Understanding the Experiences of Pregnant and Parenting Adolescents in Blantyre, Southern Malawi

UNIVERSITY OF MALAWI

APHRC

African Population and Health Research Center

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Abbreviations

ANC	Antenatal care
APHRC	African Population and Health Research Center
CAMFED	Campaign for Girls Education
CSO	Civil society organizations
CSR	Centre for Social Research
DEM	District education manager
EA	Enumeration area
FGD	Focus group discussions
IDI	In-depth interviews
IPV	Intimate partner violence
KII	Key informant interviews
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non-governmental organization
PPA	Pregnant and parenting adolescents
PSF	Primary sampling frame
MoGCDSW	Ministry of Gender, Community Development, and Social Welfare
MWK	Malawi kwacha
NSO	National Statistical Office
PPA	Pregnant and parenting adolescents
PSF	Primary sampling frame
RME	Relative margin of error
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
TA	Traditional authority
UNIMAREC	University of Malawi Research Ethics Committee
YFHS	Youth friendly-health services
YONECO	Youth Net and Counselling

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Executive Summary

Background and objectives

Close to one in three adolescent girls in Malawi begin childbearing before their 19th birthday. Early childbearing has significant negative implications for girls' health and wellness. It starts a cycle of social exclusion that often begins with their expulsion or voluntary withdrawal from school with dire socio-economic consequences. Children born to adolescent girls are also vulnerable, and excluded from full societal benefits because of their parents' poor socioeconomic status. While a constellation of actors—government, advocacy, research, and development partners—have focused on reducing teenage pregnancy, there is less attention on the wellness of the millions of pregnant and parenting adolescents (PPAs) in Sub-Saharan Africa (SSA). Very little is known about their lived experiences, including how they perceive their roles as parents, the challenges they experience, and the support they need to improve their life chances. However, robust evidence on the lived realities of PPAs can support the design and implementation of policies and programs to improve not only their wellness but also that of their children. The Centre for Social Research (CSR), University of Malawi, and the African Population and Health Research Center (APHRC) implemented a mixed-methods study in Blantyre, Malawi, to understand how early and unintended pregnancy culminates in the social exclusion of adolescent mothers. We also explored interventions that could ensure their education and economic empowerment.

Methods

We conducted a concurrent, equal status mixed-methods cross-sectional study comprising a quantitative survey (n = 669 pregnant or parenting girls) and qualitative interviews (n = 57 multiple category participants) in urban and rural Blantyre. Survey participants were selected using two-stage cluster sampling after we conducted a household listing. Overall, we conducted 44 in-depth interviews: 18 among pregnant and parenting adolescent girls, 10 among parenting boys and 16 among parents/guardians. In addition, we conducted 13 key informant interviews, four with teachers, three with policymakers, and six with community leaders and non-governmental organization (NGO) representatives. We also held two validation/dissemination workshops—one among pregnant and parenting girls in Blantyre and the other in Lilongwe—among key stakeholders, including two representatives for pregnant and parenting girls. During both meetings, key findings of the study were presented, and stakeholders not only shared their experiences but also made recommendations on ways to address challenges facing PPAs.

Summary of key findings

Most PPAs experienced an unintended pregnancy (68%), and most were still in school (60.3%) and single (81%) at the time they became pregnant. While PPAs blamed their unintended pregnancy on the lack of access to contraceptives, sexual violence, poverty, unequal gender norms, and school dropout; parents and other stakeholders believed peer influence, failure to listen to advice, and COVID–19 school closures were responsible. Unintended pregnancy exposed PPAs to shame, ridicule, stigma, and discrimination. Their social exclusion in the community made them feel sad and inferior. About half (49%) of PPAs said their partners were indifferent or unhappy about their pregnancy; one-tenth reported that partners denied paternity. Often, PPAs considered abortion when their partners denied responsibility for the pregnancy. Unintended pregnancy negatively affected relationships with partners and parents, with some PPAs reporting that their parents chased away from home._

Most PPAs (94.5%) attended antenatal care (ANC) services during pregnancy. However, qualitative interviews revealed that many did not commence ANC in the first trimester per the recommendations by the Ministry of Health (MoH). Nevertheless, some PPAs reported experiencing barriers in accessing ANC services, including the lack of money for transport and food. While half of PPAs described their general health status in the past year as 'good' or 'very good', others considered their health as 'fair' (25.2%), 'very bad' (9.9%), and 'bad' (15.4%). Many PPAs reported challenges to seeking healthcare, including concerns about drug availability (60.6%), distance to

health facilities (51.5%), cost of care (51.1%), and transport (50%), unavailability of healthcare providers (25.7%), unavailability of female healthcare providers (12.2%), and not wanting to go alone (12.2%).

Although most PPAs (61.2%) showed no depressive symptoms, a quarter (24.3%) had mild symptoms, while very few had severe symptoms (1.3%) or moderate symptoms (2.4%). The prevalence of probable depression was 14.5% (CI 12.1%–17.5%) and higher among PPAs exposed to intimate partner violence (IPV) (23.8%) than those never exposed to IPV (8.4%). As narrated by one key informant, rejection by society, parents, and even the church was a reason for depression.

Nearly all (95%) of the interviewed PPAs were out of school at the time of survey, and 74.5% stated a desire to return to school. Three-quarters of PPAs were aware of Malawi's school readmission policy that aims to promote school reentry for adolescent mothers, although many fail to return to school. Narratives from the in-depth interviews (IDI) and key informant interviews (KIIs) show several barriers to school re-entry, including poverty, parental opposition to schooling, stigma, psychological distress, limited social support, and lack of childcare support. Most PPAs said finishing primary school (77.8%), secondary school (86.1%) and university (84.8%) was very important to them. In the qualitative data, PPAs, including boys, expressed the desire to return to school in the future. The motivation to return to school included the chance to have a brighter future, be independent, and fulfill life ambitions. In the quantitative survey, PPAs stated that in order to return to school they needed support in the form of school fees (91.9%), childcare (29.8%), money (37.4%), as well as school uniforms and books (66.7%). Stakeholders interviewed suggested the need to develop and implement community by-laws on school re-entry for parenting adolescents and programs that encourage adolescent mothers to re-enroll in school, advocate for girls' rights to education, and the need to complete education for future independence.

Conclusion

Unintended pregnancy has several negative implications for girls, including exposure to stigma and discrimination, dropping out of school, as well as and poor mental and physical health and wellness. However, pregnant and parenting girls receive little support to address these challenges. Most of them were out of school, despite their willingness to return, because they lacked support in the form of childcare, school fees, money and uniforms, and materials. Without gender-responsive programming to address the challenges of PPAs, including supporting their school re-entry or empowering them to acquire vocational skills, achieving gender equality in Malawi could remain elusive.

Key recommendations

As part of this study, we probed pregnant and parenting girls and key stakeholders interviewed on plausible interventions to address the key challenges PPAs face. In addition, we held two validation workshops—one with PPAs and the other with key stakeholders from relevant civil society organizations and national and subnational government—where we jointly developed possible ways of addressing the challenges facing PPAs. Drawing from these engagements, the study recommends the following:

Increase adolescents' access to sexual and reproductive health information and services

Key government agencies, community-based organizations, non-government organisations (NGO), developmental partners, and parents must:

1. Sensitize adolescents on the connection between unintended pregnancies and socio-economic, health, education, and livelihood challenges;
2. Design, implement, and monitor comprehensive sexuality education programs to improve knowledge about sexual and reproductive health and rights (SRHR) issues, including the importance of using contraceptives; and
3. Increase access to youth-friendly (YFHS) sexual and reproductive health services to reduce early and unintended pregnancy among adolescents.

Facilitate PPAs school re-entry, retention, and completion

Relevant government ministries, teachers, mothers' groups, parents, NGOs, and developmental partners should work together to:

4. Provide educational support to PPAs returning to school: for example, school fees and other school materials;
5. Develop and implement community by-laws on school re-entry for PPAs;
6. introduce social cash transfer programs for PPAs in school to purchase school materials;
7. Promote psycho-social counseling for teenage mothers, done by those who returned to school after pregnancy and childbirth; and
8. Provide support for childcare; for example, Malawi has a wide network of community-based childcare centers where teenage mothers can send their children and pick them up after school.

Improve the livelihood of pregnant and parenting adolescents

The Ministry of Gender, Community Development, and Social Welfare (MoGCDSW) and stakeholders should explore:

9. The possibility of extending the social cash transfer program (operational since 2006 and targeted at ultra-poor households) to PPAs who are experiencing severe livelihood challenges;
10. Introducing small-scale social cash transfer programs or related interventions to address the livelihood challenges PPAs face;
11. Establishing a loan scheme and/or startup capital for PPAs to establish startups
12. Providing vocational training to PPAs.

01 Introduction

Adolescence is a critical phase for every human's physical, cognitive, social, and emotional development (Patton *et al.,* 2016). Despite adolescence being characterized as the healthiest period in an individual's life, experimental behaviors with adverse whole-of-life effects start at this stage (Laski, 2015). During this phase, most boys and girls initiate sex, often with limited knowledge of effective methods of prevention, resulting in a high rate of unintended pregnancies (Santhya & Jejeebhoy, 2015). Decades of activism, advocacy, policy-making, and programming led to a substantial decline in adolescent pregnancy and childbearing both regionally and worldwide (UNICEF, 2019). However, progress remains uneven, with a high rate of teenage pregnancy persisting in resource-poor countries and settings. About 12 million girls aged 15-19 and 777,000 girls aged 10-14 in low- and middle-income countries have given birth, and 3.9 million unsafe abortions occur among adolescent girls annually (Darroch *et al.,* 2016, Melesse *et al.,* 2020). The rate of adolescent childbearing in Sub-Saharan Africa (SSA) at 103 births per 1,000 girls far exceeds the global rate of 44 births per 1,000 girls (UNICEF, 2019). Within SSA, significant sub-regional variations exist: with an adolescent childbearing rate of 137 births per 1000 girls, Malawi is among the top 10 countries worldwide with the highest adolescent fertility rates (UNICEF, 2019).

Adolescent childbearing has severe consequences on girls and their offspring (Hobcraft & Kiermnan, 2001; Santhya, 2011 & Lee, 2010 & Kirbas *et al.,* 2016). Research consistently shows that girls aged 10-19 have a higher risk of premature births, low birth weight, perinatal deaths, childbirth complications, and maternal deaths than women aged 20 and older (Osok *et al.,* 2018 & Corcoran, 2016). Above all, pregnancy-related complications are among the leading causes of death among adolescents (Roth *et al.,* 2018 & Shah & Ahman, 2018). Several factors account for the enormous disparities in the consequences of pregnancy and childbearing for adolescents compared with older women: these factors include adolescent girls' pelvis immaturity and shorter maternal height, access to and utilization of maternity care, and exposure to IPV (Ogawa *et al.,* 2019 & Kawakita *et al.,* 2016).

