KAMUZU COLLEGE OF NURSING

Pregnancy Related Stigma Experienced by Adolescent Mothers in Blantyre District

A thesis submitted to the University of Malawi, Kamuzu College of Nursing in Fulfilment of the Requirement for the Master of Science Degree in Midwifery

By

Jessie Achsah Chirwa Msuku

Supervised by

Associate Professor A. Chimwaza

SEPTEMBER, 2016

Declaration

I, Jessie Achsah Chirwa Msuku hereby declare that this thesis on 'pregnancy related stigma experienced by adolescent mothers in Blantyre district' is my own work. This work has not been presented for any award at any university within and outside Africa. It is being submitted for the award of Master of Science degree in Midwifery in the University of Malawi, Kamuzu College of Nursing. All the sources of information that have been used have been acknowledged and added to the list of references.

Jessie Achsah Chirwa Msuku

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Name

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Signature

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Date

Certificate of Approval

The undersigned approve that this thesis represents the student's own work and has not been presented anywhere else within or outside Africa

Signature______________________________ Date___________________________

Dr. Angela Chimwaza, PhD (Associate Professor)

Main supervisor

Dedication

This thesis is dedicated to my husband Dr. Sandress Msuku and my wonderful children Theodora Palesa and Sandra-Theanna for their patience during the period of my studies.

I also dedicate it to my parents, my brothers and sisters. It is also dedicated to all adolescent girls who feel stigmatised because of their pregnancy.

Acknowledgements

I thank the Lord God almighty for seeing me through the program of MSc in Midwifery and during the write up of this thesis. May His name be highly exalted and glorified.

I also owe the following people and organization my sincere gratitude for their assistance and contributions in various ways:

- Christian Health Association of Malawi (CHAM) for providing a scholarship for this Master's degree program.
- Associate Professor Dr. A. Chimwaza, my research supervisor for her untiring support, guidance and encouragement throughout the research process.
- Dr. Rachel Rodriguez for her support during the study.
- My husband Dr. Sandress Msuku for his support during my studies
- My daughters for their patience and perseverance during the entire period of my studies
- My parents, Mr. J.W. Chirwa and Mrs. E. Chirwa (Late (R.I.P) for giving me hope in every endeavor.
- Dave and Nellie Mwanyongo, your support throughout my study was awesome, God bless you.
- Leah, Leonard and Edward for spiritual and physical support. You are so wonderful.
- Dr. Wella, Mr. Chaima and entire KCN library staff for your untiring support throughout the entire program.

Abstract

Adolescent pregnancy in Malawi is high with 26% of all births to girls aged between 15 to 19 (Malawi national Statistical Office and ICF Macro, 2011). This early childbearing for adolescents brings challenges such as stigma. This qualitative descriptive study was done using a phenomenological approach to investigate adolescent mothers' lived experiences of stigma related to adolescent pregnancy in Blantyre district. The objectives of the study were to identify the sources of pregnancy related stigma experienced by adolescents; to determine how the experience of pregnancy related stigma affect adolescent mothers' socially, academically and when utilising health services, and to determine the strategies pregnant adolescents use to cope with stigma.

The study was conducted in Blantyre between September and December 2016. Convenience sampling technique was used to select 18 pregnant adolescents attending antenatal clinic at Ndirande health centre in Blantyre. A semi-structured interview guide was used to collect data from participants on one to one in-depth interview. Nvivo 10 was used to code the data. Data was analysed using thematic content analysis guided by Colaizzi's (1978) method. Four main themes emerged from the data which were; sources of stigma; stigma to parents; effects of stigma on adolescents' life and the coping strategies used to deal with stigma.

The findings showed that the sources of stigma pregnant adolescents experienced was from within themselves (self-stigma), family members, friends and other community members. On the effects of pregnancy related stigma, pregnant adolescents face rejection, social isolation, mockery, have feelings of shame and fear, thoughts of abortion and often drop out of school because of pregnancy. Accepting their situation, praying, isolation, use of media and social support are the strategies pregnant adolescent used to cope with the experiences of stigma. Recommendations include that adolescent or youth health programs

should be intensified in schools, and support groups for pregnant adolescents should be created to assist pregnant adolescents and avoid experiences of stigma.

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List of Abbreviations

AIDS:	Acquire Immunodeficiency Syndrome
BT:	Blantyre
DHO:	District Health Office/ District Health Officer
COMREC:	College of Medicine Research and Ethics Committee
HINARI:	Health InterNetwork Access to Research Information
HIV:	Human Immune Virus
MOH:	Ministry of Health
NSO:	National Statistical Office
UNFPA:	United Nations Population Fund
WHO:	World Health Organisation

Definition of terms

Adolescent: A person (in this study a girl) between the age of 10 and 19

Adolescent mother: An adolescent with pregnancy or one who has a child

Adolescent pregnancy: A pregnancy occurring to a girl between the ages of 10 and 19 years

CHAPTER 1

Introduction and Background

Introduction

Adolescents are people from ages 10 to 19 years (World Health Organisation (WHO), 2014) and adolescence is a transition period from childhood to adulthood. It is a continuum of physical, cognitive, behavioural and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity, self-esteem and progressive independence from adults (Save the Children (U.S.) and United Nations Population Fund, 2009). Adolescents are a major source of human resource for development of a nation (Kotwal, Gupta, & Gupta, 2008). They constitute up to 18% of the world's population with about 9% being adolescent girls. About 23% are in the sub-Saharan Africa population (United Nations Children's Fund (UNICEF) & others, 2012). In Malawi, adolescent girls constitute about 24% of the total population (National Statistical Office (NSO) 2012). According to National statistical Office (2010), the population of Blantyre was 1,020,500 in 2009/2010 comprising of 714,350 adolescents. Amongst these adolescents in Blantyre district, 164, 301 girls had begun childbearing.

Background Information

Pregnancy occurring between ages 10 to 19 years is termed as teenage or adolescent pregnancy. Adolescent pregnancy is a public health problem in the whole world. The World Health Organisation estimates that worldwide, 16 million adolescents between the ages of 15 to 19 years and some 1 million under 15 years give birth each year representing 11% of births worldwide (WHO, 2013; WHO, 2016). In low and middle-income countries, almost 10% of girls become mothers by age 16 with the highest rates in sub-Saharan Africa and south-central and south-eastern Asia (WHO, 2011). Adolescent pregnancy is acceptable in some

societies such as Swaziland, where adolescent girls engage in unprotected sexual intercourse because they want to prove their fertility to society and to have social acceptability with the pregnancy (Ziyane & Ehlers, 2006). However, in some countries such as Uganda, Malawi, United Kingdom (UK), United States of America (USA) premarital sex and adolescent pregnancy is unacceptable, and pregnant adolescents face psychosocial problems in their communities which includes being chastised and stigmatised (Atuyambe, Mirembe, Tumwesigye, Kirumira, & Faxelid, 2008;Yardley, 2008;Jimmy-Gama, 2009;Wiemann, Rickert, Berenson, & Volk, 2005).

Stigma is defined as a characteristic that makes someone different from others in the category of persons available for him/her to be, and of a less desirable kind reduced in our minds from a whole and usual person to a tainted, discounted one (Goffman, 1963). Parker and Aggleton (2003), defined stigma as a negative attribute mapped unto people, who in turn by virtue of their differences, are understood to be negatively valued in society. In addition, Herek (2002) defined stigma as an enduring condition, status, or attribute that is negatively valued by society and where possession consequently discredits and creates disadvantages for individuals. Stigma is also defined as unfavourable attitudes, beliefs, and policies directed towards people (Okechukwu, 2007).

Stigma can exist in several forms, and much research focuses on the perceived, experienced, anticipated, or enacted and internalized stigma that exists for those who are vulnerable. Perceived and internalized stigma refers to the perceptions and feelings of the individual about his/her situation (Fay et al 2009). Furthermore, Fay et al (2009) asserts that perceived stigma reflects how one thinks others will respond if they knew about their problem and in the case of teenage pregnancy how people would respond to the knowledge of adolescent girl’s pregnancy. Internalised stigma is how an adolescent feels about herself

regarding the pregnancy which may include fear and shame (Fay et al., 2010). Experienced stigma reflects the actual experiences of stigma adolescents face due to pregnancy.

Parker and Aggleton (2003) assert that most studies on stigma have focused on stereotyping as part of stigma. A stereotype is a set of beliefs about the characteristics or attributes of a group of people, which can lead to stigma and discrimination (National Centre in HIV Social Research (NCHSR), 2012). Stigma is typically a social process, experienced or anticipated characterised by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group (Weiss, Ramakrishna, & Somma, 2006). In many societies this is experienced by adolescents who are pregnant or mothers as they are the subject of moral judgement from friends, families, medical professionals as well as the community as a whole (Ellis-Sloan, 2014).

Adolescents are a special group of people in reproductive health as they are still developing physically, psychologically and socially. They are faced with life experiences which includes experimentation on sexuality. For some countries they face social pressure to prove fertility and to attain a status and acceptance in the society (Wood & Jewkes, 2006; Osaikhuwuomwan & Osemwenkha, 2013; Ziyane & Ehlers, 2006) which leads to pregnancy before they reach age 20. Most of these adolescent girls have low access to health services during pregnancy because they have feelings of uneasiness, fear, shame and embarrassment (Amuyunzu-Nyamongo, Biddlecom, Ouedraogo, and Woog, 2005; Bankole and Malarcher, 2010). Similarly, Atuyambe et al. (2008) in Uganda found that adolescent mothers have poor health seeking practices for reproductive health services due to stigma in their communities. Similarly, Bearinger, Sieving, Ferguson and Sharma (2007) reported that adolescent girls avoid seeking health care services even when they have a health problem for fear of being chastised, stigmatised or punished for sexual involvement. Adolescents in Oregon faced

discrimination from health workers during prenatal care, labour and delivery because of their young age of childbearing (De Marco, Thorburn, & Zhao, 2008).

Zwang and Garenne (2009) in a study in South Africa found that when an adolescent becomes pregnant, she is isolated from friends and is stigmatised. Zwang and Garenne further state that the stigma is also applied to the adolescent mother's parents as they are regarded as failures in upbringing and controlling their adolescent girls. Similarly, Wiemann et al. (2005) in Texas, found that adolescents experience stigma from their friends, peers, parents and health workers. In other countries such as the United Kingdom, adolescents are highly stigmatised by the media and the general public (Yardley, 2008).

Craig and Stanley (2006) adds that young adolescents are stigmatised because of their age (being young) and being without a partner during pregnancy and motherhood. For the adolescents, this mostly results in social isolation, distress, mistrust, loss of confidence and often they shun health services. Freitas, Cais, Stefanello, and Botega (2008) found that pregnant adolescents in Brazil had low levels of social support, depression, traumatic life events and other psychosocial difficulties. Most adolescent girls do not attend school for fear of being stigmatised by peers (Madondo, 2013). The psychological distress experienced by pregnant adolescents was because of the unplanned pregnancy (Wilson-Mitchell, Bennet & Stennet, 2014).

In Malawi, over 35% of all pregnancies were adolescent (teenage) pregnancies (National Youth Council of Malawi, 2009). According to International Conference on Population and Development (ICPD) (2012), adolescent birth rate was at 177 per 1,000 women in 2005. Early childbearing is high with 10% of female adolescents aged 15 to 19 giving birth each year (United Nations Population Fund (UNFPA) & Population Reference Bureau, 2012). The Malawi National Statistical Office and ICF Macro (2016), states that 29% of adolescents aged 15-19 years had begun childbearing; 22% have had a live birth and 7%

were pregnant with their first child. Adolescent pregnancy and early child bearing in urban areas is at 21% and 31% in rural areas.

According to Blantyre District Health Office's statistics, in 2008, Blantyre district registered 264 pregnant adolescents attending antenatal services out of 964 representing 27.3% in three health centres (Mdeka, Mpemba, and South Lunzu). According to Mbiza (2012), this poor health seeking practice of adolescents during pregnancy was attributed to stigma and other psychological factors which include feelings of shyness, fear, reluctance to open up, denial and concealed pregnancy.

Studies in other countries worldwide have examined the experience of stigma adolescent girls face during pregnancy, childbirth and after delivery. The studies indicated that adolescent girls experience stigma from themselves, friends, peers, parents, health workers, the media and the general public (De Marco et al. 2008; Wiemann et al., 2005; Whitley & Kirmayer, 2008; Yardley, 2008). Therefore, adolescent girls shun health services, do not attend school, have poor self-confidence, suicidal attempts, social isolation and other psychosocial difficulties (Atuyambe et al., 2008; Freitas et al., 2008; Fulford & Ford-Gilboe, 2004; Whitley & Kirmayer, 2008; Yardley, 2008). In Malawi, some of the studies done on adolescents focused on use of adolescent sexual reproductive health services (ASRHS) and risk factors of adolescent (teen) pregnancies (Chalasani, Kelly, Mensch & Soler-Hampejsek, 2012; Jimmy-Gama, 2009; Mbiza, 2012; Geloo,1999; Kaphagawani, 2008; Pell et al., 2013). In the results of these studies, stigma emerged as a factor that hinders use of ASRH services (Mbiza, 2012; Jimmy-Gama, 2009). However, there is a paucity of studies that have looked in detail at the sources of stigma in relation to adolescent pregnancy and how adolescents deal with the stigma. Thus, this study sought to explore the experiences of stigma that pregnant adolescents face during pregnancy and motherhood. The study focused on the sources of stigma related to adolescent pregnancy, the effects of stigma on adolescents' life in

academics, socially and when utilising health services. In addition, the strategies that adolescents used to cope with the stigma in the community have been explored.

Statement of the Problem

Pregnant adolescents experience stigma which is manifested by feelings of shame, fear, embarrassment and social isolation during pregnancy, childbirth and after delivery. The 2008 raw data from Blantyre district indicated that 27.3% (264 out of 964) pregnant adolescents attended antenatal in three health centres. This low attendance to health services during pregnancy was attributed to stigma and other factors (Mbiza, 2012). Therefore, adolescent girls may have pregnancy related complications if they do not access health care during pregnancy because of stigma. There was a need to identify the sources of stigma pregnant adolescents experience and the effects stigma has on their lives so that interventions are identified to address the stigma pregnant adolescents' experience.

