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A local perspective on teenage pregnancies after four years of interventions carried out by the Yes I Do programme in Liwonde, Machinga district, Malawi.

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A local perspective on teenage pregnancies after four years of interventions carried out by the Yes I Do programme in Liwonde, Machinga district, Malawi.

A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Science in International Health

by

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Declaration:
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Abstract

Introduction

In Malawi, teenage pregnancies comprise 15% of maternal deaths, making childbearing one of the leading causes of adolescent death. It diminishes the girls' educational and career opportunities leading to financial and economic problems. In 2015, 29 per cent of girls aged 15 to 19 began childbearing in Malawi. This percentage has been increasing since 2010. The Yes I Do (YID) programme was implemented in Liwonde, Machinga District and aimed to reduce teenage pregnancies. Despite efforts, this was not achieved.

Objective

To gain insight into the local perceptions of teenage pregnancy to make recommendations for future development programmes.

Methodology

A secondary qualitative data analysis was performed on data collected during the YID end-line evaluation. A 'Gender and Rights'-framework, based on a framework developed by Goicolea, was applied to guide the data analysis.

Results

Community members perceive teenage pregnancy as a problem with significant medical, economic, and psychological consequences. The study identified that the root causes of teenage pregnancy are poverty, socio-cultural, and unequal gender norms, as they influence agency and freedom in the sexual and reproductive health (SRH) choices of youths. The current structures to prevent or mitigate the impact of teenage pregnancies, such as by-laws, are insufficient and might come with undesired effects, e.g., unsafe abortions.

Discussion

Future programmes should focus on economic empowerment, aligning socio-cultural practices with human rights and sensitising the community as a whole on the impact of unequal gender norms on youths' SRH and rights, in which the community members take a leadership role.

Keywords

Teenage pregnancy, Community perceptions, Malawi

Word count

13,130 words

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Abbreviations

ADC	Area Development Committee
AMREF	Amref Flying Doctors
CHAM	The Christian Health Association of Malawi
CBO	Community-Based Organisations
CHRR	Centre for Human Rights and Rehabilitation
CSE	Comprehensive Sexuality Education
CYECE	Center for Youth Empowerment and Civic Education
DSWO	District Social Welfare Officer
EDP	External Development Partners
FGD	Focus group Discussion
FPAM	Family Planning Association Malawi
GBV	Gender-based violence
HSA	Health Surveillance Assistants
HSW	Health Surveillance workers
IDI	In-depth Interview
LMIC	Low and middle-income country
MoE	Ministry of Education
MoH	Ministry of Health
MoY	Ministry of Youth
NGO	Non-governmental Organisation
PLAN	NGO
PSI	Population Services International
SSA	Sub-Saharan Africa
VSLA	Village Savings and Loan Association
WHO	World Health Organization
YCBDA	Youth Community-Based Distribution Agents

Key terms

Teenage pregnancy or adolescent pregnancy:	Pregnancy under the age of 20
Teenage pregnancy rate:	The number of teenage pregnancies per 1000 teenage girls
Child marriage:	Any formal marriage or informal union between a child under the age of 18 and an adult or another child

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1. Introduction

In my thesis research, I analysed the local perceptions of teenage pregnancies after four years of interventions carried out by the Yes I Do (YID) programme in Traditional Authority (TA) Liwonde, Machinga district, Malawi. In 2015, the organisations Plan International the Netherlands, Amref Flying Doctors, CHOICE Centre for Youth and Sexuality, KIT Royal Tropical Institute and Rutgers partnered and formed the YID Alliance. These organisations worked together on behalf of the Dutch Ministry of Foreign affairs to "foster a world where girls decide if, when, and whom to marry and if, when, and with whom to have children. Further, YID aimed for a world in which girls are protected from female genital mutilation/cutting and in which communities support girls in deciding and making their own choices" (1). The Dutch Ministry of Foreign affairs funded the programme with a total budget of €27.6 million (1). The programme was implemented between 2016 and 2020 in seven selected areas of Malawi, Ethiopia, Kenya, Mozambique, Zambia, Pakistan and Indonesia (2). In Malawi, the main objective was to reduce teenage pregnancies and child marriage in TA Liwonde, Machinga district. To achieve this, a package of interventions was developed to stimulate youth empowerment and improve youths' access to sexual and reproductive health facilities and education (3). Over the course of the programme, qualitative and quantitative data were gathered to monitor the programme's impact. Unfortunately, despite great efforts, the teenage pregnancy and child marriage rate in the intervention area was not reduced after four years of intervention (3).

As a midwife, I have worked in several settings in low-income countries. During my work, I experienced first-hand the high incidence and negative consequences of teenage pregnancies and felt the urgent need for action concerning this public health problem. During my Master's in International Health, I learned that the effectiveness of development programmes could be compromised if programmes are not fully aligned with the needs of the beneficiaries. After reading several YID evaluation reports, I wondered if the goals set were feasible and whether the programme strategy was in line with the community's needs. To answer these questions, I studied the local perceptions of teenage pregnancies in TA Liwonde, Machinga district, Malawi, after four years of intervention performed by the YID programme. Additionally, I explored how the YID programme involved key informants reflecting on the programme and what their and the community members' suggestions are for future strategies to address the issue of teenage pregnancy. With my study, I want to provide a deep inquiry into the local needs concerning teenage pregnancies in Malawi. This enables me to make recommendations for future community-responsive programmes to improve the health outcomes of pregnant teenagers and to prevent teenage pregnancy in Malawi.

2. Background

2.1 Teenage pregnancies globally

According to the World Health Organization (WHO), 18 million girls below the age of 20 years become a mother every year globally, being accountable for 11% of all births worldwide (4). The global teenage pregnancy rate is 44 per 1,000 girls aged 15-19 (5). The vast majority of these teenage pregnancies (95%) manifest in low- and middle-income countries (LMICs), and the sub-Saharan Africa (SSA) countries are taking the world's lead (6,7). Two recently performed systematic reviews found that the high level of teenage pregnancies in SSA is attributable to multiple factors, which can be categorised into: sociocultural-, environmental- and economic-, individual-, and health service-related factors (8,9). According to a recently performed systematic literature review and meta-analysis, that included data from 18 SSA countries, teenage pregnancies under the age of 18, are significantly associated with an increased risk of maternal and neonatal complications such as pre-eclampsia, eclampsia, preterm birth and maternal mortality (10). Other research found that the children of mothers under sixteen had a significantly higher chance of stillbirth, neonatal mortality, infant mortality and under-five mortality when adjusted for socio-demographical factors such as rural versus urban residency and education level (11).

2.2 Malawi's profile

2.2.1 Geographic context

Malawi is a landlocked country located in south-eastern SSA bordered by Zambia, the United Republic of Tanzania and Mozambique (figure 1). The country's capital city is Lilongwe.

Figure 1: Geographical location Malawi

2.2.2 Population demographics

The current estimated population of Malawi is 20.4 million (12). Malawi has a young, quick-growing population with, as shown in the population pyramid, a median age of 18.1 years (12,13) (figure 2). The life expectancy at birth is 68 years for females and 62 years for males. This number has been significantly increasing, as in 2000, this was still 45 years (14).

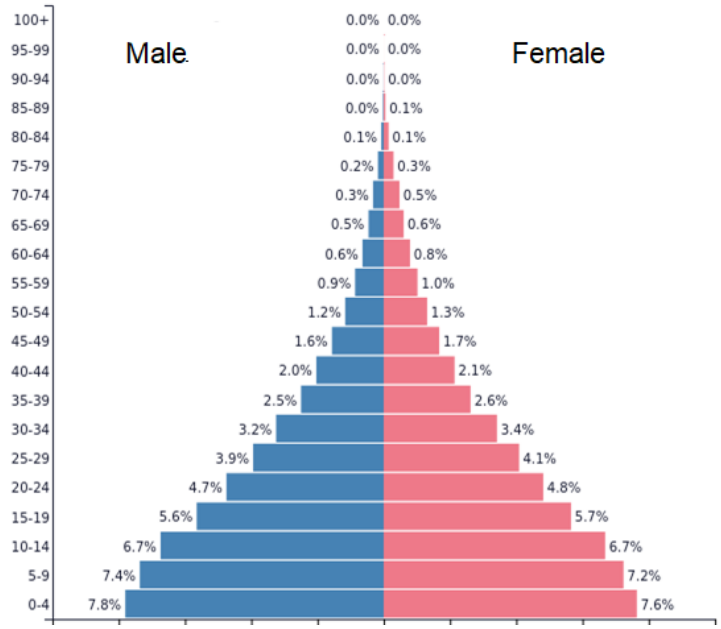


Figure 2: Population Pyramid Malawi (13)

2.2.3 Economic status and health system

Malawi is one of the poorest countries in SSA. In 2021, the country had a gross domestic product (GDP) of USD12.63 billion (15). Since 2016 economic growth has been rising; however, due to the Covid-19 pandemic, this has been disrupted, and inflation rates have been high (16). The economic growth did increase in 2021, yet it remained below pre-pandemic levels (17). In 2019, 70.1% of the Malawians lived on less than USD 2.15 a day. This percentage has been gradually increasing; in 2016, this was 65,7% (18). The youth in Malawi has limited future perspectives due to poor job opportunities (16). Furthermore, due to climate change, the country has been hazard by dry spells, tropical storms, and floods (17,19). Health system financing depends highly on donor funding; in 2015, only 20% of the total health expenditure was provided by the government. In 2019, this was 9,75% of the annual fiscal budget (20). External development partners (EDPs) provided 80% of the health expenditure (21). Throughout history, the government has been involved in several corruption cases, which led to a distrust of the government by donors and resulted in the withdrawal from funding (21,22). Many donor countries started by-passing the government by directly channelling their funds to non-governmental organisations (NGOs) (21).

Malawi provides free maternal care in public health facilities. About 60% of the health facilities are public. The Christian Health Association of Malawi (CHAM) provides a large part of health care as well. Maternal health care in such CHAM facilities is also free of charge, because of re-imbursement agreements of the CHAM with the government of Malawi (23). In 2015, 90% of births took place in health facilities (24). However, antenatal care services are underutilised. According to UNICEF, only 51% of women aged 15-49 attended at least four or more antenatal care visits (25).

2.2.4 Gender equality and educational system

Malawi is ranked in the 132th (out of 146 countries) position of the Global Gender Index (26). According to the latest data, among ever-partnered Malawian women and girls of the reproductive age, nearly 17% experienced physical and/or sexual violence by a current or former intimate partner in the previous 12 months (27).

Primary school enrolment in Malawi has been improved since 1994 when primary education became free (28,29). For secondary school, tuition fees, transport and accommodations costs are charged (30). Due to poverty, secondary and tertiary enrolment is low. However, there is an improvement as in 1992, only 2% of girls enrolled in secondary education, while this was 35% in 2018 (31–33) (see table 1).

Girls	Primary education	Secondary education	Tertiary education
Enrollment rate %	94	35	1
Compeltion rate %	80	21.9	No data
Boys	Primary education	Secondary education	Tertiary education
Enrollment rate %	93	34	2
Compeltion rate %	80	23.7	No data
2018 2019			

Table 1: School enrolment rates 2018-2019

2.3 Teenage pregnancies in Malawi

2.3.1 Teenage pregnancy rate

In Malawi, the teenage pregnancy rate is 131 per 1,000 girls aged15-19 years (34). The median age at first birth has remained 19 years since 1992 (31,35,36). The proportion of adolescents with knowledge of contraception increased from roughly 76% in 1992 to 94% in 2015. The proportion of adolescents using contraceptives increased from 11% in 1992 to 29% in 2015 (37). Despite that, the teenage pregnancy rate is increasing. According to the most recent Malawian Demographic Health Survey, in 2015-2016, 29% of the girls aged 15-19 years had started childbearing (35). This percentage, is lower than in 1992, when it was 34.2% (37). However, this percentage is higher in comparison to the previous DHS in 2010; back then, the teenage pregnancy rate was 25.6% (37).

