UNIVERSITY OF CAPE COAST

TEENAGE MOTHERS' EXPERIENCES WITH CHILDBIRTH IN THE KOMENDA-EDINA-EGUAFO-ABREM MUNICIPALITY, GHANA

REUBEN FOSTER TWINTOH

2020

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BY

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Thesis submitted to the Department of Population and Health of the Faculty of Social Sciences, College of Humanities and Legal Studies, University of Cape Coast in partial fulfillment of the requirements for the award of Master of Philosophy degree in Population and Health

MAY, 2020

DECLARATION

Candidates' Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's

Signature…………………………….Date………………………….

Name: Reuben Foster Twintoh

Supervisors' Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's

Signature……………………..Date…………………………

Name: Prof. Eugene Kofuor Maafo Darteh

ABSTRACT

Teenage childbirth is a social and public health concern in Ghana, with high prevalence in some regions in the country, including the Central Region, particularly in the KEEA Municipality. This study sought to explore teenage mothers' experiences with childbirth in the KEEA Municipality. The study utilised a cross sectional research design, where qualitative methods such as in-depth interviews and pictorial guides were used to collect the data from 30 participants. The data were analysed using a systematic qualitative oriented text analysis and NVivo 12 Pro qualitative software. Using health belief model, resilience theory and ecological systems theory, teenage mother's life experiences, feelings and circumstances with childbirth were explored. The study reveals that, teenage mothers experienced risks of postpartum haemorrhage, preterm births, low birth weight, and other neonatal conditions. Findings suggested that teenage mothers were inexperienced in some of the childcare practices. They use traditional practices that were part of their immediate environment (family) and community culture/belief when caring for their babies. For instance, putting wet towel on hot stone and apply to the umbilical stump. It emerged that teen mothers required help and social support from the microsystem consisting of the family, friends, and the baby's fathers to enable them and their babies survive, develop, and become healthy and happy in life. It is recommended that, health care professionals must be aware of the birth experiences and child care practices of teenage mothers in order to plan quality care for mother—child and ensure that the needed support, knowledge and guidance should be provided to teenage mothers to ensure their wellbeing and that of their children.

KEY WORDS

Childcare practices

Ecological systems Theory

Experiences

Qualitative study

Teenage childbirth

Teenage mother

ACKNOWLEDGEMENTS

I am highly indebted to Prof. Eugene Kofuor Maafo Darteh, my academic supervisor, for his immense and unrelenting support, guidance and supervision. I am also thankful to Dr Kwaku Kissah Korsah and Alrie Middlebrook for encouraging me to complete this work.

I acknowledge the sponsorship (research grant) of the Samuel and Emelia Brew-Butler-SGS/GRASAG through the University of Cape Coast Graduate School (GRASAG) for the financial support, which enabled me to complete my research successfully.

I also thank Prof. Kofi Awusabo-Asare, Prof. Evelyn Ansah and my supervisor for their contribution and the exposure I had in the development of the pictorial guide. I thank Fleancy Forkuo Art for the pictorial guide/diary.

I am also very grateful to all the chiefs and leaders of the sub-municipal communities of the KEEA Municipality and to all teenage mothers who agreed to participate in the study. And to my research assistants who faithfully and dutifully stayed with me right from the start till data was collected on the last study participant, I would say, 'Ayekoo'! I am most grateful.

I will also like to thank Mr. Kwamina Sekyi Dickson and Mr. Prince Justice Anku, Graduate Assistants of the Department of Population and Health, University of Cape Coast and Mr. Alfred Blay, and friends for encouraging me and ensuring that I had the assistance I needed and motivation for my work. My final gratitude goes to my family.

DEDICATION

To my mother, and in memory of my father

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LIST OF ABBREVAITION/ACRONYMS

ANC	Ante Natal Care
CHPS	Community Health Based Planning and Services
CS	Caesarean Section
EBF	Exclusive Breast Feeding
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GHS	Ghana Health Service
GoG	Government of Ghana
GSS	Ghana Statistical Service
KEEA	Komenda-Edina-Eguafo-Abrem
MGCSP	Ministry of Gender and Children and Social Protection
MoH	Ministry of Health
NASPA	National Service Personnel Association
PNC	Population National Council
PNC	Post Natal Care
PHC	Population and Housing Census
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Right
TBA	Traditional Birth Attendance
UNICEF	United Nations International Children’s Emergency Fund
UNFPA	United Nations Fund For Population
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

Teenage health and development remain a public health concern globally. As a result, the need to prevent early pregnancy and childbirth among teenage girls has been given prominence in recent years (Ahinkorah, Hagan, Seidu, Mintah, Sambah, Schack, & Hormenu, 2019; United Nations Population Fund [UNFPA], 2015). Teenage childbirth is a phenomenon that has significant implications at individual, societal, national and global levels (Dlamini, 2016). Globally, it is estimated that about 16 million teenage girls (aged 13–19) give birth every year (Word Health Organisation [WHO], 2016), with almost all (95%) of these births occurring in low- and middle-income countries (Krugu, Mevissen, Münkel, & Ruiter, 2017; UNFPA, 2015). Childbirth among teenagers is associated with adverse outcomes such as preterm delivery, eclampsia, puerperal endometritis, postpartum haemorrhage, and neonatal deaths (Darroch, Woog, Bankole, & Ashford, 2016; Gilbert, Jandial, Field, Bigelow & Danielsen, 2004; Kumar, Singh, Rai & Singh, 2013; WHO, 2018).

The WHO (2016) also showed that teenage girls who give birth before fifteen years are five times more likely to experience complications or die during delivery, as compared to women in their twenties, due to physical immaturity. Other studies have found that teenage pregnancy and childbirth have a strong association with low levels of educational achievement for young women, which, in turn, may have a negative impact on their position and potential contribution to the family, society and the nation at large (Bah, 2016).

Teenage motherhood requires support, attention from the family, and community involvement, irrespective of the mother's cultural and psychological background and socio-economic position (Eliason, Baiden, Yankey & Awusabo-Asare, 2014; Sa-ngiamsak, 2016). Teenage mothers (13 to 19) and their babies are at a social and health disadvantage because of unpreparedness and the maturity required to be a mother or parent (Bah, 2016).

A report on adolescent fertility revealed that the number of births to teenagers 15 to 19 years in sub-Saharan Africa is projected to increase in the next decades, exceeding 4.8million births from 1995 to 2020 (Gyesaw & Ankomah 2013). According to UNFPA (2013), sub-Saharan Africa had the highest prevalence of teenage pregnancy, compared to other regions of the world. The average birth rate of teenage mothers 15 to 19 in sub-Saharan Africa is 143, which is higher than the world's average of sixty five (65), which affirms that teenage pregnancy and childbearing, along with maternal and child mortality, are major challenges facing young females in African countries (Ahinkorah *et al*., 2019).

Evidence revealed that, at the end of 2011, twelve percent of teenage girls aged 13 to 19 years were either pregnant or had already given birth in Ghana (Ghana Statistical Service [GSS], Ghana Health Service [GHS] & ICF Macro, 2012). The teenage birth rate in Ghana has been increasing over time, with birth rate of 70 per 1000 women recorded in 2014 (GSS [Ghana Statistical Service], Accra, Ghana 2015 as cited in Krugu *et al.*, 2017). There are regional and district disparities in teenage childbirth in Ghana. The Ghana Demographic and Health Survey report indicated that, the rate of teenage childbirth was higher among those living in the Central Region, while the Volta Region recorded the highest rate in the country (GSS, GHS & ICF Macro, 2015).

Childbirth among teenage mothers has been identified to have the increase risk of infant and child mortality, with associated negative demographic and social consequences (Awusasbo-Asare, Abane, & Kumi-Kyereme, 2004; GSS, GHS & ICF Macro, 2015). Studies have well documented the negative impact of teenage childbearing in terms of social, economic and health outcomes, including poverty (De Jonge, 2001), high stress, family instability, and limited educational opportunities (Bah, 2016; Kirbas, Guleman & Daglar, 2016; Letourneau, Stewart & Barnather, 2004). Evidence reveals that someone who becomes a mother at the early stages of life (from 13 to 19 years) is more likely to experience health risks as a result of psychological and physiological immaturity and complications such as fistula, postpartum haemorrhage, anaemia, caesarean section, pregnancy induced hypertension and other neonatal problem (UNFPA, 2013; WHO, 2016).

Recent growing body of literature has examined attitude, behaviour, sexual health knowledge, health services and risk factors for pregnancy among teenagers (Ahinkorah *et al.*, 2019), as well as correlates and determinants of unintended teenage pregnancy (Ameyaw, 2018). Previous studies have delved into teenage pregnancy and motherhood (Gyesaw & Ankomah, 2013), unsafe abortion and contraceptive use, adolescent sexual and reproductive health (Awusabo-Asare, Biddlecom, Kumi-Kyereme, & Patterson, 2006). Besides, childbirth experiences during teenage have been seen as problematic developmentally, psychologically, physiologically and emotionally for teen mothers.

Statement of the Problem

Childbirth during teenage could involve not only medical but also psychosocial problems. These problems include gynaecological age, physiological and emotional immaturity, possibly low socio-economic level and lack of social support (Kirbas, Guleman & Daglar, 2016; UNFPA, 2015). There is a growing body of literature that suggests that there are many problems associated with teen childbirth (Ahorlu, Ady-Gyamfi, Pfeiffer, & Obrist, 2013; Gyesaw, & Ankomah, 2013; Henry & Fayorsey, 2004). A study conducted by Duncan (2017) indicates that parenting, during teenage years, is problematic developmentally and emotionally for teenage mothers. The birth of the baby is accompanied by sudden acquisition of new roles and tasks with which all new mothers must cope. Teenage girls who bear children find it extremely difficult to adequately meet their parental obligations and some end up dumping their babies in garbage pits, beaches, latrines, carriages, and even burying their babies alive (Bah, 2016). Teenage childbirth is a significant life event that requires good understanding of the life course and transition of teen mothers to adulthood (Sa-ngiamsak, 2016). Lack of knowledge and competence among teenage mothers about their new maternal roles and new-born babies can cause fear, stress and anxiety in the new-born mothers (Kridli, Ilori, & Varriest, 2013).

Teenage childbirth has become a major health and socio-economic issue in Ghana, with high prevalence in some regions in the country, including the Volta, Brong Ahafo, Western and Central Regions (GSS, GHS, & ICF Macro, 2015). Despite the effectiveness of efforts aimed at empowering and improving access to Adolescent Sexual and Reproductive Health (ASRH) and

Comprehensive Sexuality Education and Rights in Ghana, the incidence of teenage childbirth is still high and brings uncertainty about the situation in some areas, including the KEEA Municipality.

There is a dearth of qualitative studies which focus on experiences of pregnancy and motherhood among teenage mothers (Gyesaw, & Ankomah, 2013), coping with pregnancy and experiences of adolescent (Henry & Fayorsey, 2004), and teenage pregnancy and motherhood (Keller, Hilton & Twumasi-Ankara, 1999). Substantial work has been done in the KEEA Municipality in the field of adolescent sexual and reproductive health. For instance, there was a study by Eshun (2015) on factors affecting maternal health care delivery in the KEEA. In another study, an assessment of the utilisation of community-based health planning and services (CHPS) was carried out in the KEEA municipality with the findings revealing lack of midwives at the CHPS compounds (Wood, & Esena, 2013).

A recent quantitative study conducted by Ahinkorah *et al.* (2019) in the same municipality showed that, with the existence of negative socio-cultural norms, teenage girls are exposed to the risk of pregnancy. Recommendations made based on the findings of these studies raise no doubt that a further study is required to better understand the situation. According to the authors the negative health, psychological and economic impact associated with early childbirth is worrying and should not be underestimated. Teenage childbirth brings negative consequences, including school dropout, helplessness, low self-esteem, depression, and suicidal attempt than married adults (Bah, 2019). Negative behaviour such as not accessing health services (ante and postnatal care) may cause higher rate in postpartum haemorrhage, dysfunction labour, premature rapture of membrane, preterm babies or low birth weight babies and the economic outcomes for teenage mothers—poverty, unemployment and others—which may result in poor childcare practices, including poor child medications, poor feeding practices, poor accommodation and sleeping arrangement, and unhealthy child bathing practices (Ahinkorah *et al.*, 2019; Saa-Tough, 2014). The child of a teenage mother is more likely to be physically and socially handicapped than that of adult mothers (Petra, 2016; Yasmin, Kumar, & Parihar, 2014).

Whereas these quantitative studies have contributed immensely to the field of interest, there exist some knowledge gaps with regard to lived experiences. Therefore, an empirical study on teenage mothers' experiences with childbirth in the Komenda-Edina-Eguafo-Abrem municipality in the Central Region of Ghana would be worthwhile. It is, therefore, against this reason that the study, with the aim of addressing this research gap, utilises a qualitative design to explore teenage mother's lived experiences with childbirth from the teen mothers' own perspective in the KEEA Municipality.

Research Questions

The study was guided by the following questions:

i. How do teenage mothers take care of their babies in terms of breastfeeding, bathing, and sleeping arrangement, etc.?
ii. What are the postnatal challenges that teenage mothers encounter after childbirth?
iii. How do teenagers cope with and adapt to motherhood in light of the challenges they face as teenage mothers?

Objectives of the Study

The general objective of the study is to explore teenage mothers' experiences with childbirth in the KEEA Municipality. The specific objectives are to:

i. Explain teenage mother's child care practices.
ii. Evaluate postnatal challenges teenage mothers encounter after childbirth; and
iii. Explore coping strategies of teenage mothers in light of the challenges they face regarding motherhood.

Rationale of the study

The Komenda-Edina-Eguafo-Abrem Municipality in the Central Region of Ghana has been confronted with the challenge of teenage pregnancy; it has also been experiencing high teenage childbirth over the years (KEEA Health Directorate, 2016). Based on statistics from the GHS and ICF Macro (2015), teenage mothers with at least one child in the Central Region accounted for seven percent. In the Central Region, the KEEA Municipality is one of the municipalities that have high rates of teenage childbirth. In order to understand the incidence of teen childbirth and motherhood experiences, the contributing factors would need to be understood.