Broad Objective

The aim of the study was to explore the experience of pregnancy related stigma by adolescent mothers.

Specific Objectives.

The objectives of this study were to:

- Identify the sources of pregnancy related stigma faced by adolescent mothers
- Determine how the experience of pregnancy related stigma affect adolescent mothers' socially, academically and when utilising health services
- Determine the strategies pregnant adolescents use to cope with stigma

Significance of the Study

The findings of the study are expected to inform Blantyre DHO, adolescent health program planners and all those involved in adolescent health services and the whole society about the experiences of stigma pregnant adolescent girls face. The findings have provided

knowledge and understanding of the existence of stigma associated with adolescent (teen) pregnancy which would assist in the development of interventions to address stigma experienced by adolescents for them to have a healthy life during and after pregnancy.

CHAPTER 2

Literature Review

Introduction

Literature review aims at laying a foundation for the new study because it generates an understanding of what is known about a particular situation (Burns & Groove, 2009). In this chapter the researcher outlines what is already known regarding adolescent mothers' experience of pregnancy related stigma from the perspectives of the sources of stigma experienced by adolescent mothers, how stigma affects their life as a whole and the strategies they use to overcome stigma in their society.

The researcher reviewed studies that were done within Malawi, the world and from other countries in Africa which were relevant to the study. Only English read studies were reviewed for easy understanding. The studies under review were supposed to be not more than 10 years old. However, a few older studies were included in the review due to their relevance and information that they contained. The databases that were used in literature search were: HINARI, EBSCO Host, Google Scholar and PubMed. The following search terms were used; stigma, adolescent pregnancy, teen pregnancy, coping AND adolescent pregnancy, stigma AND adolescent pregnancy, adolescent mothers and stigma, adolescent pregnancy stigma AND education, experiences of stigma.

Sources of Stigma Associated with Adolescent Pregnancy

Literature shows that adolescent mothers face challenges of stigma during pregnancy and motherhood in their communities. Most adolescents experience stigma from, friends, peers, parents, teachers, strangers, community members and health workers (Whitley & Kirmayer, 2008; Wiemann et al, 2005; Yardley, 2008; De Marco et al., 2008; Fulford & Ford-Gilboe, 2004; Micah, Joy, Chris, & Halimat, 2013; James, Rooyen, & Juanita Strümpher, 2012). Whitley and Kirmayer (2008) in Canada, found that pregnant adolescents

were stigmatised by strangers in the public arena. Wiemann et al (2005) in Texas investigated feelings of being stigmatised among adolescents that were pregnant. The results of the study indicated that a significant number (39.1%) of the adolescent mothers felt stigmatised because of the pregnancy. They experienced critical comments from their parents and teachers and felt abandoned by their boyfriends. Furthermore, Yardley (2008) in the United Kingdom found that most adolescent mothers were highly stigmatised by the media and the general public.

Adolescents also experienced stigma from staff in health services in hospitals and health clinics. Adolescents in Oregon face discrimination from health workers during prenatal care, labour and delivery because of the stigma associated with their young age of childbearing (De Marco et al., 2008). Similarly, Fulford and Ford-Gilboe (2004), found that adolescent mothers experienced stigma from contact with nurses, doctors, teachers, social assistance counsellors, older people, family members and friends.

Literature revealed that stigma of adolescent pregnancy and motherhood exist in many communities with different cultures. Societal norms and culture play a role in the stigmatisation of pregnant adolescents. Pregnant adolescents and their parents face stigma from the community members (Micah, et.al, 2013; James, et.al, 2012; Arai, 2007; Bankole & Malarcher,2010). Micah et al., (2013) in a study with 40 pregnant adolescents and kid mothers in Lagos which aimed at examining the coping strategies adopted by kid (adolescent) mothers to live out their stigmatization, found that in the Yoruba culture in Nigeria, adolescent pregnancy is highly stigmatised especially when the adolescent girl is not married. Micah, et.al, further stated that it is a taboo for a girl child to be pregnant when no man has asked her hand in marriage satisfied through fulfilling the traditional rites, hence the stigma associated with it. Similarly, James, et. al (2012), in their study with pregnant adolescents, their parents and grandparents in South Africa found that adolescent pregnancy is not

accepted in Xhosa as it disrupts the functionality of the family. The adolescent is rejected and sometimes disowned by parents for fear of them being embarrassed in the society because of the girls' pregnancy. Additionally, Arai (2007), found that pregnant adolescents are not always accepted in their communities.

Effects of Stigma on Adolescent Mothers

The effects of pregnancy related stigma highlighted in the literature will only focus on adolescent's academic life, their social and health lives. Studies are reviewed about how stigma affect adolescent mothers live in the three aspects of life.

Social life.

Literature reveals that stigma affects adolescents' emotional, mental health and social relationship. Stigma results in social isolation because of misfit with their peers and negative judgements from their friends which increase feelings of stress or depression and it also erodes their self-confidence (Fulford & Ford-Gilboe, 2004). In addition, Whitley and Kirmayer (2008) found that adolescents in Canada had social difficulties because of being misjudged of being failures and faced rejections in the public arena. They felt unaccepted and devalued in their families and society. Similarly, James et al., (2012) in a study in South Africa found that the pregnant teenagers experienced rejection by their peers. Furthermore, adolescent pregnancy is not accepted in their society. Freitas et al., (2008) concurred that pregnant adolescents in Brazil had low levels of social support, depression, traumatic life events and other psychosocial difficulties. The psychological distress experienced by pregnant adolescents was because of the unplanned pregnancy (Mitchell, Bennet & Stennet, 2014). Consequently, adolescent mothers who felt stigmatised were more likely to report alcohol use than those that did not (Wiemann et al., 2005).,

Literature shows that pregnant adolescents have fear to reveal about the pregnancy to their families and their partners (boyfriends). Due to the high stigmatization of pregnancy

outside of marriage, the consequences of unprotected sex and the potential for unwanted pregnancy can have severe social costs for these young women. Young unmarried women would fear telling their partner they were pregnant because the partner might deny responsibility, and would fear telling their parents because of their reaction (Levandowski et al., 2012). Similarly, Nor, Sumari, and Shah (2014) in a study on adolescents with an unwanted pregnancy the experience found that the fear of rejection that adolescents experienced prevented them from presenting the subjects to others about the decision to take care of the baby.

Studies have also revealed that pregnant adolescents have difficulties in associating with others in the community because of feelings of shame. Yardley, (2008) and, Melvin and Uzoma (2012) found that pregnant adolescents who are unmarried have feelings of shame because of pregnancy. Melvin and Uzoma (2012), further found that pregnant adolescents are allowed to stay with their parents to cover the shame of the pregnancy. These feelings of shame also affect adolescents' utilisation of health services. Conversely, Agundiade, Titiyalo, and Opatalo (2009), found that factors such as the feelings of shame, guilt, and discrimination, disappointments in themselves and their parents and the unwillingness to become a mother at that age influenced their preference for termination. In addition, being pregnant out of wedlock had diminished opportunities for adolescent mothers to talk about their wants and needs and left them with feelings of shame, powerlessness, frustration, a disgrace to the family, and isolation (Nor et al., 2014).

Effects of stigma on academic life.

Most adolescent mothers experience stigma because of pregnancy at school from their peers and teachers which lead them to drop out of school. In addition, most pregnant teenagers are less likely to complete high school or secondary education and will not attend school during the pregnancy because of fear of being stigmatised by their peers (Wiemann et

al., 2005; Gregson, 2009; Wallace, 2011; Madondo, 2013). Stigma of adolescent pregnancy lead adolescent girls to stop attending school and often drop out of school (James et al., 2012; Edgardh, 1999; Atuyambe et al.,2008). Edgardh, (1999) and Atuyambe et al. (2008), found that adolescent pregnancy greatly affects education and that over one third of adolescent mothers drop out of school because most secondary school authorities expel pregnant teenagers from school due to pregnancy.

Literature revealed that parents of pregnant adolescents withdraw their children from school on realisation of the pregnancy. Chohan and Langa (2011) in a study with eight (8) teenage mothers in Johannesburg found that the teenage mothers were scared and shocked on finding out that they were pregnant and their parents were also disappointed in them which made the parents to withdraw their adolescent girls from education which result in the adolescent failing to cope with academic life's demands. Similarly, due to the stigma associated with teenage pregnancy or in annoyance, many parents withdraw their children from school or places where they are learning a vocation (Ebeigbe & Gharoro, 2007). Furthermore, Amoah (2013) found that pregnant adolescents reported to have dropped out of school because their parents refused to pay the school fees on realization of pregnancy. The reason of withdrawing the girls from school was that parents of adolescents view it as embarrassing and unacceptable for a pregnant teenager to mix with other school children as she was, traditionally, an outcast (James et al., 2012).

Utilisation of health services.

Pregnancy related stigma affects adolescents' utilisation of health services. Adolescents have poor health seeking behaviour due to stigma which may compromise their health during pregnancy and after delivery. Atuyambe et al. (2008), in a study with first time adolescent and adult mothers in Uganda found that adolescent mothers have poor health seeking practices for reproductive health services due to stigma in their communities.

Similarly, Bearinger et al. (2007), reported that adolescent women avoid seeking health care even when they have a health problem for fear of being chastised, stigmatised or punished for sexual involvement. Additionally, Robb, McInery and Martin (2013), found that young mothers fear judgement and have self-stigmatisation which hinders them from accessing important information from health personnel. In the same view, Ebeigbe and Gharoro, (2007), in a study with teenage mothers in Benin, Nigeria, found that a significantly larger proportion of teenagers (47.4%) were unbooked for antenatal care compared with older nullipara (25.7%). Among teenagers booked, none registered for antenatal care in the first trimester and more than half booked in the second trimester, while the rest booked in the third trimester. Attributable to the stigma associated with teenage pregnancy, many of them do not utilize available antenatal care services. Most adolescent girls have low access to health services during pregnancy because they have feelings of uneasiness, fear, shame, and embarrassment (Amuyunzu-Nyamongo et al., 2005; Bankole and Malarcher, 2010).

Literature has revealed that lack of support for pregnant adolescents result in serious health problems. In a study in Uganda, it was revealed that pregnant adolescent sought abortions as a result of stigma and lack of social support (Wallace, 2011). Additionally, Wang, Wu, Anderson and Florence (2011); Whitley and Kirmayer (2008) found that stigmatised women usually develop mental health problems such as depression and suicidal ideas. Conversely, Freitas et al., (2008) found that pregnant adolescents had higher prevalence rates than non-pregnant girls, for attempted suicide (20% *vs.* 6.3%), depression (26.3% *vs.* 13.6%) and anxiety (43.6% *vs.* 28%). These factors may complicate the pregnancy and eventually lead to the death of the baby as well as the mother.

In Malawi, adolescent pregnancy includes stigmatization of young mothers (United States Agency for International Development, 2010), which leads to poor antenatal attendance by pregnant adolescents (Mbiza, 2012). The stigma surrounding adolescent

mothers may affect their ability of utilising reproductive health services including antenatal care services which is essential during pregnancy. This may result in poor pregnancy outcome and pregnancy related complications such as miscarriage, still birth, premature birth, fistulas and babies of low birth weight (Munthali, Chimbiri & Zulu 2004).

Strategies used to Cope with Pregnancy Related Stigma by Adolescents

Studies reveal that adolescents who experience stigma withdraw from people who are judgmental or show disrespect and sometimes drop out of school to avoid stigma (SmithBattle, 2013). In addition, Yardley, (2008), found that use of humour and verbal defence were the coping strategies for adolescents who experienced stigma.

Literature revealed that social support is one of the coping strategies employed by pregnant adolescents who experienced stigma. Fulford and Ford-Gilboe, (2004) in a study with adolescent mothers in south-western Ontario, Canada, found that sources of support most frequently identified by participants were their own mothers (70%), followed by friends (52%), partners and extended family members (40%), health professionals, their own fathers (33%), and their siblings (25%). They further stated that the participants who received support had lower levels of felt stigma.

Lewis, Scarborough, Rose and Quirin (2007) in a reflective study with an adolescent mother, found that peer support assisted adolescent mothers to overcome stigma associated with pregnancy and adolescent motherhood. Similarly, Boath, Henshaw and Bradley (2013) in a study with first-time mothers aged 16-19 years old, found that social support from adolescent's mother, father, partner, family members and professional support for adolescent mothers, eliminate consequences of being an adolescent mother. They further found that peer support gave these young women an opportunity to compare their experiences of motherhood, with others in a similar situation, gain knowledge and advice and discuss some of the primary difficulties they had experienced as parents.

The adolescent mothers stated that the importance of friends or relatives in their support of young mothers is essential as they all have babies and that they do not fear judgement by them (Robb et al., 2013). Conversely, Wahn, Nissen, and Ahlberg, (2005) in their study with pregnant adolescents and parenting teens of ages ranging from 15 to 19 years in South western Sweden, found that the pregnant and parenting teenagers experienced the support that they received from their family networks as the most important for them, especially the practical support from their own mothers. This supportive relationship might have a facilitating effect on transition to parenthood. Additionally, Sekiwunga and Whyte, (2010) and Micah et al., (2013) found that teen mothers identified their mothers as a significant source of support.

Literature also indicated that adolescent mothers find support through religious activities when they are faced with challenges of early motherhood. Melvin and Uzoma (2012) in a study with adolescent mothers in Nigeria which aimed at exploring adolescent mothers' (13–20 years) subjective well-being by focusing on their childbirth, mothering experiences, and available network of supports. The results showed that some of the participants also expressed their belief in the efficacy of prayers, believing that their prayers would be answered through active engagement in religious activities when faced with challenges including stigma. Similarly, Agundiade et al., (2009), in a study with adolescent mothers on pregnancy stigmatisation and coping strategies of adolescent mothers in Nigeria found that personal resolutions which included religious measures were their coping measures for survival.

Summary of Literature Review

The literature reviewed show that adolescents who are pregnant and mothers face the challenge of stigma in various aspects of life. They face stigma in their daily life as a social being, when utilising health services which compromise their lives as pregnant women and

mothers. These adolescents have poor tendency to access health services including antenatal services because of stigma from adult women as well as health providers.