Besides sexual and reproductive health (SRH) consequences, PPAs encounter social stigma, ridicule, isolation, and social exclusion from peers, family, and community (UNICEF, 2015; Kumar *et al.,* 2018). Previous studies also show that some PPAs view their pregnancies as shameful and an obstacle to their future endeavors (Sempebwa *et al.,* 2018 & Nkwemu *et al.,* 2019). Unsurprisingly, studies show that the prevalence of mental health disorders, including depression, is higher among PPAs than their counterparts (SmithBattle & Freed, 2016; Recto and Champion, 2016; Dahmen *et al.,* 2019; Sangsawang *et al.,* 2019; Laurenzi *et al.,* 2020). Studies also show that adolescent pregnancies might lead to child marriage (Menon *et al.,* 2018). Because of the stigma associated with premarital birth, girls are married off, or decide to get married, once they are found to be pregnant to protect themselves or their family honor (Menon *et al.,* 2018; Baa-Poku, 2017; Kalimi, 2015; Mwanza, 2018; Undie and Birungi 2016; Birchall, 2018; Kabore *et al.,* 2019 & Belinda *et al.,* 2016).

Adolescent childbearing also has educational and socioeconomic consequences. It is one of the main contributors to disparity in gender roles, inequality in education, employment, and wages (Assini-Meytin & Green, 2015; Campbell, 2015; Fletcher & Wolfe, 2009; Hotz *et al.,* 2005). Available estimates suggest that more than 100 million girls drop out of school each year, with pregnancy being among the main reasons (UNICEF, 2014). In Malawi, an estimated 4.3% of students drop out of school because of pregnancy (Ministry of Education, 2018). The corresponding proportion of girls and boys who dropped out of school due to marriage were 7.7% and 1.6%, respectively (Ministry of Education, 2018). Schools immediately suspend girls once their pregnancies are confirmed (Martinez & Odhiambo, 2018). Malawi introduced the school readmission policy in 1993, allowing

school-aged mothers to resume their studies after childbirth, reversing the prior regulations prohibiting pregnant and parenting girls from re-enrolment (Samati, 2013). Under the policy, girls can request readmission from the Ministry of Education (MoE) and the school after childbirth (Martinez & Odhiambo, 2018). However, the extent to which this policy effectively facilitates school re-entry of parenting adolescents remains unknown. An assessment by Judicial Watch suggested that because of the conditional nature of the policy, it presents further barriers to school re-entry (Martinez & Odhiambo, 2018).

Studies in Malawi and elsewhere found that although the majority of out-of-school PPAs want to return, most do not do so mainly due to lack of financial and childcare support and stigma (Mwanza, 2018; Advance Family Planning, 2018; Undie *et al.,* 2015; Shahidul & Karim, 2015; Molosiwa & Moswela, 2012; Rosenberg *et al.,* 2015; Menon-*et al.,* 2016). Further, studies suggest that those who return to school are demeaned, ridiculed and humiliated by peers and teachers, resulting in self-isolation, truancy, low self-esteem, inferiority complexes, and poor concentration and grades (Menon *et al.,* 2016). The loss of educational opportunities means that girls miss important investments for their future wellness, leaving them ill-prepared for the labor force, thus limiting their economic mobility and ability to care for their families. Poor or no education perpetuates a cycle of poverty and gender inequality, which have negative implications across the life course. While the structures of many societies are unfair to girls and deny them education, those who become pregnant face additional obstacles (Birchall, 2018; Jumba & Githinji, 2018; Nyariro, 2018). Once girls are confirmed pregnant, the schools either suspend them, or they drop out because of the pregnancy or the stigma and child-related costs (Birchall, 2018; Jumba & Githinji, 2018; Nyariro, 2018), among other factors.

Preventing adolescent pregnancy is a policy priority to ensure gender equality in education. However, the goal of eliminating gender disparities in education by 2030 will be in jeopardy if substantial effort is not focused on addressing the social exclusion of PPAs. Inclusive education for PPAs, through continued schooling during pregnancy and re-entry after childbirth, is beneficial for the girls and their babies, boosting their economic potential and increasing their contribution to their communities. Studies have also shown that girls who re-enter schools are less likely to have repeat pregnancies (Karimi, 2015; McCadden, 2015), allowing them to invest in their health and socioeconomic development. Malawi is one of 26 African countries that has a school re-entry policy recognizing the adverse consequences of childbearing on adolescent girls' educational outcomes and school re-entry benefits (Birchall, 2018). However, these policies lack implementation frameworks and guidelines (Baa-Poku, 2019; McCadden, 2015; Tarus, 2020; Phiri & Machila, 2019). Evidence of the effectiveness of school re-entry policies in facilitating education for PPAs is limited. The only available evidence suggests that the school re-entry policy in Zambia did not improve years of schooling among girls who got pregnant (McCadden, 2015).

02 Research Problem Statement

While a collaboration of actors—government, advocacy, research, and development partners—focus on reducing teenage pregnancy, there is less attention on the wellness of the millions of PPAs in SSA. Evidence on the rate and correlates of school re-entry among PPAs and how the availability of school re-entry policies, or lack thereof, hinders or facilitates their readmission is limited in SSA, including Malawi. Further, very little is known about the lived experiences of PPAs, including how they perceive their roles as parents, the challenges they experience, and the support they need to improve their life chances. The limited studies on this topic mainly adopt a qualitative approach, and although useful, qualitative studies do not help us know which issues are most salient across different PPA groups. At the same time, several countries across the region, including Malawi, are debating policies, strategies, and interventions to increase school re-entry for PPAs to improve the life chances of girls as well as a gender empowerment endeavor. Sound evidence is a critical prerequisite for catalyzing the policy and intervention design and processes.

While adolescent girls are disproportionately affected by early unintended pregnancy, the literature suggests that early unintended pregnancy might adversely affect boys as they are unprepared to take on fatherhood roles (Fagan *et al.,* 2007; Hunt & Caldwell, 2015; Kiselica & Kiselica, 2014; Lee *et al.,* 2012; Elster & Lamb, 2013; Recto & Lesser, 2020). However, studies focusing on adolescent fathers are few and mainly from the global north. Some studies show that parenting fathers disproportionately report stress and depressive symptoms although very little is known about the realities of and how early unintended pregnancy affects adolescent fathers in Malawi.

Therefore, this mixed-methods study was conducted to document PPAs' lived experiences, examine their health and social wellness, and examine school re-entry gaps in policies and practices. While the primary focus for the study is on girls, we conducted qualitative interviews with parenting or soon-to-be parenting boys to understand their lived experiences, as well. The evidence generated through this study will inform advocacy and policy processes to meet Malawi's commitment to ending adolescent pregnancy by 2030 and improving PPAs' wellness.

03 Study Objectives

The overall objective of this study was to generate evidence to support advocacy and policies for PPAs.

The specific objectives of the study were to:

1. Document the lived experiences of PPAs, including the health, social, and economic challenges they face;
2. Examine how social exclusion from SRH information and services increases adolescent vulnerability to unintended pregnancies;
3. Determine the barriers and facilitators to school re-entry for PPAs; and
4. Identify promising ways of supporting PPAs to access education and livelihood opportunities, and other services.

04 Methodology

4.1 Study design

We used a mixed-methods design study to gain an in-depth understanding of the lived experiences of PPAs and examine the type and magnitude of challenges they encounter because of unintended pregnancy and childbearing.

4.2 Study site

Malawi has a high rate of adolescent childbearing and therefore offers a suitable site for studying the lived experiences of PPAs. We conducted the survey in Blantyre District in the southern part of the country. Between 2019 and 2020, the southern region districts recorded an increase in cases of child marriage, with Blantyre reporting the highest: 309 in 2020 from only eight in 2019 (MoGCDSW, 2020). Blantyre was selected because the key drivers of adolescent pregnancy are interrelated with the key drivers of child marriage.

4.3 Study Participants

4.3.1 Pregnant and parenting adolescents aged 10-19 years old

Adolescent girls aged 10-19, who were pregnant or had a biological child, and were capable of consenting and responding to the survey in the local language or in English, were eligible to participate in this study regardless of marital status. Other participants included *parenting* boys. Interviews with PPAs, including parenting boys, were aimed at understanding their lived experiences, circumstances surrounding their unintended pregnancies, reactions to pregnancy, and school re-entry programs.

4.3.2 Primary caregivers and duty bearers

Community leaders and primary carers of PPAs, including parents, guardians, and authority figures responsible for the wellness of the adolescents, participated in this study. These participants were selected purposively based on their availability and willingness to participate in the study. Community leaders and caregivers participated in discussions around norms about premarital sex, early unintended pregnancy, challenges that PPAs experience in caring for their babies, support structures available to them, marriage, and school re-entry.

4.3.3 Teachers, policymakers, and CSO staff

Teachers, CSO staff, and policymakers at the district level, such as those working in the MoE and MoGCDSW, participated in this study. These people are crucial in understanding the ecosystem and policies on adolescents' unintended pregnancies and school re-entry and their implementation.

4.4 Sample size and sampling

4.4.1 Quantitative survey

A sample of 700 PPA households was estimated to be sufficient to generate 80% statistical power for all the study outcomes of interest. The sample size was estimated based on the following parameters: in 2015, 29% of

adolescent girls in Malawi had begun childbearing (National Statistical Office [NSO] and ICF Macro, 2016); the proportion of adolescent fertility in the base population was 0.136 in Malawi; a design effect of 1.5, a relative margin of error (RME) of 0.036; average household of five members, and 5% possible incomplete responses. A two-stage cluster random sampling was followed to select study participants as follows:

- Sixty-six enumeration areas (EAs) were randomly selected from the primary sampling frame (PSF) developed by Malawi's National Statistical Office (NSO). Forty of these EAs were rural, while the rest (26) were urban.
- A household listing in sampled rural and urban EAs was conducted in the second stage. This exercise was aimed at identifying PPAs, including those with disabilities. After identifying households with PPAs, the initial idea was to randomly select 20 households with PPAs per cluster. One PPA was selected in each sampled household using the Kish grid in cases where there was more than one eligible respondent.

After collecting data from 60 EAs initially targeted, the team had not reached the minimum adjusted sample size. An extra set of eight EAs were consequently added to the sample. A total of 669 PPAs were surveyed, with 10 PPAs refusing to participate.

4.4.2 Qualitative interviews

Purposive and snowball sampling approaches were adopted to recruit informants for the qualitative component of the study. Overall, 57 interviews were conducted as detailed in Table 1. This number of interviews was sufficient to capture all diverse perspectives on the lived experiences of PPAs, and data saturation was reached.

Table 1: Number of interviews conducted in the qualitative component of the study

Respondent category	No. of interviews
In-Depth Interviews	
PPA girls	18
Parenting boys	10
Parents/guardians	16
Key Informant Interviews	
Teachers/school principals/school directors/school district managers/parents-teachers association representatives	4
Policy makers*	3
Community leaders/NGO representatives	6
Total	57

*The policy makers interviewed at the district level included officials from the District Social Welfare Office, District Education Management Office, and District Health Office.

4.5 Data collection, processing and analysis

Survey data were electronically collected on Android tablets using SurveyCTO. All devices were password-protected, and collected data were synchronized daily to a secured server held at APHRC in Nairobi. The survey data were transferred to Stata/SPSS for further cleaning and analyses at the end of data collection. Sampling weights were applied to correct for oversampling in rural areas. SVY Stata function was used to account for the complex sampling adopted in the study. Descriptive statistics were used to examine adolescents' sociodemographic, behavioral, and attitudinal characteristics and their lived experiences, including circumstances about their pregnancies, reactions to their pregnancies, and health status.

