Birth preparedness and complication readiness: assessment of perceptions and challenges experienced by pregnant adolescents, in Temeke Municipal Dar Es Salaam, Tanzania

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BIRTH PREPAREDNESS AND COMPLICATION READINESS: ASSESSMENT OF PERCEPTIONS AND CHALLENGES EXPERIENCED BY PREGNANT ADOLESCENT IN TEMEKE MUNICIPAL, DAR ES SALAAM, TANZANIA

By

Pendo Said

A Dissertation Submitted in (Partial) Fulfillment of the Requirements for the Degree of Master of Public Health

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CERTIFICATION

The undersigned certify that they he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences of dissertation entitled: **"Birth preparedness and complication readiness: assessment of perception and challenges experienced by pregnant adolescents in Temeke Municipal, Dar es Salaam Tanzania",** in (partial) fulfilment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

_____

Dr. Tumaini Nyamhanga (PhD)

(Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

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

Signature: ..... **Date:** .....

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DEDICATION

This dissertation report is dedicated to my beloved daughter Blessing Janelle.

ABSTRACT

Background: It is believed that most of poor outcomes of pregnancy are directly related to poor birth preparedness and complications readiness. According to Tanzania Demographic and Health Survey, there is a zonal disparity of knowledge and practice of BP/CR among pregnant mothers. Few studies have specifically focused their attention on BP/CR among adolescent pregnant women. Consequently, little is known on facilitators and challenges to BP/CR among adolescent pregnant women. It is this gap in knowledge this study intended to fill.

Objectives: To explore perception on birth preparedness and complication readiness among pregnant adolescent girls in Temeke district.

Methodology: qualitative method was used where by in-depth Interview were conducted among 18 adolescent pregnant women who were attending antenatal clinic at Mbagala Rangi Tatu hospital. Facility which is located in Temeke district. Data analysis for this study was done by using a thematic approach.

Results: Most participants were of the opinion that antenatal attendance is key to birth preparedness. However, when participants were asked at which age did, they start to attend antenatal clinic, majority started when pregnancy was above 5 months. Moreover, most adolescents had perception that actual preparation for childbirth is literally unaffordable as it requires money which they don't have. Challenges experienced by adolescent mothers were categorized as per ecological theory. At intrapersonal level, pregnant adolescents had emotional challenge which involved negative feelings about her fate as a teenage mother. At the interpersonal level, the pregnant adolescents lacked social support for BP/CR. They reported rejection by their male partners. Likewise, some fathers literally rejected their pregnant daughters and provided minimal support.as they provided very minimal support. At the societal level, stigma associated with teenage pregnancy and poor economic situation impaired BP/CR

Conclusion: The study has shown that pregnant adolescents' perception on birth BP/CR is very low and they have limited social support. In conclusion adolescent girls need to be educated on BP/CR and have support from society and government as well.

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ABBREVIATIONS

ANC	Antenatal Care
BP/CR	Birth Preparedness/ Complications Readiness
HC	Health Centre
IDI	In depth Interview
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
NBS	National Bureau of Statistics
RCH	Reproductive and Child Health
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic and Health Survey
TDHS-MIS	Tanzania Demographic and Health Survey and Malaria Indicator Survey
UN	United Nations
UNFP	United Nations Population Fund
WHO	World Health Organization

DEFINITION OF TERMS

Adolescent: young people between the ages of 10 and 19 years – are often thought of as a healthy group.(World Health Organization, 2009)

Challenge: In the context of this study, perception can be defined as the situation of being faced with something that's need great mental or physical effort. (Cambridge dictionary, March 2016)

Perception: In the context of this study can be define as a belief or opinion held by people. (Cambridge dictionary, March 2016

Birth preparedness and complication readiness (BP/CR): is the process of planning for normal birth and anticipating the actions needed in case of an emergency(JHPIEGO, 2001)

BP/CR matrix: can be dined as the roles (plans/actions) of policymakers, facility managers, care providers, communities, families, and women in ensuring that women and newborns receive timely appropriate and effective care.(Mbuagbaw et al., 2015)

Skilled care provider/attendant: is defined as "an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.(World Health Organization, 2009)

Birth preparedness and complication readiness: a comprehensive strategy aimed at promoting the timely utilization of skilled maternal and neonatal health care.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

The birth of baby is a major reason for celebration around the world. Societies expect women to bear children and honour women for their roles as mothers. Yet in most of the world, pregnancy and childbirth is a dangerous journey(Alexander, 2015). Maternal mortality is unacceptably high. About 830 women die from pregnancy- or childbirth-related complications around the world every day. It was estimated that in 2015, roughly 303 000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented. 99% of all maternal death occurs in developing countries. Maternal mortality is higher in women living in rural areas and among poorer communities. Young adolescents face a higher risk of complication and death as a result of pregnancy than other women (WHO, 2016).

Tanzania has made insufficient progress to attain the ended MDG5 on improving maternal health. According to Tanzania Demographic Health Survey, maternal mortality has increased from 432 to 556 (Tanzania Bureau of Statistics, 2016).

Every pregnant woman is at risk of sudden death, unpredictable complication that could end in sudden death of a woman or infant. Pregnant related complication cannot be predicted. Hence there is a need to employ methods of reducing those complications as they arise(Andarge, Nigussie, & Wondafrash, 2017).

Early childbearing adversely affect the quality of life of young mothers, their families and society(Debelew, Afework, & Yalew, 2014). In Tanzania, 27% of children are born to adolescent mothers. Unfortunately, when unplanned pregnancy occurs, more often than not, society blames the girl and leaves all the responsibility of raising the child to her and her family (UNFPA, 2014). Adolescent girls with no education are five times more likely as those with secondary or higher education to have begun childbearing (52% versus 10%). Teenage childbearing also varies by economic status ranging from 13% among adolescent women in the wealthiest household to 42% among those in the poorest household (Tanzania Bureau of Statistics, 2016).

Teenagers are at high risks of experiencing complications during pregnancy, labour and delivery. One of the strategies to prevent and manage complications is through effective preparation of birth and complications when arises.

Birth preparedness and complication readiness is the practice aimed at encouraging women, households and communities to make necessary arrangement for safe delivery including; choosing place of delivery, identifying available transport, blood donor, allocating money to pay for the services to reduce delays in reaching care when emergency arises (Ekabua et al., 2011). This is the comprehensive strategy to improve the utilization of skilled providers at birth and the key intervention to reduce maternal mortality (JHPIEGO, 2004).

1.2 Statement of the problem

Despite the tremendous reduction in Maternal Mortality Ratio (MMR) from 870 per 100,000 live births in 1990 (UN Report, 2015) to 454 per 100,000 live births (TDHS, 2010), Tanzania had not attained its target of reducing maternal mortality ratio (MMR) to 193 per 100,000 live births by December 31st, 2015. Although the Tanzania Government has put effort to address this challenge using evidence-based interventions (Bintabara, Mohamed, Mghamba, Wasswa, & Mpembeni, 2015), the current statistics are still alarming as MMR stands at 556 per 100,000 live births (Tanzania Bureau of Statistics, 2016), which is higher than the ratios reported in earlier reports 454 per 100,000 live births (Macro & NBS, 2011) and 556 per 100,000 live births (UN, 2015).

Most of the outcomes of pregnancy are directly related to poor birth preparedness and complication readiness(Urassa, Pembe, & Mganga, 2012). Birth preparedness and complication readiness (BP/CR) has been suggested by World Health Organization (WHO) as a comprehensive approach to increasing coverage of skilled delivery care and reducing the three delays to care seeking during obstetric emergencies (Hiluf & Fantahun, 2008). Many countries in Sub Saharan Africa including Tanzania have adopted this approach and included in the routine focused antenatal care. However, the approach has not has not been well studied (JHPIEGO 2004). Most of available studies has focused their attention to general population of women. Few studies have specifically examined pregnant adolescents' preparedness for safe childbirth. Consequently, little is known on perceptions about and challenges to BP/CR among adolescent pregnant women. It is this gap in knowledge this study intended to fill.