Most studies on stigma in Malawi have focused on stigma related to HIV and AIDS, and other notable medical conditions. Mbiza, 2012 in a study with pregnant adolescents found that stigma and other psychosocial factors influence the utilisation of health services. However, there is limited data to identify the sources of stigma experienced by pregnant adolescents and strategies used to overcome the stigma. The study therefore sought to investigate and add to the body of knowledge the sources of adolescent pregnancy related stigma, how the experienced stigma affects adolescents' lives and the strategies used to overcome the stigma.

CHAPTER 3

Methodology

Introduction

This section describes the methodology used during the study. The section describes the study design, study setting, study population, sample size, sampling method, inclusion criteria, pretesting of data collection tool, data collection method, data management, data analysis, trustworthiness of the data, plans for dissemination of findings and ethical consideration.

Study Design

This qualitative descriptive study used a phenomenological approach to investigate adolescent mothers' lived experiences of stigma related to adolescent pregnancy. According to Denzin and Lincoln (2005) qualitative research is an interpretive and naturalistic description of the world. This approach is useful when investigating people's experience of a particular phenomenon. Specifically, the study explored the sources of stigma, effects that pregnancy related stigma has on adolescent's social life, academic life and utilisation of reproductive health services during pregnancy and after delivery, and the coping strategies that pregnant adolescents used to cope with the stigma. The participants were interviewed using a semi-structured interview guide with probes.

Study Setting

Study setting is defined as the physical location where the data collection takes place (Polit & Beck, 2010). The study was conducted at Ndirande health centre in Blantyre district. The area was chosen because it is where more adolescent women in Blantyre register for antenatal care (Youth Friendly coordinator, BT DHO, personal communication, January, 2014) therefore it was an ideal area to conduct the study. Permission to access the health centre was obtained from the Blantyre DHO because it is one of their health centres.

Study Population

A study population according to Polit and Beck (2010) is defined as the entire population in which a researcher is interested and would generalise the results. The target population of this study was adolescent women aged 12 to 19 who were between 7 months and 9 months pregnant, and those that had delivered within a period of 2 years. The population was chosen because at 7months gestation, the pregnancy is visible, and for those that delivered within 2 years because they lived through the pregnancy and had experience.

Sampling

Sampling is defined as the process of selecting a portion or subset of the designated population to represent the entire population (Wood & Haber, 2006). This study used convenience sampling a nonprobability sampling technique. Convenience sampling is used to select participants that are available and have elements to be in the sample (Boswell & Cannon, 2011). Pregnant adolescents who were available for antenatal services on daily basis were approached because of their availability and accessibility. During screening of pregnant women, available pregnant adolescents were isolated to be screened further to check if they met the criteria for participation into the study. Therefore, only those pregnant adolescents who met the criteria were recruited to participate in the study.

Sample Size

A sample is part of the targeted population comprising of individuals that represent the characteristics of the target population (Burns & Groove, 2009). The researcher intended to interview a sample of 20 pregnant adolescents. Only 18 pregnant adolescents were interviewed. No new information came out when interviewing the 15th participant which meant that data was saturated. However, data collection continued till the 18th participant. When there was no new information emerging after interviewing the 18th participant, no further interviews were conducted. Polit and Beck (2006) states that sample size is

determined based on informational needs. Data saturation was the guiding principle in sampling. The sample size may increase or decrease depending on data saturation. Data analysis was done concurrently with data collection in order to ascertain data saturation and to identify emerging themes. The researcher paid attention to emerging themes to check when no new themes were coming out of new interviews at which point saturation had occurred.

Inclusion criteria.

Participants of the study were adolescents, 7 months pregnant or more because by this time the pregnancy is visible and those with a child less than 2 years old during the time of study because their experience was recent. They were only those adolescent girls between the ages of 12 and 19 years.

Exclusion criteria.

Adolescents who were not pregnant, a pregnancy of less than 7 months did not participate because at less than 7 months in young girls, pregnancy is mostly invisible. Adolescent mothers with a child more than 2 years old did not participate in the study because only recent experience of within 2 years was required. Those less than 12 years old did not participate because articulation of issues may be difficult for a girl younger than 12 years old.

Study Period

The study was conducted for a period of one year.

Data Collection

Data was collected using in-depth one-to-one interviews to solicit experiences of adolescent mothers regarding stigma associated with adolescent pregnancy. The interview guide was formulated in English then translated into Chichewa for easy understanding by the participants (see appendix II). The interview guide had two sections. The first section was on demographic data in which the following data were collected: age, marital status, religion,

education, occupation, number of children and age at marriage (see appendix I). The second section was on qualitative data. The data were collected from questions about the pregnancy, experiences of stigma, utilisation of health services and the strategies used to cope with stigma (see appendix II). Interviews were recorded verbatim so as to capture detailed data. An audio recorder was used to capture verbatim data and field notes were taken to capture expressions of the participants and observations during the interview.

Data Collection Process

The researcher commenced data collection after obtaining ethical approval from COMREC. Permission to start data collection was also obtained from the DHO of Blantyre district. Subsequently, the researcher obtained permission from the health centre in-charge of Ndirande health centre who then introduced the researcher to the nurse in-charge of the antenatal clinic. The nurse in-charge was briefed about the study and its objectives. Then, the nurse in-charge introduced the researcher to the department staff and clients who were present on the particular day. Participants were recruited with assistance from the nurse in-charge of the antenatal clinic of the health centre where the study took place.

Adolescents who met the criteria were included after detailed explanation of the study and its aims (Appendix IV, V & VIII). Those that accepted to participate in the study were given a consent form to sign (Appendix VI, VII & IX). All interviews were tape recorded after obtaining consent from participants to do so. A voice recorder was used to tape record all data. Names of participants were not recorded for confidentiality and privacy. However, codes were used on the field notes to keep track of the participants. Interviews were conducted in a room that provided audio and visual privacy where the adolescents felt comfortable to narrate their experience.

Each interview took approximately 30 minutes to 1 hour. Sometimes pregnant adolescents who were present did not meet the criteria to participate in the study therefore no

one was recruited on particular days. One recruited participant withdrew from participating in the study and she was allowed to do so.

Data Management and Analysis

The researcher was in control of all tape recorded and written information from the interviews. Analysis of the collected data was done simultaneously with data collection to isolate themes and adjust the interview guide to obtain more information. In qualitative research, data analysis begins when data collection begins. It is necessary to constantly review records to discover questions that need to be asked and to clarify emerging issues in subsequent interviews (Speziale & Carpenter, 2007). At the end of each interview, the researcher listened to the tape recorded information to check if the data collected was correlating and relevant to the study. In the course of listening to audio taped interviews the researcher made initial notes on emerging themes. The recorded data were transferred and stored in a computer accessed only by the researcher.

Data were then transcribed verbatim in Chichewa then translated into English. For accuracy, transcripts were read repeatedly. The researcher then proof-read the written transcripts by simultaneously reading and listening to the recorded data to avoid distortion of data. Later on, an independent person translated the English version back to Chichewa to validate the data and to ensure that the original information was not lost. Nvivo was used to code the transcribed data. Similar codes were collated and sorted into categories. Emerging themes were compared with the original data to verify accuracy.

Throughout the study, signed consent forms, transcripts and field notes were filed and kept under a lockable cupboard for safety and to maintain confidentiality. The electronic data were safely kept in the researcher’s computer and assigned a password known by the researcher.

Demographic data were analysed using descriptive statistics. Qualitative data were analysed using Colaizzi's (1978) method of analysing data which has seven steps as follows:

Stage 1: Reviewing the collected data.

The process started immediately after each interview whereby the researcher listened to the tape recorded information in order to verify if all crucial information areas had been captured and to identify areas that needed additional data. The tape recorded data were transcribed verbatim and all written data were read word by word. Each transcript was read repeatedly to familiarize with the data and generate meanings of the content.

Stage 2: Extracting significant statements.

This stage was executed after all the interviews had been completed. More data were obtained, however, the researcher was more focused on the significant data relevant to the phenomenon under study to extract significant statements. The significant statements were extracted from each transcript and jotted down in a notebook on separate pages for each interview.

Stage 3: Formulating meanings from extracted statements.

In this stage, the researcher revisited the extracted statements from each participant. The statements were put into context to understand its meaning in participants' own terms. Statements with similar meanings were grouped together into one category.

Stage 4: Organising the formulated meanings into cluster of themes.

The researcher in this stage, grouped similar statements together into categories that reflected a distinctive cluster of themes. Each theme was coded. The themes were then sorted into major themes representing the main issues that came up, and sub-themes which represented other issues that supported the major themes.

Stage 5: Integrating results into an exhaustive description of the phenomenon under study.

At this stage, the researcher defined the themes into a comprehensive description. To support each theme, the researcher isolated statements from interviews that reflected participants' feelings and ideas on a particular theme.

Stage 6: Identifying fundamental structures.

At this stage, the researcher emphasized only on the significant structures. The researcher then, organised the results so that they flow logically and make sense.

Stage 7: Member checking.

This is the final stage in the approach. The stage aims at validating the findings using member checking technique. This stage required the researcher to go back to the participants to check if the results truly reflected what they said. However, in this study, this was done immediately after each interview because it would have been impossible to take back the findings to each participant. Direct quotes from adolescents have been used to reflect the participants own true words.

Trustworthiness of the Research

In this study, the researcher used the framework that was developed by Lincoln and Guba (1985). Four criteria were suggested for developing the trustworthiness of qualitative inquiry which are credibility, dependability, confirmability and transferability as standards.

Credibility.

Credibility refers to the activities that increase the probability that findings are credible (Lincoln and Guba, 1985 as cited in Speziale and Carpenter 2007). Lincoln and Guba pointed out that credibility involves two aspects: first carrying out the study in a way that enhances the believability of the findings, and second, taking steps to demonstrate credibility in the research report (Polit & Beck, 2012). In depth interview was used in order to

obtain the real understanding of the study. The researcher also used prolonged engagement with the participant in order to have in depth understanding of the pregnant adolescents' experiences to achieve the purpose of the study. Open ended questions which were relevant to the study were used during data collection to allow the participants to provide as much information as possible. Probes were also used to prompt the participants to give relevant and true information. After each interview the researcher summarized the information and checked with the participants to verify what they articulated. Direct quotes from the participants have been used to anchor the report.

Dependability.

Dependability refers to the stability of data over time and over conditions (Polit and Beck, 2010). Dependability was enhanced through description of the methodology, objectives, the sample and analysis method (Holloway & Wheeler, 2002). This ensures dependability given that the study is replicated in the same context. In this study, the interview question scripts are kept for comparison in future with a replicated study. The researcher thoroughly documented the methodology step by step so that other researchers may repeat the process and obtain similar findings in the same context.

Confirmability.

Confirmability refers to objectivity between two or more independent people about the data's accuracy, relevance and meaning (Polit and Beck, 2010). The criteria ensured that the data obtained reflects participants' perspectives and not the researcher's views. In this study confirmability was enhanced through keeping an activity log where decisions were recorded during collection and analysis of data. The tape recorded data from interviews were presented as findings in participants on words to reflect their own views and not biases or views of the researcher. Two graduate researchers listened to the recorded interviews and the themes coded to ensure accuracy of the study results.

Transferability.

Transferability refers to the probability that the study findings have meaning to others in similar situations (Speziale & Carpenter, 2007). According to Lincoln and Guba, the investigator's role is to provide necessary descriptive data that is applicable to other contexts (Polit & Beck, 2012). Transferability was enhanced through in-depth description of the methodology and discussion of findings of the study so that others can apply data in other contexts. For validation purposes, a research diary was kept during field work which was used to write a reflective log. The diary was kept from the start of the study to the finishing of the same to record all decisions made during the study.

Ethical Considerations

Before commencement of the study the researcher obtained ethical approval for the study from the University of Malawi, College of Medicine Research and Ethics Committee (COMREC) through Kamuzu College of Nursing. After ethical approval, the researcher sought permission to commence the study from the District Health Office responsible for the health centres. Upon reaching the health facility (study site) permission was sought from the officer in-charge of the facility so that the nurse/midwife of the health centre could be assigned to assist in identifying the participants.

Informed consent of the participants, voluntary participation, ensuring privacy and confidentiality of participants were the priorities for the study. Codes were used to identify participants and no names of participants were recorded to ensure participants confidentiality. Interviews were conducted in a place where there was no interference and distraction. The room was closed to ensure physical and audio privacy of the participants. An information sheet for the details of the study was given to participants for clear understanding before participating in the study (appendix IV). For participants who reported to the clinic with their mothers, a parental consent (appendix VIII) and assent form (appendix X) were given before

enrolment into the study. Most participants were emancipated minors and they gave consent to participate in the study. This ensured that people gave an informed consent before participating in the study.

Participants and parents were told that there were no physical or psychological risks, however, in case of participants' discomfort during the study, they were free to withdraw or refuse to answer any questions. This had no effect to the care they received. All participants were told that there were no direct benefits from the study to the participants, however, the study would assist to improve the health of adolescents.

Constraints of the Study

The issues that were discussed during the interviews were sensitive that some participants found it difficult to discuss those issues. Some participants were shy to articulate and narrate their stories. Others had painful memories which made them cry during interview. They were allowed to express their feelings and when they were calm, they were allowed to continue narrating their story. Probes were utilised to source the necessary information from the participants.

The study setting may have had an influence on the participants not to talk more on stigma experiences from health workers. This was a qualitative study with no randomised sample therefore no generalisation of the findings.

Plans for Dissemination of Results

The researcher plans that the Master's degree thesis would be submitted to the University of Malawi, and a copy would be placed in the library at Kamuzu College of Nursing. Study results would be published in relevant international and local journals. In addition, results would be presented at local, regional and international conferences.

CHAPTER FOUR

Presentation of Findings

Introduction

This chapter presents the findings of the study which aimed at investigating adolescents' experiences of pregnancy related stigma in Blantyre district. The specific objectives of the study were to: identify the sources of pregnancy related stigma faced by adolescent mothers; determine how the experience of pregnancy related stigma affects adolescent mothers' socially, academically and when utilising health services; and to determine the strategies that pregnant adolescents used to cope with stigma.

