

# Unintended pregnancy among teenagers in Arusha and Zanzibar, Tanzania:

A situation analysis



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**Vision:** A world in which every birth is wanted

**Mission:** Children by choice, not chance

#### Acronyms

<b>CBD</b>	Community based distributor	<b>MVA</b>	Manual vacuum aspiration
<b>CBM</b>	Community based mobiliser	<b>OCP</b>	Oral contraceptive pill
<b>CPR</b>	Contraceptive prevalence rate	<b>PAC</b>	Post-abortion care
<b>FGD</b>	Focus group discussion	<b>QDA</b>	Qualitative data analysis
<b>FP</b>	Family planning	<b>PPH</b>	Postpartum hemorrhage
<b>IDI</b>	In-depth interview	<b>SRH</b>	Sexual and reproductive health
<b>MNCH</b>	Maternal, neonatal and child health	<b>TBA</b>	Traditional birth attendant
<b>MST</b>	Marie Stopes Tanzania		

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# 1. Executive summary

**Around the world, about one in ten of the pregnancies that occur every year are among teenagers<sup>i, ii</sup>. In sub-Saharan Africa, many women begin bearing children in their teenage years. In Tanzania, for example, almost one in four (23%) girls between the ages of 15 and 19 has either given birth or is pregnant<sup>iii</sup>. The unmet need for family planning (FP) is particularly high among teenagers in Tanzania.**

As a result, many teenage pregnancies are unplanned and unintended. Abortion is illegal in Tanzania except to save the life of the mother. This means that teenagers who wish to terminate an unintended pregnancy are more likely to undergo a self-induced abortion or turn to unqualified practitioners for procedures that can take place in unhygienic conditions. Both of these options are associated with the increased risk of adverse events – and can ultimately lead to death.

In Eastern Africa, complications after unsafe abortion cause around 18% of maternal deaths<sup>iv</sup>. Such deaths are most likely to occur among young women who are teenagers or in their early twenties<sup>v</sup>. Many more of these young women experience serious injuries following unsafe abortion, including infection, hemorrhage, cervical laceration and uterine perforation<sup>vi</sup>.

The high proportion of incomplete abortion patients among all hospital gynaecology admissions in Tanzania suggests that abortion is a significant public health problem in the country<sup>vii</sup>. This contributes to Tanzania's unacceptably high maternal mortality ratio of 454 deaths for every 100,000 live births<sup>iii</sup>. Tanzania is one of ten countries that account for almost two-thirds of all maternal deaths in the developing world<sup>viii</sup>. Post-abortion care (PAC) is one approach to reducing death rates following incomplete and unsafe abortion and resulting complications.

In order to reduce the unintended teenage pregnancy rate and resulting maternal mortality, it is essential that young people across the country – in both rural and urban areas – are able to access high quality, youth-friendly FP and PAC services.

This study is designed to fill a gap by providing information about the attitudes of teenage girls towards unplanned pregnancies, abortion and PAC services in Tanzania – thus addressing the needs of a significant proportion of the target population for averting maternal mortality. This community-based research reveals qualitative information on teenagers' perceptions towards abortion and PAC services as influenced by community perceptions, as well as their understanding of the legal implications of abortion and subsequent aftercare. The findings provide interesting insights into what motivates potential and actual service users.

## About the study

The study involved a situation analysis among 101 teenage girls aged between 12 and 19 years old in Arusha on the Tanzanian mainland and in Town West in Zanzibar. In both settings, in-depth interviews (IDIs) and focus group discussions (FGDs) were conducted in order to explore the socio-cultural context, as well as investigating:

- knowledge of and access to FP
- responses to unintended pregnancies
- knowledge and use of unsafe abortion services
- perceptions on the availability and legality of PAC services.

## Findings

This study's findings reveal that fears of stigma in relation to sexual activity and unplanned pregnancy far outweigh teenage girls' consideration of the risks in undergoing any type of abortion. Girls fear four major impacts when they have an unplanned pregnancy:

1. Losing the trust and love of their families.
2. Destroying their family's reputation.
3. Losing their opportunity of an education.
4. Being prosecuted, and possibly jailed, for having an abortion.

These fears, coupled with structural forces including general poverty and lack of access to cash for emergencies, influence young women towards clandestine abortions in unsafe places by untrained providers. They face the risk of severe complications, even death, as a result.

In summary, study participants undertook a 'risk-benefit' decision of privacy over quality of care. A similar risk-benefit calculation affects the use of FP: girls will face the risks of pregnancy and the health risks associated with unsafe abortion, rather than the reputational and perceived health risks of accessing FP services.

Girls are also fearful of accessing PAC services despite these being legal in Tanzania. Teenage girls'

deaths resulting from unsafe abortions are therefore not only due to a lack of services, but are also related to fears associated with accessing PAC services. Different types of interventions to address girls' fears may help them to avoid the risks associated with unsafe abortion, and also help them to access safe and legal PAC services.

The findings from this study highlight poor knowledge about sexual and reproductive health (SRH) among teenage girls. SRH communication strategies should be developed to target girls and young women specifically and to address the information and knowledge gap. These communication strategies should cover SRH rights, the legality of PAC services and the low cost (or free availability) and use of modern FP methods.



