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PARENTS AND COMMUNITY LEADERS' PERCEPTIONS OF TEENAGE PREGNANCY: A QUALITATIVE STUDY

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ABSTRACT

The purpose of this qualitative study was to understand the perceptions and experiences of parents and community leaders of two communities in Nigeria regarding teenage pregnancy and their understanding of teenage sexuality and contraception. In addition, the study set out to ascertain whether teenage pregnancy prevention programmes were available within the communities. The study was qualitative, contextual and exploratory utilising the Community-as-Partner Model. Eighty participants who were parents and community leaders responded to the semi-structured interview and completed a questionnaire on demographic data. Tesch's approach of data analysis was used, and descriptive statistics were used to display demographic data as well as the count of data segments that constitute categories. The findings reveal that although limited teenage pregnancy prevention initiatives were in existence, most of the participants, especially those from the North Central (NC) region of Nigeria, were not informed about them. Almost half of the participants viewed teenage pregnancy as a common occurrence in their communities of which most were from the NC region. More than two-thirds of the participants discouraged teenagers from using contraceptives. Teenage pregnancy intervention programmes and strategies must be sensitive to differences among various ethnic and religious groups. The involvement of religious and community leaders in teenage pregnancy intervention programmes and initiatives is indispensable in curtailing the high incidence of teenage pregnancies and childbirths among teenagers.

Keywords: contraceptives; community leaders; teenage pregnancy; parents; perceptions

UNISA university of south africa PRESS

Africa Journal of Nursing and Midwifery
https://upjournals.co.za/index.php/AJNM/index
Volume 19 | Number 3 | 2017 | #2810 | 19 pages

https://doi.org/10.25159/2520-5293/2810
ISSN 2520-5293 (Online), ISSN 1682 5055 (Print)

INTRODUCTION AND BACKGROUND

Having a child outside of marriage is not uncommon in many countries (WHO 2017). According to Ajala (2014, 62) and Panday et al. (2009, 9), teenage pregnancy is a social construct, which represents one of the many indices of adolescent delinquency, sexual permissiveness and moral decay. Teenage pregnancy is regarded as a major socio-medical and socio-economic phenomenon in both developed and developing countries and has become more rampant in recent times (Ibrahim and Owoeye 2012; Oyedele, Wright, and Maja 2015, 25).

Teenagers undergo a transition to adulthood. Thus, they are regarded neither as children nor as adults (Ajala 2014, 62). Teenage years are characterised by a sequence of physical and mental transformation that distinguishes this intricate period of development as a period of storm and stress; a stage of life easily complicated by teenage pregnancy. When a teenager becomes a mother, she interrupts the natural course of her teenage development and she suddenly has to face numerous unexpected responsibilities (Ajala 2014, 62; Ekefre, Ekanem, and Esien 2014, 41) for which she might not have developed the necessary psychosocial abilities or socio-economic status.

Despite the various consequences of teenage pregnancy (CDC 2010, 1; Kanku and Mash 2010, 564; Macleod and Tracey 2009, 3; Oyedele, Wright, and Maja 2014, 80; Oyedele, Wright and Maja 2015, 24; Panday et al. 2009, 3; WHO 2017) the rate of teenage pregnancy is high. Early pregnancies due to premarital sex are associated with multiple negative consequences for mothers and their offspring. Teenage pregnancies do not only have undesirable effects on the women's health and possibly that of their children, they also have socio-economic effects that make teenage pregnancies a worldwide public health and socio-economic concern (CDC 2010, 1; Kanku and Mash 2010, 564; Macleod and Tracey 2009, 3; Oyedele, Wright, and Maja 2015, 24; Panday et al. 2009, 3).