2.3.2 The drivers and protective factors of teenage pregnancies in Malawi

Geographically, there is a rural-urban differentiation regarding teenage pregnancies. In 2015, in rural areas, 31% of the adolescents aged 15-19 years had begun childbearing, while in urban areas, this was 21% (35). In a 2019 performed multi-level analysis, the drivers and protective factors for teenage pregnancies in Malawi, when adjusted for geographical factors, were explored by using the most recent DHS data (37). A complete overview of this analysis can be found in annex 1. It was found that the odds of teenage pregnancy increased as girls got older. Furthermore, it was found that having an early sexual debut, living in a union or being married to the head of the household, and not living in the same household as the girl's parents significantly increased the odds of teenage pregnancy. Protective factors for teenage pregnancy were an educational status of secondary level and above, being exposed to two out of three media sources, either newspaper, radio or tv, and living in the wealthiest household quantile (37). Other systematic reviews had comparable findings and additionally

found that low levels of self-efficacy and self-esteem among teenage girls were risk factors of teenage pregnancy (8,9).

Teenage pregnancy and child marriage are interlinked since child marriage might lead to teenage pregnancy, and unplanned teenage pregnancy might lead to (child) marriage as pregnancy out of wedlock is taboo (38). Until 2017, children between the ages of 15 and 18 were allowed to marry with parental consent. However, after adjustments of the Constitution, the minimum age of marriage is now 18 years (39,40). Despite these leveraged laws, according to UNICEF, in 2018, still 42% of the women aged 18-49 years were married or in a union before the age of 18 and 9% before the age of 15 (41). Child marriage is much more common among girls than boys, as only 6% of boys are married or in a union before age 18 and 1% before age 15 (35,42).

Finally, the high numbers of gender-based, and intimate partner violence are also an attributable factor to teenage pregnancies. It is reported that 33% of teenage pregnancies are the results of unwanted sex among women now aged 18-24 (43).

3. Problem statement, justification and objectives

3.1 Problem statement

Becoming a teenage mother in Malawi comes with increased risks of morbidity and mortality. Many of these complications are preventable if timely recognised. In Malawi, teenage pregnancies comprise 15% of maternal deaths, making childbearing one of the leading causes of adolescent death (44,45). Additionally, 56.1% of teenage pregnancies in Malawi are unintended, which makes them prone to end in unsafe abortion; safe abortions are only lawfully permitted when the life of a woman comes in danger (37). It is estimated that 6-18% of maternal deaths in Malawi result from unsafe abortions (46). Next to this, teenage pregnancy is, together with poverty, the main contributor to school dropouts. This diminishes the girls' educational and career opportunities and results in an intergenerational cycle of unemployment and poverty (47–49). Furthermore, financial struggles, high levels of responsibility at an immature age and stigmatisation put girls at risk of developing psychological problems (50).

3.2 Justification

Despite national and international efforts (among which the YID programme), the teenage pregnancy rate has been increasing since 2010, and it is predicted that this rate will further increase (51). Climate change is expected to lead to food scarcity, in combination with the high inflation rates this will increase the number of people living in poverty in Malawi, which is a driving factor behind teenage pregnancies (52,53).

Most development programmes, among which the YID programme, address socio-cultural and gender norms in their strategies to prevent teenage pregnancy. However, a recently performed ethnographic study argues that development programmes overemphasise sociocultural factors and gender norms in their strategies and lack attention to the fact that teenage pregnancies and child marriages are girls' adaptive responses to socio-economic and socio-political circumstances (54). To develop effective community-responsive development programmes, it is necessary to understand the local perceptions of teenage pregnancies, yet, little is known about this. Therefore, this study will address this knowledge gap by exploring the community perceptions of teenage pregnancy after the implementation of the YID programme in TA Liwonde, Machinga District.

3.3 Objectives

3.2.1 Overall objective

To explore the local perceptions of teenage pregnancies and their causes and consequences in Traditional Authority (TA) Liwonde, Machinga district, Malawi, to gain insight into the community needs regarding this matter and translate these findings into recommendations for future development of community-responsive programmes to address teenage pregnancies.

3.2.2 Specific objectives

1. To explore the perceptions of teenage pregnancies among community members of TA Liwonde, Machinga district, Malawi.
2. To gain insight into the sexual and reproductive health of adolescents in TA Liwonde, Machinga district, Malawi.

3. To explore the ideas of the causes and consequences of teenage pregnancies among community members and key informants of TA Liwonde, Machinga district, Malawi.
4. To shed light on what the local community members of TA Liwonde think are possible effective interventions to reduce the teenage pregnancy rate.
5. To gain insight into how key informants involved in the YID programme reflect on the YID programme.
6. To provide recommendations for future community-responsive programmes to address teenage pregnancies.

4. Methodology

4.1 Study area

The YID programme took place in TA Liwonde, Machinga District, Southern Malawi. Machinga District has a total population of 735,438 people and exists of ten Traditional Authorities (TAs). In 2018, TA Liwonde had a population of 89,424 (55)(56).

4.2 The Yes I Do programme

An in-depth explanation of the programme strategy and 'theory of change' pathways can be found in annex 2 and 3. To monitor the impact of the YID programme, a mixed-methods base- and end-line were conducted. TA Chikwewo, Machinga District, facilitated as a control area. At base-line, 1,595 and at end-line,1,622 youths aged 15-24 years were surveyed in both areas. They found that, in both areas, the teenage age pregnancy rate increased (3).

This study only uses qualitative end-line data from TA Liwonde. To get a sense of the situation in TA Liwonde, an overview of the outcomes regarding teenage pregnancy-related indicators in TA Liwonde, derived from in the base- and end-line survey with young people (15-24 years) is presented in figure 3. In 2016, 63% of the women (20-24 years) had experienced teenage pregnancy, versus the nationwide average of 29% (3,35). In 2020, despite an increase in knowledge of modern contraceptives and usage of SRH services among female and male respondents, the percentage of women who experienced teenage pregnancy increased to 70% (3). Modern contraceptive usage was only surveyed at the end-line. The percentage of women aged between 18 and 24 years who was married or in a union before the age of 18 years increased from 18% to 20% between 2016 and 2020 (3). As mentioned earlier, in 2015, nationwide, this was 42%. However, this percentage was measured among women aged 18-49 years (35).

4.3 Data collection

A qualitative methodology was used to gather data on the local perceptions of teenage pregnancies. A secondary data analysis was performed on the YID end-line data. Data collection took place in 2020 in TA Liwonde. Most interviews were conducted in the local language and translated and transcribed into English by the YID research group.

4.4 Data processing and analysis

Twenty-five transcribed in-depth interviews and seven focus group discussions were processed. A detailed overview of the study participants can be found in annex 4. After reading the transcripts to get familiar with the data, a coding framework based on the study objectives and applied framework, which is discussed in paragraph 4.5, was developed. The coding framework can be found in annex 5. A thematic analysis was performed for which NVivo 12 pro software was used. Finally, summaries were made and relevant quotes from the interviews were selected to illustrate the perceptions of teenage pregnancies shared by the participants.

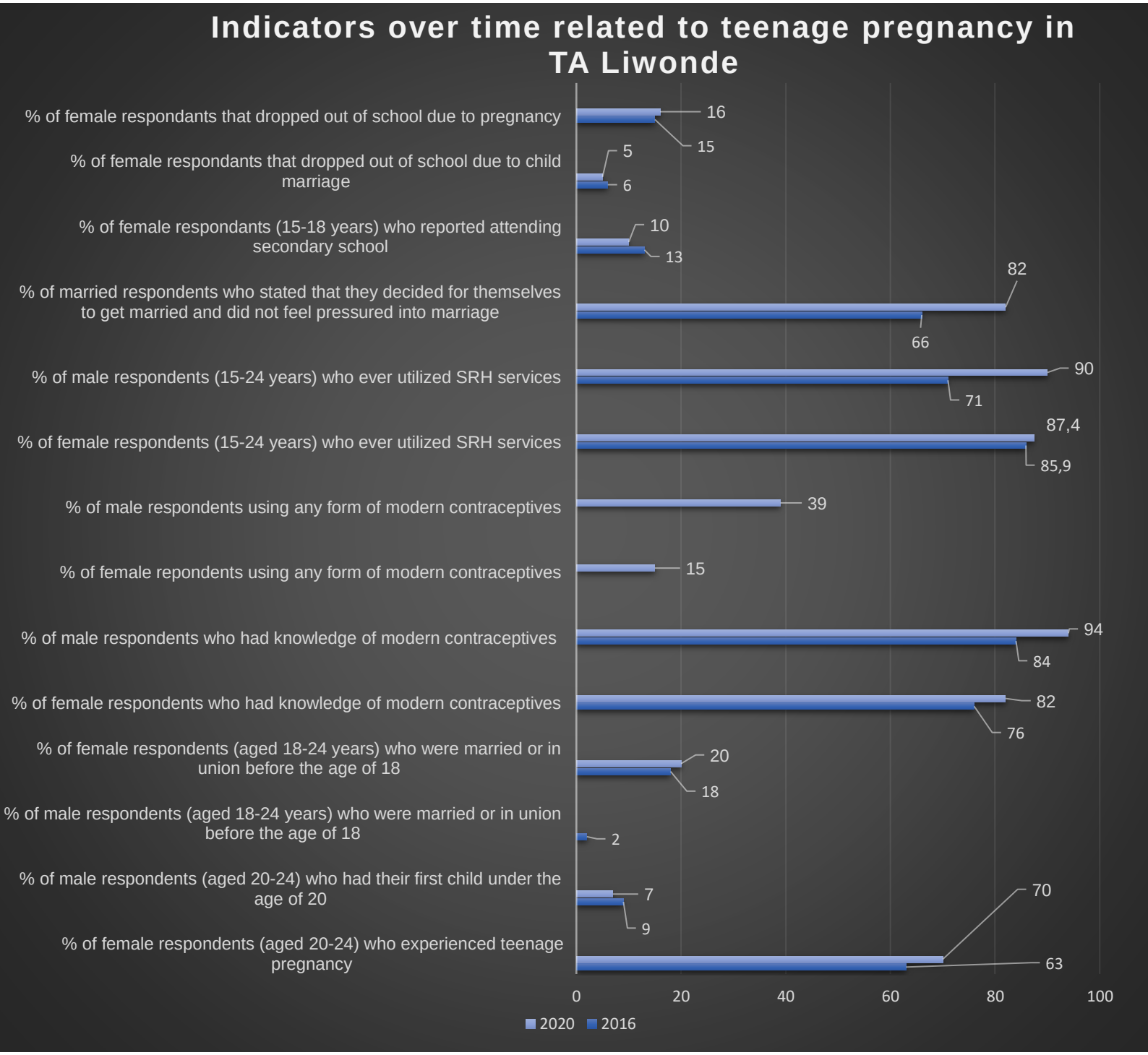


Figure 3: Indicators over time related to teenage pregnancy in TA Liwonde (56).

4.5 Analytical framework

To guide the development of the coding framework and perform the thematic data analysis, a 'gender and rights' analytical framework was applied. The framework is based on an existing framework developed by Isabel Goicolea, which can be found in annex 6. As described in the background section, literature has shown that teenage pregnancy and its incidence, causes, and consequences are interlinked with many individual and structural factors; and so will be the perceptions of teenage pregnancies.

