FACULTY OF PSYCHOLOGY AND EDUCATIONAL SCIENCES

Experiences and Needs of Teenage Mothers in Northern Uganda

MASTER DISSERTATION

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This thesis was a long journey with many ups and downs but secretly I am really very proud of the result and of my personal growth throughout. In November 2021, I had to make a top three choice for possible thesis topics. Together with my father, I went through the long list of possibilities and without hesitation, we both knew what I was going to put as my first choice: research in the international context of Africa, Uganda, concerning mental health in a post-war environment. In my cover letter at the time, I wrote:

> *I like to look for big challenges and this master's thesis does not seem like one of the easiest, both because of the setting and the topic. However, I am very motivated to embark on this path.*

These words I did occasionally regret along the way but here we are, at the end of a five-year study adventure, with this thesis as the final project, and ready for the next step. So now is my time to take a moment to thank everyone who supported me in getting here.

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Abstract

This study analyses how teenage mothers experience their pregnancy and motherhood, with a focus on their needs and support systems. A qualitative methodology was used in order to obtain a deeper understanding of teenage mothers' perspectives and experiences. Using semi-structured questionnaires, twenty-one mothers were interviewed. The data from these interviews were analysed by thematic analysis. The results were divided into five main themes, each with several sub-themes. The results show the following: (1) Pregnancy is generally experienced as problematic, while experiences of motherhood are more nuanced. (2) The girls' networks are significant as they provide advice and support but can also be associated with stigma and criticism. A lack of support from the environment is perceived as negative and generates feelings of loneliness. (3) Teenage pregnancy and school drop-out often go hand in hand. Although the girls are motivated to continue, they lack the resources. Still, they describe future aspirations of going to technical schools and starting their own businesses. (4) Adolescent mothers worry about their own physical health and that of their children but at the same time, they face many other concerns. It is crucial to address physical, as well as mental and sexual health needs, as all of these connect to their overall well-being. The findings suggest that researchers, practitioners and policymakers should consider the experiences of teenage mothers and recognize the interconnected nature of the identified themes as they are deeply intertwined in shaping the experiences of adolescent mothers.

Nederlandse Samenvatting

Deze studie beoogde te analyseren hoe tienermoeders hun zwangerschap en moederschap ervaren, met een focus op hun behoeften en ondersteuning. Er werd gebruik gemaakt van kwalitatief onderzoek om meer inzichten te krijgen in de perspectieven en ervaringen van tienermoeders. Aan de hand van semigestructureerde vragenlijsten werden eenentwintig meisjes geïnterviewd, waarna deze gegevens werden geanalyseerd aan de hand van een thematische analyse. De resultaten werden opgedeeld in vijf thema's, elk met verschillende sub-thema's. Uit de resultaten leren we het volgende: (1) Zwangerschap wordt over het algemeen als problematisch ervaren, terwijl de ervaring van moederschap meer wordt genuanceerd. (2) De netwerken van de meisjes zijn belangrijk omdat ze advies en steun bieden, maar deze kunnen ook stigma en kritiek met zich meebrengen. Een gebrek aan steun uit de omgeving wordt als negatief ervaren en genereert gevoelens van eenzaamheid. (3) Tienerzwangerschap en schooluitval gaan vaak hand in hand. Hoewel de meisjes gemotiveerd zijn om door te gaan, ontbreekt het hen aan middelen. Toch beschrijven zij toekomstige aspiraties om naar technische scholen te gaan en hun eigen onderneming te beginnen. (4) Tienermoeders maken zich zorgen over hun eigen fysieke gezondheid en die van hun kinderen, maar tegelijkertijd worden zij geconfronteerd met vele andere zorgen. Het is van cruciaal belang om zowel de fysieke als de mentale en seksuele gezondheidsbehoeften aan te pakken, aangezien deze allemaal verband houden met hun algemene welzijn. De bevindingen suggereren dat onderzoekers, hulpverleners en beleidsmakers rekening moeten houden met de ervaringen van tienermoeders en de onderlinge verbondenheid van de geïdentificeerde thema's moeten erkennen, omdat ze diep verweven zijn in het vormgeven van de ervaringen van tienermoeders.

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List of abbreviations

CCVS	*Centre for Children in Vulnerable Situations*
ESAC-HC	*East, Central and Southern Africa Health Community*
ICFI	*ICF International Inc.*
SDGs	*Sustainable Development Goals*
UBOS	*Uganda Bureau of Statistics*
UDHS	*Uganda Demographic and Health Survey*
UNFPA	*United Nations Population Fund*
UNICEF	*United Nations Children's Fund*
WHO	*World Health Organization*

Introduction

Uganda is among the top 20 countries globally with the highest rate of adolescent pregnancy (Burton, 2017) as one in four women between the ages of 15 and 19 are already mothers or are pregnant with their first child (Uganda Bureau of Statistics [UBOS] & ICF International Inc [ICFI], 2017). There are various causes and conditions that help explain teenage pregnancy, such as child marriage, educational level, low household income, and misinformation about or access to contraceptives (Akanbi et al., 2016; Wasswa et al., 2021). Teenage pregnancy carries many consequences too. Young women risk undergoing unsafe abortions, being isolated and/or stigmatized, rejection and violence within their families and community, forced marriage, school drop-out, worse employment opportunities, and poverty (United Nations Children's Fund [UNICEF], 2021). Early pregnancy can thus be seen as a health, economic, moral, and/or social problem (Akanbi et al., 2016; Sekiwunga & Whyte, 2009).

Teenage pregnancy has been a much-discussed topic over time but recently, it received renewed international attention, with its adverse effects being emphasized within the sustainable development goals (SDGs) (United Nations Population Fund [UNFPA], 2020). Research often talks about protective factors for teenagers and prevention to secure them from becoming pregnant, primarily retrieved from quantitative data. However, in doing so, they lose sight of the narratives and experiences of the young girls living in this reality. Ergo, the purpose of this master's thesis is to identify teenage mothers' perspectives on their pregnancy and motherhood by means of semi-structured interviews and thus provide an answer to the following research question: *'What are the experiences, needs and support systems of adolescents who went through or are going through teenage pregnancy?'.* This thesis will thus focus on teenage mothers' experiences on their pregnancy and motherhood, while taking a closer look at their needs and support systems. The research will also contribute to the practice improvement of the Centre for Children in Vulnerable Situations (CCVS), as it was also a preliminary investigation into the need for mental support in the communities of Kitgum, northern Uganda.

The first part of this master's thesis outlines the theoretical framework, based on existing literature. This section provides the context of teenage pregnancy in northern Uganda and a number of figures. Further attention is given to the literature on the causes, risk and protective factors, and consequences of teenage pregnancy. This is followed by a detailed discussion of the methodology, focusing on the research setting, respondents, the data collection, procedure and analysis and quality assurance. Further, there is extensive attention to the ethical considerations and

positionality of the researcher. The third chapter presents the study's findings, based on the analysis of the obtained data. These findings are then analysed while considering the existing literature in the next chapter. Chapter four also includes implications for policy and practice, limitations of the study and recommendations for further research. Last, a brief conclusion is formulated.

1. Theoretical framework

1.1. Context and numbers

An estimated 15 percent of young women give birth before the age of 18 worldwide; 95% of these pregnancies occur in developing countries (UNICEF, 2021; Loaiza & Liang, 2013). Uganda is among the top 20 countries globally with the highest rate of adolescent pregnancy (Burton, 2017) and has one of the highest rates of teenage pregnancy in Sub-Saharan Africa (UBOS & ICFI, 2012). One in four women between the age of 15 and 19 already have one or more children, are pregnant with their first child, or had a terminated pregnancy or miscarriage (UBOS & ICFI, 2017; Wasswa et al., 2021). UNICEF defines teenage pregnancy as "conceiving between the ages of 13–19 years old". However, the term is often used to refer to young women who become pregnant when they have not yet reached legal adulthood, the age of which varies across the world (Cook & Cameron, 2015). The terminology 'teen(age) pregnancy', teenage childbearing and 'adolescent pregnancy' will be used interchangeably in this master's dissertation, despite each having slightly different definitions, and will refer to the UNICEF definition, unless otherwise described.

Uganda has a long history of battling teenage pregnancy. During the war period with the Lord's Resistance Army between 1987-2009, high rape numbers were reported, and girls, some of them as young as 12 years old, became pregnant. In 1990, a law was passed by the Ugandan Parliament in which sexual intercourse with a person under the age of 18 was declared illegal (Ojulu, 2021). The Defilement Law targeted to prevent HIV outbreaks and to protect girls from pregnancy and premarital sexual activity (Sekiwunga & Whyte, 2009). This measure has not yet proven to have a big impact on teenage pregnancy rates. The law makes it difficult for young girls to search for information, talk about their sexuality, ask people for help regarding health issues and use contraception (Sekiwunga & Whyte, 2009). Furthermore, young girls seek abortion in often unsafe circumstances (Sekiwunga & Whyte, 2009; Ojulu, 2021). The Defilement Law did not only fail to protect adolescent girls from early sexual activity, but it also stimulates their families to settle for money or for marriage and the additional bridewealth when the law is violated, without involving the court. The parents of the girls are then compensated and the 'culprits' never get prosecuted (Sekiwunga & Whyte, 2009).

The country made a pledge to the East, Central and Southern Africa Health Community (ESAC-HC) to reduce adolescent pregnancy rates from 25% to 13% by 2022, but did not succeed (Ojulu, 2021). Although numbers of adolescent pregnancies have stagnated since 2006, an increase in numbers was noted in 67 out of the 136 districts in Uganda during the COVID-19 pandemic in 2020

(UNFPA, 2021). Some sources mention rising teenage pregnancy numbers due to the pandemic (UNFPA, 2020), certainly in the more vulnerable groups such as slum dwellers (Nuwematsiko et al., 2022). Research by the Makerere University School of Public Health says teenage pregnancy numbers rose by 28% during the first COVID-19 lockdown, and according to the Ugandan Education Ministry pregnancies among schoolgirls rose 30% since the start of the pandemic (Ojulu, 2021).

The battle against adolescent pregnancy is currently very significant. The UNFPA (2020) has set a new global goal to achieve results by 2030, working within three SDGs. These are 'ending unmet need for family planning', 'ending gender-based violence and all harmful practices (including child marriage)', and 'ending all preventable maternal deaths'. The impact of COVID-19 could undermine the progress made toward achieving these goals. Because of the pandemic and restricted health services, fewer people will be able to use contraception and more unintended pregnancies will happen, among which a large number will be teenage pregnancies. The number of unintended pregnancies depends on the duration and severity of health service reductions and would increase if lockdowns were to continue. (UNFPA et al., 2020).

1.2. Causes, conditions and risk factors

Out of every 1000 female Ugandan adolescents aged 15-19 years, 135 give birth each year. (Ministry of Health Uganda, 2013). According to research by Akanbi et al. (2016), different variables are related to (the prevalence of) adolescent pregnancy, such as age at the start of contraceptives, educational level, low household income, access to media, early sexual debut, siblings' sexual activity, and if siblings got pregnant (Akanbi et al., 2016; Wasswa et al., 2021). Rutaremwa (2013) and Wasswa (2021) found that marriage is one of the most significant clarifying variables for adolescents being pregnant or going through childbearing in Uganda. Child marriage also contributes to huge differences in teenage pregnancy, with a disadvantage to the poor (Wasswa et al., 2021).

1.2.1. Child marriage

Traditionally, female teenagers experience cultural and social pressure from their families and community in Uganda to start early with marriage and childbearing, mostly encouraged through economic necessity, and social and cultural norms (Sekiwunga & Whyte, 2009).

Marrying off their young children is often seen as a way for families to reduce their household expenses, gain social recognition and economic security, and protect children from pregnancy

outside of wedlock and other perils of sexual activity, such as sexually transmitted diseases. (Sekiwunga & Whyte, 2009; Wasswa et al., 2021). Further, childbearing and marriage are also often presented as valuable for women themselves to follow from both religious and societal perspectives (Bledsoe & Cohen, 1993).

Although early marriage and childbearing are often encouraged, pregnancy outside of marriage is mostly condemned and followed by social stigma (Sekiwunga & Whyte, 2009). Girls who get pregnant outside of wedlock are often forced to drop out of school or are even sent away from home (Aytuyambe et al., 2005). The stigma and collateral stress reduce the well-being of the young girls and compromise their health, as well as that of their babies. With no support from their families or their society in general, many pregnant girls seek an abortion, often in unsafe circumstances (Rutaremwa, 2013).

Though marriage at an early age is a common practice in Uganda, it is not without harm. Early marriage has a negative effect on the health, education, and economic well-being of young girls. Besides, most girls do not get much say in the matter, not about the age at which they get married, nor to whom (Jensen & Thornton, 2003). Early marriage is often described by gender equality defenders as a human rights issue and evidence suggests that early marriage can be defined as a form of sexual and gender-based violence (Gottschalk, 2007).

1.2.2. Contraceptives and family planning

Research suggests that a larger part of sexually active adolescents do not use contraceptives. The *2016 Uganda Demographic and Health Survey [2016 UDHS]* revealed that in Uganda 22% of married women, between the age of 15 and 19, do not use any form of contraception (UBOS & ICFI, 2018), and girls who marry young often do not have access to contraceptive methods, which makes it much more difficult for them to delay childbearing (Centre for Human Rights, 2018). Nevertheless, around 2 million women in Uganda want to stop or delay pregnancy but are not using contraception (UNFPA East and Southern Africa, 2022). Irregular contraceptive use, high frequency of having sex, and having multiple partners are associated with teenage pregnancy (Ochen et al., 2019).

The use of contraceptives differs between sexually active married and unmarried women; 51% of sexually active unmarried women use a contraceptive method, versus 39% of married women. Unmarried women between the age of 15 and 49 (47% use a modern method of family planning, such as sterilisation, contraceptive pills or condoms, 4% use a traditional method, such as withdrawal or the calendar rhythm method) mainly use injectables (21%), male condoms (14%),

and implants (6%). Married women often use injectables (19%), implants (6%), and traditional methods (4%). Their contraception use depends largely on whether they live in urban areas or rural areas (41% versus 33% use modern contraceptives) (UBOS & ICFI, 2017; UBOS & ICFI, 2018).