About 16 million women aged 15 to 19 years give birth each year – about 11 per cent of all births worldwide. Of these, about 95 per cent happen in low- and middle-income countries. The average teenage birth rate in middle-income countries is two times higher than in high-income countries. In low-income countries, this rate is five times as high (WHO 2017). The proportion of births that takes place during adolescence is about two per cent in China, 18 per cent in Latin America and the Caribbean and more than 50 per cent in sub-Saharan Africa. According to the Centers for Disease Control and Prevention (2016), a total of 249 078 babies were born to women aged 15 to 19 years in 2014, for a birth rate of 24.2 per 1 000 women in this age group. Still, the rate of teenage pregnancy and childbirth is considered high in the United States as well as in the United Kingdom (Centers for Disease Control and Prevention 2016; McLaren 2016).

The percentage of women who become pregnant before the age of 15 differs enormously within regions in sub-Saharan Africa. The rate in Rwanda is 0.3 per cent versus 12.2 per cent in Mozambique (WHO 2017). Likewise, in Nigeria, an estimated

23 per cent of women between the ages of 15 to 19 are teenage mothers. Similarly, 32 per cent of teenagers in rural areas of Nigeria have begun childbearing, as opposed to 10 per cent in the urban areas (Demographic and Health Survey 2014). It is argued that teenage pregnancy is not a challenge of only one government department but requires the active participation of all stakeholders (National Conference of State Legislatures 2009, 5; Oyedele, Wright, and Maja 2015, 34; Panday et al. 2009, 3).

PURPOSE AND OBJECTIVES OF THE STUDY

Although some research has been done to investigate teenage pregnancy in Nigeria (Ajala 2014; Amoran 2012, 37; Demographic and Health Survey 2014; Edukugbo 2015; Ekefre, Ekanem, and Esien 2014) there is still limited information on community involvement in the prevention of unplanned teenage pregnancy. The NC states had the highest rate while the South South (SS) states had the lowest rate of teenage pregnancy.

For the study reported on in this paper, two communities in Nigeria were selected based on the previous findings by Edukugbo (2015). The study aimed to understand the perceptions and experiences of parents and community leaders regarding teenage pregnancy using the Community-as-Partner Model (Anderson and McFarlane 2008). The objectives of the study were

- to explore the participants' understanding of teenage sexuality and contraception,
- to ascertain the current teenage pregnancy prevention programmes and initiatives that are in place within the two selected communities, and
- to compare the participants' understanding of factors relating to teenage pregnancy from two socio-economical and geographically diverse communities in Nigeria.

It is envisaged that the findings of the study will provide a deeper understanding of teenage pregnancy in Nigerian communities as part of the global community.

THEORETICAL FOUNDATION

The Community-as-Partner Model (Anderson and McFarlane 2008) served as the theoretical foundation for the study. The model focuses mainly on health promotion of individuals and families within the context of the community. Community partners (individuals, groups and the community at large) are seen as open systems in continuous interaction with the environment (Anderson and McFarlane 2008). The model portrays the community in terms of the community core, the community subsystems and the community perceptions (Anderson and McFarlane 2008; Oyedele, Wright, and Maja 2014, 81).

The individual in a defined community represents a "person" while the community is the network of "persons" in relation to their environment. Health is perceived as the resources necessary for day-to-day life whereas nursing is perceived as preventive

measures. The "world" is a global community of people with diverse cultures and beliefs.

PROBLEM STATEMENT

Teenage pregnancy is a global social and health phenomenon. Healthcare providers and other stakeholders serving in various communities need to be socio-culturally focused to understand the occurrence of teenage pregnancies and to contribute towards the reduction of teenage pregnancies. Reduction necessitates building common ground among teenagers, parents, religious and community leaders and also other stakeholders in the community. Such a common ground might be derived from information and knowledge on different stakeholders' perceptions of different variables involved in the occurrence of teenage pregnancy. Such comparable information was not available in Nigeria at the onset of this study.

RESEARCH METHODOLOGY

Study Design and Setting

This was a qualitative explorative and contextual study aimed at studying the community perceptions of teenage pregnancy in two areas in Nigeria.

