PSYCHOSOCIAL EXPERIENCES OF EARLY CHILDBEARING AMONG TEENAGERS IN ZOMBA DISTRICT, MALAWI

MSC (REPRODUCTIVE HEALTH) THESIS

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DECLARATION

I, the undersigned declare that this thesis is my own original work and effort and has never been submitted to any other institution of higher learning for similar purposes. The sources of information used in this thesis have been acknowledged using in-text citations and reference list.

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CERTIFICATE OF APPROVAL

The undersigned certifies that this thesis represents the student's own work and effort and has been submitted with my approval.

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DEDICATION

I dedicate this project is to my family. Special gratitude to my wife Tione for her encouragement and moral support. Special dedication to my children Rhema, Neema, Charis and Caren for enduring a long period of interrupted fellowship in the home.

I wish also to dedicate this work to members of the Private Bible Study and Ministry Group for your prayers that created supernatural energy, brought hope and that made me not to give up.

I wish also to dedicate this thesis to youths in the teenage group to experience emotional trauma as they go through pregnancy, labour and parenthood during this fragile period of their lives.

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ABSTRACT

Teenage childbearing in Malawi is very high (29%), and socioeconomically burdensome, with Zomba having a higher rate than the national average (34.9%). A review of literature for Malawi revealed that little was yet known about the psychosocial experiences of teenage childbearing, yet most of the teen marriages and pregnancies are occurring in this region and Zomba in particular. This study explored psychosocial experiences of early childbearing. This was an explorative descriptive qualitative study. The target population was 13-19-year-olds living in Zomba District. A purposive sample of 16 teenagers (pregnant and parenting), was recruited comprising of 8 males and 8 females. Data were collected through audio-recorded face to face in-depth interviews using an interview guide. Data were analysed using content analysis. Results revealed that teenagers' experience emotional trauma that included embarrassment, regrets, fear of parental reprimand, depression, emotional shock, and parental verbal abuse. They suffer social injustices like stigma, discrimination and rejection from parents; peers and community members. Corporal punishment and support withdrawal was part of the social problems. The study recommends that teenagers be equipped with sexual and reproductive health life skills so they can delay pregnancy; SRH policies should address gaps to ensure reproductive health services respond adequately to teenagers' psychosocial needs. Extensive research is required to focus on both couples & single teen parents; parents of teens that are experiencing or experienced childbearing and on psychosocial experiences of health workers as they manage teen parents. These findings highlight psychosocial challenges experienced by childbearing teenagers. Childbearing teenagers require quality comprehensive psychosocial services.

Key words: psychosocial experiences, coping strategies, early childbearing, emotional trauma, support withdrawal, corporal punishment, embarrassment

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ABBREVIATIONS

ECB : Early Childbearing

HIV/AIDS : Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrom

LIC : Low Income Country

MDG : Millenium Development Goal

MDHS : Malawi Demographic and Health Survey

UN : United Nations

UNDP : United Nations Development Program

UNFPA : United Nations Population Fund

UNICEF : United Nations International Children Education Fund

WHO : World Health Organisation

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

Early Childbirth, according to UNFPA (2013), refers to the childbirth experience occurring during the adolescent period i.e. the period between 10 to 19 years of age; or the childbearing experience at any time before the age of 20 years (Raymo, et al., 2015). Early Childbearing (ECB) brings traumatic psychosocial and physical experiences to adolescent parents and the new-born. Walker (2012) observed that early childbearing leads to increased rates of physical problems like vesicle vaginal fistulas and increased maternal and neonatal mortality rates due to severe and frequent illnesses; and brings such traumatic psychosocial experiences as depression, anxiety, domestic violence and denial of the school age adolescents their right to access education.

Teenage childbearing carries more risks in comparison to women giving birth within the age range of 20 to 39 years (Nove et al., 2014; Leppälahti, et al., 2013). A review of studies conducted in the United States of America indicates that pregnancy and subsequent childbirth, for most adolescent women, is often unplanned for and therefore unexpected (Adams 2012; Sedgh, Singh, & Hussain, 2014). Moreover, Adams (2012), reports that unintended pregnancies among teenagers are much higher; 82.3% compared to 44.2% in older women.

Though pregnancy is generally expected to be a normal life experience and moment of joy, it creates a considerable amount of burden and a great deal of demands even for the older women who are physically and mentally mature.This is more evident especially in sub-Saharan Africa where pregnancy and childbirth related maternal, new-born and child deaths account for over fifty per cent of the global rates (Kinney et al., 2010). Unfortunately, for many teenage women, the pregnancy comes at a time when they depend substantially on the support from their parents, older siblings, relatives and friends for both their physical and psychosocial needs (Sedgh, Singh, & Hussain, 2014).

The young woman and her equally young partner are still undergoing the process of physiological (physical) growth and psychosocial development. Hence are psychologically and socially unprepared for the event. Penfield, Cheng, and Caughey (2013), contend that these adolescents are physiologically and psychologically less mature to handle pregnancy, labour and delivery experiences compared to their older counterparts hence the many physical complications that are experienced by both the mother and her baby. The teenager’s body, and specifically the reproductive organs are immature, leading to the many critical problems they encounter which leads to dire consequences (Gibbs et al., 2012). The preceding findings imply that mature sound mental and social health for maternity clients are as crucial as having a physiologically mature and healthy body. The teenage period, in particular, is a stage when the individual tries to explore the social world including sexuality. And when they encounter problems, try to solve them using experimental and risky complex means and often times end up failing.

Early childbirth is an experience that catches many adolescents off-guard. Many of these young people have no or very little knowledge at all about their potential risk for early pregnancy and the risk for early parenthood itself and therefore do not use

contraceptives (Frost, Lindberg, & Finer, 2012). Teenagers need a lot of support and information not only to prevent pregnancy but also to make the pregnancy and birth experience more tolerable and much safer, in case they are carrying one.

Brauner-Otto and Axinn (2010), in their analysis of findings from a mixed sample (teenagers and older women) of 2676 women between the age of 15-25, done in United States of America, observed that the increasing high levels of unintended, premarital and early childbirth (ECB) experiences are a direct consequence of increasing early indulgence in early sexual experience among young people; which unfortunately, is often unprotected.

The increasing Early Child Birth (ECB) rates have a direct bearing on the increased psychosocial and economic burden for the young mother, the young couple, the community and the nation at large (Yazdkhasti et al., 2015; Makiwane, 2010). For most societies, adolescents (which include teenagers) constitute a significant proportion of the whole population therefore health and psychosocial problems affecting these young people has a great negative bearing on psychosocial and economic indicators and the general health of the entire society, both in the immediate and long term. UNICEF (2018), estimated that globally, there are about 1.2 billion adolescents (10 to 19 year olds), representing 16% of the total world's population. About 16 million 15-19 year olds and 2 million under 15-year-old girls, give birth annually and 95% of the births occur in low and middle income countries (WHO, 2014).

Additionally, WHO (2014) observed that at global level, 85 per cent of all adolescents live in low income countries and 49 per cent of the adolescents in low and middle income countries marry before the age of 18 and fourteen (14%) before the age of 15. This implies that close to 50 percent of all adolescent girls in the least developed countries experience early childbirth by the time they reach 18 years of age. In addition,

UNICEF (2018), reported that globally, about 14 million babies are born annually to very young women. And the majority of young people under the age of 18 years, are dependent on their parents or guardians. As these young people become pregnant or start parenting, significant others are also affected. These alarming statistical revelations should be a great cause for concern for all stakeholders and partners involved in planning and programming interventions targeting adolescents in general and teenagers in particular.

In a national survey done in the United States of America (USA), it was found that in 2011, 26.7% of all pregnancies in women under the age of 20 years, were among 15 to 17 year olds and 89.2% among 18 to 19 year olds (Kost & Maddow-Zimmet, 2016). The teenage pregnancy rate in the United States could be much higher than what is was reported in this study considering that the rates among 13 to 14 year olds were not included. In another study done in the United States of America, Benotsch (2014), reported that 3,674 babies were born to young girls aged 10 to 14 years. This increase in teenage pregnancies consequently denotes an increase in number of teenagers facing the psychosocial challenges related to childbearing.

The sub-Saharan region has the highest proportions of early childbearing in comparioson with other regions.. UNICEF (2017), reported that in this part of the global village, 1 in 5 (20%) adolescent girls aged 15-19 have an early childbearing experience; furthermore, in the period 2010-2015, most countries in the region reported that of all women aged 20-24, 45 per cent had a childbearing experience before the age of 18. It is also estimated that adolescent girls that experience early childbearing before the age of 18 years reach 25 % in East and Southern Africa and 28 % in West and Central Africa (Loaiz & Liang, 2013). In South Africa, overall adolescent births were estimated at 65 per 1000 live births with diversity in rates being noted among different ethnic

groups (Madvan, 2010). These statistical reports uphold the general notion that adolescent childbearing is still high in most parts of the globe including sub-Saharan Africa, which consequentially increases the psychosocial challenges and economic burden that families, households and societies encounter. The UN (2015), final report on achievement of Millennium Development Goals (MDGs) indicates that early childbearing among adolescent girls had contributed significantly to the poor achievement of these goals in sub-Saharan Africa, registering about 123 adolescent deliveries per 1000 live births. This means that adolescent childbearing (which include teenage childbearing), has significant implications in this region, considering that social, psychological and economic challenges are more pronounced in adolescents like teenagers than in older people.

Early childbearing in Malawi is not uncommon. By 2015, 29% of all women aged 15 to 20 years in Malawi, had started childbearing, an increase from 26% in 2010 (MDHS, 2015-16). Furthermore, in 2015, about 34.9% of all teenagers aged 15 to 19 years alone have had a childbearing experience in Zomba District (MDHS 2015-16). Zomba has a much higher rate compared to the national average. Besides, these figures depict that teenage pregnancy could be much higher than what was documented in this report since the status of teenagers between the age of 13 and 15 years was not reported. Since teenage childbearing in strongly linked to increased psychosocial problems, the more teenagers start childbearing, the greater the psychosocial burden that will impact on the society.

A Malawi Longitudinal Study of Families and Health (MLSFH) done in rural Malawi, shows that 19%of 12 – 15 year olds and 62.8 % of 16 – 19 year olds, respectively, had been married, indicating that close to these rates of teenagers and in these age categories, start child birth in Malawi (Bertrand-Danserean & Clarck, 2016).

Statistics show that no significant improvements have been realised in reducing teenage pregnancies despite youth programs launched in the country. For example, close to 30% of all 15-19-year-old were reported to be married and about one third (33%) of all adolescent are estimated to have been pregnant or given birth by age of 20 years (Save the Children/ICF Macro, 2009). These estimates are not very different from statistics provided in the MDHS, (2015-16) report.

Teenage pregnancies have been strongly associated with increased psychosocial and economic challenges. Divney (2012), in a study on depression during pregnancy among young couples aged 14 to 21 years, found that teenage pregnancies increase the risk for stress, anxiety and depression, and these get worse when both partners become equally affected. This causes such psychosocial challenges as poor social interactions, poor self-care and increases exposure to drug and alcohol abuse (Fishell 2010). Notwithstanding, the researcher did not find much literature on psychosocial studies done in Malawi.

Whereas, the incidence of early childbirth is steadily decreasing in some parts of the world, it likewise continues to rise in most parts of the globe, especially in the low-income countries (WHO, 2015), and in addition, the age range of young people having a birth experience continue to widen by the day.

The increase in early childbearing rate, consequentially increases the magnitude of psychosocial problems related to teen childbearing. A review of literature by the researcher found evidence of the significant negative impact of early childbirth both physical and psychosocial (Schetter & Tanner 2012; Vythilingum 2009; Sipma, Bello, Cole-Lewis & Kershaw, 2010. Notwithstanding, the literature review by the investigator showed that, in Malawi, not many of these studies endeavoured to investigate the psychosocial experiences of early childbirth of the pregnant and

parenting teenager let alone her equally young partner/spouse. In the absence of a comprehensive knowledge base about the needs of pregnant and parenting teenagers, provision of quality holistic care is impossible. It then equally follows that without holistic and quality health care provided to teenagers that are experiencing childbirth, based on scientific evidence, the consequences will be deeply rooted, widely spread and devastating.

The purpose of this study, therefore, was to explore the psychosocial experiences of early childbearing among teenage mothers and their associated adolescent teenage male partners. Psychological health includes such aspects of life as emotional reactions, maintenance of self-esteem, assertiveness, self-confidence self-acceptance and ability to develop health mechanisms to cope with childbearing experiences. It also involves maintenance of trust in those around the expectant or parenting teenager, like a sexual partner, friends and parents. The study explored such social health aspects as maintenance of meaningful relationships with parents, friends (peers) and the members of the community. Maintenance of dignity (respect) from society members, friends and siblings are some psychological facets that were also explored in this study. It further explored experiences with sustenance in social support from parents, sexual partner, friends, and rest of the society.

1.2 Background

Early childbirth continues to pose as one of the main public and reproductive health concern globally, with a more significant impact on adolescents and entire societies in the low-income countries (LIC). Over decades, early childbirth has been a huge burden owing to the numerous risks that are linked to the phenomenon. UNFPA (2013), estimated that the number of all adolescents (age between 10-19 years), had reached 1.2 billion which represented 18 percent of the entire global population. Of this

global adolescent and teenage population, 85 percent live in the least developed world (UNFPA, 2013). This has been noted to be the biggest generation of adolescents and teenagers the world has ever had. At the global level, an estimated 14 million teenagers, whether married or un-married, give birth every year (UNICEF, 2013). UNFPA (2016), recorded that in low-income countries, over 20,000 of these adolescent girls give birth daily, amounting to about 7.3 million births annually. Adolescent pregnancies have been greatly implicated in the poor performance in achieving Millennium Development Goal (MDG) number 4 in many countries, especially sub-Saharan Africa, which aimed at reducing child mortality (UNFPA, 2013). The target of this goal was to reduce under-five mortality rate by two-thirds (WHO, 2015). The problem of adolescent pregnancies (teenagers inclusive), is that it created a significant obstacle in achieving most of Millennium Development Goals (MGDs) most of which were related to improving the socioeconomic status of people such as eradicating extreme poverty and hunger, achieving universal primary education, improving maternal health and compacting HIV/AIDS (UNDP, 2015). A deeper analysis of these goals reveals that they affect the psychological state of individuals, like teenagers. Adolescent pregnancies, which include teenage pregnancies, have been observed to increase the rate and severity of complications related to pregnancy and childbirth in comparison to challenges encountered by their older counterparts in the childbearing age; which include rates of psychosocial problems like depression, anxiety, stress, unstable relationships and economic challenges among a wide range of them (Huang et al., 2014; Minnis et al., 2013).

A study conducted in United States of America among African Americans and Latina adolescents, showed that tenage childbearing expose the young woman to quite a considerable degree of stress, depression, anxiety and socioeconomic disadvantage in

comparison to their older counterparts (Huang et al., 2014). Many studies have uncovered substantial evidence that early childbearing places enormous physical, psychosocial and economic burdens on the woman, her family and the society at large. Findings of a study conducted in developing countries shows that incidence of pre-eclampsia, obstructed and prolonged labour, cephalo-pelvic disproportions, anaemia, assisted deliveries and severe haemorrhages related to childbearing are more common among teenagers and other adolescents compared to those who start child bearing at the age of 20 years or older (Santhya, 2011). These findings on physical impact of early childbearing demonstrate that the risk of maternal death in adolescents in general and teenage girls in particular, is considerably high. United Nations (2019), in its report on fertility among very young adolescents, observed that sub-Saharan Africa has the highest rate, with 10 births in every 1,000 adolescents aged 10-14 years. WHO (2018), reported that globally, deaths among 15-19 year olds are strongly related to pregnancy and childbirth complications and that 90 per cent of maternal deaths in this age group occur in low and middle income countries. WHO (2008), observed that this risk increases significantly with decreasing maternal age, with those under the age of 16 years being at four times higher risk compared to childbearing women in the age group above 20 years. Further to this, a study by Louise, de Sanjose, Diaz et al. (2009), done in eight (8) developing countries on early age at first sex and age at first pregnancy, found out that risk of cervical cancer was much higher among young women who experience early childbearing than in their older counterparts. This agrees with observations made in another study by Santhya (2011), who reported that risk of cervical cancer was two and half times higher among young women who experience ECB than in their older counterparts. Cancer as a chronic illness leads to devastating psychosocial experiences in the adolescents. Results from a hospital based cohort study

conducted in West Bengal, Benerjee et al. (2009), observed that conditions like anaemia, preterm birth and low birth weight were observed to be more common and severe in the teenage than in older women aged 20-24. The physically and mentally immature bodies of adolescent increase rate and severity of morbidity in teenagers which often brings adverse psychological and social problems on individuals some of which have long term effects (Gausia et al., 2011; Khisa & Nyamango, 2012). These physical health problems increase the psychological and socioeconomic demands on the individual, couple, family, community and nation at large, thereby creating both short term long term negative impacts.

Notwithstanding the study efforts, there is an important aspect of teenagers' health that has not been comprehensively explored, and this is the psychological and social aspect of the teenager's life experiences with childbearing. Literature provides a lot of evidence on the impact of the psychosocial health state of the individual on outcomes of pregnancy, labour and delivery and vice versa (Ghosh et al., 2009; Maric et al., 2009; Ghosh et al., 2010; Maric et al., 2010).

Though these studies were conducted in areas with a socioeconomic advantage over Malawi, they may be applicable in context as they are mostly looking at comparison of risks that women of older and younger ages carry as they begin child birth. Pregnancy is not only a physical event but also has psychosocial facets. It is evident that early childbearing comes at a point in the teen's life when their physical bodies and mental abilities are not fully developed and ready for the childbirth process.

A population based prospective study by Li, Liu and Odouli (2008); Hobel, Goldstein and Barrett (2008), revealed that poor psychological state of the mother, such as depression, increases the risk for preterm birth and low birth weight. In addition,

Moisan et al. (2016), observed that low birth weight and premature birth become significantly high in the presence of maternal distress, and low self-esteem. Prenatal maternal stress has also been observed to produce significant adverse effects on the physical and mental development of the new-born (Beydoun & Saftlas, 2008; Schetter &Tanner, 2012). Further, O'Keane and March (2007), explained that such outcomes have been linked to the specific demands brought by the childbearing experience (pregnancy, labour and delivery), which the woman finds difficult to cope with. These include the physiological changes and parenthood itself. Moreover, Ghosh, Wilhelm, Dunkel-Schetter Lombardi and Ritz (2009), add that poor social support to a pregnant woman triggers or worsens the mother's stress increasing the risk for preterm birth.

A study of 1719 women, aimed at examining the relationship between depression and anxiety of pregnant women and neonatal outcomes including gestation age and birth weight, revealed that 7.9% of the women had anxiety, 11.8% were depressed and 13.2% were both depressed and anxious (Ibanez, et al., 2012). Anxiety symptoms persist till postnatal period (Vythilingum, 2009; Agrati, 2014). Anxiety and depression symptoms during pregnancy period were manifested by both men and women; nevertheless, women exhibited more anxiety than did men (Teixeira et al., 2009). Some clients have manifestation of both depression and anxiety during childbearing (Field et al., 2010). The pregnant young and primiparas have more pronounced psychological challenges than their counterparts especially in the first trimester (Teixeira et al., 2009).

