

Experiences of Girls Dropping Out of Secondary School due to Unplanned Pregnancies in Southern Tanzania

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Abstract: *The study assessed the experiences of girls who dropped out of secondary schools due to pregnancy to inform efforts to address challenges associated with school age pregnancies. A cross-sectional survey using structured questions involved 165 secondary schoolgirls who had dropped out of school due to pregnancy in Rungwe district, Mbeya Region Tanzania. Descriptive statistics were used to summarise the data. Results shows that by the time girls got pregnant about 67.3% had more than three sexual partners. The main motive for engaging in their first sexual experience was the need for money (51.6%). Awareness of contraceptive methods and sexually transmitted diseases was fairly low. Only 14.5% of the girls knew abstinence as best method of preventing pregnancy. Almost half (46.7%) were chased away from home after being known were pregnant and 49.1% of their male partners denied the responsibility. Only 40% started antenatal clinic during their first trimester as recommended by the World Health Organisation. The majority (69.1%) experienced food problems during pregnancy and the situation worsened after delivery. Girls who get pregnant while school in Tanzania experience severe challenges. However, the solution to their problems lies within the capacity of the parents, the community and the school system.*

Keywords: Pregnancy, Adolescent, School, dropout, girls, rural, Tanzania

1. Introduction

Adolescent pregnancy and teenage motherhood are a global public health problem especially in developing countries. Annually, about 16 million adolescents aged 15 - 19 years and 2.5 million under-15 girls become pregnant globally (1). Most of these girls are from Sub-Saharan African (SSA) countries (2) where about half of all the teenage girls become pregnant before reaching their twentieth birthday (3). Population projections show that SSA would experience the highest proportion of teenage pregnancies by 2030 (3).

In Tanzania, just like in other SSA countries (4-6), teenage pregnancy is a big problem among adolescent girls and constitutes a significant national public health challenge (National Road Map Strategic Plan, 2016). In fact, country ranks 17th among countries with the highest adolescent fertility rate in Africa (7). The adolescent fertility rate in the country increased from 116 to 132 between 2010 and 2015 and by 2016, 27 per cent of Tanzanian girls aged between 15 and 19 years were mothers or pregnant for the first time. This statistic represents an increase of 4% from what was reported in 2010 (8). Teenage girls in rural areas are reported to begin childbearing earlier than their urban counterparts as 32 per cent of rural teenagers had a live birth or were pregnant, compared to 19 per cent of urban teenagers in 2016 (7, 8).

Childbearing during the teenage exposes adolescent girls to radical changes in their lives and interferes with their right to safe and successful transition into adulthood. Apart from a myriad of pregnancy-related health complications (9-11), teenage pregnancy often has socio-economic consequences

for the beleaguered adolescents, especially when it comes to education attainment. Getting pregnant while in school in Tanzania amounts to expulsion from the school system with no provision for return (12) after delivery. Moreover, school rules against pregnancy condemn girls who conceive before completing secondary education to a lifecycle of abject poverty (13). It is estimated that less than a third of the girls who complete primary schools complete the initial four years of secondary school education (14). According to the Tanzania Secondary Education Quality Improvement Programme, about 5,500 schoolgirls were unable to continue with secondary education due to pregnancy and young motherhood in 2017 (15). This statistic, in fact, fails to paint the real picture as some pregnant schoolgirls and their parents do not reveal information on their pregnancy to the school and, consequently, such pregnant girls just appear under the blanket 'label' school dropouts in official records.

Moreover, limited education attainment reduces the girls' opportunities for developing professional and vocational skills in addition to limiting their chances of getting gainful well-paying employment (3). Also, adolescent girls who get pregnant while in school reportedly receive low emotional support and experience stigma and discrimination (12, 13) get deserted by the man responsible for the pregnancy and experience food problems (16). Furthermore, they end up fairly at high risk of becoming single parents (17) for the rest of their lives. They also tend to have limited access to healthcare services (18, 19) and experience difficulties in accessing financial, moral and material support from both their parents and the men responsible for their pregnancies (20).