Study Population, Sampling Technique and Sample Size

The target population for this study comprised parents and community leaders, living in the two selected communities. Inclusion criteria included a parent with a male or female teenage child between 13 to 19 years of age or a religious or a community leader residing in the study area. Prospective participants had to be willing to participate in the study.

Eighty participants who were parents and community leaders responded to the semi-structured interview and completed a questionnaire on their demographic profile. This purposive sample size was determined by saturation of data which was achieved when 71 participants had been interviewed. Each sample group was saturated independently. A total of 71 interviews were analysed with new categories and nine interviews analysed without new categories evolving. Referential adequacy was attained, partially fulfilling the requirement of trustworthiness.

Data were collected from October to December 2016. The first author conducted and audiotaped the semi-structured interviews with parents and religious and community leaders in each of the selected communities. An interview schedule was developed to serve as a guide for the interviewer. In addition, pretest interviews were conducted before the actual data collection with four interviewees (from each community) using

participants who had similar characteristics to the study population but who were not included in the final data. The interviews were audiotaped with the participants' permission. Field notes were also taken.

Data Analysis and Trustworthiness

The interviews were transcribed verbatim. For the data analysis, a combination of three qualitative data analysis approaches were used, namely, the template analysis style, which is content analysis using open coding, followed by a template analysis, and the quasi-statistics analysis style (Creswell 2009, 192; Polit and Beck 2008, 508). Descriptive statistics were used for the presentation of all data. Approaches such as interpersonal relationship and trust-building peer examination, member checking, the authority of the researcher, dense description, consensus with independent coder and a dependability audit were employed to guarantee trustworthiness (Lincoln and Guba 1985).

Ethical Consideration

Before the start of the study, the research proposal was submitted to the Local Government Health Authority and permission to conduct the research was obtained. An official letter was also written to the Community Heads to carry out the research, and verbal permission was given. Before each interview, the participant's rights were explained and inform consent was obtained, and also permission to use an audio recorder. The interviews were conducted in a private room with only the participant and the researcher present to guarantee privacy.

FINDINGS OF THE STUDY

Demographic Profile

All eighty participants' (N = 80) verbatim interviews were subjected to template analysis after initial data saturation was attained after 71 interviews and the template constructed according to the categories and sub-categories that emerged from the data. As shown in Table 1, the participants were grouped into three age groups. Most of the participants (f = 35; N = 80; 43.75%) were in the age group 41 to 50 years.

Table 1: Demographic profile of combined sample (N = 80)

Profile	***F***	**%**
Socio-cultural groups		
Yoruba	40	50.0
Ibo	5	6.3
Esan	10	12.5
Benin	16	20.0
Auchi	8	10.0
Others	1	1.2
Age group (years)		
31–40	19	23.7
41–50	35	43.8
Above 50	26	32.5
Gender		
Male	48	60.0
Female	32	40.0

Table 2 exhibits the gender distribution of the participants. Of these 54 (67.50%; N = 80) were male and 26 (32.5%; N = 80) were female. Equal numbers of respondents (40) were selected from each of the two geopolitical areas. In both areas, the male respondents outnumbered the female respondents.

Table 2: Distribution according to gender, target group and geopolitical area

	Parents		**Community leaders**		**Total**
	Male	**Female**	**Male**	**Female**	
NC*	16	4	18	2	40
SS**	6	14	14	6	40
Total	22	18	32	8	80

**North Central State (NC)*

*** South South State (SS)*

Findings

The qualitative findings of the study are presented according to the themes and various categories generated from the data (Table 3). Each theme is described with a summary of the categories it represents. This served as a template according to which accounts (interview data) from participants were calculated after the initial data analysis and the point of data saturation.