## 2. Introduction

**Around the world, about one in ten of the pregnancies that occur every year are among teenagers<sup>i,ii</sup>. In sub-Saharan Africa, many women begin bearing children in their teenage years. In Tanzania, for example, almost one in four (23%) girls between the ages of 15 and 19 has either given birth or is pregnant, and teenage pregnancy in Tanzania is even more common in rural areas (26%) than in urban zones (15%)<sup>iii</sup>. The unmet need for family planning (FP) is particularly high among teenagers in Tanzania: currently, 16% of married women between the ages of 15 and 19 want or need to use FP services and are not currently using these services<sup>iii</sup>.**

As a result, many teenage pregnancies are unplanned and unintended. Abortion is illegal in Tanzania except to save the life of the mother. This means that teenagers who wish to terminate an unintended pregnancy are more likely to undergo a self-induced abortion or turn to unqualified practitioners for procedures that can take place in unhygienic conditions. Both of these options are associated with the increased risk of adverse events – and can ultimately lead to death.

In Eastern Africa, complications after unsafe abortion cause around 18% of maternal deaths<sup>iv</sup>. Such deaths are most likely to occur among young women who are teenagers or in their early twenties<sup>v</sup>. Many more of these young women experience serious injuries following unsafe abortion, including infection, hemorrhage, cervical laceration and uterine perforation<sup>vi</sup>.

The high proportion of incomplete abortion patients among all hospital gynaecology admissions in Tanzania suggests that abortion is a significant public health problem in the country<sup>vii</sup>. This contributes to Tanzania's unacceptably high maternal mortality ratio of 454 deaths for every 100,000 live births<sup>iii</sup>. Tanzania is one of ten countries that account for almost two-thirds of all maternal deaths in the developing world<sup>viii</sup>. Post-abortion care (PAC) is one approach to reducing death rates following incomplete and unsafe abortion

and resulting complications. The Government of Tanzania's National Maternal, Neonatal and Child Health (MNCH) Road Map recognises the potential of this approach to reducing maternal mortality<sup>ix</sup>.

Tanzania has a very young population: one in three people is aged between 10 and 24<sup>x</sup>. In order to reduce the unintended teenage pregnancy rate and resulting maternal mortality, it is essential that young people across the country – in both rural and urban areas – are able to access high quality, youth-friendly FP and PAC services.

This study is designed to fill a gap by providing information about the attitudes of teenage girls and young women towards unplanned pregnancies, abortion and PAC services in Tanzania – thus addressing the needs of a significant proportion of the target population for averting maternal mortality. This community based research reveals qualitative information on teenagers' perceptions towards abortion and PAC services as influenced by community perceptions, as well as their understanding of the legal implications of abortion and subsequent aftercare. It highlights teenagers' decision-making processes to undergo an abortion and/or to access and use PAC services and post-abortion contraception. The findings provide interesting insights into what motivates potential and actual service users.

This study aims to improve our understanding and respond more effectively to the broader context of the health-seeking behaviours of young people in relation to these essential reproductive health services in two areas of Tanzania (Arusha and Town West, Zanzibar). More specifically, the objectives of the research were to:

- 1) Gain greater understanding of community perceptions, attitudes and decision-making in relation to unintended teenage pregnancy and pregnancy prevention and termination.
- 2) Explore teenage girls' attitudes towards, access to and use of different methods of contraception, if any.
- 3) Understand teenage girls' decision-making processes and options for handling unintended pregnancy and abortion, and the participation of men, families and other social networks in their decisions.

The predominantly Islamic culture in Zanzibar provides an important contrast to the predominantly Christian population in Arusha. The use of modern methods of contraception among married women is lower in Zanzibar than the Tanzanian national average contraceptive prevalence rate (CPR) of 27.4%. This is particularly striking in the Northern (7.4%) and Town West (14.7%) regions<sup>iv</sup>. Of all the 14 clinical facilities run by Marie Stopes Tanzania (MST) nationally, the centres in Arusha and Zanzibar saw particularly high numbers of clients seeking PAC.

In both settings, in-depth interviews (IDIs) and focus group discussions (FGDs) with teenage girls and women were conducted in order to explore the socio-cultural context, as well as investigating:

- knowledge of and access to FP
- responses to unintended pregnancies
- knowledge and use of unsafe abortion services
- perceptions on the availability and legality of PAC services.



# 3. Study methodology

## 3.1 Study design, setting and participants

The study involved a situation analysis among girls and young women aged between 12 and 19 years old in Arusha on the Tanzanian mainland and in Town West in Zanzibar. Participants were either single or married, and included both in-school and out-of-school teenagers. Participants were recruited by volunteer community based mobilisers (CBMs) attached to MST centres in both regions. They used a 'snowball methodology' to recruit girls from the communities surrounding the MST centres, asking each girl recruited to suggest another girl who fitted the criteria. The CBMs sought to recruit girls who had personal experience of pregnancy. Ethical approval for the study was granted by the National Institute of Medical Research of Tanzania.

## 3.2 Data collection

The research team used qualitative research methods, specifically FGDs and IDIs, to investigate sensitive topics around unintended teenage pregnancy. FGDs explored local definitions of unintended pregnancy, perceptions towards use of FP among teenage girls, the perceived magnitude of abortion, and general knowledge and availability of PAC in their localities. IDIs explored the influences around decision-making on teenage FP use, pregnancy and abortion.

The research team administered informed consent to the study participants: the consent forms clearly stated that study participants had the right to refuse any question or to decline to participate in the research at any time, if they felt uncomfortable. Their refusal to participate in any part of the study did not affect their access to or use of MST clinic services in any way.

While ethical guidelines usually require that a parent or guardian gives consent for a minor to participate in a study, the sensitive nature of topics covered in the course of this research and the risks to the girls from any breach of confidentiality meant that parental approval was not sought on this occasion, particularly as the study does not involve any medical procedures or tests.