Extant literature documents risks for pregnancy among adolescent schoolgirls to include sexual exploitation and abuse (21, 22), inadequate information on sexuality and reproduction, and lack of access to and non-use of contraception (23-27). It also shows that limited social and financial support to the schoolgirls (25, 26), girls' curiosity, peer pressure and the cultural norms that encourage early sexual experimentation (25, 28, 29) conspire to make schoolgirls vulnerable to unplanned teenage pregnancies. Furthermore, long distances to school, especially in rural areas with no reliable transport (30) and limited school dormitories to accommodate female students contribute to the school-age pregnancy challenges (31, 32). Other reasons behind such teenage pregnancies include lack of parental guidance and counselling (32) and lack of comprehensive sexual education, both in school and at home (23, 27). Generally, it appears parents play a crucial role in sex socialisation of children up to just before puberty after which many parents and the school system shy away from what adolescents need as they go through puberty and related biological and social changes. Although the literature available provides us with useful information on factors contributing to school teenage pregnancy, little is known about the experiences of these girls just before the pregnancy, the time they learned they are pregnant and soon after their delivery in Tanzania. The current study attempted to fill this research gap.

2. Methods

This study involved girls who had dropped out of secondary school due to pregnancy in Rungwe District, Mbeya Region in Southern Tanzania between 2013 and 2018. Names of these girls and their corresponding schools were obtained from the district authorities. The schools were visited and requested for information on the villages where parents of the girls lived. Schools usually keep information on the location of parents of each of their students. Each of the parents or guardians of the identified girls were visited using the contact and addresses obtained from the school records and the respective girls contacted. Each parent was informed about the study and requested for the whereabouts of the girl. Moreover, parental permission was obtained to involve girls aged under 18 years in the study before the permission was sought from the girls themselves.

Data was collected using structured interviews which, apart from obtaining information on their demographic characteristics, also generated information on the girls' sexual experiences and the living conditions before, during and after pregnancy.

Ethical approval for the study was obtained from the Muhimbili University of Health and Allied Sciences (MUHAS) Ethical Review Board (DA/287/298/01A). This approval facilitated obtaining of the clearance and permission to conduct the study from the administrative authorities of Mbeya Region and Rungwe District, respectively. Each study participant received detailed information on the nature of the study and written informed consent was obtained. For the participants aged below 18 years consent was requested from their parents before the girls themselves provided assent. Before providing assent

the girls were informed in detail about the study and assured of their right to make decisions on either to participate in the study or not and that any decision they make will be the final decision and it will not affect them in anyway.

The data collected data was then processed and analysed using the Statistical Package and Service Solutions (SPSS) version 22 (IBM Corp., Armonk, NY, USA). The researchers proceeded to this step after obtaining the completeness and consistency of the information. Finally, the results were summarised and presented in textual and tabular formats.

3. Results

3.1 Socio-demographic characteristics of the study respondents

A total of 165 girls were recruited to participate in the study out of 174 girls that were initially identified from the district authorities' records. The remaining nine girls could not be traced because they either had moved out of the district or had changed their addresses. Their age ranged from 14 to 25 years with a median age of 18 years. More than a quota (26.8%) of these girls were aged 15 years or younger at the time they had dropped out of school and only 8.5% were aged above 18 years. Almost two-thirds (63%) became pregnant when they were in their third year of secondary school or earlier.

About a quarter of these girls (26.1%) had single parents, and 37.6% had married parents. Almost a fifth (17.0%) of the girls had separated parents and the rest had one or both parents deceased. The level of education of parents as well as their occupational status is as summarised in tables 1 and 2, respectively:

Table 1: Parents' Education Level

Level of Education	Mother % (n)	Father % (n)
No formal Education	6.7 (11)	4.8 (8)
Primary Education	32.7 (54)	30.9 (51)
Secondary Education	27.9 (46)	27.9 (46)
Post-Secondary Education	27.9 (46)	27.3 (45)
Do not know	4.8 (8)	9.1 (15)

Generally, a third of both parents had primary education and slightly one out of four had secondary or post-secondary education level. Fairly few parents were illiterate and girls who could not remember the level of education of their fathers were more than those with similar responses on their mothers.