1.3 Justification of the Study

The findings and recommendations of the study will be used to formulate focused strategies to promote uptake of BP/CR among pregnant adolescents' girls. This in turns would enhance the utilization of skilled care by reducing the three delays leading to reduced MMR and NMR in the district and help government in developing policy which focused in improving reproductive health services to adolescent girls in Tanzania.

1.4 Research Questions

1. What is the perception of pregnant adolescent girls on birth preparedness and complication readiness?
2. What are the challenges affecting pregnant adolescent girls on birth preparedness and complication readiness?

1.5 Objectives

1.5.1 Broad Objectives

To explore pregnant adolescent girl's perception and challenges on birth preparedness and complication readiness in Temeke Municipal.

1.5.2 Specific Objectives

1. To explore perception of pregnant adolescent girls on birth preparedness and complication readiness.
2. To explore challenges affecting pregnant adolescent girls on birth preparedness and complication readiness.

1.6 Conceptual Framework

To understand the experiences of unmarried adolescent pregnant women –with regard to enablers and challenges to BP/CR the ecological systems theoretical framework was applied. This theoretical framework was developed by (Bronofenbrenner, 1979).

Ecological systems theory looks at unmarried adolescent's BP and CR development within the context of the system of relationships that form her environment. Bronfenbrenner's theory defines complex "layers" of environment, each having an effect on pregnant adolescent's BP and CR.

Following is a brief description of each layer and how it provides a framework for this study.

The microsystem is 'a pattern of activities, roles, and interpersonal relationships experienced by the unmarried pregnant woman in a given setting with particular physical and material characteristics'(Bronfenbrenner, 1979). The microsystem is the immediate environment of which Temeke teenage pregnant women are a part, such as family, the father of the child, neighborhood, school and peers.

The mesosystem is a set of interrelations between two or more settings in which the person actively participates (Bronfenbrenner, 1979). This explains the connection between the microsystems such as the relationship between members of the adolescent pregnant women's family and the family of the baby's father, or the connection between the adolescent pregnant women's family and school.

The macrosystem is the culture or sub-culture in the form of social organizations and beliefs and cultural norms about pre-marital sex and pregnancy and economics. Other factors include policies regulations and laws governing handling of pregnancy among students.

The experience of being adolescent pregnant women is shaped at many levels.

Figure 1 shows the focus of the proposed study and the interrelations within the social context of teenage mothers.

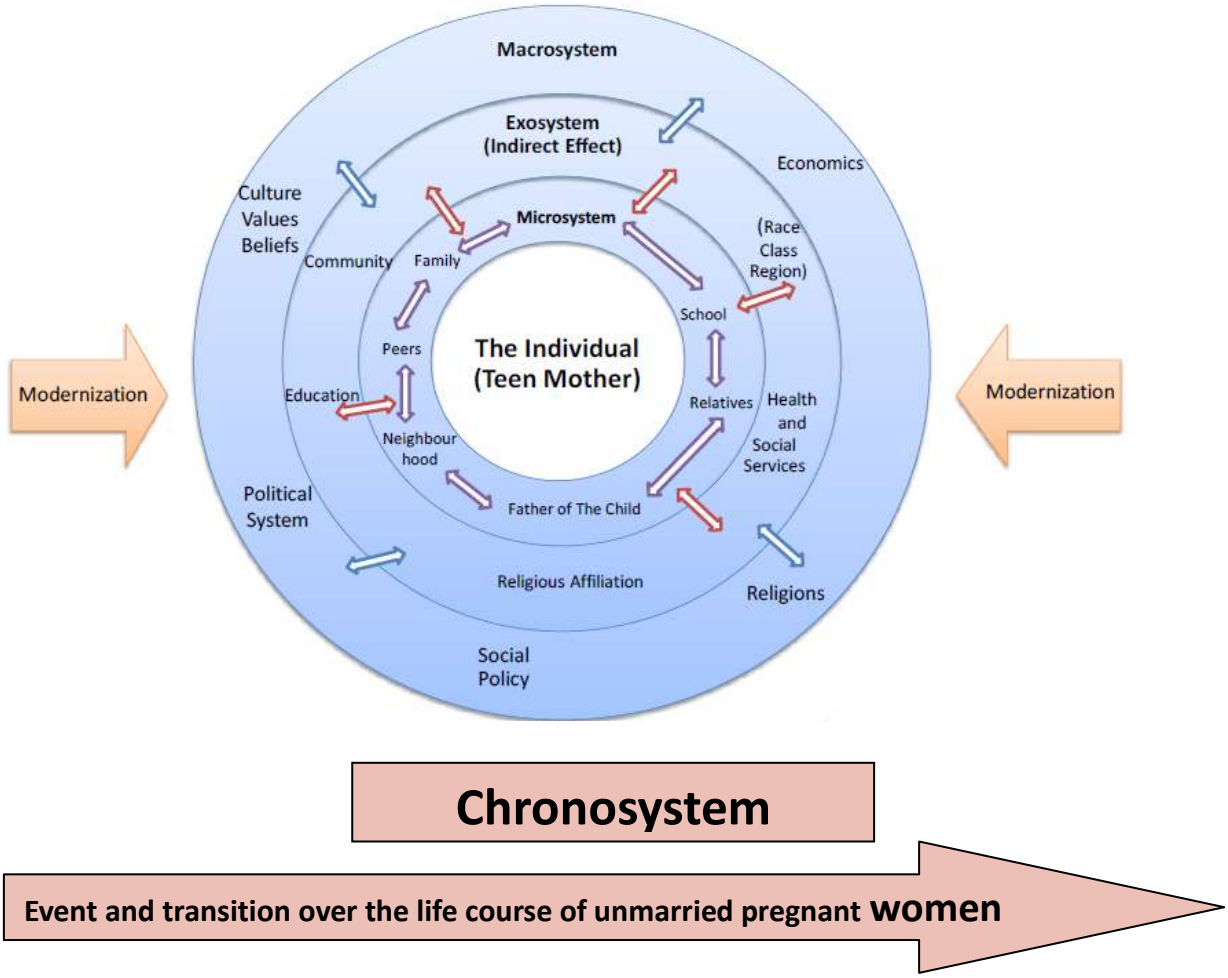

Figure 1: The conceptual framework adapted from Bronfenbrenner's Ecological Systems(Bronfenbrenner, 1979)

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter presents the reviews from previous studies on birth preparedness and complication readiness. The literature has been organized under perception of BP/CR, challenges and enabling factors of BP/CR.

2.1 Concept of birth preparedness and complication readiness

Birth preparedness and complication readiness involves planning for normal birth and anticipating the actions needed in case of an emergency (UNFPA, 2009). BP/CR is the shared responsibility among all safe motherhood stakeholders including policy makers, health care providers, communities, families and women. Each stakeholder has an important role to play as coordinated effort is effective for reducing delays that contribute to maternal and newborn mortality (IJEOMA, 2015).

According to (Thaddeus & Maine, 1994), BP/CR in essence reduces the three delays in reaching and receiving skilled care through timely decision making and taking appropriate action. The three delays that could result into poor pregnancy outcomes include: (i) delay in decision to reach skilled health care due to lack of information, inadequate knowledge about danger signs and lack of money during pregnancy and labor; (ii) delay in identifying and reaching places of access of skilled care (health facilities) due to poor roads and infrastructure, lack of family/community support, availability and cost of transportation and distance to points of skilled care; and (iii) delay in receiving adequate skilled health care due to poor status of health facilities and medical supplies, inadequately trained and poorly motivated medical staff and also inadequate referral systems.