Over 100 teenage girls (N=101, 50 in Zanzibar and 51 in Arusha) participated in the nine FGDs. A rapid scan was done during the discussions to identify participants who volunteered the information that they had had a pregnancy as a teenager and either decided to continue the pregnancy or opted for an abortion. These girls were asked for their consent to take part in an IDI. Fifteen girls gave their consent to participate in more in-depth interviews (five in Zanzibar and 10 in Arusha). All FGD and IDI participants filled in a short socio-demographic questionnaire before participating in the study.

## 3.3 Data analysis

Quantitative socio-demographic data were entered into SPSS software for analysis, while the qualitative data were transcribed. All transcripts were manually coded and then entered into the Weft Qualitative Data Analysis (QDA) programme for systematic content analysis. The use of both SPSS and Weft QDA programmes facilitated comparisons between and among the study participants' responses on particular study topics. It also enabled the research team to make quantitative comparisons by comparing volumes of text coded by a particular theme or sub-theme. This report synthesises data from the various groups and by research method.



## 4. Findings

### 4.1 Socio-demographic profile of participants and history of pregnancy and termination

Study participants ranged from 12 to 19 years old; the mean age was 16 years. Most study participants (69%) had reached secondary school education level. Among those girls who had some primary school education, 12% dropped out of school as a result of an unintended pregnancy. Further description of the cohort is outlined in Table 1.

About half of the girls (N=54) who participated in FGDs

had been pregnant. Of these girls, 42 (78%) had terminated at least one pregnancy and five (12%) had terminated two or more pregnancies. There were two study participants who had had three pregnancies. About a third (N=13) of the girls who had terminated a pregnancy experienced complication/s<sup>1</sup>.

In terms of current relationship status, the majority of participants reported having a boyfriend (63%), almost a quarter had no relationship (22%), and few girls had occasional partners, were co-habiting or married (6%, 5% and 4%, respectively).

**TABLE 1:** Socio-demographic characteristics of study participants

	%	N
<b>Level of education (N=101)</b>		
No/primary education	26%	26
Secondary education	69%	17
College education without high school	4%	4
College education after high school	1%	1
<b>Relationship status (N=101)</b>		
No relationship	22%	22
With boyfriend	63%	64
Occasional partner	6%	6
Cohabiting	5%	5
Married	4%	4
<b>Ever pregnant (N=101)</b>		
Yes	53%	54
No	47%	47
<b>Ever termination of pregnancy (N=54)</b>		
Yes	78%	42
No	22%	12
<b>Number of terminations (N=42)</b>		
1	88%	37
≥2	12%	5
<b>Ever had abortion complications (N=42)</b>		
Yes	31%	13
No	69%	29
<b>Lifetime ever use of FP (N=101)</b>		
Yes	46%	46
No	54%	55

<sup>1</sup> A 'complication' was defined as any unexpected event that occurred after an abortion requiring the young woman to seek further intervention either from the formal or informal health sector; no distinction was made between minor and major complications.

## 4.2 Unintended pregnancy

### Box 1: Interviews with study participants

*“... I felt so shy and that I have committed an unforgivable mistake because then I was very young age-wise and I was living with my parents. To be frank, I felt very bad; I viewed myself as careless...”*

*“... I felt shy because I had to quit school; people would laugh at me and that would be the end of schooling...”*

*“... myself when I got pregnant I was in standard seven. I was 13 years old by then. I informed my partner but he denied responsibility for that pregnancy...”*

*“...myself I had a boyfriend and we were in a relationship for a long time. He wanted to send a marriage proposal to my family, but he insisted that we had to have sex for him to be sure that I was sexually well before we actually get married. But unfortunately I got pregnant on the day I agreed to have sex with him and the whole marriage plan ended just there...”*

**Combined IDI participant responses of 16 to 17-year-old girls**

An ‘unintended pregnancy’ is generally understood to occur when a girl becomes pregnant without a prior decision and/or without prior consent from her sexual partner. Often unintended pregnancies are associated with unplanned sexual activities for a single girl and/or a girl at school. This includes coercive and transactional sex (sexual activity in exchange for money, goods or services). In the case of unintended pregnancies, the man involved frequently denies responsibility for the pregnancy.

Although pregnancies were reportedly common among study participants (see Table 2), this research found that community members held the view that unmarried girls were not expected to be pregnant. This was noted from study participants’ perceptions, and their reported views of the perceptions of their families and general communities. Participants reported that unintended pregnancies were handled in a clandestine manner and that community members were not informed. In most cases, terminations took place before people in the community realised that a girl was pregnant and sometimes the community did not find out at all. Girls who were unintentionally pregnant reported a tendency to hide from their community in order to avoid anticipated negative attitudes and consequences.

At the family level, unintended pregnancies among unmarried girls are often considered a family disgrace and can jeopardise a family’s status. In most cases, it was perceived that pregnancy ruins an unmarried girl’s life and future. Frequently, girls are expelled from school if they become pregnant before completing their pre-university level education in public schools. All girls in this study who reported a pregnancy became pregnant at either primary level (standards six and seven) or secondary school level (forms two and three). Except in rare cases, once a girl has had a child, she is considered an ‘adult’ and therefore should not be in school. Therefore, a pregnancy often spells the end of education for a schoolgirl.

All participants considered the risks associated with unsafe abortion to be preferable to the consequences of continuing an unintended teenage pregnancy. The fear of consequences (such as condemnation, physical punishments and expulsion from home/school) outweighed the risks of unsafe abortion and associated complications. Study participants who had terminated a pregnancy also reported that unintended pregnancies can ruin a girl’s future, including her eligibility to marry. This was reflected in the personal experiences of the IDI participants who had terminated a pregnancy and reported that their sexual partner refused to take responsibility for the pregnancy.