The findings are in two sections. The first part highlights the demographic characteristics of the 18 pregnant adolescents who participated in the study at Ndirande health centre antenatal clinic. The second part presents the analysis of qualitative data which was derived from one on one in-depth interviews with participants using a semi-structured interview guide. Six main themes emerged from reading the transcripts several times and from familiarization with the data. The themes of the study were; perpetrators of stigma; stigma to pregnant adolescents' parents; psychosocial wellbeing of pregnant adolescents; stigma as a disturber of education; utilisation of health services; and managing a spoiled identity. Direct quotes from participants have been used to demonstrate what was said. No names of participants were used in the analysis instead codes were used to identify the participants. However, the name of facility where the study was conducted has been mentioned.

Demographic Characteristics

A total of eighteen (18) pregnant adolescents within a gestation of 7 and 9 months pregnant were interviewed. The participants were within the age range of 14 and 19 years. The pregnant adolescents belonged to different religious groupings. The majority (13) of the

participants were Christians of different denominations. Table 4-1 shows the demographic characteristics of participants.

Table 4-1: Demographic characteristics of participants

Characteristics	Frequency (n=18)
Age	
14-16 years	8
17-19	10
Marital Status	
Single	11
Married	6
Separated	1
Educational Level	
None	0
Primary standard 1-5	1
Primary standard 6-8	9
Secondary form 1-2	5
Secondary form 3-4	3
Tertiary	0
Religion	
Seventh day Adventist	4
CCAP	6
Muslim	5
Other	3
Occupation	
Student	0
House wife	5
Business woman	1
Unemployed	12
Age at marriage	
14-16	4
17-19	3
Number of children	
0	17
1	1
2	0
Age at first pregnancy	
14-16	10
17-19	8

Results from Qualitative Data

The qualitative data were analysed using thematic code analysis which was guided by Colaizzi's (1978) method. The findings were clustered into six main themes. These included (1) perpetrators of stigma; (2) stigma to pregnant adolescents' parents; (3) psychosocial wellbeing of pregnant adolescents; (4) stigma as a disturber of education; (5) utilisation of maternal and child health services; and (6) managing a spoiled identity. These themes and their subthemes, categories and subcategories have been described in the sections that follow. Table 4-2 summarises the themes and their subthemes.

Table 4-2: Themes and Sub-Themes

THEME	SUB-THEME
Perpetrators of stigma	Self (self-stigma) Stigma from family members Stigma from friends Stigma from other community members
Stigma to parents	
Psychosocial wellbeing of pregnant adolescents	- Self-isolation - Rejection - Portraying negative emotions - Mockery - Emotional disclosure of trauma - Thoughts of abortion
Stigma as a disturber of education	- Withdrawal from school - Withdrawal from school because of lack of support
Utilisation of maternal and child health services	- Lack of interest - Shame and fear
Managing of a spoiled identity	- Acceptance of the pregnant situation - Use of media - Withdrawal from people - Praying - Social support

Perpetrators of Stigma

The study found that most of the participants (13) experienced stigma during pregnancy. To determine the perpetrators of stigma pregnant adolescent experienced, they were asked to explain if they were being stigmatised because of the pregnancy. Four

subthemes emerged under the theme perpetrators of stigma. These were: self (self-stigma), stigma from family members, stigma from friends, and stigma from other community members.

Self (self-stigma).

A few of the participants (n=5) experienced self-stigma during their pregnancy. The pregnant adolescents isolated themselves, had fear and feelings of shame when they were among others. They also felt that people were talking bad about them and that others were gossiping about them. They indicated that they felt that when people knew about their pregnancy they would talk badly about them and not support them anymore. They further felt that people did not want to associate with them as well as talk to them because of the pregnancy. One of the participants stated:

> The moment I heard that I was pregnant, my heart was not stable……No one stigmatised me but it was my own doing because I always stayed in the house and people would come but I was telling my sisters that they should say that I am not available. (P16)

Stigma from family members.

Most of the participants (n=8) indicated that they experienced stigma from their family members. Particularly, fathers and mothers portrayed a negative attitude towards them. Their family members did not want to talk to them. They also did not want them to live in the same house. The parents threatened to disown the girls because of the pregnancy. Some (n=3) were disowned after parents knew about the pregnancy. Their fathers were hard on them that they told them to leave the house as it was a disgrace to the family. Some parents or guardians told them to leave the house because they felt that the pregnancy was proof that they wanted to start their own lives. One of the participant commented that:

> When my father came home, instead of talking to my mother he started insulting me. He said to my mother…. 'Now tell your daughter that she should look for a house to rent with her boyfriend. I don't want her here at my house. (P8)

Another participant who stayed with her aunt also narrated that:

> I was staying with my aunt, and when she realised that I was pregnant, she told me to leave her house and stay with my boyfriend. So I left to stay with my boyfriend at Chiradzulu, but my boyfriend later on ran off without telling me where he was going. (P10)

The participants added that besides their parents not wanting them in their house, they did not want the girl to access the household food and other necessities. They withdrew the financial and material support they provided to them.

One participant said that her mother used to hide her whenever people visited their house and prevented her from having any contacts with other people. She narrated that her mother hid her when her school teacher came home to visit and enquire why she was no longer going to school. This is illustrated in this interview quote:

> ……. When anyone asked about me, they were told that 'S' is not home she has gone out. ……then even when my school teacher came home when I was in the house my mother hid me and told her that I was not home, I was at the market. (P8)

Other family members kept mocking them because of being pregnant out of wedlock. The relatives kept saying to the pregnant adolescent that the pregnancy was from the bush and without a husband (*yapatchire, yopanda bambo*) and it was a result of not listening to parents and elders. One participant indicated that her grandmothers kept mocking her for being pregnant illegally and out of wedlock. She had to say:

> My grandmothers were still teasing me, I would hear them say ‘a child who doesn’t listen to advices ends up like that, with a pregnancy’. They were calling me ‘*kaphuga*’. ‘*Kaphuga*’ is a song about illegal pregnancy, and I would hear them say ‘go and do your ‘*kaphuga*’ and get away with that pregnancy from the bush, don’t bother us here’. Then I would think ‘oh, my own relatives treating me like this. (P11)

Stigma from friends.

The participants (n=7) reported that they experienced stigma from their friends, both at school and at home. Their friends did not want to associate with them or even chat with them. The friends were gossiping and talking about their friend’s pregnancy after chatting with them. The participants indicated that the friends talked bad about them that they were proud in school and they knew that their friend would end up pregnant. These friends were laughing at them. They said that their friends deserted them because they did not want to associate with someone who was pregnant. One reason the pregnant adolescents’ friends stigmatised them was fear of being labelled “bad girls” together with them. The friends told them that they did not want to see them as they will be labelled “bad girls” who are involved sexually at a young age. One of the participant said:

> Some of my friends at home (neighbours) were not talking to me, they didn’t talk to me because of the pregnancy. Some of the friends I had at school all this time would not talk to me when I met them on the road. They just passed me by without greeting me, even if I greet them they would not respond. They were just laughing at me. (P8)

Another example on the issue of being labelled as bad girls is illustrated by one of the participants in this interview excerpt:

> Some of my friends were stigmatising me. They were not chatting with me. ……as I am pregnant now they would say amongst themselves ‘don’t chat with her she will

teach you bad things that you should also get pregnant, don't chat with her'. Saying that 'it is not necessary to chat with a pregnant girl……. we will also be called bad girls who are involved with men as young as we are. (P14)

Stigma from other community members.

The participants (n=6) experienced stigma from people in their community. They indicated that the people insulted them, mocked them and talked bad about them. The neighbours insulted them for being pregnant out of wedlock that they only wanted to bother their parents to take care of them and their pregnancy. They further added that the pregnant adolescents had to go to their 'husbands' and not bother their parents. They said they should leave the parents' house because they did a disgraceful thing to their families by being pregnant. In addition, some community members were laughing at them and did not want to associate with them. They were gossiping about them and talked bad about them whenever they see them. One participant said:

…… my neighbours eeh….one time they sat in a group talking, so they started talking about me that 'why can't you leave? Maybe you need a bag? Or maybe we should pack for you eeh.' Then, …… another woman said 'eeh you should get married …... you really want to be a mother eeh?' She talked a lot of bad things to me. (P9)

The adolescents were insulted more about the pregnancy since the adolescents were not married. They reported that their mothers' neighbours were intimidating them that since they got pregnant they will face a hardship during delivery. For those that were married they were mocked that the boyfriends married them only because of the pregnancy, otherwise the pregnancy was even unable and doubtful to be the responsibility of the man that married them.

Stigma to Parents

A few of the participants (n=3) expressed that their neighbours and their mothers' friends talked bad about their parents because of the girls' pregnancy. The findings of the study revealed that despite the stigma to the pregnant adolescent girls, their parents were also stigmatised by their neighbours and their mothers' friends. The neighbours insulted their parents especially their mothers. One reason they gave was that the parents failed to control the girls. The neighbours did not want to talk to the girls' parents. They talked bad about the girls' mothers that they did not bring up the girls well. On the issue, one participant expressed that:

> ...eeeeh... my mother's friends were saying that 'how could the daughter of the Pastor's wife get pregnant in her house?' ... when my mother goes to church the people continued to insult and talk bad about her that her daughter is pregnant… (P14)

Psychosocial Wellbeing of Pregnant Adolescents

This theme described the effects that stigma had on the participants. Five subthemes emerged under this theme. These were, self-isolation, rejection, portraying negative emotions, emotional disclosure of trauma, and thoughts of abortion.

Self-Isolation.

This is a state or a situation of being separated from others. Some participants (n=8) indicated that they had self-isolation because they were avoiding their friends and neighbours; and also to conceal the pregnancy from their friends. They indicated that the self-isolation came in as soon as they realised that they were pregnant and when others knew about the pregnancy. One reason for avoiding their friends and other people was that they were talking bad about their pregnancy. The people said that the girls had a pregnancy and would have a child without a father. The girls also reported that they felt that their friends did

not want to associate with them because of their being pregnant. Additionally, they were shy to face their friends especially their schoolmates. One of the participants explained that:

> I was just staying alone. I was always staying alone in the house; I only went out to eat *nsima* or to take a bath then I would get back in the house. It was like I just got used to staying alone. (P4)

Rejection.

This is the act of refusing to accept the pregnant adolescents. Most of the participants (9) faced rejection from parents, boyfriends and friends. The boyfriends rejected the pregnancy and denied knowing the girls. The participants reported that the boyfriends rejected them in front of their parents and denied them with influence from their relatives and friends. They indicated that their boyfriends' friends and relatives spoke badly about the girls. One participant indicated that her boyfriend's sister clearly stated that her brother would not marry her and that the pregnancy was not his responsibility. Others denied and rejected the girls because they did not want to have a child. The boyfriends said they were young to be fathers and were not ready to take the responsibility as they were also dependent on their parents. One of the participants said "when I went to my boyfriend's parent's home to explain about the pregnancy, he denied it. He denied it because of his mother. His mother told him to reject me and deny the pregnancy." (P2)

Similarly, other participants described being rejected by their parents or guardians. They explained that their parents or guardians disowned them when they heard about the pregnancy. The fathers of the girls were very angry and bitter at the news that they did not want to see the girls in the house. They indicated that they were chased from home and were told that they would be escorted to stay at their boyfriend's home. Another example of rejection and abandonment was described in the following interview excerpt:

When I realised that I missed my period I told my boyfriend that I have missed my period, so he said that 'you are lying, how can I believe that? You are lying.'……. Later when my father heard about the pregnancy he started shouting at my mother, saying that '……. I don't want your daughter here at my house, tell her to go and look for a house to stay with her boyfriend, I don't want her here anymore! (P8)

Portraying Negative Emotions.

The unpleasant emotion or thought that pregnant adolescent had because of the news of their being pregnant. Two categories emerged fear; and feelings of shame and guilt. Most of the participants (n=12) had these unpleasant emotions because of the pregnancy.

Fear

Seven (7) of the 12 pregnant adolescents reported that they were afraid to disclose their pregnancy to their parents despite their boyfriend's acceptance of being responsible for the pregnancy. The reason was fear of being chased from home, being shouted at and being disowned by their parents. They also indicated they feared that their parents would be angry with them and they would be not allowed to stay in the house.

In addition, the participants reported that they feared their guardians and those that supported their education would pull out the support. They indicated that their fear came in because of being pregnant while at school; while living in their parents' house and being pregnant at a younger age. They stated that they were worried and afraid of their parents discovering about the pregnancy. One of the participants said:

I was afraid because my parents are strict. My mum kept asking me and saying that she was suspecting that I was pregnant. She said that if I am found pregnant she will send me to the village.... for fear of telling them the truth I told my boyfriend to inform them about the pregnancy because they would not be difficult. (P14)

Another participant also described fears of being disowned by her parents as a result of the pregnancy. She stated that:

> I left my parents' house and I was staying with my boyfriend. …. Iiih, I was so afraid, I feared they would shout at me…. so I was only calling my mom, I did not call my dad. At first I called my sister. My mom said that I should not be afraid, 'it has happened there is no need to fear, and after all you will complete your studies after you deliver the baby'. That's when I got courage to call her, but I have never called my dad since. (P17)

Feelings of shame and guilt

A few (n=5) of the participants had feelings of shame. These are feelings of guilt, regret or sadness that the adolescent girls felt for being pregnant. The main reason for having shame was being pregnant at a young age. They were so ashamed to meet their friends from school when going for antenatal care services. They expressed that they felt their friends would be talking about them. They were ashamed to face elderly women at the antenatal clinic. The fact that they were pregnant made them feel ashamed about it. Despite some participants being married, they were ashamed with the pregnancy because they were young. One participant stated that:

> …I was feeling ashamed of myself considering my age and my maturity, oh no, it's not on. I was feeling ashamed of myself, there was nobody who was talking to me about my pregnancy but I was just feeling ashamed myself. It was that I myself was feeling ashamed of it, I was feeling ashamed of it. You know what, I always accept that I am young but the pregnancy just happened by chance it was not my wish. ….. but I accept it in my heart that I am what? I am young and I cannot be married at the age of 18, that's not on. (P11)

Emotional Disclosure of Trauma.

