

**Exploring Experiences of Pregnant Adolescents and Their  
Utilization of Reproductive Health Services in Ho West District,  
Ghana: A Salutogenic Approach**

**Comfort Worna Lotse**



**Thesis Submitted in Partial Fulfillment of the Requirement for the degree  
Master of Philosophy in Health Promotion, University Of Bergen**

**Spring, 2016**

**Department of Health Promotion and Development,  
Faculty of Psychology**

## Table of Content

### Contents

<b>Table of Content</b> .....	i
<b>LIST OF TABLES</b> .....	iv
<b>LIST OF FIGURES</b> .....	v
<b>DEDICATION</b> .....	vii
<b>ABSTRACT</b> .....	viii
<b>LIST OF ACRONYMS</b> .....	ix
<b>CHAPTER ONE</b> .....	1
<b>INTRODUCTION</b> .....	1
<b>1.1 Background</b> .....	1
<b>1.2 Problem Statement</b> .....	3
<b>1.3 Purpose of the Study</b> .....	3
<b>1.4 Overall Objective</b> .....	4
<b>1.5 Research Questions</b> .....	4
<b>1.6 Structure of the Thesis</b> .....	4
<b>CHAPTER TWO</b> .....	6
<b>LITERATURE REVIEW AND THEORETICAL FRAMEWORK</b> .....	6
<b>2.0 Introduction</b> .....	6
<b>2.1.1 Economic constraint</b> .....	6
<b>2.1.2 Family structure</b> .....	7
<b>2.1.3 Poor academic achievement and lack of education</b> .....	7
<b>2.1.4 Peer influence and lack of sexual and reproductive health information</b> .....	8
<b>2.1.5 Irregular antenatal and post-natal visits</b> .....	8
<b>2.1.6 Teachers</b> .....	9
<b>2.1.7 School policies</b> .....	9
<b>2.1.9 Pregnancy as a stressor</b> .....	10
<b>2.1.10 Barriers to the Utilization of Adolescent Reproductive Health Services</b> .....	10
<b>2.2.1 Social and economic support</b> .....	11
<b>2.2.2 Non-governmental organizations</b> .....	12
<b>2.3 Theoretical Framework: Salutogenesis</b> .....	12
<b>CHAPTER THREE</b> .....	15
<b>METHODOLOGY</b> .....	15

<b>3.1 Research Design</b> .....	15
<b>3.2 Study Area</b> .....	15
<b>3.3 Sampling Techniques</b> .....	16
<b>3.4 Sample Size</b> .....	17
<b>3.5 Data Collection Instruments</b> .....	19
<b>3.6 Data Collection Procedure</b> .....	19
<b>3.7 Data Management</b> .....	20
<b>3.8 Data Analysis</b> .....	20
<b>3.10 Trustworthiness</b> .....	21
<b>3.10.1 Reliability</b> .....	21
<b>3.10.2 Validity</b> .....	22
<b>3.10.3 Generalizability</b> .....	22
<b>3.10.4 Role of the Researcher</b> .....	22
<b>3.11 Ethical Consideration</b> .....	23
<b>3.11.1 Ethical clearance</b> .....	23
<b>CHAPTER FOUR</b> .....	25
<b>FINDINGS</b> .....	25
<b>4.0 Introduction</b> .....	25
<b>4.1 Stressors</b> .....	25
<b>4.1.1 Severe economic/ financial constraints</b> .....	25
<b>4.1.2 Educational constraints</b> .....	28
<b>4.1.3 Psychological, social and emotional stresses</b> .....	31
<b>4.1.4 Cultural and Religious constraints</b> .....	39
<b>4.1.5 Misinformation about and stigmatization of ARHS</b> .....	41
<b>4.2 Resources</b> .....	45
<b>4.2.1 Parents, educated family, benevolent persons and churches</b> .....	45
<b>4.2.2 Personal strength and courage (Hardiness)</b> .....	47
<b>4.2.3 Availability of reproductive health services (RHS)</b> .....	48
<b>4.2.4 The community midwife</b> .....	49
<b>4.2.5 Female teachers in the community schools</b> .....	50
<b>4.2.6 The National Health Insurance Scheme</b> .....	51
<b>4.2.7 Traditional Birth Attendants (TBAs)</b> .....	52
<b>4.2.8 Non-governmental organizations (NGOs)</b> .....	54
<b>CHAPTER FIVE</b> .....	56

<b>DISCUSSION</b> .....	56
<b>5.0 Introduction</b> .....	56
<b>5.1 Stress experiences for PAs and AMs and its implications</b> .....	56
<b>5.1.1. Abandonment and consequent financial constraints</b> .....	56
<b>6.1.2 Rejection, shame and consequent psychological and emotional problems</b> .....	58
<b>5.1.3 Educational constraints</b> .....	59
<b>5.1.4 Cultural and Religious constraints</b> .....	60
<b>5.2. Resource experience and utilization and their implication for the PAs and AMs</b> .....	61
<b>5.2.1 Personal strength</b> .....	61
<b>5.2.2 The community midwife and access to ARH services</b> .....	62
<b>5.2.3 Educated family members</b> .....	63
<b>5.2.4 Traditional Birth Attendants</b> .....	63
<b>5.3 Discussion of findings in relation to Salutogenesis</b> .....	64
<b>5.3.1 Life situation</b> .....	66
<b>5.3.2 Stressors (Please refer to subsection 5.1 under discussion)</b> .....	66
<b>5.3.3 Generalized Resistance resources (please refer to subsection 5.2 under discussion)</b> ...	66
<b>5.3.4 Life experiences and sense of coherence (SOC)</b> .....	66
<b>5.3.5 Movement towards Health</b> .....	68
<b>5.3.7 Recommendations for further Research</b> .....	69
<b>5.3.8 Summary and Conclusion</b> .....	69
<b>References</b> .....	71
<b>APPENDICES</b> .....	77
<b>Appendix 1: Explanation of the study for participants</b> .....	77
<b>Appendix 2: Informed consent form</b> .....	79
<b>Appendix 3: Explanation of the study for key informants</b> .....	80
<b>Appendix 4: Informed consent form for key informants</b> .....	82
<b>Appendix 5: Interview guide</b> .....	83
<b>Appendix 6: NSD Ethical Clearance</b> .....	88
<b>Appendix 7 GHS Ethical Clearance</b> .....	91
<b>Appendix 8: VRHD Permission</b> .....	92

**LIST OF TABLES**

<b>Table 3. 1: Gestational age of pregnant adolescents.....</b>	<b>18</b>
<b>Table 3.2: Adolescent mothers with babies below the age of 6 months .....</b>	<b>18</b>
<b>Table 3.3 Key informants .....</b>	<b>18</b>

## LIST OF FIGURES

<b>Figure 2. 1: The salutogenic model (adaptation of Mittelmark, 2010) .....</b>	<b>14</b>
<b>Figure 3.1 District map of Ho West showing the various traditional areas .....</b>	<b>16</b>
<b>Figure 3. 2: Thematic Network analysis of Data .....</b>	<b>21</b>
<b>Figure 5.1: Salutogenesis Model of Pregnant adolescents and Adolescent mothers .....</b>	<b>65</b>

## ACKNOWLEDGMENT

*“Through it all, I have learnt to trust in Jesus!”*

I thank God almighty who has been my strength and help through it all. This study has been accomplished through enormous contributions from different people who deserve to be appreciation.

My profound gratitude goes to my supervisor, associate professor Marguerite Daniel, without whom I could not have come this far. Marguerite demonstrated undaunted love and care by encouraging, supporting, advising and offering essential comments on my work. Her lectures and heart to heart talks right from the proposal writing to date offered me a lot of hope to carry on.

Associate professor Gaby Ortiz Barreda, my co-supervisor, is awesome! I felt stressed and pushed to the wall at a point but her encouraging words and constant reminders kept me going till date.

Dr Gameli Kwame Norgbe, the dean of School of Allied Health Sciences, UHAS, my co-supervisor in Ghana has been very resourceful. Although in Ghana, Gameli has often called to encourage and check every stage of my work. Gameli’s comments and supports throughout my thesis writing process were immeasurably helpful.

And to all my participants I say Kudos. You ladies have been great! Madam Agnes Tsakpa, you were my gatekeeper. Thank you for all the sacrifices you made just for me to be able to work with these wonderful girls. Miss Augustina Emefa Amoako my right hand woman. Your enormous assistance on the field was super! Thank you so much.

To all my colleagues, especially Mr Ernest Darkwah and Pascal Agbadi, “Ayekoo” not forgetting Dr. Austin Ablo, Mr Edward Essumang and Ms Eunice Kokoi Morkli-Hammond.

My support for this master programme was from the Norwegian State Educational Loan Fund (Lånkassen). I am very grateful for the generous quota scheme, an offer that made it possible for me to be equipped in order to contribute my development quota to my country, Ghana.

To my super mum, my 3 lovely children and not forgetting Mr. Noble Kwasi Alai my wonderful brother in-law; they have been my source of hope and inspiration.

My gratitude goes to all and sundry who contributed in diverse ways to make this work successful.

**DEDICATION**

I dedicate this thesis to my lovely children: Carl Louis Senyo Kojo Lotse, Vanessa Efakor Akosua Amedi, and Alexandria Edinam Yawa Amedi.



## ABSTRACT

Adolescent pregnancy (AP) is a significant public health problem across Africa. In the Volta Region of Ghana, 32% of adolescents were exposed to unintended pregnancies in 2011 due to lack of knowledge and use of available methods of contraceptives. In addition to the health consequences, adolescent pregnancy also contributes to the perpetuation of poverty cycle among populations. Although several studies have investigated problems associated with adolescent pregnancy, its risk factors and prevention, few have examined the experiences that pregnant adolescents and adolescent mothers go through in their communities. From a salutogenic theoretical perspective, this study explored adolescent lived experiences with a focus on stressors and resources inherent. Issues surrounding their utilization of reproductive health services were also explored.

**Objectives:** The objectives of the study were to identify, through exploration, stress and resource experiences of pregnant adolescents and adolescent mothers.

**Methods:** Qualitative methodology with phenomenological design was used and the salutogenic model formed the theoretical framework. Data collection techniques included in-depth interviews and focus group discussions. Interviews were conducted with 6 key informants (two Queen Mothers, two Health personnel, two teachers, and an NGO official) and 11 adolescent girls (6 pregnant and 5 mothers). Data were transcribed, coded and analysed using Attride- Stirling's thematic network analysis.

**Findings:** Five stressors emerged: a) severe economic/financial constraints before/after pregnancy, b) educational/schooling difficulties, c) Psychological, social and emotional stresses d) Cultural and Religious constraint e) Misinformation about and stigmatization of ARHS. Resources that emerged included a) support from parents, educated family, benevolent persons, female teachers, and churches b) Personal strength and courage (Hardiness) c) Availability of reproductive health services (RHS) d) The community midwife e) Traditional Birth Attendants (TBAs) f) Existence of government policies (NHIS, GES directives, NGOs).

**Conclusions:** Pregnant adolescents and adolescent mothers experience multiple stressful life events with few resources to deal with such stressors. These stressors limit their access to and utilization of adolescent reproductive health services. Stakeholder action to provide more support to adolescents and education for their families and communities are recommended. However, the pregnant adolescents and adolescent mothers in the Ho west district in the Volta Region of Ghana are able to thrive amidst all these stressors due to the strong sense of coherence—hardiness—on the part of the girls and the availability of a community midwife.

## LIST OF ACRONYMS

AM	Adolescent Mother
ANC	Ante Natal Care
ARHS	Adolescent Reproductive Health Service
CAC	Comprehensive Abortion Care
CHPS	Community Based Health Planning Services
FP	Family Planning
GHS-ERC	Ghana Health Service Ethical Review Committee
GRR'S	General Resistance Resources
GSS	Ghana Statistical Services
HIV/AIDS Syndrome	Human Immunodeficiency Virus /Acquired Immune Deficiency
HWDHD	Ho West District Health Directorate
NGO'S	Non-Governmental Organizations
NSD	Norwegian Social Science Data
PA	Pregnant Adolescent
PNC	Post Natal Care
SOC	Sense of Coherence
SRS	Specific Resistance Resource
TBAs	Traditional Birth Attendants
UNICEF	United Nations Children Education Fund
VRHD	Volta Regional Health Directorate
W.H.O	World Health Organization

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background

Although a global phenomenon, unplanned pregnancy among adolescent girls is more prevalent in developing countries. A focus on adolescent health is central to the success of many public health and health promotion programs. Every child has an inherent right to life (UNICEF, 1989). However, the rate at which adolescent girls are dying from pregnancy related complications is frightening (Lloyd, 2005). An adolescent according to World Health Organization is a person between the ages of 10 to 19 years (WHO, 1993). At the beginning of the 21<sup>st</sup> century, it is estimated that “about 16 million girls aged 15 to 19 years and some 1 million girls under 15 years give birth every year—mostly in low and middle income countries” (Lloyd, 2005). Unsafe abortion (Ujah *et al.*, 2005), obstructed labour (WHO, 2011), hypertensive disorders (Bozkaya, Mocan, Usluca, Beşer, & Gümüştekin, 1996), HIV/AIDS (Christofides *et al.*, 2014), suicides and homicides (Krulwich, Roberts, & Thompson, 2003) are among the predominant causes of mortality among pregnant adolescents. According to WHO (2011), anaemia, malaria and fistula, as a result of obstructed labour, contribute significantly to morbidity among pregnant adolescent. A greater concern is the health of children born to these adolescents, many of whom suffer from low birth weight, preterm deliveries and death.

Globally, although there are reports indicating that some countries are close to achieving the millennium development goals (MDGs), the socio-economic burden and the health implications of adolescent pregnancy is an ‘Achilles heel’ in the complete realization of MDGs 1, 2, 3, 4, 5 and 6—eradication of poverty, achieving universal primary education, women empowerment and gender equality promotion, reduction in infant mortality, reduction in maternal mortality and reversals of spread of diseases: HIV-AIDS/Malaria (WHO, 2011). And now, the sustainable development goals (SDGs) 3, 4 and 5, ensures healthy lives and promote well-being for all at all ages, ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, and achieve gender equality and empower all women and girls, also has come to sustain the MDGs.

An empirical study by Were (2007) in Kenya revealed that girls’ level of education, access to sex education, age, contraceptive use, peer pressure, cultural taboos against sexual discussions

and poverty are the main determinants of adolescent pregnancy. Qualitative studies done in the Ga-East municipality of Ghana, opined that adolescents became pregnant as a result of transactional sex to meet basic needs, sexual violence and exploitation and community prestige seeking (Awusabo-Asare, Bankole, & Kumi-Kyereme, 2008; Gyesaw & Ankomah, 2013). Many adolescent reproductive health intervention programs by government and NGOs focused on addressing the problems that are associated with adolescent pregnancy. Other studies have looked at the risk factors (causes and the effect) associated with teenage pregnancy and its prevention (Addai, 2000; Klutsey & Ankomah, 2014). Some adolescents nonetheless are able to cope with pregnancy and early motherhood induced distresses.

In the last decade, a number of quantitative studies on adolescent reproductive health primarily explored risks associated with adolescents' pregnancy, motherhood and use of adolescent reproductive health services (Chaibva, Roos & Ehlers, 2009; Hokororo *et al.*, 2014; Remes *et al.*, 2010; Rondini & Krugu, 2009; Skinner *et al.*, 2009; Smith, Skinner & Fenwick, 2012; Wahn & Nissen, 2008). Qualitative studies done in Australia about adolescent reproductive health revealed that perception plays a critical role in how adolescents cope with the decisions of adolescent health (Skinner *et al.*, 2009; J. L. Smith, Skinner, & Fenwick, 2012). The adolescents who perceived adolescent pregnancy as a barrier to their personal career and social transition to adulthood have terminated their pregnancy. However, those who did not terminate their pregnancies but continued into teen motherhood perceive teen motherhood as a resource that fosters their personal growth (J. L. Smith *et al.*, 2012). Skinner *et al.* (2009) revealed that although adolescent mothers were aware of contraception usage, they however use it inconsistently. These adolescent girls, because of their knowledge of the risks involved in pregnancy, had a firm attitude towards pregnancy prevention (Skinner *et al.*, 2009). A study done in Sweden concluded that teenage mothers are often exposed to difficult family situation, experienced school failures, engage in health risk behaviours, had lower self-esteem and display more depressive symptoms than adult mothers (Wahn & Nissen, 2008).

Studies done in sub-Saharan Africa also mainly explored risk factors that are associated with adolescent pregnancy, motherhood and utilization of reproductive health services (Hokororo *et al.*, 2014; Remes *et al.*, 2010). In Tanzania for example, Remes *et al.* (2010) revealed that adolescents engage in risky sexual and reproductive health behaviours because of modernisation, socioeconomic conditions, social norms and the difficulties parents and other adults face in raising adolescents. Another quantitative study by Hokororo *et al.* (2014) showed that pregnant adolescents and teen mothers fail to access reproductive health services because of

stigma, long waiting times, and lack of privacy in the clinics. In Zimbabwe, C. N. Chaibva, Roos, and Ehlers (2009) argued that perceptions of the adolescents about antenatal care services and national policies were some of the risks that pregnant adolescents and teen mothers are exposed to in seeking reproductive health services. Studies in Ghana, also, mainly explored risks factors (Rondini & Krugu, 2009). Rondini and Krugu (2009) noted that because adolescents are not familiar with family planning methods and their little use of contraception, adolescent girls are at high risk of unintended pregnancies and sexually transmitted infections like HIV/AIDS.

## **1.2 Problem Statement**

The 2011 multiple cluster indicator survey report estimated that 20% of adolescents (15-19 years) in Ghana have begun child bearing (Ghana Statistical Service, 2011). The survey report further indicated that 32% of adolescents in the Volta region are exposed to early child bearing, which is the region with the highest record of adolescents' early child bearing among the ten regions in Ghana. This nationally representative survey revealed that adolescents were less likely to use any method of contraception with an indication that only 17% of adolescent mothers have used any method of contraception. Only about 20% of women between the ages of 15-49 years in the Volta region have used any method of contraception. Although there is no information on the regional variation on prevalence of adolescents who have used any method of contraception, it is likely that adolescents in the Volta region still recorded the lowest use of contraception.

With regard to receiving antenatal care services, only 2.3% of adolescent mothers have not received antenatal services in the Volta Region. Generally, 81% children born to women in Ghana have received postnatal care. However, Volta Region still lags behind other regions in this domain too with 72% of children receiving postnatal care. Also, 83% of adolescent mothers have utilized postnatal care services (Ghana Statistical Service, 2011). It is against this backdrop and considering the fact that many studies have a risk factor focused (Chaibva *et al.*, 2009; Hokororo *et al.*, 2014; Remes *et al.*, 2010; Rondini & Krugu, 2009; Skinner *et al.*, 2009; Smith *et al.*, 2012; Wahn & Nissen, 2008), this study therefore explored the stressors of pregnant adolescents and adolescent mothers as well as the resources they drew on during these periods (pregnancy and motherhood) and their utilization of adolescent reproductive health services.

## **1.3 Purpose of the Study**

Studies of adolescent reproductive health have focused on risk factors. In this study I provide a resource perspective on adolescent reproductive health with emphasis on stressors of pregnant

adolescents, the resources that enabled adolescents to thrive during and after pregnancy (antepartum and postpartum) and the resources they draw on when utilizing Adolescent Reproductive Health Services (ARHS) in Ho-West District, Ghana. Indeed health promotion research is directed towards positive health and wellbeing rather than risk factors only; therefore the study' focus on resources of adolescent reproductive health makes it health promoting. The adolescent girls can take advantage of these resources in the event of pregnancy and motherhood, to enable the adolescents to thrive, take control of their health and achieve total wellbeing which is the aim of health promotion. Aaron Antonovsky (1979) postulates how stressors are highly overpowering available resources to tap on. There is the urgent need to focus on means of enabling individuals to move towards health rather than disease (Antonovsky, 1996a) as health promotion defines. This approach will inform youth policy and program planning and development to adopt a holistic view to adolescent reproductive health. Findings from this study will help inform adolescent reproductive health policy planning and implementation in Ghana, and more specifically, the Ho West District where adolescent reproductive health issues have become a public health concern.

#### **1.4 Overall Objective**

To explore the experiences of pregnant adolescents and their utilization of reproductive health services in the Ho West District.

#### **1.5 Research Questions**

The following questions guided the study:

1. What are the stressors of pregnant adolescents in the Ho-West District?
2. What enables the pregnant adolescents to thrive in the Ho-West District?
3. What are the pregnant adolescents' resources in the utilization of ARHS in the Ho-West District?

#### **1.6 Structure of the Thesis**

The thesis is organised into 6 chapters. The introductory chapter above is followed by the review of literature on pregnant adolescents and mothers and how they access and utilized reproductive health services. The review also tried to identify gaps in literature. The concept of salutogenesis is also explained since it is the model forming the theoretical backbone of the study, bringing to bear its application in the lived experiences of the pregnant adolescents and mothers in chapter 2. Chapter 3 continued with the methods and data collection, analysis of data, trustworthiness of qualitative study and the ethical issues considered while collecting data.

Findings from the study is presented in chapter 4 and followed by discussions of findings that emerged from the data and reflection on limitation the study in Chapter 5. Recommendations, summary and the conclusion arrived at from the study findings are highlighted in chapter 6.

## **CHAPTER TWO**

### **LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

#### **2.0 Introduction**

The literature review is broadly organized under two themes: stressors and resources. The stressors identified in the literature are: economic constraints, family structure, poor academic performance, lack of sexual and reproductive health information, peer influence and sexual practice, irregular antenatal and postnatal care visits, school drop outs, teachers, school policies, and pregnancy. The resources identified in the literature are: social and economic support and non-governmental organizations.

#### **2.1. Stressors in the life of pregnant adolescents and mothers**

##### **2.1.1 Economic constraint**

Studies from both the developed nations and the Global South indicated that poverty is a predisposing factor of adolescent pregnancy and teenage motherhood (Amaran, 2012; Goonewardene & Waduge, 2009; Paranjothy, Broughton, Adappa, & Fone, 2009; Viner et al., 2012). In Aberdeen, Scotland, a secondary analysis using a UK obstetric database from 1950 to 2010 revealed that adolescent pregnancy and motherhood were associated with low socio-economic status (McCall, Bhattacharya, Okpo, & Macfarlane, 2015). Also, poverty makes the teen motherhood experiences unbearable. A qualitative study done amongst African American teenagers in Albany, Georgia, revealed that financial constraints is a stressor in the life of teen mothers (Akella & Jordan, 2015). Another qualitative study done among homeless teenage mothers and soon-to-be teen mothers who were living in a short-term shelter in Chicago revealed that lack of financial resources and financial support from the boys or men who were responsible for both the new-borns and the pregnancy was a great stressor in the lives of the teen mothers (Dworsky & Meehan, 2012). Similarly, a study done among teenage mothers in Bhambayi, Kwazulu-Natal, South Africa, also revealed that financial constraint stressed the daily motherhood experience of adolescent mothers (Raniga & Mathe, 2011). Adolescent mothers were characterized with low socio-economic status in a study sample in Malaysia (Omar et al., 2010). In investigating the effects of teenage pregnancy on the educational attainment of girls, (Gyan, 2013) found that poverty was a major determinant of teenage pregnancy in a suburb of Accra, Ghana. The afore-reviewed literature does not suggest that adolescents within wealthy homes do not become pregnant or mothers.