For the qualitative arm of the study, each interview was audio-recorded after obtaining permission from respondents. All recorded interviews were transcribed and translated into English. Selected (n=5) transcripts were compared with the original recording to ensure the accuracy of the transcription. A coding framework was agreed among the researchers and configured in NVivo. The transcribed data were imported into NVivo 12 for data coding. The coding was done by three research assistants who participated in data collection. Thematic content analysis was used to analyze the qualitative data.

4.6 Validation and dissemination workshops

CSR and APHRC organized two validation/dissemination workshops in Blantyre and Lilongwe. The workshop in Blantyre was held on October 5, 2021 at Sunbird Mount Soche Hotel with 24 PPAs in attendance. The study's preliminary results were presented to them by some of the research assistants who participated in the data collection exercise. They were requested to comment on the results, provide their own personal experiences and make recommendations on how the challenges being experienced by PPAs can best be addressed. The second workshop was held in Lilongwe on October 7, 2021 at Sunbird Capital Hotel. Government officials and civil society organizations (CSOs) attended this workshop. We also invited two PPAs from the Blantyre workshop to share their stories with people at the workshop in Lilongwe. Both workshops were followed by group discussions then plenary sessions where groups presented their discussions.

4.7 Ethical considerations

Ethical approval was obtained from APHRC Ethics Review Committee and the University of Malawi Research Ethics Committee (UNIMAREC). Participation in this study was voluntary, and consent was obtained from all study participants before the administration of questionnaires or interviews/focus group discussions (FGD). Parental consent and assent were obtained for and from minors themselves. As married adolescents are considered emancipated minors, they provided informed consent.

The data collection approaches required that the research team be physically present in the community and households. To ensure the safety of the project staff and the study participants from COVID–19 infection and transmission, the research team adhered to preventive measures, namely social distancing, regular handwashing and use of hand sanitizers, and wearing face masks in the field.

05 Findings

The results presented in this report are based on data from 669 PPAs and narratives of parents, partners of PPAs, teachers, policymakers at the district level, and NGO representatives. Table 2 shows that 41% of the survey respondents were from rural Blantyre while the rest (59%) were from urban Blantyre. The average age for PPAs was 17.9 (SD 0.04) years; 45.9% of the PPAs were married or cohabiting, 12% were separated/divorced, and 42% were single. Most PPAs (73%) were protestant Christians, had primary education (66%), and never worked for pay (71%). Most PPAs became pregnant at age 18-19 (67%). Of the 699 respondents, 144 (21.4%) were pregnant for the first time, 497 (74.4%) already had one child, 27 (4.1%) had two children, and one respondent had three children. Almost all PPAs reported that they have ever been to school (99.9%).

Table 2: Sociodemographic characteristics of PPA girls

Variables	Unweighted sample		Weight sample	
	Frequency	Percent	Frequency	Percent
Residence				
Rural	275	41.1	275	38.2
Urban	394	58.9	394	61.8
Age				
13-16	87	13.2	87	13.3
17	133	19.9	133	19.9
18	199	29.6	199	29.8
19	249	37.2	249	37.1
Highest level of education				
Primary	439	65.7	440	(65.8)
Secondary	229	34.3	229	(34.2)
Religion Affiliation				
Catholic	121	18.1	121	18.2
Protestant	485	72.5	485	72.3
Islam	56	8.4	56	8.4
Traditional	7	1.1	7	1.1
Ever worked for pay				
Yes	191	28.6	191	28.7
No	478	71.5	478	71.3
Orphanhood status				
Double orphan	39	5.8	39	5.8
Single orphan	181	27.1	181	27.1
Non-orphan	449	67.1	449	67.1

Variables	Unweighted sample		Weight sample	
	Frequency	Percent	Frequency	Percent
Residence				
Living with both parents				
Not living with both parents	220	32.9	220	32.9
Living with one parent or both parents	449	67.1	449	67.1
Marital status				
Married	307	45.9	307	45.8
Separated	79	11.8	79	11.8
Single	283	42.3	283	42.3
Parental support				
Good	425	63.5	425	63.3
Fair	136	20.3	136	20.5
Poor	33	4.9	33	4.9
No support	75	11.2	75	11.2
Friends support				
Good	155	23.1	155	22.9
Fair	137	20.5	137	21.0
Poor	83	12.4	83	12.4
No support	294	44.0	294	43.7
Partner support				
Good	415	62.0	415	61.9
Fair	108	16.1	108	16.4
Poor	48	7.2	48	7.2
No support	98	14.7	98	14.5
Belong to social groups				
Yes	265	39.6	265	39.7
No	404	60.4	404	60.3

5.1 Sexual partners of PPAs

The median age at first sex among PPAs was 16 years: 80% initiated sex while still in school; most had first sex with boyfriends (89%), with 11% reporting that they had their first sex with their husbands; 43% of PPAs willingly engaged in sex on their first attempt, and one in three did not use condoms. In terms of age, most PPAs (78%) had their first sex with someone older than them.

5.2 Reasons for vulnerability to early and unintended pregnancy

Most PPAs experienced an unintended pregnancy (68%), and most were still in school (60.3%) and single (81%) at the time they became pregnant. PPAs, parents and guardians, and policymakers provided a wide range of reasons why PPAs experienced unintended pregnancies, some of which are interconnected. Table 3 shows the reasons PPAs experienced unintended pregnancies.

Table 3: Emerging themes on reasons for vulnerability to pregnancy

Themes	Illustrative quotes
Young and naïvely in love	*"I would say I was naïve, … since I had a partner and we would sleep together. I believe that is the reason I fell pregnant" (19-year-old PPA, EA 804, TA Kapeni, Blantyre).* *"You know what happens when you are in a relationship. There comes a time when you want to make someone happy, [you want to] make your lover happy" (19-year-old parenting boy, EA 48, Blantyre).*
PPAs' lack of contraceptive access and misconceptions	*"Yes, I knew about [contraceptives] but did not have access to it" (17-year-old PPA, EA 78, TA Kapeni, Blantyre).* *"…at that time, I was not using any contraceptives because I had no child then, and people always discourage young girls who have never given birth before to use contraceptives because it could affect the uterus, so I was not using any contraceptives" (19-year-old PPA, EA 804, TA Kapeni, Blantyre.*
Poverty	*"The main reason [for having unprotected sex] was to get money and be able to buy clothes and other necessities" (18-year-old PPA, EA 803, TA Lundu, Blantyre).*
Gender norms and unequal power relations	*"I was forced to sleep with him, and we were in a secluded place so I could [not] refuse, so I just accepted to sleep with him" (19-year-old PPA, EA 78, TA Kapni, Blantyre).*
Sexual abuse	*"I was raped" (17-year-old PPA, EA 78, TA Kapeni, Blantyre).* *P: "What happened is when I was still in school, my teacher used to give me money to spend so I would take it. He would sometimes send someone to fetch me while I was in class. When the student came, she would tell me that 'the teacher says you should meet him' and I would go. He would give me money, start touching/caressing my breasts, and then tell me to go. After that, I would go back to class. He would come anytime he pleased to my class and tell me to go to his class, and I would go, he would give me money and then touch my breasts, and it continued like that. During the school holiday, when we were on break, he told me that we should meet at ADMARC (an Agricultural Development and Marketing Corporation office), and I went."* *I: "That was on holiday?"* *P: "Yes, on holiday. He sent a kid to come to get me, and the kid did that. He told me that he just got paid, so let's go on the road, and I agreed. He booked a room, and we slept there until morning. In the morning, he gave me 4000* MWK [$5 USD] *to get motorbike transport so that I could get back home. I took off and got home. That was the day I got pregnant" (16-year-old PPA, EA 48, TA Lundu, Blantytre).*

School dropouts	*"The big problem was that I stopped schooling" (17-year-old PPA, EA 8, TA Kuntaja, Blantyre).*
School closure due to COVID–19	*"Closure of schools due to COVID–19 [contributed to] a lot of girls in my community ending up in the same problem. You will meet so many similar problems in my community. As parents, we believe that that was the main challenge because when children are in school, they might be attending part-time classes hence going home late so they can't do stupid things while in school" (Guardian, EA 24, TA Lundu, Blantyre).*
Peer influence	*"I think [her becoming pregnant] is because of her friends. They are the ones who encouraged her, depending on how they chatted. Sometimes I would give her little money, which would not be enough for her and her friends at school. Maybe she lost trust in her parents and started trusting her friends, that is why she ended up being pregnant, which was not right" (Female guardian, EA 39, Nkolokoti, Blantyre).* *"There are several [reasons], but first we should understand that [at] teenage stage a lot happens. When one is transitioning as they are growing, there is peer pressure, and some don't know how to handle themselves or to differentiate what is right or wrong. Then there is also an issue [with] some traditions, which in a way also encourage the youths to engage in sex" (YFHS coordinator, Blantyre).*
Failure of adolescents and young people to listen to advice	*"I blame it on her because she didn't listen. As a girl who was still in school, she was supposed to listen to the advice, and she was not supposed to be seeing boys. She needed to stay home and look at her schoolwork, but all she was doing was to take a bath and go wondering about in the village, which was dangerous because she ended up copying what others were doing, forgetting that she was killing her future" (Guardian, EA 10, Makata, Blantyre).* *"No, we did our part, and we were trying to counsel her anytime, and each time, we felt she was doing something secretly. We were telling her to work hard in school, but whenever she goes out from the house, she could do whatever, and we thought the daughter is in class at school" (Male guardian, EA 11, Mzedi, Blantyre).*

5.3 Reactions to adolescent pregnancy

Some PPAs commented on how others' reactions and opinions made them feel sad and inferior, while others were resigned to their new fate, hoping that things will get better.

5.3.1 PPA reactions to becoming pregnant

PPA reactions to becoming pregnant were mixed: while two in five reported feeling disappointed, 27% were scared, but 27.8% were happy. Those who were happy were more likely to have dropped out of school (82.7%)

before becoming pregnant. In addition, PPAs who were already married before becoming pregnant described their reaction as happy. Some PPAs reported unhappiness or disappointment because their boyfriends refused to take responsibility for the pregnancy. They were also unhappy because pregnancy meant they would no longer go to school. Others said they had no resources to take care of themselves, their pregnancy or their babies once born:

> *"It was too painful for me because I knew that my education would be affected because I couldn't go to school while pregnant. That was an excruciating thing - (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).*

> *"I was scared and disappointed. I was scared because I was a young girl, and I was also sad because I had no means to take care of my pregnancy or even take care of the baby" (16-year-old PPA, EA 24, TA Lundu, Blantyre).*

While some PPAs were worried about their education, a few said they knew they would go back to school after delivery:

> *Well, I just accepted it knowing that this is just a child, and when he grows up, I would still be able to go back to school and continue with my education" (19-year-old PPA, EA 78, TA Kapeni, Blantyre).*

Some parenting boys accepted responsibility for the pregnancy when they heard the news that their girlfriends were pregnant. In contrast, others were not all that happy, or were scared as they were not expecting the pregnancy or baby at the time.