Social challenges during childbearing are not a rare experience and often have been triggers of critical psychological problems. Some women experience poor social support (Vythilingum, 2009), financial problems (Divney et al., 2012) and poor relationships often due to financial challenges and unintended pregnancies (O'Donnel

et al., 2009). Poor social health lead to development of psychological symptoms and vice versa. Smoking was closely associated with severe symptoms of depression and anxiety (Agrati et al., 2014).

Poor pregnancy outcomes associated with psychosocial problems are multiple and take physical and psychosocial forms. A study by Ibanez, et al. (2012), show that poor mental health resulted in 5.6% of women giving birth to preterm and 12.2% to small for gestation age babies (Vythilingum, 2009; Ibanez, et al, 2012). Furthermore, antenatal stress and anxiety leads to poor pregnancy outcomes like physical defects such as poor neurodevelopment (Vythilingum, 2009; Schetter & Tanner, 2012). Additionally, Cookson et al. (2009) report that children whose mothers experienced anxiety during pregnancy had high risk for developing asthma. Mothers with poor psychological health experience poor social interactions, poor nutrition, impaired self-care and poor compliance or failure to follow medical guidelines, increased incidence of preeclampsia and operative deliveries, (Buss et al., 2010).

In a comparative study between 13- 19 year olds and older mothers, who delivered at a University Teaching Hospital in Egypt, it was observed that the rate of pregnancy-induced hypertension (PIH) was much higher in the teens [11.4%] than in older women [2.2%] (Kumar et al., 2007). A study by Banerjee et al. (2009), revealed that preterm birth was significantly higher among teen mothers aged 15–19 years than in women 20-24 years of age. Despite the increased health challenges associated with early childbearing, its incidences continue to rise at global, regional and local level. UNICEF (2008), estimated that at global level, 49% of all adolescents who live in LIC start child bearing by age of 18 years, portraying a picture that close to 50% of the adolescent have had a childbearing experience by this age. Adams (2012), found that

unintended pregnancies among teenagers were twice as high, at 82.3% compared to 44.2% in older women.

Notwithstanding, health, means much more, than just physiological well-being of the adolescent; it includes such aspects as the mind-body-sprit homoeostasis (Rosdahl & Kowalski, 2008). Rosdahl and Kowalski (2008), and WHO (1948) defined 'health' as: 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Devastating psychological and social experiences during childbearing may negatively affect the teen's life and that of future generation. Teenagers may become less productive and therefore a burden to the community if they are not emotionally and socially health. This validates the need for exploring the psychosocial aspects of teenagers' life with regard to childbearing.

Early childbearing is a huge problem in sub-Saharan Africa, with rates in some countries way above the global average. In some countries in sub-Saharan Africa, it is estimated that about 28% (West and Central Africa) and 25% (East and Southern Africa) of all adolescents have had a childbirth experience before they reach age of 18 years (Loaiza & Liang, 2013).

Despite the enormous work done to unveil the implications of adolescent and teenage childbearing, not much effort has so far been devoted to studying the psychological and sociological experiences of early childbearing on the teenage mother and father, particularly in Malawi. The inclusion of the male partners is seen to be critical as they have been noted to influence decisions made by their female counterparts and may contribute to the psychosocial experiences of their partners during pregnancy and or after childbirth (O'Keane& March, 2007).

The absence of adequate information on psychosocial experiences with early childbearing has left a critical knowledge gap as regards the care and support targeting adolescents in general and teenagers in particular. Knowledge and recognition of the significance of psychosocial aspect of the teenager's health care as regard childbirth are crucial if desirable teenager's health outcomes are to be realised. It is against this background that this study was undertaken.

1.3 Problem Statement

There is compelling evidence that negative psychosocial experiences during childbearing are common and have devastating outcomes. The early childbearing phenomenon has become a health and economic concern not only at the global and regional level but also at the local level, owing to the countless complications associated with them.

The problem at hand is that teenage childbearing is on the rise in Zomba and yet not much is known about the psychological and social challenges teenagers encounter as they enter into childbearing. Pregnancy, childbirth and parenting are both a physical as well as emotional events and quality care must be able to address both aspects. Nevertheless, the absence or inadequatw knowledge on this consequently will lead to poor reproductive health care

Furthermore, the recent Demographic and Health Survey of 2015, revealed that about thirty-five percent (34.9%) of all teenagers aged 15 to 19 years alone have had a childbearing experience in Zomba District and of these 25.1% had a live birth and 9.8 percent were pregnant at the time of survey (MDHS, 2015-16). The problem of ECB is worse for Zomba in comparison to the national average. Increase in teenage pregnancies is more likely to be followed by a corresponding increase in teenagers with psychosocial challenges related to childbearing.

A considerable number of research studies that endeavoured to investigate on the impact of early childbirth on the mother and the baby mainly focused on the physical aspect. Many of the studies have revealed a substantial amount of physical/physiological consequences of early pregnancy and childbirth that ranges from high morbidity and increased mortality rates to long-term disabilities; but not many authors have taken an effort to investigate the psychological and social implications of early pregnancy and childbirth on the female teenager in Malawi.

Furthermore, most studies so far reviewed by the investigator have not included how the teenage male partner is affected by the early and unexpected fatherhood in Malawi, where this study was proposed to be conducted. Understanding the psychological and sociological challenges that early childbirth brings on teenagers will help in designing comprehensive health care interventions and programs that target psychosocial issues related to early childbearing that may affect young women and their partners.

Additionally, this knowledge will assist to develop improved and targeted policies or strategies for promoting teenage mental and social health, and managing psychosocial challenges they face during childbearing. This will consequently contribute to improvement of the teenagers' and their babies' quality of life.

1.4 Justification of the Study

Teenage childbearing is high and on the increase in Malawi. Malawi Demographic and Health Survey [MDHS] (2015-16) report, revealed that of all women aged 15 to 20 years, 29% had already started childbearing. This was an increase from 26% in 2010.The problem of early childbearing is worse for Zomba in comparison to the national average. The MDHS (2015-16), report observed that about 34.9% of all teenagers aged 15 to 19 years alone have had a childbearing experience in Zomba

District and of these 25.1% had a live birth and 9.8 percent were pregnant at the time of survey. The increase in teenage pregnancies portrays a likelihood of corresponding increase in teenagers with psychosocial challenges related to childbearing.

A considerable amount of research work has provided evidence of devastating morbidity and mortality implications related to childbirth among women below the age of 20 years. Other studies have uncovered the serious repercussions of early childbearing has on psycho-social health state of the teenagers and the outcome of their pregnancy.

Nevertheless, not many scholars have taken the effort to explore the impact that early pregnancy and childbirth has on the psychosocial health of the teenagers in Malawi.

As the degree to which pregnancy impacts on the psychosocial health of teenage women and their equally young partners has not been adequately explored in the country, the results from this study are expected to contribute to the existing body of knowledge on the experiences of early childbearing among teenagers. This study uncovered interesting teenage psychosocial experiences in relation to childbearing. The study findings contribute to and fill some gaps in the body of knowledge as regards sexual and reproductive health with a focus on psychosocial challenges of teenage childbearing within the Malawian context and has proposed interventions targeted at meeting the unique psychosocial needs of teenage childbearing and parenthood. An interesting contribution is on the male teenager experiences who has often and for a long time been missed out in care planning for the youn people experiencing childbearing.

Additionally, this knowledge will assist to improve and develop targeted policies or strategies for promoting teenage mental and social health, and managing

psychosocial challenges they face during childbearing. This will consequently contribute to improvement of the teenagers' quality of life.

This study has also suggested areas for further study that will eventually inform both policy and practice, ultimately leading to improved quality of teenage life as they experience early childbearing.

1.5 Study Objectives

1.5.1 Broad objective.

The overall aim of this study was to explore early childbearing experiences among teenagers in Zomba District, Malawi.

1.5.2 Specific objectives.

The study was undertaken to address the following objectives:

a) to describe the psychological experiences of early childbearing among teenagers;
b) to investigate the sociological childbearing experiences among teenagers;
c) to identify factors that aggravate or relieve teenagers' experiences with childbearing.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The aim of this chapter was to describe and demonstrate an understanding of studies that have so far been conducted on adolescent childbearing. On the overall, the review was carried out for the purpose of identifying gaps in literature that formed the basis for undertaking the study. The review highlighted the effects of early childbearing on the psychosocial health of both the female and male teenagers. The review also focused on how physiological problems related to teenage childbearing affect the teens' psychosocial childbearing experiences.

A variety of sources were reviewed. The review of literature in this chapter was organized in accordance with the main study aim, which was to explore the psychosocial experiences of early childbearing among teenagers. The review focused on the childbearing experiences of the teen mother and father. Some review has also been done on how the physical problems of teen childbearing affect their psychosocial experiences. Literature search was done through various academic databases (such as EBSCOHOST, CINAHL, PUBMED and MEDLINE) in order to find out what is known about psychosocial aspects of early childbearing and identify any possible gaps, especially in the Malawian context.

Early childbearing brings a myriad of distressing consequences on adolescents. Though older women are equally affected, the prevalence and severity is known to be significantly high among teenagers and other adolescents, owing to their physically and mentally immature state. Studies have debunked innumerable complications that affect both the mother and the child. The impact of early childbearing which may either be short term and long term or both, can lead to chronic disability or mortality. It also leads to psychosocial development problems in the offspring.

2.2 Psychosocial Experiences: effects on Pregnancy, Teen Parents and Child Health

Psychosocial experiences during pregnancy, childbirth and postnatal are not uncommon and have critical effects on pregnancy, the parents, especially mother and the baby. A study undertaken in United States by Li, Liu and Odouli (2008), found that depression shortens the pregnancy period and increases the risk for preterm births and low birth weight.

Salazar-Pousada, Arroy, Hidalgo, Perez-Lopez and Chedrani (2010), observed in their comparative study of 151 pregnant adolescents, under 19 years of age and 151 older women of 20-30 years, conducted at an Obstetrics and Gynaecology Hospital in Guayaquil, Ecuador , that the majority of pregnant adolescents in their study had depression compared to older women while in yet another research study, done among a mixed age (adolescent and adults) group of pregnant women in Pakistan, about prevalence of anxiety and its associated factors, it was found that 18% of all pregnant women had either anxiety or depression (Karmalian et al., 2009).

Additionally, Spjeldaes et al. (2011), in their study of 13 teenage boys that was aimed at exploring fatherhood experiences and expectations observed that parenting

teen boys experienced stress and anxiety that became worse in the absence of support, especially from their fathers. In a study conducted in Middle Income Countries and another in United States, it was observed that depression is not only common but has a considerable negative effect on child development (Parsons et al., 2011).

Teenage is therefore a great risk factor for developing psychosocial problems during childbearing. These negative psychosocial experiences have been noted to bring significant health consequences on both the male and female teenagers, and the baby, with greater negative effects on the expectant or parenting young mother.

2.2.1 Psychosocial Experiences of Teenage Motherhood

Psychosocial experiences during pregnancy, childbirth and postnatal are not uncommon. Salazar-Pousada, Arroy, Hidalgo et al. (2010) observed, in their study of 302 pregnant women conducted at an Obstetrics and Gynaecology Hospital in Guayaquil, Ecuador, that over half (56.6%) of the 302 women in their study had depression while in yet another study, done among pregnant women in Pakistan about prevalence of anxiety and its associated factors, it was found that 18% of all pregnant women had either anxiety or depression (Karmalian et al., 2009).

Mothers who experience psychological challenges during pregnancy have poor health outcomes. Though the majority of participants in some studies reviewed below were older women of 20 years and above, the results gives an indication that the case could be similar or worse among the young pregnant or parenting teenagers. Studies have shown that childbearing problems are experienced by both the teenager and their older counterparts (O'Donnel et al., 2009). Nevertheless, in a review of articles from sub-Saharan Africa, Tebeu et al. (2011), observed that the challenges related to pregnancy and childbirth are more prevalent and greater in severity in adolescents, than

in order women; for example, cases of obstetric fistula were more prevalent in teenagers compared to older women.

In a study on effects of psychological stress on maternal complications during pregnancy, conducted in Sri Lanka, psychosocial stress was reported as one of the many risk factors for complications in pregnancy, labour and postnatal period that can lead to such conditions as pre-eclampsia (Abeysena et al., 2010). Marcus (2009), in a study done in United States of America on depression during pregnancy and its consequences, reports that psychological experiences such as depression and anxiety are associated with poor maternal weight gain, poor utilization of antenatal services and increased substance use and further highlights that clients' anxiety often peaks during the early gestation period.

Additionally, in a study about depression and anxiety in pregnancy conducted in Toronto, Canada, among a mixed age-group of pregnant women, it was found that if allowed to prolong, depression and anxiety puts expectant women at risk of instrumental deliveries like caesarean section (Fishell, 2010). Furthermore, according to one study about fear of childbirth and the risk for birth complications in nullliparas (both teenagers and adults of 20 years and above), done in the Danish National Birth Cohort, it was found that women who are often fearful during labour and delivery have an increased risk for shoulder dystocia and prolonged labour that result into instrumental deliveries (Laursen, Johan & Hedegaard, 2009), conditions that are common in teenage mothers (Fishell, 2010).

Psychological and social experiences also have an effect on each other. Negative social experiences impact critically on the psychological state of clients during childbearing. For example, social problems like low marital satisfaction, poor relationship with

husband or parents, low income and low education status influence development of anxiety, depression symptoms and worries related to pregnancy (Karmalian et al., 2009; Nasreen et al., 2011; Gourounti & Anagnostopoulos, 2013).

Physical and verbal abuse are strongly observed as triggers of depression and anxiety for women during childbearing period. Sundaram, Harman and Cook, (2014) in their study done in United States observed that postpartum hypertensive disorders such as pre-eclampsia were associated with psychological conditions like depression. A study done in the United States showed that poor socio-economic status and lack of support during pregnancy are linked to physical partner violence and poor relationships (Stiles, 2010); further to this, many experience homelessness and lack of social support during pregnancy, leading to stress and anxiety in the women (Braveman et al., 2008).

Furthermore, Whisman, Davila and Goodman (2011), in their study conducted in the United States of America, on relationship adjustment, depression and anxiety during pregnancy and the postpartum period, among pregnant women aged 19-40 years, observed that presence of maternal psychological experiences such as anxiety and depressive symptoms, influence changes in relationships whereas changes in relationships during pregnancy or postnatal period triggered depressive and anxiety symptoms.

Teenage pregnancy is associated with increased degrees of psychological and social problems relative to their older counterparts. A study on depressive symptoms and resilience among pregnant adolescents, conducted in an Obstetric and Gynaecological Hospital in Guayaquil, in Ecuador, reported that pregnant teens experience similar psychosocial issues as older gravid women, nevertheless, the teens' sociodemographic characteristics increase their vulnerability. Adolescents who

experience depression are less resilient during pregnancy and are less able to cope (Salazar-Pousada et al., 2010).

Pregnancy during the teenage period has been linked to frequent cases psychological experiences of stress and anxiety (Glynn, et al., 2008; Stiles, 2010). Kim, Connolly and Tamim (2014), in their study on effects of social support around pregnancy on post-partum depression among Canadian teen and adult mothers, reported that twice as much (14%) of teens and only 7.2% of adult mothers had an experience of depression and that lack of support made pregnant women to be five times more at risk of depression. In their study of 300 pregnant women and their partners, Teixeira, Figueiredo, Conde, Pacheco and Costa (2009), reported that primiparous women and men who were mostly young, exhibited more anxiety and depression symptoms than did their older counterparts, and that some clients had symptoms of both depression and anxiety.

Abeysema et al. (2010), observed in their study done in Sri Lanka that psychosocial stress and anxiety result into pregnancy complications. It was also found in a study of teen male partners of adolescent mothers, conducted by Neault et al. (2012) in India, that parenting stress led to teenagers resorting to alcohol abuse and smoking of marijuana, both of which are detrimental to mental health. Single parenthood and young maternal age are also associated with parenting stress in young couples aged '10-18 years' (Whisman, Davila & Goodman, 2011). In a study by Crittenden, Boris, Rice, Taylor and Olds (2009), it was found that young mothers (12-19 years) who had an unintended repeat pregnancy had much high risk for psychological experiences such as aggression.

Parenthood becomes more crucial in such circumstances where it precedes and overrides completion of education, having employment and getting married (Department of Education- of Republic of South Africa & Unicef, 2009). In a study about the impact of early motherhood in Tanzania, which was undertaken among 17-19 year olds, Sik (2015), observed that participants in her study, exclusively school going, experienced emotional shock, shame and embarrassment in themselves because they had done something that was socio-culturally unacceptable and further reported that that most of these adolescent pregnancies were unplanned.

Additionally, all study participants (17-19 years of age) dropped out of secondary school upon realisation that they were pregnant (Sik, 2015). Dropping out of school is linked to future socioeconomic challenges that these adolescents are likely to experiences including failure to proceed with education and lack of employment. These dropouts could be resulting from stigmatisation and discrimination by teachers, schoolmates and other members of society that triggered feeling of low self-esteem and reduced self-confidence.

According to Sik (2015), young women, aged 17-19 years, who participated in the study also had a distressing social experience with family members, especially parents. The study participants reported that though, their parents and significant others did not expel them from the family, the parents expressed anger, embarrassment and disappointment over the unintended pregnancy. In their comparative study between teen and adult Canadian mothers, Kim, Connolly and Tamim (2014), observed that teen mothers received lesser support from their partners throughout pregnancy compared to adult mothers.

Hence, concluding from this review of literature, teenage pregnancy and motherhood leads to negative psychosocial experiences.

2.2.2 Psychosocial Experiences of Early Fatherhood

Early childbearing has also been observed to present some negative psychosocial experiences on the life of the teenage father. In a study on early fatherhood experiences conducted in Australia, it was observed that many young fathers, though willing to take up fatherhood responsibility, felt so emotionally inadequate and ill prepared for the new role (Wilkes, Mannix & Jackson, 2011) and many perceived the support they received to achieve this as being inadequate therefore influenced the negative emotional experiences they had (Pascal, Lewis-Moss & Hsiao, 2011). Caring for the family and giving the partner and child the support they require are considered core responsibilities and expectations of every father. A study on fatherhood experiences and expectations among teenage boys in South Africa found out that failure to meet these core needs of the family is considered as falling short of being 'man enough' and lead to psychological experiences such as stress in the teenage father (Spjeldnaes et al., 2011). Such expectations are probably emotionally and socially straining for the teen fathers, hence resort to drug and alcohol abuse.