Table 2: Occupation of Parents

Type of occupation	Mother % (n)	Father % (n)
Peasant farmer	27.3 (45)	27.3 (45)
Government employee	29.7 (49)	26.1 (43)
Private employed	9.7 (16)	9.1 (15)
Business	21.8 (36)	19.4 (32)
Others	11.5 (19)	18.1 (30)

The predominant occupation of their mothers was government employment whereas their fathers were mainly peasant farmers.

By the time they conceived, almost one-third (28.5%) of the girls was living in rented facilities and 26.1% was either staying at home or in school hostels respectively. The rest were staying with other relatives or friends.

Transport to and from the school was one of the major challenges they experienced. The distance covered varied from one to eight kilometres. Many of them (60.0%) reported to cover long distances on foot at least five kilometres to and from the school. Others rode to school by bicycle (19.2%) or “boda-boda” (16.8%) (Motorcycles commonly used for private transport in many parts of the country). Only a few (4%) reported to use public transport when going or returning from school.

Sex debut and Sexual practices

Behaviours, which potentially exposed the study participants to pregnancy, were fairly common. More than a third (34.5%) had their first sexual experience before they were 15 years old. By the time they got pregnant more than two-thirds (67.3%) had more than three sexual partners. However, awareness of pregnancy prevention methods was fairly low. When asked about the best ways of avoiding pregnancy, only a few (14.5%) were aware that abstinence was the best method for preventing pregnancy among girls of their age.

Misconceptions on the possibility of getting pregnant were fairly common. More than a half (53.3%) of the girls believed it was possible for a girl to get pregnant through mutual masturbation and less than half (49.9%) knew that it was possible for a girl to get pregnant during the first sexual experience. Some (15.2%) believed that one can avoid pregnancy by taking tea without sugar or milk soon after sex.

Pregnancy experience

All the study participants were expelled from the school system soon after their pregnancy was confirmed. The pregnancies were detected through various means. Some (38.8%) were suspected by their teachers and almost a third (32.7%) suspected they were pregnant after missing their period. Others were found pregnant either after being tested (17%), being suspected by parents (6.7%) or by friends (4.8%).

When asked about the motive for the relationship that led to the pregnancy, 51.6% said they wanted money from the sexual liaison whereas 25.5% said they their sexual partners had promised them marriage. Some (13.3%) engaged in sex for pleasure whereas a few (6.1%) did so because the sexual partners had promised them gifts. Only very few (3.6%) reported being victims of rape. Partners responsible for the pregnancies were mainly “boda-boda” raiders (29.7%) or fellow students (23%). About a fifth (20.6%) of the girls conceived from relationships with their boyfriends. In the meantime, their own teachers accounted for 15.2% of the girls’ pregnancy cases.

Surprisingly, not all the girls informed the partner responsible for the pregnancies. Of those who did (86.7%) only 15% of the partners accepted responsibility for the pregnancy. Furthermore, when the parents found out about

the pregnancy almost half (46.7%) of them chased the girls away from home. Other reactions from the parents’ were either remained silence (1.2%), became angry with the girls (19.4%) punished them physically (15.2%) or scolded them (17.6%).

Many of these girls did not start antenatal care during the first trimester as recommended by the World Health Organisation (WHO) and adopted by the Tanzania government policies on maternal and childcare. Only 40% attended clinic during the first three months. Many of them (43.7%) started clinic attendance after 5 months.

Overall, social support to attend clinic appeared to be weak. Only 17.6% of the respondents were satisfied with the support they received to go to the clinic. More than half (55.8%) said they got little help and 26.7% of them did not get any assistance at all.