> *I was scared because it was my first time. I was very scared because I had no idea if I would be able to manage at my age" (18-year-old parenting boy, EA 48, TA Kuntaja, Blantyre).*

One parenting boy in Ndirande said that he was worried because her girlfriend was very young and may die during childbirth, and this made him worried that her relatives would blame it on him. Only one PPA reported that she had wanted to abort the moment she knew she was pregnant as she had wanted to finish school but was advised by her stepmother not to abort.

5.3.2 Partners' reactions

About half (51%) of PPAs stated that their partners were happy they got pregnant. They accepted responsibility for the pregnancy. Information from the qualitative component supported this quantitative finding:

> *I told him I did not have my periods this month and [therefore] I am pregnant. What he said to me was that I should [not] be worried, we will keep the pregnancy (19-year-old PPA, EA 7, TA Kapeni, Blantyre).*

Others reluctantly accepted responsibility, as they were either no longer together or after their girlfriends were chased from their parents' homes:

"He accepted it, but [he was] not very happy. If he had received it well, we could have still been together now, but because he did not receive the news well, that is why we are no longer together in a relationship" (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).

"For him to accept it, they chased me out of the home. That was when he accepted it and vowed to help me out" (17-year-old PPA, EA 8, TA Kuntaja, Blantyre).

In some cases, girls change their thoughts about the relationship with the boy who impregnated them after delivery. A parenting boy alluded to this below:

"She seems to have no more interest in me. She doesn't listen to me when I talk. Even the baby, she doesn't bring him here for me. I always have to go visit them whenever I want to see my baby" - (19-year-old parenting boy, EA 12, Ndirande, Blantyre).

One in 10 of PPAs (11%) reported denial of paternity. At the same time, others were upset or indifferent. Girls who described their partners' reactions as happy were more likely to have dropped out of school (71.6%) or married (94.6%) before becoming pregnant. In some cases, the denial of responsibility for pregnancy forces some pregnant girls to abort the pregnancy: one PPA said that the relationship with her partner deteriorated, and she terminated the pregnancy because the boyfriend denied responsibility and her parents chased her away from home._

5.3.3 Parental reactions

Overall, 62% of PPAs reported that their parents were distraught about their pregnancies. Only one in five PPAs described their parents' reaction as 'happy'; most who described their parents' reactions as joyful were either married (63.2%) or no longer in school (93.1%) when they got pregnant. While parents were generally disappointed with their girls getting pregnant, they came around to accept the situation in the long run:

"There was nothing that they did. They just said that one getting pregnant is not the end of everything because one can go back to school after giving birth" -(19-year-old PPA, EA 10, TA Makata, Blantyre).

" For my parents, I informed them that I was pregnant, and it didn't go well with them. They shouted at me, but later they accepted it, and here I am" (19-year-old PPA, EA 78, TA Kapeni, Blantyre).

Some participants, including guardians, mentioned that parents were upset because they wanted their daughters to continue school and felt they had wasted a lot of money on them:

> *"It really pained us as parents, especially the schooling part. We want these children to go to school and finish school without getting pregnant as she did. So we let them go to school alone. We believe they go there for school without knowing they do other things apart from school. We were hurt, but we had nothing to say because our daughter was already pregnant. We thought of punishing her, but we were told not to do that otherwise, she could think of taking the herbs to kill herself or aborting the pregnancy, so we let things go as she planned" - (Male guardian, EA 11, Mzedi, Blantyre).*

While parents generally accepted the pregnancy and the relationship with their sons/daughters was fine, there were isolated cases when the relationships went sour and parents went to the extent of chasing their daughters from their houses:

> *"It made me feel bad about it because they really wanted me out of their house (sindinamve bwinoyi chifukwa eeh anavuta kwambili)" -(18-year-old PPA, EA 6, Green Corner, Blantyre)*

> *They did not really accept the situation, because had it been that they did, I do not think they would have been verbally abusing me the way they do (19-year-old PPA, EA 72, Michiru, Blantyre).*

It is not only pregnant girls who might be chased away from their homes, as boys can also be chased away. For example, one PPA reported that her boyfriend accepted responsibility for her pregnancy, but his father said his son was very young and could not impregnate a girl. This boy ended up being chased out by his father:

> *They chased him away for accepting being responsible [for the pregnancy]. His uncle told his father that he must support our child here. But the father did not agree to that, so he chased him away (15-year-old PPA, EA 67, TA kuntaja, Blantyre).*

An official from the MoE in Blantyre also reported that when a girl gets pregnant most of the time, parents get furious and chase her from their home or take the girl to the person responsible for the pregnancy.

5.3.4 Reactions of peers

Peers' reactions ranged from being very upset to being happy. While many described their friends' reactions as neutral (46.4%), others said their friends were distraught (27.8%) and mocked (2.8%) them. Some respondents described their peers as discriminatory because they did not want to be friends with a teenage mother:

> *After I gave birth, the girls no longer want to interact with me; they would rather interact with fellow girls who have never given birth before. They fear those of us who have given birth would be influencing them to have children" (19-year-old PPA, EA 78, TA Kapeni, Blantyre.*

> *"Like most of my friends ... now I don't chat with them anymore. If I have friends now, they are a few from the ones I used to go to school with. Most people don't really consider me. They just see me as someone of no importance" (16-year-old PPA, EA 24, TA Lundu, Blantyre).*

This is why one key informant reported that parenting girls might return to a different school after pregnancy to avoid being mocked by both teachers and fellow learners:

> *Most of the girls, if you ask them, they would tell you that they would prefer to go to a different school than a school that they were [at] before. And the big question is why: that's the case because the teachers would judge this girl, and because of our religious beliefs, we will now start talking that this girl has sinned and the support that she would get would not be the same as the ones other learners would get. And I don't think a girl would have the confidence to raise her hand and ask a question in such an environment because if she does, that means she will draw attention to herself and would rather remain quiet (Key informant, Blantyre District Council).*

While many PPAs reported being mocked/discriminated against, a few PPAs reported no change in their peers' attitudes towards them when they became pregnant. Two PPAs said that they did not really know the attitude of their peers and community towards their pregnancies, with one saying that she did not hear anything. Another said that no one noticed her pregnancy:

> *"Okay, for the first pregnancy, it was only in its early stages, so no one noticed that I was pregnant. They only heard about my miscarriage. Even now, this pregnancy is in its early stages as well. So they don't realize that I am pregnant" (19-year-old PPA, EA 29, TA Kuntaja, Blantyre).*

Only 16.8% of PPAs said their friends were happy when they were pregnant. Those who described their friends as joyful were more likely to be out of school (99%) or married (56.6%) before becoming pregnant. Participants explained the happy and neutral reactions in the qualitative study by arguing that adolescent childbearing is normative; as such, it is no surprise when another girl becomes pregnant in the community:

> *They are happy because most girls in this community got pregnant while they were young, and they are in child marriages. So most people feel good when another person's daughter becomes pregnant so that they can be equal with others (19-year-old PPA, EA 10, TA Makata, Blantyre.*

5.4 Feelings about having a child at this time

PPAs had mixed feelings about having children at this time, with most of them feeling distraught, pain, sad, and stating that it was not a good time to have a child, it was not planned, and they did not have a source of income to care for the baby:

> *I feel sorry for myself. Looking at my age, for people to see me as a father, it really affects me because I am too young for this. I cannot be called a father, so it really affects me (18-year-old parenting boy, EA 48, TA Kuntaja).*

> *"I am not happy about it because I don't have a job, I don't have any business, and so it is tough to take care of a child on my own. Like how will I support her? And what about when she starts to eat? Where will I get the food?" - (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).*

Other PPAs were unhappy because they failed to accomplish their goals, especially continuing their education. Very few PPAs said they were happy and unworried about having children. We also asked PPAs whether they would change their situation given a chance, namely being pregnant or having a child and other related issues. Most PPAs reported that if possible, they would change their condition and never become pregnant again:

I realized that it is risky to get another child at this age, so I am going to take great care that I do not get another pregnancy (17-year-old PPA, EA 8, TA kuntaja, Blantyre).

The change I am talking of will come when I give birth. I will not be busy with boys because it is [a] bad [idea] to have another child while young. I will make sure that I take care of my child till it grows. I surely make sure that I put aside boys who can give me other problems (18-year-old PPA, EA 33, TA Nsomba, Blantyre).

Some PPAs said that if there were anything they could change about their situation, they would have continued their education instead of dropping out due to pregnancy:

" I feel like I am facing all these things because I am pregnant, but I was told that after I give birth after the child grows a little, I could go back to school, so I believe things will change for me - (19-year-old PPA, EA 72, Michiru, Blantyre).

Two PPAs said they would start a business and become successful.

5.5 Access to antenatal care services during pregnancy

Most PPAs (94.5%) attended antenatal care (ANC) services during pregnancy, although qualitative interviews revealed that many did not commence ANC in the first trimester per the MoH recommendations. One guardian in TA Makata in Blantyre reported that she encouraged her pregnant daughter to start attending ANC clinics in time to receive proper care from the clinic. She also emphasized that since her daughter was not married, she needed a letter from the chief, which she would require to take to the hospital because the man responsible was unknown.

The predominant theme from the qualitative data on ANC was respectful care and ease of access to all needed services, as captured in the excerpts below:

"I can say that it was good. Most of the people that were going for [antenatal] clinics at the time were young girls who had gotten pregnant [during] the COVID–19 pandemic, and so [the health staff] were advising us a lot. And on top of that, sometimes they would ask parents that had given birth before to leave, and we would remain only the young ones, and they would talk to us alone - (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).

"When I went to the clinic, they taught us about pregnancy; they tested us for HIV and other sexually transmitted diseases like chindoko [syphilis]. I was tested for the two. When I was tested, they told me that I was okay, and they told me that when coming for the second time, they would test me again" (16-year-old PPA, EA 24, TA Lundu, Blantyre).

Nevertheless, some PPAs and guardians reported experiencing barriers in accessing ANC services, including lack of transport, money, and food:

Economically, she faced some challenges. For instance, sometimes, she couldn't find the money for transport to the health facility for antenatal care. Sometimes she would leave without eating when going for antenatal care because there was no food in the house (Female guardian, EA 78, TA Kapeni, Blantyre).

5.6 Self-reported health status of PPAs

While half of PPAs described their past year's health status as good or very good, others described their health as fair (25.2%), very bad (9.9%), and bad (15.4%).

