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RESEARCH ARTICLE

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Exploring pregnancy-related stigma experiences among adolescents in rural Uganda

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Abstract

Introduction: Pregnant adolescents face multiple adverse experiences that vary by context due to pregnancy-related stigma. We explored experiences of pregnancy-related stigma and psychosocial issues among adolescents living in rural eastern Uganda.

Methods: We conducted in-depth semi-structured interviews with 15 adolescents (15–19 years old) who were pregnant (>3 months) or had recently given birth (<3 months) at Tororo District Hospital in Uganda. All interviews were translated from Dhopadhola to English. Thematic analysis was conducted to identify major themes, which were interpreted using the Health Stigma and Discrimination Framework.

Results: Six key themes were identified and were organized under the Health Stigma and Discrimination Framework. Social and gender norms for adolescent women and their lack of autonomy were identified as drivers and facilitators of pregnancy-related stigma. Results show how stigma is experienced by adolescents through the lack of social support, multiple forms of abuse, and negative judgement. Such manifested stigma negatively impacted their psychosocial wellbeing and resulted in limited access to socioeconomic resources and educational opportunities.

Conclusion: This study acknowledges the multilevel nature of pregnancy-related stigma among adolescents in the context of existing policy and programming. Recognizing the impact of pregnancy-related stigma on the health and wellbeing of adolescent girls necessitates prioritizing comprehensive stigma reduction interventions that address main drivers and facilitators, and that are rooted in the communities to harness support.

KEYWORDS

adolescent pregnancy, education, intimate partner violence, stigma, Uganda

1 | INTRODUCTION

Adolescent pregnancy, defined as pregnancy occurring in girls aged 10–19 years, has been a critical global health issue on account of its associations with greater risk of complications in pregnancy and childbirth due to immature reproductive systems (Vogel et al., 2015) and higher maternal mortality (Maly et al., 2017). According to the DHS survey, in 2022, 34% of women aged 20–24 years were first married or in union before age 18 (Ochen & Primus, 2023). Thus, reduction of adolescent pregnancies is a part of the United Nations Sustainable Development Goals (World Health Organization, 2024). Despite international efforts to reduce the adolescent birth rate, adolescent pregnancy remains a priority health concern affecting approximately 12 million girls under the age of 18 each year globally (World Health Organization, 2024). Sub-Saharan Africa has experienced an increasing trend in adolescent birth rate, and

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Uganda has one of the highest rates in the region at 119 live births per every 1,000 women aged 15–19 years old (Uganda Bureau of Statistics, & ICF, 2018). In 2012, this high rate translated into 25% of adolescent girls in Uganda either being pregnant or having a child (Wado et al., 2019).

Adolescent girls in Uganda face adversity in multiple realms of life, including health and education. Ugandan government statistics show that, overall, female adolescents drop out of school more frequently than their male counterparts, and when they become pregnant, birth complications and unsafe abortions lead to increased maternal deaths. (Uganda Bureau of Statistics, & ICF, 2018). Pregnant adolescents in Uganda are often neglected by the father of the baby, facing psychosocial challenges as a consequence (Apolot et al., 2020; Atuyambe et al., 2005, 2009). Studies also show that adolescent mothers frequently lack financial and social autonomy; social support from their partners, families, and communities; and, access to educational opportunities. (Apolot et al., 2020; Atuyambe et al., 2005, 2009; Maly et al., 2017; Rukundo et al., 2019). They are also vulnerable to multiple forms of abuse; the prevalence of intimate partner violence (IPV) toward pregnant adolescents is a particularly significant issue in Uganda, with up to 40% of teenagers reporting incidents of IPV during pregnancy (Auma et al., 2020; Katushabe et al., 2022). In a previous study in rural Uganda by members of our team, pregnancy-related stigma was reported by 86% of women, and in addition to IPV, it was an independent predictor of higher depression and anxiety symptoms (Asiimwe et al., 2022).

While most stigma research has articulated and evaluated stigma in terms of the experiences of individuals, there is increasing recognition of the need to assess the influence of social and structural forces in fostering and shaping experiences of stigma, and accordingly, the need to address stigma through multilevel interventions (Heijnders & Van Der Meij, 2006; Stangl et al., 2013). In this context, Stangl et al. (2019) proposed the Health Stigma and Discrimination Framework, which defines stigma as a process that operates across multiple levels of the socio-ecological spectrum. According to this Framework, the stigma process can be divided into several components: 1) drivers and facilitators; 2) stigma "marking" (i.e., labeling); 3) stigma manifestations; 4) and the outcomes of stigma for affected populations and for organizations and institutions. In this Framework, drivers and facilitators determine if stigma exists and is imposed. Stigma is imposed upon individuals or groups that receive a stigma "marking" based on a specific perceived difference that could be related to health conditions or other distinctions such as race, class, gender, sexual orientation, or occupation. Notably, an intersectional lens points to how individuals may be "marked" in ways that expose them to multiple stigmas and forms of structural oppression. Following stigma "marking," stigma manifests through a variety of stigma experiences (e.g., perceived, experienced, internalized stigma) and practices. Those manifestations lead to a range of outcomes for affected individuals, communities, and organizations or institutions that culminate in impacts on health and society overall.

