UNIVERSITY OF GHANA

COLLEGE OF HUMANITIES

EXPLORING THE EXPERIENCES OF TEENAGE MOTHERS WITH REPEAT PREGNANCIES IN ABLEKUMA SUB-METROPOLIS, ACCRA

BY

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DEPARTMENT OF SOCIAL WORK

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DECLARATION

I, Lucinda Okine declare that this thesis is my own research which was conducted under the supervision of Prof. Mavis Dako-Gyeke and Dr. Kingsley Saa-Touh Mort. All references have been duly cited. No part of this work has been submitted anywhere for another degree.

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ABSTRACT

Repeat pregnancies among teenage girls is a social problem confronting many countries, including Ghana. This study sought to: (a) find out factors contributing to repeat pregnancies among teenage mothers, (b) identify challenges faced by teenage mothers with repeat pregnancies, (c) explore the knowledge of teenage mothers with repeat pregnancies on contraceptives, and (d) ascertain the social support systems available to teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis. Utilizing a qualitative research design, convenience and snowball sampling methods were used to recruit 41 participants for the study. The sample consisted of 33 teenage mothers with repeat pregnancies and eight health workers from the Mamprobi Polyclinic. In-depth interviews and focus group discussions were utilized to gather data for the study. The data were analyzed thematically, and it was found that factors contributing to repeat pregnancies were: low level of education, truancy, early marriage, poverty, peer pressure, and sexual coercion. Furthermore, teenage mothers included in this study faced educational, financial, health challenges and psychological issues. Besides, it was found that some of the teenage mothers were stigmatized in their communities. Also, health facilities, families, friends, and schools played crucial roles in disseminating information on family planning. Additionally, although teenage mothers obtained support from their spouses, in-laws, families, neighbors, and health workers, they faced barriers, such as family members rationalizing their problems, being accused of infidelity, ignorance of formal support services, personal attitudes, and bad attitudes of some health professionals. The study concludes that teenage mothers are at risk of repeat pregnancies and therefore recommends that stakeholders, such as social workers, Planned Parenthood Ghana, and the Ministry of Health, promote education on teenage pregnancy, family planning, and available support services.
DEDICATION

I dedicate this thesis to my family especially, my father Mr. Theophilus Okine, and my mother Mrs. Veronica Okine. I also want to dedicate this work to Dollita, Sarah, Uriel, and Dr. Adjesiwor who in diverse ways helped me with their ever loving and inspirational support.
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CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Teenage pregnancy is one of the social problems in the 21st century that has received global attention (McCall, Bhattacharya, Okpo, & Macfarlane, 2015). Girls who become pregnant before 18 years may not be able to exercise their rights to protection, health, education, and adequate quality of life. This is because some of these teenage mothers drop out of school due to the pregnancy (Adu-Gyamfi, 2014; Montgomery, 2009). In addition, these girls often lose their childhood and have to take on obligations of adults without being able to enjoy the benefits of childhood (United Nations Children’s Fund (UNICEF), 2014).

The United Nations Children’s Fund defined teenage pregnancy as “a teenage girl, usually within the ages of 13 and 19 becoming pregnant” (UNICEF, 2008, p.1). Although the margin varies across the world, teenage pregnancy generally applies to all girls who become pregnant before reaching the age of legal adulthood. Teenage pregnancy affects both developed and developing countries (Sayem & Nury, 2011). At the global level, an estimated 16 million girls aged 15 to 19 years give birth every year (Dick & Ferguson, 2015) and 95 percent of these births occur in low and middle-income countries (World Health Organisation, 2014).

In sub-Saharan Africa, countries such as Kenya, Zambia, Swaziland, Tanzania, and Ghana, have policies to support teenage mothers after their birth (Maluli & Bali, 2014). The school re-entry policy is one of the strategies that has been employed to control the scourge and negative impact of teenage pregnancy and motherhood experience in the aforementioned countries (Maluli & Bali, 2014). In addition, Ghana implemented the Adolescent Reproductive Health Policy in 2000. This
policy provided a framework for adolescent reproductive health implementers and policymakers on the provision of sexual and reproductive health services to adolescents in Ghana (UNFPA, 2016). Other policies include the National Youth Policy and National Adolescent Health and Development (ADHD) program. The National Youth Policy provides broad and holistic policies for the wellbeing of adolescents. The ADHD program aims at addressing the health needs of adolescents by providing adolescent-friendly health services (Ghana Health Service, 2014). Aside from policy interventions, some of the suggested solutions to teenage pregnancy include sexual and reproductive health education, abstinence, and the use of condoms or other contraceptives. Despite these interventions, teenage pregnancy is still prevalent in many countries and many teenage girls are at risk of pregnancy.

Sub-Saharan Africa has the greatest concentration of teenage mothers where 20 to 40 percent of teenage girls have been found to become pregnant by the age of 18 (Gyesaw & Ankomah, 2013). The situation is not different in Ghana. A survey conducted in 2014 revealed that about 14 percent of young women aged 15 to 19 had begun childbearing in Ghana (Ghana Statistical Service, 2015). In addition, the proportion of teenagers who had begun sexual intercourse by age 15 increased from seven percent in 1998 to 12 percent in 2014, while the proportion who had begun childbearing in Ghana increased from 13 percent in 2008 to 14 percent in 2014 (UNFPA, 2016).

Furthermore, the top three districts that had the highest incidence of teenage pregnancies in 2014 were all in urban areas. These included the Kumasi Metropolis, the Techiman Metropolis, and the Greater Accra Metropolis (Ghana Health Service, 2014). Teenage girls who had begun childbearing in urban areas increased from 7.2 percent in 2003 to 12 percent in 2014 (UNFPA, 2016). In addition, regional trend analysis from 2012 to 2014 revealed that 60 percent of regions
in Ghana experienced an increase in teenage pregnancy (Ghana Health Service, 2014). In Greater Accra, the proportion of adolescents who had begun childbearing also increased from 6.6 percent in 2008 to 8.3 percent in 2014 (Ghana Statistical Service, 2015). Thus, teenage pregnancy remains a problem, especially in Ghana and many teenage mothers are at risk of repeat pregnancies.

Repeat pregnancies are on the rise and many teenage mothers are at risk of repeat pregnancies especially within two years of their first pregnancy (Collier, 2014; Maravilla, Betts, Couto, & Alati, 2017). In addition, one in every three teenage mothers has another pregnancy within two years after their first childbirth (Damle, Gohari, McEvoy, Desale, & Gomez-Lobo, 2015). Furthermore, Raneri and Wiemann (2007), also added that 42 percent of black, white, and Mexican-American teenage mothers experienced repeat pregnancies within 24 months after their first child and 73 percent delivered the second child.

The second birth to a teenage mother may be more challenging to the teenage mother and her child because of the increased socioeconomic impact as well as the influence of short pregnancy interval (Pinzon & Jones, 2012). There is, however, a dearth of information on factors relating to repeat pregnancies and social support systems. Also, not much information exists with regard to the knowledge of teenage mothers on contraceptives in Ghana (Krugu, Mevissen, Munkel, & Ruiter, 2017). This study therefore explored experiences of teenage mothers with repeat pregnancies in the Ablekuma sub-Metropolis, Accra.

1.2 Problem Statement

Teenage pregnancy is an issue of concern in many developing countries including Ghana. The Demographic and Health Survey in 2014 revealed that 30 percent of births recorded in Ghana were attributable to adolescents (Ghana Statistical Service, 2015). In Ghana, teenage pregnancy is
usually associated with shame, disgrace, and stigma from society. In addition, when a teenage girl becomes pregnant, her present and future may change and rarely for the better. Her education may end, her job prospects may disappear, and her vulnerabilities to dependency and poverty may increase. Furthermore, teenage girls may be more susceptible to abortion, maternal mortality, mental health issues, and child mortality. Thus, Ghana as a country may lose a great number of human resources because of teenage pregnancy.

In addition, there may be a high concentration of teenage mothers in the Ablekuma sub-Metropolis. This is because most of the communities in the area are low-income and densely populated fishing communities. Therefore, many of the teenage girls in the communities may drop out of school due to poverty, low level of education, and teenage pregnancy. This may put them at risk of repeat pregnancies as they may engage in transactional sex to fend for themselves. In addition, many sexually active teenage girls may not use contraceptives due to the negative attitudes of some health workers and inability to afford contraceptives. This may also put them at risk of repeat pregnancies. The second birth to a teenage mother may be more challenging to the teenage mother and the child due to neglect by the spouse, family or community. Repeat pregnancies among teenage girls could therefore affect the development of human capital and put a strain on the resources of the nation.

Furthermore, teenage mothers may be less likely than older mothers to engage in supporting their children emotionally and responsively. This may be due to inadequate knowledge about the child’s development or the compounding challenges they may be facing as teenage mothers with repeat pregnancies. Moreover, some single teenage mothers may be abandoned by their spouses due to fear and lack of financial means to provide for the mother and child. This could leave the teenage
mother with less financial assistance and support. Also, a lack of paternal support may increase the teenage mother’s feelings of anger, shame, and depression which could lead to the abuse and neglect of their children.

Some research has been conducted in Ghana about the effects of teenage pregnancy on the education of girls (Adu-Gyamfi, 2014), factors contributing to early sexual activity, pregnancy, contraceptive use, and unsafe abortions (Eliason, Baiden, Yankey, & Awusabo–Asare, 2014). However, not much is known about their experiences as mothers with repeat pregnancies. Thus, this study aimed to explore the experiences of teenage mothers who have had repeat pregnancies in Ablekuma sub-Metropolis, Accra.

1.3 Objectives of the Study

The objectives of the study were:

1. To find out factors contributing to repeat pregnancies among teenage mothers in Ablekuma sub-Metropolis.

2. To identify challenges faced by teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis.

3. To explore the knowledge of teenage mothers with repeat pregnancies on contraceptives in Ablekuma sub-Metropolis.

4. To ascertain the social support systems available to teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis.
1.4 Research Questions

1. What factors contribute to repeat pregnancies among teenage mothers in Ablekuma sub-Metropolis?

2. What are the challenges faced by teenage mothers in Ablekuma sub-Metropolis?

3. What knowledge do teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis have on contraceptives?

4. What social support systems are available to teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis?

1.5 Significance of the Study

This study would contribute to existing literature on teenage pregnancy, particularly repeat pregnancies. Also, this study would be a useful guide to agencies such as the Department of Social Welfare, Ministry of Health, Ministry of Gender, Children, and Social Protection, in advocating for interventions and policies geared towards addressing the issue of repeat pregnancies among teenage mothers. Furthermore, the findings of the study would inform policymakers and advocacy groups of the challenges faced by teenage mothers with repeat pregnancies. In addition, the study would be a useful tool for community health nurses in educating teenage mothers about contraceptives. Also, this study would provide insight into the support systems available to teenage mothers with repeat pregnancies and the barriers preventing teenage mothers from accessing formal support. This would help ensure that appropriate interventions are put in place to provide support for teenage mothers and their children.
1.6 Definition of Terms

Child: This refers to a person below the age of eighteen years (Government of Ghana, 1992; United Nations Convention on Rights of the Child, 1989).

Childcare: The care of children especially as a service while parents are working or in school (Merriam Webster, 2017).

Contraceptive: It is a method, device or drug used to prevent pregnancy.

Family planning: It is the use of contraceptive methods to attain a desired number of children and determine the spacing of pregnancies. It is achieved using contraceptives.

Kin support: This is when grandparents and other relatives care for children whose parents are unable to care for them. It is usually an informal arrangement between parents and relative caregivers to support them in raising their children (Child Welfare Information Gateway, 2016).

Teenage: Teenage or adolescence is defined as an individual between the ages of 10 and 19 (Ghana Statistical Service, 2012).

Teenage mother: For this study, a teenage mother refers to a girl below 20 years who has given birth.

Teenage pregnancy: Teenage pregnancy is defined as “a teenage girl, usually within the ages of 13 and 19 becoming pregnant” (UNICEF, 2008, p.1).

Repeat pregnancy: Repeat pregnancy is defined as the incidence of two or more pregnancies before the age of 20 (Aslam et al., 2017).

Social support: It is a transactional process, both verbal and nonverbal, to improve an individual’s feelings of coping, competence, belonging, and self-esteem.
(Mattson & Hall, 2011). For this study, social support includes financial support, emotional support, informational support, and kin support.

1.8 Organisation of the Study

The study is organized into five chapters. The first chapter includes the background, problem statement, objectives of the study, research questions, significance of the study, definition of terms, and organization of the study. The second chapter presents a review of the literature on repeat pregnancy as well as the theoretical perspective. Chapter three outlines the research methodology, which comprises the research design, study area, target population, study population, sampling techniques, sample size, methods of data collection, data handling, data analysis, ethical considerations, trustworthiness, and limitations of the study. Chapter four of the study focuses on presentation and discussion of findings. The fifth chapter presents the summary of findings, conclusions, recommendations, and implications for social work.
CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL PERSPECTIVE

2.1 Introduction
This chapter presents the literature review and theoretical perspective. Literature was reviewed under the following themes: (a) factors contributing to repeat pregnancies, (b) challenges faced by teenage mothers, (c) knowledge of teenage mothers on contraceptives, and (d) support systems available to teenage mothers. Additionally, the ecological systems theory and its relevance to the study are discussed.

2.2 Factors Contributing to Repeat Pregnancies
A community-based cohort study in the United States revealed that depressive symptoms and truancy significantly increased the chance of repeat pregnancies (Barnet, Liu, & DeVoe, 2008). With regard to the low level of education being a risk factor, Davis (2002) also reported that teenage mothers less than 16 years with low education had a greater chance of having another child within two years after the first child. Furthermore, Bennett, Frasso, Bellamy, Wortham, and Gross (2013) reported similar findings and added that, being educated and being Asian or white American decreases the risk of repeat pregnancies. In addition, another cohort study conducted in the United States by Montgomery (2009) reported that being expelled from school positively predicted repeat pregnancies among teenage mothers.

A study by Vieira et al. (2016) also reported similar findings and added that the young age of the mother and inadequate schooling interacts to increase the risk of repeat pregnancies. In addition, a mixed method study in Ghana reported that as education increases, childbearing decreases. The study further revealed that in 2014, 23.2 percent of adolescents with no education and 19 percent
of those with primary education had begun childbearing. However, at the junior high school and post junior high school level, adolescent childbirth was 14 and 6.2 percent, respectively. Furthermore, a quantitative study assessing the effects of teenage pregnancy on achieving Universal Basic Education in Upper Denkyira West, Ghana, revealed that 96.3 percent of the respondents had stopped school as a result of teenage pregnancy (Adu-Gyamfi, 2014).

Raneri and Wiemann (2007) further added that intimate partner violence, not being in school within three months after the first childbirth and having friends who were adolescent parents increased the risk of repeat pregnancies. Also, a cross-sectional study in Brazil revealed that sociodemographic advantages and the use of prenatal health service decreased the likelihood of repeat pregnancies (Padin et al., 2012). This was corroborated in a mixed-method systematic review by Aslam et al. (2017) in the United Kingdom who found that poverty and low future aspirations are significant risk factors for repeat pregnancies. Crittenden, Boris, Rice, Taylor, and Olds (2009), in their study of African-American teenagers, reported that being very young at first pregnancy, getting married at adolescence, and having a mother who was a teenage mother increased the susceptibility of teenage mothers to repeat pregnancies.