Education has a large effect on family planning. Women are nearly twice as likely to use modern contraceptives when they reach more than their secondary education level. Contraceptive use and family planning also increase with wealth, as the wealthiest households use almost double (42%) as many methods as the poorest (22%). In general, family planning increased as well between 2000 and 2016 with, among others, modern contraception doubling during that same period (UBOS, 2017).

Research by Akanbi et al. (2016) suggests that the age at which adolescents start using family planning methods correlates with teenage pregnancy. Adolescents who start family planning at the age of 13 years or above are more likely to become pregnant. This phenomenon connects to teenagers being fed up with the use of more common contraception such as condoms, more exploration of sexual activities, and misconceptions and lack of knowledge surrounding contraceptives, all of which increase their chances of getting pregnant (Akanbi et al., 2016).

1.2.3. Educational level and wealth index

Educational level, quality of and accessibility to education, as well as economic status and opportunities or wealth index, are factors that influence adolescent pregnancy (Nour, 2006; Ochen et al., 2019; UBOS & Macro International Inc., 2012; UNFPA, 2022). A higher number of years of education reduces the risk of teenage pregnancy significantly. Increased knowledge and agency, as well as opportunities to avoid early sexual behaviours, help prevent unintended pregnancies (Menon et al., 2018; Wado et al., 2019; Wasswa et al., 2021). Adolescents who have completed secondary school tend to have way lower pregnancy rates (15%) than those who have not (50%) (UBOS & Macro International Inc., 2012). The *2016 UDHS* employs other rates, as seen in figure 1: 35% of adolescent women with no education began childbearing, compared to 11% with more than secondary level education (UBOS, 2017).

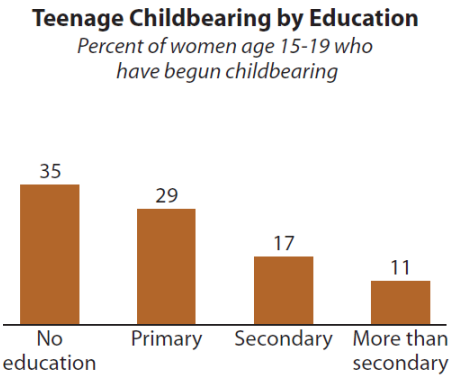

Figure 1. Teenage childbearing by Education, percent of women age 15-19 who have begun childbearing. UBOS, 2017.

Further, female adolescents without education have the highest percentage of teenage pregnancy and childbearing (30.4%), followed by those with a primary education level, whereas girls who

completed secondary education only have 13.8% going through or been through adolescent pregnancy (Rutaremwa, 2013). Despite these statistics, the research by Rutaremwa (2013) concludes that the level of education does not provide a significant positive outcome regarding teenage pregnancy rates.

Akanbi et al. (2016) found that educational level can be associated with teenage pregnancy as an individual risk factor. This may be explained by the fact that, at the age of secondary education, girls are more exposed to sex and different factors can steer them towards it, such as poverty level, hormonal development, peer group influences and pressure, idleness, social strives, etc. School drop-out or low education level may be the result of teenage pregnancy, and will also influence and increase poverty, non-attendance at school, and reduce productivity within the community and country (Akanbi et al., 2016). It may also be the result of the low value attached to girls' education and the linked expectations about early marriage, where parents sometimes refuse education for their daughters (Sekiwunga & Whyte, 2009). Another explanation is that women with more than secondary education generally tend to initiate sex much later than women with no education, with a difference of almost four years (19.8 years versus 16.0 years) (UBOS & ICFI, 2017).

On an economic level, adolescents from wealthy households are less likely to become pregnant compared to those from poorer families, with pregnancy rates of 16 versus 41 percent (UBOS & Macro International Inc., 2012). Wasswa et al. (2021) found that the household wealth index determined around 20% of inequality in teenage pregnancy in 2016 (3% in 2006 and 18% in 2011), with an increased risk of getting pregnant for adolescents in lower wealth quintiles. These findings are affirmed by other studies (Chirwa et al., 2013; Menon et al., 2018; Rutaremwa, 2013). Wealth index and education level influence one another; poorer families may be more likely to have lower education and tend to regard early marriage as a strategy to deal with economic instability, whereas adolescents from wealthier families are more likely to continue education and pursue a career (Wasswa et al., 2021).

1.2.4. Other driving (social) factors

Motherhood in childhood, a report by the UNFPA (2022), describes teenage pregnancy as often driven by a lack of meaningful choice, limited agency, and sometimes even force. Discrimination, structural gender inequality, and harmful social and gender norms are the underlying determinants, which can lead to negativity within practices, beliefs, and attitudes surrounding gender roles and sexuality, especially those of young girls.

Other impelling factors are the absence or distinction of sexual and reproductive health services, as well as protection from (sexual) violence (UNFPA, 2022). Especially sexual abuse during childhood, in certain cases combined with physical abuse, has been associated with earlier sexual experiences and younger age at first pregnancy (Fiscella et al., 1998; Madigan et al., 2014). Sexual abuse and lack of control over sex, as well as domestic violence and physical neglect, are all factors associated with the prevalence of teenage pregnancy (Ochen et al., 2019). The existence and presence of reproductive health services focused on adolescents are associated with higher knowledge and use of modern methods of pregnancy and STD prevention (Annor et al., 2021). Young women's lack of awareness about sexual and reproductive health is associated with teenage pregnancy (Ochen et al., 2019).

Ochen et al. (2019) and Wasswa et al. (2021) found that living in rural areas is associated with higher numbers of teenage pregnancies, contrary to people living in more urban areas. Furthermore, a living situation where parents are separated or divorced is linked to the prevalence of teenage pregnancy (Ochen et al., 2019). Miller et al. (2001) found that connectedness between parent and child, as well as parental supervision, counselling, and regulation of their children's activities, and the parents' view on adolescent (unprotected) intercourse influence the chances of adolescent pregnancy. Lastly, access to media (radio, television, newspapers, etc.) reduces the risk of teenagers getting pregnant; with access to more media channels, teenagers are less likely to experience pregnancy than those who do not have any access (Wasswa et al., 2021).

1.3. Consequences of teenage pregnancy

Adolescent pregnancy and childbearing can be seen as a health, economic, moral, and/or social problem (Akanbi et al., 2016; Sekiwunga & Whyte, 2009). Depending on the perspective one takes, teenage pregnancy is regarded as a health risk (primarily in Europe), or more as a moral problem (especially in Africa and the United States) (Sekiwunga & Whyte, 2009). Early pregnancy can disrupt girls' otherwise healthy development into adulthood and negatively impact their education, livelihoods, and health (UNICEF, 2021). Young women risk undergoing unsafe abortions, being isolated and/or stigmatized, reducing their status, rejection and violence within their families and community, forced marriage, school drop-out, worse employment opportunities, and poverty (UNICEF, 2021).

1.3.1. Health impact

Adolescent pregnancy is dangerous for the mother, as well as the (unborn) child; 20% of infant mortality and 28% of maternal deaths result from teenage pregnancy (UNFPA & UNICEF, n.d.).

According to the World Health Organization, complications during childbirth are the second cause of death for girls between the ages of 15 and 19 (Akanbi et al., 2016). Neal et al. (2015) even found that pregnancy and childbirth are the leading cause of death for this age category globally. A study by UNFPA (Loaiza, & Liang, 2013) shows that neonates born out of teenage pregnancy have lower survival rates. Stillbirths and deaths within the first week after birth are 50% higher among babies born to adolescent mothers than among babies born to mothers in their 20s (World Health Organization [WHO], 2014).

If the pregnancy does not result in death for the mother and/or child, many of the consequences related to teenage pregnancies still have ongoing effects long after birth, often because the girls' bodies are not physically ready for childbearing (UNICEF, 2021). For the newborn child, these pregnancies have been associated with low birth weight and health consequences due to more preterm and caesarean deliveries (Marvin-Dowle et al., 2018). Many adolescents choose abortion, often in unsafe circumstances, with maternal mortality and lasting health issues as a result (Darroch et al., 2016); For young women going through pregnancy, there are negative outcomes for their physical, mental, and emotional development (Green et al., 2009; Santhya, 2011). They risk eclampsia, puerperal endometritis, obstetric fistula, and systemic infections, way more than women who go through pregnancy at an older age. Maternal conditions are also among the top causes of disability-adjusted life years (UNICEF, 2021). Nonetheless, teenage parents tend to access fewer antenatal and maternity services (Cook & Cameron, 2015).

Finally, teenage pregnancy may also have far-reaching mental and psychological health consequences (Aujoulat et al., 2010). Pregnant girls have higher chances of partnership instability and falling victim to severe domestic violence and abuse (by family and spouse), with the youngest running the highest risk. Motherhood at an early age may also negatively affect the girls' individual self-perception, which may cause them to display risk-seeking behaviour, such as connecting to more abusive partners (Azevedo et al., 2012; Urdinola & Ospino, 2015).

1.3.2. Economic impact

Teenage pregnancy has a big impact on an economic level. Nearly half of all Ugandan adolescents put an end to their education due to teenage pregnancy, and about 64% of teenage mothers will not complete their primary education level (UBOS & ICFI, 2018; Manzi et al., 2018; UNFPA & UNICEF, n.d.). The number of girls who drop out of school is higher than that of boys, while more boys go on to secondary education (Akanbi et al., 2016). After their pregnancy, most girls do not get a second chance at education (UNFPA East and Southern Africa, 2022). Linked to their

education level, teenage mothers are three times less likely to have professional jobs and are twice more likely to be self-employed in agriculture. Hence, teenage mothers will have a lower income level which eventually affects their standard of living and risk of poverty (UNFPA & UNICEF, n.d.).

Education is often not seen as a road towards a better life for young girls. Instead, they are encouraged to get married at a young age, inter alia for material and financial support (Sekiwunga & Whyte, 2009). Almost half of the Ugandan teenagers quit their education due to adolescent pregnancy (UBOS & ICFI, 2018). Teenage pregnancy installs a barrier to continuing education after pregnancy; these young girls drop out of school, do not have any motivation to return later, and current policy is not helpful in making them re-enter, on the contrary, it makes them terminate their education (Rutaremwa, 2013; UNFPA East and Southern Africa, 2022). About 64% of teenage mothers will not achieve primary education levels (UNFPA & UNICEF, n.d.). Child marriage also impedes the girls' opportunities for further education, with their household responsibilities taking over (Shawky & Milaat, 2000).

Teenage pregnancy negatively impacts the socioeconomic status of the young mother, because of less educational chances, which also influences employment opportunities (Shawky & Milaat, 2000; UNICEF, 2021; Walker, 2012). The child, born out of teenage pregnancy, has thus a higher risk of growing up in lower socioeconomic circumstances, which puts the child at higher risk of teenage pregnancy, creating a vicious cycle (Rutaremwa, 2013). Furthermore, the chances of survival of the newborn child decrease, when being born into lower socioeconomic classes (Ministry of Health Uganda, 2013). The mother's education level is correlated with health factors, among which child survival, but poverty challenges and less possibility to consult and afford health services are related as well (Katahoire et al., 2004; Ministry of Health Uganda, 2013).

1.3.3. Social and moral impact

In these contexts, teenage childbearing is often an accepted social norm, at least for married adolescents. For unmarried women, consequences range from stigma to rejection, to violence from their partner and environment (WHO, 2020). The girls' families sometimes aim to reduce the shame brought on by the pregnancy by forced and child marriage which poses a high risk to the girl's physical, psychological, and sexual well-being (Raj, 2010). Teenage mothers have more risk of experiencing social isolation, as well as family conflicts, compared to their peers. Their children are at higher risk of being born into poverty and going through adolescent pregnancy themselves (Aujoulat et al., 2010; Cook & Cameron, 2015).

According to Sekiwunga and Whyte (2009), teenagers experience pregnancy as more shameful and morally more condemning than HIV infection, with immediate consequences for both boys and girls. They felt like they received a lot of negative and moral criticism from their parents and missed out on much-needed support from the older generation. Ellis-Sloan (2014) found that negative stereotypes keep dominating understandings of teenage pregnancy and these adolescents often go through hurtful and significant experiences of hostility and judgement regarding their identity as a teenage mother. Parents, community members and leaders often have a negative attitude towards unmarried teenage mothers, influenced by cultural and religious -based norms and beliefs regarding pregnancy outside marriage (Hanna, 2001).

The families of teenage mothers often do not provide adequate support. Boateng et al. (2023) discussed how young mothers involved themselves in sexual activities due to a lack of parental support after the first birth, which resulted in recurrent pregnancy. In a study in Australia, Hanna (2001) saw as well that there was little to no support coming from the families. In contrast, several studies found that the now grandparents were sources of support to the adolescent parents and helped them through transition into parenthood, but that support came mainly from their own mothers (Borcherding et al., 2005; Bunting and McAuley, 2004; Neale and Clayton, 2015; Sriyasak et al., 2017). The grandmother is often involved in the decision to keep the child and helps to reduce the stress of the new-found mothers (Neale and Clayton, 2015).

Further, the children's father often does not take his responsibility and he seems to escape his obligations, financially as well as in taking up some of the parental responsibilities. It is, however, not clear whether their lack of involvement is intentional or because they lack insight in what role they have to or could play (Boateng et al., 2023; Hanna, 2001). Teenage mothers often have to cope with the idea that the father of the child will not take up his responsibility (Leerlooijer et al., 2013) and adolescent mothers are also often stigmatized for their partners abandoning them (Boateng et al., 2023). Leerlooijer et al. (2013) suggest that teenage mothers remained to be dependent on the decisions of their father or their husband anyway. Hanna (2001) points out that adolescent mothers are often controlled as a group of women who have defied the norms of society. Therefore, their voices are often silenced, they are rarely taken seriously, their opinions do not matter, and their complaints are considered irrelevant because their problems were brought upon by themselves.