Despite this understanding and conceptualization of stigma, few studies have investigated pregnancy-related stigma as a dynamic social process informed by the perspectives of Ugandan adolescents themselves. Taking this approach can help elucidate stigma drivers, its most important manifestations, and the full range of its effects with consideration of lived experience. To extend our understanding of pregnancy-related stigma experiences and psychosocial well-being among adolescents in Uganda, we sought to understand how pregnancy-related stigma affects their health and wellbeing of from their own perspective. Expanding our understanding of adolescent pregnancy experiences in this way has the potential to challenge the assumptions of researchers, clinicians, and policy makers to help develop more meaningful, feasible, and effective stigma mitigation and reduction strategies.

2 | METHODS

2.1 | Study procedures and sequence

Study participants were recruited by trained study staff at a pre- and post-natal care clinic at Tororo District Hospital. Inclusion criteria were being 13–19 years old, being pregnant for at least 3 months or having a child at least 3 months old and attending care at Tororo Hospital. Adolescents who met these criteria were invited to learn about the study, at which point full eligibility was ascertained via the following exclusion criteria: current report of suicidality or ongoing receipt of psychiatric treatment. In collaboration with the clinic's attending nurses, study staff explained the purpose and procedures of the study. Interested adolescents were then given an appointment (stressing to bring to the appointment an accompanying parent or guardian if less than 18 years old) at the study office at Tororo Hospital for the informed consent procedure. To consent, participants under 18 years provided assent and a parent/guardian provided consent, while those 18 years and older provided consent after reading and being explained the consent form by a trained study staff. Women consented to participate in a questionnaire-based survey only (results published separately by Asiimwe et al., 2022) or in the survey followed by an in-depth interview. Participants were reimbursed for transport cost associated with their travel to the clinic for the interview.

2.2 | Assessment

Trained study staff (3 women, 1 man) conducted individual, semi-structured interviews with participating adolescents using an interview guide focused on assessing adolescents' experiences during and after pregnancy related to perceived stigma, well-being, self-esteem, partner relationships and perception of community support or rejection as the basis for the dialogue, along with relevant probes to expand on themes. Areas of focus for probing changed over time with iterative analysis of previous interviews, based on emerging areas of importance. All interviews were conducted in a private office space adjacent to the Tororo Hospital clinic by two study staff, one conducting the interview and another taking notes.

2.3 | Data analysis

All interviews were transcribed from interviewer notes and translated from Dhopadhola to English by the study interviewer shortly after data collection. Interviewers had experience translating similar concepts and were familiar with the context. The authors met with the interviewers to review all interviews and develop a broad understanding of context, reviewing all responses for cultural and semantic interpretation. Data saturation was determined when interviews were reviewed with interviewers, and preliminary codes were identified. The authors (IF and KS) then read interview transcripts in English several more times to become familiar with participants' responses. Thematic analysis was used to uncover and interpret the underlying themes and patterns embedded in the interviews. Authors (IF and KS) engaged in a process of open coding to identify initial patterns and recurrent concepts within the data. Subsequently, codes were refined and grouped into thematic categories through the process of axial coding, allowing for the emergence of overarching themes that encapsulate the essence of the main experiences under investigation (as described in the interview guide above).

Finally, the process of theme definition and interpretation was guided by the Health Stigma and Discrimination Framework (Stangl et al., 2019), to provide meaning and depth to the identified themes, drawing connections to the existing literature. This framework offers a comprehensive theoretical foundation that underscores the multifaceted nature of stigma, elucidating how it operates on both individual and structural levels. Within the context of adolescent pregnancy in Uganda, this framework helps illuminate the complex interplay of socio-cultural norms, healthcare systems, and discriminatory attitudes that contribute to the stigmatization of young expectant mothers.

3 | RESULTS

3.1 | Demographics

We interviewed 15 participants between the ages between 13 and 19, with a mean age of 17.9 years old. The majority of the women identified themselves as married (66%). Non-remunerated housekeeping was the most frequent form of employment reported (46%), followed by unemployed (32%) and then self-employed (10%). A majority of the participants (89%) were first time mothers.

