CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Teenage pregnancies have been among other things observed to be a major social problem among the juveniles. It is a worldwide problem which has assumed endemic proportions among the teenagers especially in the poorer nations (UNFPA, 1998). The majority of the victims of pregnancies are the school age and this has posed a greater danger and serious challenge to the fight against illiteracy, gender equity in education and progression rate of girl-child in the education system worldwide.

In Africa, particularly the Sub-Saharan Africa, the birth control practice is not as effective as that of the U.S.A (Stanley, 2007). The Sub-Saharan region has the highest rate of pregnancies with 143 pregnancies per 1000 teenagers. The highest rate of teenage pregnancy in Sub-Saharan Africa can be attributed to a large number of women who tend to marry at an early age. In West African region, Niger has the highest rate of teen pregnancies at 133 per 1000 teens. In Niger, for example, 53% of women give birth to a child before the age of 18. This is higher than the average pregnancy rate for the sub-region.

In Zambia, pregnancies among school going children sti l assume an upward trend. Pregnancies are more pronounced at lower levels of lea especially in upper basic schools. This shows higher levels of girl-child's education wastage. Rural provinces experience premature departure of girls due to pregnancies to a larger extent. This exercebates female illiteracy rates and has an adverse effect on the management of health status of both the mother and the child.

In order to address the problem of too many girls falling out of the school system, the policy of re-admission of the girls into schools, who become pregnant, between six months and one year after delivery, Zambia launched re-entry policy in 1997. Many girls have taken advantage of the policy and have returned to ol. The re-entry policy adopted by the Ministry of Education has, like HIV and AIDS, significantly contributed to the breakdown of parental care practices among mothers returning to school. Mother-

baby care is very critical between neonatal and under-five stages when children are at high risk of getting involved in accidents and contracting communicable diseases. The care arrangements teen mothers make for their young children while they are at school or unavailable to provide care themselves still remain unknown. It is against this background that the care and support systems for the children left at home when mot re-enter school was investigated.

1.2 Statement of the Problem

In Choma District, 494 girls fell out of school due to pregnancies in 05. In the following year, 393 school girls became pregnant while in 2007 431 girls left school due to pregnancies. Since the launch of re-entry policy in 1997 by the Ministry of Education, over years, many girls have taken advantage of the policy. In 2006, 144 girls re-entered school. In 2007 and 2008, 139 and 121 girls went back school respectively. However, Zambian boarding and day schools do not provide day care centres or facilities for children born to mothers going back to school. How the children of mothers re-entering school are cared for supported in the absence of the mother is not known.

In Zambia, a number of papers have been written and so studies have been undertaken related to gender mainstreaming in education and employment, pregnanc rates and their causes, the implementation of re-entry policy and girls' response to it. There is little known about the care and support systems of the children in the absence of mothers who return to school. It is on this premise that the study was carried out to investigate the care and support provided to the children of the mothers who go back to school after delivering.

1.3 Objective of Study

The main purpose of the study is to investigate the nature and quality of the care and support system of the children of teen mothers who return to school after delivery.

1.3.1 Specific Objectives

a) To assess the educational and socio-economic status of foster parents who remain with children when their mothers go back to school.

b) To identify the care and support systems provided to the children of teen-mothers going back to school.

c) To find out the extent to which the fathers are getting involved in supporting their children.

d) To investigate the environmental conditions under which young children of teen mothers going back to school are brought in.

e) To establish immunization and the breastfeeding patterns given to the children of teen mothers getting back to school.

f) To assess the health and nutritional status of children of teen mothers going back to school.

1.3.2 Research Questions

a) What is the educational background and socio-economic status of principal care providers who remain with the children when teenage mothers return to school?

b) What care and support systems are provided to the children of teenage mothers going back to school?

c) To what extent are the fathers responsible for the pregnancies of teenage mothers getting involved in supporting their children?

d) What kind of environments are the children of teenage mothers going back to school being brought up?

e) How is the immunization coverage and breastfeeding pattern among the children of teenage mothers going back to school?

f) What are the levels of stunting, wasting and underweight among the children of teenage mothers going back to school?

1.4 Rationale

The study is the first of its kind and will therefore another dimension of knowledge on the care and support systems for children whose mothers have gone back to school. The increased understanding of the quality of care and support system is very critical because it will contribute to the formulation of strategies aimed at improving quality of care and reducing incidences of illness amo children left in foster care by teenage mothers taking advantage of re-entry policy. The study will also help in realigning re-entry policy so that both the mother and the child benefit.

1.5 Conceptual Framework

The conceptual framework used in this study provides a basis for a detailed analysis of care and support systems of the children left in foster care by their mothers who re-enter school. It examines numerous inter-relationships that determine the nature and quality of care and support that are arranged while mothers are at school.

The framework is based on a number of factors. These are the fundamental variables, underlying variables, immediate factors, moderating variables and the outcome or manifestation of the interaction of the variables. The factors mentioned above are the ones which determine the quality of care and support system provided to the children. The nature and quality of care and support provided, ultimately affects the health status of a child which is manifested by levels of malnutrition (chronic or acute) according to the three anthropometric indices; height-for-age, weight-for-height and weight-for-age in a given population of children.

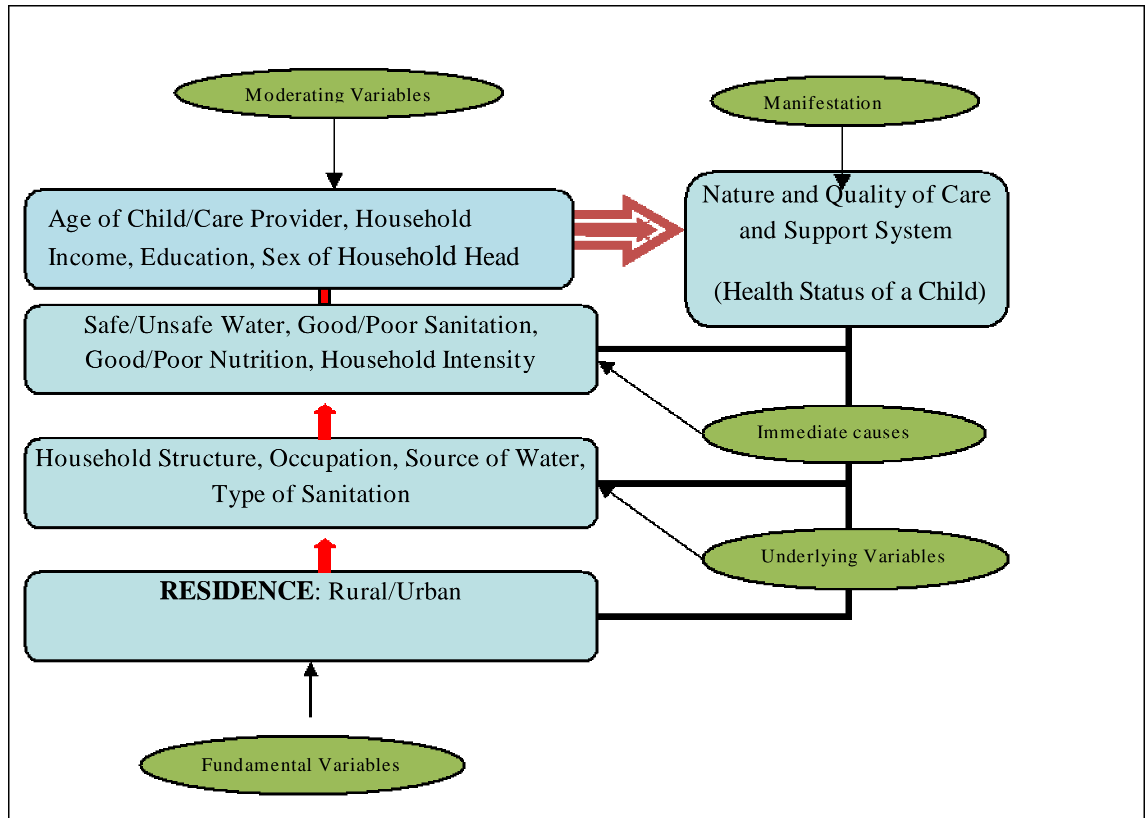
The fundamental variables include such factors as the the child and the care provider. This may be a rural or an urban area. Residence has profound influence on underlying factors such as occupation and household income, source of drinking water and sanitation. The availability and quality of underlying factors are to a large extent affected or modified by one’s residence. Rural or urban residence may vary in terms of

household structures, occupation, water quality and type of sanitation. These may influence the environments under which children are nurtured, breastfeeding and nutritional patterns and personal illness in children.

The underlying factors such as household structure, occupation, sources of water and type of sanitation determine the gravity of disease occurrence and the capacity of care providers to support and care for the children. The underlying factors therefore determine the probability of providing safe or unsafe water, good or poor sanitation, good or poor nutritional dietary needs and better or poor environments for the growth of children. The quality of water, sanitation, environmental conditions a child is subjected to and the feeding patterns have direct influence on the spread of diseases in a community. They are the immediate variables that contribute to the spread and infection of communicable diseases.

The immediate factors are further controlled or modified by moderating variables such as the age of the care provider and the child, the education level and the sex of the head of the household. Depending on the age of a child or the care provider, educational level of the care provider or the asset base of a household, the immediate cause variables can be improved upon and reduce the instances or occurrence of diseases. The modifying factors can either improve upon or deteriorate the capacity and capability to provide quality care and support systems to enhance the health status of a child.

The interaction of the fundamental, underlying, immediate and moderating variables manifest the nature and quality of the care and support systems provided which is reflected by the health status of a child as represented in the model.



Source: Modified from Chilopa and Simambo, 1998

1.6 Operational Definition of Terms

- **Exclusive Breastfeeding** - Feeding the child on milk only without any other foods even water for a period of six months from birth.
- **Complementary Breastfeeding** – Giving other foods to an infant to complement breast milk after six months from birth.
- **Infant** – a very young child below the age of one year.
- **Child** – used to cover periods of infant stage up to five years of age.
- **Under five** – child below the age of five years.
- **Neonatal** – new born babies less than one month old.

- **Teen mother** – young mother who gets pregnant while in school and delivers.
- **Foster care** – nurturing of children by people who are not biological parents to the child.
- **Re entry policy** – policy launched by government which allows girls who become pregnant while in school to go back to school after delivering.
- **Nutrition** – the process of nourishing the body.
- **Nutrition status** – the state of being nourished or malnourished and measured by the three indicators; weight-for-age to measure underweight, height-for-age to measure stunting and weight-for-height to measure wasting.
- **Morbidity** – instances of illness or departure from being well.
- **Mortality** – departure from life or absence of life
- **Partner** – man or boy in a sexual relationship outside marriage
- **Friend** – man or boy not in a sexual relationship but convinced girl to engage in a sexual act that resulted into a pregnancy.
- **Education level** – the level of formal education attained.
- **Socio-economic status** – social class and economic position of a family.
- **Household**- A group of persons who normally eat and live together. These may or may not be biologically related, but have common provisions for food or other essentials for living.
- **Head of Household**: The person all members of the household regard as the head and normally makes day-to-day decisions concerning the running of the household.

1.7 Organization of the study

The report is organized into Eight Chapters. Chapter One discusses the background of the study. It introduces the reader to the nature of the study and presents some discussions on the background. The chapter contains as well the information on the statement of the problem, background of the research problem, rationale of the study and definitions of terms used. Review of literature is done in Chapter Two. The chapter contains information on prior researches and related literature and provides explanation on what has been done in previous researches related to the study.

Methodology is discussed in Chapter Three. The chapter explains how the study was conducted and contains information on the development of the research instruments, definition of the study population, sampling methods or techniques used, data collection methods, research design used and the statistical tests that were used to analyze the data.

Chapter Four deals with the characteristics of respondents and looks at background characteristics, education attainment, literacy assessment, employment status and occupation and income levels (wealth quintiles). These are the determinants of the capacity of care providers to support and care of the young children in the absence of the mother.

Chapter Five focuses on the evolution of re-entry policy in Zambia. It provides background information on pregnancies in Zambian schools segregated by primary/secondary and by grades to show levels of education wasting. It also assesses the extent to which girls take advantage of the policy (assessment of the proportion of re-entries against rates of pregnancies) segregated by rural and urban residences, factors hindering other girls from going back to school, demographic and social characteristics of girls returning and not returning, general situation analysis of policy implementation in government, grant aided, community and private schools and existing support systems in schools for re-entry girls. Views of parents on the re-entry policy and some of the challenges they face brought by the policy are also discussed in this chapter.

In Chapter Six, the care and support systems are identified. In the same chapter, the roles of the partners as well as the environments in which children are brought up and child monitoring mechanisms to prevent injuries are discussed.

In Chapter Seven, the nutritional status, breastfeeding practices, vaccinations and personal illnesses are assessed.

Chapter Eight concludes and provides recommendations to policy makers and advocates.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The chapter presents a review of literature related to child care practices and support systems with special emphasis to the children of teen who go back to school after delivery. The chapter opens with the worldview on teenage pregnancies, health risks, social and emotional problems children born to mothers are likely to be subjected to. Infant and child care systems in the absence of the mother as revealed by different studies are also presented in the chapter.

2.2 Teenage Pregnancies: A World View

The incidence of teenage pregnancy has been identified among other issues as a serious and growing problem in the world. Worldwide, rates of teenage pregnancy range from 143 per 1000 teenagers in some sub-Saharan African countries to 2.9 per 1000 teenagers in South Korea. Every year, 14 million teenagers out of 260 million women aged 15-19 become pregnant worldwide and the majority are in the developing countries, particularly in the Sub Saharan Africa (Stanley, 2007). This accounts for 38 percent of youths aged 15-24 becoming pregnant every year in the world. Among developed countries, the United States and New Zealand have the highest levels of teenage pregnancy, while Japan and South Korea have the lowest pregnancies (Stanley, 2007). New Zealand experiences 56 pregnancies per 1000 teens ile Japan and South Korea experience 4 and 3 pregnancies per 1000 teens of age 15-19 annually, respectively.

In the United States of America (U.S.A.), approximately 1000 000 teens become pregnant each year and this accounts for about 11 percent of adolescent pregnancies (Voyadnoff and Donnelly, 1990). Such pregnancies result into 520 000 births, 405 000 abortions and 80 000 miscarriages and ultimately these affect the health status of the young mothers (Ibid).

Teenage pregnancy in the U.S.A. still remains high though between 1991 and 2005 there was a decline from 60 pregnancies per 1000 teenagers to 40.5 pregnancies per 1000 teenagers. This accounts for 13 percent of U.S.A. births involving teen mothers (Stanley,

2007). Stanley further argues that 25 percent of teenage girls who give birth have another baby within two years. This keeps girls away from school for a longer time or denied chance of going back to school. The striking feature of teenage pregnancies globally indicates that more than 80 percent of teen pregnancies are unintended and unintentional (Stanley, 2007). This can be attributed to the risky sexual behavioral pattern practices engaged by the adolescents. Another striking factor is that the same risk factors that contribute to teenage pregnancy also contribute to a high incidence of risk for HIV/AIDS and other sexually transmitted diseases. Therefore, where pregnancy rates are high, also the risk for HIV/AIDS and other sexually transmitted diseases is likely to be high.

The 2006 Teenage Pregnancy Survey conducted by the Guttmache institute (AGI), in the U.S.A. shows that each year 750 000 teenagers aged 15-19 become pregnant and most of these occurrences are experienced in the states with the largest numbers of teenagers such as California, Texas, New York and Illinois (AGI, 2006). These could have higher probability of peer influences and media exposure of youths to pornographies and sex-related literature.

According to John (2005), more than 8 000 girls under age of 16 became pregnant in England and Wales in 2003. The National Statistics show that the number of under 16 pregnancies increased by 25 percent to 8 076 in 2005. He argues further that although there were 53 fewer conceptions among girls under 14, there were 35 more at age 14 and 19 and more at age 18 in the same year. In 1990, the average age of first intercourse in Britain was 17 for boys and girls. Ten years later, th llen to 16 (John, 2005). This clearly shows the magnitude of teenage pregnancies even in the Economically Developed Countries (EDCs).

However, unlike developing countries, the rate of pregnancies in the developed countries has been declining and this has been attributed to more effective birth control practices. In Africa, particularly the Sub-Saharan Africa, the birth control practice is not as effective as that of the U.S.A (Stanley, 2007). The sexual behavior is still highly risky hence teenage pregnancy is still high. The Sub-Saharan region has the highest rate of

pregnancies with 143 pregnancies per 1000 teenagers. The highest rate of teenage pregnancy in Sub-Saharan Africa can be attributed to a large number of women who tend to marry at an early age.

In West African region, Niger has the highest rate of pregnancies at 133 per 1000 teens. In Niger, for example, 53% of women give birth to a child before the age of 18. This is higher than the average pregnancy rate for the sub region. This is followed by Nigeria with an average pregnancy rate of 103 per 1000. In Southern part of Africa, South Africa experiences 66 pregnancies per 1000 teenagers slightly higher than the USA but lower than Brazil with 73 pregnancies per 1000 (Stanley, 2007).

2.3 Healthy Risks, Social, and Emotional Problems Associated with Children born to Teenage Mothers

Teenage pregnancy is one of the important issues that need critical attention. There are health risks associated with teenage pregnancy for both the baby and the mother. Children born to teenage mothers are more likely to suffer health, social, and emotional problems than those born to mothers above the age of 20 (Swierzewski, 2007).

2.3.1 Health Risks To The Baby

The study done by Swierzewski in 2007 revealed that infants born to teenage mothers are at increased risk for a number of health risks. These risks include likelihood of low birth weight (LBW). The occurrence of low birth weight is as a result of teenage mothers themselves who are less likely to gain weight pregnancy. Low birth weight is associated with several infant and child disorder and a high rate of infant mortality. Therefore, LBW babies are more likely to have organs that are not fully developed and apparently this can result in complications such as bleeding in the brain, respiratory distress and intestinal problems.

Swierzewski's study reveals further that teenage mothers are less likely to take recommended daily prenatal multivitamins to maintain adequate nutrition during pregnancy. If not closely supervised by parents or older women, they are also less likely to receive prenatal care. Prenatal care is essential for monitoring the growth of the faetus

and the health of the mother. According to the American Medical Association (AMA), babies born to women who do not have regular prenatal care are four times more likely to die before the age of one year (infant mortality) (Child Care Bureau, 2003).

Researches carried out in the U.S. have shown high prevalence of high mortality, often associated with malnutrition and low immunization, among children under the age of five where baby care is of poor quality (Ibid). Similar trends have been observed in Africa especially among the poor communities in rural Sub-Saharan Africa. In 1990, 174 million children were malnourished though in 2000 there was a reduction to 150 million malnourished children in Sub-Saharan Africa (UNDP, 2003). Researches show that in almost all countries, rural children are at risk of malnutrition than their urban counter parts. In some countries, the percentage of rural children who are underweight is more than 50 percent higher than that of urban children (UNDP, 2003).

Low immunization coverage increases the rate of mortal In Sub-Saharan Africa immunization coverage is as low as 50 percent where as in the Latin America, the Caribbean and East Asia by 1990, immunization had reached the high levels of 70 percent (UNDP, 2003). The research revealed that most of the children under foster care are rarely exposed to immunization because foster parents and care givers often end up babysitting their nieces and nephews while they are busy with other ventures to earn a living.

Tomkins *et al.* (1989) studied children between the ages of 6 and 35 months to establish the occurrence of diarrheal. The baseline study revealed that short and underweight children were at greater risk of illness for diarrheal and fever. Underweight is an indicator for poor nutritional status in children. If care system is erratic, especially in children under the age of five, stunting, wasting, and underweight are likely to occur and this weakens the immune system thereby increasing the isk of disease burden in children.

2.3.2 Social, Emotional and Other Problems

In addition to increased health risks, children born to teenage mothers are more likely to experience social, emotional and other problems.

Bell *et al.* (1983) argue that unmarried teenage mothers find themselves alienated from the mainstream of society, so they do not get all the help they need, especially when they also have very little or no help from their families. ll *et al.* (1983) and Swierzewski (2007) state that children born from unmarried teenage mothers are less likely to receive proper nutrition, health care and, cognitive and social stimulation. As result they are at risk of the following:

- Lower academic achievement
- Abuse and neglect
- Among boys, 13 percent are likely to be incarcerated later in life and
- Among girls, 22 percent are more likely to become teenage mothers themselves.

2.4 Dilemma in Teenage Pregnancies

The research carried by Hamusonde (2003) in Lusaka revealed that to a larger extent the men responsible for adolescent preganancies were older men, the "sugar daddies". These men are already in marriage unions but have material and financial resources which they use to decieve the young girls with. The research further revealed that the old men go after young girls with a belief that the teeagers have low risks of HIV and AIDS which is a misconception. Out of 30 girls interviewed, 27 (90 percent) were made pregnant by older men and only 3 (10 perent) of them had fellow agemates responsible for their pregnancies. Njau and Wamuliu (1994) came up with similar findings that older men engaged in sexual relations with young girls.

The research showed that 80 percent of the girls were by the men responsible for their pregnancies. While some men accepted the responsibility, they never took care of the born babies. Others relocated to other towns and never to be seen by the young

mothers. The grandparents in most cases take responsibility of the upbringing of the grand child. Hamusonde (2003) further reveals that some teen mothers were not only rejected by the boyfriends but some parents also chased them away from their homes. This had negative implication on the girls regarding f l, material and psychological support. This contributed to the failure of some young mothers t go back to school.

One of the fascinating experiences of teenage mothers is their alienation from the school system. The education policies in most of the African and the traditional and cultural practices were highly descriminatory to girls. The participation of girls in education in Africa to a large extent is influenced by the cultural and societal perception of the girl-child. According to Kelly (1994) the image and treatment of the girl-child is that of a passive, submissive person who remains quietly in the background. The society perceives a girl-child as an object of marriage and source of wealth to the family through bridal price *(Lobola).* Therefore, preference to enter school is accorded more to the male counterparts.

The attitude of African society towards the girl child can be traced even in the way the school curriculum is designed which places the girl-child in the subsevient position. This image is strongly reflected in the text books that are still in use in schools (Kelly, 1994 ; Mabula and Chondoka, 1996). There has been growing disparities, particularly in the Sub-Saharan Africa, between women and men in terms of access to education. The education system for a long time in Zambia had not addressed adequately gender disparities and prior to the 1996 education policy, a child was provided more opportunities than a girl in retention and access to education.

However, with time, the traditional perception of females changed and the centrality of women's contribution to national development began to recognized (MOF, 2004). The education sector began to consider integrating gender concerns in policy matters. The quest to achieve the Millenium Development Goals (MDGs) in education begun to reconsider the position of a girl child in terms of retention and access to education.

Major reforms in some countries in education policy began taking course in Africa in the 1990s (MOE, 2006).

In order to achieve gender equality by 2015, gender discrimination in primary school enrolment remains a concern in several countries, part rly in the Sub-Saharan Africa, South Asia, Middle East and North Africa. One of the strategies is to maximize opportunities for a girl child's attainment of basic education (UNDP, 2003). This resulted into the birth of an inclusive policy of re-admitting girls who fall pregnant into the school system after they had delivered in many cou ld.