Poor or complete lack of social support to teenage fathers, which is a probable expectation of every parenting teenager is detrimental to their psychosocial health. In a study of young male partners married to adolescent mothers, done in South-western United States of America among Indian Americans, it was observed that 80% of them had ever had taken alcohol, 78% had marijuana experience and 31% had cocaine; the majority of which had no support and felt overwhelmed by parenthood (Neault et al., 2012). Neault et al. (2012), further reports that fathers who experienced these had poor relationships with their own fathers and had poor economic status. Garfield, et al

(2014), in their study on paternal mental health during transition to fatherhood, among 10, 263 young adults, conducted in United States of America, found that fatherhood is a very stressful experience and the degree of tress tends to correlate with decreasing age. Fathers who stay with their partners during the period following the birth of the baby become more depressed than non-residents, especially in the early fatherhood days -0-5year. This difference may be attributed to the fact that resident fathers become more actively involved in baby or child care while non-residents experience it 'remotely'. Further to this, a study of 14 to19-year-old fathers done among African Americans by Paschal, Lewis-Moss and Hsiao (2011), on perceived fatherhood roles and parenting behaviour, revealed that fathers who were very young, had poor and hostile relationships with their partners, were financially handicapped because they were usually unemployed and still in school. In a study done in the United States of America, it was found that poor economic status is a great challenge among young and expectant fathers (Lemay et al., 2010). Additionally, a study undertaken in Tasmania, Australia, by Ayton, and Hansen (2016), aimed at increasing understanding about young fathers' role, observed that young fathers experience challenges with such social issues as supporting their partners on encouraging breastfeeding of the baby as they feel confronted, confused and isolated by parenthood. Teenage fathers, just like their female counterparts, become psychosocially overwhelmed by the early childbearing experiences.

With these observations from different studies, it undoubtedly unveils that childbearing among teenage fathers presents a daunting psychosocial experience. The researcher did not trace any literature in Malawi on teenage childbearing and how it affects the teenage fathers' psychosocial aspect of their lives.

2.2.3 Psychosocial Experiences: Consequences on Foetus, Neonate and Child

The psychosocial challenges experienced by young parents, especially mothers have a negative impact on their offspring's well-being. According to a study undertaken in United Kingdom, with a mixed age group of women, that aimed at testing whether prenatal and postnatal anxiety and or depression in pregnant women predicted the risk of their offspring developing asthma in childhood, it was observed that children born to mothers who had anxiety during post-natal period are more likely to suffer from asthma (Cookson et al., 2009). Anxiety has a lifetime impact on the offspring. Buss, et al. (2010), reported in their study on effects of high pregnancy anxiety during mid-gestation, in a sample of pregnant women of 18 years and over, undertaken in United State of America, that children born to mothers who experienced anxiety in pregnancy and postnatal stress have been observed to have grey matter volume reductions. Additionally, a study of 992 mothers (both adult and teenagers) that aimed at examining the role of maternal anxiety disorders with onset before birth and self-perceived stress during pregnancy, conducted in Germany, revealed that anxiety had potential of being transmissible to children (Martini et al., 2008). Anxiety disorder in a pregnant or nursing woman has been noted to be transmissible to the new-born.

Two different studies done in United States of America by Glynn et al. (2008) and in the Netherlands by Loomans et al. (2012), with a mixed age cohort, revealed that increased levels of stress and anxiety leads to delivery of preterm and low birth weight babies. In a study on depression and anxiety in pregnancy (with no age specification), undertaken in Canada, it was observed that neonates born to mothers with high levels of depression and anxiety are often prone to suffer from poor adaptation, has reduced grey matter volume, slow mental development, erratic sleep and hostility; and as the

child grows, there is poor mother-child bonding, poor affect control like tantrums, poor social interactions and display more fear and anxiety in comparison to other kids (Fishell, 2010). Although these studies were generally conducted with a cross-section of age groups, they are applicable to teenagers since psychological experiences identified in these participants have also been observed to be common among teenagers and tend to be more intense.

Just as the negative psychosocial experiences of teen mothers have been found to affect the offspring, they are equally transferable from the teen fathers to their children. A study by Sipsman et al. (2010), that aimed examining whether paternal adolescent parenthood (age 13-14 years) and other factors derived from the ecological systems theory predicted the participants' adolescent fatherhood, observed that the sons of teen fathers are more likely to become teen fathers themselves later in life and often have challenges caring for their kids.

Kingston et al. (2012), reported in their study aimed at comparing maternity experiences and practices between adolescents, young and adult mothers, that early childbearing was strongly associated with multiple physical and psychological challenges in the offspring than those born to older women. Moisan, Muckle, and Belanger (2016) and Gibbs et al. (2012) observed that teen pregnancy, conducted among 15-19 year olds, was strongly linked to conditions like, low birth weight, neonatal deaths and still births. Kongnyuy et al. (2007), in their study aimed at establishing a comparison between adolescent pregnancies (age below 19 years) with controls (20-29 years), done in Yaounde, Cameroon, observed that babies of adolescent mothers are twice as much at risk of complications than those born to older women. They further highlight, in their study done in Cameroon, that preterm birth was unveiled to be significantly higher among teen mothers aged 15–19 years than in older women

20-24 years of age and low birth weight had only been associated with early childbirth, with a rate of 65.5% in the study group whereas the control group had 26.4%. Further to these findings, a comparative study done in West Bengal, by Banerjee et al. (2009), on complications of pregnancy and delivery between teen mothers and mothers between 20-24 years, found that no single new-born weighed above 3000gms in the study group while there was none that weighed less than 1500gms in the control group.

These health problems observed on offspring born to teenage parents are not only a consequence of the teenagers' physical problems, but also the negative psychosocial experiences they encounter during the period of their pregnancy and parenthood. In their study about childbearing during adolescence and off-spring mortality, Restrepo-Mondez, et al. (2011) observed that there was no significant association between maternal age and infant mortality and that neonatal mortality was only suggestive of the effects of the social and environmental factors.

2.2.4. Physiological Problems of Early Childbearing and Psychosocial Experiences of the Mother

Obstetric complications have been observed to cause development of negative psychosocial experiences in women undergoing childbearing experience. Nevertheless, rates of physical conditions encountered by teenagers who experience childbearing are much higher and more intense compared to their adult counterparts and they have a significant bearing on the teenagers' psychosocial health state (Bakker, et al., 2011). It is therefore logical to conclude that negative psychosocial experiences related to obstetric complications are similarly more widespread and pronounced in teenage parents than it is in adults.

In a case control study, on pregnancy outcomes among adolescent under 18 year of age, conducted at University College Hospital in Ibadan, Nigeria; Adeyinka, et al (2010), reported that adolescent pregnancy had more complications (44%) compared to controls which had only 22%. In a comparative retrospective study of pregnancy outcomes between teenagers 13- 19 years old and older mothers, who delivered at a University Teaching Hospital in Egypt, undertaken by Kumar et al. (2007), it was found that the rate of pregnancy-induced hypertension (PIH) was much higher in the teens than in older women (11.4% vs 2.2% respectively) and these findings are supported by observations made by Adeyinka, et al (2010) in their study, who reported that the rate of pregnancy-induced hypertension (PIH)- eclampsia and pre-eclampsia was much higher in the teens at 20% than in older women at (3.3% respectively). Further to this, similar findings were reported in a cross-sectional comparative study undertaken in Camerron (Kongnyuy et al., 2007) and a retrospective study done in Thailand (Watcharaseranee et al., 2006). Sundaram, Harman and Cook (2014), in their study about maternal morbidities and postpartum depression, observed that cases of hypertension during the antenatal period were strongly associated with postpartum depression and by inference, comparatively higher among teenagers than their older counterparts.

In their study aimed at investigating adverse pregnancy outcomes among extremely young mothers (16 years and below), Chantrapanichkul, and Chawanpaiboon (2013), observed that cases of placenta praevia, heart disease, gestational diabetes and anaemia were higher, teen mothers as opposed to older women respectively. Foruta et al. (2014), in their study on relationship between severe maternal morbidity and psychological health problems which they undertook in England, observed that obstetric haemorrhage resulted into postpartum traumatic stress disorder.

It therefore follows that the higher the rate of teenage childbearing, the greater the burden of teenage psychosocial challenges. Xie et al (2011), in a study on caesarean section and postpartum depression among Chinese women, reported that postpartum depression was strongly associated with delivery through caesarean section.

A review of the literature by Tebeu et al. (2011), unveiled that teen childbirths carried a much higher risk for obstetric fistula of between 8.9 – 86 percent and many of these were primigravidas (31-67%). In a study about experiences, psychosocial challenges and social integration of women with fistula, conducted in Uganda, in which the majority (28.4%) were young women aged 15-20 years, Warren, (2014), reported that a significant number of these women had suffered separation from their husband, developed feelings of sadness, self-dislike, shame, worthlessness, low self-esteem and had suicidal thoughts. In their study aimed at identifying causes of vesicovaginal fistulae among Nigerian women, Ijaiya, Rahman, et al. (2010), reported that vesicovaginal fistulae were highly linked to early marriage and childbirth. In a comparative study done at Kilimanjaro Christian Medical centre, on psychological symptoms among obstetric fistula patients and gynaecological outpatients in Tanzania, it was observed that obstetric complications like fistulas result in development of more depression, stress and social problems like stigma and social isolation in young mothers (Wilson et al., 2015). In another study, conditions like postpartum haemorrhage and obstetric fistulas were observed to disrupt marital and family integration as they caused prolonged hospitalisation, social isolation and in some circumstances, led to shame (Khisa & Nyamango, 2012).

Considering that the physiological problems related to pregnancy and childbirth are more pronounced in teenagers and other adolescents, it may therefore be concluded that the teenage psychological and social experiences related to these physical

complications are more pronounced in teenagers. Such revelation means that reducing early childbearing incidences and with improved care would substantially reduce the psychosocial morbidity and mortality rates related to pre-eclampsia, postpartum haemorrhage and obstetric fistulas. Further to this, a study on psychological and social consequences among women who experience a prenatal death found that these women are more likely to suffer from negative psychosocial consequences (poor relationship with spouse and feelings of guilt) compared to those who do not (Gausia, 2011)

Literature from developing countries also shows increased vulnerability of young women to sexual and reproductive health problems. For instance, the risk for cervical cancer is noted to be two and half times higher among women with early childbirth experience compared to their older counterparts (Santhya 2011; Louie, et al., (2009). This emanates from the early sexual debut that predisposes them to a greater risk for human papilloma virus infection, a microorganism responsible for causing cervical cancer. Santhya (2011), further reported that among 100 women that were diagnosed with cervical cancer, only 16% had not started child bearing before the age of 18 years. The increased risk for virulence of the pathogen in adolescent signifies the reduced degree of body resistance to the microorganism coupled with prolonged exposure to the virus. Smith et al (2013) observed that adolescents with cancer suffer significantly from psychological distress, anxiety and depression; they also suffer low self-esteem due to body changes like hair loss, skin coloration and weight changes. In addition, they suffer social isolation and great dependency on others like parents and partners (Zebrack & Isaacson, 2012).

A hospital-based four-month quantitative retrospective study conducted at Chonburi Hospital in Thailand, on incidence and complications of teenage pregnancy, with a cohort study of teenagers aged 15-19 years and a control of women aged 20-24 years,

results showed that anaemia, in general, was more prevalent among the expectant teens, 63% vs 43.6% in the study group and control group respectively (Watcharaseranee et al., 2006). Banerjee et al. (2009), observed in an independent 4-month retrospective study, conducted in West Bengal, India, on magnitude of teenage pregnancy and its complications, that a study group of young women aged 15-19 years, had a one half much higher risk for anaemia compared to the control group. Amr and Balaha (2010), in their study on minor psychiatric morbidity in young Saudi mothers, observed that maternal problems, more especially anxiety and social phobia developed as a result of anaemia.

Furthermore, early childbirth has been linked to high incidence of perineal tears, lacerations and episiotomies (Kongnyuy et al., 2007; Landyet al., 2011). Traumatic deliveries like having severe tear, an episiotomy and delivery through caesarean section have been strongly related to depression and anxiety among mothers as observed by Blackmore et al. (2011) and Xie et al. (2011). Some researchers have observed a positive correlation between increased incidence of teenage pregnancy and increased percentage of pregnant women who do not seek antenatal care (Dopkins, & Hillard, 2009). Poor antenatal care seeking behaviour, commonly associated with teenage pregnancy, is strongly associated with numerous childbearing related complications, most of which have been known to be preventable, even in resource constrained societies. Pregnancy related complications like placenta praevia (prenatal bleeding), anaemia, abnormal foetal growth and emergency caesarean section have been closely linked to development of psychosocial problems like Schizophrenia and social separation (Cannon, Jones & Robin, 2012; DiMatteo et al., 2016).

Early childbearing has a close link to the increased rates of unsafe abortions. In a descriptive cross-sectional study, carried on 521 secondary school girls and boys aged

10-19 years, in Ilorin, North Central Nigeria, it was found that 100% of the girls had ever gotten pregnant then aborted and on the other hand 87.5% of the boys reported that the girls they made pregnant were influenced by them to abort (Aderibigbe et al., 2011). Unsafe abortions are among the key causes of maternal mortality owing to the increased risk for haemorrhage due to trauma and sepsis. In their study conducted in United States on perinatal depression and trauma history, Meltzer-Brody et al. (2013) observed that birth trauma led to a fivefold increase in postpartum depression.

These life threatening obstetric complications lead to psychosocial challenges. In their study, Fottrell et al. (2010) report that women with life threatening complications, like unsafe abortions, had symptoms of psychological distress. Additionally, women who experienced a complication and perinatatl death were at high risk of developing postnatal depression compared to those with no complications (Filippi et al., 2010).

A review of the literature by Tebeu et al. (2011), found that teen childbirths carried a much higher risk for obstetric fistula of between 8.9 – 86 percent and many of these were primigravidas (31-67%). Such revelation means that reducing early childbearing incidences and with improved care would substantially reduce the morbidity and mortality rates related to pre-eclampsia, postpartum haemorrhage and obstetric fistulas. In a comparative study done at Kilimanjaro Christian Medical center, on psychological symptoms among obstetric fistula patients and gynaecological outpatients in Tanzania, it was observed that obstetric complications like fistulas result in development of more depression, stress and social problems like stigma and social isolation in young mothers (Wilson et al., 2015). In another study in Kenya, obstetric fistulas were observed to disrupt social relationships like marital and family integration as they cause prolonged hospitalisation, social isolation and in some circumstances,

lead to shame (Khisa & Nyamango, 2012). Further to this, a study conducted in low income countries, on psychological and social consequences among women who experience a prenatal death found that these women are more likely to suffer from negative psychosocial consequences like poor relationship with spouse and feelings of guilt, compared to those who do not (Gausia, 2011)

There is a strong relationship between the physical complications related to childbirth as observed above to psychosocial problems. Considering that the physiological problems related to pregnancy and childbirth are more pronounced in teenagers and other adolescents, it may therefore be concluded that the teenage psychological and social experiences related to these physical complications are more pronounced in teenagers.

In their study, Fottrell et al. (2010) reported that women with 'near miss' (life threatening complications), had symptoms of psychological distress. Additionally, women who experienced a complication and perinatatl death were at high risk of developing postnatal depression compared to those with no complications (Filippi et al., 2010).

In this review, theresearcher found no known direct physical implications of early fatherhood.

2.2.5Conclusion

So much has been researched on the psychosocial experiences early childbearing. In this review it has been observed that teenage psychosocial experiences are enormous. The psychosocial experiences affect physical well-being of teenagers and these physiological experiences of early childbearing in turn negatively impact on psychosocial experiences.

Notwithstanding, much of the literature is from the high income countries. The researcher did not find much literature on psychosocial experiences of early childbearing in sub-Saharan Africa and did not trace any information in Malawi. Furthermore, the literature available to the author on early childbearing experiences in the sub-Saharan region; does not say much on the psychosocial experiences of the teenage fathers. This review therefore unveiled some gaps in literature on early childbearing experiences among teenagers in Malawi.

CHAPTER 3:

METHODOLOGY

3.1 Introduction

In this chapter the study design, study place, population of the study, study sample and sampling technique have been described. Data collection methods, method of data analysis and research ethical issues have also been described.

3.2 Research Design

This study aimed at exploring psychosocial experiences of early childbearing among teenagers living in Zomba. The study utilised an explorative descriptive qualitative design. Qualitative explorative and descriptive study was a method of choice in this study since exploration and straight descriptions of phenomena were desired (Sandelowski, 2000).

This design aimed at exploring and describing the psychosocial aspect of early childbearing phenomenon as experienced by teenagers as they reflect on both their earlier and current meaningful events in their lives (Moule & Goodman, 2014). The qualitative descriptive study approach holds the idea that knowing any phenomenon requires knowing the facts about that phenomenon and giving those facts meaning within a particular context (Sandelowski, 2000). The experiences with a phenomenon form a fundamental data base that provides useful insights or “essence” that goes beyond the immediate case of research (Moule & Goodman, 2014). Qualitative descriptions are basic and carry a low-inference interpretation (Sandelowski, 2000).

The researcher in this study mainly focused on describing events and feelings (as experienced by participants) from the time the teenagers realised they were pregnant through to the period of parenthood. Qualitative descriptive studies involve presenting facts of the case in ordinary language (Sandelowski, 2000). Through this approach, the researcher focused on exploring the psychosocial essence of early childbirth as experienced by the teenagers and the meaning they attached to the pregnancy and childbirth process experience (Watson et al., 2008; Polit& Beck, 2010). Such experiences are better studied using descriptive rather than statistical methods (Burns & Groove, 2011). The human existence is seen as 'meaningful and interesting' hence adolescents are seen as beings living in their own world, having their own unique experiences (how and what they think about, see, hear, feel) and are conscious of their interaction with the world (Polit& Beck 2010). Furthermore, through a descriptive approach, common themes that relate to context and time of collection were identified within the data (Moule& Goodman, 2014).

Through this approach, the researcher strived to access the informants' world view and their psychosocial experiences with early pregnancy and childbirth and assisting them to describe thesethese experiences (Polit & Beck, 2010). This method of data collection helped to enrich the researcher's information on how and why the participants experience this phenomenon in the manner they did. Moreover, the researcher usedthe explorative approach to solicit the teenagers psychosocial childbearing experiences and then described these experiencesto understand (attach meaning) to the teens behaviour (Sandelowski, 2000; Moule & Goodman, 2014). Developing an understanding of individual's life experiences is seen as more critical than just describing them. To achieve this, the researcher listened to stories told by the teenagers themselves. The approach afforded the researcher an opportunity to get an

understanding of the psychological and social experiences of participants during pregnancy, labour and post delivery period.

The concept of "bracketing" was vital in this exploratory descriptive qualitative study as it promoted removal of preconceptions from the field of data collection thereby ensuring that the investigator entered the study field with an open mind (Moule & Goodman, 2014) Bracketing was applied in the process of data collection to assist the researcher to detach his own assumptions, values, interests and emotions (referred to as preconceptions), within and across the research project. In order to achieve this, the researcher first of all ensured that the aspects of the research to be explored (psychological aspects-fear, shame, self-esteem, feeling stigmatised, anger, depression and also social facets- respect/dignity, maintaining sound relationships, being accepted by parents, peers, community members), were clear to him. The researcher had to identify such aspects as: his own personal experience regarding teenage childbearing (own sister having dropped out of school due to pregnancy and reflection on feelings of it-shame and embarrassment in the midst of colleagues, anger towards the teen and how the community regarded the researcher's role in this. Other aspects included personal knowledge about problems of teen child bearing as a health worker; knowledge about young people engaging with ill-mannered friend that negatively influence their behaviour; knowledge and experience about some teens being unruly leading them to get into troubles of some kind. The researcher also reflected on an assumption that statements made by participants would likely be in self-defence and seeking empathy for their 'wrong actions'. Assumptions that parents would generally become angry and punish the teenager were also elicited in the self-reflection. The investigator documented these feelings. The researcher made reflections of his social and religious beliefs as regards teenage childbearing especially pregnancy out of

wedlock. These aspects were documented and the researcher ensured that they are referred to at each stage of the research process. This effort was necessary because preconceptions influence the gathering (what and how questions are asked), interpretation (to ensure that meaning are derived from participants' narratives and not necessarily the researcher's opinion) and presentation of data, which ultimately would affect the final study results.