3.2 | Overview of themes

Participants experienced various mechanisms of stigma related to their pregnancy and other aspects of their social identities (e.g. unemployment, adolescence). Six key themes emerged and were organized under the constituent domains of the Health Stigma and Discrimination Framework; including drivers and facilitators, stigma "marking," stigma manifestations, and the outcomes of stigma for affected populations and for organizations and institutions.

3.3 | Drivers and facilitators

3.3.1 | Social and gender norms for adolescent women

Women described how prevailing gender norms characterized by expectations regarding female behavior and premarital abstinence lead to families and communities often siding and supporting men instead of women when they become pregnant at a young age, resulting in loss of social and emotional support. As one adolescent described: "*For those ones [of community members] who can talk to the man to take his wife and child back, [they] can do that, but in most cases, people in the village support the man to marry another woman.*" This quote also illustrates how, aside from the broader issue of men abandoning

wives or not supporting children, community enforcement for men to be responsible for the woman and his child was understood by participants to be largely absent.

In interviews, there was a repeated emphasis on women's education and how pregnancy was understood by the community to interfere with women meeting social expectations for education. Families were described as having a strong preference for their daughters to complete their studies before getting married or having children on account of concerns about interruptions caused by pregnancy. According to participants, in general community members praised girls who completed school without getting pregnant, and violating this norm was conversely seen as resulting in family and community reproach. As one participant stated; "*[the] villagers also talked a lot about me saying I wasted my father's money and now I am pregnant*", and "[community members] *feel a woman who got pregnant before completing school is a prostitute and has shamed her parents*". It is important to note that some families welcomed their daughter's pregnancies when they occurred during adolescence, although those were less common.

3.3.2 | Lack of autonomy

Throughout the interviews, lack of autonomy, described as little control over decision-making and/or having little economic power, was repeatedly mentioned by participants. Specifically, many participants talked about how a lack of financial autonomy rendered them dependent on their family and male partners (i.e., affected power dynamics) and how this facilitated stigma. Most participants described that they were dependent on their husbands in making decisions about purchasing necessities and healthcare service use. As one woman shared, her husband "*is the one who handles everything that I need like food, cloths and medicine when I am not fine. … If my parents take me for hair dressing or tailoring training, that would help me to earn money that I can use to support myself and the baby for buying things like soap, sugar, food, cloths and others.*" Other participants echoed that their parents, predominantly their mothers, supplied financial resources and made decision for them about finances, their lives, school attendance and on their health service use. Although most women presented positive attitudes towards their parents, they acknowledged that this type of social subordination often resulted in financial instability. Being aware of such dependency, all participants consistently expressed that acquiring skills in income generating activities, such as hairdressing and tailoring, would enable them to work, earn money and gain independence.

3.4 | Stigma "marking"

According to participants, pregnant adolescents are frequently labeled as "*bad examples,*" "*wasted girl,*" or "*disappointment to the family*" by family members who impose negative judgements in response to knowledge of their pregnancy. Using strong words including "*useless,*" "*disappointment,*" or "*prostitute,*" participants also explained the perceived negative judgements by community members towards pregnant adolescents. In general, participants described being seen as "immoral" examples in their communities, not only bringing shame to themselves, but also setting the wrong example for their peers. Stigma marking was most prominently reported in the school setting, where participants described being shamed and labeled as "dirty" and "promiscuous." When asked about how her pregnancy was viewed by her peers at school, one young woman expressed: "*for those girls who finish their studies without getting pregnant everyone in the village praises them, but for you who dropped out of school due to pregnancy is treated as a nobody.*"

3.5 | Stigma manifestations

3.5.1 | Lack of social support

Stigma manifests through different stigma experiences, and the most common stigma experiences described related to a lack of social support. Women mentioned multiple sources of (e.g., spouse, family, community) and types of (e.g., emotional, financial) social support that are affected by pregnancy-related stigma. Most participants recounted receiving inconsistent financial aid and/or emotional support from the fathers or family members, and they frequently emphasized that a lack of social support was a significant problem for numerous pregnant adolescents in the community. Despite the fact that most women reported being married, women frequently talked about being rejected and abandoned by the father of the baby after finding out about the pregnancy, relinquishing any form of support. Further, women described men running away upon discovering their pregnancy and neglecting to offer any form of assistance. Notably, other participants also reported that some men were unable to provide financial support to their pregnant wives mostly due to unemployment, as one woman said, "*There are men who do not care at all. After making a woman pregnant they hide away without giving any support. This happens even to married women who stay with their husbands.*"

