

**DEPRESSION AMONG TEENAGE MOTHERS IN KIRA MUNICIPALITY, WAKISO  
DISTRICT, UGANDA: PREVALENCE, ASSOCIATED FACTORS AND COPING  
MECHANISMS**

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## **ABSTRACT**

Depression among teenage mothers is an increasing public health concern globally. Although research on this subject is expanding, teenage mothers remain an understudied population. This study aimed to determine the prevalence of depression, identify associated factors, and examine the coping mechanisms adopted by teenage mothers in Kira Municipality, Wakiso District, Uganda.

A mixed-methods convergent parallel research design was employed. Quantitative data were collected using a structured questionnaire incorporating the Beck Depression Inventory tool, while qualitative data were gathered through Focus Group Discussions and Key Informant Interviews.

Findings revealed a high prevalence of depression among teenage mothers, affecting 79% of the study population at varying levels of severity: 27% had Major Depressive Disorder, 17% experienced moderate depression, 20% struggled with borderline clinical depression, and 15% exhibited mild-mood disturbances. Socio-cultural factors emerged as the most significant contributors to depression, largely due to fragmented social structures in the study area.

To cope, teenage mothers adopted traditional and non-traditional mechanisms. However, most coping strategies did not fully align with the AAAQ framework, limiting equitable access to mental health support. These findings highlight the need for a multi-sectoral approach that ensures collaboration across different sectors to promote mental well-being of teenage mothers in Kira Municipality.

## DECLARATION

### Declaration

I, Nakyeyune Joselyn, hereby declare that this thesis is my original work. It has not been submitted to any other institution for the award of a degree or any other academic qualification.

### Artificial Intelligence Disclosure:

In the preparation of this thesis, I made use of artificial intelligence tools to enhance clarity and cohesion. Specifically, ChatGPT was used to refine and simplify statements for better understanding, while Grammarly was used to check and correct grammar and spelling.

**Student Name: Nakyeyune Joselyn**

A handwritten signature in black ink that reads "Nakyeyune". The signature is written in a cursive, slightly slanted style.

**Signature:**

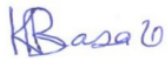
**Date: 15<sup>th</sup> April 2025**

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**Declaration by the supervisor**

I hereby declare that I have reviewed the thesis titled "Depression among teenage mothers in Kira Municipality Wakiso district Uganda: Prevalence, Associated Factors and Coping Mechanisms" submitted by Joselyn Nakyeyune. To the best of my knowledge and belief, the thesis is an original piece that conforms to the guidelines and standards set by Uganda Christian University.

I therefore recommend that the thesis be accepted for the award of Master's Degree in Public Health Leadership.



Prof. Robert Basaza

## DEDICATION

This dissertation is dedicated to all mothers who battle with depression, specifically in contexts where it's disregarded. May this research inspire you to seek the much-needed help you need to become better partners and parents.

## ACKNOWLEDGEMENTS

I extend my deepest gratitude to my supervisor, Prof. Robert Basaza, for his invaluable guidance and support throughout this research journey. His insights and encouragement have been instrumental in shaping this study, allowing me to develop a deeper appreciation of this critical public health issue and my role as a public health professional.

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## LIST OF ACRONYMS

AAAQ	Availability, Accessibility, Acceptability, Quality
CMD	Common Mental Disorders
FGD	Focus Group Discussion
KII	Key Informant Interview
LMIC	Low- and Middle-Income Countries
MoH	Ministry of Health
REC	Research and Ethics Committee
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SSA	Sub Saharan Africa
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

## OPERATION DEFINITIONS

<b>Term</b>	<b>Operational definition</b>
Common Mental Disorders	A group of distress states characterized by persistent sadness, lack of interest or pleasure in previously enjoyable activities
Coping mechanisms	Techniques that individuals employ to help them manage challenging emotional situations including depressive tendencies
Depression:	Is a Common Mental Disorder characterized by persistent sadness and a lack of interest or pleasure in previously enjoyable activities
High Income countries	Are economies with a Gross National Income per capita of \$13,846 or more
Low- and Middle-Income Countries	Are economies with a Gross National Income per capita between \$1,136 and \$4,465
Sexual Reproductive Health and Rights	Rights to reproductive and sexual health include the right to life, liberty and the security of the person; the right to health care and information; and the right to non-discrimination in the allocation of resources to health services and in their availability and accessibility
Teenage pregnancy	Pregnancy in girls within the ages of 13-19.

## CHAPTER 1 - GENERAL INTRODUCTION

### 1.1 Background to the Study

Teenage pregnancy is a significant public health concern affecting both High-Income Countries (HIC) and Low- and Middle-Income Countries (LMIC). Globally, it is estimated that 14% of teenage girls give birth before the age of 18 (UNICEF, 2022). However, teenagers in LMICs, particularly those in marginalized communities, are more susceptible to teenage pregnancies compared to their counterparts in other regions (Althabe et al., 2015). The Uganda National Adolescent Health Policy 2004 defines "adolescents" as individuals between 10 and 19 years old (Ministry of Health, 2024). According to the Uganda Demographic and Health Survey (UDHS) of 2022, 24% of adolescent girls aged 15 to 19 are either new mothers or expecting their first child (Uganda Bureau of Statistics, 2022). In comparison, teenage pregnancy rates are lower in High-Income Countries, such as the United Kingdom, where the rate is 15.8% (Office of National Statistics, 2019), and Canada, where the rate is 33.9 per 1,000 females aged 15 to 19 (Langille, 2007). This highlights the significantly higher prevalence of teenage pregnancies in Low- and Middle-Income Countries like Uganda.

High fertility rates, risky sexual behaviours, peer pressure to engage in early sex, child marriages, limited or no family support, low socio-economic status, low levels of education, and low contraceptive use are among the factors contributing to the rising trends of teenage pregnancies in Uganda (Nabugoomu, Seruwagi, & Hanning, 2020). Additionally, teenage mothers in Uganda are vulnerable to maternal and child health problems due to public or self-perceived stigma, family separation, unsafe abortion

attempts, and a lack of adolescent maternal-friendly services at health centres (Nabugoomu, Seruwagi & Hanning, 2020). While the government of Uganda has made significant strides in addressing teenage pregnancies by establishing policies and strategies such as the National Adolescent Health Policy and the National Strategy to End Child Marriage and Teenage Pregnancy 2014/2015 - 2019/2020, this public health issue was exacerbated by the COVID-19 pandemic.

According to the United Nations Population Fund (UNFPA), at least 644,955 teenage pregnancies were recorded during the COVID-19 lockdown in Uganda. Of these, 354,736 were registered in 2020 and 196,499 in the first six months of 2021 (UNFPA, 2021). The report attributes these high rates of teenage pregnancy primarily to the disruption of programs providing Sexual and Reproductive Health (SRH) information and services to schoolgirls, as well as poverty, which drove some parents to marry off their daughters for financial survival (UNFPA, 2021).

Becoming a mother as a teenager presents unique physical, social, and mental challenges. The mental and physical burdens significantly increase the risk of Common Mental Disorders (CMDs), which, if left untreated, can have detrimental impacts on both mothers and their children (Tembo et al., 2022). Depressive tendencies constitute a significant health risk for adolescents, with suicidal tendencies being the second leading cause of mortality among this group (WHO, 2018). Approximately 10% of expectant mothers and 13% of new mothers worldwide suffer from some form of mental disorder, with prevalence rates among adolescent mothers being two to three times higher in LMICs compared to HICs (Tembo et al., 2022). In Uganda, it is estimated that one in three individuals experiences depressive tendencies (Kaggwa et al., 2022).

Depression is notably one of the most CMDs, especially among teenage mothers in low-income countries (Nicolet et al., 2021).

According to the World Health Organization (WHO), depression is a Common Mental Disorder characterized by persistent sadness and a lack of interest or pleasure in previously enjoyable activities (WHO, 2023). Other symptoms include disturbed sleep, poor appetite, fatigue, and difficulty concentrating (WHO, 2023). Teenage mothers who experience untreated mental health issues like depression are more likely to become pregnant again within one to two years, have children with poor emotional and cognitive development, and use contraception less effectively (Tembo et al., 2022). The COVID-19 pandemic and its aftermath have exacerbated this public health risk among teenage mothers, particularly in Uganda's rural and urban areas, where vulnerable groups, including teenage mothers, have become more susceptible to health challenges.

### *Contextualizing the Study in Wakiso District and Kira Municipality*

Wakiso District with a population of 3,397,565 is the most populous district in Uganda (NPHC, 2024). The district has also been identified as one of the areas with the highest teenage pregnancy rates in the country, recording 10,439 cases in 2020 alone (UNFPA, 2021). This high burden is partly attributed to the district's unique socio-demographic dynamics. Wakiso is characterized by an uneven population distribution, with urban centers housing the majority of residents. This rapid urbanization is primarily driven by rural-urban migration (Uganda Bureau of Statistics, 2016).

Kira Municipality, one of the fastest-growing urban areas in Wakiso District, presents a unique socio-economic landscape that influences adolescent reproductive health outcomes (UNDP, 2017). The municipality has experienced rapid population growth, increased economic activities, and shifts in social structures, all of which contribute to the reproductive health challenges among adolescents. According to the Kira Municipality Council (2019), 11.5% of children aged 12-17 years in the area have been victims of teenage pregnancy. This high prevalence highlights the pressing need to examine the mental health challenges that teenage mothers in Kira Municipality face, particularly in a rapidly urbanizing context where socio-economic pressures, access to healthcare, and social support structures may differ from other settings.

## **1.2 Statement of the Problem**

While numerous studies have been conducted to estimate the burden of depression in Uganda (Dongomin, 2022), the focus has largely been on specific high-risk groups such as People Living with HIV, women in general, cancer patients, caregivers, university students, refugees, war victims, and children and adolescents (Kaggwa et al., 2022). However, teenage mothers—who face a heightened risk of depression (Hodgkinson et al. 2014) due to early motherhood, social stigma, economic vulnerability, and inadequate support systems—remain significantly underrepresented in existing research.

A systematic review and meta-analysis of 127 studies on depression in Uganda revealed that most studies were conducted in major urban areas, with 43 studies in the capital city, Kampala, 23 in Mbarara, and 16 in Gulu (Kaggwa et al., 2022). Despite this

concentration of research, there is limited data specifically addressing depression among teenage mothers in Uganda's rapidly urbanizing settings like Kira Municipality.

Kira Municipality, a rapidly urbanizing area with increasing rates of teenage pregnancies, has received little scholarly attention in this regard. Therefore, the absence of targeted research on depression amongst teenage mothers in settings such as Kira presents a critical gap, as their mental health needs and socio-economic struggles may differ from those in fully urbanized areas.

This study, therefore, sought to address this gap by examining the prevalence and determinants of depression among teenage mothers in Kira Municipality, thereby contributing to a more nuanced understanding of this vulnerable population's mental health challenges.

### **1.3 General and specific objectives**

#### **General objective**

The primary objective of this study was to determine the prevalence, explore associated factors and to understand the coping mechanisms for depressive tendencies among teenage mothers in Kira Municipality, Wakiso District, Uganda.

#### **The Specific objectives**

The specific objectives of this study were:

- I. To determine the prevalence of depressive tendencies among teenage mothers
- II. To explore the factors associated with depressive tendencies among teenage mothers

- III. To understand the coping mechanisms adopted by depressed teenage mothers

#### **1.4 Research questions**

To achieve the above objectives, the research tackled the following questions:

- I. What is the prevalence of depressive tendencies among teenage mothers?
- II. What are the different factors associated with depressive tendencies among teenage mothers?
- III. What are the different coping mechanisms adopted by depressed teenage mothers?

#### **1.5 Justification**

Globally, depression is one of the main health risks for adolescents (Webb et al., 2023), with prevalence rates among pregnant teenagers estimated between 16% and 44% (Hodgkinson et al., 2010). Despite the known prevalence of depression among pregnant teenagers globally, there is a paucity of research focused specifically on teenage mothers residing in rapidly urbanizing areas of LMICs. Majority of studies have focused on depression amongst pregnant and postpartum adolescents and associated risk factors among the demographic (Seakamela et al., 2023).

In Uganda specifically, limited literature exists on prevalence, associated factors and coping mechanisms of depression amongst teenage mothers in in rapidly urbanizing areas like Kira municipality. Attempts by Cox, 1999 were focused on depression amongst rural women (Cox, 1999) while Nakku, (2006) looked at postpartum major depression at six weeks in the outskirts of Kampala (Nakku, 2006). These studies not only focused

on broader sample populations without zeroing down to teenage mothers in rapidly urbanizing areas but were also done more than a decade ago.

This therefore underscores the uniqueness of this study in establishing current data on the prevalence, associated factors, and coping mechanisms of depression among teenage mothers in rapidly urbanizing settings like Kira municipality, Wakiso district.

### **1.6 Significance of the study**

The significance of this research lies in its potential to inform effective mental health programming for teenage mothers but also advance policy efforts that ultimately improve their quality of life. By understanding the prevalence, associated factors and coping mechanisms, this study contributes to the body of academic knowledge by providing empirical evidence that relevant stakeholder including Civil Society Organizations, activists, academia, and policy makers can adapt to better program for this mental health risk.

This will contribute to the development of suitable programmes of work, interventions and policies that are in alignment with the unique and contextual needs of teenage mothers. Ultimately, the goal is to ensure that teenage mother in Kira Municipality seeking for mental health support acquire services that are: available; accessible; acceptable; and of good quality for improved mental wellbeing.

### **1.6 Scope of the study**

In this sub-section, I present the content, geographical and time scope of this study.

#### **Content scope:**

Teenage mothers experience higher incidences of depression, in fact they are twice more likely to experience depression in comparison to their adult counterparts (Healthline, 2016). In view of this situation, this study focused on establishing the prevalence, associated factors and coping mechanisms for depressive tendencies amongst teenage mothers in Kira Municipality Wakiso district in. To this end, the study analyzed the availability, accessibility, acceptability and quality of coping mechanisms establishing their effectiveness for the vulnerable groups such as teenage mothers.

### **Geographical scope**

This research was conducted in Kira Municipality in Wakiso District. Uganda is 800 kilometers inland from the Indian Ocean in East Africa, which is situated across the equator (National Population and Housing Census, 2014).

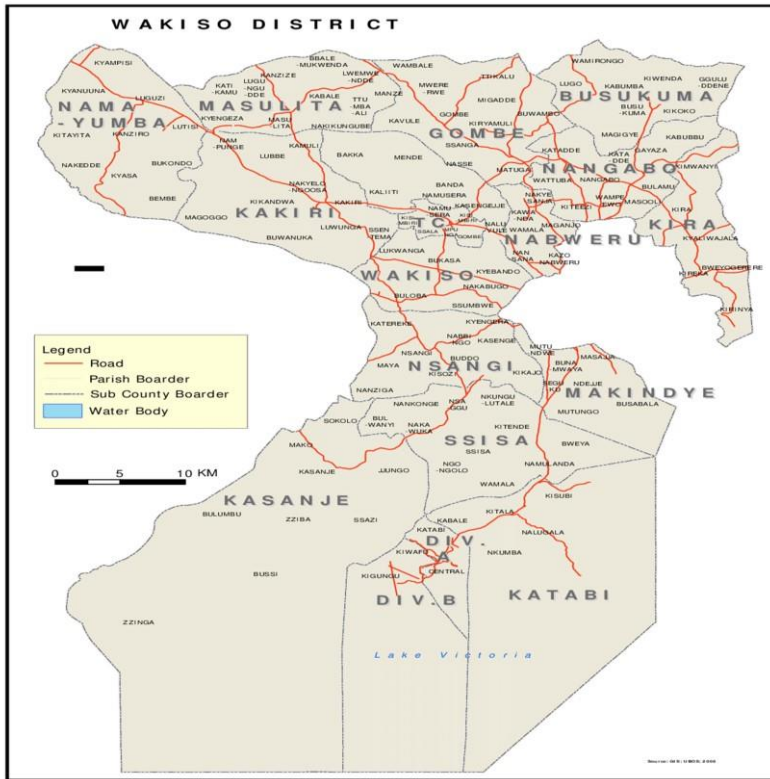
### **Map 1: Uganda**



Source: One Planet Nations online

Wakiso district is located in Uganda's central region and shares borders with Kampala, Mpigi, Luwero, Nakaseke, Mityana, Mukono and Kalangala districts (Wakiso District local Government, 2022).

## Map 2: Wakiso district



Source: (Ssemukasa et al., 2014).

As per the 2024 census, the district was listed as the most populous in Uganda with a population of 3,397,565 (NPHC, 2024).

The ratio of females to Males in Wakiso was recorded at 53 to 47, with 23.6% of the total population aged between 15 to 24 years (NPHC, 2024). 14.7% of the females in the district aged between 12 to 19 years had given birth (NPHC, 2014) and was recorded as one of the areas in Uganda that struggles with high incidences of teenage pregnancy. According to a UNFPA report, Wakiso district recorded 10,439 cases of teenage pregnancies in 2021, above other districts like Mukono which had 5535 cases, Luwero

district with 4545, Kamuli with 6535, and Mayuge with 6205 cases (UNFPA report from 2021).

The district is also characterized by an uneven population distribution where the urban centers take the bulk of the residents, a dynamism still attributed to rapid urbanization driven by rural-urban migration (Uganda Bureau of statistics, 2016).

*Time scope:* This study was conducted from September 2023 to July 2024.

### **1.8 Conceptual framework**

The conceptual framework illustrates the interaction between the independent variables, moderating variables, and the dependent variable in understanding the prevalence, associated factors, and coping mechanisms for depressive tendencies among teenage mothers in Kira Municipality, Wakiso District.

The independent variables in this study include demographic characteristics, economic factors (employment status, financial support, access to resources), and socio-cultural factors (stigma, family support, social networks). These factors influence the mental health outcomes of teenage mothers by shaping their experiences, stressors, and vulnerabilities to depressive tendencies.