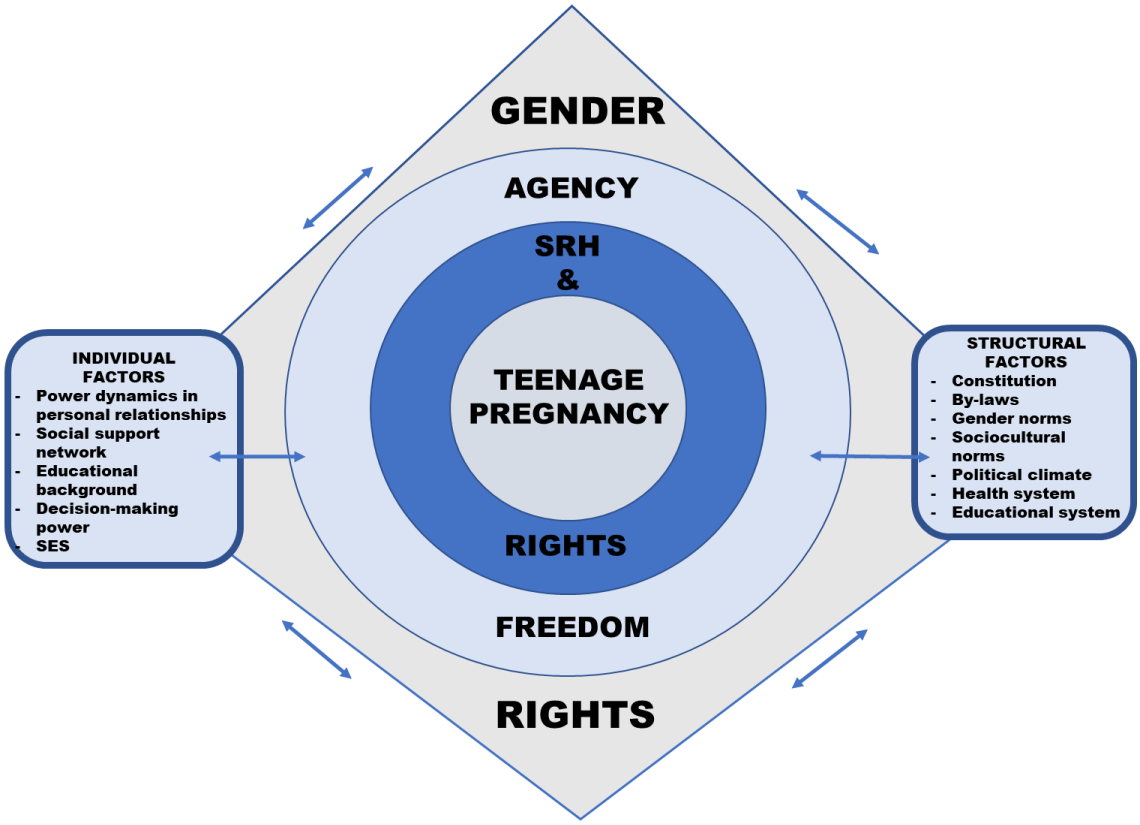


Figure 4: Gender and rights analytical framework

The circle around 'teenage pregnancy' shows that to understand the perceptions of teenage pregnancies, teenage pregnancy should not be studied as an isolated event but as an issue embedded in the broader field of sexual and reproductive health and rights. The perceptions of teenage pregnancies can be approached from a 'rights perspective' (the triangle on the bottom) and a 'gender perspective' (the triangle on top).

The rights perspective explores the level at which a person can exercise their sexual and reproductive rights. This depends on structural factors (displayed in the box on the right). Those structural factors determine whether the duty-bearers (the state and traditional authorities) can put a system of health protection (including SRH services) and SRH and rights education into place. The state should not only rule and judge but also invest in policies that promote individuals' ability to exercise their rights (57).

The SRH services should fulfil the criteria of availability, accessibility, acceptability, and quality to let a person fully enjoy their SRH and rights. These structural factors are under the direct influence of the political climate. The gender perspective explores how gender- roles and inequality effect the perceptions and exercise of SRH and rights. The level at which this happens depends on the ruling gender- and sociocultural norms, and other structural factors in society (displayed in the box on the right). The circle around teenage pregnancy and SRH and rights illustrates that the impact of the described elements of the rights and gender approach depends on the level of agency and freedom a person has concerning their sexual and reproductive health and rights choices. This is influenced by individual factors (displayed in the box on the left).

While analysing the data, it appeared that the gender- and rights approach merged, and it was challenging to fully distinguish individual and structural factors. Therefore, the framework was

used to explore the local perceptions of teenage pregnancies comprehensively but in the results chapter, the two approaches and individual and structural factors are not separated to maintain a logical reading flow. A further discussion on this follows in the discussion chapter.

4.6 Limitations

As the YID programme did not use this analytical framework, the data collection was not based on it either. The end-line mainly focused on people's perceptions on YID intervention strategies and changes in the community over time, therefore, data addressing the personal experiences of teenage pregnancy was not always probed for. Furthermore, as only end-line data were used, this study does not analyse how the local perceptions of teenage pregnancy changed over time.

5. Results

5.1 Socio-demographic characteristics of study respondents

In total, 73 people were interviewed, among which community members aged between 15 and 81 years of age and key informants. A detailed overview of the study participants, their ethnicity, religion, and occupation can be found in annex 4. The key informants were professionals who were directly or indirectly involved in the YID programme. The majority of the key informants worked for NGOs directly involved in the YID programme, being PLAN, AMREF, FPAM, CHRR, and CYECE. The other key informants were professionals who in their daily work were involved in preventing teenage pregnancies or mitigating the impact of teenage pregnancies, being: two CBO leaders, a district social welfare officer, a social worker, a district education manager, a person involved in the 'One Community' project, a headteacher, a religious leader, a chief, a nurse/midwife and a clinician/deputy youth-friendly health services coordinator. The key informants were all working Machinga district. Twenty-three respondents participated in one-on-one in-depth interviews (IDIs), two respondents in duo IDIs, and 49 respondents in seven focus group discussions (FGDs). Focus groups were formed based on sex and age.

5.2 The local perceptions of teenage pregnancies

Most of the community members said that, in general, people perceive that teenage pregnancy leads to negative consequences for all people involved. The consequences of teenage pregnancies, as described by the respondents, can be divided into three categories: medical, financial, and psychosocial (see paragraph 5.4). Only a few community members said that teenage pregnancy is considered positive or celebrative. A key informant mentioned that teenage pregnancy assured that grandparents are getting many grandchildren, and since family is their financial security system, they appreciate that. In addition, teenage pregnancy and marriage, as mentioned by a male youth, could be an escape from an abusive parental household. Community members had different ideas about the teenage pregnancy rate over time. About half of the respondents thought the incidence increased between 2016 and 2020, and about the other half thought the incidence decreased. However, most key informants believed that the teenage pregnancy rate had increased.

5.3 The local perceptions of adolescent sexual and reproductive health and rights and contributable factors of teenage pregnancy

5.3.1 Knowledge and awareness of SRH and rights

According to community members and key informants, most girls start having sexual relationships between 10 and 15 years. Most youth respondents mentioned that boys have their sexual debut from the age of 15 years, with some outlier saying from 10 years. During the interviews, all youth respondents seemed aware of the consequences of unprotected sex, as they mentioned the risks of sexually transmitted infections (STIs) and unplanned and undesired pregnancies. The majority of the youth respondents said that they received their SRH education and information via healthcare professionals. Many youth respondents described the critical role of teachers in their SRH education. Most youths said that during 'life skills' classes, they receive information about the negative consequences of premarital sex and how they could protect themselves from STIs and teenage pregnancies. In addition, the

majority of youth respondents mentioned the role of youth clubs in their SHR education; these will be further discussed in paragraph 5.6.2.

Key informants revealed some challenges that the school system experiences regarding sexuality education. According to a key informant working for an NGO, not all teachers feel comfortable teaching Comprehensive Sexuality Education (CSE), as they do not receive training before tutoring this. The secondary school curriculum offers CSE, but the primary school curriculum only touches upon some topics. Due to low secondary school enrolment, most youths do not receive CSE. Besides that, many children of secondary school age are still in primary school, making the content in their school books unsuitable. A few older community respondents mentioned that providing the youth with CSE makes them promiscuous. A key informant reported to have been involved in an SRH project which was prematurely stopped due to this belief. Yet, most youths and parents supported CSE and were grateful for the implementation of such projects.
The majority of youth respondents said to be educated about their universal human sexual and reproductive health rights, e.g., the right to have access to sexual and reproductive health services and to decide when and with whom to marry. However, some parents or elderly perceived youths who are advocating for their rights as rude.

"Sometimes it's like: yes, it makes them be rude because they are aware of what their rights are about. Sometimes maybe, the community says these things because they do not know rights of the youths. That is why maybe they say that they are rude. For example, if a young girl is being forced to get married and the girl tells her parents that she has the right to have education instead of getting married too early, the parents will say that she is being rude. In this scenario, it shows that the girl is aware of her rights, but her parents are not aware of that. Sometimes it's maybe that they are not aware of what are the rights of these youth and what they supposed to do. They may be blamed for this". **A 22-year-old female key informant working for YID NGO.**

In the line the above, a female parent described that all human rights have limits and that children in her community should not go 'beyond their human rights'. When questioned about the ability to discuss and ask questions about sensitive issues to parents, grandparents, and the elderly in general, the youths were divided. About half of the respondents felt comfortable discussing this, and the other half did not. If comfortable discussing sensitive issues, most youths felt more comfortable discussing them with their grandparents than with their parents. Most female parents said that they discuss these topics with their children and instruct them to follow the advice of NGOs and healthcare workers. Yet, most key informants described the sociocultural taboo among parents in discussing these sensitive topics with their children. According to a key informant working for an NGO, the taboo is gradually decreasing since the start of the YID programme.

5.3.2 Access to youth-friendly SRH services

Most respondents, both community members and key informants, believed that abstinence is the best form of contraception. Youths reported that during 'life skills' classes at school, teachers plead for abstinence as the first choice of contraception. Those who feel they cannot abstain have access to contraceptives available in health centres, the hospital and within the community through community outreach. According to almost all respondents, these services are accessible free of charge. Most community respondents, youths and parents, reported that SRH services in health facilities are youth-friendly and comprehensive. It was mentioned that counselling is well performed, that youths feel well assisted at the facilities and that their

healthcare providers keep their issues confidential. However, a few male youths reported the experience of unfriendly service, problems with access to contraceptives, or not being helped at the facility after a long day of waiting. According to most key informants, almost all health facilities in the area provide youth-friendly services, some offering separate days for youths only and private counselling rooms to assure confidentiality. However, some key informants came with critique regarding the attitude of healthcare workers; some healthcare workers are less youth-friendly due to the high workload. A barrier to using SRH services mentioned by some youths was the distance to the health centre, which could be up to two hours by bike. However, key informants and some community members described that youth community-based distribution agents (YCBDAs) and Health Surveillance Assistants (HSAs) help to make contraceptives more accessible for youths. According to some community members and key informants, not all communities are visited by outreach programmes. All youths and key informants reported having experienced a change in quality, availability and accessibility of youth-friendly services since the introduction of the YID programme. Before the start of the programme, youths were sent away from SRH services because they were perceived to be too young. Most of the key informants reported that due to procurement and distribution problems, health facilities have been experiencing stockouts of contraceptives. It was reported that the government is the leading distributor of contraceptives, but NGOs are also providing these services leading to a fluctuating availability of contraceptives since projects come and go. However, most community members, youths and elderly, reported a good availability of contraceptives and thought that especially condoms were easily accessible.

5.3.3 Misconceptions about contraceptives and user barriers

Some community members and several key informants reported that there are misconceptions about contraceptives, such as the belief that hormonal contraceptives are only for married couples, that they can cause fertility problems at a later age or that contraceptives make a man weak. None of de respondents reported believing in these misconceptions themselves. Despite being easily accessible, there were several barriers mentioned to condom use. According to male youth respondents, some men do not use condoms when having sexual intercourse with a young girl because they think it is unlikely that she has an STI. It was also mentioned that some girls prefer not to use condoms since this is seen as a mutual sign of trust. According to male youths, men prefer sexual intercourse without condoms because condoms have a negative effect on their sexual pleasure. These barriers, however, were not reported by female youths or grown-ups, only by boys or men.

"Doing it without a condom is like we are somewhere else. When the foreskin touches the girl, the feeling is out of this world. You even forget about death! There is even a say out there: 'you cannot eat a sweet while in a wrapper, it tastes better when you remove it from the wrapper'".
A male community member (20 years old, unmarried, no children).

Furthermore, multiple key informants reported that some youths are being stopped by their parents, often influenced by their religion, from using contraceptives.

5.3.4 Peer pressure and transactional sex

Community members of all ages often mentioned peer pressure as a cause of early sexual debut. Many respondents said that stories of friends lead to curiosity about sex. Also, youths tend to copy their parents and what they see on (social) media and when watching pornography. According to many community respondents, transactional sex is quite common. The driving force behind this was said to be poverty. Many youths said that seeing friends

having money, food, clothing, or soap obtained by transactional sex tempts others to engage in transactional sex too.

"Around here, most of the times, the people here start engaging in sex due to poverty. When they are lacking some things like soap, clothes then they start trading their bodies with money to buy things". **A male community member (22 years old, unmarried, no children).**

Some youth respondents also mentioned that young girls desire to start their own families. Seeing their friends marry and having children makes them desiring this too.