This refers to expressions of worry and feelings of hurt because of a painful experience. The findings showed that most of the participants (n=12) expressed worry and feelings of hurt with what they were experiencing from boyfriends, friends and relatives. They were worried to see that their friends stopped talking to them and that they were alone most of the times. Their relatives' comments left them worried, hurt and heart-broken. Instead of offering support they were mocking and rejecting them. They added that the rejection from their boyfriends kept them worried that they thought of aborting the pregnancy. One participant described the trauma of being rejected by her boyfriend. She said:

> I was quite affected because my boyfriend denied me, I was really affected, it pained me in my heart that 'has he really denied me?' Whenever I see him it pained my heart because I had made up my mind that he had accepted it and then later it happened that he denied me, that was not right. (P7)

The participants were worried that their parents rejected them and denied them the chance to continue with education. The parents threatened to disown them and others were disowned. They were also told to abort the pregnancy for the purpose of continuing with education. In the following interview excerpt an adolescent girl describes the experience of being forced to drop out of school, and being forced to abort the pregnancy by her parents. She said:

> When my father told me that I should no longer go to school, it hurt me so bad. He said yes, 'you should not go to school, your boyfriend has already told us that you are pregnant'. ……. Even when my mother was planning that I should abort the pregnancy, it was hurting me. It was also worse when my teacher came and told my mother that I could have passed exams and be selected to go to secondary school,

this made my mother to continue executing her plan for the abortion of my pregnancy. (P8)

Thoughts of abortion.

In addition to the worry and hurt feelings, some pregnant adolescents experienced thoughts of abortion. Stigma led the adolescent girls to having thoughts of abortion. Some of the participants (n=7) had thoughts of abortion because of the challenges they were facing as a result of their pregnancy. They reported that with the rejection of friends and fear of being disowned by their parents they thought an abortion was the solution. They also reported that they felt an abortion would give them a peace of mind and they will continue having support and love from their parents. One participant said:

> 'Of course I was not stable in my mind after knowing I was pregnant because I was also thinking of doing abortion. I thought, what will the people who pay me school fees think when they know I am pregnant?', because school fees had to come'. (P16)

For some girls, friends, boyfriends and parents, particularly their mothers, influenced them to undertake an abort so that they could continue with their education. They reported that the mothers offered to provide financial support for the girls to abort the pregnancy. They also explained that their mothers did not want anyone to know that the girls were pregnant hence encouraging the girl to terminate the pregnancy. One of the pregnant girls said:

> I heard this from my mother but I don't know who suggested this idea to my mother, I only heard her talking to the elders that 'the best way is for her to abort that pregnancy and leave that man'. My relatives said 'she will not accept that' and when they asked me I refused, I said 'I cannot abort and the way I am now I cannot do that and I will keep it. (P11)

Another participant added on the same issue that:

> Eeeeh iiih when my mother knew about my pregnancy, she did not go to my boyfriend. She just said that 'I want my child to be educated so I will take her to Banja La Mtsogolo clinic tomorrow to do what, to have an abortion. I have money I will pay for it'. She was discussing that with our neighbour that 'you want your child to write examinations, why are you tolerating her like that, just let her have an abortion'. ………my mother took it that when I get back from the village she will proceed with her plan for me to have an abortion. She could have made me have an abortion but my boyfriend refused. (P8)

For some it was their boyfriends who suggested to them to have an abortion. The girls reported that the reason the boyfriends gave was that they did not want to have a child at an early age hence telling the girls to abort once they discover they were pregnant. The boyfriend did not care about them being pregnant. This is highlighted in this interview extract:

> 'When we were in a relationship my boyfriend told me that once I discover that I am pregnant I should have an abortion because he did not want to be a father yet, but I was not happy with the idea'. (P17*)*

The findings also show that the participants' friends advised them to abort. The friends suggested to them to use drugs and other substances to terminate the pregnancy. They also reported that their friends not only did they suggest but offered them the substances and drugs to induce abortion. Their friends advised them that real girls undertake an abortion to avoid embarrassment with the pregnancy and to continue with education. Their friends mocked them with the pregnancy and pressured them to undertake an abortion. The adolescent girls reported that they had to decide whether to abort or not, of which most of

them did not heed to the advice they were given about aborting their pregnancy. One of the pregnant adolescents had to say:

> When my mother was talking about abortion, she was with my two friends and they said, 'as you are explaining that you want your daughter to have an abortion, yes go ahead the way school is nice let her have an abortion so that she should continue going to school and write the primary school leaving certificate examinations. (P8)

Another participant attempted to abort the pregnancy but failed. She said:

> …… My friends were fooling me by saying that there are certain drugs that people use for abortion, so they were saying that 'there are certain drugs, let's go and do it' it happened that I went to take those drugs but those drugs did not work, my pregnancy was still intact. (P16)

Stigma as a Disturber of Education (academics).

Two subthemes emerged under this theme namely withdrawal from school and lack of support.

Withdrawal from school.

Most of the participants (16) withdrew from school because of pregnancy. About ten (10) of the pregnant girls were still in primary school and a few (6) were in secondary school. The reason pregnant adolescents withdrew from school were fear of being recognised that they were pregnant by their friends and teachers, and being ridiculed by their classmates. The girls indicated that the pregnancy made them sick and sleepy in class hence the thought of withdrawing to avoid their friends suspecting that they were pregnant. Some were ashamed and shy when their friends knew of the pregnancy. They explained that withdrawing from school was also to avoid facing embarrassment when the pregnancy becomes visible. They called this 'self-discipline'. One of the participants said:

> I left school when my pregnancy was three (3) months old. I just left by my own will…… people became suspicious and started asking that 'how come you were not feeling nausea or dozing in class before, what is happening with you?' And then I decided to discipline myself, I stopped going to school completely. (P11)

Withdrawal from school because of lack of support.

A few of the participants (4) reported that when their parents and guardians knew of the pregnancy they forced them to withdraw from school as they would no longer support their education. Their parents were no longer willing to support their education after knowing about the pregnancy. They also said that when their friends from school knew about the pregnancy they did not support their friend rather they were gossiping and talking too much about the pregnancy. This made them uncomfortable that they no longer went to school. One of the participants said:

> My father told me that I should no longer bother myself to prepare for school because he would not allow me to go back to school.… At school people had already known that I was pregnant and when others asked that why is it that S is not coming to school. They said 'it is because she is pregnant… You know when you are the head girl the rumour spread fast. They were gossiping about me, especially about the pregnancy. … my mother … lied that I was not going to school because I am changing schools'. (P8)

Utilisation of Maternal and Child Health Services.

The present study focused on utilisation of antenatal care services. To determine the utilisation of maternal and child health services participants were asked when they started attending antenatal care services (ANC) and what influenced them. They were also asked how often they attended antenatal services and their experience at the health facility. Two

subthemes emerged under this theme which were lack of interest to attend ANC services; and feelings of shame and fear to attend ANC services.

Lack of interest to attend ANC services.

About six (6) of the participants had no interest to attend antenatal care because they felt it was not necessary to do so. They also reported that they felt that it was elderly women not teenagers who attend antenatal clinics. The reason was that they wanted to start antenatal care when the pregnancy was visible enough. They also lacked interest because they did not want to meet their friends (schoolmates) when going for antenatal services while their friends were going to school. One participant who was refusing to attend antenatal care due to lack of interest stated that:

> Iiiih! I was refusing to attend antenatal, but it was that I became sick. …. for a long time. When my mother asked her friends about my illness, they were just saying that let her go and start antenatal services, she will be assisted there. So I started antenatal but I was so bored because I did not want to start antenatal before the pregnancy was six months old. When I got sick I did not want to go straight to antenatal clinic. (P 8)

Feelings of shame and fear to attend ANC services.

The participants (8) indicated that they had feelings of shame and were afraid to attend antenatal care services. They were afraid to be scolded by the older women and nurses at the clinic because of their younger age. They explained that it was not in normal circumstances that as young as they were they should be going for antenatal services. Their young age and a single status made them to have the feelings of shame. They reported that they were not thinking that they could go to antenatal care services because they had dreams to complete their studies. Therefore, they refused to attend antenatal because they were feeling sorry for themselves because of their age. One of the participants said:

> I was still somehow feeling shame, because, of course a class is one thing and here (antenatal clinic) is another. ...But now here some people have also feelings that a child like that one, what is she doing here? A child like that one, what is she doing here? Yes, because some people look at you and think so many things about you and so forth. It was the pregnancy which made me feel ashamed. (P12)

A married adolescent said:

> You know what, I always accept that I am young. …… I was not thinking at all but I was feeling ashamed, of course it's lately that I have stopped feeling ashamed but I was feeling ashamed of myself. …… All along in the process of registering for antenatal care, I was still feeling ashamed ……. because I am young. When I went back home from the hospital, my husband asked me that 'why did you act in a shameful way embarrassing me as if you don't have a husband?' then I told him that 'I am feeling ashamed because I am too young. (P11)

Managing of a Spoiled Identity

This refers to the measures the pregnant adolescents took to manage and deal with the experience of stigma. Their image or identity was tainted because of the pregnancy thus stigma. Five subthemes emerged under this theme. These were acceptance of the pregnant situation, use of the media, withdrawal from people, praying, and social support

Acceptance of the pregnant situation.

Most of the participants (12) accepted their situation of being pregnant. They indicated that boyfriend's acceptance of the pregnancy, parents and relatives' acceptance assisted them to cope with the stigma they were experiencing within themselves and from other people. The participants stated that their self-acceptance of being pregnant helped them to move on with life despite being stigmatised by friends, parents, relatives, neighbours and

boyfriends. They reported that it was not feasible to deny the fact that they were pregnant, because the baby was still growing within them. They also stated that even though they had thoughts to abort the pregnancy, they realised that it was God who gave them the child for there are others who are longing to have children. They further expressed that it was their body which had the pregnancy therefore it did not matter whether people treated them badly because of the pregnancy. One participant revealed an example of self-acceptance, parents, boyfriend and relatives of boyfriend's acceptance shown in the following interview excerpt:

> I just accepted it, let it be that way, that's all. Of course I was not stable because I was also thinking of doing abortion but on second thought I decided not to. ... the way my mother was encouraging me, then I decided that's fine I can keep the pregnancy. My boyfriend said that 'that's fine, if you are pregnant let it be like that …. don't have an abortion because you can die'. ... At his home when they heard about it, …. they accepted it because sometimes I was going there, yes, so they accepted and said that 'yes, this person has been coming here', yes, they accepted and they did not become difficult. (P16)

The participants indicated that parents' acceptance of the pregnancy eased their stress. They reported that they were afraid that parents would disown them after knowing about the pregnancy. For this thought participants stated that they ran away from home to live with their boyfriends. However, they explained that when they contacted their parents, they were disappointed that they ran off from home. The parents accepted the situation and encouraged them to return home. Others indicated that when they thought their parents would abandon and leave them at their boyfriend's home, they told them that they would take care of them and the baby. At times being accepted occurred after being disowned and chased from the house. An example of parents' acceptance is illustrated in the interview quote:

……. then my father said ‘but look, she is your child and the husband has denied her, so what are you going to do with her?’ and then my mother said that ‘that’s alright, you will be living here in this house. (P7)

Use of media.

The media in this study refers to television, radio, newspaper or magazine. A few of the participants (4) said they used the media to deal with their stigma experience. They used to listen to the radio and watch movies as a measure of coping. These assisted them to forget all the insults they received from friends, neighbours and family members. It was also a way of letting time pass. The other reason was to avoid contact with friends who insulted them. One participant said that reading a magazine helped to clear the mind off all the bad experience. Another participant commented that:

> I was just staying at home listening to the radio and sometimes watching movies. I did this to avoid people talking about my pregnancy and insulting me…sometimes I would read magazines and newspaper to get things off my mind. (P5)

Withdrawal from people

This entails the act of shunning away from friends and other people or keeping oneself away from others. The study findings revealed that most participants (10) withdrew themselves from friends and neighbours because of their pregnancy. They reported that they told their friends to stop chatting with them. They said they chose to keep away from their friends to avoid being insulted and mocked. They felt that with a continuous contact with people they would be insulted, mocked and others gossip about them. The adolescents reported that this made them feel at ease and free of the feeling of stigma. They also said it helped them not to concentrate on what people were talking about them.

One of the participants explained as shown in the selected interview quote:

> When the pregnancy became large I told them, I think maybe you should stop chatting with me and find others to chat with because some people like gossiping 'that one has a pregnancy, she is so and so' like gossiping too much. I will also find other friends. (P7*)*

Another participant said:

> ...to avoid what was happening I chose not to talk to my neighbours. When I stay quite the whole day doing my own things, I did not have more worries about what they were talking about me and my pregnancy. (P9)

Some participants (7) stayed in the house to avoid being stigmatised due to the pregnancy. The findings revealed that they were being insulted, mocked and others gossiping about them because of the pregnancy. This made them to stay indoors to avoid people talking. They reported that when they stayed in the house they forgot all the insults people were talking about them. They also reported that they made sure to avoid activities done outdoors to avoid disturbing their minds when they see people talking outside. They said that they felt that whenever they were outside the house people were talking about them. One of the participants used to stay indoors to cope with the insults from others. She had to say "I thought that to prevent and avoid people's insults and gossip, I would rather stay in the house. In so doing they will not talk about my pregnancy or talk about me". (P14)

Another participant added that:

> I stopped going to the borehole to draw water because people were just talking about me. I told my sister to be drawing water so that people stop talking about me. They were finding a story when they saw me, so I told them to talk about something else not me. (P8)

The findings also showed that some (n=4) pregnant adolescents used sleep as one way of coping with stigma from others and themselves. They reported that this was done to get rid of the worries they were having because of the experience they were having. They stated that they would sleep during the day to avoid contact with those that gave them a hard time. They explained that sleeping and resting in the house was a better way to deal with the stigma they were experiencing from friends and neighbours. One of the participants said:

> Sometimes I would go in the house and have a nap and when I wake up my heart would be cooled. It was helping me because I was not thinking anymore when I sleep. When I woke up sometimes, I would be watching films and so forth, 'that's fine, that's the way it is. (P7)

Praying.