### **2.1.2 Family structure**

From a socio-ecological perspective, the family is the immediate environment for child growth and development (Bronfenbrenner, 1994). Therefore, the family unit is a major determinant of the occurrence of adolescent pregnancy and motherhood. A qualitative study conducted among pregnant adolescents in Uganda reveal that adolescent girls who felt neglected by their parents found themselves seeking for attention from men who finally impregnated them (Sekiwunga & Whyte, 2009). Drug abuse by family members have an association with teenage pregnancy in Estonia (Haldre, Rahu, Rahu, & Karro, 2009), a suggestive evidence that family environment plays a significant role in predicting adolescent pregnancy.

### **2.1.3 Poor academic achievement and lack of education**

Poor academic performance and teenage pregnancy are bi-directional; poor academic performance among teenage girls may lead them into early pregnancy or motherhood, and teenage pregnancy may prevent adolescent girls from creditably performing academically in schools (Bhana, Morrell, Shefer, & Ngabaza, 2010). Low academic performance was associated with teenage pregnancy among Latinas in the United States (Doğan-Ateş & Carrión-Basham, 2007). Teenagers in Estonia who dislike school were at risk of teenage pregnancy and early motherhood (Haldre et al., 2009).

Studies indicated that pregnancy among adolescents forces them to drop out of school. A qualitative study done among Hispanic teen mothers indicated that teen mothers have aspirations to attained higher education; however, because of their pregnancy and their babies, they often find it hard to return to school (Estrada, 2012). In the same study, teenage mothers indicated that due to their pregnancy they had to drop out of school (Estrada, 2012). A quantitative study revealed that low level of education was associated with teenage pregnancy among teenagers in Malaysia (Omar et al., 2010), which suggest that teenagers with low academic performance were more likely to become pregnant and eventually become teenage mothers. In the same study, teenagers who become pregnant in Malaysia were significantly more likely to drop out of school (Omar et al., 2010). Early pregnancy and childbearing in turkey were found to have limited the chances of educational attainments among pregnant adolescents (Edirne et al., 2010). A cross-sectional survey analysis by Ahorlu, Pfeiffer, and Obrist (2015) revealed that less educated girls in Accra, Ghana, were more likely to start childbearing compared to their peers who were highly educated. In the Ejisu-Juabeng district of

Ghana, adolescent girls who were out of school were more likely to become pregnant (Morhe, Tagbor, Ankobea, & Danso, 2012).

#### **2.1.4 Peer influence and lack of sexual and reproductive health information**

The period of adolescence is full of curiosity, gullibility, and intense sexual drive. Some adolescents during this period become very experimental with sex, which may result in pregnancy. Peer influence is also paramount during the period of adolescence. (Gyan, 2013) found that adolescents in a suburb of Accra, Ghana, mostly engaged in sex as a result of peer influence, which may predispose them to early pregnancy and motherhood and HIV/AIDS infection (Christofides et al., 2014).

Lack of sexual and reproductive health information or education is another predisposing factor of adolescent pregnancy and early motherhood in both developed and developing countries although it is more prevalent in developing countries (Bankole, Biddlecom, Guiella, Singh, & Zulu, 2007; Hindin & Fatusi, 2009; Rondini & Krugu, 2009). Adolescents in most part of the developing world are denied access to a comprehensive sex education (Asampong, Osafo, Bingenheimer, & Ahiadeke, 2013). Therefore, these adolescents know little or nothing about their sexual and reproductive health; incomplete or lack of sexual and reproductive health knowledge predisposes adolescents to pregnancy in Estonia (Asampong et al., 2013; Haldre et al., 2009).

#### **2.1.5 Irregular antenatal and post-natal visits**

Antenatal care (ANC) services includes a wide range of preventive and health promotion services a pregnant woman receives from health providers (Midwives and Nurses) during the period of pregnancy till delivery (Baffour-Awuah, Mwini-Nyaledzigbor, & Richter, 2015). ANC provides the opportunity for the pregnant woman to interact with health care providers, make informed decisions which results in safe motherhood and improved care of the newborn. Post natal care (PNC) also includes the total immediate care of the mother and the newborn until six weeks after delivery.

In the light of improving maternal health and reducing maternal mortality, the world health organization (WHO) came up with a new model of ANC attendance—focus antenatal care (FANC)—for developing countries (WHO, 2007). FANC requires that the expectant mother attends four (4) sessions of ANC before delivery (Baffour-Awuah et al., 2015; Pell et al., 2013). Pregnant adolescents face several barriers in accessing and utilizing ANC early and Post natal

accurately. Some of these barriers are stigmatization, low level of family and social support, delay in disclosure of pregnancy for fear of being expelled from school, decision making autonomy and inadequate financial resources, lack of adolescent friendly environment and poor attitudes of health care providers (Cynthia N Chaibva, Ehlers, & Roos, 2010; Pell et al., 2013).

As observed by Pell et al. (2013) in their study in Ghana, pregnant adolescents and teenage mothers were at risk of irregular antenatal and post-natal care visits. During antenatal and postnatal check-ups, the health needs of the pregnant adolescents, adolescent mothers and their babies are addressed. It is during these check-ups that pregnancy related complications are spotted early and addressed (Baffour-Awuah et al., 2015; Omar et al., 2010). Also, during antenatal and postnatal check-ups, information on pregnancy, motherhood, and childcare are disseminated (Baffour-Awuah et al., 2015; Omar et al., 2010). However, pregnant adolescents are at risk of not patronizing antenatal and post-natal care services (Omar et al., 2010).

#### **2.1.6 Teachers**

Some teachers in some schools in developing countries are stressors to pregnant adolescents and teenage mothers. In South Africa, Bhana et al. (2010) found that teachers viewed adolescent pregnancy in schools as a social problem and a disruption to academic life of both the pregnant adolescent and their non-pregnant peers; such teachers may not assist pregnant adolescents and teenage mothers in their schools (Bhana et al., 2010). In the same study, some of the teachers interviewed were against school policies that encouraged pregnant adolescents to be part of the school; for such teachers, the best way to deal with pregnant adolescents in schools is to dismiss them in order that their non-pregnant peers will be deterred from becoming pregnant (Bhana et al., 2010). Although quite an old study, in the northern and central Netherlands adolescent girls suffer various forms of sexual harassment from teachers (Timmerman, 2003).

#### **2.1.7 School policies**

Policies that are often intended to help pregnant adolescents end up harming them in the long run (Mashishi & Makoelle, 2014; Omwancha, 2012), in their review of teenage pregnancy policies in South Africa and Namibia, found that South African teenagers who became pregnant while in school were allowed to be in school till the seventh month of the pregnancy; these pregnant adolescent were excluded from school for up to two years after leaving the school in their seventh month. The policy of excluding pregnant adolescents from school in south Africa denied them of their constitutional right to education (Mashishi & Makoelle, 2014).

In Ghana, a realization of the negative effects of policies that exclude pregnant girls from school has led educational authorities to modify existing policies and make way for such girls to remain in school. Despite this and other interventions, lack of resources for monitoring and enforcement have still meant that traditional cultural norms and negative community attitudes still prevent some pregnant girls from remaining in school (Brückner, Martin, & Bearman, 2004).

### **2.1.9 Pregnancy as a stressor**

The adolescent pregnancy itself is a stressor in the life of the adolescents, for, majority of the adolescent pregnancies are unplanned. During the period of their pregnancies, adolescents suffer from emotional problems, sleeping problems, low self-efficacy and postpartum depression (Omar et al., 2010). Adolescent pregnancy related stigma were reported in many studies, especially in developing countries (Patel & Sen, 2012). Fear of being stigmatized by health professionals; sometimes prevent pregnant adolescents and teenage mothers from effectively communicating their needs with health service providers. Brady, Brown, Wilson, and Letherby (2008, p. 579) noted that

“as a result of negative stereotyping, practitioners too can misjudge and mislabel young women in their care. This means that relationships between young pregnant women and mothers and professionals are often complicated by unspoken misunderstandings on both sides. This lack of effective communication can lead to frustration and tension between both practices”

### **2.1.10 Barriers to the Utilization of Adolescent Reproductive Health Services**

Although majority of adolescent knew or have heard about ARHS, they still feel shy to go visit the centers (Kalo, 2006). Globally, reasons for low patronage of ARHS include poor access, availability and acceptability of the services (WHO, 2004). Lack of clear directions and services on offer, crowding, lack of privacy, appointment times that do not accommodate young people's work and school schedules, little or no accommodation for walk-in patients, and limited services and contraceptive supplies and options calling for referral are also impediments (WHO, 2004). Senderowitz, Hainsworth, and Solter (2003) in a study on rapid assessment of Reproductive Health Services reported that significant barriers posted by the current state of most RH services are perceived unwelcoming to the youth. A study in Mochudi, South Africa reported that majority of adolescents do not use ARHS either due to shyness, inaccessibility of clinics, lack of privacy, unfriendly staff, long waiting time or for others because they are not sexually active. The feedback from the adolescents is an indication of the inappropriateness of service delivery

system pertaining to adolescent sexual and reproductive Health (Ngomi, 2008). Staff being unfriendly was also a significant reason for adolescent not seeking support from this health services. Jejeebhay, Shah, and Yount (1999) reported poor quality of care for adolescents at health centers, persistent absenteeism of staff, long waiting periods, high cost of consultation and care, unfriendly treatment by staff and lack of privacy in the facilities are among factors that hinders adolescents assessment to these health centers. This finding reveals persistence of prohibitive issues to the utilization of ARHS which have been extensively studied but strategies to solve them by the concerned persons seem not to be quickly forthcoming.

## **2.2 Resources for pregnant adolescents and mothers**

### **2.2.1 Social and economic support**

Social support is a resource that reduces teen pregnancy. Community, friends, and teachers are sources of social support for pregnant adolescents and teenage mothers. In some studies, social support serves as a resource that teen mothers draw on to cope with the stress of teen pregnancy and teen motherhood. In a quantitative study, social capital, a component of social support, was seen as a protective factor in reducing teen pregnancy among states in the United States of America (Crosby & Holtgrave, 2006). The findings from this study suggest that teenagers with strong social capital would be less likely to become pregnant. Findings from a qualitative study from Australia indicated that teenage mothers receive much support from their mothers, siblings and close friends (Watts, Liamputtong, & McMichael, 2015). However, the father of the babies of the adolescent mothers and the community they found themselves were less supportive during their teenage motherhood (Watts et al., 2015).

A qualitative study conducted in Accra, Ghana, on the experiences of pregnant adolescents revealed that parents of pregnant adolescents accepted and cared for their girls who became pregnant although they were initially upset with the news of the pregnancy (Gyesaw & Ankomah, 2013). In another study in Ghana, it has been revealed that pregnant adolescents and teenage mothers relied on their parents for economic and social support (Ahorlu et al., 2015). Communities serve as a resource for pregnant adolescents (Leerlooijer et al., 2014). Having realized that communities are determinants of the psychological wellbeing of pregnant adolescents and teenage mothers, Leerlooijer et al. (2014) adopted a comprehensive community-based intervention aimed at improving the psychological and social well-being of unmarried teenage mothers in Uganda.

## 2.2.2 Non-governmental organizations

Pregnant adolescents and mothers benefit from Non-governmental organizations programs. An example of such programs is the Teenage Mothers Project in Uganda; this project provide comprehensive reproductive health services, psychosocial, and economic support to many pregnant adolescents and teenage mothers (Leerlooijer et al., 2014). The Ghana Health Service and some NGOs in Ghana also provide psychosocial, health, and socio-economic support to pregnant adolescents and mothers. Some of these NGOs include Savanna Signatures international (Savsign), Village exchange international and Marie Stopes international.

## 2.3 Theoretical Framework: Salutogenesis

Antonovsky's theory of Salutogenesis served as both the theoretical and analytical framework of the study. Salutogenesis guided the researcher to explore the stressors leading to pregnancy among adolescents, positive factors that enable pregnant adolescents to thrive and the factors that enable them to utilize Adolescent Reproductive Health Services (ARHS) in their community. In 1979, Aaron Antonovsky propounded a salutogenic theory (Antonovsky, 1996a). Salutogenesis—from the Greek words, *salus* and *genesis*—means the origin of health. Antonovsky was interested in finding the causes of health rather than the causes of diseases (Lindström & Eriksson, 2009; Pallant & Lae, 2002). After his study on Jews who survived the holocaust, a very stressful situation, Antonovsky realized that how a person responds to life situations determines the person's health status. His study emphasized that there is more to health than just the mere absence of disease or infirmity (Antonovsky, 1996a). He offered Salutogenesis as a complementary theory to research in health and wellbeing, and not a replacement of biomedical models (Mittelmark & Bull, 2013).

According to Antonovsky, two key factors enable people to move towards health (Antonovsky, 1996a). These concepts of salutogenesis are Sense of Coherence (SOC) and Generalized Resistance Resources (GRRs) (Antonovsky, 1996b; Eriksson & Lindström, 2006). Sense of Coherence (SOC) is defined as “a generalized orientation toward the world which perceives it, on a continuum, as comprehensible, manageable and meaningful” (Antonovsky, 1996a, p. 15). Out of the SOC concept, three components emerge: comprehensibility, manageability and meaningfulness (Antonovsky, 1996a; Eriksson, Lindström, & Lilja, 2007). Comprehensibility refers to “the extent to which one perceives the stimuli that confront one as consistent, structured and clear” (Eriksson *et al.*, 2007, p. 684). Manageability means “the extent to which one perceives that the resources at one's disposal are adequate to meet the life's demands

(Eriksson *et al.*, 2007, p. 684). Lastly, meaningfulness means “the extent to which one feels that life makes sense emotionally” (Eriksson *et al.*, 2007). SOC is a key element in the salutogenic theory (Antonovsky, 1996a). In Figure 2.1, a person’s life situations, life course stress exposures, GRRs and life experiences contribute to either a strong or weak SOC in the person’s move towards health and wellbeing (Antonovsky, 1996b; Mittelmark, 2010).

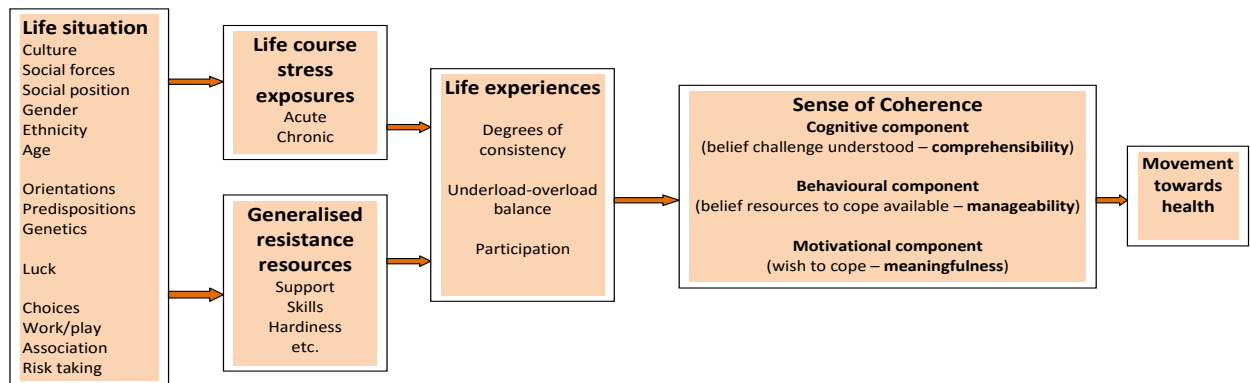
The second key concept is Generalized Resistance Resources (GRRs). GRR is defined as “...a property of a person, a collective or a situation which, as evidence or logic has indicated, facilitated successful coping with the inherent stressors of human existence” (Antonovsky, 1996a, p. 15). A person’s SOC enables him or her to understand, be able to and willing to use his or her GRRs to combat an imminent stressor from destabilizing his or her health. This implies that a person’s SOC greatly determines how his or her GRRs are utilized as an investment towards health and wellbeing.

An example of a stressor in an adolescent girl could be an unplanned pregnancy. From the model in Figure 2.1, some of the following life situational factors could influence how the pregnant adolescent will perceive her life course stressor—the unplanned pregnancy—that will not result in depleting her health: the cultural context, parental beliefs and orientations, and the social position and standing of both the adolescent girl and her parents (Mittelmark, 2010). Some GRRs that could be available for the adolescent girl includes the following: family and social support networks, hardiness and adolescent reproductive health services. Underload-overload balance will occur when the pregnant adolescent is unable to deal with the unplanned pregnancy or when she is not experiencing enough motivation to use resources that are available in her immediate environment or in the community to combat the stressor (Mittelmark, 2010). From the model, the pregnant adolescent will experience balance when the GRRs are suitable to deal with the unplanned pregnancy (the life course stressor) (Mittelmark, 2010). The pregnant adolescent’s experience with the unplanned pregnancy will greatly determine the development of her SOC. How the pregnant adolescent understands and wishes to cope with the pregnancy with the available resources she believes exist will move her towards health and wellbeing (Mittelmark, 2010).

Several studies have used the salutogenic model to explore the stressors and resources among HIV/AIDS patients, orphans, mental health patients, etc (Daniel & Mathias, 2012; Eriksson *et al.*, 2007; Midtbø, Shirima, Skovdal, & Daniel, 2012). To the best of the researcher’s knowledge, there are no studies on how pregnant adolescents thrive in the midst of social

stigma, threats of school drop outs, and harsh cultural belief systems in the Ho-West Municipality.

**Figure 2. 1: The salutogenic model (adaptation of Mittelmark, 2010)**





## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Research Design**

A qualitative research design with a phenomenological strategy was employed in this study in order to explore the subjective experiences of the participants (Green & Thorogood, 2014, p. 5). This study explored the lived experiences of pregnant adolescents and their utilization of reproductive health services, hence a phenomenological approach. Burns and Grove (2005) further describe a qualitative research design as a systematic, interactive, and subjective approach that is used to describe and to give meaning to life experiences (Burns & Grove, 2005). The design for this research study was appropriate as the researcher was able to explore and describe experiences of pregnant adolescents and their utilization of reproductive health services in the Ho West District.

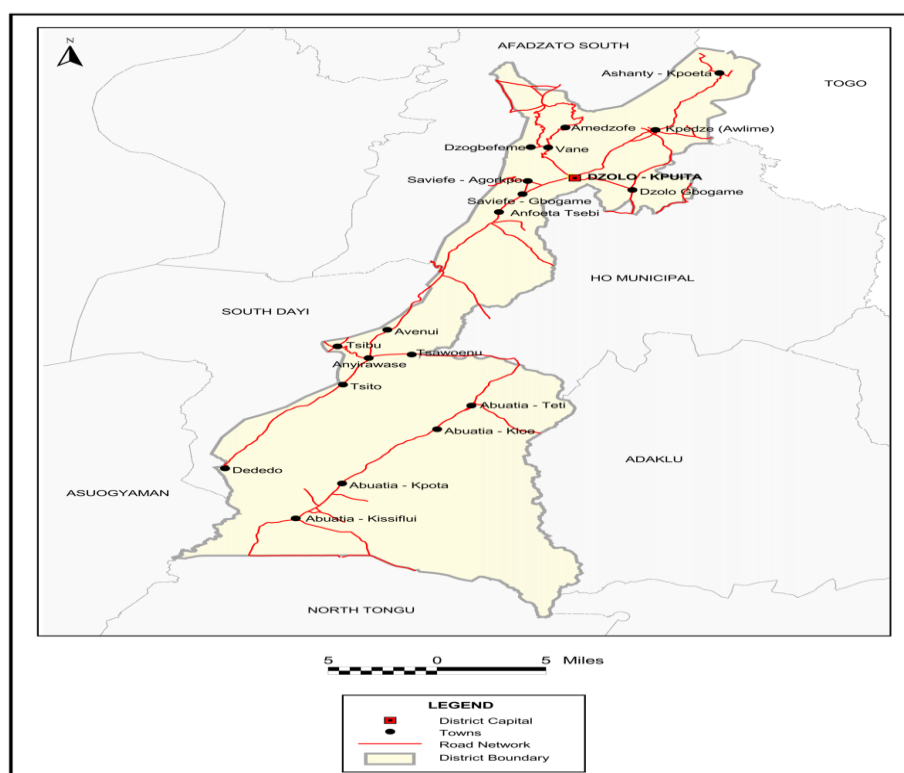
#### **3.2 Study Area**

Ho West District is one of the newly created Districts, carved out of a previous district called Ho Municipality. It was established by the Legislative Instrument (L.I) 2083 of 2012. The district is made up of seven (7) Traditional areas. The District shares boundaries with Adaklu to the South, Eastern Region to the South West, Afadjato South to the North, Ho Municipal and the Republic of Togo to the East and South Dayi to the West. The district is made up of two main ethnic groups, the Ewes and Avatimes. The current literacy rate of the district stands at 49%, which is below the Regional average of 68.5%. The main economic activity in the district is agriculture, and it employs about 74% of the total population. The crops mainly produced include maize, cassava, yams, plantain, banana, citrus, and rice, mangoes and avocado pear. The remaining 26% of the population are engaged in government establishments and construction work. The predominant religion is Christianity. There are few people who are Muslims and traditional religion practitioners.

For the purpose of this study, the Awudome traditional area, made up of six (6) farming communities in the Ho West District in the Volta Region of Ghana, was chosen. These communities were chosen because of its high level of adolescent pregnancies and motherhood. Out of these six, three (3) communities were chosen as the study sites due to the sample size and these are Avenui, Tsito and Anyirawase. The population of this area also engage in batter trading. There are primary schools in all the communities and a couple of senior secondary

schools. It also has two community clinics and 2 Community based Health Planning Services (CHPS) compounds which deliver primary health care services to its populace at their door posts.

This site was chosen because of its high level of adolescent pregnancies and motherhood. The health centre which is strategically located to provide health services to these communities was discovered to be underutilized by most of the pregnant adolescents and mothers. This was because it was quite far from the road side and also lacks basic routine antenatal drugs, making it difficult for the girls to afford the drugs since they have to purchase them even though the national health insurance scheme provides free ANC services to these clients.



**Figure 3.1 District map of Ho West showing the various traditional areas**

**Source: Ghana Statistical Service**

### 3.3 Sampling Techniques

For this study, purposive sampling was used to select pregnant adolescents and adolescent mothers aged between 16 and 19 years. A purposive sampling method involves the conscious selection of participants or elements that are representative of the phenomenon being studied (Burns & Grove, 2005). This method of sampling is used especially when the researcher has a

specific purpose in mind (Maree, 2010). In this study the researcher was interested in exploring the experiences of pregnant adolescents before, during and after delivery and to find available resources they draw on while seeking reproductive health care services.

### **3.4 Sample Size**

With regards to sample size in qualitative research, the purpose is to “explore meaning and phenomena” (Fain, 2004, p. 116) making small scale studies the preferred approach, to give the researcher the opportunity to get to know the social world of participants, increasing both the depth and quality of data. The size of a sample also depends on the resources available to the researcher. These include time, money, travel distance and personnel (LeCompte & Schensul, 2010). The findings of qualitative research are not aimed at generalizing based on population, but understanding what is happening from the participant’s perspective. Thus, in qualitative studies, the emphasis is on the appropriateness and adequacy of the sample rather than sample size (Fain, 2004; Morse, 1991).

A total of 18 participants were recruited through the aid of a gatekeeper, who had it very tough recruiting 11 participants, consisting of 6 pregnant adolescents and 5 adolescent mothers who had their babies within the past 6 months from the start of the data collection, two queen mothers, two clinicians, two teachers and one representative of an NGO. This as opposed to 1 each of the key informants proposed enabled the researcher to have different views in order to compare and contrast.