Several studies have shown that delays in care-seeking to be the most common factor for newborn mortality (Waiswa, Kallander, Peterson, Tomson, & Pariyo, 2010), delays in receiving quality care and delay in reaching the point of appropriate skilled care (Jammeh, Sundby & Vangen, 2011). Thus, promotion of BP/CR results in improved care-seeking during obstetric emergency and hence reduced morbidity and mortality related to child birth (Fullerton, Killian, & Gass, 2005). This implies that knowledge, attitude and practice

of pregnant mothers and their spouses/partners towards BP/CR is very crucial for the reduction of newborn and maternal morbidity and mortality as reviewed in detail in the following sub-sections.

2.2 Perception of pregnant adolescent girls on birth preparedness and complication readiness

Birth preparedness and complication readiness at individual level include enable the woman and her family for timely use of skilled maternal and neonatal cares based on the theory that preparing for childbirth and being ready for complications reduce delays of obtaining care (Debelew et al., 2014).Women may have different perception towards BP/CR as a result of their knowledge level, experience and beliefs.

The study conducted in Ethiopia has shown that 61.0% of women had favorable perception towards birth preparedness and complication readiness as 58.9% have attended ante natal clinic and are knowledgeable on danger signs (Debelew et al., 2014). Also the study conducted in Nigeria revealed the most women 53% had poor perception towards BP/CR as 65% of women had poor knowledge on BP/CR and 60% of women were not prepared for birth and complication (Ajibola, Deji, Olatayo, Ayodele Aremu, Bojuwoye, & Akinyemi, 2015). This implies that knowledge empowers women and influences them to have favorable perception towards BP/CR and up-taking BP/CR (August et al., 2015). However currently the community perceived the importance of attending ante natal clinic and it is the responsibility of the family to help the pregnant women for necessary preparation of birth.

Also, the study revealed that, the community perceive that giving birth is associated with some complications hence hospital delivery is safer than home delivery as complications can be dealt professionally and quickly. Community members explained that, the situation has been different from previous generation, now they understand the importance of BP/CR and hospital delivery. Also explained that traditional beliefs of limiting pregnant women eating certain foods such as eggs as are detrimental to the unborn fetus are fading away (August et al., 2015). However, unmarried women especially young girls are stigmatized and hence affecting their preparation for birth. It is perceived that; young girls don’t listen

to their parents in terms of engaging in sex and becoming pregnant before marriage. Although some mothers still feel responsible for helping their daughters ensuring they have a safe delivery (August et al., 2015).

2.3 Challenges affecting pregnant adolescent girls on birth preparedness and complication readiness

Male involvement in pregnancy and childbirth influences positive pregnancy outcomes (Kaye et al., 2014). It reduces negative maternal health behaviour, risk of preterm birth, low birth weight, foetal growth restriction and infant mortality (Padilla & Reichman, 2001). There is epidemiological and physiological evidence that male involvement reduces maternal stress by emotional, logistical and financial support (Feldman, Dunkel-Schetter, Sandman, & Wadhwa, 2000). There is negative experience such as being ignored or marginalized which is being experienced most of the time by adolescent mothers (Dolan & Coe, 2011).

The positive experiences also include receiving timely attention and adequate support from health providers (Gungor & Beji, 2007). Most of the time teenager mothers they experience negative experiences such as difficulty in men adjustment to pregnancy, childbirth and parenthood some of this situation happen soon after a conception and others adolescent mothers experience after delivery which causes some to have depression during postpartum period (Sapkota, Kobayashi, & Takase, 2012).

Pregnancy and childbirth continue to be regarded as exclusively women affairs in most African countries. Men generally do not accompany their wives for antenatal care and are not expected to be in the labour room during delivery (Iliyasu, Abubakar, Galadanci, & Aliyu, 2010). However, men are socially and economically dominant especially in Northern Nigeria, they exert a strong influence over their wives, determining the timing and conditions of sexual relation, family size and access to health care this situation makes men critical partners for the improvement of maternal mortality (Mullick, Kunene, & Wanjiru, 2005). Strategies of involving men include raising awareness about emergency obstetric condition and engaging them in birth preparedness and complication readiness but this does not happen when it comes to adolescent mothers men are not there to provide the required support (Mullick et al., 2005).

2.4 Social factors influencing experience of adolescent girls on BP/CR

The teenage childbearing is much associated to social and economic consequences for the young adolescent mother (Berthoud et al., 2004). In our contemporary world, major factor which contribute too many challenges unmarried adolescent face is poverty. Unmarried adolescent mothers face different problems depending on their family background (Alexander, 2015). Most of them, their parents are from under privileged class and according to (Berthoud et al., 2004) early parenthood creates an immediate crisis for teenage parents and their families. In most cases they even lack basic needs and this makes their life difficult in rearing their children. The economic circumstances of the family are highly related to the household structure (Aquilino, 1996).

Most of challenges in unmarried adolescent motherhood are due to cultural practices of communities as they uphold their customs and values. Social cultural values and practices of a given community have great bearing on the challenges unmarried adolescent mothers face. In rural communities' values and practices have led to many challenges they face. When girls become pregnant blame is taken to their mothers, who are blamed for teaching their daughters bad norms and practices (Alexander, 2015).

According to most of cultures pre-marital pregnancies is taken as an evil thing. Girls are punished heavily and boys or men who are responsible are left out as if they have done nothing. This term is termed as stigma, disgrace to parent and in most situation it leads to single motherhood (Berthoud et al., 2004).

In most cases after birth, unmarried adolescent mothers are not given chances to go back to school in order to complete their studies. And in Tanzania recently president has announced those girls who will get pregnant while they are at school they should not be re admitted in public school and no serious measures has been put in place to support this group (Clark, 2004).

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

An exploratory qualitative case study design was adopted to explore birth preparedness and complication readiness among pregnant adolescent girls in Temeke Municipal, Dar es Salaam region.

3.2 Study Duration

The research was conducted in period of two month from August to September 2018, at Mbagala Rangi Tatu Hospital in Temeke municipal, Dar es Salaam region.

3.3 Study Area

The study was conducted at the Mbagala Rangi tatu RCH clinic. The clinic was purposively selected because it is among the antenatal clinics which serve the largest number of pregnant women from different social backgrounds in Temeke district. Mbagala Rangi Tatu is also a referral hospital for most of the health facilities which are located in rural area of Temeke district. Reproductive and child health services (RCH) which are provided includes antenatal care, out-patient and in-patient obstetrics care, family planning services, PITC for pregnant women and PMTCT of HIV for new born of HIV positive mothers, on average the RCH section serves between 120-145 clients daily and range of 2,800-3,000 clients monthly. At least 10 of daily antenatal attendees are adolescent pregnant girls who are coming for RCH services.

3.4 Study Population

Study population comprised of pregnant adolescent girls aged 17-19 years who were in their second trimester.

3.5 Sample Size

Sample size for this study was determined by the concept of information saturation in qualitative research, the point when there was no more new information emerging (Fusch

& Ness, 2015). In this study saturation was reached after interviewing 18 pregnant adolescent girls attending RCH clinics at Mbagala Rangi Tatu Hospital.

3.6 Sampling procedure

Pregnant adolescent girls were enrolled in the study using purposive sampling technique so as to obtain rich information. Participants for IDI were identified by using antenatal nurse and antenatal card was checked to ascertain.

3.7 Inclusion criteria

All adolescent girls who were attending RCH clinic at Mbagala Rangi Tatu hospital, who are single and they have no spouse in this current pregnant.

3.8 Exclusion criteria

Adolescent girls who have spouse and they are living together or he is providing support in taking care of the current pregnant and those adolescent girls who were sick and could not tolerate being interviewed.

3.9 Data Collection Procedures

In depth Interview was conducted at RCH clinic at Mbagala Rangi Tatu Hospital. Data collection was done using a semi structured interview guide prepared in English and then translated to Swahili. Kiswahili is a national language spoken by majority of participants which allowed them to participate fully. The duration of each interview was estimated to be 45 to 90 minutes, interview were conducted before receiving services. IDI was audio taped and notes was taken to capture the facial expression, gestures and other subtle relevant clue (Mack, Woodsong, McQueen, Guest, & Namey, 2011). To maintain confidentiality of participant's interviews were conducted in a private room which was located at antenatal clinic and there was no interference.