Some of the participants (4) reported that they used prayers to overcome the challenges they were experiencing. Whenever they were insulted by their neighbours and friends they would pray or go to church for prayers. Some were encouraged by their parents to pray for those that were insulting them. It was indicated that prayer assisted them to forget about the problems they encountered on that particular day. One of the participants stated that she would go to church twice a week to let time pass so that she avoids people talking bad about her.

One participant said that she would pray for all the people particularly the neighbours that were insulting her and talking bad about her. She stated that prayer with her family assisted her to forget the insults as shown in the following selected quote:

> In our family we like praying a lot, so my parents told me that when someone does something wrong to us, we should just kneel down and what, and pray. When we pray together, I would forget all the wrong things and bad words people said about me

about my pregnancy. I knew that someday God will do a miracle for me and all those people will be ashamed. There is nothing for me to do or say for those that offend me and talk bad to me. (P9)

Another participant indicated that she prayed for her boyfriend because he rejected her and denied responsibility of the pregnancy. She said:

I just prayed that Lord, let not this rejection by my boyfriend stick too much in my mind, it might make me lose my weight, and also as a result they say if you think too much while pregnant you end up becoming sick regularly, …. because of thinking too much. ……Yes, that's how I stopped thinking and I even stopped thinking about any other person. (P7)

Social support.

Three categories emerged under this subtheme namely, support from family members, support from boyfriends and their relatives, support from fellow adolescent mothers (peers) and support from other community members.

Support from family members.

Support from family members helped them to forget their challenges and cope with the stigma. The support included provision of emotional, financial and material care to those that needed it. The findings of the study revealed that most of the participants (11) received support from their loved ones (family). It was revealed that mothers were the core providers of support to the pregnant adolescents. Their mothers were very supportive and kept encouraging them to keep the pregnancy despite the stigma they were experiencing. They were also encouraged not to worry because of the pregnancy. The mothers encouraged them that they would always go back to school after the baby is delivered. They further reported

that their mothers defended them when their fathers were shouting at them for being pregnant at a younger age. One of the participants had to say:

> …….. the way my mother was encouraging me, then I decided that's fine I can keep the pregnancy. It was my mother who sat me down and told me that 'you staying inside will not do you any good because maybe you will have bad thoughts, so you better keep on chatting with your friends, whether they will be mocking you or not don't be concerned, I have also gone through the same situation, they were mocking me but I was not concerned and don't be concerned. Of course they will mock you but by the end of the day it will come to an end, don't think that they will do anything to you and there is no any problem because tomorrow it will be their turn'. Then I went to chat with my friends and if they come I would get out and chat with them then off they went, now I feel free. (P16)

The findings revealed that apart from getting psychological support from their mothers, pregnant adolescents also received financial and material support. They said although they no longer lived in their parents' home, their mothers provided for them. They stated that they would get food and money for their day to day living to sustain them during pregnancy. A few of the participants (6) indicated that they received that kind of support from their boyfriend's mother and their own mothers. One of the participants said, "My mother support me in such a way that if I don't have food or if I don't have money, my mother gives me money." (P13)

Another participant commented that besides her mother's support, her father was also supportive when she was being stigmatised by her neighbours. She said:

> For my neighbours I was not so much worried because my parents were supportive. They were encouraging me when I explain what was happening, that some neighbours

insult me. When they encourage me I would have no worries and thought of what they were saying. Mostly I would talk to my mother and as a family she would tell my father. Most of the times I would talk to her, she was encouraging me., I also talked to my mother's best friend. I talked to her because sometimes I could not go direct to my mother, so I would speak through her. She is understanding and supportive as well. (P9)

Support from boyfriends and their relatives.

The study findings also revealed that the participants' boyfriends and their relatives offered emotional and material support for them to cope with the stigma they were facing. Their boyfriend's relatives offered material support even though the adolescents were not married. The participants said that they were discouraged from aborting the pregnancy. They stated that they wanted to abort in order to conceal the presence of the pregnancy. One of the participants said:

…. My boyfriend's parents said that it's alright, 'we will provide everything that will be needed during this period. We will be bringing anything that we can find for assistance. My parents said it was fine with them as long as I stay with them at home. (P8)

Support from fellow adolescent mothers (peers).

The study findings revealed that pregnant adolescent resorted to talking to fellow adolescent mothers to cope with the stigma they were experiencing. They reported that they felt comfortable to talk and interact with their peers who had children about their experiences. They expressed that their fellow adolescent mothers encouraged them not to mind the bad things other people were talking about them for being pregnant. Their peers told them that they had to forget all the insults people talk about them and focus on living a healthy life.

Their peers encouraged them about their similar experience when they were pregnant. The support from associating with fellow adolescent mothers were shown in the following selected quotes:

> Yes, there is a person, one of my neighbours, we are very close and I was able to confide in her everything. …. she was able to encourage me that 'don't worry too much, we have also gone through that way'. …. now I have enough courage because she encourages me up to now. (P16)

Another participant commented on the same that:

> My daily life was fine because I was able to chat with other people who were also denied by their boyfriends and in doing so they were encouraging me. I was worried but because of that I would say 'that's fine, that's the way how things should be'. (P7)

Another participant explained that she was supported and encouraged by friends to attend antenatal services. She said:

> I was afraid and ashamed to go for antenatal services because of my age then my friends were just encouraging me to go. Where I stay there are also girls who are pregnant. They were encouraging me and telling me to go and start antenatal care at the health facility. (P1)

Support from other community members.

The study findings revealed that some of the participants (6) received support from elders and other people (strangers) to cope with the challenges they were experiencing. They reported that talking to their mothers' friends about the rejection, insults and failure to associate with people because of the pregnancy helped. They indicated that they felt comfortable to talk to them other than talking to their own mothers. The participants talked to older women who encouraged them to overcome their feelings of shame and embarrassment

during prenatal visits. They expressed that they were so ashamed to get accustomed to the routines of antenatal clinics. They also reported that they were shy and ashamed to associate with others especially the older women during prenatal services. They felt talking to women who sat close to them although they did not know them would help. One participant explained in the selected quote:

> At antenatal clinic, I told a certain woman who sat close with me…. that 'I am feeling ashamed here'. Then she started laughing, 'what are you ashamed of?' Then I said that 'because it's something difficult for me, this is my first day'. She said that 'no, it's something difficult when a person is beginning. Don't feel shame and be like the way how your friends are conducting themselves', so I would stay. (P12)

Another participant explained being supported by women in her neighbourhood. She explained in this interview excerpt:

> Like women, eeh, they were encouraging me. When I say so and so were talking bad about me, so the women would encourage me that 'you are not the first and only one who did that there are others out there, girls like you who did the same. Some did not even reach the class you reached they got pregnant a long time before. (P6)

CHAPTER 5

Discussion

Introduction

This chapter presents a discussion of the research findings on the experiences of pregnancy related stigma by adolescent mothers in Blantyre. The purpose of the study was to explore the experience of pregnancy related stigma by adolescent mothers. The specific objectives of the study were to:

- Identify the sources of pregnancy related stigma faced by adolescent mothers
- Determine how the experience of pregnancy related stigma affect adolescent mothers' socially, academically and when utilizing health services.
- Determine the strategies pregnant adolescents use to cope with stigma.

However, the discussion focused on the six major themes and their sub-themes that emerged from the analysis of the data. The themes were: (1) perpetrators of stigma; (2) stigma to pregnant adolescents' parents; (3) psychosocial wellbeing of pregnant adolescents; (4) stigma as a disturber of education; (5) utilisation of maternal and child health services; and (6) managing a spoiled identity. Recommendations for improvement of adolescent reproductive health services and areas of further study have also been discussed in the chapter.

Perpetrators of Stigma

The findings of the present study revealed that the perpetrators of stigma that pregnant adolescent girls experienced were from within themselves (self-stigma), family members, friends and the community. This is consistent with the findings of Micah et al. (2013); Whitley & Kirmayer (2008); Arai (2007) and Fulford & Ford-Gilboe (2004) that pregnant adolescents experience stigma from family members, friends, strangers and others in the community. Whitley and Kirmayer (2008), found that in Canada pregnant adolescents were

stigmatised by strangers in the public arena. Wiemann et al., (2005) further support the finding that a significant number (39.1%) of adolescent mothers in their study felt stigmatised because of the pregnancy. Similar to adolescents in Wiemann et al.'s study, participants in this present study described fear of what others might think of them (self-stigma). Thus, Wiemann et al. suggest that service providers for adolescent reproductive health services should make thorough assessments in order to address effects of stigma perpetuated by all sources.

Arai (2007) found that adolescent mothers are not always accepted by others in their community. Micah et al. (2013), state that in the Yoruba culture in Nigeria, it is a taboo for a girl child to be pregnant when no man has asked her hand in marriage satisfied through fulfilling the traditional rites. Adolescent pregnancy is a source of stigmatization in Yoruba culture and several cultures in Africa. Therefore, in most communities, culture plays a role in the stigmatisation of pregnant adolescents which leads to most pregnant adolescents being stigmatised by community members.

Other studies have revealed that pregnant adolescents experience stigma from health workers, the media and the general public. The studies show that adolescents face discrimination and experience stigma from contact with nurses, doctors and other health workers during prenatal care, labour and delivery because of stigma associated with their young age of childbearing (De Marco et al., 2008; Yardley, 2008; and Fulford & Ford-Gilboe 2004). These findings are however contrary to the findings of the present study as pregnant adolescents did not highlight or mention any stigmatisation from health workers. The pregnant adolescents indicated that they were supported by the health workers in the health clinics during their prenatal services and delivery for those that were pregnant for the second time. They also did not indicate any stigmatisation or judgement by strangers in the general public rather only those that were known to them in their society.

Stigma to Parents

The study revealed that pregnant adolescents' parents faced stigmatisation because of the girls' pregnancy. Parents faced mockery and insults from people in their community. They were regarded as failures in bringing up their daughters. Zwang and Garenne (2009), concurs that stigma is also applied to the young mother's parents as they are regarded as failures in upbringing and controlling their adolescent girl. In addition, the experience of pregnancy in adolescence is usually accompanied by emotional disturbance not only for the girl child but also parents in that parents also share in the stigma (Micah et al., 2013). The parents are usually filled with shame and embarrassment because of the adolescent's pregnancy. James et al. (2012) agree that the stress of adolescent pregnancy is not only experienced by the adolescent girls but also the mother. The mother of the pregnant adolescents blames herself for failing her duties to raise the girl, face embarrassment and shame from the community members. In the present study parents' feelings of shame were shown when parents hid their pregnant girls from having any contact with people and also from proposing an abortion to conceal the pregnancy. This indicates that mothers were ashamed to let people know that the girls were pregnant for fear of being embarrassed.

Psychosocial Wellbeing of Pregnant Adolescents

Self-isolation.

The study found that pregnant adolescents isolated themselves from friends and other people because of their pregnancy. They isolated themselves to conceal the pregnancy and to avoid being embarrassed and being judged by people. They also isolated themselves for fear of being mocked and insulted by others especially the neighbours and friends. However, their friends also isolated them when they knew about the pregnancy. This finding is in line with Duckett (2009) in a study which aimed at examining the process of developing resilience following an adolescent's transition into motherhood. The results showed that social isolation

increases the likelihood of adverse outcomes and decreases the quality of parenting and support. Wiemann et al., (2005) concurs that adolescent mothers who were identified as experiencing stigma were also more likely to report isolation from friends.

Zwang and Garenne (2009) also stated that when a young woman turns from an adolescent into a young mother, she finds herself isolated from friends who no longer want to visit her. Her old friends say that she should now socialize with other mothers. Zwang and Garenne further indicated that such isolation from the peer group is often perceived negatively by young mothers who may end up blaming or neglecting their child. This is because they feel unaccepted and devalued in their families and society (Whitley & Kirmayer, 2008). In the present study the isolation resulted to worry and loneliness. This may negatively affect the well-being of the pregnant adolescent who may then opt for termination of the pregnancy or end up having postpartum depression. As such, there is need for health care providers to thoroughly assess pregnant adolescents for feelings of social isolation and abandonment from peers and partners during their encounter at the health facility. In addition, examining their social and economic support network may be important and may help to minimize feelings of anguish, despair, and other mental health difficulties that may result from isolation. Therefore, pregnant adolescents' assessment should be done holistically, assessing all aspect of their life, that is, physically, psychologically and spiritually.

Rejection.

The findings of the study revealed that pregnant adolescents faced rejection an indication that they were being stigmatised because of their pregnancy. The pregnant adolescents faced rejection from friends, family members and their partners. This is in line with the observation of Atuyambe et al. (2008) that pregnant adolescents are more likely to experience rejection by the partner, parents and to be stigmatized. The adolescents in the present study indicated that their parents were angry at them and threatened to abandon them.

Others were disowned by their parents by sending them away to their boyfriends. This finding however is different with that of Whitley and Kirmayer (2008) who observed that young mothers experienced rejection in the public arena from unknown strangers in buses, streets or at parks. Rejection of pregnant adolescents may also compel them to terminate the pregnancy which may have negative consequences for their lives.

Portraying negative emotions.

The study findings show that pregnant adolescents have feelings of shame and are afraid because of the pregnancy. They had these feelings because of their age. These findings are similar to the findings of a study done in the United Kingdom where teen mothers reported feeling resentment, fear, shame, anger, and worthlessness in response to stigmatizing experiences (Yardley, 2008). Nor et al. (2014) concurs that being pregnant out of wedlock left adolescent mothers with feelings of shame, powerlessness and frustration. Pregnant adolescents were afraid to disclose the pregnancy to their parents for fear of being chased from home, being shouted at and being disowned by their parents. They also feared losing educational support from their parents and guardians. However, literature indicates that adolescent mothers are forced to stay with their partners to cover the shame and explore the possibility of working out a socially acceptable marriage and the legitimacy of the child (Melvin & Uzoma, 2012). This is the reason most parents of pregnant adolescents suggested of leaving the girls at their boyfriends' house or aborting the pregnancy. This may show that they wanted to cover the shame that the pregnant girl brought to the family.

Thoughts of abortion.