**TABLE 2:** Total number of lifetime pregnancies

Age groups	Number of pregnancies				Total
	0	1	2	3	
12-14	10	2	0	1	13
15-17	29	37	10	1	77
18-19	8	3	0	0	11

### 4.3 Abortion

Abortion was defined by the study participants as the deliberate discontinuation of pregnancy by ingestion of medicines (either modern or traditional) or through a hospital based procedure. Safe abortion was defined as the termination of pregnancy by a well-trained health worker, carried out in a health facility setting. Unsafe abortion was defined as the termination of pregnancy using traditional medicines or other abortifacients. Unsafe abortions are carried out by either a trained or untrained provider, or self-induced within or away from a health clinic setting, in an unclean environment or at home.

Study participants reported stories of unsafe abortions in their communities where off-duty health service providers provided abortions to girls at their homes. Some girls were reported to have died as a result of these unsafe procedures.

Most of the unmarried girls viewed abortion as a solution to avoiding the consequences of unintended pregnancies and in cases where the man denied responsibility for the pregnancy. This study did not explore whether teenage girls would wish to continue with a pregnancy if social stigma was not present.

#### Box 2: Story of an unwanted pregnancy

*“...I had a very bad experience when I first got pregnant. It was three years ago in my second year at secondary school. Me and my friend had a boyfriend. I didn’t know I was pregnant when my friend asked me because she heard people at school talking about me. On that same day when I went back home, my mother asked me about the same thing. I denied it and informed my boyfriend the following day. My boyfriend denied the responsibility because we had sex only twice, one month ago.*

*My friend directed me to a Maasai woman who provided me with some boiled concoction from [the] back of a tree. I went to that woman instead of going to school that day. Unfortunately, an abortion didn’t happen until the afternoon...*

*I got money for paying the Maasai woman TSh 20,000 (US\$13) from a new boyfriend... I got another pregnancy from him three months later. My parents kicked me away from home. I went to his house, he took care of me until his parents realised that I was staying with him and warned him about my parents...*

*One day he left me in a rented house without informing me. One month later the landlord told me to vacate his house. I moved to the street, started selling dried fish. I managed to get some money and now I am taking care of my child. That man got married to another woman following his parent’s choices.”*

**19-year-old IDI participant conversation, Zanzibar**

**TABLE 3:** Characteristics of abortion providers available in the communities

Provider	Services	Location	Methods
<b>Self-induced</b>	Induces abortion oneself	Provider's home/girl's home/friend's home / abandoned houses	Ingesting modern drugs <sup>1</sup> / ingestion of 'blue' (laundry detergent)
<b>Community based distributors</b>	Termination/ referral to clinics	Provider's home/public and private clinics in the community	Modern drugs, herbal medicines
<b>Traditional birth attendants</b>	Termination of pregnancy	Provider's own home in the community	Herbal medicine, insertion of objects into the uterus
<b>Herbalists</b>	Termination of pregnancy	Provider's home/ traditional clinic	Herbal medicine
<b>Pharmacists</b>	Termination of pregnancy	Provide medicine for self-induced abortion at girl's home	Misoprostol drugs (dosage not well described)
<b>Nurse</b>	Termination of pregnancy	Public clinics, private clinics, provider's home	Modern drugs
<b>Clinicians</b>	Termination of pregnancy	Public clinics, private clinics, provider's own home	Modern drugs, Manual Vacuum Aspiration (MVA)
<b>Quacks</b>	Termination/ referral to clinics	Provider's homes/private clinics/provide medicine for self-induced abortion	Modern drugs, MVA, insertion of objects into the uterus

#### 4.3.1 Abortion providers and methods used

A range of abortion methods were described by the study participants, including both modern and traditional methods delivered by different types of providers (see Table 3). Some of the abortion providers mentioned by the study participants include clinicians, 'quacks', nurses, herbalists and traditional birth attendants (TBAs). Girls and young women frequently approach these providers when seeking to terminate unintended pregnancies.

Of those study participants who had had abortions (N=42), more girls had induced abortions themselves rather than turning to clinicians, nurses, herbalists or TBAs. Over half (N=24) had their abortion at home and most of these procedures were self-induced: 18 girls had an abortion illegally at a health clinic.

In general, peers who had already had an abortion shared details with other girls about how to carry out a self-induced abortion. Methods included ingestion of concentrated tea, blue detergent or a solution of ashes, or the vaginal insertion of unknown herbs provided by friends. Most self-induced abortions among the participants were reported to have been successful. However, some self-induced abortions ended in severe pain, heavy bleeding, vaginal discharge or a foul smell after a few days and required hospital attention. Out of the 42 girls who had had an abortion, about a third (N=13) reported that they had a complication that required treatment. However, only two of the participants who had a complication (15%) reported that they went to a public health facility for treatment. Of the 13 girls who had complications, eight had self-induced abortions and five received an abortion from a health facility.

<sup>1</sup> Ingested modern drugs: Over dosage of anti-malarial drugs, antibiotics, Misoprostol drugs. Dosage and regimens were not specified.

Community based providers such as TBAs, herbalists, community based distributors (CBDs) and pharmaceutical retailers were perceived as being very accessible for abortion services, since they were found in non-clinical settings and often worked from their homes. This study found that CBDs and TBAs are under great pressure to provide support for unintended pregnancies to girls, and even adult women, as they are often the first port of call for help. Girls and women usually visited the practitioners in their homes, since privacy is greater than in more formal clinical settings. Doctors and physicians are regarded as being less accessible, as they tend to practise only in formalised settings with higher fees than community based providers.