3.10 Data Analysis

A thematic analysis approach was used in analyzing the study findings. The English translated data was analyzed through the examination and categorization of respondent's

opinions. The analysis was carried out in three stages (Attride-Stirling, 2001). First the line-by- line coding of field notes and transcript. The coding involved breaking down the data conceptually in order to expose underlying thoughts and meaning, second stage was concerned with in depth examination and interpretation of resultant codes and their categorization into descriptive themes. The third stage was about interpretation of descriptive themes and condensing them into more abstract analytical themes.

3.11 Trustworthiness

The main issue in qualitative study is how to ensure trustworthiness. According to (Miller & Brewer, 2015) suggested four concepts which are used to ensure trustworthiness in qualitative studies. He suggested uses of credibility, (In preference to internal validity) transferability (in preference to external validity). Dependability (in reference to reliability) and confirmability (in preference to objectivity)

Credibility: in this study triangulation of data collection methods was used in order to collect information from study participants through in depth interviews. Participants were collected randomly in order for them to have chance to participate in the study and then interviews were conducted in private settings.

Transferability: Detailed background of the participant's data that establish context of the study and detail description of phenomenon in question was done. The information included number of participants included in the study, their particulars, data collection method which was used, number of in depth interviews were conducted and time period of which data was collected this is to have findings which can be applied in another situation.

Dependability: in order for this study to be dependable and been able to be repeated detailed in different settings, detailed methodological description such as study area, study population, sample size, data collection tools/methods, number of participants, data analysis approach of the study were done to enable future researchers to repeat the work.

Confirmability: in order for this study to be confirmable triangulation was used to reduce effects of investigator bias.

3.12 Ethical Consideration

Ethical clearance to carry out this research was obtained from Muhimbili University of Health and Allied Sciences (MUHAS). Institutional Review Board, while permission to conduct the research was requested from Temeke Municipal council and from the health facility which participated in the study. A written informed assent was given to pregnant adolescent girls prior to data collection. Participants were also requested to give their assent for the recording during interview, since participants were minors informed assent was given to them because at this age they are able to make decision on their own. All recorded interview transcript was kept in confidential way in a computer by PI. Informants had the right to withdraw from this study and this action did not interfered routine services which were supposed to receive during that day.

CHAPTER FOUR

4.0 FINDINGS

This chapter describes the study findings. The description of socio demographic characteristics of respondents is presented first followed by perception of participants on BP/CR, then challenges experienced by pregnant adolescent girls on BP/CR readiness.

4.1 Social demographic characteristic of correspondents

A total of 18 participants were recruited into the study. The criteria such as, they are teenager aged 15-19, they are in their second trimester of their pregnancy, and they have already started attending clinic at that particular RCH (supported with the evidence of antenatal card). All participants were single living with their parents with support from their family members and their spouse has not accepted their pregnancy. Regarding their educational achievement 78% of participants had attained primary education, 22% had had attended secondary school up to form two and then dropped from school after getting pregnant attained secondary school mostly form two and they dropped school after getting pregnant. 16 participants were prime gravida and two participants were para 2 with one living baby. All 18 participants were non-employed and they were depending on either their family for support. More than half (56%) of participants started attending clinic when pregnancy was 5months and beyond and 44% started attending clinic starting from 3 month and above. See table 1 for social demographic characteristic of participants.

Table 1: Social demographic characteristics of participants

Characteristics of participants	Total 18 = n (%)
Age	
17	7 (39%)
18	6 (33%)
19	5(28%)
Marital status	
Single	100%
Educational level	
Primary level	14 (78%)
Secondary level	4(22%)
Employment	
Non-employed	18 (100%)
Variation in parity	
Prime-gravida	16 (89%)
Para 2	2 (11%)
Residence	
Temeke	18 (100%)
Social support	
Support from a family member	18 (100%)

Perception of girls on birth preparedness and complication readiness

Results of analysis on perception of adolescent girls on birth preparedness and complication readiness can be grouped into two groups which are birth preparedness and danger signs during pregnancy and delivery and each of these will be divided into sub categories and quotes will be given to support the views of participants.

Table 2: showing categories and subcategories of birth preparedness and complication readiness for adolescent girls

1.Birth preparedness • Prioritization of antenatal care • Perception on utilization of ANC services. • Facility delivery preferred. • Actual preparation for birth requires money. 2.Danger signs during pregnancy and demand for hospital care • Recognizing danger signs • Health care services availability • Identification of blood donor

4.2 Perception on Birth preparedness

Prioritization of antenatal care

Most participants were of the opinion that antenatal attendance is the key to birth preparedness. They all perceived that it was important for the pregnant woman to start attending antenatal clinic as soon as they discover they are pregnant so that they can know about the age of pregnancy, get vaccinated, get anti-malaria and other important services which are required by pregnant woman.

> *"I have heard advertisement on the radio, encouraging mothers, to visit hospital once they discover they are pregnancy so that they can be screen for diseases and get prophylaxis for malaria" (P3)*

However, when participants were asked at which age did, they start to attend antenatal clinic, majority started when pregnancy was above 5 months, in spite of the awareness on the importance early antenatal care attendance these adolescent mothers started late and some attended ANC because of sickness.

> *"I started ANC visit when my pregnancy was six months, and I did because I was very sick but if it were not s not for the sickness, I would have waited until when my pregnancy was 8 or 7 months." (P11).*

When asked if they have any significant reasons for them to delay starting antenatal visit, they mention the following as a reason, some they did not know if they were pregnant positive as they did not know the signs, not disclosing about their pregnancy to their family because of schooling was also one of the reasons for them to start late going to antenatal.

> "*I started attending antenatal clinic when my pregnancy was 7 months, after dropping out of school I went to live with my relative who didn't ask me much as to why I was not at the school and I didn't let my family know about my status because they could kill me especially my father who wanted me to study hard. (P3).*

Actual Preparation for birth is unaffordable

Most adolescents were of the opinion that actual preparation requires money which they don't have. That preparation is literally unaffordable for many items that are required including: clothes for the baby once s/he is born, clothes for the mothers "khang" and "vitenge", cotton wool and surgical gloves.

One of the participants succinctly said this

> "*Health providers said we should prepare clothes for my newborn, khanga and vitenge which I will use them during birth and delivery at least 5 pairs of surgical gloves all these requires money and I don't have the money to buy them for the time being but I hope as times comes my mommy will buy them for me*" (P5)

Another participant has this to say

> *"We used to hear in the radio that services for a mother and baby during delivery are given for free but in actual since this is not true because at the facility nurses are insisting to prepare ourselves different materials required during birth, for me depending on my condition and my poor economic status I will prepare few items the rest I cannot afford them*." (P10)

Facility delivery is preferred:

When asked about the place where they are expecting to have their babies all of the participants preferred to deliver at the facility although they could not identify by name which facility they would like to go in case of emergency or when labor begins.

"We are I'm coming from there is no health facility nearby but as time goes by, I will plan were to go when my labor pain starts or if anything related to my condition occurs to me". (P2)

Perception of Transport to health Facility:

When asked if they are aware of the means of transport which they will use when going to health facility for delivery, majority they said they are not aware of the means and they had not saved the money for this purpose as well.

"I have not yet prepared which transport I will use to the hospital but I know once emergency occur my relatives and anyone who will be around will support me" (P5)

Danger signs during pregnancy and demand for hospital care

Recognizing danger signs

When asked if they are aware of the danger signs for a pregnant woman, some of the participants were able to mention them just like the way they were told during antenatal clinic and some they said they don't remember them but they admit to have been informed about danger signs during health talks at antenatal clinic.