The lack of social support from both the women's family and community members constituted an additional problem. When questioned about the potential familial support, one respondent articulated, "*They should not chase away pregnant women like me in most families when a girl gets pregnant and the man responsible is not ready to stay with her some parents chase away their daughters that sometimes made some people commit suicide or go stay with a distant relative.*" Several women also shared that their families would disown or turn against them leaving them with minimal support. This scorning from families and communities was exemplified by a woman describing her labor, "*When time for giving birth comes, they need to take her to hospital, take care of her, and not leave her alone to give birth at home.*"

3.5.2 | Physical, verbal, economic, and emotional abuse

Abuse is also a common stigma practice that appeared throughout the interviews. One participant shared her experiences of physical abuse from her male partner: "*Owiro ran kula (he has now turned against me). He even beat me, and I left his home.*" Participants described how some of the fathers of the babies originally accepted the pregnancy, but soon came to realize the demands and social implications they faced and began to turn against the women, and the strain from this responsibility eventually led to physical abuse. While other participants did not accept being abused themselves, they mentioned that physical abuse by male partners was a prevalent problem among pregnant adolescents in the community. Participants also described how pregnant adolescents were frequently physically abused by other family members, including stepmothers, fathers and sisters-in-law.

In addition to physical abuse, various nonphysical forms of abuse, including verbal, economic, and emotional abuse were recounted. Verbal abuse manifested in constant quarrels and fighting between pregnant women with their parents as well as with their male partners. Economic abuse came primarily from the male partners and from their own parents, who refused to financially support women or their children, even to the point of depriving them from basic needs. Emotional abuse also came from male partners in the form of infidelity and the denial of their paternity. One woman expressed the emotional toll it took on her; "*The man who made you pregnant rejects you. It hurts a lot…and now he leaves you alone with pregnancy… leaving the woman with the whole burden of bringing up the child as a single mother.*" Another woman also explained the emotional burden of male partner's infidelity, as saying, "*Women feel very bad because no woman wants her husband to love another woman, but because she has no control over him, she just keeps quiet with pain in her heart. Sometimes she can cry in private.*" Women described how they mostly live in fear of the people around them because of these experiences of abuse.

3.5.3 | Feeling judged

Women also talked about shaming and negative judgement towards them within the community. Participants described being subjected to gossip by their peers and community members, which led to strained relationships and feelings of shame and embarrassment. Some participants also shared their experience of social exclusion in school settings. They expressed fear of embarrassment resulting from the behavior of other students and teachers in school. As one participant put it, "*Students and teachers will be gossiping about you all the time.*" Another participant shared teachers' negative attitudes towards pregnant adolescents in schools by saying that "*I also feared that teachers could call me all the time asking about my pregnancy because I used to see many girls could stop coming to school when they get pregnant.*"

3.6 | Outcomes: Affected populations

3.6.1 | Lack of access to socioeconomic resources

Given the lack of financial and decision-making autonomy, adolescent women who lost social support also confronted an associated lack of access to socioeconomic resources, including daily necessities. In addition, the lack of social support, such as the provision of transportation for prenatal care visits, was described as impeding access to health services. Thus, the withdrawal of socioeconomic resources is both a way that stigma manifested and an outcome of experiences of stigma that had direct implications for health.

3.6.2 | Psychosocial well-being

Women who described facing gossiping and being laughed at by their peers and other community members described feeling embarrassed and "*out of place.*" One participant described:

> "It is just very difficult to stay in school when you are pregnant because your school mates will keep gossiping about you. Even some teachers will be calling you to the staff room and ashaming you in front of everyone. For me, I would rather wait until I give birth, then I look for what do to."

It is also important to note that embarrassment and same also reflected a way in which pregnancy-related stigma was internalized, contributing to mental health problems among women to the point of some participants talking about women experiencing suicidal thoughts. Other participants talked about feelings of loneliness, sadness and depression mostly associated to addressed maternal mental health issues such as depression, which were mostly due to mistreatment by their husbands and parents.