5.3.5 Gender- and sociocultural norms influencing agency in SRH choices

The majority of the respondents said that due to sociocultural and unequal gender norms, men have the decision-making power within the community. They have decisive power within the household too. According to a key informant, this reflects their TAs, since most chiefs are males. According to youths, they have little agency in the decisions they make in general. However, according to most key informants, some youths have agency. The level of freedom in their life choices is determined by the financial circumstances of the families they are born in. According to the respondents, boys have more agency and freedom in their SRH choices than girls. Girls can be forced by their parents into child marriage due to financial hardship, which potentially leads to teenage pregnancy. However, most respondents said this practice is less common than it used to be. It is the sociocultural norm that after marriage, the husband provides the wife with food and basic needs, which carries away some of the financial burdens of families living in poverty. Sometimes, these men are much older, leading to marriages with significant age gaps and unequal dynamics in their relationships. It was frequently reported that the number of child marriages has decreased since the start of the YID programme.

"Child marriage happens when one has not yet completed education when she has not gone higher with her education and because of that the girl has no power to decide when to have children, and how many and with who, so anytime she can wake up in the morning without realising that today I will get married, and she will end up being married and that man will tell you: 'I want to have children', you see? She cannot even decide to say: 'No, I do not want to have children let us use the contraceptives'. You know it will be difficult. Why? Because she is young, she cannot negotiate the kind of sex she wants to have with that man, so this is one of the challenges, and even in terms of her enjoying the sexual activity it is difficult, you know a man is going to be the one that will only enjoy that sexual activity…". **A 43-year-old, male key informant working for YID NGO.**

According to a key informant working for an NGO, men are dominant in decision-making in contraceptive use. Some husbands force their wives not to use any form of contraceptives, and if they do not listen, they threaten to divorce them. One of the reasons for this are the misconceptions about contraceptives. Not all girls feel empowered to propose condom use during sexual intercourse.

"There are those that can ask and insist on using a condom, and there are others, even if you have a condom and if you try not to use one, they would even bother to ask for a condom. Then there are also times that a girl would want to have unprotected sex, but the boy wants to have protected sex, and they can use a condom, so it depends". **A male community member (21 years old, unmarried, one child).**

5.3.6 Initiation ceremonies

According to all respondents, initiation camps are a deeply rooted cultural practice for which parents pay a monetary contribution to let their children participate. Respondents explained that at these camps, children are educated about all aspects of life, including culture, good morals, gender roles, sexuality, and death. Additionally, boys are circumcised and girls learn how to satisfy a man in bed. After initiation, children are considered adults. Most of the respondents, both community members and key informants, mentioned that children used to go to initiation camps from the adolescent age onwards, but lately, there is a trend that parents send their children at a younger age. Key informants mentioned that children from five years of age participate, and the majority of respondents said that the shared content is not adjusted to age. Traditionally, initiates are told that after graduating, they should have their sexual debut - preferably the night after the initiation ceremony. This practice is called 'Kusasa Fumbi', which can be translated as 'removing the dust'. For a girl, this can be with any man; there a no specific instructions given on what age the man should have. Also, some respondents said that initiators frighten youths by saying that if they do not do 'Kusasa Fumbi', they might die, their genital organs might rot, or they might not be able to conceive children in later life. Some community respondents, mainly older female parents, said that youths are not told to have their sexual debut but that they get curious about sexuality after initiation. A few said that the youths are not advised to start sexual relationships but are, on the contrary, educated about the risks of early sexual debut. A few community members and a key informant said 'Kusasa Fumbi' is no longer happening after interventions from NGOs in the district. However, most youths who recently went to initiation camps said this is still happening.

"Yao culture is kind of messed up a little because the youths are told how to take care of a man after they leave the camps. Therefore, they use aim to practice what they were taught in the initiation camps. This is even evident in the villages where you will even find a small girl telling an older man that I can carry you. From this, you can see that the youth become messed up, and all they can think about is to have sex due to what they were taught at the camps". **A 28-year-old, female key informant working as a nurse/midwife.**

5.3.7 Gender-based violence

It was frequently mentioned that the high incidence of GBV in the communities leads to an increased incidence of teenage pregnancies. Respondents said that a contributing factor to this is the long-distance girls have to walk to school. These journeys are not always safe; girls might get raped.

5.4 The local perceptions of the consequences of teenage pregnancy

5.4.1 Medical consequences of teenage pregnancy

The most frequently described consequence of teenage pregnancies was obstructed labour and the need of caesarean section due to the immature pelvis of the teenagers. The majority of respondents said that, due to obstructed labour, many young girls develop postpartum fistulas. Others mentioned STIs, hypertension, anaemia, uterine rupture, haemorrhage postpartum, cervical cancer, and maternal death as potential medical complications of teenage pregnancy. Most respondents mentioned increased chances of premature labour, dysmaturity, intra-uterine foetal death and intrapartum foetal death as negative neonatal

consequences of teenage pregnancies. According to the respondents, girls feel ashamed of their pregnancy due to stigma. Due to this, they seek care late, which accelerates the chance of complications during pregnancy and childbirth.

"She faces problems because she is still young and her body parts are not fully matured to withstand childbearing or be pregnant. And for her to look after the child, it is difficult because she is not mature enough and to society, she becomes a laughing stock. This might affect her psychologically". **A 28-year-old, female key informant working as a nurse/midwife.**

According to many community members and key informants, unsafe abortions frequently take place in the event of teenage pregnancies. It was described that teenagers get medicines and drink local herbs. According to a key informant, one of the leading indications of hospital admissions are the complications of unsafe abortion. Most respondents said that in the majority of cases, it is the parents of the girl who are forcing her to abort. Most of the time, this is because the boy who made the girl pregnant does not take responsibility for the pregnancy. Since an unsupported pregnancy would drive a poor household further into poverty, abortion is seen as the only way out.

5.4.2 Financial and psychosocial consequences of teenage pregnancy

According to many community members and key informants, teenage pregnancy often leads to marriage at a young age, as pregnancy out of wedlock is taboo. Additionally, the girl's parents often do not have the financial needs to 'feed another mouth'. Being seen as a burden has a significant psychological impact on the pregnant teenager. Her parents might force her to marry and live with the boy or men who made her pregnant. It was frequently described that age differences in marriage and financial stress could lead to unequal power relationships and intimate partner violence within marriage. Being married early and starting childbearing early eventually leads to big families and more financial problems. When a boy takes responsibility for the pregnancy, it comes with financial challenges. This has a significant impact on his quality of life and mental health as well. Community members frequently mentioned that this pressure could eventually lead to stealing.

"Your life as a person is affected. If I have a family, I would be able to think of going after jobs in other places. I would just need to take my hoe on my shoulder and go to farm. Imagine all year doing that, doing ganyu [casual labour]. That means my health and my life will be affected". **A male community member (24 years old, divorced, one child).**

The majority of the community members and key informants described the psychological consequences of teenage pregnancies. They said that teenage pregnancy targets a girl for verbal abuse in school and the community. Respondents frequently mentioned that this, combined with all the added responsibilities and financial struggles, could lead a teenage girl to commit suicide. In addition, girls who go back to school after childbirth are often bullied because of having a child. According to the community members, this leads to most teenage mothers (if re-admitted after birth) eventually dropping out of school.

5.5 Current structures in place to prevent and mitigate the impact of teenage pregnancies

5.5.1 Community bylaws

According to two key informants, the Ministry of Education (MoE) introduced a national policy that encourages girls should go back to school after teenage pregnancy and childbirth. To facilitate this, community bylaws were developed. As presented in table 2, community members and key informants had different perceptions of the development and implementation of these bylaws.

Development and enforcement of bylaws in TA Liwonde		
Version reported by	**Details on development of bylaws**	**Details on enforcement of bylaws**
Majority of key informants	The group village headmen wrote the bylaws after the government requested them to this.	Chiefs were made responsible for enforcing the bylaws.
Marjority of community members	The chiefs wrote the bylaws without the community members being involved in the process.	Chiefs were responsible for enforcing the bylaws.
Some community members	NGOs wrote the bylaws. Some community members were involved in the process.	Chiefs were made responsible for enforcing the bylaws.

Table 2: Different versions of the bylaws

As presented in table 3, also different versions of the by-laws were reported by the community members and key informants.

Details of the bylaws			
Version reported by	**Reporting the case**	**Consequences national law**	**Consequences community bylaws**
Majority of community members and key informants	The boy or man who made the teenage girl pregnant is traced down by the social welfare department and reported to child protection and the police for further investigation. The social welfare department needs to make sure that adequate support to the involved families is provided.	The court rules. If a teenage girl is made pregnant by a adult men, the men is sentenced to fourteen years in jail.	If the girl and boy are in school, they should temporarily stop. The boy should generate an income to maintain the girl. When the baby is born and has reached the age of a year, both the girl and boy go back to school as the grandmother (the mother of the girl) looks after the child. If the parents force their daughter into child marriage or refuse to let her go back to school, they could be arrested and fined again. The families of the teenagers should pay two to three goats and a few chickens to different leaders in the Traditional Authority, of which most mentioned are the village chief and the group village headman.
Some community members		The boy who made the girl pregnant could be arrested and sentenced to jail, also if the boy and the girl are in a consensual sexual relationship and both minors. Girls never get arrested.	
Some community members		The boy who made the girl pregnant is sentenced to jail if he and his family refuse to take responsibility for the pregnancy. Girls never get arrested.	

Table 3: Different versions of the bylaws II

"Some parents rush to go to the police to arrest us. So the question is, who is going to support the pregnancy if you take us to jail?". **A male community member (20 years old, not married, no children).**

According to community members, the strategy behind this is that these fines should scare off youths and keep them away from risky sexual behaviour and teenage pregnancy. According to several respondents, the community bylaws have a positive impact on the number of boys (or men) taking responsibility for the pregnancy since they fear the consequences of the bylaws. However, several community members also mentioned that the bylaws came with undesired effects, one of which is increased unsafe abortions. TAs are, according to the majority of key informants, autonomous governing bodies. This makes it complicated to get

bylaws unified on a country level. This results in families fleeing to other districts to avoid being fined or sentenced. These scenarios were mentioned by various respondents. A problem described by several key informants is that not all police officers have knowledge of the bylaws or the Constitution. According to some community members, some police officers and chiefs are corrupt and take bribes leading to cases of child marriage or teenage pregnancy not being further investigated. According several key informants, public institutions are lacking financial and human resources to set up teenage pregnancy prevention- and monitoring systems. Next to this, it was mentioned that the collaboration between public institutions could be improved.

5.5.2 Community structures

According to community respondents, when young couples are caught making sexual advances to each other, community members of older age are likely to give them SRH advice and counselling to prevent teenage pregnancies. The same system is in place in the event of teenage pregnancy. According to key informants, teenage girls often do not know they are pregnant or deny it out of fear. When other community members have suspicions that a girl is pregnant, they will tell the girl's parents or the chief about it.

5.6 Current structures in place to prevent teenage pregnancy

5.6.1 The Constitution and political will

According to the majority of the key informants, there is a national political will to address and prevent teenage pregnancies. This mostly became apparent by the constitutional changes (the ban of child marriage), however, little actions to support this are seen on a community level. Many community respondents do not have accurate knowledge of the changes in the Constitution, as it is frequently reported that youths are allowed to marry from the age of 15. Some key informants mentioned that during elections, teenage pregnancy and child marriage are popular topics among politicians, but once they are elected, the issues get neglected. Also, fragmentation within the Malawi government was described. According to key informants, the Ministry of Health (MoH) wants to increase contraceptive accessibility among youths with the aim of reducing teenage pregnancies. Yet, the MoE is not fully cooperative as they do not allow youth-friendly services to work within a 100-meter radius of schools. According to key informants, many different NGOs, among which PLAN, AMREF, CHRR, One Community, Spotlight, and many others, stepped in to bridge this gap to support the enforcement of constitutional laws by supporting the implementation of community bylaws and sensitising the communities on the negative effects of teenage pregnancies and child marriage.

5.6.2 Non-governmental organisations

A support structure introduced by NGOs and frequently mentioned by community respondents were youth groups. According to a key informant working for an NGO, at the time of the interview, there were 32 youth clubs active in TA Liwonde with the focus on educating youths on SRH and rights, providing them with contraceptives, and empowering them to claim their SRH rights. This has, according to community members, a positive impact on the incidence of teenage pregnancies. It was mentioned by key informants that YCBDAs are trained by different NGOs to make contraceptives more accessible. Organisations such as PLAN and CAMFED support girls with bursaries, school materials, and uniforms to protect

them from having transactional sex. Next to this, PLAN supports girls who dropped out of school with vocational training and capital to start a business and become financially independent.

