

**SCHOOL OF NURSING  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA, LEGON**

**PSYCHOSOCIAL EXPERIENCES OF PREGNANT ADOLESCENTS: A STUDY  
AT THE TEMA METROPOLIS**

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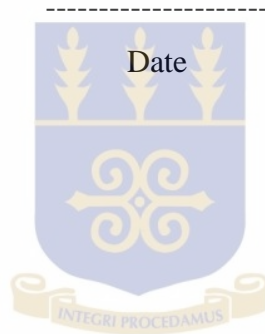
**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN  
PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF  
MPHIL NURSING DEGREE**

**JULY, 2013**

## DECLARATION

I declare that with the exception of references to other people's work which have been duly acknowledged, the views expressed in this study are mine, and have neither in part nor in whole been presented elsewhere for another degree.

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## DEDICATION

This work is dedicated to my husband Mr. Joseph Amoah, my children Nana Kwame and Ato Amoah for their support and encouragement. It is also dedicated to all pregnant adolescents who helped in diverse ways in making this research a success.



## ACKNOWLEDGMENTS

It would have been impossible to undertake this study without the generous support of many persons to whom, I hereby express my thanks and appreciation.

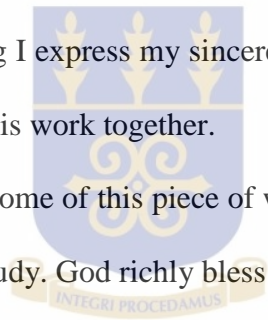
First and foremost I give thanks to the Almighty God for giving me the will power and courage to complete the work despite difficult circumstances encountered.

I wish to express my profound gratitude to my able supervisors Dr. Patience Aniteye and Mrs. Faustina Oware-Gyekye for their endless efforts and contribution through constructive guidance, assistance, suggestions and technical advice throughout the study.

My appreciation also goes to management and staff of Tema General Hospital as well as the clients who helped me in generating the meaningful data for this research.

To the Staff of School of Nursing I express my sincere thanks for the knowledge imparted to me which enabled me to put this work together.

Finally I share the joy in the outcome of this piece of work with everyone who contributed in diverse ways to support this study. God richly bless you all.



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## LIST OF ABBREVIATIONS

AIDS	:	Acquired Immune Deficiency
CAC	:	Comprehensive Abortion Care
HIV	:	Human Immunodeficiency Virus
MDG	:	Millennium Development Goal
UN	:	United Nations
UNFPA	:	United Nations Population Fund

## ABSTRACT

The number of adolescents becoming pregnant is on the increase. They are physically and psychologically immature to withstand the stress of pregnancy yet, society does not give them the necessary support they need to go through this stressful situation. The pregnant adolescents often end up with complications which increase maternal morbidity and mortality in Ghana.

The purpose of this qualitative inquiry was to explore the psychosocial experiences of pregnant adolescents in the Tema Metropolis. The study participants were made up of twelve (12), purposively sampled pregnant adolescents attending antenatal clinic at the Tema General Hospital. Individual semi-structured interviews were used to generate the data which was analyzed using content analysis.

From the experiences narrated by the participants, ten main themes emerged, which were further categorized into sub-themes. The major themes were causes of pregnancy, conditions at home, reactions of parents towards pregnancy and reactions of partners towards pregnancy. Others included reactions of friends towards pregnancy, attitude of neighbours, economic challenges, reactions of adolescents towards pregnancy, disorders in pregnancy and attitudes of midwives.

The findings indicated that pregnant adolescents faced psychological problems such as anxiety, sadness, rejection, thoughts of abortion and suicidal tendencies. Reactions from their parents, partners, peers and neighbours included beatings, anger, denial and gossiping. Some mothers were however supportive. The findings showed that pregnant adolescents were faced with an array of psychosocial problems which could hamper their overall development and wellbeing. It was recommended that the hospital management should identify a day and time to attend to only pregnant adolescents. Also, future research should focus on the coping strategies and quality of life of adolescents after delivery.

## CHAPTER ONE

### 1. Introduction

This chapter is to introduce the reader to a research carried out in the Tema Metropolis on the psychosocial experiences of pregnant adolescents. Among the issues that will be covered in this chapter are the background of the study, problem statement, purpose of the study and objectives. Other areas include the research question, significance of the study and operational definition of terms.

#### 1.1 Background

Adolescents are people between the ages of 10 to 19 years (World Health Organization, 2002). They constitute 21.9% of Ghana's population (Ghana Demographic and Health Survey, 2008). They make up a substantial proportion of Ghana's population and therefore a major human resource base of the country. Adolescents are however faced with a number of general and reproductive health problems which if not resolved, could impact immensely on the human resource of Ghana in future. Many nations worldwide express concern about the reproductive health and development of the adolescent (Omoni 2009) and Ghana is no exception.

Adolescence is the period of transition from childhood to adulthood. Sometimes, it is described as beginning with fertility or puberty and ending with maturity and independence. It is characterized by physical, psychological and social development. Physically, there is rapid gain in height and weight. This spurt typically occurs two years earlier in girls than in boys. Weight gain results in increased muscle development in boys and body fat in girls. During puberty, the changing hormonal levels play a role in activating the development of secondary sex characteristics. (Piaget, 1972).

Psychologically, there is a continuous brain development and the individual begins to use abstract concepts and principles known as formal operation stage (Piaget, 1972). Piaget also observed that cognitive maturity occurs as the social network expands, which offers more opportunities for experimenting with life. Some adolescents do not enter into this stage of cognitive development because worldly experiences play a large role in attaining formal operations (Piaget, 1972).

Socially, adolescence is also considered as a time of drifting away. For the first time in their lives, adolescents may start to view their friends and their peer groups, as more important and influential than their parents or guardians. Peer groups offer them the opportunity to develop various social skills, such as empathy, sharing and leadership. Peer groups can have a positive influence on an individual, for instance, on academic motivation and performance, but they can also have a negative influence that may lead to an increase in experimentation with drugs, in-take of alcohol, vandalism, and sexual relations among others (Arnett, 1999). They are faced with parent-child conflicts, mood changes and risky behaviour. In the search for a unique social identity for themselves, adolescents are frequently upset. Hall (1951) denoted this period as one of "Storm and Stress" adding that, conflict at this developmental stage is normal.

Adolescents might consider themselves as grown-ups and therefore mature enough to have sex. They often lack the knowledge about the consequences of unprotected sex such as unwanted pregnancy and sexually transmitted infections including HIV/AIDS (Ghana Standards for Youth Care, 2002). In many cases, they do not reveal their reproductive health problems and do not use the health care services available to them. This may be due to inadequate information, limited access to financial resources or negative attitudes of health workers (Ghana Demographic and Health Survey Report, 2008). The home environment and parents are still important for the behaviours and choices of adolescents.

Adolescent sexuality refers to sexual feelings, behaviour and development in adolescents. Sexuality and sexual desire usually begin to intensify along with the onset of puberty (Standards for Youth Care, 2002). The health profile of the youth in Ghana includes sexual and reproductive updates. In 2000, the average age at first marriage was 19.3 and the age at first sex was 18.3 but some become sexually active between 10 and 12 years. There are 38% of girls and 19.3% of boys between the ages 15 and 19 who are sexually active, and by age 19, over 80% of both sexes have experienced one sexual activity or the other. By 18 years, 48.0% of girls and 25.0% of boys would have had their first sex. About 23.0% of mothers are below 20 years (Ghana Demographic and Health Survey Report, 2003). Improved adolescent health could directly contribute to achieving internationally agreed upon goals such as reducing maternal mortality (Millennium Development Goal 5) and reversing the spread of HIV and AIDS (Millennium Development Goal 6).

Pregnancy is a natural occurrence for women and physiologically most women experience the same changes associated with childbearing. However the psychological experiences of being pregnant may differ vastly. Whilst this time could be exciting and positive for some, for others, it will be very negative, stressful and unwanted. The individual's particular developmental stage along the lifespan continuum seems to also influence the experiences of pregnancy. Unwanted pregnancy can be a major problem for a young girl to encounter in her adolescent life. A pregnant adolescent is someone who is pregnant between the ages of 10 and 19, who will deliver before her twentieth birthday. About 13 million women aged between 15 and 19 give birth each year, constituting about 11% of all births worldwide. Ninety-five percent of these births occur in low and middle income countries. Teenage pregnancy rates vary between countries because of differences in levels of sexual activity, general sex education provided and access to affordable contraceptive options. Worldwide, teenage pregnancy rates range from 143 per 1000 in some sub-Saharan



African countries to 2.9 per 1000 in South Korea (Treffers, Olikoya, Ferguson & Liljstrad, 2003). The issue of adolescent pregnancy is a constant concern to health and social-care professionals because of the complications that arise from the pregnancy, labour and childbirth process. Medical and obstetric complications can occur due to the immature physiological development of the adolescent, especially those aged 16 years and below (Cronje & Grobler, 2003). In these very young adolescent girls, the pelvic bones, skeletal and uterine muscles are not yet fully developed resulting in obstetric complications such as cephalo pelvic disproportion that can lead to prolonged labour (Cronje & Grobler, 2003; Fraser and Cooper, 2003). Medical complications that occur in pregnant adolescents include pregnancy-induced hypertension and anaemia (Cronje & Grobler, 2003). Besides medical and obstetric implications, pregnancy may have a negative effect on the education and future career possibilities of adolescent girls as they are often forced to drop out of school (Fraser & Cooper, 2003).

In the United States of America, where the problem has been more extensively studied and documented, it has been reported that more than one million teenage pregnancies occur annually, and that the problem has been rising or exploding dramatically (Domenico & Jones, 2007).

Similar situations have been described for African countries. A study in Swaziland found that about two decades ago, females aged 15 and 19 accounted for 32.8% of the total fertility rate and females in the same age group contributed to 103 births per 1000 women (10.3%) in the country, (Gatara & Muriuki, 2005).

In Ghana, Xinhua (2006) estimates that nearly one-third of the childbirths recorded in public hospitals occurred to women less than 19 years of age. The situation is more dramatic in the rural areas where small to medium sized towns are often under-represented in the hospital birth statistics.

According to the Alan Guttmacher Institute (2006), more than 90% of 15 to 19 year-olds describe their pregnancies as unwanted and more than half of these unwanted adolescent pregnancies end up in induced abortion. Fourteen percent (14%) of all unsafe abortions in low and middle income countries are among women aged between 15 and 19 years. About 2.5 million adolescents have unsafe abortions every year, and adolescents are more seriously affected by complications than older women. Although adolescents aged 10 and 19 years account for 11% of all births worldwide, they account for 23% of the overall burden of disease due to pregnancy and childbirth. In Latin America, the risk of maternal death is four times higher among adolescents younger than 16 years than among women in their twenties. Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. These include anaemia, malaria, HIV and other sexually transmitted infections, postpartum haemorrhage and mental disorders, such as depression. Up to 65% of women with obstetric fistulae developed these conditions as adolescents, with direct consequences for their lives, physically and socially. In Ghana, termination of pregnancy is high and also forms the most common cause of death among the youth.

An autopsy study carried out at Korle Bu Teaching Hospital cited abortion as the leading cause of maternal mortality among adolescents (Aboagye & Akosa, 2000).

One of the causes of teenage pregnancy is lack of information. This is because most parents do not encourage their children to talk about sex. In some cases, they provide false information regarding sex and discourage their children from participating in any informative discussion about sex. Adolescents experience physiological changes which they find difficult to discuss with their parents. The only option therefore is to discuss with their peers who often mislead them (Bell, 2006).

Sharpe, (2003) argued that peer influence is a major factor that encourages the teenage boys and girls to indulge in sexual activities since most of them do not want to fall out of

their peer groups and will do things such as early dating (as early as 12 years) to please their friends.

Most adolescents have inadequate knowledge about safe sex. They reportedly have no access to the methods of preventing pregnancy. They are also embarrassed or afraid to seek information about safe sex. This result in about 80% of adolescent pregnancies being unwanted (Standards for Youth Care, 2002).

Divorce is another major factor that contributes to pregnancy among adolescents. Girls whose mothers remarry after divorce are sometimes faced with challenges from their stepfathers and stepbrothers who rape or sexually exploit them (Strauch, 2003).

Socio-economically, adolescent girls who belong to poor families are more likely to become pregnant. They have sex in exchange for money, gifts or they are influenced by their elders including their mothers who will also benefit from this kind of relationship. Some of the girls also start this kind of relationship by themselves merely for the love of it (Strauch 2003).

Illegal relationships among teachers and adolescents are one of the causes leading to unwanted pregnancies. A study conducted in Kenya revealed that teachers are willing to give better notes and grades in exchange of sexual favours (Strauch, 2003). Strauch further stated that teenage mothers who are school dropouts may end up in low income jobs that may lead to low socio-economic status.

The age when a girl becomes pregnant is crucial and becoming a teenage mother interrupts the course of her life. Adolescents are confronted with parental responsibilities at a time when they have to deal with their own developmental task of identity verses role confusion (Erikson, 1965). When life-changing events occur in adolescents, more stress is added to the already turbulent period. Failure to succeed may lead to loss of confidence, feelings of helplessness, and self-destructive behaviours.

From the researcher's observation and also from available anecdotal evidence, there is increased rural-urban migration of adolescents in the Tema Metropolis probably for improved working and living conditions. These adolescents, who are homeless, end up virtually sleeping on the streets. There are also numerous entertainment centres (night clubs) which operate throughout the night, and this also encourages taking alcohol and sexual immorality among the adolescents who have no homes to return to after the day's work. This may have contributed to the increase in the number of pregnant adolescents, although a few of the pregnant adolescents come from reputable homes.

Even though adolescent health services have been introduced into the health sector in Ghana for over two decades, not much has been done in our hospitals to make them adolescent friendly. The experiences of pregnant adolescents may be different from that of their older counterparts. Pregnant adolescents think differently and need to be treated differently by society, health care providers and intervention programmes. It is therefore imperative to know the psychosocial experiences of these pregnant adolescents who patronize ante-natal services in our health institutions.

## **1.2 Statement of the Problem**

Adolescents are children in transition to adulthood. They are physically and psychologically immature to withstand the stresses and strains of pregnancy and childbirth (Cronje & Grobler, 2003). Although pregnancy is a normal physiological process, it is sometimes fraught with unpredictable and unforeseen health and social problems. The health problems include anaemia, pregnancy-induced hypertension, infections and haemorrhage (ante partum and postpartum). Adolescents in particular suffer from pre-eclampsia and eclampsia (Fraser & Cooper, 2003). In addition to these health problems, adolescents who become pregnant may be subjected to a myriad of psychosocial problems

which may influence the outcome of their pregnancy (Omoni, 2009). This can draw setbacks on the Millennium Development Goal Five (5) which is to improve maternal health by reducing maternal mortality by three quarters, between 1990 and 2015 (UN Initiative 2002).

Every year, 13 million women under the age of 20 give birth, accounting for up to 20% of all births worldwide ((UNFPA, 2008). Teenage pregnancy is not just a problem for low and middle income countries, but high income countries as well. In Ghana, 13% of all births were adolescents and 15% of all maternal deaths were adolescents (Ghana Demographic and Health Survey, 2008).

Specifically, in the Tema General Hospital ,adolescents form an average of 11.5% of all ante-natal registrants over the period from 2008 to 2012 (Tema General Hospital Annual Report).

This is shown in the table below:

**Table 1.1**

**Percentage of Adolescent registrants for Antenatal services from 2008 to 2012 at the Tema General Hospital**

Year	Total antenatal Registrants	Total Adolescent Registrants	Percentage of Adolescent Registrants
2008	6,869	735	10.7%
2009	10,606	996	9.3%
2010	9,185	1,002	10.9%
2011	6,229	745	12%
2012	6,126	707	11.5%
Total Average	7,803	837	11.5%

**Source: Tema General Hospital Yearly Report**

There is evidence that the adolescents are sexually active. Since some of them are not using contraceptives, unwanted pregnancy is likely to occur. When this happens, most of them regret their actions. They may also have to bear with many judgmental attitudes from family members as well as friends, making an already bad situation worse.

The attitude of health providers and other clients also make them feel uncomfortable. This leads to a default in ante-natal attendance. Most often, the men responsible for the adolescents' pregnancies are reportedly unable to take care of their own needs. They therefore leave the pregnant adolescents to go through the trying times alone. Some of them will resort to unsafe abortions which may lead to complications including death. This increases maternal morbidity and mortality in the country. This has become an issue of great concern to the government of Ghana. Pregnancy and child birth are highly welcome in Ghana but when they occur in unmarried adolescents, they bring a lot of displeasure to them and the whole family, sometimes leading to neglect of the pregnant adolescents.

The researcher, having worked at the Reproductive and Child Health Department of the Tema General Hospital for 9 years, has come into contact with many pregnant adolescents and interacted with them. She has observed the reduced quality of life, such as low weight gain, low haemoglobin levels and poor nutritional status in most of them due to financial challenges. They are also defaulters at the ante-natal clinic, and report late any time they attend clinic. This is because they look younger than other attendants who make them feel odd among the attendants. They sometimes look worried and cannot follow simple instructions given, which indicate that, they are experiencing something beyond the physical. It is for this reason that the researcher has set out to explore the psychosocial experiences of pregnant adolescents in the Tema metropolis.

### **1.3 Research Question**

The main research question of this study is: What are the psychosocial experiences of the pregnant adolescent?

### 1.4 Purpose of the Study

This study will explore and document the psychosocial experiences of the pregnant adolescents in the Tema Metropolis.

### 1.5 Objectives

The objectives of the study are to:

- 1) Identify the psychological experiences of pregnant adolescents.
- 2) Explore the social experiences of pregnant adolescents.
- 3) Examine the effects of the physical changes of pregnancy on the pregnant adolescents.
- 4) Identify the economic challenges of the pregnant adolescents.

### 1.6 Significance of the Study

The findings of this study will unravel the experiences of pregnant adolescent girls which will help policy makers, planners and all those involved in adolescent health services as well as the whole society to intensify education on adolescent sexuality and to promote their health.

It will add to the body of knowledge to help improve adolescent care.

Information from this study will serve as a reference material for further studies.

The findings will inform policy and programmes, and this may help ameliorate maternal morbidity and mortality.

### 1.7 Operational Definition

**Psychosocial:** the mind's ability to consciously or unconsciously adjust to the feeling of guilt, shame and worry in relation to one's present state or condition.

**Experience:** psychological, emotional, social and cultural exposures that the teenage mothers lived through during their pregnancies.

**Sexuality:** sexual feelings, behaviour and development.

**Teenagers:** people from the age of 13 to 19.

**Adolescents:** people from the age of 10 to 19.

**Pregnancy:** the period between conception to delivery.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1. Introduction**

This chapter presents a review of the research work related to the current study. The review was done using data bases such as Hinari, Popline, Jstor, Cinahl and Pub med. The review focused on adolescent reproductive health, the psychological experiences of pregnant adolescents and the social experiences of pregnant adolescents. Other areas explored were the effects of physical changes on pregnant adolescents and the economic challenges of pregnant adolescents.

#### **2.2 Adolescent Reproductive Health Issues**

Domenico and Jones, (2007) conducted a study on “Adolescent Pregnancy in America: Causes and Responses”. The researchers found out that adolescent females from relatively unstable family situations may become sexually intimate for a short-term sense of comfort. Parental rejection, or a lack of warmth, affection, or love, also led adolescents to seek relationships outside the family to boost their self-esteem. It was also found out that in recent times menarche occurs much earlier in adolescents and this combined with more peer pressure and less parental supervision result in the adolescent making premature sexual decisions leading to first time sexual encounters at younger ages. Sexual abuse may also alter perceptions about sexual behaviour, leading to an abused adolescent. These result in females initiating sex at an earlier age and having more partners. The researcher concluded that more young adolescent mothers give birth outside of marriage. At risk circumstances associated with adolescent pregnancy include medical complications, less

schooling and higher dropout rates, lower career aspirations, and a life encircled by poverty.

Singh, Darroch and Frost, (2001) pointed out in their study on the “Socioeconomic Disadvantage and Adolescent Women's Sexual and Reproductive Behaviour: The Case of Five High Income Countries”, that differences among developed countries in teenagers’ patterns of sexual and reproductive behaviour may partly reflect differences in the extent of disadvantage. Researchers in Canada, France, Great Britain, Sweden and the United States used the most current survey and other data to study adolescent sexual and reproductive behaviour. Comparisons were made within and across countries to assess the relationships between these behaviors and factors that may indicate disadvantage. The researcher found out that Adolescent childbearing is more likely among women with low levels of income and education than among their better-off peers. Levels of childbearing are also strongly related to race, ethnicity and immigrant status, but these differences vary across countries. Early sexual activity has little association with income, but young women who have little education are more likely to initiate intercourse during adolescence than those who are better educated. Contraceptive use at first intercourse differs substantially according to socioeconomic status in some countries but not in others. Within countries, current contraceptive use does not differ greatly according to economic status, but at each economic level, use is higher in Great Britain than in the United States. Regardless of their socioeconomic status, U.S. women are the most likely to give birth as adolescents. In addition, larger proportions of adolescents are more disadvantaged in the United States than in other high income countries. They concluded that comparatively widespread disadvantage in the United States helps explain why U.S. teenagers have higher birth rates and pregnancy rates than those in other developed countries.