Sources of support for basic needs

Mothers were the main source of support for the girls before they conceived, during the pregnancy, and after delivery as summarised in table 3. However, this support declined from 49.1% before pregnancy to 40.6% after delivery. Fathers played an insignificant role in supporting them for their basic needs, especially during pregnancy with only 1.8% of the respondents saying they had received support from their fathers. The role of the man responsible for the pregnancy in supporting the girls was also fairly weak, particularly during pregnancy with only 10.3% supporting the girls with basic needs.

Table 3: Support before, during and after pregnancy

Source of support	Before pregnancy % (n)	During pregnancy % (n)	After pregnancy % (n)
Both parents	34.5 (57)	24.2 (40)	12.7 (21)
Mother	49.1 (81)	47.3 (78)	40.6 (67)
Father	3.0 (5)	1.8 (3)	3.6 (6)
Other relatives	4.2 (7)	16.4 (27)	13.9 (23)
Man responsible/ boyfriend	13.5 (15)	10.3 (17)	29.1 (48)

Specifically, food was singled out as a problem during pregnancy and after delivery among the girls who took part in the study. More than two-thirds (69.1%) of the girls had food challenges during pregnancy including 42.4% who said they faced severe challenges in accessing food. After delivery, most (93.3%) of the girls had similar problems including 40% who experienced severe challenges. When the food challenges experienced were examined in relation to who the girls stayed with, it emerged that those who stayed with single parents, especially the mother, reported experiencing severe challenges.

4. Discussion

Stern measures are taken against schoolgirls who become pregnant in Tanzania during their primary and secondary schooling. They usually suffer expulsion from the school system (14, 33) whereas the male partner responsible—when prosecuted—is imprisoned for thirty years (34). Despite this severe punishment for both the girl and her partner, pregnancy among schoolgirls is still fairly prevalent in the

country, suggesting that these measures for suppressing sexual behaviours do not have long-term effects and, indeed, might have adverse side-effects (35). In fact, this mode of punishment pays little, if any attention, to the welfare of the baby to be born. The would-be mothers are exposed to the challenges of single parenting at the time when they generally lacked income generating skills (17). Furthermore, in many cases as evidenced in this study they were treated as social outcasts with limited access to major sources of socio-economic support in the community with no guarantees of safety nets. Removing pregnant girls from the school system condemns their opportunities for their further education (16) and employment (3) in addition to increasing risk of severe poverty (17). This type of punishment also puts the baby to-be-born in an environment where she/he will be raised by a mother who has uncertain future and, for quite some, would not have any affection from the absent imprisoned father.

This worrisome scenario calls for alternative measures to control behaviours responsible for school-age pregnancies. Such measures could include improving parenting education on sex socialisation for children, especially as they mature from childhood to adolescence. It should also include strengthening of the reproductive health education syllabus in school particularly on biological maturity and related behavioural changes during adolescence. Sex is one of the basic biological drives such as hunger and thirsty (36). Apparently, the school pregnancy challenges observed have more to do with lack of proper sex socialisation to the girls by key agents of sex socialization including parents, the community, religious leaders, and the school systems.

After all, the girls involved in this study had a fairly low level of knowledge of pregnancy prevention and misconceptions were fairly common. Very few (14.5%) were aware that abstinence is the best method of preventing pregnancy and less than a half (49.9%) knew a girl can get pregnant during first-time sexual intercourse. Similar findings have been reported from studies involving secondary school girls in Ethiopia (37), Kenya (38) and South Africa (39) suggesting weak sex socialisation of girls on sexuality and related outcomes in many African countries. Condom use was the most frequently reported pregnancy prevention method in the study most likely due to its extensive promotion for prevention of HIV infections in the social system.