2.5 Re-Admission Policy of Girls

The benefits of education in improving the overall quality of life mult ith increased participation of girls and women. The empowerment of girl-child with education is particularly associated with significant reductions in infant mortality and morbidity, improvement in family nutrition and health, lowering of fertility rates, improved chances of girl child's education and improved opportunities in both wage and non wage-sectors (MOE, 1996). According to Odaga and Heneveld (1995) most of the social and economic problems experienced in the Sub-Saharan Africa are compounded by the marginalization of women in education. Therefore, female education widens opportunities of girls and enhances freedom of choices and greater participation in decision making.

Re-entry policy in the Sub-region has been instituted to avert the discriminatory policy of expulsion of girls who fall pregant as they progress through the school system with such risks as drop-outs before reaching recognised terminal points. Girl-child education has been perceived as one of the critical approaches t reducing high levels of poverty, high fertility rate and achieving sustainable development.

Botswana is one of the first countries to implement re-admission policy in Sub-Saharan africa. Re-entry policy has been there since 1976 (Hamusonde, 2003). Since its inception, only 30 percent of entrants have taken advantage of the policy.

In Kenya, re-admission policy has been on course since 1994. According to Forum for African Women Educationists (FAWE) (1995) only 10 percent has gone back to school. A similar trend has been reflected in Cote d' Ivoire where the response was insignificant to begin with. This agrees with Odaga and Heneveld (19) who state that in the Sub-Saharan Africa where re-admission policy exist mothers were not returning to school in large numbers. However, with time the degree of resistance has dwindled and society has began to appreciate the policy. There have been nu s challenges which range from cultural, social, political and economical factors. These posed resistance to acceptance of the policy from members of society as well as education providers themselves. Some of the challenges as argued by Bayona and Kandji-Murangi (1996) include:

- Lack of understanding of the policy by both parents an pupils which sometimes met resistance.
- Innefective implementation of the policy
- Limited school places
- Social stigma associated with teenage pregnancy.

Girls who returned to school in some countries experienced problems of descrimination, mockery, harassment, violence and insensitive attitudes by the teachers themselves (Odaga and Heneveld, 1995). They further observed instances of sexual abuse of young mothers by the male pupils and teachers.

Zambia launched the re-entry policy on 13th October 1997. Since its inception in 1997, many girls have taken advantage of the policy by going back to various schools (Ministry of Education (MOE), Forum for African Women Educationists of Zambia (FAWEZA) and United Nations International Children's Emergency Fund (UNICEF), 2004).

2.6 Challenges of the Re-entry Policy

The introduction and implementation of the Re-entry policy, however, has a number of challenges that have been observed in countries where has been in practice for a long time.

One of the most difficult challenges of the re-admission policy is the care and support networks provided to the growing numbers of children in foster care. According to UNICEF (2004) young children in foster care are being the most vulnerable especially in the developing countries. The absence of the mother at a very tender age of a baby has negative implications on the health status and growth of a baby. Quality of care is very important to the psychological, social, physical and mental development of a child.

2.7 Child Care and Support Systems

Child care and support systems tend to be influenced b a number of factors which include the level of economic development of a given country, family or individual's social status and the existing coordination among families, Non-Governmental Organizations (NGOs) and communities which provide the basis for the quality of care and support systems. Globally, care and support systems vary considerably and are highly dependant upon the level of economic development, political will and careful planning in mobilization and distribution of resources. Developed countries have well established institutions for child care than it is in the developing countries. Several researches that have been done in countries where re-entry policy has been on course provide a model of care and support systems adopted by different countries.

2.7.1 Child Care and Support System in Developed Countries

In the developed nations such as the United States of ica (U.S.A.) where teenage pregnancies are very high, both the community and the government respond to the needs of young mothers and their children. These institutions, both public and private, are designed in ways that weave young children and their caregivers into the social fabric and this is based on the premise that a family's effectiveness as a childrearing system is bolstered by the existence of a supportive social network that includes people outside the immediate family. There is also increasing belief that when people feel responsible for

what happens in their neighborhoods, children benefit (http://www.carnegie.org/starting-points/startpt6.html). This is a daunting challenge, requiring good ideas and hard work of people across the nation: government officials, business leaders, agency staff, the media, community workers, religious organizations, parents, and volunteers.

According to National Center for Children in Poverty (NCCP) (2002), the USA government promotes a culture of responsibility in communities in order to prepare communities meet the needs of families with young children especially those that face multiple risk factors such as poverty, unemployment, inadequate housing and food resources. The States play a critical role by establishing a framework for community action. The USA government provides support for key services such as child care, health care, family life education, and staff training. States also play a vital role in establishing program regulations, collecting data, and allocating funds.

The study done by Child Care Bureau (2003) shows that approximately 7 billion dollars is spent each year on services related to teenage parents. This excludes actual money contributed by charitable organizations. Technical Analysis paper No 42, US, further states that 46 percent of single teenage mothers and t children receive public assistance and 50 percent of national Child Care and Development Fund (CCDF) budget is related to adolescent pregnancy.

The U.S. government developed a number of strategies to help in improving its care and support systems to both young mothers and the infants left by the teen mothers while attending schools. These strategies are tailored in such a way that they are comprehensive, coordinated, continuous and family supportive and coordinated by the American Academy of Pediatrics Committee on Early Childhood, Adoption, and Dependent Care (AAPCECAD).

The Early childhood Longitudinal Study done in U.S.A. by the Child Care Bureau (2003) identifies the following child care arrangements in the U.S.A. which can be divided into parental care, non-parental or relative care and center-based care (Flanagan and West, 2004). Centre-based care is largely government-based care which accesses funds from the Child Care and Development Fund (CCDF).

The study by Flanagan and West (2004) on ten thousand 000) children born in the United States in 2001 shows that half (50 percent) of the children were in some kind of regular non-parental childcare arrangements at nine (9) months of age, 26 percent were in relative care (often with grandmothers) at nine (9) months, 15 percent in non-relative care and 9 percent in centre-based care.

Another study on childcare arrangements by race or ethnicity carried by Child Care Bureau (2003) indicates that parental care, in the U.S., is practiced more by the white community than any other ethnic group. White children are less likely to cared for by a relative at less than nine months. According to the by the Child Care Bureau (2003), non-parental care among the whites accounts for 49 percent while among the blacks and Asians it accounts for 63 and 47 percent respectively. Hispanic relative care accounts for 46 percent. Black children are more likely to be in centre-based care than any other ethnic group. This is due to more pronounced low income levels among the blacks. Black children in centre-based care comprised 14 percent while the whites accounted for 9 percent, Hispanic for 5 percent and the Asian accounted for only 4 percent.

The findings of the study by Capizzano and Adams (2003) on the impact of income levels and care provider's employment status on the use of care arrangements show that 62 percent of children under age three in low-income families with employed care provider were less likely to be in regular non-relative care arrangement than higher-income children (68 percent). The study reveals further that children in low-income families with employed care providers were more likely than higher-income children with employed care provider to be in relative care and less likely to be in centre-based or family child care.

2.7.2 Child Care and Support System in Developing Countries

According to Hamusonde (2003), in countries like Botswana, Kenya, Corte De Voire and Malawi where the policy was implemented earlier, the children of teen mothers who get back to school are left under the care of grand parents. The level of care by these foster parents also varies according to their education standards and income levels. In

poor families, grand parents tend to venture into other errands to sustain their families hence fellow children tend to care for the children of young mothers. Odaga and Henveld (1995) further argue that fathers to the children of mothers returning to school rarely take responsibility of caring for them. Most of them run away from the girls when they are told that they are pregnant.

2.8 Environmental Factors and Health status of children

The care of children can not be adequately discussed without the integration of the environment in which they live. Child illnesses and injuries are highly influenced by the environment in which nurturing of children takes place. The association between child survival and the environment in which a child is brought up significantly shows the importance of environmental conditions in determining childhood mortality.

According to Masuy-Stroobant (1983) health education activities to improve children's health and nutritional status increasingly began to take course in the 1880s when the germ theory of diseases developed by Louis Pasteur began to be appreciated. The theory explains the spread of diseases in environments with sub-standard sanitation, poor sewage disposal, and unclean drinking water supply. The increasing awareness of the germ theory of diseases increased health education activities and there was growing agreement that the mother needed education in proper infant care practices especially feeding practices. This placed major emphasis on breastfeeding, providing clean and adequate food to non-breastfed infants, heating of milk and sterilization of bottles and keeping the baby and its direct environment clean were among important innovations developed (Masuy-Stroobant,1983). Progressively implemented activities in the United States included establishment of milk depots to ensure ready-to-use clean and bottled milk to poorer mothers who could not breastfeed their infants. In schools the value of domestic hygiene and health education among school gir began to be recognized and implemented in the school curriculum.

Williams and Galley (1995) documented the effect of poor sanitation on diarrheal diseases. In their study, they argue that areas disadvantaged with poor sanitation and overcrowding in houses exert an effect on infant and child survival through frequent

diarrheal cases. The incidence of diarrheal diseases affect the growth and physical development of children especially those under the age of five. Before 1900, in Europe and USA, infant mortality had risen due to poor sanitation, nutrition and personal hygiene. However, infant mortality decline in Europe and USA by 1900 was attributed to improvements in sanitation and nutrition (McKeown, Brown and Record, 1972).

Ewbank and Preston (1990) in their study reveal that sanitary reforms such as the provision of sewage disposal and clean water supply systems especially in towns and improved personal hygiene are a good approach towards in childhood mortality.

The introduction of re-entry policy in many countries as a response to the ever increasing number of school girls leaving school system prematurely due to pregnancies requires an integrated and multifaceted approach that ompasses the well-being of a child left at home in foster care. It is a complicated phenomenon which demands a well coordinated system in which the community, families, Non-Governmental Organizations, civic and government leaders provide a supportive social network. Flex-time system adopted by some countries is very critical This provides baby sitting mothers enough time to provide for the child's dietary needs.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The chapter explains how the study was conducted and contains information on the development of the research instruments, definition of the study population, sampling methods or techniques used, data collection methods, and the research design used.

3.2 Types and Sources of Data

The study used a combination of both primary and secon data. Primary data included information obtained directly from respondent and field observations to ascertain how children are cared for and supported. Secondary sources of data included published materials by various authors which were obtained from the University of Zambia Library, News papers and online literature through internet services.

3.3 Research Design

The study used both qualitative and quantitative methods of collecting primary data. Observations, Focus Group Discussions (FGDs) and in-depth discussions were used in qualitative data collection. In-depth discussions were done with teen mother to get some details which may not have been captured by questionnaires while Focus Group Discussions were done with some parents or guardians to the selected re-entry girls and non re-entry girls to obtain information on their views about the impact of re-entry policy on child care practices. Qualitative techniques were employed to solicit information on social issues and personal opinions from the key informants about their feelings on the re-admission policy, nature and quality of support given to children when mothers are away and problems care providers encounter in looking after the children in their care in the absence of the mother.

Quantitative methods endeavored to collect information on the income levels of the parents or guardians of teen mothers in order to establish their capacity to look after young children left in their custody when mothers return to school. The anthropometric data on the age, weight and height of the babies was also collected using quantitative method in order to establish levels of underweight, stunting and wasting among the young children in foster care.

3.4 Research Instruments

Two sets of Questionnaires were used to collect quantitative data while interview guides were used in collecting qualitative data. One set of questionnaire with open ended questions was administered to the Heads or Guidance and counseling teachers in selected schools. Questionnaires with Open ended questions were used to allow free expression among participants. A questionnaire which was administered to school girls who became pregnant and either returned or did not return to school had to a larger extent closed-ended questions to standardize responses.

In-depth discussions were done with teen mothers while FGDs were conducted with parents or guardians to get some details which may not have been captured by a questionnaire.

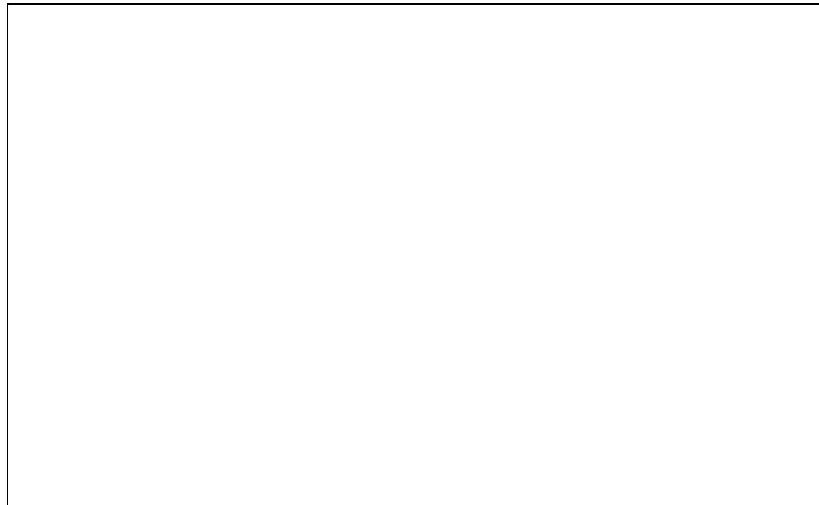
3.5 Research Area

Choma District was selected as a study area for the following reasons: The district is centrally located and the second largest in terms of p ulation after Livingstone. Its central location makes it a hub of communication network to other districts in the province thereby making it an attractive commercial trading center. Its potential in agriculture and commerce attract diverse ethnic groups who have settled in the district and this provides enough target population for the study.

Choma District has numerous schools ranging from government, mission or grant-aided, community and private schools. This made the work of the researcher easy in coming up with the sampling frame. The different agencies running schools in the district provide wider and diverse views on the implementation process of the re-entry policy. Government schools provide a model of implementing government policies and strategies which may be different from missionary agencies.

There are many day schools in the district and these provide an ideal and conducive environment for teen mothers who return to schools. Therefore, this provided an appropriate catchment area for the re-entry girls. Figure 3.1 shows population of schools in Choma District.

Fig: 3.1 Population of Schools in Choma District



Source: Choma District Census of Schools 2010

The other reason for selecting Choma is the familiarity of the district by the researcher which made accessibility to schools easier. The language competence of the researcher is also an advantage. This made interaction between the researcher and respondents, especially the parents, much easier.

3.6 Target population

The study targeted a sampling frame of 1318 girls who became pregnant in the three years preceding the case study and never returned to school and 121 girls who became pregnant and returned to school after delivering and were available in school at the time of the case study. The study also targeted 190 school administrators for the 190 schools in the district.

3.7 Sample Size

From a sampling frame of 1318 girls who became pregnant and never returned to school and 121 girls who returned to school, 85 girls were randomly selected from each group.

From 190 school administrators, 20 administrators were randomly selected to ascertain the implementation process of the re-entry policy in various schools.

3.8 Sampling techniques

The study used a combination of sampling techniques in order to establish the sample size from each sampling frame. The study had targeted 100 respondents from both re-entry and non- re-entry girls. However, only 85 re-entry girls were available in schools. Therefore, 85 mothers who never returned to school were also selected to get an equal number for comparison purposes.

A sample of eighty-five (85) re-entry girls was established using stratified and systematic sampling. Stratified sampling was selected as a sampling technique due to the availability of already established sampling frame for the girls who, after delivering, have been re-admitted to various schools in the district. The sampling frame was stratified into two strata, the re-admitted primary and secondary school girls. Once these were stratified, linear systematic sampling was used to select 85 elements from re-admitted category, after randomly selecting a number from the first interval.

The other target of eighty-five (85) school girls who fell pregnant and never returned to school was chosen using snowball sampling technique. Other Key informants who provide valuable information for the study included teachers, school administrators, school pupils, the community and parents. To establish a sample of girls who fell pregnant and never returned to school after delivering was difficult because no proper record is maintained in the institution of learning.

3.9 Pilot study

The pre-testing of data collection instruments was done for two weeks in Kalomo District. Kalomo District was chosen because it has similar geo-political and demographic characteristics of respondents to Choma District. Piloting of questionnaire was done to test clarity, strengths and weaknesses of items in the research instrument. It was also done to establish if the questionnaires would get the intended responses. After piloting, errors and weaknesses on questions were identified and

adjusted accordingly. Few questions were rephrased to nable respondents understand what the questions really sought. After questionnaires were pre-tested and corrected, data collection and analysis was done from August to November, 2009.

3.10 Limitations

A number of problems were encountered during the study. These problems made the research process difficult. Some of the limitations encountered included:

§ Schools do not keep up-to-date and comprehensive records of girls who re-entered school after delivering. There were great disparities between the information obtained at the district education offices and individual schools on the ground. This posed problems in meeting the targeted sample size.

§ Financial resources were also a limiting factor to the coverage of wider area for research. Only schools in Choma District were sampled the results of the study can therefore not be generalized to the entire nation.

§ The prevailing fuel crisis in the country during the research period delayed the research process which dragged into the examination period in schools. This was a very sensitive period due to speculations about leakages thereby any nt interactions with pupils especially those in examination classes attracted a lot of suspicions. Pupils writing final examinations also never wanted to be inconvenienced by answering to the questionnaires administered to them while they were busy preparing for their examinations.

§ To ensure reliability and validity of information provided some respondents were approached several times to ensure that the information given was correct and consistent.

§ Some schools are in the remotest part of the district and almost inaccessible. This sometimes ended in serious accidents by the researcher who was using a motor bike thereby consuming a lot of time and delay in the process of data collection.

§ A number of respondents were not found in their homes. This required constant follow-up to market areas where most of them spent time selling some merchandise to earn a living for themselves and their families.

§ Part of the study was done during the rainy season as such some areas were not easily accessible.

3.11 Data Analysis

The analysis of qualitative data assumed the descriptive and explanatory analysis. Explanatory analysis involved examining and explaining relationships between variables using frequencies, bivariates and regressions. Descriptive analysis included the aspect of examining, organizing and identification of categories, themes and patterns. Qualitative approaches used included indexing, manual and verbatim or writing and organizing data into themes.

Quantitatively collected data was analyzed using Statistical Package for Social Sciences (SPSS), Stata and Anthro computer software. Anthro-software was used to generate the z-scores upon which levels of malnutrition (stunting, underweight and wasting) were established. Cross tabulation technique was used to test relationships of variables in the data sets.

3.12 Data Presentation

The data was presented using frequencies, percentiles, graphs bar charts and table distributions using excel spreadsheet and SPSS.

CHAPTER FOUR: CHARACTERISTICS OF RESPONDENTS

4.1 Introduction

The chapter presents the background characteristics of respondents. The background information is very critical in this study because its analysis helps to determine the ability, potential, skills and the capacity of the foster parents in looking after the children of teenage mothers who return to school. It is upon these parameters that the care and support system can be evaluated as being adequate or erratic.

Some of the demographic and socio-economic characteristics of the respondents under discussion that may directly or indirectly impact on the care and support system of children include age, sex, marital status, household head, residence, education level, literacy level, employment status and income levels of those who are directly involved in the provision of care for the young children. A comparative analysis is done between teenage mothers who returned to school after delivery and those who never returned.

4.2 Background characteristics

4.2.1 Age and Sex Distribution of the guardians to teenage mothers

Table 4.1 shows the age distribution of the guardians to the teenage mothers who are in school and those out of school.

Table 4.1: Age Distribution of the guardians

Returned to School			Never Returned to School		
Age	**Frequency**	**Percent**	**Age**	**Frequency**	**Percent**
Below 20	1	1	Below 20	0	0
20-29	10	12	20-29	4	5
30-39	16	20	30-39	13	15
40-49	42	51	40-49	35	41
50-59	4	5	50-59	21	25
60+	9	11	60+	12	14
Total	**82**	**100**	**Total**	**85**	**100**

Source: Field data

The table shows that in the group of teenage mothers in school, most of their guardians are concentrated in the age groups 30-49. The percentage of the guardians to teenage mothers in school who are in the age-groups 30-49 add up to 71 percent. There are, however, a few above the age of 60 years. Population distribution for the guardians to teenage mothers out of school shows that most of the population in this group is concentrated in the age group 30-59 (81 percent) and the population above 60 years of age is slightly higher than the guardians to the teenage mothers who had returned to school.

Though the two categories of teenage mothers come from similar background, the teenage mothers who had returned to school had a comparative advantage in terms of age distribution over those who never returned to school. About 83 percent of the guardians of teenage mothers in school are still energetic (20-49) and in the most productive age group. They are below the retirement age of 55 years in Zambia hence, the probability of being in productive employment is higher than for the guardians of those who never returned to school. About 61 percent of the guardians of teenage mothers who never returned to school are in productive age group while 39 percent are in the retirement age group.

Children born to teenage mothers have numerous social and emotional problems which can impact negatively on their future growth and intel performance. These children require good parenting skills which may not be well applied if foster parents are too young or too old.

4.2.2 Sample Distribution by Marital Status

Table 4.2 shows population distribution by marital status of the guardians to teenage mothers in and out of school.

Table 4.2: Sample Distribution by Marital Status

Marital status	Returned to school		Never Returned	
	Frequency	**Percent**	**Frequency**	**Percent**
Single	15	18	13	15
Married	54	64	56	66
Widowed	11	13	14	16
Separated	0	0	1	1
Divorced	5	6	1	1
Total	**85**	**100**	**85**	**100**
Sex				
Female	46	54	34	40
Male	39	87.5	51	88.8

Source: Field data

The information presented in Table 5.2 shows that the proportion of married guardians dominates in both groups. For the category of teenage others who returned to school, the proportion of guardians who are married accounts for 64 percent while for those who never returned accounts for 66 percent. In terms of marital status by sex, 54 percent of females in the category of the teenage mothers who had returned to school at the time of the survey were married while 40 percent of females in the other group were married. The proportion of married males in the category of teenage mothers in school accounts for 87.5 percent while in the group of the teenage mot who never returned to school, married men account for 88.8 percent. Among teenage mothers in and out of school, the proportion of married females and males had the highest percentage compared to the category of singles, widowed and divorced.

The proportion of married persons is one of important in determining the quality of support and care provided to the young children of teen mothers. The majority of teenage mothers had their babies at a tender age. These lack parenting skills and need close supervision by older women. This means that, the guardians to the teenage mothers are also directly involved in providing care and support to the young children. They play a front-line role in the care and support mechanisms to ensure that the young children are well nurtured and brought up in the environments t contribute to their good health and nutritional status. While teenage mothers currently in school leave their children in

the care of their grandparents and relatives, the teenage mothers who never returned to school also get more assistance from their parents and relatives.

The married guardians are more likely to provide better care than the single, divorced and the widowed. This is because those who are married compliment each other in the support and care of young children. When one partner is committed, the other partner can remain with the young ones and provide adequately for their needs. The time spent in monitoring and caring for the young in families with stable marriages is relatively longer than where there is single parentage and this reduces risks of injuries, disease infections and poor feeding practices (Joseph and Hiedemann, 2002).

The other categories such as the single, widowed and divorced are the major bread-winners for their families and carry out tasks to sustain the livelihood of their families single handedly. Therefore, when they are busy with other errands for the livelihood of the family, care and support of young children usually tend to be left with other children, who are equally young. This increases the risks of injuries, and exposure t environments which make children highly vulnerable to disease infections (Mosley and Chen, 1984).

4.2.3 Sample Distribution by Residence and Household Composition

Table 4.3 shows the distribution of population by residence and household composition.