On the contrary, Heilborn and Cabral (2011) suggested that teenage pregnancy might not be the consequence of sexual promiscuity as is mostly portrayed. However, it is rather a sign of social status for the girl, given the poor environment many teenage girls come from and lack of professional aspirations. A mixed-method study by Quist-Adade (2017) on teenage pregnancy and adolescent sexual and reproductive health behavior in Suhum, Ghana, revealed that peer pressure from friends and classmates are factors influencing sex and repeat pregnancies. They also added
that money and financial reward also contributed to teenagers engaging in sexual activity. This finding was confirmed in a qualitative study that analyzed factors associated with teenage pregnancy among adolescents with pregnancy experience in Bolgatanga, Ghana (Krugu et al., 2017). Krugu et al. (2017) found that young women’s motivation for sexual relationships is more focused on economic factors. Other factors used to force teenage girls into sex included physical pressure, which included beating and pushing, as well as verbal pressure such as boys saying they want a proof of fertility.

Furthermore, a quantitative study in Sunyani, Ghana, on adolescent pregnancy in an urban community, revealed that the occupation of teenagers and social media were factors that contributed to teenage pregnancy (Baafi, 2015). Also, a metanalysis of 26 epidemiological studies from the United States was conducted by Maravilla et al. (2017), to find out the factors that influenced repeat pregnancies. From the analysis, they concluded that some factors contributing to repeat pregnancies among teenage mothers were lack of education, inadequate knowledge about contraception, and a history of abortion. These findings confirmed most of the earlier literature reviewed.

### 2.3 Challenges Faced by Teenage Mothers

Teenage pregnancy has several effects on the individual, the community, and even the society. In sub-Saharan Africa, mothers who are adolescents are greatly disadvantaged and face many challenges during pregnancy and early motherhood (UNFPA, 2016). As suggested by Cook and Cameron (2015), young women who have babies are less likely to finish high school, as compared to their colleagues who delay childbearing. In addition, adolescent mothers are more likely to have
children who have poorer behavioral, health and educational outcomes, and more likely to be poor as adults (Cook & Cameron, 2015).

According to Partington, Steber, Blair, and Cisler (2009), a second birth may be even more harmful and challenging to the child and mother as compared to single teenage births due to the increased socioeconomic impacts and the impact of short pregnancy intervals. Furthermore, teenage mothers with repeat pregnancies are less likely to return to school or complete high school as compared to those who have just a child. This places them at a greater risk of poverty and dependence on societal welfare in the long-term (Maravilla et al., 2017). There is also existing literature that has established a positive correlation between teenage pregnancy and educational attainment. This was reflected in a quantitative study in Ghana by Gyan (2013) which revealed that factors that predicted an increase in teenage pregnancy such as poverty and school dropouts also predicted truancy, grade repetition, and reduced study hours among teenage mothers. This was supported by Biney and Nyarko (2017) who added that teenage motherhood had a negative impact on the educational attainment of teenage girls.

In addition, a qualitative study in Ghana by Owusu-Addo, Owusu-Addo, and Morhe (2016) on the health information seeking behavior among teenagers revealed that pregnant teenagers were mostly unaware of their pregnancy which was a terrible and frustrating experience, as it had to take another person to inform them of the pregnancy. In addition to their findings, participants felt unprepared both psychologically and physically for labor since they were unaware of what to expect due to lack of information. The authors further attributed teenagers’ fear in accessing information on how to take care of their babies to intimidation because they are mixed up with the
older women during antenatal and postnatal visits. They also added that the negative attitudes of health care professionals towards teenage mothers limited their ability to access information both before and after childbirth. Lastly, many adolescent mothers refused to seek information due to social stigma and fear of being asked to abort the baby.

Furthermore, a qualitative study in the Volta Region in Ghana by Lotse (2016), revealed that teenage mothers faced financial difficulties as a result of abandonment by parents, significant others, and boyfriends due to anger and perception of shame brought on by the pregnancy. In addition, the teenage mother’s economic challenge is worsened because of her inability to engage in economic activity due to the baby she must care for or the community’s unwillingness to engage with her. Other challenges include shame, rejection, emotional and psychological problems, educational constraints and cultural and religious challenges resulting from the community norms that classify teenage sexual activity and pregnancy as unacceptable (Lotse, 2016).

In addition, another qualitative study by Watts, Mimmie, Liamputtong, & Mcmichael (2015) on the experiences of African-Australian teenage mothers in greater Melbourne, Australia, showed that teenage mothers faced challenges which affected their lives. Some of these challenges included managing the competing demands of school, work, and raising their babies, coping with increased responsibilities following the birth of the baby, and feelings of shame and embarrassment due to stigmatization by the community. Boath, Henshaw, and Bradley (2013) in their qualitative study on meeting the challenges of teenage mothers with postpartum depression in Trent, UK, also reported that the teenage mothers felt devalued due to people judging them for being mothers at an early age as well as being perceived as bad mothers.
Some studies have found positive effects of teenage pregnancy on the lives of teenage mothers (Duncan, 2007; Spear & Lock, 2003; Wahn & Nissen, 2008). Perceived benefits to teenage motherhood include feeling stronger (Duncan, 2007), having a meaningful life, maturity, and independence (Spear & Lock, 2003), becoming more responsible due to having a child they were responsible for and considering a career and education. However, a recent study by Chan et al. (2016) on suicidal ideation among teenage mothers revealed that pregnant adolescents were at a greater risk of suicide. They further added that depression, societal pressures, and expectations may buttress their findings of significantly more suicidal ideation among pregnant adolescents. This finding was supported by a quantitative study in the United States on teenage pregnancy and mental health which revealed that teenage mothers were at greater risk of depression and behavioral disorder (Corcoran, 2016).

2.4 Knowledge of Teenage Mothers on Contraceptives

Unplanned pregnancy has a direct link with low sexual health knowledge (Watts, Mimmie, Liamputtong, & Carolan, 2014). Thus, the knowledge of teenage mothers on the use of contraceptives plays a significant role in reducing the risk of repeat pregnancies. However, teenage mothers have been found to use contraception less than those who were never pregnant (Parkes, Wight, Henderson, Stephenson, & Strange, 2009). Attempts have been made in the past to attribute this to lack of knowledge, limited access to contraceptives, lack of control over contraceptive decisions, side effects of contraceptives, and violent and coercive sexual relationships (Macleod & Tracey, 2010). However, a previous study by Awusabo-Asare, Biddlecom, Kumi-Kyereme, and Patterson (2006) posited that adolescents may be aware of contraceptives but might not be
cognizant of how to use them. In addition, low contraceptive usage by teenage girls may also be influenced by the low availability of contraceptives as well as feeling ashamed to use contraceptives due to the stigma attached to contraceptive usage among young girls (Adjei, Sarfo, Asiedu, & Sarfo, 2014; Apanga & Adam, 2015).

Findings from a qualitative study which sought to find out the contraception knowledge among African-Australian women who had experienced teenage pregnancy revealed that teenage mothers had little knowledge of sexual health and contraception, resulting in their pregnancies (Watts et al., 2014). For those who even knew about contraceptives, they did not know how to use the contraceptives and how the contraceptives work.

In addition, it was also observed that many teenagers refused to use contraceptives due to the following reasons: becoming infertile, having an irregular menstrual cycle, gaining weight, getting cancer, and having to wait for about seven years before being able to conceive again (Watts et al., 2014). These findings were confirmed in a study conducted by Ochako et al. (2015) in Kenya on barriers to modern contraceptive. They found that the main barriers to contraceptive use were due to misconceptions and myths, which included infertility and other negative health consequences.

To buttress, UNFPA (2016) reported that 30 percent of sexually active teenagers did not use any contraception.

Also, a cross-sectional analytic study conducted by Somba, Mbonile, Obure, and Mahande (2014) to assess sexual behavior, contraceptive knowledge and contraceptive use among female undergraduate students of Muhimbili and Dar es Salaam Universities in Tanzania, revealed that respondents had poor knowledge on contraceptives resulting in low usage of contraceptives. They
also reported that many respondents were sexually active, with majority starting sexual activity at a young age. Of the sample of 281 young girls, 15.8 percent were pregnant. From this, 27 percent had unwanted pregnancies and 54.6 percent had an induced abortion.

Furthermore, Taffa, Haimanot, Desalegn, Tesfaye, and Mohammed (2017), also carried out a survey in Ethiopia on 246 families and 343 high school students to assess the awareness of both groups on family life education and the level of parent-adolescent communication on issues regarding young people’s sexuality. The study showed that the knowledge of young people on contraceptive and sexuality was inadequate to minimize the risk of teenage pregnancy. They also attributed the lack of knowledge of adolescents to poor education from their parents. This was because 93 percent of the parents sampled did not approve premarital sex and many of them were not comfortable educating their wards on adolescent sexuality and contraceptive use. Thus, leaving their wards to figure out changes they go through during adolescence on their own.

Widman, Choukas-Bradley, Noar, Nesi, and Garrett (2016) obtained similar findings and reported that parent-adolescent communication on issues relating to their sexual and reproductive health served as a protective factor for safer sex among youth as well as the risks of unintended pregnancy. Moreover, an analysis of data on married and unmarried adolescents from 16 diverse countries conducted by Chandra-Mouli, Camacho, and Michaud (2013) revealed that sexual activity among adolescents increased from mid to late adolescence. However, they posited that although adolescents had some knowledge on using contraceptives, they faced some barriers with regard to accessibility. These include contraceptive methods not being available to adolescents,
laws, and policies preventing unmarried adolescents from being provided with these contraceptives, and stigma surrounding the use of contraceptives by adolescents.

In addition, Chandra-Mouli et al. (2013) reported that adolescents having a poor understanding of how contraceptives are used are at the risk of pregnancies. However, they suggested that the knowledge and awareness of contraception do not necessarily translate into use. In a study using a cluster randomized trial in 40 reproductive health clinics in the United States, Harper et al. (2015) suggested that unintended pregnancy rates could be reduced through counseling on long-term contraception and access to these contraceptives during family planning visits. This is supported by the Center for Disease Control and Prevention (CDC) which recommended increasing access to contraceptive use as an approach to reducing unintended pregnancies (Centers for Disease Control and Prevention, 2013).

Furthermore, Finer and Philbin (2013), analyzed data from the national survey of family growth in the United States and found that sexual activity among younger teenagers was nonconsensual and thus, called for education on family planning as well as making contraceptive methods available before teenagers become more sexually active. In addition, a cohort study in the United States by Raneri and Wiemann (2007) revealed that not using a long-acting contraceptive within three months of delivery, increased the chances of repeat pregnancies. Also, another cohort study in the United States found that early initiation of contraception and more postpartum follow up visits will decrease the chances of repeat pregnancies among teenage mothers (Damle et al., 2015). Baldwin and Edelman (2013) also corroborated these findings by adding that, the risk of repeat pregnancies is reduced when contraceptives are initiated earlier after childbirth.
Padin et al. (2012), in a cross-sectional study in Brazil, also concluded that prevention of repeat pregnancies is a complex issue that required not only dissemination of information, but also, requires teenage mothers getting access to contraceptives, adequate healthcare, and education. The United Nations Commission for Human Rights posits that unimpeded access to family planning and reproductive health services are a fundamental right that contributes to the advancement of women worldwide (National Association of Social Workers, 2014). A human rights approach to curbing teen pregnancy, therefore, entails working with governments to remove the obstacles that prevent teenagers from exercising their rights. This entails addressing the roots of the problem, which include poverty, sexual violence and coercion, child marriage, and lack of access to education on sexual and reproductive health as well as information on contraception (UNFPA, 2016).

2.5 Support Systems Available to Teenage Mothers

For a teenager who needs parenting herself, parenting can be overwhelming (Schrag & Schmidt-Tieszen, 2014). Social support is, therefore, an important component of the emotional and physical wellbeing of mothers especially, just after childbirth (Negron, Martin, Almog, Balbierz, & Howell, 2013). Many women find it challenging to meet the demands of early motherhood (Negron et al., 2013) and for adolescent mothers with repeat pregnancies, it may be more difficult to garner support. This makes their experience of motherhood more challenging. Wahn and Nissen (2008) corroborated these findings by adding that teenage mothers are at a greater psychosocial risk and needed unique care and attention. They also added that teenage mothers may experience postpartum challenges differently from adult mothers and thus, needed more support.
Furthermore, a quantitative study by Wiemann, Agurcia, Rickert, Berenson, and Volk (2006) in the United States on absent fathers as providers, found that paternal presence, as well as financial support, led to the reduction of stress for the teenage mother. However, they also added that the paternal support for the baby is affected by the level of involvement of the father in the decision-making process during the pregnancy. Nadeem and Romo (2008) on the other hand revealed that many teenage mothers depend on their mothers for support. They further added that there are higher levels of teenage life satisfaction and positive parenting skills when teenage mothers have a close relationship with their mothers.

Also, Cheng and Pickler (2009), suggested that a range of psychological stressors is experienced by women during the postpartum period and lack of social support for women could result in depression and exposure to other risks. These findings were confirmed by Kim, Connolly, and Tamim (2014) who stated that social support after childbirth is essential for the teenage mother as it reduced the risk of postpartum depression. Thus, an effective way to help women cope with these stressors is by providing them with social support. The greater risks with regard to postpartum depression are often due to the incidence of repeat pregnancies as identified by Maravilla et al. (2017). Ahorlu, Pfeiffer, and Obrist (2015) reported that lack of social and economic support for the teenage mother may pose a greater risk than even the pregnancy itself.

Sims and Luster (2002) after conducting a cohort study in the United States reported that personal resources for teenage mothers in terms of support and motivation decreased the risk of having another pregnancy. This finding was confirmed in a mixed study by Gyan (2017) on an adolescent girl’s resilience to teenage pregnancy and motherhood in Begoro, Ghana, who revealed that access
to financial resources and support for teenage mothers helped them to secure their health and that of their babies as well as cope with pregnancy and motherhood. She further added that parents are an important source of economic support for girls and thus, should be empowered to support teenage mothers.

A secondary data analysis from a case-control study conducted by Lennon and Heaman (2015) in Manitoba, Canada, on factors associated with family resilience during pregnancy among inner-city women, emphasized the importance of family support in building the resilience of teenage mothers. They further added that women with low interpersonal support were six times more likely to have low resilience. Similarly, Brosh, Weigel, and Evans (2009) also suggested that support from families was a positive factor in furthering the career development of adolescents.

Also, De Jonge (2001) in a study on support for teenage mothers established the need for the support of health workers. She further added that due to the difficulty in detecting mental health problems among teenage mothers, they required more support and information on mental health and these services should be made available to them. In addition, DeVito (2010) conducted a study on how adolescent mothers feel about becoming a parent and reported that many teenagers felt unprepared to adapt to the responsibility of being a parent. She also added that without support, guidance, and adequate knowledge, teenage mothers may feel confused and overwhelmed in their new role as a parent. Therefore, they need support from peers who understand and can identify with their new role as a parent. This support will provide the mothers with a sense of acceptance, socialization, and stability.
Furthermore, utilizing secondary data from the Northeastern United States to analyze the impact of parenting stress and social support on child development, Huang, Costeines, Kaufman, and Ayala (2014) found that lack of social support and high level of stress on teenage mothers is associated with negative mental health status, which also negatively impacts the development of their children. Angley, Divney, Magriples, and Kershaw (2015) in a longitudinal study on social support, family functioning, and parenting competence in adolescent parents also found that a strong support structure during the postpartum period increased the level of parental competence for the adolescent mother.

2.6 Summary of Literature Review

This review showed that teenage pregnancy is still a problem affecting both developed and developing countries. Teenage mothers who experience repeat pregnancies are at greater risk of maternal and child mortality as compared to their counterparts who have had a single child. Also, repeat pregnancies may have long-term impacts on the education and career of teenage mothers. The factors contributing to repeat pregnancies included school dropout, intimate partner violence, poverty, and early marriage also contributed to repeat pregnancies. Teenage mothers also face several challenges including poverty, difficulties in managing the competing demands of school, work, and raising their babies, and feeling of shame due to stigmatization by the community.