5.6.3 Religious leaders

According to the respondents, teenage pregnancies occur in Christian and Islamic communities. The majority of both the key informants and community respondents said that religious leaders do not have a significant impact on the prevention of teenage pregnancies. According to most community respondents, their focus is on advising against premarital sex. According to key informants working for NGOs and a district education manager, religious leaders have always been difficult to collaborate with as they cannot stimulate youths to use contraceptives. However, according to most respondents, their attitudes towards contraceptives and SRH services are slowly changing.

" I remember when we had meetings with religious leaders and other local leaders when we explained to them about allowing people to access the Sexual Reproductive and Health services, they did not accept it. Even telling them: 'can you talk to your kids about SRH?' they could not believe it. It was a taboo for them, and they did not buy the idea, but now, with the same people and having so many meetings and showing them the situation, they have accepted. The percentage is not 100%, but I would say we got them at 0%, and now they are at a percentage of about 40, yes 35 or 40 per cent. That is for me if I would want to state the position where they are right now in terms of acceptance that young people can access, at least 40, or 50 there about". **A 43-year-old male key informant working for PLAN.**

5.7 Current structures in place to mitigate the impact of teenage pregnancy

5.7.1 Parents

According to community members, many parents do not have an active role in the prevention of teenage pregnancies due to the taboo on discussing sexuality. In the event of teenage pregnancies, however, parents are a major supportive structure in most cases.

"*If a young man impregnates a girl, you as a parent you are also affected. You are responsible for the pregnancy too. You end up also providing all the necessities that are required at the time of delivery. You buy a basin, wrappers, an umbrella, a razor. You need to provide eight wrappers at once. You see? You have to make sure that all these things are available".* **A female community member (75 years old, married and six children).**

The majority of the community respondents said that the first person the girl informs about her pregnancy is her mother. However, a few community respondents said that it would be more likely that she would inform her grandmother first out of fear of her mother's reaction. Others, mainly female parents, said most mothers would notice their daughter is pregnant before she tells her.

5.7.2 Teachers

Community members and key informants mentioned that some teachers are more involved in following up on teenage pregnancies and child marriage cases than others. Teachers have high workloads and classes with many students, making it, in most cases, impossible to monitor these cases.

5.7.3 Mother groups

Frequently mentioned by both community members and key informants were mother groups as a support structure. According to key informants, mother groups are active in almost all primary schools in TA Liwonde. It is an initiative which is supported by the MoE and by NGOs. Respondents described mother groups as a school-based psycho-social support system where mothers monitor cases of teenage pregnancy and child marriage, mediate between the youths and their parents, and support all involved parties to make it possible for youths to re-admit to school after giving birth. Parents can also approach the mother group as soon as they find out their child is pregnant. If families handle out of desperation due to poverty, mother groups help to find NGOs or community-based organisations, such as the child protection group or social welfare, who are willing to support these families.

5.7.4 Maternal care

According to several community respondents, including the chief, pregnant teenagers are sent back home by the healthcare providers if they come without a husband to their first antenatal clinic visit. It is requested that the girl comes back either with her husband or with a letter from the chief which explains why she is coming alone to the health facility. As soon as the chief is informed, actions to enforce the bylaws can be started. In one FGD with young boys, it is mentioned that some girls bring a 'fake husband' to avoid consequences. The majority of the community respondents reported that teenage pregnancies are referred to Machinga District Hospital for care and that medical doctors advise them to have a primary caesarean delivery because of increased medical risks of cephalopelvic disproportion during labour. These services are not available in the health centres. According to the community members, travel distance to the hospital is a barrier for teenagers to access the appropriate level of care.

The community experiences of antenatal care services to pregnant teenagers varied. Almost all female youths and parents reported that girls are being scolded, punished, and shouted at when entering antenatal clinics. Yet, most female and male respondents thought that the care they receive is equal in quality to the care other women receive. The key informants agreed with this. They described that some health facilities offer special days for teenage pregnancy antenatal and postnatal care only.

"These health providers they do shout at them when they go there. They blame them to say: 'Why early pregnant or child marriage?'. You see, as of now, they do not want to go and face these health providers. They know that they will be mocked by these health providers. They know that they will shout at. This is what they do these health providers". **A female community member (75 years old, married and six children).**

5.7.5 Community chiefs

According to the majority of the community members, the chief plays an important role in the event of teenage pregnancy, yet not much in preventing it. Chiefs provide support to girls and their families in the event of teenage pregnancy or help find suitable support structures. If necessary, they might bring the case to court to let the rule of law decide. Also, they negotiate between the girls' and boys' families to ensure that both youths can eventually return to school. According to some respondents, chiefs negatively impact teenage pregnancy incidence as they allow initiation ceremonies to continue in the traditional way. Enforcing the bylaws is, according to most respondents, the main responsibility of the chiefs. Some take this more seriously than others, as it is mentioned that some chiefs only perceive the bylaws as an

opportunity for personal gain by collecting the fines. According to many respondents, chiefs could have conflicts of interest regarding the enforcement of bylaws, as they also want to maintain their popularity and prominent position within the community.

"There is a number of strategies. The strategies are already there and are written down, even found in the bylaws formulated and kept at Tradition Authority Liwonde, but I feel the problem is with the parents because when they see that the young girl is pregnant and when the chief tries to follow the case the parents do shout at the chief saying: 'The child is not yours! I take care of her myself and I gave birth to her by myself, so you do not have to order me to send her to school!'. I also agree some of the parents say this". **A female community member (26 years old, single and number of children unknown).**

5.8 Reflections on the Yes I Do intervention and suggestions for future strategies to prevent teenage pregnancies

5.8.1 Reflections on the YID programme

Most key informants directly involved in the YID programme looked back positively on the programme. They described how it increased knowledge and awareness of SRH and rights, empowerment, and agency among youths. Also, they had the idea that awareness about the negative impact of teenage pregnancy and child marriage among community members has been raised and that local leaders and structures have been reached too. A key informant said that many new community structures supporting the rights of youths had been created over the years. Also, it was mentioned that teenage pregnancy and child marriage monitoring systems came into place. Some said that the programme decreased the number of child marriages in the intervention areas. The main critique the professionals gave was that the programme did not reach all youths and parents in the community; at the end of the programme, there were still youths who refused to participate in youth groups and parents who did not support the youth groups or the 'going back to school' campaign.
A few key informants were hesitant. They believed that, now that the programme is phased out, the interventions, e.g., youth groups, were likely to come to an end too, since some community members were opposing these activities. A critique from a professional in a leadership position at the Area Development Committee (ADC) was that the YID programme did not make enough use of the existing structures developed by CBOs.

5.8.2 Suggestions for future strategies by professionals who were involved in the programme

The majority of the professionals working for the YID NGOs had the opinion that after a period of educating, awareness raising and empowering, future programmes should focus on supporting the community to take ownership and leadership in the prevention of teenage pregnancies and child marriage. According to one respondent, at the end of the programme, not all chiefs were informed about how to enforce the bylaws. According to this key informant, as soon as all chiefs are updated, they could have a key leadership role in teenage pregnancy prevention. Most respondents thought the government should take responsibility for maintaining the efforts and progression made by the YID (and other) programme(s) by appropriately allocating budgets to public institutions (e.g., schools, the social welfare department, child protection, and the police) and supportive structures (youth and mother groups). It was said that improving the youths' prospects of life is the responsibility of all ministries and should not only be addressed by the Ministry of Youth (MoY). Yet, many

respondents thought it is too early for NGOs to withdraw; capacity should be built now that momentum is there. It was also mentioned that future programmes must be holistic, covering all drivers of teenage pregnancy, and expand upon previous programmes.

"In all sectors of government like the agriculture sector, they should also look at the youth. They should not just focus on older women and men when giving out loans or subsidy inputs. The youths should also be developed". **A male key informant working as a clinician and deputy Youth Friendly Health Services Coordinator and Machinga STI program coordinator (age unknown).**

Finally, many respondents stressed the importance of gaining financial security, since poverty was mentioned as a root cause of teenage pregnancy. To achieve this, key respondents described the importance of finishing school, good education, and vocational skills. According to several key informants, NGOs should help economic growth by providing start-up capital. It was suggested by a respondent that the private sector could step in, to provide small business loans or start-up capital to Village Savings and Loan Associations (VSLAs). Therewith, community members could start a business in cooperation to stimulate Malawi's' economic growth.

5.8.3 Suggestions for future strategies by community members

Most community members wanted NGOs to continue implementing programmes addressing teenage pregnancy. When youths were asked what strategies might work to prevent teenage pregnancies, the majority, mainly males, said they wanted to receive civic and educational training and start-up capital for their businesses.

"Usually, girls are forced to start sleeping around in search of support. They want the man to provide them with what they are missing at home, like soap and food. But if they had a source of income, like maybe the parents giving their child something to do to earn money, then they wouldn't think of getting married or think of having sex in exchange for money". **A male community member (15 years old, unmarried, no children).**

Other community members said that NGOs could help improve the youth's prospects of life by providing them with good quality CSE, stimulating them to use contraceptives if they decide not to abstain (and making these accessible) and encouraging them to finish their education. Furthermore, several participants said that the government or NGOs should support them in completing their education by paying for school fees and uniforms. Finally, several community members thought that the chiefs could have a crucial role in preventing teenage pregnancies by continuing the work of the NGOs.

"The chiefs should also take part because they are the ones who are around the villages full time, unlike the organisation representatives. They should take over from where the organisation has stopped because they come and go, unlike them". **A male community member (22 years old, not married, no children).**

6. Discussion

6.1 Youths' sexual and reproductive health and rights and the contributing factors to teenage pregnancy

The study results indicate that the quality of CSE a child or adolescent receives is determined by several factors, e.g., the highest level of attained education, the assigned teacher and whether a youth participated in a youth club. The data suggest that knowledge of SRH is there, as all youth respondents could explain the consequences of unprotected sex. The study reveals that only a small proportion of youths enrol in secondary education, where CSE is better addressed. Also, the shared content depends on the teachers' personal beliefs and comfort level in discussing sexuality. This study found that contraceptive user barriers among youths were: misconceptions on contraceptives, sociocultural norms regarding contraceptives, religious beliefs, unequal inter-relational power dynamics (within couples) and lack of accessibility to contraceptives. The analysis identified that despite teachers and parents being aware that youths have their sexual debut between the ages of 10 and 15, most believe that abstinence is the preferred method of contraception. If a girl cannot resist her sexual desires, contraceptives might be an alternative. This implies that sexually active girls are considered promiscuous, which might lead to stigmatisation, a potential user barrier for contraceptives. The respondents did not describe this phenomenon; however, a study conducted in Kenya confirmed this and led to the development of programmes addressing the stigmatisation of contraceptive use (58). Despite the fact that the majority of interviewed parents had positive attitudes towards contraceptive use to prevent teenage pregnancies, it was described by key informants and youths that many parents oppose contraceptive use. A recently performed study in rural Malawi found that negative parental attitudes cause a significant contraceptive user barrier among youths (59,60). It was found that most youths and parents feel uncomfortable discussing sensitive topics with each other. The data show that a contributing factor to early sexual debut is the lack of parental guidance and openness about sexuality. Creating openness around sexuality might prevent teenage pregnancies. A study performed in South Africa found that involving parents in CSE positively affected the prevention of teenage pregnancies (61). Further research on the impact of parental attitudes towards contraceptives on contraceptive use among youths is recommended to identify whether counselling parents could improve contraceptive uptake among youths.

The data suggest that the deeply rooted cultural practice of initiation ceremonies might be a driving factor behind teenage pregnancies, yet different experiences are reported. Some (mainly elderly) said that due to the efforts of NGOs, the harmful practice of ´Kusasa Fumbi´, in which youths are stimulated to have their sexual debut, has stopped, yet others (mainly youths) said that the practice is still present. Results identify that many community members thought that chiefs could have a leading role in aligning the content of initiation ceremonies with the universal children's human rights. Further research could focus on how, if aligned with the universal children's human rights, these ceremonies could be a culturally sensitive platform to prevent teenage pregnancies (62).