The study will investigate the experiences, causes, and consequences of childbirth amongst teenage mothers and how they manage the situation of becoming teenage mothers at such an early stage. It is envisaged that findings from this study will provide insight and serve as basis for appropriate authorities like the Municipal Health Directorate to make right decisions and develop policies to deal with adolescent and teenage childbearing and its health implications on the mothers. The study will help the KEEA Municipality and

Health Directorate under the auspices of Ghana Health Service to inform policies, practices and interventions such as ASRH and Comprehensive Sexuality Education (CSE) and form a connection with the Ghana Education Service (schools) and social workers working with the youth, parents of pregnant girls who decide to raise babies, in providing effective guidance and empowering teenage girls or mothers.

The study would also serve as basis and add to the prevailing discourse on adolescent reproductive health and maternal and child health policies and programmes. Since it would provide the fundamental information regarding childbirth experiences of teenage mothers (13-19) years. It would also help organisations (Governmental and non-governmental) dealing with teenage mothers in their planning and programming. Finally, the study will add to existing literature that will serve as reference material for other researchers who will be interested in studying or researching into a related topic. This is because it is hoped that the study will add to existing knowledge and also form the basis for further research in the country.

Definition of Terms

Postnatal: pertaining to a period immediately after childbirth.

Teenage: refers to any girl between the age period 13 and 19 years old.

Teenage childbirth: is a situation whereby a girl child between 13 and 19 years old give birth to a child.

Cope*:* may refer to the efforts meant to manage (i.e. master, reduce, minimize, etc.) social, environmental and internal demands and conflicts, which strain and/or outstep a person's resources (Bah, 2016)

Adapt: can be defined as the active or conscious efforts the teenage mothers applied over their lifespan to enable them to survive, develop, and achieve successes in relationship to childbirth and rearing or caring for their children (Bah, 2016).

Organisation of the Study

The study is organised into five chapters. Chapter One consists of the background to the study, statement of the problem, objectives (general and specific) of the study, research questions, significance of the study, definition of terms, and organisation of the study. Chapter Two deals with the review relevant literature related to the study. It covers the following sub-topics: definition of a teenage mother, concept of teen childbirth, experiences of teenage childbirth, implications of teenage childbirth, teenage motherhood experiences, and social support for teenage mothers regarding motherhood challenges, effort at managing and coping strategies of teenage mothers, and the theoretical and conceptual issues for the study. Chapter Three describes the methodological approaches used. It focuses on the study research design, study area characteristics, sources of data, target population, sampling and sample size, data collection instruments, pre-test, data collection procedures, data processing and analysis, data management, and ethical issues/considerations. Chapter Four consists of the results and discussion. It describes and discusses issues such as socio-demographic characteristics of the participants, analysis framework (main themes and sub-themes), and discussion of the results. Chapter Five, which is last chapter, provides the summary, conclusions, recommendations and suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews relevant literature related to the study. It first presents the definition of teenage mother, concept of childcare, experiences of teenage childbirth, factors contributing to teenage childbirth, implications of teenage childbirth, teenage motherhood experiences, and social support for teenage mothers regarding motherhood challenges, and effort at managing and coping strategies of teenage mothers. The chapter also discusses theoretical and conceptual framework as a basis for discussing and interpreting teenage mothers' experiences with childbirth. Health Belief Model (Sheeran & Abraham, 1995), Resilience Theory (Zimmerman & Arunkumar, 1994) and ecological systems theory (Bronfenbrenner, 1979), were used to explain and provide understanding to the research questions and objectives posed by the study.

Definition of Teenage Mother

According to WHO (2006), a teenage mother is a young woman who becomes a mother at less than 19 years of age. It also refers to a young woman who becomes a mother at age less than 20 years (before reaching adulthood, which is generally regarded as 20 years of age) (UNICEF as cited in Sa-ngiamsak, 2016).

Concept of Childcare

In the overview of the UNICEF-Cornell Colloquium report, childcare for infants and young children was defined as care giving behaviours such as breastfeeding, diagnosing illnesses, determining when a child is ready for supporting and feeding, stimulating language and other cognitive capacities and providing emotional support (Badasu, 2004).

In addition, Badasu's (2004) study of childcare among Ewe migrants in the city of Accra observes that, in traditional Ewe society, care for the children is the duty of the kin or lineage group though the mother is the primary care giver to the child. Members of the mother's kin mainly have the shared responsibility to offer help of all kinds to the mother, right from the period of pregnancy. Awumbila, Alhassan, Badasu, Bosiakoh and Dankyi (2011) note that the childcare practices common in Ghana and, by extension, West Africa include pro-parental institutions which include kin care mainly through fosterage.

Awumbila *et al.* (2011) point out that the traditional role of women being childcare givers has suffered because migration makes it quite impossible for the mothers and children to receive adequate care from extended family or for the nuclear family to live together. Connected to this, Badasu (2004) observes that, in urban areas, there is the need for women to work away from home in order to either support their families' income or solely provide a livelihood for their families, which makes childcare more problematic for the family. He further contends that infant and toddler care and feeding is clearly required on a continuous basis, and because infants cannot fend for themselves to obtain the nutrients they need such care is necessary, very intensive and requires considerable time and attention, throughout the day and night, for babies need feeding every two or three hours. The dependence on kin is for support of childcare tasks and socialisation (Henry & Fayorsey, 2002). Awumbila et al. (2011) also indicate that parents often view childcare as interfering with their ability to earn income and/or accumulate wealth, a pre-requisite for meeting the basic needs of their children or babies. This often gives rise for the call for assistant or help, especially, those in the urban settings often employing mostly kin. These findings corroborate Badasu's study which indicated that several factors at the household level, particularly family income, mother's educational status and occupation or work, affect childcare and have great consequences for child survival.

A study by Kridli, llori and Verriest (2013) revealed that the family, mother, mother in-law, and sometimes relatives may also play a major role in supporting the mother in taking care of herself and her newborn after childbirth. They indicated that first time mothers tend to get more support because they lack experience. Findings revealed that mothers educate their daughters about newborn care practices or activities such as bathing, feedings, clothing, and also about traditional medicine practices. They revealed that mother's role in helping her daughter with newborn tends to last for about forty days after childbirth (Kridli, llori & Verriest, 2013).

Experiences of Teenage Childbirth

According to Hanna (2001), teenage mothers reported negative public attitudes directed toward them wherever they found themselves. This created frustration as it happens in everyday lives and locations such as street, markets, in health centres, in medical facility, homes and places where teenage mothers themselves gather. Teen girls can be accused of deliberately becoming pregnant and bearing a child to reap the financial benefits, denied access to full participation in the same society that failed to provide them with full social support (Sa-ngiamsak, 2016). In another study by Boath, Henshaw and Bradley (as cited in Sa-ngiamsak, 2016), teenage mothers reported feeling of devalued and have to cope with the people perceiving them as being a bad mother just because they are teens and not able to fulfil the contemporary social norms of motherhood. Some of the teenage mothers tried to hide their symptoms of their postpartum depression as being afraid of healthcare professionals could take away their children from them if they mentioned that they had postpartum depression and were judged as unable to cope.

According to Sa-ngiamsak (2016), in some societies in developed countries, particularly those with well-developed welfare systems, teenage mothers were normally stigmatised by a welfare system. However, societies in many developing countries, culture and norms play a major role in stigmatising teenage mothers. This was revealed in a study conducted by Moss-Knight (2010), who investigated the experiences of pregnancy among unmarried first time pregnant adolescent attending alternative schools in Nassau. The study revealed that stigma was part of the experience of pregnant teenagers. In addition, the perception of stigmatisation began with the initial disclosure of their pregnancy and they were judged based on the teenager ‘‘spoiled mark’’ of being pregnant too early and outside wedlock, which is against their social value.

A study conducted by Ady-Gyamfi *et al.*, (2013) on evidence for policy and coping with teenage pregnancy and childbirth in Ghana found that most teenage pregnancies and childbirths are unplanned or unwanted. For teenage girls who cannot cope, they often lead to consequences such as poverty, morbidity, and mortality. However, not all teenage girls are vulnerable and lack the capacity to overcome the challenges of teenage pregnancy. In addition, Ady-Gyamfi and her associates indicated in their survey that of 1,320 girls aged 15-19 years in Accra and Begoro revealed that 16% were either pregnant or already mothers. According to WHO (2014), the health of teenagers is undermined by numerous factors which operate at the individual, family and community levels. These factors pose challenges to the health status of teenagers, which can be dealt with through the provision of health services. They also affect the wellbeing of teenagers by influencing their capacity to deal with life stressors, their ability to grow in developmentally appropriate ways and their capacity and ability to take decisions regarding health behaviours.

A study by Arthur (2012) has shown that premarital pregnancy or childbirth imposes great psychological and emotional strain on the young mothers but a teenage school girl who is dropped out of school, reprimand by her parent, or ridiculed by her friends undergoes rapid psychological and physiological changes, becomes a teenage mother and most likely to suffer material and emotional deprivation. According to Ramathuba, Khoza and Netshikweta (2012), another health issue of teenage reproduction is its association with poor pregnancy outcomes for the young mother and the child as well. Comparing with adults aged 24 years and above, childbirth during the teen years (13 to 19) has been observed to present a much higher risk of low birth weight, neonatal mortality, infant mortality and pregnancy-related medical complications. Despite the availability of free contraceptives services, most of the teenage pregnancies and childbirth remain unintended or unplanned and usually happens with certain sexual risk-taking behaviour, including early sexual debut, unprotected sex and low contraceptive usage among young people (Ady-gyamfi *et al*., 2013; Hill, Maman, Grooves & Moodley, 2015).

Factors Contributing to Teenage Childbirth

Teenage childbirth has been an emerged issue over decades and is still emerging due to some major characteristics and contributing factors, including homelessness. Hanna (2001) explains the homeless situation of teenage mothers to be as a result of a variety of factors: because of the pregnancies, some are homeless; escaping abuse; leaving home due to conflicts with family members or feeling unloved; poverty, low level of education and limitation to opportunities, disrupted family background and poor parental supervision and communication (Bowman, 2013). According to United Nation (2015), teenage childbirth is a phenomenon that has significant implications at individual, community, national and global levels. The organisation intimates that for the individual woman, childbirth at an early stage can alter her entire life. It further indicated that from the perspective of the community and government, teenage childbirth has a strong and unwelcome association with low levels of educational achievements for young women, which in turn may have a negative impact on their position and potential contribution to society (UNFPA, 2015).

Poverty is both a contributing factor and a consequence of teen childbearing (Flanagan *et al*., 2013). In some cases, poverty leads to intergenerational sex, transactional sex or simply sexual relationships which are not ideal but provides some benefits. Some studies have shown that poverty decreases a girl’s ability to negotiate condom use, and can keep her in very abusive relationships, and create a further layer of unequal power (Flanagan *et* *al*., 2013; Jewkes, Morrell & Christofides, 2009; Mkhwanazi, 2010). However, in supporting the concern about the risks associated with intergenerational sex, Pettifor and his associates (2009) revealed that family background is another common contributing risk factor that has a major influence on young people, especially teenage girls under 20 years. Barn and Mantovani (2007) have shown that growing up in a single parenthood and disrupted families (broken homes) as well as being born out of wedlock and parental divorce substantially increase the chances that women will have their first birth within ages 13 to 19years. They further revealed that one of the reasons for the increase risk of childbirth among teenage girls of single-parent families may be related to more permissive sexual attitudes, poor parental supervision or control, and the example of their own dating activities.

In the same vein, Benson (2004) indicated that pregnant teens have been found to perceive high level of family dysfunction; compared to non-pregnant teens, pregnant teens have reported poorer communication with both parents. In addition, conditions of economic poverty at both an individual and community level are related to higher rates of teenage childbirth and abortion. Another study by Klaw (2008), focusing on future goals of poor youth, showed that, because of limitations on opportunities, there are generally low expectations among teenage girls in terms of their education and career goals. Similarly, Domenico and Jones (2007) makes a connection between the lack of education and opportunities to early pregnancy through research and revealed that teenage females may become pregnant or bear child intentionally because they see no other life goals within their reach; without realistic expectation about education or occupation, pregnancy can be viewed as alternative path to economic independence and adult status.

Implications of Teenage Childbirth

According to WHO (2016), teenage childbirth has implications for the mother and the child. Babies born from teenage mothers are at 50 percent higher risk of stillbirth, being premature, and dying during the first month, compared to babies from matured mothers or adult. New-borns from teenage mothers also suffer from many independent adverse foetal outcomes, including preterm births, low birth weight, birth asphyxia, respiratory distress syndrome and birth trauma or injury (Yasmin, Kumar & Parihar, 2014). In a previous study by WHO (2008), it was shown that low birth weight increases the likelihood of future health problems and the risk of death of the baby. It also makes a child susceptible to many diseases such as diabetes and heart disease in the near future and more vulnerable to death with one month.

A similar study Shrestha (2012) showed that one out of ten babies delivered by adolescent mothers is preterm and died before reaching first birthday. An earlier study by Yadav, Choudhary, Narayan, Mandal, Sharma, Chauhan and Agrawal (2008) revealed that 790 teenage mothers identified that, out of the babies that were delivered, 84 of them were preterm, 83 were low birth weight, 19 were still birth and neonatal death took place in six of the birth. Apart from the complication in childbirth, research has shown that teenage girls who give birth each year have a greater risk of dying from maternal causes, compared to women in their twenties and thirties (WHO, 2008).