Describing teenage pregnancy as a social issue has been criticized. Cook and Cameron (2015), for instance, bring in several arguments. First, negative social outcomes associated with teenage pregnancy may not be causal, but it may be part of a more complex scheme of circumstances. If

you forget about this and start focussing on the at-risk group of teenage mothers, your prevention interventions are determined by this problem definition. This may cause one to blame individuals and focus on behaviour change, while simultaneously ignoring the wider social picture. Secondly, describing teenage pregnancy in such a way may cause stereotyping and increase the stigma that adolescents experience. This approach can socially isolate these mothers even further and prevent them from seeking help and consulting health services. Moreover, there is a danger to view all teenage pregnancies as abominable, because some adolescents may experience pregnancy, birth, and parenthood as enjoyable and rewarding (Aujoulat et al., 2010; Cook & Cameron, 2015).

1.4. A Summary

This review has outlined what definition of teenage pregnancy is being applied, and it articulated the high prevalence of teenage pregnancy in Uganda (Burton, 2017; UBOS & ICFI, 2017; Wasswa et al., 2021). The framework highlighted the attention teenage pregnancy receives on a national level, in policy, and on an international level, with objectives such as the SDGs (Ojulu, 2021; Sekiwunga & Whyte, 2009; UNFPA et al., 2020).

Further, a relatively large amount of research discusses the causes and risk factors of teenage pregnancy in adolescent girls, with attention for conditions such as child marriage, contraceptive use, education, income, gender inequality and abuse, and the absence of sexual and reproductive health services (Akanbi et al., 2016; Ochen et al., 2019; Rutaremwa, 2013; UNFPA, 2022; Wasswa et al., 2021). Another side of research on teenage pregnancy focuses on its consequences, as it has health, economic, social and moral implications (Akanbi et al., 2016; Sekiwunga & Whyte, 2009; UNICEF, 2021). Teenage women risk being isolated and/or stigmatized, getting their status reduced, experiencing rejection and violence within their families and community, forced marriage, undergoing unsafe abortions, school drop-out, worse employment opportunities, and poverty (UNICEF, 2021).

Finally, this review shows that there is often a focus on teenage mothers as an ‘at-risk’ group, which causes research to focus on risk factors, protective factors and prevention. It entails a problematisation of teenage pregnancy and motherhood in its entirety and diminishes agency and experiences of teenage mothers. This may also cause negative stereotyping and ignorance for the wider social picture and complex context (Cook & Cameron, 2015). In research, there is thus a lack of data about the experiences and perceptions of teenage mothers and less attention for their aspirations, needs, support systems and mental and sexual wellbeing.

2. Methodology

2.1. Research statement and question

Teenage pregnancy has been a much-discussed topic over time, with most research conducted on its prevalence, risk factors and consequences (Akanbi et al., 2016; Rutaremwa, 2013; Wado et al., 2019). Research often talks about risk and protective factors for teenagers and prevention to secure them from becoming pregnant. Researchers maintain a “better safe than sorry” strategy, including addressing possible government measures (Chung et al., 2018; Rutaremwa, 2013; Wado et al., 2019, etc.). This aligns with the view that every teenage pregnancy is problematic, while some of these girls may experience pregnancy or motherhood differently or more nuanced or may even be happy with it. This may result in negative stereotyping and ignorance for the wider social picture and complex context of teenage pregnancy (Cook & Cameron, 2015).

In applying this perspective, little attention has been paid to the views and experiences of the young women themselves, their needs, and what makes them resilient (support systems or assets) during and after pregnancy and childbearing. However, teenage pregnancy and motherhood prevalence are still present and even a reality for many girls. In some contexts numbers are even rising, which is, among others, associated with the COVID-19 pandemic (Ojulu, 2021). The little research that has been conducted on the narratives and experiences of teenage mothers often occurs in a different context than the African continent, mainly in the United States or other Western countries (Aujoulat et al., 2010; Hanna, 2001; Barcelos and Gubrium, 2014; Cook and Cameron, 2015; Sriyasak et al., 2017). Furthermore, researchers often revert to more quantitative methods to understand teenage pregnancy with little attention to the lived experiences of teenage mothers themselves (Akanbi et al., 2016; Lee et al, 2020; Wado et al., 2019). This results in few insights in adolescent mothers’ narratives and how teenage girls perceive their pregnancy and motherhood. Qualitative data could, however, provide opportunities to delve deeper into the complexity of teenage pregnancy and the lived experiences of adolescent mothers, as it leaves room for the narratives, feelings, desires and attitudes they experience (Onwuegbuzie & Johnson, 2006; Wilhelmy & Köhler, 2021). To get the full picture, there is thus not only a need for quantitative but also qualitative research.

The following is an outline of the existing qualitative research around teenage pregnancy. Aujoulat et al. (2010) focussed on the psychosocial and health needs of teenage mothers in the context of Belgium, with among others a focus on how teenage mothers perceive becoming a mother and the difficulty of social isolation. However, this context is so different from the one studied here that it is

hard to compare. Similarly, Hanna (2001) explored the experiences of teenage mothers in an ethnographic study. The research, however, consisted of a very small sample and was conducted in a different time and context then the current study. Further, Atuyambe et al. (2005) researched the difficulties that teenage mothers encounter in the context of Uganda, such as economic problems, issues of abortion, family and community problems. The researchers determined the need for further research on support systems of adolescent girls. Leerlooijer et al. (2013) used semi-structured interviews to evaluate the Teenage Mothers Project in Uganda. This research included different respondent groups, such as teenage mothers and community leaders, with smaller samples for each. They recommend further research regarding teenage mothers, their needs and assets as this could prove interesting. In 2001, Neale and Clayton did extensive research on the experiences of teenage pregnancy, but specifically from the point of view of teenage fathers. Very recently, Boateng et al. (2023) conducted qualitative research on the factors influencing recurrent teenage pregnancy, using in-depth interviews. Last, there is qualitative research by Ellis-Sloan (2014) that focusses on stigma and stereotypes in understanding teenage pregnancy by the use of observation and semi-structured interviews.

From these observations, the purpose of this master's thesis is to identify teenage mothers' perspectives on their pregnancy and motherhood and provide an answer to the following research question: *'What are the experiences, needs and support systems of adolescents who went through or are going through teenage pregnancy?'.*

2.2. Study Context

The battle against adolescent pregnancy is currently highly significant, including through the deployment of three SDGs that relate to the topic of teenage pregnancy: 'ending unmet need for family planning', 'ending gender-based violence and all harmful practices (including child marriage)', and 'ending all preventable maternal deaths' (UNFPA, 2020). The increased worldwide attention to this issue creates opportunities for additional research and policy focus.

The Centre for Children in Vulnerable Situations (CCVS) wants to contribute to this global research and find further insights into the needs and experiences of teenage mothers. Therefore, this study was conducted in part at the request of and in cooperation with CCVS, located in the Kitgum District in the Acholi region in northern Uganda, to contribute to their practice improvement and possibly that of other organisations in the region.

Figure 2. Kitgum District, Acholi region, northern Uganda.
Landis et al., 2014.

In the Kitgum district, a team of psychologists constructs and provides trauma counselling and therapy for people in the region, and in different villages throughout. Furthermore, CCVS is working to carry out significant studies concerning the needs of the local population and further development of their practices. They want to respond to the needs of the community, and for that, they must be identified. They requested to assess the mental health needs of teenage mothers, as there is high prevalence of teenage pregnancy in Uganda (Burton, 2017; UBOS and ICFI, 2012) and more specifically in the Acholi region and in Kitgum district where they are working. The number of births to adolescent females aged 15-19 in the Acholi Region is 134.1 – 146 per 1,000 female adolescents, which was measured within a certain reference period (UNFPA et al., 2019).

2.3. Research setting and respondents

The research is linked to the (research) Centre for Children in Vulnerable Situations. In this study, nineteen interviews took place with girls between the ages of sixteen and twenty, questioning their teenage pregnancy and motherhood. CCVS contacted their local mobilizers, who found the respondents; the researcher herself had little to do with it. The main selection criteria were the fact that the girls were within the right age category and that they had been or are going through teenage pregnancy. The different research locations were determined in consultation with the CCVS counsellors and their local mobilizers. The interviews took place in 5 different locations in Mucwini and Lagoro sub-county, in the open air in the villages of the participants themselves, to make it practically easier for the girls to participate. To provide privacy, the interviewer searched for a quiet and composed location.

Seventeen of these interviews were one-to-one, and two were with two participants at the same time. This resulted in 21 participants in total (N=21). All the girls were between thirteen and nineteen years old when they gave birth or were still pregnant, compliant with UNICEF's definition of teenage pregnancy. Due to the limited scope of the study, it was decided not to expand this study to include other interesting perspectives, such as teenage fathers, parents of teenage mothers or other persons involved such as teachers, again in consultation with CCVS.

The participant group was heterogeneous on numerous levels. First, the age at the time of the interview and the age when they became pregnant, differed among the participants. Two of the participants were not yet mothers but were pregnant at the time of the interview. One participant already lost a child and was pregnant again. One other participant lost her child at birth. Three participants already had two children. Furthermore, the marital status of the participants, as well as their living situation, was diverse. Some mothers were married or engaged, others indicated that they were separated from their husband. Some of them were living with their own parents and siblings, one of the parents or just the siblings, others with their partner, and possibly in-laws. Other personal elements were more homogeneous, such as their gender, the fact that none of the girls were in education, and the fact that all of them experienced teenage pregnancy. Nineteen out of the twenty-one participants mentioned farming as their main income source.

2.4. Data collection method

The data collection of this study is qualitative in nature, more specifically using semi-structured interviews. In these interviews, the interview manual and focus are determined beforehand, but the researcher can deviate from the pre-established manual and explore other upcoming ideas. Both the questions themselves and the sequence of the questions can be modified during the interview or new questions can be added. Respondents get the opportunity to bring forth their own elements and can add substantial ideas during the interview (Adeoye-Olatunde & Olenik, 2021). The main premeditated topics for this study are pregnancy and motherhood experiences, the relationship with the child, social support and adversity, the role of education, mental and physical health needs and/or support, and material needs.

This form of inquiry was chosen because it provides opportunities to delve deeper into in-depth, complex, difficult topics, and capture the lived experiences of people (Onwuegbuzie & Johnson, 2006; Wilhelmy & Köhler, 2021). Interviews enable participants to share their feelings, prejudices, opinions, desires, and attitudes towards different phenomena they experience. The flexibility it entails provides more security for the participant, as the interview can be stopped at any time and

participants get the opportunity to share information they define as important (Dunwoodie et al., 2022). Therefore, a study applying qualitative interviews has the capacity to give a voice to minorities and hard-to-reach populations in society that may not be heard elsewhere (Reeves et al., 2015). At last, it allows the researcher to ask questions about sensitive topics that are not always easy to ask in other settings ((Dunwoodie et al., 2022).

Upon consultation, two of the nineteen interviews were done by querying two participants simultaneously to see if this would improve their comfort level, as they could support one another. However, this proved more difficult for the interviewer to ask questions to both participants at the same time, as well as for the participants to express their ideas freely and without influencing one another. The responses are still taken into account for the analysis as they still contain interesting information, but further inquiries were done individually.

The interview manual (see appendix 1) consisted of four big components. First, important personal information was gathered, such as age, job or educational level, living situation, marital status, number of children, and age at birth of the first child (see appendix 2). Furthermore, the interview was stretched over three periods in the life of the girls (before, during, and after pregnancy), with the discovery of the pregnancy and the birth of the child as major turning points, commencing in the period after the birth and going back in time throughout the interview. The questions were based on the literature review and were checked, corrected and approved by Ilse Derluyn (promotor), Marieke Janssen (CCVS) and Ketty Lanyero (CCVS).

The required number of participants was determined during the data collection process, which took place in a limited time frame of six weeks between September and October 2022. The assessment hereof, while conducting the interviews, corresponds with the occurrence of a significant degree of saturation as a criterium for adjourning the data collection, since further collection would have been more counter-productive and would not necessarily add any new thematic information (Saunders et al., 2018).

2.5. Procedure

The research design was determined in consultation with Ilse Derluyn (promotor), Marieke Janssen (CCVS) and Ketty Lanyero (CCVS), as the study was conducted as part of the CCVS research activities. They provided the researcher with guidance, feedback and their approval on the topic of the study, the interview manual, the research locations and the informed consent (see appendix 3).

CCVS contacted the local mobilizers, whit whom they are working together, so that they could search for possible respondents, explain to them the goal of the study and ask for their consent to participate. The local mobilizers also made sure that the participants arrived for the interviews at the right location and time. The researcher tried to do the interview as close to the participants as possible but for affirmation of their anonymity, the interview never took place at their home but at a more central point in the village. If they had to use transportation, their costs were reimbursed. The mobilizers kept in contact to convey any questions from respondents after finalising the data collection.

The interviews were conducted with assistance from a translator, as the interviewer did not speak or understand the local Acholi language, nor did the participants comprehend sufficient English. The two translators from CCVS who attended were both trained in psychology and familiar with the local language and culture. They were however no official interpreters. Both signed a confidentiality form prior to the data collection.

Before the start of the interview, the interviewer and translator introduced themselves and iterated on the research goal. A small (re)introduction on the CCVS practices followed next, where the participant was asked if they had heard about this organization and their activities. The researcher went thoroughly through the informed consent with the participant to clarify important concepts and ideas such as anonymity, confidentiality, privacy, risks and benefits of the study, possibilities for withdrawal and the opportunity to ask questions at any time. Finally, the participant's consent was asked to record the interview.

The length of the interviews ranged from approximately twenty minutes to an hour. All interviews, except one, were recorded and transcribed, with the permission of the participants. For the remaining one, the interviewer took notes as the participant did not consent to the recording. All of the participants did however sign the informed consent, which was based on the informed consent of Ghent University, but adapted to this specific context and approved by CCVS.

2.6. Data-analysis

The transcriptions were coded and analyzed through the use of NVivo. According to Mortelmans (2017), it is one of the most commonly used programs for qualitative data analysis in Belgium and the Netherlands. Moreover, it is indicated by Ghent University as a high-quality research tool (Universiteit Gent, 2022). The analysis was done thematically, which is "a method for identifying, analyzing and reporting patterns (themes) within data" (Braun & Clarke, 2006). Thematic analysis is useful in reducing extensive data into clearly articulated thematic statements and is often used

to answer a research question that commences with querying “what” or “how” (Lochmiller, 2021), as is the case in this research. Furthermore, this approach to qualitative research is easier for novice qualitative researchers to be performed and a step towards more sophisticated methods (Braun & Clarke, 2006).