Another study conducted by Ikamari and Towett (2007) examined “The Timing of Sexual Initiation and Contraceptive use among Female Adolescents in Kenya”. Data were drawn from the 2003 Kenya Demographic and Health Survey. Using a quantitative method, 3,454 adolescents aged 15-24 years answered questionnaires. The results obtained indicate the onset of sexual activity is early and contraceptive use is fairly low and both the timing of first sex and contraceptive use are affected by a variety of factors. Analysis using descriptive statistics revealed that 61.7 per cent of the 3,454 adolescents were already sexually experienced as at the time of the survey with 30 percent of the adolescents having initiated sexual activity by age 19. The researchers concluded that despite engaging in unsafe sex practices, the majority of the adolescents do not view themselves as being at the risk of unwanted pregnancy and contracting HIV/AIDS.

Similarly, a study was conducted by Abdool, Karim & Preston-Whyte, (2009) of South Africa Medical Research Council, Durban, on “Youth Participation in Condom use at a Family Planning Clinic”. The researchers used quantitative method. The findings were that, despite the awareness of AIDS and teenage pregnancy, condoms were perceived as a poor choice of contraception and their use was discouraged. The researchers’ concluding remark was that, condom use among adolescents was low.

A descriptive study conducted in Ibadan metropolis in Nigeria to assess the “Health Risks of Unsafe Abortion among Adolescents” revealed that, sepsis (infection) caused by contaminated instruments or incomplete abortion, haemorrhage, injuries to reproductive organs (such as cervical laceration or uterine perforation), and toxic reactions to chemicals or drugs used to induce abortion were the common causes of maternal deaths among adolescents (Hirsch & Barker, 2006).

### 2.3 Psychological Experiences of Pregnant Adolescents

The developmental stage of an adolescent is marked by much psychological growth and maturation. These processes become complicated when they are interrupted by transitions that are atypical during the teenage years. Pregnancy is most certainly considered one of those atypical events. Pregnancy can affect the adolescent psychologically as well as being a physical, financial and academic challenge for young expectant mothers. The issues that are mostly overlooked are the psychological and emotional challenges (Hudson, Elek and Campbell-Grossman, 2000).

A study was conducted by Hudson, Elek and Campbell-Grossman (2000) on “Relationship between Levels of Depression, Self-esteem, Loneliness, and Social support among Adolescent Mothers”. Using a quantitative method, a depression scale, self-esteem scale, loneliness scale and the social support questionnaire were administered to participants during the ninth month of pregnancy and three months after delivery. The researchers reported in their findings that the depression score was high range for (53%) of the teenage mothers. Depression was associated with increased feelings of loneliness and decreased social support. Good self-esteem was correlated to social support. Loneliness on the other hand increased as a result of poor social support.

In conclusion, they stated that teenage mothers are at risk with a series of psychosocial challenges which when not resolved at the early stages could be detrimental to the health of the teenager.

Similarly, Reid and Meadows-Oliver (2007) suggested in their research on “Depression among Adolescent Mothers in the First Year Postpartum” that there was an increasing rate of depressive symptoms in the postpartum period. They reviewed 12 research-based articles to provide a better understanding of depression among adolescent mothers in the first year postpartum. The findings revealed that more family conflict, fewer social

supports, and low self-esteem were associated with increased rates of depressive symptoms in adolescent mothers during the first postpartum year. They concluded that to prevent adverse outcomes associated with depression, it is important that nurse practitioners working with these families intensify health education on support systems during pregnancy, screen adolescent mothers for depression and refer them for treatment as needed.

A related study was conducted by Fergusson, Horwood, and Ridder (2000) on the “Extent to which Abortion has Harmful Consequences for Mental Health of the Teenager”. The researchers examined the linkages between having an abortion and mental health outcomes over the interval from age 15–25 years. The data were gathered as part of the Christchurch Health and Development Study at New Zealand, a 25 year longitudinal study of a birth cohort of New Zealand children. Information was obtained on: the history of pregnancy and abortion for female participants over the interval from 15–25 years; measures on mental disorders and suicidal behaviour over the intervals 15–18, 18–21 and 21–25 years; and childhood, family and related confounding factors. The researchers found out that forty-one percent of women had become pregnant on at least one occasion prior to age 25, with 14.6% having had an abortion. Those having an abortion had elevated rates of subsequent mental health problems including depression, anxiety, suicidal behaviours and substance use disorders. This association persisted after adjustment for confounding factors. They concluded that abortion in teenagers may be associated with increased risks of mental health problems.

In another related study, Clemmens (2002) used structured interviews and focus group discussions together with the scale measurements on similar variables which produced much better understanding. Clemmens (2002) sampled 20 adolescent mothers aged between 16 and 18 who were participating in programmes for adolescent mothers in the

North-Eastern cities of the United States of America. The sample comprised of adolescent mothers who reported feeling depressed since the birth of their babies. Generally, these mothers had experienced normal deliveries and no complications were reported for both the mothers and the babies. All the participants were at school and the age of babies ranged from 1 to 11 months at the time of the interview. Participants in Clemmens' (2002) study had no history of being treated for depression. Participants reported feeling scared with the sudden realisation of motherhood. Some felt abandoned and rejected by partners and peers, whilst others indicated being overwhelmed with questions and not understanding the experience of depression and what was happening to them. Some participants reported feeling confused by the experience. Clemmens, (2002) concluded that poor social support could lead to depression in teenage mothers.

However, Logsdon, Birkimer, Simpson, and Looney (2005) argued in their study on "Postpartum Depression and Social Support in Adolescents" that social support intervention delivered to pregnant adolescent girls between 32 and 36 weeks of gestation does not prevent symptoms of depression at 6 weeks postpartum. They used a repeated measures design to collect the data at a teenage parenting programme from 128 pregnant and postpartum adolescents. The main outcome measure was symptoms of depression at 6 weeks postpartum. The researchers found out that there were no significant differences found in Centre for Epidemiological Studies of Depression instrument scores among the groups at 6 weeks postpartum. Using path analysis, the authors found that predictors of symptoms of depression at 6 weeks postpartum were receiving more support from friends, family, and others and having low self esteem. Therefore the researcher concluded that social support has no effect on pregnant adolescents becoming depressed.

According to Ramathesele, (2007) adolescent motherhood has been found to be associated with depressive symptoms. A study conducted in South Africa reported that the transition

from adolescence to motherhood is accompanied by some psychological consequences. Participants in the study reported feeling robbed of their adolescence, possibilities in the future and their chances for a good life. The teenagers were reported to be “far from being emotionally, cognitively and socially ready for the prospect of motherhood”. The researcher concluded that, pregnant teenagers should not be treated like outcasts, but they should rather be supported to achieve success in their future endeavours.

Lehana and Van Rhyn (2003) conducted a phenomenological investigation of the “Experiences of Pregnancy by Unmarried Adolescents in Maseru”. A phenomenological approach was used to explore and describe the experiences of sixteen (16) pregnant unmarried adolescents in the Maseru District in Lesotho. The researchers reported that the reactions of the unmarried adolescents towards their pregnancies were Fear, Denial, Confusion, Worry, Misery, Shame, Anger, Hope, Depression and Bad feelings. They also indicated that the reactions of parents and relatives towards the pregnant adolescents were Anger, Hurt or Acceptance while those of the boyfriends or sexual partners were Fear, Surprise, Denial, or Acceptance. They concluded that adolescents in Maseru expressed shyness or a sense of shame when they found out their abdomen was enlarging. They also had serious psychosocial experiences which impacted negatively on their life.

Kessler (2003) explored the “Emotional Experiences of Unmarried Pregnant Adolescents. The researcher found out that adolescents aged between 15 and 17 years were more than twice as likely as adult mothers to be depressed. Also, younger teenagers (15–17 years) reported more symptoms of severe depression than the older group (18 – 19 years). This indicates that, school-going teenagers and younger teenagers tend to experience more symptoms of psychological and emotional distress. Thoughts about abortion were found to have preoccupied the younger teenagers. The researcher concluded that unmarried

pregnant adolescents experience depressive symptoms after child birth than married adolescents.

Smith (2004) conducted a study on “Pregnancy Perceptions among Adolescents” using a descriptive design. Participants were allowed to discuss their concerns and needs during pregnancy in their own words. The purpose was to gain insight into adolescent females' personal perceptions about pregnancy particularly with regards to their physiological and emotional concerns or needs, methods of sharing those concerns or needs, coping strategies, social support, future aspirations and intervention modalities. Questionnaires were administered to eighty (80) participants, between the ages of 13 to 19 years obtaining prenatal health care services at a community based clinic in North Carolina. The researcher reported that twenty-five participants reported a range of physiological and emotional perspectives on the pregnancy experience. Further analysis of data revealed insight on coping strategies, support systems, future aspirations, and intervention modalities with implications for future research efforts.

The author concluded that enhanced nurse interactions, utilization of group support, telephone reinforcement, as well as age and population specific strategies may prove effective in supporting pregnant adolescents to cope with physiological and emotional concerns or needs.

The qualitative method used for the above research was appropriate in generating in-depth data on pregnant adolescent girl's experiences. The current study also used qualitative method as it is the only way in-depth information could be obtained, since there is little publication on this area in Ghana. However, in concluding the author suggested interventions to improve only psychological and emotional needs.

According to Fergusson and Woodward (2011) suicidal behaviour and its correlates remain relatively understudied in pregnant teenagers. They used a cross-sectional study of



871 pregnant teenagers, recipient of prenatal medical assistance by the national public health system in the urban area of Pelotas, Southern Brazil. Suicidal behaviour and psychiatric disorders were assessed with the Mini International Neuropsychiatric Interview; the Abuse Assessment Screen was used to identify physical or sexual abuse; social support was assessed with the Medical Outcomes Survey Social Support Scale; a self-report questionnaire was used to collect socio-demographic, obstetric and other psychosocial data.

They found out that prevalence of suicidal behaviour was 13.3%; lifetime suicide attempts were 7.4%, with 1.3% reporting attempting suicide within the last month. After adjustment, they also found that there were significant associations of suicidal behaviour within the 18–19 year old subgroup, low education, prior abortion, previous major depression, and physical abuse within the last 12 months. Pregnant teenagers with high social support showed prevalence ratios less than those with low social support. Furthermore, a wide range of psychiatric disorders, most notably major depressive disorder and panic disorder remained associated with suicidal behaviour after adjustment. The researchers concluded that suicidal behaviour is a relatively common feature in pregnant teenagers, frequently associated with psychiatric disorders.

Zabin, Astone and Emerson (1993) argued that adolescent pregnancy was considered a shameful event; however, the perception of some adolescents was that, they have achieved developmental expectations. According to Zabin, Astone & Emerson (1993), adolescent girls may see pregnancy as a means of achieving adulthood, finding a purpose in life, having someone to love, or strengthening the relationship with their sexual partners. The need to strengthen relationships can also be seen in the context of developing some kind of bonding with others. Unfortunately, most pregnant adolescents may not have such mental disposition.

Sodi (2008) suggested in a study on the “Psychological Impact of Teenage Pregnancy on Pregnant Teenagers” that teenage pregnancy is a psychologically stressful experience. The study was conducted at Capricorn District (Limpopo Province). Using both quantitative and qualitative methods, fifty two (52) pregnant teenagers were conveniently sampled to participate in the study. The results showed that teenage pregnancy is a psychologically stressful experience that is associated with conditions such as anxiety, insomnia, depression, social isolation and somatic symptoms. On realizing the pregnancy, participants reacted with fear and denial. They also thought about terminating the pregnancy as they considered teenage pregnancy to be a shameful situation. There was also an indication that teenage pregnancy was seen as part of development. For some participants, the support that they got from their families and boyfriends was perceived as very crucial in minimising the psychological distress associated with teenage pregnancy. The conclusion drawn by the researcher was that in order to cope with these distressing symptoms, various strategies employed by the participants to cope with their pregnancies were found to include actions like associating with those considered supportive and also engaging in activities that kept their minds away from their pregnancies. Child Support Grant was found to play no role in motivating teenagers to be pregnant.

Woo and Twinn (2004) argued in their research conducted on the “Health needs of Hong Kong Chinese Pregnant Adolescents” that the outcomes of adolescent pregnancy have been associated with health risks such as obstetric complications, depression, and educational risks such as school dropout and reduced employment opportunities.

An exploratory qualitative approach was used with a purposive sample of 10 Hong Kong Chinese pregnant adolescents. Semi-structured interviews were used to explore adolescents’ perceptions of their psychological, social and health needs. The researchers found out that the initial reaction of the adolescents was denying being pregnant, they then

try to use folk remedies to terminate the pregnancy. Psychologically, they felt hopeless about their situation but had no choice than to adapt to the situations. The researchers also found out that the adolescents were not using contraceptives and they lacked social support from health providers and significant others leaving them lonely. The authors concluded that despite the different cultural context of the setting, pregnant adolescents have similar health needs. The commonalities of health needs among pregnant adolescents are psychological reactions towards their pregnancy and perception of lack of control over the outcomes of sexual activity.

## **2.4 Social Experiences of Pregnant Adolescents**

Getting pregnant during adolescence is a common experience for girls who live in low income countries.

De Vito, (2007) conducted a qualitative study on “How Adolescent Mothers Feel about becoming a Parent” using narrative comments collected over a seven- month period from 126 adolescent mothers. The study reported that after pregnancy and childbirth, several adolescent mothers’ relationship with their partners did not meet expectations. In many of the cases, the partners became less involved in the relationship, and in other cases, they ended the relationship. The researcher concluded that the more emotional and tangible support the adolescent mother received from the father of the newborn, the higher the adolescent mother's self-evaluation of parenting. However, for some of the adolescent mothers in the study sample, the partners were not consistently supportive or did not share parenting duties, but when he was available, the baby's father provided both emotional and tangible support, especially when the adolescent's own mother was not a part of her life.

The research methodology followed the tenets of a qualitative research. The methodology, especially the interviewing method used by the researcher to collect data was appropriate

for the study. This is because, the author was able to probe or explore and obtained in-depth information on participants' experiences.

Similar study was conducted by Whitehead (2008), on "Relationships in Teenage Pregnant Women and the Fathers of their Unborn Children". The aim of the study was to explore the relationship between the teenage pregnant women and the fathers of their unborn children within the context of two contrasting demographic areas of the UK. A qualitative approach was used to explore and describe the experiences of 47 teenage pregnant women using semi structured interviews. It was found to be statistically significant that the age, employment status and education of the baby's father can influence the continuance of the partnership between the participant and that of the father of her baby.

She concluded that there was a disillusionment felt by some teenage pregnant women towards the fathers of their unborn babies which is related to them being unable to provide financial support. Their inability to contribute to the welfare of their partners and babies may be a significant factor in the breakdown of relationships between the prospective parents and hence the emergence of the 'absent' father.

Higginbottom, Owen, Mathers, Marsh, and Kirkham (2006) conducted a study on "Early Parenthood among Young People of Minority Ethnic Origin in England". They used a qualitative approach to explore the teenage parenting experiences of ethnic minority young parents in England. Data was collected using focus group interviews, in-depth semi-structured interviews and a telephone survey. The participants were service providers, adolescents, partners of the adolescents and grandmothers. In all, 136 people were used. They reported the following findings: that adolescents experienced discrimination and unsolicited comments were passed by the general public regarding their status. Most of the adolescents had support from their mothers. They also found out that it is common for young single men to deny parentage when a sexual partner becomes pregnant due to fear

of taking responsibility, however a few of the adolescents were still in a relationship with their partners and the adolescents had educational and career aspirations.

The researchers concluded that there is a need to specify needs rather than generalising across all minority ethnic communities regarding early parenthood. Young parents of Muslim faith clearly do not view teenage or early pregnancy, as a problem, unless it occurs outside marriage. Most teenage parents in this study had clear career, or educational goals. Many had difficulties in obtaining appropriate child-care, financial, and other support to materialise these goals. Policy needs to reflect on the wide range of experiences among young parents and to ensure that currently successful support service models are adequately and sustainably funded.

Some studies conducted in high income countries to identify the reaction of adolescent girls to their pregnancies. The results showed that the pregnancies were mostly unplanned and as a result, the adolescents reacted to the experiences differently. The adolescent mothers reported that they felt sad, disappointed, shocked and depressed after their pregnancies were confirmed and they realized that they must adjust to the unexpected demands of being adults. It was further indicated that some started by denying the pregnancy at first, before they could inform their parents who, in most cases received the news with anger and disappointment. The adolescents had to deal with disapproval and dissatisfaction shown by significant others such as parents and siblings (Mpetshwa 2000, De Jong 2001, and Clemmens, 2002).

James, Rooyen, Strumpher, (2011) pointed out that Pregnant teenagers experienced a change in their relationships with significant others due to expectations that was not met.

In their qualitative study on “Experiences of Teenage Pregnancy among Xhosa Families” they interviewed ten (10) pregnant teenagers, eight mothers, two fathers, seven grandmothers and three grandfathers from the same families independently and privately.

Findings showed that parents experienced overwhelming emotions due to the unexpected pregnancy of their child, and loss of control as the pregnancy could not be reversed. They also found out that the pregnant teenagers experienced emotional turmoil as they strived to cope with their pregnancy. Parents of the pregnant teenagers experienced sadness and hurt as a result of disappointment and embarrassment created by the unexpected pregnancy of their teenage child. In the researchers' conclusion, they stated that, teenage pregnancy was experienced differently by different generations within the same family, but all the experiences culminated in anger that hampered the necessary parental support for the pregnant teenager. They also stated that parents felt cheated and unappreciated when the teenagers became pregnant, and were angry with the teenagers. This led to lack of support during pregnancy which could easily affect the well-being of the unborn child, as teenagers are not supervised and experience acute emotional stress.

Fergusson and Woodward (2000) argued out that teenage pregnancy leads to educational underachievement in female adolescents. The researchers examined the relationship between teenage pregnancy and educational under achievement in a cohort of 520 teenagers. The results showed that teenagers who became pregnant by the age of 18 years were at increased risk of poor achievement in the national School Certificate examinations, or leaving school without qualifications, and of failing to complete their sixth-form year at high school. In addition, pregnant teenagers had lower rates of participation in tertiary education and training than their non pregnant peers. Subsequent analyses showed that the links between teenage pregnancy and tertiary educational participation were largely non causal and reflected the earlier academic ability, behaviour, and family circumstances of young women who became pregnant. In contrast, antecedent child and family factors only partially explained associations between teenage pregnancy and high school participation and achievement. The conclusion drawn was that after

adjustment for these factors, significant associations remained between teenage pregnancy and educational achievement at high school.

A study that was conducted at Ga-Rankuwa Hospital, focused on the social and educational background of 70 adolescent mothers who had delivered their babies at the hospital between April and September 2005. Structured interviews were used to collect data. The findings showed that, even though most of the participants managed to talk to somebody, some were scared to tell their parents until their families realised that they were pregnant (Kekesi, 2007).

Similarly, a study done by Mpetshwa (2000) focusing on seven adolescent mothers, found that community members tended to have a wide range of negative reactions towards pregnant teenagers. Some members of the community tended to react with shock whilst others gossiped about the parents of the adolescents. In some churches, the members who became pregnant were refused an opportunity to participate in congregational activities. Some of the participants in Mpetshwa's (2000) study further reported that they experienced a lot of ill-treatment from their family members, especially their parents who felt betrayed by their children who became pregnant.

## **2.5 Effects of the Physical Changes on Pregnant Adolescent**

Pregnancy is associated with dramatic changes in a woman's body shape and size, and for many women, these changes trigger mixed emotions. Being pregnant could be a difficult issue to deal with. A recent study by Collingwood (2010) evaluated changes in adolescent women's weight and body satisfaction from before pregnancy to one month after delivery. It found that mothers were on average 4kg heavier after delivery than before becoming pregnant, and were less satisfied with their weight and shape after delivery. Researchers from the University of Minnesota followed 506 adolescent women over a longer time frame up to nine months following birth. The women's body dissatisfaction increased

significantly over this time. Despite losing an average of 4kg, their mean weight remained an average of 3.5kg above the pre-pregnancy weight (Gjerdingen, Fontaine & Miner, 2009). The results from the study by the University of Minnesota also indicated that body dissatisfaction after nine months was associated with overeating or poor appetite, higher current weight, worse mental health (particularly depression) and poor breast feeding practices.