The gatekeeper had to liaise with the mission hospital in order to recruit the number of participants required for this study. The gatekeeper was also very helpful in the area of finding a good setting for the interviews and the group meetings and administered and witnessed the signing of the consent forms. This data collection would not have been successful without her total commitment and support. Adolescents who were not pregnant and those who were mothers but are over 6 months were excluded.

**Table 3.1: Gestational age of pregnant adolescents**

Pseudonyms	Age	Gestational Age
Dzidzi	17 years	4 months
Abla	18 years	6 months
Edudzi	17 years	7 months
Afi	16 years	8 months
Sena	16 years	8 months
Efe	17 months	4 months

NB: non-pregnant and adolescent girls were excluded

**Table 3.2: Adolescent mothers with babies below the age of 6 months**

Pseudonyms	Ages	Age of babies
Nana	16 years	3 months
Amavi	16 years	2 months 1 week
Edzeani	17 years	4 months
Elolo	19 years	1 month 2 weeks
Adukonu	17 years	5 months 3 weeks

NB: Adolescent mothers with babies more than 6 months old were excluded

**Table 3.3 Key informants**

Titles	Age	Occupation
Queen mother 1	66 years	Retired teacher
Queen mother 2	74 years	Petty trading
School Head 1	52 years	Teaching
School Head 2	48 years	Teaching
Community Midwife	63 years	Midwifery
Community Health Nurse	35 years	Nursing
NGO Official	32 years	Project director

### **3.5 Data Collection Instruments**

Data collection in qualitative research involves the gathering of information from variety of data sources. For instance, data collection could be done through observation and interviews. The term ‘generating’ data is used in qualitative data, rather than ‘collecting’ data (Holloway & Wheeler, 2013). The fundamental aim of a qualitative researcher should involve the positioning of him or herself close to the participants so as to gain access to, and describe personal experiences and interpret their meanings in specific settings (Polgar & Thomas, 2008). Green and Thorogood (2014, p. 55) indicate that there are a variety of data gathering methods that can be used in qualitative-based research. These methods include unstructured interviews, participant observation, focus group discussions and analysis of personal texts or document.

### **3.6 Data Collection Procedure**

In this study, data was gathered through face to face in-depth interviews with all participants at their own convenient time, using a semi-structured interview schedule or guide (see appendix 5) for a duration of 45min per participant. Since the researcher understood the Ewe language, which was the preferred option of most of the participants, the translations and interpretations were done by the researcher. With an interview schedule or guide, the researcher collects similar types of data from all informants (Holloway & Wheeler, 2013). The interview guide has the advantage of ensuring that the questioning followed a sequence and the factors involving the subject matter being investigated are being tracked and tackled (Holloway & Wheeler, 2013; Polit & Beck, 2008).

Three focus group discussions were also held with six pregnant adolescents and five adolescent mothers for about 2 hours. A focus group discussion serves as a means of extracting vital and maximum amount of information within a short time frame. With the help of a research assistant, a field note book was kept. Field notes contain detailed accounts of all that transpires during interviews and focus group discussion (Green & Thorogood, 2014, p. 130). The researcher facilitated the focus group discussion and the individual face-to-face interviews, and the research assistant manually kept a record of both verbal and non-verbal cues of participants during the research process as a backup (Welman, Kruger, & Mitchell, 2005).

Ice breakers were introduced by some participants as a warm up exercise. Personal notes was compiled by the researcher following the interview and these notes were based on observations

(Watson, McKenna, Cowman, & Keady, 2008). The data collection process was audio taped with the aid of a Dictaphone and transcribed (Creswell 2014).

### **3.7 Data Management**

A digital audio recorder was used to capture interviews and focus group sessions. The recordings were transcribed after most sessions in order to be updated on information that might need further probing and to enhance data cleaning. The transcribed data was saved in a Microsoft word format and was kept on a password protected personal computer and on a personal flash disk—kept under lock and key—where nobody can access it.

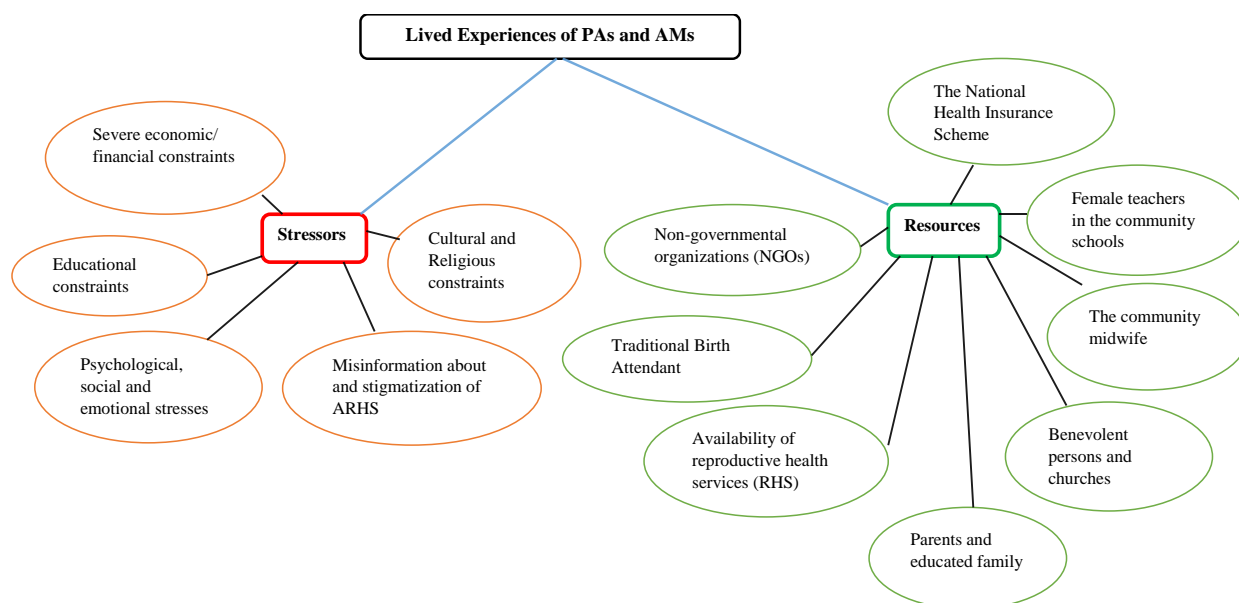
Even though there were frequent power outages, the data collection process was not affected because the laptop computer was always charged and spare batteries were always carried. All data will be stored a maximum of two years, after which it will be destroyed. That will be in August, 2018. Transcribed data will only be accessible to my supervisor.

### **3.8 Data Analysis**

Data from this study was analysed using thematic content analysis with the aid of Attride-Stirling's method of thematic network analysis (Attride-Stirling, 2001). Thematic analysis requires that the researcher search for, and identify common threads that extend throughout an entire interview (Morse & Field, 1995). In order to identify themes, the researcher must step back and reflect on what the participants are saying, why and how they are saying what they are saying (Morse & Field, 1995). Themes are usually indicated by the data, but not described specifically by the participants. It is upon critical reflection and being close to the data that the researcher can identify themes.

Data was coded and categorised into basic themes, then into organising themes and finally into a global theme or themes through open code version 4.0. Coding and categorizing are used in order to assist in the process of analysis so that theory can be evolved and integrated (Holloway & Wheeler, 2013, p. 158). In brief, basic themes were structured into organizing themes. An organizing theme comprises of many different basic themes with several ideas. A group of organizing themes come together to form a global theme. A global theme in effect is the principal theme of the data.

### **3.9 Thematic Network**



**Figure 3. 2: Thematic Network analysis of Data**

### 3.10 Trustworthiness

Trustworthiness can be defined as “the ways we work to meet the criteria of validity, reliability/credibility, and believability of our research—as assessed by the academy, our communities, and our participants”(Harrison, MacGibbon, & Morton, 2001, p. 324). In order to ensure trustworthiness in qualitative research, there must be an establishment of rigour in qualitative research findings, since the issue of evaluating qualitative research with quantitative criteria is keenly contested by qualitative research.

#### 3.10.1 Reliability

Reliability means “the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions” (Hammersley, 1992, p. 67). To ensure reliability in this study, transcripts were checked to make sure they did not contain obvious mistakes made during transcription.

**Inter-coder reliability** In order to ensure a high degree of consistency in the generation of codes, different researchers—my colleagues and my supervisors—counter coded the data. Counter coding of data by different researchers ensure inter-coder reliability (Creswell 2014; Whitley & Kite, 2012). Reliability was further ensured by discussing the findings of the study with the researchers who participated in the counter coding; this discussion process attracted critical comments that improve the trustworthiness of the study.

### **3.10.2 Validity**

Validity in qualitative study deals with the level of accuracy demonstrated by the researcher in the presentation of what actually happened during the research process (Pilnick & Swift, 2011). There are two types of validity: external and internal validity. In order to enhance validity, this study employed triangulation (multiple sources of data generation): focus group discussion, in-depth interviews and observations. These methods were able to produce same or similar findings. Also, respondent validation (member checking) could not be carried out although the researcher had planned to do. Member checking was not done because of financial constraints.

### **3.10.3 Generalizability**

This refers to the extent to which research findings can be used to develop concepts, understand phenomena and theoretical propositions that are relevant to other settings and other groups of individuals (Draper, 2004). There are two types of generalizability: empirical and theoretical. The value of good qualitative research is determined by the particular “thick description” and the themes developed in the context of a specific site. Greene and Caracelli (1997) states that “particularity, rather than generalizability, is the hall mark of good qualitative research.” The findings of this study will, therefore, be first generalized on pregnant adolescents’ studies and also help make sense of the adolescent’s situation and adolescent health care deliveries in Ho West, Ho District.

### **3.10.4 Role of the Researcher**

Reflexivity, also known as the “knower’s mirror” is recommended as a key strategy and a very important aspect of enhancing credibility of qualitative research (Draper & Swift, 2011; Swift & Tischler, 2010). Qualitative research will not be complete without the researcher’s reflection on his or her role as a key research instrument, personal values, assumptions and biases at the primary stage of the study.

The researcher is a trained general nurse with several years of experience of working with people in different age groups and different life situations such as that of the pregnant adolescent. However, she was not to wear nursing “cap” whilst collecting the data for this study and it is imperative that the participants also do not picture her as a nurse. Therefore the researcher did not present herself as a nurse in order ensure that participants provide valid information, especially where it has to do with nurse client relationship and access to ARHS. In order to maintain the researcher’s role as a student aiming to learn from these adolescents’



experiences of having to thrive with their pregnancies and motherhood, the gatekeeper was not informed initially about the researchers background, until the researcher was identified by a colleague of the profession on one of the visits to the gatekeeper, who let the “cat out of the bag”. This development however, did not deter the gatekeeper from taking up her role after a vivid explanation was given to her and the need to work under cover. During all interviews and focus group meetings, the gatekeeper was not allowed to be part since she was well known to most of the participants who happened to be her clients or former clients. Furthermore, meeting places were arranged far from the health facility where no one could see nor identify the participants, thereby influencing their responses.

As a woman and a mother, the researcher reflected on her understanding of what a person needs for support and what creates well-being. It was important that the researcher is aware of these while conducting this study. Exploring the experiences of pregnant adolescents puts the researcher in a position where she needed to be focused and keep an open mind before, during, and even after the data collection period in order not to let her biases influence the data collection and its interpretation.

The researcher, therefore, focused on her role as a student, aiming to learn from these adolescents’ experiences. Looking at the power relationship that could easily have become an issue, it was important that the participants understood that she was there to learn from them, and that the information they provided was very valuable for her and for the study. This was emphasized at the beginning of every meeting. In the study, the participants were the experts in their situation and not the researcher.

### **3.11 Ethical Consideration**

#### **3.11.1 Ethical clearance**

The researcher submitted the proposal to the Norwegian Social Sciences Statistics Data (NSD), Norway but she did not receive approval before leaving Norway for the field work, in Ghana. However, the NSD approval arrived after my arrival in Ghana (see appendix 6). Also, the researcher consulted and submitted same proposal to the Ghana Health Service Ethical Review Committee (GHS-ERC) for ethical clearance on reaching Ghana in the first week. The proposal was further submitted to the Volta Regional Health Directorate (VRHD) in the home country with an application seeking permission to start the study whilst awaiting response from the ERC-GHS, since time was running out. The permission was granted (see appendix 8) to enter

the Ho west district by the Regional Health Director. Further permission was taken from the District Health Director to enter the study site. The stress of obtaining ethical approval in Ghana was in itself worth studying. Final approval was granted on the 1<sup>st</sup> of September, 2015 (see appendix 7) when the data collection was almost over.

Participants of this study were not exposed to any known risk. However, some forms of tiredness and discomforts were experienced especially by the pregnant adolescents during the focus group sessions due to prolong sitting, but the researcher introduced the icebreaking periods to curtail the discomforts. Snacks were provided by the researcher during the focus group discussion meetings and tokens were given as a form of appreciation to participants for their time and contributions as stated in the informed consent and explanation sheets.

The key informants were also appreciated with tokens of packs of toilet soaps and towels. A written informed consent was sought from all the participants with the aid of the gatekeeper who served as the witness to signatories. The reason and nature of the research was in English but explained in details in the local language to those who could not read nor write, assuring them of anonymity and confidentiality and the right to quit at any stage in the study. The main ethical principles—confidentiality, anonymity, non-maleficence and beneficence—were well explained to participants and key informants and adhered strictly to (see appendix 1&3).

All signed consent forms (see appendix 2&4) were returned and copies were given to the participants together with the explanation forms. Voluntary participation was emphasized by underlining in the explanation sheets and the consent forms respectively. The participants being aware that the research was not funded were not expecting any form of cash or gifts so they were very appreciative of the tokens offered. Participants were informed about interview sessions a minimum of two weeks—by phone and followed up by the gatekeeper as a reminder—before the actual interview date. All attempts were made not to disrupt schedules of participants such as the market and farming days. The participants were promised that the findings together with the necessary recommendations will be communicated to the community to help influence policy and opinion leaders' decisions concerning the pregnant adolescent and mothers' wellbeing and reproductive health service.

## CHAPTER FOUR

### FINDINGS

#### 4.0 Introduction

This section presents the life and RHS access experiences of pregnant adolescents and adolescent mothers. Views of key informants who live and work with these adolescents in local communities are included. For clarity, the presentation here follows the various themes that emerged from the data as demonstrated in the thematic network analysis. Stressors and resources identified as global themes, organizing themes and their basic themes through the views and experiences of participants are also reported, relating it to the research questions stated earlier.

#### 4.1 Stressors

##### 4.1.1 Severe economic/ financial constraints

Pregnant adolescents and adolescent mothers recounted experiencing severe economic constraints at various levels of their personal and community lives. The in-depth interviews in particular revealed seeming difficulties from various angles ranging from the very financial backgrounds of parents of these adolescents that were seen to have contributed to the pregnancies in the first place, to pregnancy period economic incapacitation and post-birth financial neglect from parents, family and male partners:

*“...I got into this situation [Pregnancy] due to circumstances surrounding my schooling. How? My school was in Tsito (name of school withheld). Sometimes I walked from Avenui where I lived all the way to Tsito to attend school because my parents couldn't give me money for transport. So I needed to take a guy [have a boyfriend] who could take care of me. The man responsible for my pregnancy used to pay my school fees and provide my basic needs”* (Edudzi, pregnant adolescent).

This seemed to be an experience shared by the majority of the adolescent participants, as another participant recounted:

*“... I got pregnant because my mother couldn't provide for all my needs. This informed my decision to go for a boyfriend who can help me”* (Dzidzi, pregnant adolescent)

A third participant also said:

*“...when I asked for something I needed, I never got it from my parents. Sometimes even pad for my menses. So I decided to go for a boyfriend who would help me with some of these petty things”* (Nana, adolescent mother)

These accounts made it clear that parental poverty was a key contributing factor to the pregnancies in the first place. Some participants went further to recount how they struggled to get three square meals per day in the periods leading up to their pregnancies and key informants who participated in this study corroborated adolescent participant accounts by blaming parental poverty for contributing to the pregnancies:

*“...most parents also pushed their daughters to go and look for money even by sleeping with older men. This is usually because of the poverty level and most of such parents also had teenage deliveries so they do not find anything wrong in pushing their children in...”*(community midwife).

This other key informant said:

*“...nothing I see is the cause other than the girls wanting material things that their parents could not offer them, to please the men. Also, sometimes even where they sleep is a problem...”* (Mamaga 2, queen mother)

The financial situation seemed to get worse for most adolescents after they got pregnant. Participant accounts included a cessation of financial support from parents and other family who tended to place the financial responsibility of the pregnancy and upkeep of the pregnant girls on the men responsible for the pregnancies, most of whom were either poor themselves, had absconded upon news of the pregnancy or simply refused to take responsibility for the pregnancy:

*“...my boyfriend comes once a while to give me GHC40 and it takes him 2 to 3 months to come by again. It is my paternal auntie I mostly go to in times of need, but she also sometimes tell me to go to my boyfriend[...] my mother is jobless and my father is angry with me so he doesn't give me money anymore...there is nothing much at home for me”* (Nana, adolescent mother)

The experience of another pregnant adolescent was that of neglect from both parents and boyfriend:

*“...my boyfriend has simply refused to give me any money...he doesn't care about me at all...and my mother is dead, as for my father I have not seen him for a long*

*time...my paternal uncles and aunties said I should not worry them with money issues...”(Abla, pregnant adolescent)*

Key informants expressed views that supported the accounts of pregnant adolescent participants:

*“...because at times when it happens this way, the parents totally ignore these girls. They are left on their own to fend for themselves and their babies. It’s only a few parents who are able to give the needed support...in cases where they are from very poor backgrounds; it becomes a real problem...” (School head 1)*

Another key informant said:

*“...Most often the men responsible try to dodge their responsibilities. In fact they deny the pregnancy completely...” (Community health nurse)*

A representative of an NGO that works with adolescent girls in the local communities also said:

*“...they go for the illegal or unsafe methods of abortion and develop complications that often results in death. For those who keep the pregnancy the guys who impregnate them are often equally poor and are not normally able to take care of them...”(NGO Official)*

The already difficult financial situation seemed to be exacerbated by the pregnant adolescents’ and adolescent mothers’ own inability to engage in economic activities that they previously did to support themselves and their families. Participants recounted feeling weak and unable to sell on the market, help on the farms or do petty trading:

*“...hmm, this pregnancy has really disturbed me. I have no one, as it is now...there are certain jobs, like some petty trading that I used to do. Now I cannot even do that because I am always feeling so weak and heavy. I wanted to save some money and enter into an apprenticeship in sewing but look at me, I cannot even move...” (Abla, pregnant adolescent).*

Another adolescent participant said:

*“...Early on, I could join my auntie in her business on the market even though I was not fit. But now I can’t do that...That gets me thinking every day...how can I feed this baby hmmm...”(Amavi, adolescent mother)*

To some community members, the pregnant adolescents’ inability to help their families in their businesses and on their farms is often misread as laziness and leads the families to refuse to give any financial assistance:

*“...Ok. Some of them used to do petty trading while others followed their parents to farm if they were to go farming. Some also followed their mothers to the market to help them in trading if their mothers were traders .But with the pregnancy, they cannot do that and the families think they are lazy[...]so no food for the lazy man...”*(Community health nurse 2)

For the majority of the participants, the tremendous economic or financial difficulties had profound negative implications for them especially in accessing RHS and adhering to advice and recommendations made by reproductive health nurses:

*“...one of my challenges is that I do not have adequate money of my own. Sometimes I wish to eat some fruits as advised by the nurses in the clinic and some other kinds of food like egg, but I am unable to do so because I depended on my auntie who always said she had no money...”* (Sena, pregnant adolescent)

A second participant recounted experiences of having to rely on public benevolence:

*“...like feeding myself and buying of necessary items are very difficult for me. If I go out and someone gives me money, that is what I depend on. I was 6 months pregnant before I started attending the clinic. Because I had no money...”* (Nana, adolescent mother)

For another participant, the implication was involuntary fasting one day at a time:

*“...today like this, I had only one cedi on me so I was planning to go to church to go and fast. Then I remembered I had this interview so I came. Sometimes, in the night, I go very hungry but because there is nothing to eat, I just drink water, waiting for the next day...”* (Edudzi, pregnant adolescent)

#### **4.1.2 Educational constraints**

Economic or financial difficulty was not the only experience that participants recounted during interviews and focus group discussions. Experiences of constraints in education including stigma, shame and eventual abandonment of school altogether were also recounted. The majority of participants felt they had to drop out of school because they were ashamed:

*“...dropping out of school was my own decision...I did that in order to avoid the teasing, mockery and stigmatization. I am naturally a shy person and I was so much ashamed when I got pregnant...”* (Afi, pregnant adolescent).

Another participant shared a similar experience:

*“...shame, mockery and teasing were the main reasons why I withdrew from school and many girls like me do that...they just stop going to school.”*(Dzidzi, pregnant adolescent)

An adolescent mother also recounted her experience when she was pregnant;

*“...because of how my mates and friends were teasing and laughing at me, I could not continue my school”* (Nana, adolescent mother).

A community member also shared similar views on how the mockery and teasing really affected the girls

*“...it affects their academic life, so you see, their performance dropping, dropping, dropping..., so these are some of the things they go through and eventually they quit”* (School head 1)

Other community informants rather had sympathy for the girls and sought to encourage schools to understand the situation of pregnant girls and help rather than mock them:

*“We added in one of our school health programs that in case someone gets pregnant, it could happen to any other person so that person should not be a source of mockery or anything. They should not look at the person as an outcast because it could happen to them also”* (Community midwife)

A pregnant adolescent felt there was no way she could go back to school first because of the pregnancy and then, because she felt she was not intelligent:

*“...For schooling, I cannot go back. I stopped schooling because of the pregnancy and now even if someone is ready to support me, I cannot go because I am not intelligent. I would rather prefer to learn a trade...”* (Nana, adolescent mother)

For another participant, it was just too late to go to school after becoming pregnant and it would be too much to ask of her auntie who was supporting her:

*“...Hmmm, as it is now, going back to school is already late...my aunty is single handedly supporting me, my siblings and her own children, now she will be supporting my child too, it would be too much for her to pay for my education on top of that...I can't do that to her...”*(Abla, pregnant adolescent)

Some key informants thought that sometimes, the schools involved are unwilling to accept the girls once they become pregnant for reputational reasons:

*“...when the girls become pregnant, their academic performances often drop and this puts the schools involved in a bad light. No one would want to send their child to that school for fear of their daughters getting pregnant so the schools make it uncomfortable for pregnant girls to stay”* (Community Health Nurse)

The queen mother of one of the communities shared this view when she said:

*“...We want our children to progress in education, but whether the girls can go back to school after having their babies depends on their parents and especially the teachers in the school...”* (Mamaga 1, Queen mother)

Some school authorities rather tended to attribute the education disruption of pregnant adolescents to financial reasons:

*“...Oh, I think they drop out of school as a result of the pregnancy because they have to work and fend for themselves and the baby...”* (School Head, 1).

It became evident through the interviews and focus group discussions that varied reasons were assigned to the schooling disruption of pregnant girls depending on who was being interviewed. The interesting thing observed was that, while some of the girls had given up on school, others were hopeful of continuing with school once they get the necessary financial and social support after delivery:

*“...if I get the support to further my education, I will return to school... I endured all the hardships with pregnancy and wrote the exams so that one day I can go back to school if I get a helper”* (Edudzi, Pregnant Adolescent)

Similarly, a participant said:

*“...I can only go back to school which I so much want to, if I get financial support”* (Elolo, Adolescent Mother).