The thematic analysis is done as described in Lochmiller’s article ‘Conducting Thematic Analysis with Qualitative Data’ (2021). It starts with coding the interviews and in doing so identifying robust categories, which entail certain recurring patterns, ending up with a hierarchical coding frame (see appendix 4). Subsequently, these patterns serve as a basis for further analysis, perceiving correlations between data and developing thematic statements. In this interpretative phase, themes are determined and these are related back to the research question. In further discussion, these ideas are related back to the relevant literature. In this study, five interesting main themes emerged: the experiences of teenage pregnancy and motherhood, family and network, education and economic objectives, physical health, and last, mental health and counselling.

2.7. Quality of the study

To perform scientific research, certain criteria need to be kept in mind to keep up the quality of the study. Validity and reliability are often used in quantitative research but are contested as useful criteria in qualitative research (Hayashi et al., 2019). Denzin and Lincoln (2005) argue for a replacement of these older concepts, with newer, more suitable terms to evaluate qualitative studies. Lincoln & Guba (1985) come up with a solution of reconceptualizing the quantitative concepts of internal and external validity, reliability and objectivity to credibility, transferability, dependability and confirmability, under the umbrella term of trustworthiness.

Credibility, which is similar to internal validity, aligns with the representativeness of the data (Thomas & Magilvy, 2011). In this study, it is guaranteed through a continuous focus on the non-committal nature and confidentiality of participation, by devoting sufficient time to the introduction and the informed consent, by asking multiple times if the respondents have any questions and if their answers were understood correctly, and by thorough reflection about the positionality of the researcher. Furthermore, credibility is maximized by using the quotes of participants literally in the result section.

Transferability indicates how one can determine the extent to which the findings of a particular analysis have applicability in other contexts or with other participants, (Lincoln & Guba, 1985) and is similar to quantitative research’s external validity. Qualitative research is never generalizable or statistically representative of the whole population, rather it is about the specific experiences of a

subgroup. However, transferability in the study is pursued by describing the respondents' demographic characteristics and the geographic boundaries of the study as clearly as possible.

Dependability occurs through transparency and disclosure of the researcher's decisions and research process and relates to the concept of reliability. Other independent researchers should be able to recreate the research design and reproduce the research process -(Thomas & Magilvy, 2011). To guarantee dependability, the research design, data collection process procedure, and data analysis are submitted in a detailed description above. Further, all the interviews were conducted by one person, as to maximize the constancy of the data collection.

Lastly, *confirmability*, or objectivity, occurs when credibility, transferability, and dependability have been established. It relates to the need in qualitative research for reflection and a critical view of oneself by the researcher (Thomas & Magilvy, 2011). In this study, the researcher committed to a deliberate effort to pursue the direction of the interview that the participants indicate. Further, conversations were held with different people involved about the positionality of the researcher, the difficulty of countering an underlying Western perspective, and the consequences thereof on the interpretation of the data. The latter also drew on existing literature.

2.8. Ethical considerations

Throughout the whole research, the ethical protocol of Ghent University was implemented. The participants got an explanation of the research, first by the mobilizers and then again before the start of the interview. Following was an explanation of the informed consent, which was verbally translated, and in which the main principles of this protocol recurred. In this way, an attempt was made to clarify to participants which rights they hold.

All the participants were treated with respect during the whole research process. Further, the research ensured full confidentiality and anonymity. No names or other tangible information is or will be shared. Participants were able to quit or express concerns without conditions. Further, partaking only happens out of the participant's own choice. Talking about their experiences and needs could prove difficult and confounding for participants, a risk that was recognized throughout the data collection. To support them, they were assured that it was not a problem if they did not wish to answer questions.

The research, the interview manual, and the informed consent were acknowledged and approved by the (research) Centre for Children in Vulnerable Situations (CCVS) (see appendix 5). In this different context, after consultation with CCVS and based on literature (Flicker and Guta, 2008),

the informed consent of the participant's parents or guardians was not asked, since this might increase pressure on these girls who often no longer live with their parents.

The researcher and translator present also tried to pay attention to nonverbal behaviours. In case of any doubts or long silence, which indicated a hesitation by the participant to answer, this was respected. The translator's psychosocial and cultural knowledge played a crucial role here. Still, despite efforts to be diligent and considerate, it is recognized that participation in this study may have had a potentially adverse effect on the emotional well-being of certain respondents. Whereas this was not possible in this research project due to the limited time frame and a lack of time and resources on the part of CCVS, it might be more suitable and ethical in future research, to install psychological counselling and provide possibilities for redirection or referral toward other support services.

The researcher's presence created certain expectations among the participants; mainly financial and material support or continued visits. However, these expectations could not be realized in the context of a master's thesis. For some of the participants, however, the recognition as individuals with their own agency, made the experience valuable. When the researcher asked for questions or feedback on the interview, one of the participants responded with the following citation:

"I advise you that you have to continue with the spirit that you people are having because for me, I thought, like for us, we are child mothers, are now being neglected. But some people are thinking about us." (Respondent 20).

2.9. Positionality of the researcher

In qualitative research, the researcher is the prime instrument of data collection. Reflexivity on the researcher's positionality and its impact on the interviews is therefore seen as an important strategy in the research process (Berger, 2013; D'Cruz et al., 2007; McGrath et al., 2019). Berger (2013) points to a different reflexive attitude when one has not lived the experiences of the participants themselves. The researcher in this study had never been in northern Uganda. Before the start of the interviews, however, the researcher resided in Kitgum for three weeks, getting to know some of the local language and customs. The researcher had never been in contact with people going through teenage pregnancy either. The lack of knowledge and feeling with both the local context and the experience of teenage pregnancy, undoubtedly influenced the research process.

Studying the unfamiliar has several benefits and at the same time presents certain challenges. The researcher may approach the uncharted from a fresh point of view, with new questions which may

lead towards innovative ideas. Further, this position could turn the interview into an empowering experience as the respondent has assumed the role of expert (Berger and Malkinson, 2000). On the other hand, if the researcher has not lived an experience personally, he or she can never fully understand what it feels like to go through or be in a certain situation. Further, it can prove difficult for a 'stranger' to comprehend subtle expressions, associations or non-verbal cues, which an 'insider' might otherwise identify (Berger, 2013). Therefore, the role of the interpreters was important in this research.

Researchers in qualitative studies can influence the dynamics between themselves and the participants and the interpretations of findings. They might ignore, disregard or overemphasize certain aspects of the participant's narratives or maintain a certain bias throughout the data analysis. Therefore, it is important, as researchers, to ask ourselves questions about the influence of our personal, sociocultural, and emotional background on the research process, as it makes us more diligent and allows for more depth and nuance in the research findings (Berger, 2013; Dunwoodie et al., 2022). However, this does not mean that the interviewer should be seen as someone contaminating or biasing the data, but rather as a co-creator of data together with the interviewee, where his or her previous experiences, skills and background can be of use, only through adequate consideration and reflection (McGrath et al., 2019).

Characteristics such as age, gender, nationality, personal beliefs and experiences, and emotional responses to the participants, undoubtedly have an impact on the entire research process (Berger, 2013). In this study, it is thus necessary to keep in mind some important characteristics of the researcher. First, the researcher is a woman, not much older than the participants who were interviewed. Furthermore, the interviewer is educated, whereas the participants were not able to finish their schooling. In northern Uganda, people are very religious, but this is not the case for the researcher, on the contrary. Last, the researcher was not familiar with the context or the language and there is the aspect of being white and Western, which inherently holds certain power imbalances.

In today's society, equality, violence, poverty and oppression are important global challenges. There is a danger in ignoring these challenges as Western researchers, with undeserved privileges and authority, that leads to the reproduction and strengthening of these unequal structures. Hence, there is a need for reflection upon the power dynamics inherent to research in a postcolonial context, and linked to that, come up with strategies for conducting empowering research that prevents the misrepresentation and exploitation of participants (Vanner, 2015). Potter and Hepburn (2012) emphasize the importance for qualitative researchers to be constantly aware of their own

stakes, interests and theoretical orientations, as these affect the interpretation of research findings. While working in a postcolonial geographical context, being white and born in the former colonial country may have an important impact upon the relationships that can be established during the research (Griffiths, 2017).

According to Kang (2020), subjectivity is not insuperable, nor does it need to be overcome. It does, however, need to be recognized, explored, and well addressed to prevent the researcher from unintentionally marginalizing minorities. Trying to retrieve oppressed voices, actually enhances the appropriation of voice and inherently implies the further silencing of these minorities. Postcolonial writers state that experience is beyond 'capture', and representation always risks appropriation (Griffiths, 2017). A reflexive attitude on the part of the researcher is thus imperative to minimize possible limitations of our positionality and enhance its strengths. Reflexivity, positionality and identity are useful as sites of more ethical engagement, through which it becomes possible for western researchers to write about people in the South without at the same time claiming to speak for them (Griffiths, 2017; Kang, 2020)

Vanner (2015) points to three important reflections around language, consent and giving back. First, using the local languages in research settings, demonstrates respect for the local community, which could help to develop trust between the community, participants and researcher. Again, this highlights the importance of the interpreters in the research. As Griffiths (2017) mentioned in his research, to avoid the obligation of speaking English reduces the power imbalance between researcher and researched. Of course, there is also a downside to this in that translation always holds the possibility of miscommunication and loss of nuance (Mackenzie et al., 2007). The choice was made to write down the research in English, to already partly address a language barrier, but still a language that the participants have a very limited command of. However, this way the research is available to CCVS. A Dutch summary will be made available.

Second, there is a need for continuous negotiation and reaffirmation of participants' comfort and commitment during the research process, as prior written consent does not adequately guarantees the full consent of participants (Shamim and Qureshi, 2013). This was addressed by asking in between questions whether they still felt comfortable and allowing silences in response as well. Last, she asserts that research projects must give back to the communities in which the research took place, such that it benefits the community and the participants. There are, however, various interpretations of how to implement this. The research raised awareness within the community about the research topic, and in the future it might help install further counselling and support on the part of CCVS or other organizations.

3. Results

This chapter provides a presentation of the results based on the analysis of the obtained data. The research findings reflect an answer to the research question, thus clarifying experiences, needs and support systems of teenage mothers in the context of Northern Uganda. The first part of the results section covers how the participants experienced their pregnancy and motherhood. Further parts deal with the girls' family and network, education, economic situation and, lastly, mental and physical health, all related back to their pregnancy and motherhood.

3.1. Experiences of teenage pregnancy and motherhood

Pregnancy is mostly experienced negatively by adolescent girls. They often encounter pregnancy as an accident, sometimes initiated under pressure by their "husband". In most cases they don't feel prepared to become a mother. They feel like they are too young to be pregnant and to be able to take care of their child.

> *My age was not yet ready to get pregnant.* (participant 19)
>
> *Being a mother, when you are not prepared to become a mother, is hard. Because there are so many things you need to have, you may not have it, especially if you are alone.* (participant 8).

Different elements are perceived as scary by the adolescent girls. Having to deliver is one of those. But more general, the soon-to-be mothers are scared for the health of the child and their own. Some girls had tough experiences: two of the young women lost their babies at birth, another girl had to go through a painful caesarean section and one of the girls did not get to see her child for two weeks as the child was very sick. On top of that, many girls fear a lack of support by their environment throughout the pregnancy and after delivery. Especially the "person responsible", the husband, does often not acknowledge the child, thus leaving the young mother and child behind to fend for themselves. Especially then, the girls experience a lack of resources to take care of the child.

> *I felt like when delivery started, if there is no one to help, I will be in trouble. (*Participant 6)

Thirteen of the young mothers don't want to go through pregnancy again in the future, six others don't for at least a few years. They prioritize to raise their child and maybe go back to school themselves. They experience a lack of resources and support to complete another pregnancy successfully. In some cases, they fear that their husband might still reject them for the second

pregnancy. Other girls already got separated during the first pregnancy and don't want to go through that again.

> *Because of the way I am, I think now I should first stay and weigh how my life will be. Because if I hurry with giving birth, then no one will stand for me*. (Participant 1)

Being a mother is, on the other hand, not always experienced as something bad. Seventeen of the girls expressed feelings of happiness with the arrival of their child and most of them enjoyed keeping the child close. The two mothers who lost their child, express their grief and sadness over that loss.

> *When she is seated near me, she loves playing. Whatever I tell her, she will be following and she likes what I tell her, what I say to her. So it makes me happy.* (Participant 8)

> *When I produced, the child stayed for one hour and then died. When the child died, I was not happy. I still think about the child.* (Participant 3)

The adolescent girls were asked to formulate some advice for other young girls, who are not pregnant. Talking from their own experiences and as actors in their own lives, they elaborated on two major ideas. Their main recommendation is not to "produce" early, but instead to continue education. Related to this, a few of them mentioned that getting pregnant early can be very tough, as living with the husband could prove difficult, and in addition, there is a big chance that "the one responsible" does not acknowledge the child as his. The other recommendation that was made multiple times is that young girls should be listening to advice from the right people, mainly their parents, and avoid having bad peer groups.

> *If you go and produce, I will tell her, you first continue with your education. Because if they produce, their husband will not keep the child.* (Participant 18)

> *Tell them to continue their education. Because staying with a husband is not easy. They should attend to their parents and whatever advice they give them.* (Participant 9)

3.2. Family and network

In teenage pregnancies, the girls' families play an important role. Especially the mother and the husband are often seen as important figures in the lives of the girls. The mother is most often named as the person who is present at birth, helps to take care of the baby along the way, offers advice and comforts her daughter. The husband helps to take care of the baby, provides the family with money and resources and is, although less common than the mother, present at birth. When

these people are not around for support, the girls often experience and indicate the situation as problematic, especially if this concerns the husband. However, this is often the case. Fifteen participants described either being separated from their husband, lacking his support or both.