### 4.3.2 Choosing an abortion provider

There were some differences reported in the choice of abortion method between Zanzibar and Arusha. Self-induced abortion was very commonly reported among participants in Zanzibar. In Arusha, 'quacks' and TBAs/herbalists ('wabibi wa kimasai' – 'old Maasai women' in Kiswahili) were mentioned more frequently. In Zanzibar, none of the participants who had previously had an abortion visited any of the listed providers. Instead, abortions were self-induced or assisted by friends and mothers at home or in another clandestine place. In Arusha, only one of 18 study participants performed a self-induced abortion; others visited the providers listed in Table 3. Participants seeking abortion services reported they were easily able to get information from peers, who were very well-informed about the location of providers and could easily provide referrals.

This study highlighted two important factors affecting teenage girls' choice of abortion providers – namely, accessibility of provider and cost of abortion services. FGD participants discussed providers' accessibility in terms of how easy it was to recognise a potential provider and how approachable they were. This kind of information is passed along from young women to their peers. Participants were able to terminate a pregnancy based on information they had received from peers or from home (including mothers, sisters or relatives).

Peers were also able to provide information about costs for abortion services. Participants reported that it was not easy for them to go to formal clinical settings for abortion services, because they had heard that these were more expensive than other providers, especially in the private sector. Other providers were reported to be a bit cheaper, while self-induced abortion was deemed to be the cheapest method of all. Cost is an important factor for young women considering an abortion provider, as they frequently do not have their own income. Access to cash typically comes from family members, such as the father. This study was not able to provide detailed information regarding comparative prices for abortion services.

Self-administered abortifacients were more usually followed by traditional procedures of caring for a person who has had an abortion, which is very similar to treating a woman who has delivered a live baby. FGD participants reported that, in cases of continued abdominal pain or continued bleeding or discharge, the person would be taken to a medical facility for further consultation. This is commonly referred to as 'kusafishwa', which literally means draining of the remaining materials of conception.

### 4.3.3 Types of abortifacients used

Different abortifacients were used by girls both in and out-of-school. In order of frequency, these included: concentrated teas; boiled Muarobaini tree leaves/roots; traditional lime Magadi ya kienyeji; strong boiled aloe vera leaves; and an unidentifiable concoction provided by Maasai women. Meanwhile, schoolgirls commonly used orally administered washing detergents ('Blue') or inserted objects like twigs of a plant (traditionally known as Mhogo Mpera) into the uterus to loosen the cervix, leading to foetal evacuation.

Study participants mentioned a well-known drug purchased from retail pharmacies and even non-pharmaceutical shops. None of the study participants knew the name of the particular drug. Following discussion with an experienced health service provider in Arusha (see Box 3), it was deduced that the girls were referring to Misoprostol. The health service provider mentioned that Misoprostol and Mifepristone are the most commonly available drugs in pharmacies

that are used off-label for medical abortion in Arusha. Misoprostol was registered in Tanzania in early 2011 for prevention of postpartum hemorrhage (PPH). Three tablets (600 mcg) are included in the delivery kit, which is widely available to enable easy access for women and/or service providers. This study did not explore what dosage of Misoprostol was used to induce abortion by women, without receiving any information from a clinician.

### Box 3: Conversation with health service provider in Arusha

*“...Two types of drugs are currently available in the market in Arusha region: Mifepristone and Misoprostol. If the study participants repeatedly mentioned it, then it is most likely to be Misoprostol, because it is sold everywhere just like sweets and is used for off label abortion. It is available even in backstreet shops; no conditions are imposed on purchasing this drug. Even those who have never been to school, those who can't even read... if you need it now you can get it from any shop. You know Misoprostol is currently sold at an extremely cheap price with the rationale of preventing women's deaths as a result of post-partum haemorrhage (PPH). Currently Misoprostol is sold at TSh 4,500 to 5,000 [approximately US\$ 3] for a single pack of 20 tablets. Mifepristone is also available in big pharmacies but sold under a gynecologist's prescription only...”*

### 4.3.4 Challenges in accessing abortion services

#### Perceptions and experiences of safe and unsafe abortion

A range of abortion methods were described by the study participants, including both modern and traditional methods delivered by different types of providers (see Table 3). Some of the abortion providers mentioned by the study participants include clinicians, ‘quacks’, nurses, herbalists and traditional birth attendants (TBAs). Girls and young women frequently approach these providers when seeking to terminate unintended pregnancies.

Of those study participants who had had abortions (N=42), more girls had induced abortions themselves rather than turning to clinicians, nurses, herbalists or TBAs. Over half (N=24) had their abortion at home and most of these procedures were self-induced: 18 girls had an abortion illegally at a health clinic.

#### Stigma associated with abortion services

A range of abortion methods were described by the study participants, including both modern and traditional methods delivered by different types of providers (see Table 3). Some of the abortion providers mentioned by the study participants include clinicians, ‘quacks’, nurses, herbalists and traditional birth attendants (TBAs). Girls and young women frequently approach these providers when seeking to terminate unintended pregnancies.

#### Financial barriers

The costs charged by providers in formal facilities were reported to be extremely high. In one of the FGDs in Zanzibar, study participants reported that the common cost for abortion services in a well-known private clinic is TSh 70,000 (US\$45). Young women often struggle to finance the whole procedure themselves to ensure privacy. Lack of cash to pay for abortion services can be a result of girls being rejected by their parents for bringing shame to the family. It can also be exacerbated by rejection from sexual partners, which

#### Box 4: Stigma surrounding abortion

*“... I told the doctor that I had a problem with malarial drugs. He asked if I had sex before taking the drugs. He then asked if I went through a pregnancy test before taking the drugs. He then sent me for a pregnancy test, where I was found pregnant. I started crying. When he asked if I had any problem, I told him I was still at school, but I felt shy to tell him directly that I wanted to terminate it fearing that he would perceive me as a killer, as we usually label the women who do pregnancy termination ...”*

#### Conversation with 17-year-old IDI participant, Arusha

leaves them with no one to support them financially to access a safe procedure.