A decline in body satisfaction is important in its own right, but it is also important because it may contribute to other problems. Duncombe, Havighurst, Halland and Frankling (2008) identified that as adolescents, body image prior to pregnancy and the tendency to compare themselves to others physically are linked to post-pregnancy body dissatisfaction. They indicated that this may contribute to a vicious cycle in which depression provokes body dissatisfaction through diminished self-esteem or overeating. The cycle may increase the risk for postpartum eating disorders. They further reported that, the combination of psychological stressors of new motherhood and body image concerns, intensified by the residual bodily changes of pregnancy, may predispose women to have an exacerbation in eating disorder symptoms and the development of postpartum mood disorder. They further pointed out that depression can make mothers non-responsive, inconsistent, or rejecting the infant, placing the mother-baby attachment at risk. Eating disorder may compound these risks, with medical and psychological risks becoming increasingly apparent.

Most adolescent women want to return to a normal weight after childbirth. The cultural 'thinness' mindset could unfortunately have negative repercussions on a mother's mental health (Gjerdingen, Fontaine, & Miner, 2009). However, Gjerdingen, Fontaine, and Miner (2009) found that most African women had greater body satisfaction.

Adolescent pregnancies have been associated with adverse social and health outcomes for both mother and children. Pregnancy and childbirth related complications are the leading



causes of death for girls aged 15-19, meaning that 70,000 adolescent girls die each year from these causes (Fraser & Cooper, 2003).

The body of a woman has to naturally develop to such an extent that it can comfortably accommodate a developing baby. An underdeveloped body would obviously pose some problems for both the woman and the baby she carries. An adolescent would be considered physically underdeveloped to comfortably accommodate a baby. Such underdevelopment is reported to pose a greater health risk to the individuals concerned (Muangpin, Tiansawad, Kantaruksa, Yimyam, & Vonderheid, 2010).

A study conducted by Trivedi, (2000) sought to compare the “Different Obstetric Parameters of Adolescent Women and Adult Women in New Zealand”. The results indicated that the average birth weight for the two groups had a 500g difference, with the adolescent mothers’ babies in the lower end whilst adult women’s babies weighed at the upper end. Seven in the adolescent mothers’ group had neonatal birth defects compared to the adult women’s group who only had one birth defect. The adolescent mothers’ group had fifteen breech deliveries of which eleven were delivered by Caesarean section. The adult women’s group had seven breech deliveries, of which three were delivered by caesarean section. The most common cause for Caesarean section in adolescent mothers was obstructed labour or poor progress in labour. With regard to pre-eclampsia or gestational hypertension, 26 adolescent mothers were found to have the condition as compared to 16 women from the adult group. Based on the findings of this study, it appears that teenage pregnancy poses considerable obstetric health problems to the teenager herself and the child. If these pregnant adolescents are not managed well, it will have a negative effect on the goal of reducing maternal mortality by the year 2015.

Lewis, Hickey, Doherty and Skinner (2009) carried out a study on “How does Pregnancy Outcomes Differ in Teenage Mothers”. The researchers used a cross-sectional descriptive

analysis of nulliparous women with single pregnancies who delivered at the sole tertiary obstetric hospital in Western Australia between June 2004 and September 2006. The main outcome measures were maternal risk factors, pregnancy characteristics, and obstetric and perinatal outcomes for teenage and adult pregnancies. Findings showed that out of the 4,896 births reviewed, 560 (11%) were to teenage mothers. Teenagers were more likely to be indigenous and to experience maternal risk factors such as anaemia and smoking. Indigenous women were more likely than non-Indigenous women to be smokers, with young Indigenous teenagers (aged 12–16 years) being most likely to smoke. The adolescents were at more risk of preterm delivery less than 37 weeks' gestation, admission to special care nursery and low birth weight. However, older teenagers (aged 17–18 years) were the group at highest risk of stillbirth. The researchers concluded that indigenous teenagers need special attention, and there is significant scope for public health interventions around anaemia and still birth.

## **2.6 Economic Challenges of the Adolescent Pregnant Girl**

Literature on adolescent pregnancy has reported socio-economic difficulties experienced by adolescents who become pregnant during their teenage years (De Jong, 2001; Hanna, 2001). According to Bissel (2000), women who become adolescent mothers are more likely to be socio-economically disadvantaged later in life when compared to women who tend to delay childbearing.

A report by Turner (2004) suggests that adolescent pregnancy perpetuates poor socio-economic background. Her study found that pregnant teenagers from deprived socio-economic backgrounds tended to keep their pregnancies, and their counterparts from relatively affluent backgrounds usually aborted their pregnancies. Turner's (2004) work however failed to examine the influence of parents or caretakers as well as knowledge on

abortion in those with deprived socio-economic backgrounds. This will be explored in this study. Also, Turner (2004) could not establish variations in the prevalence rate of adolescent pregnancies in the two socio-economic backgrounds as baselines for this finding. Without such a baseline, this finding may lack content generalisability. The baseline becomes more necessary because as Bissel (2000) identified, adolescents from affluent socio-economic backgrounds may better know how to avoid adolescent pregnancy.

According to Hobcraft and Kiernan (2001) adolescent mothers were more likely to be having no educational qualifications at age 33. This results in the adolescents being in social housing and being recipients of state social grants. If they are employed, they are more likely to do low-income jobs. Furthermore, these women who became teenage mothers were more likely to experience longer periods of unemployment, single parenthood and higher levels of poverty. Bissel, (2000) reported that pregnant adolescents experience significantly more maladjustment than their non-pregnant counterparts, and were also found to be less likely to manipulate the environment in a positive manner. The implication here is that pregnant adolescents tend to have their identity development interfered with, as they find themselves grappling with developmental issues that are not appropriate for their age. In the majority of cases, adolescent mothers are not in a position to go back to school after delivery as they are forced to look after their children. In some cases, the young mothers' physical health conditions do not make it conducive for them to go back to school. Whilst some young women may be prevented from going back to school as a result of these factors, De Jong, (2001) found that there are some cases of adolescents who may use their pregnant status to deliberately escape the demands of school education. Some were reported to have dropped out because they had to look after their children whilst others discontinued with their studies due to financial difficulties.

Still, others were reported to have dropped out because their parents refused to pay the school fees on realization of pregnancy. The issue of financial problems being a reason for teenage mothers dropping out of school and the tendency to blame mothers for the behaviour of their teenage daughters, seems to perpetuate the patriarchal notions that are prevalent in most African societies. Mpetshwa (2000) also shares this view.

Relationships with partners were also referred to as being negative as a result of the pregnancy. Less than half of teenage mothers in De Visser and Le Roux's (1996) study indicated that relationships with partners did not really materialize even though in some families, partners assisted in supporting the children. A South African study conducted by Eshbaugh, (2011) with adolescents found that these young people were not happy about their pregnancies. Most participants in Eshbaugh, (2011) study also perceived their pregnancies to be a source of crisis for themselves and their families. It was also reported in the same study that having a child did not raise one's social status, instead this experience was perceived as a disgrace in the eyes of parents and the community.

## **2.6 Conclusion**

The main aim of this chapter was to review literature on the psychosocial experiences of pregnant adolescents. A number of challenges such as complications of pregnancy, dissatisfied body image after child birth and depression were found to be associated with adolescent pregnancy. The adolescents were not ready for the stress from pregnancy and its related social issues. The experiences were found to impact negatively on the psychological functioning of the adolescents. Notwithstanding these unpleasant consequences, adolescent pregnancy is reported to be on the increase.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This section describes the type of study and it includes the research design, research setting, target population, sample size and sampling technique. Other areas include the method of data collection, data collection tool, data management, data analysis, rigour and ethical considerations.

#### **3.2 Research Design**

Research design is the overall plan for obtaining answers to the research questions being studied (Polit & Beck 2008). In this study, the researcher used the interpretive descriptive approach, which is an example of qualitative research described by Thorne (2008) to answer the research question. Interpretive descriptive approach is a smaller scale qualitative inquiry of a clinical phenomenon that uses inductive analytic approaches such as informed questioning and reflective or critical examination in order to gain understanding into a phenomenon. This method was designed by a nurse researcher to address nursing problems, and to generate knowledge for the nursing profession (Thorne 2008).

This design was deemed appropriate for the research question because it will help the researcher to explore the meaning of the lived experience and explain the psychosocial experiences of the pregnant adolescents. The information gained from this research will help professional nurses as well as nursing practice.

### 3.3 Research Setting

The research was carried out at the Tema General Hospital in the Tema Metropolis in the Greater Accra Region of Ghana. The Tema General Hospital is a district hospital situated at Tema West Constituency, near the Tema-Ashaiman highway.

The hospital was built in 1954 by William Harcrow and Sons, a company which constructed the Tema Harbour to serve the needs of their staff. It was handed over to the government of Ghana in 1962 when they completed the construction of the harbour.

The hospital is headed by a Medical Director working closely with the core management team, made up of the Head of Nursing, Head of Medicine, Head of Health Service Administration, Head of Pharmacy and Head of Finance. All the professionals working at the hospital work under one of the members of the core management team. The hospital serves the following catchment areas; Tema township and its satellite towns such as Tema New Town, Kpone, Ashaiman, Afienya, Kakasunanka, Katamanso, Apollonian, Dawhenya, Prampram, Sakumono, Lashibi, Klagon and extending as far as Nungua, Dawa, Sege, Kesseh and Ada.

It serves a total population of approximately 628,053. The hospital has 14 Wards and 30 Units with a bed capacity of 294. It renders the following services: Internal Medicine, Surgical Services, Pediatrics, Obstetrics, Gynecology, Reproductive and Child Health. Other services include Eye, Dental, Ear, Nose and Throat, and special clinics such as Diabetic Clinic, Sickle Cell Clinic, Dermatological Clinic, Asthma Clinic, and Antiretroviral Clinic. The hospital also renders support services such as Physiotherapy, Laboratory services, Radiography, Pharmacy, Laundry, Mortuary, Birth and Death Registry, and Catering services for both staff and patients. The personnel providing the above services are Doctors, Professionals and Auxiliaries Nurses and Midwives, Pharmacists and Pharmacy Technicians, Biochemists and Laboratory Technicians, Disease

Control Officers, Records Officers, House Keeping Staff, Drivers, Security Men, Kitchen Staff and Mortuary Attendants.

The hospital also provides a 24-hour specialist and general services on both Out-Patient and In-Patient bases. The hospital, in addition to being situated in a highly industrial city, is also very close to three major highways namely, the Accra-Tema Motorway, Tema-Aflao and Tema-Akosombo roads. These are all accident prone and therefore a lot of road accidents and industrial accident cases are referred to the hospital. It also receives lot of referrals from the surrounding private and company clinics.

The antenatal unit of the hospital is manned by eight midwives. The clinic practise focus antenatal care and each midwife is assigned to a cubicle. The unit does not have a midwife who has been trained in Adolescent Health Services since the only one trained is on retirement. When the pregnant women visit the antenatal clinic, they are assigned to a midwife who attends to them till they deliver. The unit receives a lot of referred pregnant adolescents from private and company clinics.

### **3.4 Target Population**

The target population for the study included all pregnant adolescents attending antenatal clinic at the Tema General Hospital during the period of the study.

#### **Inclusion Criteria**

The sample was made up of pregnant adolescents who were between the ages of 16 and 19 and this was because at this age, the adolescents could articulate and could better narrate their experiences. They were unmarried, and were in their third trimester giving them ample time to gather considerable psychosocial experiences to share.

Pregnant adolescents who consented to participate in the study and could speak English, or any of the following Ghanaian languages “Ga”, “Twi” or “Fanti”.

This was due to the fact that the researcher understands and can speak the above languages.

### **Exclusion Criteria**

Pregnant adolescents who were married or co-habiting with their partners were excluded. This was because after marriage in Ghana, it is expected that the woman becomes pregnant. When this happens they are given the necessary support they need.

### **3.5 Sample Size and Sampling Technique**

Purposive sampling was used to recruit participants as the researcher had a specific purpose in mind, therefore the sample chosen shared the same characteristics and had experienced the phenomenon being investigated (Maree, 2010). Such a sample was suitable for this study, which aimed to gain rich in-depth data. Pregnant adolescents were identified from antenatal clinic registers with the assistance of midwives who work at the clinic. The midwife assisted the researcher to locate the registers, compiled about 40 names and contact details of the adolescents who were in their third trimester and who gave the necessary information. The midwife introduced the researcher to the pregnant adolescents and the researcher gave them verbal information about the study during their next visit. Those who were interested were recruited to participate in the research. The list compiled was more than the number of adolescents needed for the study. This ensured that the final list was not known to the midwife. The pregnant adolescents were later telephoned by the researcher who arranged for an appointment. During that appointment, the researcher explained the research objectives and methods of data collection, including all ethical issues to the participants. Some of those who agreed to participate were interviewed immediately and others at other appointments arranged at the participants' convenience.



Interpretive description could be conducted on a sample of almost any size. The most important idea was to have enough rich data to explain the phenomenon. It could be as small as five participants or as large as 30 participants (Throne, 2008). A sample size of twelve (12) pregnant adolescents gave enough information to explain the psychosocial experience of the pregnant adolescents.

### **3.6 Data Gathering Tool**

In qualitative research, interview and observation are required to gather data (Burns & Grove, 2001). An individual semi-structured interview was conducted with the participants using interview guide. The interview guide is a tool for collecting data through a set of open ended questions asked in a specific order (De Vos, Fouche & Delport, 2005).

The guide was divided into two main parts. Part A comprised of questions eliciting demographic data and Part B was made up of questions on the participants' psychosocial experiences.

### **3.7 Data Gathering Technique**

A convenient interview day and venue was scheduled with the participants.

The researcher explained the objectives and benefits of the study to the participants. English or other Ghanaian languages such as “Fanti”, “Twi” or “Ga” were used during the interview. This was because the researcher is fluent in these languages and it was easy for her to transcribe after the interview. Individual semi-structured interviews were conducted with the participants. The interview took between 45-60 minutes depending on individuality.

All interviewed data were audio-recorded and transcribed verbatim for concurrent analysis.

In addition, field notes were taken to capture mannerisms that could not be recorded. The interview questions were constructed to explore information regarding the psychosocial experiences of the pregnant adolescents. Probes were used to follow up on open-ended questions in order to elicit in-depth information. Participants were interviewed individually and there were follow up interviews for five (5) of the participants.

### **3.8 Data Analysis**

Data analysis is a stage in the research where the researcher has opportunity to put into words shared experiences of the participants. Qualitative data analysis entails listening carefully to narratives, sharing descriptions and understanding what has been said, always maintaining the highest degree of integrity (Carpenter & Speziale, 2007).

In this research, content analysis was used to analyse the transcribed data. Content analysis represents a process of identifying and coding data. It involves coding one piece of data (one interview) and comparing it with all others that may be similar or different in order to develop conceptualizations of the possible relations between various pieces of data. It capitalizes on a period of immersion in the data and periods of strategic withdrawal or distancing in which a more reflective analytic process is made possible (Thorne, 2008). Audio recordings of the interview data were transcribed verbatim (in exactly the same words of the participants). Transcriptions were checked against recordings for accuracy. The researcher commenced the analysis as soon as data generation began; that is data collection and data analysis took place concurrently. The data was read over and over to understand. Coding was done using a carefully developed thematic code frame (see appendix C). Themes and patterns were generated within the interview accounts. The

researcher then compared the accounts of different participants and came out with similar or different experiences. The purpose was to generate knowledge about common themes and patterns within their experiences.

The emerging themes and sub-themes were reviewed by the researcher and supervisor and the relationships among categories were used to describe the psychosocial experiences of participants. Field notes were reviewed to add to the information obtained and the need to go back to the interviewee was assessed.

### **3.9 Data Management**

The interview material was kept locked in the researcher's custody. Only the researcher and her supervisors had access to it. Demographic data were separated from the interview data to make sure that no connections could be made between them. The transcripts will be kept for about five (5) years following completion of the study. If the need to be used for further analysis arises, ethical clearance will be obtained.

### **3.10 Rigour**

Rigour in qualitative research ensures the avoidance of bias in the research findings. The aim of rigour is to precisely represent participants' experiences. In order to maintain methodological coherence, Thorne's (1997), guidelines on evaluation criteria in qualitative design was applied.

#### **Epistemological Integrity**

This requires that there is methodological coherence throughout the research that is the research questions, design, sampling and analysis should be congruent. The researcher ensured that Thorne's design, method of analysis and rigour were used to ensure this methodological coherence.

**Representative Credibility**

This is what Lincoln and Guba (1985) refer to as credibility. There was consistency between the interpretations of the research findings and expected sampling strategy.

The researcher ensured that the people who have experienced the phenomenon were interviewed, that is, pregnant adolescents. Representative quotations from transcribed words were submitted to experts to seek their agreement on whether audio-recording was the same as the transcribed information. Peer debriefing was done with those interested in adolescent health services.

**Analytic Logic**

Carpenter and Speziale (2007) refer to analytic logic as transferability. This was used during the data collection and analysis phase to ensure that the findings were logical and clear to the reader. The researcher ensured that a step-by-step record was kept by which data can be traced to their source to provide documentary evidence of activities or events. This will make it possible for other researchers to follow in their research. This was accomplished by providing an in-depth description of the findings from the original data. Quotations from the data were included in the final report.

**Interpretive Authority**

This refers to the trustworthiness of the interpretation of the data, that is, others can trust that the interpretation of the data illustrates some truth beyond personal biases and experiences of the researcher. The researcher obtained feedback from the participants to check if she had the stories right. The researcher, being aware of her own prejudice paid attention to participants who provided different data from what every participant is giving that is deviant cases.

### 3.11 Ethical Considerations

Prior to the study, an ethical approval was obtained from the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana, Legon. After approval, a Letter of Introduction was collected from the School of Nursing and permission was sought from the Medical Director and Deputy Director of Nursing Services in charge of Tema General Hospital as well as the Principal Midwifery Officer in-charge of the antenatal clinic. Consent forms were given to participants to read and for those who could not read, it was translated into the two selected Ghanaian languages of their choice, so that, they could understand and decide to either participate or decline. In the case of participants who were less than 18 years and were staying with their parents, participants' assent and parent or guardian consent were sought. They were assured of anonymity and privacy. This was done by not using names of the participants, and demographic data was separated from the rest of the data, transcripts and the research findings. Since the research evoked some sensitive sentiments of the adolescent participants, the researcher arranged with the public health nurse who was a trained counselor in-charge of public health unit to counsel the participants who broke down and wept during narration of their experiences.

## CHAPTER FOUR

### FINDINGS

#### 4.1 Introduction

This chapter covers the analysis and description of data on participants' psychosocial experiences following unwanted pregnancies. It first highlights participants' demographic characteristics since these are valuable in interpreting the data. This is followed by the shared experiences of participants in the form of choicest quotes. Ten major themes emerged from the familiarization with the data or immersion in the data which involved reading and re-reading of the transcripts. The themes were:

- Causes of pregnancy
- Conditions at home
- Reactions of parents towards pregnancy
- Reactions of partners towards pregnancy
- Reactions of friends towards pregnancy
- Attitudes of neighbours
- Economic challenges
- Reactions of adolescents towards pregnancy
- Disorders in pregnancy
- Attitudes of midwives

Following indexing (coding) and categorization of the data based on identified patterns, sub – themes were identified and appropriately categorized under the major themes. The themes and sub-themes are highlighted in table two (2) below and also described in the ensuing presentation.

