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BARRIERS TO ACCESS REPRODUCTIVE HEALTHCARE FOR PREGNANT ADOLESCENT GIRLS: A QUALITATIVE STUDY IN TANZANIA

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Abstract

Aims—In Tanzania, approximately 25% of adolescents give birth and 50% more become sexually active during adolescence. We hypothesised that reproductive health education and services for adolescent girls are inaccessible and conducted this study to gain insights into their perceptions of sexually-transmitted infections (STIs) and barriers to reproductive health service utilisation in rural Mwanza, Tanzania.

Methods—We conducted nine focus group among pregnant adolescents aged 15–20 years. Data was transcribed, translated, and coded for relevant themes using NVivo10 software for qualitative data analysis.

Results—Most participants were aware of the dangers of STIs to themselves and their unborn babies, but did not perceive themselves as at risk of acquiring STIs. They viewed condoms as ineffective for preventing STIs and pregnancies and unnecessary for those in committed relationships. Stigma, and long waiting times and lack of privacy in the clinics discouraged young females from seeking reproductive healthcare.

Conclusion—Reproductive healthcare for adolescent girls who are not pregnant is practically nonexistent in Tanzania. Healthcare access for pregnant young women is also limited. Targeted changes to increase clinic accessibility and to provide reproductive health education to all rather than only pregnant women have the potential to address these gaps.

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Keywords

adolescent; pregnancy; reproductive health; sexually transmitted disease; Mwanza

BACKGROUND

In Tanzania,12% of girls become sexually active before 15 years of age and over 50% commence sexual activity during between the ages of 13 and 20 years (1,2). By age 19, one quarter of young women are pregnant or have already given birth (2,3). Early sexual activity is more common among less-educated women, particularly those in rural settings, and Tanzanian law permits marriage over age 12 with parental approval and does not prohibit sex with girls older than 14 years (1–5). When early sexual activity leads to early motherhood, this often limits women's opportunities to pursue better education, employment and income and, ultimately, to have control over their lives (3). Once pregnant, young females are more vulnerable to health complications including HIV, sexually-transmitted infections (STIs), high-risk births, anaemia, maternal malnutrition and development of obstetric fistulae than pregnant adult women (6–10).

Improving reproductive healthcare through provision of youth-friendly services has been a priority of the Tanzanian Ministry of Health since 2001 (11,12), with recommendations that local health management teams should introduce youth-friendly reproductive healthcare in their plans of operations and integrate youth-friendly reproductive health services into public health facilities. The Ministry of Health also recommends supporting all young people's access to reproductive health information and services and increasing collaboration among governmental, non-governmental, and private organizations in promoting youth friendly services (11). Specific recommendations include: setting a separate space or special times for young clients, ensuring adequate space and sufficient privacy, and provision of educational material on site.

Prior research in northwest Tanzania has demonstrated both the high prevalence of, and severe knowledge gap regarding, STIs in pregnant young females living in the region. A study from 2004 demonstrated marked deficits in adolescents' understanding of STIs (13) and our recent work in 2012 showed that adolescents' quantitative knowledge of STIs remains extremely poor (14), suggesting that room for additional improvement is still vast.

To address this gap, we conducted a qualitative study among pregnant adolescent girls in order to explore barriers to reproductive healthcare and to seek simple ways that care and treatment can be improved in this vulnerable population. We aimed to identify obstacles and realistic interventions that could effectively increase care-seeking and retention for this population, thereby having the potential to diminish both maternal and child morbidity and mortality.

PATIENTS AND METHODS

Study setting

The study was conducted between March and September 2013 in four rural and semi-rural districts of the Mwanza region (Ilemela, Kwimba, Magu and Misungwi) in northwestern Tanzania. The predominant ethnic group in this region is the Sukuma tribe. The main religion is Christianity, and the principal economic activities are farming and fishing (15). Our previous work in the same area showed that nearly half of pregnant young women had one or more STI, and 99% of the participants had poor knowledge of STIs based on World Health Organization criteria (16).