In addition, teenage motherhood had a negative impact on the educational attainment of teenagers and put teenage mothers at greater risk of suicide. Furthermore, findings on knowledge of teenage mothers on contraceptives revealed that although unplanned pregnancies are highly correlated with contraceptive use, many teenage mothers do not use contraceptives. With regard to the social
support systems available to teenage mothers, it has been reported that teenage mothers found the demands of motherhood very challenging and required support. Thus, lack of social support for adolescent mothers during postpartum, may result in depression and repeat pregnancies.

2.7 Theoretical Perspective: Ecological Systems Theory by Urie Bronfenbrenner (1979)

The experience of teenage mothers in Ablekuma sub-Metropolis was explained through the lens of the ecological systems propounded by Urie Bronfenbrenner (Bronfenbrenner, 1979). The ecology of human development is defined by Bronfenbrenner (1979) as the scientific study of the progressive, mutual accommodation throughout the life course between a growing human being and the changing properties of the immediate settings in which he lives as this process is affected by relations between these settings and by larger contexts in which the settings are embedded.

This theory was developed to understand human development within the context of the relationships that form a person’s environment (Johnson, 2008). Bronfenbrenner (1995) posited that the environment comprises five nested systems which interact and can both affect and be affected by an individual’s development. An individual’s interaction with these systems can either be positive or negative. These systems are the micro, meso, exo, macro, and chronosystems.

2.7.1 The Microsystem

The microsystem is defined as the pattern of roles, activities, and interpersonal relationships experienced by a developing person in a given setting and contain other people with distinctive characteristics of personality, temperament, and systems of beliefs (Bronfenbrenner, 1995). For a child, the microsystem is her closest environment and includes structures with which she maintains
physical contact. Structures in the microsystem include the family, school, peers, neighborhood or church group (Tudge, Mokrova, Hatfield, & Karnik, 2009).

2.7.2 The Mesosystem

The mesosystem consists of the linkages, interrelationships, and processes between the microsystems and how they affect or influence the development and behavior of the child. For instance, the relationship between the child’s home and school, church, and school, et cetera. (Bronfenbrenner, 1995).

2.7.3 The Exosystem

The exosystem according to Urie Bronfenbrenner (1995), is made up of larger social systems and comprises of events, decisions, and contingencies over which the individual has no influence. However, it directly or indirectly impacts the development of a person e.g. the relationship between the home and the parent’s workplace (Johnson, 2008). This is significant because such events have an impact on the environment in which the child grows.

2.7.4 The Macrosystem

Bronfenbrenner (1995) explains the macrosystem to comprise the overarching pattern of micro, meso, and exosystems characteristic of a given culture, subculture or other broader social context, with reference to belief systems, lifestyles, resources, opportunities, life course options, and patterns of social interchange that are embedded in each of these systems. These include cultural norms and values as well as policies and how they influence the child. In addition, cultural values affect individuals and influence them to behave in particular ways (Corcoran, Franklin, & Bennett, 2000).
2.7.5 The Chronosystem

The chronosystem is a description of the evolution, development or stream of developments of the external systems in time (Johnson, 2008). This system can cover either a long or short period. It also describes the changes in the systems over time that affect or influence the development and behavior of the child (Johnson, 2008). For instance, the death of a breadwinner and its impact on the child’s life.

2.7.6 Application of the Ecological Systems Theory to the Study

Applying the ecological systems theory to the study, the various systems (micro, meso, exo, macro, and chronosystems) interact with the teenage mother to influence the risk of repeat pregnancy (Figure 1). The teenage mothers’ immediate environment (microsystem) could put her at risk of repeat pregnancy. The factors interacting with the teenage mother’s microsystem may include the teenage mothers’ parents, spouse, school, peers, neighborhood, church group, and hospital. For example, peer pressure may force teenage girls to engage in sexual activity which could result in pregnancy.

The teenage mother’s mesosystem are the various systems in the teenage mother’s immediate environment, which interact to affect the teenage mother. For example, the relationship between the teenage mother’s home and the school could interact to affect the education of the teenage mother. Thus, the poor performance of a teenage mother in school may result in parents criticizing and withdrawing them from school. This may lead teenage mothers dropping out of school which could put them at risk of repeat pregnancies. The exosystem of the teenage mother refers to the contingencies over which the teenage mother had no influence, however, may affect the teenage
mother. Thus, the exosystem may be the relationship between the teenage mothers’ home and their parent’s workplace. For instance, the stress and pressure from the spouse’s workplaces were found to result in the abuse of teenage mothers.

The macrosystem consists of societal values and cultural norms as well as governmental policies and how they affect the teenage mother. For instance, if policies are not put in place to support the teenage mother once she gets pregnant, it could result in significant challenges for the mother which could put her at risk of repeat pregnancies due to transactional sex to support her child.

The fifth system, the chronosystem which encompasses change over time, could also interact with the teenage mother. For example, the sudden realization of an unintended pregnancy could result in the disruption of the teenage mother’s schooling and this could lead to early marriage and poor relationship with family and friends.
Figure 1. An ecological model showing how the nested systems in the teenage mother’s environment interact to influence the risk of repeat pregnancies

2.7.7 Usefulness of the theory

The ecological systems theory was useful in helping me gain an in-depth understanding of the experiences of teenage mothers with repeat pregnancies from a multi-dimensional perspective (Bronfenbrenner, 1979). This is because the systems theory takes into consideration all factors
influencing a phenomenon from the micro to the macrosystems. Therefore, the theory enabled me to understand the factors contributing to repeat pregnancies by highlighting elements within the micro, meso, and macrosystems (family, peers, school, community, policy) that could result in repeat pregnancies or put teenage mothers at risk of repeat pregnancies.

The theory enabled me to identify the knowledge of teenage mothers on contraceptives, by helping me identify sources of information on contraceptives, knowledge on contraceptives and misconceptions on the use of contraceptives. In addition, the theory enabled me to understand the challenges teenage mothers face after their pregnancies due to their interactions with the various systems. Finally, the theory was also useful in identifying support systems in the micro, meso, and macrosystems where resources can be garnered to support the teenage mother. This helped provide suggestions to prevent subsequent pregnancies as well as identify barriers to utilizing the supports available to teenage mothers with repeat pregnancies.
CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter outlines the methodology utilized for this study. The research methodology included the research design, study area, target population, study population, sampling technique and recruitment, sample size, methods of data collection, data handling, data analysis, ethical considerations, trustworthiness and limitations of the study.

3.2 Research Design

A qualitative research design was used to explore the experiences of teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis, Accra, Ghana. This was appropriate for the study because according to Creswell and Creswell (2017), a qualitative research design provides an in-depth understanding of what people experience. In addition, this design allows researchers to understand a phenomenon from the perspective of an individual as well as a population rather than just generalized results (Onwuegbuzie & Collins, 2007).

The qualitative approach utilized in this study was phenomenology. This is because this approach is ideal for the study of lived experiences. Furthermore, a phenomenological approach of inquiry gives insight into what people experience and how they experience what they experience (Byrne, 2001). Most importantly, the phenomenon is investigated from the perspective of the communities and individuals affected (Priest, 2002). Thus, using this approach enabled me to gain deep insight into the lives of teenage mothers and to understand their experiences.
3.3 Study Area

Greater Accra is the capital city of Ghana located in the southern part of the country. It is one of the largest cities in Ghana with a population of 1,665,086 representing 16.3 percent of the country’s population (Ghana Statistical Service, 2012). In addition, the Greater Accra Metropolis was part of the urban areas in Ghana, that had the highest cases of teenage pregnancy (Ghana Health Service, 2014). The study site, Ablekuma sub-Metropolis is the largest of the six sub-Metropolis in the Accra Metropolis. The Ablekuma sub-Metropolis is bound on the north by the Accra-Winneba road, on the south by the Gulf of Guinea, on the east by the Kokroko Hills, and on the west by the Odaw stream. Administratively, Ablekuma sub-Metropolis is comprised of Ablekuma North, Ablekuma South, and Ablekuma Central.

Ablekuma sub-Metropolis has a population of 257,543 representing 48.9 percent of the population of Accra Metropolis. There are 195,507 women (15-49 years) in the sub-Metropolis, which represent 24 percent of the population (Mamprobi Polyclinic, 2017). About 62 percent of Ablekuma sub-Metropolis residents are employed in the informal sector. Trading, fish mongering and fishing are the main occupations of the residents. This is because many of the communities are found along the coastline. The formal sector provides jobs for about 33 percent of the residents. In addition, non-governmental and international organizations employ close to three percent of the residents (Mamprobi Polyclinic, 2017).

There are about 46 primary health facilities serving the Ablekuma sub-Metropolis. This comprises three public health facilities (Mamprobi Polyclinic, Dansoman Polyclinic, and Korle-Bu Teaching Hospital), and about 43 private health facilities (two hospitals, 12 maternity homes, and 29 clinics).
Mamprobi Polyclinic, the main health facility of focus in this study, was established in 1992 (Mamprobi Polyclinic, 2017). It serves the majority of pregnant women in the Metropolis and has a high patient turnover due to the free and focus on antenatal care. The Polyclinic is a 53-bed capacity health facility and operates under the supervision of Ghana Health Service, Ministry of Health. The Polyclinic served about 24,254 pregnant women and assisted in the delivery of 4,216 babies in 2016 (Mamprobi Polyclinic, 2017).

3.4 Target Population

For this research, the target population was teenage mothers in Ablekuma sub-Metropolis, Accra. Key informants who were health officials at the Mamprobi Polyclinic were also targeted.

3.5 Study Population

Study population or sample refers to a subset of the population which have been selected by the researcher for his/her study purpose (Rubin & Babbie, 2017). In this research, the sample that was drawn from the entire population were teenage mothers below 20 years who had one child and were pregnant with the second child and those who had two or more children. Thus, participants sampled fitted into these criteria.

Key informants were also selected. This included health officials at the Mamprobi Polyclinic. The purpose of this was for data triangulation, a method used in the qualitative approach to establish validity by collecting data from multiple sources to arrive at consistency across data sources (Golafshani, 2003). In addition, the health workers at the Mamprobi Polyclinic had different fields of expertise in working with the teenage mothers. The health workers included Head of Adolescent Reproductive Health Unit, Head of Antenatal Care Unit, Head of Family Planning Unit, Head of
Nutrition, Head of Postnatal Care, Head of Counselling, a Nurse at the Antenatal Care, and a Social Worker.

3.6 Sampling Techniques and Recruitment

Convenience and snowball sampling were used to recruit teenage mothers. Dornyei (2007) described convenience sampling as a type of non-probability sampling where members of a target population that meet certain criteria are included in a study. For example, the criteria may include geographical proximity, ease of accessibility, and availability at a given time. Also, convenience sampling is often used in qualitative exploratory studies (Rubin & Babbie, 2017). Thus, I recruited teenage mothers with repeat pregnancies who were attending antenatal and postnatal care at the Mamprobi Polyclinic and were available and willing to participate in the study. However, beyond the hospital, snowball sampling was used to recruit teenage mothers from the community. This was because not all the teenage mothers visited the hospital and utilized its services. Thus, the teenage mothers who were interviewed at the hospital referred me to other teenage mothers in the community who were willing and available to participate in the study.

Furthermore, purposive sampling was utilized in recruiting key informants (health workers) at the Mamprobi Polyclinic. Etikan, Musa, and Alkassim (2016) defines purposive sampling as the deliberate choice of a participant due to the qualities the participant possesses. This is because participants possess characteristics, roles, opinions, knowledge, ideas or experiences that are particularly relevant to a study (Creswell and Creswell, 2017)). In recruiting the key informants, the head of antenatal care at the Mamprobi Polyclinic referred me to other key informants who worked with the teenage mothers. The purpose of the key informant interviews was for data
triangulation because these health workers had been working with teenage mothers for years and had experience and knowledge due to working with my target population.

3.7 Sample Size

Forty-one participants were sampled for this study. This included 33 teenage mothers with repeat pregnancies and eight key informants. A further breakdown of the 33 teenage mothers were 14 individual interviews and 19 teenage mothers in two focus group discussions. The first focus group consisted of nine and the second focus group consisted of 10 teenage mothers with repeat pregnancies. Mason (2010), in a review of qualitative studies, suggests that the sample size for a qualitative study should be a minimum of 5-25 cases as it would be enough to obtain adequate data. Similarly, Fusch and Ness (2015), also recommend that the sample size for a focus group should be 6-12 participants. This was to ensure that the groups were small enough for participants to share their thoughts and yet large enough to create a diverse group.

Using focus group discussions enabled me to unveil aspects of repeat pregnancies that would have been difficult to obtain through individual interviews. In addition, Lambert and Loiselle (2008) posit that combining focus groups and individual interviews enhance data richness and depth of inquiry. The first focus group discussion was held in the hospital (Mamprobi Polyclinic) with teenage mothers with the incidence of repeat pregnancy who utilize the services of the hospital, while the second focus group discussion was held in the community (Chorkor), with the teenage mothers who did not utilize the hospitals’ services. Furthermore, Bowen (2008) suggested that the sample size for a qualitative study should be based on the point of saturation. Taking a cue from his insight, the study ended when there was no new information coming from participants.
3.8 Methods of Data Collection

The methods of data collection for this study were in-depth interviews (face-to-face) with the participants and two focus group discussions with the aid of an interview guide. This allowed me to freely probe the research participants for more information. Details of the study were explained to each of the participants and they were informed of their right to withdraw from the study if they did not feel comfortable at any point in the study. In addition, the participants were not forced to participate in the study. Informed consents were obtained from the parents of the participants and an assent from the participants who were less than 18 years old before the interviews begun.

Furthermore, the interviews were conducted in Ga, Twi or English language depending on the language the participants understood and could freely express themselves in. These languages were selected because they are the predominant languages spoken in the community. The individual interviews with teenage mothers and health workers lasted on average between 40 to 90 minutes and were conducted at a time and a place convenient to the participants. Furthermore, the focus group discussions with the teenage mothers lasted between 90 to 120 minutes. All the interviews were audio recorded with permission from participants. At the end of each interview, the data in the local dialects were immediately translated into English to identify areas where more clarifications were needed or issues that I felt were not covered well.

3.9 Data Handling

All the recorded interviews were transcribed and saved on a personal computer. This was secured with a password known only to me. A copy of the transcribed interviews was sent into my email as a back-up in case of any challenges such as break down of the laptop or in case the laptop got
stolen. The email was also secured with a password known only to me. The transcriptions had no original names of the participants but pseudonyms. The transcribed interviews were also numbered and matched to each of the participants appropriately. These were filed and stored separately and upon submission of the written research, they will be deleted.

3.10 Data Analysis

Data analysis involves making sense of the data gathered. I inferred from Attride-Stirling’s (2001) guide to thematic network analysis in qualitative research. By this, the data was transcribed, and the basic themes were generated and refined into organizing and global themes. Thus, the findings presented are the global themes. These themes were grouped to relate them to the research questions. Interpretations were made based on the findings of the study and by comparing them with information reviewed from the literature. The following outlines the procedure that was used:

1. I listened to the audio recordings of the interviews and transcribed the interview in English. Then I read through the transcriptions. I did this several times to ensure they were consistent and accurate. By doing this, I became familiar with the data and was able to identify recurring ideas and issues raised by participants.

2. The recurring ideas were then grouped broadly under the objectives of the study. These included the factors contributing to repeat pregnancies, challenges faced by teenage mothers with repeat pregnancies, knowledge of teenage mothers on contraceptives, and support systems available to teenage mothers with repeat pregnancies. Sub-themes were identified under these broad objectives and were all linked to answering the research questions.