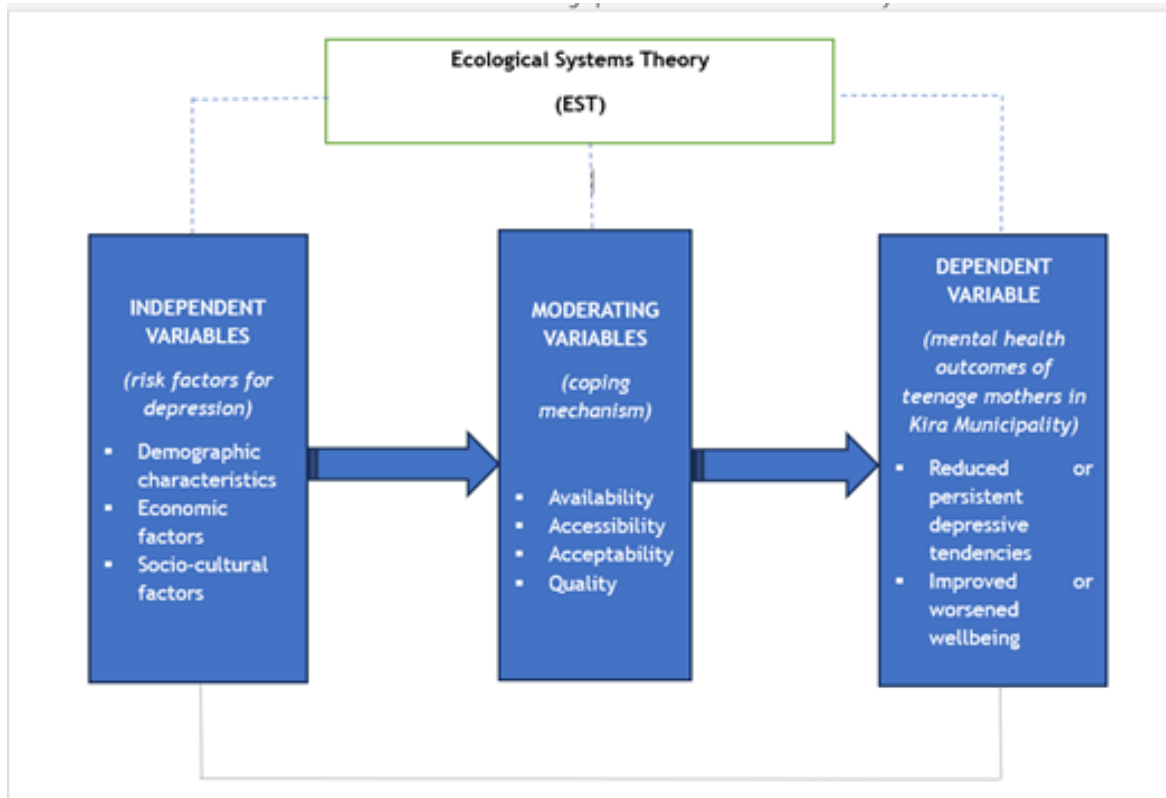
The moderating variables focus on the availability, accessibility, acceptability, and quality of different coping mechanisms adopted by teenage mothers. The effectiveness of these mechanisms can either mitigate or exacerbate the impact of the independent variables on the mental health outcomes of teenage mothers.

The dependent variable in this framework is the mental health outcomes of teenage mothers, specifically their susceptibility to depressive tendencies. The interaction between the independent and moderating variables determines the extent to which these mothers experience and manage depression.

This conceptual framework is grounded in Bronfenbrenner's Ecological Systems Theory (EST), which emphasizes the role of interconnected environmental systems in shaping an individual's development and well-being. The EST identifies multiple levels of influence, from the immediate environment to broader societal structures, that interact to impact teenage mothers' mental health.

By applying the Ecological Systems Theory, this conceptual framework provides a comprehensive understanding of how various levels of environmental factors interact to influence depressive tendencies among teenage mothers in Kira Municipality. It highlights the importance of both direct and indirect influences, as well as the need for effective, accessible, and acceptable coping mechanisms to improve mental health

outcomes.



**FIGURE 1:** Study Conceptual framework

Source: Researcher's construct

## 1.9 Theoretical framework

### The AAAQ framework

The “Availability, Accessibility, Acceptability, Quality” (AAAQ) framework was used in this study to assess the effectiveness of the coping mechanisms used by teenage mothers in Kira Municipality, Wakiso district. Also commonly referred to as the right to health framework, the AAAQ framework was originally developed for the healthcare sector, as a way of advancing the right to health (Zhang, 2018). This framework is informed by the International Covenant on Economic, Social and Cultural Rights under

General comment 14, that guarantees the right to health stating that governments have the mandate to protect, respect and promote individual's enjoyment to available, accessible, acceptable and quality (AAAQ) health services (UN Economic and Social Council-ECOSOC, 2000). Human rights frameworks such as the above are legally, politically, and morally binding to all governments to ensure that they protect basic freedoms and the fundamental requirements of a dignified life (Yamin, 2014).

For purposes of this research, the researcher tailored the four facets of the framework to the definitions elaborated in the next text:

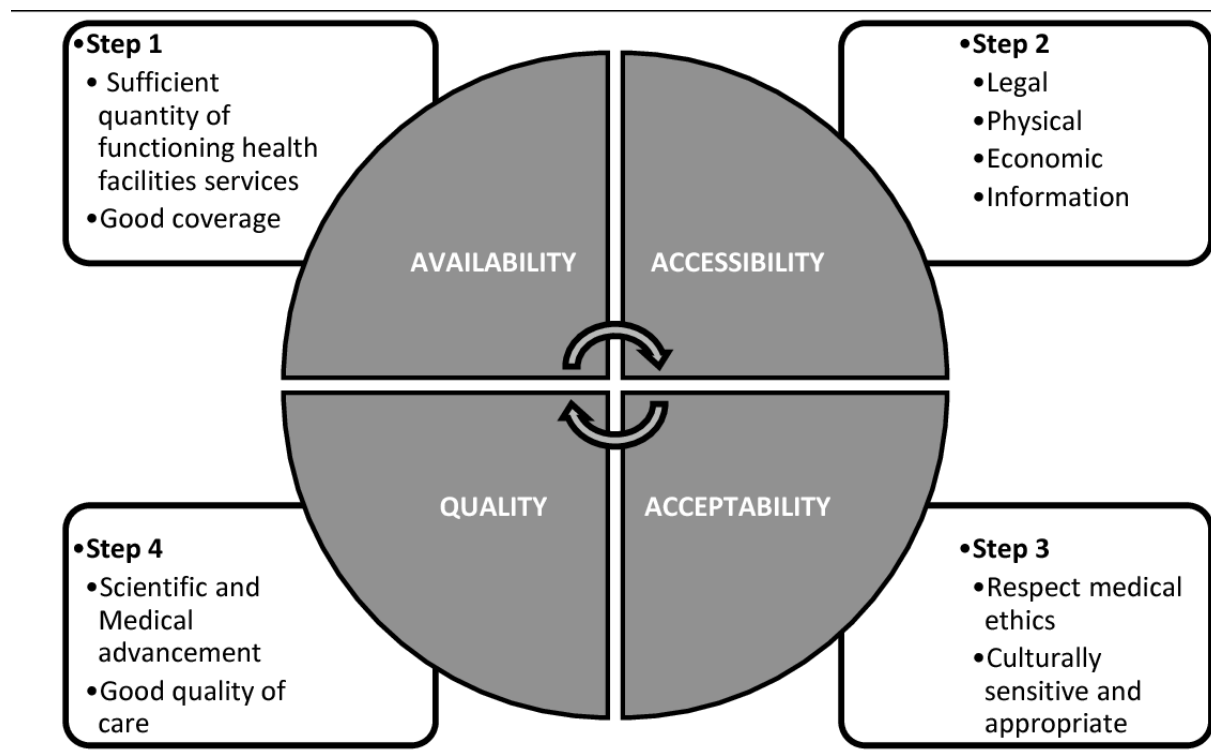
*Availability:* This focused on the existence of the different types of coping structures/mechanisms that teenage mothers with depressive tendencies in Kira municipality, Wakiso district used. This facet also analyzed the functionality of these mechanisms to meet the specific needs of teenage mothers.

*Accessibility:* This facet of the framework focused on: physical access (distance and to the preferred option); financial access (affordability of the available options); and information access (whether or not information is availed in an inclusive manner and by who).

*Acceptability:* Conformity to cultural/religious values and confidentiality are the key aspects that were considered to establish the acceptability of the coping mechanisms in the study area.

*Quality:* To establish the quality of the coping mechanisms, the study focused on understanding whether drugs were available and services offered by skilled personnel.

Based on the above four variables, the study assessed the equitability of the coping mechanism adopted by teenage mothers in Kira municipality through a human rights lens. Figure 2 further explains the relationship between the variables.



**Figure 2:** AAAQ framework

Source: WHO (2007, P.2)

## Chapter 2: LITERATURE REVIEW

### 2.0 Introduction

In this chapter, a review of existing literature on the prevalence, associated factors and coping mechanisms of depression among teenage mothers is conducted. The literature review specifically focuses on issues that are in relation with the study objectives including:

- a. Mental health and depression
- b. Assessment of depressive tendencies
- c. Assessment of economic and socio-cultural factors associated with depression
- d. An analysis of the different coping mechanisms
- e. Gaps in existing literature

### 2.1 Mental health and depression

The World Health Organization defines health as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Nobile et al., 2014). This definition highlights health as a key component in the realization of the general wellbeing of an individual. WHO goes ahead to further define mental health as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community (WHO, 2022). The importance of mental wellbeing is emphasized in different commitments including Sustainable Development Goal (SDG) 3.4 that focuses on

reducing premature mortality from non-communicable diseases by one third through preventing, treating and promoting mental health and well-being.

Notably, mental disorders remain among the leading causes of ill-health and disability worldwide affecting one in four people in the world at some point in their lives (WHO, 2001). There are various types of mental disorders ranging from; mood disorders (depression and bipolar); anxiety disorders; personality disorders; psychotic disorders (WHO, 2022) among others. Disorders such as depression, anxiety, bipolar, post-traumatic stress are also referred to as Common Mental Disorders. WHO defines depression as a Common Mental Disorder which is characterized by persistent sadness, lack of interest in previously rewarding activities, disruption of sleep, less appetite, tiredness and poor concentration (WHO, 2022). Globally, it is estimated that approximately 280 million people are living with depression with approximately 85% of these living in Low-and Middle-Income countries receiving no treatment (Strong minds, 2023).

Depression is one of the leading causes of disability around the world contributing greatly to the global burden of disease and if not treated, its effects are long-lasting and can dramatically affect a person's ability to function and live a rewarding life (Reddy, 2010). During or after pregnancy, women are highly susceptible to depression hence resulting into approximately 9% of pregnancy-related deaths (Bauman et al., 2018). If untreated, the effects of depression can trickle down from the mother to the newborn baby resulting in behavioral problems (Bauman et al., 2018).

## **2.2 Assessment of depressive tendencies**

To establish the prevalence of depression amongst populations, different depression assessment instruments have been developed and adapted. These assessment instruments are crucial in establishing the initial depression symptoms and determining possible care treatment options (APA, 2013). The Beck Depression Inventory (BDI), Center for Epidemiologic Studies Depression Scale, Hamilton Depression Rating Scale, and Children's Depression Rating Scale are among many of the readily available depression assessment tools. To understand the prevalence and manifestation of depression amongst teenage mothers in Kira municipality, I used the Beck Depression Inventory Tool.

The BDI is a common instrument for assessing behavioral symptoms and depression prevalence to test for depression amongst individuals aged 13 to 80 years (Jackson-Koku, G., 2016). The ten-minute assessment tool is used by individuals to fill out 21 self-report items which are centered on the overall assessment of a symptom utilizing a multiple-choice response form (Jackson-Koku, G., 2016). The end-user only checks/marks/circles one of the four boxes offered in front of each question to determine one of the four possible responses for each question. After filling out the entire form, the total score is summed up to establish the prevalence of depression in individuals. For this particular instrument, the symptom's prevalence is measured on a range of one to three, with depression being the main symptom. The highest possible total for the whole test would be sixty-three. This would mean that the participant circled number three on all twenty-one questions. While the lowest possible score for

the test would be zero implying that the participant circled zero on each question. The different scores in the tool and their interpretation are elaborated in table 1;

**Table 1: Beck Depression Inventory score interpretation**

<b>Total Score</b>	<b>Prevalence of Depression</b>
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

**Source:** Jackson-Koku (2016).

Extreme and severe depression are classified under Major Depressive Disorders by the World Health Organization. These are determined when a person exhibits symptoms such as a chronically low or sad mood, anhedonia, or reduced interest in enjoyable activities, feelings of worthlessness or guilt, exhaustion, difficulty concentrating, changes in appetite, agitation or psychomotor retardation, disturbed sleep patterns, or suicidal thoughts (Bains, 2020). These disorders are also known to be sternly incapacitating and one of the costliest diseases to society (Kessler et al., 2003). They further have profound social and economic ramifications (Katon, 2003).

**Moderate depression** on the other hand involves feeling blue temporarily (Kristeen, 2018). While less severe, moderate depression symptoms are akin to those of severe

depression and have the potential to cause noticeable problems in relationships with others daily (American Psychiatric Association, 2013).

**Clinical depression** is defined by Cleveland Clinic, as a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy (Cleveland Clinic, 2022). It is known to affect sleep, appetite and the ability to think clearly and if left untreated, it can significantly impair the ability to function daily including overall quality of life (Cleveland Clinic, 2022). People who suffer from clinical depression are more vulnerable to anxiety disorders and substance use disorders, all of which heighten the likelihood of committing suicide (Bains, 2020).

### **2.3 Factors associated with depression among teenage mothers**

Adolescent mental health continues to remain a disregarded health issue globally (Kathryn et al., 2021), yet fifty per cent of mental health disorders are established by 14 years of age and, 75% before 24 years of age (Kessler et al., 2007). Depression is one of the most common psychiatric disorders in adolescents globally (Jane Costello, 2006). Globally, mental health disorders such as depression are a leading cause of disability, affecting an estimated 10-20% of children and adolescents (Kieling et al., 2011). These estimates aren't wholly representative as the coverage of prevalence data for mental disorders among adolescents remains limited, particularly within LMICs skewing global estimates (Erskine et al., 2017).

Early and unplanned pregnancies in Sub-Saharan Africa are linked to poor mother and child health outcomes, societal stigma, and limited access to opportunities and care, ultimately leading to CMD such as depression (Manasi et al., 2022). Depression is

aggravated by various factors including economic and socio-cultural (European Union, 2021) as expounded in the subsequent text:

### **2.3.1 Economic Factors**

The World Bank currently estimates Uganda's Gross Domestic Product (GDP) per capita at USD 964.4 (World Bank Data Bank, 2022). In a study conducted by Rafa et al., 2017, Wakiso district was cited as having the largest GDP per capita (\$3,250), followed by Kampala (\$2,655) and Mukono (\$1,738) (Rafa et al., 2017).

According to the Annual Labour Force Survey (ALFS) 2017-18, Uganda's population was estimated at 38 million people with approximately 51% of the population being female (Uganda Bureau of Statistics, 2019). Close to two thirds (64.2%) of the country's population was estimated to be employed in the agriculture, forestry and fishery sector with over 77% of people aged five and older engaged in unpaid care work, where a greater percentage were women (89%) (UBOS, 2019). Notably, the report indicated 34.8% of the proportion of the working-age population is between 15 - 24 years with 47.1% engaging in purely subsistence agriculture while 95.1% of this population engaged in informal employment (Uganda Bureau of Statistics, 2019).

Until 2021, Uganda's minimum wage remained at Uganda shillings (UGX) 6000 (about USD 1.6) per month since 1984 (Wambuga, 2016). As of 2012, 194.50k people were living below \$1.90/day (Mahler, 2022). Economic factors, are one the main factors associated with depression, with women being 15.9% more likely to have maternal depression while facing financial difficulties (Ziyi W et al., 2000). For a new mother to successfully transition from pregnancy to childbirth, financial resources are essential to ensure that

they have the basic requirements for themselves and their newborn child. However, it should be noted that majority of the teenage mothers depend on their parents/guardians for support as many of them don't have jobs or dependent partners to sustain them during this new phase of their lives. Some of the economic factors that contribute to depression among teenage mothers include:

### ***Low household income***

For many of the families living in LMICs like Uganda, economic survival is a major challenge. According to the Uganda Bureau of Statistics, a significant number of the families residing in peri-urban areas are engaged in informal or low-skilled work and individuals work as daily laborers, street vendors, domestic helpers, or engage in small-scale agriculture (UBOS, 2018). A report issued by UNICEF in 2020 further highlighted that nearly half of Ugandan households experience multidimensional poverty (a non-traditional way of measuring *poverty beyond monetary deprivations to also tackle aspects such as access to education and basic infrastructure*) of 47%, with more than double this population lives in monetary poverty (conventional method of measuring poverty that strictly focuses on lack of income) (UNICEF, 2020).

As of 2016, the international poverty line measure of \$1.90 indicated an increase in the poverty rates in Uganda with 41.7% of the population living in extreme poverty (Owori, 2020). A large majority (85%) of households in Uganda earn less than 50,000 UGX per month, and less than 4% earn more than 200,000 UGX per month (Mackri et al, 2013). The Uganda National Survey Report of 2019/2020 indicated that the median monthly household income was UGX 190,000 with urban households having higher income

compared to their rural counterparts while female-led households had lower incomes than the male-led household (UBOS, 2021).

As such, for teenage mothers who essentially depend on their families, low household income levels significantly impact their health treatment making it ineffective, insufficient, and unfair (Meenakshi, 2022). It is believed that households with low income are more likely to experience depression than those with higher income (Adama et al., 2015). The high cost of therapy, forces teenage mothers to choose between living with untreated CMDs including depression, or seeking treatment from traditional or religious authorities (Manasi et al., 2022). According to the national strategy to end child marriage and teenage pregnancies (NSCM&TP), teenage pregnancies can potentially decrease household incomes (NSCM&TP, 2022) as teenage mothers are three times less likely to have professional jobs and twice more likely to be self-employed in agriculture (UDHS,2016).

### ***Low partner's income***

While Early pregnancy disproportionately affects girls more, Uganda's fathers' population majorly consists of teenagers, adults, and young adults (AfriChild, 2021). In Uganda like many countries, the expectation is that once a teenager becomes pregnant, then her partner must take on the full responsibility for both her, the pregnancy and soon to be new baby. However, majority of teenage and young adult fathers, are either still under the care of their parents or in school. Many of the partners of teenage mothers abandon any responsibility towards them after they become pregnant, while the greatest percentage of those who are involved are hardly in any position to provide the needed financial support to their partners.

Notably, financial stress for majority of the teenage mothers is in many cases worsened by absent fathers (Ziyi W et al., 2000). Specifically, most of the teenage mothers in rural areas of Uganda live with their parents instead of their children's fathers, as the majority of them had allegedly denied responsibility or run off for fear of being arrested by police (Nabugoomu et al., 2018). Therefore, for many of the struggling partners, the anticipation of a further decrease in income due to new responsibilities in many cases has resulted in partners abandoning the teenage mothers and their newborn children. Given the taxing economic responsibility that is required after birth, such abandonment by a partner will in many instances negatively affect the new mother's emotional well-being resulting in depressive tendencies.