The study found that the stigma pregnant adolescents felt and perceived drove them to think of aborting the pregnancy. They thought that the only way of concealing the pregnancy and avoiding stigma was an abortion. This is consistent with the findings of Micah et al., (2013) that the magnitude of stigmatization and social disapproval constitute motivation for

adolescent pregnant women to consider abortion as negotiable option to avoid stigmatization and public shame. Levandowski et al., (2012) concurs that pregnant adolescents think of abortion or may resort to abortion in response to fears of parental reaction, fears their partner would deny responsibility, and/or desires to continue schooling. Similarly, Wallace (2011), found that stigma, coupled with lack of support from families and society at large, compels some unmarried pregnant adolescents to seek abortion. In addition, for the adolescent mothers, factors such as the feelings of shame, guilt, and discrimination, disappointments in themselves and their parents and the unwillingness to become a mother at that age influenced their preference for termination of the pregnancy (Melvin & Uzoma, 2012; Agundiade et al., 2009). This clearly indicates that most pregnancies in adolescence are unplanned, unwanted and they are disapproved by society hence more cases of abortion are reported to have been done by adolescents (teenagers). The adolescents also think of terminating the pregnancy to be able to continue with their education, hide their shame from friends and society.

It was found that despite a self-initiated thought to abort the pregnancy, their friends, partners and parents also influenced them to consider an abortion as a way of concealing the pregnancy. It is documented in literature that parents may wish to abort their daughter's pregnancy to prevent likely stigmatization they (parents) may suffer in the process (Micah et al., 2013; Chigona & Chetty, 2008; Levandowski et al., 2012).

However, Richter and Mlambo (2005), noted that other adolescent mothers do not support abortion. They argue that it is better to keep the baby rather than risking not being able to have babies at a later stage because of an abortion. This finding was similar to that of the present study. Some pregnant adolescents in this study did not succumb to the advice of friends, boyfriends and parents to have an abortion. They opted to keep the pregnancy other than risking their lives during an abortion. However, some attempted to abort the pregnancy to conceal it and avoid the shame and embarrassment but failed to terminate the pregnancy.

Stigma as a Disturber of Education (academics).

The study revealed that most of the adolescents withdrew from school because of fear of being embarrassed by the pregnancy and being mocked by their friends at school. This finding is in line with the findings of Edgardh (1999) and Amoah (2013) that pregnant adolescents are more often school drop-outs because of feelings of shyness, shame and embarrassment when the pregnancy become obvious. Pregnant adolescents indicated that they felt that it was 'self-discipline' to drop out of school. They were shy and wanted to avoid ridicule from their classmates when they discovered about the pregnancy. Physical effects of pregnancy such as being sleepy in class forced them to withdraw from school as they felt that their friends and teachers would start questioning their behaviour. This is evident that with pregnancy demands and experience of shame and embarrassment in school, pregnant adolescent could not put up with demands of education.

The findings indicate that parents of pregnant adolescents also played a role in withdrawing the girls from school. They refused to support the pregnant girls with education because of the pregnancy. This is similar to the observation of Amoah (2013), that pregnant adolescents reported to have dropped out because their parents refused to pay the school fees on realization of pregnancy. One reason that is documented in literature for parents to withdraw the pregnant adolescents from school is that the parents view it as embarrassing and unacceptable for a pregnant teenager to mix with other school children as she was, traditionally, an outcast (James et al., 2012). Although in anger and disappointment parents withdraw their girls from school, they need to encourage them to continue with their education after delivering the baby. This calls for health personnel working with adolescents to encourage parents to support the girls to return to school after delivering the baby. Otherwise, despite the stigma experience being out of school may also be stressful to the girls because they feel their future has been cut off.

Utilisation of Maternal and Child Health Services.

The findings indicate that pregnant adolescents did not have any interest to utilise the health services provided during pregnancy especially antenatal care. They indicated that they felt it was not necessary to attend antenatal care therefore they refused to go for antenatal care despite being advised to do so. Similar to other literature, it was also found that most adolescents reported late for initial antenatal care for fear of being embarrassed when they meet friends when going for antenatal care. They further explained that they were afraid to be scolded by older women and nurses at antenatal clinic. This is concurrent with the observations of Bearinger et al. (2007) and Ebeigbe and Gharoro, (2007). Bearinger et al. (2007) found that adolescent women avoid seeking health care even when they have a health problem for fear of being chastised, stigmatised or punished for sexual involvement. Similarly, Ebeigbe and Gharoro, (2007) in a study with pregnant adolescents found that a significantly larger proportion of teenagers (47.4%) were unbooked for antenatal care compared with older nullipara (25.7%). Among teenagers booked, none registered for antenatal care in the first trimester. Ebeigbe and Gharoro further indicated that more than half, booked in the second trimester, while the rest booked in the third trimester. One documented reason in literature pregnant adolescents give is that they fail to realise the presence of pregnancy until someone else told them that's why they report late for antenatal care. They further stated that they had not planned to become pregnant hence not reporting for antenatal care early (Brubaker, 2007). Due to the stigma associated with teenage pregnancy, many of them do not utilize available antenatal care services. This is the reason why few pregnant adolescents are registered for antenatal care in most of the health centres in Blantyre district. However, despite refusing to attend antenatal care and a lack of interest, pregnant adolescents were encouraged by their mothers to attend antenatal for the wellbeing of the baby and their own health.

Furthermore, it was found that fear, and feelings of shame because of their young age were other factors that made them not to attend antenatal services. Despite some of the adolescents being married, their young age made them uncomfortable to attend antenatal services for fear of being stigmatised by older women and nurses. This is similar to the observation of (Robb et al., 2013) that young mothers had a fear of being stigmatised and were stigmatising themselves. This prevented them from asking for the care and support they needed. However, the present study found that the pregnant adolescents were not stigmatised by the older women and nurses. Nurses and older women at antenatal clinic offered care and support to the pregnant adolescents as it is offered to any pregnant woman. Pregnant adolescents have a perception that older women would scold them when they are seen at antenatal clinic. This is because of cultural norms in the society that girls are not expected to indulge in sexual activity at a younger age. According to Bankole and Malacher (2010), girls are particularly affected by the social stigma concerning adolescent sex in developing countries, where cultural norms are usually more permissive of male sexual behaviour.

Managing of a Spoiled Identity

Use of media.

The study found that pregnant adolescents used the media as a measure to cope with the stigma they were experiencing. Listening to the radio, reading magazines and watching television were the important modes of clearing the mind off the stigma experience. Although pregnant adolescents in the present study found the media as a way of coping with stigma during pregnancy, the media (radio and television) was a source of stigma for pregnant adolescents in the United Kingdom (Yardley, 2008). This suggests that what may be the source of stigma to others may be a coping strategy for others. This has been clearly stated by the present study and Yardley's study.

Withdrawal from people

The findings indicate that some pregnant adolescents socially withdrew themselves from their friends and from school as a way to avoid being stigmatised by pregnancy. They reported isolating themselves as a way to deal with the experiences they had from people. They resorted to stop talking and chatting with their friends especially those that were schoolmates. The feelings of shame and embarrassment amongst their peers led them to withdraw from them. This finding is consistent with that of Zwang and Garenne (2009); and Fulford and Ford-Gilboe (2004). Zwang and Garenne (2009), found that when a young woman turns from an adolescent into a young mother, she can find herself isolated from friends. The young mother will tend to isolate herself in order to avoid unpleasant comments or mockery that will hurt her. Fulford and Ford-Gilboe (2004) found that the young (adolescent) mothers often put up physical and emotional walls around themselves to minimize the stigma. The mothers' isolation stemmed from both their responses to stigma and their changing relationships with friends. Although the pregnant adolescents isolated themselves as a way of coping with stigma, they were still worried because they felt lonely and needed friends to talk to. Therefore, there is need for significant others and people in the society to assist these pregnant adolescents to be able to socialise with others.

Social support.

The study found that most adolescents who had social support coped with the experience of stigma. Social support was vital for the pregnant adolescents to cope with the stigma they were facing. This finding is consistent with Wahn et al., (2005)'s finding that teenage mothers more than others require social support in and outside the health care system. Social support buffers the individual from stressful experiences and is composed of diverse resources available to the individual through social ties to other individuals and groups (Wahn et al., 2005).

The study found that the main sources of support were from pregnant adolescents' mothers, their partners, friends and other family members. The finding is similar to those of Fulford and Ford-Gilboe, (2004) and Boath et al. (2013). In a study with teenage mothers, Boath et al. (2013) found that social support from adolescents' mother, father, partner, family members and professional support, eliminated consequences of being an adolescent mother. Similarly, Fulford and Ford-Gilboe (2004) in their study with adolescent mothers in south western Ontario, Canada found that the adolescent's own mother, friends, partners, and extended family members offered them support. However, some pregnant adolescents in the present study highlighted receiving health professional support as observed by Boath et. al. They indicated that they received care without experiences of stigma when associating with health professionals in the hospital.

The study further found that pregnant adolescents' mothers were the primary source of support who offered them psychological, material and financial support. Those that had mothers who experienced adolescent pregnancy offered encouragements to the pregnant girls with their own life experiences. This is in line with Wahn et al. (2005) that the pregnant and parenting teenagers experienced the support that they received from their family networks as the most important for them, especially the practical support from their own mothers. Similarly, Sekiwunga and Whyte (2010) indicated that teen mothers identified their mothers as a significant source of support. Pregnant adolescents felt more comfortable to confide in their mothers about their experiences, and their mothers were very supportive.

Peer support was also one important strategy the pregnant adolescents used to cope with the experienced stigma. They associated with fellow adolescent mothers to learn from their past experiences. Boath et al., (2013) concurs that peer support gave young women an opportunity to compare their experiences of motherhood, with others who were in a similar situation, gain knowledge and advice and discuss some of the primary difficulties they had

experienced as parents. In a similar view Robb et al., (2013) observed that the importance of friends or relatives in the support of young mothers was that they would ask them their experience as they all have babies and that the adolescents did not fear judgement by them. Additionally, Lewis et al., (2007), in their study with an adolescent mother observed that peer support was instrumental to her development into a young mother. Her ability to empower other adolescent mothers and getting support from others assisted in dealing with the stigma of being a young mother. Peer support is essential in adolescents who experience stigma as it is a forum to express their challenges. In the current study, pregnant adolescents associated with friends who had been pregnant before for support. Their peers encouraged them with their own experiences during their pregnancy. This made the pregnant adolescents to be at ease and cope with the stigma they were experiencing. These findings are not in agreement with the findings of James et al., (2012) who found that turning to peers was not an option as the pregnant teenagers experienced rejection by their peers.

Conclusion

The study has revealed that pregnant adolescents are stigmatised with their pregnancy when it is known to other people. It was found that pregnant adolescents experience stigma from family members, friends, themselves (self-stigma) and other community members. Pregnant adolescents are rejected, ridiculed, insulted, mocked and abandoned by their families, friends, boyfriends and the community.

Adolescent pregnancy has many effects on the lives of the adolescents. The stigma affects their social life, academic life and their health. Most of the times, because of the stigma adolescents, isolate themselves, face rejection, mockery, have feelings of shame and fear, withdraw from school and have lack of interest to report for antenatal services. The study further revealed that with support from the family, peers and other community members, adolescents who experience stigma related to pregnancy cope well with the stigma.

Therefore, there is need for more support of these pregnant adolescents so that incidences of abortion as perpetuated by stigma are reduced. Health professionals and school authorities should take part in supporting these adolescents who become pregnant while at school.

Recommendations

In light of the findings of this study, the following recommendation are important to address issues that are highlighted in line with best practice in adolescent reproductive health.

- The Blantyre DHO's adolescents' or youth health programs should be intensified in all centres of their catchment area. Specifically, programs that promote contraceptive use in adolescence to avoid unwanted pregnancies.
- The MOH in collaboration with school authorities should educate adolescents the consequences of unwanted or unplanned pregnancies. Youth corners for adolescents who are sexually active should be created in schools for them to easily access contraception.
- There is need to reinforce and ensure youth friendly health services (YFHS) are really offered at health facilities in the country. Adolescents feel ashamed and shy to access family planning services to avoid unplanned pregnancies, and antenatal services when they are pregnant.
- It is also important for health personnel to follow YFHS and encourage pregnant adolescents to attend and register for antenatal services when they discover that they are pregnant. The findings indicated that adolescents preferred attending antenatal in the third trimester because of fear and feelings of shame to associate with elderly women.
- There is need for community mobilisation to address issues of stigma associated with pregnancy and rather organise or create groups that would support pregnant adolescents. The groups could comprise of older women or adolescent mothers who

would be able to provide social support to pregnant adolescents throughout their pregnancy and when they deliver their babies.

- There is also need for support from school authorities to encourage pregnant adolescents to return to school after delivering their baby.
- Parents should be discouraged from marrying off the pregnant girls when they are not ready for marriage, rather encourage them to go back to school. This would assist the girls to attain their educational goals.
- Girls need to be empowered when they are young to avoid early sexual activities. Some cultural practices that promote early sexual activities for girls especially in the southern region need to be reviewed. These practices, lead to unwanted pregnancies thereby increasing incidences of stigma for the girls hence high rates of abortion.

Areas that Need Further Study

The study identified some gaps that need to be addressed through further studies with a focus on the following areas:

- Experiences of mothers and fathers of pregnant adolescent girls.
- The community's perception of girls who become pregnant at a younger age.
- Health workers' perceptions and attitudes towards adolescent pregnancy.
- Identification of availability of pregnant adolescents' support groups that promote adolescents' psychological and physical well-being.
- Adolescents knowledge of the consequences of unplanned pregnancy

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Appendices

Appendix I: Demographic data collection tool

Demographic data	**Responses**
Age	
Marital status	
Age at marriage (if married)	
Number of children	
Age at first pregnancy	
Religion	
Educational level	
Occupation	

Appendix II: Interview guide English version

Pregnancy

Explain your experience about the first pregnancy

What was your reaction when you realised that you were pregnant?

What did other people say about the news of your pregnancy?

Experience of stigma

Have you ever been stigmatised?

Explain how you were stigmatised

Describe how you felt with this experience

How did this experience affect your life?

Utilisation of health services

When did you start attending antenatal services?

What influenced you to start attending antenatal services?

How often did you attend antenatal services?