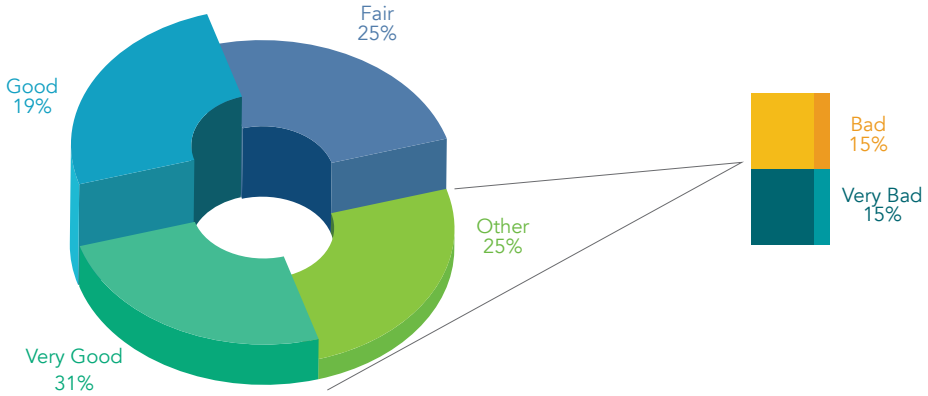

Figure 1: Overall health status of PPAs in the last year

Figure 2 shows that about 58% of the PPAs described their past month's health status as good or very good, while 24%, 12%, and 6% described their past month's health status as fair, bad, and very bad, respectively.

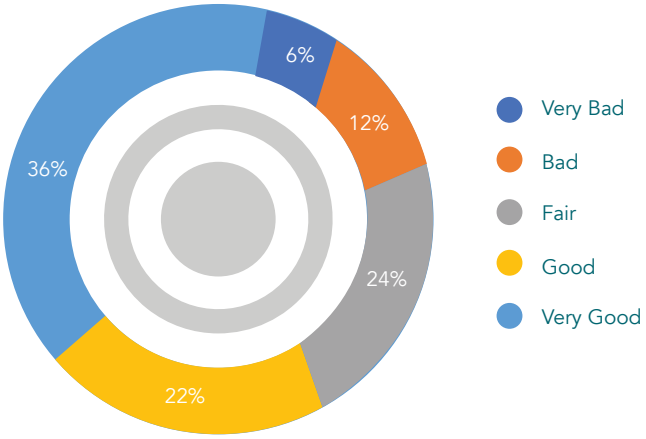

Figure 2: Health status of PPAs in the past month

Table 4 shows that little more than a quarter of the PPAs (28.1%) reported having had a fever in the past month. Other symptoms reported included recurring fatigue (17%), diarrhea (14.5%), night sweats (13.6%), cough and shortness of breath (12.5%), rapid weight loss (9.2%), and recurring vomiting (6.6%).

Table 4: Health problems in the past month

Health problems in the past month	Frequency (N=669)	Percentage
Fever	190	28.1
Recurring fatigue/weakness	114	17.0
Recurring diarrhea	97	14.5
Night sweats	92	13.6
Recurring coughing or shortness of breath	84	12.5
Rapid weight loss	63	9.2
Recurring vomiting	45	6.6

Most PPAs also reported that they did not have any health problems during their pregnancies, while some had minor problems, including the shortage of food because their partners did not have any. One PPA reported having black vaginal discharge, which led people to think she was bewitched; her partner advised against seeking care from local herbalists:

"I used to have black vaginal discharge. When I went to the hospital, they gave me medicine to take. On the other hand, people at home thought maybe someone was behind this and suggested seeing a local herbalist. But the father of my baby refused this and said I should just be taking the medicine the doctor gave me because mixing two methods is not good" (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).

A few pregnant adolescents were reported to experience major health problems, as explained below:

> *"There were a lot of health issues. She began experiencing something like malaria. I took her to the clinic. The nurse said she must be visiting the clinic frequently because she had complications. Then she only went there for a month. Later she started experiencing backache and stomach ache. I took her to the clinic again, then that's when she gave birth to a dead premature baby. Then they referred us to Queen Elizabeth [Central] Hospital for a DMC while others took home the baby's body for burial" -(Guardian, EA 29, TA Kuntaja, Blantyre).*

Another PPA in Nkolokoti experienced repeated high blood pressure episodes but delivered successfully. Some parents of PPAs did not really know the challenges their children experienced during pregnancy because they were staying with boyfriends/husbands. Figure 3 shows that 72% of PPAs had visited a health facility in the past six months.

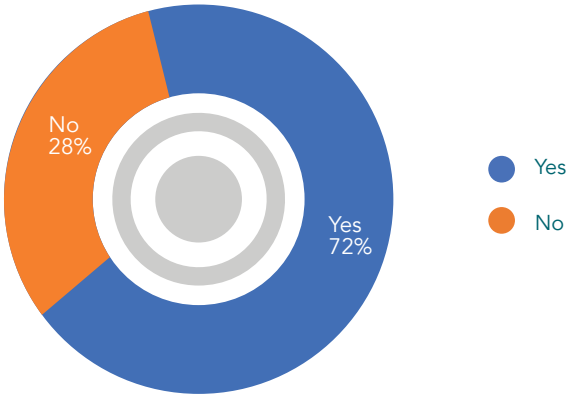

Figure 3: Health facility visit in the past six months

Table 4 below shows that most PPAs who visited a health facility in the past six months (n=481) mostly received care at public health clinics (70.7%) and public hospitals (32.9%).

Table 5: Health facilities visited in the past six months

Health facilities visited in the past six months	Freq n=481	Percent
Public health clinic	342	70.7
Public hospital	157	32.9
Private hospital	20	4.3
Private health clinic	14	2.9
Pharmacy	9	1.8
Mission hospital	8	1.6
Mobile clinics	8	1.6
Traditional healer	3	0.6
Mission health clinic	2	0.4
NGO clinic	1	0.2

Most PPAs visited health facilities for their general health (51.0%), child health (31.6%), antenatal care (25.8%), delivery care (10.4%), and family planning services (7.1%).

Many PPAs reported challenges to seeking healthcare. As can be seen in Table 5 below, these challenges included concerns around drug availability (60.6%), distance to health facilities (51.5%), cost of care (51.1%), and transport (50.0%). A few PPAs reported concerns around the unavailability of healthcare providers (25.7%) or female providers (12.2%) and not wanting to go alone (12.2%) (Table 5).

Table 6: Barriers to accessing healthcare

When you are sick and need medical advice or treatment, which of the following presents a problem	No Freq (%)	Yes Freq (%)
Concern that there may be no drugs available	266 (39.4)	403 (60.6)
The distance to the health facility	322 (48.4)	347 (51.6)
Getting money needed for treatment	327 (48.9)	342 (51.1)
Having to take transport	333 (50.0)	333 (50.0)
Concern that there may not be any health provider	498 (74.3)	171 (25.7)
Not wanting to go alone	559 (83.6)	110 (16.4)
Concern that there may not be a female health provider	589 (87.8)	80 (12.2)
Getting permission to go	618 (92.1)	51 (7.9)
Anything else	651 (97.3)	18 (2.7)

Some of these challenges were also mentioned during the IDIs, as narrated below:

> *There were a lot of challenges. Things like wrappers [chitenje[1]] were not easy to access when it was time for antenatal clinic, money to get a motorbike transport to and from the clinic, it was even hard for me to access food and at times I would get sick often (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).*

5.7 Mental health

PPAs reported symptoms of depression during the past two weeks using the 9-item Patient Health Questionnaire (PHQ-9). The PHQ-9 uses *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV) diagnostic criteria to assess depressive symptomatology *(e.g.,* problems with sleep, energy problems, low self-esteem, and inability to experience pleasure) on a four-point scale ranging from 0 ("not at all") to 3 ("nearly every day"). We summarized the scores across the nine items. We estimated the severity of depression as none (scores 0–4), mild (5–9), moderate (10–14), moderately severe (15–19), and severe (20–27).

Most PPAs (61.2%) showed no depressive symptoms, while a quarter (24.3%) had mild depression. Very few had severe depression (1.3%) and moderately severe depression (2.4%). Using a score of 10 as a threshold, the prevalence of depression was 14.5% (CI 12.1%–17.5%). Moderate to severe depressive symptom prevalence was higher among PPAs exposed to IPV (23.8%) than those who had not experienced to IPV (8.4%).

1 *Chitenge is an East African, West African and Central African fabric, worn by women and wrapped around the chest or waist, over the head as a headscarf, or as a baby sling*

As narrated by one key informant, rejection by society, parents, and even the church was a reason for depression:

> *"Again, girls undergo certain psychological problems because our society rejects you when you get pregnant before you are married. Sometimes parents send you away or even in church they would excommunicate you, so some suffer depression" - (YFHS coordinator, Blantyre).*

We also looked at the mental health challenges for PPAs during the COVID–19 pandemic: over a quarter of the PPAs reported being much more worried (28.7%) and afraid (28%) than before the pandemic. One in five PPAs were much more restless (19.7%), frustrated (17.9%), anxious (23.2%), stressed (22.6%), and bored (21.2%) than before the pandemic.

5.8 COVID-19 and PPAs

5.8.1 Awareness about COVID-19

Almost all PPAs (99.5%) were aware of COVID–19. However, only 13.7% knew someone who had COVID–19. None of the PPAs had COVID–19 nor their parents or partners. Of the 90 PPAs who knew someone who had COVID–19, 13.3% said the person was a family member outside their household, while 86.7% said it was someone else outside their home.

5.8.2 Main fears about COVID-19

Most PPAs considered COVID–19 to be a deadly virus (73.3%). Only 41.9% believed COVID–19 had no treatment/cure. About two in five PPAs feared a loss of income. A similar proportion was concerned because it was hard to keep away from crowds (36.6%). Only a few PPAs expressed concerns about an increase in the crime rate (8%), not knowing where to get treatment (8.3%), inability to pay rent (8.6%), lack of transportation (12%), being quarantined (17%) or hospitalized (26.6%) and food shortage (20.7%). About 47.3% of the PPAs alluded to being very worried about going to public places like the market or health center. Only 138 PPAs (20.7%) indicated that they were not concerned, while the rest (31.9%) were somewhat worried.

Table 7: Main fears about coronavirus

Main fears	Freq (%)
Death/deadly virus/virus kills	488 (73.3)
No treatment/cure	279 (41.9)
Loss of income	257 (38.6)
It is hard to keep away from crowds	245 (36.6)
Being hospitalized	178 (26.6)
Food shortage	138 (20.7)
Being quarantined	114 (17)
No transport	80 (12)
Other (specify)	80 (12)
Inability to pay rent	57 (8.6)
Don't know where to get treatment	55 (8.3)
Increase in crime	53 (8)
Don't know	26 (3.9)
Refused to answer	15 (2.2)

5.8.3 COVID-19 and access to SRHR services

Most PPAs did not encounter any challenges accessing SRHR services during the pandemic. However, overall, 8.2% had problems accessing ANC, contraceptives (8.2%), menstrual hygiene products (3.9%), and maternity care (3.6%) (Table 8).

Table 8: SRHR challenges during COVID-19 pandemic

Difficulties accessing SRH services during COVID-19 pandemic	Freq. N=669	%
Antenatal care	56	8.4
Contraceptive services	55	8.2
Well baby	52	7.8
Menstrual hygiene products (*e.g.* pads)	26	3.9
Maternity care	24	3.6
HIV testing	18	2.7
Other*	13	1.9
STI testing	11	1.6
Post-abortion care	2	0.3

**Difficulties include the following anecdotes: business is hard; health workers not helping us accordingly; protest due to COVID; the doctor hit her because she scolded her for almost letting her child fall down; could not enter the hospital because she forgot her mask; sometimes hospitals were closed; they limited the number of women getting antenatal care to 20 to 30 per week; if you missed then you could only try going earlier the other month; health workers lacked PPE and were not attending to patients*

5.8.4 Main challenges experienced during the COVID-19 pandemic

A substantial proportion of PPAs had difficulties making money (50.7%), meeting their needs (43%), and finding jobs (33.5%). In addition, one in five PPAs reported having trouble taking care of their children (22%), studying (14.2%), gaining school admission (7.6%), and keeping a job (9.9%). A few PPAs employed seeking help from well-wishers and engaging in economic activities as coping strategies.