The desire to go back to school however comes with a twist: most adolescent mothers wanted to go back to a different school than the ones they were attending prior to the pregnancy for obvious reasons. A school head confirmed this when he said:

*“A few come back...but for most others, because of shyness, they go to other schools to complete. Most of those who do not drop out either come back or take transfer to other schools where they are not known to complete the school”* (School head 2)

In the opinion of some community witnesses, the prospects of going back to school for pregnant adolescent girls is very slim considering the extent of shaming. Thus a key participant was of the view that even if given the necessary support after delivery, most girls would hardly get back in school:



*“...very few of them anyway, may be one out of ten go back to school. I remember there was one in Anyirawase community whose grandmother took the baby and asked the girl to go back to school... the girl started and got pregnant again and this time the grand mother said she could not do anything more so the girl is now at home doing nothing”*(Community midwife).

#### **4.1.3 Psychological, social and emotional stresses**

The string of stressful experiences that pregnant adolescents and adolescent mothers recounted also included psychological, social and emotional stresses. There were accounts of self-pity and self-hatred, fear and panic regarding how parents would react upon discovering the pregnancy and social rejection and shaming at the hands of the general community:

*“...Well, ever since I got pregnant I have come to know that I am worthless...I mean what kind of a girl gets pregnant while in school?, is it not only bad girls who do that?[...]so I know I am a bad girl no question about that...and I hate myself for that, I used to be a good girl and the pride of my parents until I got pregnant...”*(Afi, pregnant adolescent)

For another participant, the pregnancy made her feel pity for herself:

*“...It’s only pity that I have for myself now...look at me and look at the other girls who are not pregnant...the difference is clear...they can dress and look good, they can go to parties and be happy in school (wipes tears off face)[...] I used to be part of them, but now, see how horrible I look...no food, no one cares about me...and when this baby comes out, what will happen to us?[...]I can’t even buy my own food, how can I buy my baby’s food?...hmmmm...”*(Edudzi, pregnant adolescent )

For some other participants, the feelings they had about themselves largely stemmed from the reactions of their parents after they became pregnant and the treatment they received from significant others who, under normal circumstances, were expected to provide social support to them in difficult situations:

*“...Hmmm, when I got pregnant, I refused to abort the baby. So my father disowned me, he does not call me and never cares...”* (Edudzi, Pregnant Adolescent).

Another pregnant girl said:

*“My father disowned me outright.... My mother cried every day for almost one week and then became cold to me from then on. It was some months later before she started warming up to me again...even then, I was still sent away to live with my auntie in Akuse till I delivered” (Edzeani, Adolescent Mother).*

There were also accounts of beatings and manhandling:

*“...Eeeiish! Sister, it was war! None of my parents were happy about the pregnancy. I tried to hide it as much as possible for fear of what could happen to me. My mother actually locked me up in a room after she confirmed it, and gave me the beatings of my life” (Dzidzi, pregnant adolescent).*

One other participant recounted:

*“Well, that is another story of my life...my father grabbed me by my hair and dragged me all the way from our house to the family home of my then boyfriend and told them to keep me because he didn’t want to see my face again...the boy’s family also dragged me back to my father’s house saying their son was not responsible...I just didn’t belong anywhere, no one wanted me...I was left alone with my pregnancy and it was a very difficult situation for me...”(Nana, Adolescent Mother)*

Yet another pregnant adolescent recounted:

*“Care is a major problem. Our parents do not meet our needs and because you are pregnant now, it is quite difficult to even put a request before them.... my father was annoyed and sacked me from the house, so i went to the boy and the parents and they received me into their home, but they later on started treating me bad” (Adukonu, Adolescent Mother).*

Some accounts given by community informants who live and work with the girls shed more light on the psychosocial and emotional experiences of pregnant adolescents and adolescent mothers:

*“...When these things happen, most parents in the community totally ignore the girls.... It’s only a few parents who are able to give the needed support. So most of the girls resort to self-pity and self-hatred...and for those who have delivered, there is an increased risk of another pregnancy because most of them befriend men for support...” (Head of school 1)*

A queen of one of the communities agreed that parents were too harsh on the girls and suggested that they should rather be drawn closer;

*“Sure, I can tell you for a fact that the girls experience a lot of difficulty and emotional torture....some parents can be incredibly harsh on their daughters when it happens [...] ignoring or refusing to talk to, or disowning a girl of that age who herself may be struggling to understand what is happening to her can cause a lot of emotional pain for the girl.. We don’t have to be harsh on them [...] we have to speak to them in a loving and caring manner”* (Mamaga 1, Queen mother)”

To a community midwife, the experiences of the pregnant adolescents in the community are that of stress and hardship:

*“Some of the parents don’t take it kindly so they reject the girls and sometimes send them to the boy’s parents who do not turn out to be caring. So some of the girls are sort of stressed and face all sorts of hardships”* (Community midwife).

The extended family structure (made up of uncles, cousins, aunties, grandparents etc.) which is known to be a crucial source of social support in African societies also seemed to fail adolescent girls when they are pregnant. There were stories of total rejection from extended family for varying reasons:

*“...None of my cousins, aunties and uncles cared about whether I feed or not. They did not support me in anyway [...] I was simply a bad girl no one wanted to associate with”* (Nana, Adolescent Mother)

Another participant said:

*“...My uncles and my aunties were so annoyed and asked me to leave their house and go to my boyfriend’s family house...they did not want me around because I would be a bad influence to their daughters”* (Edudzi, pregnant adolescent).

An adolescent mother recounted being faced with caring for her baby all alone with no experience in child care and no one to teach her anything:

*“The pregnancy brought a lot of suffering upon me...I didn’t know what to do and the birth was complicated...it was extremely painful...I thought I would die. Right now, I do not have any one helping me with the baby, no one to teach me how to bath her and handle her in other ways. I have managed to teach myself a few things and I keep going...”* (Elolo, Adolescent Mother).

In addition to parental and extended family rejection, the pregnant adolescents and adolescent mothers also faced rejection from the men who impregnated them. For some participants, the real emotional torture came from their boyfriends or, in some instances, men friends who took

advantage of them, showered them with gifts and sweet words of how beautiful they looked and then turned around to reject them and abuse them after they got them pregnant.

*“...The usual way the boys admire you is no more there. Even the man or boy who impregnates you begins to feel shy or embarrassed when you are around him. They don’t want to be close to you [...] they treat you like dirt...”* (Dzizi, pregnant adolescent)

*“...They get angry even if someone mentions your name in connection with them...”* (Abla, pregnant adolescent).

One participant recounted how her boyfriend used to proudly walk the streets of the village hand-in-hand with her in the evenings bragging to other boys how beautiful she was in the weeks leading up to the pregnancy only to become physically abusive towards her after she got pregnant:

*“...The father of this baby was a proud man and envy to other boys before I became pregnant. He would walk the streets with me and brag to other boys that I was the most beautiful girl in the village. When I became pregnant, the pride suddenly left him and all that was left was beatings for me if I ever tried to get close to him (wipes off tears) [...] I just don’t know how that happens...”* (Adukonu, Adolescent Mother).

One participant expressed suspicion that their boyfriends are influenced by their families to act the way they do, perhaps to avoid bearing financial responsibility for the pregnancy:

*“My boyfriend wanted me to abort the pregnancy upon the advice of his mother. The mother said the family didn’t have money to take care of me so if I went ahead to have the baby, I would have to bear all the responsibility alone. When I refused, he denied being responsible for the pregnancy...”* (Edudzi, pregnant adolescent).

A key informant in the community empathized with the plight of the pregnant adolescent girl when she said:

*“...Sadly, when they get pregnant, the boys deny the pregnancy. Then the burden falls on the parents especially the mothers because usually the fathers pull out. It is when the girls and parents have suffered through the process and the child is growing, then you will see them coming forward to claim ownership* (Mamaga 2, Queen mother)

To another pregnant girl, the men just take a clue from how the community reacts to the pregnant girl and treat them the same way:

*“...if the boy sees that your own parents and community cares less about you, they also don’t care. It mostly depends on the men and the homes they come from...”*

(Sena, pregnant adolescent)

Indeed, the focus group discussions revealed that the general community reaction to pregnant girls and adolescent mothers seemed to be negative, as both pregnant girls and key informants who participated in this study shared stories of community rejection, shaming and isolation:

*“...usually it is common to see old friends scatter when the news goes out that you are pregnant. Some may want to stick but their parents will not allow them”* (Sena, pregnant adolescent)

Another recounted adult community members advising her friend to withdraw from her;

*“Even if they come close to you, people will warn them. For example when I got pregnant, my best friend was cautioned by a neighbor to stay away from me. Asking her if she has not realized that I was pregnant...Yea, that’s what happens”*

(Edudzi, pregnant adolescent)

Another confirmed this by saying:

*“...Yes, this is because they feel you will be a bad influence to your friends who could become pregnant as well...”* (Afi, pregnant adolescent).

These accounts of pregnant girls were confirmed in interviews with key community informants who said the fear of peer influence often drives some parents to warn their daughters to stay away from their friends who had become pregnant. To these key informants, such actions compound the situation of the pregnant girl who very likely faces rejection from her own parents and family:

*“...it’s a sad situation for the girls my sister...these are children, some as young as 13 year old...their parents have thrown them out of home, their boyfriends threaten them with violence, and their best friends pull away from them upon instructions from their parents...they are all alone, lost in a cruel world...”*(Male NGO Official).

Another informant said.

*“...I can tell you it’s difficult...some parents forbid their children from going near their friends who had become pregnant because they fear peer pressure...so the pregnant girl is left alone with no friends and family...when they come to the clinic and we even need an adult to sign something for them, it becomes difficult...”*(community midwife)

The situation creates feelings of embarrassment and shame for the girls according to their own accounts leading some of them to prefer self-isolation in order to escape the community treatment:

For one adolescent mother, her self-isolation is a result of embarrassment from not knowing what to do when the baby starts to cry:

*“...I am unable to attend many gatherings like church services and parties because people keep talking and shouting at me especially when he (the baby) starts crying and I don’t know what to do...they make me feel so inferior”* (Nana, Adolescent Mother)

To another participant, just the look in people’s eyes when she shows herself in public is enough to make her want to stay at home for ever:

*“...some people look at you in an insulting manner and that is so embarrassing that I feel like staying at home for ever...”* (Sena, Pregnant Adolescent)

Reflecting typical teenage behavior, one pregnant girl preferred to stay at home because she was embarrassed with her looks. Her body shape with the pregnancy according to her has shattered her self-esteem and pride:

*“I have had sleepless nights and shed some tears[...] my tommy is so big it embarrasses me and having to wear that ugly maternity dress just shatters my self-esteem[...]I have no pride...I can’t go into community gatherings in that...it makes me feel so out of place...it is better to avoid the public...”* (Edudzi, Pregnant Adolescent).

A community observer working for a NGO shared observations of ill-treatment of pregnant adolescents at the hands of even professionals in the community who are supposed to provide help:

*“One thing we know is that these girls face sarcasm and ill treatment even when they attend antenatal and post-natal clinics...most of them therefore resort to traditional herbalists and that can be dangerous...”*(Male NGO official)

The community ostracizing pregnant girls becomes worse for girls who are unable to identify the men who got them pregnant. Through the focus group discussions, it became clear that a situation like that is regarded as shameful not only to the girl, but to her entire family:

*“... Most people that were nice to you do not come close to you anymore. They will be pointing fingers at you. It’s usually petty gossips and insults especially if*

*the girl does not know the owner of the pregnancy...” (Adukonu, Adolescent Mother).*

Another pregnant girl saw her own situation as better than other pregnant girls who could not identify which man got them pregnant:

*“...My situation is bad I know, but I pity the other girls who are not able to identify who exactly got them pregnant...theirs is worse because the shame is not for them alone, it’s for their entire family...” (Afi, Pregnant Adolescent)*

One such girl who could not identify which man got her pregnant confirmed this:

*“...Teenage pregnancy is something the community frowns on, and for girls like me, it’s worse because we are unable to identify the specific man who got us pregnant...in my case, three men were doing me favours with my school expenses, and they all demanded sex in return, so when I got pregnant, I didn’t know which of them it belonged to but one of them accepted responsibility afterwards[...]my father said he feels like committing suicide... people kept telling me to abort the pregnancy, but I was afraid I could die from that...” (Edzeani, Adolescent Mother).*

Another one recounted how she felt society has lost confidence in her:

*“...Those who used to help would no longer be willing to support because they don’t see anything good coming out of you in the near future...a girl who does not even know who got her pregnant...” (Fafa, Pregnant Adolescent)*

A lack of community support measures or systems for adolescents in general, and girls who get pregnant to be specific was observed by the research team during the weeks of data collection. A confirmation of this came up in the focus group discussion when the majority of participants agreed that since the community frowns on adolescent pregnancy, there are no forms of support for the pregnant girls and mothers to help them get back to school, or get on with life:

*“...There is no form of support from the community for the pregnant adolescent. It’s something nobody wants to talk about so if it happens, it is you and your family...” (Adukonu, Adolescent Mother).*

Another said:

*“...but the community has no laid down structures to provide support for the adolescent mother to go back to school if she wishes. So if your family cannot support you, that’s the end of your education and life” (Nana, Adolescent Mother)*

Two participants however recounted receiving some form of support from their churches. Their accounts revealed that some churches in the community had some form of constitution that made provisions for support to be provided for members on occasions like the death of a relative or upon the birth of a child. They however explained that such support is only given to members who pay their church dues:

*“...There is no support from the community...but in my case, I got some support from my church when I gave birth because that is the tradition in the church...members who pay their dues get support when they lose a relative or when they have a new baby...my parents paid, so I got the support”* (Nana, Adolescent Mother).

The second one said:

*“There is nothing from the community like that...close relatives might visit with gifts. If the teenager is very active in a church, then the church welfare can give out some support. But apart from that, it is you and your God...”* (Abla, Pregnant Adolescent).

This was confirmed when two adult community leaders said:

*“The community should be able to support but unfortunately the Awudome community has no support system in place for the pregnant girl”* (Mamaga 2, Queen mother).

*“We do not have such support programs or groups in place now. The community also has nothing in place for the girls to return to school after delivery but that will depend on the parents and the teachers. If the girl is not shy, she can remain in school till it is time for her to deliver and return to school after delivery”* (Mamaga 1, Queen mother)

Another adult community member said there were some support measures in the community but they were scrapped because people thought it encouraged the young people to go into premature sexual relations:

*“...Ok some time ago, we had these adolescent support groups, we had peer groups and leaders who were trained in those aspects but for some time now those things are not functioning because people think it encourages girls to sleep with the men..”* (Community midwife)



#### 4.1.4 Cultural and Religious constraints

The lack of community support systems for adolescents and young people, particularly pregnant adolescents and adolescent mothers, as well as the seeming negative community attitudes towards pregnant adolescents seemed to be deeply rooted in the culture and dominant religious beliefs and practices in the study communities. Both young and adult participants agreed during interviews and focus group discussions that adolescent pregnancy is a serious breach of the standards of behavior for young people in the culture of their communities, though it is rampant, and also an affront to the dominant Christian religious code. For some of the villages, it emerged that a girl who gets pregnant while in school has gone wayward and one who cannot identify the man who made her pregnant commits a taboo. Abortion is seen as highly dangerous because anyone who does that risks the wrath of the village deity:

*“Teenage pregnancy is not acceptable in my village, it’s a breach of the behavior code in our culture so everyone sees the pregnant girl as a wayward girl....it’s a taboo not to be able to identify the man who made you pregnant...that is serious”*  
(Abla, Pregnant Adolescent)

Another participant said:

*“...I knew I had committed a serious offence when I got pregnant and all the men I pointed out denied responsibility. Some people secretly advised me to go for abortion but our village deity would kill me if I tried it, that is what our elders say...It was better to keep it and face the scourge...”*(Edzeani, Adolescent mother)

The fear of the wrath of the deity was confirmed by another participant who said:

*“...I kept this pregnancy because I was afraid I would die if I tried to abort it. In this community, I have heard that they have placed a curse on abortion, so anyone who tries it will die.”*(Dzidzi, Pregnant Adolescent)

Some key members of the communities where data were collected also shared similar views about the place of adolescent pregnancy, abortion and adolescent motherhood in the culture of their communities and how these impact on the lives of adolescent girls who get pregnant or become mothers:

*“...Teenage pregnancy is not accepted in our culture, it’s something our community frowns on and it is a shame for a family to have an adolescent girl become a mother. Most parents and families tend to distance themselves from adolescent girls who become pregnant. They are left on their own and i think that makes the problem worse...”* (Mamaga 1, Queen mother).

Another community leader said:

*“...In the past girls like that would become outcasts, the elders would perform rituals and escort them out of the village especially if they couldn't identify the men who made them pregnant and also casts stones on the roof their parent...but now because of government laws, you can't cast them out, so their families and most community people just stay away from them...”* (Mamaga 2, Queen mother)

Mamaga 1 had this to share on adolescent abortion:

*“...What? you mean if a girl like that tried an abortion?[...]well it would be a case between the girl, her family and the village deity...the deity is against abortion, because it is murder and I agree with that[...]so we don't encourage it at all...”* (Mamaga 1, Queen mother).

The perception that adolescent pregnancy and attempts at abortion breaches cultural norms and should therefore not be entertained was shared even by professional health personnel in the community:

*“...mmmmmm! ok. What I can say is that in our culture as Africans and Ghanaians, you know, when an adolescent becomes pregnant it brings about so many things so our culture does not embrace it.... from the family to community and to the nation at large, it's not allowed culturally. But emmm, it seems we are violating our cultural norms I will say, if we make it okay for them to abort...”* (Community midwife).

Clearly, it could be observed that the extent of rejection an adolescent pregnant girl or mother faced was wide and this seemed to be made legitimate by the very culture of the communities to which they belonged. In the words of the pregnant adolescents and mothers who took part in this study, adolescent pregnancy and motherhood was an effective cord-cutter between themselves and the rest of their community including their own families?

*“When I became pregnant, my whole life began to fall apart...this pregnancy has effectively cut the cord between not only myself and the community but my very own family...I do not feel like I belong here anymore....and I can tell you that is the situation for other girls who are pregnant”* (Edzeani, Adolescent Mother).

In one interview, an adolescent mother shed some light on the reason why the culture and the community is so much against adolescent pregnancy and motherhood:

*“...in times of festival celebrations, young maidens are mostly selected and adorned with ornaments to play special roles. When all the young girls are getting pregnant, the community will lack girls during those seasons and it will be a*

*shame [...] so if you get pregnant, you have shamed your community...” (Dzidzi, Adolescent Pregnancy)*

To one adult community resident however, it is rather the decline of strong cultural rules and practices that has contributed to increases in the rate of adolescent pregnancy:

*“Puberty rite processes included talking to the young girls about the ‘egbelele’ rite and that if any of them got pregnant without going through that, it was called Brameyue fu’ which was a taboo in this area. If it happened like that, the community youth would throw stones on the roof of the girl’s father to show that the family had committed abomination...today it is not there, so they feel free to get pregnant...” (Mamaga 2, Queen mother).*

Another queen mother’s view seemed to challenge the notion that the cessation of the traditional cultural practices on puberty was to blame for the rise in adolescent pregnancies. To her it was rather those practices that opened the way for the girls to get pregnant:

*“Our cultural practices included monitoring a girl for some time and then performing the puberty rite called ‘egbelele’ for her [...] that rite then initiated the girl into womanhood. Example, there is this girl that I know, just one year after taking her through the rites, she got pregnant because she was free to do that...I don’t think it was a good practice” (Mamaga 1, Queen mother).*

#### **4.1.5 Misinformation about and stigmatization of ARHS**

An interesting observation the research team made during the data gathering process was that adolescents in the communities, apart from being largely misinformed about the range of protective sex options, were also shy of patronizing the few they knew about. During the focus group discussion, most participants were notably quiet and when the moderator asked why, one participant boldly said they were shy to talk about that. When they were convinced to feel free and talk because this was only an academic research exercise, most participants admitted that they did not patronize RHS because they had been told that most of the contraceptive options available were dangerous and also they were afraid of being labeled as “bad girls”:

*“...I don’t know so much about reproductive health services...only family planning... that one I have heard a lot about family planning. I heard from town*

*folks that when you do family planning, you may never give birth that is why I did not go for it...*"(Edzeani, Pregnant adolescent)

Another participant said:

*"I know of family planning which I can access after giving birth so that I don't get pregnant again. I had always wanted to patronize contraceptives before this pregnancy but I have a cousin who said she did the injectable and it was not good for her so I should never try any if not I would have problems."*(Abla, Pregnant Adolescent)

The fear of being called a "bad girl" also played into adolescent girls' unwillingness to patronize RHS:

*"...hmmm, when my boyfriend started having sex with me, he told me to go and get some contraceptives, but...hmm...only bad girls do that because if I had gone to the RHS facility for contraceptives, then they would get to know that I was having sex...so when I got pregnant, my boyfriend became angry with me for not obeying him..."* (Afi, Pregnant Adolescent)

An experience shared by another participant cast some doubt on the observation of professional ethics by RHS personnel in the communities:

*"...Me?...I would never go there...one of my friends went there, and the next day one of the nurses there told her parents that she had come there looking for contraceptives and that she was having sex[...]she was beaten mercilessly by her father..."*(Fafa, pregnant adolescent)

Thus it became obvious that key stakeholders in adolescent reproductive health (RHS personnel, parents and the general community) were part of the reason why adolescents were not patronizing the service. Indeed the environment was not enabling enough for the ARHS to thrive and promote the sexual and reproductive health of the adolescents.

Some key informants confirmed the experiences recounted by some of the adolescents by saying that they thought the general community and especially parents were the reason why RHS for adolescents in the community was not working well.