The study demonstrates a potential correlation between the high incidence of gender-based violence in the community and the high teenage pregnancy rate. This is in line with previous studies (27,43). The study identifies that despite some respondents saying that the practice is less common than before, forced child marriage out of poverty is a major contributable factor of teenage pregnancies. In some cases, girls are married off to older men, which leads to unequal inter-relational power dynamics and intimate partner violence. These findings are

supported by other studies identifying inequal gender norms and child marriage as major driving factors behind teenage pregnancies in Malawi (63). The study reveals, next to sociocultural- and inequal gender norms, poverty is one of the root causes of teenage pregnancy as it could lead to school drop-out as parents cannot afford school uniforms and materials. The study showed that school dropouts potentially lead to early sexual debut, as girls have no other purpose in life. If girls are in school, poverty could lead to transactional sex, where girls need the support of (young) men to be able to cover school fees or transport. Transactional sex also happens under the pressure of peers, as teenage girls desire to be maintained by men with nice food or clothes. This is in line with other study findings, which found that finishing secondary education or living in the highest wealth quantile were the strongest protective factors of teenage pregnancy (37,64).

6.2 Consequences of teenage pregnancy

The study shows that teenage pregnancy often leads to child marriage or marriage at a young age. Also, it is the main contributor to school dropouts among girls. Starting childbearing at a young age leads to having big families. As most girls do not re-admit to school after a teenage pregnancy, they have limited future career opportunities, which makes maintaining their families challenging. This shows how teenage pregnancy enforces the cycle of poverty (43). Even though teenage pregnancies are very common in the community, the study identifies that stigma around teenage pregnancy is present in the community as girls are perceived as promiscuous and a burden for their families when they become pregnant.

The study shows that pregnant teenagers face different barriers to enrolment in care. Due to the described stigmatisation, girls often keep their pregnancy a secret, which results in late healthcare-seeking behaviour. Also, the study identified that unmarried teenagers need to have an official letter from the chief before they are accepted in antenatal care without a husband; if they arrive without a letter, they will be sent home. There is a great likelihood that it is a very difficult step for a young girl to go and tell the chief about the pregnancy, which might also lead to a delay in the enrolment of antenatal care. These findings are supported by other research, which has shown that teenagers are less likely to have a minimum of four antenatal care visits in comparison to women older than 19 years (65). The study suggests that community respondents have adequate knowledge of the medical risks of teenage pregnancy as they named STIs, e.g., HIV/AIDS, hypertension, anaemia, uterine rupture, haemorrhage postpartum, cervical cancer, premature labour, neonatal dysmaturity, intra-uterine foetal death, intrapartum foetal death and maternal death as correlated medical risks with teenage pregnancy. Many of these complications are preventable if a girl has access to the right level of care at the right time. Most community members know that teenage girls have the medical advice to give birth in Machinga District Hospital due to the increased risk of obstructed labour due to cephalopelvic disproportion caesarean. The study suggests that delay in healthcare-seeking behaviour among pregnant teenagers is common, as obstetric fistula was the most frequently mentioned complication of teenage pregnancy. Data show that other contributing factors to delays are the travel distance to the hospital and the lack of money for transportation costs. The MoH is currently addressing this problem by constructing mother waiting rooms (66).

The results identify the significant impact teenage pregnancy has on the psychological condition of a teenage girl, as it was mentioned multiple times that some girls commit suicide because of their pregnancy. Other studies have shown that this is a significant problem in SSA (67,68). Therefore, it is highly recommended to investigate the psychological impact of teenage pregnancies in Malawi and the current structures to support these girls.

6.3 Support systems in place to prevent teenage pregnancies

According to a recently published report by the Malawi Human Rights Commission and Southern Africa Litigation Centre, bylaws only positively affect the teenage pregnancy rate if the community members write their scope, content and implementation strategy (43). This study identified that the community members in TA Liwonde do not have ownership over the bylaws as there is much unclarity about the exact details. The YID programme helped to implement bylaws, which punished community members in case a boy (or his family) did not take responsibility for the pregnancy, in case parents were forcing their child to marriage (whether pregnant or not), or if parents did not allow their child to re-admit to school after the pregnancy. The study revealed that the bylaws left room for misuse and corruption by the involved chiefs and police officers. The study also revealed cases in the community where a boy and a girl (both minors) became pregnant while having a consensual relationship but were fined or sentenced to jail if the family did not pay the fine. This suggests that already low-income families are driven further into poverty due to these bylaws, making it even more challenging to 'feed another mouth'. The bylaws came with good intentions; however, they potentially infringe on universal human rights (e.g., the right to privacy and sexual freedom) (43,69). Currently, cases in which youths are incorrectly punished are reviewed at the Mzuzu High Court (43,70,71). Other undesired effects of the bylaws identified in the study are that due to fear of the bylaws, some parents force their children to (unsafe) abortions or flee (whilst pregnant) to another district to avoid fines. As the leading cause of hospital admission in the district is unsafe abortion, there might be a correlation with the bylaws. Further research to investigate the local perceptions of the bylaws is recommended.

6.4 Reflection on the YID programme

Many factors contributing to teenage pregnancy identified by this study were addressed in the interventions of the YID programme, although the economic empowerment component of the programme was very small. Furthermore, it might be debated whether the set goals were feasible in just four years, as this study revealed that the root causes of teenage pregnancy are poverty and deeply rooted socio-cultural- and gender norms, which are unlikely to reform in a short time frame.

6.5 Future strategies to address teenage pregnancies

This study reveals that there is the political will to address teenage pregnancies; however, due to chronic underfunding, the Malawi government struggles to bring improvement within the communities. These findings are supported by a study which recently reviewed the country's ´National Youth Policy´ which addresses teenage pregnancy (72).

The study results partially support and reject the in the background described 'culturalism theory', in which an ethnographic researcher claims that international development programmes impose Western-Liberal ideologies by overemphasising socio-cultural- and gender norms in addressing teenage pregnancy and under emphasising the root cause of teenage pregnancy, being it a girls' adaptive response to the socio-economic and socio-political circumstances (54). This study brought several socio-cultural- and gender inequality-related factors contributing to teenage pregnancy to light, which, if addressed over a more extended period, could effectively reduce the teenage pregnancy rate. This rejects the

‘culturism theory’; however, many manifestations of gender inequalities, e.g., around transactional sex and forced child marriage, are driven by poverty. Furthermore, the results of this study identify that youths have limited future perspectives; according to the community members, even if they finish their education, only a few might get a government job. This supports the ‘culturism theory’; if the country’s economy improves, this would improve youths’ future perspectives and, eventually, could lead to a decrease in teenage pregnancies. It might be discussed whether international development programmes have the ability to boost the local economy of low-income countries; however, governments who are spending significant budgets on international development programmes keep at the same time international tax agreements in place which facilitate cross-border tax abuse. If this ends, Malawi’s government revenue might increase in such a way that, with the proper governmental leadership, Malawians might escape the circle of poverty (73).

6.6 The relevance of the analytical framework

The framework helped to explore the local perceptions of teenage pregnancies comprehensively. Secondary data analysis was done with a big data set available from the YID alliance. The framework guided the creation of the coding framework, which helped to gather research-relevant data from the data set. The framework provided clear boundaries for my scope of research.

When writing the results chapter, first, I pre-processed the data by exploring attributable factors of teenage pregnancy from a rights perspective and a gender perspective. I labelled influencing factors in the perception of teenage pregnancy as individual- or structural factors. However, while doing this, it felt that I was making artificial cut-off points in fluid concepts. An example of this are the initiation ceremonies; one could approach these from a rights perspective since minors are exposed to practices which could have a negative impact on their sexual and reproductive health and rights. Alternatively, one could approach initiation ceremonies from a gender perspective as the focus at these camps is on gender roles, since girls learn how to please and satisfy a man, and boys learn how to be a ‘real’ man. Initiation ceremonies are a structural factor of influence on the agency and freedom of SRH choices as it is a deeply rooted cultural practice. At the individual and family level, the initiation ceremonies influence the agency and freedom of SRH choices, as it depends on the parents whether the child participates in the initiation camp. Therefore, I decided not to use the framework as a layout in my results chapter. It is up for debate whether a framework that looks more at the relationship between the individual and structural factors, such as The Dahlgren-Whitehead model of Health Determinants, would have been more applicable (74). However, when applied, it became apparent that the framework functioned as intended to preserve objectivity and maintain the scope and outline of the research. Also, it gave a clear insight into the interlinkage between sexual and reproductive rights, gender- and sociocultural norms and how structural factors penetrate on the individual level. In conclusion, the framework was helpful in my research. Therefore, I recommend that other researchers use it again.

6.7 Limitations and strengths of the study

It is important to note that a sampling bias might have occurred since a considerable number of research participants were involved in the YID programme. As data were collected for the YID end-line evaluation, all participants needed to be knowledgeable about the YID programme. The likelihood that the lives of youths have been subjected to similar influences, such as YID youth clubs, could mean that their opinions automatically converge. This could have led to a decreased level of external validity of the study.

Among the respondents aged 15-19 years participating in the study, no one had experienced teenage pregnancy themselves or mentioned being pregnant at the time of the interview, or this was not reported. Among the respondents aged 20-24 years participating in the study, several had children; however, there were no direct questions about how they experienced being pregnant or becoming a parent at a young age. As this study explored the local perceptions of teenage pregnancy, it would have been of great value to include these experiences.

Many statements made by the research participants were about other people in the community instead of about themselves. Examples of this are the statements about misconceptions about contraceptives in the community: participants mentioned that 'some people' believe these misconceptions, yet none of the respondents reported believing in this themselves. Finally, the community perspectives were often not aligned with the key informants' perceptions of SRH and rights, e.g., the perspectives on contraceptive availability: this was assessed as sufficient by the community members, yet, frequent stockouts were mentioned by the key informants. In further research, it is recommended that measures are taken to prevent sampling bias, more pregnant teenagers and teenage parents are included, and more questions about experiences of teenage pregnancy and parenthood are included in the interview guide.

7. Conclusion

This thesis study has explored the local perceptions of teenage pregnancies, including the causes and consequences after four years of interventions by the YID programme in TA Liwonde, Machinga district, Malawi. In particular, the study gained insight into the community's needs regarding teenage pregnancies. Additionally, the study outlined the reflections on the YID programme from the key informants involved in the YID interventions. Finally, it also explored the community members' and key informants' suggestions for future programmes to address teenage pregnancies.

7.1 The local perceptions of teenage pregnancy

This thesis study concludes that the local community (youths aged 15 – 24 years, elderly, and key informants) consider teenage pregnancy a problem with negative medical, economic, and psychological consequences. Teenage pregnancy is considered a problem that should be addressed to improve the future perspectives of youths in the community.

7.2 The local perceptions of the causes of teenage pregnancy

This study reveals that the root causes of teenage pregnancy in TA Liwonde are poverty and socio-cultural and unequal gender norms. It can be concluded that many youths in TA Liwonde have early sexual debuts and, despite having access to youth-friendly SRH services and contraceptives, have unprotected sex. The study identifies child marriage, school drop-outs, peer pressure, transactional sex, lack of parental guidance, and initiation ceremonies as the main driving factors of early sexual debut. The study reveals that community members had different ideas of what impact initiation ceremonies have on the SRH and rights of youths. According to some community members, the harmful practice of 'Kusasa Fumbi' has ended, and according to others (mainly youths and key informants), this practice still exists. The study reveals that discussing sensitive issues with their children is taboo for many parents in the community. It can be concluded that there is a great likelihood that if children come back from initiation camps with an indoctrinated view on SRH and rights, their parents will not clarify this view. The study reveals that many youths had unprotected sex due to the influence of socio-cultural norms and religious beliefs on contraceptive use and misconceptions about contraceptives. It can be concluded that this contributes to the high teenage pregnancy rate in TA Liwonde.

7.3 The local perceptions of the consequences of teenage pregnancy

The study reveals that pregnant teenage girls are stigmatised as promiscuous, particularly if the pregnancy is out of wedlock. They are seen as a burden for their families. The study reveals that stigma, financial stress, and community bylaws can cause psychological problems among young girls, which might lead to unsafe abortions or even suicide. Despite the fact that most community members think bylaws are successful in preventing teenage pregnancies, it can be concluded that they come with undesired effects, such as unsafe abortion and delays in healthcare-seeking behaviour. Also, they can infringe on adolescent human rights of privacy and sexual freedom and lead to increased financial hardship. It can be concluded that girls are likely to receive inappropriate care during pregnancy. Girls require a letter from the chief before they can enrol in antenatal care, might be treated disrespectfully at health facilities and are, because of increased medical risks, referred to Machinga District Hospital. Yet, they might not have the financial means to go there. In conclusion, many obstacles must be overcome to receive the right level of care at the right time leading to preventable medical complications. Besides the psychological and medical consequences, the study reveals school drop-out, forced child marriage (as pregnancy out of wedlock is

taboo), intimate partner violence, big families, and financial problems as consequences of teenage pregnancies. The study identified that the current structures in place to prevent teenage pregnancy and mitigate the impact of teenage pregnancy are insufficient.