**Table 4.1**  
**TABLE OF THEMES AND SUB-THEMES**

<b>THEMES</b>	<b>SUB-THEMES</b>
Causes of Pregnancy	<ul style="list-style-type: none"> <li>• Rape</li> <li>• Ignorance</li> <li>• Peer Pressure</li> </ul>
Conditions at Home	<ul style="list-style-type: none"> <li>• Unhappy Family</li> <li>• Disagreement / Quarrels/ Argument</li> </ul>
Reactions of Parents	<ul style="list-style-type: none"> <li>• Anger</li> <li>• Beatings</li> <li>• Rejection</li> <li>• Supportive mother</li> </ul>
Reactions of Partners	<ul style="list-style-type: none"> <li>• Anger</li> <li>• Denial</li> <li>• No support</li> </ul>
Reactions of Peers/Friends	<ul style="list-style-type: none"> <li>• Gossiping</li> <li>• Betrayal</li> </ul>
Attitudes of Neighbours	<ul style="list-style-type: none"> <li>• Gossiping</li> </ul>
Economic Challenges	<ul style="list-style-type: none"> <li>• Lack Of Fund</li> </ul>
Reactions of Adolescents	<ul style="list-style-type: none"> <li>• Sadness</li> <li>• Shyness</li> <li>• Anxiety</li> <li>• Worries</li> <li>• Suicidal tendencies</li> <li>• Thoughts of abortion</li> <li>• Anger</li> <li>• Denial</li> <li>• Loneliness</li> </ul>
Disorders In Pregnancy	<ul style="list-style-type: none"> <li>• Dizziness</li> <li>• Waist pains</li> <li>• Swollen feet</li> <li>• High Blood Pressure</li> <li>• Insomnia</li> </ul>
Attitudes of Midwives	<ul style="list-style-type: none"> <li>• Positive attitude</li> <li>• Negative attitude</li> </ul>

**Source: Interviewed Data**

For a meaningful presentation of findings, the demographic characteristics of participants are first outlined.

#### **4.2 Demographic characteristics of Participants**

In this study, twelve (12) pregnant adolescents in their third trimester were interviewed. They were recruited from the Tema General Hospital's Antenatal Clinic and were interviewed at venues of their choice. The participants were within the ages of sixteen (16) and nineteen (19) years. They belonged to the Ga, Ewe and Akan ethnic groups and could all speak English together with their local languages. Their level of education ranged from JHS three (3) to SHS four (4). Seven (7) out of the twelve participants were in school when the pregnancy occurred. They had to drop out of school when they could not cope with taunts from their class mates and pressure of school work. All the participants in the study had siblings. The number of siblings of the participants ranged from one (1) to nine (9). Six of the twelve (12) participants were staying with both parents and siblings at the time of the interview. Four of them were staying with their mothers and siblings. One participant was staying with her grandmother due to a broken home. Another participant was staying with her sister due to the death of both parents. The demographic characteristics of the participants are shown in table on APPENDIX A.

In the ensuing sections, the themes and sub-themes are presented.

#### **4.3 Causes of Pregnancy**

This section focuses on the participants' experiences related to the causes of their pregnancy. It covers the range of circumstances that led to the pregnancy.

Three sub-themes emerged from this theme. They were:

1. Rape
2. Ignorance
3. Peer pressure



#### 4.3.1 Rape

This refers to having sex with adolescents without their consent. The findings of the study revealed that some of the pregnant adolescents in this study were raped. Five out of the twelve participants' pregnancy were as a result of rape. These girls were deceived, lured and coerced into having sex as shown by the following quotes.

The issue of rape was evident in the words of an eighteen (18) year-old adolescent who stated:

*He said he will give me a special thing and I said oh what is the special thing and he said unless I visit him before he will give me the special thing. So I went to his house and he took me to one of his friend's house. He forced and had sex with me.*

*PA, age 18 years*

*When my sister and her husband left the house for work. Her husband came back home and met me bathing. When I went to the room to dress up he came in to rape me and warned me not to tell anybody or else I will be a dead body.*

*PE, age 16 years*

*I was sacked from school and while I was in the house, a certain brother asked me why I have not been going to school and I told him. He told me he will give me the money so that I can go back to school. He asked me to come to his house to collect the money, when I went he forced and slept with me before giving me the money.*

*PG, age 17 years*

One of the adolescent girls was lured and coerced to drink at a party.

It appeared something had been added to the drink so she got intoxicated and was not aware of what was done to her.

*When we went to the party everybody was drinking beer and other alcoholic drinks but I have not drunk some before. My friends forced me to drink some. When I finished drinking what I was given I did not see what happen but I woke up the next morning in the boy's room naked. I asked him what he did to me but he didn't tell me but I felt pains in my private part (genital area).*

*PL, age 16 years*

#### 4.3.2 Ignorance

The findings of the study also revealed that some of the participants lacked knowledge on how they could get pregnant. Six of the participants were ignorant about how they could get pregnant as shown in the selected quotes:

*When we were about to have sex I told him to use condom and he said it was my first time so I will not get pregnant. I agreed, not knowing I could get pregnant with the first sex.*

**PA, age 18 years**

*Yes I know condom is for protection but I thought it is for grown-ups, I mean married couples so I did not have the idea to go for it.*

**PC, age 19 years**

*At that time I was only thinking about the money and that was my first time I did not know that just one sex can make me pregnant.*

**PG, age 17 years**

*I have not been using it, we always do it without condom but I do not get pregnant, this time I do not know what happened.*

**PH, age 18 years**

The adolescents appeared to have some knowledge about the use of condoms for prevention of pregnancy. However, there were some misconceptions or fallacies about sex, pregnancy and its prevention.

#### 4.3.3 Peer Pressure

Peer pressure is a common feature among adolescents. It is a situation where pressure is put on adolescents to copy their friends. Peer pressure was also identified as a cause of pregnancy among adolescents in the study. Peer pressure was expressed by six participants in various ways. This is evidenced in the following quotes:

*A friend introduced her boyfriend's friend to me and we became friends. Later he proposed to me and I*

*refused, but my friend convinced me to accept the proposal that the boy was a good boy so I accepted it.*

***PD, age 19 years***

*For me, it was a friend who introduced me to the man, she said the man is a responsible person and will like to help me. I agreed and we started dating. I was faced with a financial hardship and he opted to help me pay my fees. And he ended up impregnating me.*

***PC, age 19 years***

*I was staying with my auntie who operates a chop bar and this boy patronizes our service. He told me he wanted to date me but I refused. Each time he buys from us he leaves his balance for me. One of the girls whom I work with told me not to treat the guy that way otherwise he will stop giving me tips. I also need the money so I agree and we started dating.*

***PH, age 18 years***

*He said boyfriend and girlfriend relationship but I told him I do not want to engage in that relationship now. My friends said they are rich and every girl in the area wants to be his friend so I should agree. They kept telling me this for some time so I agreed to be his girlfriend.*

***PL, age 16 years***

In addition to the pressure on some of the adolescents to enter into relationships, it was also found that, money was used as an incentive or bait to attract the adolescents. Some of them obliged to enter into the relationship out of financial constraints, although they initially refused. Necessity or the element of poverty pushed them to enter into relationships which led to the pregnancy in question.

#### **4.4. Conditions at Home**

This section focuses on conditions in participants' homes. The findings of the study showed that, issues surrounding the pregnancy of the adolescents' affected immediate family members. This distorted the happy and peaceful conditions that prevailed in their

homes. Nine of the participants attested to the fact that conditions at home had changed.

Two sub themes emerged from the analysis of the data under this theme. These were:

1. Unhappy family
2. Disagreements/Quarrels/Arguments

#### 4.4.1 Unhappy Family

This involves the pregnant adolescent being dissatisfied with the conditions in the house. Six of the participants regretted destroying the happiness of the family. It was found out that siblings of the pregnant adolescents were also unhappy due to the treatment the parents gave to the pregnant adolescents. This is shown in the quotes of selected participants shown below:

*My mum gets angry with me very often since I became pregnant. But my dad does not talk with me at all so there is no happiness in the house any more for me and this has affected everybody in the house.*

**PA, age 18 years**

*There is tension in the house and this has affected the happiness in the house. My siblings and me are not happy due to the shouting and insults we get from our parents. Before my pregnancy my parents were not behaving that way.*

**PB, age 18 years**

*There is no peace in the house because when my grandmother is insulting me my cousins are also sad and worried, my parent left us since we were in the nursery up to now. No money, not visiting and my grandparents also did their best when they could not afford they left us on our own. So they can't blame anybody.*

**PC, age 19 years**

*Each day there is a new problem in the house. I think my family has been affected by my actions and it really hurts me. Nobody seems to be happy these days.*

**PL, age 16 years**

#### 4.4.2 Disagreements/Quarrels/Arguments

This was a situation where there was persistent exchange of words in the house between parents of pregnant adolescents. Some of the fathers blamed the mothers for what had happened to their daughters hence the arguments. Three of the participants gave evidence that showed that there were disagreements at home:

*The whole family is arguing, some of them think I am a bad girl others think otherwise. There is tension between my sister and the husband. This time the least thing they argue and exchange words after that my sister will call my auntie and report the issue to her. It is becoming a big issue. My auntie also says what has happened is a taboo so the man have to kill a goat to pacify my sister. Everyday another issue comes out that makes my family members sad.*

**PE, age 16 years**

*Yes, I think the peace and love that the family has been enjoying in the past years has been destroyed. My parents no longer agree on simple issues and my mother is always sad and isolates herself. My brother and I also become confused and not knowing what to do. This creates a lot of tension in the house and I regret my action so much. I wish I can do something about the pregnancy to change situations in the house.*

**PF, age 18 years**

*My family is suffering because of my behaviour and unfortunately my innocent mother is at the receiving end of my father's anger. As soon as my dad sees any effort of my mother trying to help me then he picks quarrels or argument with her blaming her for my condition. When this happens I become confused for the whole day.*

**PL, age 16 years**

The adolescents' pregnancies brought disharmony in most homes. It generated arguments and quarrels. Parents blamed one another for poor parenting and family cohesion was destroyed. The pregnancies of the adolescents which were unwanted or unplanned, negatively affected family dynamics. The sections that follow shed more light on this.

#### 4.5. Reactions of Parents/Family

This section covers reactions of parents and it is one of the major themes that emerged from the analysis. It deals with all that parents did and said when they realised that their adolescent girls were pregnant. Reactions of parents and family contributed either positively or negatively to the psychosocial experiences of the pregnant adolescents. The findings of the study revealed that the majority of the parents were disappointed by the behaviours of their daughters. This compelled the parents to react in different ways towards their daughters. Four sub themes emerged from this major theme:

1. Anger
2. Beatings
3. Rejection
4. Support from Mother

##### 4.5.1 Anger

This involves a state of extreme displeasure or one who is enraged. The findings showed that all the parents and family members developed feelings of anger towards their pregnant adolescents. All the twelve (12) participants reported this. The angry parents maltreated their daughters which made them regret their actions. These were evident in quotes of selected participants as follows:

*When my dad came from USA and he was informed he became angry. Madam, I have not seen my dad in that mood before. My dad's attitude grows worse by the day. I mean if he gets information about me it makes him more angry so I do not call him neither does my mother give him information about me.*

**PB, age 18 years**

*My grandmother and my aunties, they do not care whether you eat or not they do not care whether I go to the hospital or not. My grandmother does not want me in the house. It has not been easy, the way my*

*grandmother has been harsh to me. The guy is no more in Ghana. He has gone to Nigeria so my grandparents are asking me to leave the house to go and look for the guy.*

**PC, age 19 years**

*My parents were angry and said they could not cater for any “fucking” pregnancy and was driven out of the house. They have not talked to me for the past six months, they do not even know what I eat or where I sleep.*

**PD, age 19 years**

*My sister, for being angry with me and not giving me the opportunity to tell my side of the story before she threw me out of her house. The rest of the family does not care about me. They are still angry with me.*

**PE, age 16 years**

*She asked me who was responsible but I did not talk so she informed my daddy and they were very angry with me. My mother insulted me she said I am very useless and good for nothing child. This time my mother is very harsh on me as soon as she sees me then she is angry.*

**PK, age 16 years**

#### 4.5.2 Beatings

The findings of the study also revealed that, parents inflicted pain on their pregnant adolescents through beating. Four of the participants reported that they were beaten by their parents:

*When my dad heard about my pregnancy he become angry and he beat me very well (she started crying) I will never forget the beatings.*

**PA, age 18 years**

*When we got home my dad gave me multiple slaps and I fell on the ground that was the first time my dad had laid hands on me. Life at home wasn't the same again.*

**PI, age 16 years**

*When we got home my mother beat me and put ginger in my private part (she started crying). She asked me not to go to school again.*

**PL, age 16 years**

The findings showed that some of the parents of the pregnant adolescents were not only angry with their wards for behaviours they deemed “wayward” but also wanted to inflict pain on their pregnant adolescents as a way of punishing them. They vented out their anger through slaps or beatings which they believed might act as deterrents for any such unapproved behaviours which the Ghanaian society frowns upon.

Some of the pregnant adolescents were ejected out of their homes out of anger by the parents. The next section describes the plight of such adolescents.

#### 4.5.3 Rejection

This consists of reports of participants who were thrown out of their home by their parents when they noticed that they were pregnant. Findings of the study indicated that these parents did not search for their daughters after they threw them out of the home. Where the pregnant adolescents sought for shelter and their up-keep, has not been the concern of these parents. Four of the participants were thrown out of their homes. The following were some quotes of participants who were thrown out of their homes.

*When he was told, he threw me out of the house. I had to stay with my mother's friend for the six weeks that he spent in Ghana. He said as far as he is concerned I am not part of his family again.*

**PB, age 18 years**

The adolescent was thrown out of her home when her father who lived abroad came to hear the news of her pregnancy. The father was angry with her and disowned her. Another adolescent expressed:

*When we got home, I was beaten and driven out of the house. I thought my parents were just threatening me. They did not allow me into the house. After all my pleadings I had to sleep outside the house till the following morning. They have not talked to me for the past six months, they do not even know what I eat or where I sleep.*

**PD, age 19 years**



Apart from parents, other relatives also exhibited anger at the adolescents. For instance, siblings especially older ones were equally angry and gave no room for the pregnant adolescents to explain how the pregnancy occurred as indicated in this scenario:

*The way my sister was harsh on me, she did not allow me to tell my side of the story before she threw me out of her house. She just doesn't want to see me again.*

*PE, age 16 years*

#### **4.5.4. Support from Mother**

According to some participants their mothers gave them all forms of help in cash or kind throughout the pregnancy. Participants reported that their parents were angry and reacted very harshly to them, however, some mothers later changed their attitudes and supported their daughters. This fact was confirmed to me by seven of the participants:

*My mum has been taking good care of me, my mum provides my needs. When I complain of headache she will give me money to go to the hospital. She said she cannot do much about my dad's behaviour but only time will change the situation.*

*PA, age 18 years*

*My mother though she is not happy about the issue, She keeps saying it has happened and she cannot reverse the situation so I should learn my lesson very well. She also provides my needs if she has money, I have to wait till she gets money before she meets some needs but I think she is doing her best. My mother is now better she is able to tolerate me now than she did at the beginning.*

*PB, age 18 years*

*My mother though she is a worker she makes time to accompany me to the Antenatal clinic each time I have an appointment. The other day, when I refused to accompany her to do shopping for the baby she went alone and when she brought the items, those that I was not interested in she sent them back to change them. She has been very supportive.*

*PF, age 18 years*

*My mother gives me food to eat and attends to me when I am sick. She also helped me by buying some of the items on the baby's list I was given to buy.*

***PI, age 17 years***

*My mother has been most helpful. She has been providing me with money for hospital and the other time I fell ill she accompanied me to the hospital. If it hadn't been her my life would have been miserable.*

***PL, age 16 years***

It appeared most of the pregnant adolescents received support from their mothers. Even though some mothers were initially angry, they turned out to be helpful and supportive too.

**4.6 Reactions of Partners**

This section focused on all the things partners did or said when they realized that their adolescent girl friends were pregnant. The findings of the study revealed that, partners did not behave the same way upon hearing that their adolescent girl friends were pregnant. The reactions of the partners included:

1. Anger
2. Denial
3. Lack of support

**4.6.1. Anger**

Some partners developed feelings of anger towards their adolescent girlfriends when they realised they were pregnant. Three of the participants expressed that their partners were angry:

*...He became angry with me so we were not on talking terms. When I told him I was pregnant he became angry and he said he wants me to complete my education before I give birth for him.*

***PA, age 18 years***

Some partners of the adolescent girls were angry merely because a single bout of sexual pleasure had resulted in a pregnancy they were not ready for. Other partners were angry because they were not ready financially to bear the cost of the responsibilities and expenses that go with pregnancy. One partner displaced his anger on the adolescent and referred to her as a devil.

*Since I become pregnant he is always angry with me, any time I ask him for money he gets angry and insults me. He said I am a devil who has come into his life to destroy him.*

**PG, age 17 years**

#### **4.6.2. Denial**

This refers to partners refusing to accept responsibility for the pregnancy of the adolescent girls. The findings revealed that, some of the partners were married men with children, and they informed the adolescents only when they got pregnant. Some of the partners were also not prepared to be fathers at that time and moved away from where the adolescents could find them. Five of the participants lamented about their ordeal:

*That was the time he told me that he is married and that if I decide to keep the pregnancy he will have nothing to do with me again and he is not responsible for the pregnancy. I thought it was an empty threat but madam he was serious and since then I have not set eyes on this man again.*

**PB, age 18 years**

*I was dating two boys so I informed the two of them, my first boyfriend asked me to abort it which I agreed. But the second boy said he was not responsible so if I name him as the father of my baby he will kill me. When my parents got to know that I am pregnant, they reported to the police so I was asked to send them to the boy's house. When we got there we were told he has moved out from the ghetto to his home town. I was not able to tell them there was a second one since he has made it clear he was not responsible.*

**PD, age 19 years**

*He denied being responsible for my pregnancy and everybody believed him and they think I am rather the bad girl. I am speaking the truth he is the only person who slept with me.*

*PE, age 16 years*

*Hmmm It is not easy at all when I told the guy that I'm pregnant he told me he was married with two kids in his home town and that is why he traveled so there is no way he can accept the pregnancy and that he is not responsible.*

*PI, age 16 years*

The vast majority of the men responsible for the adolescent girls' pregnancy denied responsibility to the utter dismay of the young girls. One of the men threatened to kill the girl if she disclosed to anyone about his involvement. The girls felt threatened, betrayed and abandoned.

#### **4.6.3 Lack of support**

This covers the worries and concerns expressed by participants with regards to lack of support from partners of the pregnant adolescents. The findings of the study showed that most partners were not responsible or failed to take responsibility of their actions. This worsened the situations of some of the participants who belonged to broken homes with a single parent, who is struggling to cater for the needs of these adolescents and their siblings. Others come from families where both parents do not earn much income to cater for the needs of the family. Nine (9) of the participants reported facing this situation. The quotes below portray the situation:

*The boy and the family do not want to take care of me. I find it difficult to buy the food I have been asked to eat. Sometimes the blood tonic that they write for me is not bought so I have to make do with the one that I get from the hospital which I have to take three times a day and I am not able to take. When I am going to the hospital and I ask him for money he will say he will give it to me but ends up not giving me anything.*

*PA, age 18 years*

*No support not even a pin from him, he does not look for me to ask how I am doing. He doesn't care what happens to me, it is my prayer that God will punish him just as he is punishing me.*

**PB, age 18 years**

*Not much when I call him he will say he will be back soon but it has been months. He does not send me money. He thinks I am not pregnant but I just want his money. He is just full of empty promises.*

**PC, age 19 years**

*We are not on talking terms, he is not supporting me he is not doing anything for me he just impregnated me that's all.*

**PK, age 16 years**

*He does not give me money. The other time that he and his friends saw me they laughed at me and I felt so bad. I wish I had not got involved with him at all.*

**PL, age 16 years**

The adolescent girls and their families look forward to remittance from the boys or men responsible for the pregnancy. They also expect the boy's or men's family to support or help the pregnant girls by providing their needs, including the demands of antenatal care. Some of the girls feel abandoned and one was filled with sentiments of retaliation. One of the partners of the adolescent girls thought the girl was not really pregnant, and he believed the girl was posing to be pregnant in order to extort money from him. This appeared to be the reason behind his "rejection" of the pregnant girl. In the ensuing section, the reactions of the adolescent girls' friends are highlighted.

#### **4.7 Reactions of Peers / Friends**

This section deals with issues relating to all that peers or friends of the pregnant adolescents said or did to their friends when they realized their friends were pregnant. The findings indicated that friends of the pregnant adolescents behaved negatively towards them. The reactions included the following:

1. Rejection
2. Gossiping

#### 4.7.1 Rejection

This refers to situations where adolescents did not support their friends during the time of their pregnancy when they were needed most. Being pregnant at an adolescent age is an indication that the pregnant girl is a bad girl and thus nobody would like to associate herself with the stigma of adolescent pregnancy. Four of the participants expressed this:

*They thought people might say they are also bad girls so they do not visit me. I am also shy to visit them. As for my best friend at school, she said her mother has warned her not to talk with me again because I am a bad girl.*

**PA, age 18 years**

*They do not visit me anymore because my mother insulted one of them when she visited me. Some of them have been laughing at me when I visit them and they behave as if I have an infectious disease which will infect them when they come near me.*

**PI, age 17 years**

*They don't visit me for us to talk. I feel so bad at all that is happening. They don't want me in their company any longer because I asked one of them why and she told me birds of the same feather flock together.*

**PK, age 16 years**

*I have not been seeing my friends who advised me to have a boyfriend because my mother met them on their way home from school and insulted them so they are angry and don't want to talk to me. They do not call me anymore.*

**PL, age 16 years**

The pregnant adolescent girls felt rejected and isolated. They were deserted by their friends and peers primarily due to warnings they had received from their parents, mothers especially, not to associate with their pregnant peers. The girls felt stereotyped and

stigmatized, as one described they were treated like persons with infectious diseases. This they described as demoralizing.