Study design

We conducted a qualitative study in which we invited pregnant girls aged 15 to 20 years to participate in small, private focus group discussions that were led by the female principal investigator (AH). In this region, girls do not typically present for antenatal care until approximately 6 months of pregnancy, and the mean pregnancy age among study participants was approximately 8 months. Therefore, we assumed that the majority of 20-year-olds had become pregnant as adolescents. Moreover, most rural girls in the region do not know their actual birth date but only their birth year, and consider themselves to be 20 years old on January 1 of the year that they will actually turn 20. Therefore, many girls reporting that they were 20 years old between March and September were actually still 19 years old. For both of these reasons, we made the decision to include those reporting that they were 20 years old in this study of adolescent pregnancies.

Discussions focused on the reproductive health knowledge and practices as well as factors hindering access to reproductive health services in young females who are pregnant. Focus group discussions were conducted until the data saturation was reached. Participants were approached during their routine local antenatal clinic visits. The number of participants in the discussion group depended on the number of willing adolescents available at clinic on the interview day.

Data collection

Discussions were conducted in Kiswahili, the language in which all study participants were fluent, and were led by the principal investigator with the assistance of two other native Kiswahili speakers. A structured list of open-ended questions (Appendix 1) was used during the interviews. The interviewer had freedom to deviate from the structured questions and also used a set of probes to facilitate discussion. Discussions lasted for approximately 45 to 60 minutes, and at the end of discussions participants had an opportunity to receive one-on-one consultation with a specialist obstetrician/gynecologist who was a member of the study team.

All discussions were audiotaped using a digital audio-recorder and transcribed into Microsoft Word. Data were subsequently translated into English by a professional translation service in Mwanza, Tanzania. English transcripts were imported into NVivo10 software (QSR International, Doncaster, Australia) for further qualitative analysis.

Data Analysis

We performed a thematic analysis using interpretative phenomenology to explore participants' perspectives on topics related to young females reproductive healthcare (17). The goal of this analytical method is to explore individuals' personal perspectives on an issue rather than to describe the issue objectively (17). Our initial analysis involved a thorough reading of all transcripts by study investigators to determine prevailing explicit and implicit themes. Subsequently, two members of the study team independently coded each interview. Coding was compared and differences were discussed until consensus was reached. Codes were then developed into more conceptual categories and key themes were identified. Participants' direct statements were selected to illustrate these themes. Themes were subsequently presented to the entire study team. Only minor discrepancies were noted, and these were resolved by a group consensus.

Ethical considerations

Ethical approvals were granted by the research ethics committees at Bugando Medical Centre, the National Institute for Medical Research in Tanzania, and Weill Cornell Medical College. In order to participate in this study, girls aged 18 and above provided written informed consent. Those younger than 18 provided assent and their parent/guardian provided consent.

RESULTS

Characteristics of respondents

A total of 49 participants were interviewed in 9 focus group discussions. None of the interviewees was formally employed. Only two young women were in formalized legal marriages, while 40 (82%) reported that they were living with their partners/boyfriends. The remaining seven reported that they were either single or were not living with their partners. While nineteen participants (39%) were attending for their first pregnancy, the majority (30, 61%) were attending for the second pregnancy or above.

STI knowledge, practices and misconceptions

Participants in all groups identified STIs as being among the serious health problems faced by pregnant women. Syphilis, gonorrhoea and HIV/AIDS were mentioned as STIs by all groups, and most were aware that STIs can be transmitted from mother to unborn child and can cause miscarriages or stillbirths. Those who had already been pregnant at least once before tended to have more knowledge, and attributed this knowledge to teaching offered by nurses at antenatal clinics:

> "Frankly speaking… we depend on what the nurses tell us when we come to clinic." (20 years, fourth pregnancy)

> "They (nurses) tell us everything (about reproductive health), and if you want to know more you can ask questions and they answer." (19 years, first pregnancy)