### **2.3.2 Socio-cultural Factors**

Supportive social structures and relationships have the potential to buffer stressful conditions faced by teenage mothers, hence positively influencing their psychological well-being (Roye et al., 1996). In LMICs factors such as interpersonal and family-related problems, challenges with in-laws, domestic violence, lack of a partner or social support, and low levels of schooling are some of the identified factors associated with female adolescent depression (Fisher et al., 2012). The socio-cultural factors are a major accelerator of depression among teenage mothers especially in countries like Uganda where patriarchy, pregnancy taboos and cultural norms are a big part of the day-to-day lives of individuals (Husain et al., 2006). These factors range from intimate partner violence, domestic abuse by in-laws, low self-esteem, low social support, taboos and cultural and religious beliefs among others as elaborated the next text:

## ***Patriarchy***

Societal constructs that endorse men's supremacy over women are widely defined as patriarchy (Johri, 2023). This as a result has increased discrimination based on sex or gender also commonly known as gender inequality. Gender inequality is believed to significantly contribute to women's risk of experiencing depressive tendencies (Ali, et al., 2009). While, Uganda is predominately a patriarchal society where socio-cultural, economic, and political power is mostly held by men (UBOS, 2019), the 1995 constitution of the Republic of Uganda as amended, under Article 21(1) guarantees equality of all persons under the law in all spheres of political, social and cultural life and the enjoyment of equal protection by the law in all aspects (Office of the Auditor General - OAG, 2015).

At the national level, the state is commended for making strides towards addressing gender inequalities through the establishment of policies such as the 2006 Uganda National Gender Policy (Ministry of Gender, Labor and Social Development, 2018). This policy sets forth social protection programmes like the Labour Works Programme, the Youth Livelihoods Programme (YLP), and the Uganda Women Entrepreneurship Programme (UWEP), among others, that have been significant in reducing gender inequalities in the country (MGLSD, 2018). Additionally, framework initiatives such as gender mainstreaming have been established to redress gender imbalances, amongst all government agencies, including Local Governments (Uganda Gender Policy, 2007). However, while these programs and initiatives have expanded opportunities to attain gender equality, societal systems that endorse men's supremacy over women remain (UBOS, 2019).

Wakiso is recognized as one of the districts that have prioritized the promotion of gender equality and equity at the local district level (Wakiso DDP, 2010/15). In 2014, the district developed a Gender Policy, even though its finalization and implementation are yet to be actualized (OAG, 2015). While these efforts are recognized at the institutional level, it is key to note that patriarchal tendencies were still dominant in Wakiso both at the community and household levels. These structural and system constraints impede the mental well-being of marginalized groups including teenage mothers.

In a study conducted on factors associated with depressive tendencies among postpartum mothers in a rural district in Uganda, it was established that male partners of postpartum women were a major factor that contributed to depressive tendencies (Kakyo et al., 2012). A statistically significant relationship was found between depression and factors such as the number of female sexual partners the husband has; current problems in marriage; partner's parity and the husband's support during the postpartum period (Kakyo et al., 2012). While these are an accelerator for depression among postpartum mothers in general, the situation was even worse for teenage mothers as the majority of their pregnancies were with absentee partners who didn't provide the physical, social or emotional support that they require post-delivery (Tembo et al., 2023).

### **Stigma**

According to Goffman's 1963 stigma theory, stigma was characterized as a "deeply discrediting attribute", that was hinged on the social construction of identity (Sumbane et al., 2023, Maleka, 2020). Stigma was believed to take on different components

including; labelling, stereotyping, separation, status loss, and discrimination (Maleka, 2020). In research conducted in a Texas hospital it was established that 39.1% of teen mothers felt stigmatized as a result of their pregnancy (Constance et al., 2005). For majority of the teenage mothers, it was believed that this social isolation was mostly imposed by peers, members of the community, family members, media, and healthcare staff (Ntshayintshayi et al., 2022; Mutahi et al., 2022). While for others, stigmatization was based on defying the age norms for parenting thus viewed as promiscuous (Mudau 2019; Pueyo 2022).

Notably, this social isolation and rejection of teenage mothers made them feel ashamed of themselves and unaccepted by the community (Mogamedi et al., 2023). The challenges of teenage motherhood were exacerbated by stigma which had negative psychological outcomes, such as social disengagement from others and certain social circles that made it difficult for them to cope hence impacting their mental and physical health and resulting in depression in some cases (Mogamedi et al., 2023).

This situation may in fact be considered higher in LMICs like Uganda where there is little understanding and appreciation of the challenges that emerges as a result of teenage pregnancy. Due to this limited understanding, stigmatization, teasing, and mockery significantly contribute to diminishing teenage mothers' self-worth hence putting them at a higher risk for developing depressive tendencies.

### ***Low partner involvement***

The transition to motherhood is believed to be a challenging and emotional journey that involves major changes in psychological, social, and physiological components aggregating the risk of mental health challenges such as depression (Kebede et al., 2022). Scholars have shown that unplanned and unsupported pregnancies are in many ways associated with mental health challenges (Abadiga, 2019). However, the majority of teenage relationships involving children/teenagers end within the first year of the child's birth with 8 out of 10 teenage fathers never marrying their child's mother (Debolina R, 2022).

In a study carried out in North West Ethiopia, it was established that postpartum depression was 2.34 times more common in women whose partners were not actively involved in Maternal Newborn and Child Health (MNCH) services than in women whose partners were actively involved (Kebede et al., 2022). Mothers experience less postpartum depression when they have a stable family life with involved co-parents (Debolina R, 2022). In rural Uganda specifically, unmarried teenage mothers face two times the stigma resulting in mental distress (Webb et al., 2023). This limited or no involvement of partners of teenage mothers in parenting greatly increases the likelihood of depressive tendencies amongst teenage mothers.

### ***Substance abuse***

Substance abuse refers to the harmful use of alcohol or illicit drugs (WHO, 2015). For the majority of the people that abuse substances, peer and family influence are

believed to be a main factor in increasing acceptance and access to alcohol and illicit drugs (Henry et al., (2019). Substance abuse can have detrimental effects on an individual's physical, mental, and emotional well-being (Henry et al., 2019). In Uganda, it is estimated that approximately 23.3% of adolescents have used alcohol (Michelle, 2023) while 16% of urban centres youth abuse drugs (Tumusime, 2022). In comparison to the global estimates of 13% of newborn mothers that typically experience depression (WHO, 2019), depressive tendencies are noted as being higher among newborn mothers with a history of substance abuse ranging from 19.7% and 46% (Destiny, 2021).

In a study conducted on the psychosocial health of adolescent unmarried mothers residing in rural Uganda, communities explicitly described substance abuse as a major factor associated with depressive tendencies among teenage mothers (Webb et al., 2023). Notably, substance abuse is even higher among teenage mothers who are twice as likely to abuse illegal drugs in comparison to their older counterparts making them more susceptible to depressive tendencies (Brad D, 2004). Among pregnant teenagers, studies have acknowledged experiences of Gender Based Violence and its correlation to substance abuse (Tung et al., 2020). In many of the reported cases of substance abuse, pregnant teenagers indicated that it was a way of escaping from their emotions and challenges (Lopez et al., 2011).

### ***Cultural norms and beliefs***

Culture influences how people deal with mental health challenges and whether or not to seek help as it provides a crucial framework for; experiences, common ideas, attitudes, and norms for emotional response (Bina, 2008). In many cultures around the

world, the postpartum period is associated with a lot of rituals including social isolation (Cindy et al., 2007) where in some instances, women are considered to be unclean until the postpartum period of bleeding has discontinued (Chien et al., 2006). For instance, in the Arabic community, new mothers are prohibited from entering other people's homes or entering through the front door of their own homes to avoid offending guardian spirits (Rice PL, 2000).

For majority of the teenage mothers' their experiences are shaped by social norms and culture, which impact their mental health (Tembo et al., 2023). Many of the communities in Uganda are shaped and defined by cultural norms and religious or traditional beliefs. In some regions of the country, for instance, child marriages are a social norm that is widely practiced with parenthood viewed as an indication of adulthood (Webb et al., 2023).

In Lira district, there is a market known as the "Moo Cwari" ("to look for your husband") market where girls are sold in exchange for livestock (UNFPA, 2020) and it is culturally acceptable. While Uganda's government considers child marriage as a form of sexual abuse motherhood without a spouse has been associated with increased stigma and disgrace in traditionally rural communities that uphold cultural norms and beliefs (Webb et al., 2023). In addition to the above-mentioned, bride capture, bride price, and Female Genital Mutilation are also common norms in Uganda. However, these cultural norms, beliefs, practices and perceptions are key drivers of teenage pregnancy and mental health challenges among the age group ((NSCM&TP, 2022).

Aside from norms and beliefs that result in teenage pregnancies and later on depression among teenage mothers, some beliefs impede access to mental health services. Specifically, the belief in traditional healers as they are often the first or only source of help-seeking when teenage mothers (especially those residing in rural Uganda) are faced with mental health challenges (Molodynski et al., 2017). In many African cultures, non-psychotic mental challenges such as depressive tendencies aren't regarded in medical terms thus undermined by support systems including; communities, relatives and practitioners (Johnson et al., 2009) but rather referred to traditional healers for help. Additionally, the cultural philosophy surrounding sexuality in different religions such as the Catholic religion affects how teenage girls seek Sexual Reproductive Health and Rights services, such as contraception, maternity and childcare services, STI prevention and diagnosis, and information services (Achen et al., 2021).

As such, the above-mentioned beliefs, norms and perceptions while often done to safeguard the new mother and child, in most cases heighten feelings of loneliness hence increasing the vulnerability to depressive tendencies. The situation is even worse for teenage mothers who are experiencing motherhood for the first time yet have little or no access to avenues for interacting with the rest of the world hence leading to depressive tendencies.

#### **2.4 Copping mechanisms**

There are various ways in which individuals and communities deal with depression including psychological and pharmacological interventions (Mayo et al., 2014). However, the above interventions are more readily available and accessible in high-

income countries (WHO, 2001). Furthermore, the World Health Organization highlights that support services for depression in low- and Middle-Income Countries, are often absent or underdeveloped thus resulting in a lack of treatment (WHO, 2001).

Coping involves continuously modifying one's behavior and mental models to handle the perceived problems of both our "internal and external demands (Mitchell, 2004). Thus, coping mechanisms are the techniques that individuals employ to help them manage challenging emotional situations including depressive tendencies (Good Therapy, 2023).

Coping is typically classified into three (Rich, 2020):

- a) Problem-focused coping: This method is action-oriented and focuses on taking action to reduce stress by giving oneself a sense of control over the issue.
- b) Coping by reappraisal: This category involves changing one's perspective to reduce the threat in a circumstance.
- c) Emotion-focused coping: This involves supporting an individual to control their emotional response to a stressful situation.

On the other hand, two major categories of coping mechanisms exist active (conscious attempts to lessen stress and intentional understanding of the cause of depression) and avoidant (ignoring the cause of depression) (Good Therapy, 2023). Therefore, these can be either adaptive implying that they have positive health consequences or maladaptive resulting in negative consequences.

According to research carried out by Musese, 2018 on *mental health and coping strategies of teenage mothers in the Kavango region*, it was established that they used both emotion-focused coping and reappraisal coping mechanisms (Musese, 2018). Some

of the coping mechanisms highlighted included the use of; supportive structures; dependence on ongoing motivation and encouragement and family members including parents, siblings, extended family members, friends and boyfriends (Musese, 2018). It is believed that these mechanisms greatly contribute to lowering depressive tendencies among teenage mothers (Huang et al., 2014).

Therefore, this research was keen on exploring the prevalence, associated factors and coping mechanisms adopted by teenage mothers as an understudied population as evidenced in the literature review above.

## **2.5 Gap in existing literature**

The existing literature indicated that while extensive research had been conducted to establish the depression burden among different groups such as people living with HIV, women, refugees among others, there remained a significant gap in data on the prevalence of depression specifically among teenage mothers. As a result, there was limited statistical evidence on the prevalence of depression within this demographic, making it difficult to quantify the burden of the condition.

Additionally, while several studies had explored the factors associated with depression, the majority had not established which of these factors were most predominant especially amongst vulnerable groups like teenage mothers. As a result, there was limited clarity on whether socio-economic status, lack of family support, stigma, or other variables played a more significant role in influencing depressive tendencies among this demographic.

Lastly, although coping mechanisms for mental health challenges had been widely examined, very few studies had explicitly investigated how teenage mothers navigated depression. Even fewer studies had evaluated these coping strategies through a human rights lens to assess their accessibility, effectiveness, and equitability.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.0 Introduction**

This chapter expounds on the methodology that was adopted to achieve the study objectives. It includes; the study design, population and sampling techniques, selection procedure, data collection methods, protocol for data collection, data collection instruments and equipment, quality control, strategy for data collection, processing and analysis and ethical consideration.

### **3.1 Research design**

This study design was a convergent parallel design (mixed methods) involving both qualitative and quantitative data collection methods. The quantitative data collection methods focused on the use of a close-ended research questionnaire (BDI). On the other hand, the researcher skewed qualitative data collection methods to the collection of data through the use of open-ended research guides (Key Informant and Focus Group Discussion guides) in an attempt to answer the research questions (Creswell, 2014).

### **3.2 Area of study**

The research was conducted in Kira municipality which is located in Wakiso district the most populous district in Uganda. Kira municipality comprises of three divisions of Namugongo, Kira and Bweyogere and as of 2020, its population was estimated at 462,900 people (UBOS, 2020). Kira is reportedly one of the rapidly growing urban areas characterized by its varied socio-economic landscape, including areas with well-developed infrastructure and others that are still developing (UNDP, 2017).

### **3.3. Source of information**

The main source of information in this study was primary data. The researcher collected primary data from Key Informant Interviews, Focus Group Discussions and survey tool (BDI).

### **3.4 Study population and sampling techniques**

#### **Study Population**

The research targeted two categories/sets of participants:

*a) Teenage mothers aged between 16 - 19 years residing in Kira municipality, Wakiso district:*

While teenage mothers are generally known to constitute ages 10 - 19 years, this study focused on ages 16-19 years as 16 years is the globally recognized age of consent. Additionally, this specific age group was informed by the UDHS, 2022 statistics that highlight that 24% of girls aged 15 to 19 are either new mothers or expecting their first child (UBOS, 2022). These participants were chosen specifically based on their experiences as teenage mothers. Given the location of the study, a key criterion was that the teenage mother had to reside in Kira municipality, Wakiso district.

*b) key informants:*

For the Key Informant interviews, I recruited different stakeholders including the health Centre III in-charge, Non-Governmental Organizations (NGO) centre managers/executive directors; counsellors and youth representatives.

## **Sampling technique**

This study employed a two-stage sampling technique to identify participants and key informants. The first stage involved purposive sampling to select organizations that directly engage with teenage mothers in Kira Municipality, particularly those focusing on mental health and human rights issues ensuring that they were relevant to the study's objectives. Three organizations were chosen based on their active involvement in supporting teenage mothers: Tukole Art Cultural Inspirations, Community Health Advocates Association Wakiso, and Mirianka Source Teenage Girls.

In the second stage, simple random sampling was used to select individual teenage mothers from a list of participants provided by these organizations. From this list, 200 teenage mothers were randomly selected, ensuring that each eligible participant had an equal chance of being included. This sampling method was designed to ensure a fair and unbiased representation of teenage mothers in the study, which was critical for the reliability and validity of the findings.

## **Determining the Study Sample Size**

### *Teenage mothers*

The study focused on teenage mothers residing in Kira Municipality, Wakiso District. The total population of teenage mothers in the area, as identified through collaboration with three organizations actively working with this demographic, was 410 individuals. To determine the appropriate sample size for this study, the Krejcie and Morgan (1970) sample size determination table was used. According to the table, a sample size of 200

teenage mothers was deemed statistically sufficient for the study's objectives, considering the population size of 410.

**Table 2: Krejcie and Morgan Table**

<i>Table for Determining Sample Size of a Known Population</i>									
N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	1000000	384

*Note: N is Population Size; S is Sample Size* *Source: Krejcie & Morgan, 1970*

**Source:** (Krejcie and Morgan, 1970)

### *Focus Group Discussions and Key Informant Interviews*

In addition to the 200 teenage mothers who participated in the study, qualitative data collection methods were employed to gain deeper insights into the factors associated with depression among teenage mothers and the coping mechanisms they utilized. Specifically, five Focus Group Discussions (FGDs) were conducted, each comprising 10-12 teenage mothers residing in Kira Municipality.

Furthermore, 10 key informant interviews were conducted with stakeholders who were purposively selected based on their expertise and direct engagement with teenage mothers. These key informants included the in-charge of Health Centre III, counselors, Community Health Advocates, youth representatives, and Civil Society Organization representatives. Their insights provided a broader understanding of the factors influencing the mental health of teenage mothers in Kira Municipality.

#### **Inclusion and Exclusion criteria**

*Inclusion:* Teenage mothers aged 16 - 19 years residing in Kira Municipality, Wakiso district.

*Exclusion:* None of the respondents was excluded.

#### **3.5 Selection procedure/protocol for data collection**

The data collection process followed a structured protocol, beginning with obtaining ethical clearance from the Research and Ethics Committee at Uganda Christian University. Once approval was granted, the researcher sought permission from Kira Municipality through the Town Clerk's office. Clearance was also obtained from the organizations engaged in this study, ensuring that the study was conducted in compliance with ethical and institutional guidelines.

Following approvals, the researcher coordinated with the selected organizations to schedule interviews. On the designated interview days, the organizations facilitated the participation of teenage mothers by inviting them to take part in the surveys. Informed consent was obtained from each participant before proceeding with data

collection. To maintain confidentiality, all interviews were conducted in private settings.

### **3.6 Data collection instruments and equipment**

*Beck Depression Inventory tool - see Appendix I*

The Beck Depression Inventory questionnaire was used to fully identify and evaluate how depression manifests in teenage mothers in Kira Municipality, Wakiso district. This self-assessment instrument was used for this study as it has been proven to be effective in the past when used with adolescents (who were part of our target group) to determine depressive symptoms and gauge the prevalence of depression (Mosanya et al., 2022). Additionally, it's one of the most popular questionnaires for evaluating a person's depression prevalence and its validity and reliability have been examined in a variety of global demographics (Osman, 2004). Aside from its suitability for our target population as elaborated in section 2.2, this depression self-assessment tool has also been utilized in the Ugandan setting before in different research, including one that compared two districts in Uganda to determine the prevalence of depression (Ovuga, 2005).

The list of Item Categories for the BDI questionnaire include:

1. Sadness
2. Pessimism
3. Past Failure
4. Loss of Pleasure
5. Guilty Feelings
6. Punishment Feelings
7. Self-Dislike
8. Self-Criticalness
9. Suicidal Thoughts or Wishes
10. Crying
11. Agitation

- 12. Loss of Interest
- 13. Indecisiveness
- 14. Worthlessness
- 15. Loss of Energy
- 16. Changes in Sleeping Pattern
- 17. Irritability
- 18. Changes in Appetite
- 19. Concentration Difficulty
- 20. Tiredness or Fatigue
- 21. Loss of Interest in Sex

As elaborated under section 2.2, this self-assessment tool tackled 21 items total on a 4-point BDI scale, ranging from 0 (no symptoms) to 3 (severe symptoms) where cumulative scores were ranked as follows:

1 - 10	These ups and down are considered normal
11 - 16	Mild mood disturbance
17 - 20	Borderline clinical depression
21 - 30	Moderate depression
31 - 40	Severe depression
40 Above	Extreme depression

Each survey with a teenage mother was a roughly 30-minute guided session by the researcher to prevent any misunderstandings given the special demands (both linguistic and interpretational) of the targeted research participants. These surveys were conducted in private rooms allocated by the respective organizations to ensure privacy.