What was your experience at the health facility?

Coping strategies

Have you ever turned to anyone for help with the experience of stigma?

What did you do to cope with the experience of stigma?

How effective was it?

Appendix III: Chichewa interview guide

Mafunso

Nkhani yokhudza pakati

Tafotokozani mbiri ya pakati/mimba yanu yoyamba

Mutazindikira kuti ndinu woyembekezera munachita chiyani?

Nanga anthu ena anati chiyani atamva kuti ndinu woyembekezera

Mbiri za kusalidwa kamba ka mimba/pakati.

Munayamba mwasalidwapo kamba ka mimbayi?

Tandifotokozereni zomwe zinachitika

Tafotokozani mmene munamvera m'moyo mwanu kamba ka zimenezi

Tandifotokozereni mmene izi zinakhudzira moyo wanu wa tsiku ndi tsiku

Kagwiritsidwe ntchito ka zaumoyo/chipatala

Munayamba sikelo mimba ili miyezi ingati?

Chinakuchititsani ndi chani kuti mukayambe sikelo?

Ku sikelo mumapita mowirikiza bwanji?

Tafotokozani zomwe mumakumana nazo mukapita ku sikelo.

Njira zodzithandizira

Munayamba mwafikirapo munthu wina pa nkhani yosalidwa ndi pakati/mimba?

Fotokozani zomwe munachita mutakumana ndi mavuto a mtundu wina uli onse kamba ka kusalidwa chifukwa cha pakati/mimba

Tafotokozani mmene munathandizikira mutachita zimenezo?

Appendix IV: Information Sheet

INFORMATION LETTER FOR A RESEARCH STUDY ON PREGNANCY RELATED STIGMA EXPERIENCES BY ADOLESCENT MOTHERS IN BLANTYRE DISTRICT

Dear Participants,

My name is Jessie Chirwa Msuku, a student at the University of Malawi, Kamuzu College of Nursing pursuing a Master of Science degree in Midwifery. I am conducting a research project on Experiences of pregnancy related stigma by adolescent mothers. The aim of the study is to explore the experience of pregnancy related stigma by adolescent mothers.

You are being invited to participate in this study because you are an adolescent who is pregnant and a mother. Participation in the study is entirely voluntary. You are free to participate or withdraw from the study at any point. You are free to refuse to answer any questions. Your refusal to participate in the study or refuse to answer some questions or to withdraw will not affect your access to the health services at this facility from any health care provider. There are no direct benefits for participating in this study. However, the completed study will inform the health care providers to improve adolescent reproductive health services.

The study does not have any physical risks to you, however if there are any psychological or emotional harm feel free to express your concerns and complaints during the study. All information gathered will be treated with confidentiality and only the researcher will have access to it. Names of participants will not be used hence codes will be used to identify participants.

You are requested to sign a consent form to indicate your agreement to participate in the study. Interviews will be conducted in a quiet place where people will not be able to see, hear, disturb and distract. The interview will take about 45 to 60 minutes.

Thank you for taking time to read the information sheet.

Appendix V: Information sheet – Chichewa version

KALATA YODZIWITSA ZA KAFUKUFUKU KWA OTENGA MBALI

Ine ndine Jessie Achsah Chirwa Msuku, ophunzira pa sukulu ya ukachenjede ya Kamuzu College of Nursing. Ndikuphunzira za ukadaulo wauzamba ndipo monga mbali imodzi ya maphunziro ndikuyenera kupanga kafukufuku yemwe akukhudza atsikana achichepere a zaka 12 mpaka 19. Kafukufukuyi ndi otchedwa "**zomwe atsikana amakumana nazo kamba ka kusalidwa chifukwa cha pakati**".

Mukuitanidwa kutenga nawo mbali pa kafukufukuyi chifukwa ndinu mtsikana amene muli ndi pakati, komanso muli ndi mwana ochepera zaka ziwiri. Muli ndi ufulu kutenga mbali kapena ayi mu kafukufukuyu pakuti simukuumilizidwa. Mungathe kusiya kafukufukuyi nthawi ina iliyonse ngati mukuona kuti mutero komanso muli ndi ufulu kusayankha mafunso. Izi sizisokoneza kalandiridwe ka chithandizo chanu kwa anamwino. Kafukufukuyi adzandandiza kupititsa patsogolo ntchio zotukula moyo wa atsikana omwe amkhala ndi pakati adakali aang'ono komanso amene abereka adakali aang'ono.

Pakafukufukuyi palibe cholowa china chilichonse ngakhale chiopsezo chamtundu uli onse kwa inu. Koma ngati mwapsinjika muli ndi ufulu kufotokoza nkhawa zanu. Zonse zomwe zitakambidwe pa kafukufukuyi zidzakhala zachinsinsi. Maina anu sadzalembedwa paliponse kotero nambala idzagwiritsidwa ntchito ngati chidziwitso cha otenga mbali.

Pakuvomereza kwanu kutenga mbali mu kafukufukuyi mukupemphedwa kusayina kalata wa chivomerezo. Zokambirana zonse zidzachitika kwa mphindi 45 kapena ola limodzi pamalo achinsinsi.

Zikomo kwambiri powerenga.

Appendix VI: Consent Form

CONSENT FORM FOR STUDY PARTICIPANTS

I………………………………………………, confirm that I have read and understood the description of the research project, and that I have had an opportunity to ask questions about the project. I understand that my participation is voluntary and that I am free to withdraw at any time without any negative consequences.

I understand that I may decline to answer any particular question or questions. I understand that my responses will be kept strictly confidential, that my name or identity will not be linked to any research materials, and that I will not be identified or identifiable in any report or reports that result from the research.

I give permission for the researcher to have access to my anonymized responses.

I voluntarily agree to take part in the research project as described above.

Participant Name (Please print)　　　　Participant Signature

Jessie Achsah Chirwa Msuku __________　　　　____________________________________

Researcher's Name (please print)　　　　Researcher's signature

Appendix VII: consent form – Chichewa

Ine ndawerenga (wina wandiwerengera) ndipo ndamvetsa ndondomeko zones zokhudza kafukufuku ameneyi. Ndikudziwa kuti sindili okakamizidwa kutenga mbali mu kafukufuku ameneyu ndipo ngati ndisiya kapena sindiyankha mafunso ena sipakhala zovuta zilizonse.

Ndamvetsetsa kuti zonse zokambidwa pa kafukufuku zikhala zachinsinsi ndipo ndzin langa silidzapezeka paliponse pokhuudzana ndi kafukufuku. Kotero ndikupereka chilolezo kwa ofufuza kundifunsa mafunso okhudza kafukufukuyi.

Ndikuvomera kutenga nawo mbali mu kafukufuku mosakakamizidwa.

_______________________________ _______________________________

Dzina la otenga mbali otenga mbali asayine/tsindikizani chala

Jessie Achsah Chirwa Msuku_______ _________________________________

Dzina la ofufuza asayine

Appendix VIII: Parental Consent Form

Dear Parent,

My name is Jessie Chirwa Msuku, a student at the University of Malawi, Kamuzu College of Nursing pursuing a Master of Science degree in Midwifery. I am conducting a research project on Experiences of Pregnancy Related Stigma by Adolescent Mothers in Blantyre District. The aim of the study is to explore the experience of pregnancy related stigma by adolescent mothers.

Your child is invited to participate in a research title stated above. You are entreated to read the information below very careful before you agree to allow your child to take part in the research.

General Information about Research

The purpose of the study is to explore the experiences of pregnancy related stigma by adolescent mothers.

Your child will be required to answer interview questions which will take 45 to 60 minutes to go through the interview using an interview guide in a room that will ensure your child's privacy. The interview will be audio recorded with your child's permission and field notes will be taken on event that cannot be recorded. The recordings will be transcribed in exactly the same words as your child used them and then analysed.

Possible Risks and Discomforts

Your child will not be exposed to any risk or discomfort in this research. However, in case of emotional discomfort, your child is free to withdraw at any point or refuse to answer any questions. This will not affect the care that will be provided.

Possible Benefits

Your child will not receive any direct benefit for participating but the findings of the study will be used to improve the health of pregnant adolescents. It will also inform health providers especially Midwives to improve their provision of services to pregnant adolescents.

Confidentiality

All the information that your child will provide will be known to the researcher and her supervisors. Codes will be used to identify your child therefore your child's name will not be recorded on any information your child will give except the agreement form. The information your child will provide will be kept in a lockable cabin where nobody will have access except for the researcher.

Voluntary Participation and Right to Leave the Research

Be assured that your child's participation in this study is merely voluntary. Your child has the right to participate or refuse to participate and this will not affect the service your child is entitled to. Your child has the right to withdraw from the research at any point.

Contacts for Additional Information

If you or your child has any questions now or at any point during the course of the study, please feel free to ask. For further information, please contact: Jessie Chirwa Msuku, Kamuzu College of Nursing, P.O Box 415, Blantyre. Contact number: 0999 229 040.

For other queries please do not hesitate and contact the Chairperson, College of Medicine Research and Ethics Committee, P/Bag 360, Chichiri, Blantyre 3.

Appendix IX: Parent Agreement Form

I have read the information sheet describing the research study on Pregnancy Related Stigma Experienced by Adolescent Mothers in Blantyre. I have been given an opportunity to ask questions about the research.

I agree that my child should participate in this study voluntarily.

____

Name and signature or mark of parent or guardian

Appendix X: Child Assent Form

My name is Jessie Chirwa Msuku, a student at the University of Malawi, Kamuzu College of Nursing pursuing a Master of Science degree in Midwifery. I am conducting a research project on Experiences of pregnancy related stigma by adolescent mothers. The aim of the study is to explore the experience of pregnancy related stigma by adolescent mothers.

You are being invited to participate in this study because you are an adolescent who is pregnant and a mother. Participation in the study is entirely voluntary. You are requested to participate because I would like to learn more about the experiences of pregnant adolescents and adolescent mothers. It will take 45 to 60 minutes to participate. If you agree to participate in the study, you will be asked to answer interview questions about your experiences. The interview will be audio taped with your permission.

Your participation in this study will not result in a direct benefit to you but the findings will be used to improve adolescent health services. However, there are no risks associated to this research. You are free to refuse to answer any questions or to withdraw from the study at any point you feel uncomfortable. All your information will be kept confidential.

You should discuss about this study with your parents before you decide whether or not to participate. I will also ask for permission of your participation from your parents. You are free to refuse to participate in the study even when your parents grant the permission that you can participate.

By signing below, it means that you understand and know the issues concerning this research study. If you do not want to participate in this study, please do not sign this assent form. You and your parents will be given a copy of this form after it has been signed.

This assent form has been read and understood. All procedures have been clearly understood. I have been given an opportunity to ask questions about the research. I agree to voluntarily participate.

Child's Name………………………… Signature/ Thumbprint………………...

Researcher's Name………………………… Researcher's Signature……………

Appendix XI: Letter of Approval from Blantyre DHO

Telephone: Blantyre 0 1875332 / 01 877 401
Fax: 01 875 430 / 01 872 551

Communication should be addressed to:
The District Health Officer

In reply please quote No. ....

DISTRICT HEALTH OFFICE
P/BAG 66
BLANTYRE
MALAWI

4th February, 2015

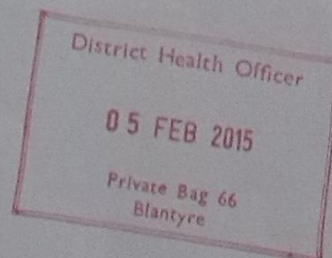
Mrs Jessica A. Chirwa Msuku
Kamuzu College of Nursing
P.O Box 415
BLANTYRE

Dear Sir

PERMISSION TO CONDUCT STUDY IN BLANTYRE

I write to inform you that Mrs Jessie A. Chirwa Msuku will be permitted to conduct her research on **Pregnancy Related Stigma Experiences by Adolescent Mother's** in our health facilities in the district subject to recommendation of the ethics committee.

Your assistance will be appreciated



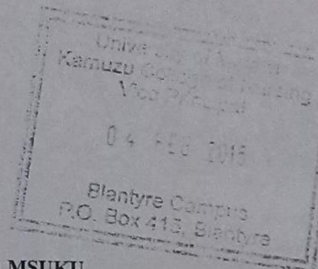
Dr Medson Matchaya
DISTRICT HEALTH OFFICER

Appendix XII: Introductory Letter from Kamuzu College of Nursing

KAMUZU COLLEGE OF NURSING

PRINCIPAL
DR. A. MALATA, DipNur, MRM
B.Sc. MN, Ph.D.

P.O BOX 415, BLANTYRE, MALAWI
TELEPHONE: 01 873623/01 880183
FAX: 01 875341
EMAIL: viceprincipal@kcn.unima.mw
Website: www.kcn.unima.mw



4th February 2015

The District Health Officer,

Blantyre District Health Office

BLANTYRE

Dear Sir/Madam,

INTRODUCTION OF MRS JESSIE A. CHIRWA MSUKU

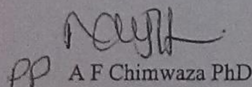
I write to introduce to you Jessie Achsah Chirwa Msuku who is pursuing Master of Science Degree in Midwifery at Kamuzu College of Nursing. She is currently working on her research proposal and the title is "Pregnancy Related Stigma Experienced by Adolescent Mothers in Blantyre district, Malawi".

I wish to acknowledge that the topic is very important and relevant to the Malawi situation. The findings of the study will assist in development of strategies to address stigma that adolescent girls experience during and after pregnancy.

My writing is to request permission for her to conduct the research study at Ndirande Health centre.

Thank you for your usual assistance.

Yours faithfully,



PP A F Chimwaza PhD

COORDINATOR – MASTERS IN CHILD HEALTH PROGRAM

Appendix XIII: Certificate of Ethics Approval from COMREC

UNIVERSITY OF MALAWI

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.02/15/1689- Pregnancy related stigma experienced by adolescent mothers in Blantyre district by Jessie A. Chirwa-Msuku

On 23 April 2015

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

Dr. C. Dzamalala- VICE Chairperson (COMREC)

Approved by College of Medicine
23 APR 2015
(COMREC)
Research and Ethics Committee

23/04/2015
Date