Table 4.3: Distribution of Respondents by Residence and household head

	Returned to School		Never returned	
Residence	**Frequency**	**Percent**	**Frequency**	**Percent**
Urban	25	29.4	19	22.3
Rural	60	70.6	66	77.7
Total	**85**	**100**	**85**	**100**
Household head	**Frequency**	**Percent**	**Frequency**	**Percent**
Female headed	24	28	23	27
Male headed	60	71	61	72
Child headed	1	1	1	1
Total	**85**	**100**	**85**	**100**

Source: Field data

Residence of respondents is another proxy determinant of the quality of care provided to the children of teenage mothers who are left in foster care while mothers are in school. Urban areas are more likely to have better social amenities than rural areas hence, place of residence indirectly or directly influence the provision of services such as health care, education and people's income levels.

The majority of the respondents came from rural areas and this accounts for 71 percent among teenage mothers who returned to school and 78 percent among those who never returned to school. The proportion of those who live in urban areas is relatively higher among the teenage mothers who returned to school (29 percent) than among teenage mothers who never returned to school (22 percent). Urban areas have better health facilities and the distance to the facilities is relat vely shorter than rural areas. Children in urban areas are more likely to receive better antenatal care services than counter parts in rural areas. Therefore, the children of teenage mothers currently in school are likely to have better health care services than those whose mothers are out of school since they form the majority in the urban areas.

The key aspects of household composition and size are characteristics because they are associated with household welfare. Sex of the head of household is more likely to determine the level of income and the nutritional status of children within the household. Households headed by a male are more likely to have stable income than those headed by females due to socio-economic conditions. Female-headed households are typically poorer than male-headed households. As indicated earlier, women constitute the bulk of people living in poverty in the Sub-Saharan Africa hence, children in female headed household are more likely to have health and nutritional problems (Holmboe and Wandel, 1992).

Table 4.3 shows further that 28 percent of households in the group of teenage mothers who returned to school were female-headed while 71 percent in the same category are male-headed households, and 1 percent was child-headed households. Among those who never returned to school, female-headed households account for 27 percent while male-

headed households account for 77 percent. In both groups, male-headed households were more than the female-headed households.

The results of analyzed data on the household size shows that the average household size in the category of teenage mothers currently in school (8.6) is higher than in the category of teenage mothers currently not in school (7.8). The averages for both categories are higher than the national average of 4.9 persons per household (CSO, 2007). The rural/urban analysis shows that the size of households in both categories is higher in urban areas than in rural areas. This pattern is similar to the findings of the Living Conditions Monitoring Survey Report of 2004 (CSO, 2004).

Economic resources are often limited in larger households and where the size of the household is large, the distribution of household per capita income is relatively small. This affects adversely the general living standards in the households. Crowding in households also can lead to health problems and this can affect the physical development of young children who are highly vulnerable to opportu infections.

4.2.4 Educational Attainment of care providers

Educational attainment of care providers is another key determinant of the quality of care and support provided to young children under foster care. The level of education of the care provider has a significant bearing on the socio-economic status, food security and health and nutritional status of the members of a given family especially the young children. Education attainment is generally associated with improved socio-economic status. Improvement in the socio-economic status of the principal care provider is likely to have a beneficial effect on child's health and nutritional status (Mbango and Namfua, 1992). Educational attainment goes along with a number of benefits and is one of the aspects that bring inequality in any given society. Education provides individuals or society opportunities to improve their living standards, and quality of life. According to Watkins (1999) education, particularly education of girls and women greatly enhances the ability of households to manage health problems, improve nutrition, ensure more effective diagnosis, and demand timely treatment. Table 4.4 presents information on education attainment of care providers.

Table 4.4: Educational Attainment of care providers

Education Level	Returned to School		Never Returned to School	
	Frequency	**Percent**	**Frequency**	**Percent**
Primary	37	44	50	59
Secondary	40	47	25	29
Tertiary	6	7	5	6
never attended school	2	2	5	6
Total	**85**	**100**	**85**	**100**

Source: Field data

The assessment of education attainment between the two groups shows considerable variation. In the group of teenage mothers who never returned to school the proportion of care providers with primary education (59 percent) higher than the group with teenage mothers in school (44 percent). The level of secondary education relatively higher among the care providers of teenage mothers in school, accounting for 47 percent, while among those who never returned is at 29 percent. Though there was no significant difference between those who attained post secondary education in both groups, the percentage of the care providers who never attended school was significantly higher with the care providers for the children of teenage mothers out of school than those in school. Only 2 percent of care providers of children of teenage mothers in school have no formal education compared to 6 percent among teenage mothers out of school.

The difference between the two groups of respondents in terms of educational attainment clearly suggests that the two groups' care and support systems are likely to be different. The higher educational attainment by the care providers for the children of teenage mothers in school suggests improved living standards and quality life among the children left in their care. These care providers more likely to feed the children at the right time and in the right quantities of different classes of food. They are also more likely to detect dangerous signs in children's health thereby have higher ability to manage health problems, improve nutrition, ensure more effective diagnosis, and demand timely treatment than their counterparts in the other group.

4.2.5 Literacy Assessment

In this study, literacy was assessed by the respondent ability to read simple statement in Zambia's official language, English, and the commonly spoken local languages in the district, Chitonga, Bemba and Nyanja. However, Chitonga is the most widely used local language in rural areas of Choma District. Table 4.5 shows the percent distribution of respondents according to their level of literacy.

Table 4.5: Literacy Levels

Ability to read	Returned to School		Never Returned	
	Frequency	**Percent**	**Frequency**	**Percent**
Easily	52	61	39	46
with difficulty	29	34	35	41
not at all	4	5	11	13
Total	**85**	**100**	**85**	**100**

Source: Field data

More than six in ten (61 percent) respondents are lite in the category of respondents whose teenage mothers returned to school compared with more than four in ten (46 percent) care providers of children whose never returned to school. However, about 34 percent of care providers to the children of teenage mothers in school can read with difficulties and 4 percent can not read at all compared to 41 percent and 13 percent respectively in the other group. This means that among teen mothers in school, 39 percent of children are at a risk of receiving erratic care compared to 54 percent of the teenage mothers out of school. The higher risk of improper care rising from inadequate understanding of simple instructions is to a larger extent more likely to prevail among the care providers to the children of teenage mothers out of school.

Assessment of literacy level by residence shows low literacy level among the rural care providers in both groups. This implies that the majority of care providers in rural areas can not read simple sentences or instructions.

The ability to read simple statements is a very important skill required in good child care practices. In urban areas where literacy levels are high, care providers, if the child is

sick, are more likely to administer medicine at the right time and in correct dosages as prescribed by medical practitioners than their counterparts in rural areas. rural areas, the higher level of illiteracy or inability to read puts children at greater risks. The care providers who are illiterate are more likely to fail to administer first aid in case of injuries, poisoning or other problems to the children in their care. These care providers can hardly identify critical signs which may require urgent medical attention thereby a delay for medical attention is more eminent among the literate care providers. Infant feeding practices is more likely to be erratic when the care provider can not read simple instructions. This is because preparation and storage of certain foodstuffs for children require following prescribed steps. Illiterate care providers are more likely not to follow instructions thereby giving foods which may be sub-standard or expired to the children placed in their care.

4.2.6 Employment Status

Employment status is an important variable which determines one's income and standard of living. Income is an important tool in the alleviation of poverty as well as a measure of people's welfare because consumption of goo and services are dependant upon the level of family income (CSO, 2004). Households with stable employment and income are able to control the prevalence of diseases easily and families enjoy quality and nutritious foodstuffs and generally the well being of the family is enhanced. Table 4.6 presents employment status of care providers for both t children of teenage mothers currently in school and those currently out of school.

Table 4.6: Employment Status

	Returned		**Never returned**	
Employment status	**Frequency**	**Percent**	**Frequency**	**Percent**
public service	12	14.1	5	6.1
private sector	6	7.1	9	11
business	28	32.9	34	41.5
none	39	45.9	34	41.5
Total	**85**	**100**	**82**	**100**

Source: Field data

Table 4.6 shows that 21.2 percent of care providers to the children of teenage mothers in school are employed in formal employment (public and private sectors) with stable and regular income compared to 17.1 percent of teenage mothers out of school. The majority of care providers to the children of teenage out of school are in informal sector doing various small scale businesses. various types of business carried out which provide respondents with source of livelihood include poultry farming, gardening, selling milk, subsistence agriculture, saloon, shop keeping, marketeering, basketry and taxi driving. This category of care providers account for 41.5 percent compared to 32.9 percent among the care providers to children of teenage mothers in school. Those not employed at all, account for 45.9 percent and 41.5 percent for the care providers to the children of teenage mothers in school and out of school respectively.

4.2.7 Household Income

In order to establish monthly household income, income from all income generating activities was summed up. This is used to measure the welfare of the household and its potential to support a child in foster care. Four wealth quintiles were established and these are lowest, second lowest, middle and highest wealth quintile as indicated in Table 4.7.

Table 4.7: Monthly Income Levels

	Returned		Never Returned	
Wealth Quintiles	**Frequency**	**Percent**	**Frequency**	**Percent**
Lowest	53	62	66	78
Second	16	19	14	16
Middle	10	12	4	5
Highest	6	7	1	1
Total	**85**	**100**	**85**	**100**

Source: Field data

Those in the lowest quintile have a monthly income of 000 and below. The second lowest quintile comprises households whose monthly income is above K500 000 but less than K1000 000. The households with a monthly income above K1000 000 but less than

K5000 000 belongs to the middle wealth quintile where as those with income more than K5000 000 per month are in the category of the highest wealth quintile.

In terms of income distribution between households with teenage mothers in school and households with teenage mothers out of school, most of the household with teenage mothers out of school fall into lowest wealth quintile (78 percent). As monthly income begins to increase, on the contrary, the number of households with teenage mothers currently out of school begins to decline.

Figure 4.1 shows that the proportion of teenage mothers in school that come from households with higher monthly income are significantly more than households where teenage mothers who are out of school come from.

Fig 4.1: Comparative Analysis of Monthly Income between teenage mothers in and out of school

Source: Field data

Stable and higher monthly income for households where mothers in school come from can be attributed to the higher employment and education status of their parents or guardians. The assistance of some of the teenage mothers currently in school by some organizations paying for their school fees indirectly contributes to the welfare of their children also. The money these teenage mothers are supposed to pay as school fees goes towards the welfare of their children at home. This places children of teenage mothers in school in a better and higher income status than those of teenage mothers out of school. This also suggests improved care and support system among the children of teenage mothers in school.

CHAPTER FIVE: EVOLUTION OF THE RE-ENTRY POLICY

5.1 Introduction

As already observed in Chapter One of this report, pregnancies have been among other things observed to be a major social problem among the juveniles. Teenage pregnancies have been a major set back in the attainment of one of the Millennium Development Goals which promotes universal education (MOE, 1996). One of the priority areas of the MDGs includes the advancement of girl-child education by providing appropriate support systems that provide equal opportunities to both boys and girls in accessing education. However, the vision of promoting girl-child education is being frustrated by high levels of pregnancies among school going children.

Zambia, like any other country in Sub-Saharan Africa, shares similar experiences in terms of teen pregnancies. The majority of teen pregnancies occur among the school going females. Childbearing in Zambia begins early and by the age of 15-19, 32 percent of women will have become pregnant though the levels and trends vary between rural and urban areas (CSO *et al.*, 2003).

The study by Malungo *et al.* (1995) on Out of School Youth reveals that girls stay in school for a shorter period than boys and are victims numerous problems encountered by the out of school youths due to their early departure from the formal school system.

5.2 Levels and Trends of Pregnancies in Zambian Schools

Pregnancies among school going children in Zambia have been an upward trend as shown in Figure 5.1 below. Lack of appropriate data on pregnancies by Ministry of Education before 2000, limits the presentation of leve and trends of pregnancies to the period after 2000. The data on pregnancies in this period can show in retrospect the gravity of the problem of teenage pregnancies among school going children.

Fig 5.1: Pregnancies in Zambian Basic and Secondary Schools by year

Source: Education Statistical Bulletin 2007

Table 5.1 further shows trends and levels of pregnancies by grade in Zambian schools at national level in the years 2005 to 2007.

Table 5.1: Pregnancies in Zambian Schools by Grade and year at National Level

Year	G1	G2	G3	G4	G 5	G 6	G 7	G 8	G 9	G 10	G 11	G 12	Total
2005	14	21	77	381	806	1616	3073	1863	2552	359	618	614	11994
2006	11	34	104	385	883	1696	3425	2153	2690	436	694	622	13133
2007	3	13	82	316	793	1793	3846	2523	3001	377	610	585	13942
Total	**28**	**68**	**263**	**1082**	**2482**	**5105**	**10344**	**6539**	**8243**	**1172**	**1922**	**1821**	**39069**

Source: Education Statistical Bulletin 2007

According to MOE (2005) there were a total of 9 111 pregnancies in the year 2004 in Basic Schools. Educational statistics for 2005 show disparities between rural and urban areas in terms of pregnancy rates. There were more rural pregnancies in Basic Schools (7 706) than there were in Urban Schools (1 405) in the same year. This shows a higher level of education wastage in girl-child education especially that pregnancies are experienced at lower levels of education as shown in Table 4.1. Kelly (1994) states that a rural girl-child is at the most severe educational disadvantage and wastage than boys. Twice as many girls as boys drop out of school during primary cycle. This is even worse in rural areas where 10-20 percent dropout is experienced between grades 1 and 4 (Kelly, 1994). Kelly argues further that the dropout rate increases substentially in grades 5 and 6 especially for rural girls.

Rural provices experience premature departure of girls due to pregnancies to a larger extent.This exercebates female illiteracy rates and has an adverse effect on the management of health status of both the mother and the child. Teenage mothers assume responsibility of looking after infants at a tender age and lack experience of proper child care. The high dropout rates especially in rural areas have quite a number of implications for these periphery or economically depressed areas. The low participation of girls in education subsequently translates into higher fertility rates and poverty levels. The longer the period of exposure to the risk of child bearing that the teenage mothers are exposed to increases the total fertility rate (Lucas and Meyer, 1994).

5.3 Impact of pregnancies on drop-out, progression and completion rates of girls

Table 5.2 presents aggregate drop-out rates by sex for primary, basic and high schools at national level.

Table 5.2: Drop-out Rates at National Level

Grade	Sex	Y E A R S						
		2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
1 - 9.	**Female**	3.9	2.9	3.4	3.0	3.0	2.9	2.7
	Male	3.4	2.4	2.5	2.1	2.2	2	1.7
	Average	**3.6**	**2.6**	**2.9**	**2.5**	**2.6**	**2.4**	**2.2**
10 -12.	**Female**	2.3	2.3	2.9	2.9	2.6	2.1	1.7
	Male	1.5	1.1	1.5	1.3	1.2	0.8	0.6
	Average	**1.8**	**1.6**	**2.1**	**2.0**	**1.8**	**1.4**	**1.1**

Source: Educational Statistics 2008

As indicated in Table 5.2, the drop-out rate for girls generally is higher than for boys at both basic education and high school levels. The variation in the drop-out rate between boys and girls has equally affected the completion rate for girls at the national level. Table 5.3 presents data on completion rates for boys and girls at national level.

Table 5.3: Completion Rate at national Level

Grade	Sex	YEARS						
		2002	2003	2004	2005	2006	2007	2008
1 - 9.	**Female**	31.9	34.8	34.4	39.1	39.3	43.32	46.8
	Male	38.8	41.4	42.8	46.4	47.2	50.73	55.7
	Average	**35.3**	**38.1**	**38.5**	**42.7**	**43.2**	**47.0**	**51.2**
10 -12.	**Female**	11.6	13.0	13.0	15.0	14.8	17.22	18.9
	Male	17.4	18.0	18.4	20.1	20.6	22.24	25.0
	Average	**14.4**	**15.4**	**15.7**	**17.6**	**17.7**	**19.71**	**22.0**

Source: Educational Statistics 2008

The completion rate shows some disparity between boys and girls. The completion rate for girls over the seven years under review has been lower than that of the boys. There are several reasons that are attributed to disparities in drop-out and completion rates for boys and girls.

The cultural and traditional perspective of society on a girl-child has always been negative and in most of the traditional societies, a g l child's education has been given lesser attention than it deserves. Gender biasness, particularly against girls, has always been a major factor in the low enrolment, retention and progression rates of girls in schools at all levels. Girls have been treated as objects of marriage and placed in the subservient position. As Malungo *et al.* (1995) put it, many parents have fears about girls' early pregnancies. The long distances to schools particularly in rural areas disadvantage more the girls than boys in accessing education. These factors entail girls are less valued than boys in many families and left to do house chores while boys are sent to school.

Prior to 1997 re-entry policy, girls who became pregnant while in school were never allowed to continue with their education. The policy of expelling out of school system at that time contributed significantly to higher drop-out rates, low progression and completion rates of girls. As indicated in Table 5.3, the completion rate for girls since 2002 has always been below that of boys. This has a serious implication on the welfare

of women as well as national economic development. Due to their low education status, women are disadvantaged in wage employment and continue to be marginalized in wage employment (Bardouille, 1992).

The benefits of education in improving the overall quality of life multiply with increased participation of girls and women in education. The empowerment of girl-child with education is particularly associated with the significant reductions in infant mortality and morbidity, improvement in family nutrition and health, lowering of fertility rates, improved opportunities in both wage and non wage-sectors (MOE, 1996). According to Odaga and Heneveld (1995) most of the social and econo problems experienced in the Sub Saharan Africa are compounded by the marginalization of women in education. Therefore, female education widens opportunities of girls and enhances freedom of choices and greater participation in decision making. accrued benefits of female education with time began to be recognized and appreciated. The traditional perception of females eventually started to change and the centrality of women's contribution to national development began to be recognized. The education sector began to consider gender concerns in policy matters.

5.4 Policy Changes and Introduction of the Re-entry Policy in Education

Policy changes to enhance equality in education provision began to take in the mid 1990s. According to the Programme for Advancement of Girls' Education (PAGE) Newsletter Vol.1 Issue No.2 of 1997, the Ministry of Education between 1995 and 1997 began to implement gender concerns within the education policy framework. Various projects and activities whose aim and objectives were advance the girl-child's education through equal access, retention and their progression were implemented. Among the most successful projects implemented included PAGE, Zambia Education Rehabilitation Project (ZERP), Action to Improve English, Mathematics and Science (AIMES) and Self-Help Action Plan for Education (SHAPE).

A number of studies were carried out to assess the nature of problems that girls faced in schools. The Comprehensive Education Analysis (CEA) was conducted with the view to ascertain the exact nature and magnitude of the problems affecting girl-child's education

PAGE (MOE), (1997). The recommendations of the research studies undertaken translated into the development of PAGE which was specifically established to address gender inequality in education. Through PAGE, a number of research studies, extensive advocacy and sensitization on behalf of girl-child, education and capacity building were implemented in order to address gender disparities in education (Kelly, 1997).

In 1997, a conference on girl's education was held in Lusaka to consider affirmative actions on the existing gender disparities in education. The symposium's concerns hinged on unbalanced enrolment ratios between boys and girls, drop-out rates, progression and completion rates of girls. Policy changes were effected by the Ministry of Education which was supportive to the advancement of girl education. According to PAGE (MOE) (1997) the most important affirmative actions boldly taken were:

- Implementation of 1:1 girl-boy ratio in 1997 to all entrants to grades 8 and 10.
- Twenty-five (25) percent of government bursaries at the University of Zambia was reserved for female students only while both female and male students were to compete for the remaining 75 percent equally.
- Abolishing of the policy of expelling girls who became pregnant. Since 1997, the government through the Ministry of Education introduced the Re-entry policy which provides for the re-admission of girls that were expelled from school on account of pregnancy.

5.5 Extent to Which Girls Take Advantage of re-entry Policy

Since the inception of re-entry policy in 1997, a considerable number of girls have returned to various schools. Table 5.4 shows the number of girls returning to school against those who fell pregnant by years at national level.

Table 5.4: Pregnancies and re-admissions at national level

Years	2001	2002	2003	2004	2005	2006	2007
Basic School Pregnancies	3,663	4,405	6,528	9,111	12,370	11,381	12,370
Basic School Re-admissions	1,322	1,836	2,626	3,899	4,470	3,870	4,692
High School Pregnancies	765	655	988	1,330	1,572	1,752	1,566
High School Re-admissions	606	505	802	932	1,019	1,082	1,019

Source: Educational Statistics 2007

The statistics on pregnancies and re-admissions at national level show that since 2000 the proportion of girls going back to school is relati ly below the average percentage of the girls who never return to school annually. The pregnancy rate keeps on increasing annually and the pregnancy rates are proportionally higher at basic schools than at high schools. However, the percentage of response to the re-entry policy is proportionally higher at high school level than at basic schools. The pattern of response to the re-entry policy shows disparities by residence also. As presented in table 5.5, while pregnancies are higher in rural areas and lower in urban areas. Re-admissions on the contrary are higher in urban areas than in rural areas.

Table 5.5: Distribution of Pregnancies and Re-admissions by rural/urban

YEAR	PREGNANCIES			RE-ADMISSIONS		
	Rural	Urban	Total	Rural	Urban	Total
2005	7,706 (85%)	1,405 (15%)	9,111 (100%)	2,975 (36%)	1,104 (79%)	3,899 (43%)
2006	8,892 (85%)	1,511 (15%)	10,403 (100%)	3,197 (36%)	580 (38%)	3,777 (36%)
2007	9,940 (87%)	1,441 (13%)	11,381 (100%)	3,230 (32%)	640 (44%)	3,870 (34%)
2008	10,661 (86%)	1,709 (14%)	12,370 (100%)	3,744 (35%)	726 (42%)	4,470 (36%)

Source: Educational Statistics 2008

Since 2000, 86 percent of pregnancies on average have in rural areas and only 14 percent have taken place in urban areas. Out of 86 percent of the pregnancies taking

place each year in rural areas, only 35 percent of gir who became pregnant returned to school compared to 51 percent of girls in urban areas became pregnant and took advantage of the re-entry policy and went back to school to continue with their education. The overall response to re-entry policy at national level accounts for 37 percent only. This is even below the urban response to the re-entry policy countrywide. Therefore, the response to the re-entry policy at national level is below 50 percent. This implies that the majority of the girls (63 percent) are not taking advantage of the re-entry policy.

5.6 Extent to Which Girls Take Advantage of the Policy In Choma District

Table 5.6 below shows pregnancies and pregnancy readmissions in the district by grades and year.

Table 5.6: Pregnancies by grade and year in Choma District

Year	G1	G2	G3	G4	G5	G6	G7	G8	G9	G10	G11	G12	Total
2005	0	0	0	3	16	34	124	99	149	30	19	20	494
2006	0	0	2	1	8	37	93	96	119	10	13	14	393
2007	0	0	0	3	11	31	117	99	125	13	20	12	431

Source: Zambia Annual School Census 2007

The statistical data on occurrence of pregnancies in the district show that there are instances of children getting pregnant even at the lower grades.

In 2005, total pregnancies in Choma District were 494. This accounted for 4 percent of total national pregnancies. Almost a similar trend was observed in the subsequent years, 2006 and 2007 in which pregnancies in the district accounted for 3 percent of total national pregnancies each year.

Even though pregnancy rates are high in the district, e-admissions are relatively lower than expected.