*"...when health professionals come into this village to organize discussions and education programmes on sexual health and protective sex for the young people in*

*this village, most parents would forbid their adolescent children from attending...one parent told me she doesn't want her daughter learning about sex and another said she heard her son telling someone on phone about how to use a condom so she has stopped him from attending these programmes...”(Community Health Nurse).*

Another was of the view that the community itself looks out for adolescents who attend these programmes and later use that to insult them as being bad children, sometimes including even pastors in the community:

*“..I think the only RHS programme that this community would understand would be one that only teaches abstinence and nothing else...(laughs)...children who attend these programmes usually get insulted ...and sometimes even pastors use that to preach in their churches and call these children “children of the devil”(Community midwife).*

From experiences recounted, the situation makes it difficult for adolescents who are already pregnant to attend the RHS facility for help and advice on how to handle themselves and the pregnancy. Most pregnant adolescent participants expressed the fear of being reproached by the service personnel and being insulted by community members on the way to the facility. With no one to accompany them to the facility, most pregnant adolescents simply found it safer to be at home:

*“...I have not thought of going there (the RHS facility) yet...the nurse there once told my mother that she suspected I was having sex, and I denied it[...]so now I'm shy to go there...she will insult me if I go there...”(Fafa, Pregnant Adolescent )*

Another participant said:

*“...me?...oh no...where will I even pass to go to that place (referring to the RHS facility)...I would receive a thousand insults on the way before I get there and get reproached again when I get there[...]It's better for me to stay home and eat well...”(Afi, pregnant adolescent)*

One other participant said:

*“... Well, I have thought of going there for some time, but the thing is, there is no one to accompany me there [...] my parents will certainly not do that, and my best*

*friend too has been warned by her parents to stay away from me [...] If I walk there alone, they will be sneering at me on the way that's why I haven't gone yet [...] but I will go there before this baby comes out..."* (Abla, Pregnant Adolescent)

One pregnant adolescent recounted boldly going there and to her surprise receiving good counsel and supportive service from the head midwife at the facility. She said she was encouraged to go there on her next scheduled appointment but the midwife was absent and the assistants there were very cross with her:

*"...The head midwife is good...the first time I was bold enough to go there, she was so nice to me [...] but on my next appointment, she was absent and the assistants there were telling me that instead of focusing on my studies I went having sex and I am bringing a baby into this world to suffer [...] I will only go there when the midwife is around..."* (Sena, Pregnant Adolescent)

Adolescent mothers rather seemed bolder and able to deal with the community sneering and reproach and therefore seemed to patronize RHS more frequently. For most of them, they were used to the insults and stigma and no more cared what people would say and for others, experiences of difficult birth, poverty, and the fear of getting pregnant again made them willing to brave the stigma and get advice from the RHS facility:

*"...I stayed home because of the insults when I was pregnant, and I nearly died from birth complications...they can say whatever they want, I know I am already rejected, I have nothing else to lose[...]it's better to get advice and protect myself.. So I will go there..."* (Elolo, Adolescent Mother)

Another said:

*"...Well, I do not work, and my parents have refused to give me any financial support, so how will I eat and feed my child too?...the only way is to be with a man and that will mean another pregnancy on the way [...] from my past experience, it is better to be insulted and protected than to fear insult and put myself through that situation again [...]I will go there even if they beat me..."*(Nana, Adolescent Mother)

## 4.2 Resources

### 4.2.1 Parents, educated family, benevolent persons and churches

Interestingly, some of the very factors that accounted for stressors experienced by pregnant adolescents and adolescent mothers, also seemed to be a form of Generalized Resistance Resources (GRRs) for some of the participants. These were factors that helped pregnant adolescents and adolescent mothers with their situation to some extent, with some even thriving despite the stressors. There were experiences of some form of social support coming from a few parents and mostly from educated extended family members who lived in the cities and some benevolent who lived in the communities. Churches in the communities, despite being against premarital sex and especially sexual activity among children also seemed to be a good GRR upon which pregnant adolescents and adolescent mothers could count. The majority of participating pregnant adolescents and adolescent mothers agreed especially to the resourcefulness of their churches in their situations:

*“...I thank God that we have this church in the village. When I got pregnant, I was an active member in the youth ministry, so I was really ashamed but after the pastor reproached me for bringing shame to the church, he encouraged the ministry to be supportive of me[...] they have been my friends through it all...”*(Adukonu, Adolescent Mother)

Another recounted receiving financial support from the church:

*“...The church constitution makes provision for members who pay their dues to receive some money from the church on occasions like weddings, funerals or birth of a baby[...]so when I had my baby, I got paid...it was really helpful...”*(Elolo, Adolescent mother)

For another participant, the cold attitude of her parents drove her into the compassion of the pastor and his wife:

*“...when my parents became cold towards me, I wasn't comfortable at home, so I would wake up early dawn to come to the church compound and clean the place...the pastor and his wife became compassionate towards me and started giving me money and counseling...soon the whole church became warm towards me..”*(Nana, Adolescent Mother)

Though participants agreed facing parental rejection at the onset of pregnancy and sometimes, throughout the pregnancy period, some recounted experiences in which angry parents would rather give money and some items to people outside the family to give to the pregnant daughter because they still didn't want to see their faces:

*"...My father rejected me alright...he wanted to have nothing to do with me...but once a while, one of his friends would come to me and say your father said I should give you this...sometimes money, other times, may be food or baby stuff [...] I could feel the pain that my dad didn't want to see me...but I couldn't blame him too much...the items really helped..."* (Dzidzi, Pregnant Adolescent)

One key informant confirmed this experience with a different, interesting explanation demonstrating how the community environment was indeed not supportive of families who experience adolescent pregnancy:

*"...yes that is true...but from my experience, sometimes it isn't that the parent doesn't want to see the pregnant child...they just want to avoid being labeled a bad parent by the community...My friend gave me items for his pregnant daughter not because he hated her...but because people would say he was a bad father encouraging his daughter to be pregnant..."* (Community midwife)

No matter the channel through which these forms of parental support were delivered, pregnant adolescents and adolescent mothers agreed that they were an important resource that helped them cope with their situation.

Some participants also recounted receiving support mostly from educated members of their extended families who lived in the cities. There were accounts of educated extended family making regular phone calls to pregnant adolescents to inquire about how they were faring and encouraging them to hold on to the pregnancy and attend the RHS facility to stay healthy:

*"...My only friend was my cousin who lived with her parents in Accra and was attending university. She would call me every weekend during my pregnancy to find out how I was doing and tell me that my child would be as beautiful as me [...] I really looked forward to her call every weekend... she just gave me so much hope..."* (Eduzi, Pregnant Adolescent)

For another participant, it was her father's brother who was living and working in Accra who intervened to get her parents to warm up to her:



*“...My parents now support me after 8 months of pregnancy thanks to my father’s elder brother who is an accountant in Accra. When he heard what was happening to me, he came down here and called a meeting with my parents and blasted them for abandoning me[...]ever since, my parents have become friendly to me and give me money and other stuff...”*(Sena, Pregnant Adolescent)

Another participant praised some benevolent others in the village community:

*“...Someone I could count on?[...] I don’t think so, except may be some community members who see me and have some compassion towards me [...] this pregnancy has made me so frail and weak, I was a big bubbly girl before I got pregnant, so when they see me like this, they feel my pain and support me with food stuffs and some clothes. I would say I count on their help every time [...] they do so well for me...”* (Abla, Pregnant Adolescent)

#### **4.2.2 Personal strength and courage (Hardiness)**

For the most part, all participants—both adolescents and key informants—agreed that it was up to the adolescent to muster courage and find inner strength to deal with the situation and remain healthy both mentally and physically. The general consensus was that a pregnant adolescent girl or an adolescent mother could not expect to be accepted and treated well in the community largely because the community culture, dominant religion and structure seemed to be designed to be negative towards the concept of adolescent pregnancy and motherhood and even the very thought that adolescents are having sex:

*“...when you get pregnant, it becomes known that you have been having sex....and that is unacceptable adolescent behavior in this community[...]we are Christians...so definitely, you will face rejection [...]it would then be up to you to find strength within yourself to continue living here...”*(Edudzi, pregnant Adolescent)

A pregnant adolescent said:

*“...I would say I have become stronger through the months of pregnancy...this community is designed to be against people like me [...]I am used to that, so I go about my life paying no attention to them (referring to the community)[...]I have*

*accepted that I have no one but myself [... ]I feel better and healthier now than when it began...” (Abla, pregnant Adolescent)*

An adolescent mother said:

*“...Oh... no one but myself[... ]I brought this on myself so I have to deal with it...no need for self-pity again[... ]I have a son now and I must be strong for him[... ]I am determined to ride this storm” (Edzaeni, adolescent mother)*

Some of the adolescents had decided to brave the community stigma and take to petty trading to fend for themselves though many people do not buy from them:

*“..I do petty trading now[... ]I don't care what they think of me[... ]I have to eat and take care of my baby[... ]I sell coconut toffees and when I take it to the market most people from this community do not buy from me but others from outside this village buy from me. I am ok with that...” (Adukonu, Adolescent mother)*

#### **4.2.3 Availability of reproductive health services (RHS)**

Adolescent reproductive health services are readily available and accessible. Most of the participants are aware of these services but did not patronize it due to societal perceptions of people who go close to the service points, coupled with the myths, misinformation and misconceptions and inadequate knowledge about the services.

*“Sometimes when you go to buy in the chemical shops and there happens to be an elderly person around, the kind of look or remarks from them when they hear you mention a method is so embarrassing so it does not motivate you to go back [... ] but now, the nurses who come to the community to weigh the kids, provide the RHS. What I also know is that they make sure there are not too many people around before they do it. I am planning to go and do family planning so that I don't get pregnant again.” (Nana, Adolescent Mother).*

Most of them have fallen victims of non-patronization of the services and have resolved to access it after delivery to prevent another pregnancy

*“However, looking at what I am going through now, I have planned to go in for the monthly one” (Edzeani, adolescent mother)*

#### 4.2.4 The community midwife

Indeed despite the general community attitude being described as negative towards pregnant adolescents and adolescent mothers, the community midwife stood out as a huge resource with some pregnant adolescent girls describing her in some instances as a “fountain”- which in the local community culture means –the resource that makes all things flourish. For most participating pregnant adolescents, the midwife was the most friendly health personnel in the community and the only reason they even think of attending the clinic. She was described as the only one who says nothing about being a bad girl but everything about being a bad mother if she found out that you do not attend the clinic regularly. It emerged from the focus group discussions and interviews that most of the pregnant adolescents who braved the stigma and community sneering to attend the RHS facility found the strength to do this partly through the encouragement of the midwife:

*“...like I said, I attend the clinic when the head midwife is around[...]she makes you feel like what has happened to you is not so bad and that if you attend the clinic regularly, you and your baby would be alright, the others are not so nice...”*(Nana, Adolescent mother).

*“The midwife is so nice but some of the other nurses do not give me prompt attention”* (Abla, Pregnant Adolescent)

The midwife relates so well with community leaders. She sorts the advice of leaders especially the queen mother regarding the welfare of pregnant girls in the communities. In complicated issues, like the pregnant girls refusing to accept referrals to the municipal or regional hospitals.

*“For the midwife we have at the clinic, she sometimes comes to report to me if she finds a problem with any of the girls and the necessary intervention is carried out. If they need to go to a bigger hospital she explains ...when the midwife is around, she keeps in touch with me so I could contact the girls. She is one person the girls can count on when they become pregnant...she does so well...”* (Mamaga 1, Queen Mother).

The head teacher of one of the community basic schools described how the school’s relationship with the head midwife changed from sour to sweet after the school authorities realized that they were judging the midwife wrongly:

*“...From the beginning some of my staff thought she was the one encouraging the girls to engage in sex with all that pressure on us to organize sex education programmes [...] she even got the District Director of Education to put pressure on us...when we began doing it, the pregnancy rate for that year went down a little, and we saw that she was rather helping the school[...]I would say she is very good...”* (School head, 2).

Almost all participants attested to the fact that the midwife has a very good relationship with the school regarding adolescent pregnancy issues. Anytime the school needs her assistance in such cases, she is readily available to discuss and render help

*“With our clinic over here, the midwife, she’s been very helpful and supportive. Anytime a girl gets pregnant we go to see her on the quiet so the moment the girls come she receives them nicely into her home. There are moments I recall she keeps some of them in her home until the time of delivery and then they go to their parents who then take them to trafalga ( the regional hospital) for delivery”* (School Head 1)

So the community and the midwife have very healthy relationship in terms of the pregnant girls’ welfare. She also discusses the need for parent and the community to support the girls

#### **4.2.5 Female teachers in the community schools**

It also emerged that the females among the teaching staff of the community basic schools were also a resource for adolescent girls who got pregnant and those who became mothers. Most of the participating adolescents described them as being good in monitoring how the male teachers related to some of the girls in the schools as it happened occasionally that some male teachers took advantage of the girls and sometimes impregnated them. For the few girls who had been lucky to go back to school after having their babies, it emerged that the female teachers played key roles in apologizing to their parents and encouraging them not to give up on their daughters:

*“...Oh I know one girl who is back in school now after having her baby...but she was lucky that when the female teachers went to apologize to her father, the man accepted and listened to their advice....they do that a lot, but some parents listen to them and others don’t...”*(Afi, Adolescent Mother)

One pregnant adolescent actually had the motivation from the back-to-school girl’s case that she would go and talk to her teachers to go and apologize to her parents as they did for that girl:

*“...I haven’t lost hope...I know that if I go and see the female teachers, they will help me...they did it for one of my friends and she is now back to school [...] I only pray that my parents will listen to them...but I am sure that if I go to see them, they will go and talk to my parents for me...”* (Efe, Pregnant Adolescent)

Key informants explained that the teachers in the schools do not come from the village and therefore do not share the community ideas about rejecting pregnant adolescents. According to one informant, while the community itself does not trust the male teachers because of previous incidents of some of them impregnating school girls, the female teachers were respected because most parents in the community would like to see their daughters become as polished and educated as them. This gives the female teachers that power to influence parents to get their daughters back to school after pregnancy and delivery:

*“...I think that is because the teachers do not come from this community so they see things differently...they come from the cities and you know in those places children are spoilt so when they come here, they do not see teenage pregnancy as bad as we see it...”* (Mamaga 2, Queen mother)

Another community elder said:

*“...As for the female teachers we respect them because we want our daughters to be as polished and educated as they are...so when they come to you, they can convince you...but the males would not dare because they are part of the problem...some of them impregnate the girls...”* (Mamaga 1, Queen mother)

#### **4.2.6 The National Health Insurance Scheme**

In the face of rejection from parents and stigma from community, most pregnant adolescents face severe economic and financial constraints. However, most participating adolescents agreed that this financial constraint fortunately does not include access to health care and RHS. Thanks to the introduction of the National Health Insurance Scheme (NHIS) by the government of Ghana in 2005. The scheme makes provisions for adolescents (including pregnant ones), children and the aged registered with the scheme to access health care free of charge. For pregnant adolescents, this includes pre and post-natal care implying that pregnant adolescents were relieved of the problem of having to pay for healthcare services:

*“...luckily for me, I am registered with the NHIS so I don’t have to pay when I go to the clinic... I just don’t go often because of how they will look at me...” (Afi, Pregnant Adolescent)*

However, some of the participating pregnant adolescents still faced problems accessing complete care through the scheme. There were complaints of some expensive but essential treatments and services that were not listed on the NHIS and had to be paid for:

*“...Yea some of my friends who are pregnant use the NHIS, but in my case, any time I go there they tell me the test I have to do is not listed on the scheme so I have to pay[...]and I have no money so I don’t go there anymore...”(Edudzi, Pregnant Adolescent)*

A key informant described the NHIS as being helpful in the past and a frustrating resource in the present:

*“...well, maybe I can say they could rely on the NHIS but that was in the past...these days, that scheme does not cover the essential things...they only give you paracetamol...you have to pay for the things you really need...sometimes when you present the card at the pharmacy, their faces look angry because they say the government does not pay...it’s a frustrating resource presently...” (Mamaga 1, Queen mother).*

Despite the ‘frustration’ using the NHIS most participating pregnant adolescents thought that in the midst of their social and financial situation, it was still a resource that is better than nothing.

#### **4.2.7 Traditional Birth Attendants (TBAs)**

The local Ghanaian traditional health system includes native herbal doctors and midwives who, historically, had been the pillars in health care delivery before the advent of modern medicine. In rural areas in modern day Ghana, these practitioners still exist and are still active ‘health professionals’, attending to the health care needs of rural populations. Though there have been government campaigns to try to get people to go to the hospitals instead of these local native practitioners whose practices are largely unregulated and therefore untrusted in the modern world. Local rural populations seem to have deep-seated trust in them believing that their ancestors lived long because they patronized the services of these individuals. In the Awudome area, this idea is hugely popular and traditional midwives, called Traditional Birth Attendants (TBAs)

have been a huge resource especially for pregnant adolescent girls who are cash-strapped as a result of rejection from both parents and boyfriends:

*“...my grandma is a TBA...she has delivered so many children in this village over the years...so she handled the delivery of my baby[...]had it not been for her, I don't know what I would have done...”*(Nana, Adolescent Mother).

A queen mother in one of the villages described the TBAs as better than hospital midwives because they were more experienced:

*“...myself, I had all my children through the village TBA...what do those small girls at the hospital know? If you are not careful they will make things worse and doctors will have to operate you...I encourage the girls to go to the village TBA because they are more experienced and it is even cheaper there...”*(Mamaga 2, Queen mother).

One village elder described how she had suggested to the village chief that the community should come together to contribute and pay something to the TBA in their village so that all pregnant girls could go there instead of going to the hospitals to face insults and pay expensive prices but was rejected:

*“...I once suggested that we should contribute and pay the TBA so that the girls can go there and avoid the insults and expensive prices at the hospitals, but the chief told me the insults are good for the girls and the heavy prices mean that the girls will be careful when they think about having sex...”* (Mamaga 2, Queen mother).

But most of the girls would prefer to deliver their babies at the clinic or hospital given the chance to make their own decisions with reasons that, they will receive prompt care in case of complication.

*“I will prefer to deliver at the clinic because I am sure to get the necessary care. They can help me if there is a problem with my delivery. Besides, I don't think the home delivery is advisable because they can't treat difficult problems”* (Abla, Pregnant Adolescent).

In all, the participants agreed that indeed the TBAs have become a resource for pregnant adolescents because they are cheaper and treat the girls well. Again, some explained that the

TBAs are usually located at places in the villages where the girls do not have to walk through the village street to go and see them. Thus going to the TBA means avoiding the public eyes, accessing cheaper service, and following your village tradition.

#### **4.2.8 Non-governmental organizations (NGOs)**

There are three main NGOs in the Ho municipality (Marie Stopes International, Village Exchange International and Savanna Signatures), with the mission of helping adolescents to have access to ARHS information and services during the time of data collection. One of them was included in this study (Savanna Signatures, SavSign) and its representative was interviewed. This NGO was also into training adolescent mothers to acquire skills in some handicrafts. It emerged that, the organization was having on-going adolescent reproductive health education programmes within the Volta Region where the Awudome community is located. The representative said the NGO also provided skills training for adolescent mothers who could not go back to school. This was serving as resources for the adolescent mothers.

*“...currently we have skill training sessions for adolescent mothers who have not been able to go back to school...we are teaching them sewing, hair dressing and other skills...we also have information sessions where we educate them on the use of contraceptives to prevent further pregnancy...”(Male NGO Official)*

The head of school confirmed this by saying:

*“... We have this NGO called NUYAWA and they come to talk to the children about the ramifications of teen sex and also provide their services at the clinic for students who will need it. So far that is what we have been doing...” (Head of school 1)*

One participating adolescent mother confirmed benefiting from the NUYAWA skill training programme:

*“...now I sew and patch clothes for people for a living...the NUYAWA people taught me sewing when I was pregnant[...]so when I had my baby I put a table in front of my grandmother’s house and my uncle from Accra bought me a sewing machine[...]so that is how I survive...”(Amavi, Adolescent mother)*

To sum it all, the data collection exercise revealed that pregnant adolescents and adolescent mothers in the *Awudome* area of the Volta Region of Ghana go through several stressful



situations ranging from economic and financial difficulties to rejection from almost all angles of their social environments. This exposes them to emotional pain and deteriorating mental and physical health. They are largely denied crucial social support, their education is often cut short and they are generally left alone to fend for themselves. However, within the context of these difficulties, the adolescents who find themselves in this situation manage to identify and utilize some few available resources including their own personal inner strength and courage, the community midwife, help from churches, benevolent individuals, educated extended family, health and education personnel and Non-governmental organizations who design and implement support programmes for them.

The implications of these findings for the adolescent population of the *Awudome* area especially pregnant adolescents and adolescent mothers, the communities involved in this study and public health stakeholders as well as implications for future research are discussed in the next chapter of this project.

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.0 Introduction**

The findings from this study show that, the general experiences of pregnant adolescents and adolescent mothers are that of severe stress stemming from a lack of a supportive general social, economic, cultural and policy environment. However, in the midst of these stressors, individual personal strength, and support from willing actors within the communities served as generalized resistance resources upon which the adolescents could draw on to cope with their situation.

#### **5.1 Stress experiences for PAs and AMs and its implications**

##### **5.1.1. Abandonment and consequent financial constraints**

It emerged in this study that, aside the general economic difficulties faced by families in the area, intentional abandonment of the pregnant adolescent or adolescent mother by parents, boyfriends and significant others stemming from anger and perceptions of shame brought on by the pregnancy accounts for financial difficulties faced by adolescent girls who become pregnant. The plight of the adolescent girls is worsened by their own inability to engage in economic activity as a result of the pregnancy or the baby they have to care for, as well as the general community's unwillingness to engage with them.

For the pregnant adolescent girl, the implications of such abandonment by parents and the man responsible for the pregnancy and the lack of financial resources may be profound for her present condition, her unborn child and her future prospects. First, the lack of financial assistance means that the pregnant adolescent may not be able to access resources necessary for a pregnant woman such as balanced diets and medicinal supplements that, according to reproductive health professionals, help keep the mother healthy to benefit the developing fetus (Gyesaw & Ankomah, 2013; Hokororo et al., 2014). In this situation, the health of the mother whose biological system may itself not be ready enough to carry a baby may be at risk (Arthur, 2012).

Again, as observed by Atuyambe, Mirembe, Tumwesigye, Kirumira, and Faxelid (2008) most pregnant adolescents are experiencing pregnancy—a condition that triggers a string of biological processes and hormonal changes in the female body (Mulder et al., 2002), for the first time. Without any prior experience, all first time mothers (including even adults) need profound support from both health professionals and family to be able to understand what is happening to

their body and how to manage it. For an adolescent girl, such help and support may be even more crucial considering that the hormonal and other biological changes that come with pregnancy may be occurring in a body that may be too young. Regular observation by health personnel and support from experienced adults in the family are therefore necessary to help the pregnant child sail through the period. While existing government provisions on adolescent health care and the NHIS of Ghana should make it easy for pregnant adolescents especially to access antenatal care and receive support from health professionals (Abor, Abekah-Nkrumah, Sakyi, Adjasi, & Abor, 2011), a seemingly hostile community environment and negative attitudes of some of the trained health professionals themselves seems to be a road block to this access. The denial of this form of a supportive environment necessarily implies profound risk to the health of both the adolescent girl and the unborn child.

For an adolescent mother, while the risk of pregnancy complications due to lack of financial resources may be over, there are still negative implications for themselves and their babies stemming largely from inadequate patronization of post-natal care services due to community stigmatization, lack of finances and inadequate information. The lack of financial resources and support from family implies a limitation in access to basic needs such as food, clothes, medications and other supplements that the infant may need for its development and the mother for her recovery from the biological changes orchestrated by the pregnancy. Considering findings reported by (Akella & Jordan, 2015) that most post birth self-harm observed in young mothers are a result of lack of support from parents and male partners, the present findings give cause for concern. As observed by Coard, Nitz, and Felice (2000) adolescent mothers, desperate for financial resources to access these things, may resort to the same tactics that got them pregnant in the first place—taking boyfriends and indulging in sexual activity. When this occurs, the risk of a second pregnancy rises, depreciating any chances of a return to school and the attainment of skill training for a better economic future. Thus a vicious cycle of reproduction and consequent poverty may begin in the young life of the adolescent mother.

While the experience of stress and hardship is a hugely documented occurrence for pregnant adolescents and adolescent mothers, (Greydanus, Pratt, & Patel, 2012; Kalil & Kunz, 2000; Larson, 2007; Pogoy, Verzosa, Coming, & Agustino, 2014), most research have found evidence to attribute these experiences to general parental and community poverty especially in developing countries (Ponnet, 2014) and minority communities in some developed countries (Larson, 2007). This present study differs in this attribution as it emerged that intentional abandonment, rather than general community poverty, is the key causal factor of financial and

other difficulties faced by pregnant adolescents and adolescent mothers in the Ho west district of Ghana.