3.7 | Outcome: Organizations and institutions

3.7.1 | Lack of educational opportunities

Experiences with enacted pregnancy-related stigma were extensively described at the school level throughout the participant interviews, who specifically described harmful norms and views relating to adolescent pregnancy and sexuality expressed by their peers and school staff. Thirteen of the 15 women interviewed stated that they were no longer in school. Although the reasons for which women were not in school included lack of financial resources and transport, most women reported quitting school at some point during their pregnancy or after getting married (with or without pregnancy). As elucidated by one participant who stated, "*I stopped going to school and I decided to get married because my parents told me that there was no money to buy school materials for me and pay for my fees.*"

Women who stopped going to school during their pregnancy specifically described it was because of feeling shamed by their peers and school personnel. Women talked about being labeled with negative terms (as described in marking) and ridiculed at school, and how they were treated unfairly or rudely by school personnel. Several women also expressed that their families and the school personnel did not allow them to continue with school as soon as they found out the adolescent was pregnant, articulated by one woman saying, "*Most schools do not accept women who are pregnant. They keep disturbing such women with many questions and shaming them all the time.*" In general, pregnant adolescents are not welcomed in the school environment because they are perceived as a negative example for other women. The physical effects of being pregnant and lack of accommodations by school staff for pregnant and/or lactating adolescents prevented them from being able to continue in school. For instance, participants described how they were too sick or too tired to attend classes on a regular basis.

4 | DISCUSSION

This qualitative study explored adolescent pregnancy stigma experience among women living in rural eastern Uganda. Participants' experiences of pregnancy-related stigma within various social environments were described as significantly shaping their livelihoods. While stigma has been previously documented in the context of adolescent pregnancy (Apolot et al., 2020; Atuyambe et al., 2009; Crooks et al., 2022; Maly et al., 2017; Rukundo et al., 2019), our study adds to these findings by focusing on stigma mechanisms derived from the Health Stigma and Discrimination Framework and identifying social domains in which pregnancy-related stigma is relevant to adolescents in Uganda from a perspective of lived experience. We identified gendered social norms and a lack of financial autonomy as facilitators of pregnancy-related stigma, leading to stigma "marking." Important manifestations of stigma included the lack of social support, multiple forms of abuse, and perceived social judgement while outcomes of stigma of greatest concern to adolescent mothers included the lack of access to socioeconomic resources, psychosocial well-being, as well as the lack of educational opportunities.

In the context of Uganda, the widely held cultural expectation for women is to fulfill a traditional role marked by domestic activities, including cooking, child rearing, cleaning, and managing the home (Adams, 2020). These prospects were described by participants as facilitating the stigmatization of young expectant mothers who are seen as diverging from the norm. In particular and as observed in other Sub-Saharan African countries (Yakubu & Salisu, 2018), women recounted how prevailing expectations regarding female sexual behavior with an emphasis on the importance of premarital abstinence created a hostile environment for pregnant adolescents. These findings underscore the discrepancy between societal norms and expectations and the reality of lives, especially for adolescents who become pregnant. Understanding the impact of these norms and the stigma marking they result in is crucial for developing effective interventions that challenge and transform societal attitudes and foster an environment that supports rather than condemns adolescent mothers, ultimately contributing to improved maternal and child well-being.

Similarly, women described how the absence of financial autonomy significantly contributed to the generation and perpetuation of pregnancy-related stigma among adolescents in this context. As in our study, previous reports describe several sources of financial support to adolescents that vary according to their available supportive network, but that for the most part tend to be insufficient and unstable (Atuyambe et al., 2009; Ickes et al., 2016). Our study further addressed this theme from the participants' perspective, describing how they view themselves as economically dependent on their families and/or partners and as a potential burden to their communities as a whole. Consequently, this lack of economic independence hindered the agency of adolescent mothers and perpetuated societal judgment and discrimination, highlighting the intricate interplay between financial autonomy, social expectations, and the persistence of stigma surrounding adolescent pregnancy. Addressing these dynamics is essential for comprehensive interventions aimed at dismantling stigma and fostering an environment that supports the well-being and inclusion of young mothers.

For the most part, adolescent pregnancy in this context was described occurring as an unplanned and unwanted event, resulting in shame and rejection, with subsequent adverse consequences. Among these, women described stigma "marking" and negative labeling as a frequent and pervasive societal phenomenon that involved the assignment of negative stereotypes to young mothers by family and community members. The consequences of this stigma marking were profound, leading to the marginalization and isolation of adolescent mothers within their communities. This social condemnation often results in adverse psychosocial outcomes, hindering the emotional well-being of young mothers and impeding their access to essential support systems (Apolot et al., 2020; Atuyambe et al., 2005, 2009; Rukundo et al., 2019). In addition to being marked by their pregnancy, women and girls living in these contexts frequently bear the main responsibility for caregiving. Thus, the impact of parenthood on girls is disproportionately severe, with a direct connection to gender-based inequalities.