Table 3: Main themes and categories generated from the data

Main theme	Category
Values and beliefs	Knowledge of teenage pregnancy prevention programmes Meaning and acceptance of dating Cultural beliefs about dating Cultural beliefs about teenage sexual experimentation Occurrence of teenage pregnancy Family support for pregnant teenagers Contributing factors in teenage pregnancy occurrences Recognition of role in the prevention of teenage pregnancy Teenage pregnancy prevention strategies
Health and social services	Definition and knowledge of contraceptives Types of contraceptives Acceptance of contraceptive use among teenagers
Communication	Importance and existence of parent-child communication in the family Parent involvement in teenage sex education Teenagers' peer-pressure resistance
Perceptions	Expected age and cultural beliefs regarding teenage sexual experimentation Perceptions of problems and benefits associated with teenage pregnancy

Values and Beliefs

Knowledge of Community Teenage Pregnancy Prevention Programmes

Of the 80 interviews conducted, only 22 (27.5%; N = 80) contained a comment or an account relating to the programme on the prevention of teenage pregnancies. This means that 72.5% (f = 58; N = 80) of the participants were not aware of any intervention programme or initiative at community level focusing on the prevention of unplanned teenage pregnancies. The analysis indicated that in the NC area, only eight (20%; n = 40) of the interviews contained an indication relating to strategies to prevent teenage pregnancies. Of these three parents mentioned teenage sex education in school. Of the five religious and community leaders, one cited church-based teenage

programmes, one cited teenage sex education in school, one cited teenage programmes organised by the Drug Abuse Agency, and two participants mentioned a school health visit by the Ministry of Health. Similarly, 14 (35%; n = 40) of the participants from the SS region mentioned various intervention programmes. Teenage sex education in schools was mentioned by two parents and two community members. Church-based teenage programmes were cited by six participants (two parents and four community leaders), while a radio programme on teenage sexual health organised by the Society for Family Health was mentioned by two parents and two community leaders. The absence of citations on strategies to curb teenage pregnancies is alarming.

Meaning, Acceptance and Cultural Beliefs about Dating

Dating was viewed by all 80 participants as an intimate relationship between two persons, ideally of opposite sex, coming together to get to know each other better with the sole aim of getting married. However, it is not supposed to involve sexual intercourse.

During the interviews, 72.3% (f = 58; N = 80) of the participants expressed that dating is acceptable. Of these, 23 (39.7%; n = 58) participants indicated that dating is only for those 20 years of age and older, and 35 (60.3%; n = 58) participants was of the opinion that dating should only be practised after the age of 25 years. Of the respondents, 25 (43%; n = 58) were from the NC (15 parents and 10 community leaders) while 33 (57%; n = 58) were from the SS (18 parents and 15 community leaders). Of the respondents, 22 (27.5%; N = 80) were pertinently not in support of dating.

Of the participants, 44 (55%; N = 80) stated that their culture sees dating as a necessary stage in youth development as it allows couples to get to know each other well ahead of the fulfilment of their marriage rites. Half of the participants (f = 20; n = 40; 50%) were from the NC (10 from each sample group) and 24 (n = 40; 605) from the SS of which 11 were parents and 13 community leaders. The following are examples (from a community leader and a parent from the NC) of expressions relating to dating:

> As a pastor, I don't accept dating because of the temptation. If there is no intention to be husband and wife, there is tendency it will lead to sin.

> In our culture, it is the foundation for marriage, and if it is done with like two to three years they will know themselves very well and avoid separation.

Cultural Beliefs about Teenage Sexual Experimentation

Participants' opinions were taken as regards the age at which teenagers are expected to get involved in sexual relationships. Less than a quarter (f = 18; N = 80; 22.5%) of the participants stated that teenagers can begin to initiate sexual relationships from the ages of 20 years and older. However, the majority (62 of 80) are of the opinion that teenagers are only allowed to engage in a sexual relationship once they are married (16 parents

and 17 community leaders from the NC, 13 parents and 16 community leaders from the SS).

With respect to cultural beliefs regarding sexual experimentation among teenagers, all the participants unanimously opined that their cultures forbade teenagers from having a sexual relationship.