#### 4.7.2 Gossiping

This refers to adolescents spreading false information about their pregnant friends. This was a key concern to the pregnant adolescents during the narration of their stories. One of the pregnant adolescents was disappointed about the way her friend gossiped about her after she had confided in her. This brought a lot of embarrassment to the pregnant adolescent who tried to avoid her mates. The pregnant adolescents also interpreted the behaviour of their friends as hatred because they referred to them as bad girls. Three of the participants shared their experiences:

*Those close to me treat me well; it is those who like gossiping that are spreading the information about me which make people look at me in a way. This is a big problem for me apart from that I do not have any problem with my peers. My friend that introduced me to the guy was my senior and she has completed the school so I do not see her again.*

**PC, age 19 years**

*Some of my friends hurt me because they said I am a bad girl. They gossip behind my back so I do not want to have anything to do with them.*

**PB, age 18 years**

*I met one of my mates who asked me whether it is true that I am pregnant and I told her the truth. She went to tell all my friends so it was all over the place and everybody thinks I am a bad girl. When I see them, I run away because I am very shy, so I don't talk to them at all.*

**PG, age 17 years**

## 4.8. Reactions of Neighbours

This section covers the way people in the community behaved towards the pregnant adolescents. In many of the Ghanaian communities, people expect only married women to be pregnant. If this happens to an unmarried person especially an adolescent, they encounter the displeasure of the community members. This was experienced by the participants in the form of gossip.

### 4.8.1 Gossiping

This is the situation where neighbours spread negative information about pregnant adolescents in the community. The pregnant adolescents were worried about the way older women in the community would castigate them and not their own children who are either behaving just like these adolescents or even worse. Neighbours sometimes spread false information about pregnant adolescents. Some mothers in the neighborhood told their adolescent girls not to talk or associate with the pregnant girls. This was experienced by five of the participants. Other participants moved into new locations where much was not known about them:

*They have children who are doing worse things than me but they are gossiping about me and behaving as if their children are angles. Since I became pregnant most of them have told their children not to talk to me because I will influence them to be pregnant. Sometime ago one of the women called me and said a whole lot of annoying things like I did not take my time instead of me to go to school I decided to go out with men.*

**PD, age 19 years**

Some friends and their parents were hypocritical in their behaviour towards them. In their presence, they show empathy, pretending they empathize with them but in their absence they gossiped about them:

*They usually gossip behind me but when they see me they pretend they care so I only greet them that is all.*



*Some do not talk to me, and when they see me, they do not greet me and I do not greet them either.*

**PC, age 19 years**

*Me, I am not looking or listening to what they say or do, they are gossips even when I was not pregnant they gossip about the way I dress and the guys I talk to, now it is worse yet when they see me they pretend everything is well. One of them left her children and advised me which makes me feel guilty.*

**PE, age 16 years**

Some women called the pregnant adolescents and scolded them and asked them why they did not focus on their books but chose to follow men which provoked the adolescents:

*Some of them have been insulting me. They can call me and tell me all sorts of things like you are a small girl instead of you sticking to your books you are rather sticking to men and when I reply, by telling her this is none of her business she complain to my mother that I do not respect. They are gossipers and I don't like them.*

**PF, age 18 years**

## **4.9. ECONOMIC CHALLENGES**

### **4.9.1. Lack of Funds**

This involved the hardships or challenges encountered in meeting their needs. The adolescents in the study did not have money to meet their needs, even though antenatal services are free. Sometimes they had to buy medicines that are not covered by the National Health Insurance Scheme. They also had to buy a list of items that the babies and mothers would need during labour. They also needed to buy food. Seven (7) of the participants who were not supported by both parents and partners encountered such financial difficulties which were depicted in the selected quotes below:

*I have not been able to buy anything on the list I was given from the Antenatal clinic and I do not know how I will be able to buy them. Before I became pregnant my dad has been sending my mother money for housekeeping and my siblings and I our monthly*

*allowances, this time it is not monthly and when he is sending money he takes me out so I do not have money on my own. I sometimes have to fall on my junior brother for money to even buy food.*

**PB, age 18 years**

*I do not have money on my own or a regular source of income. Sometimes I go hungry with no money to buy food. I depend solely on my friend for my needs and since she is just helping me I can't go to her for everything.*

**PC, age 19 years**

*The midwife gave me a list of items to buy but up till now I have not bought them because I don't have money. She keeps on asking when I will buy them and I get confused when this happens. If I should deliver today I do not know what my baby will wear.*

**PD, age 19 years**

*Sometimes I have to go up and down the street to sell plantain chips but because I am not strong I am not able to do that so I don't sell much. Some go bad, I also eat some when I am hungry and at the end I don't get any profit from what I sell.*

**PJ, age 16 years**

#### **4.10 Reactions of Pregnant Adolescents**

This section highlights all that the adolescents did or said when they realized that they were pregnant. The adolescents were not expecting the pregnancy when it happened. This exposed them to a series of psychological encounters. These effects include:

1. Sadness
2. Shyness
3. Anxiety
4. Worries
5. Suicidal Tendencies
6. Thoughts of Abortion
7. Anger

8. Denial
9. Loneliness

#### 4.10.1. Sadness

This refers to the adolescents' sense of unhappiness about the behaviour of their parents and significant others. Findings of the study revealed that all the twelve participants were sad and wept when they realised or were told that they were pregnant. This was evident in their narrations as indicated in selected quotes below:

*Madam my whole world came to an end, since that day I have been weeping and I have not stopped to wipe my tears. Madam I do not know when I will stop crying. This pregnancy has brought a lot of sorrow to me. I am always sad, I get sad when I think about my dad's attitude. I have been crying and praying to God to change my dad*

**PB, age 18 years**

*I wept for weeks as if my parents were dead. At that time no amount of advice could calm me down at the hospital, I cannot remember how I went home that day. They told me not to abort the pregnancy so I thought everything is going to be alright, not knowing life was going to be miserable for me. My grandmother does not want me in the house and as I have told you already she makes me sad each time we come into contact.*

**PC, age 19 years**

*Mummy I was sad, I do not have any helper there is no money at home and I am going to add another person. I can't live my normal life any more, I can't meet with friends as I used to because of what they will say. This makes me weep each time I think or talk about my situation.*

**PD, age 19 years**

*When my mother told me I became sad and I wept for days because I am not ready to be Pregnant. I had wanted to save some money to go back to school and gain a profession before I give birth but it did not happen that way so I am very sad about my situation.*

**PH, age 18 years**

*Hmm madam when I was told that I was pregnant I wept and since then any time I get up from my bed I weep. When I see my friends dressed up going out or to school I become sad and I weep. My auntie just does not want to see me and that makes me very sad.*

**PL, age 16 years**

#### 4.10.2 Shyness

The findings of the study showed that pregnant adolescents felt embarrassed about being pregnant, especially when all the signs of pregnancy such as big abdomen, weight gain and enlarged breasts started showing. All the twelve (12) participants shared the same experience. They all dropped out of school and some of them hid from visitors at home. They avoided social gatherings such as church or parties and sometimes refused to go out unless they had no choice but to do so. They disguised themselves when they had to go out in order to conceal their identity:

*I feel shy to go out I even feel shy to come out of the room when my mother get visitors. The only time I have no choice but to go out is when I have to go for antenatal clinic. I no longer play active role in social activities in school and church. I can't go to parties of family members or friends because I am shy. ...when I see somebody I know, I will walk fast and take another route so that we do not meet. Sometime I will have to hide and continue my journey later when the person is gone.*

**PB, age 18 years**

*I am shy to go out with my big tummy so when my grandmother sends me around the neighborhood I do not go. I was determined to complete my education but I feel shy to go to school so I dropped out of school.*

**PC, age 17 years**

One of the participants avoided interaction with others when her mother was not at home by locking herself in the room all day:

*I feel shy to go out so I am always in the house when my mother leaves for the market to sell, I just lock the*

*door and stay indoors till she comes back. If somebody knocks I don't go and see who is there.*

***PG, age 17 years***

*Now that my abdomen is big I am shy to go out and I am always in the house, when I am sent to buy items nearby I always have to use cloth to cover myself so that people will not be able to identify me. When I am coming to the hospital I try to use my bag to cover my abdomen.*

***PJ, age 16 years***

*I feel very shy when I go out because people will be looking at me. The women at the Antenatal clinic will be looking at me because I have a small body. The first time I came one of the women asked me my age when I told her, she said I thought you are ten years. I still feel shy but I am trying to manage and come because the midwife said it is very important for me to attend the clinic.*

***PL, age 16 years***

#### **4.10.3 Anxiety**

The findings also revealed that participants often experienced anxiety. Anxiety is an unexplained fear or uneasiness experienced by the pregnant adolescent in this study over issues related to their pregnancies. Five of the participants expressed feelings of anxiety which were due to either changes in their body, behaviour of family members or fear of labour. Other causes of anxiety were fear of their fathers getting the information about their pregnancy. One participant experienced insomnia due to fear of the unknown. Participants have also heard much about labour delivery pains and were anxious about how it was going to be. Others were also anxious about the way the midwives were going to handle them during labour:

*I am now anxious, I am not able to sleep well when I go to bed I think about the treatment my grandmother is giving me till I sleep. When I wake up each day I*

*become more anxious not knowing what the day carries for me.*

***PC, age 19 years***

*Now the challenging issue left to deal with is delivery. I am very anxious as the day of delivery draws near, since I entered the ninth month I have been very anxious not knowing how painful delivery is. I have never been myself the anxiety keeps increasing having heard a lot about delivery. I am anxious about the labour pains and the behavior of midwives at the labour ward they have been beating the pregnant women.*

***PH, age 18 years***

*For some time I became anxious each day waiting to hear from my father whether he has got the information. I became more and more anxious each time my father calls me for something. I became scared ended up making a lot of mistakes like breaking glasses, plates and burning food when I am cooking.*

***PI, age 17 years***

*I was anxious when my stomach started growing bigger and my breast enlarged. I now have a different shape. I don't even know that this will happen to me so soon.*

***PJ, age 16 years***

#### **4.10.4 Worries**

Participants reported of worrying in their shared experiences. This was the situation where the pregnant adolescents were unduly concerned about their pregnant states. One participant was worried because she had lost the chance of travelling. Most of the participants showed signs of remorse in their narration which made them worried. Some participants were also worried about their future not knowing how to care for their babies to be able to go back to school to become professionals. They showed signs of regret,

wishing it had never happened to them. Others were worried about behaviours of family members and significant others. This was reported by eight (8) of the participants:

*My dad is in the U.S.A. and when my elder sister completed SHS she went to the U.S. to continue her education. Now it is my turn to go look at what has happened to me if I could turn back the time I will not repeat what I have done. I am thinking about my future how to go back to school and become a professional like my parents.*

**PB, age 18 years**

*Mummy, things are more difficult now. Apart from my school I am thinking about how to raise my child. How to raise money to buy the things I need and how to inform my daddy, he will kill me because he had somebody who was prepared to marry me but I refused in the name of wanting to complete my education.*

**PG, age 17 years**

*My mother is struggling to cater for my younger siblings. My mother sent me there to work so that I can help her cater for my younger siblings but now I have become a burden on her. I think I have lost it. My Auntie said she could not work with me again so I have to come back to my mother. When I think about this I become worried and I do not know what to do.*

**PH, age 18 years**

*I am just thinking, I wish I can abort this pregnancy to be free. I keep asking myself why this should happen to me and not other mates of mine. I am so worried that my mother always complain that I no longer can't concentrate on anything I do I always make mistakes.*

**PJ, age 16 years**

*My biggest challenge is the insults I always receive from my mother on the least provocation. Any time I ask for something she reminds me that she did not ask me to be pregnant but asked me go to school. This makes me regret my actions and I'm thinking every day.*

**PL, age 16 years**

#### 4.10.5 Suicidal Tendencies

According to participants in this study, they had thoughts of taking their own lives when they realised that they were pregnant. This happened when the adolescents felt there was no hope in their situation and therefore living was useless. Some thought their parents would kill them upon hearing that they were pregnant, so they reckoned it would be better they do it themselves. This was evident in the narrations of five (5) of the participants as indicated in their quotes as follows:

*I had wanted to drink medicine and die because when my parents hear about it they will kill me so I wanted to die before they kill me.*

**PA, age 18 years**

*They always make me feel bad. I am always thinking and I am sad sometimes I feel like killing myself then me and my baby will die and go. Since dead people do not worry about life issues so I will not worry any more.*

**PC, age 19 years**

*I decided to drink medicine and die. When I name my sister's husband as being responsible for the pregnancy he will kill me so it is better when I do it myself. Life is hopeless and I do not feel like living again. It is a painful situation madam.*

**PE, age 16 years**

*When I vacated and I came home for the long vacation I started falling sick not knowing that the abortion was not done I tested positive again this time my mother was aware so I knew the best option is to kill myself before we get home. On the way home I wanted to jump out of the taxi so I open the taxi but my mother shouted at me to close the door, again I did not have the boldness to do it.*

**PJ, age 16 years**



#### 4.10.6 Thoughts of Abortion

The first thought that ran through the minds of the pregnant adolescents upon realizing that they were pregnant was abortion. Their reactions indicated that the pregnancies were unwanted and the only option was to abort the pregnancy. They thought this would solve all the problems that they were anticipating. Some of the participants wanted a therapeutic abortion but were discouraged because, they were in their second trimester. Others could not afford the amount because both the adolescent and her partner were students. Some of the pregnant adolescents decided to abort the pregnancy by drinking medicine, but then, they did not know what type of medicine to drink. Others decided to seek help from friends or drink concoctions, yet they were afraid of the consequences. Seven (7) of the participants reported having thoughts of abortion:

*After the doctor examined me he said I am five months pregnant which he confirmed with a pregnancy test. I opted for abortion but I was told the pregnancy was too old and if I try it I may end up with complications.*

**PC, age 19 years**

*I decided to drink medicine to abort the pregnancy but I did not know of any drug which can be use to abort the pregnancy whiles I was still asking my friends my mother got to know that I was pregnant.*

**PE, age 16 years**

*Instantly I felt the only solution was abortion. Both of us were students how are we going to raise three hundred Ghana cedis to do it. I decided to drink medicine and abort it myself again I did not have the boldness to drink the medicine. A friend gave me another medicine and I took it two days later I started bleeding so I thought that was all.*

**PJ, age 16 years**

*I want to drink medicine to abort this pregnancy but something is telling me not to do it. The way I am suffering in the house I think I have to try hard and do*

*it so that all my problems will be over. I don't want to continue with this pregnancy any more I'm suffering.*

***PL, age 16 years***

#### **4.10.7 Anger**

Feelings of anger that the adolescent develops towards herself or her partner due to the unplanned pregnancy was one of the sub-themes generated from the interview. Some of the adolescents were angry with themselves for allowing themselves to be pregnant. Others were angry with their partners for not taking up their responsibilities. Some of the participants also got angry with their friends who encouraged them to go into the relationships to have intimacy with the men. Nine (9) of the participants confirmed this fact. Five (5) out of the nine (9) were angry with themselves whiles four (4) were angry with their partners and their friends who influenced them. This was shown in some of their quotes below:

*I get angry at myself and ask why God did not give this child to a lot of couples out there who are moving heaven and earth to get a child and me who have no need for a child now getting one. Why God why me, in fact I became angry and confused especially when my father is also insulting me.*

***PB, age 18 years***

*It is a painful situation I get angry with my sister's husband for putting me and my sister into this situation.*

***PE, age 19 years***

*I think I have lost it, I get angry at myself and the my friend who advised me to have sex with him for what I have done. My Auntie said she could not work with me again. So I have to come back to my mother with empty hands.*

***PH, age 18 years***

#### 4.10.8 Loneliness

As part of the coping strategies of the adolescents to their situations, they isolated themselves from others or vice versa. They stated that the comments that people make and the way people look at them made them isolate themselves from others. They also stated that, some of their friends did not want to associate themselves with them because, people might think they were also bad girls. Five (5) of the participants stated this in their narration:

*I try not to get in his way. I stay in our room alone the whole day sometimes not eating anything.*

**PA, age 18 years**

*Some of my friends hurt me because they said I am a bad girl. They gossip behind me so I do not want to have anything to do with them I am always alone. I can't go to parties of family members or friends. The whole family will have to leave me alone in the house when it is time for such occasions.*

**PB, age 18 years**

*I am stuck indoors I don't involve myself in social activities any more. I don't have a dress to wear to those functions and when I go I can't stand the gossiping and pretence that my friends or family members will put up. What is the point if I should go and come back sad from people's reaction? This makes me feel so lonely.*

**PC, age 19 years**

*They have changed their attitude towards me and it is not the same again, because of that I am always sitting at one place thinking. I am lonely and isolated.*

**PJ, age 16 years**

#### 4.10.9 Denial

Pregnant adolescents in this study started by refusing to accept the reality of being pregnant till the signs of pregnancy started showing. They did this to prevent ill treatments

from their parents. Four (4) of the participants confirmed denying being pregnant till their abdomen started growing big before they admitted being pregnant:

*For me how to break the news to my grandmother was a very big challenge knowing who she is and what she can do. She asked me several times but I denied because of the hardship I will face in the house.*

**PC, age 19 years**

*When the first test proved positive I refused to accept the result. I did a second one and it was also positive, then I did a third, fourth and the fifth all proving positive then I believed I was pregnant.*

**PJ, age 16 years**

*This is when my problem started at that time my mother was suspecting I was pregnant. When she asked me I was scared so I denied it and she said she was taking me to the hospital to check then I told her the truth but it was due to rape.*

**PI, age 16 years**

#### **4.11 Disorders of Pregnancy**

During pregnancy, there are physiological changes that occur in the woman. These physiological changes can produce disorders which may be minor or major. Disorders of pregnancy are feelings of unwell by adolescents during the pregnancy. Findings of the study revealed that, all the participants had one disorder or the other. Some were minor while others were major.