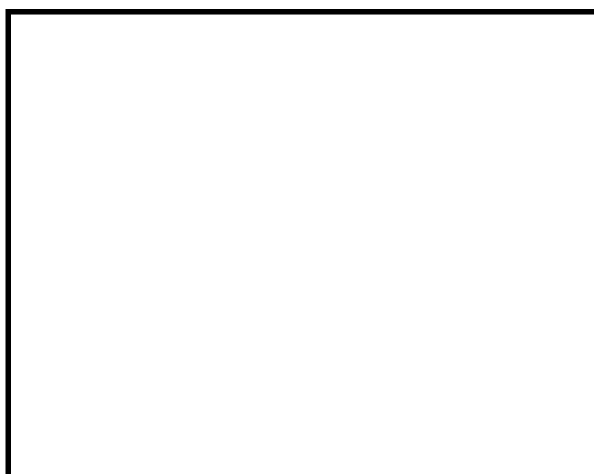
Table 5.7 and Figure 5.2 show pregnancy re-admissions by grade and comparative analysis of pregnancies and re-admissions respectively over a three year period in Choma District.

Table 5.7: Pregnancies by grade and year in Choma District

Year	G1	G2	G3	G4	G5	G6	G 7	G8	G9	G10	G11	G12	Total
2006	0	0	0	0	0	2	12	32	57	10	18	13	144
2007	0	0	1	0	0	0	17	37	63	4	8	9	139
2008	0	0	0	0	0	1	8	39	59	0	6	8	121

Source: Field data

Fig 5.2: Pregnancies and Re-admission Levels in Choma District



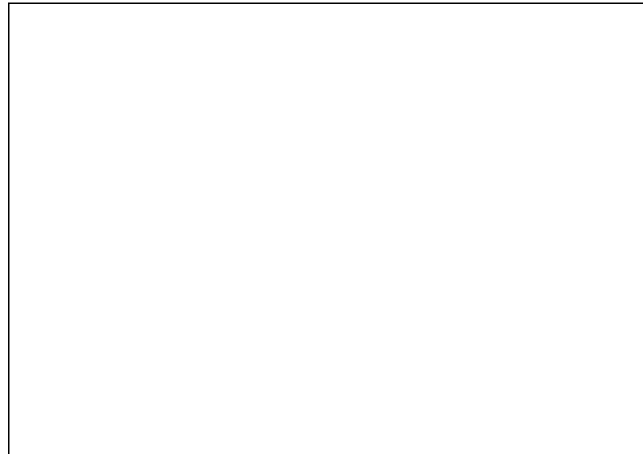
Source: Field data

In the year 2005, only 144 girls returned to school after delivery. This accounts for only 29 percent of girls who fell pregnant in the year who returned to school. In the following years, 139 girls returned in 2006 and only 121 returned in 2007. This accounts for 35 percent and 28 percent of girls who returned to school in 2006 and 2007 respectively. On average each year in Choma District only 31 percent of girls who become pregnant return to school after delivery. This is below the national average of 37 percent. Therefore, the proportion of girls taking advantage of re-entry policy against those who never return to school after delivery in Choma District is very low.

5.7 Factors hindering other girls from going back to school

Several reasons were advanced as to why some girls never retuned to school. Figure 5.3 presents some of the reasons hindering some girls from going back to school despite the introduction of re-entry policy in 1997.

Fig 5.3: Factors hindering other girls from going back to school



Source: Field data

The findings show that the majority of teenage mothers who fail to go back to school are due to financial problems. This accounts for 38.8 percent of teenage mothers who at the time of the survey had never returned to school. Another reason given for not going back to school was that teenge mothers still wanted to take care of their babies. About 37.6 percent of teenage mothers felt that if they went back to school, their children would not be cared for and supported adequately. While 17.6 percent of teenage mothers indicated that their parents are no longer willing to support them, 16.5 percent stated that they are no longer intereted in school. Lack of interest among teenage mothers arise from the fear of being stigmatized, over aged and desire to marry. Some teenage mothers expressed the desire to re-enter school, but due to the parents' desire to marry them off they failed to go back to school. This accounts for 5 of teenage mothers out of school. In traditional society, some parents value the bride price they obtain after marrying off their daughters more than school. Therefore, there is a tendency to marry them off at a very tender school going age. This is more pronounced in rural areas than in urban areas.

The findings show further that 5 percent of the teenage mothers currently not in school are not aware of the re-entry policy. They have the desire to go back to school but are ignorant of policy changes which no longer prohibit girls to go back to school after dropping out due to pregnancy. The 5 percent of the respondents are more likely to come from rural area where policy awareness is not widely campaigned due to limited media publicity and inadequacies by some school administrators in policy intepretations and implementation. This is similar to the findings by Bayona and Kandji-Murangi (1996) where re-entry policy in Kenya almost met resistance due to innefective implementation and interpretation by education providers themselves.

5.8 General assessment of the implementation of re-entry policy in schools

The assessment of the implementation process of the 1997 Re-entry Policy in various schools in the district was based on the guidelines provided by the Ministry of Education. Re-entry policy is a government policy which should be followed by government and government grant-aided or faith-based schools. In Choma District, the following agencies run a number of schools in partnership with government which pays teachers' salaries and provides grants for the running of schools. Mission agencies in partnership with government in the provision of education include the United Church of Zambia (UCZ), Brethren in Christ (BIC), Anglican Church and Pilgrim Wesleyan Church (PWC). The Catholic Church runs a private school for boys only and the assessment of re-entry policy could not be done since there is no provision for female students.

The study generally reveals some disparities in the implementation of the policy between government and grant-aided or mission schools. While in government schools all girls are allowed to re-enter school system, mission or grant-aided schools do not fully support the re-entry policy. The study shows that in some mission schools girls found to be pregnant are immediately sent away and given forced transfer. The government policy of allowing a girl to be in school u to the seventh month of pregnancy, unless due to obstetric complications a medical doctor advises a girl to be given maternity leave early, is not adhered to. According to MOE, FAWEZA and

UNICEF (2004) transfers of girls should not be mandatory, though a girl may choose to transfer to another school. Mandatory transfers still occur in mission or grant-aided schools contrary to the provisions of the re-entry policy guidelines. However, about 25 percent of some grant-aided (mission) schools have adopted flexible attitude and some re-entry girls were allowed to continue with their education.

One of the profound findings of the study was lack of records on pregnancies and re-entry cases in most of the schools. About 30 percent of schools in the district have proper documentation of occurrence of pregnancies and re-entry of girls in the school system. For the 30 percent, 20 percent of the schools with good record keeping are high schools. The deficiency in the recording of such important occurrences can be attributed to incompetence in the Careers and Guidance Department due to lack of trained human resource in the department. Though in al schools Re-entry Policy Guideline documents have been distributed, little has been done to read through and understand the procedures of how implementation should be done.

The role of a trained counselor is very critical if the re-entry policy has to be effected comprehensively in schools. The school counselors are communication link between the school and girls who fall pregnant in schools. About 90 percent of schools in the district rarely conduct serious counseling programmes girls who fall pregnant and re-enter school system. Due to poor data collection on pregnancies and re-entry cases and record keeping, tracking of girls who become pregnant is still a big challenge.

Though some schools through the Parents and Teachers' ssociations (PTA) carry out sensitization programmes about re-entry policy, communication between schools and parents to girls who become pregnant explaining the re-entry policy is rarely done in most of the schools. The inadequate sensitization of parents and girls about the re-entry policy has contributed, to a larger extent, to the low response rate to the re-entry policy by girls who are dropping out of school as a result of pregnancy.

Despite the above observed weaknesses, generally the district is on course of implementing the policy and on the right track of gett back into schools girls who become pregnant.

5.9 The Challenges of Re-entry Policy in schools

There are a number of challenges that were brought forward by the implementers of re-entry policy in schools. These challenges affect school environments and the implementation of the policy. The respondents outlined the following challenges:

- Multiple pregnancies among some girls. Several girls have experienced more than one pregnancy while in school. Such girls are wrong models to the other girls who may misunderstand the re-entry policy.
- Re-entry policy has been abused by some girls. Some girls engage themselves in unprotected sex since they know that they will be given another chance to be in school.
- The re-entry girls are a source of problems in school. These lowered discipline in school because they tend to go out of bounds and influence other girls into promiscuity. Some girls who re-enter school are advanced in age hence they develop sexual relations with some teachers.
- There is lack of co-operation by some parents with school authorities. Some parents do not adhere to the requirements of re-entry policy and instead of encouraging their daughters to go back to school, they marry them off at a very tender age.
- Some girls rarely show up after they have delivered.
- There are instances of stigmatization which contributes to disappearance of some girls from school.

5.10 The Challenges of Re-entry Policy to girls who re-enter school

A number of challenges were sited by girls who go back to school after they have delivered. Some of the challenges include:

- Stigmatization by fellow pupils and some teachers.

- Girls are sometimes disturbed by parents who ridicule them over their left in their care. Babies are sometimes brought crying to ool for breastfeeding. There were instances cited when teenage mothers were disturbed during final examinations by their grandparents who could come and demand for the teenage mothers to come out of examination rooms to take care of their babies.

- Girls are sometimes called back home to take their chi to clinics for treatment and antenatal care services. This affects their learning process and academic performance.

- Finding maids is expensive and difficult for teenage mothers who have limited resources to meet school requirements as well as for their children.

- Some of the re-entry girls complained that they are taken advantage of and abused by some male teachers.

- Lack of facilities in schools to facilitate care of teenage mothers children in school particularly breastfeeding mothers.

5.11 Existing support systems in schools for re-entry girls

The study identified four measures implemented in schools to support the welfare of teenage mothers who go back to school after they have delivered. These are:

1. The teenage mothers in some schools are exempted from n co-curricular activities to help them have more time for their children in the afternoons. The flex-time introduced for babysitting mothers in some schools is a very important approach which improves on the mother-baby attachment. If children are denied opportunities to be with the mother, they become attached to the care providers who may be maids and adopt different social behaviour which may impact negatively on their behaviour when they grow up.

2. Some schools conduct counseling programmes in order to enhance naturalization of the teenage mothers in the school environment in which they come back as mothers.

Through School Health and Nutrition (SHN) activities, teen mothers benefit on how to improve on the health and nutrition status of their children also.

3. Some teenage mothers receive monetary assistance from l wishers to enhance their education. Several organizations have come to the aid of teenage who can not afford to pay for their school fees. Table 5.8 shows sources of support for the welfare of teenage mothers who are currently in school.

Table 5.8: Sources of support for teenage mother in school

Source of support	**Number supported**	**Percent**
Parents	53	62.4
Relatives to teenage mother	24	28.2
Relatives to the child's father	6	7.1
GRZ Bursaries (OVC)	4	4.7
Teen mother herself	3	3.5
Family Health Care	3	3.5
CHANGES	1	1.2
Youth Development Organization (YDO)	1	1.2

Source: Field data

Table 5.8 shows that the larger percentage (62.4 percent) of ort comes from the parents of teenage mothers. Most of the parents have stable employment and better income and are able to pay school fees for their daughters. As indicated in Table 4.7 most of the parents and guardians to the teenage mothers currently in school have stable and higher income than those whose teenage mothers are out of school. They have the capacity to pay for their daughters' education and for the welfare of teenage mothers' children. Relatives also contribute considerably for the welfare of teenage mothers' education and relative support accounts for 28.2 percent. About 4 percent of teenage mothers pay for themselves through small business activities such hair plaiting, gardening and sewing and selling table cloths. Little support comes from the relatives of

the child's father and this accounts for 7.1 percent only. Most of the support from the relatives or parents of the child's father usually comes after they have been confronted by teenage mothers' relatives.

Reacting to the low support from the child's father's one parent whose daughter became pregnant while in school and is among those who returned to school said:

> When you think you have educated your daughter and you expect her to help her brothers and sisters, vultures come and destroy your daughter. What makes me get annoyed is the attitude of these boys who only know how to impregnant someone's daughter but they don't know that we spend a lot to take them to school. Me I took the boy to those who are intelligent and his father was made to sign that they will take back my daughter to school and pay for all her school fees until she completes school.

Other organizations involved in the support of teenage mothers include Family Health Care, CHANGES, GRZ Bursaries and Youth Development Organization (YDO).

5.12 Views of Parents on the Re-entry Policy

There were diverse views with regards to the re-entry policy formulated by the government to enable girls who fall out of school due pregnancy return to school. The majority of the parents interviewed supported the returning of girls who fall pregnant into the school system but they differed on the implementation aspect. However, there were others who do no subscribe to the introduction of re-entry policy. During a Focus Group Discussion (FGD) among parents and guardians, one parent reacted against the introduction of re-entry policy, he said:

> Re-entry policy is not a good system! *lyaba paso lyakuti bana kabaile koona abasankwa* (it is an authority that girls should just be sleeping or engaging in sexual intercourse with boys). These days girls no longer fear to become pregnant because they know that they will go back to school. Look at AIDS! *Muuka oyu ulabamana* (they will perish) because to them it is now a game. This system has come to finish our children (girls).

Most of the parents (58 percent) expressed their view that girls going back to school after they have delivered should not be allowed to re-enter in the regular system but through Academic Production Unit (APU) classes.

One woman in the group argued:

> We have no problem with our girls going back to school. It is time which has changed; children nowadays no longer listen to parents. If we don't take them back to school girls will be behind in education. To help them may be is to take them to 'solar schools' (APU) so that they don't spoil other girls.

One of the parents in the group who had retired from active employment added that:

> There was no problem with the girls being assimilated into the regular education system. If the reasons advanced for not allowing re-entry girls to enter the regular system again were based on disciplinary measures, restraining girls from abusing the re-entry policy and spoiling young girls in school, then I suggest that the decision to make on which system should absorb re-entry girls should be age specific and the number of pregnancies the girl has experienced. I therefore suggest that the girls below the age of 17 should be allowed to re-enter the regular system and any one above 17 should re-enter through APU system. Those who fall pregnant more than once regardless of age should be absorbed in the APU classes.

At the end of the discussion, however, 58 percent of the discussants expressed their view that girls going back to school after they have delivered should not be allowed to re-enter in the regular school system but through APU classes. Thirty-five (35) percent supported the assimilation of teenage mothers through he normal or regular system. About 7 percent argued that the decision to make on which system should absorb re-entry girls should be age specific regardless of whether it is a single pregnancy or multiple pregnancies.

CHAPTER SIX: CARE AND SUPPORT SYSTEMS OF CHILDREN OF TEENAGE MOTHERS IN SCHOOL

6.1 Introduction

The chapter presents the findings of the study on the care arrangements available to the children of teenage mothers when they are at school or otherwise unavailable to provide care themselves. Young children grow up in a multifaceted environment with wide range of risks and this requires a mix of strategies and resources that enhance their well-being. The study identifies and examines existing care and support arrangements, involvement of parents in the care and supportive mechanism, the effect of variables such as income, residence, age of a child, and education on the quality of care systems. The environment in which children are brought up is critically examined to assess its impact on the well being of the young children.

6.2 Childcare and Support System for teenage mothers in and out of school

6.2.1 Types of Childcare system

The study identifies three types of care arrangements the children of teenage mothers in and out of school. The care arrangements include parental relative-care and non-relative care. Parental care strictly refers to the care provided by the biological parents of the child; the mother and the father, either both or as a single parent. Relative care includes care provided by the grandparents of the child, brothers and sisters of the teenage mother and other close relatives such as the aunties and uncles to the teenage mother. Non-parental care refers to the care provided by maids or people not related to the parents of the child. Apparently, there is no government or Non-Governmental Organisations such as orphanages involved in the welfare of children left by teen mothers when they return to school.

Table 6.1 shows care arrangements for the children of mothers currently in school.

Table 6.1: Care systems by teenage mothers in school

Childcare arrangement	Category	Frequency	Percent
Relative Care	Grand Parents	58	72.5
	Bothers and sisters to mother	10	12.5
	Other relatives	6	7.5
Non-Relative Care	Maids	2	2.5
Parental Care	Mothers*	(31)	(39)*
	Father of child	4	5
Total		**80**	**100**

* *Provide care when out of school therefore children in this category are cared for by other care systems.*

Among the teenage mothers in school, relative care dominates other care systems and accounts for 92.5 percent. This implies that 92.5 percent of the children of teenage mothers in school are cared for by their relatives. Regarding the relative-care system, other sub-groups have been identified which include children being looked after by their grandparents and this forms the largest care system within the sub-group at 72.5 percent. While 12.5 percent are being looked after by brothers and sisters to teenage mother, 7.5 percent are cared for by other relatives. Children in the category of non-relative care are being cared for by maids and this accounts for 2.5 percent. Parental care in the category of children of teenage mothers in school is provided by teenage mothers themselves. This is because their children are still young and being breastfed. The teenage mothers still breastfeeding are day pupils in various schools and take care of their babies when they are released from school in the afternoon and weekends. Parental care by the father's child is literally low in this category. This can be attributed to lack of marriage commitment since the girls have been taken back to school by their parents. While the fathers to the children of teenage mothers out of school are involved in caring for their children, among the teenage mothers in school, only 5 percent of the fathers were involved in the care of the children.

Table 6.2 shows care systems among the teenage mothers out of school.

Table 6.2: Care systems by teenage mothers out of school

Childcare Arrangement	Category	Frequency	Percent	Category percent Total
Relative Care	Grandparents	23	28.4	
	Bothers and sisters to mother	1	1.2	
	Other relatives	3	3.7	**33.3**
Non Relative Care	Maids	0	0	0
Parental Care	Mothers	35	43.2	
	Fathers	19	23.5	**66.7**
Total		**81**	**100**	**100**

According to the table, relative care system is less practiced among teenage mothers out of school. In this category, only 33.3 percent of children of teenage mothers currently out of school are cared for by relatives. Twenty-eight (28.4) percent of these children are being looked after by grandparents, 3.7 percent by other relatives and 1.2 percent by brothers and sisters to the teenage mothers. Parental is highly practiced among the teenage mothers out of school (66.7 percent) contrary the teenage mothers in school. Fathers to young children are getting more involved in the care of their children among teenage mothers who are out of school. This is because most of these mothers are either married or there are strong intentions of getting marr to the fathers of their children. Teenage mothers out of school have no obligation with school activities hence they are most of the times available to provide care themselves to the children. Non-relative care is absent among teenage mothers who never returned to school.

6.2.2 Support systems

Support for the children of teenage mothers in and out of school includes financial, material and emotional support which contributes to the well being of a child. The study identifies support provided by the community, Faith-Based-Organizations (FBOs) and individuals. Table 6.3 shows various sectors involved in the support of the c of teenage mothers.

Table 6.3: Support systems of children in and out of school

Source of Support	Returned to school		Never returned	
	Frequency	**Percent**	**Frequency**	**Percent**
Relatives	58	72.5	33	39.5
Father of child/relatives	11	13.7	29	35.8
Community	6	7.5	8	9.9
Political Leaders	3	3.8	8	9.9
Faith-Based Organizations (FBOs)	2	2.5	4	4.9
NGOs	0	0	0	0
Total	**80**	**100**	**82**	**100**

Source: Field data

The data presented in the table shows that the children of teen mothers from both groups receive support from similar categories. The highest support from the two groups comes from relatives and father of the child. There is little support that comes from Faith-Based Organizations and the community. The Non-Governmental Organizations (NGOs) are not involved in the support of the children of teenage mothers who are in or out of school.

The findings of the study reveal that families of children of teenage mothers are the first line of response to the care of young children. Children are absorbed in the extended family system and cared for by various members of the The extended family system provides a better option to enable teenage mothers complete their school life. However, the researcher observed that families are struggling under the strain and failing to provide fully for the children's needs. The study's findings tally with the findings of the study conducted by Williamson (2000) which reveals the weakening of family social support networks because of the impact of HIV and AIDS. Due to HIV and AIDS pandemic, the productive age groups and young men in employment have died. Many households are headed by women and the elderly, who are already at the edge of poverty and these, have to stretch their meager resources further to accommodate additional children.

As shown in Table 4.2, there is an increasing number of children in the care of single parents, who could have lost the other partner, divorced or widowed. This implies tremendous pressure exerted on single parentage system.

The children's care and support system in the study area differ from that of the developed countries. While in the developed countries government, the community and other organizations work as partners in the well-being of children, in Zambia there is no government or Non-Governmental Organization (NGOs) involvement in the welfare of the children of teenage mothers who leave their children when they re-enter school. There is little attention focused on linking child welfare practices with strategies that can effectively address the risks that these young children face and strengthen their families.

The risks of health development are especially pronounced in infants who comprise the largest cohort of young children in developing countries like Zambia. The separation of infants or young children from their mothers at an early stage of development exposes these children to a wide range of risks such as medical, health, emotional and behavioral problems. The inconsistent and unresponsive care giving which they are often subjected to sets the stage for potentially serious emotional and behavioral difficulties and attachment disorders which may impact negatively on societies they grow up in. Children who have spent part of their childhood in foster care are more likely than other children to suffer adverse outcomes such as dropping out of school, teen pregnancy, homelessness and incarceration (Dicker *et al.*, 2002).

In the era where societies are devastated by the HIV and AIDS pandemic and an increasing number of street kids, proper child care and support becomes very critical. The increasing number of teenage mothers leaving their children in other hands is a timely bomb which, if not well handled may drive more children into streets.

6.3 Extent to which Father of children get involved in supporting their children

In order to establish the extent to which partners get involved in the support of their children, it is worthy to discuss their characteristics to determine their parenting potential and ability. Variables such as the education, occupation, marital status of the people responsible for teenage mothers' pregnancies wi l be analyzed since they can influence parenting skills and ability. Table 6.4 shows characteristic background of partners responsible for the pregnancies.

Table 6.4 Characteristics background of partners

Background Characteristics of persons responsible for pregnancies	**Returned to school**		**Never returned to school**	
Those responsible for pregnancies	**Frequency**	**Percent**	**Frequency**	**Percent**
Partner	63	74.1	53	64.7
Mere friend	18	21.2	21	24.7
Relative	3	3.5	9	10.6
Raped	1	1.2	0	0
Total	**85**	**100**	**83**	**100**
Marital Status				
Single	68	80	59	69.4
Married	16	18.8	26	30.6
Divorced	1	1.2	0	0
Total	**85**	**100**	**85**	**100**
Education Level				
Never been to school	1	1.2	2	2.4
Primary	13	15.3	22	25.9
secondary	63	74.1	57	67
Post Secondary	8	9.4	4	4.7
	85	**100**	**85**	**100**
Occupation				
None	25	29.4	30	35.3
Still in school	34	40	21	24.7
Small Scale Business	9	10.6	20	23.5
Private Sector	10	11.3	9	10.6
Public sector	7	8.2	5	5.9
Total	**85**	**100**	**85**	**100**

Table 6.4 Characteristic background of partners continued				
Age-Group				
17-20	21	24.7	27	31.8
21-24	43	50.6	37	43.5
25-29	13	15.3	17	20
30-34	4	4.7	2	2.4
35-39	3	3.5	2	2.4
40-44	1	1.2	0	0
Total	**85**	**100**	**85**	**100**
Marriage intentions				
Never intend to marry	59	69.4	43	50.6
Intend to marry	19	22.4	22	25.9
Married	5	5.9	17	20
Not yet decided	2	2.4	3	3.5
Total	**85**	**100**	**85**	**100**
Reaction of male partner to pregnancy				
Accepted	75	88.2	72	84.7
Rejected	7	8.2	9	10.6
Disappeared	3	3.5	4	4.7
Total	**85**	**100**	**85**	**100**
Extent of support by male partner				
Never give support	76	95	52	64.2
Give support	4	5	29	35.8
Total	**80**	**100**	**81**	**100**

Source: Field data

Analysis of pregnancies among teenage mothers in Table 4 shows that girls are usually made pregnant by their partners or boyfriends, mere fr relatives, and unknown or known people through forced sex. The majority of the pregnancies are caused by arranged sex with partners. A comparison between teenage mothers in school and those out of school shows that 74.1 percent of teenage mothers in school were made pregnant by their partners (boyfriends) compared to 64.7 percent among those out of school. Sexual relations with mere friends or non boyfriends rank second in pregnancy rates among school girls in Choma District while pregnancies resulting from sexual relations with relatives rank third. The study revealed that sexual relations with relatives occur in

extended family settings. The traditionally constructed "wife and husband" phenomenon among cousins sometimes tends to be abused and end up pregnancies within a household. Some pregnancies experienced were also between brothers-in-laws and sisters-in-laws. The study revealed further that some pregnancies among school girls are due to peer pressure. Innocent girls are lured into anti-social behavior and truancy and influenced to go to drinking places or guest houses where they are introduced to elicit drinks and become sexually abused under the influence drugs added into beer, or beer, particularly *tujilijili,* (packs of strong alcohol) into soft drinks for those who do not take beer.