Occurrence, Acceptance and Family Support

The interviewed participants were asked about the frequency of teenage pregnancies in their communities. Of the participants, 44 (55%; N = 80) stated that teenage pregnancy is not frequent in their communities. Conversely, 20 (50%; n = 40) of the participants from the NC (13 parents and seven community leaders) and 16 (40%; n = 40) from the SS (7 parents and nine community leaders) indicated that teenage pregnancies are frequent, even rampant, in their communities.

Regarding the acceptability of teenage pregnancy, 79 (99%; N = 80) of the participants indicated that pregnancies among teenagers are not at all acceptable. Only one community leader from the SS stated that it was conditionally acceptable if both individuals agreed to it and planned on getting married.

Of the participants, 63 (78.8%; N = 80) indicated that neither families nor parents support or accept teenage pregnancies in their communities, as it is seen as a "very bad occurrence". However, the remaining 17 (21.26%; N = 80) participants, of which five were parents and four were community leaders from the NC, and eight parents from the SS, mentioned that despite not showing support for the teenage girls from the onset, families eventually render support and accept the situation. All 20 community leaders from the SS geopolitical area stated that mostly no family support is given to pregnant teenagers. The following are examples of citations from a community leader from the NC and a community leader from the SS, relating to the occurrence, acceptability and frequency of teenage pregnancies in communities:

> As a person, teenage pregnancy repulses me. Societally, it is an aberration and abuse to the female. It deprives a child of her future and should not be encouraged for any reason but from a Christian perspective, since abortion is a sin; then the family have no choice but to support the child.

> No, family don't support the girl at the beginning but at the end of the day they end up accepting it because there is nothing they can do about, it is not because they like it but what will they do since such has happened.

Perceived Contributing Causes of Teenage Pregnancy

Perceived risk factors that might contribute towards teenage pregnancies were classified as personal, psychosocial, family, economic, media and societal as indicated in Table 4.

Table 4: Accounts of perceived risk factors contributing to teenage pregnancies (N = 80)

Categories	Sub-categories	A	B	C	D	Total accounts	% of possible accounts
Personal factors	Ignorance and lack of sex information	17	14	16	14	61	76.25
	Covetousness	11	4	10	6	31	38.75
	Indiscipline	14	15	11	11	51	67.75
Psychosocial factors	Loneliness	6	5	10	6	27	33.75
	Low self-esteem	6	6	5	10	27	33.75
	Peer acceptance	12	10	12	11	45	56.25
Societal and media pressures	Peer pressure	10	14	11	10	45	56.25
	Illiteracy	6	5	7	11	29	36.25
	Rape and incest	2	4	5	1	12	15.00
	Media influence	4	10	12	7	33	41.25
	Social network	11	13	14	10	48	60.00
Family reasons	Divorce and separation	11	12	14	12	49	61.25
	Lack of love or parental guidance	10	12	11	13	46	57.5
	Living with grandparents or relatives	10	13	11	10	44	55.00
	Lack of role model/ religious upbringing	3	10	12	12	37	46.25
	Polygamy	6	2	7	2	17	21.25
Economic reasons	Poverty	12	14	15	18	59	73.75
	Street hawking	11	12	10	10	43	53.75

A: Parents (NC), B: Parents (SS), C: Community leaders (NC), D: Community leaders (SS)

This table reflects the responses for each subcategory out of a possible 80 accounts. Notable findings are that more participants from the NC viewed polygamy as a perceived cause of teenage pregnancy. The mentioning of street hawking is a topic not found in the literature and is thus "unique" to the findings.

Teenage Pregnancy Prevention Strategies and Role Recognition

Regarding role recognition in the prevention of teenage pregnancy within the communities, participants indicated that they recognised that they have roles to play as parents, and as religious and community leaders. These roles are fulfilled through their involvement in sex education, preventive health strategies, youth programmes and personal and family strategies cautioning youngsters especially during the adolescent age.

On teenage pregnancy prevention strategies, participants' responses were grouped into sex education, preventive healthcare, youth programmes and community engagement, personal and family life strategies (Table 5).