Additionally, structured open-ended KII and FGD guides were used to analyze the factors associated with depression among teenage mothers in Kira Municipality, Wakiso district,

the different coping mechanisms adopted and their conformity to the AAAQ framework. This allowed for a deeper exploration and interaction with the interviewees to identify the root of the problem. Interviews were recorded using voice recorders and note-taking concurrently to make sure we didn't miss any important points that came up.

### **3.6 Quality control**

The research assistants were trained on data collection techniques. The interview guides were pre-tested in Kasangati that has similar characteristics with the study area. Additionally, the study tools were proofread to make sure all flaws were eliminated.

### **3.7 Data processing and analysis**

The quantitative data from the survey was analyzed using SPSS version 26 and univariate analysis on the quantitative data collected from the 200 participants to determine the prevalence of depressive tendencies and identify factors associated with depression.

The qualitative data was analyzed through coding and theming. Field notes and audio recordings were used to gather data. In compliance with the recommendations of Uganda Christian University's Research and Ethics Committee (REC), audio recordings were transcribed verbatim, anonymously processed, and safely kept. The verbatim transcription enabled the development of interview transcripts through which descriptive concepts were coded and later on grouped into themes that were relevant to the research objectives.

### **3.8 Ethical considerations**

Participation in the research was voluntary and respondents were taken through an informed consent process before participation. Each respondent was provided with a

written informed consent form, providing details about the research and later requested to sign the same. On the other hand, participants that were unable to read had the form read out to them and they signed with their thumb print while participants that were more conversant with Luganda, had it translated to them for their understanding. Each respondent was allowed to ask questions where they needed more information, before deciding to endorse the informed consent form. Respondents under 18 years especially the teenage mothers who were married were treated as “emancipated minors” per the Uganda National Guidelines for Research Involving Humans as Research Participants.

In anticipation of distress, the researcher engaged counsellors from the participating organizations to provide psychological support. Additionally, contacts of some organizations (the majority of whom I engaged in the interviews) that provide counselling services and mental health support were provided to all teenage mothers who took part in the research to be able to reach out for help at their convenience. A toll-free number (0800 21 21 21) for mental health support was provided to the respondents for any further psychosocial support.

Notably, respondents were free to withdraw from the FGDs, stop the Key Informant Interview at any time, or decline to respond to any of the questions even when I didn't experience any such cases. For purposes of anonymity, a numbering system was used where each respondent in the FGD was allocated a number in no particular order.

## CHAPTER 4: DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF RESULTS

### 4.0 Introduction

This chapter presents the study results/findings.

### 4.1 Demographics of study participants

A total of 200 teenage mothers residing in Kira municipality, Wakiso district took part in this survey. Tables 3 expounds on the demographics of the teenage mothers.

**Table 3:** Age of the teenage mothers in the survey

		Frequency	Per cent (%)
Valid	.00	1	.5
	16 years	5	2.5
	17 years	50	25.0
	18 years	102	51.0
	19 years	42	21.0
	Total	200	100.0

**Sample Size and Age Range:** The sample consisted of 200 participants. The ages of the participants ranged from 16 to 19 years, with no participants younger than 16 or older than 19.

**Age Distribution:** Majority of the participants were aged 17 and 18 years where more than half of the participants 102 (51.0%) were 18 years old and 50 (25%) were 17 years old.

5 Focus Group Discussions and 10 key informant interviews were conducted. The details of the demographics of the FGDs and KIIs are expounded in tables 4 and 5:

**Table 4: Demographics of the Focus Group Discussion participants**

<i>Respondents Age bracket (Years)</i>	<i>Age</i>	<i>Number of respondents in age bracket</i>
	16	5
	17	13
	18	8
	19	24
<i>Age of respondents' children (Years)</i>	<i>Percentage of respondents' children in the age category</i>	
<i>Below 1 year</i>	8%	
<i>1</i>	47%	
<i>2</i>	33%	
<i>3</i>	2%	
<i>Number of children</i>	<i>Number of respondents in category</i>	
<i>1</i>	49	
<i>2</i>	1	

**Table 5: Gender of Key Informants**

<b>Sector</b>	<b>Designations</b>	<b>Gender</b>		
		<b>Female</b>	<b>Male</b>	<b>Others</b>
<b>Health</b>	Bweyogerere Health center III in charge			
	Kirinya Health Center III in charge			
	Counsellor			
<b>Leaders in the community</b>	Community Health Advocate			
<b>Local Government</b>	Youth representative			
<b>Civil Society</b>	NGO Executive Director (2)			
	CBO Founder			

	NGO Program Officer (2)			
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Source: Researcher's construct

#### 4.2 Prevalence of depression

To determine the prevalence of depression, the researcher analyzed the individual BDI scores of study participants, assessing their symptoms against the standardized BDI scale to categorize different levels of depression as elaborated in table 6:

**Table 6: Summary of BDI Results:**

<b>BDI scores</b>	<b>Level of depression</b>	<b>Percentage of Interviewees under the category</b>
<b>1 - 10</b>	These ups and down are considered normal	21%
<b>11 - 16</b>	Mild mood disturbance	(15%)
<b>17 - 20</b>	Borderline clinical depression	(20%)
<b>21 - 30</b>	Moderate depression	(17%)
<b>31 - 40</b>	Severe depression	(11%)
<b>40 Above</b>	Extreme depression	(16%)

This distribution illustrates the varying degrees of mood disturbances among the adolescent population surveyed, highlighting the significant presence of mild to extreme depression in this group. To further understand the prevalence of the different depressive symptoms, the researcher further analyzed each of the 21 sections of the BDI questionnaire as presented in tables 7 to 27:

**Table 7: Sadness**

	Frequency	Percent (%)
Valid	3	1.5
I do not feel sad	45	22.5
I feel sad	38	19.0
I am sad all the time	55	27.5
I am so sad and unhappy that I can't do it	59	29.5
Total	200	100.0

From this section, the most frequently selected response was "I am so sad and unhappy that I can't do it," selected by 59 participants (29.5%) and the second most frequent response was "I am sad all the time," selected by 55 participants (27.5%). These results demonstrate the distribution of sadness levels reported by the study population, with more than half (57%) of the teenage mothers reporting that they are sad all the time or so sad and unhappy.

**Table 8: Pessimism**

	Frequency	Percent (%)
Valid	3	1.5
I am not particularly discouraged about the future	33	16.5
I feel discouraged about the future	45	22.5
I feel I have nothing to look forward to	89	44.5
I feel the future is hopeless and that things can not improve	30	15.0
Total	200	100.0

Findings indicated that the most frequently selected response was "I feel I have nothing to look forward to," chosen by 89 participants, representing 44.5% of the sample which nearly half of the study population.

**Table 9: Past failure**

		Frequency	Percent (%)
Valid		3	1.5
	I do not feel like a failure	32	16.0
	I feel like I have failed more than the average person	23	11.5
	As I look back on my life, all I can see is a lot of failures	81	40.5
	I feel I am a complete failure as a person	61	30.5
	N - Total	200	100.0

"As I look back on my life, all I can see is a lot of failures," was the most frequently selected response chosen by 81 participants, representing 40.5% of the sample demonstrating a notable prevalence of negative perceptions of past failures and a sense of personal inadequacy within the study population.

**Table 10: Satisfaction**

		Frequency	Percent (%)
Valid	I get as much satisfaction out of things as I used to	6	3.0
	I don't enjoy things the way I used to	94	47.0
	I don't get real satisfaction out of anything anymore	81	40.5
	I am dissatisfied or bored with everything	16	8.0
	Total	197	98.5
Missing	System	3	1.5
Total		200	100.0

There was a notable decline in personal satisfaction, with 47.7% reporting a lack of enjoyment in activities and 41.1% feeling no real satisfaction from anything.

**Table 11: Guilty feelings**

		Frequency	Percent
Valid	I don't feel particularly guilty	52	26.0
	I feel guilt a good part of the time	22	11.0
	I feel quite guilty most of the time	90	45.0
	I feel guilty most of the time	33	16.5
	Total	197	98.5
Missing	System	3	1.5
Total		200	100.0

45.7% of the participants reported feeling quite guilty most of the time, with an additional 16.8% feeling guilty consistently indicating a significant emotional burden, which can severely impact mental health and overall functioning.

**Table 12: Punishment**

		Frequency	Percent
Valid		3	1.5
	0	29	14.5
	1	77	38.5
	2	57	28.5
	3	34	17.0
	Total	200	100.0

Participants exhibited a range of self-punishment tendencies, with 38.5% experiencing moderate self-punishment and 17% feeling extreme self-punishment. This range reflects the extent of self-critical thoughts and behaviors, commonly observed in depression.

**Table 13: Disappointment**

	Frequency	Percent (%)
Valid	3	1.5
I don't feel disappointed in myself	64	32.0
I am disappointed in myself	61	30.5
I am disgusted with myself	42	21.0
I hate myself	30	15.0
Total	200	100.0

30.5% of the participants expressed being disappointed in themselves and 15% feeling self-hatred. These feelings of self-disappointment and disgust are indicative of severe self-esteem issues often seen in depressive disorders.

**Table 14: Self-criticism**

	Frequency	Percent (%)
Valid	3	1.5
I don't feel I am any worse than anybody else	21	10.5
I am critical of myself for my weaknesses or mistakes	23	11.5
I blame myself all the time for my faults	68	34.0
I blame myself for everything bad that happens	85	42.5
Total	200	100.0

The findings indicated that the most frequently selected response was "I blame myself for everything bad that happens," chosen by 85 participants, representing 42.5% of the

sample followed by "I blame myself all the time for my faults," selected by 68 participants (34.0%).

**Table 15: Suicidal thoughts**

	Frequency	Percent (%)
Valid	3	1.5
I don't have any thoughts of killing myself	72	36.0
I have thoughts of killing myself but I would not carry them out	35	17.5
i would like to kill myself	66	33.0
I would kill myself if I had the chance	24	12.0
Total	200	100.0

While the most frequently chosen response was "I don't have any thoughts of killing myself," selected by 72 participants, representing 36.0% of the total sample, on the contrary, the second most popular response was "I would like to kill myself" which was 66 participants (33%) of the population.

**Table 16: Crying**

	Frequency	Percent (%)
Valid	3	1.5
I dont' cry any more than usual	55	27.5
I cry more now than I used to	23	11.5
I cry all the time now	55	27.5
I used to be able to cry, but now I can't cry even though I want to	64	32.0
Total	200	100.0

The data showed varied crying patterns. While 27.5% reported crying more than usual or all the time, a significant 32% felt they can no longer cry despite wanting to. This

suggested a spectrum of emotional expression difficulties, with some experiencing increased crying and others feeling emotionally numb.

**Table 17: Irritability**

		Frequency	Percent (%)
Valid	I am no more irritated by things than I ever was	28	14.0
	I am slightly more irritated now than usual	46	23.0
	I am quite annoyed or irritated a good deal of the time	71	35.5
	I feel irritated all the time	52	26.0
	Total	197	98.5
Missing	System	3	1.5
Total		200	100.0

Most participants experienced increased irritation, with 35.5% feeling quite annoyed often, and 26% feeling irritated all the time. This heightened irritability suggested a significant level of emotional distress, which can exacerbate depressive symptoms.

**Table 18: Loss of interest in other people**

		Frequency	Percent (%)
Valid		3	1.5
	0	39	19.5
	1	62	31.0
	2	84	42.0
	3	12	6.0
	Total	200	100.0

The most frequently chosen response was "2," selected by 84 participants, representing 42.0% of the total sample an indication that a significant proportion of the participants experienced a moderate level of loss of interest in other people.

**Table 19: Decision making**

	Frequency	Percent (%)
Valid	3	1.5
I make decisions about as well as I ever could	9	4.5
I put off making decisions more than I used to	53	26.5
I have greater difficulty in making decisions more than I used to	101	50.5
I can't make decisions at all any more	34	17.0
Total	200	100.0

The majority (50.5%) of participants experienced greater difficulty in making decisions compared to the past, while 17% report were unable to make decisions at all suggesting that indecisiveness is a prevalent issue, often indicative of severe depressive symptoms affecting cognitive function.

**Table 20: Feeling of worthlessness**

	Frequency	Percent (%)
Valid	3	1.5
I don't feel that I look any worse than I used to	56	28.0
I am worried that I am looking old or unattractive	38	19.0
I feel there are permanent changes in my appearance that make feel unattractive	86	43.0
I believe that I look ugly	17	8.5
Total	200	100.0

The findings highlighted that 86 participants (43%) experienced feelings of unworthiness as they indicated that they felt there are permanent changes in their appearances that made them feel unattractive.

**Table 21:** Loss of energy

	Frequency	Percent (%)
Valid	3	1.5
I can work about as well as before	25	12.5
It takes an extra effort to get started at doing something	56	28.0
I have to push myself very hard to do anything	101	50.5
I can't do any work at all	15	7.5
Total	200	100.0

Participants reported a significant decline in work performance, with 50.5% struggling to push themselves to complete tasks and 7.5% unable to work at all indicating severe impact on productivity and work-related functionality, correlating with depression's debilitating effects.

**Table 22:** Change in sleep

	Frequency	Percent (%)
Valid	3	1.5
i can sleep as well as usual	14	7.0
I don't sleep as well as I used to	86	43.0
I wake up 1-2 hours earlier than usual and find it hard to get back to sleep	71	35.5
I wake up several hours earlier than I used to and cannot get back to sleep	26	13.0
Total	200	100.0

Sleep disturbances were prevalent, with 43% reporting worse sleep quality and 35.5% waking up significantly earlier than usual. These issues indicate widespread sleep problems among participants, which are often associated with depressive disorders.

**Table 23: Tiredness**

	Frequency	Percent (%)
Valid	3	1.5
I don't get more tired than usual	37	18.5
I get tired more easily than I used to	55	27.5
I get tired from doing almost anything	72	36.0
I am too tired to do anything	33	16.5
Total	200	100.0

Fatigue was widely reported, with 36% of the participants reporting getting tired from doing almost anything and 16.5% feeling too tired to do anything.

**Table 24: Appetite**

	Frequency	Percent (%)
Valid	3	1.5
My appetite is no worse than usual	23	11.5
My appetite is not as good as it used to be	88	44.0
My appetite is much worse now	60	30.0
I have no appetite at all anymore	26	13.0
Total	200	100.0

The most frequently chosen response was "My appetite is not as good as it used to be," selected by 88 participants, representing 44.0% of the total sample. An indication that

a significant portion of the participants were experiencing a decline in their appetite compared to their usual levels.

**Table 25: Loss of weight**

		Frequency	Percent (%)
Valid	I haven't lost much weight, if any, lately	26	13.0
	I have lost more than 2kgs	43	21.5
	I have lost more than 5kgs	90	45.0
	I have lost more than 7kgs	38	19.0
	Total	197	98.5
Missing	System	3	1.5
Total		200	100.0

Weight loss of more than 5kgs was noted at 45.7% reflecting a significant symptom of depression, affecting over 60% of participants who have lost weight, either moderately or severely.

**Table 26: Health**

		Frequency	Percent (%)
Valid	I am no worried about my health than usual	37	18.5
	I am worried about physical problems like aches, pains, upset, stomach or constipation	43	21.5
	I am very worried about physical problems and it's hard to think of much else	105	52.5
	I am so worried about my physical problems that I cannot think of anything else	12	6.0
	Total	197	98.5
Missing	System	3	1.5
Total		200	100.0

More than half of the study participants (53.3%) were very worried about physical problems, affecting their overall mental focus. This high level of health-related anxiety reflects the intersection of physical and mental health issues in depressive disorders.

**Table 27: Loss of interest in sex**

	Frequency	Percent (%)
Valid	3	1.5
I am less interested in sex than I used to be.	42	21.0
I have almost no interest in sex	78	39.0
I have lost interest in sex completely	77	38.5
Total	200	100.0

The most frequently chosen response was "I have lost interest in sex completely," selected by 78 participants, representing 39.0% of the total sample. The percentage of participants reporting a complete loss of interest in sex (38%), paired with a sizable proportion selecting the option indicating a near-complete lack of sexual desire (39%), represents more than half of the study population (77%).

### 4.3 Associated factors

After thematic analysis of the FGDs and KIIs, the following themes emerged in line with the associated factors in table 27:

**Table 28: Theme description**

Low Levels of Income	Teenage mothers and their partners lacked sufficient financial resources to support their existing families, let alone an additional family member (newborn baby).
Unemployment and Unemployability	Unemployment and lack of employable skills were major stressors that contributed to depressive tendencies, as it made them vulnerable to abuse and exploitation.
Rejection by Relatives and Friends	Becoming pregnant led to rejection and stigma from parents, guardians, and the community, forcing some teenage mothers to resettle elsewhere in search of a fresh start.
Mockery and Insults	Teenage mothers experienced significant mockery and insults from the community, friends, and relatives, which made them feel sad, alone, and unworthy.
Self-Stigma and Discrimination	The constant negative experiences led many teenage mothers to believe they were unworthy and not deserving of better treatment.
Shame and Bias	Shame and bias were identified as significant contributors to depressive tendencies among teenage mothers
Broken Families.	Many teenage mothers came from single-parent or step-parent households prior to becoming pregnant
Partner Desertion (Abandonment)	The majority of teenage mothers were deserted by the fathers of their babies, leading to increased stress and lack of support.

Cultural Beliefs	Cultural beliefs were found to significantly contribute to depressive tendencies among teenage mothers in the Kira municipality, Wakiso area
Risky Social Behaviors	Some teenage mothers engaged in risky social behaviors, such as sex work, as a means of earning a living due to high unemployment and the need for basic necessities

#### 4.3.1 FGDs and KIs findings:

To understand the factors associated with depressive tendencies in Kira Municipality, Wakiso district, the researcher conducted FGDs and Key informant interviews. The associated factors were classified into economic and socio-cultural factors.

##### ***Economic Factors***

This study illuminated economic factors as associated factors to depressive tendencies amongst teenage mothers in Kira Municipality, Wakiso district majorly manifested themselves through low-income levels and unemployment & unemployability as illustrated below:

##### ***Low-income levels***

The study found that low levels of income and unemployment/unemployability were major contributors to depressive tendencies among teenage mothers in Kira Municipality, Wakiso district. Many of the respondents reported that neither they nor their partners had enough money to adequately provide for their existing families, let alone the additional financial burden of a newborn baby. This lack of stable income and employable skills made them highly vulnerable to exploitation and abuse, further

exacerbating their mental health challenges. This economic instability was a significant source of stress and anxiety for the teenage mothers.