The observation of family anger at a pregnant adolescent for bringing shame to the family and the consequent abandonment in this study also confirms findings reported by Salami, Ayegboyin, and Adedeji (2015), that communities in certain developing countries have cultural and behavioral expectations of female children that exposes the child to abandonment, mistreatment and sometimes even violent abuse if these expectations are breached especially by the incidence of a pregnancy outside marriage. In the face of this evidence, community education on parental responsibility towards adolescent children could be a necessary and viable intervention for the population studied.

### **6.1.2 Rejection, shame and consequent psychological and emotional problems**

Although widespread financial difficulties for pregnant adolescents and adolescent mothers were generally reported, it also emerged in this study that some parents preferred to stay away from their pregnant adolescent daughters and rather provided whatever support they had for them through their friends and acquaintances. This, according to the participants in this study, was a result of fear of criticism for being a bad parent. Unquestionably therefore, it became evident that parents of pregnant adolescents and adolescent mothers definitely felt a sense of shame that made them unwilling to accommodate or associate with such daughters. In addition to this, the men responsible for the pregnancy were also found to be largely shamed by the pregnancy and therefore unwilling to associate with the girls who, as reported by some participants, used to be their 'sweet hearts'. Considering that developmental psychologists describe adolescents as largely impressionistic (Schonberg & Tellerman, 1997; Wilson-Mitchell, Bennett, & Stennett, 2014), always in need of recognition especially from the opposite sex (Shivers, 2011, p. 20), and emotionally volatile (Glover, 2011), the implication of this sort of rejection and betrayal from such significant people is likely to be traumatic to the adolescent pregnant girl. This may further be compounded by the pregnant girl's own feelings of shame from the acknowledgement of breaking the rules for being a 'good girl' in the community as observed in the findings. As observed, this often resulted in self-isolation and a self-imposed 'house arrest' for the pregnant girl or mother. In the condition of pregnancy, such experiences may be detrimental to the emotional health of the mother which may precipitate harmful consequences for the development of the unborn baby (Glover, 2011; Watts et al., 2015; Weinstock, 2005). For the mother herself, these experiences are recipes for the occurrence of psychological problems such as depression, lowered self-esteem and even sometimes suicidal

ideation (M. V. Smith, Shao, Howell, Lin, & Yonkers, 2011; Stanton, Lawn, Hussein, McCaw-Binns, & Webber, 2012). For girls who have already had their babies, existing research (Sit & Wisner, 2009; Stanton et al., 2012) suggests that the experience of such pregnancy-related stressors may cause maternal ambivalence towards the infant as the mother may tend to see the infant as the source of her problems. In extreme cases, this may lead to the mother harming the infant, herself or both.

### **5.1.3 Educational constraints**

The complex chain of negative events triggered by the incidence of a pregnancy or child birth in an adolescent girl was also found to include a disruption in the schooling or education of the girl. Indeed for some of the girls, it meant a complete end to their formal education. Reports of male school teachers being responsible for some pregnancies and the pregnant girl being stigmatized and becoming an 'ugly' taint of her school's image were recorded. For some schools, the fear of parents withdrawing their children from the school fearing bad influence from pregnant school girls was enough for them to refuse to accept former pupils who had given birth and were willing to come back to school (Simwapenga-Hamusonde, 2011; J. L. Smith et al., 2012). For girls who were still pregnant and willing to continue schooling, some of the schools were found to adopt tactics that made the girls uncomfortable enough to give up. Though this is a breach of regulations from the Ghana Education Service (GES) that allows pregnant girls to continue schooling until such a time that they are incapable, the situation seemed to be still on-going in the communities where data were collected.

As observed by Domenico and Jones (2007), the disruption, and sometimes complete cessation of formal education as a result of pregnancy, leaves most pregnant adolescents giving up on their planned future careers and losing any hopes for a better future. Coupled with rejection from family and community, the pregnant adolescent or adolescent mother in the Awudome area faces a difficult life situation that, historically, has led to suicide among young people in some populations (Chauke, 2013; Darisi, 2007; Wilson-Mitchell et al., 2014). The situation holds implications not only for the adolescent girl caught in this web of difficulty, but also for community and national youth development which is a crucial backbone to national development. The cessation of education for young girls necessarily implies diminishing future educated human resource for their communities and their country and the psychological problems that may result from the seeming 360 degree rejection and experience of stress necessarily implies an increased probability of rise in future mental health costs for the country.

#### **5.1.4 Cultural and Religious constraints**

The findings also revealed that the seeming community-wide stigma and rejection faced by pregnant adolescents and adolescent mothers resulted from community belief systems, norms and practices that classify adolescent sexual activity as unacceptable, and therefore lead to the negative labeling of adolescent pregnant girls and mothers. This is consistent with findings reported by (Chauke, 2013) who observed that local community cultural perceptions often acts as impediment for the freedom of adolescent pregnant girls. This labeling undoubtedly could be one reason accounting for the unwillingness of the males who get these girls pregnant to accept the pregnancy or even associate with the girls any more, leaving the girls feeling betrayed. The revelation that abortion (Ghana abortion Law No. 102 of 22 February, 1985), an option that, if safely done by a qualified medical professional in government or private institution duly registered, could save the situation for the young adolescent girl is considered a taboo in the community makes the case of the pregnant adolescent hopeless. Also, the ‘nail in the coffin’ for these girls was the revelation that ancient traditional cultural rituals that sentenced adolescent pregnant girls and not their male partners to be ostracized were still being perpetrated in modified ways. Modern day Ghanaian society has health and social life policies such as the Comprehensive Abortion Care (CAC) (Hesse & Samba, 2006) and post abortion care (Rasch, Yambesi, & Massawe, 2006) that make abortion legal, free and an option to be considered by any pregnant woman who so wishes (Oduro & Otsin, 2014).

The existence of harmful cultural norms and practices about teenage pregnancy that are still being perpetrated in some communities implies that either public education campaigns on these policies mounted by the government have not effectively reached rural communities like Awudome, the campaign strategies themselves have not been effective or that there is a plain, simple lack of strategies for enforcing these policies (Sundaram, Juarez, Bankole, & Singh, 2012). The policy environment therefore, as observed in this study, is not supportive enough for the lives and health of this group of adolescents and their families. Perhaps further future research should try to delve into the kinds of implementation strategies for adolescent reproductive health that the Ghana Health Service has in place first, and then a research evaluation of these strategies carried out to ascertain their effectiveness.

Overall, the totality of stressors experienced by pregnant adolescents and adolescent mothers seems quiet overwhelming as all angles of community social life beginning right from the family home of the adolescent and extending through community health facilities to the broader community environment seems to be working together to squeeze out the already ‘troubled’

adolescent. From financial constraints to educational constraints, parental and community rejection to feelings of guilty, the pregnant adolescent and adolescent mother in the Awudome area of the Volta Region of Ghana seem to be in real big trouble.

## **5.2. Resource experience and utilization and their implication for the PAs and AMs**

### **5.2.1 Personal strength**

The Salutogenesis theory that guided the conduct of this study argues that individuals' ability to identify and utilize generalized resistance resources within their environments leads to the formation of a sense of coherence (SOC) that determines their ability to cope with whatever stressful circumstances they may be facing and even sometimes thrive in that environment despite the existence of stressors (Antonovsky, 1996a). Thus, logically, the more resources the individual is able to identify and utilize, the stronger the sense of coherence that develops and the better the individual is able to thrive in the face of stressors (Gyan, 2013; Hintermair, 2004). Indeed this argument was confirmed when the findings in this study showed that in the midst of their stressful situations, some pregnant adolescents and adolescent mothers seemed to be able to draw strength from personal mentality and willing actors within their communities to keep going. Some pregnant adolescents recounted gradually mentally assessing their situation and developing some form of hardiness to face up to their challenges and take their futures in their own hand. There were some mothers who had given up on hiding from the public scourge and had become brave enough to show themselves in public, those who had taken themselves to community agents who were willing to help them to acquire skill training to engage in petty economic activity as well as those who had become determined, braved the ridicule and scorn to access safe sex services such as contraceptives from the community RHS facility. Whilst the development of such hardiness could be an indication of the extent of desperation that the pregnant adolescent or adolescent mother is in, it is also a demonstration of their ability to be resourceful mentally for themselves and a willingness to subscribe to measures that ensure that they get themselves up and doing.

The implication of this is that, should there be formal community measures to safeguard the health and wellbeing as well as continuous education or economic activity of the pregnant adolescent or adolescent mother, the adolescent would patronize it and the vicious cycle of poverty could be broken. As observed by (Gyan, 2013), reintegration of adolescent mothers into schools helps their continuous educational development and gives them a chance to build a future for themselves and their babies. Simwapenga-Hamusonde (2011) also found that

adolescents who have experienced pregnancy and child birth and have been reintegrated into school are less likely to engage in sexual activity that may re-expose them to pregnancy as compared to those who have not had the experience before. In this regard, the demonstration of hardiness by the adolescents could be a personal resource into which parents and stakeholders could tap to rescue pregnant adolescents and adolescent mothers in the Awudome community.

### **5.2.2 The community midwife and access to ARH services**

Aside the personal resource utilized by the pregnant adolescents and adolescent mothers to try to deal with their situation, certain willing actors within the communities had also become resources for the adolescents to cope with their situation and get some access to reproductive health services. Key among these actors was the midwife of the community clinic. Indeed, both adolescents and key informants in the community agreed that the midwife had been a resource by giving advice, routinely checking up on pregnant adolescents and working with community stakeholders to try and get some help for pregnant adolescents and adolescent mothers.

Despite working together with some staff who, according to the findings, contributes to the shaming of pregnant adolescents, the midwife is described as being the exception and always being positive with the adolescents. Thus, the midwife became an agent through whom the pregnant girls and adolescent mothers accessed reproductive health services. The findings reveal a difficult work situation for the midwife in the communities. The community midwife works in an environment that is not supportive of adolescent reproductive health and sometimes even facing accusations of contributing to teenage pregnancy. The implication is that, in the absence of this single midwife, government programmes to ensure the health of adolescents become non-functional, and the adolescents refuse patronization.

The revelations suggest an urgent need for government and other stakeholder support for the midwife in order to help her help pregnant adolescents and adolescent mothers. Indeed, this observation about the midwife is consistent with the findings of (Warenus et al., 2006) who reported that in the midst of difficulty, community midwives usually become the beacon of trust for most adolescent pregnant girls, playing key roles as stakeholders in adolescent reproductive health. Ahanonu (2014) observes that communities with properly trained midwives often do better in issues of adolescent reproductive health. The findings here suggest a need for reassessment and retraining of reproductive health staff in rural communities like Awudome as it has been revealed that the staff themselves may be stressors instead of resources for pregnant adolescents.



### **5.2.3 Educated family members**

Educated family members living in cities also emerged as resources for pregnant adolescents and adolescent mothers. These actors played different roles ranging from advice and encouragement, to financial support that gave pregnant adolescents and adolescent mothers something to look up to in the face of local family and community rejection. This is consistent with findings obtained by Madkour, Xie, and Harville (2013) who reported a positive relationship between parental and family education and support for pregnant teenage daughters. This particular finding imply that the development and implementation of educational interventions targeted at parents and local family of adolescent pregnant girls could go a long way to help improve the understanding of the plights of the pregnant adolescent, and soothe the relationship between family and daughter.

### **5.2.4 Traditional Birth Attendants**

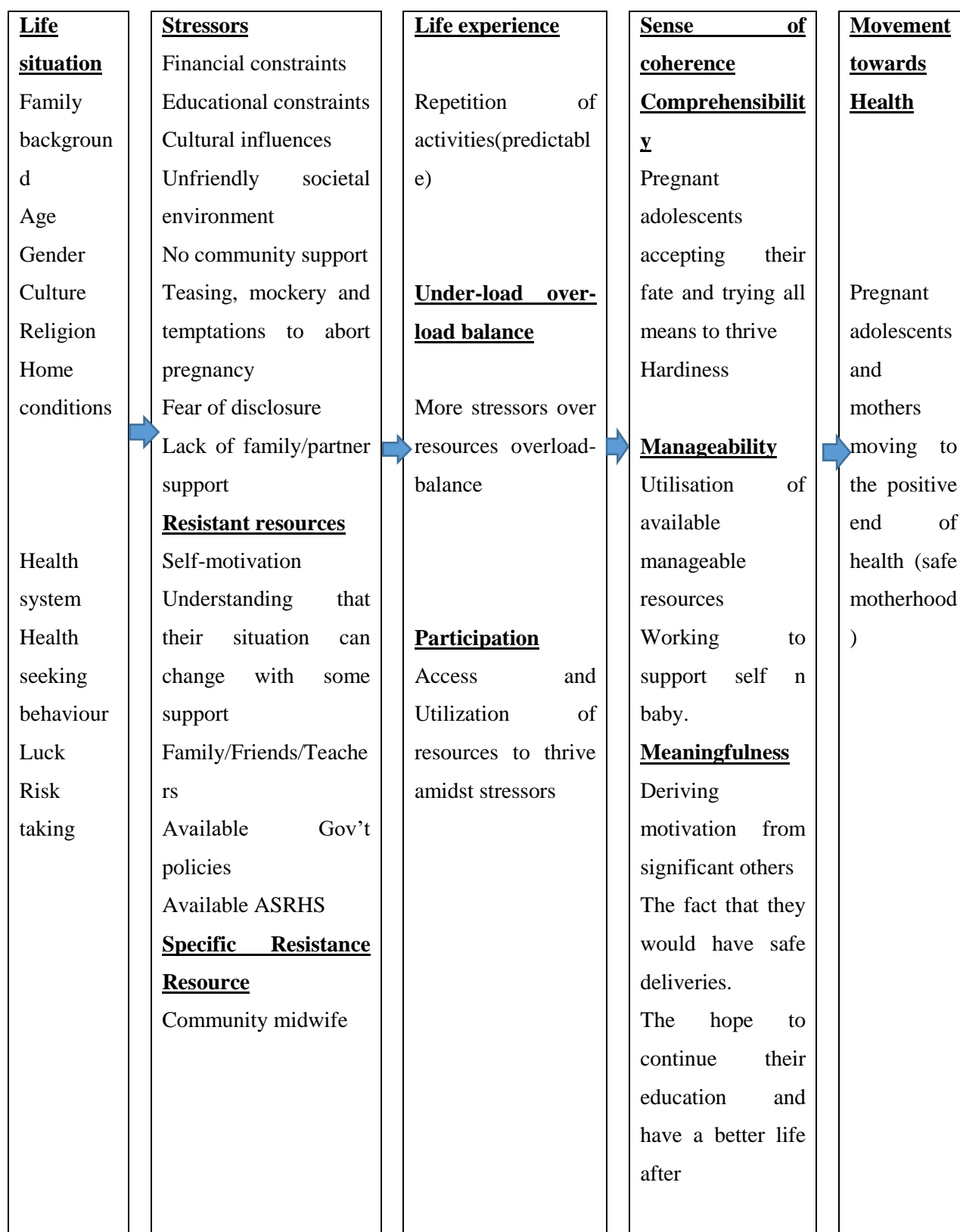
Traditional birth attendants were seen as a resource because they provided alternative cheap midwifery services and were seen as patrons of the local traditions of midwifery (Byrne & Morgan, 2011). Coupled with their locations at sites that are often obscured from public eyes, pregnant adolescents found them to be safe, cheap and convenient alternatives to the ‘hostile’ public clinic (when the midwife is not present) where they get reproached and treated with some form of disdain for being bad girls. This finding holds both positive and negative implications. On the positive side, the TBAs offer the girls a sanctuary from the sneering public and give them care and delivery services that are affordable (Crissman et al., 2013).

However, the Ghana Health Service has reservations to the practices of most TBAs because these practices are not scientifically tested and proven to be safe, thus it is outside the scope of modern conventional midwifery practices (Byrne & Morgan, 2011; Crissman et al., 2013). In this sense, pregnant adolescents who patronize their services may be exposed to risks and unhealthy practices that may end up harming them instead of helping them. The government of Ghana and its Ministry of Health has programmes that train some of these TBAs to bring them up to date with modern safe midwifery practices; it would be a good idea for these training programmes to be intensified in the Awudome area and other rural communities where culture and tradition may prevent pregnant adolescents and adolescent mothers from accessing crucial health care services so that they can provide better and safer care.

To sum it all up, this study has revealed that pregnant adolescents and adolescent mothers in the *Awudome* area of the Volta Region of Ghana face tremendous stressors ranging from self-pity and guilty consciences, through parental and local family rejection to community-wide rejection and stigmatization that end up preventing them from accessing crucial public health services necessary for themselves and their babies. In the face of these stressors, these adolescents have few resources mainly from their own mental capacities, benevolent individuals and willing actors within their communities to help them cope with the situation. Thus, a complex web of non-supportive family, poisonous community culture and norms regarding adolescent pregnancy and abortion and existing but ill-enforced health policies come together to create a stressful environment within which the pregnant adolescent has to carry her pregnancy to term and the adolescent mother has to live and raise her child. The situation calls for urgent discussion and the design and implementation of interventions from all stakeholders to help adolescent in the study location.

### **5.3 Discussion of findings in relation to Salutogenesis**

As explained in the second chapter, salutogenesis focuses on factors that move individuals to health rather than those factors that cause diseases. Also, salutogenesis theorizes that people's view of their life, the strength they have to realize the negative situations around them, and their ability to tap into the available resources around them to achieve health Sense of Coherence (SOC) (Eriksson *et al.*, 2007). This section of the discussion brings to bear how the researcher adds to salutogenesis by highlighting the life situations around pregnant adolescents and mothers which exposed them to severe life course stressors and the available resources that they drew on, tapping on their experiences and how they are able to use their SOC to move them towards thriving.



**Figure 5.1: Salutogenesis Model of Pregnant adolescents and Adolescent mothers**

The above model (Figure 5.1) shows that the life situations of adolescents have influenced their lives. These life courses have contributed immensely to their getting pregnant and becoming mothers, exposing them to so much external and internal pressure resulting in stressful experiences. These girls are not happy and comfortable with the condition they find themselves. However, with access and utilization of available resources, a strong GRRs and SOC, they strive to cope with the stressors which eventually lead to healthy lives and wellbeing.

### **5.3.1 Life situation**

The life situation of the adolescents in this study seems to comprise of high levels of stress from different angles of their lives (please refer to fist part of discussion). General community culture and environment played key roles in producing stressors for the adolescents. In the midst of these stressors however, there seemed to be the development of a gradual sense of coherence as the adolescent pregnant girls and mothers gradually gained an understanding and acceptance of their situation. Some moved to identify resources within their environment which helped them cope with their situations, and others became bold enough to brave the community scorn and take action to help them by accessing reproductive health services. At the point of data collection for this study, most adolescents reported becoming used to the situation and beginning to live their lives without caring much or being bogged down by shame.

### **5.3.2 Stressors (Please refer to subsection 5.1 under discussion)**

### **5.3.3 Generalized Resistance resources (please refer to subsection 5.2 under discussion)**

### **5.3.4 Life experiences and sense of coherence (SOC)**

From the life situation of the adolescents studied in this project, their experiences in life were that of immense stress with few resources to deal with it. The stressors were multi-dimensional and consistent, implying that all angles of social and or community life were fraught with difficulties for pregnant adolescents and adolescent mothers. Experiences of rejection from loved ones and a sense of guilt and shame contributed significantly to the this stress experience and the pregnant adolescents and adolescent mothers ended up isolating themselves in order to escape the scorn.

#### ***5.3.4.1 Consistency and comprehensibility***

The consistency of the stressful experiences and the lack of support or resources seemed to gradually build a sense of hardiness in the adolescents. As they gradually began to comprehend and accept their new statuses as “bad girls” in their communities, the girls tended to see no need to entertain their sense of shame and isolation as they began to understand that doing that would only worsen their situations. The few resources—key among them the community midwife—available to these adolescents, played important roles in giving them this sense of understanding of their situation and consequent energy to face up to the challenges.

From a salutogenic theoretical perspective, hardiness is an important factor in the adolescents’ ability to identify generalized resistance resources that could help them thrive. As they began to understand, often through the community midwife, the necessity to shed the fear and shame and rise up to act to save themselves, most adolescent girls reported coming out of their shells to engage in productive activities. Together, the sense of comprehensibility and identification and use of available resources built a sense of coherence that made the pregnant adolescents begin to thrive in their situation.

#### ***5.3.4.2 Underload/overload balance and manageability***

The situation of underload balance results when the life experiences produce more resources that outweigh the stressors. An overload balance results in more stressors over resources (Antonovsky, 1996a). In the case of pregnant adolescents and adolescent mothers in this study, it was realized that the life stressors were more than the resistant resources. From their family homes, to their schools, churches, clinics and other community spaces, stressful situations kept confronting them. The available resources were minimal, yet, some adolescent managed to tap into these resources to help themselves. Against a comprehension of the fact that the stressors facing them were the normal trend for adolescents who get themselves pregnant in that particular community, some of the pregnant adolescent and adolescent mothers began to turn things around. With a supportive midwife and available services, the adolescents began to take charge of their lives and health. They actually were managing to squeeze help out of any little available opportunity. This confirms the salutogenesis position that the way to thriving depends on an understanding that stressors in one’s life are manageable Antonovsky (1979, p. 89).

### **5.3.2.2 Participation**

The adolescents whose experiences were explored in this study actively participated in getting help for themselves after seemingly developing a sense of coherence of their situation. Realizing that they had a resource in the midwife, most adolescents reported accessing reproductive health services and antenatal care services anytime she was around. This action, which Antonovsky refers to as “socially valued decision-making” (Antonovsky, 1996a, p. 15) was a key beginning to a new life for pregnant adolescents and adolescent mothers. It does confirm the salutogenesis argument that comprehension of one’s situation in consistent stressful life experiences may create a strong SOC which enables individuals to “reach out and apply the resources appropriate to that stressor” (Antonovsky, 1996a, p. 15). By being bold to come out of their houses and move through the community to get to the clinic, the adolescents actively applied the available resources to face their stressors.

### **5.3.5 Movement towards Health**

Movement towards health and wellbeing requires a strong SOC in order to overcome all the life course stressors and negative experiences. The pregnant adolescents and mothers in this study moved towards health and well-being because they developed a strong SOC, which enabled them to utilize available resources to keep themselves going. Actions like approaching the NGO for skill training on their own, taking themselves to the reproductive health clinic to get help with contraceptives and reaching out to educated family in the cities for help indicate a movement toward health. These actions yielded results for some of the adolescents as they reported becoming more comfortable than they used to be in their communities. For some, the zeal to go back to school was still present and this is a positive indication of thriving.

### **5.3.6 Limitation of the Study**

Being a qualitative study, the idea was to listen to and document the subjective experiences of the adolescents within a context. The study findings therefore best apply to the context from which data was collected. Cross-context applications of the findings may therefore not yield the best results. Limited resources and difficulties in securing permissions especially from local authorities in the study location also affected the number of participants that the research team was able to reach. The small number of participants means that the study findings may not generalize on broader populations. However, transferability to contexts that are similar to the studied context could be possible on theoretical basis.

Secondly, the researcher would have loved to include boys or men in the study to have diverse views on the experiences of the pregnant girls and also get in-depth knowledge into the experiences of some of these men who have been responsible for these teen pregnancies. Also parents of these pregnant adolescents' inclusion would have offered a broader knowledge to the real family backgrounds of the girls.