As in other studies (Apolot et al., 2020; Maly et al., 2017), women we interviewed described being subjected to physical and verbal abuse by partners and family members as manifestations of stigma on adolescent pregnancy, significantly challenging their livelihoods. Our findings also identified more diverse forms of abuse endured by pregnant adolescents, including economic and emotional abuse. Recognizing various forms of abuse is crucial for understanding the complex nature of stigma related to adolescent pregnancy in Uganda. Despite the limited body of literature, prior studies on successful programs highlight a diverse array of intervention designs for violence prevention, including financial support and community mobilization, reflecting the need for multifaceted, structural approaches (Abramsky et al., 2016, 2018; Pronyk et al., 2006). Limited income generation opportunities have been largely unaddressed in previous literature in the context of adolescent pregnancy experiences, pointing to the importance of engaging pregnant adolescents themselves in work to assess potential services and interventions.

We learned from the women interviewed that their pregnancy was associated with unmet need for care and support from family and community relationships. Women described how prevailing socio-cultural, family and religious expectations led to strained familial relationships, as families may grapple with feelings of shame or disappointment, which is described in the literature as affiliate stigma (Ali et al., 2012; Mitter et al., 2019). Community members, influenced by societal stigma, frequently withdrew support, compounding the isolation felt by young mothers. This loss of social support not only exacerbates the challenges associated with adolescent pregnancy but also underscores the need for targeted interventions that address the multifaceted dimensions of stigma to foster a more compassionate and understanding community response.

Another outcome identified was the lack of educational opportunities. Although noted previously in other studies, (Maly et al., 2017), we specifically captured women's willingness not only to continue with their education by attending school, but also to acquire income generating skills popular in this context (e.g. hairdressing or tailoring). However, we learned from interviews that although families generally recognized the value of completing an education, the stigma associated with an adolescent pregnancy negatively impacted their school attendance. Women discussed how school policies were not conducive to parenting. Also, the educational environment was described as being hostile towards pregnant adolescents and reinforced by societal judgment and discriminatory attitudes acting as barriers, compelling many young mothers to disengage from formal education due to fear of ostracism and compromised mental well-being. Based on these results, interventions designed to mitigate the adverse effects of pregnancy-related stigma on adolescent school attendance in Uganda are imperative and should encompass comprehensive strategies, including targeted educational programs, community sensitization initiatives, and the establishment of supportive policies, aiming to foster an inclusive and non-judgmental educational environment that encourages the retention of pregnant adolescents in school. An example of one such intervention includes a media campaign in Zambia (Zuilkowski, 2019) centered on radio programming to enhance awareness of relevant policies and to garner widespread support for school reentry by adolescent mothers, coupled with policy dialogues engaging school principals and staff. Other recent examples include complementary activities of family planning and contraceptive services, life and skills counseling (including self-esteem and overcoming social stigma and discrimination) to adolescents, their families and the fathers of the adolescents' children, and financial support (covering school-related expenses) have been successfully implemented in Jamaica (Amo-Adjeji, 2023) and Kenya (Undie et al, 2015). This is especially important given that lack of financial autonomy was described as in turn facilitating stigma further.

This study should be viewed in light of several limitations. Our results may not be generalizable to other adolescents in Uganda given the multiple ethnicities and religions in the country. Participants were enrolled from an antenatal clinic, also

limiting the generalizability of our results given that these women may not fully represent the diversity of pregnant adolescents in Uganda, as some of the most stigmatized adolescents may not have the same help-seeking behaviors or be able to be connected to care. Social desirability could have influenced participant responses regarding sexual violence and mental health problems leading to an underreporting of these or other sensitive issues. In fact, a previous study by our research team on the same study population reported a high prevalence of sexual IPV and depression among pregnant adolescents and mothers, and showed that the experiences of perceived stigma and sexual IPV were independently associated with depressive symptoms (Asiimwe et al., 2022). The fact that one of the interviewers was a male may have precluded some women in particular from talking about sexual abuse more openly. Lastly, note-taking (as opposed to recordings) and translation of interviews from Dhapadhola to English could have introduced the possibility of errors or loss of nuance during the translation process. We tried to minimize this by employing bilingual translators from the same geographical area as the participants who possessed a deep understanding of the cultural and contextual nuances of the source and target languages, enabling to capture the subtleties of meaning, tone and cultural references within the interview data.

As researchers conducting a qualitative study on adolescent pregnancy experiences in Uganda, we recognize the importance of acknowledging our positionality within the research process. Our backgrounds, experiences, and perspectives may influence how we interpret and understand the data collected. We fully recognize our positionality as outsiders to the communities under study underscores the need for humility, cultural sensitivity, and a commitment to ethical research practices. We approach our research with respect for the voices and experiences of the participants, aiming to amplify their perspectives rather than imposing our own interpretations.