According to United Nations Population Fund (2015), the risk of maternal death for adolescent mothers in low- and middle-income countries is double that of older females and they face significantly higher rates of obstetric fistulae than their older peers. About 70,000 adolescents in developing countries experience death annually due to causes related to pregnancy and childbirth. Depression is another health problem that has been found to be associated with teenage childbirth. In a study conducted by Clemmens (2002), it was found that most of the teenage mothers reported feeling depressed after childbirth. No participant reported feeling scared with the sudden realisation of motherhood. Some felt abandoned and rejected by partners and peers whilst others indicated being overwhelmed with questioning and not understanding the experiences of depression and what was happening to them.

In the same vein, although the negative outcomes of teenage parenting are well documented, it is clear that social and economic factors contribute greatly to the outcomes for teenage mothers. Raj and associates (2010) found that, regardless of whether teenage mother came from rich or poor countries, they shared some similarities in their socio-economic background. Teenage mothers were more likely to come from economically poor families, have a history of low education and be the daughters of teenage mothers. Raj *et al*., (2010) further show that life experiences of teenage mothers can be both negative and positive depending on such factors as cultural context (each which may have different beliefs and norms); where support networks of socio-economic background of teenage mothers received from their family, school, friends, baby's father and welfare systems available.

In Ghana, birth among teenagers occurs either before marriage or after marriage, and to a large extent, constitutes an important indicator of adolescent sexual and reproductive health (Awusabo-Asare *et al*., 2006). In a national household survey of 4,430 respondents on the sexual and reproductive health of adolescents, Awusabo-Asare *et al*. (2006) report that thirteen percent (13%) of teenagers aged between 15 and 19, had ever been pregnant and another nine percent (9%) ever had a child. The study findings indicate that one in 10 females in a union gave birth before age 15. Of the 1,235 females aged 15–19 years interviewed, 7% were married or living with a partner as if married. The implication is that early marriage and teenage pregnancy are major issues in the country, thus suggesting vulnerability. Atuyambe *et al.* (2008) studied adolescent and adult first time mothers' health seeking practices during pregnancy and early motherhood and found the average age of teenage mother to be 18 years. Moreover, a little over a decade after Nabila and Fayorsey (1996) had conducted their study among adolescent in Accra and Kumasi, a similar study by the Institute of Statistical Social and Economic Research and Regional Institute of Population Studies (2009) on the decision-making process of north-south child migrants in Accra and Kumasi found that the majority (54.4%) of the girls were aged between 15 and 19 years while about a third (26.4%) of them were aged between 10 and 14 years. The findings of these studies suggest that many young females in their teens are becoming pregnant and indicate the low usage of contraceptives among them in spite of reported high knowledge and awareness level on contraceptives (WHO, 2007).

Another implication of childbirth is the issue of competence of parenting or motherhood. Studies comparing infant care competence of younger adolescent and older adolescent mothers indicate that older adolescent mothers aged between seventeen and nineteen had significantly higher levels of perceived parenting competence and significantly better home environments scores, compared with younger (15-17 years of age) adolescent mothers (Secco, Ateah, Woodgate, & Moffatt, 2002). Previous research made a distinction in the role of child bearing age, from family income, maternal education, family type, maternal race/ethnicity, and child sex and age and found that adolescent mothers were significantly less supportive, more detached and intrusive as compared with the older non-adolescent mothers (Berlin et al., 2002). This is consistent with previous findings on the effect of age on parenting competence (Luster & Dubow, 1990). However, the age significance of the teenage mother has been challenged by the researches of Ermisch (2003) and Ermisch and Pevalin, (2005). In their studies, they found that the association of a teen-birth with outcomes did not differ significantly between women giving birth aged under 18 and women with a first birth aged between 18 and 19 years. In addition, a comparison of teenage mothers with women starting childbearing later did not identify these consequences because the women who became teenage mothers had different 'outcomes', that is, household income at a later age anyway, even if they had not given birth as teenagers. Moreover, Luster and Dubow (1990) examined the quality of care provided and found that older adolescent mothers had both higher levels of esteem at the time of the new-born and significantly more favourable home environments.

Teenage Motherhood Experiences

Over the years, several studies have found that many teenagers view parenting and motherhood as a positive experience although they acknowledge the increased responsibility, roles and restrictions placed on their time (Gyesaw, & Ankomah, 2013; Henry & Fayorsay, 2004; Keller Hilton &

Twumasi-Ankrah, 1999). Many teenagers view parenting as important to their lives and demonstrate a desire to meet the needs of their children by being good mothers. A previous study by Smith, Battle and Leonard (1995) found that pregnancy and childbirth brought meaning and positive life changes into the lives of some teenage mothers. Most pregnant and childbearing teenage females believe that pregnancy caused them to become more independent and elevated them to adult status (Spear & Lock, 2003).

A qualitative study conducted by Gyesaw and Ankomah (2013) on the experiences of teenage mothers in a suburb of Accra identified a number of reasons why they became pregnant. They found that lack of education, teenage sexual experiment, sexual violence and abuse and transactional sex as well as mothers desire to be a mother are responsible for their pregnancy. The findings of the study further indicate that many of the respondents did not know that they were pregnant as they still menstruated during their first trimester. All the participants testified to the pain of labour, but did not express regret bearing a child except the interruption in their education. The study found partner's reaction to be positive, while parents of these girls received the news of their daughter's pregnancy with shock, unhappiness and upset. Fathers, in particular, refused to accept the news while mothers had no problem accepting the outcome of their daughter's pregnancy.

In the Philippines, a study conducted by Pogoy, Verzosa, Coming and Agustino (2014) on the lived experiences of early pregnancy among teenagers found lack of sexual knowledge as a having impact on teenagers who usually engaged in early sexual activities. The study's findings also indicated that respondents did not get any responsible sexual information at school. They further established that teenage mothers were in position to go back to school after childbirth as they were forced to look after their babies. The researchers asserted that there were some cases where teenagers used their pregnant status to deliberately escape the demands of high school education. They finally concluded that child rearing among teenage mothers was a great challenge for them because they were not fully prepared, even though they faced it with courage.

In a similar vein, Cater and Coleman (2006), in their study of planned parenthood, found that many teenage parents are ambivalent in that their pregnancies were unplanned, and seemed that they did not mind whether they had a baby or not. They further revealed that contraception was rarely used, with the young women not caring about avoiding the possibility of pregnancy. However, the finding of the unplanned pregnancies is not supported by the idea that teenage girls plan pregnancies with the expectation that childbirth will boost their self-esteem. Again, teenage childbirth, however, appears to be an unplanned result of an attempt to bring about a balance between the conflicting needs for attention and connection and for independence.

A study by Arenson (as cited in Spear & Lock, 2003) explored how teenage mothers perceived themselves as parents. Their perceptions were based on the general themes of life event, relationship, and perceptions of self in the world, information seeking, and strengths. Life events referred to life experiences that teenagers thought influenced their current situation. Again, Hobcraft and Kiernan (2001) revealed that teenagers who become mothers are more likely to have experienced negative outcomes by age 33. It revealed that by age 33, early mothers were 4.4 times as likely to have been alone parent, and three times more likely to have lived in social housing, twice as likely to have received no qualifications, and forty percent more likely to have a low household income, be in general poor or fair health, and to view their life as unsatisfactory.

A study conducted by Oweis (2009) on childbirth experiences of mothers indicated that most participants were unhappy with their childbirth experiences and felt that they did not have any control over the experience. The finding revealed that majority of the mothers thought childbirth was more painful than what they had anticipated because they did not understand many of the different procedures being done, and they were scared, and lacked control. Several studies have shown that there is increased health risk for both mother and child, including complications, low birth weight, developmental and mental disability, and high infant mortality and morbidity babies are two to three times more likely to die in their first year, compared to babies born to older mothers (Bowman, 2013; Swedish, Rothenberg, Fuchs, & Rosenberg, 2010; WHO, 2016). Another study done by Hanna (2001) contends that motherhood is a struggle, but more importantly that teenage mothers need appropriate support in a number of ways, including parenting. It was further asserted that good parenting protects against future problematic behaviour but governments are slow to acknowledge this and provide appropriate resources. Meanwhile, literature clearly demonstrates that motherhood and parenting in the teen period are a disadvantage for both mother and the child, educationally, socially, psychologically and developmentally.

Social Support for Teenage Mothers Regarding Motherhood Challenges

Green and Rodgers (2001) defined social support in terms of the qualities of specific interactions between people, their perception of support and connectedness or more simply as having people to turn to for information, material assistance or emotional support. Teenage motherhood or parenting transition in general is a major developmental high point for all women but particularly stressful for teenage girls experiencing motherhood for the first time. Research has shown that adult and teenage mothers receive different sources of support. According to Gyesaw and Ankomah (2013), teenage mothers in Accra require support and community involvement, regardless of age and socio-economic position. Indeed, Williams (2005) demonstrates how marital relationship for adult mothers is important with regard to providing social support during pregnancy and after childbirth.

Another study by Green and Smith (2006) looked at the changes and continuity in childbirth and parenting practices across three generations of women in the United Arab Emirates, and reported that a factor that was continuous across all three generations (daughter, mother and grandmother) was that most women identified their mother as the most significant source of information for direction and education after birth. The finding also revealed that some trends were changing across the generations, including fewer adolescent births and decreasing birth rates in the younger generation, more daughters giving birth in a hospital setting with a doctor present that their mothers or grandmothers and significantly fewer daughter were reported to breastfeed than the older generation. Similarly, Gee and Rhodes' (2003) study of teenage mother's relationship with their children's biological fathers argue that being a teenage mother is a time that these mothers struggle to negotiate their new maternal roles and responsibilities, to cope with the physical, emotional and cognitive challenges of the teenage period. They particularly found that African American adolescent mothers often face additional adversities stemming from racial oppression and economic hardship. Another study by Lander (2010) contends that social support offered by parents, peers and teachers has been recognised to play an important role in the emotional and psychological wellbeing of teenage mothers. Lander further argues that being a teenage mother requires a special need for social support in order to help teenage mother navigate the many changes and transition during that period of development in their lives.

A study by Davis (2002) disputes that young women's lifestyle can easily arise in the sharing of childbearing responsibilities. However, disappointment and frustration with male partners are common. Young mothers with limited resources often find it difficult to reciprocate the support that they have received, creating an uncomfortable imbalance in the relationship (Gee & Rhodes, 2003). Teenage mothers often face problems with their male partners, ranging from disappointment over unmet expectations for financial and childcare assistance to serious conflict, difficult break ups, and physical and sexual assault (Leadbeater & Way, 2001). A study by Wall-Weiler, Ross and Nickel (2016) content that social support facilitates access to material resources such as clothing and shelter, and to financial, educational, medical and employment. Assistance is also important to overcoming adversities. They further revealed that teenage mothers from all social class have aspirations that reflect mainstream values about educational and vocational achievement, but only those who have the knowledge, skills and means to realise their aspirations can provide a positive future for themselves and their babies. Similarly, Bunting and McAuley (2004) reported that another main source of support for pregnant teen or teenage mother is friends. Friends offer emotional support and someone to talk to about daily activities. The same study found that peer social support was significantly related to the reduction of parenting stress, particularly with regard to high level of emotional support provided by this group.

Effort at Managing and Coping Strategies of Teenage Mothers

Coping is an important construct in understanding how teenage mothers react to the stressors and adjustment they experience in their lives (Garcia, 2010). Saa-Touh's (2014:p45) conceptualisation of coping is commonly used as ''constantly changing cognitive and behavioural effort a person makes used of to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person''. According to this approach, coping refers only to effort driven activities that require adaptation, and not all the things that a person does in relation to the environment. Additionally the phrases constant changing and specific demands reflect the dynamic nature of coping as a process rather than an individual trait or style. As such, coping is conceptualised as what the individual actually thinks or does to manage specific demands within specific contexts. As the context changes, there is the likelihood that individual's method of coping may change. The effort also permits the inclusion of any strategy that individual employs to manage the situation regardless of how well or badly it works for that individual (Saa-Touh, 2014).

Kaye (2008), in a longitudinal qualitative study in Uganda involving twenty–two teenage mothers in in-depth interviews and six focus group discussions among pregnant adolescent who were followed from pregnancy to childbirth, revealed that they frequently adopted emotion-focused coping style for the stress of pregnancy and motherhood. Some of the coping styles include the acceptance of the adolescent pregnancy, moral support to the adolescent mother and material and financial support to look after the child. There were important factors that minimised the adolescents' stress and enabled them to cope adequately with pregnancy and subsequently motherhood. Besides, Kaye argues that paternity acceptance is a coping strategy adopted by teenage mothers. Results of the study revealed that a major source of distress for teenage mothers is the unwillingness of partners to accept paternity for reasons including jeopardizing their education and employment. Additionally, the new identity and status as a mother was explained by teenage mothers as a coping strategy. Teenage mothers explained their new identity and status gave them a sense of satisfaction and fulfilment. In addition, taking risks was found to be another coping strategy teenage mothers adopted in their experience as teenage mothers.

Several studies have highlighted young women embracing motherhood (Brown, Raynor, & Lee, 2011; Bunting, & McAuley, 2004; Jewkes, Morrell & Christofides, 2009; Pandey *et al.*, 2009). A study conducted by Pandey and associates (2009) revealed that many teenage mothers made conscious choices to keep their babies, embraced motherhood, managed their lives well and continued to succeed at school and were good mothers. However, Cohan (2010) also indicated that the young mothers in her study acknowledged that motherhood was demanding and challenging, especially when the baby was sick or they had a lot of school work. In the same vein, many teenage mothers wanted to stay home and care for their babies, which would reinforce the attitudes of teenage mothers as reckless because they do not return to school. Despite most young being competent, loving mothers and the moral outrage is misplaced. One still needs to reflect on whether motherhood as a young teenager under 20 years is desirable, whether it limits opportunity for young teens and the potential negative impact for the children (Jewkes, Morrell & Christofides, 2009).