> *My life is not easy at all. Because there is no one helping me taking care of my child apart from my mother.* (Participant 10)

Not only the mother but also the father plays an important role in how the girls experience their motherhood. The father is often seen as the person who determines whether or not the daughter can stay in her parental home or needs to be taken to her husbands' place and whether or not she can continue school after giving birth. Six participants referred to a lack of support from or the absence of either both parents or the father. Nine participants indicated that their father is a support person, mainly by letting them stay in the parental house and supporting them financially. This does not necessarily mean that the father is also comforting and emotionally supportive, quite the contrary. Especially concerning announcing the pregnancy, seven adolescent girls express fear of consequences and report subsequent disputes ('quarrelling'). Three of them also report abuse.

> *My mom was happy but my father was not happy [with the pregnancy]. He was abusing me, insulting me, he used bad language on me. Now [that the baby is born] he loves the baby.* (Participant 2)

When revealing the pregnancy, the young women are often also afraid for reactions from other people in their environment and the consequences thereof. As some girls experienced, telling family could imply having to move from the parental home to the husband's place, without input of the girl herself. Telling the father of the child may lead to him evading his responsibilities. In some cases, however, family members see that the girls are pregnant before they do themselves.

> *My auntie came and she was staying with us in the same house. She told me 'you are pregnant' and for me, I was not even aware that I am pregnant.* (Participant 13)

Several girls mentioned very specific people who had played an important role for them, confidents besides their parents or husband, from whom they received advice and support. In most cases this was a female person, e.g. an elder sister, a niece, an aunt, a grandmother, a sister-in-law or a girlfriend. In general, fewer male figures, brothers or uncles for example, featured as supporting figures. However, when asked who they turn to for help, a few girls did mention their brothers, but always among a list of other people.

> *I told my elder sister and one of my closest friends. I told them that I am pregnant but that I want to do the abortion. They said, do not do it. (…) The second time, I told my sister and mother. They told me that after delivery, I should not now conceive again*. (Participant 18)

Conversely, very specific individuals were also identified several times as having a significant negative influence. The one responsible is often mentioned in this context, mostly for not being there and leaving the pregnant adolescents behind. There are, however, specific accounts of devastating incidents on the part of the husband. One girl mentioned her husband putting pressure for pregnancy, to be able to 'disorganize' her from school. Another girl mentioned cases of alcohol use and subsequent abusive behaviour. One participant mentioned that she and the one responsible are related and also mentioned she would not want to see him again. This could imply serious circumstances of sexual abuse. Further, three participants mentioned negative influence and advice by bad peer groups. Finally, one participant gave a detailed account of her stepmother's abusive and bullying behaviour.

> *Mother was not there. And I was staying with a stepmom. And she was not taking me well. That's why I decided to get married. (…) Yeah even me when I go back home I will not feel. I will feel sad because of what they did on me sometimes. My stepmother was not a good person on me. That's why I decided to move away when I was 15 years old. (…) When my stepmother made me like going somewhere to see some of the friends of hers and when she come back home and she found that I did not do something good. She always threatening me that she was going to kill me. There sometimes that I run to the bus and stayed there. (…) People gave me advice that I should not get pregnant but because of what my stepmother did on me, that's why I decided to get married.* (Participant 17).

3.3. Education and economic objectives

None of the participants were attending school at the time of the interview. For this, they offered three explanations themselves: fifteen participants mentioned their pregnancy as the reason to quit school, four others the fact that they were not able to pay school fees, and two participants experienced unusual familial circumstances, namely an abusive father keeping her from going to school and both parents dying.

> *[I stopped going to school] when I was pregnant. At three months. I would wake up in the morning and I would go to the garden.* (Participant 2)

I stopped going to school earlier, before pregnancy. Money was not there to pay my school fees. (Participant 11)

Most of the participants stopped going to school while still in primary education. Six girls stopped in P6, four of them quit in P7, which is the last year of primary school in Uganda, and then one participant indicated having stopped in P4 and another in S2 (secondary school). The other nine participants did not state quite clearly in which year they stopped going to school. Having to quit school caused lots of worries for the participants. The participants sometimes felt like they owed their parents for giving them the opportunity to study and they often felt like their families would have preferred them continuing their education before getting pregnant.

They kept saying that... everyone at our place was like... I was going to really study, but now I have become pregnant, so they won't see how I study. (…) I began thinking so much, and I said now I am pregnant and yet I have been in school. They paid a lot of money on me. What will I do, to pay back this money? (Participant 8)

Eighteen participants stated they want to continue education. They emphasise the importance of schooling in their advice to fellow peer girls. They realize that finishing education would have had a positive impact on their lives. However, even if they want to continue their school career, they experience a lack of resources. One participant mentioned restarting after pregnancy, but she had to stop again because she could no longer pay the school fees. Seven other girls explicitly mentioned the excessive school fees or a lack of money as barriers to go back to school.

People are saying that with my age, there is nothing, but to go back to school. But for me, myself I feel like I don't have money. I tell other girls like if they want to go back to school while someone is there paying their school fees, they should go back to school. Even if I go back, money is not there, but if money was there, I would go. (Participant 21)

There is a big focus on continuing education, but more specifically going to technical or “vocational” school. Eleven participants explicitly stated, when going back, they would like to go to these more technically oriented schools, where they would be able to acquire a certain new skill, such as tailoring, sewing, hairdressing. This could create some sort of income increase in their home, as this gives them the opportunity to offer their services to people living in their villages.

I don't have a job and I don't go to school. My parents are there but I want to go back to vocational school. My uncle told me that I should first deliver, if I deliver then they will take me back to school, like in vocational school. (…) I want to go back to technical school. It is

going to be possible. My father told me that I am going to start. I am excited. (Participant 16)

A higher cash inflow would be more than welcome for many of these participants. They do not only often lack the resources to restart education, but they also experience a lack of money and resources in general. Sixteen participants indicated they needed additional money to provide for their family, to buy clothes, to supply pregnancy materials, such as soap, basins and maternity clothes, to pay for health care, and to take care of the child.

I want to have money. I want to buy things for my child. Clothes for the child, I want to have some things to keep for my child, like cattle and stuff. (Participant 12)

What is not easy for me like when the child is sick, money is not there and other things like soap, it's not easy to get. Before producing nothing was almost difficult, because I was staying with my mother. Now that I am produced, life is not easy. Even if I ask for man to buy soap, they cannot give, even if I am sick, they do not buy any drug. Life was easy, because when I get money I do anything that I want, buy clothes, but nowadays I don't even have clothes at my place, my husband's. (Participant 20)

Seventeen participants came up with possible 'business' ideas to raise their income, twelve of them named multiple options. These ideas ranged widely from a girl brewing local drinks to multiple girls wanting to become a hairdresser or tailor.

I am thinking of something to do so that it would keep me. Like a job. Sewing or hairdressing. For me what I was thinking, when I was pregnant, I was thinking about getting things to do so that I get money out of it. (Participant 13)

Fifteen participants mentioned farming as their income source, and for the most part the only income of these families. By harvesting or digging other people's gardens, they do get some, but very little, money to survive. Nine participants mentioned farming, selling in the market or keeping livestock as also being a possible income source in the future, although they often refer to an improvement of the current situation, and for which they would need a starting budget, for example, to purchase livestock.

Farming, keeping chicken. I am not feeling about keeping the chicken but I found myself now keeping the chicken. If I produce I am feeling like having some business. I want to be a seller in the market. (Participant 4)

3.4. Physical health

The adolescent girls emphasise the importance of physical health throughout the whole process of becoming a mother, and it is often pointed at as something they worry about. They are anxious about giving birth and, although many of these girls did not intend to become pregnant, once the child is there, his or her health is considered a key element.

> *My life is hard. My child is always sickly and it makes my life very hard. When my child is sick, I feel very sad. I need money, so that when my baby is sick, I can take my baby to the health facility.* (Participant 2)

> *Sometimes I don't feel happy, I feel bad, I feel sad. Because sometimes my child fell sick and no one used to help.* (Participant 7)

However, to avoid becoming pregnant (again), most girls are open to using contraceptives. Some of them are already using it. Still, it proves difficult for many of them to start the use of contraceptives. Their spouses don't want to deal with family planning and make promises to take their responsibility if pregnancy were to occur, and at times do put pressure to produce. Further, there is a lot of misinformation going around, which makes these girls fear for their health and reproductive possibilities in the future.

> *I used pills but I stopped and then got pregnant. I stopped on purpose because people were talking about not being able to produce if you take it at a young age.* (Participant 5)

Many of these young women don't easily realize they are pregnant. Only after a few months it becomes clear when their body starts to change. Sometimes other people, family or doctors, actually alert them to the fact that they are pregnant. During the pregnancy then, many of these young women struggle with the idea of becoming a mother at this age. They often start thinking about the possibilities of having an abortion. Whether this was triggered by the advice of others or not, differs among them. However, many family members and friends also advise against abortion at all costs, because of the dangers it brings to mother and child and how disrespectful it would be to God. None of the participants reported having actually attempted an abortion.

> *I thought I was doing abortion. My mother stopped me. Yeah, I thought if I did [have a baby], it was going to be a blunder. It was not going to be good. Those days I thought that doing abortion is not a bad thing, but nowadays I really know that abortion is a bad thing to God and even to people. (…) My mother quarrelled on me because I thought of doing abortion*

but she told me that doing abortion is not good. My grandmother said the same thing as my mother, that doing abortion is not good. (…) Yeah, I also got some bad advice from people. People gave me advice to do abortion. Village people. I did not do anything but only that I got time to bring my pregnancy to the father to do it. (Participant 20)

During pregnancy, few women indicated any major physical changes or difficulties other than growing bigger, being nauseated and vomiting, and occasional symptoms such as fatigue, decreased appetite and pain. Only one mother mentions antenatal care during the pregnancy. The next concern in their path was often childbirth itself. Delivery mostly took place in the hospital, in the presence of a physician. One girl mentioned delivering on her way home from the garden, but a doctor was present there as well. Family is in many cases present at the time of the delivery. Twelve girls mentioned the presence of their mother at birth, the mother-in-law was also named four times, as well as the husband.

Yeah, everything went well [when giving birth]. I was healthy and the child also. I was happy. My mom and grandmother, and the father also was around. And some young assistants were around. The doctor was there, in the hospital. (Participant 14)

The delivery is seen as a scary, rapidly approaching event. And rightly so, several young mothers face health issues for themselves or the child immediately after birth. Two participants even lost their child at birth. If mother and child survive, they often keep facing difficulties regarding their health. They need follow-up care but often don't have the resources to return to the hospital multiple times and receive care. During the whole process of receiving care during and after pregnancy, the problem of a lack of money persists.

Don't have a child. I produced but the child died. Because I came to my home when I was 17 years. When I produced, the child died. But I am pregnant again. When I produced I was put on the drip. Then afterwards the doctor discharged me to go back home. From home again, it wasn't well. Again they took me back to the hospital. The doctor had to put again another drip, blood. (…) I should look for a way to get money so that I use the money for going with it to the hospital. That money can help me when I go to the hospital. And maybe I need to be operated, that money can help. (Participant 3)

Besides, they do have questions for health workers and personal during pregnancy, as well as after, but they often do not feel like they are able to ask these questions. This contributes to misinformation and myths about, among other things, chances of getting pregnant, abortion, contraception, how to take care of the baby, and so on. As another result, these women are not

being informed about the health of their child during pregnancy, possible options, the dangers and the consequences of certain choices, etc. Of course, there are also adolescent girls who do ask their questions and get sufficient clarity and information.

> *For me, I went to the doctor. I did not ask any questions. Because I was fearing to ask the doctor. I was having trust but I had fear. I was having questions but only that I had fear. (…) My question was to the doctor... I wanted to ask the doctor 'how can I keep the pregnancy, the child in my womb?*' (Participant 7)

> *No, I never used [contraceptives]. I thought I cannot even conceive.* (Participant 10)

3.5. Mental health and counselling

These teenage girls report experiencing strong emotions such as fear, doubt, unhappiness, sadness. These emotions relate back to various topics, such as the pregnancy itself, health issues, education, uncertainty regarding or lack of presence of the husband, the upbringing of the child and looking after their family. Many of these issues were already brought up before, as these themes give the girls reasons for worrying and are pointed out as important.

> *I feel sad because of pregnancy. (…) I was having a lot of thoughts about it, because I was still young. Nothing of like becoming a mother. Because no one was there to take care of me. That's why I got married. (…) Before producing, I was happy. Now, I am not happy. Because if I compare me and my friends, I see there is a lot of gap. That's why I am not feeling happy now.* (Participant 21)

These worries are reinforced through the stigma or the fear of stigma that comes with pregnancy at a young age. Thirteen girls mentioned experiencing stigma or shame or people talking about them. Many of these girls are afraid of the responses of their environment. The adolescent girls sometimes experience harsh reactions from their close network but are further stigmatized or shamed by people in the neighbourhood, which makes them even more insecure about the pregnancy. They do try not to react to it, or even try to avoid certain encounters and to ignore the gossiping and stigmatisation.

> *I felt shame. I didn't hear any stigma. But I didn't do anything. I would sit with them [who I did not want to know about the pregnancy], I would stay with people, everyone, only that my interaction with them was now different. There were some people that I didn't want them to learn, to know that I was pregnant. My teachers.* (Participant 1)

Some people talk bad about me. But I don't care about it. [I did not want to tell] some of my friends because of the gossip. They did [gossip]. (…) I experienced stigma but I was ignoring that. (Participant 5)

Sometimes, they feel ashamed and fear stigmatisation for no reason, since it turns out afterwards that it does not appear to them as if people are talking behind their back and they don't experience stigma after all. This does however influence their actions while being pregnant, for example in daring to disclose the pregnancy.

Yeah sometimes I get really sad because of the conditions I am going through. I did not want to tell it to anyone because I was fearing. Because I was still young. [But when people found out] people did not even talk bad on me. (Participant 11)

The girls occasionally experience a lack of choice, they have little to no say in important decisions which influences their confidence and security level during and after pregnancy. For example, whether she and the baby stay with her parents or her partner, or whether they get married, is mostly decided without hearing the girl.