Despite limitations, the accounts summarized here can inform policy and program that aim to improve the health and wellbeing of pregnant adolescents in Uganda. Our identification of multilevel stigma processes through the Health Stigma and Discrimination Framework and a variety of actors involved in the challenges adolescent mothers face, including male partners, parents, community, and peer students as well as teachers at school, is critical to acknowledge in the development of multi-level stigma-reduction interventions. In addition, the critical influence of the narrative that "pregnancy interrupts education" and the repeated mention of interests in income generation opportunities suggest that continuing education and training in specific income generating activities can be important components of interventions that seek to reduce stigma and improve wellbeing overall. Furthermore, the significant contribution of pregnancy-related stigma to the suffering of these women and the impact of stigma as a process suggests the importance of comprehensive stigma reduction interventions as an integrated part of responding to the needs of pregnant adolescents and adolescent mothers.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS APPROVAL STATEMENT

This study was approved by the Institutional Review Boards at Michigan State University and the School of Medicine Research and Ethics Committee at Makerere University.

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REFERENCES

Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., Kyegombe, N., & Watts, C. (2016). The impact of SASA!, a community mobilisation intervention, on women's experiences of intimate partner violence: Secondary findings from a cluster randomised trial in Kampala, Uganda. *Journal of Epidemiology and Community Health*, *70*(8), 818–825. https://doi.org/10.1136/jech-2015-206665

Abramsky, T., Musuya, T., Namy, S., Watts, C., & Michau, L. (2018). Changing the norms that drive intimate partner violence: Findings from a cluster randomised trial on what predisposes bystanders to take action in Kampala, Uganda. *BMJ Global Health*, *3*(6), e001109. https://doi.org/10.1136/bmjgh-2018-001109

Adams, C. (2020). Toward an institutional perspective on social capital health interventions: Lay community health workers as social capital builders. *Sociology of Health & Illness*, *42*(1), 95–110. https://doi.org/10.1111/1467-9566.12992

Ali, A., Hassiotis, A., Strydom, A., & King, M. (2012). Self stigma in people with intellectual disabilities and courtesy stigma in family carers: A systematic review. *Research in Developmental Disabilities*, *33*(6), 2122–2140. https://doi.org/10.1016/j.ridd.2012.06.013

Amo-Adjei, J., Caffe, S., Simpson, Z., Harris, M., & Chandra-Mouli, V. (2023). "Second chances" for adolescent mothers: Four decades of insights and lessons on effectiveness and scale-up of Jamaica's PAM. *American Journal of Sexuality Education*, *18*(2), 318–351. https://doi.org/10.1080/15546128.2022.2093808

Apolot, R. R., Tetui, M., Nyachwo, E. B., Waldman, L., Morgan, R., Aanyu, C., Mutebi, A., Kiwanuka, S. N., & Ekirapa, E. (2020). Maternal health challenges experienced by adolescents; could community score cards address them? A case study of Kibuku district– Uganda. *International Journal for Equity in Health*, *19*, 191. https://doi.org/10.1186/s12939-020-01267-4

Asiimwe, R., Tseng, C.-F., Murray, S. M., Ojuka, J. C., Arima, E. G., & Familiar-Lopez, I. (2022). Association of pregnancy-related stigma and intimate partner violence with anxiety and depression among adolescents. *Journal of Adolescence*, *94*(2), 270–275. https://doi.org/10.1002/jad.12008

Atuyambe, L., Mirembe, F., Annika, J., Kirumira, E. K., & Faxelid, E. (2009). Seeking safety and empathy: Adolescent health seeking behavior during pregnancy and early motherhood in central Uganda. *Journal of Adolescence*, *32*(4), 781–796. https://doi.org/10.1016/j.adolescence.2008.10.012

Atuyambe, L., Mirembe, F., Johansson, A., Kirumira, E. K., & Faxelid, E. (2005). Experiences of pregnant adolescents—Voices from Wakiso district, Uganda. *African Health Sciences*, *5*(4), 304–309.

Auma, A. G., Ayebare, E., Olwit, C., Ndeezi, G., Nankabirwa, V., & Tumwine, J. K. (2020). Intimate partner violence among pregnant teenagers in Lira district, Northern Uganda: A cross-sectional study. *African Journal of Midwifery and Women's Health*, *14*(4), 1–11. https://doi.org/10.12968/ajmw.2020.0011

Crooks, R., Bedwell, C., & Lavender, T. (2022). Adolescent experiences of pregnancy in low-and middle-income countries: A meta-synthesis of qualitative studies. *BMC Pregnancy and Childbirth*, *22*, 702. https://doi.org/10.1186/s12884-022-05022-1

Heijnders, M., & Van Der Meij, S. (2006). The fight against stigma: An overview of stigma-reduction strategies and interventions. *Psychology, Health & Medicine*, *11*(3), 353–363. https://doi.org/10.1080/13548500600595327