Prevention Strategy: Sex Education Strategies

Sex education strategies were mentioned by a high percentage of the participants, mostly in the seventies. The lowest percentage (60%) referred to governmental sex education campaigns and the highest percentage (77.5%) referred to abstinence programmes and sex education at home. Sex education at school and the church covered the middle ground.

The following is a citation from a community leader from the SS relating to sex education in a broader context:

> I am a product of the society, so I am indebted to the young ones to educate them on the dangers inherent in teenage pregnancy. There should be proper awareness through the media against teenage pregnancy and the churches should stand against it, warning them against the evil and danger of teenage pregnancy.

Prevention Strategy: Preventive Healthcare Strategies

The count of citations relating to preventive health strategies is alarming. Only 13.75 per cent of the participants mentioned the use of contraceptives as a strategy to curb teenage pregnancies. The lowest counts are from community leaders of a count of nil for the NC and only two for the SS geopolitical area. The low score might be interpreted in terms of religion (Islam and Christian) as far as community leaders are concerned. The same might be said about parents and also their guard against possible promiscuity.

Further analysis showed that 48 of 80 of the male participants had inadequate knowledge of contraceptives. Various methods of contraceptive methods mentioned include condoms, contraceptives pills and injections, coil and implant, the intra-uterine device, and calendar and permanent methods. The following is an example of a participant's (a community leader from the NC) opposition to teenagers using contraceptives:

Table 5: Citations relating to teenage pregnancy preventive strategies

Categories	Sub-categories	A	B	C	D	Total accounts	% of possible accounts
Sex education strategies	Sex education campaigns by government	12	10	10	11	43	60.00
	Early sex education at home	14	15	16	17	62	77.5
	Sex education in school	15	16	14	15	60	75.00
	Sex education programme in church	10	12	18	17	57	71.25
	Abstinence from sex	15	12	17	18	62	77.5
Preventive healthcare strategies	Use of contraceptives	4	5	0	2	11	13.75
	School health visit	10	4	0	0	14	17.50
Youth programmes and community engagement strategies	Participation in social clubs like debate clubs	0	0	0	5	5	6.25
	Provision of skills training centres for teenagers	6	5	8	11	30	37.50
	Provision of quality education by Government	8	4	10	12	34	42.50
	Good role models in the community	6	5	10	9	30	37.50
Personal and family life strategies	Adequate provision at home	16	10	14	14	54	67.50
	Home discipline/religious upbringing in homes	14	16	15	12	57	71.25
	Involvement in church activities from young age	11	10	16	17	54	67.50
	Focus on education	13	12	12	14	51	63.75
	Good parent-child communication	12	14	14	16	56	70.00
	Self-determination and discipline	10	14	8	6	38	47.50
	Control over social media/ network	5	7	12	11	35	43.75
	Praying for teenagers	0	0	8	11	19	23.75

A: Parents (NC), B: Parents (SS), C: Community leaders (NC), D: Community leaders (SS)

> Never, teenagers should not have sex, not to talk of using contraceptives, if you accept that, you are encouraging them to be wayward, there are some parents whose daughter got pregnant, and they abort the pregnancy for her, now, the particular girl is now having a problem. The girl will be turned into a public dog.

Regarding contraceptive acceptance, the participants responded to the enquiry that sought to find out if they accepted the use of contraceptives as a means to prevent unwanted pregnancies and sexually transmitted diseases (STDs) among teenagers. Responses observed were categorical; 61 of 80 (35 parents and 26 community leaders) expressed that they do not accept nor encourage the use of contraceptives among teenagers, while less than a quarter (19 of 80) expressed that they encourage teenagers to use contraceptives.

Likewise, the mentioning of school health visits came from only 17.50 per cent of the participants and these were all parents. This might imply parents' association of schools with learning more than with health.