In spite of acceptable knowledge about consequences of STIs, most participants did not perceive themselves as at risk of acquiring STIs. In fact, many were confident that they were not at any risk of STIs or HIV because they had previously tested negative for these infections:

> "Any relationship puts you into danger, especially if your man goes out, but once you have tested and you are negative, you are safe." (20 years, third pregnancy)

> "I have tested for HIV and STIs three times … so I think I am safe… If I was to get the diseases I would have been positive already." (19 years, third pregnancy)

Condom use

Many participants perceived condoms as ineffective for preventing STIs and unnecessary for those in committed relationships:

> "Myself I do not trust [condoms]. I know people who are using them and they are HIV positive. I have never used them… I am in this relationship for four years, with the same man, though I cannot say that I trust him completely but I am still negative." (20 years, second pregnancy)

> "I don't think they do [offer any protection against STIs].I don't trust them, no matter how they try to convince us, they are for promiscuous women, those who go out with many men. Why use condoms if you are with one man only?" (18 years, second pregnancy)

No participant in any of the nine groups mentioned the usefulness of condoms for pregnancy prevention:

> Principal Investigator: "What about child spacing? Do you want to use condoms to plan when to get children and when not to?"

> Study participant: "You do that with condoms?? I don't think so!!" (20 years, second pregnancy)

Moreover, women in all groups asserted that their partners would not agree to condom use:

> "Many men get married in order to enjoy sex without condoms, condoms are being used before marriage, after marriage men always say that you should trust one another, even if he goes out with other women he will still want you to trust him." (17 years, first pregnancy)

> "If you want to be abused by your husband….just tell him about condoms." (18 years, first pregnancy)

Several participants suggested persuading their men to use condoms for relationships outside of marriage:

> "Some risks [of contacting STIs] exist, that's why I think that it is good to persuade our men, even if they do not want to use them with their wives, they should use [condoms] when they go out." (20 years, third pregnancy)

Problems with reproductive health services

All groups agreed that the only place where young women can get sexual and reproductive health services is at the antenatal clinics, and that these are intended specifically for pregnant women. They identified three key shortcomings in the current clinic system that discourages them from seeking care: lack of privacy, unkind healthcare workers, and long waiting times.

Lack of privacy—Participants in all nine groups cited lack of privacy as a key factor hindering pregnant young women from seeking reproductive health services. It was clear that they perceived the antenatal clinic as their only healthcare option, but that due to lack of privacy many felt that they could not seek help for their sexually-related problems:

> "You can't be satisfied if there is not even a room for clinic services, they examine you in a hallway where all the others are seeing, there is no chance to express yourself if you have any problem… this clinic is only useful when you do not have serious problems." (17 years, first pregnancy)

> "I would like to come to a place where I could have at least… have some privacy and I can speak openly and freely… They teach us in groups and they expect you to ask questions about your problems in a group… this is impossible… there is no privacy; the only privacy you can get is when you are HIV positive… They will call you alone in the room and tell you." (20 years, third pregnancy)

> "The issues of sexual health and pregnancy are intimate, sometimes you feel shy to ask questions during these teachings… For example this is my first pregnancy and there are many things I would like to know, but the clinic is always overcrowded and there are no chances to ask private questions." (19 years, first pregnancy)

These young women also explained that their families and communities often feel that it is their right to know the young females' health issues and this prevents many from seeking care:

> "Sometimes our relatives and neighbors can just decide to come to clinic so that they can find out what is wrong with you… they even go and ask nurses about your problems… because they are older than you; they feel that they have the right to get information about you." (20 years, third pregnancy)

> "I was hesitant, I came for the first time and my neighbors- two ladies were here, and these ladies gossip a lot, it is a small village and they will tell everyone about your problems, and I knew I have some problems… I didn't want them to find out about my problems. You know …. They might ask the nurse about my results, so I didn't do the tests and I didn't come to clinic until when I was in labor, and I delivered a dead baby." (20 years, second pregnancy)