During the in-depth discussion one re-entry girl had this to say on how she became pregnant:

> I had sex for the first time with a man I didn't know. My friend persuaded me to escort her into town one weekend. We went out of bounds to see her boyfriend who later took us to a guest house. He introduced me t another friend. I can't remember what happened after taking soft drinks; I only found myself alone and naked in one of the rooms in the guest house the following morning. Later I discovered I was pregnant and I was expelled from school. I was only told what happened by the same friend who took me to town when the baby was two years and that is when I came to know the father of my baby. I hate him so much.

Table 6.4 shows further that the majority of the people responsible for the pregnancies have at least attained secondary education. However, 40 percent of those responsible for pregnancies among teenage mothers in school are still boys compared to the 24.7 percent among teenage mothers out of school. This implies limited parenting capacity for these boys since they equally still depend on their parents for livelihood and other school requirements. The support given to their children is highly limited and this means that the parents to the person responsible for the pregnancy play double role of looking after the teenage father's school welfare as well as supporting the teenage father's child. The limiting factors to supporting their children among still school going teenage fathers

is limited income and are still too young to bear the responsibility of after their children.

Table 6.4 also shows that although most of the teenage mothers were made pregnant by males in their age-group who may have completed secondary education recently or still in school, some girls however, were made pregnant by elderly partners or friends who were already married. Among teenage mothers in school, 18.8 percent of teenage mothers were made pregnant by males who were already married compared to 30.6 percent among teenage mothers out of school. Most of married men use sex outside marriage with young girls for personal satisfaction and fulfillment of misconceptions about the cure of HIV and AIDS. They rarely think about the consequences that come thereafter.

The study shows that there is very low support of children among married men. Only three married men (3.75 percent) are involved in the support of the children they have with teenage mothers in school.

Support of a child by an already married man can be influenced by a number of factors. These factors can be income of the man responsible, ag fference between the man and a girl, the acceptability of the pregnancy to the man, his intention to marry the teenage mother and the acceptability of the teenage mother to the wife or wives of the person who made her pregnant. The fear of the reaction of the wife or wives at home compel some men to ignore children born out of the matrimonial home.

When the teenage mothers were asked whether the persons responsible for the pregnancy intended to marry them or not, 22 percent of them had intentions of marrying the teen mothers in school while 71.8 percent had no intentions of marrying the girls and 6.2 percent had not yet decided whether to marry the girl or not. Among the teenage mothers out of school 20 percent of them had already married the persons responsible for their pregnancy and 26 percent had strong intentions to marry them.

The assessment of variables such as marital status of person responsible, child's father's occupation, child's father 's education level, their to marry teenage mothers,

reaction of person responsible after being told that the girl was pregnant and support given to children reveal very interesting information.

Multiple regression analysis was done to asses the variables affecting support of children among men who make school girls pregnant. Table 6.5 presents the results of multiple regression analysis.

Table 6.5 Variables affecting support of children by men responsible for pregnancy

Variables	Unstandardized Coefficients		Standardized Coefficients	t-test	Sig.	95% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	1.098	.354		3.100	.003	.392	1.804
Marital status of person responsible	.003	.099	.004	.031	.975	-.195	.201
Child's father's occupation	-.003	.035	-.011	-.094	.926	-.073	.067
Child's father educ. level	-.012	.105	-.013	-.111	.912	-.221	.198
Intending to marry	.248	.126	.233	1.958	.054	-.004	.500
Reaction of person responsible	.100	.130	.091	.766	.446	-.160	.360

Source: Field data

The results of the multiple regression model at less than 10 percent show positive correlation between intentions of marrying the mother of a child and the support given to the child. Men with an intention to marry the mother are more likely to support the child than those without such intentions. There was a weaker correlation between the reaction of the person responsible for the pregnancy, the marital status of a person and the support rendered to the child. The education level and the occupation of the father of the child married have a negative correlation on the support the father gives to his child born to a teenage mother. The more educated the fathers become and the higher the profile of jobs they posses usually have no intention of marrying school girls because they are in the lower social and academic status than themselves. The overall prevalent factor that influences support for the children by persons responsible for pregnancy was the intention to marry the girl.

The assessment of the extent to which fathers are getting involved in the support of their children shows an irresponsible behavior by the majority of them. Among teenage mothers currently in school only 5 percent of the fathers are involved in the care and support of their children compared to 35.8 percent among the fathers to the children of teenage mothers currently out of school. Almost 95 percent of fathers among teenage mothers in school do no render any support to their children compared to 64.2 percent among those who never returned to school. Grandparents in most cases take responsibility of up-bringing their grand children. The findings of the study are similar to the findings by Hamusonde (2003) and Njau and Wamuliu (1994).

The low level of support observed among children of teenage mothers in school is associated with the intervention put by the parents of the young girls who fall pregnant while in school. Parents do not want to marry off their daughters before completing school. They prefer their children to continue with school and break off relationship with their boyfriends. Because partners are denied chance to marry these girls, they rarely support their children. The other factor contributing to low support of their children hinges on low income base among teenage fathers who are still in school. Forty (40) percent of teenage fathers are still school going young males and are in the dependant age-group. These have no financial resources of their own for the support of their children. The children born out of rape or forced sex are most l ly to receive less care and support from the perpetrators of rape. Among the teenage mothers who never returned to school, the proportion of those who marry the fathers of children (20 percent) is high compared to 6 percent among those in school. This explains why even the support given to their children is quite high.

6.4 Environment and Child monitoring

The environment in which children grow is one of the important determinants of children's health. Keeping the child and its direct environment clean is very critical in reducing occurrence of diseases, injuries, and infant and child mortality. In order to critically assess the health status of the children of teenage mothers currently in school, the nature and types of houses in which the children live were examined. Crowding in houses and rooms in which children sleep is another variant that can directly affect the

child's health and may lead to faltered growth. Table 6.6 presents the nature of environment in which the children of teenage mothers currently in and out of school are being brought up.

Table 6.6: Environment in which children live in

Environment in which children live in		Returned to school		Never returned to school	
		Frequency	**Percent**	**Frequency**	**Percent**
Type of wall	Bricks	48	60	64	79.0
	Pole and mud	3	3.8	3	3.7
	Grass hut	3	3.8	1	1.2
	Plastered with cement	26	33	13	16.0
	Total	**80**	**100**	**81**	**100**
Type of roof	Iron roof	43	53.8	24	29.6
	Grass thatched	27	33.8	48	59.3
	Tent	1	1.3	0	0.0
	Tiles	1	1.3	0	0.0
	Asbestos	8	10.0	9	11.1
	Total	**80**	**100**	**81**	**100.0**
Type of floor	Natural (earth/sand)	30	37.5	56	69.1
	Tiles	3	3.8	1	1.2
	Cement	45	56.3	23	28.4
	Carpet	2	2.5	1	1.2
	Total	**80**	**100**	**81**	**100**
Number of sleeping rooms	1	16	20	41	50.6
	2	22	27.5	17	21.0
	3	32	40	12	14.8
	4	8	10	10	12.3
	5	1	1.3	0	0.0
	6	1	1.3	1	1.2
	Total	**80**	**100**	**81**	**100**
Number sharing bedroom with Child	1	4	5	7	8.6
	2	24	30	25	30.9
	3	33	41.3	26	32.1
	4	15	18.8	17	21.0
	5	3	3.8	2	2.5
	6	1	1.3	2	2.5
	7	0	0	1	1.2
	8	0	0	1	1.2
	Total	**80**	**100**	**81**	**100**

Table 6.6: Environment in which children live in continued					
Sharing beddings with child	yes	41	51.25	26	32.1
	no	39	48.75	55	67.9
	Total	**80**	**100**	**81**	**100**
Adequate clothes/ Beddings for warmth	yes	47	58.75	38	47.5
	no	33	41.25	42	52.5
	Total	**80**	**100**	**80**	**100**
Source of dinking Water	piped	11	13.75	10	12.3
	public tap	11	13.75	3	3.7
	traditional well	5	6.25	4	4.9
	shallow well	6	7.5	10	12.3
	river/stream	8	10	16	19.8
	bore hole	39	48.75	38	46.9
	Total	**80**	**100**	**81**	**100**
Type of toilet facility	own flush	10	12.5	5	6.2
	shared flush	4	5	2	2.5
	own pit	40	50	34	42.0
	shared pit	23	28.7	34	42.0
	No facility/bush	3	3.8	6	7.4
	Total	**80**	**100**	**81**	**100**
Child monitoring	always	31	39.2	55	69.6
	rarely	47	59.5	22	27.8
	never	1	1.3	2	2.5
	Total	**79**	**100**	**79**	**100**
Staying with the child	always	9	11.4	56	70
	frequently	22	27.8	15	18.8
	rarely	47	59.5	9	11.3
	never	1	1.3	0	0
	Total	**79**	**100**	**80**	**100**

Source: Field data

The analysis of the type of wall of the houses, in which the children of teenage mothers in and out of school live, shows that the majority of these children live in house made

of bricks but not plastered. Among teenage mothers in ol, 60 percent of their children live in houses made of bricks which are not plastered compared to 79 percent of the children of teenage mothers out of school. The children who live in houses with well plastered walls account for 33 percent for the children of teenage mothers in school compared to 16 percent of the teenage mothers who are ut of school. Houses made of grass, mud and poles and those with walls which are not plastered are good hiding and breeding places for insects such as bed bugs, lice, and others which can cause various diseases and skin disorder in young children. Percentage distribution of the types of wall presented in Table 6.6 shows that 67.7 percent of children of teenage mothers in school who live in grass structures, mud and poles and unplastered houses are at a risk of contracting diseases and skin disorder caused by various insects compared to 83.9 percent of those of teenage mothers out of school.

Table 6.6 shows that 37.5 percent of the children of teenage mothers in school live in houses with natural (earth/sand) floor compared with 69.1 percent among the teenage mothers out of school. About 56.3 percent of teenage mothers' children in school live in houses with floor made of cement while among the teenage mothers out of school 28.4 percent live in houses with floors made of cement. Natural floors accumulate a lot of dust and when kept dump they become ideal places for development of harmful bacteria and germs. Diseases such as flue, worm infection and cough are common in earth/sand floors when humidity and dust are high.

The cross tabulation of prevalence of diseases and the type of the floor variables showed that coughing was more frequent in houses with natural floor and cement. The incidence of coughing was lower in houses with floors with tiles and carpets. The high incidence of coughing in natural and cement floors can be attributed to low hygienic levels maintained in most of such households. The high dust content and crowding in houses contributed to occurrence of higher levels of coughing. Tiled and carpeted floors are usually associated with high social and income status a household. In these households, people are able to employ maids to help maintain the cleanliness of the house and this explains lower incidences of flue and cough in tiled and carpeted floors.

The researcher observed that it was a common practice that single roomed houses were partitioned by *chitenge* cloth to separate sleeping space from a living room. The same living room, which may have walls decorated with reed mats and locally made plastic flowers, were used as a storeroom for mealie meal, water and cooking utensils. This type of environment, if not well maintained, can be a source of harmful bacteria and spread of communicable diseases.

The study reveals further that there are instances of sharing the bedroom and beddings of a child with other users such as visitors in both categories. This shows that children in both categories are at the risk of contracting communicable diseases due to high incidence of sharing a bedroom and child's beddings with visitors. The high instances of sharing of beddings and bedroom with small children in urban areas can be attributed to regular visits by rural dwellers to relatives in urban areas. These come from different and low hygienic places and are potential carriers of various communicable diseases.

Sanitary reforms, which include provision of sewage disposal (availability of toilet facilities), and clean water, and child monitoring are some of the important determinants of infant and child survival.

It was observed further that although the common urban source of drinking water include piped or tap water, shallow wells are also used as source of water especially in shanty compounds. Such sources of water put children at a higher risk of contracting diarrheal diseases due to poor sewer and solid waste management experienced in towns. In rural areas sources of drinking water included boreholes, open wells, rivers and streams. When asked how often they treated drinking water either by boiling or adding chlorine, rural residents never boil or treat drinking water with chlorine. In urban areas, there were instances of treating water by boiling as well as chlorinating in some households. Other households indicated that they depen on water treatment done by the Southern Water and Sewerage Company (SWASCO).

Toilet facility is one of the critical facilities needed if diseases such as diarrhea and cholera are to be controlled and minimized. According Table 6.6, households with teenage mothers currently in school account for 12.5 percent of own of flush toilets

compared to 6.2 percent for households with teenage mothers out of school. Own pit latrines account for 50 percent among households with mothers in school compared with 42 percent of those out of school. However, shared pit latrines and lack of toilet facility is commonly practiced among households with teenage mothers out of school. Shared pit latrine ownership accounts for 28.7 percent in households where teenage mothers in school compared with 42 percent where teenage mothers out of school are. Poor toilet facilities were observed to be higher in rural areas than urban areas and rural areas apparently have the majority of children of teenage mothers who out of school. Table 6.7 shows the prevalence of diarrheal disease by source of drinking water and toilet facility.

Table 6.7: Prevalence of diarrheal disease

Source of drinking water	**Diarrheal frequency**	**Diarrheal Percent**	**Toilet facility**	**Diarrheal Frequency**	**Diarrheal Percent**
Piped (Tap water)	17	10	Own flush toilet	2	1
Shared or Public tap	58	35	Shared flush toilet	66	40
Shallow well	63	38	Own pit latrine	5	3
River/stream	25	15	Shared pit latrine	56	34
bore hole	3	2	No facility/bush	36	22
Total	**165**	**100**	**Total**	**165**	**100**

Assessment of the prevalence of diarrheal diseases by urce of drinking water shows highest incidence of diarrheal among children of teenage mothers where households use shared or public tap and shallow wells at 35 percent and 38 percent respectively. This is followed by households whose source of water is rivers and streams. Tap water accounted for 10 percent of diarrheal incidence and the lowest was from water from the bore holes. The sources recording high incidences of diarrheal disease are highly prone to contamination due to poor sewer disposal system. Piped water becomes dangerous when there are leakages which can allow entrance of bacterium from solid wastes and urine.

Assessment by toilet facility showed high incidence of diarrheal disease reported from households using shared flush toilets (40 percent), shared pit latrines (34 percent) and where there was no toilet facility (bush) (22 percent). Shared toilet facilities are open to many people. This makes them vulnerable to various diseases. Human waste deposited in open bushes, if not buried, allows flies to come in contact with them. The flies then carry germs and bacteria into foodstuffs consumed by young ones who later develop diarrhea after eating the food.

Child monitoring is one of the measures which is very important in the prevention of injuries and contraction of some of the diseases such water borne or those contracted by direct contacts with patients or environments which may result in contracting a disease.

As shown by Table 6.6 child monitoring among teenage mothers out of school is better than those currently in school. This can be attributed to the absence of the mother and children may be left in the care of other children when the principal care taker becomes busy with other activities to earn a living. This puts the young children to high risks of personal injuries and contracting other diseases (Mosley and Chen, 2004).

Personal observations by the researcher on the monitoring of the children among teenage mothers out of school revealed that most of these teenage mothers are marketers who carry with them their babies into the markets. Children play around market places which are full of garbage. Despite the claim that they stay with their children regularly, they are equally at the same risk of sustaining injuries and contracting diseases. This puts a general challenge on teenagers having children before they are economically ready to support such children.

CHAPTER SEVEN: HEALTH AND NUTRITIONAL STATUS OF CHILDREN

7.1 Introduction

The chapter discusses the health and nutritional status of the children left by mothers who returned to school after delivery. A comparative analysis is done between the children of the mothers who returned to school and those who never returned to assess the impact of re-entry policy on the health and nutritional status of children whose mothers returned to school.

Child health and nutritional status is one of the critical parameters that directly indicate the well being of the current population as well as that of posterity. According to CSO (2004) child nutrition and health problems directly indicate food scarcity, limited dietary diversity and lack of appropriate environments in supp of child health in a given population.

In order to assess the health and nutritional status of children left by the mothers who returned to school, the study collected information for all living children on their immunization coverage, prevalence of diarrhea, pneumonia, malaria, child feeding practices and anthropometric data (age, height and weight) to assess the nutritional status of children.

7.2 Children's health care

Children are at the risk of being infected by childhood infectious diseases such as mumps, measles, chicken/small pox, whooping cough, gastroenteritis, diphtheria, tuberculosis (TB), tetanus, and polio. These diseases can be spread from one another in various ways and can be fatal if not properly managed. Therefore, to protect babies and children from the infectious diseases, immunization or vaccination of the children is very critical.

7.3 Immunization coverage

Immunization is one of the widely used public health strategy for the prevention of vaccine-preventable diseases. In order to reduce the burden of diseases and ultimately child morbidity, vaccination against communicable diseases has been one of the major

interventions taken by the government to promote good child health and reduce infant and child mortality. Vaccinations against communicable diseases take place nearly all health centres in Zambia. Mothers go through antenatal lessons on maternal and child care practices to help them look after themselves and their babies during pregnancy and after delivery. Each child is provided with an antenatal or clinic card in which the child's weight is recorded to monitor its growth. For children whose mothers had either lost the clinic card or had no clinic card at all, information obtained on child vaccination or immunization was based on mother's knowledge. The mother supplied information by recalling the child's history of vaccination. Those with clinic cards information on child vaccination was copied from the clinic cards to the questionnaires.

According to CSO *et al.* (2007), a child is considered to be fully immunized when he/she has received one dose of BCG, a vaccination against tuberculosis (TB), three doses each of DPT and polio vaccines and one dose of measles vaccine by the age of 12 months

Table 7.1 presents immunization coverage among children aged 12-59 months of teenage mothers in and out of school. The age cohort 12-59 months was used to establish levels of immunization or vaccination coverage in this study because going by World Health Organisation (WHO) guidelines, a child is assumed to have received all vaccinations by the age of 12 months. In this study, all the children observed were under the age of 5 years hence 59 months was used as the upper age limit in months. Table 7.1 shows percentage distribution of immunization among mothers in and out of school.

Table 7.1 Immunization coverage of children aged 12-59 months among the Teenage mothers in and out of school

Immunization Coverage	**Returned to school**		**Never returned**	
	Frequency	**Percent**	**Frequency**	**Percent**
Fully Vaccinated	42	63.6	37	68.5
Partially vaccinated	24	36.4	17	31.5
Total	**66**	**100**	**54**	**100**

Source: Field data

According to the data in Table 7.1, 63.6 percent of the children aged 12-59 months of mothers in school were fully vaccinated against various communicable diseases. Among the children out of school, 68.5 percent of the children aged 12-59 months were fully vaccinated. Immunization coverage among the children whose mothers returned to school is slightly lower than those whose mothers did ot. This implies that the proportion of children exposed to the risk of being infected by communicable diseases is higher among teenage mothers currently in school. The absence of the mother affects the immunization of children especially the children who are no longer being breastfed.

Full vaccination against preventable diseases gives protection against infection and spread of preventable diseases. Partial vaccination is very dangerous and puts a child at risk of dying from the disease being immunized against. When a child is subjected to partial vaccination, the immune system is compromised nd once infected, treatment of the disease becomes complicated.

7.3.1 Immunization coverage of children 0-24 months by educational status of care provider

Analysis by educational status shows a close correlation between the education of care provider and vaccination coverage. Figure 7.1 shows child vaccination by educational status of care provider.

Figure: 7.1: Vaccinations by Education level of care provider

Source: Field data

As indicated in Figure 7.1, immunisation increases with the level of education attained by the care provider. Care providers with higher levels of education are more likely to take their children for vaccinations than those with lower education level. The care providers that have never been to school and those with primary education have 50 percent level of immunisation each while those with secondary and tertiary education have 63 percent and 67 percent levels of immunisation respectively.

Immunization is very critical in the reduction of child and infant mortality. Where immunization is scarcely carried out, infant and child mortality have been observed to be higher (UNDP, 2003). Education is empowerment, hence, educated care providers are not only better able to gain information about health and nutrition, but are also far more likely to make use of preventive health-care services, thereby reducing the risk of infectious diseases (Watkins, 1999). The risk of child infection and infant mortality is more likely to be higher among care providers with low education levels.

The research findings agree with the study by World Bank and UNICEF in Mali, Bolivia, Nepal, Zambia, Ghana and the Philippines in which education had profound influence in reducing child mortality by 8 percent and an increase in use of healthy facilities by more than 70 percent for each additional year of education to the care providers particularly education of mothers. As the level of education increases, care providers are more likely to register for ante-natal care and more likely to immunise their children than those with low or no education at all (Watkins, 1999).

7.3.2 Immunization coverage of children aged 0-59 months by residence

Table 7.2 presents data on vaccination levels by residence of the care provider. Comparisons by rural and urban immunization coverage show notable differences with higher immunization coverage in the urban areas than in the rural areas. Urban immunization coverage accounts for 56 percent of fully immunized children as opposed to 51 percent in rural areas.

Table 7.2: Vaccinations by Residence

Immunization coverage Levels	Residence				Total	
	Urban		Rural			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Fully vaccinated	14	56	28	51	42	53
Partially vaccinated	11	44	27	49	38	47
Total	**25**	**100**	**55**	**100**	**80**	**100**

Source: Field data

Low vaccination levels in rural areas can be attributed to the low education attainment of women and social and cultural influences in these economically disadvantaged areas. The proportion of women in rural areas who are in the lowest education level is relatively higher than the proportion of women in the areas. The proportion of women in the low education level in rural areas conversely forms the majority of infant and child care providers. Cultural influences apparently seem to be stronger in rural areas than in urban areas. Most of the girls are forced into early marriages before their physiological body mechanism is ready for the immense of providing care for children. Early marriages rob these girls of opportunities to excel higher in education and such incidences result into low participation of women in income generating activities, productive capacities and decision making. Cultural social constructions which place women in subservient position are more pronounced in rural settings than in the urban areas. The subservient position women occupy is another factor contributing to low vaccinations in rural areas. Women in rural areas little or no opportunities to make their own decisions especially during the rainy season when agricultural activ es take precedence over child vaccinations.