3.3 Study Population

The target population under this study were teenagers aged between 13 and 19 years. This cohort was a group of teenagers either expectant or parenting, and had lived in Zomba for a year or so. For those that were parenti was to be under one year of age. Another characteristic of the study population was that it included teenage spouses or sexual partners. They were targeted because they had either a pregnancy or childbirth experience or both and their memories were still fresh and may have been accustomed to the social-cultural environment in Zomba.

The inclusion of the male partners was seen to be critical as they have been noted to influence decisions made by their female counterparts and may contribute to the psychosocial experiences of their partners during pregnancy and or after childbirth (O'Keane& March, 2007).

3.4Sample Size

As a rule of the thumb, a maximum of 30 participants is recommended if data saturation has not been reached (Specziale & Carpenter, 2007; Burns & Groove, 2009). For this research project, a maximum sample of n=20 teenage participants who were either expecting a baby or parenting, was planned; 10 females (5 pregnant and 5 mothering) and 10 males (5 whose female partners were expectant and 5 teen fathers).

The determination of a sample of 20 participants was arrived at because this was a small scale study.

This sample size was considered large enough to elicit as much information as possible from both female and male participants and both from those expecting a baby and those who were parenting at the time of study on psychosocial experiences of early childbearing. Furthermore, the reason for including both male and female participants was the likelihood of having different psychosocial experiences with childbearing, since females actually carry the pregnancy while the male partner is an affected or concerned. The sample was categorised into two: young teens (13-16 years- 5 couples), and older teens (17-19 years-5 couples). Purposive sampling was employed to select participnats into this study. The researcher checked in each client' health passport to identify the age of potential participants. Health workers at the facility were used to identify potential female clients who inturn were used as contacts for their partners. If the age of the potential female participant was within the range of 13-19 years, she was picked for further screening to check if her partner was also a teenager. Once the male partner's age was confirmed, the couple was then introduced to the study. Thereafter, they were asked if they could be interested to participate in the study and those that accepted were given a consent form and then were interviewed. In cases where the female client reported alone at the clinic without the partner, she was requested to ask her teen partner to come to the clinic. For antenatal participants, most couples were identified during the initial visit probably because males are encouraged to accompany their spouses on this particular visit. For post-natal clients, the majority were recruited on discharge from postnatal ward. Most male participants were available on the day of discharge.

The researcher kept record of the number of teens in each age range. The researcher ensured that either the partners are in the same age range or one in either group. Hence the record of number of male or female participants was kept separate. The study explored experiences of both the married, and the unmarried.

In the course of data collection, 16 participants were recruited, 8 females and 8 males as data saturation was reached at this point. This comprised of 3 girls with their partners (6 teens) and one couple (2 teens) who were parenting and 4 girls were expectant (2 couples and 2 teens who were just sexual partners). Data saturation was reached at the point when 16 participants had been interviewed, 8 females and 8 males. Data saturation was achieved when there was no new data, no new themes and no new codes were being generated from the interviews (psychosocial experiences). As such no additional interviews were done as the researcher viewed that key issues were satisfactorily and sufficiently covered.

In qualitative studies, smaller samples are advised. This smaller sample therefore afforded the researcher to develop a good relationship with participants and spend ample time with them as they described their life experiences in-depth (Moule & Goodman, 2014).

On the other hand, some scholars argue that there is no standard rule for sample size in qualitative research and therefore data saturation is considered a determinant of the size (Polit & Beck, 2010).

3.5Sampling/Recruitment Technique

Purposive sampling was employed in recruiting participants. Moule and Goodman (2014), encourages that descriptive qualitative studies should utilise purposive sampling technique, which includes participants who have had relevant experiences to talk about the childbearing during teenage period. The recruitment of

participants was also purposive as it was based on the researcher's judgement of who fitted into the inclusion criteria of the study. Purposive sampling technique is employed in qualitative descriptive research in order to recruit participants considered information-rich on the targeted phenomenon (Sandelowski, 2000). This allowed the researcher to recruit only those participants with targeted traits.

The study participants were recruited from the antenatal clinic (8 participants) and from postnatal ward and under-five clinic (8 participants). The idea was to elicit fresh information on teenagers' psychosocial experiences with pregnancy and with labour and delivery. Though the sample consisted of both the pregnant with their partners and the parenting mothers with their partners, the data are consistent since main focus was on their psychosocial experiences with pregnancy and childbearing. Much richer data was collected from the parenting group as they narrated their psychosocial experiences with both pregnancy and parenting.

During the data collection activity, the researcher followed the following procedure. First, client at the antenatal, postnatal and underfive clinics and postnatal ward were sensitised en mass about the research activity taking place. Brief explanations were given about the target population and the reasons. Then potential participants (teenagers who were pregnant or were parenting) were approached. These were identified through midwives who were on duty in these departments on each particular working day. The researcher had to screen participants through brief interviews and through their maternity information cards and child's under-five card (for those who were parenting children outside the neonatal period). Teenage couples were the sample of interest in the study for convenience. Those teenage couples who were deemed fit into the study criteria were asked if they were interested to participate. Then couples who accepted to participate were given consent forms to sign.

3.6 Study Place

This study was conducted in Zomba District at Matawale Health centre, a primary health care facility within Zomba Urban. This is a health facility that provided reproductive health and midwifery services. Health centres are first level health care provision facilities in Malawi, which refer cases beyond their capacity to the district hospitals. The researcher chose to conduct the study at the health centre because as a first level health care facility, it usually attends to clients with minimal or no obvious complications. The facility also provides such health care services as outpatient, under-five care and family planning services. Additionally, this health centre receives more clients and it was anticipated that the investigator would find research participants more readily compared to a health care facility at a higher level.

3.7 Inclusion and exclusion criteria

3.7.1 Inclusion criteria

This study recruited all teenage women and their partners that fitted into the following criteria:

- All teenagers aged 13 to 19 years who gave consent to participate in this study
- Expectant at the time of study or gave birth within the past 12 months at the time of study
- Female teenager married or unmarried between 13 and 19 years of age, who gave consent or their parent/guardian (if under 18 years) assented their participation
- Young partners (fathers) aged 13-19 years, who gave consent or parent/guardian gave assent (under 18 years) of participation

- Those who gave consent were eligible to participate in the study to avoid an element of coercion. For participants who were accompanied by their parents, the parents were asked for assent for participation of their child. Parents either gave assent or asked their child if they were willing to participate. Those that agreed to participate through after their parents' assent or gave consent indecently were recruited into the study. Some teenagers were not accompanied by parents, mostly those who came seeking for antenatal services. These were asked to participate and were recruited into the sample after giving consent. Both prospective teenage fathers and the teen fathers formed part of study participants considering that they were equally affected by the unexpected pregnancy and childbirth.

The inclusion of the male partners was seen to be critical as they have been noted to influence decisions made by their female counterparts and may contribute to the psychosocial experiences of their partners during pregnancy and or after childbirth (O'Keane& March 2007).

3.7.2 Exclusion criteria

All young people not meeting the criteria specified in 3.7.1 above were excluded.

3.8 Data Collection and Management

3.8.1 Data collection instrument.

A semi-structured in-depth interview guide was employed and data was collected through face to face interview (Appendix B). Semi-structured interviews were used because the investigator hadreadily prepared broad questions that he soughtto be answered (Polit& Beck 2010). Individual open-ended questions were used during the semistructured interviews as they provide flexibility in how the study participants

articulate their experiences and provide a broad range of information about childbearing (Sandelowski, 2000). Additionally, probes were used to elicit more pertinent information that may have been concealed by the participant. A data collection instrument was developed and had three sections. Section A of the guide explored the demographic data of study participants. Section B focused on participants' psychological experiences with early childbirth. This focused on uncovering the psychological experiences (mental and emotional i.e. thoughts and feelings) encountered by teens from the time of pregnancy through to a year of nursing a child. Section C contained questions on social experiences (relationships, personal dignity, and support from) with the partner, friends, parents and other relatives with regard to the early pregnancy and birth of the baby. This section also explored any aggravating or relieving factors to the traumatic psychosocial experiences of the teenage mothers and their associated partners that are available. Any psychosocial support or deprivation was also investigated.

In order to improve the quality of the information collected through the interview guide, pre-testing was done at St. Luke's Hospital, to evaluate ability of the study instrument to collect desired data. Improvements were then made accordingly. Some questions were modified while few others were removed from the interview guide. Clients included in the pretesting did not participate in the actual study.

3.8.2 Data collection process

An introductory letter about the researcher, the study and a letter seeking permission to conduct the study were submitted to the District Health Officer (DHO) for Zomba, following ethical approval from College of Medicine Research and Ethical Committee (COMREC). The permission letter, from the DHO, was then taken to the Health Centre Management. Verbal explanations were provided to the management of

the health facility on the purpose of the study and how it was to be conducted. The health centre manager provided the investigator with a designated place within the facility to ensure that subjects are interviewed in close to similar environments. The designated room was free from human traffic and in a location where other clients, guardians and clinic staff could not have visual access or overhear the conversation between the client and the interviewer. The chosen place promoted freedom and comfort and that ensured visual and more especially audio privacy and confidentiality for each participant to express themselves.

Potential participants, couples or sexual partners (who fitted into the inclusion criteria) were given clear explanations of the purpose and process of the study so that participation was based on an informed decision. The participants were informed that all interviews were to be done by the researcher himself. They were all told that interviews were anonymous and therefore it was unnecessary for them to disclose their names and that identification of each interviewed participant was to be through serial numbers. Each potential participant was told that the study touched such aspects as their feelings or emotional and social (relationship with parents, teachers, peers and the community), experiences as regard being pregnant or having got their partner pregnant, and emotional and social experiences with parenthood.The participants were told that participation was voluntary and they were free to ask question; not answer a question if they are not comfortable though their responses to each question were vital to the research. They were at liberty to withdraw their participation at any time if the so wished. Potential participants were also told that there were no direct benefits for them as they participate in the research process. Participants, with or without the parent's/guadian's presence (for those that came to the clinic alone) were told that they are asked to participate in the study because they are teenagers who are pregnant or

parenting. Participants were informed that the interview was to be audio recorded so that they give consent to have the interview recorded. analysis. Participants were then allowed to ask questions, express fears and concerns regarding anything to do with the study and the researcher provided answers to all question regarding the study. Potential participants were also informed that they were free to contact the author's supervisor or other relevant authorities if they felt that their rights were violated in some way. When the purspose and explations became clear to the potential participants, and parents, for those teenagers who were accompanied by parents, were asked for their willingness to allow participation of their teenager in this study. For those that reported to the health centre alone and those over nineteen years of age, consent was directly sought from them, mostly antenatal clients. All parents who were contacted told the researcher that their child should consent if they are willing. Each participant that was willing to participate was provided with a consent form to sign, as evidence that participation was without coercion. Participants in this study were either married couples or unmarried partners. Nevertheless, interviews were done individually. Each participant independently gave consent. For very young participants, those between 13 and 16 years, parental assent was sort. All consent forms were signed before each interview session commenced.

In-depth individual interviews were then carried out with each study participant who consented. Each interview session was audio taped and then later transcribed verbatim and analysed. In the process of interview, some short notes were taken on some critical statements or non-verbal cues made by participants to enrich the data. On average each interview lasted 40 minutes.

The interview guide was initially pre-tested before the main study was carried out. This ensured that the researcher gets a feel of how the flow of the interview will

be. Nevertheless, the researcher was conscious of the fact that each interview with respective participants may be unique. As part of ensuring consistency, all data was collected by the researcher himself. Young women or couples visiting the antenatal, under-five and postnatal clinics and those in post-natal ward and were about to be discharged, were interviewed. The interviews were conducted before or soon after the clients receive their services, depending on individual client's convenience. This was one way promoting participants' rights and free participation and flexibility of the interview process. In addition, some potential participants were next on the que to receive care and were allowed to receive the care first, while others were far, therefore interviewing such participants before receiving care was time saving.

3.8.3Trustworthiness of Data

In order to ensure that data remains trustworthy, four aspects of the data were evaluated, namely: dependability, credibility, confirmability and transferability. As a way of promoting the same, a second person was asked to listen to the interview tapes and verify the transcriptions.

3.8.3.1 Credibility.

Several efforts were made to ensure that confidence was maintained in the truthfulness of the findings. The investigator employed techniques as suggested by Lincoln and Guba (1985), that involves ensuring that the study findings remain credible (believed as a true representation of the participants' views, experiences and beliefs). Additionally, it portrays a clear understanding of the context in which the study is being undertaken. During interviews, the researcher had to see to it that there is prolonged engagement with participants by giving them ample time to ask questions and express their fears, employment of probes and through active listening to encourage the participants to talk more. Investing sufficient time, i.e. the researcher had to avoid

rushing through the process as this would make the participant feel alienated from the investigator, and this would reduce their psychosocial sense of security, during the execution of the study ensured that participants build a sense of trust in the researcher and created an atmosphere that allowed the teenagers to express themselves freely and the researcher to have a clear understanding of the context in which ECB psychosocial experiences took place (Lincoln & Guba, 1985). Spending adequate time with participants allowed the researcher to test any misinformation introduced by distortions either of self (pre-conceptions) or of the respondents. The researcher ensured that he does not rush through the interview and asked the participants to clarify their experiences. Paraphrasing of participants statements was done to ensure the researcher got exactly what the participant meant, like: 'when I got pregnant I lost hope'. The investigator probed on what was meant by such a statement. The author tried to build trust with participants by showing courtesy in asking question and responding to the teenagers' questions. The author also allowed the participant to communicate in manner (words they use among youth) they felt comfortable to express how their experiences were. Questions were rephrased if the participants showed that did not understand or when they did not seem to have gotten the idea clearly before they responded because poorly asked questions may lead to distortions. On average, each interview lasted 40 minutes. However, each session was basically controlled and directed by participants' extent or freedom of self-expression.

Going along with prolonged engagement was prolonged observation. Lincoln and Guba (1985) explains that prolonged observation assists in identifying characteristics and elements in study participants that are most pertinent to the phenomenon or issue under investigation.

Peer debriefing, was also utilised. An independent peer, a faculty member, was used to test the methodological design of the study. This helped in modification of the in-depth interview guide to suit its purpose (Lincoln & Guba, 1985).

The next technique is member check. Using this technique, credibility was ensured by subjecting the data, analysis, data categories, interpretation and conclusions to a test by stakeholders (Lincoln et al., 1985). In this case, information given by participants was verified through paraphrasing certain statements given by them. Where necessary, on specific portions of the interview, the interview was played back to the participants to verify if what they said was what they really meant. Supervisor also assumed this role as they were consulted and gave comments on the analysis of data and development of themes.

3.8.3.2 Dependability.

This refers to the research ability to stand the test of time (Moule & Goodman, 2014). In order to ensure dependability, an audit inquiry was utilised. Independent professionals such as supervisors examined the research process including methodology and the data collection instruments such as how questions were framed and this ensured that it met the required standards (Lincoln & Guba 1985; Polit & Beck, 2010). The process was also examined by COMREC especially the methodology and ethical aspect before the study was undertaken.

3.8.3.3 Confirmability.

This is a measure of objectivity in the collected data (Moule & Goodman 2014). It is the state of confidence to generate same results if the research was carried out by two or more independent people on the data's accuracy, relevance and meaning (Polit & Beck, 2010). As a means to ensure confirmability, a confirmability audit was conducted and to form a basis for objectivity (Lincoln & Guba, 1985). In order to

promote confirmability, 'data reconstruction and product synthesis was done. This process included analysing the structure of categories (themes, definitions and relationships), findings and conclusions i.e. interpretation and inferences; and the final report (Lincoln & Guba, 1985).

Confirmability in this study was concerned with ensuring that collected data is representative of the information participants provided to the investigator. Study participants' responses were recorded and verified in the process where necessary and possible to ensure that what was recorded was what was exactly said and meant. Documentation in the bracketing book was also part of the data for analysis (i.e. the researcher's feelings, thoughts, and emotions as he collected data), (Moule & Goodman, 2014). During transcription, and analysis of data to derive themes, the investigstor constantly made reference to his documentaed feelings, experiences and beliefs and congnition on the topic under study. Cross referencing was made and the audio recorded interview revisited to exclude contamination of data by these personal experiences, feelings, and cognition (recorded in the bracketing book), so that as much as possible only participants' experiences take centre stage in the analysis.

3.8.3.4Transferability.

This is a test of whether the results will be able to hold the same claims in the same context in future or in some other context (Lincoln & Guba, 1985). It refers to the degree to which findings can be applied to other settings or similar groups (Polit & Beck, 2010). The study was conducted at a health facility setting and the process of sampling and data collection were described clearly (Moule & Goodman, 2014).

3.9 Data Management and Analysis

After each interview schedule for the day, the researcher listened through the recorded information. This was to ensure that data made sense or was meaningful and

provided an opportunity for verification with clients where feasible on the next visit to the health facility. The collected data for each day was then transcribed verbatim in Chichewa then translated into English. Content analysis was used to analyse the data. This type of analysis is suitable for this kind of research because the study required simple reporting of common issues as described by the teenagers (Thorogood, 2004). Qualitative analysis is the best approach as it helps to methodically explore large volumes of documented information unobstructively, so as to identify some trends and patterns of words used by teenagers (Gbricks, 2007).

Similar data was then put into same group or category for coding (Polit & Beck, 2010). Data was transcribed back to Chichewa by an independent person as a way of testing and ensuring that original content and meanings were not lost. Following the analysis, themes and subthemes emerged and are predented in table 1.

3.10 Study Findings

3.10.1Presentation of Findings

The main results of this study have been presented in themes as they emerged from the interviews with study participants (Table 4.3). Subthemes were also generated where it was deemed appropriate. Direct quotes have been used to present the expressions and feelings of participants.

3.10.2 Dissemination of Results

The results of this project will be disseminated at national and international forums. Additionally, copies of the work are to be made available to Zomba District Health Office, Zomba Central Hospital, St. Luke's Mission Hospital, Kamuzu College of Nursing Library, Ministry of Health Headquarters, College of Medicine Library and COMREC Secretariat. The results will also be available at The National Health

Sciences Research Committee (NHSRC) and the University Research and Publication Committee (URPC) through COMREC Secretariat heritage.

3.11Ethical Consideration

The researcher in this study strived to ensure that rights of study participants are safe-guarded at all cost. The researcher endeavoured that ethical and legal standards governing research work on humans, and young people and children in particular, were followed. First ethical approval to conduct this study was sought from College of Medicine Research Committee (COMREC) as it is mandated to approve studies of such nature. Ideally, parents, guardians or their significant others were to assent the participation of adolescents under 18 years for them to participate. Nevertheless, for purposes of privacy and confidentiality of the participants, as provided in the Sexual and Reproductive Health and Rights Policy, a waver was requested from COMREC to interview teens under 18 years without parental or guardian consent if they were not accompanied by parents/guardians and where these young people were independently willing and then consented to participate. And thereafter, Zomba District Health Office and Matawale Health Centre Management granted permission to conduct the study at the health centre. They were informed that participants targeted in this study were teenagers aged 13 to 19 years, both the married and unmarried, who were currently pregnant or were parenting. It was also explained that each participant was to be interviewed individually by the researcher himself following their consent and that each interview session was to be recorded for purposes of storing information for analysis.