"I have attended clinic two times and during the first visit, one of the nurses was teaching us about danger signs to a mother and the baby during pregnancy and after delivery but I remember only anemia others I have forgot" (P2)

Another participant has the following answer when she was asked about her knowledge on danger signs

"A nurse said to us about the danger signs during pregnancy and I just remember few of them which are severe headache, watery vaginal discharge, blurred vision, and severe head ache, not feeling a baby kicking for the whole day, these are just few of the danger signs I can remember" (P13)

Participants expressed that most of the conditions that they have mentioned as a better managed by health professional so it's good if you experience one of the danger signs you should see the doctor for further support.

"if any of the complication which we were told such as bleeding, it's better to run to health facility so that you can get treatment as early as possible" (P9)

Perception on early identification of blood donor

One of the challenges which pregnant women may face is severe bleeding during labor and delivery and this may lead to post-partum hemorrhage, as one of initiative to save the life of the mother if this occurs most of the time women are asked to identify a person who will be there to donate blood when this happens. During RCH visits pregnant women are insisted to identify relative or person who will be there to donate blood when emergency occurs. Some these adolescent pregnancy girls they were educated during health session at RCH in the importance of identifying a person who will be there to help them to donate blood in case of emergency and this is what they have said,

"*At the clinic nurse told us to have a relative who will be there to help me in case of emergency but I have not prepared anyone but I hope once I communicate with my family members, they will be there to help me" (P5)*

Some of girls when asked on their perception towards early identification of blood donor who will be there to support them in case of emergency, they said they have never heard of this during RCH visit and there is no any initiative which have been done. One of the participants has this to say

"Since I have started to attend my clinic when I was five months pregnant, no one has said to me about preparing blood donor and I have not communicated with any of my family member about this, but I hope if that will happen to me during labor and delivery my mother will help me to coordinate this with other members of my family" (P12)

Other participants said this.

"I have not informed my family members if they are required to donate blood, but I will late them know today and ask other members of the family to prepare themselves for donating blood if there will be any challenge, but I hope God is good I won't reach that stage" (P1)

4.3 Challenges faced by pregnant adolescent girls

To understand challenges experienced by adolescent pregnant girls, conceptual framework for this research used The Ecological Systems Theory from Bronfrenbrenner (1979). These challenges have been grouped into Microsystem, Exosystem and Macrosystem. As discussed below.

Intrapersonal Challenges

These are challenges which are experienced by participants themselves at individual levels and these are.

Emotional Stress

The most common emotional challenges for these teenagers were feelings about her fate as a teenage mother, having unplanned pregnancy brought initial negative feelings for most of participants, they felt they were too young to have a baby and they were not ready to take full responsibilities of motherhood.

One of the participants has this to say

> "*When the test showed two red stripes, I felt shocked. My body was shaking. I wondered if I was really pregnant. Was it real? I was so scared if my parents knew this, what were they going to do with me? I did not really know what to do. I was not ready to have a baby"* (P6)

Another participant had this to say

> *"At the moment I have more negative feelings. I am frustrated not knowing if I can look after my baby. I do not have any support from the baby's father like others while he used to tell me he loves me and he will never abandon me" (P 4).*

The biggest fear which was shown by these adolescent girls was they were afraid of the challenges which are coming with motherhood considering themselves young and they see motherhood as very big commitment and requires high level of maturity and readiness.

One of the participants had this to say

> *"I was shocked, frightened and there were many thoughts in my mind...I did not want to keep the baby" (*P 2).

Another participant this is what has to say

> *"My first feeling was being very upset. I was not ready to have a baby. This thing should not have happened to me"* (P 3).

Others emotions rose because their male partners rejected the pregnancy and they did not enough support from their family members, also seeing other mothers with their partners was really tough for them one of the participants has this to say

> *"When I saw other mothers have their support from their husband, I feel sad, that I have no one around to support me and my unborn baby." (P6)*

Disappointment of Failing Family's Expectations

The main reason behind the very negative feelings of participants was they thought they had failed to meet their families' expectations. This was particularly true of participants who were still at school when they became pregnant. The family expectations for a daughter as opposed to son are quite different in our society.

> *"I just felt sorry that I had disappointed my mum so much. It was all my fault. I made a mistake"* (P 2).

Another participant has this to say

> *"I feel really guilty about what I have done...My mother expected me to have a high education*". (P 6).

Some participants were the youngest daughter of the family and hence carried very high hopes and expectations from the rest of the family who worked hard to give them a good education (which was seen as one way out of poverty for the whole family).

> *"I feel so sorry that I disappointed my mother. She looked after me and gives me the best she can but I disappointed her a lot by having a baby at such a young age and not finishing my education" (*P 7).

Another participant said this

> "*I felt guilty and really sorry. My parents put high hopes on me because I am the youngest one in our family and my elder sister didn't finish high school as well. So,*

> *they really expected that I might be the one who could make them proud. I am their last hope to have a high education in our family"* (P 14).

The high expectations of their family created pressure for these participants when they found out they were pregnant and that the better future which they dreamt of might now not be possible.

Financial Challenges

The majority of participants reported to have challenges with financial this was attributed to the fact that adolescents are still young and they do not have means or earnings. Most of them they are depending on the support from the family and those which claim to get support from the family they mentioned the only source of money for them is from a small business which her mother is doing and it does not produce much profit.

> "*The only source of money which I have is my mother, and she is getting the money by selling small items around our neighborhood and the money she gets is not enough, to support all of us, so we just make sure we have food at the table" (P 4)*

Some of adolescent girls before being pregnant they have their own means of making income within their surrounding but after becoming pregnant they find it's hard for them to keep on doing manual activities which give them income.

> *"Before being pregnant I was working as fundi cherehani at our area the work which was payable to me because per day I was capable of getting five thousand and during holidays like Christmas and Eid income was high, but since my conception by body was not cooperative so I decided to stop" (P18)*

For these teenage adolescent girls financial is one of the biggest challenges to them and majority of them did not have a single source of income during the period of data collection, they were depending from their family for financial support.

When asked if they have started to save funds for emergency, majority they said they have not saved anything because they do not have any activities which will help them to earn income and save some amount.

"I'm 8 months pregnant and I don't have money saved for hospital in case of emergency and I don't know which transport will I use to get there, but I hope my relatives will help me be it by tax or motorcycle" (P7)

Interpersonal Challenges

Absence of male partner support

Most of the time during pregnancy men are seen as financial provider for their partners but when it comes to adolescent girls' the situation is different, these male partners are not there. Some they run away to different places to avoid responsibilities of taking care of the girl during the period of pregnancy and once the baby is born. Some men may opt to stay within the same vicinity but they don't agree to take care of the pregnancy. So due to this the situation become very difficult to these adolescent girls as they luck financial support from their male partners.

"*The father of my baby run away when I disclosed to him about my pregnancy and said I should not look for him even after delivery, I have no one to give me money and at the clinic we were told to prepare ourselves for the things which are required but I will not do that due to my situation, even if I will tell my grandmother she is not in apposition to assist me" (P16)*

Social Challenges: these are challenges which were experienced from the participants from the societies where they are came and these are

Luck of Support from the family members but at the end family is what they have

During pregnancy, pregnant women are expected to get support from their family members and the support required is performing house hold chores such as cooking, washing clothes, fetching water and running small errands, most of the adolescent girls were not getting enough support from their family members as their pregnancy was unwanted, they were still in school, so they did not have anyone to help them during this time.

"*I'm living with my grandmother, she knows about my pregnancy but she does not help me in any domestic work at home and most of the time she assign me different task for me to do and if I remind her about my condition she usually tell me*

pregnant is not sickness so make sure you work, and if you don't do it yourself don't expect anyone to support you. (P8)"

When they were probed if there is any support which they are expecting from their relatives when time for delivery comes, most of them said they will get support and they will be assisted though it will not be a very long support but at least there will be someone to take them to hospital for delivery and assist them during the first two weeks of delivery.