Theoretical and Conceptual issues for the Study

Theoretical and conceptual issues provide important bases that direct research studies especially in the choice of method of study and direction to follow. The ecological systems theory developed by Bronfenbrenner (1979), Health Belief Model by Sheeran and Abraham (1995), and the resilience theory by Zimmerman and Arunkumar (1994) were used in this study. The conceptual issues have been examined to find out the extent to which they help to explain issues in the present study. This segment begins with the theories (Health Belief Model and Resilience theory) and concludes with the conceptual framework (Ecological systems theory) for the study.

Health Belief Model

According to Glanz, Rimer, and Lewis (2002), the health belief model is considered the most frequently used or adapted theory in health education and health promotion. Health Belief Model (HBM) is a psychological model which was developed in the 1950s. The model, since then, became popular among researchers and has either been adopted or adapted in several ways to explain various long-term and short-term health behaviours which include risky sexual behaviour and attitudes. The model also attempts to explain and predict health behaviour of people based on various demographic and social variables. The model was originally developed in order to explain engagement in one-time health-related behaviours such as being screened for pregnancy or receiving an immunization after childbirth. Eventually, the health belief model was applied to more substantial, long-term behaviour change such as diet modification, exercise, and smoking, pregnancy and childbirth etc. Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-efficacy) was a key component of health behaviour change. The model considers beliefs about the consequences of health practices and the possibility and the effect to put them into action. According to the HBM, behaviour evaluation depends on the perceived benefit of the prevention (for instance, pregnancy prevention and perceived barriers, both material and psychological with regards to specific health problem or challenges).

The health belief model was utilised because of its ability to explain the variable in the present study. This is because the quest to understand the determinant of health behaviour has intensified as evidence accumulated concerning the teenage mother's experiences with childbirth. According to the above version of the health belief model, action in the HBM is guided by beliefs about the impact of the pregnancy and childbirth outcomes and its consequences, thus factors that influence the teenage pregnancy and childbirth (threat perception) which depends on: perceived susceptibility or the beliefs about how vulnerable a person (teenage mother) in this case considers herself in relation to a certain condition or health problem and perceived severity of illness or health problems and its consequences of early childbirth, for instance, postnatal outcomes. It also considers health motivation or readiness to be concerned about health matters. Sheeran and Abraham (1995) theorize that the model has key variables that influence an individual decision to either take action or prevent an action. These variables include the demographic variables or individual characteristics, psychosocial, and structural variables and can affect perceptions (i.e., perceived seriousness, susceptibility, benefits, and barriers) of health-related behaviours. Demographic variables include age, sex, race, ethnicity, religion and education, among others. Psychosocial variables include personality, social class, and peer and reference group pressure, among others. Structural variables include knowledge about a given condition and prior contact with the condition, among other factors. The health belief model suggests that modifying variables affect health-related behaviours indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers. Perceived severity refers to the subjective assessment of the severity of a health problem and its potential consequences, for instance, the consequences of teenage pregnancy and the risk of childbirth. The health belief model proposes that individuals who perceive a given health problem, for example, pregnancy or childbirth, as serious are more likely to engage in behaviours to prevent the health problem or situation from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability, pain or death) as well as broader impacts of the disease. Perceived susceptibility refers to the subjective assessment of the risk of developing a health problem. The health belief model predicts that individuals, in the case, teenagers who perceive that they are susceptible to a particular health problem, will engage in behaviours to reduce their risk of getting pregnant. Individuals or teenagers with low perceived susceptibility may deny that they are at risk of getting pregnant.

The combination of perceived seriousness and perceived susceptibility is referred to as a perceived threat. Perceived seriousness and perceived susceptibility to a given health condition in ‘teenage childbirth’ depend on knowledge about the condition. The health belief model predicts that higher perceived threat leads to a higher likelihood of engagement in health-promoting behaviours. Health-related behaviours are also influenced by the perceived benefits of taking action. Perceived benefits refer to an individual’s assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease the risk of getting pregnant. If an individual (teenage mother) believes that a particular action will reduce susceptibility to a health problem (childbirth complications) or decrease its seriousness, then she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action.

Moreover, health-related behaviours are also a function of perceived barriers to taking action. Perceived barriers refer to an individual’s assessment of the obstacles to behaviour change. Even if an individual perceives a health condition as threatening and believes that a particular action (childbirth) will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour (risky sexual activity). In other words, the perceived benefits must outweigh the perceived barriers in order for behaviour change to occur. Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., postnatal outcomes) and discomfort (e.g., pain, dizziness, emotional upset) involved in engaging in the behaviour. The health belief model posits that a cue, or trigger, is necessary for promoting engagement in health-promoting behaviours. Cues to action can be internal or external. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. Self-efficacy was added to the four components of the health belief model (i.e., perceived susceptibility, seriousness, benefits, and barriers) in 1988. Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour. Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviours. According to Lawson and Lawson (1992), one of the strengths of HBM is the implication for developing intervention towards behaviour change. Aside this strength, Lawson and Lawson proposed few limitations, including the fact that only selected component of the model has been used by researchers without testing or using the whole model.

Resilience Theory

The term resilience has been explained by different authors, and it is commonly used to refer to a person's capacity to adapt, recover from or remain strong in times of hardship, risk-taking, despite repeated exposure to stressful experiences (Luthar, & Cicchetti, 2000; Masten, Best, & Garmezy, 2000). According to Ledesma (2014), resilience is the ability to bounce back from adversity, frustration, and misfortune. Literature suggests a number of variables that characterise resilience. These variables include positive self-esteem, hardiness, strong coping skills, a sense of serious threat to adaptation of development (Janas, 2002). Perry (2002) sees resilience as the capacity to face stressors without any significant negative disruption in functioning. In developmental literature, resilience is typically discussed in terms of protective psychological risk factors that foster the development of positive outcomes and healthy personality characteristics (Bonanno as cited in Ledesma, 2014). Resilience is also used interchangeable with positive coping, adaptation and persistence (Greene et al. as cited in Ledesma, 2014). Bearing a child while still a teenager poses many risks and challenges not only for the young first-time mother and the child (children in the case of twins) but also for their extended families and the communities in which they live. Challenges include balancing the need to take care of yourself and your child (child care) with the responsibilities of parenthood, including being able to provide the financial, physical and emotional needs of the infant/child while working through the normal developmental tasks of teenager. Confronted with these challenges, some teenage mothers exhibit resilience and manage to satisfy their own developmental needs as well as those of their children. These mothers find ways to continue their education and support themselves economically. Other teenage mothers may overcome by the complexities and stresses evoked by early parenthood and manifest signs of developmental distress, including depression, anxiety and low self-esteem (Ledesma, 2014).

The discourse of resilience has been broadly discussed from two points of view or schools of thought. The first school of thought sees the individual as the locus of change and sees resilience as something intrapersonal, indeed, a trait inherent in the individual. This view lends itself to prominent theorists like Bandura (1994), who developed the concept of self-efficacy. Another school of thought which developed over time and which reflects a more topical view of resilience is that view which sees resilience as an outcome of positive interaction between the individual and his/her social environment (Rutter, 1987). Again, Ungar, Brown, Liebenberg, Othman, Kwong, Armstrong and Gilgun (2007) have played a pivotal role in moving this viewpoint forward and have highlighted the need to recognise resilience in relation to the opportunities that are available for personal growth of individuals.

Bandura (as cited in Saa-Touh, 2014) contends that people's belief about their self-efficacy is developed by four main sources of influence: the mastery of experiences, and that a resilient sense of efficacy requires experience in overcoming obstacles through perseverant effort; vicarious experiences provided by social models; social persuasion as a way of strengthening people's beliefs that they have what it takes to succeed; while reducing people's stress reactions and altering their negative emotional proclivities and misinterpretations of their physical state. The "sense of coherence" concept, on the other hand, is a theoretical formulation by Antonovsky (1987) that provides a central explanation for the role of stress in human functioning. He argues that, beyond the specific stress factors that one might encounter in life, and beyond your perception and response to events, what determines whether stress will cause you harm is whether or not the stress violates your sense of coherence.

Coping and resilience both have a strong history in, and connotations to, Western psychological sciences, rooted in a focus on individual capabilities, traits and strategies. However, arguably because of its metaphorical understanding, social studies have embraced the concept of resilience and transformed it into a concept that is increasingly used to investigate the dynamic and social processes that help individuals deal with hardship. Coping, on the other hand, continues to be conceptualised as the cognitive and behavioural response of individuals (teenage mothers) to deal with hardship (Lazarus, 1993). Although coping is seen as a process that can change over time and is the result of a dynamic interplay between a person and his or her environment (Lazarus & Folkman, 1984 cited in Saa-Touh, 2014), the unit of analysis, and the locus of change of much coping research remains at the level of the individual, for instance, teenage mother.

Conceptual Framework of Ecological Systems Theory

An ecological perspective encourages one to consider the holistic environment for an individual. The Conceptual Framework of Ecological Systems Theory draws heavily on Bronfenbrenner's (1979) model of ecology of human development, suggesting that parenting is the result of the complex interplay of individual, relationship, social, cultural and environmental factors and understanding parental roles. These factors must be considered in terms of their existence at each level and their interaction across each level. Bronfenbrenner's ecological systems theory adapted by Jack (as cited in Saa-Touh, 2014) in a study on ecological influences on parenting and child development, and also in the study of the life experiences of unmarried teenage mothers articulates a broad number of factors that explain the ecological perspective of individuals in families. The main factors include the social ecology of families, linkages between stresses in families, protective factors, individual and structural influences on social support networks and community-level influences on social support and parenting.

Firstly, the concept social ecology of families is in connection to the ecological model first outlined by Bronfenbrenner (1979) that focuses on the balance of stresses and support in the family environment and the interactions or relationship between them. It, thus, relates to the first level which Bronfenbrenner refers to as the microsystem, which incorporates the immediate environment surrounding the individual and those people with whom the individual interacts, for example, family members, neighbours and peers, to mention but a few. It questions the aspects of the teenage mother's environment that have the most significant effect on the baby's growth and development. The concept further questions the factors that influence parents or teenage mother in the way that they bring up their children. For Bronfenbrenner, the individual (teenage mother) is not a passive recipient of experiences but is someone who reciprocally interacts with others and helps to construct the microsystem. Research conducted on relationships outside of the family suggests influences on parental behaviour and child development. This brings into perspective the role of the environment in child development as well as parenting (Belsky, 1984).

In a study by the National Campaign to end Pregnancy (2004) in the United States, the findings show that teen pregnancy is closely linked to poverty and single parenthood. It also found that infants of teenage mothers received inadequate care because teen mothers are too young to master the demanding job of being mother or parent. The study further indicates that teen mothers were unable to provide the kind of environment and immediate support that infants and/or very young children required for optimal growth and development. Bronfenbrenner's (1979) model for analysing the social environment of the individual in families in which parenting capacity to meet children's developmental needs is related to external factors such as the parents' living patterns, the adequacy of available childcare, the level of social support provided by peers, friends and neighbours, the quality of local welfare services and the safety of the community in which the individuals live.

A teenage mother with childbirth is a social phenomenon that takes place in the society. An attempt to understand teenage mothers' experiences with childbirth and coping strategies in light of the challenges they face regarding motherhood, answers to these questions help bring to light the ecological perspective within this particular study. The second concept of this theoretical perspective articulates stresses on families. This concept looks at the effects of inequalities. Thus, the categorization of teenage mothers' childcare practices as one of the socially excluded brings to the fore the issue of inequalities in society. Jack (2000) argues a link between inequality and personal health and development as issues with demonstrable body of empirical evidence from around the world. In other words, teenage mothers living in poverty are more likely to suffer childbirth complication and other ill health.

This second level preposition is what Bronfenbrennner's human ecology underscores as the mesosystem, which fundamentally seeks to incorporate the relationship that occurs within the microsystem. An example of this is the interaction between the family and the teenage mother, the family and support networks or the family and the school. Therefore, the thrust of this concept is that levels of inequality are associated with the experience of stress. This study set out to explore teenage mother experiences with childbirth. Protective factors are the third concept articulated by Jack (2000) with regard to ecological influences on parenting and child development which can be likened to Bronfenbrenner’s exosystem which has indirect impact on the teenage mother's life. For example, the Komenda-Edina-Eguafo-Abrem Municipality (KEEA) should work in close collaboration with the Department of Social Welfare, which has strong roles in influencing the quality of parenting to regulate and ensure social support. Resilience and social capital are considered influencing factors to parenting. For example, research findings (Jack as cited in Saa-Touh, 2014) indicate that network relationships that provide social support have been found to be associated with positive influences on families, parents and children.

Again, Saa-Touh (2014) argues that social supports constitute a web of relationships that exist between individuals and a wide range of people including relatives, friends, neighbours, work colleagues and professionals. The structure of these networks in terms of size, proximity, and frequency of contact are useful for parent to child interactions. Jack (2000) explains that children growing up in high-risk environments can be protected by an enduring relationship with a special person outside of their household. Thus, this concept of resilience articulates that a recognition and achievement outside of the home (perhaps educational or sporting success in a church or youth group) could lead to improved life chances in adulthood.

Jack (2000), describes social capital as constituting the last range of protective factors to be considered which Bronfenbrenner (1979) describes as the macrosystem, which refers to the larger social and cultural environment under which all the systems exist. Jack suggests that it is arguably the most important of the wider community environment on children’s development.

Social capital consists of a wide range of community-level interactions, both informal and formal, between members of a particular population. The next concept is individual and structural influences on social support networks as sources of coping mechanisms. This concept argues that parental characteristics, educational level and income play influencing roles in parenting and child development and, therefore, level of coping for teenage mothers. Werner (as cited in Badasu, 2004) makes the point that education has been shown to have a significant impact on social networks and that higher educational achievement is associated with larger social networks. Likewise, Hartlep and Ellis (2010) contend that if education is held constant, household income would emerge as an important variable with regard to parental involvement in the education of the child.