Each participant (who fitted into the inclusion criteria) was given clear explanations of the purpose and process of the study so that participation was based on an informed decision. Each participant, with or without the parent's/guadian's presence

(for those that came to the clinic alone) was told that they were asked to participate in the study because they are a teenager who is pregnant or parenting.

Then they were informed that the study sought to explore their psychosocial experiences from the time they got pregnant, and for those who have children, their experiences with parenting. Each potential participant was told that the study touched such aspects as their feelings or emotions and social (relationship with parents, teachers, peers and the community), experiences as regard being pregnant or having got their partner pregnant, and emotional and social experiences with parenthood. Each participant was informed that participation was voluntary and that they had a right to say no to participation. Moreover, potential participnats were appraised that there was no direct benefit for them as they participate in the research process. They were informed that despite being recruited into the study, they were free to withdraw at any point or interrupt the investigator to ask questions during the interview session. Furthermore, participants were told that they were not under obligation to answer every question, though answering each question was vital for the purposes of this study. Participants were informed that the interview was to be audio recorded so that they give consent to have the interview recorded. In order to ensure confidentiality of participants and the information they provide, they were informed that provision of names was not necessary and that their specific recordings will only be identified by individual serial numbers or codes.

Participants were then allowed to ask questions, express fears and concerns regarding anything to do with the study and the researcher provided answers to all question regarding the study. Potential participants were also informed that they were free to contact the author's supervisor or other relevant authorities if they felt that their rights were violated in some way. When the purpose and expiations became clear to the

potential participants; and parents, for those teenagers who were accompanied by parents, were asked for their willingness to allow participation of their teenager in this study. For those that reported to the health centre alone and those over nineteen years of age, consent was directly sought from them, mostly antenatal clients. All parents who were contacted told the researcher that their child should consent if they are willing. Each participant that was willing to participate was provided with a consent form to sign, as evidence that participation was without coercion. As a confirmation that they had understood and wilfully accepted to participate in the study, each participant was requested to sign a consent form as all participants knew how to write (Appendix C). Ideally, parents, guardians or their significant others were toassent the participation of adolescents under 18 years for them to participate. Nevertheless, for purposes of privacy and confidentiality of the participants, as provided in the Sexual and Reproductive Health and Rights Policy, a waver was requested from College of Medicine Research and Ethical Committee, to interview willing teens under 18 years without parental or guardian consent. This was applied where the participants were eager to take part in the study despite their parents' objection. Therefore, all participants, who took part in this study, consented their participation in the study by themselves.

A special room, designated for the interviews was requested at the facility, which ensured there were no auditory and visual privacy violations in the process. Moreover, in studies like this one, participants may become emotional and breakdown. In order to carter for such eventualities, the researcher identified a counsellor to attend to them. Respect and confidentiality for study participants' values, cultural traditions and social practices was upheld at all times. The investigator also provided for ample

time in the event where a participant was to take some time to reflect on their situation or experiences.

3.12 Constraints in the Study

No major challenges were encountered in this study.

3.13 Study Period

This study was undertaken between October 2016 and October 2017. Events are detailed in the study calendar (Appendix A).

3.14 Study Requirements

3.14.1 Study personnel.

Apart from the researcher, other personnel required for the success of this study were two study supervisors and two other professional midwives. The researcher was responsible for all administrative work including bookings and questionnaires design and printing. He also carried out the actual collection and analysis of study data. He was also responsible for preparation and dissemination of study results. The two research supervisors were responsible for ensuring that the quality of the study process and results were upheld. They were consulted to provide technical expertise to ensure standards for research work were upheld throughout the process. This was necessary to ensure that results remained credible. The two professional midwives were required to assist in the pre-testing of the study instrument on some teenagers at St Luke's Hospital. They pre-tested the interview guide independently of each other and the researcher. After the pretesting, the two independently reviewed the guide and gave feedback to the researcher.

CHAPTER 4

STUDY FINDINGS

4.1Introduction

This chapter presents the findings of the study which was conducted to explore the ‘‘psychosocial experiences of early childbearing among teenagers’ aged 13-19 years in Zomba District. The results have been presented by intertwining data and interpretation according to themes and sub-themes, with direct quotes from participants, to confirm that the data came from the study participants and assisted to evaluate quality of data collected.

These results are presented according to study objectives which were: psychological implications of early childbearing young mothers aged 13-19 years, sociological impact of early childbearing on young mothers, psychological experiences of young fathers aged 13-19 years with early childbearing, sociological impact of early childbearing on young fathers and socio-cultural and individual factors that aggravate or reduce negative psychological experiences of adolescents with early childbearing.

4.2 Participants’ Socio-demographic Characteristics

This study was conducted through in-depth interviews with 8 teenage females and 8 teenage males. Teenagers who participated in the study were between the ages of 13-19 years. Six (6) of the study participants were married (officially/) and the rest (10) were un married (were either co-habiting or living separately).

On participants' ethnic background, 6 were Lomwe,7 Chewa, 2 were Yawo and 1 was Tumbuka. Twelve (12) participants were from a Christian background and 4 were Muslims. Most participants reported coming from the rural areas of Zomba District. Each of the participants was carrying either their first pregnancy or baby. Among the female participants, four (4) were pregnant and the other four (4) were parenting. Ten (10) participants dropped from primary and six (6) secondary school, respectively. Furthermore, female participants' analysis showed that the majority (5) were in school at the time they got pregnant and 3 were out of school. Amongst these female participants, five (5) were in primary school and two (2) in secondary school education at the time they got pregnant and one (1) had already dropped out of school by the time she got pregnant. Additionally, all male participants were in school at the time their partners got pregnant. Five (5) of the males were in secondary school while three (3) were in primary school.

4.3 Main Study Findings

A summary of the main findings on participants' psychosocial experiences with childbearing are presented under themes and sub-themes in Table 4.3.

Table 4.3. 1 Themes and sub-themes

Main Themes	**Sub-themes**
Emotionally Traumatic Experience	Early childbearing-a chagrin Shame and Regrets
	Depression and Anger
	Disbelief
Harsh Consequences	Fear of Reprimand Parental animosity Punishable Conduct - Support Depravity
	- Aggression - Bear it Alone
Uncertainties and Concerns	Lost future
	Scared of Complications
Arduous Responsibility	Multiplied pain Positive coping
Volatile Relationships	Discrimination & Rejection
	-Parental and sibling rejection
	-Peer rejection -Community rejection
Coping Strategies	Parental Support Unhealthy Coping

Influencing Factors	Parental Expectations Untimely

4.3.1 Early childbearing-a chagrin

Participants expressed emotional shock and psychological distress the moment they realised they are pregnant as the pregnancy brought feelings of shame, depression, anger and disappointment.

4.3.1.1 Shame and Regrets

Both the male and female participants expressed feelings of shame and embarrassment upon realisation that they are pregnant. Furthermore, others still felt they had betrayed the trust their parents had in them and this made them develop hard feelings and regrets. Few others never knew they were pregnant until an elderly person asked them.

> One female participant had this to say, "I felt shame at first. Since the 'problem' is with you, you feel ashamed. But what can you do about it, nothing. ….you are not expected to be pregnant while in school. I thought people will say I was very promiscuous" [FT 03]

> And a male participant said, "When she informed me she was pregnant, I was afraid to face my dad. Each time I came close to him, it was as though he already knew what had happened. I was sore afraid" [MT07]

> "I regretted and blamed myself for the pregnancy. I thought I was so careless; I should have used condoms. But then, what could I do, it had happened and I could not run away from it and I thought it would be harsh to the girl for me to deny responsibility" [MT 05]

4.3.1.2 Depression and Anger

Most participants expressed having felt, depressed, disappointed and sad about their situation. The male participants expressed regret for their own actions and blamed

themselves for the pregnancy while the females felt sad and depressed. This was a common reaction among those who were in school at the time they got or made their girlfriends pregnant. Such a reaction emanated from participants' perception that their future had turned uncertain, especially on education. The most of participants described how they were disappointed in themselves. They expressed having emotional shock and anger with self. Such emotional reactions were linked to parental, peer and societal expectations which were a total mismatch of what they did. Most participants expressed that parents and the community expected them to get married formally and not get pregnant out of wedlock.

Most participants verbalized that they felt there was something they could have done to avoid getting pregnant but couldn't just do it as one male participant narrates:

In expressing their experiences, some participants had this to say……

> "I was under great stress and thought my friends, being age mates with me would understand my situation. I felt more depressed when I saw that they could not freely mix up with me as before" [MT 04]

> "I feel so bad within me, especially when I think of all the love, support and encouragement my parents had shown to me……so I contemplated to abort the pregnancy, so I can continue with school" [FT08]

4.3.1.3 Disbelief

Participants, both females and males expressed that they had doubts about them being pregnant. Both groups thought they were young and that the pregnancy had come too early in the life.

Some of them had this to say: …

> "When I realised I had not seen my period that month, I told my boyfriend……. He just downplayed it ……and said that I should not worry, it (the pregnancy) cannot happen that quick or else I should go for a test to confirm"..[FT01]

> "I was shocked when she told me that she didn't see her menses that month…..In disbelief, I just told her that it happens to some people and the menses will return in few days, but it never did…….Then I suggested a pregnancy test which to my surprise, came positive……I thought the pregnancy came too early"…..[MT06]

4.4. Harsh Consequences

Under this theme, emerged two sub-themes: Grappled with fear, Parental animosity and punishable conduct.

4.4.1 Fear of Reprimand

They dreaded possible unbearable parental reactions which made them experience mental torture even before their parents and guardians knew of their pregnancy. The mere imagination of facing their parents while pregnant was greatly stressful. For others, they mere thought of going through labour experience created even more fear.

> "I feared that my parents would shout at me and may throw me out of the home and even beat me. I wasn't sure if reporting to them was going to be safe for me" [FT 02].

> "I was staying with my elder sister……...And she used to warn me that if I did anything stupid, I would suffer the consequences. ……I was very afraid to tell her what had happened…" [F04]

4.4.2 Parental Animosity

Participants expressed their parents/guardians had reacted with anger and displeasure because they had become pregnant unexpectedly.

In narrating their experiences some participants said: …

> "My mum was very displeased that I got pregnant…… She was angry and asked me what I had benefited from getting pregnant while in school" [FT05] .

> "When my parents became suspicious of my status, they called me one day and quizzed me if I were pregnant……. When I confessed that it was true both of them (parents) were angry and started shouting at me" [FT06]

> "They (parents) were angry……. they were very disappointed because am their first born……. They said I was a bad example" [MT04]

4.4.3 Punishable conduct

Most of the participants expressed parental animosity. They reported that their parents were so angry that they reprimanded the participants by withdrawing their support. Others stated that they were driven out of their parents' home. They expressed having being exposed to corporal punishment and withdrawal of financial support like school fees. Such experiences were particularly characteristic of participants who got or had got their girlfriends pregnant while in school.

> "My mum said I was good for nothing, what I know it to play and sleep around with useless boys and that I have just wasted their money and that I should pay back…… she drove me out of the home to live my granny……. She said I should bear the consequences of my actions alone" [FT03]

> "My dad was very displeased and was very angry with me……..He beat me up and I was afraid to stay home………..he said I had grown up to be in school and will have to fend for my needs and that of my partner…….He told me that hence forth he had nothing to do with me……I was frustrated and didn't know what to do next…" [MT 01]

> "I had not seen my parents getting angry with me like that for years……I was so afraid……and later they told me to go and live with my boyfriend because 'we have done away with you'………That's how I got married" [FT05]

On the contrary, the parental reaction for some participants was different. They expressed that some parents reacted calmly. The teenagers reported that their parents looked disappointed, unhappy and depressed upon hearing such news. However, they were never unkind to them. Some parents, while expressing disappointment and disapproval of the pregnancy, immediately accepted the status quo and committed themselves to provide assorted assistance. Additionally, participant who became pregnant while out of school had no fear of parental reprimand. This was the case because they started childbearing when they were married and their relationships were endorsed by their parents or guardians. Culturally, it is more acceptable to get pregnant while in marriage regardless of the age.

Some participants had this to say:

> "When my grandmother confirmed to my parents that I was pregnant, they both looked very sad. My dad was concerned that I could not proceed with my education but they never punished me in any way as I had feared" [FT 04]

> "My parents accepted the situation though they were sad for me to drop out of school……They told me that they will take care of my girlfriend and the baby after birth……. They encouraged me to continue with school [MT05]

> "I got pregnant after I left school…. I was already in marriage and staying with my husband that time……My parents, especially my mom was happy that I will have a baby" [FT 07]

4.5 Uncertainties and Concerns

This study has revealed that pregnancy in teenagers creates a number of concerns and fears. Under this theme, two other sub-categories were developed: concern for a lost future and economic burden and the fear of pregnancy and child birth complications.

4.5.1Lost Future

Participants expressed the feeling that they had lost a future due to discontinuation in education. Some thought there was nothing they could do and therefore the only option is to get married. With the interrupted or perceived loss of education opportunities, the participants felt that they could never secure any good job in future that could earn them a living.

A participant had this to say, “When I realized I was pregnant, the immediate thought was that I had lost my opportunity to proceed with my education……So without a good education in this country, you cannot have a good job. [MT 04]

Another participant added, “Someone, (not my parents), was paying for my school fees…...I think the pregnancy is a disappointment to them and I doubt if they will still be interested……...My parents struggle to find money to support me and my siblings…...it’s sad I am in this…. [FT06]

4.5.2 Fear of Complications

A considerable proportion of participants expressed fears and possible complications that may occur during pregnancy and the birth of the baby. Some teenagers expressed fears that both the mother and the baby might develop complications such as bleeding and baby’s failure to breathe. Furthermore, participants reported having knowledge that both mother and baby are at risk of dying. However, other participants never anticipated any problems.

One participant said, “What I am afraid of is an operation and death. I have heard people say that labour is not easy and the mother and the baby sometimes die or may have big problems” [FT 01]

And another echoed, “We are told that it’s so dangerous to give birth at my age……Am so scared though have seen few other young girls giving birth” [FT06]

Interestingly, in spite of some teenagers having these fears, others reported that they were not afraid of anything. They just expected that everything will go on well both during pregnancy, labour and delivery and thereafter.

> One participant had this to say, "I don't expect any complications…….am not scared of anything of that sought…...If it happens there is nothing else I can do……may be doctors will know how they will help" [FT07]

> Another participant said "…. People say it not good to start bearing children while young…. But since it has happened already, what else can you do…. fearing will not change anything for her…. I will just trust God" [MT 8]

4.6Arduous Responsibility

Participants in this study described parenthood as being a burdensome experience. They expressed that it was stressful and demands a lot of time, commitment and resources. The male participants stated that experience with parenthood is that it required a good financial base necessary to meet their needs those of their newborn such as food and clothing and this created stress and anxiety as those demands were mostly far from being met. The participants also expressed that parenthood (because of its demands) isolated them. Most of the female participants stated that motherhood limited their freedom of association with other teens.

Some participants had this to say; …

> "Being a mother is demanding. The baby needs a lot of things that require money but I don't have any……I have no job and nobody shows willingness to

help……. So you just have to think of other means of getting the money you want, though it might not be the best way. You take a risk" [FT 06]

"Mmmmm, fatherhood is not easy…. It demands a lot from you, time, money……. You also stay awake sometimes at night as the baby is crying and yet you can't guess the problem with him…... Then there is food, it's just unbearable" [MT 02]

"…another big challenge to me is the kind of care I must provide for myself and the baby to be born, and you just don't have time to spend with friend……. You are all alone and lonely most of the time……. I'm not so sure I will make it because am not working and my boyfriend too……. We were still in school and were not ready for this sort of responsibility" [FT 02]

"It happened while I was still in school…. Had no job, no business, no money…. I was depending on my parents, then, came this little baby……You start thinking of where and how you can get money to buy food and clothes……. Now I understand why someone turned to alcoholism and drugs, the pressure is too much" [MT01]

4.7 Volatile Relationships

The study revealed that participants had varying experiences in the respect to relationships with different members of their family, peers and the community. Most participants expressed that relationships were disrupted while they remained stable for some. Most participants expressed that they felt discriminated and rejected by own parents, siblings, peers and the community.

The relationship experience was further sub-categorised into: discrimination and rejection by parents and siblings, discrimination and rejection by peers and discrimination and rejection by the community.

4.7.1 Discrimination and Rejection by Parents and siblings

The participants' described an assortment of experiences in their relationship with parents. The participants expressed that relationships especially with parents, were strained. Furthermore, the environment in the home was in many cases volatile. The teens expressed concern over the loss of respect, regard and trust their parents had towards them. Relationships were so appalling that some participants reported having been rejected and thrown out of their parents' homes and went to live with other relations, especially grandparents. The participants, both male and female, expressed that they felt loss of the worthiness parents and siblings had previously placed on them and that some of their siblings were so unhappy to see them pregnant such that they tried to coerce them to terminate the pregnancy.

Most participants, particularly females, expressed that social distance widened between them and parents and siblings. Participants felt they were 'abruptly weaned' from the parental love they enjoyed initially. Due to such unhealthy parent-child relationship, participants reported that parents withdrew their moral, material and financial support. The participants expressed that they substantially felt that abrupt change and theystated their parents' reaction as being normal but some complained that some were over reactive, which made their condition worse.

Participants had this to say;

> "Honestly, my parents had been so good until this pregnancy came. We have, since then, never been in good terms. Though I live with them, I

still feel there is something missing between us. They don't talk to me as regularly as they used to" [FT 03]

"Things have significantly changed……They used to talk to me so often, not a single day passed, but now it's as if we live in two different worlds" [FT 02]

"My elder sister was very displeased that I refused to terminate my pregnancy……She did it when she got pregnant herself and dad was mad at her…… She wanted me to do the same but I disagreed with her and she got angry" [FT 03]

4.7.2 Discrimination and Rejection by Peers

Most participants expressed having experienced rejection, stigmatization and discrimination from peers. They reported having felt unwelcomed among their peers, were rejected and became isolated. They stated that their peers spoke in a derogatory manner to them and they felt inferior and therefore un-qualified to be in the company of their own peers. They reported that their peers considered them as 'too senior' to associate with. Most participants expressed that they were treated as 'aliens' by their own long-time friends. Participants stated that their non-pregnant and non-parenting peers feared to associate with them because they would be labelled as 'doing the same' by society members.

A participant said, "The challenge is that anybody who gets pregnant in my area is considered an adult…. Your friends suddenly feel as though you are much older than them and therefore not fitting in the group……Friends discriminate and talk disgraceful things about you in groups" …[FT02]

Another one echoed, “Your friends consider you as someone who knows much greater sexual and reproductive health issues that only adults should know. So they feel you don’t fit in the group and may talk issues at different levels; and how your friends behave tells you, you are not welcome” [MT 04]

“I was under great stress and thought my friends, being age mates with me would understand my situation. I felt more depressed when I saw that they could not freely mix up with me as before” [MT 04]

While some participants expressed that they had bad relationship with peers, others reported to have received considerable support and encouragement from them. They stated that they got support on how to care for themselves and how to be emotionally strong and assertive;

One participant had this to say, “One of my friends was very good to me……she encouraged me and that gave me hope” …. [FT08]

Another said in agreement, “When I informed my long-time friend who lives in Lilongwe, he asked me why I had done it. But he was very supportive. He gave me some advice since he went through a similar experience before” [MT 03]

4.7.3 Community Discrimination and Rejection

Participants also expressed their socially challenging experiences in relating with members of their community. They reported having being stigmatised and discriminated against by community members. These challenges were more pronounced among female respondents. Some participants expressed that they were

insulted and disrespected for getting pregnant. Male participants generally verbalized no concerns with community members. Only a few male teens reported that people laughed at them for failing to continue with their education.