7.4 Reflections on the YID programme and strategies for future programmes to prevent teenage pregnancy

This study concludes that the YID programme addressed most of the contributable factors of teenage pregnancy in TA Liwonde. It can be concluded that key informants involved in the YID programme reflect positively on the programme despite the aims of preventing child marriage and teenage pregnancies were not achieved.

The study revealed that according to involved key informants, future programmes should focus on community ownership in preventing teenage pregnancies; after years of community sensitisation on the negative effects of teenage pregnancy and child marriage, it is now time for community members to lead their own process. The study identified that community members preferred future programmes to focus on economic empowerment by providing youths' business starters' capital. Additionally, community members desire current programmes focussing on SRH and rights education, SRH services accessibility, education enrolment, and re-admission after childbirth to continue. In conclusion: to make future programmes community-responsive, programmes should provide the community with tools to take ownership and leadership in preventing teenage pregnancies. These tools should focus on economic empowerment and socio-cultural- norms and gender inequality affecting the SRH and rights of youths.

7.5 Recommendations

Below, recommendations for future strategies to address teenage pregnancies are displayed. The recommendations addressed to the government have priority. The recommendations for future community-responsive programmes are not in order of urgency. Figure 5 illustrates the conclusion and recommendations of this study.

7.5.1 Recommendations for the government of Malawi

1. It is recommended that (international) revenue in Malawi is increased to give the countries' development programmes more financial space. The proceeds from this should be spent progressively and benefit the broader population focusing on ending poverty, improving public services (including access to contraceptives) and preventing teenage pregnancy. A task force should be established, and time-bound action plans, including monitoring and evaluating systems, should be developed to achieve this.

2. It is recommended that a government campaign for respectful maternal care for teenage girls is started. Community bylaws should be in line with the Constitution and human rights. Teenage girls should be encouraged to enrol timely in care and, at their first visit, be informed about existing support structures. The usage of mother waiting rooms should be promoted to increase the number of in-hospital births.

7.5.2 Recommendations for future community-responsive programmes to prevent teenage pregnancy

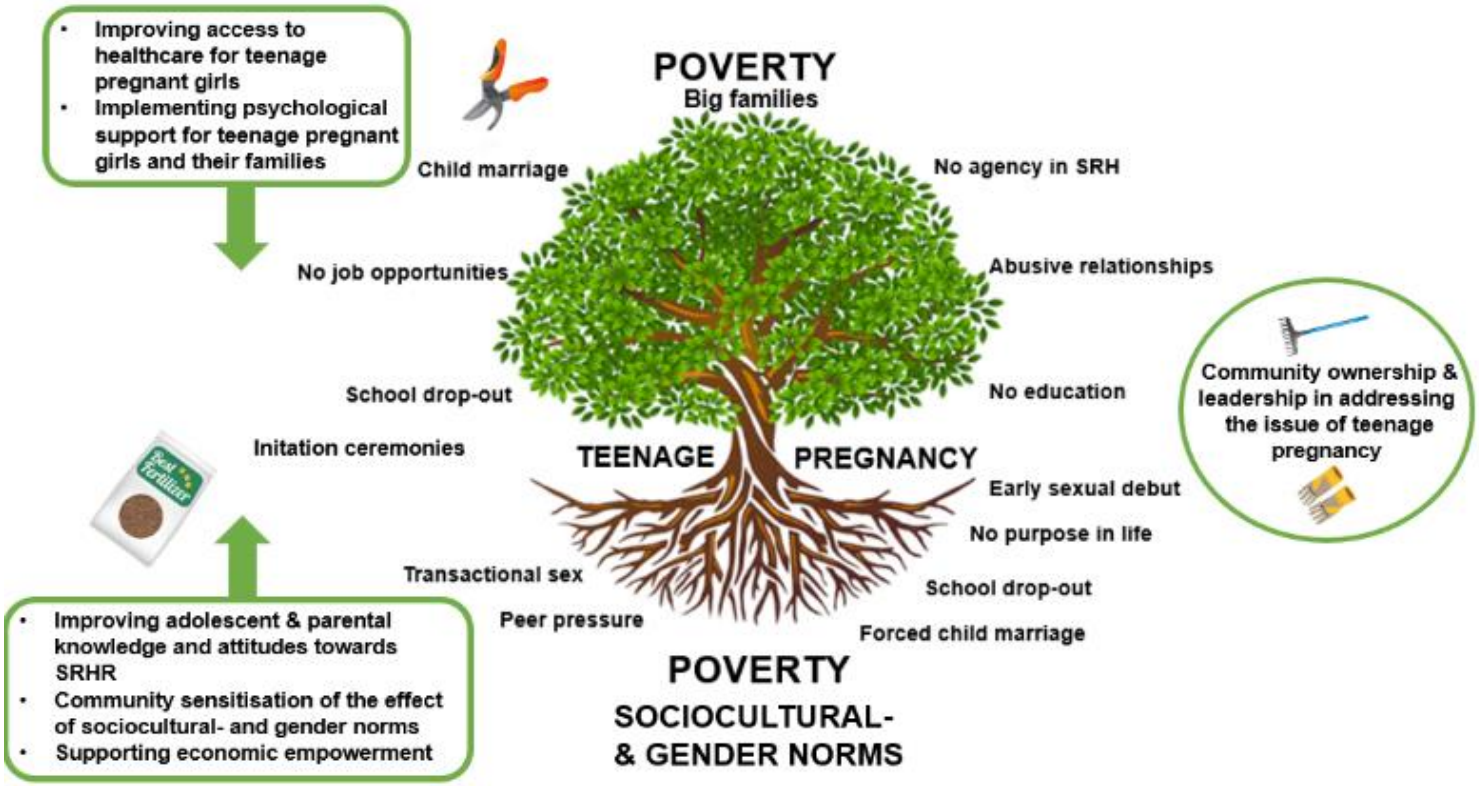
3. It is recommended that in future programmes, communities are provided with tools enabling them to take ownership and leadership in addressing the issue of teenage pregnancy. NGOs and the government should implement programmes that emphasise educational and economic empowerment by supporting girls to stay in school, providing vocational skill training and capital to start a business. This could be a gift or, to make it more sustainable, an interest free-loan. As parents are the main contributor to the financial maintenance of young girls, it is also recommended that capital is provided to existing VSLA groups in which parents participate. By facilitating community meetings where youths get the opportunity to speak and the elderly and chiefs listen, youths' vision on the impact of socio-cultural- and gender norms on their SRH and rights can be shared. Therewith, a community-led social movement can be started. By facilitating chiefs' meetings on a district level, districtwide community-led teenage pregnancy prevention strategies can be implemented.

4. As not all youths have been reached yet, it is recommended that NGOs continue their interventions focusing on community sensitisation on the negative consequences of child marriage and teenage pregnancy, SRH and rights, and the impact of socio-cultural- and unequal gender norms on teenage pregnancies. It is recommended that future youth groups incorporate combatting the stigma of teenage pregnancy and include anti-bullying programs. Support systems should be in place for existing youth clubs to ensure they continue after a programme has been phased out. NGOs should partner up and build on each other's accomplishments. Monitoring systems should be in place to evaluate progression.

5. It is recommended that NGOs focus on parental engagement in future programmes. In parent groups (fathers included), parents are taught the same content as youths during youth groups. In addition, they receive training in talking about sexuality and openness about sensitive issues with their children.

7.5.3 Recommendations for future community-responsive programmes to mitigate the consequences of teenage pregnancy

6. It is recommended that NGOs extend the role of mother groups in their programmes to mitigate the impact of teenage pregnancies. Currently, the main task of mother groups is encouraging girls to re-admitting to school after childbirth, but this should be extended to psychological support groups. The support groups should be available for in and out-of-school youths and support girls through pregnancy and motherhood. It is recommended to make use of role models.



This picture illustrates how poverty and sociocultural- and gender norms, as root causes, influence factors that lead to teenage pregnancy, the trunk. The branches represent the consequences of teenage pregnancy and how these consequences eventually lead to increased poverty levels: the leaves. As the leaves fall and feed the soil, an intergenerational cycle of poverty and teenage pregnancy is enforced, and history repeats itself.

The square boxes display recommendations for future community-responsive programmes linked to the recommendations in the text. In the box on the bottom, metaphorically illustrated with fertiliser, strategies focused on addressing the roots of the problem are displayed (text recommendations 1, 3, 4 and 5). In the box on the top, metaphorically illustrated with a pruning shear, strategies focussing on mitigating the consequences of teenage pregnancies are displayed (text recommendations 2 and 6).

In the circle on the right, a key message is shared. Future programmes should provide the community with tools that give them ownership and leadership in addressing the issue of teenage pregnancy (text recommendation 3).

Figure 5: Teenage pregnancies in TA Liwonde: Conclusion and Recommendations

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Appendix 1: multi-level analysis of risk and protective factors for teenage pregnancy in Malawi

Wado et al. used DHS data to "examine trends and risk factors associated with adolescent pregnancy(37). A multilevel logistic regression analysis was used to identify the net effects of individual, household and community level contextual variables on adolescent pregnancy after adjusting for potential confounders". The results are presented in table 4.

Variables	OR
Age in years (ref = 15)	
16	2.25(1.47-3.43)**
17	5.89(3.86-8.98)**
18	9.31(6.14-14.11)**
19	18.02(11.6-28.1)**
Educational status (ref = no education)	
Primary education	0,92(0.54-1.67)
Secondary and above	0.37(0.20-0.71)**
Age at sexual debut (ref = 18 to 19)	
No sex	1.00
5 to 14	5.03(3.38-7.49)**
15 to 17	2.81(2.02-3.92)**
Exposure to media (newspaper, radio, TV) (ref = non)	
One of the three	1.01(0.80-1.26)
Two of the three	0.66(0.45-0.95)*
All three sources	0.52(0.25-1.00)
Wealth index (ref = poorest)	
Poorer	0.67(0.49-1.05)
Middle	0.82(0.59-1.13)
Richer	0.80(0.57-1.13)
Richest	0.46(0.32-0.68)**
Relationship to head of household (ref = daughter)	
Spouse	4.91(3.79-6.37)**
Living with relatives or others	1.23(0.99-1.54)*
Sex of the household head (male = ref)	
Female	1.08(0.88-1.34)
Community level poverty (ref = low)	
High	1.09(0.85-1.39)
Community level education (ref = low)	
High	1.12(0.84-1.47)
* significant at P <0,05 ** significant at P <0,01	

Table 4: multi-level analysis of risk and protective factors for teenage pregnancy in Malawi(37)

Appendix 2: The Yes I Do programme

The YID alliance developed a multiple intervention programme based to achieve the following strategic goals:

1. To change attitudes of child marriage and teenage pregnancies among community members and gatekeepers and stimulate them to take action to prevent this.
2. To stimulate adolescent girls and boys to be meaningfully engaged in claiming their SRH rights.
3. To support adolescent girls and boys to take informed action on their sexual health.
4. To offer adolescent girls alternatives beyond child marriage and teenage pregnancies through education and economic empowerment.
5. To stimulate policymakers and duty-bearers to develop and implement laws and policies in relation to child marriage.

These strategic goals had the aim of driving a social movement to eliminate child marriage and reduce teenage pregnancy(2). On the next page, a comprehensive overview of the 'theory of change' of the YID programme is presented.

In Malawi, the YID programme, a package of interventions, was implemented under the lead of Plan International in collaboration with AMREF, FPAM, CYECE, and CHRR. The strategy of these interventions was to reduce teenage pregnancies and child marriage by creating gender-inequality awareness among the youth and their caregivers, governmental institutions, civil society organisations, an community leaders. During two years, weekly 'Champions of Change'- peer-led youth groups were organised to sensitize youths on the consequences of teenage pregnancies and child marriages, educate them on SRH, and empower them to claim their SRH rights. Additionally, the program supported the District Health Office in providing youth-friendly SRH services, including community outreach programmes. Furthermore, the program supported traditional leaders with the implementation of community bylaws to outlaw child marriage, supported the police investigation of child marriages, trained teachers in giving CSE, coordinated the 'Champions of Change' in school programme and paid school fees and provided school materials for girls (3).