Five (5) disorders emerged from the analysis:

1. Dizziness
2. Waist Pains
3. Swollen Feet
4. High Blood Pressure
5. Insomnia

#### 4.11.1 Dizziness

The pregnant adolescents in the study shared their experiences on how they felt dizzy when they were hungry or when they eat light food but they felt better after eating a heavy meal. Some of the participants felt like falling down, shake or sway when they were hungry. One of the participants said she had lost weight since she became pregnant and that is causing the dizziness. The adolescents did not have any regular source of income, and this led to the adolescents having to wait till the family meal was ready before they could get some food to eat. Other participants associated the dizziness with anaemia and were put on treatment. Six (6) of the participants shared their experiences:

*Sometimes I feel dizzy especially when I am hungry and I sway when I am walking. The whole body will be shaking but it will stop when I finish eating.*

**PA, age 18 years**

*I am not strong nowadays when I drink tea in the morning I feel dizzy and I feel like fainting but when I eat "Kenkey or banku", I become better.*

**PG, age 17 years**

*I sometimes feel dizzy but the midwife says my blood level is low that is why I feel dizzy so I should take my blood medicine. When I am hungry my whole body shakes till I eat something. I can also see that I have reduced in weight.*

**PJ, age 16 years**

*The dizziness comes when I am hungry, before I became pregnant I could fast but now when I am hungry I feel very dizzy like I will fall down.*

**PL, age 16 years**

#### 4.11.2 Waist Pain

Waist pain was one of the minor disorders participants reported of. Five of the participants stated they had regular waist pains. Two of the participants said medication relieved their waist pains. Another participant stated that, her midwife had explained the condition to her

and that is why she was not anxious. A third participant associated her waist pain to lower abdominal pains and a general feeling of ill health. This she said had reduced her daily activity:

*I also have waist pain, I get a bit better when I take my medicine but it comes back later. I always complain to the midwife but she said it is due to the baby descending into the pelvis so I am not worried but it is very uncomfortable.*

**PB, age 18 years**

*I have waist pains, sometimes throughout the day I will be in pain. I find it difficult to lie down.*

**PI, age 16 years**

*I always have waist pains but the midwife says it is the pregnancy and that is why I am very anxious of late.*

**PI, age 16 years**

*I also have waist pains and lower abdominal pains very often. I have been helping my mother to sell at the market but now I feel uncomfortable when I m doing all the work I use to do. I am always sick so I have to be in bed.*

**PL, age 16 years**

#### 4.11.3 Swollen Feet

Swollen feet were one of the minor disorders the pregnant adolescents cited. As many as ten (10) out of twelve (12) respondents cited it, which may be an indication that it was a common occurrence with pregnant women. Of all the respondents, only one mentioned swelling of both her hands and feet. Most of the respondents said their midwives explained the swelling of the lower extremities to them hence they were not unduly worried about the disorder:

*I find it difficult to sit or lie on my back to learn I am able to lie on my side only. There are also a lot of body pains. Once in a while I get malaria, weakness and other things just look at my feet and hands they are swollen but I know what is wrong with me the midwife*

*explained it to me that during the last month of pregnancy the swollen feet is due to weight of the baby.*

**PB, age 18 years**

*I can see that I am no longer strong I easily fall sick and I easily get tired when I am doing something. My feet are swollen but the midwife says it is not a serious problem.*

**PK, age 16 years**

#### **4.11.4 High Blood Pressure**

High blood pressure is the only major disorders in pregnancy cited by four participants. According to the participants, they had been on admission on two or more occasions due to persistent high blood pressure. They also cited some signs and symptoms that are related to hypertension such as palpitation, headaches and fatigue. All the respondents have had education about their condition hence, they were relaxed and did not seem to be worried about their condition. Respondents had been referred to see an obstetrician, and three of them were on medication as at the time of data collection:

*I have been admitted to the hospital twice due to high blood pressure. I get tired when I do little things for myself and my heart beats faster even if I have to walk for a short distance. I often get headaches but I am on medication and the midwife has explained to me that it is due to the blood pressure. She also told me it is mild so I should take my medications so as to keep the blood pressure low. I am okay with the explanation so I am not worried.*

**PC, age 19 years**

*Not too good this morning my midwife said I am developing hypertension in pregnancy because my BP was 170/ 100mmHg. I have been referred to see a doctor, she said if I continue to worry my blood pressure will not settle but I don't think I am worried. I also get headaches.*

**PE, age 19 years**

*I am no longer strong, I have been in and out of the hospital due to high blood pressure. The midwife has*

explained it to me. She says I should take my medicine and I will be alright.

**PF, age 18 years**

#### **4.11.5 Insomnia**

Another minor disorder that the respondents expressed was insomnia. According to the respondents, they stayed awake for long hours during the night before they were able to sleep. One of the respondents cited frequency in micturation as well as discomfort from the size of the abdomen as the cause of the disturbance in her sleeping pattern. This was reported by three (3) participants.

*Of late I find it difficult to sleep when I wake up to pass urine I am not able to sleep again. Sometimes it is heartburn so I can't sleep, I will be crying but my mum will not help me. It is sometimes difficult to sit or lie down. When it happens this way and I do not know what to do, I just cry and cry till I sleep.*

**PA, age 18 years**

#### **4.12. Attitudes of Midwives**

This section covers the experiences participants encountered at the antenatal clinic. Attitudes of midwives are the way midwives treated the pregnant adolescents when they visit antenatal clinic. The experiences shared by the participants though were good; some of them had mixed feelings about the midwives in the unit. There were various comments from all the participants which were both good and bad experiences. Two sub-themes emerged from this main theme.

1. Positive Attitudes
2. Negative Attitudes



#### 4.12.1 Positive Attitudes

This concerns the good treatment midwives gave to pregnant adolescents when they visited antenatal clinic. Tema General Hospital practices focus antenatal which requires that the clients see only one midwife throughout the pregnancy. These midwives establish good rapport with the participants, explain every procedure to their level of understanding and counsel them when necessary. Seven (7) of the participants shared their experience on the positive attitudes of the midwives. The participants cited instances where midwives gave them money to buy food to enable them have their anti-malaria drug under direct observational therapy. They also said the midwives treated them with respect:

*She has been very good to me. She always encourages me when she sees that I am not happy. The other day she advised me to go back to school as soon as I get someone to take care of my baby. I think she is doing a good job.*

**PA, age 18 years**

*...But the midwife who attends to me is very caring and treats me as if I am an adult who has come for her service. She takes her time to explain issues to me. I like her very much because she makes me feel at home each time I visit the antenatal clinic.*

**PB, age 18 years**

*She is very nice, and she has been advising me to go to school and not pay attention to what my mates will say or do. She said if my uniform is small I should open it so that people will not suspect I am pregnant. She encourages me and she said I should not be sad. She is very good.*

**PD, age 19 years**

*My midwife is a good woman and she has been treating me very well. The other day she gave me money to buy food to eat to be able to take my drugs in her presence. I like her very much I wish she is my mother. She is the only person who understands that this pregnancy is an accident.*

**PJ, age 16 years**

#### 4.12.2 Negative Attitudes

Negative attitudes were the bad treatment midwives give to pregnant adolescents when they visit antenatal clinic. Even though some midwives gave their best, others did their worst. Six (6) of the participants shared the negative attitudes of the midwives. Some of the midwives passed abusive or derogatory comments which hurt the participants. Others were also interested in selling their baby items to these pregnant adolescents who already had financial challenges:

*Some of the midwives insult us especially the old nurse who sits at the table who will assign a new client to a midwife. She makes me regret for visiting the antenatal.*

**PB, age 18 years**

*...But sometimes she will be doing some styles, she can put up a behaviour that will hurt you in one way or the other but I do not have a choice so I don't say anything. I just have to forget and move on.*

**PC, age 19 years**

*I don't like the old nurse at the OPD at all, each time I give my card to her she will pass insulting comments example children of today you want to do what your parents do. I wish she is not the first person I have to see before I get a care.*

**PE, age 19 years**

*The last time I came my midwife was off so the second midwife I saw likes demanding money she wants me to buy the baby items that she is selling. She asked me whether I have bought the items on the list I was given to me, when I said not all. She said small girls, you do not take advice look at you pregnant not knowing who impregnated you and you cannot buy the items you need. Come to the labour ward with empty hands and your baby will be put on a sheet of paper.*

**PL, age 16 years**

#### 4.13 Conclusion

From the above findings, it is evident that pregnant adolescents encounter a lot of psychosocial problems which are not observable like physical illness. Participants were

emotionally disturbed by the conditions they found themselves in. For some of them, it was realised from their unspoken words that, they had no control over their situation than to try and cope with the situation one day at a time. Others had their eyes filled with tears during the interview but tried not to cry. Four of them broke down in tears and wept bitterly to the extent that, they could not continue with the interview that day. All the participants bowed down their heads as a sign of guilt or shame throughout the interview.

The findings of this study confirmed that the transition to motherhood is accompanied by a number of social and psychological consequences that place the pregnant adolescents at risk in terms of later life adjustment.

These encounters always put them in a state of despair. Thus, interaction with these adolescents revealed that they had real problems and therefore it is important as health workers to know the psychosocial experiences of pregnant adolescents, in order to help them cope with their situation.

#### **4.14 Perception about Interviewees**

The researcher approached twenty (20) participants most of whom were reluctant in bringing out their experiences during the interview sessions due to shyness and the sensitive nature of the information they had to share. However, some were willing to participate and showed keen interest in the interview. The researcher also observed that, some of these participants were so worried about their condition that, they thought participating in the interview would help relieve them of the stress and anxiety they were going through.

Some participants saw the interview as a bother and an intrusion into their private affairs. Participants who had knowledge about research were eager and ready to be involved in the research hence only educated participants were used. Some were also relaxed and felt

comfortable probably because they knew as a nurse, the researcher could help relieve them of their problems. Notwithstanding the few problems encountered, the interview sessions were successful and therefore the researcher could achieve the objectives of the research.

## CHAPTER FIVE

### DISCUSSION

#### 5.1 Introduction

This chapter presents a discussion of the research findings on the psychosocial experiences of pregnant adolescents in the Tema Metropolis. The purpose of the research was to explore and document the psychosocial experiences of pregnant adolescents. The objectives of the research were to:

- Identify the psychological experiences of pregnant adolescents
- Explore the social experiences of pregnant adolescents
- Identify the economic challenges of pregnant adolescents
- Examine the effects of the physical changes on the pregnant adolescents

Ten major themes emerged from a thorough and systematic analysis of the data. In addition to the themes, arrays of corresponding sub-themes were also identified. The themes and their corresponding sub-themes were:

#### 1. Causes of Pregnancy

- Rape
- Ignorance
- Peer Pressure

#### 2. Reactions of Adolescents towards Pregnancy

- Anger
- Anxiety
- Denial
- Loneliness
- Sadness
- Shyness

- Suicidal Tendencies
- Thought of Abortion
- Worries

**3. Conditions at Home**

- Unhappy home
- Disagreement/Quarrels/Argument

**4. Reactions of Parents towards Pregnancy**

- Anger
- Beatings
- Rejection
- Supportive Mother

**5. Reactions of Partners towards Pregnancy**

- Anger
- Denial
- Lack of Support

**6. Reactions of Friends towards Pregnancy**

Rejection

Gossiping

**7. Attitudes of Neighbours**

- Gossiping

**8. Economic Challenges**

- Lack of Funds

**9. Minor Disorders of Pregnancy**

- Dizziness
- Waist Pains

- Swollen Feet
- High Blood Pressure
- Insomnia

#### **10. Attitudes of Midwives**

- Positive Attitudes
- Negative Attitudes

In the ensuing sections, the themes and their sub-themes are discussed under the appropriate objectives under which they fall. The discussions were done in relation to the literature reviewed. Each major theme is now taken in turns.

### **5.2 Psychological Experiences**

#### **5.2.1 Causes of Pregnancy**

The findings of the present study reveal that the main contributing factor to pregnancy among the adolescents was poverty. This is in line with the observation by Kirby, D. (2000) which indicates that the interaction between race, social deprivation and fertility is a strong one. He noted that in California, the proportion of families living below the poverty level within a given zip-code area was highly related to the birth rate among adolescents. A similar view was expressed by Strauch (2003), whose study revealed that socio-economically, adolescent girls who belong to poor families are more likely to become pregnant. They have sex in exchange for money, gifts or they were influenced by their elders including their mothers who also benefit from this kind of relationship.

The underlying cause of most of the pregnancies in this study was poverty, however, the main causes include rape, ignorance and peer pressure. Some of the participants were enticed with money and raped. Others had to stay with other family members due to financial challenges and this led to the adolescents being raped by the men in the family.

This is similar to the findings of Strauch, (2003) which shared that girls, whose mothers remarry after divorce, are sometimes faced with challenges from their stepfathers and stepbrothers who rape or sexually exploit them.

For some of the participants, money was used as an incentive and this led them ignorantly into unprotected sex, resulting in the pregnancy. This finding is in agreement with a study in Standards for Youth Care, (2002) which revealed that most adolescents had inadequate knowledge about safe sex. They reportedly have no access to the methods of preventing pregnancy. They were also embarrassed or afraid to seek information about safe sex, which makes about 80% of adolescent pregnancies unplanned. A similar view shared by Abdool, Karim and Prestonwhyte, (2009) was that, despite the awareness of AIDS and teenage pregnancy, condoms were perceived as poor choice of contraceptive, and their use was discouraged among adolescents. Contrary to the findings of the current study, Henshaw (2007) posited that compared to two decades ago, fewer adolescents are sexually active today, and sexually active adolescents are using condoms more often hence pregnancy and birth rates are declining.

In Ghana, due to our cultural practices, most families do not give reproductive health education to their adolescents. This is left to teachers at school as part of the school curriculum to teach. This sometimes led to the adolescents being ignorant in some aspects of reproductive health. In this study, the adolescents have heard about condoms as a means for preventing pregnancy but were not using it because it is a family planning method and they thought family planning is meant for adults. Others erroneously thought that, the first episode of sex cannot cause pregnancy so they did not use the condoms for protection against pregnancy. There are implications here. Since some adolescents are sexually active and yet fail to use condoms, they are liable to contract sexually transmitted infections



including HIV/AIDS in addition to the unwanted pregnancies and their attendant problems. Thus education is therefore paramount.

Others got pregnant due to peer pressure. Their peers encouraged them to extort money from men which paved the way for the men to take advantage of them, leading to the pregnancy. This conforms with a report of Shape, (2003), that peer influence is a major factor that encourages teenage boys and girls to indulge in sexual activities, since most of them do not want to fall out of their peer groups and will do things such as early dating (as early as 12 years) to please their friends.

This study revealed that the adolescents were in need of money but did not want to give in to the men involved, till their peers or friends encouraged them to go into the relationship to benefit from the men financially. Others were in the relationship but do not want to engage in any sexual activities, but their friends convinced them to do it, in order not to lose their partners as well as their sources of funds.

## **5.2.2 Reactions of Adolescents towards Pregnancy**

### **5.2.2.1 Sadness**

In the present study, sadness emerged as a reaction of adolescents towards their pregnancies. This finding is consistent with that of Ramathesele, (2007) which noted that pregnant adolescents of the South African Traditional Xhosa culture demonstrated sadness and despair when they had to describe their experiences of their pregnancies.

On the contrary, some adolescents who intentionally became pregnant saw pregnancy as a positive choice and a way of maturing into a more adult role (Herrman, & Waterhouse, 2011).

The adolescents in the current study were still in school when the unplanned pregnancies occurred. They had to drop out of school, not knowing what their future was going to be.

The thought of these problems put all the participants in a state of intense grief and sadness since they saw their situation as uncomfortable and hopeless. This state of sadness was explicit in the expressions of participants, some of whom shed tears during the interview.

#### **5.2.2.2 Shyness**

The current study showed that the adolescents felt shy and embarrassed about their conditions when the pregnancies became obvious. This finding corroborates that of a study conducted by Lehana, and Van Rhyn (2003) which indicated that adolescents in Basotho expressed shyness or a sense of shame when they found out their abdomens were enlarging.

When a married adult becomes pregnant, she is deemed to be emotionally and physically mature to deal with all the effects of the pregnancy. Her reaction is that of joy and confidence as these are the expectations of society and the culture in Ghana (Nukunya 2003). In the case of unmarried adolescents, their reaction is that of guilt and shame since they are still in a transition from childhood to adulthood. In the current study, all the participants expressed a sense of guilt and shyness in their narrations. They gave instances where they would hide when the family had visitors, how they disguised themselves when they had to go out and sometimes refusing to go when they were sent by their parents.

#### **5.2.2.3 Anxiety**

Anxiety was also identified as a sub-theme of the reaction of pregnant adolescents. This finding was in agreement with that of Lehana and Van Rhyn (2003), who reported that teenage mothers tended to be more anxious compared to teenage non-mothers. The

anxiety in teenage mothers was attributed to the fact that culturally, the father of the child may not marry the teenager.

The pregnant adolescents in this study encountered a lot of problems especially ill treatment from their parents and their partners. This left the adolescents very anxious, and they therefore considered their condition unbearable. Another factor might be due to the fact that in the Tema Metropolis there are no well structured and well patronized counseling and educational centres for pregnant adolescents. The adolescent-friendly corner in the hospital, lack nurses trained in adolescent health issues to help the adolescents. Churches also frown on adolescent pregnancy, and as a result the adolescents could not go there for help. Pregnant adolescents often live in a state of anxiety and emotional tension, especially when their parents and other significant others do not give them the necessary support they need. Referring to the findings of the current study, a participant stated, “I wake in the morning very anxious not knowing what the day have for me”. This describes the state of many of the pregnant adolescents interviewed in this study.

#### **5.2.2.4 Worries**

Participants also expressed getting worried most of the time, and the fact that they always thought about their pregnancies, their future and the treatments that they received from their friends, parents and partners. They revealed that, thoughts that went through their minds included the fact that they would not be able to achieve their career objectives, they would not be able to go back to school, will they get somebody to care for their babies for them to go back to school?, how would they meet their financial obligations and will their fathers accept them back?. This is consistent with the finding of Ollborn (2007) which showed that lack of resources such as housing, child care, and financial support is a worry

to pregnant teenagers and it explains the negative effect of teenage parenthood on their academic prospects. A similar view was shared by Fergusson and Woodward (2000) who confirmed that young women who became pregnant by the age of 18 years were at increased risk of poor performance in both basic and second cycle School Certificate examinations, or leaving school without certificates, and failing to complete their sixth-form year at high school which is a worry to the teenagers. In addition, pregnant adolescents had lower rates of participation in tertiary education and training colleges than their non-pregnant peers.

#### **5.2.2.5 Suicidal Tendencies**

Risky behaviours increase during adolescence and this exposes the adolescent to danger. Among these risky behaviours are suicidal tendencies. The main cause of these suicidal tendencies is not known but it is believed that the adolescence period is a difficult transition for most of the adolescents for a combination of reasons. Changes in abstract cognition, surges in sex hormones, increases in social stress, and conflicts over autonomy during this natural period of transition are the contributing factors to the development of suicidal tendencies (Arnett, 1999). Almost all the adolescents involved in this study, considered suicide at one time or another during the course of the pregnancy. For some of the participants, these suicidal thoughts occurred when they found out that they were pregnant and they were scared of their parents. Others had these thoughts when they felt rejected by their parents and after their partners had denied being responsible for the pregnancies. These exposed the pregnant adolescents to increased social stress which was compounded by the surge in the sex hormones which results in suicidal tendencies. The pregnant adolescents shared how sad they were about their condition, and if they are not helped out and they become extremely sad, they could develop depression which will

make it easier for them to commit suicide. This is consistent with the study of Fergusson and Woodward (2011) which showed that pregnant adolescents who had better social supports are less likely to have suicidal tendencies.

#### **5.2.2.6. Thoughts of Abortion**

Consistent with the study finding of Sodi (1999) which indicated pregnant adolescents thought about performing illegal abortions when they discovered that they were pregnant, the adolescents in the current study considered abortion as a remedy to their situation. Adolescents and adults (married and unmarried) invariably resort to abortion for unwanted or unplanned pregnancies. The marginalized and vulnerable people, of whom adolescents constitute a part, often seek unsafe abortion. Unsafe abortion contributes to maternal mortality in Ghana. In order to achieve millennium development goal 5, there must be improvement in maternal health. Unsafe abortion must be prevented through primary, secondary and tertiary prevention. Primary prevention is where the individual is well informed about family planning methods and she uses them appropriately to prevent pregnancy. In secondary prevention, the woman has an unplanned pregnancy and has made an informed choice of terminating the pregnancy. She is given the necessary help to have a safe abortion at the hospital. Comprehensive abortion care which includes post abortion care is given. The tertiary prevention is where the pregnant woman was not helped with her unplanned pregnancy. She goes in for unsafe abortion and develops complications. The health providers come in and manage the woman (comprehensive abortion care standards and protocol 2006).

The thoughts of abortion ran through the minds of the adolescents because the pregnancies were unwanted. They were still in school and did not want to drop out of school. Some of them were not ready to become parents yet. They were also afraid of their parents and the

reaction of society. These reasons pushed them to want to get rid of the pregnancy, before anybody would notice it.

#### **5.2.2.7 Anger**

Anger was one of the reactions of adolescents towards their pregnancies. Due to the stigmatization of pregnant adolescent and the ostracism experienced by some, the adolescents demonstrated an intense anger about the circumstances. In some cases, the adolescents blamed themselves. Others blamed their partners or their friends who were their accomplices. Some were angry because they did not use contraceptives, others blamed themselves for not being strong enough to refuse to engage in a sexual relationship until they were ready to be mothers. These emotions of anger were confirmed in the findings of a study by James, Rooyen, Strumpher, (2012) which indicated that the turmoil experienced by pregnant teenagers was caused by the overwhelming emotions they experienced in relation to their pregnancies such as breakdown in relationships with their parents, families and peers. Since these negative emotions are most likely to lead to unsafe abortion and suicide, counseling cannot be overemphasized. Adolescents who are confronted with the myriad of problems associated with unplanned pregnancies need options counseling and social support according to the tenets of the Ghana Health Service (2006) protocol and standards on comprehensive abortion care (CAC).

#### **5.2.2.8 Denial**

In this study, the adolescents upon learning that they were pregnant initially denied it. Similarly Parekh and De la Rey (1997) found in their study that most teenagers denied the pregnancy at first, before they could inform their parents who, in most cases received the news with anger and disappointment. In the present study, participants expressed that upon

discovering that they were pregnant they were shocked and in denial. They maintained that, they did not think that they were pregnant even when they had missed their menstruations. Statements by one of the participants confirmed the extent of the shock and subsequent denial as well as wishing that the pregnancy was non-existent. They further expressed that in no time they were confronted with the reality of being pregnant, the truth became obvious and they could not deny the fact any more. The adolescents denied being pregnant because, Ghanaian culture frowns on adolescent pregnancy. They also wanted to prevent the ill treatment that would be meted out to them by their parents.