Unkind healthcare workers—Another commonly-mentioned obstacle to reproductive healthcare was the attitudes of healthcare workers. Many young female described experiences in which healthcare workers were harsh, judgmental, or not trustworthy to keep their health information private:

> "Some do fear, the nurses… are very harsh. They will tease you, you are such a small girl and you are pregnant! But sometimes you didn't want to get married and you didn't even want to become pregnant." (19 years, third pregnancy)

> "When you come late… they (nurses) don't consider that you have come from far to get the services… Sometimes they can refuse to examine you because you have come late, but imagine, you have walked a long distance, you have reached here, they are still here but they tell you 'No services, come tomorrow'… If you do not have serious problems you will not bother to come again." (19 years, third pregnancy)

Long waiting times

Participants described how spending many hours at the clinic prevented them from accomplishing farm work or other essential daily tasks. Long waits also discouraged some young women from seeking care altogether.

> "When you are late here you will not be served, though you can come early, but they can start work late." (20 years, third pregnancy)

> "Sometimes we have to wait for long, since there are few nurses here, they have to finish other things first and then they come to examine us. We are coming because we have to come, and there is nowhere else to go." (18 years, first pregnancy)

Community and cultural issues impeding access to sexual and reproductive health services

Discussions revealed significant cultural barriers that impair young women's' ability to seek care both before and during pregnancy. Many participants explained that, when they became pregnant, they faced relational problems with families, partners and the community. Issues were particularly exacerbated for unmarried adolescents.

Shame/Stigma

Unmarried pregnant adolescents felt ashamed in front of their peers, neighbours, and even relatives and also were afraid to visit health facilities:

> "In my first pregnancy, I was only 14 years and I was still at school, and the man had not yet paid the dowry, so it was shameful for me and my parents… therefore I couldn't attend the clinic, I was not coming out of my parents' house. When I had to go to fetch water I did at night so that people would not see me. In these circumstances you will not be able to come to the clinics no matter what." (20 years, third pregnancy)

> "In my first pregnancy, I didn't want to come to clinic, I was shy. I was young and not married and I was afraid that everyone will laugh at me." (20 years, second pregnancy)

Should adolescent reproductive healthcare be available to girls prior to first pregnancy?

Beliefs that reproductive health services should be offered only to adults and married women were common:

> "Sex is for married couples, and [reproductive health] services should be for couples too." (19 years, second pregnancy)

> "Young girls do not need any sexual education, maybe until they are married." (20 years, second pregnancy)

> "No these [clinics and information sessions] are for adults and married women, we are also told about condoms and the Nyota ya kijani [family planning issues]- these services are not for young and unmarried women." (19 years, third pregnancy)

In contrast, several girls expressed dismay with current norms for adolescent healthcare and suggested that adolescent girls should be taught more about reproductive health:

> "The best service to give to young girls and school girls is to help them abstain from sex… Unfortunately there is nowhere where they can go and be helped." (17 years, first pregnancy)

> "Girls are not told the truth at home, so when they meet experienced suitors [older men], they spoil them [get them pregnant]. Once you are pregnant when you come to clinic is when you hear that there are family planning service, HIV [prevention] and others, and you are being told now that pregnancy in young girls is dangerous while you are already pregnant and possibly you have contacted HIV already." (18 years, second pregnancy)

Of note, responses did not seem to vary by age. When we analyzed data without the comments of girls who reported that they were 20 years old, our findings remained constant.

DISCUSSION

Although promoting adolescent health has been a priority of the Tanzanian Ministry of Health since 2001 (12), our findings demonstrate that adolescent girls in Mwanza continue to experience difficulties accessing reproductive health services. Even pregnant adolescents who were actively seeking antenatal care at reproductive health centers held misconceptions about STIs, did not understand contraception, and highlighted many health systems issues and community norms that obstruct reproductive healthcare in this vulnerable population. Given that once a young girl becomes pregnant in much of sub-Saharan Africa she must forego her education, career, and independence and her risk for mortality increases (1), improving access to reproductive health services for adolescent girls and women is an imperative women's rights issue.