3. I analyzed the data under the various themes, whilst comparing them with literature.
4. Finally, I deduced conclusions from the analysis and made recommendations.

3.11 Ethical Considerations

**IRB ethical clearance and approval:** Ethical clearance for the study was sought from the Ethics Committee for Humanities (ECH), University of Ghana, in January 2018 and approved in February 2018.

**Child assent:** A child’s affirmative agreement to participate in a research. Children were not forced to participate in the study. I obtained assent from them before beginning the interview. This was obtained because some participants were less than 18 years old. However, for teenage mothers who were more than 18 years old, the study was explained to them and their consent (written or oral) taken.

**Confidentiality:** In reporting of the findings, I used pseudonyms in place of the actual names of research participants. This was to ensure that participants identities were not revealed.

**Informed consent:** The purpose of the study was explained to participants before they willingly gave information without being coerced. In addition, parent’s/ caregiver’s consent (written or oral) was sought before interviewing the children. Also, for participants who were 18 to 20 years old, their consent (written or oral) was taken since they are adults.

**Plagiarism:** Plagiarism was avoided by acknowledging all referenced sources.

**Voluntary participation:** Participants were not coerced to take part in the research.

3.12 Credibility and Trustworthiness

Member checking and peer briefing were used to ensure credibility (Golafshani, 2003). Through member checking, which is an aspect of developing trustworthiness and credibility in qualitative
research, all participants were asked to validate the study during the interview process and after the final transcription. With peer briefing, research supervisors and colleagues were consulted to confirm the validity of the study and to probe my thinking around the research process.

3.1 Limitations of the Study

Since it was difficult getting the exact English equivalent for some keywords in Ga and Twi, I may have lost some information when analyzing the data. However, as much as possible, I tried to find similar words for the terms used by participants to minimize these losses. Again, the cannot be generalized due to the methodology used. However, it gave in-depth information into the phenomenon of repeat pregnancies among teenage mothers.
CHAPTER FOUR
PRESENTATION OF FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents the findings of the study as well as a discussion of the findings. Firstly, the demographic information of the participants is presented. This is followed by the factors contributing to repeat pregnancies among teenage mothers in Ablekuma sub-Metropolis. In addition, the challenges faced by teenage mothers with repeat pregnancies, their knowledge on contraceptives, and the support systems available to them are presented. Furthermore, the findings are discussed in relation to the reviewed literature and the ecological systems theory.

4.2 Socio-Demographic Characteristics of Participants

Forty-one participants were interviewed for this study (Table 1). This comprised of 33 teenage mothers with repeat pregnancies and eight key informants. The key informants were health workers at the Mamprobi Polyclinic. They included Head of Adolescent Reproductive Unit, Head of Antenatal Care Unit, Head of Family Planning Unit, Head of Nutrition, Head of Postnatal Care, Head of Counselling, Social Worker, and a Nurse at the Antenatal Care.

The study found that the age of teenage mothers ranged from 16 to 19 years old (Table 1). In addition, the age of teenage mothers at first pregnancy ranged from 11 to 16 years. The number of children per teenage mother ranged from two to four. Furthermore, the age of key informants also ranged from 31 to 58 years and the number of years of service of key informants was three to eight years. With regard to the place of residence, teenage mothers were either living by themselves,
with their parents, or partners. The teenage mothers were from four ethnic groups including Akan, Ewe, Hausa, and Ga.

Majority of the teenage mothers identified as either Christians or Muslims. With regard to the level of education of the teenage mothers, there was one teenage mother with no formal education while majority dropped out of school at elementary, Junior High School, Senior High School, and vocational school level. Majority of the teenage mothers dropped out of school before they became pregnant. Also, 16 of the teenage mothers were employed. The teenage mothers were mostly employed in the informal sector. In addition, many of the teenage mothers were single. Furthermore, eight of the teenage mothers had a family history of teenage pregnancy.
### Table 1. Social-demographic characteristics of teenage mothers and key informants interviewed

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*Percentages were calculated based on the total number of participants who were employed (n=16)

**Percentages were calculated based on the total number of participants with a family history of teenage pregnancy (n=8).
4.3 Factors Contributing to Repeat Pregnancies

Teenage mothers with repeat pregnancy shared their experiences regarding circumstances that led to their repeat pregnancies and the key informants shared their views, as well. Factors identified were: (a) low level of education and truancy, (b) early marriage, (c) poverty and transactional sex, (d) peer pressure, and (e) sexual coercion.

4.3.1 Low Level of Education and Truancy

The study found that a low level of education was one of the factors that contributed to repeat pregnancies among teenagers. While some of the teenage mothers dropped out of school and subsequently became pregnant, others did not attend school because their parents refused to support their education. A teenage mother revealed how she would rather go to her boyfriend’s house rather than going to school which subsequently led to her pregnancy:

As for me, school is not for me, so when my mother enrolled me in school, I did not go. I will take the money and act like I was going to school, then, I will go to my boyfriend’s house. When school closes, then I come back home. Sometimes I sleep over at his place. I kept going there for a while before I realized, I was pregnant, so I had to marry him (Teenage mother 2, Individual interview).

Another teenage mother expressed how she decided to stop school after she got a boyfriend:

My mother put me to school but after a while, I decided to get a boyfriend and dropped out of school. I used to go and sleep over at my boyfriend’s place and that is how I got pregnant (Teenage mother 3, Focus group 2).
This teenage mother attributed her truancy to the lack of parental support:

> *When I was growing up, my father and my mother had separated, and my father had married a new woman. The house was not a good place to be...I remember I was in primary and I told him my school uniform had torn, and I needed some books. He did not care he rather insulted me and told me to find my own money, so I decided to run away from the house. I had to drop out of school because of all these problems. When I came to stay in this area, that was when I met my first boyfriend. He impregnated me and promised* (Teenage mother 7, Individual interview).

A teenage mother indicated that she did not pursue her education because her mother discouraged her and pushed her into selling:

> *I wanted to go to school, but my mother said it was not important. She discouraged me to the point that I started missing school, then later I stopped. She then asked me to come and sell fish with her and I obliged* (Teenage mother 3, Focus group 2).

A key informant further attested that when the parents of these teenage mothers are not educated, they are not able to support their children to further their education, further leading to truancy, which is a risk factor for repeat pregnancies:

> *If the parents are illiterates, they don’t value education. So, you see that the girl will be roaming about, then by the time you realize she is pregnant* (Key informant 4, Mamprobi Polyclinic).

### 4.3.2 Early Marriage

Some of the teenage mothers discussed how their first pregnancy contributed to an early marriage or cohabitation with their spouses, leading to repeat pregnancies. Other teenage mothers were
given out for marriage at an early age to prevent birth out of wedlock. This early marriage resulted in their pregnancies. A teenage mother expressed how young she was when she got married:

*I was given to my husband at age 14 to marry him so it was from our marriage that we had my two children. My mother said it was better for my sisters and me to get married early than to get pregnant out of wedlock, so she made all of us marry at a very early age* (Teenage mother 3, Individual interview).

A teenage mother expressed how her parents made her get married after her first birth, leading to her repeat pregnancy:

*After my first born, my parents took me to my boyfriend’s house and insisted he must marry me. So, we got married and that was when I got pregnant again with my second child* (Teenage Mother 7, Individual interview).

This teenage mother described how she got married after her first pregnancy:

*After my first pregnancy, we got married and gave birth to our other children. We did not go to church or sign any documents, his family only came to see my family with schnapps and once both families agreed, that was our marriage* (Teenage mother 8, Individual interview).

A key informant emphasized that early marriage is one of the causes of repeat pregnancies:

*Child marriage is a problem in these communities. As soon as you get pregnant for a boy, the boy is your husband. The boy’s parents will just bring a bottle of gin or something with some small money and that’s all. That’s marriage! Before you realize they are pregnant again* (Key informant 7, Mamprobi Polyclinic).
A teenage mother expressed how she was forced to go and live with her boyfriend after her pregnancy because her parents felt it was the responsibility of the spouse and not them:

_I was staying with my mother after I gave birth, but she told me her place was not big enough for me and my child, so she forced me to go to my husband’s house. She said he got me pregnant, so it was his responsibility to take care of me, not hers. I had to leave to go and stay with my husband. We were living together for about two years, when I found out I was pregnant again_ (Teenage mother 13, Individual interview).

### 4.3.3 Poverty and Transactional Sex

Some of the teenage mothers discussed how poverty influenced their sexual activity. Money and financial reward were what motivated teenage mothers to engage in sexual activity. Transactional sex for these teenage mothers usually begun with the need for food. This expanded to other basic needs. Teenage mothers who were not able to afford these needs engaged in sexual activity to be able to fend for themselves. This put them at risk of repeat pregnancies.

A teenage mother explained how she had to engage in sexual activity to be able to fend for herself and her children:

_My boyfriend was the one giving me money for food and my clothes so anytime he wanted to sleep with me, I could not refuse_ (Teenage mother 11, Individual interview).

Additionally, a teenage mother attributed her transactional sex to lack of parental support after her first pregnancy:

_After my first pregnancy, my parents decided to give up on me. They were not willing to even give me money for food, clothes or antenatal care so I had to struggle to raise the child. When things became too hard for me, I decided to enter another relationship to get_
financial support. He gives me money to take care of myself and my child, so I got pregnant for him (Teenage mother 7, Focus group 1).

A key informant also expressed that lack of financial support from the family leads to repeat pregnancies:

Some of these girls, because of poverty or lack of financial support at home, they run to people for help and they end up having sex with them and this is what results in their pregnancies (Key informant 5, Mamprobi Polyclinic).

A key informant further revealed how financial problems are a risk factor for repeat pregnancies:

The main cause of repeat pregnancies is poverty. If the teenage mother needs something for the baby and she can’t afford it, the easiest way is to go to another man for support. Sometimes the man will give the girl just five cedis or food and impregnate her (Key informant 3, Mamprobi Polyclinic).

4.3.4 Peer Pressure

Peer pressure from friends was another factor that influenced repeat pregnancies. Teenage mothers discussed how having more children reflected a woman’s fertility and how the stigma associated with not having children led to their pregnancies. A teenage mother expressed how her friends pushed her into a relationship, leading to her pregnancies:

My friends made me go into the relationship. They had all given birth and they used to laugh at me. They used to call me a child, so I wanted to prove to them that I was a woman too. They introduced me to a guy and, it was him who impregnated me (Teenage mother 2, Individual interview).
This teenage mother revealed how her friends suggested she has sex and decided to experiment, which resulted in her pregnancies:

*My friends used to talk about sex and they said it was a good experience, so should try it.*

*I decided to try it and that was how I got pregnant (Teenage mother 4, Focus group 1).*

A key informant added that some of the teenage mothers started engaging in sexual activity because of peer pressure and prestige:

*Some of the teenage mothers start having sex because of peer pressure. Their friends tease them for not engaging in sexual activities and this is what makes many of them start having sex (Key informant 3, Mamprobi Polyclinic).*

Another key informant added that the stigma of being called names by their peers is what influenced teenage mothers to listen to their friends:

*You know in Chorkor, for example, its normal to start having sex at a young age. It is normal for teenagers between 15-18 years to have children. If a teenager is above 18 years and you don’t have a child, her friends will see her as barren. So, the girls listen to their friends and end up getting pregnant (Key informant 7, Mamprobi Polyclinic).*

### 4.3.5 Sexual Coercion

Sexual coercion was explained as a contributory factor to repeat pregnancies. Teenage mothers narrated how on a regular basis their sexual partners come home drunk and demand sex from them. Teenage mothers shared how they often resisted their partners’ sexual advances. These situations, they explained easily got their sexual partners agitated thus, resulting in violence and coerced sexual activity. Some of the participants revealed experiencing repeat pregnancies during moments of coerced sexual activity.
One teenage mother vividly shared her experience:

*My second boyfriend forced himself on me. One day, I went to visit him, and he tried sleeping with me, when I refused, he slapped me and told me I was sleeping with someone else that is why I was not allowing him. I had to agree just to prove to him that it was not true. I did not want to get pregnant again, but he kept forcing me and now, I am pregnant again (Teenage mother 1, Individual interview).*

Other means of forcing these teenage mothers into sex included verbal pressure by boys saying that they wanted a proof of fertility. A teenage mother also expressed how she was pressured into engaging in sexual activity, just to keep her relationship:

*My boyfriend said he wanted children. I told him I was not ready. He said that if I do not give him a child, he will find another woman who is willing to. I was scared and did not want to lose him, so I agreed. We just had our second child (Teenage mother 4, Focus group 2).*

A key informant further added that, aside intimate partner violence, some of the teenage mothers were physically abused and coerced into sexual activity by their parents, leading to pregnancies.

*They face abuse from their parents, spouses, and guardians. For example, a girl complained here that her stepfather started sleeping with her since she was 12 years. Now the girl is 15 years old and she is now tired, so she reported the case. The girl said they beat her and made her abort the baby the first time. Now she is pregnant again and there are sores and other infections all over her body. Presently the girl is not living with the parents because they sacked her (Key informant 7, Mamprobi Polyclinic).*
4.4 Challenges Faced by Teenage Mothers with Repeat Pregnancies

The findings from the study showed that teenage mothers faced several challenges. The teenage mothers expressed how their repeat pregnancies increased the challenges and the stress they had to go through to take care of themselves and their children. These challenges included educational, financial, and health challenges and stigmatization.

4.4.1 Educational Challenges

Some of the teenage mothers mentioned that they had to drop out of school because of their pregnancies. The teenage mothers explained that it was difficult combining their caretaking roles with their education. For some teenage mothers, their parents refused to support them after their repeat pregnancies. Thus, they dropped out of school to fend for themselves and their children. In addition, some teenage mothers explained their fear of stigmatization when they return to school. A teenage mother expressed how difficult it was for her to go back to school because she felt her friends had gone ahead of her and she will be stigmatized if she returned to school:

*When I found out I was pregnant with my second child I had to give up my plans of ever going to school. It was hard for me to go back to school because all my friends in my class had completed school, so I will be the only adult in the class and I was shy. I also felt people will talk about me and laugh at me (Teenage mother 1, Individual interview).*

A teenage mother also expressed how she was given another chance to return to school after her first pregnancy and how the news of her second pregnancy, resulted in her dream being crashed. This teenage mother spoke in tears and despair:

*I wanted to become a journalist, but now that I have given birth to these two children, I have realized I can never achieve this goal. My father said if I did not get pregnant again,
he will give me another chance and take me back to school. So, the last chance I had was after my first child, but after I got pregnant again, everything came crumbling. My father does not even talk to me (Teenage mother 2, Individual interview).

This teenage mother added that she stopped school because she needed to stay at home to raise her children after her second child:

When I got to J.H.S 2, I got pregnant again, so I stopped the school to take care of my children (Teenage mother 7, Focus group 1).

A key informant who indicated that teenage mothers drop out of school after their repeat pregnancies because they frustrated due to lack of spousal and parental support:

For many of these teenage mothers, their parents stop taking care of them after their repeat pregnancies. So, after giving birth they get frustrated and drop out of school (Key informant 6, Mamprobi Polyclinic).

A key informant also expressed how the teenage mothers gave up on their goals and dreams because of the pregnancy:

Most of the teenage mothers have dreams of becoming teachers, nurses, et cetera but because of the pregnancy, they couldn’t continue their school (Key informant 1, Mamprobi Polyclinic).