When girls reach puberty, they are not exposed to what such biological changes mean, and the mechanism for helping them to cope with the resulting biological and social changes (40). In this regard, improved sex and reproductive health education in secondary schools could fill this gap (41). However, reproductive health education is currently taught as part of Biology, Civics and Social Studies with teachers, who are ill-prepared and shy to teach sexuality topics, giving the topic little attention (18, 25, 42). In fact, the current approach to sex and reproductive health education through the school system leaves much of what girls should know as part of their maturation untouched. The situation is further complicated when expected concepts are taught by teachers with limited knowledge, skills and confidence when talking about sexuality topics such as sexual health, types of sexual behaviours and contraceptive use (42). Moreover, teachers

and parents are reported to shy away from sex-related discussions with the adolescent girls and boys due to social and cultural reasons; some of them believe that the adolescents would initiate sexual activities based on what they are taught (43). Parents, neighbours and the community, on the other hand, appear to be doing well in sex socialisation during early childhood (44). Yet, these roles appear to decline as children approach maturity, and the school system—where most of them are expected to be—pays little attention to such roles. This leaves schoolgirls maturing from childhood to adolescence to fend for themselves in knowledge and skills acquisition to fill the yawning gap on sex and their sexuality.

In this study, more than a quarter of the girls had their first sexual experience before they were aged 15 years. Early sexual debut among girls and related consequences pose quite a health challenge in many Sub-Saharan African countries such as Ethiopia (45), Nigeria (46), Ghana, Malawi and Uganda (47). Such behaviours are condemned for exposing young girls to a myriad of negative sexual and reproductive health outcomes, including unwanted pregnancies and poor education outcomes (48), whose lasting effect could extend to adulthood.

The girls in this study had a myriad of challenges which prompted them to indulge in sexual relations as one of their coping mechanisms. Many of them reported transport problems and, as a result, they had to walk long distances to and from school. Some had to look for assistance from “boda-boda” riders who are notorious for luring young girls to sex using their motorcycles as bait (49). Similar findings have also been reported by Watson et al. in Uganda (50).

Mothers of the girls involved in this study generally appeared to be sympathetic with the girls’ plight after being impregnated and provided them with the much-needed support. In the African cultural settings and Tanzanian context, fathers are generally the disciplinarians and primary providers of households (51-53). However, in the current study, male parents played a minimum role in facilitating the accessibility to basic needs for the girls before, during and even after delivery. This appears to be a change from what traditionally is expected to be the fathers’ role in taking care of the children. Similarly, very few male partners responsible for the pregnancies provided social and material support for basic needs, hence suggesting that the intention for engaging in the sexual encounter that led to the pregnancy precluded pregnancy as one of the potential outcomes.

Food, which is an important basic need, was reported to be inadequate by many of the girls before and during the pregnancy as well as after delivery. Paradoxically, the region where this study was conducted is one of the country’s breadbaskets in Tanzania. However, the reasons behind these schoolgirls going hungry in major food growing areas were not explored in this study. Nevertheless, food problems were also reported as one of the serious challenges experienced by pregnant adolescent in rural Uganda (16). It is not surprising, therefore, to find that those children born to adolescent mothers are often malnourished (54). Thus, the shortage of food for pregnant teenage girls has far-reaching

consequences for the growth and development of mother or the foetus due to the competition for the limited intake of nutrients (55). Given the role that nutrition plays in improving adolescent girls' health and that of their offspring (56), there is a need for co-ordinated efforts among parents and the community in general to ensure access to food among adolescents girls for improved maternal health outcomes.

5. Conclusion

Girls who get pregnancy while in school appear to experience a lot of problems before, during and after conception. Most of these challenges could be linked to poor sexuality socialisation by parents, the community and the school system. As such, this study has established an urgent need for interventions aimed to provide effective, sufficient and appropriate sex socialisation for school girls to contain school-age pregnancies rather than continue perpetuating a culture of silence and treating sex topics among adolescents as taboo, hence leaving them to their devices and ever vulnerable to sexual predators and opportunists taking advantage of the naivety of the teenage schoolgirls.

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