Appendix 3: The Yes I Do programme's Theory of Change

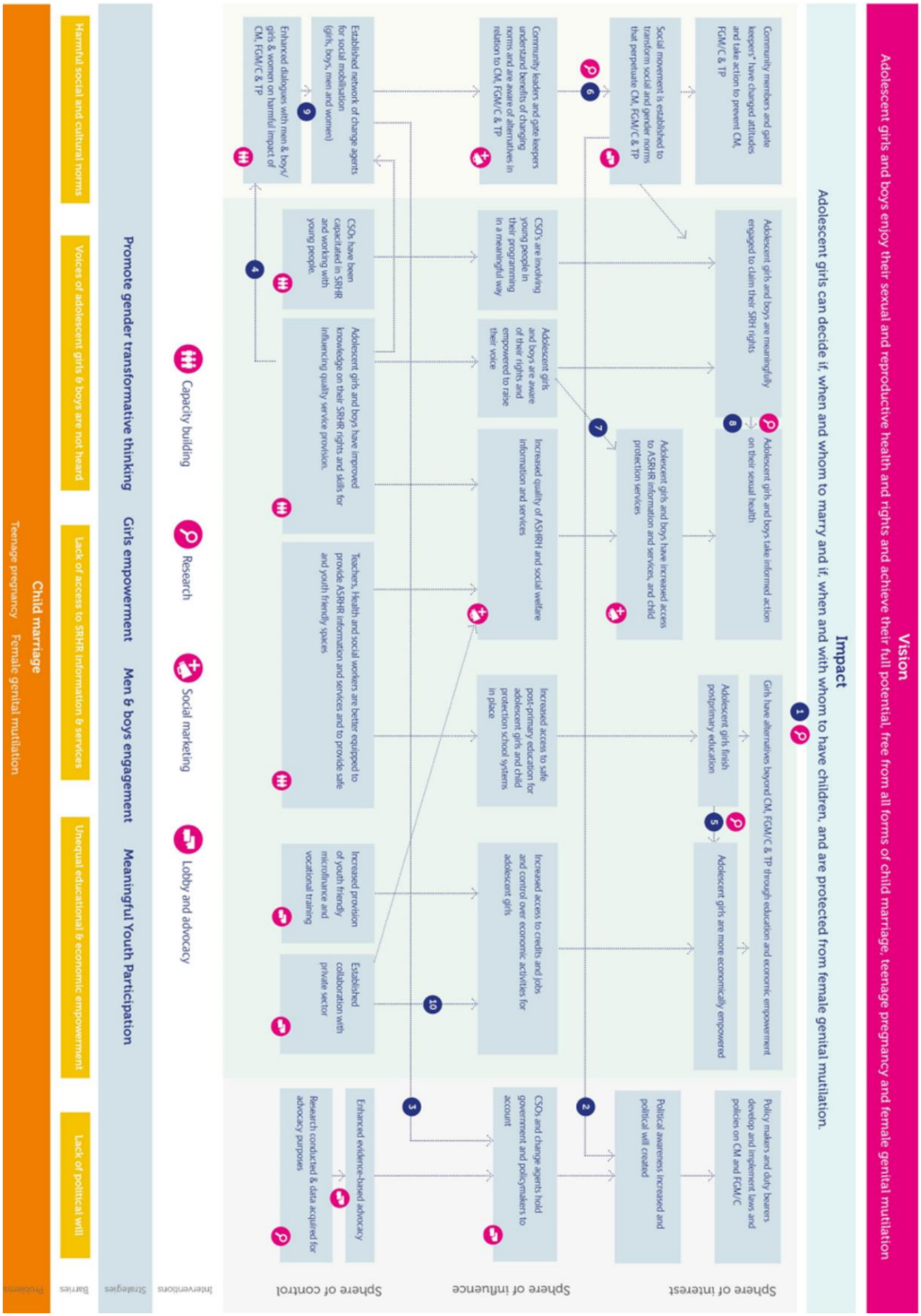

Figure 6: Yes I Do Theory of Change (2)

Appendix 4: Community setting and socio-demographic characteristics of the study respondents

Community setting

The YID programme took place in TA Liwonde, Machinga District, located in Southern Malawi (map see figure 7). People in TA Liwonde live in a matrilineal society in which leadership roles are passed down through the female's family, and, after marriage, the husband shall stay in his wife's village and among her kin (55). Within the kin, the maternal uncle is the owner of the clan, giving him the decision-making power concerning teenage pregnancy and child marriage. Most households in Machinga are generally poor and do not have access to piped water and electricity or owned motorised transport. Most people do not have access to television. Some people have mobile phones, but only 10% have mobile phones with internet, making the radio and newspaper the most used media source(55). The quality of education is generally low and challenged by a shortage of training materials and teachers(56).

Figure 7: Geographic location Machinga District (76)

Socio-demographic characteristics of the study respondents

When the focus groups were formed, community respondents were categorised in groups as follows: female youths aged 15–19 years, female youths aged 20-24 years, female parents aged 39-81 years, male youths aged 15-19 years, and male youths aged 20-24 years. The sex, age, parental, marital, and educational status are displayed in table 5. As presented, in one male FGD with 10 participants, it was not reported whether the participants had children. The majority of the key informants were not questioned about their sex, parental, marital and educational status.

Ethnicity, religion, education, and occupation

Among all respondents, Yao was the dominant ethnic group. The large majority of the respondents were Muslim, others were Christian. The majority of youths dropped out of school. If still in school, the youths were more often in primary than secondary school. Among community member respondents, the main occupations for males who were not in school were farming and doing business. Among females who were not in school, the main occupation was farming. Some of the youths of 15-19 years who were still in school did casual labour.

Respondent category	N	No. of R having children	No. of R married	The lowest level of education	Highest level of education
Females 15-19 years	7	0	0	Standard 6	Form 4
Females 20-24 years	15	15	10	Standard 5	Form 4
Female parents 39-81 years	7	7	5	None	Standard 7
Males 15-19 years	12	No data	0	Standard 3	Form 4
Males 20-24 years	16	5	3	Standard 4	Form 4
Key informants*	16	-	-	-	-
Total	73	27	18	None	Form 4

Table 5: Socio-demographic characteristics of the study respondents(76)

Appendix 5: Coding framework

- **Demographics**
- **Gender perspective**
  - **Gender norms**
    - Gender roles
      - Gender roles within marriage and family life
      - Gender roles regarding in professional carreer (education, work)
      - Being a good boy
      - Being a good girl
    - Gender equality
      - Inter relational power dynamics (decision making power)
      - Gender equality in education and carreer opportunities
    - Observed changes overtime
  - **Socio-culutral norms**
    - Change over time
    - Cultural beliefs and practices in relation to sexuality and reproduction (including initiation ceremonies)
      - Desired age at first childbearing
    - Socio-cultural norms, beliefs, and practices in relation to marriage
      - Desired age at first marriage
      - Child marriage
- **Perceptions of parenthood**
- **Role of religion in perception of teenage pregnancy**
- **Career opportunities for youths**
- **Perceptions of teenage pregnancies**
  - **Role of religion in perception of TP**
  - **Causes of teenage pregnancy**
    - Child marriage leading to teenage pregnancy
    - Abuse
    - Low level of education
    - Influence of (social) media, copying behaviour
    - Alcohol and/or smoking leading to risky sexual behaviour
    - Lack of access to SRH services and contraceptives, lack of knowledge on contraceptives
    - Peer pressure to start sexual relationships
    - Risky sexual behavior (multiple partnes, transactional sex)
    - Comprehensive Sexuality Education
    - Sexual desire
    - Religion
    - Poverty
    - Not having a purpose in life (school drop-out, limited alternative jobs)
    - Desire to become mother or enter a new phase in life
  - **Consequences of teenage pregnancy**
    - Consequences, experiences, and emotions for/of boys and young men
      - Negative consequences
      - Positive consequences
    - Consequences, experiences, and emotions for/of girls and young women
      - Negative consequences
      - Positive consequences
  - **Roles of different stakeholders in the event of teenage pregnancy**
    - Teachers
    - (I)NGO's, development programmes
    - Boy or men (of his family) who made the girl pregnant
    - Community leaders, community structures or initiatives
    - Police, court
    - Healthcare workers, social welfare department, child protection
    - Parents of the pregnant girl
- **Recommendations for development programmes with the aim to prevent teenage pregnancies**
  - Feedback on YID programme
  - Negative feedback on international development programmes
  - Positive feedback on international development programmes
  - Suggestions for programme strategies
- **Rights Perspective**
  - Awerness and excersise of sexual and reproductive health rights
  - Agency in decision making power regarding to sexual and reproductive health and rights
  - Political will and community bylaws to reduce teenage pregnancies and child marriage
- **Roles of different stakeholders in prevention of teenage pregnancy**
  - Community leaders
  - Community-based organisations or initiatives
  - Healthcare workers, social welfare department, child protection
  - Parents
  - Private sector
  - (I)NGOs (development programmes)
  - Teachers
  - Police
- **Sexual and reproductive health**
  - SRH Services
    - Acces to SRH services (including maternal health, ANC)
    - Quality of SRH services (including maternal health, ANC) (youth friendly, respectfull care)
    - Change over time
  - SRH and rights information and education
  - SRH issues among the youth

Appendix 6: The Gender and Rights conceptual framework by Isabel Goicolea

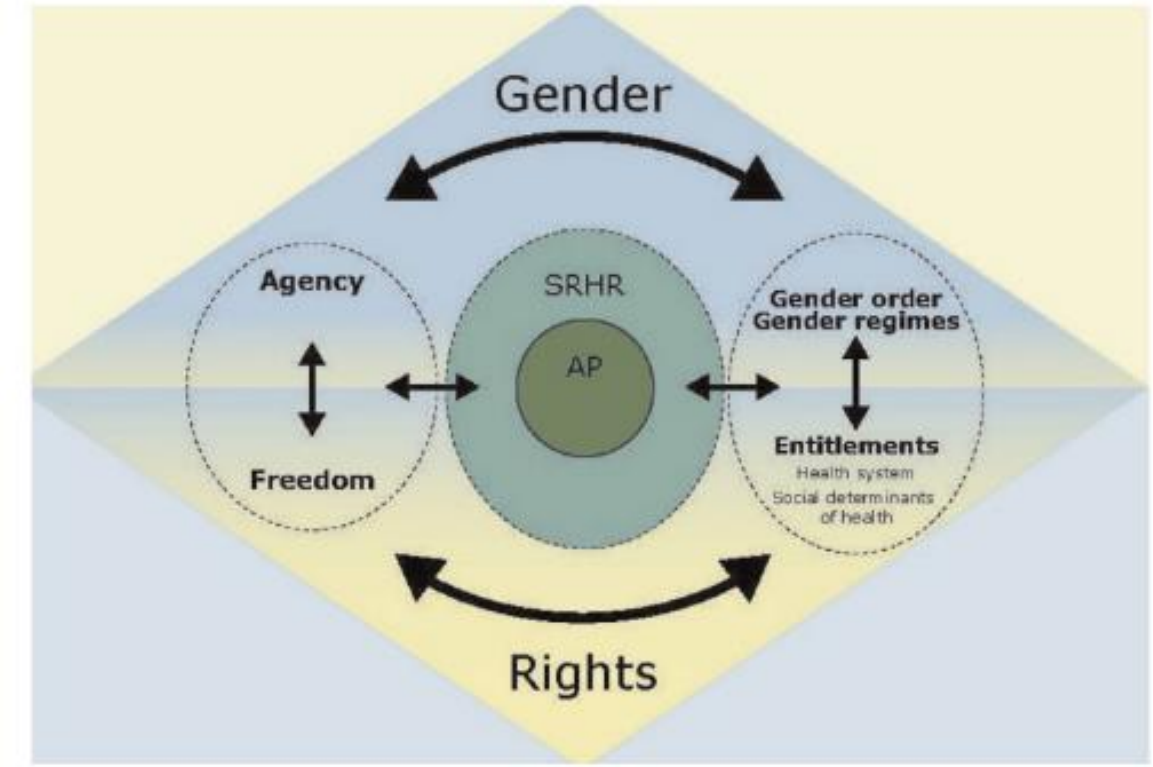

Figure 8: The Gender and Rights conceptua framework by Isabel Goicolea(57)