When asked why children miss vaccination schedules, one mother said:

> During the farming season my husband rarely allows me to take the child to antenatal clinics for vaccination. We are kept busy working in fields and this creates vaccination lapses or completely abandoning the exercise.

Immunisation controls illnesses and prevents the spread of diseases. When vaccination of diseases is low the probability of getting infected with preventable diseases becomes high thereby increasing disease burden in a given population. Children who do not consistently receive antenatal care services and vaccinations are more likely to have faltered growth and infected by diseases such as TB, polio or measles.

7.3.3 Immunization coverage by sex of care provider and head of household

Immunization coverage as revealed by the study is also influenced by the sex of the care provider and the head of the household. Table 7.3 shows percentage distribution of levels of child immunisation by sex of the care provider.

Table 7.3: Child-vaccinations by Sex of care provider

Immunization coverage Levels	Sex of care provider				Total	
	Female		Male			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Fully vaccinated	33	55	9	45	42	53
Partially vaccinated	27	45	11	55	38	47
Total	**60**	**100**	**20**	**100**	**80**	**100**

Source: Field data

According to the results in Table 7.3, female care providers are more likely to take children to the antenatal clinics for immunisation than male counterparts. In households where the care provider is female, percentage of fully vaccinated children accounts for 55 percent while for male care providers, fully vaccinated children is at 45 percent. This shows that children who are cared for by males are at a higher risk of contracting infectious diseases than those whose care is provided females. Table 7.4 presents levels of vaccination by head of household.

Table 7.4: Vaccinations by head of the household

Immunization coverage Levels	Sex of care provider					
	Female-headed		Male-headed		Child-headed	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Fully vaccinated	17	71	24	44	0	0
Partially vaccinated	7	29	31	56	1	100
Total	**24**	100	**55**	**100**	**1**	**100**

Source: Field data

Data in Table 7.4 shows that when the head of a household is female, vaccination of children tends to be higher than where the head of household is either male or a child. The highest risk of contracting preventable infectious diseases, regardless of sex, is in a child-headed household. In female-headed households vaccination of children is higher by 27 percent than in male-headed households. Females are more attached to the nurturing of the family than the males. Females are more exposed to antenatal lessons related to child care during antenatal and postnatal clinics than men. Male counterparts rarely attend antenatal and postnatal clinics. This limits their understanding of the importance of child vaccination. Males usually become busy with survival strategies for the family and this in most cases compels males to leave infants and children in the care of fellow young children who may not follow strictly the vaccination programmes of young children if no elderly person is present to remind them to go to a health facility.

7.3.4 Specific Vaccinations

Vaccination against specific diseases was also taken into consideration. Table 7.5 shows data on percentages of children aged 0-59 months who had received specific vaccines at the time of the research.

Table 7.5 Percentage Distribution of Specific Vaccinations

	BCG	POLIO	DPT	MEASLES
Returned	94%	94%	93%	75%
Never returned	99%	95%	93%	72%

Source: Field data

According to the data in Table 7.5, among the teenage mothers who had returned to school, 94 percent of their children aged 0-59 months received BCG vaccine while among teenage mothers who never returned to school BCG vaccination accounted for 99 percent. Among the teenage mothers in school, 94 percent had received polio vaccines compared to 95 percent among the children of teenage mothers who never returned to school. DPT vaccinations accounted for 93 percent to both groups while measles vaccination level was higher with the children of teenage mothers who had returned to school at 75 percent compared with 72 percent among the children who never returned to school.

According to WHO guidelines for child vaccination, the BCG immunization takes place at birth and protects babies against tuberculosis. When the baby is 2 months old, it is given the first doses of DPT and polio to prevent the by from contracting infectious diseases such as diphtheria, whooping cough (pertussis) tetanus and polio. The second doses of DPT and polio are given at 3 months after the last ones. At 9 months of age, a child should be vaccinated against measles. The DPT and polio boosters are given to children when they are 18 months old (CSO *et al.*, 2001-2002). Booster doses are needed for long-lasting immunity. The last prevention of diseases by immunization is done at 6 years old when the child receives BCG revaccination and DPT and polio boosters.

Immunisation, except for measles, is generally high among the children whose mothers never returned to school. However, in both groups children have been adequately vaccinated against all dangerous diseases which have higher likelihood of causing infant mortality.

7.4 Child Feeding Practices

7.4.1 Breast Feeding and Supplements

Breastfeeding is beneficial to both the mother and the child. Chisumpa (1996) states that human milk biologically provides both nutritional and ological protection to a new born child in the first 6 months. The first milk contains colostrum which is highly nutritious and contains a high concentration of anti bodies which give protection to the

baby in the absence of a fully developed immune system, hence morbidity and mortlity risks are reduced.

Shorter periods of breastfeeding could lead to increased diarrhoeal diseases, malnutrion and child mortality (Bader, 1976; Wray, 1978). Breast milk does not pose da of contamination as in the case of bottle feeding. Table 7.6 shows percentage distribution of children ever breastfed

Table 7.6: Child breastfeedind Status

Child breastfeeding Practices	Returned to school		Never returned	
	Frequency	Percent	Frequency	Percent
Ever breastfed	85	100	84	99
Never breastfed	0	0	1	1
Total	**85**	**100**	**85**	**100**

Source: Field data

The analysis of data on child feeding practices shows that all the children of the teenage mothers in school had ever breastfed. This intels that all the children had at one time been introduced to breast feeding. The proportion of children ever breastfed among the children of teenage mothers who never returned to scho is at 99 percent. Only 1 percent of children was never breastfed due to sores on the nipples of the mothers's breasts. This indicates that breastfeeding is highly practiced among teenage mothers in Choma District.

The pattern of breastfeeding among mothers in and out of school shows improvement in number of children ever breastfed compared with the findings of the Living Conditions and Monitoring Survey Reports of 1998 and 2004 (CSO,1998/2004). In 1998, 96 percent of children had ever breastfed and in 2004 the percentage had dropped by 7 percent to 89 percent. However, the survey report of 2007 shows an improvement at national level in the percentage of children who ever breastfed. CSO *et al.* (2007) shows that 89 percent of the children born in the 5 years preceding the survey were ever breastfed. The national trend of children ever breastfed as revealed in 2007 Demographic and Health survey report is reflected in the findings of the sample survey conducted in ma District among mothers in and out of school.

The proportion of children that were still being breastfed was taken into consideration. This was disaggregated by age and residence. Table7.7 shows the proportion of children 0-24 months who were still being breasfed by age and residence.

Table 7.7: Percentage Distribution of children (0-24 months) still breastfeeding by age and residence

Age-group	Returned to school		Never returned to school	
	Frequency	Percent	Frequency	Percent
0-3	2	3	8	10
4-7	7	9	11	14
8-11	5	6	8	10
12-15	9	11	15	19
16-19	4	5	5	6
20-23	3	4	2	3
24-27	1	1	0	0
Total	**31**	**39**	**49**	**61**
Residence				
Urban	11	35	11	22
Rural	20	65	38	78
Total	**31**	**100**	**49**	**100**

Source: Field data

The analyzed data show that 39 percent of children of teenage mothers in school were still being breastfed. Among the teenage mothers out of school, 61 percent of the children were still being breastfed. In both groups, the children still being breastfed ranged from 0-24 months of age. There is evidence of teen mothers getting back to school while their children are below the age of 6 months as prescribed by the re-entry policy guidelines. Children below the age of 6 months are highly vulnerable to disease infections and proper infant care is very critical at age. Early return of mothers to school is not recommended as it affects the breastfeeding pattern and exposes young children to high risks of child mortality and faltered growth. However, the high proportion of teenage mothers in school comprises those with children in the age-group 12-15 months. Among the teenage mothers out of school, the proportion of teenage mothers with children below the age of 12 months still breastfeeding is higher than among the teenage mothers in school. These, probably, would want to adequately

breastfeed and care for their children until they reach the weaning age before returning to school.

Analysis by residence shows that in both groups the percentage of children living in rural areas who were still being breastfed was higher the children in urban. Among the mothers in school, 65 percent of children living in rural areas were still being breastfed compared to 35 percent of children in the urban area. The pattern is similar to those who never retuned to school where rural children who were still being breastfed at the time of the survey accounted for 78 percent compared to 22 percent of those in the urban area.

7.4.2 Duration of Breastfeeding

The duration of breastfeeding is based on the breastfeeding status of the proportion of children born within the period of 5 years preceding the survey. Table 7.8 presents data on the mean and median breastfeeding period in months for children born in 5 years preceding the survey to mothers in and out of school.

Table 7.8: Duration and frequency of breastfeeding in months among mothers in and out of school

Category of mothers	Mean breast-feeding period	Median breast-feeding period	mean breast-feeding frequency	Early weaning	Late weaning	Duration of breastfeeding	
						Rural	Urban
Returned to school	13	14	4	11	14	14	11
Never returned	15	20	6	18	23	23	18

Source: Field data

According to the table, the mean breastfeeding duration for the children of mothers who returned to school is 13 months while for the children of mothers never returned is 15 months. This means that each child of a teenage mother in school had been breastfed for at least 13 months while for those out of school for at least 15 months. The median breastfeeding duration for children of mothers in school and those who never returned is 14 months and 20 months respectively. However, while the majority of the children had been breastfed for 18 months (mode) among mothers out of school, there were early

weaning practices observed among the mothers in school particularly those who secured places in boarding schools. Some children were weaned early as 11 months from the same group while among mothers who never returned to school early weaning was at 18 months and late weaning was at 23 months.

The duration of breastfeeding, however, varied with residence. The breastfeeding period generally tends to be longer in rural areas than in urban areas. The study reveals that rural children are breastfed for the duration of almost 24 months contrary to an average duration of 18 months in urban areas for the mothers out of school.

The shorter period of breastfeeding in urban areas can be attributed to the large proportion of teenage mothers going back to school. Those returning to school in urban areas are more than those in rural areas. The average iod of going back to school in urban areas is 1 year and this tends to reduce the duration of breastfeeding among teenage mothers. Parents in rural areas have less desire to send back the girl-child to school after disappointing them by getting pregnant. They would rather have their daughters in marriage and benefit from the bride price.

In rural areas, traditional beliefs are strictly followed. Traditionally, a child is supposed to be breastfed for not less than 24 months and in most cases this belief is highly upheld in rural areas than in urban areas thereby prolonging the breastfeeding period. Poverty levels are more pronounced in rural areas and this limits households' capacity to buy food supplements or introducing children to bottle feeding. The poor economic environment in rural areas subject mothers to rely more on breast milk than other food supplements to feed their children.

7.4.3 Frequency of Breastfeeding

The frequency of breastfeeding in the study considered only the breastfeeding that occurred during day time. According to CSO *et al.* (2007) it is important that children are frequently breastfed as this improves production of milk in mothers. Going by WHO/UNICEF (1998), the recommended mean optimal breastfeeding times during day-time is seven (7) and five (5) at night.

The mean frequency of breastfeeding among the teenage mothers in school is 4 times in a day, while for those out of school is 6 times. This can be attributed to the absence of the teenage mother during part of the day when she is lessons at school. The mean frequency of breastfeeding for the children of teenage mothers who returned to school is generally below the recommendations for mean optimal feeding times by WHO/UNICEF. The frequency of breastfeeding for the children of mothers out of school meets the recommended mean optimal breastfeeding times during the day. The study reveals further that the frequency of breastfeeding reduces with the age of a child, that is, as the child grows older supplementary food is required because milk alone is not sufficient. Generally, in both groups, it was observed that the frequency of breastfeeding children began to decline once the children started receiving supplementary foods.

7.4.4 Bottle Feeding and Other Supplements

Table7.9 presents data on the introduction of bottle feeding to the children of mothers in and out of school.

Table 7.9: Introduction of bottle feeding to children of mothers in and out of school

Category of Mothers	Returned to school		Not returned to school	
	Frequency	**Percent**	**Frequency**	**Percent**
Introduced to bottle feeding	13	16	5	6
Never introduced to bottle feeding	66	84	75	94
Total	**79**	**100**	**80**	**100**

Source: Field data

According to Table 7.9, 16 percent of children born to teenage mothers in school were introduced to bottle while 66 percent were not introduced bottle feeding at all. Among the teenage mothers who never returned to school, bottle feeding was not as highly practiced as among teenage mothers in school. There were only 6 percent of teenage mothers in this category who introduced their children to bottle feeding while 94 percent never introduced their children to bottle feeding. The bigger proportion of children

introduced to breastfeeding among mothers in school is due to the mothers returning to school while the baby is still small.

Timing of bottle feeding was also considered in the study. There were considerable variations between children of mothers in school and those who out of school. Table 7.10 shows timing of bottle feeding by age among children of mothers in and out of school.

Table 7.10: Timing of bottle feeding by age

Timing of b/feeding by age	Returned	Percentage	Never returned	Percentage
One month	4	30	1	20
Two months	1	8	0	0
Three months	1	8	1	20
Four months	1	8	0	0
Five months	2	15	1	20
Six months	1	8	2	40
Above Six	3	23	0	0
Total	**13**	**100**	**5**	**100**

Source: Field data

According to Table 7.10, four children were introduced to bottle feeding among the mothers in school within the first month of birth. This accounts 30 percent of the children introduced to bottle feeding. Among the mothers who never returned to school only one child was introduced to bottle feeding within the first month of birth and this accounts for 20 percent of children introduced to bottle feeding. The 20 percent of children among teenage mothers who never returned to school was introduced to bottle feeding at an early stage because of some sores that had developed on the mother's breasts hence the child was not allowed to breastfeed. Bottle feeding can rightly be introduced to a child at 6 months. However, among the children of mothers in school, 77 percent were introduced to bottle feeding at less than 6 months. Only 23 percent were introduced to bottle feeding at the right age. Among teenage mothers out of school, all the five children introduced to bottle feeding were below the age of 6 months. Early introduction of children to bottle feeding exposes them to the risk of disease infection.

Analysis of data from the two groups shows early introduction of bottle feeding among teenage mothers that returned to school. This is due to the absence of the mother and instances of teenage mothers in some cases of going back to school too early when the child is in still in the early stages of breastfeeding.

The study revealed further that food supplements were introduced to children in both groups at an early stage. According to CSO *et al.* (2007), food supplements in form of solids and semi-solids can rightly be introduced to a child in addition to breast milk from 6 months until age 24 months or more when the child is fully weaned. CSO *et al.* (2007) further argue that early supplementation exposes infants to pathogens and increases their risk of disease infection. The other reasons advanced include disturbances in the in-take of breast milk by a child and exposing children to food supplements of poor nutritional value especially in lower resource settings. This can affect optimal child growth. Table 7.11 presents data on children introduced to food supplements. These are further disaggregated by residence.

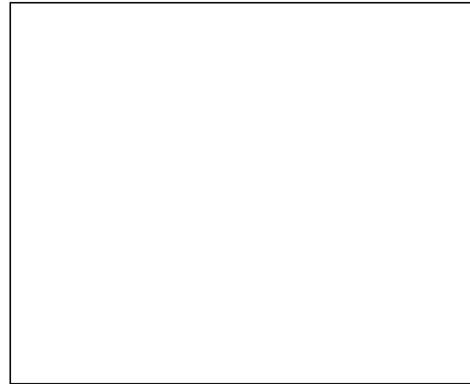
Table 7:11 Percent distribution of children introduced to food supplements among mothers in and out of school.

Category of Mothers	**Introduced to food supplements**		**Never introduced to food supplements**	
	Frequency	Percent	Frequency	Percent
Returned to school	77	97.6	2	2.4
Never returned	69	86	11	14

The results show that 97.6 percent of the children of the mothers in school had already been introduced to supplementary foods such as water, other liquids, and marshy foods at below 6 months of age compared to 86 percent of children among mothers out of school. However, there were variations in giving food supplements between children of mothers living in urban areas and mothers who live in l areas. The proportion of mothers who live in rural areas had higher percentage of children being given food

supplements accounting for 70 percent compared to urban areas with 30 percent only as shown in Figure 7.2.

Fig 7.2: Proportion of children given food supplements by residence



Source: Field data

7.4.5 Exclusive Breastfeeding

Although generally breastfeeding is highly practiced by both children of mothers returning to school and children of mothers who never to school, exclusive breastfeeding is not a common practice in the district. Among the children of mothers who returned to school only 2.4 percent of children below 6 months were exclusively breastfed compared to 14 percent of the children of mothers who never returned to school. About 98 percent and 86 percent of children below 6 months received water and food supplements among mothers who returned and never d to school respectively. Children who are not exclusively breastfed are at greater risk of exposure to pathogens and disease infections (CSO *et al.*, 2007). Most of the children of teenage mothers in Choma District are highly at risk of disease infection and faltered growth.

7.5 Nutritional Status of Children

The nutritional status of children of mothers who returned to school was assessed by collecting anthropometric measurements of children below 6 years. This was compared with the children of mothers who never returned to school to ascertain if re-entry policy had an impact on the health status of children who are left by their mothers who re-enter school system. The weight, height and age of a child provide the basis for evaluation of

the overall nutritional and health status of a child and identification of sub-groups of children who are at high risk of faltered growth and disease contraction which in certain cases might result in fatality.

The commonly adopted nutritional indices of physical growth used to describe the nutritional status of children are stunting, wasting and underweight. The indices were generated using the Anthro-software package and expressed as standard deviation or Z-scores. This report adopts Z-scores of an international reference defined by the U.S National Center for Health Statistics (NCHS) and accepted by Center for Disease Control (CDC) for the purpose of comparison with the nutritional status of children under study (WHO, 2006; CSO, 1992).

The levels of malnutrition among the children of mothers in school are presented in Tables 7.12 and 7.13. The tables show levels of stunting, wasting and underweight by demographic characteristics and sex of a child.

Table 7.12 Nutritional status of children of teenage mothers in school by age and sex

Percentage of children under five years (1-59 months) who are classified as undernourished according to three anthropometric indices: height-for-age, weight-for-height, and weight-for-age by age and sex, Choma District Schools.

Demographic Characteristics	(Stunting) Height-for-age		(Wasting) Weight-for-height		(Underweight) Weight-for-age		Number of children
	Percentage Below -3 SD	Percentage Below -2 SD	Percentage Below -3 SD	Percentage below -2 SD	Percentage Below -3 SD	Percentage below -2 SD	
Age							
Under 6 months	3.8	6.3	0	0	0	0	6
6-11 months	7.5	7.5	0	0	0	1.25	9
12-23 months	27.5	35.0	1.3	2.6	5	6.25	35
24-35 months	11.3	18.8	0	1.3	2.5	6.25	19
36-47 months	6.3	8.8	0	0	1.25	2.5	7
48-59 months	2.5	2.5	0	0	1.25	1.25	4
Sex							
Male	33.8	43.8	0	2.6	8.8	12.5	42
Female	25.0	35.0	1.3	1.3	1.2	5.0	38
All children	**58.8**	**78.8**	**1.3**	**3.9**	**10**	**17.5**	**80**

Source: Field data

Table 7.13 Nutritional status of children of teenage mothers out of school by age and sex

Percentage of children under five years (1-59 months) who are classified as undernourished according to three anthropometric indices: height-for-age, weight-for-height, and weight-for-age by age and sex, Choma District Schools.

Demographic Characteristics	(Stunting) Height-for-age		(Wasting) Weight-for-height		(Underweight) Weight-for-age		Number of children
	Percentage below -3SD	**Percentage below -2 SD**	**Percentage Below -3SD**	**Percentage below -2 SD**	**Percentage Below -3SD**	**Percentage Below -2 SD**	
Age							
Under 6 months	10.2	12.8	0	1.4	1.3	2.6	13
6-11 months	7.7	11.5	0	0	0	2.6	12
12-23 months	26.9	33.3	1.4	1.4	5.1	11.5	31
24-35 months	11.5	16.6	0	1.4	0	1.3	15
36-47 months	2.6	3.8	0	0	0	2.6	3
48-59 months	3.8	5.1	0	0	0	1.3	4
Sex							
Male	37.2	46.1	0	1.4	3.8	14.1	39
Female	25.6	37.2	1.4	2.8	2.6	7.7	39
All children	**62.8**	**83.3**	**1.4**	**4.2**	**6.4**	**21.8**	**78**

Source: Field data

7.5.1 Stunting (Height-for-age)

Stunting (Height-for-age) is a condition reflecting the cumulative effect of chronic malnutrition. It is an indication of long-standing dietary inadequacy and a measure of overall social deprivation (Bandeke *et al.*, 2006). Height-for-age is less sensitive to short-term nutritional interventions. Nothing much can be done to avert it within a short time. Stunting is associated with poor socio-economic conditions.

A child is considered to be stunted when height-for-age Z-score is below minus two standard deviation (-2 SD) and severely stunted when below minus three (-3 SD) (CSO, 1992). The results in Table 7.12 show that 78.8 percent of children of mothers in school were stunted. The percentage of children whose height-for-age Z-scores were below minus three (-3 SD) was at 58.8 percent. This means that almost 60 percent of the children of teenage mothers in school were severely stunted.

The majority of the children fall below the minus two standard deviation (-2 SD) of WHO standards. This indicates that most of the children among mothers in school have been subjected to long-standing diatery inadequacy.

The malnutrition levels of the children of teenage mothers out of school were also assessed. The data in Table 7.13 show that 83.3 percent of children of mothers out of school were stunted. Severe stunting was equally higher (62.8 percent) among the children of teenage mothers out of school than for the children of mothers in school which was at 58.8 percent.

The comparative analysis of children in the two categories shows that the level of stunting is higher in the children of mothers who never returned to school than the children with mothers in school. However, majority of the children in both groups are below minus two standard deviation (-2 SD), an indication of chronic malnutrition in the population of children under study.

7.5.2 Wasting (Weight-for-Height)

Weight-for-Height (wasting) is low weight in relation to height. is failure to gain weight in relation to weight. Wasting is sensitive to short term changes and because of this, it is useful in evaluating the benefits of nutritional interactions (Bandeke *et al.*, 2006). Children are considered thin or wasted if weight-for-height Z-scores are below minus two standard deviation (-2 SD) and severely wasted when below minus three (-3 SD) from the median of the reference population (CSO, 8). Wasting is caused by recent illness or sudden loss of appetite resulting into fat loss.

The prevalence of wasted children among the children of teenage mothers in school is 3.9 percent while for teenage mothers out of school is 4.2 percent. Tables 7.12 and 7.13 indicate further that the percentage of severely wasted children are at 1.3 percent among teenage mothers in school compared to 1.4 among teenage mothers out of school. Levels of wasting are still high among the children of teenage mothers out of school.

7.5.3 Under-weight (Weight-for-age)

Under-weight (Weight-for-age) is expressed as failure to gain weight in relation to age. This results from chronic or current malnutrition (CSO, 1998).

Tables 7.12 and 7.13 show further that 17.5 percent of children of mothers school are underweight compared to 21.8 percent of the children of teenage mothers out of school. The proportion of children who are severely under-weight however, is higher among teenage mothers in school (10 percent) compared with 6.4 percent among teenage mothers out of school.

Generally, the three indices of malnutrition show the status of the children of teenage mothers currently in school is better than for the hildren whose mothers are out of school.