### **5.3.7 Recommendations for further Research**

This study covered only three communities in the Ho west district. There is the need to spread the research to a wider population and to use a quantitative approach to enhance generalizability. Also the researcher deem it fit to further study into the unmet needs of family planning/adolescent reproductive health services in the Ho west district to further help influence and inform policy restructuring to meet the needs of adolescents.

There is the need for reassessment and retraining of reproductive health staff in rural communities like *Awudome*. The findings revealed that the staff themselves may be stressors instead of resources for pregnant adolescents. The attitudes of healthcare providers in *Awudome* may be preventing pregnant adolescents to access safe services. Midwives should be equipped with health promoting skills and not only to educate. Non-Governmental organizations that are into adolescent health issues should be encouraged since it was observed that all NGOs that used to take up adolescent health promotion issues in the *Awudome* areas are all not functioning.

Community support groups for the welfare of the pregnant adolescent should be encouraged to offer help to ensure safe motherhood in the community. A revision of the Ghana health promotion policy need to have a keen look at health promotion in schools and also improve access to information on adolescent reproductive health service.

### **5.3.8 Summary and Conclusion**

This study aimed at exploring the lived experiences of pregnant adolescents and their utilization of reproductive health services in the *Awudome* area of the Ho west district in the Volta Region of Ghana. The study examines the stressors pregnant adolescents' face, the resources that are available to them and their access and utilization of reproductive health services.

Data was collected using qualitative techniques including in-depth interviews and focus group discussions with themes bothering on the lived experiences of adolescents. Stressors found included severe economic/financial constraints, cultural and religious constraints, educational

constraints, psychological, social and emotional stress, lack of community support and misinformation and stigmatization of ARHS. However, the pregnant adolescents have resources like parents, educated family, benevolent churches, personal strength and courage (hardiness), availability of reproductive health services (RHS), community midwife, female teachers in the community schools, the National Health Insurance Scheme and traditional birth attendants (TBAs) available to them to use. It was also found that most of the stressors emanated from the culture, religion and family backgrounds of the adolescents which exposed them to risks of pregnancy. But with the generalized resistant resources and specific resistant resource (midwife), these pregnant adolescents and adolescent mothers were thriving.

Sense of coherence, as described in the theory of salutogenesis, was found profound in these pregnant adolescents and mothers as they were able to comprehend, manage and make meaning out of their situation. This enabled them to move towards health and well-being (safe mother, safe baby) which is health promoting. This led to low maternal mortality which is Ghana's paramount public health issue.

This study has contributed to knowledge in the area of adolescent reproductive health issues in the Volta regional context of Ghana and contributed to the literature in this area by presenting information on stressors and resources experienced by pregnant adolescents and adolescent mothers.



## References

- Abor, P. A., Abekah-Nkrumah, G., Sakyi, K., Adjasi, C. K., & Abor, J. (2011). The socio-economic determinants of maternal health care utilization in Ghana. *International Journal of Social Economics*, 38(7), 628-648.
- Addai, I. (2000). Determinants of use of maternal–child health services in rural Ghana. *Journal of Biosocial Science*, 32(01), 1-15.
- Ahanonu, E. L. (2014). Attitudes of healthcare providers towards providing contraceptives for unmarried adolescents in Ibadan, Nigeria. *Journal of family & reproductive health*, 8(1), 33-40.
- Ahorlu, C. K., Pfeiffer, C., & Obrist, B. (2015). Socio-cultural and economic factors influencing adolescents' resilience against the threat of teenage pregnancy: a cross-sectional survey in Accra, Ghana. *Reproductive health*, 12(1), 1-12. doi:10.1186/s12978-015-0113-9
- Akella, D., & Jordan, M. (2015). Impact of Social and Cultural Factors on Teenage Pregnancy. *Journal of Health Disparities Research and Practice*, 8(1), 41-62.
- Amoran, O. E. (2012). A comparative analysis of predictors of teenage pregnancy and its prevention in a rural town in Western Nigeria. *Int J Equity Health*, 11(1), 1-7.
- Antonovsky, A. (1979). *Health, stress, and coping*. Washington: Jossey-Bass.
- Antonovsky, A. (1996a). The salutogenic model as a theory to guide health promotion. *Health promotion international*, 11(1), 11-18.
- Antonovsky, A. (1996b). The sense of coherence: An historical and future perspective. *Israel Journal of Medical Sciences*, 32(3-4), 170-178.
- Arthur, E. (2012). Wealth and antenatal care use: implications for maternal health care utilisation in Ghana. *Health economics review*, 2(1), 1-8.
- Asampong, E., Osafo, J., Bingenheimer, J. B., & Ahiadeke, C. (2013). Adolescents and parents' perceptions of best time for sex and sexual communications from two communities in the Eastern and Volta Regions of Ghana: implications for HIV and AIDS education. *BMC international health and human rights*, 13(1), 1-11.
- Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative research*, 1(3), 385-405.
- Atuyambe, L., Mirembe, F., Tumwesigye, N. M., Kirumira, E. K., & Fanelid, E. (2008). Adolescent and adult first time mothers' health seeking practices during pregnancy and early motherhood in Wakiso district, central Uganda. *Reprod Health*, 5(13), 4755-4755.
- Awusabo-Asare, K., Bankole, A., & Kumi-Kyereme, A. (2008). Views of adults on adolescent sexual and reproductive health: qualitative evidence from Ghana. New York: Guttmacher Institute.
- Baffour-Awuah, A., Mwini-Nyaledzigbor, P., & Richter, S. (2015). Enhancing focused antenatal care in Ghana: An exploration into perceptions of practicing midwives. *International Journal of Africa Nursing Sciences*, 2, 59-64. doi:10.1016/j.ijans.2015.02.001
- Bankole, A., Biddlecom, A., Guiella, G., Singh, S., & Zulu, E. (2007). Sexual behavior, knowledge and information sources of very young adolescents in four sub-Saharan African countries. *African journal of reproductive health*, 11(3), 28.
- Bhana, D., Morrell, R., Shefer, T., & Ngabaza, S. (2010). South African teachers' responses to teenage pregnancy and teenage mothers in schools. *Cult Health Sex*, 12(8), 871-883.
- Bozkaya, H., Mocan, H., Usluca, H., Beşer, E., & Gümüştekin, D. (1996). A retrospective analysis of adolescent pregnancies. *Gynaecologic and Obstetric Investigation*, 42(3), 146-150.
- Brady, G., Brown, G., Wilson, C., & Letherby, G. (2008). New ways with young mothers—how services can better meet their needs. *MIDIRS Midwifery Digest*, 18(4), 579-581.
- Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husten & T. N. Postlethwaite (Eds.), *International encyclopedia of education* (2 ed., Vol. 3, pp. 1643-1647). New York: Elsevier Science.
- Brückner, H., Martin, A., & Bearman, P. S. (2004). Ambivalence and pregnancy: adolescents' attitudes, contraceptive use and pregnancy. *Perspectives on sexual and reproductive health*, 36(6), 248-257.

- Burns, N., & Grove, S. (2005). *The Practice of Nursing Research*. St Louis, Missouri: Elsevier.
- Byrne, A., & Morgan, A. (2011). How the integration of traditional birth attendants with formal health systems can increase skilled birth attendance. *International Journal of Gynecology & Obstetrics*, *115*(2), 127-134.
- Chaibva, C. N., Ehlers, V. J., & Roos, J. H. (2010). Midwives' perceptions about adolescents' utilisation of public prenatal services in Bulawayo, Zimbabwe. *Midwifery*, *26*(6), e16-e20.
- Chaibva, C. N., Roos, J. H., & Ehlers, V. J. (2009). Adolescent mothers' non-utilisation of antenatal care services in Bulawayo, Zimbabwe. *Curationis*, *32*(3), 14-21.
- Chauke, H. (2013). *The challenges experienced by teenage mothers in secondary schools: the case of Hlanganani South Circuit*. (MEd), University of Limpopo (Turfloop Campus), Limpopo. Retrieved from [ulspace.ul.ac.za/bitstream/handle/10386/962/Chauke\\_h\\_2013.pdf?sequence=1](http://ulspace.ul.ac.za/bitstream/handle/10386/962/Chauke_h_2013.pdf?sequence=1)
- Christofides, N. J., Jewkes, R. K., Dunkle, K. L., Nduna, M., Shai, N. J., & Sterk, C. (2014). Early adolescent pregnancy increases risk of incident HIV infection in the Eastern Cape, South Africa: a longitudinal study. *Journal of the International AIDS Society*, *17*(1), 1-7.
- Coard, S. I., Nitz, K., & Felice, M. E. (2000). Repeat pregnancy among urban adolescents: sociodemographic, family, and health factors. *Adolescence*, *35*(137), 193-200.
- Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, . Thousand Oaks: SAGE.
- Crissman, H., Engmann, C., Adanu, R., Nimako, D., Crespo, K., & Moyer, C. (2013). Shifting norms: pregnant women's perspectives on skilled birth attendance and facility-based delivery in rural Ghana. *African journal of reproductive health*, *17*(1), 15-26.
- Crosby, R. A., & Holtgrave, D. R. (2006). The protective value of social capital against teen pregnancy: a state-level analysis. *Journal of Adolescent Health*, *38*(5), 556-559.
- Daniel, M., & Mathias, A. (2012). Challenges and coping strategies of orphaned children in Tanzania who are not adequately cared for by adults. *African Journal of AIDS research*, *11*(3), 191-201.
- Darisi, T. (2007). " It Doesn't Matter if You're 15 or 45, Having a Child is a Difficult Experience": Reflexivity and Resistance in Young Mothers' Constructions of Identity. *Journal of the Motherhood Initiative for Research and Community Involvement*, *9*(1), 29-41.
- Doğan-Ateş, A., & Carrión-Basham, C. Y. (2007). Teenage pregnancy among Latinas examining risk and protective factors. *Hispanic Journal of Behavioral Sciences*, *29*(4), 554-569.
- Domenico, D. M., & Jones, K. H. (2007). Career aspirations of women in the 20th century. *Journal of career and technical education*, *22*(2).
- Draper, A. K. (2004). The principles and application of qualitative research. *Proceedings of the Nutrition Society*, *63*(04), 641-646.
- Draper, A. K., & Swift, J. A. (2011). Qualitative research in nutrition and dietetics: data collection issues. *Journal of Human Nutrition and Dietetics*, *24*(1), 3-12.
- Dworsky, A., & Meehan, P. (2012). The parenting experiences of homeless adolescent mothers and mothers-to-be: Perspectives from a shelter sample. *Children and Youth Services Review*, *34*(10), 2117-2122.
- Edirne, T., Can, M., Kulusari, A., Yildizhan, R., Adali, E., & Akdag, B. (2010). Trends, characteristics, and outcomes of adolescent pregnancy in eastern Turkey. *International Journal of Gynecology & Obstetrics*, *110*(2), 105-108.
- Eriksson, M., & Lindström, B. (2006). Antonovsky's sense of coherence scale and the relation with health: a systematic review. *Journal of epidemiology and community health*, *60*(5), 376-381.
- Eriksson, M., Lindström, B., & Lilja, J. (2007). A sense of coherence and health. Salutogenesis in a societal context: Åland, a special case? *Journal of Epidemiology and Community Health*, *61*(8), 684-688.
- Estrada, O. (2012). *Exploring Hispanic Teenage Pregnancy and School Resiliency: A Hermeneutic Phenomenology Study*. Liberty University.
- Fain, J. (2004). *Selecting the Sample and Setting. Reading, Understanding and Applying Nursing Research: A text and workbook* (2 ed.). Philadelphia: F.A. Davis Co.

- Ghana Statistical Service. (2011). Ghana Multiple Indicator Cluster Survey with an enhanced Malaria Module and Biomarker, Final Report. Accra, Ghana: Ghana Statistical Service.
- Glover, V. (2011). The effects of prenatal stress on child behavioural and cognitive outcomes start at the beginning *Encyclopedia on Early Childhood Development* (pp. 1-5). London: Centre of Excellence for Early Childhood Development.
- Goonewardene, I., & Waduge, R. (2009). Adverse effects of teenage pregnancy. *Ceylon Medical Journal*, 50(3), 116-120.
- Green, J., & Thorogood, N. (2014). *Qualitative Methods for Health Research*, . Thousand Oaks: Sage.
- Greene, J. C., & Caracelli, V. J. (1997). Defining and describing the paradigm issue in mixed-method evaluation. *New directions for evaluation*, 1997(74), 5-17. doi:10.1002/ev.1068
- Greydanus, D. E., Pratt, H. D., & Patel, D. R. (2012). Concepts of contraception for adolescent and young adult women with chronic illness and disability. *Disease-a-Month*, 58(5), 258-320.
- Gyan, C. (2013). The Effects of Teenage Pregnancy on the Educational Attainment of Girls at Chorkor, a Suburb of Accra. *Journal of Educational and Social Research*, 3(3), 53-60.
- Gyesaw, N. Y. K., & Ankomah, A. (2013). Experiences of pregnancy and motherhood among teenage mothers in a suburb of Accra, Ghana: a qualitative study. *International journal of women's health*, 5, 773-779.
- Haldre, K., Rahu, K., Rahu, M., & Karro, H. (2009). Individual and familial factors associated with teenage pregnancy: an interview study. *The European Journal of Public Health*, 19(3), 266-270.
- Hammersley, M. (1992). Some reflections on ethnography and validity 1. *Qualitative Studies in Education*, 5(3), 195-203.
- Harrison, J., MacGibbon, L., & Morton, M. (2001). Regimes of trustworthiness in qualitative research: The rigors of reciprocity. *Qualitative inquiry*, 7(3), 323-345.
- Hesse, A., & Samba, A. (2006). *Comprehensive Reproductive Health in Ghana. DAWN global project in collaboration with DAWN Anglophone Africa*. Accra, Ghana: University of Ghana medical school.
- Hindin, M. J., & Fatusi, A. O. (2009). Adolescent sexual and reproductive health in developing countries: an overview of trends and interventions. *International perspectives on sexual and reproductive health*, 35(2), 58-62.
- Hintermair, M. (2004). Sense of coherence: a relevant resource in the coping process of mothers of deaf and hard-of-hearing children? *Journal of deaf studies and deaf education*, 9(1), 15-26.
- Hokororo, A., Kihunrwa, A. F., Kalluvya, S., Changanalucha, J., Fitzgerald, D. W., & Downs, J. A. (2014). Barriers to access reproductive health care for pregnant adolescent girls: a qualitative study in Tanzania. *Acta Paediatr*. doi:10.1111/apa.12886
- Holloway, I., & Wheeler, S. (2013). *Qualitative Research in Nursing and Healthcare*. Oxford: John Wiley & Sons.
- Jejeebhoy, S. J., Shah, I. H., & Yount, K. M. (1999). *Sexual and Reproductive Health for Adolescents. Annual technical report*. Abidjan, Cote d'Ivoire.
- Kalil, A., & Kunz, J. (2000). *Long Term Effects of Teenage Childbearing on Mental Health in Young Adulthood*. Paper presented at the Evanston, Illinois, Northwestern University, Paper presented as part of the JCPR: Poverty Research Seminars.
- Kalo, J. (2006). *Utilization of adolescent reproductive health services by young people in Vanuatu*. UNFPA Office of the Pacific Community: United Nations Population Fund.
- Klutsey, E. E., & Ankomah, A. (2014). Factors associated with induced abortion at selected hospitals in the Volta Region, Ghana. *International journal of women's health*, 6, 809-815. doi:10.2147/IJWH.S62018
- Krulewitch, C. J., Roberts, D. W., & Thompson, L. S. (2003). Adolescent pregnancy and homicide: Findings from the Maryland Office of the Chief Medical Examiner, 1994-1998. *Child maltreatment*, 8(2), 122-128.
- Larson, C. P. (2007). Poverty during pregnancy: Its effects on child health outcomes. *Paediatrics & child health*, 12(8), 673.
- LeCompte, M. D., & Schensul, J. J. (2010). *Designing and Conducting Ethnographic Research*, (Vol. 1). Walnut Creek, CA: AltaMira Press.

- Leerlooijer, J. N., Kok, G., Weyusya, J., Bos, A. E., Ruiter, R. A., Rijdsdijk, L. E., . . . Bartholomew, L. K. (2014). Applying Intervention Mapping to develop a community-based intervention aimed at improved psychological and social well-being of unmarried teenage mothers in Uganda. *Health Educ Res*, cyu020.
- Lindström, B., & Eriksson, M. (2009). The salutogenic approach to the making of HiAP/healthy public policy: illustrated by a case study. *Global health promotion*, 16(1), 17-28.
- Lloyd, C. B. (2005). *Growing Up Global:: The Changing Transitions to Adulthood in Developing Countries*: National Academies Press.
- Madkour, A. S., Xie, Y., & Harville, E. W. (2013). The Association Between Prepregnancy Parental Support and Control and Adolescent Girls' Pregnancy Resolution Decisions. *Journal of Adolescent Health*, 53(3), 413-419.
- Maree, K. (2010). *First steps in research*. Pretoria: Van Schaik Publishers.
- Mashishi, N., & Makoelle, T. (2014). Inclusion or Exclusion Ramifications of Teenage Pregnancy: A Comparative Analysis of Namibia and South African Schools Pregnancy Policies. *Mediterranean Journal of Social Sciences*, 5(14), 374.
- McCall, S. J., Bhattacharya, S., Okpo, E., & Macfarlane, G. J. (2015). Evaluating the social determinants of teenage pregnancy: a temporal analysis using a UK obstetric database from 1950 to 2010. *Journal of epidemiology and community health*, 69(1), 49-54.
- Midtbø, V., Shirima, V., Skovdal, M., & Daniel, M. (2012). How disclosure and antiretroviral therapy help HIV-infected adolescents in sub-Saharan Africa cope with stigma. *African Journal of AIDS Research*, 11(3), 261-271.
- Mittelmark, M. B. (2010). *From risks to resources*. Paper presented at the Exploring the SOCdeterminantsfor health. The 3rd International Research Seminar on Salutogenesisand the 3rd Meeting of the IUHPE GWG-SAL, Geneva, Switzerland.
- Mittelmark, M. B., & Bull, T. (2013). The salutogenic model of health in health promotion research. *Global Health Promotion*, 20(2), 30-38.
- Morhe, E. S., Tagbor, H. K., Ankobea, F. K., & Danso, K. A. (2012). Reproductive experiences of teenagers in the Ejisu-Juabeng district of Ghana. *International Journal of Gynecology & Obstetrics*, 118(2), 137-140.
- Morse, J. M. (1991). Strategies for Sampling In: Morse J. M, editors. *Qualitative Nursing Research: A Contemporary Dialogue*: London: Sage Publications.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals. (2nd ed.)*. Thousand Oaks, CA: Sage.
- Mulder, E., De Medina, P. R., Huizink, A., Van den Bergh, B., Buitelaar, J., & Visser, G. (2002). Prenatal maternal stress: effects on pregnancy and the (unborn) child. *Early human development*, 70(1), 3-14.
- Ngomi, K. B. (2008). *Utilisation of sexual and reproductive health services by secondary school adolescents in Mochudi*. (Master's), UNIVERSITY OF SOUTH AFRICA, Mochudi. Retrieved from <http://uir.unisa.ac.za/handle/10500/1356>
- Oduro, G. Y., & Otsin, M. N. A. (2014). "Abortion—It Is My Own Body": Women's Narratives About Influences on Their Abortion Decisions in Ghana. *Health care for women international*, 35(7-9), 918-936.
- Omar, K., Hasim, S., Muhammad, N. A., Jaffar, A., Hashim, S. M., & Siraj, H. H. (2010). Adolescent pregnancy outcomes and risk factors in Malaysia. *International Journal of Gynecology & Obstetrics*, 111(3), 220-223.
- Omwancha, K. M. (2012). *The implementation of an educational re-entry policy for girls after teenage pregnancy: A case study of public secondary schools in the Kuria District, Kenya*. (Doctoral), Victoria University of Wellington, Victoria. Retrieved from [researcharchive.vuw.ac.nz/xmlui/bitstream/handle/10063/2382/thesis.pdf?sequence=1](http://researcharchive.vuw.ac.nz/xmlui/bitstream/handle/10063/2382/thesis.pdf?sequence=1)
- Pallant, J. F., & Lae, L. (2002). Sense of coherence, well-being, coping and personality factors: further evaluation of the sense of coherence scale. *Personality and Individual Differences*, 33(1), 39-48.