#### **5.2.2.9 Loneliness**

The adolescents in the current study expressed loneliness as part of their reaction towards their pregnancies. The participants often intentionally isolated themselves from social functions. Among the reasons given for their intentional isolation was to avoid harsh treatment from their parents. Another reason they gave was to avoid people commenting on their pregnancies and sometimes pretending they cared even though they gossiped in their absence. This finding corroborates that of Higginbottom, Owen, Mathers, Marsh and Kirkham (2006) which indicated that pregnant teenagers felt lonely and desperate which described the adolescent's sense of isolation and despair in adapting to their new role as a parent. Most of the adolescents belonged to different social groups in their churches and schools, but had to abandon these groups because of the pregnancy. Reflecting on how sociable they had been before, this made them feel lonely and rejected.

## **5.3 SOCIAL EXPERIENCES**

### **5.3.1 Conditions at Home**

#### **5.3.1.1 Unhappy Family**

Participants shared how their families had been very unhappy due to their conditions. They said the tension in their homes had affected the happiness in the home. Their parents were not happy and because of that, they shouted and insulted them at the least provocation. This made them and their siblings unhappy. This was not the atmosphere in their homes before they became pregnant, and their parents were not behaving that way before the pregnancy. The behaviour of the parents was not strange. Every parent has high expectations for his or her children. They invariably educate their children and wish to see them grow up as responsible adults to care for them also in their old age. This is one of the reasons why Ghanaian and other African parents invest so much in their children. It acts as a form of “insurance” for them in their old age. It therefore comes as a shattered hope if a child in whom much has been invested becomes pregnant and as a result fails to achieve the parents’ dreams. This loss of hope and thwarted plans are devastating to parents with high expectations. This appears to be the main cause of their unhappiness. As a ripple effect all siblings and family members become unhappy.

#### **5.3.1.2 Disagreements/Quarrels/Arguments**

Participants also expressed that, there were always arguments between their parents and sometimes with other family members. Some family members saw the pregnant adolescents as bad girls while others thought otherwise. Some fathers of the pregnant adolescents blamed their mothers for the pregnancy because they claimed the mothers did not train or bring up their daughters well with good morals. This created a lot of tension between the parents and sometimes with the family members. One participant said at the



least provocation her parents argued and exchanged words. The pregnant adolescents were affected negatively, knowing that they were the cause of the problems in the house. This made the adolescents regret their action and wished they could correct all their mistakes to restore peace in the home.

### **5.3.2 Reactions of Parents/Family**

#### **5.3.2.1 Anger**

Anger was one of the reactions of parents when they heard their adolescents were pregnant. The parents were disappointed as they least expected such behaviour from their daughters. This led to mal-treatment of the pregnant adolescents. According to some of the participants they came from broken homes with financial challenges and adding another person to the family meant increasing the financial challenges of the family. For some of the parents the shame and embarrassment the pregnant adolescent brought to the family made the parents angry. Some parent were prominent people in their church and community and thus having a pregnant adolescent meant inability to manage their home. This is similar to the findings of James, Rooyen, and Strumpher, (2011) which shared that the parents felt cheated and unappreciated when their teenagers became pregnant, and were angry with the teenagers. The anger exhibited by the parents to the pregnant adolescents is justifiable. Parents look forward to see their children behave admirably and responsibly in society. Every parent's wish is for the child to behave as society expects a reflection of good socialization on the part of the parent. If children behave contrary to the norms of society, part of the blame goes to the parents. Either the parents are seen as being morally weak themselves or are blamed for not training their children well. The family is stigmatized or stereotyped.

### **5.3.2.2 Beatings**

The findings of this study indicated that parents subjected their adolescent girls to beatings. Some of the pregnant adolescents expressed their ordeal in tears of how they were beaten by either their father or mother when they got the information about their pregnancy. Some of the pregnant adolescents stated that, that was the first time they had been beaten by a parent. One participant stated that after she had been beaten her mother put grinded ginger into her genital organ. In Ghana it is a way of punishing naughty children. These ill treatment meted out to the pregnant adolescents by their own parents could be regarded as domestic violence and violating the rights of the adolescents. These could contribute to low esteem in the adolescents in future. It could also lead to the adolescent losing the love they had for their parents and could pay them back in their old age when it is time for these adolescents to cater for these parents.

### **5.3.2.3 Rejection**

Among the reactions of parents towards their pregnant adolescents was ejection of the pregnant adolescent from their homes. Some of the adolescents expressed disappointment at how their parents ejected them from their home. Some of the parents refused to take the adolescents back, and for six months they did not know where their pregnant adolescents lived and how they fared. These pregnant adolescents were being supported by neighbours and friends who were not close relations of these adolescents thus making it impossible for them to share their problems with them. This finding is in agreement with those of Davies, (2002) which showed that the extent of embarrassment of the unwanted pregnancy to the family can be so severe that the pregnant teenager is rejected or even thrown out of her home resulting in the loss of parental support she needs during pregnancy. The cessation of parental support could affect teaching and learning of parental skills, which

are critical abilities that pregnant adolescents need to acquire in order to transit into better motherhood.

#### **5.2.3.4 The Support of Mothers**

The support received from mothers was one of the reactions of parents to the pregnant adolescents. Some participants expressed how their mothers later accepted and supported them. They described the initial stages as “fracture” in family relationships. As the pregnancy advanced the relationship between them and their mothers improved. They received physical, psychological and social help from their mothers. They also reported that though their mothers were disappointed a closer relationship developed with their mothers than had existed before and the mothers did their best. The adolescents who had this support from mothers had the hope to complete their education and achieve their future dreams. It was therefore clear that for adolescents to have a positive psychosocial and economic experiences depend on the mother’s support. The findings are in line with that of Higginbottom, Owen, Mathers, Marsh and Kirkham (2006) which shared that most commonly, the young women in the study identified their mothers as their most significant supporter, both in terms of practical help, advice and psychological support. Mothers therefore appeared to be sources of support for adolescents facing challenges. This could be tapped and used in adolescent-friendly programmes.

### **5.3.3 Reactions of Partners**

#### **5.3.3.1 Anger**

Like parents, anger was one of the reactions of partners when they first had the information that their adolescent girlfriends were pregnant. The partners expressed anger when they were confronted by the parents of the adolescents to take up responsibility of

the pregnancy. They got angry when the pregnant adolescents asked them for money to enable them seek medical attention. Some of the partners got angry at the adolescents because their friends made fun of them. Some did not want to see the pregnant adolescents. Others blamed the pregnant adolescents for allowing themselves to get pregnant by not using any contraceptives.

#### **5.3.3.2 Denial**

Among the social experiences of the participants was denial by their partners when they became pregnant. The partners did not give the adolescents the correct information about themselves. Some of the partners were already married with children and there was no way they could accept the pregnancy from another woman. Some partners were unemployed and could not cater for the needs of the adolescents so they denied being responsible. Others were students and accepting responsibility could lead to rejection by their parents so they did not accept responsibility. However two of the participants in this study indicated being in a good relationship with their partners. They shared how these partners have been supportive in terms of their physical, psychological and social needs. This observation is in agreement with the findings of Higginbottom, Owen, Mathers, Marsh and Kirkham (2006) which indicated that it is common for young single men to deny parentage when a sexual partner becomes pregnant, due to fear of taking responsibility. However, the researchers indicated few of their participants had an enduring relationship with the partners and were all positive about their role as fathers to be.

### **5.3.3.3 Lack of support**

In this study most of the adolescent stated that they had no support from their partners be it physical, psychological and social. According to De Vito, (2007) the more emotional and tangible support the adolescent mother received from the father of the newborn, the higher the adolescent mother's self-evaluation of parenting. However, for many of the adolescent mothers in the study sample, the father of the newborn was not consistently supportive or did not share parenting duties; but when he was available, the baby's father provided both emotional and tangible support, especially when the adolescent's own mother was not a part of her life.

This study identified that there is a disillusionment felt by some pregnant adolescents towards their partners which is related to them being unable to provide financial support. Their inability to contribute to the welfare of the adolescents may be a significant factor in the breakdown of relationships between the prospective parents and hence the emergence of the 'absent' father in the future.

### **5.3.4 Reactions of Peers / Friends**

#### **5.3.4.1 Rejection**

In Ghana, people normally determine one's character from that of her friends. It is for this reason that the peers of the pregnant adolescents rejected them. According to Gouws, Kruger and Burger, (2000), teenagers primarily turn to their peers when faced with parental neglect and rejection. However, in this study, turning to peers was not an option as the pregnant adolescents experienced rejection from their peers. Such experiences were expressed by some of the participants. According to the participants their peers thought people might say they are also bad girls so they did not visit them. Some of the peers were warned by their parents not to talk to the pregnant adolescents again because they were

bad girls. Others rejected the pregnant adolescents because the mother of the pregnant adolescents insulted them. It may be that those mothers were disappointed by their children getting pregnant prematurely shattering all their hopes of a bright future. The insults of the friends of their pregnant adolescent girls may be due to frustration leading to displaced anger.

#### **5.3.4.2 Gossiping**

Gossiping was also one of the troubling sub-themes that emerged as reactions of peers towards the pregnant adolescents. Friends of the pregnant adolescents spread false information about them in their school which made them uncomfortable to remain in school. This led to all participants having dropped out of school as at the time of the interview.

The problem of adolescent pregnancy among school girls is a major concern in many countries. Adolescent pregnancy has been cited as a constraint in the elimination of gender disparities in education, and in the achievement of the Millennium Development Goals of universal primary education and gender equality in education by 2015 (MDG 2).

In a country where the adage “*when you educate a woman you educate a nation*” holds so true, the repercussions of girls dropping out of school due to pregnancy cannot be underestimated.

From anecdotal evidence from the Ghana Education Service, pregnant adolescents have the right to stay in school till they deliver but most school authorities dismiss such girls to serve as a deterrent to other students. However those who have registered for external examination are allowed to write the examination by West Africa Examination Council.

### **5.3.5 Reactions of Neighbours**

#### **5.3.5.1 Gossiping**

The most prominent reaction of neighbours towards the pregnant adolescents was gossiping. In most Ghanaian communities it is the norm that, people expects only married women to be pregnant. If unmarried person especially an adolescent becomes pregnant, they encounter the displeasure of the community members. The pregnant adolescents were worried about the way older women in the community castigated them and not their own children who were even worse morally. Neighbours sometimes spread false information about them although teen mothers are currently more visible in the community than in the past, teen pregnancy and parenting are still stigmatized. Similar sentiments were shared by participants in Mpetshwa's study (2000) in which community members tended to have a wide range of negative reactions towards adolescent mothers. There is a need for intensive community education for community members to desist from ill-treating pregnant adolescents even though they have community norms. Such untoward reactions will make this adolescent resort to unsafe abortions or suicide. These adolescents need support, compassionate counseling and direction. The creation of more functional teen corners cannot be over emphasized.

### **5.3.6 Attitudes of Midwives**

#### **5.3.6.1 Positive Attitudes**

Positive attitude was one of the reactions of midwives towards the pregnant adolescent when they visited the antenatal clinic. Some of the midwives received and treated the pregnant adolescent in their care like adults. These midwives received them well, established good rapport with the pregnant adolescents, explained issues to their level of understanding and counseled them where necessary. Most of the participants experienced

positive attitude from the midwives. Some of the participants were even given money by the midwives to buy food so that they could have their dose of anti-malaria treatment in the presence of the midwife as expected. These midwives demonstrated a high level of professionalism and empathy. Though they did not have formal training in adolescent health they were able to manage them holistically.

#### **5.3.6.2 Negative Attitudes**

Although some participants expressed positive attitudes from the midwives others were badly treated by midwives at Tema General Hospital because of their age. Attitudes of some doctors and midwives are important as they determine whether services are attractive to clients or not. This study had showed that some health workers are not responding adequately to adolescent maternal health needs. Some midwives were said to be harsh and abusive to some participants. They blamed and intimidated the pregnant adolescents. If midwives have negative attitudes, adolescents will avoid health services and end up seeking help from unprofessional sources and later come back with complications which will either increase maternal morbidity or mortality. Similar finding was reported by Herrman, (2008) which indicated that Health Workers in public health facilities had negative attitudes towards pregnant teenagers. They were rude, abusive, and threaten the pregnant teenagers. In order to address the relatively higher maternal mortality rate and to improve access, quality and continuity of antenatal care to pregnant women, the Government of Ghana adopted the World Health Organisation focused antenatal care package in 2002. Focused antenatal care is refer to the services provided by midwives, according to individualized comprehensive care and emphasizes on disease detection rather than just risk assessment. This can be affected by the attitude of the service providers. In this study two main type of attitudes of service providers were identified.



The positive attitude helped the adolescents and a negative attitude demoralized the adolescents. It is therefore very important for the midwives to be trained in adolescent health.

## **5.4 Economic Challenges**

### **5.4.1 Lack of Funds**

The lack of funds was found to be a major economic challenge of the pregnant adolescents. All the participants indicated that their pregnancies were unwanted and unexpected. The partners also denied responsibility, and this shifted the financial burden unto the parents who were already struggling to cater for the adolescents' needs before the pregnancy. Some parents were not expecting their adolescents to become pregnant, so out of shame and anger abandoned the pregnant adolescents, thereby throwing the pregnant adolescents into financial difficulties. This situation further compounded the pregnant adolescents' plight, making them stressed-out during pregnancy. Whilst this move by the parent is to punish the pregnant adolescent, it worsen and the already stressful situation since this is the time the adolescents needed financial support and encouragement to enable them go through the pregnancy. Similar findings were shared by Robson and Berthoud (2002) which showed that parents blamed the girls for the pregnancy that would bring another economic burden to the family, adding to an already strained economic situation.

## **5.5 Physical Experience**

### **5.5.1 Disorders of Pregnancy**

During pregnancy the woman undergoes physiological changes, these physiological changes are due to the effects of specific hormones. The changes prepare the woman to

nurture the foetus, prepare her body for labour and develop her breast for lactation. The physiological changes manifest in physical signs and symptoms known as disorders of pregnancy (Bennett & Brown 1996).

Participants in the current study had physical experiences apart from psychosocial and economic encounters. Prevailing disorders were Dizziness, Waist Pains, Swollen Feet, High Blood Pressure and Insomnia.

#### **5.5.1.1 Dizziness**

Specifically, participants expressed that they often felt dizzy when they were hungry but the condition improved after eating. This could be due to hypoglycemia in most of the adolescents. During adolescence, there is growth spurt which corresponds with an increased appetite in the adolescents (Lahey 2001). Pregnancy is also a period where most of the women experience changes in their sense of taste, leading to dietary changes and food craving (Bennett, & Brown, 1996). The pregnant adolescents found themselves in these two transitions where the nutritional requirement is high therefore exposing most of them to a nutritional status which was less than their body requirement. Late in pregnancy the weight of the uterine contents presses on the inferior vena cava and slows the return of blood to the heart causing dizziness and fainting attacks in some pregnant women (Jamieson 1996) and this could be the cause of the dizziness in the pregnant adolescents. In addition when their Antenatal records were checked, their haemoglobin level ranged from 8g/dl to 11g/dl. The haemoglobin level was not adequate to support both the foetus and the adolescent, and this could explain why they complained of dizziness. According to World Health Organisation (2010), haemoglobin estimation of ten (10) and below is referred to as anaemia in pregnancy which implies that all the participants were anaemic,

hence the dizziness. The lack of funds and hunger could have contributed to their anaemic condition.

#### **5.5.1.2 Waist Pains**

Waist pain was another disorder most of the participants experienced. They shared that they had the pains throughout the day and could only be relieved after they had taken their prescribed analgesics. As the baby continued to gain weight, progesterone and relaxin relaxed the joints between the bones in the pelvis especially the symphysis pubis to enlarge the pelvic cavity. This is known as “GIVE” which paves the way for the foetus to pass through the pelvic cavity during delivery (Bennett, & Brown 1996). These changes could cause pain in the lower back and the waist in the third trimester. This could be the reason why most of the participants complained of waist pains since they were all in their third trimester. The adolescents needed compassionate counseling and education to allay their anxiety.

#### **5.5.1.3 Swollen Feet**

Another minor disorder participants complained of was swollen feet. According to (Bennett, & Brown 1996) as the uterus grows it puts pressure on the veins that returned blood from the feet and legs. This slows down the return of blood causing fluid to flow into the tissues leading to (oedema) swollen feet and ankles which subsides in the morning and reoccur during the day. This is the normal physiology of pregnancy. It might be considered a problem when it persists for a long time and it is accompanied with other symptoms. Most of the participants in this study were well informed about this symptom by their midwives and therefore were not worried about it. However, a few of the

participants who had additional symptoms such as High Blood Pressure were worried about their condition.

#### **5.5.1.4 High Blood Pressure**

High Blood Pressure was another problem some participants complained about. They stated that they had been on admission two or three times when they entered their third trimester. Extremes of age, pregnant for the first time (primi-gravida) and having a family history of hypertension, are some of the predisposing factors for pregnancy induced hypertension. The participants who complained of high blood pressure and had the above history coupled with their psychosocial problems, predisposed them to the hypertension. They were referred to doctors for further management and were all put on medications. This was similar to the report of Guttmacher, (2001) which states that potential health conditions often associated with adolescent pregnancies are hypertension, pre-eclampsia or diabetes.

#### **5.5.1.5 Insomnia**

The study revealed that the participants also had problems with their sleep patterns. Some participants stated that they had interrupted sleep patterns especially when they had to wake up several times to pass urine in the night. Some of them complained of their inability to assume a comfortable position. This made it difficult for them to have a continuous uninterrupted sleep. This is also a common disorder of pregnancy during the third trimester. During the last trimester the presenting part of the foetus descends into the pelvic cavity, this exerts pressure on the urinary bladder causing frequency in micturation. When this happens in the night it could disturb the sleep of pregnant adolescents. There is an increase in blood supply to the uterus on lying down, this sometimes causes the baby to

move a lot which may disturbs the sleep of the pregnant adolescents. At this stage the pregnancy may bring an increase anxiety into the pregnant woman due to fear of the unknown and this could lead to sleep disturbances (Bennett, & Brown 1996). The pregnant adolescents need education on these causes to help them relax during this stage.

## CHAPTER SIX

### SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

In this chapter, a summary of the whole research has been given and some conclusions drawn. The implications of the study for nursing practice, policy and research also have been drawn. The limitations encountered during the study have been outlined and due recommendations have been made based on the study findings.

#### 6.1 Summary and Conclusion

This study set out to find and document issues on the psychosocial experiences of pregnant adolescents in the Tema Metropolis, in order to provide nursing knowledge which will improve nursing care.

According to the World Health Organisation (2002) adolescents are people between the ages of 10 to 19 years. They make up 21.9 % of Ghana's population and are therefore a major human resource base of the country (Ghana Demographic and Health Survey Report). Adolescents are however faced with a number of general and reproductive health issues such as adolescent pregnancy. They are people in transition from childhood to adulthood and therefore not matured enough to carry pregnancy (Steinberg, 2007).

The incidence of adolescent pregnancy is reportedly on the increase in Ghana, even though data from rural areas on adolescent pregnancy are not available. They form 13% of all births in Ghana and contraceptive prevalence rate among adolescents is 8.5% (Ghana Demographic and Health Survey Report 2008). Adolescent pregnancy is associated with an important psychosocial adaptation. The study was qualitative in nature and it was conducted at the Tema General Hospital in Tema, Ghana. Tema General Hospital was chosen for this research because it is a referral hospital for all pregnant adolescents in and around the Tema Metropolis.

Twelve (12) pregnant adolescents (between the ages of 16 and 19 years) from the Antenatal Clinic of the Tema General Hospital were interviewed. The interview was based on their psychosocial problems which were audio taped and transcribed verbatim. Through content analysis, ten major themes emerged which were sub-divided into sub-themes. The major themes included;

- Causes of pregnancy
- Conditions at home
- Reactions of parents towards pregnancy
- Reactions of partners towards pregnancy
- Reactions of friends towards pregnancy
- Attitude of neighbours
- Economic challenges
- Reactions of adolescent towards pregnancy
- Disorders in pregnancy
- Attitudes of midwives

The themes were discussed under the four objectives of the study which included:

Psychological experiences which covered Causes of pregnancy and Reactions of adolescents towards their pregnancy.

Participants' social experiences covered the conditions at home, reactions of parents, partners, friends and neighbours towards the pregnant adolescents, and attitudes of midwives.

The economic challenges were discussed under lack of funds whilst the physical experiences were covered under the disorders in pregnancy.