"*Currently I'm living with my mother, when I'm about to deliver my mother will be the one to take me to hospital, and she has said to me that, once the baby is born I will support you for few days so that I can regain my energy back and once I become stable I have to take care of my baby on my own, because when she has me no one was there to help her so she will also do the same for me" (P2)*

Another participant who was a form two drop out said this when she was asked if she is getting any support from her family members during this time of pregnancy

"*I was living with my mother before the pregnancy and she really reprimanded me for getting pregnant. Mother was really upset and depressed. She fumed at me, 'I have spent millions on your education and now this has happened'." (P16)*

Rejection from parents

Majority of respondents indicated their parents or guardians were not happy on learning that they were pregnant. To many parents, the pregnancies came as a surprise. Parental reaction varied. Nearly all parents were upset and some were shocked

"*My parents were very upset with me because they thought with the pregnancy that I would not go back to school." (P5)*

A few mentioned that reactions from fathers were much more intense and difficult to handle. While the reactions of mothers were sharp, immediate, and often vocal, the fathers were deeply troubled, intensely moody, and felt deeply hurt.

"My dad was very angry. He didn't talk to me for about three months. My mother had to go talk to him on my behalf before he forgave me." (P8).

Disappointed her. I used to tell her that I would try to have the highest education that I could and have a good job so I could look after my parents" (P 6)

Disapproval of teenage pregnancy by community members:

Disapproval of teenage pregnancy is a cultural phenomenon and is still there. It results into self-stigma; an adolescent may delay starting ANC suspecting that older pregnant women and even health staff would gossip and look down upon the young expectant mother.

The few negative remarks received from their close community were more about the teenagers being too young to should childbirth responsibility. One of the participants said

"Some people said that I am pregnant at a very young age and how would I be able to look after the baby. How will the baby survive? And when I came back to live with my grandmother, they said who will look after whom. My grandmother will look after me or I will look after my grandmother" (P1)

Another participant has this to say.

"Some neighbors talked behind my back. My friends heard about it and told me...They said I was away from home for studies but instead of studying I ended up getting pregnant. I have not helped my mother with anything apart from increasing. I was pregnant without a husband (P5)

Economic Factors

Generally, unfavorable economic situation affects the parent's capacity to support their daughters. Parents of these young adolescent girls did not have formal employment and they have been engaging in small scale businesses which have minimal returns and this limits the capacity to meet the needs of their adolescent girls. Moreover, local community leaders who were interviewed pointed out that whereas the countrywide adverse economic situation disproportionately affected women, early pregnancy makes teen age girls' economic prospects much worse. This affects their capacity to meet basic needs for BP/CR

CHAPTER FIVE

5.0 DISCUSSION

Perception of pregnant adolescent girls on birth preparedness and complication readiness

Most participants were of the opinion that antenatal attendance is key to birth preparedness. And preferred facility delivery. These findings suggest these adolescents had heard health education messages on CP/CR at clinics or through mass media but they delay in starting ANC visits. Similar studies conducted by(Gross, Alba, Glass, Schellenberg, & Obrist, 2012) in south eastern of Tanzania has shown similar results of adolescent girls delaying in starting ANC beyond the recommended time by ministry of health in spite of being aware that they required to start ANC as soon as possible.

Notwithstanding positive perception about ANC and facility delivery, most adolescents in this study had perception that actual preparation for safe childbirth is literally unaffordable as it requires money which they don't have. This finding implies that pregnant adolescents alone may not practically attain BP/CR. It remains at a theoretical level. Studies reported by(Gross et al., 2012) and (Kabakyenga, Östergren, Turyakira, & Pettersson, 2011) reported similar findings. Which showed that most of pregnant adolescent girls they had negative influence of lacking social and financial support and these made it difficult for them to prepare materials required for mother and baby during delivery and the same reason made some of women prefer to deliver at home due to lack of money to take them to facility for delivery and ANC booking.

Findings from this study show that perception of danger sign during pregnancy were very low among these adolescent girls, very few remembered what they were taught by health providers during antenatal visits and majority they don't remember them and takes time for them to mention the danger signs they are aware of. Similar findings was observed in studies done in North Ethiopia, Uganda and Kenya (Mutiso, Qureshi, & Kinuthia, 2008)and(Hiluf & Fantahun, 2008). This low perception on danger signs during pregnancy to adolescent girls is largely contributed by the fact that these pregnant women they visit clinic late hours and miss the health talks session, another reason is due to their age they

are still young and have not accepted motherhood responsibilities seriously. Knowledge of key danger signs is necessary to women and their families because once they become aware it will enable them to seek for health care faster once they occur.

Actual preparation for birth is unaffordable: when asked about preparation for equipment which are required during birth and delivery a high number of responded reported not to have prepared anything due to lack of money, most of these pregnant adolescent girls they are depending from their families for financial support as they don't mean of making income. This finding is different from the studies done in Uganda, Kenya, Burkina Faso and Nigeria(Kabakyenga et al., 2011). This difference may be due to the fact that those women of other studies they were married and have support from their male while participants of this study are adolescent girls who have no one to support them and their male partners don't support them.

Early identification of blood donor: the findings of this study show that no participant had identified person who will be there to donate blood in case of emergency. This finding is comparable with other studies which was done at Ethiopia and Nigeria(Nawal & Goli, 2013) and (Ajibola et al., 2015). This may be due to the thought that blood transfusion is considered to be a critical condition and few women think they will reach that condition especially if they have not been told to be anemic during their Antenatal visits.

Transport arrangement and emergency fund**:** lack for the money and transport is a barrier to seeking care as well as identifying and reaching medical facility(WHO, 1994). The money save by a woman or her family can pay for health services, supplies, transport and any other vital cost when it is required, and if a woman can afford to pay for the cost its more likely to seek for health care(JHPIEGO, 2001). The findings from this study shows that majority of participants they don't have emergency money and they don't know which means of transport they will use when an emergency occur. This is different from a study which was conducted in Nepal which showed that women after getting pregnancy they start to prepare emergency fund(McPherson, Khadka, Moore, & Sharma, 2006). Differences may be contributed by the population study, while this study used pregnant adolescent girls who don't have any support from their male partners the one in Nepal participants were married women who had support from their male partners and others were working.

Challenges affecting adolescent pregnant girls on birth preparedness and complication readiness

Emotional Stress:

This study found that emotional stress was a major challenge that consumed adolescent's energy to engage in BP/CR. The stress arose from within adolescents because of immaturity with respect to childbirth and parenting responsibilities. Another cause of stress was blame and/or rejection, and limited / lack of social support, all these impaired BP/CR. These results are similar to the one conducted by(Gross et al., 2012) which showed that lack of social support and financial support to adolescent pregnant girls contributed to stress in their lives and impaired their morale to attend ANC visits for different services.

Lack of Social support:

The findings from this study has found that lack of support from male partner was one of the challenges, this made these young adolescent mothers to worry about the future of their lives and the baby who will be born. The findings of this study is similar to the one conducted by (Ilika & Anthony, 2007) in Southern East Nigeria which showed that most adolescent girls who fall pregnant were experienced lack of social support from their partners and others were rejected by their families due to shame they have brought in their families. Another study which was done by (Aquilino, 1996) showed similar results to this study.

Stigma against teenage pregnancy: the findings of the study showed that these teenage adolescent girls were experiencing stigma from the community where they are coming from and their families as well and they were labeled and given bad names as well. The study done by (Alexander, 2015) in Mombasa Kenya showed similar findings with this study that, adolescent girls were experiencing stigma at different levels of service provision including such as RCH.

Economic difficulty:

Financial Challenges: this was one of the challenges which was faced by these adolescent girls, most of them they did not have support from their male partners and they were depending on their family for support. Research from Kenya(Wamalwa et al., 2017) showed that adolescent girls were facing a financial challenges and depends on their family

for support, study which was done to adolescent mothers in Thailand by (Sa-ngiamsak, 2016) has showed similar results, participants from these two researches were also adolescent girls and they also reported experiencing financial challenges as they were a bonded with their partners.