*“... My partner is a boda boda rider (commercial motorcycle rider) and struggles with getting daily income. On days when he has no money, he tells me to devise means as a “woman”, ... but I am a stay-at-home mother how am I supposed to devise means? This makes me sad and I dread each day because I feel like am not “woman enough” to take care of my family”. (Participant 11)*

*“My partner does not render any support for the medical bills yet my parents that always took care of me got very angry with me once they found out about the pregnancy. Right now, we are surviving on God’s mercy and support from random strangers. We barely have any resources to take care of the baby and ourselves... I feel like we are a burden to my family, my partner and society generally”. (Participant 4)*

*“...I am unable to get the basic needs for my babies and this makes me feel like a failure. There have been many instances where I have failed to provided even milk or clothing, it makes me feel very bad. When I don’t have drink no food to feed...it brings me sadness.” (Participant 5)*

### *Unemployment and Unemployability*

Interviewees from the FGDs highlighted unemployment and unemployability as a great stressor that contributed to depressive tendencies. This was majorly because it made them vulnerable to violations/abuse and exploitation from their partners/guardians.

*“... The other challenge is that many people don’t want to give us jobs because we have children. They are of the view that the children will get in the way of our work. Whenever we go to ask for jobs, they first question we get is ...do you have a child? And if the response is yes, you never hear back from them. This makes me sad and I just resort to staying at home in bed...” (Participant 6)*

*“Before getting pregnant, I worked as a house maid and I could afford to take care of my basic needs. However, after this my boss let me go and I moved in with the father of my son who also later left. I now need to look for food for the baby and all our basic needs including paying rent yet finding a job has become nearly impossible. When I get lucky, I manage to get a few people that want me to help them wash their clothes but the little that I get from that is barely enough to sustain my baby and I. There is no stable work for people like me”. (Participant 2)*

*“After giving birth, I have found it very difficult to bounce back into the working environment. I struggle with just getting through my normal day later on trying to get my work done”. (Participant 7)*

## **Socio-cultural factors**

Themes aligned to socio-cultural factors were prominent in this study. These were manifested through rejection, mockery, and discrimination from their own families, friends, and the broader community:

### *Rejection by relatives and friends*

Narratives shared by the participants in this study powerfully illustrate the profound social and emotional toll that pregnant teenagers in Kira Municipality, Wakiso district often face as a result of parental and community rejection. As exemplified in the account below, the discovery of pregnancy can lead to outright rejection and abandonment by one's own family:

*"When my father found out that I was pregnant, he chased me from home and my life has never been the same, I felt and still feel very devastated by this act..."*

(Participant 4)

This ostracization not only severs critical emotional and financial ties, but also leaves the teenage mothers with a profound sense of being "cast out" from their own communities:

*"I currently have two children but I remember vividly my first pregnancy, I lost all my friends and everyone gave up on me. Many of them told me that their parents no longer approved of our friendship and as such they had been asked to keep away from me as I would teach them bad manners. (Participant 5)*

The impact of this social rejection extends beyond the individual, as the teenage mothers must also grapple with the loss of their intimate relationships, further compounding their feelings of worthlessness and abandonment.

*"When you give birth, the man gives up on you and he finds other women and he says you are no longer beautiful and attractive to him. This makes me upset and I feel like am no longer good enough" (Participant 8)*

Perhaps the most devastating was the sense of utter hopelessness and despair that arose when even one's own family and community turned their backs against them.

*"Men will do anything to get with you the first time, the father of my son lied to me and even showed me his friend's home as his, the moment I got pregnant, I couldn't trace him anymore and I learnt that the home was for his friend. This makes me feel like killing myself because even my own people have abandoned me because they think it's a disgrace to be pregnant at my age and later on be abandoned by my partner." (Participant 10)*

### *Mockery and insults*

While the teenage mothers are already grappling with the immense challenges of early parenthood, finding illustrated that they must also confront the relentless barrage of derogatory comments and judgmental attitudes from those around them, further exacerbating their sense of isolation and unworthiness.

*"The thing that makes me very anxious lately is walking alone as people constantly insult me since I have a baby. For instance, whenever I pass by boda boda men (commercial motorcycle riders) I am insulted until I am out of sight. At the time I was pregnant the insults were, so cruel to an extent that I felt like going for an abortion because I just wanted everyone to stop." (Participant 11)*

This pervasive hostility and shaming behavior, can also manifest in the form of unwanted sexual advances and further stigmatization.

*"The challenges that we face as teenage mothers are many, for instance, when you are walking somewhere men insult you saying you gave birth early, in fact it's their belief that you can have sex any time with anyone and use this to ask for sexual favors but when you refuse, they insult you further. This is very annoying, stressful and makes me afraid of walking alone."* (Participant 5)

The psychological toll of this societal stigma is further emphasized by Participants' decisions to relocate in search of a more welcoming environment, only to find that the insults and finger-pointing continued.

*"Every single day I walk out with my baby, I have people pointing fingers at me saying, 'a baby gave birth to another baby'. In fact, this is one of the reasons as to why I decided to move from my hometown but it hasn't changed, people continue with the insults and I feel attacked and alone."* (Participant 7)

Poignant observations by participants underscored the deeply personal nature of these attacks, which left teenage mothers feeling undeserving of empathy or support:

*"On several occasions, I have had people from my neighborhood say 'she used to show off but she was put in her place the only qualification she has no is in marriage'. These statements hurt more than people think because every day I am alone I feel like am being punished for something I did yet other people feel like I deserves to be this miserable".* (Participant 3)

### *Self-stigma and discrimination*

The participants' narratives and key informant insights gathered in this study painted a troubling picture of the immense psychological toll faced by teenage mothers in Kira Municipality, Wakiso district. Overwhelmed by the challenges they confront, many of these teenage mothers had internalized a deep sense of unworthiness and self-loathing, which further undermined their ability to overcome the obstacles before them.

The accumulation of problems and societal judgement had in fact led some teenage mothers to deeply regret their decision to give birth, even questioning whether they deserved the hardships they now faced.

*"...whenever I think about all the problems that continue to follow me since I got pregnant, I greatly regret the decision to give birth. I wish I had done things differently. Maybe, just maybe then my life would turn out better than it is right now. I hate myself for all these things that have happened but perhaps I deserve them..."* (Participant 6)

This profound self-deprecation and sense of self-blame was further re-echoed in the accounts by other participants who expressed a deep sense of pain and a lingering question of whether the negative perceptions were indeed justified.

*"I have a lot of pain, I breakdown every now and then. I keep asking myself how someone as young as me has so many problems but perhaps I am what they all say and think of me... good for nothing."* (Participant 2)

### *Shame and bias*

In the KII, it was evident that shame and bias hugely contributed to depressive tendencies amongst teenage mothers.

*“People disregard teenage mothers emphasizing that they are of no use to society. In a community dialogue that I once attended, a teenage mother got up to make submissions and someone from the crowd yelled ‘you are a good for nothing...your contributions are not relevant’. It is this bias towards the teenage mothers that drives them into depressive tendencies” (KII 10)*

*“Due to the various life challenges, many of the teenage mothers are driven to self-pity and end up losing hope for their future. This as a result leads them to become even sadder and isolate themselves from society the more” (KII 3)*

### *Intergenerational Cycles of Broken Families*

The narratives shared by these young women painted a picture of a complex web of challenges, where the legacy of single-parent households, absent fathers, and financial instability has profoundly shaped their own experiences of parenthood. As illustrated in the quotes below, many of the teenage mothers were themselves raised by single parents (mainly their mothers), who now found themselves burdened with the additional responsibility of caring for their grandchildren.

*“I was raised by a single mother and it has always been hard for us as a family. But ever since I gave birth, things have even become worse as she now has to take care of my child too. I can't help but feel responsible for all this suffering that we are experiencing...” (Participant 8)*

This sense of guilt and responsibility for perpetuating the cycle of family fragmentation was a common thread woven through the participants' narratives. Narrations further highlighted the devastating impact of absent fathers, in their own childhood and now in the lives of their child.

*"My father walked away from our lives when I was a young girl and I never got a chance to know him. My partner has also abandoned me and the baby, as an adult now I feel like I can handle this rejection because it's what I have experienced all my life, I am just saddened for my baby because like me. she will also never get to know her father."* (Participant 2)

The intergenerational nature of these challenges was further exemplified by the sentiments expressed by Participants, where the stigma and disappointment associated with teenage pregnancy has been passed down from one generation to the next.

*"Being the first child, I let down my mother greatly, she continuously mentions that I have set a terrible example for my sibling yet I was her hope of redeeming us from our many financial challenges. In passing she says you will all become like me if you're not careful, alone with children to raise all by yourselves..."*  
(Participant 8)

### ***Partner desertion (abandonment)***

As evidenced by the findings of the study, the sudden and often abrupt desertion of the partners of teenage mothers contributed to depressive symptoms amongst the study population. Accounts recalled by participant illustrated the precarious position that the

teenage mothers found themselves in when their partners, who are often also minors, were unable or unwilling to provide the necessary support.

*"The father of my child was underage and like me, he was also in school when I got pregnant, he had no job and his parents were very strict. Being a student like me, he had no capacity to support the pregnancy or even the new born baby. He walked away the second I told him about the pregnancy saying the whole situation would get in the way of his future and also tannish his reputation in his family. I had to figure out pregnancy and parenthood all by myself."*(participant 2)

These experiences shared by participants underscored the compounding challenges that arose when teenage mothers were abandoned by their partners and find themselves in increasingly dire circumstances, such as homelessness and financial instability.

*"The other challenge is that the man and the side of the man that was responsible for the pregnancy didn't render any support during the pregnancy later on after I gave birth even when the baby is sick. I have suffered a lot during this period and on different occasions I have thought of giving up my child or even committing suicide such that all this is over."*(Participant 9)

The insights provided by the key informants further illuminated the disturbing patterns of partner abandonment, where some partners resorted to using appalling excuses and justifications to distance themselves from their responsibilities.

*"For many of the teenage mothers that have reported being abandoned by their partners, they state that they come up with excuses as lame as 'in our family we don't give birth to short children', its statements such as these that*

*disorganize the teenage mothers further affecting their mental and emotional well-being". (KII 8)*

### **Cultural norms and beliefs**

Cultural norms and beliefs have continued to contribute to depressive symptoms amongst teenage mother in Kira Municipality, Wakiso district. A harrowing account from one participant, described the devastating consequences of her family's response to her pregnancy.

*"My uncle defiled me and this is how I ended up becoming pregnant. When I told my parents that my uncle was responsible for the pregnancy, they said this was an abomination and it would lead to a lot of shame for the family. They insisted that I stay at home as they tried to support both me and the baby. This whole situation and the fact that my family refuses to get to the bottom of this huge problem makes me extremely sad and angry at the same time." (Participant 3)*

This experience underscored the ways in which cultural beliefs can further victimize and isolate teenage mothers, exacerbating their mental health challenges. Recollections from participants resonated with this theme, highlighting the coercive pressure of cultural norms and the lasting impact on her well-being of teenage mothers.

*"As teenage mothers, we have many challenges. One of my main challenges is that in my culture it's an abomination to give birth while one is not officially married. And so, when my parents found out that I was pregnant, they insisted that the father of my baby marries me off such that I don't bring disgrace to the family. Every single day I look at this man and everything he has put me through*

*and I am upset. I think about taking my life sometimes but for the sake of my child decide to soldier on. I resent my parents for marrying me off to this man simply because of a belief/norm..." (Participant 11)*

Insights shared by Key Informant Interviewees further illuminated the complex interplay between cultural beliefs and mental health challenges:

*"In some communities here, teenage pregnancy is believed to be a curse therefore, when a girl gets married while at home, she is forced to go to a traditional healer who is believed to play a critical role in taking away these curses." (KII 8)*

### ***Risky social behaviors***

Faced with high rates of unemployment and the pressing need to provide for their families, some of these teenage mothers had resorted to engaging in sex work as a means of earning a living. As captured, the decision to turn to sex work, was often driven by desperation and a lack of viable alternatives, that often had profound and devastating impacts on the mental well-being of the teenage mothers.

*"In order to ensure survival for the kids and their families, some of the teenage mothers that are abandoned by partners and later on parents end up opting for seemingly easier options such as sex work. While this brings in easy money, for many of those that I have engaged with, it makes them feel unworthy and ashamed so they isolate themselves." (KII 7)*

### ***Overarching Themes:***

Across the economic and socio-cultural factors, a common theme was the teenage mothers' profound sense of powerlessness and lack of agency. The combination of financial instability, social rejection, and cultural bias left them feeling trapped, with limited options or support systems. This overwhelming feeling of being devalued and undeserving of better treatment was a key driver of their depressive tendencies amongst the study population.

These findings highlighted the critical importance of addressing the issue elaborated above. Policymakers, healthcare providers, and community organizations must work collaboratively to develop and implement robust support mechanisms that cater to the unique needs of this vulnerable population.

#### **4.4 Objective 3 of study on the Coping mechanisms**

In order to deal with the depressive tendencies highlighted in the previous chapter, the teenage mothers and Key Informants highlighted a couple of coping mechanisms that teenage mothers in Kira Municipality, Wakiso district used to cope with the depressive tendencies.

For purposes of this study, these mechanisms were classified into traditional and non-traditional coping mechanisms. *Traditional coping mechanisms* referred to conventional measures both structured or unstructured that are typically used by communities when dealing with depression amongst while the non-traditional coping mechanisms referred to non-conventional means that are hardly used by communities to deal with depressive tendencies.

These highlighted coping mechanisms were assessed through the lens of the AAAQ framework to establish their availability, accessibility, acceptability and quality. Table 28 expounds on the above:

**Table 29: Coping mechanisms and AAAQ**

<b>Coping Mechanism</b>	<b>Availability</b>	<b>Accessibility</b>	<b>Acceptability</b>	<b>Quality</b>
Traditional Coping Mechanisms				
Churches	High	High	High	High
Counselors	Low	Low	High	Low
Elders	Low	Low	High	High
Nontraditional Coping Mechanisms				
Peers	High	High	High	High
Traditional Media (Radio, TV)	High	High	High	High
Social Media	High	High	Low	Low
Disruptive Behaviors (Alcohol, Drugs, Smoking)	High	High	Low	Low

*Source: Researcher's construct*

*Summary of the Key points:*

Churches, peers, and traditional media appeared to be the most commonly used traditional coping mechanisms. While, counselors and elders had limited availability and accessibility, they were generally acceptable and viewed as being of quality.

In terms of the nontraditional coping mechanisms, social media use was widespread, but its acceptability and quality to address depression amongst the target group was unclear. Disruptive behaviors like substance use were also highlighted as a coping mechanism that some of the teenage mothers in Kira Municipality, Wakiso district adopted.

#### **4.4.1 Traditional coping mechanisms**

##### ***Churches***

For many of the teenage mothers in Kira municipality, churches symbolized a place of “hope” and as such they went there to get reassurance that things will get better or interact with other people that have been through similar situations and can support them to make sense of their own lives.

*“When I feel sad, I go to church, this helps take away my stress and makes me feel better. There are also days when they bring counselling sessions to use so we are able to get help free of charge” (Participant 1)*

*“As a counsellor, I get many teenage mothers tell me that going to church is therapy as they feel more accepted” (KII 3)*

*“At church, I feel more at peace and I get the sense that things will get better. Even through their projects they are able to provide some food for my baby so this makes me feel better after long sad days” (Participant 8)*

##### ***Counseling services***

Counseling services were also cited as a valuable coping mechanism for the teenage mothers residing in Kira municipality, though access and availability of the same was noted as minimal. Teenage mothers that reported having used counselling services before to deal with depressive tendencies noted that it was the only professional coping mechanism that they were aware of in their communities.

*“I heard of counselling services at the health facility from my church and I have been there before to get help although it’s far from my home making it difficult for me to constantly access this professional help” (Participant 4)*

*“I work with a health facility and my main focus is to provide counselling services including to teenage mothers and some of them come to access them but of course this is just a few of them so am not sure where the rest get these services” (KII 4)*

### **Elders**

Study findings indicated that teenage mothers in Kira municipality, Wakiso district viewed elders such as their parents and guardians as a great source of encouragement when dealing with depression.

*“I fortunately have a really good relationship with my mother in-law who has been a great source of encouragement and has provided support beyond measure. Without her, everything around me falls apart but she has been very instrumental in helping me get through this very trying moment as a teenage mother” (Participant 2)*

*“While I am single, unemployed and with a child, my mother provides for our basic needs. This makes me feel sad because I feel like I am a burden to her but at the same time I draw strength from the same situation when I hear about other teenage mothers that have been abandoned by their parents. In times when I need anyone to talk to her, she has constantly been my first point of contact.” (Participant 4)*

*“Since I got pregnant, my guardian has been pivotal in the whole situation and not to say that she wasn’t disappointed... but she continuously lectures me and encourages me and says that I need to make better decisions now that I am a mother” (Participant 11)*

#### **4.4.2 Non-traditional coping mechanisms**

The teenage mothers also highlighted some coping mechanisms that in this research we have highlighted as non-traditional.

##### **Peer support**

Throughout the focus group discussions, it was evident that the most immediate point of contact for teenage mothers in Kira municipality when dealing with depression were their peers. For the majority of them this particular coping mechanism was critical as they felt like they would relate more with their challenges but also at the same time not judge them as some had been through similar challenges.

*“My friends take away my stress and they are supportive. Last week, they organized a birthday party where I was invited and I felt really happy in that*

*moment. Whenever I am with them, I am free of all my worries and doubts because we are able to have so much fun” (Participant 6)*

*“Speaking to my friends always lifts my spirits and moods. Even on the toughest of days, with my friends by my side I feel like I can come through everything. They not only share with me ways in which I can deal with my problems but also share with me some of their things including food for the baby so this gives me courage” (Participant 1)*

*“Me and my best friend have become sisters; in fact, I call her my sister because she has supported me more than my sisters or mother. She constantly checks on me and also encourages me to be strong even when she’s not a mother herself. This brightens up my day and has helped me realize that I can pull through this rather tough time” (Participant 2)*

### **Traditional media (radio, TV talk shows)**

Radio and Television talk shows were noted as central in helping teenage mothers deal with their depression challenges.