Community-level influences on social support and parenting is the last concept articulated by Jack (2000) as influencing parenting and child development and its resultant impact on coping for teenage mothers. It is argued that the social ecology of families and development outcomes of children are strongly influenced by the communities in which they are located. For example, Coulton et al. (as cited in Saa-Touh, 2014) report that poor urban communities generally have restricted ties between neighbours and a greater reliance on family relationship. It is important to ascertain which of these factors apply in the case of teenage mothers in the KEEA Municipality.

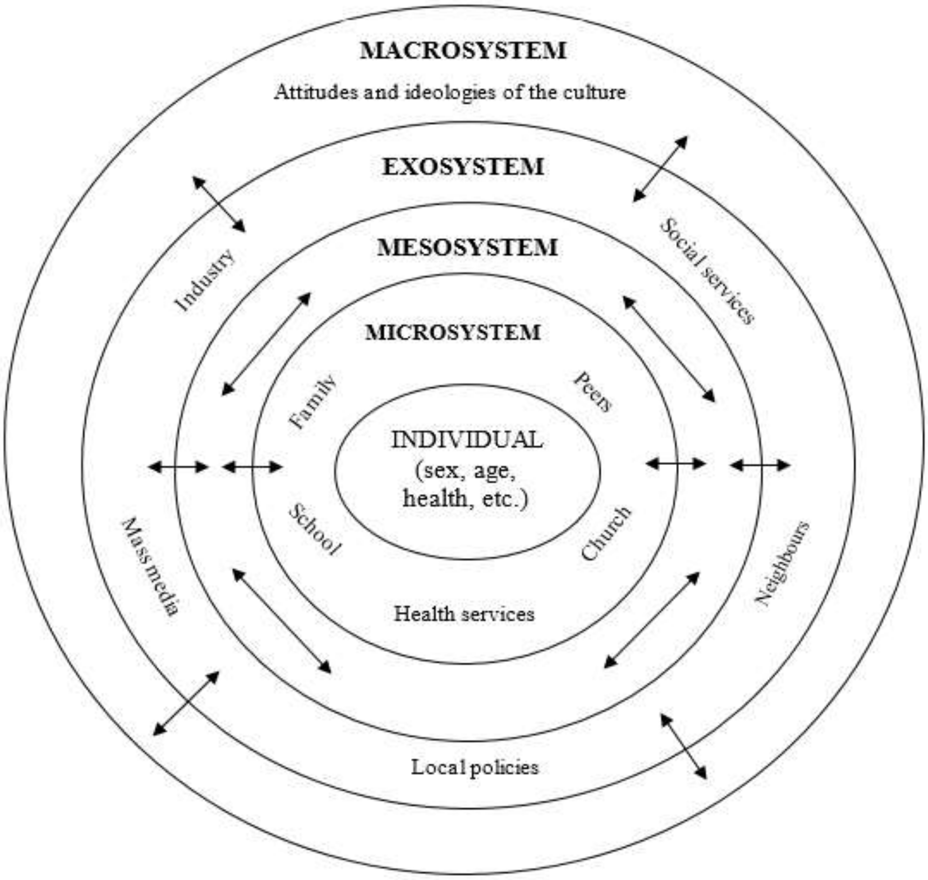

Figure 1: Conceptual Framework of Ecological Systems Theory

Source: (Bronfenbrenner, 1979)

Conceptual Framework for the Study

To understand the context of the lived experiences of teenage mothers, this study is underpinned by an original version of the ecological systems theory (EST) developed by Bronfenbrenner (1979). This theory has been applied in studying teenage mothers' experiences. Few studies include Saa-Touh (2014) and Sa-ngiamsak (2016). The ecological systems theory is a study of the progressive, mutual accommodation between the developing person and the changing properties of the immediate and broader perspective in which the person lives (Bronfenbrenner, 1979). This theory concentrates on the layers of the environment (identified by Bronfenbrenner as micro, meso, exo, macro and chrono system) and focuses on the interaction between the individual, for instance, the teenage mother, and her environment based on the events and processes that occur in each of these systems (Johnson, 2005). The systems have been briefly described looking at how each layer is interpreted and explained to provide framework for the present study.

The first and immediate layer ‘microsystem’ is a pattern and trend of activities, roles, and interpersonal relationship experiences of the developing person in a giving context or setting with particular physical and material characteristics (Bronfenbrenner, 1979). In other words, the microsystem is the immediate environment of which, for instance, teenage mothers in the KEEA are a part, such as family, the father of the child, neighbourhood, school and peers etc. It is the layer closest to these teenage mothers and where direct contact is made. At this level, relationships have an impact in two directions which Bronfenbrenner calls ‘‘bi-directional influences’’. The mesosystem is a set of interrelations between two or more settings in which the person (teenage mother) actively participates. In other words, a mesosystem is a system of micro systems. For example, using the microsystem identified in this study, a microsystem would be the connection between the microsystem such as the relationship between members of the teenage mother’s family and between her family and the family of the baby’s father, or the connection between the teenage mothers’ family and mother’s home or school.

The ecosystem contains the external environment settings or patterns and other social systems that indirectly affect the development of the person. For instance, in this study, the exosystem of the KEEA teenage mothers is the community, media, organisations, religion, health and other social services.

The macrosystem, which is seen as the broader layer, includes the attitudes and ideologies of culture, sub-culture in the form of social organisations, beliefs/norms and lifestyle. This system contains all of the various beliefs, and values of the culture, and is made up of written and unwritten principles that regulate the behaviour of the person. These principles (which include law, politics, religion, education, economics, and the ethnicity) endow individual's life with meaning and values and controls the nature and scope of the interactions between the various levels of the total social system. In this study, it is somehow understood that communities in the KEEA culture and beliefs shape the teenage mothers' behaviour and experiences. Chronosystem was later added by Bronfenbrenner, which is made up of all the other levels. It accounts for the temporal changes in the individual or teenage mother's environment or life and social-historical events that occur or happen over time and their influences on the interactions between developing individual (teenage mothers) and the micro, exo, and macrosystems in which they are embedded (Johnson as cited in Sa-ngiamsak, 2016).

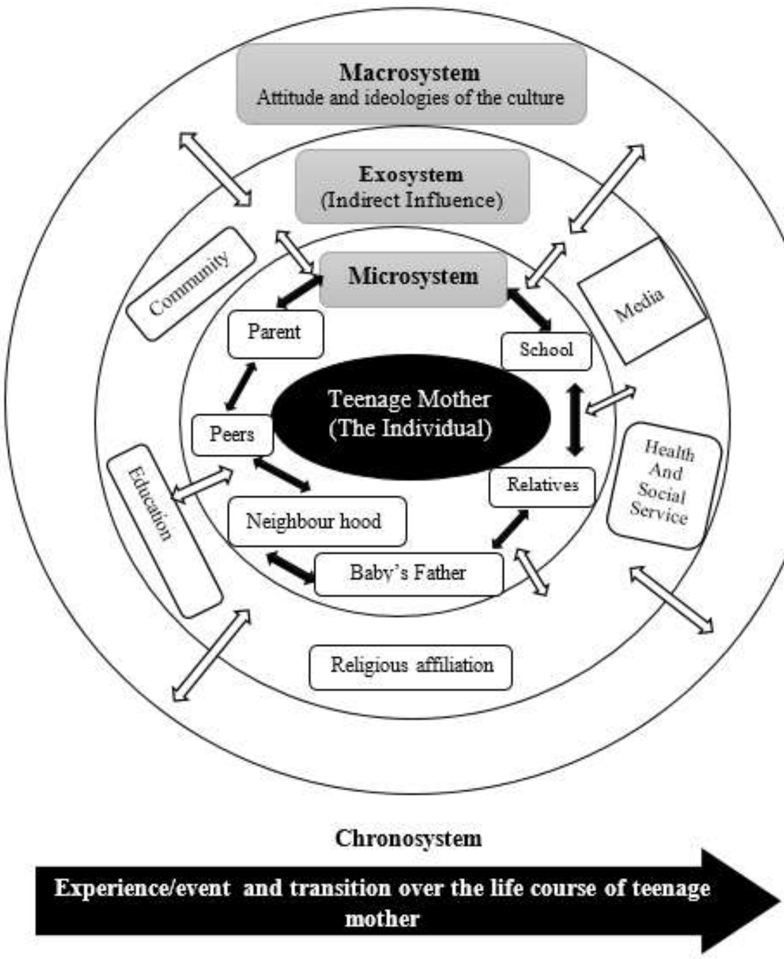

Figure 2: Adapted Ecological Systems Framework

Source: (Bronfenbrenner, 1979)

Figure 2 highlights the focus of the study and the interactions within the social context of teenage mothers. This includes the individual (teenage mother), her family, the baby's father, neighbourhood, school and peer or relatives as the microsystem. The exosystem in this study is the teenage mother's community, religious affiliation, media, health and social services system. The macro system comprises ideologies and attitudes of cultures and sub-cultures including beliefs, values, and other political systems, religion, economic systems and social policy which have indirect influence on other systems. Finally, the chronosystem refers to the experiences/events and transitions that occur over the life course of the teenage mother. Although it is very crucial to acknowledge that being a teenage mother affect not only the teen mother herself, but also her family, community/ society and the country at large, the focus of this study is on experiences of teenage mothers with childbirth in the KEEA Municipality.

The limitation of the ecological systems theory according to Christensen (2010) for instance, argues that ecological systems theory dwells so much on the negative effects of how an individual develops when exposed to adversity. This implies that, the theoretical perspective did not provide the possible success out of difficult situation or circumstances. It is within this context that Benard and Enger advocate that ecological theory is lacking on the dimension of resilience (as cited in Saa-Touh, 2014). The basic contention of the ecological systems theory has often remained that the individual develops within a context. For instance, Panquette and Ryan (2001) point out that individuals need to be recognised for their individual conditions and further argued that the individual's ability to influence his or her success should be the focus of attention instead of context.

Aside the few weaknesses, there are also strengths that have been identified. One of the strengths of the conceptual framework of the ecological systems theory by Brofennbrenner lies in the fact that it incorporates the constructs of several models such as the health belief model and the resilience theory. It also examined development from different layers of relationship: macro system, exosystems, microsystem and chronosystem. This study is underpinned by this model since it focused on factors such as the technological, environmental, attitudes and ideologies of culture that depend on each other and influence everyday life. These factors or systems have been modified to help in order to understand the scope and the impact of the health and social context on 'childbirth' experiences and where challenges, constraints, coping strategies, support or combination of both positive and negative experiences exist. The experiences of being a teenage mother are shaped at many levels. The ecological systems theory provides a framework to explore these levels and the interactions between them. This makes it useful because the framework includes the multi-dimensional social context and it provides a multi-layered analysis of the study.

Summary of the Literature Review

The segment summarises the main issues that have emerged from the literature review and their implications for the development of this study. The issues relate to teenage mothers' experiences with childbirth or motherhood as reflected in the literature review. Indeed, previous studies reviewed on the experiences of teenage girls on pregnancy, childbirth and childcare practices were mostly qualitative. Findings of earlier studies suggest that teenage mothers' experience of childbirth was one of a crisis situation for the individual girls and their parents/family. The social life of most of these teen mothers was significantly curtailed, while others held positive views of motherhood. The review also highlights the unplanned nature of pregnancies among teenage girls and looked at the risks and vulnerabilities teenage girls as mothers largely faced. It sheds light on the fact that teenage mothers suffer from educational disruptions as they often drop out of school to give birth. They also suffer complications and other socio-economic difficulties. Teenage mothers in the literature are less likely to be living with partners as they are often unemployed-prone and low income earners.

Coping strategy or coping is seen as the process of managing external and/or internal demands that exceed the resources of the person and a process that is sensitive to both the environment and the personality of the teenage mother while childcare is described to mean direct and indirect material, financial and emotional support, from both the individuals, set up for the purpose of meeting the needs of the child (ren). Coping has been categorized as emotion- and problem-focused while childcare practice arrangements include kin care, non-relative home care and centre/hospital care. The two categories of coping may facilitate or impede a person’s attempt to manage stressful situations. Theories (Resilience, Ecological Systems, and Health Believe Model) employed in this study, on the other hand, have been noted to mean a person’s capacity to adapt, recover from or remain strong in times of hardship and difficulties or challenges. At the individual level, positive temperament and cognitive ability to process negative experiences have been argued in the literature as crucial to resilience. Again, having a sense of personal and collective identity, and adherence to cultural practices, values and beliefs to some extent are determinants of resilience. The literature also discussed the empirical findings of previous studies and set out the theoretical and conceptual framework of this study, with regard to filling or addressing the research gap.

The health belief model, the resilience theory and the ecological systems theory have been employed as underpinning theoretical frameworks to help find answers to the research questions or objectives of this study. First, health belief model has been employed to examine psychological and health related issues, including postnatal challenges that teenage mothers encounter during and after childbirth, including birth complications, fear of taking care of their baby, and how they are able to overcome the challenges based on the some motivation health factors, and perceived knowledge of the healthcare practices, for instance, knowledge of childcare practices such as child's position and attachment, breast feeding, child bathing, sleeping arrangements etc. Second, the resilience theory examined the challenges associated with parenting, particularly with the childcare practices and mother-child developmental issues (social and economic).

Finally, the ecological systems theory, which was also adapted as a conceptual framework for the study explained the various forms of supports and also helped in understanding the coping strategies of teenage mothers in the study area (KEEA Municipality). The ecological systems framework places teenage mothers at the centre of their social context, where their life experiences, feelings and circumstances with childbirth were explored. In addition, the theory looked at the kind of environment that children born to teen mothers require for optimal development. Protective factors such as social support, availability and accessible resources and resilience were considered factors influencing teenage mothers' practices, parenting and motherhood in their life course transition.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter provides a description of the study area, study design, target population, sample and sampling procedure, sources of data, data collection instrument, and data collection procedures. Other issues covered in this section include pre-test of the instrument, data management, data analysis and ethical consideration of the study.