I had to stay with my husband. In my thing I wanted to go back to my parents, I go and plead so that they take me back to school. But these people don't want me to go back home so that I plead to my parents. (Participant 3)

Together with a lack of choice, they also often experience a lack of support, as mentioned before. This is part of why these girls see teenage pregnancy as something negative, perceive their lives as difficult and encounter these strong emotions. It also makes them to feel very lonely at times. Feelings of loneliness seem to stem from a lack of support, having to take care of the child of their own and experiences of stigma, which leads them to avoid some people and sometimes even stay at home.

There is not any changes. But a lot of thoughts coming to my mind. (…) I feel bad, I feel sad. I feel sad because sometimes I feel like I am lonely but those days I was with my classmates, now I am at home. (Participant 6)

When asked if talking to girls going through similar experiences would add value to their lives, nineteen girls mention they are already doing this in some kind of way and/or that it could be very helpful. Talking with one another, sharing, learning from and giving advice to each other are seen as supportive. Only one participant mentions explicitly that it would not be helpful at all, because she likes to deal with it on her own, by sitting still and being quiet.

> *I talked with somebody, a friend, and when I talked to this person, the person advised me and after that I felt better. (…) When I talk with somebody I feel encouraged. Because the person gives me advice, I also give advice to the person. So, [other girls] would give me advice. Some of them would tell me not to abort, and then when I told the teacher, a female teacher, she told me to continue studying, and she told me not to abort because if I abort, I might die. So I continued. So when the pregnancy became big, I had to drop out of school.* (Participant 1)

Twelve participants also indicate that meetings and conversations with professional counsellors could prove helpful, as they received more training and provide proper support. Two girls are more sceptical as they have not yet been given any support, so they could not say if it would be helpful.

> *[Talking to a professional] might help. What I want, if possible, is maybe some advice on how I can look after my child. I think if I am advised, then it would help me to look after my child. From the person who can advise me best, with a health worker. Cause my mother is old, she cannot guide me well. (…) Since I gave birth, before finishing what I am supposed to do, are you people ready to support me to go back to school.* (Participant 8)

> *I have not yet tried. They are not near me, I thought, I am now thinking they do not even help me.* (Participant 21)

Last, five participants also mention their belief in God as a way of getting some certainty, a way of knowing what to do. It is mainly used to receive some reassure from themselves or others when deciding what to do with the pregnancy.

> *I went to the doctor. I had questions. I told the doctor that 'now I am pregnant while I am still young, is it going to be possible?' Doctor said 'do not fear, god is there'.* (Participant 17)

3.6. A summary

This section outlined the five main themes and related sub themes, that emerged from the analysis of the interview data.

Theme one threw a glance at the experiences of young mothers regarding their pregnancy, which was, in general, perceived as negative and results in an advice for others not to produce early. Most girls don't want to go through pregnancy themselves either. **Theme two** delineates important support figures in the lives of the adolescent mothers, such as the mother and the husband, who have a key role in supporting them. However, this turns around when these people are absent, not supportive, or abusive. In **theme three** education and the economic objectives are discussed and linked to one another. Although none of the participants are attending school, they stress the importance thereof and their desire to continue education. They focus primarily on technical school, where they could be able to learn a new skill and in doing so, create an opportunity to improve their economic situation.

Theme four reports the participants' experiences regarding their physical health, and its' enduring importance throughout pregnancy and motherhood. It touches on topics such as contraception, abortion, the role of doctors and hospitals and the dangers of a lack of resources and information. The **final theme** narrates on the strong emotions that these girls experience and the role that stigma, a lack of choice and a lack of support play in this. Mental strengthening could then be found in talking to other girls and advising each other, meeting with professional counsellors and relying on religion for reassurance.

4. Discussion

This study aimed to explore the experiences of adolescent mothers while taking a closer look at their needs and support systems. In this section, the findings will be reviewed in light of the existing literature. Hereafter, some recommendations for policy, practice, and future research will be made, and the study's limitations will be addressed.

4.1. Interpretation of the results

Firstly, throughout the analysis, it became clear that young women's experiences of pregnancy versus motherhood each take on their own significance. Pregnancy is, in general, perceived as problematic by the soon-to-be mothers themselves, largely due to their young age and being unprepared for motherhood. Further, there are other factors that influence the negative experience of pregnancy, such as pressure to conceive, doubts about abortion, negative reactions from their close environment, and the concern that they do not have sufficient resources and support to care for the child when it is born. The experience of motherhood, however, is more nuanced. Although the overall idea is still that life as a young mother is hard and having a child brings additional challenges, the presence of the child is experienced as positive and an added value to their lives. Adolescents also hold on to hopeful goals in their lives such as going back to school or starting their own business. Cook and Cameron (2015) reported that it is dangerous to fully judge teenage pregnancy and motherhood as abominable. They do point to the fact that teenage mothers may experience parenthood as enjoyable and rewarding but otherwise, there is little coverage of this in literature.

Secondly, the needs and support systems of adolescent mothers relate to each other. Where a certain aspect may be a supportive factor in one case, the lack thereof creates a need in another one. Three broad themes emerged from the analysis, in which needs and support systems are interwoven. The first theme deals with the support networks of teenage mothers, their strengths and weaknesses and the disadvantages of a lack of support. The second theme regards teenage mothers' outlook on education and occupation, including their hopes for the future. The third theme concerns teenage mothers' physical and mental health needs and the value they attribute to them.

4.1.1. Support network

UNICEF (2021) warns against the rejection and violence of adolescent mothers within families and communities. Adolescent mothers often have to rely on their personal networks to be able to take care of their children. They fall back on several important people, namely their parents and spouse

and then very personal support figures, who are mostly female. The latter has received little attention in research, however, these people were of great significance to the girls as they gave advice and support.

Miller et al. (2001) point towards the importance of connectedness and counselling between parent and child, as it influences the chances of adolescent pregnancy. In the analysis, however, opposite testimonies emerged about whether the teenage mothers experienced support from the immediate environment. This is consistent with the existing literature regarding the older generation's support. Teenage mothers often miss out on support from their parents (Boateng et al., 2023; Hanna, 2001; Sekiwunga and Whyte, 2009). This creates a lack of resources, advice, and people to fall back on and to help take care of the child. To substantiate the testimonies of support from parents, there are also several studies that found that the now grandparents were sources of support to adolescent parents and helped them through the transition into parenthood (Borcherding et al., 2005; Bunting and McAuley, 2004; Neale and Clayton, 2015; Sriyasak et al., 2017). In our study, this support came mainly from the mother by being present at significant times, such as the delivery, giving advice, and helping to take care of the baby. Neale and Clayton (2015) are in line with these data and elaborate further that the mother is often involved in the decision-making of keeping the child and helps reduce the stress of the new-found mothers. Further, the literature corresponds with the research results, in that the children's father often leaves the adolescent mother and his child and seems to escape his obligations. The young women experience this as negative, or as Leerlooijer et al. (2013) suggest, they have to cope with the idea that this person will not take up his responsibility. Research indicates the lack of information on the intentionality or insights of the father, but this study did not probe the father's motives and ideas any further. Cook and Cameron (2015) suggest that it is problematic when these support figures are not around as teenage mothers risk experiencing social isolation. This study came to similar results. The adolescent girls feel very lonely at times, and this seems to stem from a lack of support, having to take care of a child on their own and experiencing stigma.

The WHO (2020) reports stigma as one of the consequences of teenage pregnancy out of wedlock. This idea is supported by other literature (Hanna, 2001; Raj, 2010). An important sidenote regards the idea of differences in stigma for married versus unmarried teenage mothers. In literature, there is much attention towards the differences in perception by the community of adolescent mothers depending on whether they are married or not (Hanna, 2001; Raj, 2010; WHO, 2020). In this study, it became clear that no such division is possible. During the interviews, it was sometimes hard to keep track of whether they had been married, or just together. And even then, sometimes the girls

were separated but the man continued to support them. This indicates greater complexity than simply being married or not. Boateng et al. (2013) then also state that adolescent mothers are often stigmatized for their partners abandoning them. Literature also indicates that teenagers, boys as well as girls, experience pregnancy as very shameful and morally condemning. Teenage mothers notice the negative attitudes towards their pregnancy and receive moral criticism from their parents, community members and leaders. They often have to go through hurtful experiences of hostility and judgement regarding their identity as a teenage mother (Ellis-Sloan, 2014; Hanna, 2001; Sekiwunga and Whyte, 2009). In this study, the adolescent mothers reported experiencing stigma and harsh reactions from their close environment, as well as their community. This resulted in them shying away from possible negative encounters. Some of them, however, reported being afraid of stigmatisation but afterwards did not experience it. The literature pays little attention to this phenomenon.

The presence of support persons is not a guarantee of escaping stigma or other negative elements. Further, there are risks inherently associated with their presence. This study shows that adolescent girls occasionally experience a lack of choice, where they have little to no say in important decisions which influences their confidence and security level during and after pregnancy. These decisions concern among others getting married or not, staying in the parental home or moving to the partner's home and quitting school. The UNFPA (2022) describes teenage pregnancy as often driven by a lack of meaningful choice, limited agency, and sometimes even force. Discrimination, structural gender inequality, and harmful social and gender norms are the underlying determinants, which can lead to negativity within practices, beliefs, and attitudes surrounding gender roles and sexuality, especially those of young girls. Hanna (2001) points out that adolescent mothers are often controlled as a group of women who have defied the norms of society. Therefore, their voices are often silenced, they are rarely taken seriously, their opinions do not matter, and their complaints are considered irrelevant because their problems were brought upon by themselves. Leerlooijer et al. (2013) suggest that teenage mothers remained dependent on the decisions of their father or their husband. In this study, there were accounts of pressure, force, and ignorance of the women's appeals regarding contraceptives, becoming pregnant, their living situation and education.

In addition, there is also a risk of violence and abuse. Literature warns against partner instability and violence, family conflicts and domestic abuse. Sexual and physical abuse during childhood is known to be associated with earlier sexual experiences and teenage pregnancy (Fiscella et al., 1998; Madigan et al., 2014). Motherhood at an early age may then also negatively affect the girls' individual self-perception, which may cause them to connect to more abusive partners. This creates

a vicious cycle, where the younger the mother is, the higher her risk (Azevedo et al., 2012; Cook & Cameron, 2015; Urdinola & Ospino, 2015; WHO, 2020). In this study, there were also several testimonies of abuse, both before and after delivery and several others feared disputes and abuse. However, the accounts seemed to be less common than the literature suggests.

4.1.2. Education and economic objectives

The discontinuation of education is an explanatory variable for teenage pregnancy, as well as a consequence thereof. According to the literature, educational level and quality of and access to education are factors that influence adolescent pregnancy. Adolescents who have completed secondary education tend to have way lower pregnancy rates than those who have not (Nour, 2006; Ochen et al., 2019; UBOS & Macro International Inc., 2012; UNFPA, 2022). A higher number of years of education reduces the risk of teenage pregnancy significantly. Increased knowledge and agency, as well as opportunities to avoid early sexual behaviours, help prevent unintended pregnancies (Menon et al., 2018; Wado et al., 2019; Wasswa et al., 2021). Simultaneously, nearly half of all Ugandan adolescents put an end to their education due to teenage pregnancy, and about 64% of teenage mothers will not complete their primary education level (UBOS & ICFI, 2018; Manzi et al., 2018; UNFPA & UNICEF, n.d.). In this study, all the teenage mothers quit education, most of them while they were in primary education, some before pregnancy, because of school fees or familial circumstances, and others because of the pregnancy itself. This corresponds with the available, mostly quantitative, literature. They experienced this discontinuation as problematic and it brought up a lot of worries and feelings of guilt towards their family, as they paid lots of money and preferred for their child to continue education. There is little further research on how adolescent girls experience this.

Teenage pregnancy installs a barrier to continuing education after pregnancy; these young girls drop out of school and do not have any motivation to return later (Rutaremwa, 2013; UNFPA East and Southern Africa, 2022). This study shows that teenage mothers most certainly don't lack motivation, on the contrary. They want to continue their education and emphasize the importance of schooling for fellow peer girls. They realize what positive impact finishing education could have on their lives but even if they want to continue their school career, they experience a lack of resources which makes it impossible to go back to school with its high enrolment fees. The young women, however, keep their hopes up and talk about going back to technical or vocational school to learn a new skill and from there, start their own business. There is little attention in existing literature for the aspirations, dreams and hopes of these girls and their outlooks on the future, which is unfortunate as it does seem to be something that the young women hold on to. Yet there is

attention for the actual difficulties that their future could hold. After their pregnancy, most girls do not get a second chance at education (UNFPA East and Southern Africa, 2022), among others because child marriage and teenage pregnancy impede girls' opportunities for further education, with their household responsibilities taking over (Shawky & Milaat, 2000). Current policy is not helpful in making them re-enter either, on the contrary, it makes them terminate their education (Rutaremwa, 2013; UNFPA East and Southern Africa, 2022).

Research also found that teenage mothers are three times less likely to have professional jobs and are twice more likely to be self-employed in agriculture. Teenage pregnancy negatively impacts the socioeconomic status of the young mother, because of less educational chances, which also influences employment opportunities. Hence, teenage mothers will have a lower income level which eventually affects their standard of living and risk of poverty. (Shawky & Milaat, 2000; UNFPA and UNICEF, n.d.; UNICEF, 2021; Walker, 2012). The child, born out of teenage pregnancy, has thus a higher risk of growing up in lower socioeconomic circumstances. Adolescents in lower wealth quintiles have an increased risk of getting pregnant, putting the child at a higher risk of teenage pregnancy, thus creating a vicious cycle (Rutaremwa, 2013; Wasswa et al., 2021). This study confirms the ideas above, in that adolescent mothers experience resource and income shortages, which negatively affects their well-being and that of their families. A higher cash inflow would be more than welcome for them but, as research suggests, they often fall back on a low income from agriculture. Yet again, research has paid little attention to the aspirations of these young mothers. Many of them have ideas on ways to make money, congruent with their desire to pursue technical education, and what they could do to change their future. Accordingly, they often refer to a future improvement in their current situation, although they also indicate that this might require a certain starting amount. With this, they refer to their need for more resources and income.