In the IDIs, eight girls (seven girls who had had an abortion and one who continued the pregnancy) mentioned that the cost of services influenced their decision. Three participants decided to go for cheaper providers (ie clinicians working outside their usual facility or ‘off-duty’), thus avoiding costs such as registration fees, consultation fees, pregnancy tests and expensive drugs. Two others chose to go to a TBA. One secondary schoolgirl decided to ingest ‘blue’ washing detergent to induce her abortion; she reported that she was luckily allowed to go home for treatment of abnormal menstrual bleeding. She then moved to her friend’s home where she recovered before returning to school. Another IDI respondent was taken to a clinic for an abortion by her boyfriend, but they were not able to afford the requested fee (TSh 55,000 – US\$32). Instead, her boyfriend bought some concoctions from a Maasai woman, boiled it and she successfully induced an abortion and was able to go back to school within eight hours.

#### 4.3.5 Involvement in abortion decision-making and social support

The findings from this study indicate that three key groups are involved and hence shape girls’ decision-making when seeking an abortion: 1) sexual partner; 2) family members and 3) friends. Study participants highlighted that, in most cases, when the male partner is informed about the girl’s pregnancy status, he denies responsibility. As a result, the girls usually either make the decision to terminate the pregnancy on their own or inform their friends or family members, especially their mothers or sisters.

Participants noted that a male partner’s behaviour is due to their unwillingness as young men to enter married life or to become a parent. In some instances, a partner’s denial is perceived to be due to lack of funds, as they are often unemployed or in school. Nonetheless, male partners were repeatedly mentioned as the first person to give advice to a girl about whether she should seek an abortion. In some cases, partners provided assistance by paying for the abortion, locating an abortion provider, making arrangements with a provider and sometimes providing the location for a procedure. Participants frequently perceived the primary motivation for most male partners who assisted to be self-interest, because they were trying to keep the pregnancy a secret and/or avoid responsibility for caring for the baby. There was no mention of the social stigma associated with the partner’s involvement in getting teenage girls pregnant.

Participants also talked about family members influencing their decisions on whether and where to go for an abortion. This is usually done for two key reasons: keeping the pregnancy secret to protect the family’s reputation, and supporting the girl’s desire to remain in school. Mothers and sisters (especially elder sisters) usually tried to make sure that fathers and other male family members were prevented from finding out any information. In some instances, young women were taken to hospitals for safe abortions to avoid any complications that might raise suspicions among family members and the school administration. This is influenced by the community perception that mothers are to be blamed for their daughters’ perceived ‘misbehaviour’.

Friends were repeatedly mentioned as the key social support for providing encouragement and emotional support just after a young woman realises she is pregnant. Friends provided advice on how to deal with the pregnancy, including suggestions about who should be informed, as well as how to locate an abortion provider. Sometimes they provided shelter for the girl to conduct a self-induced abortion. Friends also actively facilitated the communication links between the pregnant girls and their male partners. If all else failed, they were the ones who prepared the abortifacient (eg by boiling Muarobaini tree leaves or making a concentrated tea). Friends also sometimes provided financial support. In summary, friends provided the key source of support, especially when girls were away from home (eg at boarding school) and their influence was far greater than that of parents.

#### 4.3.5 Awareness of the legal status of abortion

All study participants knew that abortion is illegal in Tanzania, except to save the life of the mother. None of the study participants knew of any circumstances where abortion was legal. For participants, every abortion was considered illegal and they expected to end up in jail if they were caught having an abortion. Even though some study participants felt that abortion was inevitable for teenage girls, especially those who were still at school or staying with their parents, most of them condemned it. The study participants viewed abortion as killing an innocent baby. There was a clear disconnect between what the participants felt teenage girls have to do if they experience an unintended pregnancy, and their general attitudes towards abortion.

#### 4.4 Post-abortion care (PAC)

Post-abortion care is defined as emergency treatment services for incomplete abortion and related complications. The aim is to reduce the risk of death, by using appropriate technologies. All study participants understood that PAC covers services provided after a woman has been through any kind of abortion. Very few of them mentioned actual activities involved during the provision of PAC services, such as removal of any remaining products of conception in the uterus, which is usually performed at a formal health facility.

Instead, the majority of study participants referred to

#### Box 5: Problems with post-abortion care

*“... my mother told me that my niece died some years back when she went for an abortion; she had blood clotted in her stomach because she was not sponged with hot water...”*

**16-year-old IDI participant, Zanzibar**

*“... I took some blue (washing detergent) but I was very worried for two days because there was no way I could get hot water to shower at school. On the third day I requested from the class teacher that I needed to collect some medicine from home. I then went to my friend’s home where my friend was secretly boiling some water for me, for four days before I went back to school. She was providing some tetracycline medicines, two tablets in the morning, mid-day and afternoon for two weeks. I did not get any problem until now.”*

**17-year-old IDI participant, Arusha**

PAC as services rendered at home after a girl has had an abortion. This included provision of hot and soft foods like ‘Mtori’ (a stew of ground banana and meat soup), enough bed rest for proper recovery and washing with hot water to allow the remaining blood to flow out of the uterus.

The study participants’ perceptions of PAC services were not necessarily connected to clinical care. Any clinical complications and/or infections associated with abortions were less likely to be identified if the girl was kept at home. Two participants decided to continue their unplanned pregnancies because they heard of other girls who had had abortions and had died several weeks later because there was no one to take care of them after the procedure. The participants stated that PAC services based at health facilities were of great importance, but mentioned that it was not easy to access these services. One reason why it was difficult for them to access these services was that abortions are usually done secretly, and any complications should be handled in a similar way. Secondly, the girls felt too disempowered to visit health clinics and seek



safe abortion services. They also felt equally disempowered, and even fearful, to explain to service providers that they had had an abortion and needed services to address related complications. As a result, PAC services were seen as inaccessible and were underutilised.