- Paranjothy, S., Broughton, H., Adappa, R., & Fone, D. (2009). Teenage pregnancy: who suffers? *Archives of disease in childhood*, *94*(3), 239-245.
- Patel, P. H., & Sen, B. (2012). Teen motherhood and long-term health consequences. *Matern Child Health J*, *16*(5), 1063-1071.
- Pell, C., Meñaca, A., Were, F., Afrah, N. A., Chatio, S., Manda-Taylor, L., . . . Kalilani, L. (2013). Factors affecting antenatal care attendance: results from qualitative studies in Ghana, Kenya and Malawi. *PLoS One*, *8*(1), e53747.
- Pilnick, A., & Swift, J. (2011). Qualitative research in nutrition and dietetics: assessing quality. *Journal of Human Nutrition and Dietetics*, *24*(3), 209-214.
- Pogoy, A. M., Verzosa, R., Coming, N. S., & Agustino, R. G. (2014). Lived experiences of early pregnancy among teenagers: a phenomenological study. *European Scientific Journal*, *10*(2), 157-169.
- Polgar, S., & Thomas, S. (2008). Research in the health sciences. *Melbourne: Churchill-Livingston*.
- Polit, D. F., & Beck, C. T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*: Lippincott Williams & Wilkins.
- Ponnet, K. (2014). Financial stress, parent functioning and adolescent problem behavior: an Actor–Partner interdependence approach to family stress processes in low-, middle-, and high-income families. *Journal of youth and adolescence*, *43*(10), 1752-1769.
- Raniga, T., & Mathe, S. (2011). Private lives, public issues: childbearing experiences of adolescent mothers in the era of HIV and AIDS in Bhambayi, KwaZulu-Natal, South Africa. *Social Work/Maatskaplike Werk*, *47*(3), 338-349.
- Rasch, V., Yambesi, F., & Massawe, S. (2006). Post-abortion care and voluntary HIV counselling and testing--an example of integrating HIV prevention into reproductive health services. *Trop Med Int Health*, *11*(5), 697-704. doi:10.1111/j.1365-3156.2006.01607.x
- Remes, P., Renju, J., Nyalali, K., Medard, L., Kimaryo, M., Changalucha, J., . . . Wight, D. (2010). Dusty discos and dangerous desires: community perceptions of adolescent sexual and reproductive health risks and vulnerability and the potential role of parents in rural Mwanza, Tanzania. *Cult Health Sex*, *12*(3), 279-292. doi:10.1080/13691050903395145
- Rondini, S., & Krugu, J. K. (2009). Knowledge, attitude and practices study on reproductive health among secondary school students in Bolgatanga, upper east region, Ghana. *Afr J Reprod Health*, *13*(4), 51-66.
- Salami, K. K., Ayegboyin, M., & Adedeji, I. A. (2015). Unmet social needs and teenage pregnancy in Ogbomosho, South-western Nigeria. *African health sciences*, *14*(4), 959-966.
- Schonberg, R., & Tellerman, J. S. (1997). The use of the SUN group program with high-risk adolescents. *Journal of Child and Adolescent Group Therapy*, *7*(3), 107-118.
- Sekiwunga, R., & Whyte, S. R. (2009). Poor parenting: teenagers' views on adolescent pregnancies in Eastern Uganda. *African journal of reproductive health*, *13*(4), 113-128.
- Senderowitz, J., Hainsworth, G., & Solter, C. (2003). A rapid assessment of youth friendly reproductive health services.
- Shivers, J. (2011). *Programming recreational services*. Canada: Jones & Bartlett Learning.
- Simwapenga-Hamusonde, B. (2011). Teenage mothers and their re-admission into schools: The case of secondary schools in Lusaka urban from 1997-1999. Lusaka.
- Sit, D. K., & Wisner, K. L. (2009). The identification of postpartum depression. *Clinical obstetrics and gynecology*, *52*(3), 456.
- Skinner, S. R., Smith, J., Fenwick, J., Hendriks, J., Fyfe, S., & Kendall, G. (2009). Pregnancy and protection: perceptions, attitudes and experiences of Australian female adolescents. *Women Birth*, *22*(2), 50-56. doi:10.1016/j.wombi.2008.12.001
- Smith, J. L., Skinner, S. R., & Fenwick, J. (2012). Perceptions of teen motherhood in Australian adolescent females: life-line or lifederailment. *Women Birth*, *25*(4), 181-186. doi:10.1016/j.wombi.2011.10.007
- Smith, M. V., Shao, L., Howell, H., Lin, H., & Yonkers, K. A. (2011). Perinatal depression and birth outcomes in a Healthy Start project. *Matern Child Health J*, *15*(3), 401-409. doi:10.1007/s10995-010-0595-6

- Stanton, C., Lawn, J. E., Hussein, J., McCaw-Binns, A., & Webber, R. (2012). The epidemiology of stillbirths and neonatal deaths *Maternal and perinatal health in developing countries*. Oxfordshire, UK: CABI Publishing (pp. 51-63).
- Sundaram, A., Juarez, F., Bankole, A., & Singh, S. (2012). Factors associated with abortion-seeking and obtaining a safe abortion in Ghana. *Stud Fam Plann*, 43(4), 273-286.
- Swift, J., & Tischler, V. (2010). Qualitative research in nutrition and dietetics: getting started. *Journal of Human nutrition and Dietetics*, 23(6), 559-566.
- Timmerman, G. (2003). Sexual harassment of adolescents perpetrated by teachers and by peers: An exploration of the dynamics of power, culture, and gender in secondary schools. *Sex Roles*, 48(5-6), 231-244.
- Ujah, I., Aisien, O., Mutahir, J., Vanderjagt, D., Glew, R., & Uguru, V. (2005). Maternal mortality among adolescent women in Jos, North-Central, Nigeria. *Journal of Obstetrics & Gynecology*, 25(1), 3-6.
- UNICEF. (1989). Convention on the Rights of the Child. New York City.
- Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet*, 379(9826), 1641-1652.
- Wahn, E. H., & Nissen, E. (2008). Sociodemographic background, lifestyle and psychosocial conditions of Swedish teenage mothers and their perception of health and social support during pregnancy and childbirth. *Scand J Public Health*, 36(4), 415-423. doi:10.1177/1403494807085315
- Warenus, L. U., Faxelid, E. A., Chishimba, P. N., Musandu, J. O., Ong'any, A. A., & Nissen, E. B. (2006). Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reproductive Health Matters*, 14(27), 119-128.
- Watson, R., McKenna, H., Cowman, S., & Keady, J. (2008). *Nursing Research: Designs and Methods*. Toronto: Elsevier Health Sciences.
- Watts, M. C. N. C., Liamputtong, P., & Mcmichael, C. (2015). Early motherhood: a qualitative study exploring the experiences of African Australian teenage mothers in greater Melbourne, Australia. *BMC public health*, 15(1), 1.
- Weinstock, M. (2005). The potential influence of maternal stress hormones on development and mental health of the offspring. *Brain, behavior, and immunity*, 19(4), 296-308.
- Welman, C., Kruger, F., & Mitchell, B. (2005). *Research methodology*: Oxford University Press.
- Were, M. (2007). Determinants of teenage pregnancies: The case of Busia District in Kenya. *Economics & Human Biology*, 5(2), 322-339.
- Whitley, B. E., & Kite, M. E. (2012). *Principles of Research in Behavioral Science*, . London: Routledge.
- WHO. (1993). *The health of young people: A challenge and a promise*. Geneva: World Health Organisation.
- WHO. (2004). *Adolescent-friendly Health Services in South-East Asia Region: Report of Regional Consultation 9-14 February 2004*. Bali Indonesia /SEARO New Delhi.: World Health Organization.
- WHO. (2007). Provision of effective antenatal care: Standards for maternal and neonatal care. *Integrated Management of Pregnancy and Childbirth (IMPAC)*. Geneva: world Health Organization.
- WHO. (2011). Early marriages, adolescent and young pregnancies. Report by the Secretariat. Executive Board. *130th Session (Geneva, 1st December 2011), Document EB130/12*. Geneva: World Health Organization.
- Wilson-Mitchell, K., Bennett, J., & Stennett, R. (2014). Psychological health and life experiences of pregnant adolescent mothers in Jamaica. *International journal of environmental research and public health*, 11(5), 4729-4744.

## APPENDICES

### Appendix 1: Explanation of the study for participants

Title of Study	Exploring experiences of pregnant adolescents and their utilization of reproductive health services, Ghana: A Salutogenic Approach
Principal Investigator	Comfort Worna Lotse, MPhil student, University of Bergen, Norway.
Supervisors	Dr. Marguerite Daniel (PhD). Principal Supervisor (University of Bergen)

This study is in fulfilment of the requirement for the Master of Philosophy in Health Promotion programme that I am pursuing at the University of Bergen, Norway. It is not a funded research project. The project touches on the important issue of adolescent pregnancy and motherhood. I believe that working with you on a topic like this will bring your experiences to bear on the issue which will definitely enrich my data as realistic accounts of the phenomenon of adolescent pregnancy, motherhood and the ability of adolescents' access to reproductive health services in the community, will be highlighted.

The sample will comprise three separate groups as participants. Nine pregnant adolescents as one group, Eight adolescent mothers as another group and nine (9) key informants (3 queen mother, 2 clinicians, 3 teachers and 1 NGO staff) as the third group. Three focus group meetings will be held and lasting for about 2hours and individual interviews (in-depth) lasting about an hour. Group and individual confidentiality will be ensured. Data recorded and transcribed will be coded and will remain in the custody of the Principal Investigator and transmitted only to the Supervisor in Norway. Names of respondents will not be included in the report or mentioned in any form of presentation. The recordings will be destroyed after transcription is done. All gathered data will be made anonymous by 31.08.2017.

**Participation is voluntary** and participants are free to withdraw from the programme anytime they feel they no longer want to be part of the research process. Participants are also at liberty to decline to answer any question that they do not want to answer. Participants will be requested to read and sign or information read to them and thumbprint if not literate, the attached form if they agree to participate. The principal investigator will express her appreciation for their co-operation.

Comfort Worna Lotse.

Hannah Frimpong

Dept. of Health promotion and development  
and Dev't GHS-ERC Administrator

Tel: 0244123949/+4740292063

Tel: +23324323522/507041223

Email: cworna@yahoo.com

Email: Hannah.Frimpong@ghsamil.org

Supervisor: Dr. Marguerite Daniel

Director, Int. Master's in Health Promotion

Tel: +4755583220/+4797432721

Email: [marguerite.daniel@uib.no](mailto:marguerite.daniel@uib.no)



## **Appendix 2: Informed consent form**

The purpose of the study has been explained to me and I have understood. My participation in the study will involve a focus group discussion and a face to face interview session

I am also told that participation is voluntary, I am free to withdraw at any stage of the study without incurring any penalty and my name will also not be mentioned anywhere in the report or any form of presentation and whatever have been discussed will not be traced to me.

The information I provide will not be passed on to anybody in the community or elsewhere except the researcher's supervisor in Norway. I am also aware that the recordings will be destroyed after the researcher has transcribed the data and all gathered data will be coded to ensure confidentiality and made anonymous by 31<sup>st</sup> of August, 2017.

**Also, I am aware that there no risks associated with this study but I may experience some form of discomfort as a result of the prolong sitting, and the researcher will show her appreciation for my time and contribution.**

Name : .....

Thumb print:

Signature: .....

Date : .....

Witnessed: .....

Signature: .....

Date: .....

### Appendix 3: Explanation of the study for key informants

<b>Title of Study</b>	Exploring experiences of pregnant adolescents and their utilization of reproductive health services, Ghana: A Salutogenic Approach
<b>Principal Investigator</b>	Comfort Worna Lotse, MPhil student, University of Bergen, Norway.
<b>Supervisors:</b>	Marguerite Daniel (PhD). Principal Supervisor (University of Bergen)

This study is in fulfilment of the requirement for the Master of Philosophy in Health Promotion programme that I am pursuing at the University of Bergen, Norway. It is not a funded research project. The project touches on the important issue of adolescent pregnancy and motherhood. I believe that working with you on a topic like this will bring your experiences to bear on the issue which will definitely enrich my data as realistic accounts of the phenomenon of adolescent pregnancy and motherhood and the ability of adolescents' access to reproductive health services in the community, will be highlighted. The sample will comprise three separate groups as participants. Nine (9) pregnant adolescents as one group, eight adolescent mothers as another group and nine key informants (3 queen mothers, 2 clinicians, 3 teachers and 1 NGO staff).

An individual interview (in-depth) lasting about an hour will be held for you as a key informant. Individual confidentiality will be ensured. Data recorded and transcribed will be in the custody of the Principal Investigator and transmitted only to the Supervisor in Norway. Names of respondents will not be included in the report or mentioned in any form of presentation. The recordings will be destroyed after transcription is done. All gathered data will be made anonymous by 31.08.2017

**Participation is voluntary** and participants are free to withdraw from the programme anytime they feel they no longer want to be part of the research process. Participants are also at liberty to decline to answer any question that they do not want to answer. Participants will be requested to read and sign or thumbprint if not literate, the attached form if they agree to participate. The principal investigator will express her appreciation for their co-operation.

Comfort Worna Lotse.

Hannah Frimpong

Department of health promotion and development  
promotion and Dev't      GHS-ERC Administrator

Tel: 0244123949/+4740292063

Tel: +23324323522/507041223

Email: cworna@yahoo.com

Email: Hannah.Frimpong@ghsamil.org

Supervisor: Dr. Marguerite Daniel

Director, Int'l Master's in Health

Tel: +4755583220/+4797432721

Email: Marguerite.daniel@uib.no

#### **Appendix 4: Informed consent form for key informants**

The purpose of the study has been explained to me and I have understood. My participation in the study will involve a face to face in-depth interview session lasting about an hour.

I am also told that participation is voluntary. I am free to withdraw at any stage of the study without incurring any penalty. My name will also not be mentioned anywhere in the report or any form of presentation.

Whatever has been discussed will not be traced to me. The information I provide will not be passed on to anybody in the community or elsewhere except the researcher's supervisor in Norway to ensure confidentiality.

I am also aware that the recordings will be destroyed after the researcher has transcribed the data. All gathered data will be coded and anonymised by 31<sup>st</sup> of August, 2017.

Also, I am aware that there no risks associated with this study and the researcher will show her appreciation for my time and contribution.

Name : .....

Thumb print:

Signature: .....

Date : .....

Witness: .....

Signature: .....

Date: .....

## **Appendix 5: Interview guide**

### **Pregnant adolescents**

Greetings.

I am Comfort Worna Lotse, a student researcher from the University of Bergen. I intend to find a few things from you which could help in improving health care services to you and the community.

As already explained, participation in this study is voluntary. You are free to refuse to answer any of the questions I may ask. If you do not understand any of the questions, you can ask me for clarification. You can opt out of this interview at any point without incurring any penalty.

1. How are you doing?
  2. How old are you?
  3. How old is your pregnancy?
  4. Are you married? If yes, what does your partner do for a living?
- OR
5. Is the man responsible for this pregnancy taking care of you? (Probe: how often does he remit you if he is away?)
  6. What do you do to support yourself?
  7. How many times do you feed yourself in a day? If doing nothing, how do you get supported? Who?)
  8. What do you think might have been the cause of this pregnancy and how? (Probe: Peer, parental or societal pressure, norms, money, rape etc.)
  9. What cultural practices in this environment do you think might have influenced your decisions concerning this pregnancy?
  10. Do you live with your parents, alone or with your partner?
  11. How has pregnancy affected your life?
  12. What were your parents' reaction when they found that you are pregnant?
  13. What was the community's reaction towards you? (For example your friends, extended family, teachers, etc)
  14. What happened to your education and why?

15. Do you attend antenatal clinic? If yes, (when did you start? Where, how often, by which means) If no, (any barriers or why?) which other means do you resort to? Traditional healers, traditional birth attendants, others? )
16. Where do you intend to have your baby delivered (health facility or home). Why?
17. Do you face any difficulties accessing health care delivery?  
If yes, what are they? If no, what are your strengths or motivation to attend the clinic?  
(Parental, spousal, other family, social, government, information etc)
18. How are you treated by the clinical staff?
19. How do you finance your health care needs?
20. How will your future life be different because of this pregnancy?
21. I can see you are doing very well, what other resources or support do you have that helps you in in thriving?

### **Adolescent mothers**

Greetings.

I am Comfort Worna Lotse, a student researcher from the University of Bergen. I intend to find a few things from you which could help in improving health care services to you and the community.

As already explained, participation in this study is voluntary. You are free to refuse to answer any of the questions I may ask. If you do not understand any of the questions, you can ask me for clarification. You can opt out of this interview at any point without incurring any penalty.

1. How are you doing?
2. How old are you?
3. How old is your baby?
4. Are you married? If yes, what does your husband do for a living?  
If No, what does your partner or father of your baby do?
5. How has the cultural practices of this community influenced your decision to have this baby?
6. How has being a mother affected your life? (If they give only negative answers you can also ask for positive effects)
7. What challenges did you face when you were pregnant?
8. Any challenges you are going through as a result of being a mother at this age?
9. What happened to your education?

10. What was the reaction of your parents, school mates and society when you got pregnant?
11. Is the father of the baby taking care of you and the baby?  
If yes, how? If no, who does?
12. Which supports do you rely on for the care of your baby?  
(Parents, spouse/partner, other families, society, government, information)
13. Do you attend postnatal clinic?  
If yes, (where, which means?) If no, why? (Any barriers?)
14. Where did you deliver your baby? And why?
15. What are your strengths or motivation to attend?
16. How are you and your baby treated in the clinic/hospital?
17. Do you have any intentions of going back to school or learning a trade?
18. How will your future life be different because of early motherhood?

### **Key informants**

#### Greetings

I am Comfort Worna Lotse, a student researcher from the University of Bergen. I intend to find a few things from you which could help in improving health care services to you and the community.

As already explained, participation in this study is voluntary. You are free to refuse to answer any of the questions I may ask. If you do not understand any of the questions, you can ask me for clarification. You can opt out of this interview at any point without incurring any penalty.

1. What is the prevalence of adolescent pregnancy in the communities?
2. What is the cultural perspective of adolescent pregnancy?
3. How do you think the cultural practices and norms of this community could influence adolescent pregnancy and motherhood?
4. How does adolescent pregnancy and motherhood affect the school, community, women folks and society as a whole?
5. What measures have been instituted to make sure the men responsible for these pregnancies play their role as fathers?
6. What are being done to curb these issues of stigma, shame etc. when the adolescent gets pregnant?

7. Who should support the pregnant adolescent and adolescent mothers to thrive and how?
8. What specific adolescent programs have the community in place for the pregnant adolescent?
9. Are there some forms of adolescent support groups? Peer groups, community support groups, motherhood support groups?
10. How do clinicians receive and treat the pregnant adolescent and the adolescent mother?
11. What measures are in place to encourage adolescent access to reproductive health services?

### **Focus Group Discussion Guide**

Greetings.

I am Comfort Worna Lotse, a student researcher from the University of Bergen. I intend to find a few things from you through this discussion session, which could help in improving health care services to you, other adolescent and the community.

As already explained, participation in this study is voluntary. You are free to refuse to answer any of the questions I may ask. You are also free to contribute to this discussion bearing in mind that confidentiality is guaranteed. If you do not understand any of the questions, you can ask me for clarification. You can opt out of this discussion at any point without incurring any penalty or denial of medical services.

1. What are the social norms regarding adolescent pregnancy in this area?
2. How do people relate to pregnant girls?
3. How do pregnant girls and mothers feel when in the mist of the public?
4. What is the cultural perspective of adolescent pregnancy?
5. How do you think the cultural practices and norms of this community could influence adolescent pregnancy and motherhood?
6. How does adolescent pregnancy and motherhood affect the school, community, women folks and society as a whole?
7. What major stressors do adolescents face during pregnancy, delivery and after delivery?  
probe
8. What is the community's contribution to the welfare of pregnant adolescents and mothers?



9. What package does the community have for adolescents who wish to stay in school while pregnant or go back to school after delivery?
10. How is the adolescent who wants to utilize reproductive health services receive? Probe
11. What is the user and provider relationship in terms of adolescent reproductive health services?
12. What motivates the adolescent to use available reproductive health services? Probe
13. What other methods of reproductive health services does the pregnant adolescent and mothers resort to?

## Appendix 6: NSD Ethical Clearance

**Norsk samfunnsvitenskapelig datatjeneste AS**  
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



Harald Hårfages gate 29  
N 5007 Bergen  
Norway  
Tel: +47-55 58 21 17  
Fax: +47-55 58 96 50  
nsd@nsd.uib.no  
www.nsd.uib.no  
Org.nr. 985 321 884

Marguerite Daniel  
HEMIL-senteret Universitetet i Bergen  
Christiesgt. 13  
5015 BERGEN

Vår dato: 01.07.2015

Vår ref: 43445 / 3 / LB

Deres dato:

Deres ref:

### TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 12.05.2015. Meldingen gjelder prosjektet:

43445	<i>Exploring experiences of pregnant adolescents and their utilization of reproductive health services, Ghana: A Salutogenic Approach</i>
<i>Behandlingsansvarlig</i>	<i>Universitetet i Bergen, ved institusjonens øverste leder</i>
<i>Daglig ansvarlig</i>	<i>Marguerite Daniel</i>
<i>Student</i>	<i>Comfort Worna Lotse</i>

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.08.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Lene Christine M. Brandt

Kontaktperson: Lene Christine M. Brandt tlf: 55 58 89 26

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

*Avdelingskontoret / District Offices*

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no  
TRONDHJEM: NSD, Norges teknisk naturvitenskapelige universitet, 7491 Trondheim. Tel: +47 73 59 19 07. kyrr.svarva@svt.ntnu.no  
TROMSØ: NSD, SVI, Universitetet i Tromsø, 9037 Tromsø. Tel: +47 77 61 43 36. nsdmaa@svi.uib.no

Vedlegg: Prosjektvurdering  
Kopi: Comfort Worna Lotse cworna@yahoo.com

## Personvernombudet for forskning



### Prosjektvurdering - Kommentar

Prosjektnr: 43445

The sample consists of pregnant adolescents and adolescent mothers above the age of 16 years old, one queen mother, one clinician, one teacher and one representative of an NGO in the Municipality. They will be recruited through gatekeepers. When recruiting through gatekeepers we recommend that contact/information about the project is forwarded by the gatekeeper on behalf of the student, so that the sample recruits itself. Please note that when recruiting through the gatekeepers it is important to underline that participation is voluntary.

The sample will receive written information about the project, and give their consent to participate. The letter of information and consent form are somewhat incomplete, and we ask that the following is changed/added:

- It is added that "All gathered data will be made anonymous by 31.08.2017".
- The contact information of the student and the supervisor is added.
- It should be underlined that "Participation is voluntary".

Data will be gathered through personal interviews and focus group discussions. Sensitive information relating to health, cf. Personal Data Act § 2, no. 8 c), might be registered.

There will be registered some information about third persons (partner/family). Please note that identifying information about third persons should only be registered when necessary for the scientific purpose of the project. The information should be reduced to a minimum and should not be sensitive, and must be made anonymous in the publication. As long as the disadvantage for third persons is reduced in this way, the project leader can be exempted from the duty to inform third persons.

The Data Protection Official presupposes that the researcher follows internal routines of Universitetet i Bergen regarding data security. If personal data is to be stored on a private computer/portable storage devices, the information should be adequately encrypted.

By telephone with Marguerite Daniel 30.06.2015, it is reported that the estimated end date of the project is 31.08.2017. According to the notification form all collected data will be made anonymous by this date. Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting audio files

Since the adolescents could be considered a vulnerable group, we further refer to the Research Ethical guidelines for social sciences, humanities, law and theology (NESH), in particular chapter B. paragraph 14 (confidentiality) and Section C. paragraph 22 (consideration for vulnerable groups).

## Appendix 7 GHS Ethical Clearance

### GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

*In case of reply the  
number and date of this  
Letter should be quoted.*

*My Ref. :GHS-ERC: 3  
Your Ref. No.*



Research & Development Division  
Ghana Health Service  
P. O. Box MB 190  
Accra  
Tel: +233-302-681109  
Fax + 233-302-685424  
Email: Hannah.Frimpong@ghsmail.org

1<sup>st</sup> September, 2015

Comfort Worna Lotse  
University of Bergen  
Department of Health Promotion and Development  
Norway

#### **ETHICS APPROVAL - ID NO: GHS-ERC: 08/06/15**

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

#### **“Exploring Experiences of Pregnant Adolescents and their Utilization of Reproductive Health Services in the Ho West Municipality, Ghana: A Salutogenic Approach”**

This approval requires that you inform the Ethics Review Committee (ERC) when the study begins and provide Mid-term reports of the study to the Ethics Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

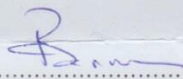
You are also required to report all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please note that this approval is given for a period of 12 months, beginning 1<sup>st</sup> September, 2015 to 31<sup>st</sup> August, 2016.

However, you are required to request for renewal of your study if it lasts for more than 12 months.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....

DR. CYNTHIA BANNERMAN  
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra



## Appendix 8: VRHD Permission

In case of reply, the number and the date of this letter should be quoted

My Ref. No. VRHD/PN/460

Your Ref. No.....

- Our GHS Core Values**
- PEOPLE-CENTRED SERVICES
  - PROFESSIONALISM
  - TEAM WORK
  - INNOVATION/EXCELLENCE
  - DISCIPLINE
  - INTEGRITY



Volta Regional Health Directorate  
GHANA HEALTH SERVICE  
P. O. BOX 72  
HO. V/R.  
Tel: (03620) 28210  
Fax: (03620) 28244  
[volta-health@4u.com.gh](mailto:volta-health@4u.com.gh)

16 July, 2015

THE DISTRICT DIRECTOR OF HEALTH SERVICES  
HO WEST DISTRICT HEALTH DIRECTORATE  
GHANA HEALTH SERVICE  
DZOLOKPUITA

Dear Sir/Madam,

**INTRODUCTORY LETTER**  
**MS. COMFORT WORNA LOTSE – STUDENT UNIVERSITY OF BERGEN, NORWAY**

This is to introduce to you the above mentioned student who has my instruction to conduct Qualitative Research in the Awudome Community on "Adolescent Pregnant Girls and Mothers using a salutogenic approach".

I would be grateful if you could give her the needed assistant to enable her conduct the research successfully.

Counting on your usual co-operation.

Thank you.

(DR. JOSEPH TEYE NUERTEY)  
REGIONAL DIRECTOR OF HEALTH SERVICES  
VOLTA REGION

Cc: Ms. Comfort Worna Lotse ✓