Acknowledging these psychosocial experiences of pregnant adolescents will help clinicians especially midwives who work at the antenatal clinic and the labour wards to

provide the needed professional support which will help the adolescents cope better with their unwanted pregnancies. The study can therefore be said to be relevant and beneficial to nursing practice as well as general service delivery.

In conclusion, adolescent pregnancy is largely regarded as a public health concern in Ghana where there is lack of financial and social support for adolescents who reach motherhood too early. Psychosocial consequences of adolescent pregnancy depend on acceptance from parents, partners, peers and the society at large. This study revealed that, pregnant adolescents face family and community problems such as stigma, financial constraints and rejection which impact negatively on the lives of the adolescents. This may pose impediments in the overall development of the adolescent. This necessitated the ongoing psychosocial assessment of adolescent pregnancy.

## **6.2. Implications for Nursing Practice, Policy and Research**

The psychosocial experiences of pregnant adolescents come with a wide variety of implications for nursing. Some adolescents may look like adults but they are not.

They need time to know themselves, understand themselves, their bodies, new roles and relationships.

Adolescence, a transition period and motherhood, can be daunting and environmental, family and personal factors can make this transition even more challenging. When adolescents become pregnant, it means embarking on a new way of life that challenges the adolescent's coping mechanisms. Health providers especially obstetricians and midwives working at the antenatal clinics, mostly concentrate on the medical aspects of the pregnancy, neglecting the psychological aspects of adolescent pregnancy. However psychosocial assessments and support are part of midwife's role in providing maternal



care. Also the World Health Organisation, (1948) definition of “Health” encompasses the physical, social and mental aspects of life.

These psychosocial assessments may also play an important role in assessing the coping mechanisms used by adolescents and family members so that the adolescent’s perspective on these issues could be approached within the client-centered paradigm. In order for pregnant adolescents to attain optimal quality of life, it is essential to help them handle their psychosocial challenges. The midwife can accomplish this by providing comfort and safety to the pregnant adolescents, encouraging them to express their concerns and feelings. The midwife can also embark on client education and counseling as expected by the Ministry of Health.

### **6.3 Limitations of the Study**

The small sample size of twelve could not be a good representation of adolescents in Ghana.

Another limitation was that the research was carried out on school going adolescents and therefore does not cover pregnant adolescents who have dropped out of school already or illiterate adolescents.

The majority of the participants preferred being interviewed at the hospital after they had gone through their antenatal checkups and were already tired. They then spent another hour with the researcher which could be stressful for a pregnant woman.

The research was carried out at the Tema General Hospital and therefore did not cover those who did not attend any antenatal clinic and those who sought antenatal services at private hospitals.

## 6.4 Recommendations

Based on the research findings, the following recommendations were made:

- Counseling centers should be attached to the antenatal clinic to counsel adolescents and their families adequately throughout their antenatal period.
- Initial and ongoing psychosocial assessment of pregnant adolescents should be done by midwives.
- The hospital management should identify a day and time to attend to pregnant adolescents only.
- The Ministry of Health should collaborate with Ministry of Education to intensify education on Reproductive Health in first and second cycle institutions.
- The Ghana Health Service and the management of the Tema General Hospital should make collaborative efforts at ensuring that midwives working at the antenatal unit receive periodic training through workshops, in-service training, seminars and conferences on adolescent issues to enable them deliver quality maternal care to these clients.
- The management of the Tema General Hospital should intensify efforts at acquiring the needed logistics and equipment for the provision of quality maternal care.
- The government in collaboration with the Ghana Health Service and Tema General Hospital as part of their policies should sponsor midwives to upgrade their knowledge in adolescent health. This is because, the researcher found out that none of the midwives has been trained in adolescent health care and therefore lack knowledge in handling pregnant adolescents.

## 6.5 Future Research

- Future research on pregnant adolescents should capture their coping strategies and quality of life of adolescents after delivery.
- Future research should also involve the role or support of partners to the pregnant adolescents.

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**APPENDICES****APPENDIX A  
DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS**

<b>Participants</b>	<b>Age In Years</b>	<b>Level Of Education</b>	<b>Number Of Siblings</b>	<b>Tribe of participants</b>	<b>Languages Spoken</b>	<b>Gestational Age</b>	<b>Living with both parents</b>
PA	18	SHS 2	3	Akan	English, Ga, Twi	8 Months	Yes
PB	18	SHS 3	3	Akan	English,Twi,	8 Month 2 weeks	Yes
PC	19	SHS 4	5	Ewe	English, Twi, Ewe	8 Months	Yes
PD	19	JHS 3	5	Akan	English, Twi	7 Months	Yes
PE	16	JHS 3	4	Akan	English, Twi,	9 Months	Yes
PF	18	SHS 4	1	Akan	English, Twi	9 months	Yes
PG	17	JHS 3	3	Dangoma	English, Twi	8 Months 3 Weeks	No
PH	18	JHS 3	9	Ga	English, Ga, Twi	8 Month	Yes
PI	17	JHS 2	6	Ga	English, Ga, Twi	9 Months	Yes
PJ	16	SHS 1	5	Ga	English, Ga, Twi	8 Months	Yes
PK	16	SHS 1	4	Ewe	English, Twi	8 Months	Yes
PL	16	JHS 3	1	Ga	English, Ga	7months	Yes

**Source: Transcribed Interview**

## **APPENDIX B**

### **INTERVIEW GUIDE**

#### **1. Demographic Background**

Participants' initials

Age of participant

What are you doing now?

How many siblings do you have?

Whom are you staying with?

How old is your pregnancy?

#### **SECTION B**

What circumstances led to this pregnancy?

What was your reaction when you were told that you were pregnant?

How would you describe your current situation?

What has been the most challenging part of your pregnancy?

Who has been most helpful? In what ways has he/she been most helpful?

Who has been the least helpful? In what ways has he /she been least helpful?

What are the attitudes of your family of origin, partner, neighbours, peers, school and health care providers towards you?

What is the change in relationship between you and partner since this pregnancy?

How has the physical changes of your body affected you?

What are the specific changes that have affected you?

Who looks after you now?

How are your needs met?

What are your economic challenges?

How would you describe support of your boyfriend and family?

How would you describe your health status generally now that you are pregnant?

**APPENDIX C****Thematic code frame**

THEMES	CODE	DESCRIPTION
1. CAUSE OF PREGNANCY	CAOP	How adolescents become pregnant.
a. Rape	Rap	Having sex with adolescents without their consent.
b. ignorance	ign	Adolescents isolating themselves from others or vice versa.
c. Peer pressure	ppe	Pressure on adolescents to copy friends
2. REACTION OF ADOLESCENT	ROA	All that the adolescents do or say when they realize that they are pregnant.
a. Sadness	Sad	Adolescent being unhappy about the behaviour of their parents and significant others.
b. Shyness	Shy	Pregnant Adolescents feeling embarrassed about being pregnant.
c. Anxiety	Anx	Unexplained fear experienced by pregnant adolescent over issues related to their pregnancy.
d. Worries	wor	Pregnant adolescents unduly concerned about their pregnant state.
e. Suicidal tendencies	sut	Pregnant adolescent thinking of taking her own life
f. Thought of abortion	toa	Pregnant adolescent thinking of getting rid of the pregnancy.
g. Anger	ang /ado	Feelings of anger that the adolescent develops towards self or partner due to unplanned pregnancy.
	den	Adolescents refusing to accept the reality of being pregnant.
h. Denial		Adolescents isolating themselves from others or vice versa.

i. Loneliness	lon	Conditions in house of the pregnant adolescent at a particular time.
3. CONDITION IN THE HOUSE	CITH	Persistent exchange of words in the house between parents of pregnant adolescent.
a. Disagreement / Quarrels/ Argument	dqa	Pregnant adolescent being discontent with the conditions in the house.
b. No happiness	noh	All parents do or say when they realize that their adolescents are pregnant.
4. REACTIONS OF PARENTS	ROPA	Feeling of anger parents develop towards their adolescents due to unplanned pregnancy.
a. Anger	ang /par	Parents inflicting pain on their pregnant adolescents through hitting.
b. Beatings	bea	Parents throwing their pregnant children out of the house.
c. Rejection	rej	All forms help mothers give to her daughter in cash or kind throughout the pregnancy.
d. Support from mother	sfm	All the things guys do or say when they realize that their adolescent girl friends are pregnant.
5. REACTIONS OF PARTNERS	REOP	Feeling of anger partners develop towards their adolescent girl friends
a. Anger	ang/par	Partners refusing to accept the responsibility of impregnating their girl friends
b. Denial	den	No form of help from partner to pregnant adolescent
c. No support	nos	All that adolescents say or do to their friends when they realized that their friends are pregnant.

6. REACTION OF PEERS/FRIEND	ROPF	Adolescents spreading information about their pregnant friends.
	gos	Adolescents not standing by their friends in times of pregnancy when they are needed most.
	bet	The way the people in the community behave towards the pregnant adolescent
a. Gossiping		
b. Betrayal		
7. ATTITUDE OF NEIGHBOURS	ATON	Neighbours spreading negative information about pregnant adolescents
	gos	Financial hardship faced by adolescents
	ECOC	Adolescent do not have money to her meet needs.
a. Gossiping		
8. ECONOMIC CHALLENGE	lof	Feeling of unwell by adolescents during the pregnancy.
	MDIP	Pregnant adolescent feeling that she is about to fall.
	diz	Pregnant adolescent having discomfort in the waist.
a. Lack of funds		
9. MINOR DISORDERS IN PREGNANCY	wap	Pregnant adolescent feeling their feet are swollen.
	swf	Pregnant adolescents having persistent elevation of blood pressure.
	hbp	Staying awake for long hours during the night.
	ins	The way midwives treat the pregnant adolescent when they visit ANC
		Good treatments midwives give to
a. Dizziness		
b. waist pain		
c. swollen feet		
d. high blood pressure		

e. insomnia	AOM	pregnant adolescent when they visit ANC
	pat	Bad treatments midwives give to pregnant adolescent when they visit ANC
10. ATTITUDE OF MIDWIVES	nat	
a. positive attitude		
b. negative attitude		

## APPENDIX D

### CONSENT FORM

Title: Psychosocial Experiences of Pregnant Adolescents: A Study at the Tema Metropolis

**Principal Investigator:** Elizah Amoah

**Address:** University of Ghana, School of Nursing, P.O. Box 43, Legon.

Dear Respondent,

You are invited to participate in a research title stated above. You are entreated to read the information below very careful before you agree to take part.

#### **General Information about Research**

The purpose of the study is to explore and document the psycho-social experiences of the Pregnant Adolescents. The study will address the following objectives to:

- 1) Identify the emotional experiences of pregnant adolescents.
- 2) Determine the effects of the physical changes of pregnancy on the pregnant adolescents.
- 3) Explore the social experiences of pregnant adolescents.
- 4) Identify the economic challenges of the pregnant adolescents.

You will be required to answer interview questions which will take you 45 to 60 minutes to go through the interview at a convenient place of your choice. This will be audio recorded with your permission and field notes will be taken on event that cannot be recorded. The recordings will be transcribed in exactly the same words as you used them and then analysed. The findings will be discussed by comparing it to other related researches and conclusion drawn. The report will be shared with midwives and public health nurses who deal with adolescents.



**Possible Risks and Discomforts**

You will not be exposed to any risk during the research.

**Possible Benefits**

You will not receive any direct benefit for participating but the findings of the study will be used to counsel other Pregnant Adolescents and their parents. It will also inform health providers especially Midwives to improve the services they render to Pregnant Adolescents.

**Confidentiality**

All the information you will provide will be known exclusively to the researcher and her supervisors. Your name will not be included in any of the information you give me except the agreement form. The interview will be done at a place where nobody will be able to identify you. The information you provide will be kept under lock for five years and if the need to use it again arises, permission will be sought from you.

**Compensation**

You will be given Lunch after the interview due to the fact that you are pregnant and will have to spend extra time after you have been attended to by your midwife.

**Voluntary Participation and Right to Leave the Research**

Please be assured that your participation in this study is solely voluntary. You have the right to participate or refuse to participate and this will not result in any penalty in the service you are entitled to. You have the right to drop out of the research at any time you desire.

### **Contacts for Additional Information**

If you have any questions now or at any point during the course of the study, please feel free to ask. For further information please contact Elizah Amoah, School of Nursing, University of Ghana, Legon. Telephone: 0244991802.

### **Your Rights as a Participant**

This research has been reviewed and approved by the Noguchi Memorial Institute for Medical Research Institutional Review Board (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: [nirb@noguchi.mimcom.org](mailto:nirb@noguchi.mimcom.org) or [HBaidoo@noguchi.mimcom.org](mailto:HBaidoo@noguchi.mimcom.org).

### **VOLUNTEER AGREEMENT**

The above document describing the benefits, risks and procedures for the research title Psychosocial Experiences of Pregnant Adolescent: A Study at the Tema Metropolis has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

---

Date

---

Name and signature or mark of volunteer

**If volunteers cannot read 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.

---

Date

---

Name and signature of witness

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.

---

Date

---

Name Signature of Person Who Obtained Consent

## APPENDIX E

### PARENTAL CONSENT FORM

**Title:** Psychosocial Experiences of Pregnant Adolescents: A Study at the Tema Metropolis

**Principal Investigator:** Elizah Amoah

**Address:** University of Ghana, School of Nursing, P.O. Box 43, Legon

Dear Parent,

Your child is invited to participate in a research title stated above. You are entreated to read the information below very careful before you agree to allow your child to take part in the research.

#### General Information about Research

The purpose of the study is to explore and document the psycho-social experiences of the Pregnant Adolescents. The study will address the four objectives to:

- 1) Identify the psychological experiences of pregnant adolescents.
- 2) Explore the social experiences of pregnant adolescents. .
- 3) Identify the economic challenges of the pregnant adolescents.
- 4) Examine the effects of the physical changes of pregnancy on the pregnant adolescents.

Your child will be required to answer interview questions which will take 45 to 60 minutes to go through the interview using an interview guide in a convent place of your child's choice. This will be audio recorded with your child's permission and field notes will be taken on event that cannot be record. The recordings will be transcribed in exactly the same words as your child used them and then analysed. The findings will be discussed by

comparing it to other related researches and conclusion drawn. The report will be shared with midwives and public health nurses who deal with adolescents' health issues.

**Possible Risks and Discomforts**

Your child will not be exposed to any risk or discomfort in this research.

**Possible Benefits**

Your child will not receive any direct benefit for participating but the findings of the study will be used to counsel other Pregnant Adolescents and their parents. It will also inform health providers especially Midwives to improve the services they render to Pregnant Adolescents.

**Confidentiality**

All the information that your child will provide will be known exclusively to the researcher and her supervisors. Your child's name will not be included in any of the information your child will give me except the agreement form. The interview will be done at a place where nobody will be able to identify your child. The information your child provides will be kept under lock for five years and if the need to use it again arises permission will be sought from you and your child.

**Compensation**

Your child will be given lunch after the interview due to the fact that she is pregnant and will have to spend extra time with me after she has been attended to by her midwife.

**Voluntary Participation and Right to Leave the Research**

Please be assured that your child's participation in this study is solely voluntary. Your child has the right to participate or refuse to participate and this will not result in any penalty in the service your child is entitled to. Your child has the right to drop out of the research at any time she desire.

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**Contacts for Additional Information**

If you or your child has any questions now or at any point during the course of the study, please feel free to ask. For further information please contact Elizah Amoah, School of Nursing, University of Ghana, Legon. Telephone: 0244991802 or email: [akuaelizah@gmail.com](mailto:akuaelizah@gmail.com).

**Your Child's Rights as a Participant**

This research has been reviewed and approved by the Noguchi Memorial Institute for Medical Research Institutional Review Board (NMIMR-IRB). If you have any questions about your child's rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: [nirb@noguchi.mimcom.org](mailto:nirb@noguchi.mimcom.org) or [HBaidoo@noguchi.mimcom.org](mailto:HBaidoo@noguchi.mimcom.org) .

### **VOLUNTEER AGREEMENT**

The above document describing the benefits, risks and procedures for the research title Psychosocial Experiences of Pregnant Adolescent: A Study at the Tema Metropolis has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree that my child should participate as a volunteer.

---

Date

---

Name and signature or mark of parent or guardian

**If volunteers cannot read the form themselves, a witness must sign here:**

I was present while the benefits, risks and procedures were read to the child's parent or guardian. All questions were answered and the child's parent has agreed that his or her child should take part in the research.

---

Date

---

Name and signature of witness

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.

---

Date

---

Name Signature of Person Who Obtained Consent

## **APPENDIX F**

### **CHILD ASSENT FORM**

My name is Elizah Amoah and I am from the school of Nursing at University of Ghana. I am conducting a research study entitled Psychosocial Experiences of the pregnant Adolescents: A study at Tema Metropolis. I am asking you to take part in this research study because I am trying to learn more about pregnant adolescents. It will take you one hour to participate.

If you agree to be in this study, you will be asked to answer Interview questions about your experiences throughout your pregnancy and it will be audio taped with your permission.

Your participation in this study will not result in a direct benefit to you but the findings will be used to improve adolescent health services. However, there are no risks associated to this research.

You can stop participating at any time if you feel uncomfortable. No one will be angry with you if you do not want to participate.

Your information will be kept confidential. No one will be able to know how you responded to the questions and your information will be known to the researcher alone.

You may ask me any questions about this study. You can call me at any time on 0244991802 or talk to me the next time you see me.



Please talk about this study with your parents before you decide whether or not to participate. I will also ask permission from your parents before you are enrolled into the study. Even if your parents say “yes” you can still decide not to participate.

By signing below, it means that you understand and know the issues concerning this research study. If you do not want to participate in this study, please do not sign this assent form. You and your parents will be given a copy of this form after you have signed it.

This assent form which describes the benefits, risks and procedures for the research titled Psychosocial Experiences of pregnant Adolescents: A study at Tema Metropolis has been read and or explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate.

**Child’s Name:**..... **Researcher’s Name:** .....

**Child’s Signature/ Thumbprint:**..... **Researcher’s Signature:**.....

**Date:**..... **Date:** .....

## APPENDIX G

### INTRODUCTORY LETTER

**SCHOOL OF NURSING**  
**COLLEGE OF HEALTH SCIENCES**  
**UNIVERSITY OF GHANA**  
**LEGON**

Telephone: 021-513255 (Dean)  
Ext. 6206  
021-513250 } Secretary  
028 9531213  
Fax: 513255  
E-mail: [nursing@ug.edu.gh](mailto:nursing@ug.edu.gh)



P. O. Box LG 43  
LEGON, GHANA

Our Ref: SON/F.11.....  
Your Ref:.....

July 11, 2013

The Medical Director  
Tema General Hospital  
Tema.

Dear Sir,

**INTRODUCTORY LETTER**

I write to introduce to you Elizah Amoah, an M.Phil student of the School of Nursing, University of Ghana, Legon. She is conducting a research on "Psycho-social Experiences of Pregnant Adolescent: A Study at Tema Metropolis."

I should be grateful if you could offer her assistance.

Thank you.

Yours faithfully,



Dr. Mrs. Patience Aniteye  
SUPERVISOR

INTEGRI PROCEEDAMUS

## APPENDIX H

## ETHICAL CLEARANCE

**NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH**  
*Established 1979* *A Constituent of the College of Health Sciences*  
University of Ghana

**INSTITUTIONAL REVIEW BOARD**

Phone: +233-302-916438 (Direct)  
+233-289-522574  
Fax: +233-302-502182/513202  
E-mail: [nirb@noguchi.mimcom.org](mailto:nirb@noguchi.mimcom.org)  
Telex No: 2556 UGL GH

Post Office Box LG 581  
Legon, Accra  
Ghana

My Ref. No: DF.22  
Your Ref. No:

14<sup>th</sup> November, 2012

**ETHICAL CLEARANCE**

**FEDERALWIDE ASSURANCE FWA 00001824** **IRB 00001276**

**NMIMR-IRB CPN 026/12-13** **IORG 0000908**

On 14<sup>th</sup> November, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

**TITLE OF PROTOCOL : Psychosocial Experiences of Pregnant Adolescent: A Study at the Tema Metropolis**

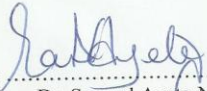
**PRINCIPAL INVESTIGATOR : Elizah Amoah (MPhil Student)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 13<sup>th</sup> November, 2013. You are to submit annual reports for continuing review.

Signature of Chairman:   
Rev. Dr. Samuel Ayete-Nyampong  
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram  
Director, Noguchi Memorial Institute  
for Medical Research, University of Ghana, Legon