All PPAs interviewed affirmed that COVID–19 had worsened their precarious livelihood, making them unable to find casual employment to meet their needs, especially for food. This has heightened their worry about having enough resources to care for their babies. Due to COVID–19 restrictions on travel, some are unable to travel in search of jobs, while a few who often clean rich people's houses were laid off to avoid spread. The experience of a 19-year-old mother who lives with her parent buttresses this view:

> *"As one way of trying to get money, we go and look for casual labor such as cleaning in the gated houses, but with the COVID–19 situation, they send us back. Even when we travel to look for casual labor, we don't have the same freedom as we did before the COVID–19 restrictions - (19-year-old PPA, EA 78, TA Kapeni, Blantyre).*

Some PPAs who plan to set up a business could not move forward with their plans due to the restriction on large gatherings meant markets were closed:

"There are so many challenges that I am facing, such as failure to start up businesses because of the preventive measures to control the spread of the pandemic, such as avoiding overcrowded places such as markets. This is very difficult because I do not have the opportunity to make money" (19-year-old PPA, EA 10, Makata, Blantyre).

One PPA said it is even more challenging for her to get food because her business has suffered from COVID–19 restrictions.

5.9 Precarious livelihoods of PPAs

Nearly a third of the PPAs (28.6%) reported having ever engaged in paid work. Of those who ever worked for pay, a higher proportion was in the urban (31.2%) than rural (24.7%) settings. Most PPAs (83.8%) who had ever worked started before age 18. A quarter of the respondents (25.1%) were currently working, with more in urban (27.6%) than rural (20.6%). Table 9 shows that PPAs were primarily engaged in domestic/childcare (48.7%) and informal work (25.7%).

Table 9: Main occupation of PPAs who were currently working

Occupation	Percentage (N=191)
Domestic work/childcare	48.7
Informal work	25.7
Agriculture/fishing	10.5
Hospitality	4.7
Construction	4.2
Wholesale and retail	3.7
Manufacturing	2.1
Formal work	0.5

Participants in the IDIs mentioned two main sources of livelihood: informal work (popularly known as *ganyu* in the local language) and running small-scale businesses. They perform menial jobs, including shelling maize, harvesting, and working in other people's businesses, including barbershops. In addition, the guardians worked as water carriers, house cleaners, charcoal sellers, quarry stones and sand sellers:

"There are a lot of economic challenges because in my village, for one to earn money, you venture into the business of selling charcoal. That's when one can find some money to support a family or else farming, but due to poor rainfall, it has been hard to find money through farming. So it's tough to earn money -(Guardian, EA 24, TA Lundu, Blantyre).

" I do sell rocks. I have a place where I break rocks into small sizes where people with cars come and buy [from] us (Male guardian, EA 11, Mzedi, Blantyre).

However, many PPAs were unemployed and dependent on their parents/guardians and the partners who impregnated them to give them money:

Currently, I don't have any source of income. I depend on my mum, who would bring things home, and I just received from her. I don't have any means of income (18-year-old PPA, EA 6, Green Corner, Blantyre).

I'm not doing any business or working. So if I get any money, that means the father of my child has sent something, or my parents have given me something (19-year-old PPA, EA 804, TA Kapeni, Blantyre).

In addition, some PPAs also reported that relatives or well-wishers gave them money. However, almost all PPAs said that the money they got was generally inadequate for their needs. Some guardians described engaging in farming as their primary source of income:

We have a small piece of land where we grow crops like peas. Sometimes we sell them to get money and buy necessities (Guardian, EA 29, TA Kuntaja, Blantyre).

Almost all PPAs depended on their parents for financial and material support before pregnancy, but most described it as inadequate. Pregnancy exacerbated their already dire situation, creating more difficulties than usual. For example, a PPA who returned to school explained that she relied on casual jobs like laundry services to support herself and her baby. She noted that the money she made from this labor was far from sufficient to cater to their needs and that they were barely surviving.

PPAs face several financial challenges, including difficulty affording transport to the clinic for antenatal care, personal hygiene products, food, and baby supplies. A married, 18-year-old PPA's response typifies every struggle of adolescent mothers searching for resources to meet their needs. She depends solely on her partner for money and material supplies, particularly soap, to wash her baby's clothes. She turns unused clothes into reusable nappies. Soap is crucial to ensure the clothes, including nappies, are clean and usable, yet her spouse often returns without money or soap. When asked if the support she receives from her spouse was adequate, she said:

"If things don't go well, he comes home without soap, so I end up washing the baby's nappies without soap" (18-year-old PPA, EA 29, TA Lundu, Blantyre).

This PPA said that she begs neighbors for soap, and if no one helps, the nappies go unwashed.

Several PPAs experienced food insecurity during and post-pregnancy. Food insecurity affects not only the PPAs but also their entire households. They described food insecurity as not having enough to eat or lacking access to the food they craved at the time. For example, a 16-year-old parenting girl who became pregnant at 14, and currently lives alone, described her food challenges:

"There were a lot of challenges. If I craved some food, I would not have it. When I went to my friend's house, whatever food I found was the one I would eat. So I was just eating just because I was hungry -(16-year-old PPA, EA 24, TA Lundu, Blantyre).

Some PPAs believed hunger was the main reason they became sick during pregnancy. Some informants, including guardians, said PPAs often attend ANC services unfed. Many PPAs insisted that they would need capital to start running some small-scale businesses to provide for themselves and their children adequately:

"If I could do a small business, the little that I could get from there I would be able to support myself and my child at home -(19-year-old PPA, EA 78, TA Kapeni, Blantyre).

Some PPAs were very specific about the businesses they wanted to run, such as a grocery. It is not only PPAs who would need capital to start a small-scale business: some guardians also reported that if they could find capital, they could start a business to funds school fees for their daughter and care for her child. One guardian suggested that PPAs should be capacitated with vocational skills such as tailoring and hairdressing. A key informant working for a CSO said:

I think we need to have a policy in place … supporting girls who have gotten pregnant at a young age. I would say these policies … [could] be put in place to support or … improve the programs that are already on the ground [so they can] provide girls with skills, vocational or entrepreneurship training, where they can be trained on how they can [create] small businesses so that they can survive on their own (NGO staff, Blantyre).

5.10 Aspirations and expectations

Most PPAs considered finishing primary school (77.8%), secondary school (86.1%), and university (84.8%) as very important to them. In the qualitative data, PPAs, including some parenting boys, expressed the desire to return to school in the future. The motivation to return to school included the chance to have a brighter future, be independent, and fulfill life ambitions:

I want to go back to school so that I can fulfill my ambitions (18-year-old PPA, EA 29, TA Kuntaja, Blantyre).

I intend to go back to school, and I will be able to work hard in school and be able to be independent in future (19-year-old PPA, EA 78, TA Kapeni, Blantyre).

While PPA girls and boys may want to re-enroll in school, they might opt for other options, such as businesses, due to prevailing challenges, as narrated below:

My plans right now if someone can assist me with my education, I can go back to school. But with the way things are now because I lack certain things to go back to school, my plans were when I get enough money; my wife should start a business while I am also doing other things on the side (18-year-old parenting boy, EA 48, TA Kuntaja, Blantyre).

The central theme among parents/guardians of PPAs immediate school re-entry after delivery. Several guardians said that they encouraged their daughters to go back to school following childbirth:

What I can tell her is that she has to go back to school. Going back to school makes your future bright, not mine, as an old woman but yours since you are still young and energetic. I can tell them that if you go to school, you are making your future plus the kids you have today. They have to be moving with time; these days, everyone needs school, work, and all other things. If you fail to go to school, it means you are inviting self-problems. We will be gone by the time you are old enough and need our support. (Guardian, EA 39, Nkolokoti, Blantyre).

Some PPAs said that they also wanted their children to go to school. These PPAs provided several reasons for desiring their children to go to school, including creating time for themselves to engage in casual jobs and for the children to have good jobs in the future and help their parents:

…because when he [the child] is around, he gives me a tough time and does not give me a chance to go do casual jobs (17-year-old PPA, EA 78, TA Kapeni, Blantyre).

I want him to further his education so that when things become difficult or hard for me, he will be able to help me (19-year-old PPA, EA 804, TA Kapeni, Blantyre).

In the survey, many PPAs had high aspirations for owning homes (90.4%), caring for their parents (93%) and children (93.1%), getting good jobs (91.4%), getting married (76.2%), and having admiration and respect from their friends (86.1%).

5.11 Concerns of PPAs

PPAs expressed several concerns, including not completing education (60.9%) and getting a good job (63%). More than half worried about being unable to provide for their children (53.6%) and about their health (51.5%). About half of PPAs (49.1%) were worried about having enough to eat. A substantial proportion of PPAs (41.7%) was concerned about contracting HIV. One in three PPAs worried about insecurity, rape, or mugging. PPAs were least worried about harassment from the police (14.7%) and getting married (20.4%).

5.12 Perceived life chances

Most PPAs who dropped out of primary (59.3% of 405) and secondary education (50.4% of 643) rated their chances of completing it as low; less than a quarter thought the odds were high. Similarly, most who never attended secondary school rated their chances of ever enrolling as low (57.5%), with 22.9% indicating their chances were high. Among 664 PPAs yet to enter university, 386 (58.1%) rated their chances of going to university low, with only 19.4% rating their chances as high. Only 26.4% and 28.6% perceived their chances of earning money and having a job they love, respectively, as high. Slightly more than one in three (35.6%) deemed their chances of owning a home high. Two in five PPAs had high expectations for a happy family, and close to half (47.2%) had high hopes for good health most of the time.

5.13 Sources of support for PPAs

We asked PPAs and other key informants about the nature of support available to them. Responses are summarized in this section.

5.13.1 Sources of support for childcare

Most PPAs reported being responsible for childcare themselves, with some assistance when available from their mothers or grandmothers. Only one PPA in TA Lundu said her mother-in-law helped with childcare because she lives in her mother-in-law's home. Some key informants believed that parents of the parenting girl should mind the baby while the mother goes to school:

When it comes to financial support, that should be left to the parents because they are still with their parents to help them. If they allow her to source money on her own through manual labor, she can become pregnant again. *But they should still care for the child for things like clothes and shoes. They should take the big responsibility of caring for the child and the grandchild -(Member, Parent Teacher Association, TA Kuntaja, Blantyre).*

One guardian said that if the PPA found a job, she would not take care of her grandchild; although 58% of PPAs reportedly had a reliable person providing child support.