Our findings suggest numerous concrete ways that key barriers to healthcare within the health system can be addressed. Participants in our study consistently noted factors such as lack of privacy, long waiting hours and unkind healthcare workers as hindrances to their utilisation of services. These findings support and extend those of previous studies, which have identified that both married and unmarried women are highly sensitive to healthcare providers' attitudes and are easily discouraged from seeking care (3,9,11,18–21). Our study participants also expressed their need for private conversations with healthcare workers, which is currently not possible during routine antenatal care. Special attention is particularly needed for adolescents who are pregnant since they are more likely to have STIs, to fear HIV testing, and to require more explanation of health issues than older women (6,21). These are major challenges in overburdened primary care clinics in which human resources are scarce. Our discussions with young women suggest that creativity and flexibility at individual clinics may allow needs of young women to be met more effectively. For example, clinics could dedicate one nurse for several designated hours per week to providing prioritised care for adolescents, with the recognition that this will decrease the overall burden of work at the clinic by preventing pregnancies and STIs and by providing adolescents with otherwise-inaccessible knowledge. Nurses would need specialized training in adolescent-friendly services but other costs could be minimal.

Moreover, our work reveals that extending adolescent healthcare beyond antenatal clinics is imperative. Previous studies in Mwanza have shown that many adolescents do not perceive themselves as needing sexual health services (13,19).Our findings suggest that this is because girls have been socialised to believe that reproductive health services are for pregnant and married women only. The majority of young women in this study identified major problems with adolescent reproductive healthcare but, despite direct questioning, very few even expressed the desire for reproductive health services prior to pregnancy. Our study participants explained that they did not learn about contraception until they were already pregnant, and that the only message that is socially acceptable to teach schoolgirls and unmarried adolescents is abstinence. Consistent with other studies, they also thought their parents would not want them to learn about reproductive health issues in school because this could encourage them to be promiscuous (6,22–24). These community concepts run counter to the WHO recommendations that adolescents should be provided with information, not only on delaying the start of sexual activity, but also on contraception, STIs and how to access services(6).

Within the antenatal clinic setting we noted significant room for improvement in pregnant girls' knowledge of STIs. Although aware of existence and dangers of STIs to pregnant women and their unborn babies, most of our study participants held misconceptions about the risks of STI transmission, and how to prevent STIs—arguably more important than dealing with the consequences once they become infected. This is surprising considering that these women were attending antenatal clinics, where they received regular teaching on various reproductive and child health issues including STIs. Almost all participants in this study did not believe in the effectiveness of condoms for either STI or pregnancy prevention. Low condom use has also been reported by others throughout Tanzania and sub-Saharan Africa in general, with young girls frequently reporting not using condoms and, after getting pregnant, expecting their boyfriends to marry them (19,25,26). This situation is similar to our prior findings that many girls reported sexual situations that put them at high risk for STIs and HIV such as being in a polygamous relationship or their partners spending significant time travelling (unpublished data). The same girls thought that once they had tested negative for HIV and syphilis they would remain protected from contracting STIs or HIV in the future. Our study supports findings of a systematic review of risky behavior among pregnant adolescents, which reported that sexual risk behavior does not decrease once an adolescent becomes pregnant (27). Thus there remains an urgent need to bolster outreach and education for this population at high risk for HIV and STIs (27).

In any culture, the healthcare-seeking behavior of pregnant adolescents is influenced by a set of factors operating at individual, family, school, community and societal levels (6,28). The

WHO states that the failure of family and community to convince adolescents of the value of antenatal care reflects that culture's social, economic and political barriers to pregnant adolescents' access to antenatal care (6). Our study participants exemplified this problem, admitting that either they themselves or their peers were not willing to seek antenatal care. Unmarried study participants felt ashamed to seek antenatal care in front of the community, and similar stigma both for unmarried girls and their parents has been reported by others (1,6).Other studies, and one girl's story in our study, document that shame leading to lack of seeking antenatal care can lead to poor pregnancy outcomes (29,30). We urge advocacy at the community level, with a major focus on partners and parents, in order to protect the rights of both pregnant and non-pregnant young women and to increase their access to reproductive health services.