*“Since I spend a lot of my time at home these days, tuning to radio talk shows makes me feel like I am in touch with other people. I tune into Bukedde 1 on Sunday to a programme called Twezze Buggy. Here I am able to hear about the challenges and experiences of other people. This keeps me motivated but also inspired knowing that am not the only one dealing with such challenges” (Participant 11)*

*“I have a radio talk show that I tune into via Salt FM. They have prayers and the presenter prays for people with different challenges. So, I use that as an opportunity to also pray for myself and my baby and I hope that someday God will hear my prayers” (Participant 7)*

*“When nothing makes sense, I have religiously tuned into Prime radio to a programme called “Lwaki nze” the host shares people’s stories and callers call in to give guidance on how the person can deal with this challenge. This has helped me realize that am not alone and that no situation is permanent” (Participant 3)*

*“I watch movies and TV. It helps me feel better when am going through stressful situations” (Participant 5)*

### **Social media:**

In an era where social media has become more prominent especially amongst young people, many of the teenage mothers in Kira Municipality reported using YouTube, Facebook, TikTok, and Instagram as avenues to deal with depressive situations while accessing information to better understand what they are going through. These interactions not only enabled them associate with other people that were going through the same situation and share experiences but also entertained them helping them forget about everything that wasn’t going well in their lives at least in the moment.

*“I use tiktok a lot to distract myself from all my challenges. It has a lot of funny content that makes me laugh and happy and feel good” (Participant 3)*

*“On facebook, I have made many friends that I chat with and also share with some of my problems and they encourage me. When am chatting with them, I feel better and happy” (Participant 5)*

*“When am on social media, I see a lot of people that are having a good life. This inspires me not to focus on my current situation but rather work hard to make a better life for my child and I” (Participant 4)*

### **Disruptive social behavior:**

During the focus Group discussions, it was also evident that some of the teenage mothers had resorted to alcohol, drugs, and smoking as a way of dealing with their depressive tendencies.

*“I know many people disagree with me, but for me whenever I feel sad, I resort to drinking, it helps me forget about my problems. I try as much as possible not to become a nonsense when I drink or even to do it to the extent that can affect me to become incapable of taking care of my child” (Participant 5)*

*“I also sometimes drink to forget about my problems. These things that we are going through are very hard especially at this age and drinking helps me forget” (Participant 11)*

### **Self-help:**

To cope with all these depressive tendencies some teenage mothers in Kira municipality reported that they resorted to self-help avenues.

*“I no longer trust anyone. When my friends found out that I was pregnant they all abandoned me, in fact I had to leave and go to another village to try and get a fresh start. All I have is my son so I work hard not to let him down so this keeps me motivated and encouraged” (Participant 3)*

*“I have a lot of pain, but whenever I cry, I suddenly feel much better. I keep encouraging myself that life will get better” (Participant 11)*

Overall, findings highlighted in this chapter indicated the prevalence of the depression amongst teenage mothers in Kira municipality, while elaborating the different associated factors and coping mechanism adopted when dealing with these depressive symptoms as per the responses from the survey, FGDs and KIIs.

## CHAPTER 5: DISCUSSION OF FINDINGS

### 5.0 Introduction

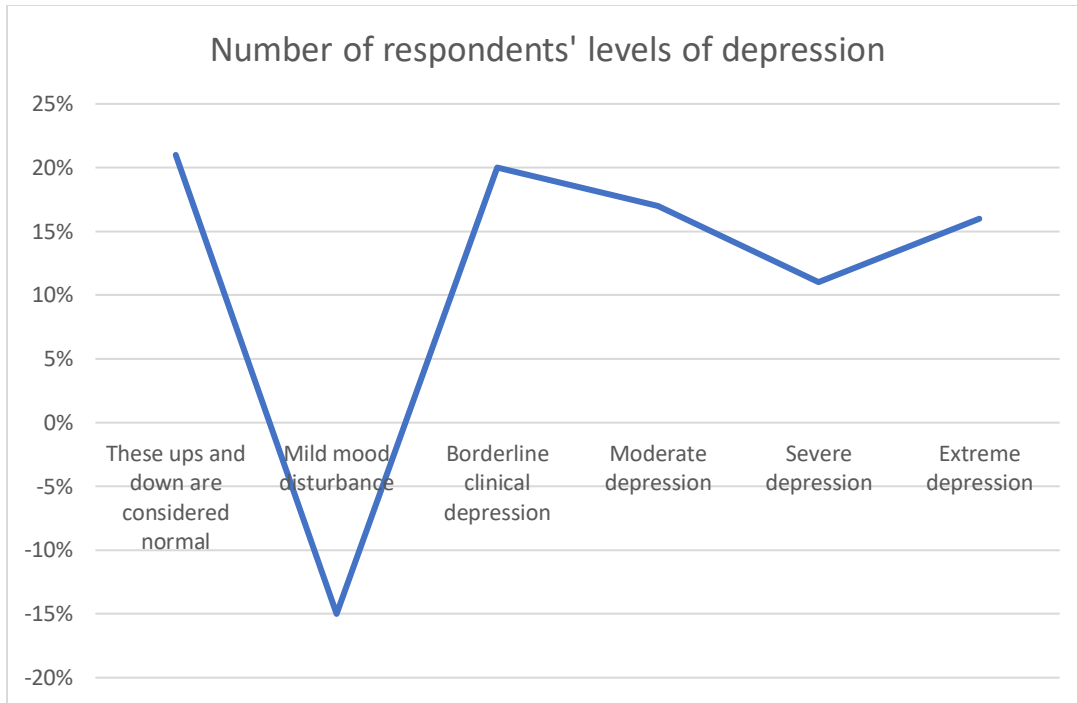
This chapter discusses the findings highlighted in chapter four above in line with the study objectives. It also further analyzes the coping mechanisms against the AAAQ framework to establish their Availability, Accessibility, Acceptability, and Quality.

#### 5.1 Objective 1: *Determining the prevalence of depression amongst teenage mothers in Kira Municipality*

##### *Depressive Symptoms among Teenage Mothers: A Concerning Trend*

The study revealed a high prevalence of depression among teenage mothers in Kira Municipality, with 79% of respondents experiencing some level of depressive symptoms. This figure significantly surpasses global estimates, where depression among teenage mothers ranges between 16% and 44% (Hodgkinson et al., 2014). The elevated rate highlights a critical mental health concern in the local context, likely exacerbated by the socio-economic and cultural environment in peri-urban areas like Kira.

#### **A graphical representation of the levels of depressive symptoms**



*Source: Researcher's construct*

### *Prevalence of Major Depressive Disorder (MDD) Among Teenage Mothers in Kira Municipality*

Among the 79% who exhibited depressive symptoms, 27% of teenage mothers were found to have Major Depressive Disorder. This level places them at the upper end of global prevalence rates and signals a serious mental health emergency. According to the World Health Organization, MDD is one of the most disabling disorders globally, linked to suicidal ideation, impaired functioning, and chronic emotional distress (Nemeroff, 2007).

In Uganda's context, where over 85% of households earn less than UGX 50,000 monthly (Mackri et al., 2013), mental health services are often inaccessible or unaffordable. Consequently, many teenage mothers reported either avoiding treatment altogether or

turning to informal support systems, such as religious institutions or traditional healers (Manasi et al., 2022). This limited access to appropriate care contributes to the severity and persistence of MDD among adolescent mothers.

#### *Moderate Depression: A Significant Mental Health Burden*

In addition to MDD, 17% of teenage mothers reported symptoms consistent with moderate depression. Although less severe, moderate depression was associated with persistent sadness, social withdrawal (42%), and chronic fatigue (36%), significantly affecting the mothers' ability to engage in parenting, education, or employment.

These findings are supported by national strategies and demographic data. The National Strategy to End Child Marriage and Teenage Pregnancy (NSCM&TP, 2022) underscores that teenage pregnancy significantly lowers future income potential, as adolescent mothers are three times less likely to obtain professional jobs and twice as likely to engage in small-scale agriculture (UDHS, 2016). This limited economic future compounds their psychological burden, contributing to prolonged moderate depressive episodes.

#### *Borderline Clinical Depression: An Early Warning Sign*

Approximately 20% of the teenage mothers surveyed fell within the category of borderline clinical depression, where emotional distress was notable but did not fully meet diagnostic thresholds for clinical depression. Symptoms such as loss of appetite (44%) and indecisiveness (26.5%) were frequently reported. These early indicators of emotional strain point to a population at high risk of developing more severe mental health disorders if timely and targeted interventions are not put in place.

### *Mild Mood Disturbance and Normal Mood Variations*

About 15% of the teenage mothers exhibited mild mood disturbances, including sadness and irritability, while 21% fell within the range of normal mood variations—experiencing transient emotions like disappointment (32%) and irritability (14%). Although these cases do not warrant clinical diagnosis, they serve as entry points for mental health challenges amongst teenage mothers in areas like Kira municipality.

### *Key Drivers of Depression Among Teenage Mothers*

The study also identified low self-esteem, excessive crying, negative self-perception, and strained relationships as the most common psychosocial drivers of depression. Self-criticism was reported by 42% of respondents, a finding that aligns with prior research emphasizing that adolescent mothers frequently experience guilt and feelings of failure (Buzi et al., 2016; Thompson et al., 2005). These drivers highlight the urgent need for tailored psychosocial interventions that address self-worth, resilience, and coping strategies among teenage mothers.

### **5.2 Objective 2: *Determining the associated factors of depressive tendencies amongst teenage mothers in Kira municipality, Wakiso district***

Economic constraints emerged as a significant stressor among the teenage mothers who participated in this study. Many reported low or no income, unemployment, and unemployability as key contributors to their mental distress. A majority of the respondents lacked financial independence and depended heavily on their families—many of which were already grappling with economic hardship. This dependency, compounded by limited access to stable employment opportunities, heightened their

sense of hopelessness, anxiety, and self-doubt, thereby increasing their vulnerability to depression.

These findings are consistent with national-level statistics that reflect the broader economic struggles faced by households in Uganda. According to the Uganda Bureau of Statistics (UBOS, 2018), a significant proportion of families in rapidly urbanizing areas like Kira Municipality engage in informal or low-skilled work such as street vending, casual labor, and domestic work—forms of employment that offer little stability or income. Given that most teenage mothers are still in school or have dropped out due to pregnancy, they have little to no earning capacity. Their reliance on these low-income households contributes to poor mental health outcomes. According to UNICEF (2020), nearly 47% of Ugandan households experience multidimensional poverty, and over 41.7% live in extreme poverty on less than \$1.90 per day (Owori, 2020). This economic vulnerability directly affects access to health services, nutritious food, and education—factors that are crucial for adolescent well-being and recovery from mental health issues.

For teenage mothers, poverty limits not only access to professional mental health care but also forces many to turn to traditional or religious authorities, which may not always offer effective support. As Manasi et al. (2022) argue, the high cost of therapy compels families to choose between basic survival and professional treatment, a decision that often results in prolonged or untreated common mental disorders such as depression. This aligns with findings from Adama et al. (2015), who observed that households with lower incomes are significantly more likely to experience depression than higher-income households.

In addition to household-level economic struggles, the low or non-existent income of partners also emerged as a stressor. Many teenage mothers reported abandonment by their partners soon after becoming pregnant, with most citing the partner's financial incapacity or fear of legal consequences. AfriChild (2021) and Nabugoomu et al. (2018) both highlight that most teenage fathers in Uganda are themselves adolescents or young adults—often still in school or dependent on their own families. Consequently, many of them are either unwilling or unable to provide financial support, leaving teenage mothers to bear the emotional and economic burden alone.

This partner abandonment further exacerbates the financial strain and leads to emotional trauma, increasing the likelihood of depressive symptoms. As Ziyi W. et al. (2000) suggest, the absence of paternal involvement is strongly linked to higher rates of depression among adolescent mothers, particularly in rural and peri-urban contexts where social support systems are weak.

Furthermore, the National Strategy to End Child Marriage and Teenage Pregnancy (NSCM&TP, 2022) underscores that teenage pregnancies are not only a health concern but also a major driver of intergenerational poverty. Teenage mothers are three times less likely to secure professional employment and are twice as likely to remain confined to subsistence agriculture (UDHS, 2016), limiting their prospects for economic mobility and increasing their mental health risks.

**5.3 Objective three:** *Establishing coping mechanisms that are adapted by teenage mothers dealing with depressive tendencies in Kira Municipality, Wakiso district.*

This study sought to establish the coping mechanisms adopted by teenage mothers experiencing depressive tendencies in Kira Municipality, Wakiso District. The findings indicated that teenage mothers employed a combination of traditional and non-traditional strategies to manage emotional distress. These coping mechanisms aligned with the theoretical classifications by Rich (2020), who categorized coping strategies into problem-focused, emotion-focused, and reappraisal-based approaches, as well as Good Therapy (2023), which grouped them under active (adaptive) and avoidant (maladaptive) mechanisms.

**Classification of Coping Mechanisms**

Traditional coping mechanisms—such as seeking support from religious leaders, elders, and professional counsellors—were primarily classified as active and problem-focused, aimed at addressing the root causes of distress. In contrast, non-traditional coping mechanisms, including peer support, use of social media, and, in some instances, substance use, encompassed both emotion-focused and avoidant strategies. The majority of teenage mothers in the study reported a greater reliance on non-traditional approaches, largely due to their ease of access and perceived availability. These findings were consistent with the World Health Organization's (2001) report, which emphasized that psychological interventions tend to be more available in high-income countries, whereas support services in low- and middle-income countries (LMICs) are often underdeveloped or absent.

### 5.3.1 Availability, Accessibility, Acceptability, and Quality of Coping Mechanisms

To assess the appropriateness and effectiveness of these coping mechanisms, the study utilized the AAAQ framework—Availability, Accessibility, Acceptability, and Quality.

**Availability:** Uganda was reported to have only one national psychiatric hospital and five regional facilities offering psychiatric services (Webb et al., 2023). In Kira Municipality, the first Health Centre IV was established in 2022, and although some Health Centre IIIs and IIs offered basic counselling services, the overall availability of structured mental health interventions remained limited. Consequently, most teenage mothers turned to informal sources of support, such as peer groups and digital platforms, which were perceived as more readily available.

**Accessibility:** The study considered physical distance, financial constraints, and awareness levels as key factors influencing access to coping mechanisms. Data from the 2014 Uganda Bureau of Statistics (UBOS) indicated that approximately 20.7% of the Kira Municipality population lived more than five kilometres from the nearest public health facility. Qualitative findings further revealed that despite being aware of available services, many teenage mothers were unable to access them due to long distances. These limitations were reflective of WHO's (2001) findings that access to mental health services in LMICs remains severely constrained.

**Acceptability:** The findings demonstrated that coping strategies such as counselling, faith-based support, and traditional media engagement were generally viewed as socially and culturally acceptable. However, the acceptability of formal counselling services was diminished in some cases due to concerns over confidentiality breaches.

Some participants reported that private information shared with counsellors had been disclosed to parents or guardians without consent, undermining trust in formal mental health services. On the other hand, maladaptive coping strategies such as substance use were widely regarded as socially unacceptable, yet they continued to be adopted due to the absence of alternative support systems.

**Quality:** Counselling services were found to be the only coping intervention provided by trained professionals. However, the delivery of these services was undermined by chronic shortages of medications, under-staffing, and a lack of essential equipment. These challenges mirrored broader issues facing Uganda's public health system, especially in rapidly urbanizing areas like Kira Municipality, where infrastructure development often outpaces service delivery capacity (Kira Municipality, 2024).

These findings suggested that maladaptive or avoidant coping mechanisms, such as substance use, tended to worsen depressive symptoms and potentially lead to long-term psychological harm. Conversely, teenage mothers who accessed active coping mechanisms—such as counselling, emotional support from peers, or guidance from elders—reported improved mental well-being. These observations underscore the urgent need to strengthen adolescent-friendly mental health services that are confidential, culturally sensitive, affordable, and geographically accessible.

The study's findings were consistent with previous research by Musese (2018) and Huang et al. (2014), which emphasized the value of emotion-focused and reappraisal-based strategies such as emotional support from family and peers. These informal networks

were identified as the most viable and commonly used mechanisms in the absence of formalized mental health structures.

#### **5.4 Study limitations**

Like other self-applicable inventories, the assessment tool (BDI) used presented the same problems where scores could easily be inflated, downplayed, or even fabricated by the respondents (Wang et al, 2021). Therefore, to address this, we encouraged teenage mothers to be honest in their assessments and created an opportunity for researchers to clarify statements that weren't clear to respondents.

The age bracket that we targeted constituted some minors. To address this, we specifically target emancipated minors following the guidance of the Uganda National Council of Science and Technology on dealing with research on humans.

## **CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS**

### **6.0 Introduction**

This chapter concludes and gives recommendations on the prevalence, associated factors and coping mechanisms adopted by teenage mothers experiencing depressive tendencies in Kira Municipality, Wakiso district. It also presents areas for further research are presented.

### **6.1 Conclusion**

The findings of this study clearly indicate that depression is highly prevalent among teenage mothers in Kira Municipality, affecting 79% of the study population at varying levels of severity. Specifically, 27% of teenage mothers were found to have Major Depressive Disorder, 17% experienced moderate depression, 20% struggled with borderline clinical depression, 15% dealt with mild mood disturbances, while only 21% exhibited normal mood variations. These statistics highlight a critical mental health challenge, with a significant proportion of teenage mothers at risk of further psychological distress and long-term mental health complications if appropriate interventions are not implemented.

Addressing the cycle of depression among teenage mothers in Kira Municipality requires a multifaceted approach that tackles both economic and socio-cultural determinants. Economic constraints, coupled with entrenched societal norms, contribute significantly to the persistence of depressive tendencies among this vulnerable group. Therefore, the implementation of economic empowerment programs alongside interventions that challenge and transform harmful socio-cultural practices is essential. A holistic

approach that integrates financial independence with social and emotional support will enable teenage mothers to develop resilience and improve their mental well-being.

In response to depressive tendencies, teenage mothers in Kira Municipality employed various coping mechanisms, which were broadly categorized as either active or avoidant strategies. While some teenage mothers actively sought support through counseling services, peer interactions, and religious institutions, a significant majority predominantly relied on avoidant coping mechanisms. This preference for avoidant strategies was largely influenced by the limited availability and accessibility of structured mental health services. Despite the existence of various coping strategies, their overall efficiency and effectiveness remained constrained due to barriers in availability, accessibility, acceptability, and quality.

The assessment of coping mechanisms using the AAAQ framework further revealed that most strategies aligned with only one, two, or three facets of the framework rather than all four. Even those mechanisms that adhered to all four facets did not fully satisfy all their respective components, limiting their overall effectiveness in addressing depressive tendencies. These findings underscore the urgent need to strengthen mental health services, enhance accessibility to professional counseling, and implement community-based interventions tailored to the specific needs of teenage mothers in Kira Municipality. By addressing these gaps, stakeholders can foster a supportive environment that promotes long-term mental health and resilience among this at-risk population.

## **6.2 Recommendations**

In light of the study findings, addressing the mental health needs of teenage mothers in Kira Municipality requires a multi-sectoral approach that fosters collaboration among key stakeholders. The complexities of depression among teenage mothers demand coordinated efforts from the government, civil society organizations, and academia to develop sustainable interventions that enhance mental well-being. By leveraging the strengths of each sector, this approach ensures that teenage mothers receive holistic, accessible, and impactful support systems. The following recommendations outline targeted strategies for each sector to effectively tackle depressive tendencies among teenage mothers in Kira Municipality.