5.13.2 Support from parents

Nearly two-thirds of the PPAs (64%) indicated they benefited from parental support during pregnancy. During the IDIs, many parents/guardians claimed they provided all the support their daughters required during pregnancy. Some parenting boys also said that their parents provided the support their pregnant girls needed during this period. Some guardians, PPAs, and parenting boys specified the support that parents provided to PPAs, including taking care of the child, giving money, buying clothes, soap, and food:

> *"Whatever she demands, we could buy it for her. We could buy her wrappers(swaddling clothes), blankets in preparation for the baby. We could give her babies' clothes. We kept some materials for delivery. At the time we were receiving antenatal care, we were advised to keep some money, and sometimes we could be referred to Queen Elizabeth Central Hospital, but she delivered her baby at Limbe. So we managed to get her all that stuff, but in a hard way -Guardian, EA 1, Nkolokoti, Blantyre).*

In addition to material support, parents and guardians also provided care and love to their pregnant and parenting children:

> *"Taking care of her, giving her love and support, because when some parents realize that their daughter is pregnant, all they do is shout, insult and say all manner of bad things. In other cases, they may make her miss her meals or say she must go to the man responsible for her pregnancy, which I did not do. I showed her love and support" - (Female Guardian, TA Chigalu, Blantyre).*

> *"I had to show her that I still care so that she should [not] be worried most of the time. We said we would make do with what we have; if anything, we will be engaging in casual jobs [Ganyu] together if we needed money for anything to use at home" -(Female guardian, EA 78, TA Kapeni, Blantyre).*

Many guardians also reported that before and after the daughters became pregnant, they also advised their PPAs that they should not become pregnant again:

> *Ever since she became pregnant, I have been caring for her, giving her advice, and encouraging her that this is not the end of your life. She should have the motivation to return to school when she delivered her child. She should not think that her future has been destroyed, but there is time that she will return to school—giving her the required care that a pregnant person needs Female guardian, EA 39, Nkolokoti, Blantyre).*

To support their PPAs, some parents did casual jobs, while one guardian from TA Kuntaja in Blantyre reported that they sold their farmland to earn money for necessities.

5.13.3 Spousal/partner support

More than half (62%) of the PPAs reported receiving support from the child's father. However, a noticeable percentage (15%) of fathers provided no support. As in the survey, many PPAs during IDIs reported that their partners supported them. However, financial support from partners was often inadequate, in part because partners themselves had limited financial resources. Similarly, married PPAs noted that their husbands were responsible for everything despite support being inadequate:

He usually sends money, but it's always not enough to support the baby['s] daily needs (19-year-old PPA, EA 78, TA Kapeni, Blantyre).

My support has been in terms of money or sometimes basic needs like soap. Although this is the case, I cannot say that I send a lot of money because I earn very little (19-year-old parenting boy, TA Kapeni, Blantyre).

However, some PPAs reported no support from the child's father. Some would-be parenting boys denied responsibility for pregnancies and were unavailable to support the girl. In most cases, the girl took no legal action against the boys to provide support.

5.13.4 Support from peers

More than half (55%) of PPAs reported that they received poor or no support from their peers, which aligns with results from the qualitative data. PPAs generally said that peers provided very little support in babysitting, for example.

5.13.5 Support from NGOs

We found few NGOs working in Blantyre to support PPAs. For example, a vice-chairperson in TA Chigaru in Blantyre reported no NGOs working there to support adolescent mothers' education. However, she emphasized that there is a critical need for PPAs to be supported with food and learning materials to pursue their education. Also, a key informant reported that CAMFED [an NGO] has been supporting adolescent girls with bursaries and economic empowerment support since 2009.

5.14 Education

Most PPAs (95%) (N=631) stopped going to school. Table 10 shows the reasons PPAs were not in school.

Table 10: Why PPAs were not in school (N=631)

Reason for dropping out of school	Percentage (N=631)
Got pregnant	48.2
Lack of school fees, uniforms, materials	31.9
Not interested	8.2
Sickness	2.2
Got married	1.7
Needed/wanted to earn money	1.7
Completed primary	1.1
Got a job	0.2

Table 10 shows two main reasons PPAs dropped out of school: they got pregnant (48.2%) and lacked school fees, uniforms, and school materials (31.9%). Some PPA re-enrolled after childbirth, but retention is typically a challenge because many cannot raise school fees or meet other needs. For example, one parenting boy said he did not drop out of school when his girlfriend got pregnant but had difficulties finding school fees as most of the money went to care for his child:

There are some ways that this pregnancy has affected my life. For example, my education has been affected because the money, which might have been allocated for my fees, is used for supporting the child to the point that I sometimes have no fees for my school. In addition to that, instead of focusing on education, my mind gets confused due to thinking about the child" (19-year-old parenting girl, TA Kapeni, Blantyre).

I withdrew from school, and after giving birth I returned to school, then I stopped again due to lack of school fees, but now I have started going back to school again (19-year-old PPA, EA 78, TA Kapeni, Blantyre).

Guardians and key informants also reported that girls withdraw from school when pregnant. However, a key informant noted that girls could return to school following childbirth to continue their education:

I can't remember the exact number, but some have returned to school after giving birth, including those who just dropped out from school and have also returned to school for other reasons. But it also depends on the capabilities of the household as well. Some drop out of school due to poverty at home and end up getting pregnant. So for such families, it's hard for the girl to return to school after giving birth - (Vice-chair, Mother Group, TA Chigalu).

A teacher said when girls are pregnant during or close to an examination, the school allows them to sit the exam, provided the girls feel no shame. While some PPAs returned to school post-partum, some drop out again because of mockery and abusive interactions with other learners. Some do not even attempt to return to school after childbirth because of this reason:

Yes, she was at school, and for this, I was telling her this policy where teenage mothers can go to school while pregnant. She refused to go back to school. She told me that her friend would be laughing at her. Even her teacher came to her the other day encouraging her to get back to school; she refused. She told him she wouldn't because her friends would laugh at her badly - Male guardian, EA 11, Mzedi), Blantyre).

Most PPAs (74.5%) said they would like to go back to school. A PPA said she wanted to return, but could not because of her pregnancy. Some married girls explained that they planned to discuss their interest in returning to school with their husbands. Similarly, a parenting boy noted his interest to re-enter school but explained this would be a challenge because he needed to financially support his wife and child. Figure 4 summarizes the responses of what support PPAs need in order to return to school. The majority (92%) mentioned school fees.

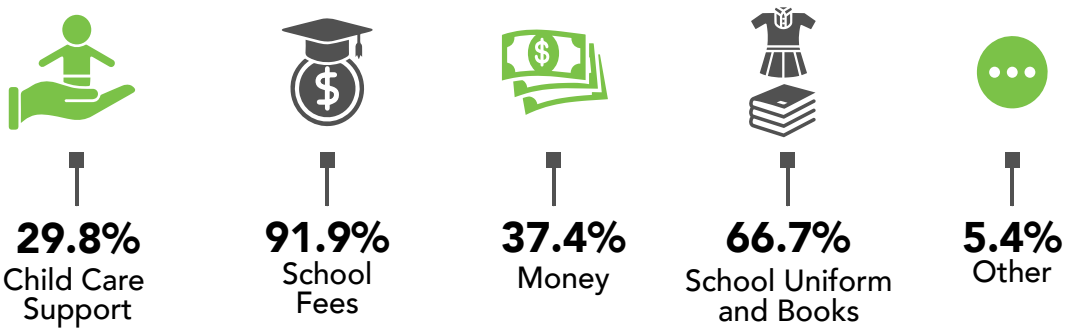

Figure 4: What PPAs need to go back to school (n=622)

Many PPAs said pregnancy and childbirth affected them psychologically and affected their school performances:

> *My education retrogressed because I was always thinking about my child; what am I going to feed my baby, where am I going to get the money to buy the baby some clothes" (19-year-old PPA, EA 78, TA Kapeni, Blantyre).*

> *Since the day I found out that I was pregnant up to now, I find it very hard for me even to study because I feel like I destroyed my future (19-year-old PPA, EA 72, Michiru, Blantyre).*

Although many PPAs were psychologically affected by the pregnancy, only one key informant at the Blantyre District Council mentioned that these PPAs would require psychosocial support for them to return to school:

> *Psychologically, these girls are affected after they have given birth and are back in school. Their fellow learners are advised not to make fun of their friends, but you know it's difficult to control children's behavior, and they would be poking fun of these girls simply because they have given birth—"iwe mmayi" [you woman]—and all sorts of names. So psychologically, we need to prepare them to report isolated cases that are poking fun [at] her. If she is not doing well in class, she also would need some attention, because in some cases, what is happening to her child at home could also be affecting her lessons. In some cases, she could even be missing some classes to attend to her child. For example, if the child is sick and she needs to take the child for medical attention, she would need to be assisted on the lessons that she missed" (Key informant, Blantyre District Council).*

5.14.1 Barriers to school re-entry

Three-quarters (75%) of PPAs were aware of the Government of Malawi school readmission policy. In the qualitative interviews, PPAs explained this policy allows girls to return to school post-partum and continue their education. Some key informants, such as the District Education Office and members of mother groups, reported that some girls withdrew from school due to pregnancy and went back to school after they delivered. Despite the policy, many PPAs fail to return to school. Narratives from the IDI and KIIs show several barriers to school re-entry, such as poverty, parental opposition to schooling, stigma, psychological distress, limited social support, and lack of childcare support. Table 11 provides illustrative quotes for each of these barriers.

Table 11: Key barriers to school re-entry

Barriers to school re-entry	Illustrative quotes
Poverty	*"There were other challenges that forced me to quit. I had difficulties in finding the money to support my child. That is the reason I decided to give up on school and concentrate on my child" (19-year-old parenting boy, EA 12, Ndirande-Gumulira, Blantyre).*
Parental opposition to schooling	*"When I got pregnant, my parents asked me what I would do in terms of school. I told them that there was nothing I could do. When I gave birth, I asked them if I could go back to school; they refused" (19-year-old PPA, EA 804, TA Kapeni, Blantyre).*

Barriers to school re-entry	Illustrative quotes
Stigma and bullying	*"The biggest challenge is that some learners talk badly about [PPAs]. They tease them about having a baby, which usually affects them mentally. Sometimes even teachers talk badly to them because they already have a child, but having a child cannot stop one from completing their education" (Chair, Mother Group, TA Chigalu M, Blantyre).* *"What can prevent teen mothers to return to school is if they are shy and uncomfortable for their friends to know that they breastfeed" (Member, Parent Teacher Association).*
Psychological distress	*"Since the day I found out that I was pregnant up to now, I find it very hard for me even to study because I feel like I destroyed my future" (19-year-old PPA, EA 72, Michiru, Blantyre).*
Limited social support	*"Lack of encouragement in our local areas may also be a contributing factor. Commonly, most of the parents did not go further with their education and the life they have passed through is having children and dependence on the family* (e.g., *their husband, farming,* etc.). *If we are in towns, there are many people [who] are working, who are like role models to such girls, while here the girls will just say that since my mum got impregnated and got married, maybe that is part of life. Therefore, I can say that lack of role models is among the issues that may prevent teen mothers from going back to school" (Teacher, TA Nsomba, Blantyre).*

5.14.2 Facilitators of school re-entry

Informants in this study, including key informants, guardians, and PPAs, mentioned four significant factors that could facilitate school re-entry for parenting girls. First, they noted the importance of ensuring that PPAs access school fees and school materials. Second, they underscored the need to develop and implement community by-laws on school re-entry for parenting adolescents. Third, some participants noted the need for programs that encourage adolescent mothers to re-enroll in school and advocate for girls' rights to education and the need to complete education for future independence. Finally, some participants highlighted the need for childcare support.

