friendly	43	19	6
Would recommend RH service to friend	17	22	29

3.4 Types of Pregnancy Prevention Methods known by the Respondents

The results in Table 5 show that the majority of the respondents were aware of pills as a pregnancy prevention method followed by the use of condoms and injection. Other methods were abstinence, sterilization, loops, calendar and traditional medicine although; these were not as popular as the earlier mentioned ones. Moreover, abstinence was to some not an effective way of preventing teen pregnancies. The research findings are comparable to those of a study conducted among Ghanaian adolescents whereby it was reported that the most common type of contraception known was condom (42.3%) followed by the pill (24.3%). Others were injections (3.3%), "traditional" 23.3%, withdrawal (4.3%). Other methods such as sterilization (male/female), intrauterine device (IUD), and diaphragm and these were the least commonly known (Hagan and Buxton, 2012). The study's finding is also similar to observations by a study conducted in Bangladesh among adolescents where the most common known preventive method were reported to be the oral pill (99.3%) and condom (85.3%) followed by injectables (72.7%): tubectomy (37.5%), IUDs (34.3%), and traditional methods were the least known (Rahman and Kabir, 2008). The importance of pregnancy prevention methods is emphasized by the quotes below;

> *"It is impossible to keep yourself without doing something once you have done it before"* (A 15 year old R*espondent*, Mtwara Municipality, October 23, 2014*).*
>
> *"I do not believe in abstinence now because I already have a lover. I would rather use condoms"* (An 18 year old Respondent, Mtwara Municipality, October 23, 2014).
>
> *"I think abstinence is the most effective way of contraception because once you stay by yourself you will not get pregnant"* (A 14 year old FGD Participant, Mtwara District, October 27, 2014).
>
> *"Keeping yourself from having sex is only possible if you do not have a lover"* (A 17 year old FGD Participant, Mtwara District, October 27, 2014).

In Tanzania, contraceptives are supposed to be provided free at government health centres (URT, 2003 and Munir, 2012). However, some respondents pointed out that they had purchased contraceptives from health facilities. When asked why they sold contraceptives at some health facilities, a 43 year old key informant claimed that, it was a service charge in order to meet up with costs of purchase and restocking due to the

constant shortages of free contraceptives in the region. Another 35 year old key informant, said, "*Sometimes there is a shortage of contraceptives at our facility. So to make sure our clients do not go home without getting the same, we buy the contraceptives ourselves and sell to them in order to cover the costs. However, they are normally sold cheap*". Based on the study's observation it would be better if, contraceptives were provided free of charge and kept in confidentiality for easy accessibility by teenagers. The above is supported by a study conducted in Zimbabwe by Erulkar *et al.* (2005) among adolescents whereby it was reported that having confidential services and at a low cost or free of charge were the most important characteristics for youth in accessing reproductive health services.

Table 5: Pregnancy prevention methods known by respondents (n = 104)

Pregnancy prevention methods known	Frequency	Percent
Pills	86	83.5
Condom	83	80.6
Injection	81	78.6
Implant	38	36.9
Loops	22	21.4
Abstinence	16	15.5
Calendar	9	8.7
Sterilization	3	2.9
Traditional Medicine	3	2.9

4.0 Conclusions and recommendations

As pointed out earlier the study on which the paper is based was guided by the Social Learning Theory (SLT). Generally, the theory was found to be relevant in the study areas whereby pragmatic evidence on factors influencing teenage pregnancy in the region clearly show that, specific interpersonal factors were responsible for teenage pregnancy: these include weak family connections and poor parental support, peer pressure and culture among others. Furthermore, respondents admitted to have limited skills and knowledge on how to prevent teenage pregnancy. Based on the findings on which this paper is based, the SLT has been useful in showing the links to the factors influencing teenage pregnancy in Mtwara region.

Based on the study's findings it can thus be concluded that, teenage girls in Mtwara Region are vulnerable to the risk of teenage pregnancy and may fall pregnant at any time without completing secondary school due to a multitude of factors which include, poverty, lack of sexual and reproductive health education, unfavorable cultural practices (*Jando* and *unyango*), poor parental support and peer pressure. It is also concluded that among the above mentioned factors poverty was the major one. It is further concluded that teenagers in Mtwara region lack access to adequate sexual reproductive health (SRH) support. Generally, though SRH services are there they do not adequately meet the needs of the youth.

Based on the study's findings and conclusions it is recommended that, households be empowered to earn sufficient income to provide for their families, particular emphasis should be put on non-farm income generating activities. It is also recommended that youth friendly SRH services be established in the study areas; doing so will improve youth's access to the same. Lastly, since the study on which this paper is based only covered female students, there is a need for another one to cover teenagers of both sexes to determine their level of understanding of reproductive health issues. Results of the proposed study could generate pertinent empirical information which could inform strategies and programmes aimed at improving all youths' accessibility to reproductive health services.

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