Prevention Strategy: Youth Programmes and Community Engagement Strategies

Of the participants, 52 (65%; N = 80) stated that parent-child communication should be such that the parents communicate to their children life lessons on a day-to-day basis. The remaining 28 (35%; N = 80) participants stated that it is a relationship that existed between the parent and the child such that both parties get to know and trust each other so that matters of a sexual nature could be discussed openly. All the participants agreed that the parent-child relationship or involvement should be taken seriously to ensure parents' alertness to any problems teenagers might experience.

Participants were asked to attest to whether there is parent-child communication in their homes. More than two-thirds, 69 (86.25%; N = 80), of the respondents (35 parents and 34 community leaders) expressed a cordial parent-child relationship in their homes. Four participants from the SS (two parents and two community leaders) stated that it did exist in their homes but not on a regular basis. Only seven (three parents and two community leaders from the NC, two community leaders from the SS) participants admitted that it did not exist in their homes at the time of data gathering.

With regard to parents educating their teenage children on sexuality matters at home, all the participants (N = 80) indicated that parents must provide sex education to their children from a young age. Notwithstanding, nine (11.25%; N = 80) of the participants, all males (six from the NC, four parents and two community leaders, and three community leaders from the SS), said that it could be difficult at times especially when one considers that culture does not permit it. The following are statements made by participants (a community leader from the NC and a community leader from the SS) in this regard:

> It is through parent-child communication that they relate to each other. Yes of course. As my children were growing up, I and my wife took it upon ourselves to teach our children in the way of the Lord and about sex so as for them to know what to do to avoid pregnancy. We also taught them things about the parts of their bodies.
>
> Not all the time, you see culture does not permit us to talk about sex with kids, but I am sometimes trying to talk to them.

Participants' were also asked their opinion as to how teenagers can resist peer pressure relating to sexual involvements and hence teenage pregnancy. Their views were categorised into personal responsibility and determination, family and community support. From the findings, a remarkable view from parents and community leaders from the NC was the idea that teenagers should report all cases of peer pressure to their parents. Also, community leaders from the two regions were of the opinion that if teenagers become born-again Christians they believe it will fortify them against all forms of peer pressure.

Perceptions of Problems and Benefits Associated with Teenage Pregnancy

Perceived consequences of teenage pregnancy and childbearing as expressed by the participants were grouped into health, economic and social implications (Table 6). A notable finding from the community leaders from both regions is the perceived consequences of a cycle of events – that teenage pregnancy can become a recurring event in a family.

Table 6: Accounts of perceived implications of teenage pregnancy and childbearing

Categories	Sub-categories	A	B	C	D	Total accounts	% of possible accounts
Health consequences	STIs/HIV/AIDS	10	11	10	8	39	48.75
	Abortion	10	10	5	6	31	38.75
	Difficult labour	0	5	6	0	11	13.75
	Psychological depression	8	7	7	5	27	33.75
	Untimely death	10	11	8	7	36	45.00
Economic consequences	Extra burden to parents	18	16	17	15	66	82.50
	Increase in crime rate	10	11	12	11	44	55.00
	Bleak future	13	12	13	14	52	65.00
	Overpopulation	12	11	11	13	47	58.75
	Poverty	20	18	18	16	72	90.00

Social consequences	Loss of family hope	11	12	10	8	41	51.25
	School dropout	14	14	12	11	51	63.75
	Single parenting	10	15	11	12	48	60.00
	Family shame/ embarrassment	14	13	10	7	44	55.00
	Cycle of event (recurring teenage pregnancies in the family)	0	0	6	10	16	20.00
	Subsequent pregnancy and childbirth	4	6	7	10	27	33.75
	Child abuse and abandonment	10	12	11	14	47	58.75

A: Parents (NC), B: Parents (SS), C: Community leaders (NC), D: Community leaders (SS)

Participants were asked about the potential benefits of teenage pregnancy and childbirth; all participants indicated that there is no benefit associated with teenage pregnancy.