Some participants expressed themselves in this manner:

> "People (the community) talk a lot when such a thing happens. Some would say that 'you were too busy with boys and neglected your education'. They don't give you respect. They despise you, so you can't be free to relate with such people" [FT 05]

> "You get embarrassed……You actually hear some people (community members) talking about you…. Even in your hearing, they actually speak bad words about you…. They say, 'Young as she is, she likes indulging in sex…...she is very loose and doesn't know how to say no to boys" [FT04]

On the other hand, other participants expressed having experienced more respect from community members for getting pregnant. Pregnant teenagers were treated as adults by older people.

> A participants had this to say, "Before I got pregnant, many people treated me like a small girl. But when I got pregnant people started treating me with respect" [FT 06]

> And another echoed, "Now that am a father, people in my village give me respect……. They take you as a grown up despite your age…...And they culturally cease to call you by your name, they address you by your child's name" [MT08]

4.8. Coping Mechanisms

4.8.1 Parental Support

Here participants expressed having some relief from the stress of pregnancy and parenthood. Their main source of respite was the positive reaction of their parents. Though most parents had initially reacted with hostility, participants reported that they later came to terms with reality and started supporting them. Participants stated that their favourable parentalreaction provided much relief compared to good relationships with peers and the rest of the community. Nevertheless, others still found solace in peer support.

Participants had this to say in the narration of experiences:

> "I felt less and less stress when my parents said they will pay for my school fees and also help me take care of my baby" [FT 05]

> "Mmmh, my relationship with them (parents) was good before I got pregnant. But the pregnancy changed everything. My parents initially distanced themselves from me, but things have since improved, because despite their anger, I think they realised my pregnancy status could not change" [FT 06]

> "My parents just accepted the situation. They told me they will take care of my girlfriend and the baby after birth…... They encouraged me to continue with school" [MT05]

> "My father said that I knew what I was doing, am not a little baby'. Therefore, I should hence forth fend for myself, my pregnant girlfriend and the baby. But he later changed his mind and started supporting me,

especially after the birth of the baby. I think he became concerned with the kind of life I was living" [MT 03]

4.8.2 Unhealthy Coping

Additionally, a considerable number of participants expressed that they found solace in some risky behaviours. Most of them, especially boys, who were forced into marriage, reported that they found comfort in drugs and alcohol. They stated that they started smoking Indian hemp and took alcohol excessively which, as they admitted, gave them temporally relief as the drugs and alcohol made them to divert their attention from the pregnancy or baby demands. Further to this, the female participants, both the married and unmarried, who had insufficient or no support at all (either from partner or parents), stated that they resorted to having extra sexual relationships with older men or other young men who pledged to provide them the support they so much needed.

> The participants had this to say "The pregnancy came at a point when I had nothing…. I was dependent on my parents. So when they withdrew their support I dint know what to do…. I was worried most of the time so one of my friends introduced me to Chamba (Indian hemp) …. No, I refused at first but because of the current pressure, I had to try…. It elevated my mood and temporarily took away all my worries, so I have to take it again" [MT 04]

> Another participant added, "When I noticed that my boyfriend couldn't afford to support me and my baby, I engaged in another relationship because he gives me something which I use to support myself and the baby…… My parents were reluctant to help and my granny is old and weak to support me adequately" [FT 03]

4.9 Influencing Factors

4.9.1 Reaction from parents and siblings

The study revealed that most participants encountered these negative experiences because of what is expected of them not only by their family members but also the community at large. They expressed that it was never expected of them to become pregnant or make someone pregnant while in school.

A participant had this to say:

> One female participant had this to say, "
>
> "My pregnancy was not a very big problem to me; but when I thought of what my parents would do to me upon knowing that I am pregnant and what my elder sisters (siblings) will say, this created fear and depression in me. As I said, you are not expected to be pregnant while in school" [FT 03]

4.9.2 Untimely

The emotional experiences also emanated from the fact that participants never expected that they could start childbearing at that moment in time. For most of them advent of the pregnancy was a shock.

Ons participant said….

> "The pregnancy really came so suddenly. I was not ready for it. It was a big shock to hear that she was expectant. The mere thought of becoming a father to someone at my age was like a huge load.…...I felt like am carrying something heavy" …. [MT06]

4.9.3 Cultural and Religious Influence

Most participants expressed that there was no significant cultural and religious impact on their experiences with childbearing. Nevertheless, some participants reported that cultural expectations as regards care and conduct during pregnancy conflicted with what they received from health workers. As young people, they had a tough time considering which advice to follow. Main issues were hinged on sexuality and nutrition. Some few participants stated that their religious faith influenced them to refrain from abortion as 'the expected baby is innocent regardless of whatever happened.' Othersexpressed that they felt a sense of guilt and shame because they had gone off course in relation to their faith expectations.

> One participant had this to say, "The only challenge I encountered was the right type of food that my partner should eat while she is expectant………At home we were advised not to take certain foods and restricted us on sex till the baby is born and yet doctors encourage us on the same" [MT07]

> Another echoed, "I was advised that it was not safe for the baby for me to have sex while pregnant…...But the 'nurses' here (clinic) said that there wasn't any danger unless I am not feeling well or told by the doctor" [FT08]

4.10 Conclusion

The findings revealed that both male and female participants experiencing early childbearing, are subjected to numerous and divergent psychosocial challenges. These experiences include such psychological aspects as feelings of shame, embarrassment and regrets, Depression and self-anger, disbelief of being pregnant or having made a

partner pregnant, fear of parental punishment. Social experiences including parental animosity and punishment such as support depravity, corporal punishment, being driven out of parental home were not uncommon. They also expressed burdensome roles of parenthood. Participants encountered strained relationships including stigmatization, discrimination and rejection from parents, peers and the community. These psychosocial experiences led to risky coping like alcohol and drug abuse.

CHAPTER 5

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter intends to provide insights into the study findings. The researcher staves to highlight the major findings of the study while concurrently trying to make sense out of them. The chapter also point to the implication of the findings on the sexual and reproductive health services provided to teenagers experiencing early childbearing. The author provides some recommendations in relation to the findings of this study. This chapter's focus is on the two objectives of the study namely:

a) to describe the psychological experiences of early childbearing among teenagers;
b) to investigate the sociological childbearing experiences among teenagers;
c) to identify factors that aggravate or relieve teenagers' experiences with childbearing.

The discussion of study findings under each objective follows themes and subthemes that were derived from the data analysis.

5.2 Discussion

The findings in this study showed that participants went through a wide range of psychosocial experiences regarding early childbearing (ECB). These results indicate that ECB has harmful psychosocial impact on teenagers' life (Kyari & Ayodele, 2014), just as much as this phenomenon has on their physical health (Banerjee et al., 2009). In this study it has been observed that early childbearing (ECB), brings significant psychological experiences like, uncertainties about the future, emotional stress, anger,

fear, depression, feelings of regret and shame. A number of social experiences related to early childbearing were also observed and these included parental animosity, being punished for getting pregnant (support withdrawal, separation from parents), strained relationships with parents/guardians and siblings, peers and community members. Other social experiences were burdensome roles of parenthood, withdrawal of parental and peer support and coping with negative experiences of early childbearing. It was observed in the study that cultural and religious beliefs had some influence on early childbearing experiences. Despite working with a small sample, these results still provide great insights into the psychosocial experiences of early childbearing that may be applicable in diverse social-cultural and economic contexts.

The first objective of this study was to explore the participants' psychosocial experiences with early child bearing. The individual in-depth interviews unveiled that teenagers experience a wide range of negative psychosocial experiences during pregnancy and parenting.

5.2.1 Early Childbearing: A chagrin

As noted from the results, the most participants regretted being or having made their partner pregnant, only a few did not show any regrets. In their study, Ankella and Jordan (2014) observed that most participants experienced regrets and stress despite the support provided to them by family members, their teachers and peers. Both female and male participants equally exhibited a substantial degree of remorse, contrary to observations made by Arai (2009), where he found that only a few participants regretted being mothers, and others actually perceived some benefits from teen childbearing (Herrman, 2008). The differences in findings here could be attributed to the variances in the socio-cultural background from which the participants were drawn. Mollborn (2010), reported that girls were more likely to report embarrassment compared to their

male counterparts and that higher socio-economic status teens reported more embarrassment.

In this study, depression, emotional shock, shame and embarrassment were a common psychological experience and both male and female participants, especially among those who were still in school at the time they got pregnant or impregnated their partner. Similar findings were reported by Kingston, et al. (2012) and Moisan et al. (2016) in their studies where they observed that adolescent mothers were more likely to experience depression and low self-esteem than older women. Observations made in other studies show that early childbearing leads to more depression and anxiety (Figueirodo, Pacheco, & Costa 2007; Salazar-Pousada, et al., 2010; Whisman, Davila & Goodman 2011). Depression and feelings of shame were observed to trigger suicidal ideas (Alio et al., 2010); participants expressed feelings of shame and embarrassment (Watts, Liamputtong & Mcmichael, 2015). Additionally, feelings of shame have also been expressed by teenagers in some studies (Bah, 2016).

These observations were found to be common among school dropouts (Sik, 2015). The researcher is of the view that the psychological experiences were based on regrets of their actions and lack facts about sexual and reproductive life issues and this kind of outcome was least expected. East, Chien and Barber (2012), noted that increased pregnancy intendedness predicts the adolescents increased level of stress and anxieties. The researcher suggests that this kind of psychological reaction is an indication of either the teenagers' lack of knowledge and misinformation or misunderstanding of their body's reproductive physiology and therefore the need to provide them with the psychological support they require in such stressful times. Bah (2016), observed that teenagers needed accurate balanced information about sexuality, sexual behaviour and contraception and other skills about sexual activity.

Rolling out of a robust Youth Friendly Health Services(YFHS) program that is based on prevailing sexual, cultural, psychosocial needs should be able to contain the growing problem of teen pregnancy (intended or unintended) and the psychosocial challenges it brings. East et al (2012), in their study found that adolescents desire to be pregnant decreased from 76% while pregnant to 26%, and unwantedness increased from 5% to 33%, respectively, after childbirth. This clearly emphasises the point that teenagers lack knowledge and need guidance on what pregnancy and childbirth entail; and many of them don't really have that desire to become or get their girlfriend pregnant. East, Chien and Barber, 2012, noted that increased pregnancy unintendedness predicts the adolescents increased level of stress and anxieties.

The researcher, thus, suggests that sexual and reproductive health education provided to teenagers in schools must not only be aimed at fulfilling the curriculum but ensuring that teens be guided to develop personal life skills that are relevant in either helping them avoid pregnancy or positively go through it. This will consequently reduce the unhealthy psychological reactions they exhibit in the event of a pregnancy. Literature provides support that emotions of shock, shame and embarrassment are not uncommon in early childbearing experiences (Sik, 2015); Teens were by and large coerced to a pregnancy test and then forced to drop out of school, as school staff and classmates discriminated them. Teenage mothers have an increased risk for psychological challenges related to pregnancy than do their older counterparts (Lanzi, Bert & Jacobs, 2009). Teen parents must therefore be given deliberate special attention as regards psychosocial care. In conclusion of their study, Gyesaw and Ankomah (2013), highlighted the need for parents to be given the right knowledge and appropriate techniques in teenage sex education, so they can equally equip their teens. Parents, teachers and the rest of the community need therefore to consider the cognitive and

social development level of teenagers ensure constructive disciplinary actions are utilised in the process.

The results in this study are further supported by findings of Figueiredo, Pacheco, and Costa (2007) and Flaherty and Sadler (2011), who report that adolescent mothers were found to be more depressed compared to their adult counterparts; even where demographic background characteristics were taken into consideration, adolescent were still much more at risk. Mollborn and Morningstar (2009), while acknowledging that teenagers experiencing childbearing had psychological distress, they however ruled out the link between the two. It is worthy noting that some female teenagers in the current study did not even recognise that they were pregnant implying strongly that they do not even know and understand physiological changes taking place in their own bodies.

5.2.2Harsh consequences

Participants expressed being fearful about parental reprimand which most of them had to experience. These social experiences included corporal punishment, withdrawal of support, feelings of insecurity and being thrown out of parental home. Expectant and parenting teenagers' experiences of hostility from parents were also in some studies (Gyesaw & Ankomah, 2013) and that fathers' reaction was more intense and unbearable. The researcher is of the opinion that most teenagers do not feel free and have little or no trust to relate and communicate with their parents on critical issues affecting their lives. Lack of parental social closeness with their children makes them more vulnerable to negative external influence, to which teenagers may try to seek emotional comfort and or information. Lack of social closeness between teenagers and their parents increases their stress, as they are likely to have no one to share their concerns with (Brown et al., 2012). It could also be argued here that the teenagers'

feelings about parental reaction, suggests existence of a critical social gap between parents and their adolescents on the extent to which they discuss and share information on matters to do with sexual and reproductive health. Health care programs targeting young people should be deliberately designed to include a comprehensive culturally sensitive sexual and reproductive health component so that it holistically responds to the needs of expectant teens.

Gyesaw and Ankomah (2013), noted that teenagers feared how parents would react upon hearing that they were pregnant. The teenagers fear of parental reaction could be seen as something rooted and buried in their sub consciousness over a long period, only to be unveiled when they commit an act that parents greatly disapprove. Pregnancy for the teenager attracts manifold sanctions including withdrawal of material resources (Mollborn, 2009). Early childbearing is considered a violation of both family cultural norms and therefore any deviants must be punished. Targeting society members (parents) and culture custodians (traditional leaders), to ensure they protect and preserve the pregnant teenage rights to social security is crucial.

5.2.3 Parental Animosity

Parents reacted with a hostile attitude towards their teenagers. Their reaction vindicated the participants' fears of being reprimanded harshly by those whom they trusted and depended upon, and expected to be their source for different forms of support. They reported being beaten and expelled from parental homes as punishment for being pregnant. Over reaction of parents shows extreme expectations parents usually have from their children and thus demanding a one hundred percent compliance to home norms. The reaction also shows that parents have very little or no knowledge at all about the mental, psycho-sexual and reproductive health developmental milestone of their children. Findings in this study concurs with studies by other researchers.

Gyesaw and Ankomah (2013), observed that teenage mothers were so concerned about how their parents and guardians were not amused at the realisation of their being pregnant; furthermore, fathers' reaction was so physical, more intense and unbearable while mothers were mostly vocal and instant.

About 97% of the pregnant adolescents and young women reported to have suffered violence such as beating and verbal abuse from family members (Ilika & Anthony, 2004). Sellers et al. (2011), in a study on adolescent mothers' relationship with their own mothers, observed that some young mothers experienced hostility from parents and this in turn impacted negatively on their emotional control and resulted in poor parenting of their own children. Da Cunha Coelho et al. (2014), observed that affectionless control of adolescents and neglectful parenting was common and pushed pregnant adolescents into developing suicidal ideation (13.3%) and 9% had suicidal attempts (Hodgkinson, Southammakosane & Lewin, 2014). Parental anger came from their own feelings and fear of being labelled as failures who could not help their teenagers prevent a pregnancy (Masuko & Masuko, 2017).

5.2.4 Arduous Responsibility

In this study participants' description of parenthood was that it was a burdensome and stressful experience, demanding a lot of time, commitment and resources necessary to meet their needs and those of their new-born such as food and clothing. These findings corroborate with those reported by Mangeli et al. (2017) in their study where they found that teen mothers found motherhood as a big challenge. The great stress of responsibility is probably related to lack of knowledge and skills in parenthood. Most teenage mothers experience difficulties with parenting with some expressing that the challenges have helped them to mature mentally (Bowman, 2013). These teenagers are still undergoing the process of psychosocial development and have not mastered

psychosocial strategies in dealing with life's challenges and this created stress and anxiety as those demands were mostly far from being met. The participants also expressed that parenthood (because of its demands) isolated them. Most of the female participants stated that motherhood limited their freedom of association with other teens. Findings by Mangeli, et al. (2017) where they observed that teenagers desired to be with friends but pregnancy and parenting deprived them of the fun of being with friends and peers, concur with those in this study. The huge demands of caring for the pregnancy and or parenting abruptly ends the connectivity with teenage pleasures and entertainment.

5.2.5 Uncertain and Concerned

Participants in this study were deeply concerned as most of them evisaged the possible lost prospects of having a promising future having dropped out of school. It is evident from this result that teenagers do not know of their rights to return to school even after having delivered the baby. The researcher strongly views this as an indication of lack of knowledge on the part of affected teen and absence of guidance from those teenagers look up to for information and support such as teachers and parents. This is supported by study findings by Mumah et al. (2014), in which they uncovered that adolescents greatly believed that childbearing had deprived them of the opportunities to carry on with their education. The feeling that getting pregnant is a permanent stabling block to continued education could increase the pregnant teen's psychological trauma.

Teenagers overtly expressed that parenthood was an awful responsibility. Their description of their child caring experience was that is stressful, financially demanding and time consuming, limiting to free will and hard to cope with. This finding is supported by that of Herrman (2008) and DeVito (2010), where she reports that adolescent mothers found parenthood to be burdensome and limited their free

participation in activities adolescents enjoy doing and further complained that parenting robbed them of the right to make decisions as to when to do what. Further to that, teenagers feel that parenthood competed for their time and commitment to schooling (Watts, Liamputong & McMichael, 2015).

These teenagers were left to provide for their needs and that of their baby alone at a time when they had not expected a baby and therefore were unprepared for him emotionally and financially. The researcher is of the opinion that leaving parenting teenagers to fend for themselves is detrimental to their psychosocial health and that of their new-borns. They and their babies are not only prone to psychosocial trauma, but also to physical challenges like poor nutrition, anaemia and infections. Poverty is a very strong catalyst for a myriad of social and physical problems. Such parenthood experience is likely to lead to development or worsen already existing psychosocial problems in the teenager. Hodgikinson et al. (2014), reports that adolescent parenthood was strongly associated with increased risk of substance abuse. The researcher is of the view that parental, guardians' and communities'' support is crucial during teen parenting.

5.2.6 Volatile Relationships

This theme represents the participants' social experiences with early childbearing which was the second study objective. Generally, the participants in this study had very appalling relationships especially with parents, peers, and the community. Similar findings are reported by Arai, (2009), who found that teenagers expressed to have experienced poor relationships with parents which had a significant bearing on their parenting and that the teenage parents experienced antagonism from community members though this never limited their freedom of movement. Lindhorst and Oxford (2008), reported that hostile reaction or treatment portrayed by an intimate

relation such as parent or peers has a great negative implication on the psychological state of adolescent parents.

A number of studies have revealed the importance of programs that promote parental involvement in the affairs of their adolescent children. For instance, a health, nurturant parenting environment was observed to reduce risky sexual behaviours by age 16 and prevented pregnancy by age 19 (Kogan et al., 2013). Additionally, parental active involvement (active communication) in affairs of their children such as teen pregnancy prevetion is crucial in preventing and mitigating the psychosocial impact associated with teen child bearing (Silk & Romero, 2014).