4.1.3. Physical, mental and sexual health

Early pregnancy can disrupt girls' otherwise healthy development and is dangerous for the mother, as well as the (unborn) child (UNFPA & UNICEF, n.d.; UNICEF, 2021). In Africa, however, teenage pregnancy is primarily determined to be a moral problem, whereas in Europe it is perceived more as a health risk (Sekiwunga & Whyte, 2009). In this study, teenage mothers did attach great importance to their health and that of their children, based on their experiences. They signify physical health as something they worry about throughout the whole process of becoming a mother and stress how important it is for them to make sure their child stays healthy and gets the best chances in life. The women indicate feelings of anxiety, sadness and doubt regarding pregnancy, childbirth and motherhood. There is, however, little room for those concerns in existing research.

More generally, there is less focus on the mental or sexual well-being than on the physical well-being of teenage mothers, although, according to this study, they seem to be embedded and connected to each other. Aujoulat et al. (2010 and Azevedo et al. (2012) do suggest that teenage pregnancy may have far-reaching mental and psychological health consequences. The young women in this study express many mental concerns, starting during pregnancy with the struggle of getting used to the idea of becoming a mother. The girls were not intending to get pregnant at this time and did not easily realize they were pregnant. When this became clear, many of them worried about the consequences and the options they had left. Some girls thought about having an abortion, with other people offering both positive and negative advice to choose this. Abortion entails, however, a risk, as adolescents often undergo it in unsafe circumstances, with maternal mortality and lasting health issues as a result (Darroch et al., 2016). The mother is then often involved in the decision to keep the child (Neale and Clayton, 2015), which we also saw in this study. Some girls also rely on their belief in God, as a directory to make decisions regarding pregnancy and childbirth. In existing research, religion is mainly mentioned as creating norms and beliefs that instigate a more negative view of teenage pregnancy out of wedlock, but less attention towards the mental support it could provide.

In this study, the adolescents dreaded giving birth. Delivery is seen as this scary, rapidly approaching event, which could be dangerous for mother and child. Statistics reinforce their concerns, as complications during childbirth are the second highest cause of death for girls between the ages of 15 and 19 (Akanbi et al., 2016) and neonates born out of teenage pregnancy have lower survival rates (Loaiza, & Liang, 2013). In the limited sample of our study, several young mothers faced health issues for themselves or their child immediately after birth and two mothers had already lost a child, and expressed their grief and sadness over that loss. There is again little focus in the literature on how teenage mothers cope with that uncertainty and possible mourning afterwards.

UNICEF (2021) states that the girls' bodies are not physically ready for childbearing with ongoing consequences even long after birth. Yet, teenage parents tend to access fewer antenatal and maternity services (Cook & Cameron, 2015). The UNFPA (2022) also points to the absence or distinction of sexual and reproductive health services, which contributes to young women's lack of awareness about sexual and reproductive health and the use of modern contraceptive methods, which is in turn associated with teenage pregnancy (Ochen et al., 2019). In the current study, although they go to the hospital or doctor during their pregnancy, they often do not feel comfortable asking their questions so they continue to have a lack of information or misinformation on

reproductive and sexual health, pregnancy, contraceptive use, abortion, and so on. The use of antenatal care, as well as contraceptive use, did seem to be infrequent. Then also, research suggests that a larger part of sexually active adolescents do not use contraceptives (UBOS & ICFI, 2018), and girls who marry young often do not have access to contraceptive methods, which makes it much more difficult for them to delay childbearing (Centre for Human Rights, 2018). Misconceptions and lack of knowledge surrounding contraceptives increase adolescents' chances of getting pregnant (Akanbi et al., 2016). Statistics from the UNFPA East and Southern Africa (2022) already pointed out the fact that around 2 million people in Uganda want to stop or delay pregnancy, but are not using contraception to prevent this from happening. Before their pregnancy, the adolescents in this study did mostly not use contraception, often because of misinformation. After going through pregnancy once, adolescent mothers in this study, are not now eager to become pregnant again. Quite the contrary, the adolescents have other ideas on how their lives should take a turn and more of them are open to using contraceptives, but many are still not doing it.

4.2. Implications for policy and practice

Although these themes were now discussed separately, it seems important for practice and policy to keep in mind that they are interconnect. As Cook and Cameron (2015) point out, there is a need for a more nuanced view while simultaneously taking into account the wider social picture and the more complex scheme of circumstances. The themes discussed above influence each other and build on one another. For instance, the presence of strong support networks, including personal support figures and access to resources, can greatly influence an adolescent mother's ability to pursue education and economic opportunities. Conversely, limited support networks and societal stigma can impede their educational aspirations and hinder their economic prospects. By recognizing the interconnectedness of these themes, policymakers and practitioners can adopt a holistic approach to support adolescent mothers. Policies and interventions should aim to address these interrelated aspects collectively, rather than in isolation, to ensure comprehensive support that encompasses social, educational, economic, and health-related dimensions.

Cook and Cameron (2015) also suggest that it is dangerous to start viewing all teenage pregnancies as equal or abominable and describing adolescent mothers as one specific at-risk group may cause stereotyping and increase the stigma they experience. The testimonials above indicate that the experience of teenage pregnancy cannot be thrown into one simple formula, each teenager has their own experiences and concerns. Of course, there are recurring elements for

many of them, such as a lack of resources and the importance of schooling. In determining new policy or practices, it is important to keep this in mind.

Policies could adopt several measures, such as…

… a commitment to reintegrating teenage mothers into education, with the necessary additional support to make this possible, with a particular focus on technical education.
… encouragement and empowerment of adolescent girls in setting up their own businesses and providing the necessary support, while recognizing their aspirations and potential.
… creating space for and allowing young people's sexual development and the importance of contraception in education.
… increasing accessibility of health services, care and information, regarding not just physical, but also mental and sexual health. Therefore, train doctors and other health workers in their social and communication skills and install affordable and youth-friendly health services.
… rethinking current policies that problematise and stigmatise young people's sexuality.

Practices also could keep in mind different measures to install targeted interventions and support strategies tailored to adolescent mothers' specific needs. It is important to take the context into account in supporting young women and mothers. While doing so, it could prove useful to include the personal network of teenage mothers, with its own strengths and weaknesses, and address stigma and social isolation. Be careful, however, for the way in which teenage mothers are described and portrayed as this helps determine intervention and could potentially overcome stigmatising ideas in communities.

As, talking with one another, sharing, learning from and giving advice to each other are seen as supportive by teenage mothers, it could thus prove interesting, specifically in mental health services, to set up discussion and support groups within the communities for teenage mothers. They also indicated that meetings and conversations with professional counsellors could prove helpful, as professionals received training and provide proper support.

4.3. Limitations

While the results of this study do reveal some relevant findings regarding the experiences, needs and support systems of teenage mothers, several limitations of the study must be taken into account. The first limitation concerns sample size and homogeneity. Theoretical saturation was reached after interviewing twenty-one participants, although a larger sample size could have permitted the detection of significant differences or even common experiences and needs of

teenage mothers, reinforcing the results. Since the sample is relatively limited (N = 21) and there is variety in terms of age, number of children, age at which they became parents, living situation and marital status, the study results cannot be generalised to the entire population. However, the use of qualitative research, more specifically semi-structured interviews, is of importance as it provides opportunities to delve deeper into in-depth, complex, difficult topics, and capture the lived experiences of people (Onwuegbuzie & Johnson, 2006; Wilhelmy & Köhler, 2021). The research starts with the voluntary participation of respondents, which suggests that these participants were motivated to begin with. There is, however, a possibility that participants gave socially desirable answers or that they still expected positive impacts or support. This is somewhat countered by a guarantee of anonymity and privacy protection. It would probably have been an added value to offer psychological support separate from the interview but this was not possible due to the limited time, resources and scope of the study. For practical reasons, the participants were interviewed close to where they lived, which resulted in some of them knowing one another. This could directly or indirectly influence their opinions and recount of experiences, especially in the two interviews where two participants were interviewed at the same time.

In addition, it is important to note that the research results were collected and analysed by only one researcher which increases the potential of misinterpretations and biases (Berger, 2013; Dunwoodie et al., 2022). The duration of residence in Uganda, and consequently the duration of the study, was relatively limited. There were no opportunities to engage in multiple interviews with the same respondent. Therefore, the limited bond of trust between the respondents and the researcher could possibly entail that the respondents did not dare to speak completely openly. Since only one interview was conducted each time, it was not possible to ask additional questions or test certain interpretations again after analysing the research results. As a result, certain interpretations may lack nuance or may even be wrong. The language barrier and the limited understanding of the research context also caused a limitation. There is thus a risk of cultural bias in the interpretation of the results (Potter and Hepburn, 2012; Vanner, 2015). Therefore, the interview protocol was reviewed multiple times, by the supervisor of the research and two CCVS colleagues, which made alternations possible. Furthermore, the interpreters were crucial as they could provide the researcher with additional information on culturally determined subjects in order to diminish cultural bias. Furthermore, it is very likely that information got lost during the interviews since this was a process of continuous interpretation between Acholi and English. The interpreter had to interpret their answers at once, which inevitably should have led to a loss of data. To counteract this, there were regular checks that the researcher and translator had understood each other correctly in both questions and answers.

4.4. Recommendations for further research

There are numerous potentially interesting avenues to expand on and complement this research. First, one can take away that it may be important in general, when studying human beings, to pay more attention to people's experiences and perceptions. Specifically for teenage mothers, there is a major focus on the negative consequences of teenage pregnancy but research focuses to a lesser extent on their perceptions and views. Therefore, it could prove useful to extend this study to a larger group of the population, to strengthen the trustworthiness and contribute to a more nuanced understanding of the complex dynamics that influence the lives of adolescent mothers. Similarly, it might be auspicious to re-examine what other conclusions would come up in other contexts than Northern Uganda. Researchers also could take a closer look at the intentions, perspectives and experiences of teenage fathers, since most of the existing data is drawn from a mother's perspective. Other possibilities are the perceptions of the parents of teenage mothers or that of the children born out of teenage pregnancy. This could bring valuable insights from a different angle.

Further research could start with other questions from local organisations such as CCVS,. Because of the broadly defined research questions of this study, it could be appropriate to explore one aspect of the findings in greater depth in follow-up research. More research could, for example, happen on the specific mental health issues that teenage mother experience and what could possibly improve their mental well-being. Research could also look specifically into the experiences of adolescents who went through teenage pregnancy but aborted or lost their baby, and how they cope and mourn afterwards. One last example of a possible study could be about the specific needs that adolescents encounter in returning to education after going through pregnancy, with more specificities regarding technical schooling and their support needs in this specific context.

Conclusion

Uganda is among the top 20 countries globally with the highest rate of adolescent pregnancy (Burton, 2017), with early childbearing thus being a reality for many teenage girls. Existing research focuses mainly on its prevalence, risk factors and consequences (Akanbi et al., 2016; Rutaremwa, 2013; Wado et al., 2019), but there is a lack of qualitative research, providing insights in the narratives and experiences of teenage mothers. In the context of northern Uganda, the current study aimed at analysing how teenage mothers experience their pregnancy and motherhood, as well as which needs and support systems arise. The qualitative data obtained in this study revealed distinct experiences of pregnancy and motherhood for these young women. Pregnancy was generally perceived as problematic due to factors such as young age, lack of preparedness, negative reactions from the environment, and insufficient resources and support. In contrast, motherhood was still experienced as difficult, but more nuanced. The presence of the child was seen as positive and adding value to their lives and the young mothers expressed aspirations for their future, such as returning to school or starting their own business.

The study identified three broad themes that connected to the needs and support systems of adolescent mothers. The first theme focused on support networks, highlighting the significance of family in providing advice and support. However, there were mixed testimonies regarding support from immediate family members, with some adolescent mothers lacking support from their parents or the father of their child. Stigma was also a notable issue, with teenage mothers experiencing negative attitudes, moral criticism, and stigma from their close environment and community, which led to feelings of loneliness and social isolation (Cook & Cameron, 2015; Ellis-Sloan, 2014; Hanna, 2001; Sekiwunga and Whyte, 2009; WHO, 2020). Additionally, there were instances of limited agency and control over important decisions, as well as risks of violence and abuse.

The second theme addressed education and economic objectives. The majority of teenage mothers did not complete primary education, due to financial constraints, familial circumstances, or the pregnancy itself. They expressed strong motivation and a desire to continue their education, recognizing its importance for their future, but faced barriers such as lack of resources and high enrolment fees. Nevertheless, these young women remain hopeful and discuss the possibility of attending technical school to acquire new skills and start their own businesses. Teenage mothers are, however, less likely to have professional jobs and more likely to be self-employed in agriculture, which contributes to lower income levels, reduced standards of living, and an increased risk of poverty (Shawky & Milaat, 2000; UNFPA & UNICEF, n.d.; UNICEF, 2021; Walker, 2012).

This study confirms that adolescent mothers experience resource and income shortages, which negatively affect their well-being and that of their families. While they express ideas and aspirations for improving their financial situations and changing their futures, they often lack the necessary resources and starting capital to do so.

The third theme focused on the physical, mental, and sexual health of adolescent mothers, which is closely linked to their overall well-being. Pregnancy at a young age poses unique challenges and risks, both for the adolescent mother and her child (Loaiza, & Liang, 2013; Marvin-Dowle et al., 2018; UNFPA & UNICEF, n.d.; UNICEF, 2021). Adolescent mothers expressed concerns about their physical health and that of their children. Addressing the physical health concerns is crucial, but it is equally important to acknowledge the mental and sexual health needs of these young mothers, as teenage pregnancy may have far-reaching mental and psychological consequences (Azevedo et al., 2012; Urdinola & Ospino, 2015).

Based on the findings, several recommendations can be made for policy and practice but most importantly, policies and interventions should aim to address these interrelated aspects collectively, rather than in isolation, to ensure comprehensive support that encompasses social, educational, economic, and health-related dimensions. It is essential to recognize the interconnected nature of the three identified themes as they are deeply intertwined in shaping the experiences of adolescent mothers.

It is important to acknowledge the limitations of this study, which primarily relied on qualitative data from a specific context. The findings may not be generalizable to all adolescent mothers or other cultural settings. Further research using larger and more diverse samples is needed to deepen our understanding of the experiences and support needs of adolescent mothers across different contexts.