4.4.2 Financial Challenges

The teenage mothers expressed the financial difficulties they faced because they were either abandoned by their spouses or parents. In some cases, their spouses denied the pregnancy due to anger and feeling of shame because of the pregnancy.
A teenage mother expressed how her economic challenges were worsened because of her inability to engage in economic activity due to the baby she must care for or the community’s unwillingness to engage with her:

*Because of this pregnancy, I can’t even work. I don’t have anyone to take care of my children while I go to work. This has made it very difficult for me to even fend for myself. The few times I go to work too, things are not good. Sometimes I go and sit there the whole day, and no one buys anything (Teenage mother 7, Individual interview).*

This teenage mother expressed how she and her children had to sleep on empty stomachs sometimes because they could not afford the meal:

*I am really struggling. Sometimes there is no money at home, so we have to sleep on empty stomachs (Teenage mother 8, Individual interview).*

A teenage mother added that her spouse told her he will not support her financially if she refused to abort her pregnancy:

*He then told me since I have decided to keep the baby, he will not provide any financial support for the child and I and said I agree (Teenage mother 5, Focus group 1).*

A key informant expressed how some of the fathers denied the pregnancy and any financial responsibility associated with the birth of the child:

*Some of the teenage mothers come to the hospital and tell me that the person they gave birth for said he is not responsible, so he won’t even give them any money for food or even for the hospital. Some of them cannot even buy milo to drink or soap to bath (Key informant 1, Mamprobi Polyclinic).*
According to a key informant, because many of the teenage mothers are not working, they struggle to support themselves financially:

*They are not working so how can they fend for themselves and their babies? Eating even becomes a problem because the boy who got you pregnant is a teenager and he himself is struggling to take care of himself and he is not working so how can he take care of you?*  
*(Key informant 2, Mamprobi Polyclinic).*

### 4.4.3 Health Challenges and Psychological Issues

The study also revealed that teenage mothers faced health challenges. The challenges included health challenges and psychological issues. These included complications during pregnancy, feeling of shame, anger and rejection, depression, and suicidal ideations.

A teenage mother expressed how she lost her child due to preterm birth and complications during her childbirth:

*I almost lost my life when I was giving birth because I was bleeding a lot. I had my baby in the seventh month, so it was a premature baby and I lost the baby a week afterward because the baby was so small. It was very hard for me because the child’s father was not even there to support me (Teenage Mother 1, Individual interview).*

Sharing a stakeholder perspective on the issue of health challenges faced by teenage mothers, a key informant revealed how some of the teenage mothers had serious complications during their childbirth, and in some cases leading to maternal deaths:

*Because teenage mothers are so young and do not have money to come for antenatal care, some of them have serious complications such as preeclampsia and placenta abruption when they are giving birth. Also due to the stress they face as teenage mothers, they are...*
highly prone to preterm birth. There was even a girl who died the other day, she was just 15 and she had intrauterine growth restriction due to the fibroid and she did not come to the hospital for us to detect it early (Key informant 2, Mamprobi Polyclinic).

Another key informant added that some of the teenage mothers had anemia and malnutrition and complications:

*Some of the teenage mothers come with low blood level, severe anemia, some come with malnutrition and complications such as eclampsia, all because they do not eat well (Key informant 2, Mamprobi Polyclinic).*

The teenage mothers also expressed the psychological issues they faced. They expressed their frustrations due to neglect by their spouses. A teenage mother revealed how the challenges she was facing had affected her emotionally:

*I am really hurt and unhappy because all the promises he made to me before I got pregnant were lies. I have to struggle to take care of the children alone. Because of all these problems, sometimes I become so depressed and absent-minded. Sometimes when my children even come to ask me for money, I get angry and shout at them or beat them (Teenage mother 4, Individual interview).*

This teenage mother expressed how she became so absent-minded that it almost cost her life and her attempt of killing herself because of the challenges she was facing:

*My boyfriend is not providing for me and the children. One day I was thinking about all these problems, I was crossing the road and my mind was not even on the cars passing, so a car knocked me down. My boyfriend did even not pass by to visit me on my sick bed. I had used all the money I had on me for my hospital bills and I was even owing to some people.*
My children and I were hungry but when I told him, he said he doesn’t care. I broke down in tears and I almost killed myself that day. I just wanted to put an end to all my problems (Teenage mother 5, Individual interview).

A key informant revealed that some of the teenage mothers were depressed and had suicidal ideations:

*Some of these teenage mothers come here so depressed, wanting to kill themselves or wanting to commit an abortion, so we must be there for them. We also educate them because, most of them have lost hope* (Key informant 2, Mamprobi Polyclinic)

### 4.4.5 Stigmatization

Teenage mothers expressed the stigma they had to face because of community norms that emphasize the importance of the child to be named by his or her father. Other teenage mothers were stigmatized for getting pregnant out of wedlock. In addition, some teenage mothers were stigmatized because they were abandoned by their spouses.

A teenage mother narrated how she was stigmatized by the community:

*In this community, outdooring of a child is very important. Every woman expects the father of her child to come and perform the naming ceremony so if he does not come, it is a big disgrace on you and your family and even on the new baby. Everyone will call you names. That is why I am very hurt because he did not come and name the child. Some people say it is because I have slept with so many men that I do not know who the father of the baby is, whilst others, call my child, a bastard* (Teenage mother 12, Individual interview).
A teenage mother also expressed the stigma she had to face in the community for getting pregnant out of wedlock:

*The community members insulted me when I got pregnant. You know what they say about unmarried women who get pregnant, so they said all sorts of things about me (Teenage mother 12, Individual interview).*

Another teenage mother revealed how her child was denied because her spouse said her child looked like her elder brother:

*When I gave birth, the child looked like my brother. My boyfriend said since the baby looks like my elder brother, he is not responsible. He accused me of a lot of things and asked me to pack and leave his house (Teenage mother 2, Focus group 2).*

A key informant expressed how teenage mothers are stigmatized in the community:

*Some of these teenage mothers are laughed at by the community members. They call them names like prostitutes and call their children bastards because they feel they do not know who the father of the child is (Key informant 2, Mamprobi Polyclinic).*

### 4.5 Teenage Mothers’ Knowledge of Contraceptives

The findings revealed that many teenage mothers had limited knowledge and misconceptions about contraceptives. The main issues included: (a) sources of information, (b) knowledge about the benefits of contraception, (c) myths about contraceptives, and (d) barriers to contraceptive use

#### 4.5.1 Sources of Information

The main sources of information on contraceptives were from peers, nurses at the hospital (usually during antenatal and postnatal visits), schools, and parents.
4.5.1.1 Friends as Sources of Information

Teenage mothers indicated that their friends who have used contraceptives as important sources of information. A teenage mother spoke about how her friend told her about contraceptives:

A friend told me about contraceptives and I wanted to do it. When I decided to do it, another friend came to tell me that it was not a good idea (Teenage mother 7, Individual interview).

Still commenting on friends as a source of information, a participant said:

My friends who have used it said they rather got pregnant or sick after using it. So, they told me not to try it (Teenage mother 6, Focus group 2).

4.5.1.2 Nurses as Sources of Information

Nurses were found to be a very source of information on contraceptives for teenage mothers. Teenage mothers expressed how during their antenatal and postnatal visits, the nurses spoke to them about contraceptives:

I use contraceptives because I was told by a nurse when I went for weighing to use it after I gave birth to my second child. So, I use it and it is very helpful for me (Teenage mother 5, Individual interview).

Community visits by nurses was another way teenage mothers were educated on contraceptives. A teenage mother said:

A nurse came to our community to talk about contraceptives. She said it was not expensive and that it was only 1 cedi for adolescents, so I decided to go for it. So far it is ok for me (Teenage mother 4, Focus group 2).
4.5.1.3 School as a Source of Information

The school was also revealed as a source of information on reproductive health by the teenage mothers. However, they felt the information they received was not adequate:

*We learned a few things about reproductive health in science when we were in primary school. However, they do not give us more details on family planning (Teenage mother 5, Focus group 2).*

4.5.1.4 Parents as Sources of Information

Parents also acted as sources of information on contraceptives and teenage mothers expressed their views on how their parents handled sex education at home. Some teenage mothers indicated that their parents educated them on contraceptives, while others expressed that their parents were uncomfortable discussing issues on sex and family planning with them.

A teenage mother narrated how her parents handled sex education at home:

*My mother discussed issues relating to sex and contraceptives with me. As soon as I had my menstruation, she called me and told me that, now that I have had my menses, if I go and sleep with a man, I will get pregnant (Teenage mother 1, Focus group 2).*

Commenting further on parents as sources of information, a teenage mother revealed how her family never informed her about contraceptives until she got pregnant:

*My mother never spoke about family planning. You cannot talk about topics like relationships, family planning or sex in front of her. It was after I got pregnant that she said, if only she had told me about contraceptives, I would not have gotten pregnant (Teenage mother 3, Focus group 1).*
According to a teenage mother, her parents never took the time to explain to her the implications of having sex with an opposite sex:

_In my house my parents never spoke about family planning, even when we are all watching tv and people start kissing, my parents will just tell my siblings and I to either go to the room or change the channel (Teenage mother 5, Focus group 1)._ 

A key informant added that many parents are embarrassed to educate their teenage daughters on sex and contraceptives:

_The parents don’t educate their teenage daughters on contraceptives. It appears they feel shy to talk about contraceptives. Most of these adolescents who come to us, they will tell you they do not know anything about contraceptives. You won’t even get one out of ten people telling you that their mothers talk to them about sex (Key informant 3, Mamprobi Polyclinic)._ 

### 4.5.2 Knowledge about the Benefits of Contraception

Findings from the study indicated that teenage mothers lacked adequate knowledge of contraceptives. However, some teenage mothers were able to cite some benefits associated with contraceptives. The benefits they mentioned included prevention of unwanted pregnancies, the spacing of children, and the prevention of sexually transmitted infections (STI’s).

A teenage mother mentioned some benefits of using contraceptives:

_The nurse said, it helps prevent unwanted pregnancies and allows women to space their births and be able to take care of their children. She also said the condom can help you prevent HIV and other infections too. I did not listen to her the first time, so I got pregnant_
again. But after this second child, I want to consider the one year for a start (Teenage mother 9, Focus group 1).

A teenage mother said that she knew about contraceptives and felt it will be helpful for her:

I have heard of contraceptives. I heard that if you have given birth and you want to wait before your next child, it will help you space your births (Teenage mother 11, Individual interview).

This teenage mother revealed the benefits of contraception, based on the information she received during her antenatal visits:

The nurses said contraceptives can help prevent unplanned pregnancies. So, me when I went, I told them I wanted five years, but the nurse said my blood pressure was high, so they did three years for me (Teenage mother 1, Focus group 2).

Some of the teenage mothers said that they had heard of contraceptives but did not know the purpose. According to this participant:

I have heard of contraceptives, but I do not know its purpose and I have not used it before. (Teenage mother 7, Focus group 2).

A key informant further revealed that many of the teenage mothers she spoke to did not have adequate information about contraceptives or the methods available:

Most of these teenage mothers were not aware of the fact that there was something that could protect them from unwanted pregnancies, so when they are told, some of them want to start using it. As for the types or methods, they do not know it at all (Key informant 1, Mamprobi Polyclinic).
Another key informant revealed some types of contraceptive methods available:

We have the injectables (norigynon, depo), long-term implants (jadelle, or implanol).

These are implants inserted in the upper arm. We also have the pill, Intra Uterine Device (IUD) and condom (Key informant 4, Mamprobi Polyclinic).

4.5.3 Misconceptions about Contraceptives

Many teenage mothers spoke about the loss of weight, weight gain, heart problems, cessation of the menstrual cycle, losing blood, and death as some of the negatives effects contraceptives.

A teenage mother expressed her view on how bad she thought using contraceptives were:

Some people say when they use contraceptives, they get sick, whilst others say they get heart problems or lose or gain weight. So, I know contraceptives are not good at all. I was am scared that if I use contraceptives, I may fall sick (Teenage mother 1, Individual interview).

Contraceptives were associated with death, loss of weight and blood as indicated by this teenage mother:

I know that if the man does not really stay at home and you use contraceptives, you can become barren or the contraceptive will suck all your blood and make you lose a lot of weight and can even kill you (Teenage mother 6, Individual interview).

A teenage mother expressed that using contraceptives could contribute to infertility:

When you use a contraceptive, it will make you barren, so I do not want to do it so that when it gets to the time I am ready for a pregnancy, it makes me barren (Teenage mother 3, Focus group 1).
For this teenage mother, using contraceptives could result in infections:

*I also heard contraceptives give women infections, so I do not like contraceptives. So, after I even gave birth to my first born, I still did not use it. Contraceptives make people very fat and can make you sick* (Teenage mother 2, Focus group 2).

A key informant shared her insights from experiences gathered through working with teenage mothers in the hospital. She said:

*I did a little inquiry to why they did not want to use contraceptive and I realized that they said that they heard that it will make them fat or slim, or even give them heart problems. Also, they feel shy to talk about reproductive health issues, and then they feel they will be stigmatized* (Key informant 3, Mamprobi Polyclinic).

### 4.5.4 Barriers to Contraceptive Use

Some of the teenage mothers expressed fear in accessing information on contraception. They also expressed the feeling of stigma and intimidation, whenever they went for contraceptives and they were mixed with the older women.

A teenage mother said:

*When we go to the hospital for contraceptives, people will be looking at you like you are a bad girl or you have done something wrong. It is very uncomfortable. Sometimes too they will just waste your time and make you sit there for a very long time. That is why I do not even waste my time to go to the hospital for it* (Teenage mother 8, Focus group 2).
When teenage mothers are discouraged by their spouses, they tend to use contraceptives less as revealed by this teenage mother:

*When my husband found out I was using a contraceptive he got angry and said if I do not stop using it, he will throw me and my children out of the house. So, I decided to stop using contraceptives. He also said he did not marry me to just come and sit at home, but to give birth so I must stop using the contraceptives (Teenage mother 2, Individual interview).*

For some teenage mothers, contraceptives could be a threat in their marriages. A participant explained that contraceptives could bring about issues of trust in a marriage since the men do not like it:

*You know our husbands do not like contraceptives. They say it does not even make them enjoy the sex. It can even bring about issues of trust because he will think you want to sleep with another man (Teenage mother 6, Focus group 2).*

A key informant indicated that spousal consent played a critical role in the use of contraceptives by teenage mothers:

*What prevents them from using the contraceptives is sometimes the male partners. They normally say when the women are doing family planning, they become promiscuous. That’s what they think, they think when they come for it would rather damage the relationship. They will not allow them to come for it at all (Key informant 1, Mamprobi Polyclinic).*

Another teenage mother revealed how parents’ religious values can discourage a teenage mother from using contraceptives:

*A nurse told me about family planning when I gave birth to my firstborn. Before I could do it, my mother said no, and that family planning destroys the womb. She said once I do
it, I will never give birth again because using contraceptives is a sin in our church. She also told me that the boy’s mother will say that after I came to live with her son, I did not give birth, so I decided not to do it (Teenage mother 13, Individual interview).

A key informant corroborated this by adding that lack of knowledge and use of contraceptives is because of the inadequate sex education at home by the family and due to religious values:

Yes, teenage mothers lack knowledge of contraceptives. In Ghana, it is now that they are trying to talk about sex. But it is a taboo in our custom. Because they will tell you as Christians, you don’t have to talk about sex with your children. Sex education is a taboo. It’s a taboo so most of it they are innocent. They do not know about family planning then they want to try. As soon as they try, not knowing their menstrual cycle, they will get pregnant (Key informant 4, Mamprobi Polyclinic).