#### 4.4.1 Perceptions of and barriers to PAC services

In terms of community perceptions and the legal situation, the study participants reported that PAC is as stigmatised as abortion. PAC is considered to be an illegal service and if the community members discover that someone sought PAC services, they would view that girl as 'a killer'. Girls reported fearing that using PAC services could mean being discovered and handed over to police, and ultimately to being prosecuted for committing an abortion. Although they expressed that PAC services are of great importance, none of the study participants perceived the services as being legal in Tanzania. Participants expressed the view that there are varying legal consequences for a service provider if they are discovered to have performed an abortion or PAC. They acknowledged that service providers would not be prosecuted for performing PAC services; instead, consequences were perceived to fall to the girl or woman undergoing the procedure.

#### 4.5 Knowledge and use of family planning

Knowledge about FP among study participants was very high: few study participants reported that they were not confident with the information they have about FP and almost all reported that they have been given information about FP. To them, FP meant using different contraceptive methods in order to have the desired number of children spaced at preferred intervals, involving a couple's consent.

Half of the study participants (N=46) reported that they had used FP in the past, and most of them had done so after they had terminated a pregnancy or given birth. The FP methods known and used by participants included condoms, oral contraceptive pills (OCP), injectables, implants and the natural calendar method. Of the 46 study participants who had reported using modern FP methods, condoms (63%) and OCP (22%) were the most commonly used methods.

#### Box 6: Perceptions of family planning

*“...Interviewer: What do you understand about family planning? What are different types of family planning?”*

*Respondent 1: Determining [the] number of children you want to have in life.*

*Respondent 2: Child spacing.*

*Respondent 3: Is an agreement between father and mother on number of children preferred.*

*Respondent 4: Is that situation of having a child sometime after you had the previous one.*

*Respondent 5: Planning child spacing...”*

**FGD participant responses, 14 to 17-year-old girls**

#### 4.5.1 Challenges to FP use

##### Access

Study participants reported that access to contraceptive methods, like condoms and OCPs, was straightforward, and that they were available in retail shops and small pharmacies. The OCPs are sold at relatively low prices (TSh 500-1,000–US\$ 0.30-0.60) for three cycles in retail shops and pharmacies, and are available free of charge in public health clinics.

However, study participants reported that provider attitudes towards teenagers using FP, and especially unmarried teenagers, made access difficult. Unmarried adolescents mistrusted providers and did not feel they were treated in a private or confidential manner, especially by personnel in general retail shops and pharmacies. Study participants reported feeling insecure when buying their chosen FP method because they could be seen by anyone in the shop. Nurses working at public health clinics may have been in the community for a long time and know most of the people in the village, so study participants felt it was

very likely that they would report back to their parents (mothers in particular) if they tried to access FP.

### **Information**

While study participants claimed to have information about FP, there were still many challenges to accessing and using FP for teenage girls. Participants revealed a poor understanding of the disadvantages of FP. Among non-users, many believed that modern FP methods were unhealthy because they cause complications and side effects. Girls received information on FP from their friends and other family members, particularly mothers and sisters, rather than from service providers. Marie Stopes was only mentioned by one study participant as having conducted FP sensitisation among young people in Arusha over two years ago.



## 5. Discussion

**This study's findings reveal that fears of stigma in relation to sexual activity and unplanned pregnancy far outweigh teenage girls' consideration of the risks in undergoing any type of abortion. Girls fear four major impacts when they have an unplanned pregnancy:**

1. Losing the trust and love of their families
2. Destroying their family's reputation
3. Losing their opportunity of an education, and
4. Being prosecuted, and possibly jailed, for having an abortion.

These fears, coupled with structural forces including general poverty and lack of access to cash for emergencies, influence young women towards clandestine abortions in unsafe places by untrained providers. They face the risk of severe complications, even death, as a result.

In summary, study participants undertook a 'risk-benefit' decision of privacy over quality of care. A similar risk-benefit calculation affects the use of FP: girls will face the risks of pregnancy and the health risks associated with unsafe abortion, rather than the reputational and perceived health risks of accessing FP services.

Girls are also fearful of accessing PAC services despite these being legal in Tanzania. Teenage girls' deaths resulting from unsafe abortions are therefore not only due to a lack of services, but are also related to fears associated with accessing PAC services. Different types of interventions to address girls' fears may help them to avoid the risks associated with unsafe abortion, and also help them to access safe and legal PAC services.

The findings from this study highlight poor knowledge about SRH among teenage girls. SRH communication strategies should be developed to target girls and young women specifically and to address the information and knowledge gap. These communication strategies should cover SRH rights, the legality of PAC services and the low cost (or free availability) and use of modern FP methods.

Use of FP among young women in Tanzania does not match their pregnancy prevention needs resulting in high unmet need for FP. This study showed that sexual activity is often sporadic and unpredictable, and that pregnancy may result from a girl's first sexual encounter, which makes pregnancy prevention particularly challenging. Low uptake, inconsistent use and discontinuation of short-term FP methods such as condoms among teenage girls are reportedly high in Africa. Other studies suggest that the use of an implant, rather than oral or injectable contraceptives, could have a big impact on unintended pregnancy and its consequences in this age group. Increasing reproductive health and FP service uptake among young unmarried women, for whom the health risks and consequences of unplanned pregnancy are of particular concern, will require the provision of more targeted promotion of life skills support and access to youth-friendly FP services for adolescents.