Study Area

The study was conducted in the Komenda-Edina-Eguafo-Abrem Municipality in the Central Region of Ghana. The municipality, with its administrative capital Elmina, is one of the twenty (20) municipal assemblies in the Central Region of Ghana. The municipality is bounded on the south by the Atlantic Ocean (Gulf of Guinea), the east by the Cape Coast Metropolis, the north by the Twifo Hemang - Lower Denkyira District and the west by the Mpohor - Wassa East District and Shama District. Perched between longitude 1^{o} 20' West and 1^{o} 40' West and latitude 5^{o} 05' North and 5^{o} North 15' North, the district covers an area of 1'372.45 square kilometres 919.95 square miles (2010 PHC).

Economic Activities of the Study Area

The municipality does not have any large industrial establishment. However, there are several small-scale enterprises located throughout the municipality, which offer employment opportunities to many people. These include salt making, boat making, oil extraction, garages, services such as tailoring and dressmaking, barbering and hairdressing (Eshun, 2015). The

KEEA Municipal Assembly can boast of fishing, farming, and salt winning as the main economic development activities (GSS, 2014; KEEA Municipal Assembly, 2014).

Social and Cultural Characteristics of the Study Area

The Komenda Edina Eguafo Abrem (KEEA) Municipality is one of the 20 old districts in the Central Region. It has four traditional areas which are Komenda, Edina, Eguafo and Abirem. Elmina/Edina is the municipal capital, which became independent from the Cape Coast Municipal Council in 1988. The municipality has some unique cultural festivals, notable among them ‘Bakatue’. These festivals attract many visitors home and abroad, including tourists from Europe and America (Eshun, 2015; KEEA Municipal Assembly, 2014).

Healthcare Distribution of the Study Area

According to the Municipal Health Directorate (2011), the municipality is divided into five (5) sub-municipalities as shown in Table 1. and profile of the Health institution, Types, Ownership and Status in Table 2.

Table 1: Summary of Sub-Municipal Health Profile

Sub-municipal	Population	Community		CHPS
Elmina	50,740	33	16	2
Abrem-Agona	30,749	22	18	3
Komenda	30749	13	12	1
Kissi	26,135	22	14	2
Ankaful	15,443	10	14	1
Total	153,816	100	74	9

Source: KEEA Municipal Directorate (2011)

Table 2: Profile of the Health Institutions, Types, Ownership and Status

Sub-Municipal	Institution	Type	Ownership	Status
Elmina	Urban H.C	Health centre	Government	Functional
	Brenu Akyinim	CHPS Zone	Quasi-Gov't	Functional
	Bronyibima	CHPS Zone	Quasi-Gov't	Functional
	Paa wattenberg	Maternity	Private	Closed
	Good Shepherd	Maternity	Private	Functional
Abrem-Agona	Agona H.C	Health Centre	Government	Functional
	Benyadze CHPS	CHPS Zone	Quasi-Gov't	Functional
	SAP CHPS	CHPS Zone	Quasi-Gov't	Functional
	Berase CHPS	CHPS Zone	Quasi-Gov't	Closed
	Bando Han Med.C	Clinic	Quasi-Gov't	Functional
Komenda	Komenda H.C	Health Centre	Government	Functional
	Nyame Tease	Maternity	Private	Functional
	Aburansa CHPS	CHPS Zone	Quasi Gov't	Functional

Table 2 Cont'd

Kissi	Kissi H. C	Health Centre	Government	Functional
	Antseambua	CHPS Zone	Quasi-Gov't	Functional
	Abeyee	CHPS Zone	Quasi-Gov't	Functional
Ankaful	Leproy/G.H	District Hosp.	Government	Functional
	Psychiatric	Tertiary Hosp.	Government	Functional
	Contagious Dis. Prisons	Prisons	Government	Functional
	Atonkwa CHPS	CHPS Zone	Quasi-Gov't	Closed

Source: Wood, & Esena, (2013)

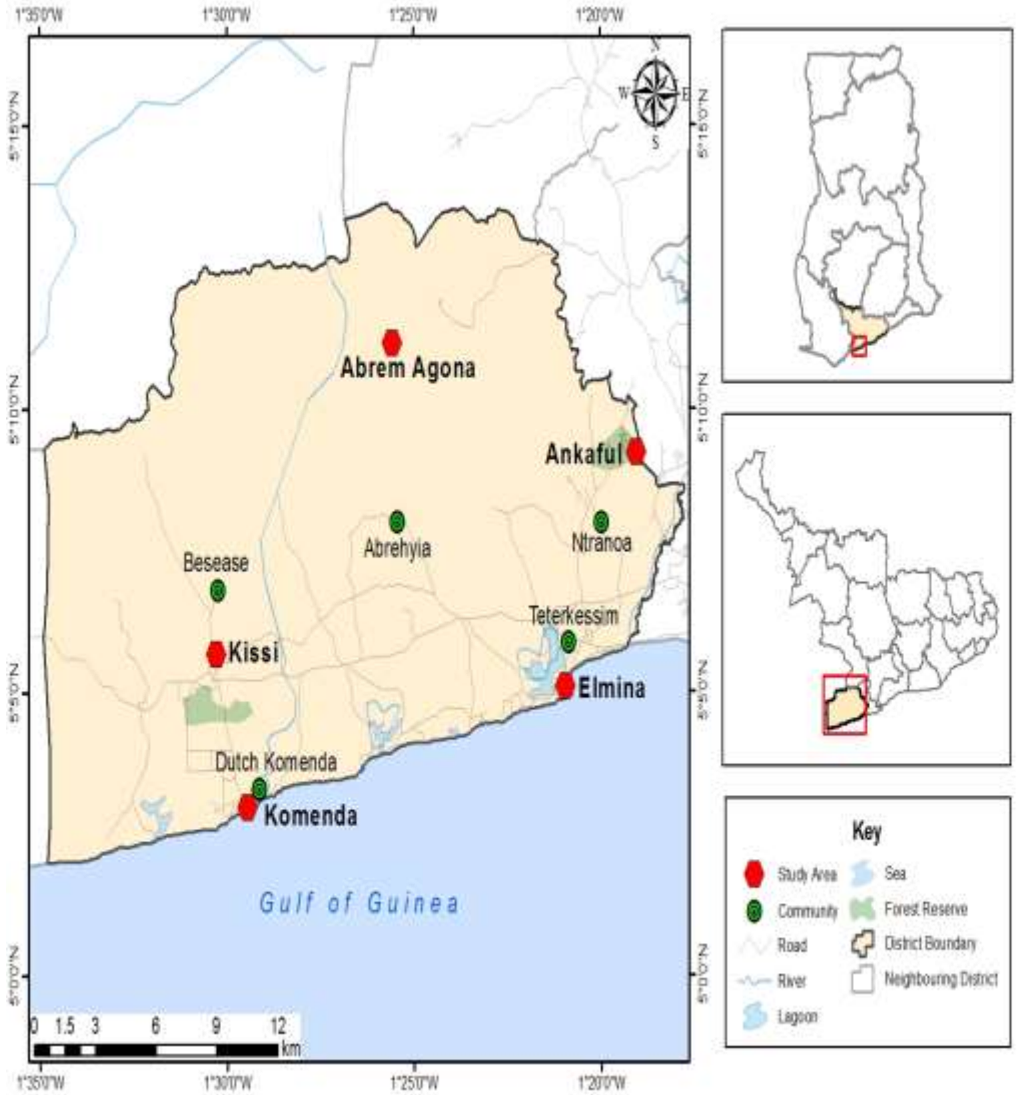

Figure 3: Map of the Study Area (KEEA)

Source: GIS Lab of the Department of Geography and Regional Planning, University of Cape Coast (May, 2019)

Research Design

This qualitative study was conducted cross-sectionally. The study was cross-sectional because data were collected from the teenage mothers only once without the intention of going back to conduct further interviews or future follow ups (Adde, Darteh, Kumi-Kyereme & Amu, 2018). The philosophical perspective of the study is the interpretivist and phenomenological research paradigm was used because it seeks to explore a phenomenon from the perspective of those who experience the phenomena (Matua & Van Der Wal, 2015). The perspective of the study explains the experience and how we experience a phenomenon or situation such as values, meanings, intentions, morals, feelings, and life experiences (Matua, & Van Der Wal, 2015).With the aid of this design, the study was able to elicit data from study participants on childcare practices, postnatal challenges teenage mothers encounter and coping strategies in light of the challenges they face regarding motherhood within a period at a time point. The cross-sectional design helped the study to explore teenage mothers' experiences with childbirth in the KEEA Municipality.

Target Population

The study targeted teenage mothers aged 13 to 19 years in the KEEA Municipality. However, mothers with a child above two years were excluded from the study. This was to reduce recall biases. Also, teenage mothers with children more than two years might have passed the childbirth experiences stage, for instance, breast feeding (exclusive and complementary breastfeeding) and other postnatal experiences. The study, therefore, aimed at getting pertinent information in relation to teenage mothers' experiences with childbirth.

Sampling and Sample Size

A purposive sampling technique was used to select participants for the study. The reason for using this technique was that it helped to choose population carefully based on the features that were of interest. The focus of the study was on teenage mothers' experiences with childbirth; therefore, the technique helped to select teenage mothers (participants) who were most qualified for the study.

Teenage mothers were purposively selected from the five sub-communities in the KEEA Municipality (Table 3). Community entry was properly done since the investigator shares common cultural background, for instance, speaks the same language. Participants were identified with assistance from the community leaders such as chief, assemblyman or the gatekeeper. Individual (one-on-one) meetings were organized for teenage mothers and they were briefed about the purpose of the study. The teenage mothers (participants) who met the criteria (after screening) with the help of the field assistants and agreed to take part in the study were asked to propose or decide on a venue/place, and time for the interview to be conducted based on the data collection plan (see Table 4).

The decision or choice of a sample size for the in-depth interview was guided by the need to obtain pertinent information or rich data. In all, thirty (30) participants (six participants each) were selected from the five sub-communities for the study with the concept of saturation in mind. After performing high in-depth individual interviews with the participants, data saturation was achieved. The point of saturation was based on the recommendation by Marshall, Cardon, Poddar, and Fontenot (2013), who have shown that theoretical saturation mostly occurs between 10 and 30 interviews. Table 3 shows the number of participants selected from the communities in the KEEA Municipality for the study.

Table 3: Communities and Number of Participants Selected

Community	No. of Participants Selected
Elmina (Teterkesim)	6
Komenda (Dutch Komenda)	6
Kiss (Kissi)	6
Ankaful (Ntranoa)	6
Abrem-Agona (Abrehyia)	6
Total	30

Source: Twintoh (2019)

Data Collection Instruments

The research instruments used for this study were in-depth interview guide (IDI) and pictorial guide. The interview guide was developed from literature. A thorough literature review of research related to teenage mothers' experiences with childbirth was performed prior to the development of the instruments, with the aim of identifying interview questions that have been identified by other studies or researchers based on the objectives of this present study. The instrument was broadly categorised into four sections: Section A, B, C and D. The first section (section A) looked at the teenage mothers' background or socio-demographic characteristics: teenage mothers' age, level of education, religion, marital status, number of children and current occupation. The second section (section B) focused on childcare practices of teenage mothers. The third section (section C) dealt with postpartum challenges teenage mothers encounter during and after childbirth, and the last section which is the Section D elicited information on teenage mothers' coping strategies regarding motherhood in light of the challenges they face after childbirth.

In addition, “Photo-diary; pictorial guide interview’’ method (Zimmerman & Wieder, 1977), referred to in this segment as simply the “pictorial-guide interview method’’, combines photos and/or visual representations in support of an interview. It was used to explore teenage mothers’ experiences with childbirth. Using both interview guide and images (pictorial guide) based methods augment data collection completeness (Rubbin & Rubbin, 2005). While interviews (IDIs) enhance historical completeness, for instance, on teenage mothers’ background characteristics and their experiences with childcare practices and postpartum challenges and coping strategies in light of the challenges they face, pictorial guide helps improve the data by adding features and enhance completeness. For instance, with regard to knowledge on breastfeeding positioning and attachments, child bathing practices, sleeping arrangements, postpartum complications, etc. The pictorial guide was used and served the function of supplementing the interviews (although of varying quality) in that they provide the researcher that opportunity to gain at least some modicum of access to naturally occurring events whose meaning can then be explored in the interview. When these guides are used as the basis of intensive interviewing, they support questions and data generated in a number of ways. They serve as a memory aid and as a way of accessing past and current situations, experiences and emotions during the interview. For the interviewer, the benefits of photo guide interview derive from the researcher’s ability to prepare for the interview. This allows the interviewer to get in touch with the participants’ world to some extent and to develop and empathic understanding of the interviewees and their experiences. In addition, the pictorial guide allows the interviewer to gain insight into the interviewees' experiences. The researcher may also formulate situation-specific questions, including ones where the interviewee compares and contrasts different pictures in the guide. There is a danger that the photo-guide method is viewed from a neo-positivist perspective, as the notion of a diary/guide or questions in general and photos, in particular, imply that the recorded events really happened in the manner described. However, given my local perspective in this study, this method was viewed as a way of structuring the narrative reconstruction of the participants' lived experience and its meaning in an interview setting.

Pre-testing

The pretesting of the instrument was done in Amamoma, a community located in the Cape Coast Metropolis. Amamoma was considered for pre-testing the instrument because it exhibits similar characteristics to the study area. For instance, Amamoma is among the top three settlements of Cape Coast Metropolitan assembly with high prevalence cases of teenage childbirth (Cape Coast Metropolitan Assembly, 2016). Six (6) teenage mothers were used to pre-test the instrument. The participants were asked to decide on the day and time and venue for the interview and later they were followed up in their homes for the interviews. This helped in adjusting and restructuring of the instrument (guide) in a well-sequenced order and any misplaced questions (e.g., warm up question and some leading question like do you breastfeed your child?) were then arranged and finally clarification were made to ensure correct positioning and correction of the questions that seem ambiguous, bias, errors, and any shortcomings that embed in the instrument for data collection for the study.