In addition, negative personal experiences of using contraceptives could prevent further use as revealed by a participant:

As for family planning, everyone should run away from it. It is not good at all. Can you imagine it almost killed my mother? My mother said that when she used family planning after my little sister was born, she bled continuously for almost three months, it was scary, and she became anemic. They said there was a blood clot in her stomach and they decided to operate on her... Later, she developed a stroke and died out of that. So, you see, contraceptives are evil! (Teenage mother 4, Individual interview).
A participant also mentioned that using contraceptives was associated with promiscuity. Thus, this discouraged her from using contraceptives:

*Some people use it as prepaid. Oh sister, prepaid means they do the family planning so that they can get to sleep with a lot of men without getting pregnant. I have friends who have more than four boyfriends, so they use this to protect themselves. Because of this when people see that you are using family planning, they start saying that you are sleeping with other men (Teenage mother 7, Focus group 2).*

Commenting further on barriers to contraceptive use, a teenage mother narrated how she was ridiculed by the members in the community:

*When you do it, it makes you skinny. Then people will be laughing at you saying that you have become like dry fish. That is why I stopped using it. Also, some people will call you a cheat. They will say you did it because you want to be able to sleep with different men and not get pregnant. Now I am not using it and when I get pregnant again, I will give birth (Teenage mother 5, Focus group 2).*

### 4.6 Support Systems Available to Teenage Mothers

The findings indicated that teenage mothers with repeat pregnancies received support from different sources and these included both formal and informal support. The formal support consisted of a counseling at the health center and subsidized prices of contraceptives. Informal support also consisted of provision of food, clothing, support with the payment of health bills, and taking care of the baby while the teenage mother is at work. This form of support was from families, friends, neighbors, and spouses.
4.6.1 Sources and Forms of Support

Teenage mothers expressed that they received support from their spouses, in-laws, families, neighbors, and health workers. The support received by the teenage mothers included emotional, financial, informational, and kin support. Key informants also expressed how they provided support to teenage mothers.

A teenage mother revealed how her spouse and in-law provided support for her:

*It is my husband and mother-in-law who support me. My in-law gives me some of the food sometimes. Occasionally, my husband gives me money (Teenage mother 3, Individual interview).*

This teenage mother expressed how her grandmother supports her. She said:

*It is my grandmother that helps me take care of the baby (sobs). My child and I are living with her now. She is the one who gives us food and a place to sleep. She even takes care of my children for me when I want to go to town (Teenage mother 10, Individual interview).*

A teenage mother expressed how her neighbors were of assistance to her:

*The few people who helped me were my neighbors. For instance, when I am going to town, I leave my children for them and they watch them for me till I come back. Sometimes when they see I do not have money to buy food for my children, they give me money. Occasionally, my neighbors buy dresses for my children too (Teenage mother 7, Individual interview).*

A teenage mother further revealed how her mother’s support helped her take care of her children:

*My elder sister and my mother helped my children and I. They were the ones who even paid my hospital bills when I got discharged. I still haven’t learned how to raise the*
children. It is my mother who helps me and teaches me every day (Teenage mother 3, Focus group 2).

Health care providers also provided support to teenage mothers in the form of counseling and linking them to other sources of support:

_Sometimes, we counsel them because some of them come here very depressed. Some even want to kill themselves because they feel all hope is lost and no one wants to help them._

_For some of them, we even try to get people to support them to pay their fees. These people act as the adopted parents and support them (Key informant 7, Mamprobi Polyclinic)._ 

Teenage mothers who did not receive enough support from their spouses, in-laws, and families supported themselves through trading and begging from community members. However, when they could not afford to provide for their children, they occasionally neglected them.

A teenage mother narrated how she supported herself and her child and how she neglected her child occasionally when she could not afford to provide for her child:

_Before and after I gave birth, I used to sell fruits, so it helped me to get a little money to support myself. However, sometimes, when I go to the market, nobody buys anything, so I just don’t mind the children when they are hungry. It is not my fault, I cannot afford to put food on the table everyday... I do not even take them to school because I cannot afford to pay the fees (Teenage mother 13, Individual interview)._
In addition, teenage mothers expressed how they beg from community members or borrow from their neighbors to support themselves:

*Sometimes, I go and borrow from people. Other times, I beg too. I know it is a disgrace when you are begging, but for the sake of my child, I must do it. If not, the child cannot eat (Teenage mother 14, Individual interview).*

Some of the teenage mothers had to beg in order to provide food for themselves and their children:

*I beg for money from community members to support myself. I stand at a place, asking for one cedi. Sometimes I am able to raise money to cook for the day. Sometimes, when I beg, I can even get 30 cedis, which is a lot of money (Teenage mother 10, Focus group 2).*

Other teenage mothers had to take money from their spouses without permission. A teenage mother said:

*Since my husband is always saying he does not have money, I have started going through all his clothes and removing any money I see. When he comes to ask if I have seen anything, I tell him I have not (Teenage mother 9, Focus group 1).*

### 4.6.2 Barriers to Accessing Support

Teenage mothers expressed a lot of needs, including support in taking care of their children, counseling when they are depressed, the need for spousal support, and support from family or caregivers when they are abused. However, certain factors impeded them from accessing support. These included family members rationalizing their problems, being accused of infidelity, ignorance of formal support services, personal attitudes, and attitudes of health professionals.
This teenage mother was in tears when she narrated how she was accused of infidelity, thus denying her and her child the paternal support of her spouse:

I went to my boyfriend’s house to explain to his family that my baby was his son. But they insulted me and pushed me out of the house and they told me I was a liar and a cheat. They had already said that the baby was for someone else, and I was trying to accuse their son. Their son also stood there and denied being the father. Now I am taking care of the children alone with no support (Teenage mother 8, Individual interview).

A teenage mother expressed how she was not supported by her partner and her mother because they were too busy at work:

I had to raise the children alone because no one was willing to support me. It was so difficult for me to handle all my responsibilities, so I could not return to school or even work. When I ask my husband for support in taking care of the children, he will tell me that he is busy and has a lot of work to do, so he does not have time. He does not bring any money home for the work he says he is doing too. When I call my mother for help in taking care of the children too, she will tell me she is busy with her work and cannot put her life on hold to support my children (Teenage Mother 3, Individual interview).

This teenage mother narrated how she was rather threatened when she decided to report her spouse for abusing her:

When he beats me, and I report him to his mother, she tells me that beating is part of every marriage and that she is sure I said something to make her son angry. When I threaten to tell the police, she will insult me and tell me that if I make the police arrest her son, she will make sure the marriage ends that same day (Teenage mother 9, Individual interview).
Ignorance also served as a barrier to teenage mothers accessing support. A key informant revealed that teenage mothers and health workers were ignorant of the support systems:

*The support systems are there but how to even talk to them is the issue so unless the person comes to the service provider. But then they themselves they are not aware of where the services are. Some of them come and they do not know we have social welfare here. Also, they do not know that they can report their abuses to Domestic Violence and Victim Support Unit (DOVVSU). Sometimes some of us do not know all the support systems available too, so we have to be educated so that we can link the teenage mothers to those services when they come to see us (Key informant 3, Mamprobi Polyclinic).*

The attitudes of teenage mothers could also prevent people from helping them. According to a teenage mother, once a teenage mother does not make good use of a support being provided to her, she could lose that assistance:

*I think that the problem of neglect is sometimes from us, so once someone decides to support us, whether in our education or learning a skill, we must try to also focus and complete it... If you do not focus and you keep getting pregnant, the person helping you will get tired (Teenage mother 1, Focus group 1).*

Additionally, a key informant added that some attitudes of health workers could discourage the teenage mothers from accessing support from the hospital:

*When they come to the hospital and we scream at them or treat them badly, they will rather fall into the wrong hands, or go for information on family planning from the wrong people which will result in other repeat pregnancies (Key informant 8, Mamprobi Polyclinic).*
4.7 Discussion of the Findings

The study investigated the following objectives: (a) to find out factors contributing to repeat pregnancies among teenage mothers, (b) to identify challenges faced by teenage mothers with repeat pregnancies, (c) to explore the knowledge of teenage mothers with repeat pregnancies on contraceptives, and (d) to ascertain the social support systems available to teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis.

It was found that teenage girls who dropped out of school early (elementary school level), and those with no education had more children as compared to those who dropped out in senior high school. This could be because they stayed out of school for a long time. In addition, the study found that teenage mothers were from diverse ethnic groups. However, there were no cultural differences amongst the teenage mothers. This could be because they were subsumed by the dominant cultural environment which was the Ga community. In addition, about one-third of the teenage mothers were married. This suggests that a significant proportion of teenage mothers got married at an early age. Furthermore, teenage mothers who got married at an early age were found to have more children than those who got married at an older age. These findings were in line with Crittenden et al. (2009) who observed that being very young at first pregnancy and getting married at adolescence increased the risk of repeat pregnancies.

The findings further indicated that low level of education and truancy were risk factors for repeat pregnancies among teenage mothers. Teenage mothers who dropped out of school found themselves mostly idle and spent their time in the homes of their spouses. This was a risk factor for repeat pregnancies. In addition, many of the teenage mothers who had an initial pregnancy felt
reluctant returning to school, putting them at risk of repeat pregnancies. Similar findings were observed by Barnet et al. (2008) who reported that truancy significantly increased the chance of repeat pregnancies.

In addition, early marriage and cohabiting were found to be at risk of repeat pregnancies. This was because cultural norms in the community in the study area encourage early marriage. Thus, some teenage mothers were given out for marriage at a young age, putting them at risk of repeat pregnancies. This is contrary to the United Nations Convention on the rights of the child which prohibits girls under 18 years from getting married. Also, the legal age of marriage in Ghana is 18 years and above. Any person under the age of 18 years is considered a child and is not permitted to marry under the law. Thus, although Ghana is trying to eradicate child marriage, there are cultural norms that make it difficult to achieve this goal (UN General Assembly, 1992). Once a child is given in for marriage, she is seen as an adult and is expected by her family and the community to reproduce. These findings were in line with Vieira et al. (2016) who reported that the young age of the mother and early marriage interact to increase the risk of repeat pregnancies.

Furthermore, parents of some teenage mothers held the belief that by giving their daughters out for marriage at an early age, they (daughters) will be protected from unwanted pregnancies and sexually transmitted infections. This is also supported by the ecological systems theory, which reveals that the teenage mother’s immediate environment (microsystem) can put her at risk of repeat pregnancies. If a teenage mother’s family (microsystem) forces her into an early marriage, she is at a risk of repeat pregnancy.
Poverty and transactional sex were also found to lead to repeat pregnancies. Teenage mothers expressed how they engaged in sexual activity for financial gain. They viewed transactional sex as a means of gaining money to support themselves and their children. Some teenage mothers moved on to different men once they were not getting money for food, clothing, and medical bills from their old spouses. Once the teenage mothers were gaining financially from the relationship, they felt obligated to offer sexual favors to their partners whenever it is requested. This resulted in repeat pregnancies. These findings agree with the findings by Aslam et al. (2017) and Krugu et al. (2017) who found that young women’s motivation for sexual relationships is more focused on economic factors. These findings are also supported by the ecological systems theory. Thus, when a teenage mother grows up in a poor home where parents are not able to provide for her, she is likely to engage in sexual activities which could result in repeat pregnancies.

Furthermore, the findings revealed that peer pressure was a risk factor to repeat pregnancies among teenage mothers. Teenage mothers were found to engage in sexual activity to prove their fertility to their friends. Others also engaged in sexual activity just for experimentation based on stories they have heard from their friends. In addition, some of the teenage mothers viewed having more children as a sign of prestige. These findings suggest that teenage mothers engaged in sexual activity to avoid stigmatization by their friends. This supports the findings by Heilborn and Cabral (2011) who suggested that teenage pregnancy might not be the consequence of sexual promiscuity as is mostly portrayed but rather a sign of social status for the girl. Additionally, a study by Quist-Adade (2017), revealed that peer pressure from friends and classmates are factors influencing sex and repeat pregnancies.
This study also found sexual coercion as a risk factor to repeat pregnancies. Some teenage mothers were physically and sexually abused by their drunk partners, leading to their pregnancies. Married teenage mothers were coerced into sexual activity by being threatened with divorce. This agrees with Raneri and Wiemann (2007) who revealed that intimate partner violence increased the risk of repeat pregnancies. Additionally, teenage girls could be forced into sex through physical pressure (e.g. beating and pushing), as well as verbal pressure such as boys saying they want a proof of fertility (Krugu et al., 2017).

Furthermore, the findings of the study revealed that teenage mothers with repeat pregnancies faced several challenges. These included educational challenges. Repeat pregnancies were found to lead to teenage mothers dropping out of school to raise their children. Teenage mothers dropped out of school because of the stigma of having two children and being in school. In addition, some teenage mothers were given a chance to pursue their education after their first pregnancy but lost that opportunity after they had their second child. This is consistent with Biney and Nyarko (2017) who added that teenage motherhood had a negative impact on the educational attainment of teenage girls. The ecological systems theory also supports this finding suggesting that if the parents’ work makes them too busy to support their daughter (exosystem), she is more likely to drop out of school and stay at home to raise the child which is a risk factor for repeat pregnancy.

The study also found that teenage mothers faced financial challenges because of the abandonment by their spouses, in-laws, and parents after their repeat pregnancies. The study also found that teenage mothers were not able to engage in economic activities due to the children they must care for. Furthermore, teenage mothers were left to fend for themselves when they refused to abort a
child as suggested by their partners. In addition, teenage mothers lost the financial support of their parents after their repeat pregnancies. These findings confirmed the findings by Lotse (2016), who revealed that teenage mothers faced financial difficulties as a result of abandonment by parents, significant others, and boyfriends. Additionally, the study found that due to the increased challenges of repeat pregnancies, teenage mothers became frustrated and had feelings of anger, rejection, depression, and suicidal ideations. Corcoran (2016) reported in a study on teenage pregnancy and mental health that teenage mothers were at high risk for depression.

Some teenage mothers faced stigma and shame when they gave birth out of wedlock or when their children were not named by their spouses. This was because in the cultural context, although childbearing is celebrated, a mother is expected to be with a responsible man who would name her child. However, if that child is not named by his or her father, the teenage mother is stigmatized by the community. These findings support the findings of Lotse (2016) who added that teenage mothers faced challenges including shame, rejection, and emotional and psychological problems because of community norms that classify teenage sexual activity and pregnancy as unacceptable. This is supported by the ecological systems theory, which suggests that cultural values affect individuals and influence them to behave in particular ways (Corcoran et al., 2000). Therefore, if a teenage mother grows up in an environment where the naming of a child is seen as important (macrosystem), she may face stigma and shame when her child is not named by the father. This could lead to depression and other mental health challenges.

Moreover, some of the teenage mothers abused their children out of frustration, while others neglected their children. This agrees with Cook & Cameron (2015), who found that adolescent
mothers are more likely to have children who have poorer behavioral, health and educational outcomes, and more likely to be poor as adults. Teenage mothers with repeat pregnancies faced health challenges such as preeclampsia, placental abruption, intrauterine growth restriction, and preterm birth. They were also found to have high blood pressure, anemia, and malnutrition due to the stress they faced as teenage mothers. These findings support the findings by the World Health Organisation (2018), which reported that teenage mothers with repeat pregnancy faced an increased risk of low birth weight, preterm delivery, eclampsia, and systemic infections.