Poor relationships between pregnant or parenting teenagers and other members of society have been reported by Jorm and Wright (2008), who observed that stigmatisation from teachers was common and this led to depression, alcohol misuse, social phobia and psychosis. The perceived stigmatization results in negative cognitive, emotional and behavioural effects (Whitley & Kirmayer, 2008). As observed in this study, some participants initially had good relationships with their parents or guardians and with peers and the community; nevertheless, the advent of pregnancy strained these relationships. Shanok and Miller (2007), observed in their study that adolescents, 13-19 years had appalling relationships with their family, community members and people in public. In another study, Leerlooijer et al. (2013), observed that supportive community involvement is vital in uplifting the plight of childbearing teenagers.

Basing on this exposé, the researcher argues that being pregnant as a teen is considered a deviation from the general norms and expectations. Teenage pregnancy is deemed a taboo and any culprit suffers social isolation. Further to this, parental or guardian, peer and community overreaction, makes early childbearing a huge

psychosocial burden for teens. Atuyambe et al. (2008), found that young mothers experience stigmatisation even in health care setting thereby hampering them from accessing sexual and reproductive health services. The investigator therefore postulates that pregnant teen be given special and adequate psychosocial support during pregnancy and parenthood period. Therefore, parents and communities at large require information to change their attitude towards teen pregnancy and to modify their approach to more modest startegies in dealing with the situation, since maintaining the status quo has been proven to be yielding more harm than good. Affectionless controlling and neglectful parenting approach negatively impacts on the mental health status of the teenager (da Cunha et al., 2014); with some teens failing to cope and then conceive suicidal ideas. Pregnant and parenting teenagers perceive the stigma from parents, peers and the community, and they acknowledge that this leads to harmful cognitive, emotional and behavioural effects like isolation and loneliness. (Whitley & Krmayer, 2008; Alio et al., 2010). Herrman (2008) reported similar findings as in this study, that the consequence of getting pregnant as a teenager disrupts relationships leading to loss of friends, as peers don't like friends who are parenting. Stigmatization of the adolescent mother contributes to distress, and loss of confidence/self-esteem and dropping out of school (Flaherty & Sadler, 2011; SmithBattle, 2013). Hostile reaction or treatment from intimate relations leads to serious negative implications on the psychosocial state of the adolescent mother, such as feelings of shame, resentment, worthlessness and anger (SmithBattle, 2013; Agrawalet al., 2014).

Additionally, in the same study, Herrman (2008) observed that teenagers verbalised that pregnancy can cause a male partner to leave you, a finding not observed in this study. The stigmatisation, discrimination and rejection suffered by teenagers experiencing childbearing, has a great bearing on how they cope with the stress of the

pregnancy itself, especially when it is portrayed by closest relations. Hostile reaction or treatment from intimate relations leads to serious negative implications on the psychosocial state of the adolescent mother (Lindhorst & Oxford, 2008). Studies have revealed that violence related to early childbearing does not originate from parents alone but also from intimate partners (Gibson et al., 2015). Brown, Harris, et al. (2012) observed that adolescent mothers were exposed to higher levels of violence from intimate partners. Incidencts of intimate partner violence including physical and verbal assaults are common with early childbearing (Newman, & Campbell, 2010; Brown, Harris et al., 2011); and is associated with increased divorce rates (Alio et al., 2010).

Nevertheless, some teenagers (83%), gave an account that they got along quite well with mothers and others (78%), with their fathers, portraying a picture that there are some parents or guardians who seemingly recognise the vulnerability of teenage period. Shanok and Miller's finding agrees with results from this study in which participants reported that some parents were calm in their reaction. Gyesaw and Ankoma (2013); Huang et al. (2015), observed that pregnant and parenting teenagers whose own parents had initially been hostile, but later got calm in their reaction improved their coping and parenting behaviours. Such parents might have considered their possible contribution to the advent of the teen's pregnancy through their parenting style. The researcher is of the view that such parents might have considered their possible contribution to the advent of the teen's pregnancy through their parenting style and that the teenagers are not to be blamed entirely for their actions.

This study also revealed that teenagers had good relationships with their school teachers. For instance, some received counselling from their teachers after realisation that they were pregnant. Contrary to this, Shanok and Miller (2007), report that institutional councillors overtly expressed disapproval of teen pregnancy to a

considerable degree. Shefer, Bhana and Morrel (2013), found out that academic institutions are overtly viewed as places pregnancy and parenting are disapproved. The social environment in which the pregnant teenagers find themselves, is generally ominous, resulting in a wide range of negative psychosocial experiences. Drawing conclusions following a study investigating the relationship between teenage childbearing and psychological distress among coeducational secondary schools, Harden et al. (2009), highlight that health relationships with social care givers like parents and educational institutions (teachers), may reduce the distress and increase expectations for the future.

Onyeka et al. (2011), provides some compelling statistics about how teachers in educational institutions react to teenage pregnancy; they report that in the study 28% of public and 48% of private schools either immediately suspended or expelled pregnant girl learners from school; furthermore, only 4% of public and 15% of private schools provided some counselling before the girls were sent home. While stigmatisation and discrimination by teachers against pregnant teens was evident in some of the previous studies, participants in this study reported positive encounters with their teachers.

5.2.7 Coping Strategies

This study found out that parents' and peers' positive reaction has a great impact on the teenagers' psychosocial experience with childbearing. This finding agrees with those from other studies who observed that support from relations who act as mentors was critical in reducing stress and anxiety among adolescent mothers (Hurd & Zimmerman, 2010). This finding supports the result observed here. Parents and peers are therefore vital key agents in promoting and strengthening the pregnant or parenting

teen's coping strategies. The researcher therefore finds it imperative to actively involve these two agents in care of pregnant teens with their consent and as may be feasible.

It was observed in this study that the teenagers, pregnant or parenting, found solace in drug and alcohol abuse to ease the stress and pressure of parenthood, notably among those where no support was forth coming. Similar observations were made in other studies where pregnant and parenting teenagers resorted to the use tobacco and Marijuana (De Genna, Cornelius & Donovan, 2009; Hodgkinson, Southammakosane & Lewis, 2014). Others, in this study, especially females, resorted to having multiple sexual partners for financial gains, which in itself is another hazardous behaviour. They resorted to taking alcohol and smoking marijuana (Indian hemp) to divert their attention from pregnancy and child care demands. Depression, common with teen childbirths is closely linked to drug and alcohol misuse tendencies (Barnet, Liu & DeVoe 2008; Flaherty & Sadler, 2011). In their study, Hulland, Brown, et al., (2015) found that there was no association between teenage childbearing and having multiple sex partners.

The researcher's opinion is that poor or ineffective coping mechanisms push teenagers to substance misuse and for mostly girls, to have multiple sexual partners, who in most cases are much older men, who have financial power. Hence providing them with the necessary attention and support they require at this critical period is likely to salvage them from mental and social harms which may sometimes be of long term impact. Brown et al. (2012), proposed that offering social support to the pregnant or parenting teenager would significantly reduce depressive symptoms; which of course as noted earlier, is associated with substance abuse. Hurd and Zimmerman (2010), made similar observation as above and proposed that support from relatives and friends would act as a critical intervention in reducing stress and anxiety among mothering teens. Parents must be equipped with information on what stressful experiences their pregnant

children go through and how this can potentially push teens into much greater life long psychosocial problems, and what responsibility they carry as parents to minumise the harm.

5.2.8 Influencing Factors

A couple of factors influence on how teenagers go through the childbearing experience. As revealed in this study, one of the crucial factors is how parents and guardians react following revelation that their daughter is pregnant or has made someone pregnant. No literature was found at the time of this study on influencing factors. Delaying the pregnancy and a calm reaction from parents are crucial in reducing psychosocial challenges faced by teenage childbearing.

5.3 Recommendations

5.3.1 Policy, Programs and Service Delivery

Health care workers should ensure that teenagers who are pregnant or parenting are given proper psychosocial conselling and support. Proper and adequate knowledge and skills will help these teenagers to navigate through childbearing with minimal psychosocial trauma, reducing the mental and social problems they encounter and be able to handle them positively.

Teenagers, both males and females, should be educated to be assertive and be equipped with life skills related to sexual and reproductive health. They should be imparted with knowledge on how their bodies function, abstainance, mutual faithfulness and the benefits of contraceptive use. This will not just prevent unintended pregnancy but also keep them in school.

The researcher recommends that youth sexual and reproductive health policies should also be critically analysed and possibly reformulated to ensure they address the need to reduce teenage pregnancies.

This study also recommends that maternity health care providers should be equipped with a compressive package of knowledge and skills to address adequately the contemporary psychosocial needs of the teenagers that experience early childbearing.

Considering the public stigma and discrimination expressed by teenagers, tailor-made programs targeting all young people (peers), the community and parents need to be put in place to improve their attitude towards pregnant and parenting teenagers since their actions have been observed to have a significant bearing on their psychosocial experiences. And information on this may be main streamed in existing community based or outreach activities.

Youth Friendly Health Services (YFHS) must be critically analysed in the long term. Its comprehensiveness and implementation strategies may require modification to meet the diverse psychosocial needs of teenagers.

5.3.2 Implication for Research

The researcher recommends studies on contemporary influencing factors to increasing rate of early childbearing in Zomba. Identification and subsequent addressing of such factors would probably assist in policies and strategies to reduce teenage childbearing. A more extensive study on psychosocial experiences of early childbearing in Malawi is also necessary. Other studies could also focus on factors that influence psychosocial experiences with early childbearing.

Current policies, programs and services should undergo a thorough review to identify gaps and barriers in meeting psychosocial needs of young people and sexual and reproductive health needs in general.

Studies on parenting knowledge and skills are also vital as they make unveil the needs and challenges parents face in raising up adolescents. Such studies would help develop tailor made programs and education materials to assist parents raise up teenagers in a health manner.

5.4 Study Limitations

Results of this study may not be transferable to the entire region considering that the sample was taken within the locality of one district and may not be representative of the adolescent population in whole region. In addition, the social-cultural context in Malawi within which this phenomenon occurs is diverse to considerable extent. However, the researcher observes that these study results can still be useful in providing some direction in policy, service and interventions programming within Zomba and surrounding Districts.

5.5 Conclussion

Teenagers (both females and males) encounter a wide rage of psychosocial experiences with childbearing and these have been observed to place on them ernomous demands and obligations. These experiences include depression, feelings of shame and embarrassement, deprivation or withdrawal of support, financial hardhips, strained relationships with parents including stigmatization and rejection (leading to isolation) from family members, peers and the public. Consequently, these experiences cause stress beyond the teenagers control.

For most of the teenagers, these experiencess become unbearable pushing these growing and developing young people to resort to behaviours that are detrimental to their health as they are strained beyond their capacity to cope positively. Hence are forced into seeking relief from drug and alcohol abuse and having multiple sexual partners. Female and male teens experiencing childbearing go through these traumatising psychosocial experiences and require prompt attention. Their immediate emotional feelings of regret, shock, shame and embarrasement are to a considerable extent, aggravated by the overreaction of the closest relationships such as parents and peers than does the community. This forces them into making detrimental decisions and resort to use of poor coping mechanisms that may jeopardise their psychosocial such as having multiple sexual partners and smoking marijuana.

The literature review has provided ample evidence about the psychosocial challenges of early childbearing including deprivation or withdrawal of support, financial hardships, strained relationships with parents, peers and community members. The environment in which the pregnant or parenting teenagers find themselves is generally hostile i.e the home and the community, the school; and this may interfere with their right to seek medical care as they may feel intimidated, discriminated, and rejected. This therefore may cause the teenagers to feel unwelcome to report to health care settings which are places they are likely to meet the very people who stimgatise and discrimate against them.

It is critical to that teenagers should be equipped with knowledge and skills that will help them delay childbearing. Policies that address adolescent's sexual and reproductive health needs require review to identify and fill gaps that made be identified. More intensive and extensive studies are required on psychosocial experiences of teenage childbearing.

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APPENDICES

AppendixA: Study Introduction to Participants

This is a study that aims at learning from young mothers and their partners about their psychosocial experiences in relation to pregnancy and childbirth. You are selected to participate in this study because you are young mother/male partner. The study is vital in that it will go a long way in assisting in identifying gaps in care that are aimed at promoting the mental health of young women and as well as their partners.

Your participation is entirely on a voluntary basis. The discussions will be recorded on tape if you consent to do so. Any time you feel uncomfortable during the conversation, you are free to interrupt or withdraw from the study. Your choice of whether you participate or not have no influence on the services you receive from this health facility. But if you chose to participate, you will be required to sign a consent form or put a thumb print in lieu of the signature. This study is nationally approved by COMREC to ensure participants are protected from psychological and physical harm all the time. There are no known risks you may experience during this study at the moment.

The researcher will also maintain confidentiality and therefore your identification by name is not necessary. You may also decline to respond to any questions you feel uncomfortable with.

There is no direct individual benefit for participating in this study but the information you provide will help improve interventions targeting improvement of young people's experience with childbirth.

Thank you.

Appendix A: Uthenga wa Kafukufuku Kwa Otengapo Mbali (Chichewa Version)

Kafukufukuyu akachitika ndi cholinga choti tiphunzirepo ndi kuzindikira zoona zenizeni zimene atsikana ndi anyamata amene ayamba ubereki asanafike zaka 20, amakumana nazo, pamene ali woyembekezera, pamene akubereka komanso nthawi imene akulera mwana wobadwayo. Inu mwasankhidwa kuti mutengepo mbali mu kafukufikuyu chifukwa ndinu wachinyamata.

Kafukufuku amaeneyu ndiwofunika kwambiri chifikwa akuyembekeka kuti athandiza kupeza njira zopitritsira umoyo wa achinyamata patsogolo makamaka pamene apezeka kuti ndi woyembekezera.

Kutengapo mbali kwanu pa kafukufukuyu sikochita kukakamiza.Zokambirana zonse zidzajambulidwa pa tepi pamene mwavomereza kutenga mbali mukafukufukuyu.Muli ndi ufulu woyimitsa mafunso nthawi iliyonse pamene mukufinsidwa komanso mungathe kusiyira panjira ngati mungafune.Kutenga kapena kusatengapo mbali pa kafukufukuyu ameneyu sikudzakhudzasokoneza mwa njira ina iliyonse, thandizo lomwe mungalandire kuno ku chipatala.

Mukasankha kutengapo mbali, mudzafunsidwa susayinira pa pepala kapena kudinda ndi chala chanu ngati umboni woti mwavomereza kutengapo mbali. Kafukufukuyu ndi wovomerezeka ndi bungwe limene limateteza ufulu wa anthu amane akutenga mbali pa kafukufuku wokhudza za umoyo wa anthu la COMREC. Pakali pano, palibe chiopsezo china chili chonse chodziwika chomwe chingachitike ngati munthu wasankha kutengapo mbali pakafukufukuyu.

Wotsogolera za kafufukuyu ali ndi udindo wakunsunga chinsinsi cha wina aliyense wotengapo mbali. Chifukwa cha ichi, ngati mbali imodzi yonsungira chinsinsi cha aliyense wotenga mbali mukafukufukuyu, sikofunika kupereka dzina lanu.Mafunso amene mukuona kuti simungayankhe chifukwa cha zifikwa zina, muli ndi ufulu kudziwitsa wofunsa mafunsowo.

Palibe pindu lililonse lomwe mungapeze panokha ngati mungavomere kutenga nawo mbali mu kafukufukyu.Komabe zotsatira za kafukufukyu zidzathandiza kupeza njira zabwino zothandizira achinyamata womwe amatenga pathupi kuti azithandizidwa mokwanira.

Zikomo.

Appendix B: Participants' Consent Form

CONSENT TO PARTICIPATE IN A STUDY ON IMPACT OF EARLY CHILDBIRTH ON PSYCHOSOCIAL HEALTH OF TEENAGERS AGED 13 TO 19 YEARS IN ZOMBA.

In signing this document I am giving consent to participate in a study that aims at exploring lived psychosocial experiences of adolescents and teenagers experiencing early childbirth being conducted by Lumwira Henry Dzuwalatsoka.

I understand that I have been purposively sampled outusing prepared criteriato participate in this study because I am one of the young mothers/partners currently having an early childbirth experience.

I understand that the information will be confidential and that no names will be used. I can decline to answer any specific questions or decide to withdraw my participation at any time. I have been informed that participating in this study or refusal will have no effect on the care and support that I and my child will receive from the hospital. I also understand that I will be allowed to ask questions and give clarifications wherever necessary.

In case you have questions pertaining to your participation in the study, or about your rights as a research participant, or any concerns or complaints about this study, please do not hesitate to contact me Lumwira Henry Dzuwalatsoka on 0888515063 or my research supervisors Dr Diana Jere at Kamuzu College of Nursing on 0991 02 99 09 or the Principal, Prof. Ellen Chirwa on 00991 259 543. You may also contact the COMREC Secrétariat on 01 874 377 0r 0999 460 737.I agree to take part in this study on a voluntary basis.

……………………………	…..………………	……..…….....................
Name of Participant	Date	Signature/Thumb Print
…………………………...	………………….	……………………….
Name of researcher	Date	Signature

Appendix B: Participants' Consent Form (Chichewa Version)

KUVOMEREZA KUTENGAPO MBALI PA KAFUKUFUKU WOKHUDZA ACHINYAMATA A ZAKA 13-19 AMENE AYAMBA UBEREKI

Pakusayina chikalatachi ndikupeleka chilolezo kwa a Lumwira Henry Dzuwalatsoka omwe ndi ophunzira kusukulu ya anamwino ya Kamuzu College of Nursing. kuti nditenga nawo mbali pa kafukufuku yemwe cholinga chake ndikufufuza zomweachinyamata amene ayamba ubereki amakumana nazo.

Ndikumvetsetsa kuti maere andigwera kuti nditenge nawo mbali mukafukufukuyu chifukwa choti inenso ndine wachinyamata amene ndili woyembekezera/ ndili ndi mwana.

Ndauzidwa kuti zokambirana zanthu zikhala zachinsinsi ndipo kupereka dzina langa sikofunikira.Ndili ndi ufulu kukana kuyankha funso lililonse ngakhale kulekera panjira mafinso asanathe.Ndauzidwanso kuti palibe chiopsezo chilichonse polowa nawo kafukufuku ameneyu kapena kukana.Kuvomera kutegna nawo mbali kapena kukana sikudzasintha chithandizo chomwe ine ndi mwana wanga tingalandire kuchipatala kuno.

Ndine wololedwa kufunsa funso lililonse kapena kufotozera wofunsa, chilichonse chokhuzda kafukufukuyu ngati pali poyenera.

Mutakhala ndi mafunso kapena madandaulo monga wotenga nawo mbali mukafukufukuyu lumikizanani ndi a Lumwira Henry Dzuwalatsoka. Mukhozanso kufunsa kwa wondiyang'anira Dr Diana Jere pa 0991 029 909, woyang'anira Kamuzu College of Nursing Prof. Ellen Chirwa pa 0991 259 543 kapena ofesi ya COMREC pa 01 874 377 0r 0999 460 737.Ine ndikuvomera kutenga nawo mbali mukafukufukuyu mwakufuna kwanga.