Ickes, S. B., Heymsfield, G. A., Wright, T. W., & Baguma, C. (2017). "Generally the young mom suffers much:" Socio-cultural influences of maternal capabilities and nutrition care in Uganda. *Maternal & Child Nutrition*, *13*(3), e12365. https://doi.org/10.1111/mcn.12365

Katushabe, E., Asiimwe, J. B., & Batwala, V. (2022). Intimate partner violence disclosure and associated factors among pregnant women attending a city hospital in South-Western Uganda: A cross-sectional study. *BMC Pregnancy and Childbirth*, *22*(1), 484. https://doi.org/10.1186/s12884-022-04812-x

Maly, C., McClendon, K. A., Baumgartner, J. N., Nakyanjo, N., Ddaaki, W. G., Serwadda, D., Nalugoda, F. K., Wawer, M. J., Bonnevie, E., & Wagman, J. A. (2017). Perceptions of adolescent pregnancy among teenage girls in Rakai, Uganda. *Global Qualitative Nursing Research*, *4*, 233339361772055. https://doi.org/10.1177/2333393617720555

Mitter, N., Ali, A., & Scior, K. (2019). Stigma experienced by families of individuals with intellectual disabilities and autism: A systematic review. *Research in Developmental Disabilities*, *89*, 10–21. https://doi.org/10.1016/j.ridd.2019.03.001

Ochen, A. M., & Primus, C. C. (2023). Family planning uptake and its associated factors among women of reproductive age in Uganda: An insight from the Uganda demographic and health survey 2016. *PLOS Global Public Health*, *3*(12), e0001102. https://doi.org/10.1371/journal.pgph.0001102

Pronyk, P. M., Hargreaves, J. R., Kim, J. C., Morison, L. A., Phetla, G., Watts, C., Busza, J., & Porter, J. D. (2006). Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: A cluster randomised trial. *The Lancet*, *368*(9551), 1973–1983. https://doi.org/10.1016/S0140-6736(06)69744-4

Rukundo, G. Z., Abaasa, C., Natukunda, P. B., & Allain, D. (2019). Parents' and caretakers' perceptions and concerns about accessibility of antenatal services by pregnant teenagers in Mbarara municipality, Uganda. *Midwifery*, *72*, 74–79. https://doi.org/10.1016/j.midw.2019.02.011

Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., C. Simbayi, L., Barré, I., & Dovidio, J. F. (2019). The health stigma and discrimination framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*, *17*, 31. https://doi.org/10.1186/s12916-019-1271-3

Stangl, A. L., Lloyd, J. K., Brady, L. M., Holland, C. E., & Baral, S. (2013). A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: How far have we come? *Journal of the International AIDS Society*, *16*(3), 18734. https://doi.org/10.7448/IAS.16.3.18734

Uganda Bureau of Statistics, & ICF. (2018). *Uganda Demographic and Health Survey* (p. 2016). Uganda Bureau of Statistics, & ICF. https://dhsprogram.com/publications/publication-fr333-dhs-final-reports.cfm

Undie, C.-C., Birungi, H., Odwe, G., & Obare, F. (2015). *Expanding access to secondary school education for teenage mothers in Kenya: A baseline study report*. Population Council. https://doi.org/10.31899/rh4.1041

Vogel, J. P., Pileggi-Castro, C., Chandra-Mouli, V., Pileggi, V. N., Souza, J. P., Chou, D., & Say, L. (2015). Millennium development goal 5 and adolescents: Looking back, moving forward. *Archives of Disease in Childhood*, *100*(1), S43–S47. https://doi.org/10.1136/archdischild-2013-305514

Wado, Y. D., Sully, E. A., & Mumah, J. N. (2019). Pregnancy and early motherhood among adolescents in five East African countries: A multi-level analysis of risk and protective factors. *BMC Pregnancy and Childbirth*, *19*(1), 59. https://doi.org/10.1186/s12884-019-2204-z

World Health Organization. (2024). *Adolescent pregnancy*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

Yakubu, I., & Salisu, W. J. (2018). Determinants of adolescent pregnancy in sub-Saharan Africa: A systematic review. *Reproductive Health*, *15*, 15. https://doi.org/10.1186/s12978-018-0460-4

Zuilkowski, S. S., Henning, M., Zulu, J., & Matafwali, B. (2019). Zambia's school re-entry policy for adolescent mothers: Examining impacts beyond re-enrollment. *International Journal of Educational Development*, *64*, 1–7. https://doi.org/10.1016/j.ijedudev.2018.11.001

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