### **6.2.1 Recommendations for the Government to:**

- Integrate mental health services into existing maternal and child health programs, ensuring routine screening, timely referrals, and access to professional support for teenage mothers experiencing depressive tendencies.
- Leverage non-traditional coping mechanisms, such as social media, to reach teenage mothers with digital mental health resources, given its widespread accessibility, acceptability, and appeal within this demographic.
- Expand access to professional mental health services by increasing funding for low-cost or free counseling programs tailored to teenage mothers, particularly in under-resourced communities.
- Collaborate with civil society organizations and development partners to implement targeted mental health awareness campaigns that challenge stigma,

encourage help-seeking behavior, and promote evidence-based coping mechanisms.

#### **6.2.2 For Civil Society Organizations to:**

- Strengthen community-based peer support networks that provide safe spaces for teenage mothers to share experiences, receive emotional support, and build resilience.
- Facilitate economic empowerment initiatives, such as vocational training and financial literacy programs, to reduce economic stressors that exacerbate depression among teenage mothers.
- Partner with media outlets to produce educational content, including radio and television programs, that amplify the voices of teenage mothers, showcase effective coping strategies, and promote positive mental health narratives.

#### **6.2.3 For Academia:**

- Conduct further research to evaluate the effectiveness and safety of social media as a coping mechanism for depression among teenage mothers, ensuring its potential for providing structured, evidence-based mental health support.
- Assess the long-term impact of coping mechanisms, both traditional and non-traditional, to determine their effectiveness in improving the mental health and overall well-being of teenage mothers.
- Collaborate with policymakers and civil society to translate research findings into policies, programs, and interventions that directly address the mental health challenges faced by teenage mothers.

By addressing the gaps identified through the AAAQ framework these stakeholders can create inclusive, sustainable, and effective mental health interventions for teenage mothers.

### **6.3 AREAS FOR FURTHER RESEARCH**

Effectiveness and long-term impact of coping mechanisms:

- Conduct longitudinal studies to evaluate the long-term effects of different coping mechanisms, both traditional and nontraditional, on the mental health and overall well-being of teenage mothers.
- Assess the impact of these coping mechanisms on various outcomes, such as symptom reduction, social functioning, educational attainment, and parenting outcomes.

Acceptability and quality of social media as a coping mechanism:

- Explore the specific ways in which teenage mothers are using social media platforms (e.g., YouTube, Facebook, TikTok, Instagram) to cope with depression.
- Evaluate the quality and reliability of the mental health-related information and support available on these platforms, and how it aligns with evidence-based practices.
- Investigate the factors that influence the acceptability and perceived effectiveness of social media as a coping mechanism among teenage mothers.

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## LIST OF APPENDICES

### APPENDIX I - Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it. :
- 3 I am so sad and unhappy that I can't stand it.

2.

- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.

- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.

- 3 I am dissatisfied or bored with everything.
- 5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.
- 6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.
- 7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.
- 8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.
- 9.
- 0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

12.

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions more than I used to.

3 I can't make decisions at all anymore.

14.

- 0 I don't feel that I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel there are permanent changes in my appearance that make me look unattractive
- 3 I believe that I look ugly.

15.

- 0 I can work about as well as before.
- 1 It takes an extra effort to get started at doing something.
- 2 I have to push myself very hard to do anything.
- 3 I can't do any work at all.

16.

- 0 I can sleep as well as usual.
- 1 I don't sleep as well as I used to.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.

3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.

1 I have lost more than 2kgs.

2 I have lost more than 5kgs.

3 I have lost more than 7kgs.

20.

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.

1. I am less interested in sex than I used to be.

2. I have almost no interest in sex.

3. I have lost interest in sex completely.

### **Interpreting the Beck Depression Inventory**

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the score:

#### **Beck depression inventory**

Total Score	Prevalence of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

**Source:** Jackson-Koku, G., 2016.

## APPENDIX II - KEY INFORMANT INTERVIEW GUIDE

<b>INTRODUCTION</b>		
This interview aims to establish the prevalence and contributing factors towards depression among teenage mothers in Wakiso district.		
<b>GENERAL INFORMATION</b>		
<b>Interview ID No</b>	<b>Date</b>	<b>Name of interviewer</b>
<b>Name of study participant</b>	<b>Sub-county</b>	<b>Village</b>
<ol style="list-style-type: none"> <li>1. Can you please introduce yourself and your experience or expertise in working with teenage mothers?</li> <li>2. In your opinion, what are the common challenges and stressors faced by teenage mothers that may contribute to depression?</li> <li>3. From your observations or interactions, what are some of the associated factors to depression among teenage mothers?</li> <li>4. How do you think societal attitudes and stigma surrounding teenage pregnancy impact the mental health and well-being of teenage mothers?</li> <li>5. What are some of the key socio-cultural and cultural factors that teenage mothers face, which might contribute to their depressive symptoms?</li> <li>6. Can you discuss any specific family-related factors that you believe contribute to depression among teenage mothers? For example, family support, dynamics, or relationships.</li> </ol>		

7. In your experience, what are some of coping mechanisms that teenage mothers use when dealing with depressive tendencies?
8. In your opinion, are these Available, accessible, acceptable and of quality?
9. What are some of the barriers that teenage mothers face in accessing mental health support or seeking help for their depressive symptoms?
10. In your opinion, what are some effective interventions or strategies that can be implemented to prevent or address depression among teenage mothers?

Source: Researcher's construct

**THANK YOU**

**END**

## APPENDIX III - FOCUS GROUP DISCUSSION GUIDE

<b>INTRODUCTION</b>		
This interview aims to establish the prevalence and contributing factors towards depression among teenage mothers in Wakiso district.		
<b>GENERAL INFORMATION</b>		
FGD ID No.	Date	Sub-county
1. Please introduce yourselves briefly, including your age and the age of your child(ren).		
<b>Section 1: Understanding Personal Experiences</b>		
<ul style="list-style-type: none"> <li>▪ Can you share any personal experiences or challenges you have faced as a teenage mother that have affected your mental health?</li> <li>▪ Have you ever experienced symptoms of depression or low mood since becoming a teenage mother? If yes, could you describe those experiences?</li> <li>▪ How do you feel motherhood and being a teenager simultaneously contribute to your mental well-being?</li> </ul>		
<b>Section 2: Identifying Triggers and Stressors</b>		
<ul style="list-style-type: none"> <li>▪ What are some factors or situations that you believe contribute to feelings of depression among teenage mothers?</li> <li>▪ Can you provide specific examples of stressful situations that have had an impact on your mental health as a teenage mother?</li> <li>▪ How do you think societal perceptions and attitudes towards teenage mothers influence their mental well-being?</li> </ul>		
<b>Section 3: Coping Mechanisms and Support Systems</b>		
<ul style="list-style-type: none"> <li>▪ What strategies or coping mechanisms do you use to manage depressive symptoms?</li> <li>▪ Do you feel supported in your role as a teenage mother?</li> </ul>		

- Can you describe the sources of support you have or lack in your life?
- What resources or support do you think would be beneficial for teenage mothers dealing with depression?
- In your opinion, are these coping mechanisms available, accessible, acceptable and of quality?

#### **Section 4: Seeking Help and Accessing Support**

- Have you sought professional help or received any form of mental health support for depression as a teenage mother? If yes, please share your experience. If no, what factors have prevented you from seeking help?
- What barriers or challenges do you face when it comes to accessing mental health services or support?
- What improvements or changes would you like to see in the availability and accessibility of mental health support for teenage mothers?

#### **Section 4: Self-Care and Mental Well-being**

- 14. How do you prioritize self-care while balancing the responsibilities of motherhood and being a teenager?
- Are there any activities or practices that you find helpful in maintaining or improving your mental well-being as a teenage mother?

#### **Conclusion:**

- Is there anything else you would like to share about your experiences with depression as a teenage mother?

**Source:** Researcher's construct

**THANK YOU**

**END**

## APPENDIX IV - CONSENT FORM

I..... voluntarily agree to participate in this research study.

1. I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
2. I have heard the purpose and nature of the study explained to me and I have had the opportunity to ask questions about the study.
3. I understand that my participation involves sharing my experiences of depression among teenage mothers in Mukono district.
4. I agree to my interview being audio-recorded.
5. I understand that all information I provide for this study will be treated confidentially.
6. I understand that in any report on the results of this research, my identity will remain anonymous.
7. I understand that a signed consent form and original audio recording will be retained in a safe place until Uganda Christian University approves the dissertation of the researcher (student).
8. I understand that a transcript of my interview in which all identifying information has been removed will be retained for two years from the date of approval of the dissertation of the researcher (student) by Uganda Christian University.

9. I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Signature/thumb print of the study participant

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**Signature of participant**

-----

**Date**

I believe the participant is giving informed consent to participate in this study

-----

**Signature of researcher**

**Date**



# UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

UGANDA CHRISTIAN UNIVERSITY  
SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

## DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: ...15<sup>th</sup> April 2025 ....

Name of Candidate: ...Nakyeyune Joselyn... Reg. No: ..... RM22M07/002.....

Title of Dissertation ...Depression among teenage mothers in Kira Municipality, Wakiso District, Uganda: Prevalence, Associated Factors and Coping Mechanisms ...

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR <i>(and where the response has been placed)</i>
1	The candidate should include the definitions of depression and coping in the operational definitions.	<ul style="list-style-type: none"> <li>Depression: Is a Common Mental Disorder characterized by persistent sadness and a lack of interest or pleasure in previously enjoyable activities</li> <li>Coping mechanisms: Techniques that individuals employ to help them manage challenging emotional situations including depressive tendencies</li> </ul>	These have been included in the description section <b>See page XIII</b>
2	The candidate should change Objectives ii and iii the read as follows since they were assessed qualitatively.	This recommendation was adopted and the objective were revised as below: <b>Objective ii:</b> To explore the factors associated with depressive tendencies among	These have been adjusted as guided. <b>See page 5</b>

	<p>ii The explore factors associated with depressive tendencies among teenage mothers.</p> <p>iii To Understand the coping mechanisms adopted by depressed teenage mothers</p>	<p>teenage mothers</p> <p><b>Objective iii:</b> To understand the coping mechanisms adopted by depressed teenage mothers</p>	
3	<p>The candidate should Review the methods section and give a detailed account of:-</p> <p>a) Quantities component the study procedure, sampling technique and data management should be describe.</p> <p>b) The qualitative component the candidate should describe the sample size considerations for the FGDs and Key informants, how and who conducted the interview and their qualification, where the interviews with the girls and health workers took place? How long the interviews lasted? The language in which the interview were conducted and if there was a need for translation of the interviews and who did this?</p>	<p><b>Sampling Technique</b></p> <p>This study employed a two-stage sampling technique to identify participants and key informants. The first stage involved purposive sampling to select organizations that directly engage with teenage mothers in Kira Municipality, particularly those focusing on mental health and human rights issues ensuring that they were relevant to the study's objectives. Three organizations were chosen based on their active involvement in supporting teenage mothers: Tukole Art Cultural Inspirations, Community Health Advocates Association Wakiso, and Mirianka Source Teenage Girls.</p> <p>In the second stage, simple random sampling was used to select individual teenage mothers from a list of participants provided by these organizations. From this list, 200 teenage mothers were randomly selected, ensuring that each eligible participant had an equal chance of being included. This sampling method was designed to ensure a fair and unbiased representation of teenage mothers in the study, which was critical for the reliability and validity of the findings.</p> <p><b>Determining the Study Sample Size</b></p> <p><i>Teenage mothers</i></p> <p>The study focused on teenage mothers residing in Kira Municipality, Wakiso District. The total population of teenage mothers in the area, as identified through collaboration with three organizations actively working with this demographic, was 410 individuals. To determine the appropriate sample size for this study, the Krejcie and Morgan (1970) sample size determination table was used. According to the table, a sample size of 200 teenage mothers was deemed statistically sufficient for the study's objectives, considering the population size of 410.</p> <p><i>FGD &amp; KII</i></p> <p>In addition to the 200 teenage mothers who participated in the study, qualitative data collection methods were employed to gain deeper insights into the factors associated with depression among teenage mothers and the coping mechanisms they utilized. Specifically, five Focus Group Discussions (FGDs) were conducted,</p>	<p>This is the revised version of the sampling and, data collection procedure. It is coherent ensuring easy flow. The question on the organizations, number of organizations, and how they were selected was also addressed in the sampling section</p> <p><b>See page 34</b></p> <p><b>See page 35</b></p> <p><b>See page 36</b></p>

		<p>each comprising 10-12 teenage mothers residing in Kira Municipality.</p> <p>Furthermore, 10 key informant interviews were conducted with stakeholders who were purposively selected based on their expertise and direct engagement with teenage mothers. These key informants included the in-charge of Health Centre III, counselors, Community Health Advocates, youth representatives, and Civil Society Organization representatives. Their insights provided a broader understanding of the factors influencing the mental health of teenage mothers in Kira Municipality.</p> <p><b>Data collection procedure</b></p> <p>The data collection process followed a structured protocol, beginning with obtaining ethical clearance from the Research and Ethics Committee at Uganda Christian University. Once approval was granted, the researcher sought permission from Kira Municipality through the Town Clerk's office. Clearance was also obtained from the organizations engaged in this study, ensuring that the study was conducted in compliance with ethical and institutional guidelines.</p> <p>Following approvals, the researcher coordinated with the selected organizations to schedule interviews. On the designated interview days, the organizations facilitated the participation of teenage mothers by inviting them to take part in the surveys. Informed consent was obtained from each participant before proceeding with data collection. To maintain confidentiality, all interviews were conducted in private settings.</p>	<p><b>See page 37</b></p> <p>Duration of the interviews is also highlighted including language used for the interviews - see page 38 under data collection tools</p>
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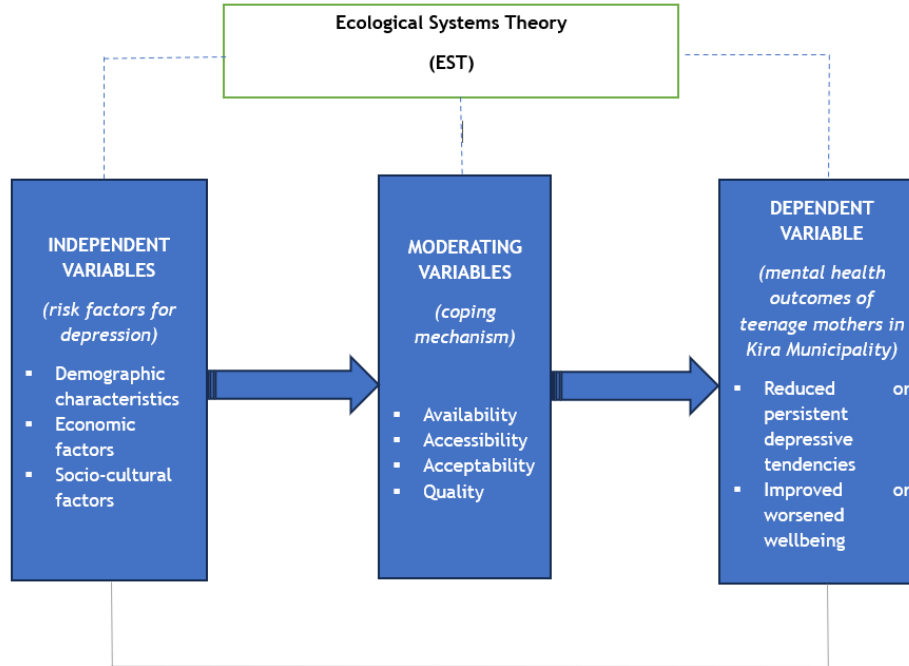
SN	COMMENTS BY INTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	<p>Background</p> <p><i>The background is well written BUT it should say something about Kira Municipality and Wakiso... what is happening there that made you consider doing this study in that area?</i></p>	<p><b>Contextualizing the Study in Wakiso District and Kira Municipality</b></p> <p>Wakiso District with a population of 3,397,565 is the most populous district in Uganda (NPHC, 2024). The district has also been identified as one of the areas with the highest teenage pregnancy rates in the country, recording 10,439 cases in 2020 alone (UNFPA, 2021). This high burden is partly attributed to the district's unique socio-demographic dynamics. Wakiso is characterized by an uneven population distribution, with urban centers housing the majority of residents. This rapid urbanization is primarily driven by rural-urban migration (Uganda Bureau of Statistics, 2016).</p> <p>Kira Municipality, one of the fastest-growing urban areas in Wakiso District, presents a unique socio-economic landscape that influences adolescent reproductive health outcomes (UNDP, 2017). The municipality has experienced rapid population growth, increased economic activities, and shifts in social structures, all of which contribute to the reproductive health challenges among adolescents. According to the Kira Municipality Council (2019), 11.5% of children aged 12-17 years in the area have been victims of teenage pregnancy. This high prevalence highlights the pressing need to examine the mental health challenges that teenage mothers in Kira Municipality face, particularly in a rapidly urbanizing context where socio-economic pressures, access to healthcare, and social support structures may differ from other settings.</p>	<p>I have added a sub section under background on “Contextualizing the Study in Wakiso District and Kira Municipality”</p> <p><b>See pages 3 and 4</b></p>
2	<p>Problem statement</p> <p><i>This is weak. Paragraph one seems to focus more on depression in general and it does not point to a gap in research on depression among teenage mothers in an urban setting in Uganda.</i></p>	<p>While numerous studies have been conducted to estimate the burden of depression in Uganda (Dongomin, 2022), the focus has largely been on specific high-risk groups such as People Living with HIV, women in general, cancer patients, caregivers, university students, refugees, war victims, and children and adolescents (Kaggwa et al., 2022). However, teenage mothers—who face a heightened risk of depression (Hodgkinson et al. 2014) due to early motherhood, social stigma, economic vulnerability, and inadequate support systems—remain significantly underrepresented in existing research.</p> <p>A systematic review and meta-analysis of 127 studies on depression in Uganda revealed that most studies were conducted in major urban areas, with 43 studies in the capital city, Kampala, 23 in Mbarara, and 16 in Gulu (Kaggwa et al., 2022). Despite this concentration of research, there is limited data specifically addressing depression among teenage mothers in Uganda's rapidly urbanizing settings like Kira Municipality.</p> <p>Kira Municipality, a rapidly urbanizing area with increasing rates of teenage pregnancies, has received little scholarly attention in this regard. Therefore, the absence of targeted research on depression amongst teenage mothers in settings such as Kira presents a critical gap, as their mental health needs and socio-economic struggles may differ from those in fully urbanized areas.</p> <p>This study, therefore, sought to address this gap by examining the prevalence and determinants of</p>	<p>This revised version first focuses on why the target group then why the study setting clearly elaborating the gap in research</p> <p><b>See pages 4 &amp; 5</b></p>

		depression among teenage mothers in Kira Municipality, thereby contributing to a more nuanced understanding of this vulnerable population's mental health challenges.	
3	Literature review Relevant literature reviewed. The knowledge gap at the end of literature chapter needs to be revised according to the comment in the book.	<p>The existing literature indicated that while extensive research had been conducted to establish the depression burden among different groups such as people living with HIV, women, refugees among others, there remained a significant gap in data on the prevalence of depression specifically among teenage mothers. As a result, there was limited statistical evidence on the prevalence of depression within this demographic, making it difficult to quantify the burden of the condition.</p> <p>Additionally, while several studies had explored the factors associated with depression, the majority had not established which of these factors were most predominant especially amongst vulnerable groups like teenage mothers. As a result, there was limited clarity on whether socio-economic status, lack of family support, stigma, or other variables played a more significant role in influencing depressive tendencies among this demographic.</p> <p>Lastly, although coping mechanisms for mental health challenges had been widely examined, very few studies had explicitly investigated how teenage mothers navigated depression. Even fewer studies had evaluated these coping strategies through a human rights lens to assess their accessibility, effectiveness, and equitability.</p>	<p>I have revised this section based on the viva power point presentation that clearly highlight the gaps under each of the three research objectives.</p> <p><b>See pages 32 &amp; 33</b></p>

4

Conceptual framework

The theoretical framework does not seem to be well aligned with this study. Coping mechanisms are strategies that people use to manage stressful situations. These are mostly internal mental/emotional/behavioral strategies. The theoretical framework seems to be focused on the nature and quality of services that could be used! Findings are likely to be more quantitative than qualitative!