……………………… ………………… ………………………..

Dzina la otenga mbali	Tsiku	Sayinani/Dindani ndi chala
……………………….	…………………..	…………………..
Dzina la ochita kafukufuku	Tsiku	Sayinani

Appendix C: Parent's Assent Form (English Version)

In signing this document I am giving consent for my daughter/son to participate in a study that aims at exploring lived psychosocial experiences of adolescents and teenagers experiencing early childbirth being conducted by Lumwira Henry Dzuwalatsoka.

I understand that all information given by my daughter/son will be kept onfidential and will solely be used for the purpose of this study. I also understand there are no direct benefits to my daughter in participating in this study but may benefit indirectly by receiving improved services in future.

Name of Parent:…………………………………Signature:………………………………..

Date: …………………………………………

Appendix C: Parent'sAssent Form (Chichewa Version)

KUVOMEREZA KUTENGAPO MBALI PA KAFUKUFUKU WOKHUDZA ACHINYAMATA A ZAKA 13-19 AMENE AYAMBA UBEREKI

Pakusayina chikalatachi ndikupeleka chilolezo kwa a Lumwira Henry Dzuwalatsoka omwe ndi ophunzira kusukulu ya anamwino ya Kamuzu College of Nursing. kutimwana wanga atenge nawo mbali pa kafukufuku yemwe cholinga chake ndikufufuza zomweachinyamata amene ayamba ubereki amakumana nazo.

Ndikuzindikira kuti zomwe mwana wanga adzafotokoza zidzasungidwa mwa chinsinsi komanso zidzagwiritsidwa ntchito pa nthawi ya kafukufuku yokhayi. Ndikuzindikiranso kuti palibe phindu lobwera kwa mwanayu payekha potenga mbali pa kafukufukuyu. Koma mwanayu akhoza kupindula pamene zotsatira za kafukufukuyu zidzathandiza kupititsa patsogolo thandizo lomwe achinyamata omwe ali oyembekezera amalandira.

Dzina la kholo:…………………………………Sayinani/Dindani:……………………………

Tsiku: …………………………………………

Appendix D: In-Depth Interview Guide (for teen mothers)

Interview schedule number

Participant number ……………………………

Date: ………………………………..

Part A: Demographic Data

i. How old are you? (Age in years) …………………………
ii. What tribe are you? 1. Lomwe 2. Yawo 3. Chewa 4. Tumbuka 5. Sena
iii.
6. other (specify)…………………………….

iv. What is your religion? 1. Christian 2. Moslem

3. Other (specify)…………………………

v. Are you married? 1. Yes, 2. No

vi. Were you in school at the time you became pregnant? 1. Yes, 2. No

vii. What is the level of your education?1.Primary 2. Secondary. 3 College 4. Iliterate
viii. How long have you lived in Zomba? 1. 12 months, 2. Over months
ix. How old is your pregnancy? (If already delivered skip to vii) 1. below 37 weeks 2. 37 weeks
x. How old is your baby? (In Months) ………………………………

Part B: Topical Questions

1. **For those who are pregnant**

a) **Psychological Experience with pregnancy**

(***How has pregnancy affected your emotions and feelings***)?How does is it like to be pregnant at your age

What thoughts came into your mind upon realising you were pregnant?

How did you feel the moment you realised you were pregnant?

How did you react to yourself?

What is your feel about your state of respect and dignity from people around you and the societies?

b) **Social Experiencewith pregnancy**

How has the pregnancy affected your relationships?

To whom did you report first about your pregnancy? Why?

How did that person react to the news?

How has the pregnancy affected your relationship with parents?

How has it affected your relationship with teachers or significant others?

How did your peers react to the pregnancy?

How did the community members react to you being pregnant?

How did your partner react to the news?

How did their reaction affect you?

What made your negative feelings worse? Worsened your relationships?

What made you feel relieved? What improved your relationships?

What do you anticipate to be the experience during labour and delivery?

c) Socio-cultural factors and individual traits

How did your cultural beliefs affect or influence your experience with this pregnancy?

How did your personal character affect your reaction and experience with this pregnancy?

2. For those who have given birth

Psychological experience with teen motherhood

What is it like to be young and a mother (***How do you feel to be a mother at this age***)?

How has motherhood experience affected your mental and emotional state?

What was your experience like during ante natal, labour and after thebirth of your child?

Did your labour and delivery experiences match with what you expected antenatally?

How has/did the birth of this baby affect you? How has motherhood role affected you?

Sociological experience with teen motherhood

How has the new role of a mother affected your relationship withyour(How has this new role affected your social life)?

- Parents?
- Siblings?
- Partner?
- Friends?
- Society/community at large?

Socio-cultural factors and individual traits

How have your cultural beliefs affected or influence your experience with motherhood?

How has your personal character affectedyour reaction and experience with motherhood?

Additional Comments

Can you share with me the kind of support you get and from whom?

Do you have any more experiences you wish to share?

Appendix D: In-Depth Interview Guide for female teens (Chichewa Version)

Nambala ya fomu: ……………………………….

Nambala ya wotenga mbali pa kafukufiku ……………………………

Tsiku : ………………………………..

Gawo A: Mbiri ya Wotenga mbali pa kafukufuku

i. Muli ndi zaka zingati zakubadwa? …………………………
ii. Kodi ndinu a mtundu wanji? 1. Lomwe 2. Yawo 3. Chewa 4. Tumbuka 5. Sena. 6. Zina………………………..
iii. Ndinu a chipembedzo chanji?1.Chikhristu 2. Chisilamu

3.Zina…………………

iv. Kodi muli pa banja? 1. Inde, 2. Ayi

v. Kodi munali pa sukulu panthawi yomwe munakhala oyembekezera? 1. Inde, 2. Ayi
vi. Sukulu mudalekeza pati 1.Pulayimale 2.Secondare 3. Coleji 4 Wosaphuzira
vii. Mumapeza bwaji thandizo pa moyo wanu wa tsiku ndi tsiku 1. Ntchito 2.Businezi 3. Others, specify
viii. Mwakhala zaka zungati mu boma la Zomba? 1. Miyezi 12 2. Kupitirira chaka
ix. Mimba yanu ndi ya miyezi ingati? (Ngati anabereka pitani ku x) 1. Yochepera miyezi 9 2. Yakwana miyezi 9
x. Mwana wanu ali ndi miyezi ingati? …………………………
xi. Muli ndi ana angati? 1. M'modzi 2 Awiri kapena kupitirapo

Gawo B: Mafunso

1. **Mafunso kwa amene adakali oyembekezera**

a) **Zochitika m'malingaliro**

Mukukhudziwa bwanji m'malingaliro kukhala woyembekezera pamene mudakali wang'ono?

Maganizo amene munali nawo ndi watani mutazindikira kuti ndinu oyembekezera ?

Inu mutazindikira kuti ndinu woyembekezera, mudamva bwanji mumtima mwanu?

Mudadziganizira zotani mutazindikira kuti ndinu woyembekezera?

Mukuona bwanji za ulemu womwe anthu amdera lanu amkupatsani?

Maganizo anu ndi wotani pokhudza zomwe zidzachitike nthawi yobereka?

b) **Kukhudizdwa kwa maubale**

Kodi mimba yanu inakhudza motani ubale wanu ndi anthu ena?

Munthu woyamba kumuuza kuti ndinu woyembekezera adali ndani?Chifukwa chiyani mudaganiza zowuza munthu amaneyu?

Mutawadziwita za kuti ndinu woyembekezera, iwo adati bwanji?

Ubale wanu ndi makolo udakhudzidwa bwanji atazindikira kuti ndinu woyembekezera?

Nanga ubale wanu ndi anzanu, aphunzitsi kapena achibale ena udakhdzidwa bwanji?

Uthenga woti ndinu woyembekera, nzanu adaulandira bwanji?

Anthu a mdera lanu adaulandira bwanji uthengawu?

Nanga bwenzi lanu adazilandira bwanji mutawauza kuti muli woyembekezera?

Mudakhudzidwa bwanji ndi mmene adachitira atalandira uthenga umenewu?

c) Zikhulupiriro ndi zikhalidwe

Ndi zikhulupiriro zotani zomwe zinakhudza makhalidwe anthu pokhala munthu woyembekezera?

Kanganizidwe ndi chikhalidwe chanu cha tsiku ndi tsiku zinakhudza bwanji momwe munalandirira khani ya kukhala ndi pakati?

2. Mafunso kwa amene anabereka kale (Ali ndi mwana)

a) Zochitika m'malingaliro

Mukumva bwanji mumtima kukhala mayi mudakali wang'no?

Kukhala woyembekezera pa msinkhu ngati wanuwu, wakhudza bwanji kaganizidwe kanu?

Kodi zimene munkayembezera kukumana nazo pobereka ndi zofanana ndi zomwe zinakuchitikirani?

Kodi kukhala mai kukukukhudzani bwanji?

b) Zokhudza maubale ndi anthu ena

Udindo wanu watsopano wokhala mai unakhudza/ukudzudza bwanji ubale wanu ndi:

- Makolo?
- Abale ndi alongo anu?
- Bwenzi lanu?
- Anzanu?

Mumalandira chithandizo chotani ndipo amapereka chithandizocho ndani?

Udindo wanu wokhala mai wakhudza bwanji umoyo wanu wa tsiku ndi tsiku?

Kodi muli ndi ndemanga iliyonse imene mukufuna kugawana nane zokhudza nkhani takambiranayi?

Appendix E: In-Depth Interview Guide (for teen fathers)

Interview schedule number…………… Participant number………………

Date: ………………………………..

Part A: Demographic Data

i. How old are you? (Age in years) …………………………
ii. What tribe are you? 1. Lomwe 2. Yawo 3. Chewa 4. Tumbuka 5. Sena
iii. What is your religion? 1. Christian 2 Moslem 6. Others (specify)…………………….

iv. Are you married? 1. Yes, 2. No

v.Were you in school at the time your partner became pregnant? 1. Yes, 2. No

vi. How long have you lived in Zomba? 1. 12 months, 2. Over months

vii. How old is the pregnancyof your partner? (If already delivered skip to vii)
1. below 37 weeks 2. 37 weeks
viii. How old is your baby? (In Months)
…………………………

Part B: Topical Questions

3. For those whose partners are pregnant

a. Psychological Experience with pregnancy

How does it feel to be anexpectant father at your age (***How has it affected your emotions and feelings***)?

How did you react to the news when your partner informed you she was pregnant for you?

What thoughts came into your mind upon realising you will soon become a father?

How did it feel the moment you realised you were expecting a baby?

How did you react to yourself?

What is your feel about your state of respect and dignity from people around you and the societies?

What made you feel worse or relieved?

b. Social Experience with pregnancy

How has being a prospective father affected your relationships?

Did you report to anybody about the pregnancy of your partner? Why did you report to that particular person?

How did that person react to the news?

How has the pregnancy affected your relationship with parents?

How has it affected your relationship with teachers or significant others?

How did your peers react to the news?

How did the community members react to you being a prospective father?

How did your partner react to the news?

How did their reaction affect you?

What is worseningor strengthening your relationships during this period?

What made you feel relieved? What improved your relationships?

What do you anticipate to be the experience during labour, delivery and to be a father?

c. **Socio-cultural factors and individual traits**

How did your cultural beliefs affect or influence your experience of being a prospective father?

How did your personal character affect your reaction and experience with this pregnancy?

d. **For those who are already fathers**

Psychological experience with teen fatherhood

What is it like to be young and a father (***How do you feel to be a father at this age***)?

How hasfatherhood experience affected your mental and emotional state?

What was your experience like during antenatal period and during the birth of your child?

Did the labour and delivery experiences of your spouse match with what you expected antenatally?

How has/did the birth of this baby affect you? How has fatherhood role affected you?

Sociological experience with teen fatherhood

(How has this new role affected your social life)?How has the new role of a father affected your relationship with your:

- Parents?
- Siblings?
- Partner?

- Friends?
- Society/community at large?

Socio-cultural factors and individual traits

How did your cultural beliefs affect or influence your experience of being a young father?

How has your personal character affect your reaction and experience with fatherhood?

Additional comments on the subject

Can you share with me the kind of support you get and from whom?

Do you have any more experiences you wish to share?

Appendix F: In-Depth Interview Guide for male teens (Chichewa Version)

Nambala ya fomu: ……………………………….

Nambala ya wotenga mbali pa kafukufiku ……………………………

Tsiku : ………………………………..

Gawo A: Mbiri ya Wotenga mbali pa kafukufuku

iv. Muli ndi zaka zingati zakubadwa? …………………………
v. Kodi ndinu a mtundu wanji? 1. Lomwe 2. Yawo 3. Chewa 4. Tumbuka 5. Sena. 6. Zina………………………..
vi. Ndinu a chipembedzo chanji? 1.Chikhristu 2. Chisilamu

3.Zina…………………

iv. Kodi muli pa banja? 1. Inde, 2. Ayi

xii. Kodi munali pa sukulu panthawi yomwe wokondwedwa wanu anakhala oyembekezera? 1. Inde, 2. Ayi
xiii. Sukulu mudalekeza pati 1.Pulayimale 2.Secondare 3. Coleji 4 Wosaphuzira
xiv. Mumapeza bwaji thandizo pa moyo wanu wa tsiku ndi tsiku 1. Ntchito 2.Businezi 3. Others, specify………………………………….
xv. Mwakhala zaka zungati mu boma la Zomba? 1. Miyezi 12 2. Kupitirira chaka
xvi. Mimba ya mkazi/bwenzi lanu ndi ya miyezi ingati? (Ngati anabereka pitani ku x) 1. Yochepera miyezi 9 2. Yakwana miyezi 9
xvii. Mwana wanu ali ndi miyezi ingati? …………………………
xviii. Muli ndi ana angati? 1. M’modzi 2 Awiri kapena kupitirapo

Gawo B: Mafunso

1.Mafunso kwa amene apabanja/apaubwenzi awo akadali oyembekezera

a) Zochitika m’malingaliro

Mukukhudziwa bwanji m’malingaliro pamene mukuyembekezera kukhala bamboo mudakali wang’ono?

Maganizo amene munali nawo ndi watani mutazindikira kuti wachikondi wanu ndi oyembekezera ?

Inu mutazindikira kuti apabanja/bwenzi lanu ndi woyembekezera, mudamva bwanji mumtima mwanu?

Mudadziganizira zotani mutazindikira kuti mkazi/bwenzi lanu ndi woyembekezera?

Mukuona bwanji za ulemu womwe anthu amdera lanu amkupatsani?

Maganizo anu ndi wotani pokhudza zomwe zidzachitike pamene wachikondi wanu akubereka?

b.Kukhudizdwa kwa maubale

Kodi mimba ya wachikondi wanu inakhudza motani ubale wanu ndi anthu ena?

Munthu woyamba kumuuza kuti iye ndi woyembekezera adali ndani?Chifukwa chiyani mudaganiza zowuza munthu amaneyu?

Mutamudziwitsa za kuti iye ndi woyembekezera, iwo adati bwanji?

Ubale wanu ndi makolo udakhudzidwa/wakhudzidwa bwanji atazindikira kuti mukuyembekezera kukhala ndi mwana?

Nanga ubale wanu ndi anzanu, aphunzitsi kapena achibale ena udakhudzidwa bwanji?

Uthenga woti bwenzi lanu ndi woyembekezera, anzanu adaulandira bwanji?

Anthu a mdera lanu adaulandira bwanji uthengawu?

Nanga bwenzi lanu adakhudzidwa bwanji atazindikira kuti ndi woyembekezera?

Mudakhudzidwa bwanji ndi mmene adachitira atazindikira?

c.Zikhulupiriro ndi zikhalidwe

Ndi zikhulupiriro zotani zomwe zinakhudza makhalidwe anthu pokhala mnyamata woyembekezera kukhala bambo posachedwa?

Kaganizidwe ndi chikhalidwe chanu cha tsiku ndi tsiku zinakhudza bwanji momwe munalandirira khani ya kukhala ndi pakati?

2.Mafunso kwa amene achikondi awo anabereka kale (Ali ndi mwana)

a.Zochitika m'malingaliro

Mukumva bwanji mumtima kukhala bambo mudakali wang'no?

Kukhala bambo pa msinkhu ngati wanuwu, wakhudza bwanji kaganizidwe kanu?

Kodi zimene munkayembezera kukumana nazo pakubereka kwa mkazi wanu ndi zofanana ndi zomwe zinakuchitikirani?

Kodi kukhala ndi udindo ngati bambo kukukukhudzani bwanji?

b.Zokhudza maubale ndi anthu ena

Udindo wanu watsopano wokhala bambo unakhudza/ukudzudza bwanji ubale wanu ndi:

- Makolo?
- Abale ndi alongo anu?
- Bwenzi lanu?
- Anzanu?

Mumalandira chithandizo chotani?Ndipo amapereka chithandizocho ndani?

Udindo wanu wokhala bambo wakhudza bwanji umoyo wanu wa tsiku ndi tsiku?

Kodi muli ndi ndemanga iliyonse imene mukufuna kugawana nane zokhudza nkhani takambiranayi?

Appendix G: Budgetary Estimate

Item	**Quantity**	**Unit cost (MK)**	**Total (MK)**
Reams of photocopying paper	8	2500.00	20, 000.00
Ruled paper	1	2500.00	2, 500.00
Data traveller 4GB	2	5,000.00	10, 000.00
Photocopying Interview Guides	6	50.00	300.00
Photocopying 40 pages proposal	5	50.00	10, 000.00
Printing & Binding of Dissertation	8	7, 000.00	56, 000.00
Voice Recorder	1	60, 000.00	60, 000.00
Batteries for voice recorder	4packs	3, 000.00	12, 000.00
Ball point pens	8	100.00	800.00
Pencils	2	50.00	100.00

COMREC Fee	1	100,000.00	100,000.00
Transport for participants	16	500.00	8, 000.00
Fuel (Data collection)			43, 680.00
Transport re-imbursement for 2 professionals	4	700.00	2, 800.00
Refreshments during orientation	3	500.00	1, 500.00
Lunch for professionals during orientation and instrument testing	2	5, 000.00	10, 000.00
Document Bag	1	8, 000.00	8, 000.00
Sub-Total			**352,680.00**
Contingency (10%) of budget			35, 268.00
Grand Total			**387.948.00**
10% COM Admin. fee			**38, 794.80**

Institutional Contribution to Budget

The health facility, Matawale Health Centre, provided space for conducting interviews. St. Luke's College of Nursing and Midwifery provided office space for storage of study materials and for data analysis.

Justification of the Research Budget

A number of resources were used to carry out this study. Stationery was required for printing, photocopying and binding, from the development of the proposal to the time when data was analysed to the when report was submitted. The notepads were needed for handwritten field notes. A tape recorder was used for audio recording of the interview sessions. Public transportation was used when travelling to the health facility. For clients who travelled from far, transport refund was provided for. A ten percent incidental allocation covered the rescheduled trips to the clinic.

Appendix H: Study Calendar

Activity	**October 2016**	**Nov 2016 – Apr2017**	**May-Jun 2017**	**Jun- 2017**	**→Dec 2017**		
Identification of study topic and developing objectives							
Literature review and proposal development							
Submission to COMREC							
Data collection, analysis & report writing							
Thesis Submission							
Internal and External Thesis Review							
Thesis Defence							