Further, participants identified school materials, including books, funds, and money for school meals, as prerequisites for school re-entry:

> *Some failed school due to a lack of money. Others had no food to eat; hence they opted to be at home. Now I feel that the government has to come in with support. They have to support families where these girls come from with food and money. With that, those who failed school because of money and food will go back to school without any problem. I think the government should do something and girls will go back to school -(Male guardian, EA 11, Mzedi, Blantyre).*

A key informant suggested introducing a unique cash transfer program for in-school children, enabling them to buy the educational materials they might need. Many informants advised that the community should develop by-laws relating to child marriages and school re-entry for adolescent mothers and fathers. Some informants acknowledged that these bylaws, if developed, would help because they have seen girls going back to school:

In trying to prevent teenage pregnancy, there are by-laws whereby when one is found pregnant while still not married, one has to pay something to the chief as Chindapusa (*fine for doing something stupid*)**.** *We also have some NGOs working in the community like Jhpiego, which encourages girls in school, even those who have ever given birth; they are encouraging them that not all is lost, but they can still go back to school and continue with their education. We also have Youth Net and Counselling (YONECO), which is also working in this community -(Female guardian, EA 78, TA Kapeni, Blantyre).*

Many participants also reflected on the importance of propagating information on girls' rights to education to facilitate adolescent mothers' return to school, as the quote below illustrates:

"Yes, it would be helpful, since it would be encouraging girls that they have the right to go back to school even after childbirth" (19-year-old PPA, EA 10, Makata, Blantyre).

One PPA suggested that organizations fighting for girls' rights to education should engage communities and encourage girls to return to school. Another PPA added that it would facilitate re-entry if people moved door-to-door, encouraging them to go back to school. A few informants suggested that the formation of youth groups would help to facilitate adolescent mothers' re-entry into school. One PPA, for example, felt that groups offer youth opportunities to discuss issues affecting them and supporting bodies to connect with them:

Some are forming youth clubs where they encourage the youths to work hard on their education because their future would depend on education. So it's vital that they go back to school so it's through these clubs that youths could be encouraged to go back to school -(Female guardian, EA 78, TA Kapeni, Blantyre).

A key informant in TA Chigalu reported that there are already existing programs at the community level where mother groups follow up with adolescent mothers and encourage them to go back to school:

We make follow-ups in the villages by talking with parents and learners who for some reason do not go to school. We try to find out why they are not in school, and we encourage their parents to support their child's education. So if a girl is pregnant, we monitor them and try to talk with them by encouraging them that they still stand a chance to go back to school after giving birth. So we give them a word of encouragement", Vice-chair, Mother Group, TA Chigalu).

This key informant further explained that mother groups work with the school to identify learners in need, not only girls, to help them with school uniforms and other learning materials. As they make rounds in the villages, when they come across a group of school-going children who are not going to school, they try to understand from them why they are not in school, and they also meet their parents to find out why they are not sending their children to school. The mother group, in some cases, helps purchase uniforms for needy students.

Some informants, including guardians, reported that for teenage mothers to go back to school, there would be a need for someone to help with childcare so that their mothers go back to school. A key informant from Blantyre City Council believed that the PPA needs to be assisted with childcare to go back to school:

Parents have a bigger role to play because usually these girls … return to school no more than a year after they have given birth. But at that point, the child would still be breastfeeding, so to allow the mother to get back to school, the family needs to get supplementary food that they could be giving to the child as their daughter goes back to school. As the adolescent parent returns to school, and if their child is not being taken care of, it means it will be tough for her to concentrate in school, unlike if she would feel that her child is safe and is being well taken care of - (Key informant, Blantyre District Council).

06 Discussions, Conclusions and Recommendations

This section focuses on discussion, conclusions, and recommendations on several problems that PPAs experience, including those relating to their SRH, seeking healthcare, COVID–19, and school re-entry.

6.1 Adolescent sexual and reproductive health

Adolescent childbearing is a major problem in Malawi and in SSA, where it is estimated that one in five adolescents begin childbearing in their adolescence (Odu *et al.,* 2015). Most adolescent pregnancies are unintended, mainly due to the lack of contraceptives, poverty, rape, sexual abuse, and peer pressure. Kaphagawani (2016) also identified these factors, but added the lack of knowledge about SRH issues and gender inequality. Unintended pregnancies can be effectively prevented through consistent condom use. However, the current study found that condoms and other contraceptives use among adolescents is low, collaborating previous research *(e.g.,* Kaphagawani, 2016), including at first sex (Munthali *et al.,* 2006; Health Policy Project, 2015).

Unprotected intercourse among adolescents exposes them to the risk of unintended pregnancies and STIs, including HIV. This study also found that failure to use contraceptives might also be due to misperceptions about contraception, including that it is unhealthy for people who have not given birth before. If they use these contraceptives, they might not bear children. Such a misperception has also been identified in other studies *(e.g.,* Nash *et al.,* 2019; Self *et al.,* 2018 & Dombola *et al.,* 2021).

MoGCDSW and the Ministry of Youth and Sports and Social Welfare are key government ministries responsible for children's health and welfare, including PPAs. Many civil society organizations, including youth-led organizations, work with these key government ministries implementing interventions to address critical challenges experienced by children, including PPAs.

Therefore, we recommend that various stakeholders, including community leaders, led by key government agencies, work in concert to:

- Sensitize adolescents on the connection between unintended pregnancies and socioeconomic, health, education, and livelihood challenges;
- Design, implement, and monitor comprehensive sexuality education programs to improve knowledge about SRHR issues, including the importance of using contraceptives; and
- Improve access to contraceptives by creating demand and ensuring availability the community level.

6.2 Antenatal clinic services

We found no major challenges in ANC utilization apart from delays in commencement until after the first trimester, against the WHO's recommendation. Delayed commencement of ANC is a problem for PPAs and adult women too. There are several reasons women delay in starting ANC; for example, Chimatiro, *et al.* (2018) found that some women hide the pregnancy to avoid being bewitched (also see Munthali and Mvula, 2009).

- The MoH should use its different structures, including the health surveillance assistants and other community-level mechanisms (e.g., chiefs, mother groups, and youth) to create awareness among PPAs and other adolescents the need to start accessing ANC services in the first trimester.

6.3 Seeking other healthcare services

Many PPAs reported visiting a health facility six months before this study. PPAs experienced a wide range of challenges in seeking healthcare, including out-of-stock of medicines, long distances to health facilities, healthcare cost, and transport to health facilities. Malawi's Health Sector Strategic Plan 2017-2022 (MoH, 2017) and the National Youth Friendly Health Services Strategy 2016-2020 also identified these problems (MoH, 2015). The delivery of health services in public health facilities is free, except for some paying wards in central hospitals (MoH, 2017). When PPAs refer to cost as a barrier in seeking healthcare, they refer to private health facilities that charge user fees.

Concerning health-seeking practices during pregnancy among adolescents, Mbiza *et al.* (2014) identified timidity, fear, stigma, long distances to facilities, the lack of adolescent-friendly services, and inaccessible roads as major access barriers. Therefore, to address these challenges, the MoH, in conjunction with other stakeholders, should:

- Enhance access to YFHS as a comprehensive evaluation of the delivery of such services found that only a third of young people were aware of the YFHS and about 13% reported ever accessing such services (Feyistan et al., 2014); and
- Design and implement outreach clinics targeting young people, including PPAs.

6.4 Livelihoods

Most PPAs reported that they experienced challenges in taking care of themselves, their pregnancies, and their babies, because they did not have a source of income. Other challenges included failing to afford personal hygiene supplies, food, baby clothes, and nappies. In some cases, the boys and men who impregnate girls either could not effectively support them, or denied responsibility for the pregnancy. Previous studies in Malawi also reported that some boys or men who impregnate adolescent girls refused responsibility for the pregnancy (Nash *et al.,* 2019), which worsens the livelihood situation of PPAs. Therefore, PPAs struggle to take care of themselves and their babies and not many NGOs help PPA girls.

We make the following recommendations to improve their livelihood:

- MoGCDSW and stakeholders should explore the possibility of extending the social cash transfer program (operational since 2006 and targeted at ultra-poor households) to PPAs who are experiencing severe livelihood challenges;
- Introduce small-scale social cash transfer or related interventions so PPAs can also address their livelihood challenges; and
- Establish a soft loan scheme so PPAs can fund small-scale business startups.

6.5 COVID-19

The COVID–19 pandemic had negative effects in different sectors in Malawi, including the closure of schools and scarcity of job opportunities, as reported in this and other studies (UNDP, 2020; Thula *et al.,* 2020; Ambler *et al.,* 2021). Less than 10% of the respondents in this current study said that the COVID–19 pandemic made it challenging to access SRH services. However, the MoH acknowledges a decline in the uptake of YFHS, including family planning, due to COVID–19. Young people believed that health facilities were hotspots for COVID–19; hence they stayed away from facilities. The closure of YFHS centers, and the suspension of mobile YFHS clinics due to COVID–19, exacerbated low service utilization (MoH, 2020).

The following recommendations could cushion the effects of COVID–19 for PPAs:

- Continued creation of awareness about the COVID–19 pandemic and its effects; and
- Promotion of COVID–19 prevention measures.

6.6 School re-entry for PPAs

When adolescent girls get pregnant, they often drop out of school, and most of them do not go back after childbirth. This study found that PPAs reported that motherhood negatively affects their pursuit of education. Our finding is similar to Nash, *et al.* (2019), who concluded that motherhood marks the end of girls' education as they drop out out of school. While they might want to return, it is difficult, and only possible, with family support for the child, including payment for all other costs.

The Ministry of Education, Science and Technology introduced the school readmission policy in 1993, which aims to allow girls who dropped out of school because of pregnancy to re-enroll after delivery. Most participants in this study were aware of the school readmission policy, although they noted many other challenges besides policy, such as poverty, the lack of childcare support, stigma, and discriminatory practices by fellow students, teachers, and community members. Some studies also found that girls who left school due to pregnancy or marriage do not return due to the same factors identified in this study, including the stigma of being a school-age mother (Samati, 2013; Rugimbana & Liwewe, 2013 & Munthali & Kok, 2016). In addition, some parents are generally opposed to their daughters going back to school after they have delivered, preferring they get married instead (Samati, 2013).

We suggest the following to facilitate PPAs school re-entry, retention, and completion:

- Provide educational support to PPAs returning to school, for example, school fees and other school materials;
- Develop and implement community by-laws on school re-entry for PPAs;
- Introduce social cash transfer programs for PPAs in school to purchase school materials;
- Promote psychosocial counseling for teenage mothers, among others, which should be done by those who returned to school after pregnancy and childbirth;
- Provide support for childcare, for example, Malawi has a wide network of community-based childcare centers where teenage mothers can send their children and pick them up after school;
- Provide capital to PPAs to start small-scale businesses; and
- Provide vocational training to PPAs.

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