Source of Data

The study made use of primary data which was collected from teenage mothers aged 13 to 19 years. The in-depth interview guide was designed to elicit information from teenage mothers. The data captured information on the childcare practices of teenage mothers, postpartum challenges teenage mothers encounter and coping strategies teenage mothers adopt in light of the challenges they face regarding motherhood at that early stage of life in the KEEA Municipality.

Data Collection

Data collection was done in May 2019. The data collection lasted for fourteen days (two weeks). The first four days were used for the preparation of the research team and community entry and ten days were used for the actual data collection respectively (See Table 4). Prior to the data collection, the field assistants (females) from the Cape Coast Nursing and Midwifery Training College assisted in identifying teenage mothers for the in-depth interview with assistance from the community leaders such as chief, assemblyman or the gatekeeper. Before the commencement of the interview, the participants were informed about the purpose of the study. In order to encourage the participants to open up, the investigator re-iterated the fact the study was purely for academic purposes and therefore participants should feel comfortable and be free to participate fully in the study. Additionally, participants were briefed on the issues of confidentiality and anonymity, and were assured that no name will be attached to the data. The selected participants consented to participate freely. The interviewer read and explained the 'participant concept' (Appendix E) and the informed consent form (Appendix F) to the participant in their own language (Akan/Fante) they best understood and agreed. Participants were asked to either sign or tick a consent form indicating they have willingly chosen to participate in the study.

The face-to-face interview method was employed during the data collection. An in-depth interview (IDIs) was conducted with participants on a one-on-one basis in their homes to ensure that participants fully understood and were able to respond very well to every question. This helped the participants reflect and talk about their experiences with childbirth and also to explore more depth entries to ensure data quality (completeness, honesty/trustworthiness and credibility). Both recording and field notes were taken. Averagely, the interview lasted for about 40 to 75 minutes.

Table 4: Data Collection Plan

Number	Study Area	Date	Study Location
1	Elmina	6^{th} and 7^{th} May, 2019	Teterkesim
2	Komenda	8^{th} and 9^{th} May, 2019	Dutch-Komenda
3	Kissi	10^{th} and 11^{th} May, 2019	Besease
4	Abrem-Agona	12^{th} and 13^{th} May, 2019	Abrehyia
5	Ankaful	15^{th} and 16^{th} May, 2019	Ntranoa

Source: Twintoh (2019)

Data Processing and Analysis

The data were managed with the help of a systematic qualitative oriented text analysis (Richards, 2005), and NVivo 12 Pro qualitative software. The issues were described, interpreted, summarized and organized into themes (parent nodes) and sub-themes (child nodes) to demonstrate the key issues that were identified from the data for analysis (Richards, 2005; Bazeley & Jackson, 2013).

First, all audio recorded interviews were transcribed verbatim and field notes were equally typed into MS Word and then introduced/uploaded to NVivo 12 Pro to help create parent and child nodes (coding), thus categorization of the main themes and subthemes. Subsequently, during the analysis processes, it was realized that getting their experiences need to be examined according to how the investigator saw their expressions. Systematic qualitative oriented text analysis was used to develop a framework for analysis (see Figure 4) to gain an intuitive sense of the data and to determine his own approach to managing and coding data rather than have it defined by software solely. The data were then coded using basic search techniques and categorisation (Richards, 2005). The interviews were then examined for content by focusing on what teenage mothers expressed about their experiences, feelings and circumstance with childbirth, according to how their meanings based on the categories related to each other and constructed themes to explain the linkages with the help of the software.

A numeric scheme of coding was employed to mark all parts of the written discourse that contained one category or another (classification). 1, for instance, was used to code ‘Breastfeeding’, 2 for ‘Childbirth complications’, 3 for' Social support' and so on. These categories were then reduced into a much smaller size by grouping similar and related ones so as to arrive at new generated categories which were largely 'analyst constructed typologies'. In the process of analysis about 96 codes, 17 categories, and three main themes were obtained. Specific participant's quotations were represented by identity number (pseudonyms) PD1 to PD30 (see Table 6). Finally, quotations were used to support the views raised by the participants (Graneheim, & Lundman, 2004; Kondracki, Wellman, & Amundson, 2002). This was done by editing the information that was gathered from the interviews (verbatim). This, however, did not alter the meaning of the subjective views as expressed by the participants in any way. Three main themes were finally captured as the parent nodes: (a) teenage mother's childcare practices, (b) major challenges teenage mothers encounter, and (c) coping strategies regarding motherhood.

Following the systematic qualitative text oriented analysis framework, the entire data were subsequently organised and catalogued according to identification number or pseudonyms (PD1, 2, 3…30). In the subsequent stage of the analysis, the data were repetitively read through, revisited time and again to achieve ample immersion. Further to immersion, a closed examination of the data yielded several categories, including child positioning and attachment, knowledge on exclusive and complementary feeding, benefit of breastfeeding, sense of child feeling hunger and satisfies, sleeping arrangements, child bathing practices, childbirth complications, education challenges, financial challenges, sense of being a teenage mother, baby's father's attitude denial, and responsibility, plan for the child's future, teenage mother's future plans, social support and self-motivation and advice for other teen mothers. These were captured to enhance and simplify the data for analysis (see Figure 4). Also, statements of the respondents were presented as quotes to substantiate the views expressed. All the conceptual expressions and patterns that emerged from participants were categorised in a way that reflected the salient and subtle meaning participants attached to their expressions. As a further analysis of data progressed, the initially identified concepts and categories were constantly interpreted and modified to build an understanding and coherent picture of teenage mothers' experiences with childbirth.

Data Management

After each day's interview, the recorded interviews as well as field notes were kept confidential. Thirty (30) data files were created containing information gathered about every participant. The data obtained were protected from unauthorised access and confidentiality and privacy of the data were fully assured. Information obtained from participants was introduced or typed with the help of Microsoft Word and the soft copies were locked with a password in 'my dropbox' a computer software. The hard copies (field notebooks) were properly burnt afterwards. All the information (soft copies) would be kept by the principal investigator for about 3 years to allow for publication of research, after which they would be properly obliterated. Hence, anonymity of respondents was ensured by using pseudonyms (PD) instead of the real names.

Ethical Issues

The following ethical guidelines were followed to be consistent with all the standards required to conduct a research. First, copies of the research proposal were submitted to the University of Cape Coast Institutional Review Board Secretariat (UCC-IRB) for assessment and ethical clearance. After obtaining the approval, an introductory letter from the Department of Population and Health and the IRB approval letter ETHICAL CLEARNACE-ID: (UCCIRB/CHLRB/2019/09) with (REF: UCC/IRB/A/2016/37) were given to the KEEA Municipal Health Directorate and permission was sought from the public health officer to carry out the study in the selected communities. In addition, to ensure free and informed consent and participation in the community entry and recruitment process, some of the leaders (chiefs) as well as some influential people (assembly men) in the selected communities were briefed about the purpose of the study and permission was sought from them before the commencement of the field works/data collection.

Also, consent was sought from the respondents/teenage mothers before interviewing them. With participants who were minors (13 to 19 years), consent was sought from their parents or guardians as well as the teenage mothers themselves before interviewing them. In addition to this, the investigators identified themselves to the participants to avoid false impression. The investigators briefed them about the purpose of the study, participation concept, the data collection approach, informed consent form and every item on the instrument (guide).

Again, before any interview took place, teenage mothers (the participants) who could read in English were given a written consent form to read and freely decide to participate in the study by signing. On the other hand, with those who could not read, the interviewer reads the informed consent form to them in the language they best understood and made sure that the respondents agreed to participate and thumb-printed the consent form before interviews were conducted and tape recorded. After every interview, the recorded voice and field notes, were stored/kept safely to conform to the ethics of the confidentiality. Further, participation in the study was not made compulsory. Participants were informed that their participation was completely voluntary; confidential and anonymity were fully assured and respected. There was no information that could reveal or identify the names of the participants.

Strength and Limitations

Handling issues of trustworthiness and rigour in qualitative study is very crucial. In a qualitative study, generalisation and reliability usually play a minor role unlike in a quantitative study (Creswell, 2003) cited in (Sa-ngiamsak, 2016). The trustworthiness of a research depends on how the study is conducted fairly, ethically and ensuring that the results represent as exactly as possible the experiences of the participants (Sa-ngiamsak, 2016). In this study, the potential threats to the trustworthiness of qualitative research such as credibility, transferability, dependability and conformability were necessary addressed and demonstrated to avoid researcher and participants biases. For example, after each interview the main content of the issues were summarised to the participants to be sure if their responses have been captured accurately. Again, only teenage mothers 13 to 19 years with a child aged two years or less were included in the study to reduce the risk of recall biases.

Whereas this strategy contributes to the strength of the evidence, it is also likely that we have missed out on some vital information about life experiences for these young mothers as a result of early childbirth. The study used the cross-sectional study design and this cannot capture the transition and changes regarding teenage motherhood which makes their future life/experiences uncertain. Follow up studies are further suggested. However, our interest was mainly to unravel the actual childbirth experiences of these mothers, a crucial aspect that seems to be missing in the current discourse.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents the results that were obtained from the study. The results of the study are presented based on the objectives of the study. The results are subsequently discussed with existing empirical literature. The study explored teenage mothers' experiences during childbirth and after their baby was born and how the immediate environment and the systems played a role in their lives in the KEEA Municipality. Using ecological systems theory where teenage mothers are placed at the centre of their social context, their lived experiences, feelings and opinions of the phenomenon were presented. This section involves the presentation of the data and analysis of the data.

Background/Socio-Demographic Characteristic of the Participants

This section covers the socio-demographic and background characteristics of teenage mothers, namely, age, marital status, educational level, religion and occupation. A total 30 teenage mothers were selected from the five sub-communities in the KEEA Municipality. Of the 30 interviewed, the mean age of the participants was 17.5 years. Only three of them had completed Senior High School and were married, whereas 19 of them were never married (single). 27 of the participants were Christian, whereas 3 were Muslims. Half of the participants had no occupation. However, 6 of them engaged in petty trading while others were engaged in vocational and mobile banking services.

Table 5: Socio-Demographic Characteristics of the Participants

Variable	Frequency (N) (N=30)	Percentage (%) (100%)
Age (in completed years)		
16	1	3.3
17	6	20.0
18	8	26.7
19	15	50.0
Level of Education		
Primary	9	30.0
JHS	18	60.0
SHS	3	10.0
Marital Status		
Never married	19	63.3
Married	3	10.0
Cohabiting	8	26.7
Religion		
Christian	27	90.0
Islamic	3	10.0
Occupation		
Not working	15	50.0
Petty trading	6	20.0
Seamstress	4	13.3
Hairdresser	3	10.0
Mobile banking/Transfer	2	6.7

Source: Twintoh (2019)

Analysis Framework

With the help of a systematic qualitative oriented text analysis and NVivo 12 Pro qualitative software, the data were summarised, explained and organised into themes and categories (sub-themes) to demonstrate the key issues that were identified from the data for analysis (Bazeley, &

Jackson, 2013; Richards, 2005). Three major themes that were identified during the data analysis reflected on the objectives of the study. These themes form the essential structure of the experiences of the teenage mothers. The parent nodes (main themes) and child nodes (sub-themes) or categorisation of issues are depicted in thematic framework (Figure 4).

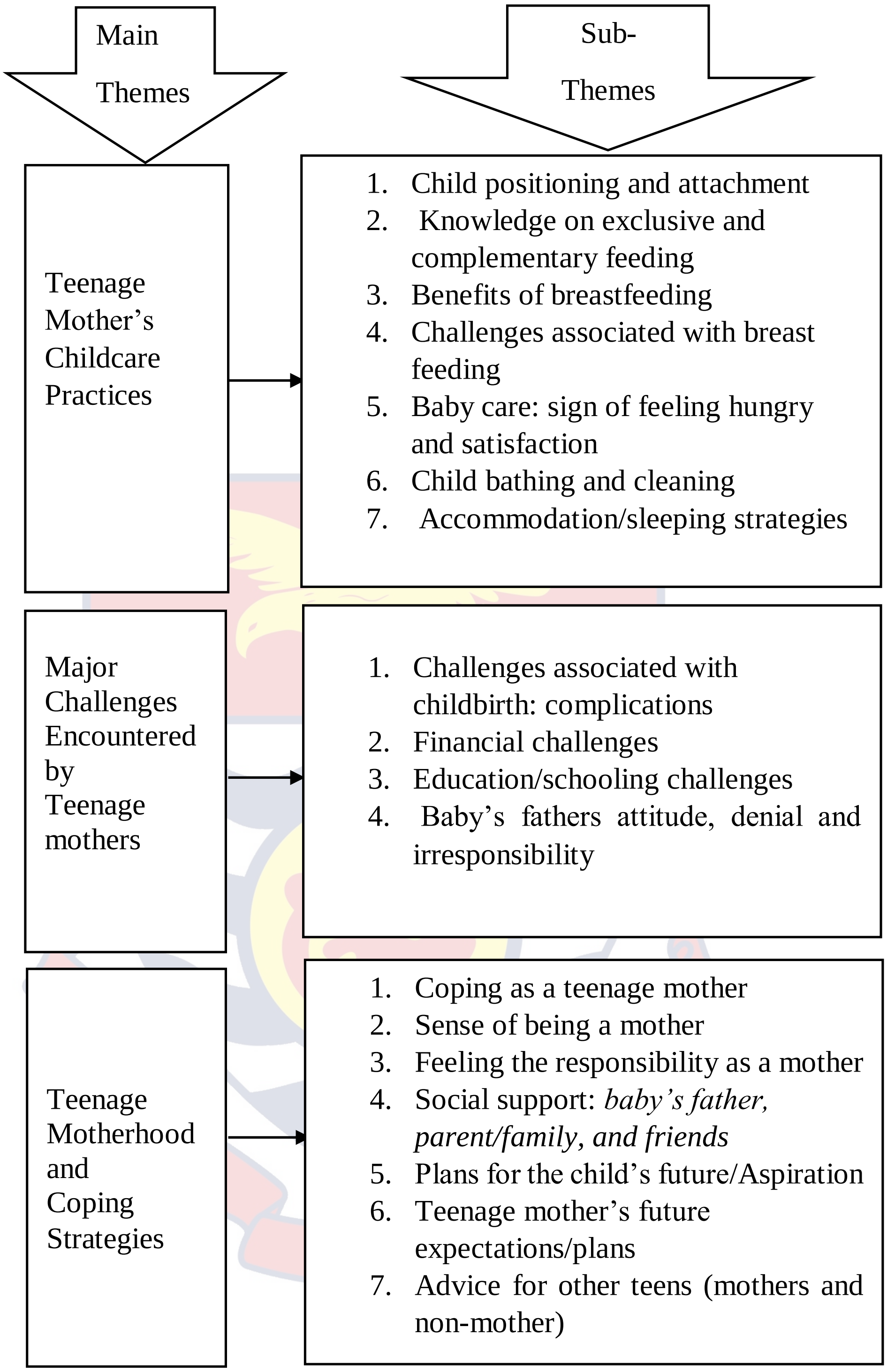

Figure 4: Themes and Categorisation of issues (sub-themes)

Teenage Mother's Child Care Practices

One of the objectives of the study was to explore teenage mothers' childcare practices. Children or babies (less than two years) are such a pleasure to watch and they are also very delicate (Ghana Health Service [GHS], 2011).