Lack of adolescent friendly ANC, Delivery, and Post-delivery services

Youth-friendly health services are a key strategy for improving young people's health. The findings from this study has shown that Youth friendly services to pregnancy adolescent girls is not provided and they are being treated the same like other pregnant women who are experienced and matured in terms of age, due to this some of important information are being missed especially if a girl is experiencing domestic violence, if the health facilities were providing youth friendly services these adolescent girls would be treated different health providers would be in a position to explore more about their lives and if they are passing through crisis. Results of this study are similar to the one which was conducted in South Africa (Geary, Gómez-Olivé, Kahn, Tollman, & Norris, 2014) which shows that youth friendly services were not provided in primary health care facilities and barriers which leads to youth not utilizing the services was attitude of health providers and space was not enough to most of the facilities to accommodate youths who wants to use the service.

5.1 Study Limitations

i. This qualitative study to explore birth preparedness and complication readiness for adolescent girls was done in only one district of Temeke, therefore the findings of this study cannot be generalized.

ii. Qualitative study is not enough to give conclusion, if possible a larger studies should be done which will combine different methodologies and reach large population.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This research explored perception on birth preparedness and complication readiness to a small group of pregnant adolescent girls in Tanzania, lack of or limited social support impairs their involvement in BP/CR. The challenges identified in this study suggest a comprehensive approach to support adolescent girls who get pregnant so that they can have good outcome of their pregnancy.

6.2 Recommendations

The findings from this research have implications for policy, practice, and future research regarding BP/CR among adolescents in Tanzania. It's recommended that

i. Family support is very important for adolescent pregnant girls, if the girl will get enough support from the family during this transition of new responsibilities it will easy her motherhood journey and even assist them in preparation birth and any complication which may arise.
ii. There is a need to extend youth friendly services to cover ANC, delivery and postpartum care for adolescent pregnant.
iii. Establishment of psychosocial support groups for teenage mothers within the communities will help these young girls to share experience and provide a platform for them to learn and grow while raising their children.

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APPENDICES

Appendix I: Interview Guideline – English version

Interview Guideline for Unmarried Adolescent Girls

TITLE: Birth preparedness' and complication readiness among unmarried adolescents mothers in Temeke municipal, Dar es Salaam

Site……..

Interview No…

Date:……..

Start:…….. End:……..

Interviewer:……..

Note taker:……

REGULATIONS FOR THE INTERVIEW:

1. There will be no judging to participants
2. All information said will be kept confidential, no name is required.
3. We will be recording the talking

PART I: DEMOGRAPHIC CHARACTERISTICS.

If you don't mind first I would like to ask some personal questions

1. How old are you?
2. What's the level of your education?
3. Who are you living with?
4. What do you do for living?

PART II: PERCEPTION ON BIRTH PREPAREDNESS AND COMPLICATION READINESS.

5. How many pregnancy have you had before? (probe on the number of babies alive)
6. What is the gestational age of your pregnancy?
7. Are you attending antenatal clinic with your current pregnancy? (If yes ask how many times she has been to antenatal clinic?
8. At what gestational age did you start going for antenatal visits?
9. Do you know danger signs of pregnancy? If yes what do you know please explain.
10. Did you receive health advice from health care provider during your ANC visit?
11. Have you identified which facility will you go in case of obstetric emergency and delivery?
12. Which facility? Is it a government or private facility? (If private facility who will you pay for your cost?)
13. Do you have any active insurance card?
14. What do you understand by birth preparedness and complication readiness?

Probe on: Means of transport to take to hospital, delivery supplies/materials and blood donor in case of emergency.

PART III: CHALLENGES AFFECTING BIRTH PREPAREDNESS AND COMPLICATION READINESSAMONG UNMARRIED PREGNANT ADOLESCENT.

15. How did you react when you find out you were pregnant? And what was the reaction of your family when they find out you were pregnant?
16. What support do you have on this period of time?
    Probe on economic support, source of support, is it your family? Your partner? Social support who is giving you support? Your family? Partner?
17. How do you meet your nutritional needs related to pregnancy?
    Probe on the role of her family, role of her male partner.

18. Where do you plan to deliver your baby and why?
    Probe health facility-which type of facility and why? Home delivery with assistance of TBA why? Support?
19. How friendly has facility where you attend ANC been to you?
    Probe on services received including vaccination during the first ANC visit, SP for malaria prevention, Health education on various topics including danger signs for mother and the baby.
20. Where do you plan to stay after delivery of your baby? And why?
21. Is there anything important we have not discussed with you and you would like to share?

Interview closure

Thank you.

Appendix II: Dodoso – Swahili Version

Dodoso Kuhusu Maandalizi kabla ya kujifungua na kukabiliana na ujauzito kwa vijana wa kike

Jina la kituo…….

Number ya utambulisho ya msailiwa ..…

Tarehe:……..

Mwanzo:…….. Mwisho:……..

Jina la msahili:……..

Sehemu ya I: Utangulizi

Anza kwa kujitambulisha na kumshukuru kukubali

Utambulisho: Mtafiti Mkuu, Mtafifi Msaidizi

MADHUMUNI YA MAHOJIANO HAYA

Madhumuni ya Mahojiano haya ni kujua mawazo yako na uzoefu wako kuhusu maandalizi kabla ya kujifungua na utayari wa kukabiliana na changamoto zitokanazo na uzazi kwa vijana wenye umri mdogo.

KANUNI ZA MAHOJIANO

I. Hakuna kukunyooshea kidole wala kukuhukumu
II. Mahojiano yote ni siri, hakuna kutaja majina
III. Tutakuwa tunarekodi mahojiano

Kwanza: Ningependa kujua vitu vichache kuhusu wewe

1. Una umri gani?
2. Kiwango chako cha elimu ni kipi?
3. Unaishi na nani?
4. Kuna shughuli gani unafanya ya kukuingizia kipato?

Sehemu ya pili: Mtazamo wako kuhusu maandalizi ya kujifungua na utayari wa kukabiliana na changamaoto za uzazi kwa vijana wenye umri mdogo.

5. Hii ni mimba yako ya ngapi? (Je una watoto wengine wanao ishi?)
6. Mimba yako ya sasa ina umri gani?
7. Je umeanza kuudhuria clinic mimba ikiwa na umri gani?
8. Je unajua dalili zozote za hatari kwa mama mjamzito? (kama ndio je unaweza kutuelezea ni dalili gani unazo zifahamu?
9. Je umepata ushauri wowote wa kiafya kuhusiana na ujauzito wako wakati ulipoenda cliniki ya wajawazito (Dodosa wamemshauri kuhusu nini?)
10. Je umeshajua ni kituo gani utakwenda kama ikitokea umepata dharura wakati wa ujauzito wako?
11. Kituo gani? Je ni cha serikali ama cha mtu binafsi? (kama ni kituo cha binafsi je nani atakulipia gharama zako za matibabu)
12. Je una bima ya afya?
13. Je unaelewa nini kuhusu maandalizi kabla ya kujifungua na kujiandaa kukabiliana na chngamoto zinazo weza kutokea wakati wa ujauzito na kujifungua? (dodosa kuhusu njia ya usafiri itakayo tumika kumfikisha kituo cha afya, maandalizi ya vifaa vya mama na mtoto vitakavyotumika wakati wa uchungu na kujifungua, Mtu wa kuchangia damu endapo itatokea damu inahitajika).