CONCLUSIONS AND RECOMMENDATIONS

The high prevalence of unwanted pregnancies and STIs is exacerbated by adolescents' inability to access quality, youth-friendly reproductive health information and care in Tanzania and much of sub-Saharan Africa. Our work highlights the urgency of tailoring antenatal care programs in Tanzania to meet the needs of adolescents. It also suggests the potential utility of community-based interventions in order to improve access to health education for girls prior to pregnancy, and of exploring the psychosocial and psychiatric ramifications of early pregnancy as well. Current studies are ongoing in order to document clinic-based and community-based interventions that are most effective in promoting care-seeking and improving care overall for this vulnerable population.

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APPENDIX 1: Focus Group Discussion Questions

1. People face many different health problems. What are the greatest problems that pregnant women/girls here face?
2. Do you think that sexually-transmitted infections are common in adolescents, or not? Since you are an adolescent, do you think that you are at risk of sexually-transmitted infections?
3. What kinds of sexual relationships do you think contribute most to sexually-transmitted infections and HIV? Can married people get STIs/HIV?
4. What can people do to protect themselves from STIs/HIV?
5. What do you know about condoms? Do you think you would be able to convince your partner to use them? What are some ways that you might be able to do this?
6. What can girls do if they need medical help—for example, if they are pregnant and need prenatal care or if they have symptoms that could be an STI?
7. Why do you think adolescent girls who are pregnant may not come to clinic for prenatal care? What are some ways we could improve the clinic to help more young pregnant girls receive prenatal care?
8. Can you tell me if there are places and people you know of which young people like yourself are able to visit and talk to, to find out STIs and sexual and reproductive health in general?

KEY NOTES

- This work documents major hindrances in adolescents' ability to access reproductive health services in Tanzania.
- We report that reproductive healthcare for adolescent females who are not pregnant is practically nonexistent, and that even for pregnant young women, major barriers in the current system impair healthcare access.
- Our findings suggest small, targeted changes that can be made to the clinic system in order to increase clinic accessibility in this vulnerable population.

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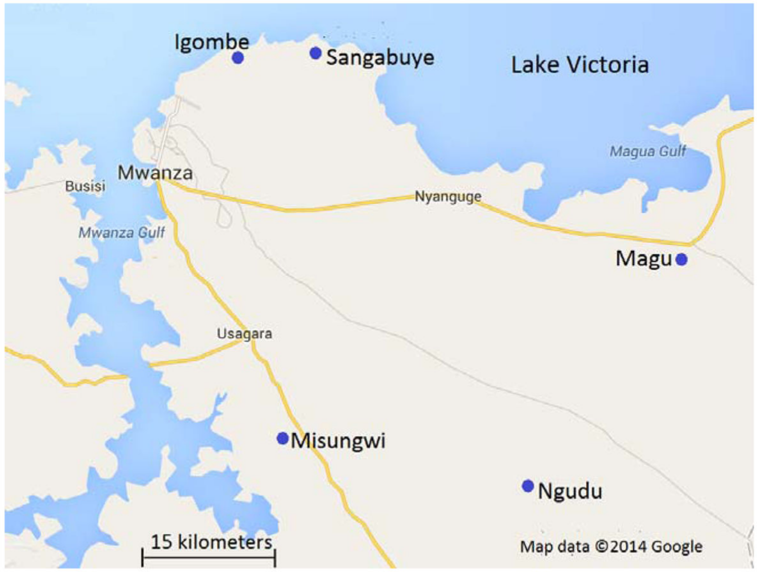

Figure 1.

Map of the Mwanza region showing Mwanza city and the surrounding rural study sites.