With regard to the knowledge of teenage mothers on contraceptives, findings from this study revealed the sources of information on contraceptives for teenage mothers included peers, the school, health centers such as clinics and hospitals, community visits by nurses, and from their family. Teenage mothers learned about contraceptives whilst attending either antenatal or postnatal visits where nurses took the opportunity to educate them on contraceptives. This supports the findings by Tsikouras et al. (2018), who reported that teenage mothers acquired information on contraceptives from the family, sexual partner, family members, and the school. However, this study found many teenage mothers were not educated on sex and contraception by their parents. These findings are consistent with the findings by Taffa et al. (2017), who revealed that parents did not approve premarital sex and many of them were not comfortable educating their wards on adolescent sexuality and contraceptive use. The findings of this study further support the microsystem of ecological systems theory by Urie Bronfenbrenner (1979). Thus, if parents and teachers are not comfortable educating teenagers on sex, abstinence, and contraceptives, they are put at risk of believing myths from peers which could put them at risk of repeat pregnancies. Teenage mothers were also found to have some knowledge of contraceptives, benefits, and how
they work. Additionally, some of the teenage mothers were aware of the contraceptive methods but not sure of how contraceptives work. Furthermore, teenage mothers were found to have concerns about the side effects of using contraceptives on their fertility and health. They mentioned that the use of contraceptives could result in weight gain or loss of weight, irregular bleeding, cessation of the menstrual cycle, and in some cases death. These discouraged teenage mothers from using contraceptives. The study also found that these fears and misconceptions were based on rumors from family members and friends. Due to these misconceptions, teenage mothers have been found to use contraception less than those who were never pregnant (Parkes et al., 2009).

These findings also agree with the findings by Watts et al. (2014), who observed that teenagers refused to use contraceptives due to misconceptions including becoming infertile, having an irregular menstrual cycle, gaining weight, getting cancer, and waiting for years before to conceive again.

The study also found out that although teenage mothers were interested in acquiring knowledge on contraceptives, they feared being stigmatized and intimidated by older women when they go to the hospital to access contraceptives. In addition, lack of partner consent was as a barrier in the use of contraceptives. Teenage mothers expressed that, using contraceptives without the permission of their partners could result in divorce, neglect or being thrown out of the house. Thus, teenage mothers who were married were found to use contraceptive less as compared to those who were not married. Also, teenage mothers did not use contraceptives because of stigmatization and the fear of being accused of promiscuity. In addition, negative attitudes of health workers were also a barrier to teenage mothers accessing information on contraceptives. This agrees with Owusu-Addo et al. (2016) who revealed that teenagers’ fear in accessing information on how to
take care of their babies is linked to stigma and feeling intimidated because they are mixed up with the older women during antenatal and postnatal visits.

With regard to the sources and forms of support, this study found that some of the teenage mothers received support from their spouses, in-laws, family, neighbors, and health workers. The forms of support included financial, informational, emotional, and kin support. Support for teenage mothers enabled them to support themselves and their children. This agrees with the findings by Wiemann et al. (2006) that paternal presence, as well as financial support, led to the reduction of stress for the teenage mother. Also, De Jonge (2001) in a study on support for teenage mothers established the need for the support of health workers. In addition, findings by Gyan (2017) revealed that access to financial resources and support for teenage mothers helped them to secure their health and cope with motherhood. These are in tandem with the ecological systems theory, which posits that when the young mother has the support of her family, friends, spouse (microsystem), she is more likely to cope with her situation as a mother as well as her attempt to reintegrate into society after the pregnancy.

On the other hand, some of the teenage mothers expressed neglect by their spouses and families. Thus, they had to rely on friends, health facilities or neighbors for survival. Some of the teenage mothers had to struggle to survive on their own. Furthermore, neglect by the family and paternal involvement was found to negatively affect the mental health of teenage mothers. This agrees with Wahn and Nissen (2008) who reported that teenage mothers are at a greater psychosocial risk and needed unique care and attention. In addition, Cheng and Pickler (2009), suggested that a range of psychological stressors is experienced by women during the postpartum period and lack of social
support for women could result in depression and exposure to other risks. These findings support the ecological systems theory, that when a teenage mother is stigmatized and discriminated against by her family, friends, and community (micro, meso and macrosystems), it can result in adverse effects on her mental, psychological, and emotional well-being.

The study found that certain factors impeded teenage mothers from accessing support. This included family members rationalizing their problems especially when they reported cases of abuse, being accused of infidelity, ignorance of places to seek support from, personal attitudes, and negative attitudes of health professionals. This confirmed a study by Owusu-Addo et al. (2016) in Ghana which revealed that the negative attitudes of health care professionals towards teenage mothers limited their ability to access information both before and after childbirth. They further added that most adolescent mothers refused to seek information due to social stigma and fear of being asked to abort the baby. Allnock and Miller (2013) also supported these findings by adding that, barriers to seeking help among young people included victims having nobody to turn to, the absence of a trustworthy person to tell, feelings of isolation, inability of others to recognize the abuse, their fears and anxieties manipulated by the perpetrator, and anxiety over the confidentiality of their information.
CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction
This chapter summarizes the findings and conclusions from the study. The chapter also provides recommendations for policy, implications for social work, and further research.

5.2 Summary of Findings
The study found that a low level of education and truancy, early marriage, poverty, transactional sex, and cohabitation were risk factors for repeat pregnancies. Furthermore, the findings revealed that peer pressure was a contributing factor to repeat pregnancies among teenage mothers. Teenage mothers were also found to engage in sexual activity to prove their fertility to their friends while others engaged in sexual activity just for experimentation. Another factor contributing to repeat pregnancies was sexual coercion. In some cases, sexual abuses led to pregnancies.

Furthermore, the study revealed that teenage mothers with repeat pregnancies faced several challenges. Repeat pregnancies resulted in teenage mothers dropping out of school to raise their children. The study also found that teenage mothers faced financial challenges because of abandonment by their spouses, in-laws, and parents after their repeat pregnancies. Additionally, the study found that due to the increased challenges of repeat pregnancies, teenage mothers were frustrated and had feelings of anger, rejection, depression, and suicidal ideations. Thus, teenage mothers faced mental health challenges due to repeat pregnancies.
Other health challenges teenage mothers with repeat pregnancies faced included preeclampsia, placental abruption, intrauterine growth restriction, and preterm birth. Teenage mothers were also found to have anemia and malnutrition. The results also revealed that sexual coercion was both a cause and challenge of repeat pregnancies. This study also revealed that teenage mothers with repeat pregnancies faced social and cultural challenges because of community norms that emphasize the importance of a father naming his child. Teenage mothers whose children were not named by their spouses faced stigma and shame in the community.

With regard to the knowledge teenage mothers with repeat pregnancies have on contraceptives, the study found that teenage mothers obtained information on contraceptives from peers, family, schools, health centers such as clinics and hospitals, and community visits by nurses. However, this study found that parents found it difficult to discuss sex and contraception with their children. Teenage mothers with repeat pregnancies were also found to have some knowledge on contraceptives and their benefits. However, some of the teenage mothers were not sure how the contraceptive methods work. Furthermore, misconceptions and fear of the side effects of contraceptives deterred many teenage mothers from using contraceptives. They expressed how the use of contraceptives could result in weight gain or weight loss, irregular bleeding, cessation of the menstrual cycle, and in some cases death. In addition, lack of partner consent also emerged as a barrier to contraceptive use among teenage mothers.

With regard to the sources and forms of support, this study found that teenage mothers mostly received support from their spouses, in-laws, family, neighbors, and health workers. On the other hand, some of the teenage mothers also expressed neglect by their spouses and families. The forms
of support included financial, informational, emotional, and kin support. It was apparent from the research findings that most teenage mothers received support, especially from family and friends after their first pregnancy. Thus, it appears most teenage mothers were given a “second chance” by their families and relatives. However, their repeated pregnancies appeared to be the “breaking point” in family support.

The support of family members was also found to be very critical in assisting the teenage mother acquiring parenting skills, as well as securing her health and that of her child. Furthermore, neglect by the family and paternal involvement was found to negatively affect the mental health of teenage mothers. Additionally, certain factors impeded teenage mothers from accessing support. This included family members rationalizing their problems especially when they reported cases of abuse, accusations of infidelity, ignorance of places to seek support, personal attitudes, and negative attitudes of health professionals.

5.3 Conclusions of the Study

The study explored the experiences of teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis. The findings of the study revealed that repeat pregnancies were influenced by a low level of education and truancy, early marriage, poverty and transactional sex, peer pressure, and sexual coercion.

From the findings, it was concluded that repeat pregnancy is a social problem since it could result in adverse effects on the life of the teenage mother and her child. A second birth may be even more harmful and challenging to the child and mother as compared to single teenage births due to the increased socioeconomic impacts (Partington et al., 2009). Teenage mothers with repeat
pregnancies faced educational, financial, health challenges and shame and embarrassment due to stigmatization by the community.

Even though the health centers, family, friends, and school play a crucial role in disseminating information on contraception, there appeared to be a gap in the information disseminated by parents and the peers of these teenage mothers with repeat pregnancies. This is because parents did not approve premarital sex and most of them were not comfortable educating their wards on adolescent sexuality and contraceptive use (Taffa et al., 2017). This results in information being omitted which are important in empowering teenage mothers to make informed choices. Furthermore, the study concludes that teenage mothers with repeat pregnancies feared to use contraceptives. This was because of the lack of adequate information and uncertainty about the effects of contraceptives. Additionally, cultural norms and beliefs on contraceptives and institutional challenges are concluded to be major barriers to access and utilization of contraceptives by teenage mothers with repeat pregnancies.

Furthermore, the study concludes that there are support systems available to teenage mothers with repeat pregnancies. These are usually spouses, in-laws, family, neighbors, and health workers as well as institutional support from the health centers. However, some of the teenage mothers did not receive support from their spouses, family, and community. In addition, teenage mothers faced barriers to accessing support. These barriers include family members rationalizing their problems especially when they report cases of abuse, accusations of infidelity, ignorance of places to seek support, personal attitudes, and negative attitudes of health professionals.
Also, since the experiences of teenage mothers with repeat pregnancies have implications for development, it can be concluded that repeat pregnancy is a complex issue and must be understood from a multidimensional perspective. Repeat pregnancies impact the various systems that teenage mothers are involved in, as well as other systems they are not directly involved in but affect their development. This is in tandem with the ecological systems theory by Urie Bronfenbrenner (1979).

**5.4 Recommendations**

The study found that factors contributing to repeat pregnancies included early marriage, truancy, peer pressure, poverty, and sexual coercion. Based on these findings, it is recommended that community nurses should increase visits to communities to educate teenagers on repeat pregnancies and contraceptive use. This will help reduce repeat pregnancies. In addition, it is recommended that the government makes the National Health Insurance Scheme (NHIS) free for teenage mothers. This is because some of the teenage mothers included in this study faced complications during pregnancy and childbirth because they did not access healthcare due to financial challenges.

Also, teenage mothers who visited the hospital were found to have more knowledge of contraceptives. It is the expectation that, making the NHIS free will encourage more teenage mothers to access health care, thereby giving the health workers the opportunity to educate them on the use of contraceptives. This would lead to a reduction in repeat pregnancies. Furthermore, the Livelihood Empowerment Against Poverty (LEAP), should be expanded to cover teenage mothers. This is because, the goal of the LEAP programme is to provide support to the vulnerable people in society, to enable them to meet their basic needs (food, clothing, and shelter). This study
found that teenage mothers were vulnerable and at risk of repeat pregnancies because they could not afford to meet these basic needs. It is the expectation that, if these teenage mothers receive support from LEAP, they can support themselves and their children and avoid engaging in sexual activity for financial gain and possibly pull themselves out of poverty.

Also, government, civil society, and community members must work together to ensure that girls have access to education. Once the girls pursue higher education, they are more likely to avoid child marriage. Again, community members need to be educated more on the harmful effects of child marriage on the child, the community, and society. Moreover, existing laws in Ghana on child marriage must be enforced when girls are at risk of child marriage or when those who are already married seek justice and protection. Furthermore, the study found that teenage mothers with repeat pregnancies faced financial, educational, and health challenges. Thus, the study recommends that government and non-governmental organizations provide skill training centers for teenage mothers. This would give them the opportunity to acquire a skill and get a job, further leading to the empowerment of these teenage mothers. This would help reduce the challenges they face as teenage mothers with repeat pregnancies.

Also, the study found that sexual coercion contributed to repeat pregnancies. This study recommends that since teenage mothers who were abused were not aware that the abuse is an infringement of their rights, DOVVSU in collaboration with non-governmental organizations like Marie Stopes International should organize educational programs in this regard. Since access to contraceptives is essential to the wellbeing of women and communities, as well as helps prevent repeat pregnancies, it is important that measures be taken to educate teenage mothers on the
benefits of contraceptives. Also, efforts must be made to increase the accessibility of contraceptives to teenage mothers. Some of the teenage mothers indicated that the contraceptives they used were not effective. This led them to advise their friends against the use of contraceptives. Thus, it would be helpful to know the specific types of contraceptives used by these teenage mothers. This will help determine whether these issues were due to ineffective contraceptives or incorrect (or misuse) of these contraceptives. If these contraceptives are determined to be effective but used wrongly, resources can be channeled into educating teenage mothers on the way to use these contraceptives. On the other hand, if these contraceptives were ineffective because they were fake or placebo drugs, the appropriate stakeholders (Food and Drugs Authority, Ministry of Health, et cetera) need to take steps to get rid of these contraceptives from the market.

This study also recommends that there is an adolescent health center in every hospital or clinic. This is because of the stigma associated with teenage mothers attending antenatal and postnatal care with the older women during antenatal and postnatal visits. The adolescent health center will help prevent this stigma and help accommodate the unique needs of teenage mothers. The study found that although teenage mothers with repeat pregnancies received support from their families, friends, and health centers, these supports were not adequate, making it difficult for teenage mothers with repeat pregnancies to reintegrate with the society after their pregnancy. It is, therefore, recommended that family members, community, government, and non-governmental organizations should be involved in the reintegration process as they provide support for teenage mothers. The Department of Social Welfare and the health centers should collaborate to educate the community about the importance of support systems to the teenage mother.
This study used a qualitative approach. Since it would be difficult to generalize the findings of this study, it would be important to replicate this study in other regions in Ghana. This would allow for comparison of the experiences of teenage mothers with repeat pregnancies across various locations in Ghana. This information once identified and addressed, would help reduce the incidence of repeat pregnancies in Ghana.

5.5 Implications for Social Work

The experiences of teenage mothers with repeat pregnancies is a complex issue and must be targeted by social workers from a multidimensional perspective (individual, family, community, policy). This includes working with the teenage mother to meet her psychosocial needs. In addition, the teenage mothers’ family and community must be educated on the negative impacts of teenage pregnancy and child marriage on the teenage mother and society. Given that the teenage mothers in this study could not afford to educate their children, social workers should lobby for policies that would support teenage mothers and their children. In addition, social workers should advocate for after-school learning centers in the communities for the children of teenage mothers to help them get the opportunity to work or go to school.

Social workers (educators) should educate teenage mothers at the community level on factors leading to repeat pregnancies, as well as the importance of using contraceptives. This sensitization should target both men and women and should emphasize how contraceptives can help build healthy families and communities. This would help reduce repeat pregnancies and help clear the misconceptions of teenage mothers on contraceptives. It would also help address issues of partner consent and ensure that men are supportive of women’s family planning decisions.
It would be useful if social workers could advocate for skill training centers that would be easily accessible to teenage mothers. In addition, the skill training centers could make provision for child care facilities to enable teenage mothers who do not have child care support to enroll in the training. This would give them the opportunity to acquire skills and get a job, further leading to the empowerment of teenage mothers. This would help reduce the challenges they face as teenage mothers.