Revised write-up of conceptual framework

The conceptual framework illustrates the interaction between independent variables, moderating variables, and the dependent variable in understanding the prevalence, associated factors, and coping mechanisms for depressive tendencies among teenage mothers in Kira Municipality, Wakiso District.

The independent variables in this study include demographic characteristics, economic factors (employment status, financial support, access to resources), and socio-cultural factors (stigma, family support, social networks). These factors influence the mental health outcomes of teenage mothers by shaping their experiences, stressors, and vulnerabilities to depressive tendencies.

The moderating variables focus on the availability, accessibility, acceptability, and quality of different coping mechanisms adopted by teenage mothers. The effectiveness of these mechanisms can either mitigate or exacerbate the impact of the independent variables on the mental health outcomes of teenage mothers.

The dependent variable in this framework is the mental health outcomes of teenage mothers,

I have reworked the conceptual framework to ensure that it reflects how the different variables including the coping mechanisms impact on mental health outcomes of teenage mothers in Kira municipality.

See page 11 & 12

		<p>specifically their susceptibility to depressive tendencies. The interaction between the independent and moderating variables determines the extent to which these mothers experience and manage depression.</p> <p>This conceptual framework is grounded in Bronfenbrenner’s Ecological Systems Theory (EST), which emphasizes the role of interconnected environmental systems in shaping an individual’s development and well-being. The EST identifies multiple levels of influence, from the immediate environment to broader societal structures, that interact to impact teenage mothers’ mental health.</p> <p>By applying the Ecological Systems Theory, this conceptual framework provides a comprehensive understanding of how various levels of environmental factors interact to influence depressive tendencies among teenage mothers in Kira Municipality. It highlights the importance of both direct and indirect influences, as well as the need for effective, accessible, and acceptable coping mechanisms to improve mental health outcomes.</p>	
5	<p>Sampling</p> <p>Description of the sample determination and sampling technique is vague! It should be accurately documented to communicate clearly how you determined the sample size and how the selection was done. For example when you say that “...The Krejcie and Morgan (1970) table was used to select 200 teenage mothers...” That is not clear because the table is used to determine the sample size and not to select participants! You say that “Krejcie and Morgan formula to determine sampling size” but again you say</p>	<p>These comments are addressed under question 3 under the external examiner’s section</p>	<p><b>See pages 34 - 37</b></p>

	<p>that the table was used. Please be consistent and clear in this area.</p> <p>The data collection procedure is not clear at all. Institutions are mentioned in section on sampling technique BUT which organizations? How many? How were they selected? Data from teenage mothers is expected to be quantitative BUT random sampling is not communicated! So clarity is need in this section.</p>		
6	<p>Chapter 4</p> <p>Chapter 4 should be started on a new page.</p>	Chapter 4 starts on a fresh page now	<p>Addressed</p> <p>See page 44</p>
7	<p>Data presentation</p> <p>After presenting the findings in table 6, table 7-27 look un necessary! Perhaps you could do this analysis following the instructions on this page :</p> <p><a href="https://www.ismanet.org/doctoryourspirit/pdfs/Beck-Depression-Inventory-BDI.pdf">https://www.ismanet.org/doctoryourspirit/pdfs/Beck-Depression-Inventory-BDI.pdf</a></p> <p>The summary at the bottom gives a good</p>	<p>In the revised version I replaced table 6 to reflect the findings as per the summary analysis by the BDI. This better elaborates the prevalence of depression amongst the teenage mothers and the severity.</p> <p>I have still maintained tables 7-27 to help elaborate the symptoms manifested by the different participants and which was most prevalent.</p> <p><b>Discussion section</b></p> <p><b>Objective one:</b></p> <p><i>Depressive Symptoms Among Teenage Mothers: A Concerning Trend</i></p> <p>The study revealed a high prevalence of depression among teenage mothers in Kira Municipality,</p>	<p>I have revised these sections to align with the statistics from the literature review.</p>

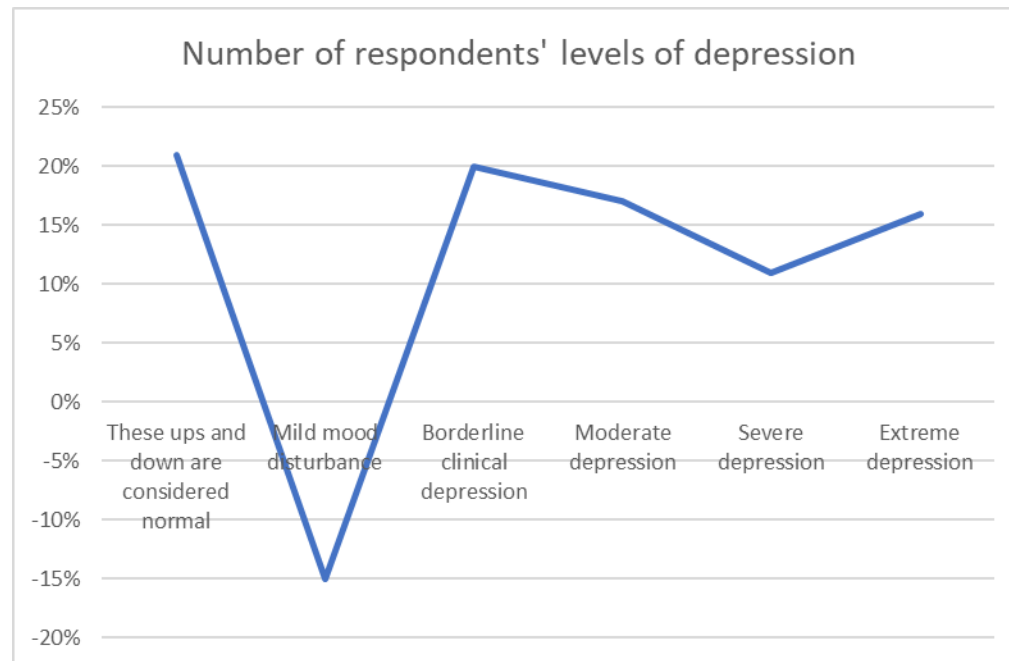
idea of the burden of the problem . You could then summarize what proportions lay in th categories mild to extreme...That would make the “Summary of Depression Prevalence” clearer . After reorganizing your quantitative and qualitative findings-then discussion will be even easier!

Qualitative data and data on objective two were well presented and the theoretical framework well applied .

The discussion section is fairly done BUT there is limited reference to comparable literature!

with 79% of respondents experiencing some level of depressive symptoms. This figure significantly surpasses global estimates, where depression among teenage mothers ranges between 16% and 44% (Hodgkinson et al., 2014). The elevated rate highlights a critical mental health concern in the local context, likely exacerbated by the socio-economic and cultural environment in peri-urban areas like Kira.

A graphical representation of the levels of depressive symptoms



Source: Researcher's construct

*Prevalence of Major Depressive Disorder (MDD) Among Teenage Mothers in Kira Municipality*

Among the 79% who exhibited depressive symptoms, 27% of teenage mothers were found to have Major Depressive Disorder. This level places them at the upper end of global prevalence rates and signals a serious mental health emergency. According to the World Health Organization, MDD is one of the most disabling disorders globally, linked to suicidal ideation, impaired functioning, and chronic emotional distress (Nemeroff, 2007).

In Uganda's context, where over 85% of households earn less than UGX 50,000 monthly (Mackri et

See pages 80 - 89

al., 2013), mental health services are often inaccessible or unaffordable. Consequently, many teenage mothers reported either avoiding treatment altogether or turning to informal support systems, such as religious institutions or traditional healers (Manasi et al., 2022). This limited access to appropriate care contributes to the severity and persistence of MDD among adolescent mothers.

*Moderate Depression: A Significant Mental Health Burden*

In addition to MDD, 17% of teenage mothers reported symptoms consistent with moderate depression. Although less severe, moderate depression was associated with persistent sadness, social withdrawal (42%), and chronic fatigue (36%), significantly affecting the mothers' ability to engage in parenting, education, or employment.

These findings are supported by national strategies and demographic data. The National Strategy to End Child Marriage and Teenage Pregnancy (NSCM&TP, 2022) underscores that teenage pregnancy significantly lowers future income potential, as adolescent mothers are three times less likely to obtain professional jobs and twice as likely to engage in small-scale agriculture (UDHS, 2016). This limited economic future compounds their psychological burden, contributing to prolonged moderate depressive episodes.

*Borderline Clinical Depression: An Early Warning Sign*

Approximately 20% of the teenage mothers surveyed fell within the category of borderline clinical depression, where emotional distress was notable but did not fully meet diagnostic thresholds for clinical depression. Symptoms such as loss of appetite (44%) and indecisiveness (26.5%) were frequently reported. These early indicators of emotional strain point to a population at high risk of developing more severe mental health disorders if timely and targeted interventions are not put in place.

*Mild Mood Disturbance and Normal Mood Variations*

About 15% of the teenage mothers exhibited mild mood disturbances, including sadness and irritability, while 21% fell within the range of normal mood variations—experiencing transient emotions like disappointment (32%) and irritability (14%). Although these cases do not warrant clinical diagnosis, they serve as entry points for mental health challenges amongst teenage mothers in areas like Kira municipality.

**Key Drivers of Depression Among Teenage Mothers**

The study also identified low self-esteem, excessive crying, negative self-perception, and strained relationships as the most common psychosocial drivers of depression. Self-criticism was reported by 42% of respondents, a finding that aligns with prior research emphasizing that adolescent mothers frequently experience guilt and feelings of failure (Buzi et al., 2016; Thompson et al., 2005). These drivers highlight the urgent need for tailored psychosocial interventions that address self-worth,

		<p>resilience, and coping strategies among teenage mothers.</p> <p><b>Objective two:</b></p> <p>Economic constraints emerged as a significant stressor among the teenage mothers who participated in this study. Many reported low or no income, unemployment, and unemployability as key contributors to their mental distress. A majority of the respondents lacked financial independence and depended heavily on their families—many of which were already grappling with economic hardship. This dependency, compounded by limited access to stable employment opportunities, heightened their sense of hopelessness, anxiety, and self-doubt, thereby increasing their vulnerability to depression.</p> <p>These findings are consistent with national-level statistics that reflect the broader economic struggles faced by households in Uganda. According to the Uganda Bureau of Statistics (UBOS, 2018), a significant proportion of families in rapidly urbanizing areas like Kira Municipality engage in informal or low-skilled work such as street vending, casual labor, and domestic work—forms of employment that offer little stability or income. Given that most teenage mothers are still in school or have dropped out due to pregnancy, they have little to no earning capacity. Their reliance on these low-income households contributes to poor mental health outcomes. According to UNICEF (2020), nearly 47% of Ugandan households experience multidimensional poverty, and over 41.7% live in extreme poverty on less than \$1.90 per day (Owori, 2020). This economic vulnerability directly affects access to health services, nutritious food, and education—factors that are crucial for adolescent well-being and recovery from mental health issues.</p> <p>For teenage mothers, poverty limits not only access to professional mental health care but also forces many to turn to traditional or religious authorities, which may not always offer effective support. As Manasi et al. (2022) argue, the high cost of therapy compels families to choose between basic survival and professional treatment, a decision that often results in prolonged or untreated common mental disorders such as depression. This aligns with findings from Adama et al. (2015), who observed that households with lower incomes are significantly more likely to experience depression than higher-income households.</p> <p>In addition to household-level economic struggles, the low or non-existent income of partners also emerged as a stressor. Many teenage mothers reported abandonment by their partners soon after becoming pregnant, with most citing the partner’s financial incapacity or fear of legal consequences. AfriChild (2021) and Nabugoomu et al. (2018) both highlight that most teenage fathers in Uganda are themselves adolescents or young adults—often still in school or dependent on their own families. Consequently, many of them are either unwilling or unable to provide financial support, leaving teenage mothers to bear the emotional and economic burden alone.</p> <p>This partner abandonment further exacerbates the financial strain and leads to emotional trauma, increasing the likelihood of depressive symptoms. As Ziyi W. et al. (2000) suggest, the absence of paternal involvement is strongly linked to higher rates of depression among adolescent mothers,</p>	
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		<p>particularly in rural and peri-urban contexts where social support systems are weak.</p> <p>Furthermore, the National Strategy to End Child Marriage and Teenage Pregnancy (NSCM&amp;TP, 2022) underscores that teenage pregnancies are not only a health concern but also a major driver of intergenerational poverty. Teenage mothers are three times less likely to secure professional employment and are twice as likely to remain confined to subsistence agriculture (UDHS, 2016), limiting their prospects for economic mobility and increasing their mental health risks.</p> <p><b>Objective three</b></p> <p><i>Coping Mechanisms Adopted by Teenage Mothers in Kira Municipality</i></p> <p>This study sought to establish the coping mechanisms adopted by teenage mothers experiencing depressive tendencies in Kira Municipality, Wakiso District. The findings indicated that teenage mothers employed a combination of traditional and non-traditional strategies to manage emotional distress. These coping mechanisms aligned with the theoretical classifications by Rich (2020), who categorized coping strategies into problem-focused, emotion-focused, and reappraisal-based approaches, as well as Good Therapy (2023), which grouped them under active (adaptive) and avoidant (maladaptive) mechanisms.</p> <p><b>Classification of Coping Mechanisms</b></p> <p>Traditional coping mechanisms—such as seeking support from religious leaders, elders, and professional counsellors—were primarily classified as active and problem-focused, aimed at addressing the root causes of distress. In contrast, non-traditional coping mechanisms, including peer support, use of social media, and, in some instances, substance use, encompassed both emotion-focused and avoidant strategies. The majority of teenage mothers in the study reported a greater reliance on non-traditional approaches, largely due to their ease of access and perceived availability. These findings were consistent with the World Health Organization’s (2001) report, which emphasized that psychological interventions tend to be more available in high-income countries, whereas support services in low- and middle-income countries (LMICs) are often underdeveloped or absent.</p> <p><b>Evaluation Based on the AAAQ Framework</b></p> <p>To assess the appropriateness and effectiveness of these coping mechanisms, the study utilized the AAAQ framework—Availability, Accessibility, Acceptability, and Quality.</p> <ul style="list-style-type: none"> <li>• <b>Availability:</b> Uganda was reported to have only one national psychiatric hospital and five regional facilities offering psychiatric services (Webb et al., 2023). In Kira Municipality, the first Health Centre IV was established in 2022, and although some Health Centre IIIs and IIs offered basic counselling services, the overall availability of structured mental health interventions remained limited. Consequently, most teenage mothers turned to informal sources of support, such as peer groups and digital platforms, which were perceived as</li> </ul>	
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		<p>more readily available.</p> <ul style="list-style-type: none"> <li>• <b>Accessibility:</b> The study considered physical distance, financial constraints, and awareness levels as key factors influencing access to coping mechanisms. Data from the 2014 Uganda Bureau of Statistics (UBOS) indicated that approximately 20.7% of the Kira Municipality population lived more than five kilometres from the nearest public health facility. Qualitative findings further revealed that despite being aware of available services, many teenage mothers were unable to access them due to long distances. These limitations were reflective of WHO’s (2001) findings that access to mental health services in LMICs remains severely constrained.</li> <li>• <b>Acceptability:</b> The findings demonstrated that coping strategies such as counselling, faith-based support, and traditional media engagement were generally viewed as socially and culturally acceptable. However, the acceptability of formal counselling services was diminished in some cases due to concerns over confidentiality breaches. Some participants reported that private information shared with counsellors had been disclosed to parents or guardians without consent, undermining trust in formal mental health services. On the other hand, maladaptive coping strategies such as substance use were widely regarded as socially unacceptable, yet they continued to be adopted due to the absence of alternative support systems.</li> <li>• <b>Quality:</b> Counselling services were found to be the only coping intervention provided by trained professionals. However, the delivery of these services was undermined by chronic shortages of medications, under-staffing, and a lack of essential equipment. These challenges mirrored broader issues facing Uganda’s public health system, especially in rapidly urbanizing areas like Kira Municipality, where infrastructure development often outpaces service delivery capacity (Kira Municipality, 2024).</li> </ul> <p>These findings suggested that maladaptive or avoidant coping mechanisms, such as substance use, tended to worsen depressive symptoms and potentially lead to long-term psychological harm. Conversely, teenage mothers who accessed active coping mechanisms—such as counselling, emotional support from peers, or guidance from elders—reported improved mental well-being. These observations underscore the urgent need to strengthen adolescent-friendly mental health services that are confidential, culturally sensitive, affordable, and geographically accessible.</p> <p>The study’s findings were consistent with previous research by Musese (2018) and Huang et al. (2014), which emphasized the value of emotion-focused and reappraisal-based strategies such as emotional support from family and peers. These informal networks were identified as the most viable and commonly used mechanisms in the absence of formalized mental health structures.</p>	
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SN	COMMENTS BY VIVA VOCE PANNEL	ACTION TAKEN	INDICATOR
1	Refine the statement of the problem	This was addressed under question 2 of the internal examiner	See pages 4 & 5
2	Refocus recommendation to the results of the study	Addressed	See pages 92 & 93
3	Align the Conceptual Framework and the theoretical framework	This is addressed under question 4 of the internal examiner	See pages 11 & 12

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