Matatizo yanayo wapata vijana kwenye maandalizi kabla ya kujifungua na kukabilana na changamoto wakati na baada ya kujifungua

14. Je ulijisikiaje pale ulipogundua kuwa una ujauzito? Na je familia yako ilijisikiaje pale walipojua kuwa una ujauzito?
15. Nani anaye kuhudumia katika kipindi hiki cha ujauzito?
16. Je wanakupa sapoti gani kwa sasa?
17. Dodosa kuhusu sapoti ya kiuchumi, chanzo cha sapoti, Je ni familia yako? Mwenza wako aliyekupa ujauzito?
18. Je unahakikishaje kuwa unapata mahitaji yako yote ya lishe wakati huu wa ujauzito? (dodosa kuhusu jukumu la familia yake na jukumu la mwenzi wake kama yupo)

19. Je umepanga kujifungulia wapi mtoto wako? (Dodosa kuhusu utayari wa kufika huko ikitokea dharura,)

    Dodosa ni kituo kipi cha afya(zahanati, kituo cha afy au hospitali), Atazalia nyumbani kwa msaada wa mkunga? Kwa vituo vyote hivyo aseme kwanini
20. Je kituo unachoenda kwa ajili ya huduma, je unaonaje huduma zao? Ni rafiki kwako? Watoa huduma wamekuchukuliaje?
21. Huduma zipi wamekupatia kituoni mpaka sasa? (dodosa kuhusu chanjo wakati wa ujauzito, SP kwa ajili ya kumkinga mama na malaria,elimu ya afya kuhusu dalili za hatari kwa mama mjamzito na dalili za hatari kwa mtoto)
22. Umepanga kukaa wapi na mtoto baada ya kujifungua?
23. Je kuna kitu chochote cha muhimu kuhusu ujauzito kwa vijana ambacho hatujakuuliza na ungependa kukiseme kwa jamii?

Mwisho wa mahojiano

Asante sana.

Appendix III: Consent Form – English version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED HEALTH SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS

ID NO

Introduction

Greetings! My name is **Pendo Said,** a researcher from Muhimbili University of Health and allied sciences (MUHAS). I am conducting a study on birth preparedness and complication readiness at Temeke District. The aim of this research is to explore challenges of birth preparedness and complication readiness among unmarried adolescent mothers who are living in Temeke district.

Participation in the study

You are kindly requested to participate in this study. If you accept to participate in this study your particulars/information will be taken and used for the purpose of this research and this will certainly not bother you or cause any discomfort to you.

Confidentiality

You are strongly assured of the confidentiality of the information obtained that will only be used for the purpose of this research and anonymity will highly be observed when collecting data and compiling report. To assure you, even your name will not be required to appear in our conversation.

Risk to participant

No anticipated risk or harm that may result from participating in this study.

Rights to Withdraw and Alternatives

Participation in this study is voluntarily and you have the right to refuse to participate or withdraw from the study even if you have already given your consent. Refusal to participate or withdraw from the study will not involve penalty or loss of any benefits to which you are otherwise entitled.

Contact Person

The principal investigator, Pendo Said (0625812613) is a key contact person with regard to any queries about this study. If you ever have questions about your rights as a participant, you may contact or call Director of Research and Publications Committee Prof. Joyce Masala at MUHAS, P.O. Box 65001, Dar es Salaam. Tel: 2150302-6.

Signing of the consent

If you agree to participate in this study please sign in this consent form.

I …… have read and understood the contents of this form and I have been given satisfactory explanation with all my questions answered. I therefore consent to participate in this study.

Signature of participant …….

Date ……

Signature of research assistant……

Date ……

Appendix IV: Informed Consent – Swahili Version

CHUO KIKUU CHA AFYA NA SAYANSI SHIRIKISHI MUHIMBILI.

KURUGENZI YA UTAFITI NA UCHAPISHAJI

Ridhaa ya Kushiriki Katika Utafiti

Namba ya Utambulisho | | | |

Habari, Jina langu naitwa Pendo Saidi ni mwanafunzi wa shahada ya juu ya uzamili ya Afya ya Jamii katika Chuo kikuu cha Afya na Sayansi Shirikishi Muhimbili. Kwa sasa nafanya utafiti kuhusu maandalizi ya kabla ya kujifungua kwa wasichana wenye ujauzito katika wilaya ya Temeke mkoa wa Dar es salaam. Lengo kuu la huu utafiti ni kuchunguza uelewa na sababu pamoja na changamoto kwa wasichana wajawazito kuhusu maandalizi kabla ya kujifungua.

Ushiriki katika utafiti

Unaombwa kushiriki katika utafiti huu. Ukikubali kushiriki utafiti huu taarifa zako zitachukuliwa kwa ajili ya utafiti tu na si vinginevyo na ushiriki wako ni ridhaa yako binafsi na huru pasipo madhara yoyote.

Usiri

Taarifa zote utakazotoa zitatuzwa katika usiri mkubwa, hutatakiwa kujaza jina lako, taarifa zako zitakusanywa kwa namba ya utambulisho pekee na kama majibu yatatangazwa au kutolewa taarifa katika mkutano wakisayansi hakutatolewa jina au taarifa yoyote inayokutambulisha wewe.

Athari

Utafiti huu hauna aina yoyote ya athari kimwili, kibaologia au kiakili.

Haki ya kujitoa katika utafiti

Ushiriki wako katika utafiti huu ni hiari yako na una haki kukataa kuto kushiriki au kujiondoa katika utafiti huu hata kama umetoa kibali cha kushiriki. Kukataa kushiriki au kujiondoa katika utafiti hutatoa fidia au kupoteza faida zako.

Nani wa Kuwasiliana

Kama kuna swali lolote lile kuhusu utafiti huu, wasilliana na mtafiti mkuu Pendo Said, kwa namba ya simu ya mkononi +255 625812613). Kama una swali lolote kuhusu haki zako kama mshiriki unaweza kuwasiliana na mkuu kamatiya kitengo cha utafiti na utangazaji Prof. Joyce Masala katika Chuo kikuu cha Afya na Sayansi Shirikishi Muhimbili, Sanduku la Posta 65001, Dar es Salaam. Simu: +255 2150302-6.

Madhiriano ya Ushiriki wa Utafiti

Kama unakubali

Je? Unakubali kushiriki, weka alama ya tiki (√) katika kisanduku husika

Ndiyo ☐ Hapana ☐

Mimi, _____ nimeelezwa / nimesoma maelezo yote ya fomu hii na nimejibiwa maswali yangu yote. Nimekubali kushiriki katika utafiti huu.

Sahihi ya mshiriki _____Tarehe _____

Sahihi ya mtafiti _____ Tarehe _____

Appendix V: Letter for Ethical Clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

P.O. Box 65001
DAR ES SALAAM
TANZANIA
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Tel G/Line: +255-22-2150302/6 Ext. 1015
Direct Line: +255-22-2151378
Telefax: 255-22-2150465
E-mail: dpgs@muhas.ac.tz

Ref. No. DA.287/298/01A/ 27th July, 2018

Ms. Pendo Said
MPH-Distance Learning
MUHAS

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: BIRTH PREPAREDNESS AND COMPLICATION READINESS AMONG PREGNANT ADOLESCENTS'S GIRLS IN TEMEKE MUNICIPAL, DAR ES SALAAM

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from 27th July, 2018 to 26th July, 2019. In case you do not complete data analysis and dissertation report writing by 26th July, 2019, you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Emmanuel Balandya
ACTING: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Medicine

Appendix VI: Introduction Letter

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

P.O. Box 65001
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E-mail: dpgs@muhas.ac.tz

Ref. No. HD/MUH/T.405/2015

31st July, 2018

District Executive Director,
Temeke District
DAR ES SALAAM.

Re: INTRODUCTION LETTER

The bearer of this letter Ms. Pendo Said is a student at Muhimbili University of Health and Allied Sciences (MUHAS) who is pursuing MPH-Distance Learning.

As part of her studies she intends to do a study titled:"***Birth preparedness and complication readiness among pregnant adolescents girls in Temeke Municipal Council, Dar es Salaam".***

The research has been approved by the Chairman of University Senate.

Kindly provide her the necessary assistance to facilitate the conduct of her research.

We thank you for your cooperation.

Ms. T.C. Kayama
For: DIRECTOR, POSTGRADUATE STUDIES

cc: Dean, School of Public Health and Social Sciences
cc: Ms Pendo Said