This could be that girls or teenage mothers out of school have limited resources to feed their children while the guardians to children whose mothers are in school are providing their children's nutritional dietary needs. Teenage mothers out of scho are often neglected by their families and tend to fend for themselves. They spend more time on activities that provide them with means of livelihood caring for the child. The teenage mothers selling in markets leave homes very early and come back very late. They usually leave their children with neighbours, young sisters or brothers to care for their children. Those who go with their children in business places such as markets rarely cook for their children but fed their children on *vitumbuwa* (flitters) and left over food nearly every day. This subjects children to chronic malnutrition or faltered growth.

Among teenage mothers in school, their children are mostly left with grandparents who may have better parenting skills. These children are more likely to be subjected to better care and feeding practices which reduce the prevalence of malnutrition. The environments in which these children live are better than for the children of those mothers out of school. The poor environments and feeding patterns contribute to episodes of illnesses within a short period of time which can lead to loss of appetite causing loss of weight and the on-set of malnutrition. The erratic care and food scarcity

result into under nutrition in children and within a s period of time a child becomes thin or wasted.

The majority of children of teenage mothers out of school have been chronically under malnourished over a long period. This is because, as mentioned earlier, their mothers are most of the times busy with activities that sustain their livelihood and young children are left home being cared for by other children who may not wash clothes and bath the young ones as well as failing to provide adequately their dietary needs to enable children grow well. Some of the children who are under parental care among teenage mothers out of school are cared for by mothers who are still very ung and without parental skills. These do not regularly follow the recommended feeding patterns for young children and this denies the child the necessary nutritious foods. this is repeatedly done over a long time, the child becomes chronically malnourished or stunted.

7.7 Nutritional status by age of the children of teenage mothers in and out of school

The analysis of the data by demographic characteristics such as age and sex of children of teenage mothers in and out of school in Tables 7.12 and 7.13 show that stunting increases with increasing age. The proportion of children stunted is highest in age group 12-23 months (Table 7.12). More than thrice as many children aged 12-23 months are stunted as children 6-11 months. Data from the survey shows that poor nutrition mainly affects children between the ages of 1 and 3 years (12-35 moths). This is because children begin to receive less care from their mothers thereby depriving a child of its dietary and social needs. The results of the study confirm findings from previous surveys. The study by Devi and Geervani (1994) on the relationship between maternal use of time and children's health and nutritional status found that at 2 years of age, children begin to receive less intensive care because hers begin to get involved into other economic activities. This could have a negative effect on child nutrition.

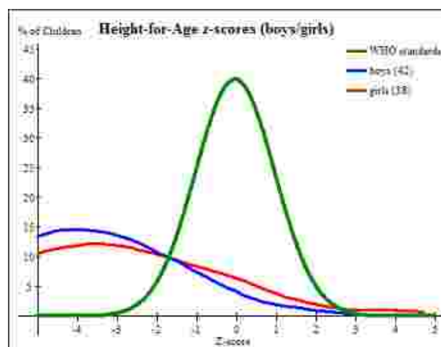
Wasting (weight-for-height) is not common in the children below the age of 11 months in the two categories of children. However, wasting begins to manifest in children aged 12-23 months.

The positive effect of breastfeeding reduces considerably incidences of underweight in children under the age of 6 months. Underweight is not there in the children of mothers in school while among mothers out of school only 1.3 percent of children are underweight. This is due to early introduction of bottle feeding to the children who could not be breastfed because of sores on the nipples as indicated in Table 7.10.

7.8 Nutritional Status by sex of the children of teenage mothers in and out of school

The analysis of nutritional status among children of teenage mothers in and out of school using the three indices; stunting, wasting and underweight, shows gender disparities. The Prevalence of chronic malnutrition (stunting) by sex, based on height-for-age Z-scores, shows higher levels of stunting with males than females in both categories as indicated in Figure 7.3.

Fig 7.3: Prevalence of chronic malnutrition (stunting) by sex based on height-for-age z-scores of the children of teenage mothers in of school

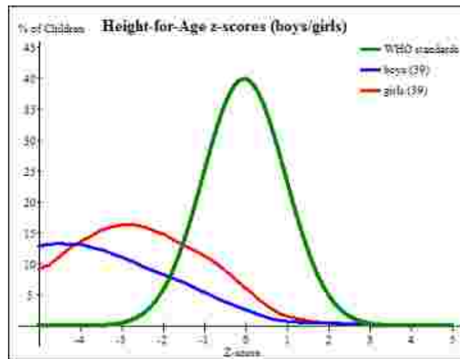


Source: Field data

As indicated in Table 7.12, 43.8 percent of the boys among the teenage mothers in school are stunted compared to 35 percent of girls. Among the children of teenage mothers in school who are stunted, 33.8 percent are severely stunted compared to 35 percent of severely stunted girls.

Figure 7.4 shows the prevalence of chronic malnutrition (stunting) by sex, based on height-for-age Z-scores of the children of teenage mothers out of school.

Fig 7.4: Prevalence of chronic malnutrition (stunting) by sex based on height-for-age z-scores of the children of teenage mothers out of school

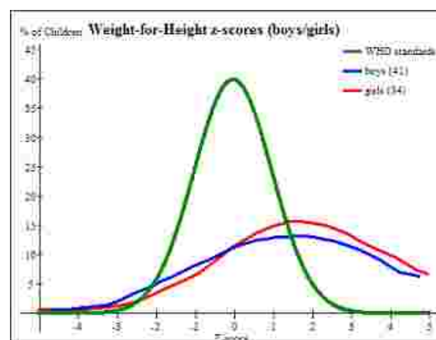


Source: Field data

Among the children of teenage mothers out of school, 46.1 percent of boys are stunted compared to 37.2 percent among girls as indicated in Table 7.13. The proportion of severely stunted boys account for 37.2 compared to 25.6 among the stunted girls.

The level of acute malnutrition (wasting) among the children of mothers in and out of school was also assessed. The results among the children of mothers in school show that males are more likely to be affected by acute malnutrition than females. As indicated in Table 7.12, 2.6 percent of male children among teenage mothers in scho have acute malnutrition while only 1.3 percent of female children are wasted. However, females are more affected by severe wasting (1.3 percent) than males (0 percent). Figure 7.5 shows the prevalence of acute malnutrition (wasting) by gender.

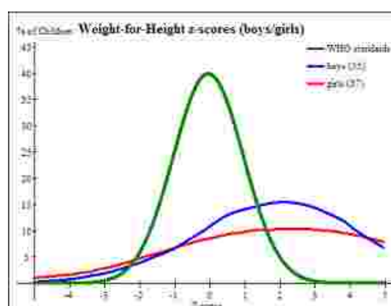
Fig. 7. 5: Prevalence of acute malnutrition (wasting) by sex based on weight-for-height z-scores of the children of teenage mothers in of school



Source: Field data

Among the teenage mothers out of school the prevalence of acute malnutrition (wasting) by sex also shows variation between boys and girls. Among the children of teenage mothers out of school, the prevalence of acute malnutrition among girls is higher than for boys. As indicated in Table 7.13, 2.8 percent of girls are wasted compared to 1.4 percent for the boys. The percentage of severely wasted girls is at 2.8 percent while no male child was severely wasted. Figure 7.6 shows the prevalence of wasting by gender.

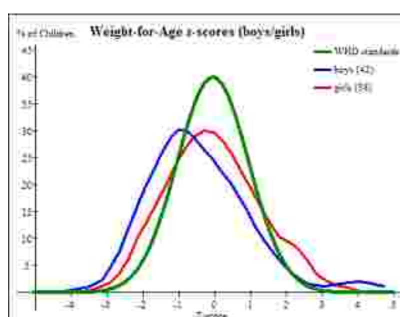
Fig. 7.6: Prevalence of acute malnutrition (wasting) by sex based on weight-for-height z-scores of the children of teenage mothers out of school



Source: Field data

Table 7.12 and Fig 7.7 show the percentage of children under-five years classified as underweight by sex based on height-for-age Z-scores among the teenage mothers in school. According to the data in the table, 12.5 percent of the boys are underweight while 5 percent of the girls are underweight. The prevalence of underweight is higher among boys than girls. The severely underweight boys account for 8.8 percent compared to 1.2 for girls.

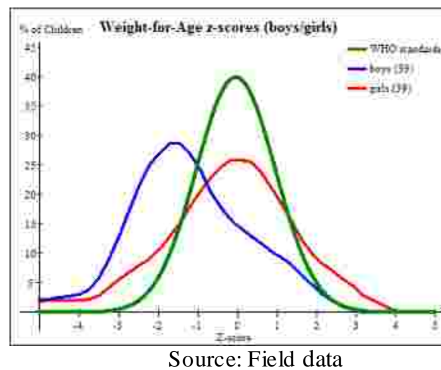
Fig 7.7: Prevalence of underweight by sex based on height-for-age z-scores of the children of teenage mothers currently in of school



Source: Field data

The prevalence of underweight among the children of teenage mothers out of school shows higher percentage of underweight for boys than for the girls. The percentage distribution shows that 14.1 percent of the boys are underweight compared to 7.7 percent of girls. Boys who are severely underweight in this category account for 3.8 percent while 2.6 percent of the girls are underweight (See Table 7:13). Figure 7.8 presents the levels of wasting among girls and boys among the teenage mothers out of school.

Fig 7.8: Prevalence of underweight by sex based on height-for-age z-scores of the children of teenage mothers currently in of school



Source: Field data

The research conducted by Wandel and Halmboe-Ottesen in Tanzania shows higher prevalence of malnutrition among girls than boys (Wandel and Halmboe-Ottesen, 1992). However, the results of most of the researches conducted have shown higher levels of malnutrition among boys than girls (Bandeke, 2006). This study agrees with research conducted by Bandeke and others whose results also confirm that the prevalence of malnutrition is higher among boys than girls. The cause of gender disparities in nutritional status is a challenge that requires specific study to ascertain causes.

7.9 Nutritional Status by selected socio-economic characteristics

Nutritional status was also considered among the selected socio-economic characteristics. Selected characteristics include; residence, education and the income levels to assess their influence on nutritional status of children whose mothers are in or out of school. Table 7.14 shows percentage distribution of children under-five years classified as undernourished according to three anthropometric indices, stunting, wasting and underweight by selected socio-economic characteristics.

Table 7.14 Nutritional status by selected socio-economic characteristics

Percentage of children under five years who are classified as undernourished according to three anthropometric indices, height-for-age, weight-for-height, and weight-for-age by age selected socio - economic characteristics, Choma District.

Demographic characteristics	(Stunting) Height-for-age		(Wasting) Weight-for-height		(Underweight) Weight-for-age		Number of children
	Percentage Below -3 SD	Percentage Below -2 SD	Percentage Below -3 SD	Percentage Below -2 SD	Percentage below -3 SD	Percentage below -2 SD	
Residence							
Rural	43.7	56.3	1.3	3.9	8.7	13.8	55
Urban	15.0	22.5	0	0	1.3	3.7	25
Education							
No education	0.0	0.0	0	0	0	0.0	2
Primary	32.5	38.7	0	0	2.5	7.5	36
Secondary	25.0	32.5	1.3	3.9	6.2	8.7	36
Tertiary (Higher)	1.3	7.5	0	0	1.3	1.3	6
Income							
Lowest wealth quintile	37.5	45.8	1.3	3.9	4.3	10.8	49
Second lowest quintile	10.6	15.8	0	0	1.4	1.3	13
Middle wealth quintile	6.7	10.6	0	0	2.9	2.7	9
Highest wealth quintile	4.0	6.6	0	0	1.4	2.7	5
All children	**58.8**	**78.8**	**1.3**	**3.9**	**10.0**	**17.5**	**80**

Source: Field data

The analysis of anthropometric data by socioeconomic characteristics shows that stunting is higher among rural than urban children. The percentage of stunting in the rural area was reported at 56.3 compared to 22.5 percent in urban areas. Similarly, severe stunting is higher in rural areas than in the urban children. According to three anthropometric indices shown in Table 7.14, among the children of care providers with primary education, stunting is higher than the care providers and guardians with secondary or higher education. Among care providers with primary education, stunting was reported at at 38.7 percent and 32.5 percent among care providers with secondary education. The lowest level of stunting was reported at 1.3 percent among children cared for by care providers with tertiary or higher education.

With regard to level of wasting and underweight, rural areas still show higher levels. There is a negative relationship between levels of wasting, underweight and education of the care provider. While levels of stunting tend to decline with an increase in education

level, wasting and underweight seem not to be affected by education of the care provider until one attains tertiary level.

The wealth resource of a household has an influence on the nutritional status of children. As shown in Table 7.12, levels of stunting, wasting and underweight are consistently higher among households in the lowest wealth quintile. As wealth resources increase in a population, stunting, wasting and underweight tend to reduce. This explains why rural areas have higher percentages of children stunted. Rural areas are generally economically disadvantaged with high levels of poverty. People especially mothers and young children, hardly have all dietary needs in terms of right quantity. This highly exposes children to the risks of faltered growth.

A multiple regression model was run to determine the most important factors that affect the nutritional status of the children of teenage mothers currently in school. Table 7.15 shows the results of the regression model.

Table 7.15 Variables affecting nutritional status of children (1-59 months) of teenage mothers in school

Variable	Un-standardized Coefficients		Standardized Coefficients	Sig.	95% Confidence Interval for B	
	B	Std. Error	Beta		Lower Bound	Upper Bound
Constant	.587	.223		.010	.143	1.030
Residence	.131	.099	.148	.191	-.067	.329
Education level	.168	.065	.301	.012	.298	.039
Monthly income	.164	.052	.376	.002	.060	.268

Source: Field data

The variables considered included residence of the child, education l of care provider and the income of the household. Table 7.15 shows a very strong positive correlation between nutritional status and the level of income and education of the care provider. Residence of the care provider has weaker correlation with nutritional status of young children. However, the educational background especially of the and the head of household has an important influence on the child's nutrition at less than 5 percent level of significance. The results of multiple regression model show an even

stronger correlation between the income of a household at less than 1 percent level of significance and the nutritional status of the children of teenage in school. This suggests that the asset base of a household is more important than the education level of the care provider in enhancing the nutritional status of a child. The hi the educational level and income level the better the nutritional status of children being cared for regardless of their residence.

CHAPTER EIGHT: SUMMARY, CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

The chapter summarizes the study on the nature of care and support systems and the health and nutritional status of the children of teenage mothers who re-enter school after they have delivered**.**

8.2 Conclusions

The number of children left in foster care has been on the increase since the introduction of re-entry policy. The care systems identified for the children left by mothers who re-enter school include parental care, relative care and non-relative care. Relative care is highly practiced among the children of teenage mothers in school while parental care dominates among the teenage mothers who never returned to school. The larger proportion of care providers in the category of relative care are the grandparents to the young children who take over the responsibility of looking after their grand-children when the mother is not available to provide care herself. Non-relative care is, however, only provided to the children of teenage mothers who are in school. Care of children in this category is predominantly provided by maids who are paid by relatives to the teenage mother.

Faith-Based-Organizations (FBOs) and Community participation in the support of children in foster care is not well coordinated as in countries. There is currently no streamlined support directed towards the hildren left by teenage mothers going back to school. Most of the beneficiaries of support provided by FBOs and Non-Governmental Organizations (NGOs) are the Orphans and Children (OVC). The greater percentage of support comes from relatives. The community involvement is more pronounced at birth when traditionally the immediate community presents gifts to the newly born babies.

The main problem faced by all teenage mothers is inadequate support by the people responsible for their pregnancies. The majority of the men responsible for pregnancies rarely marry the teenage mothers and hardly provide support to their children.

The study also revealed that there are disparities in terms of education and socio-economic status among the care providers. The proportion of care providers for the children of teenage mothers in school with higher educational background is higher compared to the teenage mothers out of school. Literacy and income levels are equally higher among care providers of children of teenage mothers who are in school. This is an indication that the majority of the school girls who return to school after they have delivered come from families with better socio-economic status compared to the teenage mothers who never returned to school.

Though generally children come from similar environments, variations in socio-economic backgrounds dictate the nature of housing units in which the children under study live, the sources of drinking water, and toilet facilities used by the children. The housing units in which the children of teenage mothers who are in school live are generally better than those whose mothers never returned to school. The use of burnt bricks and plastering in most of housing units for children of teenage mothers in school reduces hiding and breeding places for parasites. The of the teenage mothers who never returned to school come from rural areas and the floor of their housing units are predominantly natural (earth/sand). The study further revealed that the majority of the children reported to have suffered from a cough were from such housing units.

Sharing of bedroom and beddings with the children by visitors is a common practice in both categories of teenage mothers (Table 6.7). However the habit is more pronounced among teenage mothers in school. Since the majority of them are in urban areas, crowding in household is higher in urban areas, compelling sharing of bedrooms and beddings whenever visitors come. This means that the probability of acquiring communicable diseases is higher among the children of mothers in school than those who never returned to school.

The major sources of drinking water in urban areas include tap water and boreholes. However, shallow wells are a common source of water in squatter settlements. In rural areas, wells, boreholes, streams and rivers are used as sources of water. The frequently used sources of water in rural areas include rivers or streams and wells. The rural water

supplies are rarely or never chlorinated. As a result, they are common vehicles for waterborne diseases.

Solid waste management is of poor quality in rural areas. In urban areas, flush toilets are common though in squatter settlements sharing of toilets has been observed to be a common practice. However, in rural areas absence of toilet facilities is common and this compels people to use bush as an alternative. This contributes to the spread of diarrheal diseases especially among children who are highly vulnerable. Since the teenage mothers who never returned to school form the majority in rural areas, risks of contracting waterborne diseases and diarrheal diseases was found to be higher among children of teenage mothers who never returned to school.

Immunization coverage among the children of teenage mothers in and out of school is generally high in Choma District. However, it is slightly higher among the children of teenage mothers out of school than among the children of teenage mothers currently in school. This can be attributed to the absence of the teenage mother.

Even if breastfeeding is commonly practiced in both categories, the duration of breastfeeding is shorter for the children of teenage mothers who returned to school. On average, teenage mothers in rural areas have longer duration of breastfeeding than their counterparts in urban areas. The frequency of day time breastfeeding is shorter with the teenage mothers who never returned to school.

There is early introduction of food supplements in both groups though it is highly practiced in rural areas due to low educational levels and high poverty levels.

Bottle feeding is more practiced by teenage mothers in school especially those who go back when the child is still in the early stage of breastfeeding.

Generally, levels of exclusive breastfeeding are low to both categories. However, exclusive breastfeeding is lower with children of teenage mothers in school than those whose mothers never returned to school.

The commonly adopted indices of physical growth show the prevalence of chronic malnutrition (stunting), acute malnutrition (wasting) under weight to be higher among the children of teenage mothers who never returned to school. The nutritional status of the children of teenage mothers who returned to school is generally better than for the children of teenage mothers who never returned to school. This can be attributed to higher income levels (asset base) among the care providers for the children of teenage mothers who returned to school. The residence of the c of teenage mothers has an influence on their nutritional status. The nutritional status of children in urban areas was better than those in rural areas.

8.3 Recommendations

- § There is need to strengthen counseling and sensitization of girls on the effects of getting pregnant while in school so that girls do not abuse the Re-entry policy.

- § The minimum time frame suggested for teenage mothers to return to school should be adjusted from six months to one year so that the duration of breastfeeding is not disturbed.

- § Adult literacy programmes should be enhanced and should include baby care lessons especially to mothers so that they are equipped with necessary skills to look after children. This would minimize instances of illness in babies and children.

- § Traditional and community leaders should be encouraged to promote good hygiene and sanitation as there is strong correlation between the presence of a latrine and nutritional status of children.

- § Government should provide clean and safe water to its community, especially among children born to teen mothers, to reduce instances of waterborne diseases.

§ The socio-economic status of the principal child care takers should be improved especially mothers who form larger percentage of care providers. This would go along way in improving the nutritional status of children.

§ The care of children who are between the age of one year and three years should be intensified because it is the age when children become more vulnerable to moderate and severe forms of malnutrition.

§ Schools should design special facilities that would help breastfeeding teenage mothers care for their children especially during examination time so that they do not get disturbed by care providers.

§ Non-Governmental Organisations, Faith-Based-Organisations (FBOs) and other institutions should provide resources for teen mothers' school through small and medium entrepreneurship (SME) to care providers or teen mothers themselves.

§ Engage mission institutions to also appreciate and implement the re-entry policy.

§ Collaborating partners should provide grants and loan facilities to girls who become pregnant.

§ Men responsible for pregnancies should be sensitized and counseled so that they become responsible and help in upbringing their children and legal frame should be enacted to protect teen mothers from being mistreated by men responsible for pregnancies.

§ The Communities need to build up a sense of its own identity and power over its own affairs. Besides visiting affected children and families, monitoring these households to ensure that the children are not being abused or exploited will contribute considerably to the health and physical development of the children left in either relative of non-relative care.

REFERENCES

Bayona, E. L. M. and Kandji-Murangi, I. (1996) **Botswana's Pregnancy Related Educational Policies and their Implications on Ex-Pregnant Girls' Education and Productivity**, Nairobi, Academy Science Publishers.

Bandeke, T. Mahgoub, S. E. and Nnepi, M. (2006) **Factors affecting prevalence of malnutrition among children under-three year of age in Botswana**; African Journal of Food and Agricultural Nutrition, Volume 6. No.1, 2006.

Bell, C.A., Casto, G. and Daniel (1983) **Ameliorating the impact of teenage pregnancy on Parent and Child**, Child welfare, 62, 167-178.

Caldwell, J. C., (1979) **Education as a factor in mortality decline: an examination of Nigerian data, Population Studies** 33(3), 395-413.

Capizzano, J., and Main, R. (2005). **Many young children spend long hours in child care** (Snapshot of America's Families III No. 22). Washington, DC: Urban Institute. (www.childcareresearch.org/location/ccrca5802)

Central Statistical Office (Zambia), Central Board of lth (Zambia) and ORC Macro. 2003 *Zambia Demographic and Health Survey 2001-2002*. Calverton, Maryland, USA: Central Statistical Office, Central Board of Health, and ORC Macro.

Central Statistical Office (2003) **Zambia Demographic and Health Survey**, Lusaka,

Central Statistical Office (1998) **Living Conditions in Zambia**, Preliminary Report, Lusaka,

Central Statistical Office (2004) **Living Conditions Monitoring Survey Report**, Lusaka.

Central Statistical Office (1992) **Zambia Demographic and Health Survey**, Lusaka

Central Statistical Office, Ministry of health, UNZA (2007) **Zambia Demographic and Health Survey**, Lusaka.

Chilopa B.M. and Simambo, D. (1998) The Quality of Child Health and its Effects on under-five Morbidity in Zambia: The case of Diarrhoea, Lusaka

Chisumpa, H. V. (1996) **Breastfeeding Patterns and Birth Spacing in Zambia,** MA Dissertation, University of Ghana, Legon

Dicker, S., Gordon, E. and Knitzer, J. (2002) **Improving the Odds for the Healthy Development of Young Children in Foster Care,** Columbia University Press, Columbia

Ewbank, D. C. and Preston, S. H., (1990) **Personal health behaviour and the decline in infant and child mortality: the United States, 1900-1930**, in: J. Caldwell, S. Findley, P. Caldwell, G.Santow, W. Cosford, J. Braid and D. Broers-freeman eds., *Health Transition: the cultural, social and behavioural determinants of health (Health Transition tre*, The Australian National University, Canberra) 116-149.