Information should also be provided to boys and men to promote responsible decision-making in their sexual relationships, especially in parts of Africa where cross-generational sexual relationships are reportedly very common and where the male partner often has control over FP use<sup>xiv</sup>. Through appropriate channels, the risks of unsafe abortion and the availability and legality of PAC services should be made clear to teenage girls and their prospective male partners. Teenage girls specifically should be provided with information about the prevalence of unsafe abortions in their own community and how to recognise unsafe abortion providers. Helping girls to develop an 'emergency plan' and build trusted referral networks would help to empower girls in this respect.

Girls' fears around abortion are deeply rooted in community social norms in Tanzania, which expect that a young girl will not have a sexual relationship before marriage. Sexual activities in these settings are constrained by clear norms of abstinence among school pupils, female sexual respectability and taboos around the discussion of sex. Young people appear to manage these contradictions by concealing their sexual relationships<sup>xv, xvi</sup>. This almost certainly contributes to the short duration of relationships and the high levels of partner change, and is in line with concealed clandestine abortion and fears of seeking PAC services.

Interventions that aim to reduce unsafe abortion among teenage girls should consider targeting the social context that influences the clandestine nature of abortion and barriers to accessing PAC services. Community engagement should be placed at the heart of such interventions, focusing on key gatekeepers such as parents, religious leaders, health workers, special community groups and known unsafe abortion providers. Gatekeepers are traditionally seen as providing protection to the younger generation. Information provided to these gatekeepers should include both the magnitude and associated risks of unsafe abortions in their communities. Advocacy is needed to engage gatekeepers in communication strategies that protect and support teenage girls.

Further research is needed to understand what gatekeepers know about the meaning, availability, access, use and legality of PAC in order to develop targeted messages for them. In most cases, female family members reportedly hid information about unintended pregnancies and abortion from men, serving to reinforce men's perceptions of very unrealistic social norms. It would therefore be worth trying to address some of the social norms around unintended pregnancy and use of PAC services, especially for teenage girls.

Private and public health facilities should be encouraged to review costs to ensure that the price of PAC is not a barrier to teenage girls who want to access these services. A voucher scheme might be a potential opportunity to respond to this challenge of cash flow among teenage girls. Studies in Nicaragua and Kenya highlight significantly higher use of adolescent SRH services among recipients of vouchers than among non-recipients. Voucher schemes for subsidised or free SRH services for young people, with the aim of encouraging uptake in both private and public sectors, give adolescents a choice of services so that they can pick the providers they feel most comfortable with without facing the obstacle of cost. Community-based mobilisers and other community-based providers such as quacks, TBAs, pharmacists and other preferred providers could be used as agents to distribute vouchers ensuring that girls seeking subsidised PAC services receive what is required for safe and comprehensive reproductive healthcare.

The availability of abortion-inducing Misoprostol drugs in the pharmaceutical market in Tanzania increases access to abortion for young women, alongside other abortifacients that have been highlighted in the study. Further studies should be conducted to understand the knowledge, attitudes and practices in relation to its use and availability in the Tanzanian context.

Teenage girls are greatly influenced by their peers' advice and support (including economic) about whether to have an abortion and the choice of method and provider. Improving outreach to peer groups and tapping into girls' networks both in and out of schools holds strong potential for reaching this at-risk population. Literature suggests that peer education is most effective as a component of wider interventions targeting the knowledge and behaviour of peers and their social networks. Peers may act as counsellors, condom distributors and they may provide referrals to formal health services.<sup>xviii</sup> Peer education could be crucial for transmitting messages related to contraception as a means of preventing unplanned pregnancies and also about PAC service availability. They could provide timely referrals and support their peers when they face complications related to unsafe abortion.

Government and non-governmental agencies working with community-based health volunteers should harness their ability to reach younger populations. Training should include the realities of adolescents' SRH experiences, such as the advantages and disadvantages of different FP methods, prevalence of unintended teenage pregnancies in their communities, prevalence of deaths and complications as a result of unsafe abortions, and the importance of referring teenage girls to trained PAC providers for those who may experience complications as a result of unsafe abortion.

Building on the safe motherhood strategy in Tanzania that discourages TBAs from attempting deliveries, agencies should develop ways of working with community abortion providers to be advocates, rather than practising clinicians, so as to discourage provision of abortion services in their homes or other clandestine locations. Through dedicated training, TBAs, traditional practitioners, quacks and other easily accessible and preferred abortion providers in the

communities can be transformed into referral agents for PAC services, even in a restricted environment like Tanzania.

Under Tanzanian law, PAC services are legal. However, for the majority of study participants, it was unclear whether a girl or woman could be prosecuted for pregnancy termination if they accessed PAC after an unsafe abortion. Clarity is also needed on the conditions under which abortion is legal.



## 6. Conclusion

**The sexual and reproductive health needs of teenage girls in Tanzania are strongly influenced by the prevalent social norms, which lead to fear of accessing life-saving PAC interventions after experiencing unsafe abortions. Provision of generalised services alone is not sufficient to meet these needs; instead targeted services are needed for this specific age group, including PAC for teenage girls who are most at risk from unplanned pregnancies.**

These targeted services should include reduced prices for PAC services, as well as information that will help teenage girls to use modern FP methods and identify and avoid unsafe abortion providers. Parents, religious leaders, elders in the community and law enforcement agencies should all be targeted with information about the high number of deaths as a result of unsafe abortion and the legality of PAC across Tanzania.

This will help to reduce Tanzania's unacceptably high maternal mortality ratio of 454 deaths for every 100,000 live births.<sup>iv</sup>

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