Since teenage mothers in this study experienced different forms of sexual coercion and were vulnerable, social workers could advocate for changes in policies and programs and formulation of new policies that will focus on domestic violence against teenage mothers. In addition, social workers could work with religious bodies, ethnic groups and institutions like the schools within the community to influence behavioral change that could reduce sexual coercion of teenage mothers. Furthermore, clinical social workers should collaborate with medical doctors, psychologists, psychiatrists, and other health workers to screen for mental health when teenage mothers come to see them. This is because many teenage mothers in the study experienced mental health challenges. Thus, the screening will enable the social worker to detect the mental health challenge and offer the appropriate counseling.
REFERENCES


and qualitative and realist synthesis of implementation factors and user engagement. *BMC Medicine, 15*(1), 1-13. doi:10.1186/s12916-017-0904-7


doi:10.1080/13691058.2016.1216167


APPENDICES
APPENDIX I

Demographic Information

1. What is your age ________________________________

2. What is your ethnicity? Please mark the one that applies to you.
   
   Ga -Adangbe __________
   
   Akan _________
   
   Ewe _________
   
   Hausa _______________
   
   Other ________________________

3. What is your religion? Please mark the one that applies to you.
   
   Christian ______________
   
   Muslim ______________
   
   Traditional Religion_______________
   
   other______ please specify ________________________________

4. What is your level of education? Please mark the one that applies to you.
   
   a. Elementary________________________
   
   b. Junior high education _______________
   
   c. Senior high education
   
   d. Others ___________________ please specify _______________________

5. What is your current marital status? Please mark the one that applies to you.
   
   Married ________________  Divorced ________________
   
   Single ___________________  Co- habitng ___________________
Widowed ________________ Separated ________________

6. Was the marriage or cohabitation before / after the pregnancy? _______

7. Are you working? Yes / No

8. If yes, what work do you do __________________________________________

9. Is this your first child? Yes / No

10. If no, how many children do you have? ____________________________

11. Do you live with your Parents? Yes / No

12. At what age did you become Pregnant? ____________________________

13. Were you in school when you got pregnant? Yes/ No

14. Did you drop out of school because of the pregnancy? Yes / No

15. Is there any history of teen pregnancies in the family? Yes / No

16. If yes, who in the family? ________________________________
APPENDIX II

Interview Protocol for Teenage Mothers

My name is Lucinda Okine. I am a student from Department of Social Work, University of Ghana. As part of my MPhil Program, I am conducting a study on the experiences of teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis, Accra. As a Social Work student, your input will help give me a better understanding of the experiences of teenage mothers with repeat pregnancies. I will be asking 12 open-ended questions. This interview is anonymous and the information gathered will be treated with confidentiality.

1. Tell me about yourself. How would you describe your situation and experience of teenage pregnancy?

2. What factors contributed to your first and second birth (probe: how different were both circumstances).

3. What challenges do you face as a teenage mother (probes: educational, financial, raising the child, physical health).

4. How did your family react when they found out you were carrying a second child? (probe: reaction from partner, community).

5. What do you know about contraceptives? (probe: how you heard about it, which contraceptive(s) do prefer to use and why? did you receive any sex education prior to any of your births).

6. What are your views on parents discussing sex education with their children? (probe: whether they will discuss sex education with their own children).

7. How was the topic of sex education handled when you were growing up in your family?
8. How will you define your social support systems (probe: who are they?).

9. How does your support network provide support to you? (probe: support from parents, extended family, nurses, father of the baby, community members, challenges in accessing support).

10. What are your future career/educational plans?

11. How do you plan to support your children?

12. How would you want to be supported so you feel empowered to achieve your personal goals and avoid another unintended pregnancy? (probe: by the community, parents, health workers, father of the baby).
APPENDIX III

Interview Protocol for Health Workers

My name is Lucinda Okine. I am a student from Department of Social Work, University of Ghana. As part of my MPhil Program, I am conducting a study on the experiences of teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis, Accra. As a Social Work student, your input will give me a better understanding of the experiences of teenage mothers with repeat pregnancies. I will be asking 9 open-ended questions. This interview is anonymous and the information gathered will be treated with confidentiality.

1. Tell me about yourself. (probe: how long have you been working with the teenage mothers and what trends have you observed)?

2. What do you think contribute to repeat pregnancies in this community?

3. What are some of the challenges teenage mothers face?

4. What do you think are some of the views of teenage mothers on the use of contraceptives?

5. What are your views on parents discussing sex education with their children?

6. How will you describe the support systems available to teenage mothers in this community? (probe: who are they?).

7. How does the teenage mother’s support network provide support to them? (probe: Parents, extended family, nurses, father of the baby, community members).

8. What are some of the future career/educational plans teenage mothers share with you?

9. How do you think these adolescents can be supported to feel empowered to achieve their personal goals and prevent other unintended pregnancies? (probe: by the community, parents, health workers, father of the baby).
APPENDIX IV

Focus Group Discussion

My name is Lucinda Okine. I am a student from Department of Social Work, University of Ghana. Today I would like to have a conversation with you about your experiences as teenage mothers with repeat pregnancies. What I am trying to accomplish before we leave here today is to get a better understanding of the factors contributing to repeat pregnancy, challenges faced by teenage mothers, knowledge of teenage mothers on contraceptives, support systems available to teenage mothers. Are there any questions?

I will also like us to go over some rules to ensure a smooth discussion. First, let’s all put our phones on silent mode, so we are not interrupted. This helps me to keep track of what people are saying. Also, anyone that wants to contribute can signal me by raising her hand. Please do not interrupt someone when they are talking. Also, everything you say today will be kept confidential. I will summarize the things you say and combine it with another focus group discussion I will be having.

One of my jobs today as the moderator is to make sure we discuss all the issues we planned to discuss. Just to get us started, let us have everyone tell us their names, and other information you may be interested in.

Questions

1. What factors contributed to your first and second birth (probe: how different were both circumstances).
2. What challenges do you face as a teenage mother (probes: educational, financial, raising the child, physical health).

3. What do you know about contraceptives? (probe: how you heard about it, which contraceptive do prefer to use and why, did you receive any sex education prior to any of your births).

4. What are your views on parents discussing sex education with their children? (probe: whether they will discuss sex education with their own children).

5. How does your support network provide support to you? (probe: support from Parents, extended family, nurses, father of the baby, community members, challenges in accessing support).

6. How would you want to be supported so you feel empowered to achieve your personal goals and avoid another unintended pregnancy? (probe: by the community, parents, health workers, father of the baby).
APPENDIX V

IRB Ethical Clearance and Approval

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No. ........................... 21st February, 2018

Ms. Lucinda Okine
Department of Social Work
University of Ghana
Legon

Dear Ms. Okine,

ECH 093/17-18: EXPLORING THE EXPERIENCES OF TEENAGE MOTHERS WITH REPEAT PREGNANCIES IN ABLEKUMA SUB-METROPOLIS

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 20/08/18
On Agenda for: Initial Submission
Date of Submission: 15/01/18
ECH Action: Approved
Reporting: Quarterly

Please accept my congratulations.

Yours Sincerely,

Rev Prof. J. O. Y. Mante
ECH Chair

CC: Prof. Mavis Dako-Gyekye, Department of Social Work, University of Ghana.

Tel: +233-303933866  Email: ech@ug.edu.gh | ech@isser.edu.gh
APPENDIX VI

Child Assent Form

UNIVERSITY OF GHANA

Ethics Committee for Humanities (ECH)

CHILD ASSENT FORM

Section A- BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>Title of Study:</th>
<th>Exploring the Experiences of Teenage Mothers with Repeat Pregnancies in Ablekuma Sub-Metropolis, Accra</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Investigator:</td>
<td>Lucinda Okine</td>
</tr>
<tr>
<td>Certified Protocol Number</td>
<td></td>
</tr>
</tbody>
</table>

Section B- ASSENT TO PARTICIPATE IN RESEARCH

General Information about Research

You are invited to participate in an academic research aimed at exploring the experiences of teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis, Accra. The purpose of this study is to gain an insight into the factors contributing to repeat pregnancies, challenges faced by teenage mothers, their knowledge on contraceptives, and the support systems available to them. You will be expected to participate in a 60-90 minutes interview. You will also be required to answer 12 open ended questions in addition to demographic information. Please feel free to ask questions if you do not understand anything.

Benefits/Risks of the study

Being in this study will bring you no harm. There are no direct benefits to you for participating in this study. However, your answers will help me learn more about your experiences as a teenage mother and ways to prevent teenage pregnancy as well as provide support for you and your child.

Although the risks to your participation in this study may be little, you will be asked questions relating to your sexual activity and experiences with repeat pregnancy. There is a possibility of some of the questions making you feel uncomfortable. However, you do not have to answer the questions that make you uncomfortable. You may also stop answering questions or stop the interview at any time without any consequences.
In addition, if you are part of the focus group discussion, you may have to share your experiences with the group. There is a possibility that this information may become public which may cause some negative experiences if this information is learned by others. To protect against these risks, group members will be asked to indicate that no information discussed in the focus group will be shared outside the group. Group members who indicate that they do not think they may be able to keep information confidential will be asked not to participate in the focus group discussion. Furthermore, you do not have to answer any question that you feel uncomfortable answering in a group. You may also stop answering questions or leave the group at any time without any consequences.

Confidentiality

I will be very careful to keep your answers to the interview questions private. During and after the study, I will keep all information I collect about you locked up and password protected. Also, when I finish this study, I will write a report about what I have learnt. This report will not include your name or any information indicating that you were in the study.

Compensation

You will be given refreshment (food and drink) and honorarium (a toy for your child) at the end of the interview.

Withdrawal from Study

You do not have to participate in this study. It is up to you. You can say no now, or you can even change your mind later. No one will be upset with you if you decide not to be in this study. If you choose to stop before we are finished, any answers you already gave will be destroyed. There is no penalty for stopping.

Contact for Additional Information

If you have questions about the study, you can contact:
Lucinda Okine (Investigator), Department of Social Work, University of Ghana, P. O. Box 419, Accra, lokine002@st.ug.edu.gh, 0206748206.

Prof. Mavis Dako-Gyekye, (Supervisor), Department of Social Work, University of Ghana mavidako@yahoo.com, 0278143979.

Also, if you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.
Section C: PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give my assent to participate in this study. I will not have waived any of my rights by signing this assent form. Upon signing this form, I will receive a copy for my personal records."

_________________________  ________________________
Name of Participant

_________________________  ________________________
Signature or mark of Participant  Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered, and the volunteer has agreed to take part in the research.

_________________________  ________________________
Name of witness

_________________________  ________________________
Signature of witness / Mark  Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_________________________  ________________________
Name of Person who Obtained Assent

_________________________  ________________________
Signature of Person who Obtained Assent  Date
APPENDIX VII

Guardian/Parental Protocol Consent Form

UNIVERSITY OF GHANA

Ethics Committee for Humanities (ECH)

GUARDIAN /PARENTAL PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>Title of Study:</th>
<th>Exploring the Experiences of Teenage Mothers with Repeat Pregnancies in Ablekuma Sub-Metropolis, Accra</th>
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<td>Lucinda Okine</td>
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<tr>
<td>Certified Protocol Number</td>
<td></td>
</tr>
</tbody>
</table>

Section B- CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

Your child is invited to participate in an academic research aimed at exploring the experiences of teenage mothers with repeat pregnancies in Ablekuma sub-Metropolis, Accra. The purpose of this study is to gain an insight into the factors contributing to repeat pregnancies, challenges faced by teenage mothers, their knowledge on contraceptives, and the support systems available to them. Your child will be expected to participate in a 60-90 minutes interview. Your child will also be required to answer 12 open-ended questions in addition to demographic information. Please feel free to ask questions if you do not understand anything.
Benefits/Risks of the study

There are no direct benefits to your child’s participation in the study. However, information provided by your child will ensure that policy interventions are geared towards preventing teenage pregnancies and providing support systems for teenage mothers.

Although the risks and discomforts are minimal, your child will be asked questions relating to her sexual activity and experiences with repeat pregnancy. There is a possibility that some of the questions will be uncomfortable for your child to answer. However, your child will not be forced to answer every question. She can also decide to stop answering questions or stop the interview at any time without any consequences.

In addition, if your child is part of the focus group discussion, she may have to share her experiences with the group. There is a possibility that this information may become public and thus, cause some negative experiences if this information is learned by others. To protect against these risks, group members will be asked to indicate that no information discussed in the focus group will be shared outside the group. Group members who indicate that they do not think they may be able to keep information confidential will be asked not to participate in the focus group discussion. Furthermore, your child may decide not to answer any question that she may feel uncomfortable answering in a group. She may also stop answering questions or leave the group at any time without consequences.

Confidentiality

No identifying information will be included in the answers your child provides. Pseudonyms will be used in place of your child’s name to ensure that her identity is not revealed. Also, the recorded audio will be destroyed once the study is complete to ensure that no other person has access to the data. Furthermore, the data will be used exclusively by the investigator and her academic supervisors/unit. No other person will be granted access to the data without your written consent.

Compensation

Your child will be given refreshment (food and drink) and honorarium (a toy for her child) at the end of the interview.

Withdrawal from Study

Following your consent, participation of your child in this study remains voluntary. Your child may also refuse to answer any question she may feel uncomfortable with and may withdraw at any time without penalty. In addition, your child will not be adversely affected if she declines to participate or withdraw from the study.
Contact for Additional Information

You can contact the following if you have any questions about the research. Lucinda Okine (Investigator), Department of Social Work, University of Ghana P. O. Box 419, Accra, lokine002@st.ug.edu.gh, 0206748206.

Prof. Mavis Dako-Gyekye, (Supervisor), Department of Social Work, University of Ghana mavisdako@yahoo.com, 0278143979.

Also, if you have any question about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

Name of Participants

Signature or mark of participants Date
If participants cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered, and the volunteer has agreed to take part in the research.

__________________________
Name of witness

__________________________    _____________
Signature of witness /Mark    Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

__________________________
Name of Person who Obtained Consent

__________________________    _____________
Signature of Person who Obtained Consent    Date
APPENDIX VIII

Health Official Consent Form

UNIVERSITY OF GHANA

Ethics Committee for Humanities (ECH)

HEALTH OFFICIAL CONSENT FORM

Section A- BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>Title of Study:</th>
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<td>Certified Protocol Number</td>
<td></td>
</tr>
</tbody>
</table>

Section B- CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

You are invited to participate in an academic research project which is aimed at exploring the lived experiences of teenage mothers with repeat pregnancies in Ablekuma Sub-Metropolis, Accra. The purpose of this study is to provide insight into the factors contributing to repeat pregnancies, challenges teenage mothers face, their knowledge on contraceptives and the support systems available to them. You will be expected to participate in a 60-90 minutes interview. You will also be required to answer 9 open ended questions. Please feel free to ask questions if you do not understand anything.

Benefits/Risks of the study

Being in this study will bring you no harm. There are no direct benefits to you for participating in this study. However, it will help me learn more about the experiences of teenage mothers and ways to prevent teenage pregnancy as well as provide support for them and their child.
Confidentiality

I will be very careful to keep your answers to the interview questions private. Before and after the study I will keep all information I collect locked up and password protected. Also, when I finish this study I will write a report about what I have learnt. This report will not include your name or that you were in the study.

Compensation

You will be given refreshment (biscuit and drink) at the end of the interview.

Withdrawal from Study

You do not have to participate in this study. It is up to you. You can say no now, or you can even change your mind later. No one will be upset with you if you decide not to be in this study. If you choose to stop before we are finished, any answers you already gave will be destroyed. There is no penalty for stopping.

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Section C - PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give my consent to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this form, I will receive a copy for my personal records."

__________________________
Name of Participant

__________________________  ______________________
Signature or mark of Participant  Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered, and the volunteer has agreed to take part in the research.

__________________________
Name of witness

__________________________
Signature of witness / Mark  Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

__________________________