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Appendices

Appendix 1 - Interview manual

FACULTY OF PSYCHOLOGY AND EDUCATIONAL SCIENCES

UNIVERSITEIT GENT

Interview Manual Adolescent Mothers – depth interview

Introduction (20min)

1. Present myself + Information & consent form
2. General questions Presentation of the participant

- What is your age?
- Where do you live? Who also lives with you?
- Are you married?
- Do you go to school or what is your job?
- What is your economic status?
- How many children do you have? How old are they?
- At what age did you first become a mother?
- Do you know what CCVS is and what they do?

3. Question: I would like to record this interview so I can remember better what you tell me. Is that okay? I will delete the recording afterward. If you don't want that, I will take notes.
4. Explanation of the interview

   We will start talking about your life now, as a mother, and then we will talk about your pregnancy. I will draw a life map during the interview.

The interview (1h)

Birth and Motherhood (30min)
You recently became a mother… how are you doing?

1. **Being a mother**
   - Do you like being a mother?
   - Do you feel capable of taking care of the child?
   - Do you want to get pregnant again?
     - How many children do you want?
   - Do you have any advice for other young mothers?
2. **Birth**
   - Did everything go well with the birth?
     - Were you and the child healthy?
     - Who was there when you gave birth? Parents? Husband? Doctor?
   - When your baby just arrived, were you happy then?
3. **Relationship with your child**
   - How is your child doing?
   - Do you like to keep the child close to you?
   - Are you happy with this baby? Why (not)?
4. **Reactions of the environment**
   - Who is around to support you and the baby?
     - Were your parents happy with the baby?
     - Were your siblings happy with the baby?
     - Was the father of your baby happy?
     - Were your aunties and uncles happy with the baby?
   - How did your neighbours / classmates / colleagues react?

- If you walk through the village with the baby, how do other people react?
  - Do you sometimes experience any stigma or feel ashamed?

5. **Changes**
   - Can you still go to school / work now you have a baby?
   - Do you live in a new place since you have the baby?
   - Has your body changed due to the birth?
6. **Needs**
   - Do you sometimes feel bad/sad now?
     - Would you feel better if you could talk about it?
   - Can you talk to other girls here who also were pregnant?
     - Would it help you to be able to talk to other girls about your experiences and feelings?
   - How is your body doing since the birth? Do you feel healthy?
   - Do you have any other needs?

The pregnancy (20 min)
Before you gave birth to your child, you were pregnant for 9 months. Do you remember that time?

7. **Pregnancy**
   - Were you happy when you first knew you were going to have a child?
   - Was it scary?
   - Did you feel ready to become a mother?
   - Did you want to get pregnant?
   - Did your parents want you to get pregnant?
   - Did other people want you to get pregnant?
8. **Changes**
   - Did you stop going to school during your pregnancy?
   - What did you like to do while you were pregnant?
   - You grew a big belly. Did your body change in other ways?
   - What else changed for you while being pregnant?
9. **Reactions of the environment**
   - Did you tell anyone you were pregnant?
     - Who did you tell (first)?
     - Was there a person that you did not want to tell?
     - Did you tell the father of the child?
   - Did your parents feel happy when they knew you were pregnant?
   - Did your friends feel happy when they found out you were pregnant?
   - Did you experience any stigma or shame during your pregnancy or while telling people?
10. **Needs**
    - Did you go to a doctor when you were pregnant?
      - Did you have questions about your health or body changes?
    - Did you feel lonely or supported during your pregnancy?
      - Who was there for you?
      - Who did you miss most in this period?
    - Would it have helped if you could talk to other girls who are or were pregnant?
    - During your pregnancy, did you have any other needs you want to talk about?
      - How did you deal with this?

Before the pregnancy (10 min)
Now, do you still remember the time before you were pregnant?

11. Situation
- What activities did you like to do?
  - Do you still do that sometimes?
  - If no, would you like to do this again?
- Did you go to school?
- Did you have a lot of friends?
  - Do you still see them?
- Did you have a boyfriend?
  - Is he the father of the child?
- Did you feel happy in this period?

12. View on children
- When you had sex, did you want to have a child?
- Did you take anticonception?

Conclusion (5 min)

- Do you want to add or share anything else for the interview?
- Do you have any other questions or feedback for me or CCVS?

Appendix 2 - Participant overview

Age participants	N
16	1
17	8
18	6
19	4
20	2

Number of children	N
0	4
1	14
2	3

Pregnant or child died

Age when first being a mother	N
13	2
14	2
15	1
16	7
17	3 + 1 (still pregnant)
18	3 + 1 (still pregnant)
19	1

Age of the children	N
Not yet born	3
0 till 1 years	6
1 till 2 years	5
2 years	4
3 years	3
4 years	1
5 years	1
Child died	2

N = 25

Job of the girl	N
Farming	6
Sewing	1
Nothing (mentioned)	14
Going to school	0

Job of the parents or husband	N
Farming	19
Boda-driver and farming	1
Nothing mentioned	1

Living place	N
Mucwini Subcounty	14
Komnuru	6
Padwong	2
Jepae	1
Owiny	5
Lagoro Subcounty	7
Alero	7

Living Situation (mentioned)	N
With family	15
Mother, father (and siblings)	5
Only mother (and siblings)	6
Only mother (and siblings) + grandmother	1
Only father (and siblings)	1
No parents, only siblings	2
With husband	6
Only Husband	3
Husband + extended family	3

Marital Status	N
Married	2
Engaged	2
Not married	17
... of which "Separated"	8

Appendix 3 - Informed consent

SECTION 1 - INFORMATION LETTER FOR PARTICIPANTS IN RESEARCH

Title of the study: The needs, experiences, and resilience factors of adolescent girls (16 - 19 years old) during and after adolescent pregnancy?

Through in-depth interview or focus group (all personal data will be made anonymous)

Language: English (with translation if necessary)

This is a study conducted by Ghent University in collaboration with the center for children in vulnerable situations (CCVS). The responsible researchers are:

Lies Blancke
Department of social work and social pedagogy (student)
Ghent University
Email: lies.blancke@ugent.be
Phone no.: 0781270410

Ilse Derluyn
Department of social work and social pedagogy (promotor)
Ghent University
Email: ilse.derluyn@ugent.be
Phone no.: /

UNIVERSITEIT GENT

CCVS

A. Information about the study

I am a student at Ghent University (in Belgium). For CCVS here in Kitgum, I will research the topic of teenage pregnancy and specifically the experiences of adolescent girls (16 – 19 years).

You are invited to participate in this study about teenage pregnancy. Together we will go through this information form, and then you can decide if you are okay to do the interview. You can always ask questions if you don't understand. If you are okay with it, you can also sign your name on this document.

What is the purpose of the research?

In this interview, I want to talk about your experiences as a young mother and about the time when you were pregnant.

Ethical Approval

Ghent University has some rules to protect you, as a participant, during interviews. The researcher will follow these ethical rules[1]. During the interview, the European rules will also be followed[2].

[1] [Verslag (ugent.be)]
[2] https://allea.org/code-of-conduct/

B. Information about participation

What does participating in this study mean?

If we do an individual interview it will last for an estimated 1h30, a focus group up to 2h, with questions about your experiences and life before, during, and after your pregnancy. If you are okay with it, the researcher will record the conversation so she can remember the information you give.

Nobody can force you to do the interview, you choose to do it yourself. You may refuse to do the interview and you may always quit the study without telling why. If you don't want to do the interview or if you want to quit, there will be no negative consequences for you.

What are the risks and benefits of participating in this study?

It could be difficult to talk about this, so the interview can be paused or stopped at any time, just as participation throughout the study. There is no further known ongoing risk associated with this study.

We can learn more about teenage pregnancy through these interviews. You can talk about your pregnancy and your being a mother, and help other girls going through the same situation. This interview may help you get insight into your own experiences. There are no further benefits expected.

Is there any compensation or reward provided when participating in this study?

There is no material reward or compensation for doing the interview. If there are any questions, we can see if a redirection is possible.

C. Privacy and Personal Data Information

Information on Privacy and Personal Data

The researcher will ask about things such as your age, family situation, living and work situation. The researcher will not share this information with anyone else. The only people who will know that you were sharing this information are yourself, the researcher, and the translator, who signed a document that they are not going to share any of your information. The processing of this information is according to Belgian Regulations.

Are you okay with participating in the research and the researcher gathering this information? Can you please sign the last page so the researcher can be sure you are okay with it? You can also just put your fingerprint.

Reuse of data

Other researchers might also be interested in the information I find in the research. Then, they could ask the researcher to use the information gathered, but they will never get to know your name, age, or other personal information.

Your rights regarding your personal data

In accordance with European and Belgian privacy law, your privacy is respected. As already indicated, you may quit the interview or study at any time without telling why. You can also ask the researcher to have any personal data removed.

If you have any questions, please tell the researcher or mail/call her.

Telephone number: 0781270410
E-mail: lies.blancke@ugent.be

SECTION 2 – CONSENT FORM

A. Consent for participation in the research

Method: interview / focus group

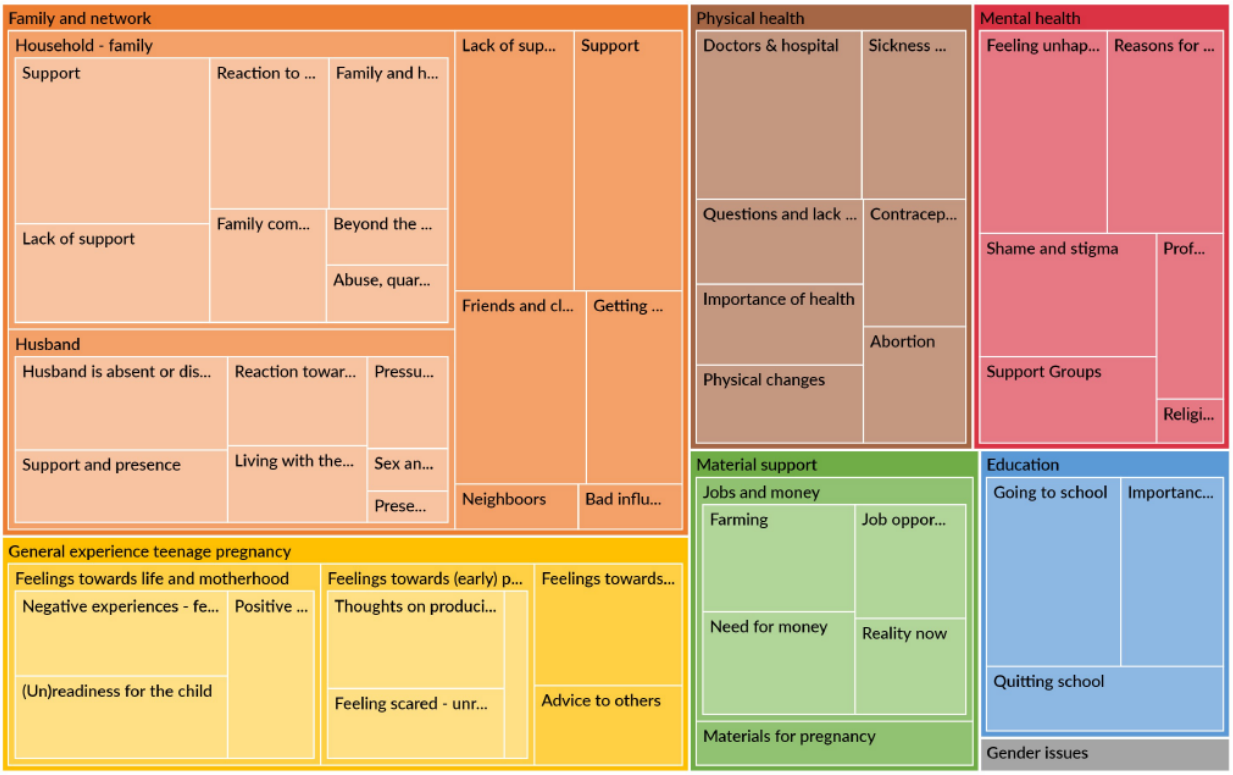
Please check the appropriate box	Yes	No
I choose myself to do this interview and the researcher can know my name, age and other personal information.	o	o
I know that I can always quit the study without telling why, and that it won't have any negative consequences.	o	o
The information sheet was explained and I understand the information sheet. I could ask questions if I did not understand it.	o	o

Date: …. /…. /……

Name participant	Name researcher
Signature	Signature

OR

Appendix 4 - Coding frame



Appendix 5 - Approval by CCVS

Master Dissertation: the needs, experiences, and resilience factors of teenage girls (16 - 20 years) during and after adolescent pregnancy? (working title)

Ethical approval letter by the local organization

Researcher: Lies Blancke (student at Ghent University)

Local organization: Centre for Children in Vulnerable Situations (CCVS)

Target audience: adolescent girls (aged 16 - 20 years old)

Data collection: semi-structured interviews (all personal data will be made anonymous)

Language: English

Dear,

This research was conducted under the guidance of CCVS, in Uganda. The research design, questions, and informed consent were verified, improved, and approved by the organization to not entail any harm or aggravating questions for the participants. Our organization works with the local communities on a daily basis and has gathered a lot of insight into the best possible ways to reach, communicate with, and address the local communities. This background was also used to instigate this research.

In the following paragraphs, you find the thought process of some choices that were made with regard to the research design and ethical considerations.

Informed consent

The informed consent is based on the one used for research by the faculty of psychology and educational sciences at Ghent University. Because it will be used in communities where English is not the main language, the IC has been simplified so the participants can understand it better. The main and important principles of anonymization, privacy protection, voluntary participation, and the possibility to withdraw from the research, are still present.

The participants are between 16 and 20 years old and the active IC is addressed to the girls themselves. If possible, the parents will be informed that their child will participate in research through the community leaders or the counsellors from CCVS. The participants will be asked to sign the informed consent. There is a possibility that they don't want to sign by their name. As an alternative, we might use a fingerprint as a signature.

The interview manual

The questions for the interviews were read and approved by a counsellor at CCVS. The interview will take place in English, with a translator present (if possible someone from CCVS).

Kind Regards,

Lanyero Ketty (Cln. Psy- CCVS Uganda)