FAWE (1995) **School Drop-outs and Adolescent Pregnancy**, Nairobi, FAWE.

Flanagan, K. and West, J. (2004). **Children born in 2001: First results from the base year of the Early Childhood Longitudinal Study,** Birth Cohort (ECLS–B) (NCES 2005–036). Washington, DC: National Center for Education Statistics. (www.childcareresearch.org/location/ccrca4623)

Hamusonde, B. S. (2003) **Teenage Mothers and Their Re-Admission into Schools**, MA Dissertation, UNZA, Lusaka.

Holmboe-Ottesen, G. and Wandel, M. (1992) **Women's work in agriculture and Child Nutrition in Tanzania**. J Trop Pediatr.

Japan Institute for Labour (JIL) (2001) **Survey on Women's work and Family Life**, Japan.

Joseph, J. M. and Hiedemann, B. G. (2002) **The demand for non-relative child care among families with infants and toddlers**: A double-hurdle approach. Journal of Population economics, 15(3), 495-526.

Kelly, M. J. (1994) B**elow the Poverty Line in Education: A Situational Analysis of Girl-Child Education in Zambia**, Lusaka UNICEF

Kelly, M. J,. Msango, H. J. and Subulwa, C. M. (1999) **Girls Education A situation Analysis at the Provincial Level of Girl Child Educati in Zambia,** Lusaka.

Lucas, D. and Meyers, P. (1994) **Beginning Population Studies**, National Centre for Development Studies, Australia

Masuy-Stroobant, G. (2001) **The Determinants of Infant Mortality: how far are conceptual frameworks really modeled?** Rome, Paris.

Mbango, M. and Namfua, P. (1992) **Some determinants of Nutritional Status of one-to-four year old children in low income urban areas in Tanzania**, J Trop Pediatr.1991; 38 (6): 229-306.

Mabula-Kankasa, T. and Chondoka, Y. A. (1996) **In the Best Interest of Girl Child: Effects of Cultural and Legal Environment on Education for Zambian Girls**, Lusaka, UNICEF with Ministry of education.

McKeown, T., Brown, R.G., Record, R. G., (1972) **An interpretation of the modern rise of population in Europe**, Population Studies 26(3), 345-382.

Malungo, R. Ntalasha, H. Tembo, R. and Mukuka, L. (1995) **Out of School Youth**, ZERP, Lusaka, Zambia

Mosley, W. H. and Chen, L. C. (1984) **An analytical framework for the study of child survival in developing countries**, Population and Development Review 10 (supplement), 25-45.

MOE, FAWEZA and UNICEF (2004) **Guidelines for the Re-entry Policy**, Lusaka, Zambia.

MOE (2005) **Educational Statistics Bulletin**, Lusaka

MOFNP (2007) **National Population Policy**, Lusaka, Zambia.

MOE (1996) **Educating Our Future: National Policy on Education,** Lusaka

Ministry of Health (2008) **Child Health Policy**, Lusaka, Zambia

Nunn, G. and Parish, T.S. (1982) **Personal and Familial adjustments as a function of family type**, Phi Delta Kappir, 64,141.

Odaga, A. and Henveld, W. (1995) **Girls and Schools in Sub-Saharan Africa**, Washington, World Bank

PAGE (MOE) (1997) a **strategy for improving the quality of education for girls and boys** News Letter Vol. 1 Issue No. 2, December 1997.

Sachiko, I. and Shingou, I. (2005) **Support for Balancing Work and Child care**, Japan.

Swierzewski, J. S. (2007) **Teenage Pregnancy: Overview; Risks to the baby, Other consequences of teenage pregnancy,** University Press, New York.

The Allan Guttmacher Institute (AGI) (2006) **Sharing Responsibilities: Women, Society and Abortion Worldwide**, New York, AGI.

UNAIDS (2000) **"AIDS epidemic update: December 2000"** Geneva: UNAIDS

UNDP (2003) **Development Policy Journal: The Millennium Development Goals**, Oxford University Press, New York.

U.S. Child Care Bureau (2003) **Child Care and Development fund (CCDF):** Report to congress. Washington, DC: U.S. Department of Health and Human services.

Vandmoortele, J. and Delamonica, E (2000) "**The 'education vaccine' against HIV", Current Issues in Comparative Education** (Online), Vol.3, No.1, [www.tc.columbia.edu/cice/vol103nrl].

Voyadnoff, P. and Donnelly, B. (1990) **Adolescent Sexuality and Pregnancy**, Publication Inc, California.

Watkins, K (1999) **Break the Cycle of Poverty**, Oxfam International, Oxford

Williams, N. and Galley, C., (1995) **Urban-rural differentials in infant mortality in Victorian England,** Population Studies 49, 401-420

WHO (1994) **Mother Baby Package: Implementing Safe Motherhood in Countries**, New York.

World Health Organization and United Nations Children's Fund (WHO/UNICEF) (1998) **Complementary Feeding of Young Children in Developing Countries: A review of current scientific knowledge,** Geneva, Switzerland: World Health Organization, WHO/NUT98.1.

Appendix 1: Questionnaires

Questionnaire number:	

For office purposes only

UNIVERSITY OF ZAMBIA

Care and support mechanism for children of teen mothers going back to school

Dear Respondent,

Thank you for participating in this research. Your answers to this questionnaire will be confidential and are completely anonymous. You are not required to give your name or any form of identity.

INSTRUCTIONS

Please respond to the following questions as truthfully as possible. Where there are options, select the appropriate response by putting a cross (x) in the box of your choice.

SECTION 1: RESPONDENT'S BACKGROUND

A: (FOSTER PARENTS OR CARE PROVIDERS)

1. Sex

Female		1
Male		2

2. Age in years

3. Marital Status

Single		1
Married		2
Widowed		3
Separated		4
Divorced		5

4. Residence

Urban		1
Rural		2

5. Who is the head of the household?
6.

Female headed		1
Male headed		2
Child headed		3

7. Have you ever attended school?

Yes		1
No		2

8. What is the highest level of school you attended?

Primary		1
Secondary		2
Tertiary		3

9. How many years did you complete at that level?

10. Can you read and understand simple statements?

Easily		1
With difficulty		2
Not at all		3

11. Occupation

Public service		1
Private sector		2
Business		3
None		4
Retired		5

If in business, please specify type of business……………………………………………………......................

12. What is your monthly income?

Less than K 500 000		1
K 500 000 – K 1 000 000		2
K 1 000 000 – K 5000 000		3
K 5000 000 – K10 000 000		4
Above K10 000 000		5

A. TEEN MOTHERS NEVER RETURNED TO SCHOOL

13. Are you aware that the Zambian government since 1997 has been allowing girls who become pregnant while in school to go back to school?

Yes		1
No		2

14. If the answer to question 21 is yes, what could be the reasons for you not going back to school?

(Circle all mentioned answers)

Financial problems	A
To look after the baby fully	B
Parents are no longer willing	C
No longer interested in school	D
Others	E

If OTHER: PLEASE specify the reasons……………………………………………………………

B: TEEN MOTHERS RE-ADMITTED TO SCHOOL

15. Age in years ………………………………………… | | |

16. Which year were you sent out of school?

MM	YY

17. How old were you when you were sent out of school? | | |

18. Last grade attended when you became pregnant………… | | |

19. Grade re-entered………………………………… | | |

20. Year of re-admission………………

MM	YY

21. How old were you at re-admission? | | |

22. Who pays school fees for the teen mother?

Father of child		1
Parents		2
Relatives		3
Teen mother herself		4
Other		5

If other, please specify……………………………………………………………………………

23. Type of school attended before being sent away

Boarding	Government		1
	Mission		2
	Private		3
Day	Government		4
	Mission		5
	Private		6

24. Type of re-admitting school………………………

Boarding	Government	1
	Mission	2
	Private	3
Day	Government	4
	Mission	5
	Private	6

25. Do you have other pregnancies other than the one which ade you be sent away from school?

Yes		1
No		2

26. If the answer is yes, how old were you when you first came pregnant?

27. If more than one pregnancy, how long did it take befor getting pregnant again?

1 year		1
2 years		2
3 years		3
4 years		4

28. What did the pregnancy result into?

Live birth		1
Still birth miscarriage		2 3

29. Who is responsible for the pregnancy?

Partner		1
Friend		2
Relative Other		3 4

If OTHER: PLEASE specify the person responsible……………………………………

30. Child's father's educational level

Primary		1
Secondary		2
Tertiary		3
None		4

31. Child's father's occupation

Still in school		1
Public sector		2
Private sector		3
Businessman		4
none		5

If in business, please specify type of business…………………………………………………….……........

32. How old is the person responsible for the pregnancy?

33. Marital status of the person responsible for the pregnancy

Single		1
Married		2
Widowed		3
Separated		4
Divorced		5

34. Did the same person responsible for the pregnancy marry you?

Yes		1
No		2

Yes		1

35. If not, do you intend to get married to the same person responsible for the pregnancy?

No		2

Yes		1
No		2

36. Were you forced into the sexual encounter that resulte nto the pregnancy?

37. What was the reaction of the person responsible when you informed him of the pregnancy?

Accepted		1
Rejected		2
Disappeared		3
Other		4

If OTHER: PLEASE specify ……………………………………………………………

38. What was the reaction of your parents when they discovered that you were pregnant?

Accepted		1
Hostile but retained in a home		2
Hostile and sent away		3
Other		4

If OTHER: PLEASE specify the reaction…………………………………….

39. If the reaction of your parents was hostile, have they accepted the child as part of the family when you are at school?

Yes		1
No		2

40. What was the reaction of your parents towards the father of the child?

Accepted		1
Hostile		2
Other		3

SECTION: 2 FAMILY CARE AND SUPPORT SYSTEM

41. Age of the baby………………………………

Years	Months

42. Whom does the child remain with when the mother is at ool?

Father of child		1
Grand parents		2
Close relatives		3
Brothers/sisters		4
Nurseries		5
Others		6

If OTHER: PLEASE specify exactly the one taking care of the child………………………………

43. If the child is in a nursery or regular school, what t of school does the child go to?

Public school (Government)		1
Private School		2
Community School		3

44. If the child is in a nursery or regular school, who pa s the child's school fees?

Father of child	1
Grand parents	2
Close relatives	3
Brothers/sisters to teen mother	4
Mother	5
Others	6

If OTHER: PLEASE specify exactly the one who pays for the child………………………………

47. When you are away at school, do you think your child is adequately cared for?

Agree		1
Strongly agree		2
Disagree		3
Strongly disagree		4

48. Who buys clothes such as uniform for the child?

Father of child	1
Grand parents	2
Close relatives	3
Brothers/sisters to teen mother	4
Mother	5
Others	6

If OTHER: PLEASE specify the one who buys uniform for the child………………………………

49. Who pays school fees for the child?

Father of child	1
Grand parents	2
Close relatives	3
Brothers/sisters to teen mother	4
Herself	5
Others	6

If OTHER: PLEASE specify exactly the one who pays scho fees…………………………………

50. Are those who remain with the child in employment?

Yes		1
No		2

51. What type of employment are they engaged in?

Public service		1
Private sector		2
Business		3
None		4

If in business, please specify type of business………………………………………………………......................

52. Does the father of the child get involved in the care nd support of the child when you are away at school?

Yes		1
No		2

53. If the answer to question **48** is yes, what support does the father provide to the child?

(Circle all mentioned answers)

Financial	A
Material	B
Food	C
Other	D

If OTHER: PLEASE specify exactly the nature of support provided…………………………………………

54. Does the child receive any support from the father's relatives?

Yes		1
No		2

55. Who gives support from the father's side?

(Circle all mentioned answers)

Father of child	A
Grand parents	B
Close relatives	C
Uncles	D
Aunts	E
Others	F

If OTHER: PLEASE specify……………………………………..……………

56. What nature of support does the child receive from the father's relatives?

(Circle all mentioned answers)

Financial	A
Material	B
Food	C
Other	D

If OTHER: PLEASE specify exactly the nature of support received……………………………

SECTION: 3 COMMUNITY CARE AND SUPPORT SYSTEM

57. Does the immediate community get involved in the suppo t of the child?

Yes		1
No		2

58. Who in the community provides the support?

(Circle all mentioned answers)

Church leaders	A
Chiefs	B
Councilors Member of Parliament	C D
Headmen	E
Other	F

If OTHER: PLEASE specify exactly who provides……………………………….…………..……………

59. If the answer to question **53** is yes, what kind of support does it provide?

(Circle all mentioned answers)

Financial	A
Material	B
Food	C
Other	D

If OTHER: PLEASE specify exactly the nature of support provided………………………………

60. Are there non governmental organizations involved in assisting the children left by mothers?

Yes		1
No		2

61. If the answer in 56 is yes, state the organizations involved

62. What kind of support do the organizations mentioned above provide to the child?

(Circle all mentioned answers)

Financial	A
Material	B
Food	C
Other	D

If OTHER: PLEASE specify exactly the nature of support received……………………………

63. Are there Faith Based Organizations (F.B.Os) such as orphanages established to look after the vulnerable children when the mothers are way at school?

Yes		1
No		2

64. What assistance do these organizations provide in the upbringing of the children of teen mothers going back to school?

(Circle all mentioned answers)

Financial	A
Material	B
Food Other	C D
Moral/spiritual	E
emotional	F

If OTHER: PLEASE specify exactly the nature of support received……………………………

65. Are community leaders such as chiefs, headmen, and chu ch leaders getting involved in the welfare of the children whose mothers get re admitted to schools?

Yes		1
No		2

66. If the answer to question **61** is yes, what kind of support do they give?

(Circle all mentioned answers)

Financial	A
Material	B
Food	C
Other	D
Moral/spiritual	E
Emotional	F

If OTHER: PLEASE specify exactly the nature of support provided………………………………

67. Are political leaders getting involved in mobilizing resources to support teen mothers and their children when they get back to school?

Yes		1
No		2

68. If yes, what types of resources are mobilized?

(Circle all mentioned answers)

Financial	A
Material	B
Food	C
Other	D
Moral/spiritual	E
Emotional	F

SECTION: 4 PERSONAL ILLNESSES AND HEALTH STATUS OF A CHILD

a) Immunization

69. Do you have a card where vaccinations are written down?

Yes		1
No		2
Yes but lost		

70. If yes, copy the vaccination dates for each vaccine fr m the card

	Vaccine	D	D	M	M	Y	Y
66.1	**BCG**						
66.2	**Polio 1**						
66.3	**Polio 2**						
66.4	**Polio 3**						
66.5	**Polio 4**						
66.6 66.7	**DPT 1** **DPT 2**						
66.8	**DPT 3**						
66.9	**Measles**						

71. Has the child received any vaccinations that are **not** recorded on the above card?

Yes		1
No		2

If yes specify…………………………………………………………………………………….

<u>**Question 64 should be asked where the card is lost***</u>**

72. **<u>Please tell me if the child received any of the following vaccinations.</u>**

a. An injection in the left forearm that caused a scar (BCG vaccination against TB)

Yes		1
No		2

b. Drops in the mouth (Polio Vaccination)

Yes		1
No		2

If yes state number of times ☐

c. Vaccine in the right thigh or buttock (DPT for whooping cough)

Yes		1
No		2

If yes state number of times ☐

d. Injection against measles

Yes		1
No		2

73. Has the child been frequently ill with a cough?

Yes		1
No		2

74. Has the child been frequently ill with diarrhea?

Yes		1
No		2

75. Has the child been frequently ill with malaria?

Yes	1
No	2

76. Has the child been frequently ill with pneumonia?

Yes		1
No		2

b) Curative measures

77. Did you seek treatment for any of the diseases listed above?

Yes		1
No		2

78. Where did you seek advice or treatment from?

Public Health facility		1
Private health facility		2
Traditional healer		3
Other		4

If OTHER: PLEASE specify the facility used……………………………….…………….

79. Who takes the child for medical attention when sick?

Father to the child		1
Grand parents Friends		2 3
Mother		4
Other		5

If others please specify………………………………………………………..

80. Do you have knowledge on how to prepare Oral Rehydrati n Salts (ORS) fluids?

Yes		1
No		2

81. Is the child given ORS fluids whenever he/she has diarrhea?

Yes		1
No		2

82. How often does the child sleep under a mosquito net

Always Sometimes		1 2
Never		3

C Environmental Factors

83. What kind of wall does the shelter in which the child lives in made of?

Bricks		1
Pole and mud		2
Grass hut		3
Plastered with cement		4
Other		5

If OTHER; please specify………………………………………………………………….

84. What kind of roof is the shelter made of?

Iron roof Grass thatched	1 2
Tent	3
Tiles	4
Asbestos	5
Other	6

If OTHER; please specify…………………………………………………………………………

85. Could you describe the main material of the floor of t house in which the child sleeps?

Natural (earth/sand)		1
wood		2
Tiles		3
cement		3
carpet		4
Other		6

If OTHER; please specify……………………………………………………………………

86. Size of the house hold ☐

87. How many sleeping rooms has the house got? ☐

88. How many people sleep in the same bedroom where the child sleeps? ☐

89. Do you have instances where visitors share the same beddings and bedroom with the child?

Yes		1
No		2

90. Has the child got adequate clothing and beddings to ca er for all seasons especially the cold season?

Yes		1
No		2

91. Source of drinking water for the child

Piped		1
Public tap		2
Traditional well		3
Shallow well		4
River or stream		5
Bore hole		6

92. Type of toilet facility available

Own flush	1
Shared flush	2
Own pit	3
Shared pit	4
Bush	5
No facility	6

93. Approximate distance from the well to the toilet

94. How often do you monitor the child's movements around he home?

Always		1
Rarely		2
Never		3

95. How long do you stay with a child?

always		1
frequently		2
Rarely		3
Never		4

SECTION: 5 INFANT FEEDING AND HABIT TRAINING

96. Did you ever breastfed the child?

Yes		1
No		2

97. If yes, how long did you breastfeed the child?

	Months

98. If no, why did you not breastfeed?

Mother ill/weak		1
Child ill/weak		2
Child died		3
Nipple/Breast problem		4
Child refused		5
Went to school immediately		6
Other		7

If other, specify……………………………………………………………………………………

99. Is the child still breastfeeding?

Yes		1
No		2

100.How many times did/do you breastfeed the child in a da ?

	times

101.Was bottle feeding introduced to the child?

Yes		1
No		2

102.If yes, indicate timing of bottle feeding

Months

103.Apart from milk has the child been introduced to water and mushy foods?

Yes		1
No		2

104. How old was the child when introduced to marshy (porridge) and solid (*nshima*) foods?

Months

SECTION: 6 NUTRITIONAL STATUS OF CHILDREN

105. What type of foods below do you give to a child within a week to eat?

	Type of food	**Yes**	**No**	
101.1	Eggs			1
101.2	Milk			2
101.3	Groundnuts			3
101.4	meat			4
101.5	beans			5
101.6	Porridge with groundnuts			6
101.7	Plain porridge			7
101.8	fish			8
101.9	vegetables			9
101.10	nshima			10
101.11	Fruits			11
101.12	Local Brew (*Chibwantu*)			12
101.13	*Delele*			13
101.14	Left over nshima (*Cimbala or ndala*)			14
101.15	Kapenta			15
101.16	Other			16

If OTHER, specify……………………………………………………………..……………..

106. **Anthropometric data for the children**

Age (in years)	
Height (in centimeters)	
Weight (in kilograms)	

Appendix: 2

INTERVIEW GUIDE FOR IN-DEPTH DISCUSION

UNIVERSITY OF ZAMBIA

Care and support mechanism for children of teen mothers going back to school

---

1. **BACKGROUND**
   a. Do you support the idea of sending back school girls who become pregnant while in school?
   b. To what extent is re-entry policy taken advantage of by girls who fall out of school due to pregnancies? Is it likely to contribute egnancy rates?
   c. Who facilitates the going back of girls to school?
   d. What support system is available both at home and school for t e returning girls?
   e. Are the children of teen mothers allowed to be breastfed at school?
   f. What are the peer and teacher response and reaction to the returning teen mothers?
   g. What are some of the hurdles hindering girls to go back to school?

2. **EDUCATION**
   h. How is the performance of the returning girls at schoo ?
   i. Is there any interference of mothers by babies while a school?
   j. Are teen mothers called back home to nurse their children while at school?
   k. What could be the ideal time interval for the teen mothers to go back to school after delivery?
   l. When not at school, does the girl stay with the boy who made her pregnant?

3. **CARE AND SUPPORT SYSTEM**
   m. In the era of HIV and AIDS, do you find it easy to support children left girls who return to school?

n. With the prevailing economic hardships, how do you tak care of children left by teen mothers adequately when you also need enough time and resources to fend for yourselves?
o. Do receiving schools to returning girls provide facilities for baby care while teen mothers are at school?
p. Is there any support provided by schools to both mothe nd their children?
q. What challenges do you face in the caring and supporti g of the children who remain when mothers go back to school?
r. Are you working for a member of your family, someone else or self employed?
s. Do you take the child with you when you are working?
t. Who usually takes care of the child when you are working?
u. Who usually takes the child for immunization?
v. Who prepares Oral Rehydration Salts (ORS)?

Appendix 3: Interview schedule for Heads/Guidance teachers

Questionnaire number:

For office purposes only

UNIVERSITY OF ZAMBIA

Care and support mechanism for children of teen mothers going back to school

Dear Respondent,

Thank you for participating in this research. Your answers to this questionnaire will be confidential and are completely anonymous. You are not required to give you name or any form of identity.

INSTRUCTIONS

Please respond to the following questions as truthfully as possible. here there are options, select the appropriate response by putting a cross (x) in the box of your choice.

Part 1: Details of school

1. Type of school

Day	Single sex	1
	Co-education	2
Boarding	Single sex	3
	Co-education	4

2. Agency

GRZ	1
Community school	2
Private	3
Faith-Based (Grant-aided)	4

3. Job title of respondent

Head	1
Deputy Head	2
School counselor	3
Other	4

If other please specify……………………………………………………………….

Part 2: General situation analysis of policy implement tion in schools

4. Are you aware of the re-entry policy introduced by the government through the ministry of education?..

5. Are you in support of the policy as a school?......... ....

6. To what extent does your school get involved in the implementation of the policy?... ....

7. How many pregnancies occurred in the following years?

2008	
2007	
2006	
2005	

8. Are the girls taking advantage of the policy at your school?..............................

9. How many girls have so far taken advantage of re-entry policy at your school in the following years?

2008	
2007	
2006	
2005	

10. If the answer to question 8 is no, what could be some of the obstacles hinderi g them from going back to school?... ....

11. Do you have school-based activities/projects that promote re-entry policy?............

12. How often do you conduct counseling sessions for the girls who become pregnant while in school and later decide to go back to school?...

13. Are there antenatal arrangements facilitated by your school for teenage mothers and girls who fall pregnant while in school?.......... ....

14. Are there day care arrangements for the children of te ge mothers in your school?... ....

15. How do you facilitate for the care and support of the young children of teenage mothers in school?...

16. Is the school engaged in sensitization programmes to p rents about re-entry policy?... ....

17. When does the school authorities send away girls from found to be pregnant from school?... ....
.

18. Is there stigmatization by teachers or pupils to the re-entry girls?............................

19. What measures has the school put to minimize stigmatiz tion of re-entry girls?... ....

20. What challenges do you face in the implementation of re-entry policy?..................
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………