DISCUSSION

The Demographic and Health Survey's (2014) report shows disparities of teenage pregnancy rates within the different geopolitical zones in Nigeria. A rate of 36 per cent was reported in the North West, 32 per cent in the North East, 19 per cent in the NC, 12 per cent in the SS, and eight per cent in the South East and the South West regions. Similarly, as revealed in this study, most of the participants from the NC area reported incidences of teenage pregnancy in their communities. However, contrary to the hypothesis of Oyedele, Wright, and Maja (2014, 85) that African culture places a high value on fertility and that this presumably influences early conception, the majority of respondents in this study considered teenage pregnancy culturally unacceptable.

Teenager's sexual behaviour can be influenced by numerous protective and risk factors. These include factors such as the individual, environment, peers, partners and culture. Communities can develop interventions that are effective if protective and risk factors are properly identified (Healthy Teen Network 2010, 3; Jackson County Michigan Report 2007, 11; Minnesota Department of Health Fact Sheet 2010, 1). As revealed in the study, participants mentioned various preventive strategies such as sex education at homes, schools and churches as well as within the community through campaigns, school health visits, good role models and proper home training, provision of a skills training centre, quality education and involvement of teenagers in church activities.

Over the years, several studies have indicated insufficient knowledge regarding reproduction, sexuality, contraceptives and inadequate family planning facilities as

some of the reasons why teenagers do not use contraceptives thus, increasing their risk of getting pregnant (Mbokane and Ehlers 2007, 43). Macleod and Tracey (2009, 9) mentioned that teenagers might not usually have access to the precise sexuality information because there is the probability of citing friends as their most common source of sexuality information. As shown in this study, although all the participants have prior knowledge of contraceptives, more than two-thirds (61 of 80) were totally against the idea of teenagers having access to contraceptives.

Although it is easy for parents to believe that they have lost their influence over their children as they reach the teenage years, the reality remains that parents do matter; parents are seen as the best source of sex education. Teenagers need support, guidance and care from parents as much as younger children (Teenage Pregnancy Unit 2005, 5). Equally, all the participants in this study expressed the importance of quality parent-child communication in the prevention of teenage pregnancy.

According to the WHO (2017), although adolescents aged 10 to 19 years account for 11 per cent of all births worldwide, they also account for 23 per cent of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth. Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. Similarly, participants in this study expressed various consequences of teenage pregnancy to the teenage girl, her family and the community.

CONCLUSION AND RECOMMENDATIONS

As reported in the study, religious belief is an important predictor of teenage pregnancy and childbirths, as it forms a conscious and fundamental part of a teenager's relationship with people. This study acknowledges the role of religion in teenage pregnancy. Teenage pregnancy intervention programmes and strategies must be sensitive to various peculiarities of different ethnic groups as well as religious beliefs. Hence, the involvement of religious and community leaders as forerunners of teenage pregnancy community intervention programmes and initiatives will be an effective method to curtail the high incidence of teenage pregnancy and childbirths.

Likewise, as reported in the study, economic deprivation is a significant risk factor in the occurrence of teenage pregnancy. Thus, it is paramount to ensure that strategies and programmes ameliorating poverty are more effective and could prove effective in reducing the incidence of teenage pregnancy and childbirth in Nigeria.

The problem of teenage pregnancy must be solved within the context of the individual, family, and the community. Community partnership and collaboration of resources are required to reduce the high rate of teenage pregnancy in the community. With regard to changing the healthcare environment, faith communities are increasingly forming partnerships with nursing and health services for the purpose of health promotion. Schools need to be included in this collaboration in Nigeria as holistic nursing care recognises the dynamic relationship between spirituality and health of mind and body

throughout the life span. Therefore, culture, religious belief and social differences must be specially considered in the planning of community intervention programmes and strategies in teenage pregnancy prevention.

LIMITATION

The limitation of the study is the purposive sampling of parents and community leaders living in the two selected communities in Kwara and Edo States in Nigeria, hence the results are not generalisable to a larger context.

ACKNOWLEDGEMENTS

The authors wish to thank all who granted permission for this study to be conducted, and every participant who agreed to be interviewed.

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