Children need to be given the maximum attention and care in their everyday lives. In this study, teenage mothers were asked about childcare practices, including child positioning and attachment of babies when breastfeeding (exclusive breastfeeding and complementary feeding), child bathing and cleaning practices, accommodation and sleeping strategies, difficulties and challenges associated with breastfeeding were observed. Most of the pertinent issues gathered from the participants through the in-depth interviews have been described and interpreted in the following sub-themes.

Child's Positioning and Attachment

The teenage mothers demonstrated healthy and good child position and attachment when breastfeeding their babies, irrespective of whether deliveries were at home or hospital. Participants had this to say:

> ''*Yes! I sit down and put my baby on my lap/legs and support the head like the one showing in the pictorial guide [picture 2] and I hold the breast in the mouth of my baby. This helps the baby to suck or feed well because if I don't do it this way the breast milk can pass through the baby's nose''*. ¬PD 1, 17years with a male child.

To corroborate this statement, a teenage mother, 18 years with 5 months female child noted the following:

> *''Yes! Like the one you showed in the pictorial guide (picture 2). I usually put my baby on my legs and carry her in my arms to breastfeed well because if I don't do it this way my baby can vomit or the breast milk can enter the head and it can great*

problem for my baby''. ¬PD 3, 18years with 5months female child.

Another teenage mother with 3 months male child who struggled to position her baby when breastfeeding had this to say:

''…Yes! But when I started breastfeeding my baby, hmm!, It was very difficult for me because at a point in time I had to use one hand to hold her neck side and use the other hand to control my breast to ensure that I breast feed her well. In my usual ways I put my baby on my lap and raise his head up a bit. I hold my baby the same way it is shown in the book. [Pictorial guide; picture 2]…'' ¬PD 13, 18 years with 3months male child.

Exclusive Breastfeeding

According to the Ministry of Health (MoH) or Ghana Health Service (GHS), starting breastfeeding early, especially within 30 minutes is a good practice. Breast milk provides all the food and water a baby needs in the first six months of life and this liquid protects the child. Teenage mothers were asked to share their views about exclusive breastfeeding and why they think exclusive breastfeeding is beneficial for every mother to know and do as a requirement for the child growth and development. More than half of the participants (teenage mothers) indicated that they breastfed their babies well because they know the reasons and benefits for breastfeeding their babies exclusively. When asked directly 'do you do exclusive breastfeeding? Why?', a participant had this to say:

''Yes, I breastfeed my baby all the time, I know the breast milk has all the nutrients my child needs and it is safe and natural. God specifically made it for me to be given to my baby so I have to give the breast milk to my child anytime my child needs it either in the morning, afternoon, evening and even at dawn to help my baby grow well and get stronger'' ¬PD 20, 18 years with 3 months female child.

To buttress this quotation, another participant who practiced exclusive breastfeeding had this to say:

***"…**Yes, I have been breastfeeding my baby exclusively right after birth. I knew it was good for my baby. I will continue to breastfeed exclusively until he gets to six months, then I will give him food! That is what the doctor even told me…''.* ¬PD1, 17 years with a male child.

On exclusive breastfeeding, some of the teenage mothers decided strongly to breastfeed her baby exclusively until the baby gets to age 6 months before they can give any formulae or food to the baby. For instance, a teenage mother 17 years with a 2 months baby had this to say:

''…Yes, breast milk is the only food I have to offer to my baby until she grows up a bit like from 6mounth to 1 year before I can I give other food or liquid....'' ¬PD14, 17 years, with 2 month child.

Benefits of Exclusive Breastfeeding

Iddrisu, (2013), stipulated the use of breast milk as the sole food for babies until the end of the first year. Teenage mothers believed that the only food for their babies was breast milk. Almost all participants mention some of the benefits or importance of exclusive breastfeeding and indicated the need to breastfeed. In spite of the challenges associated with the breast feeding practices. Some of the participants mentioned the following benefits:

> *''I know that breast milk is the only food for my baby at this time, so I breastfeed her because I know my baby can become strong and healthy when I breastfeed her from now till the time I have to cut breastfeeding.''* ¬PD 3, 18 years with a female child.

This further corroborated by a 19 year old mother with a baby aged 4 months

> *''… It helps my baby to grow well and protect my baby against any infections and makes my baby strong and healthy…''*. ¬PD11, 19 years with 4 months child.

It was further added:

> *''…Breastfeeding my baby exclusively, I know it opens the baby's mind…''* ¬PD12, 19 years with a female child.

Another participant aged 19 years, who observed that the baby sleeps whenever she breastfeeds her well mentioned that:

> *''…My baby stops crying and sleeps anytime I breastfeed her well…''* ¬PD16, 19 years, with a female child.

Knowledge on Breastfeeding

Teenage mothers are faced with the task of learning to breastfeed their babies through guidance, discipline, nurture, and support. Each of these tasks mentioned is complex and requires some level of knowledge and problem solving skills (Bah, 2016). Knowledge therefore appears to be more important in determining why, how, where and when teen mothers seek help or information to breast feed their babies very well. Almost all the teenage mothers mentioned varied means through which they acquired knowledge on breastfeeding. Teenage mothers get knowledge (information, support and guidance) on breast feeding through the community nurses, mother, friends, family guidance and observation. Teenage mothers were asked about what they know about breast feeding. Some participants had this to say:

> *‘‘…My mother provides me with support and educates me on the kind of food items which, when eaten can increase milk supply and shows me how to position the baby for optimal and successful feeding…’’* ¬PD 2, 19 years with 3 weeks child.

Another participant who gained knowledge of breastfeeding from her previous practice by allowing her younger sibling to suck the breast before she gave birth stated that:

> *‘‘…at times, when our mother was busy she will ask me to breastfeed her even though I was not having breast milk but I will put the breast in her mouth when she was crying for*

the breast till our mother finishes…'' ¬PD 13, 18 years with 3 months child.

Another teenage mother was practicing exclusive breastfeeding based on what the nurse told her when she gave birth at the facility had this to say:

> *''…Mmm, when I gave birth, the nurse told me that I should breastfeed my baby for six months before I can give my baby any food so I am just doing that…''* ¬PD 7, 18 years with female child.

Complementary Feeding

Teenage mothers mentioned why they give complementary food to their babies and how those foods or formulas also help their babies. Participants whose babies were above six months mentioned the kinds of food they give to their babies and what they think complementary feeding does for their babies. With the aid of illustration in the pictorial guide, teenage mothers mentioned what they feed their babies with, as complementary food, and how they do it. Some of the participants had this to say:

> *''…Yes! I have been preparing porridge for my baby because my breast milk is not enough or insufficient for my baby […] when feeding I do it like number three in the guide but the baby's back attached my chest…''* ¬PD 18, 17 years with 10 months female child.

This further corroborated by a teenage mother aged 19 years with 7 months child

''....Oooh yes, sometimes I give my baby Cerelac and porridge [koko] but I prepare [koko] at home I don't buy it outside. Yes, I use the same position in book [pointing at picture 3 in pictorial guide] when feeding my baby. I know when I give other food for my baby, it also makes my baby healthy and stronger…'' ¬PD 9, 19 years with 7months child.

Some participants also mentioned why they give formula [complementary feeding] to their babies apart from breast milk.

''...I started giving my child food because when I gave birth my baby was very tiny so my Auntie and my mother asked me to give my child food and water. Hm […]. Surprisingly, my baby can eat anything like porridge [koko], and rice water. Yeah […] I do it like in the picture 3…''¬PD 10, 19 years with 20 months child.

Another teenage mother who reported having insufficient breast milk had this to say:

''...I give my baby porridge, cowbell mix and water for now because the breast milk is not sufficient for him so I have even decided that when she is one year old I will stop breastfeeding and give her other heavy food like mashed kenkay, rice, [...] Yes, I put my baby on my lap like it shown in the pictorial guide 3 when I am feeding her…'' ¬PD 17, 19 years, 10 month female child.

It further corroborated by a participant who indicated that she uses formulas to feed her baby because the baby was underweight or had low birth weight and perceived that breast milk alone was not be sufficient and could not satisfy the baby:

> *‘‘Hmm […]it is like my breast milk is insufficient for my baby, when I gave birth to my baby, he was too small [underweight] and the nurses asked me to buy NAN milk [formulae] to feed him because the breast milk will not be sufficient for my baby. So I give it to him, but not all the time that I feed him, if not it will get finished so fast’’.* ¬PD 11, 19 years with a male child.

Challenges associated with Breastfeeding

Generally, teenage mothers were determined as to the benefit and the need to breastfeed their babies well. While others reported convenient experiences (problem-free), few viewed their experiences to be problematic or challenging. Many recalled issues that had to be overcome in order for them to continue breastfeeding for longer, but the situation was unpleasant for them to continue doing so when there are difficulties with latch, sore nipples, tickling and abdomen and breast pain. It was not the case that teenage mothers who experienced these problems were unable to breastfeed exclusively. However, participants reported some difficulties and unpleasant experiences regarding breastfeeding. These were some observations made by the participants:

> *‘‘… I felt some pain from stomach/abdomen as my baby suckled, and this continued for a while so I went to the*

hospital and the nurse told me my womb is getting back to its shape and he prescribed medicine for me but it was still unbearable…'' ¬PD 22, 17 years, with female child.

This further corroborated by a teenage mother aged 18years with a female child

''… I nearly stopped because I did not like putting breast into my baby's mouth because it tickles and feel pains and there was a little [insufficient] breast milk too but I don't have money to buy those s3 NAN 1 or s3 NAN 2 […] I don't even know how to mention it mpo, hm! [She giggled]….'' ¬PD3, 18 years with female child.

Another participant whose husband likes to suck the breast had this say:

''…Hmm[…]initially, the moment I put the breast into my baby's mouth and if he starts sucking it I begin to feel for sex but now I am used to it. [She giggled and related that…] my husband likes to suck my breast paaa…'' ¬PD 28, 19 years with 4 months male child.

Another participant who had nipple sore and needed help noted that:

''…I wanted a nurse who could take care of me and tell me about my nipple problem, there was a nipple sore and it really pained me so I did not breastfeed my baby for some time because I was retracting and I could not decide whether or not to breastfeed my baby…'' ¬PD 11, 19 years with male child.

Another participant got disappointed at herself perceiving that her breast felt like a stone, a 19 years old teenage mother indicated that:

> *‘‘...When new milk comes it hurt, it really feels bad. I sometimes put ice on it and it dries up like stone, then my baby will have no milk. So that is why I could not do it, I decided to quit because my breasts felt like hard stones....’’*
>
> ¬PD9, 19 years with a male child.

Notwithstanding the challenges, a teenage mother 18 years mentioned how she was able to overcome her nipple sore with assistance from her mother. She indicated that:

> *‘‘...I was able to sustain breastfeeding even when my baby was sick and when I had sore around my nipple, my mother helped me and suggested that I should use beeswax as a home remedy for sore nipples...’’* ¬PD21, 18 years with a male child.

Baby Care: Signs of Hunger and Satisfaction

According to the general baby care services by Ghana Health Service (2011), babies do not need so much to stay comfortable and crying is the only sign that the baby is uncomfortable, hungry or in pain. Once you are sure that the baby is not sick or not wet, crying may be the sign of hunger, discomfort or in pain. In this present study, teenage mothers were asked to share their knowledge or experiences on how they get to know when their baby is hungry and some signs of feeling satisfied when breastfeeding and the majority of participants shared similar views. Some of the participants noted the signs their babies make when they are hungry:

''... my child sometimes cries hard...'' ¬PD7; 18 years, with 3 month child.

Another participant had this to say:

''... is either my baby licks the lip or will cry...'' ¬PD3; 18 years with 5 months child.

This further corroborated by a teenage mother aged 19 years

''..., my baby will be shaking her tongue and rub it is around the lip...'' ¬PD8; aged 19 years.

It was further added:

''... I will see the baby struggling...'' ¬PD16; 19 years.

With regards to the sense of feeling that the child is satisfied when being breastfed, some participants also expressed some feelings and signs [sound] that the babies make when they are satisfied with breast milk. The following are some statements made by the teenage mothers during the interview:

''[When my baby is satisfied...] my baby will reject the breast when I give it to her, so [when I see that...] I turn her back against my lap and hit her at the back lightly [...] this act of hitting the baby's back gently is called 'abatan bo', the baby will make a sound like 'kio', that sound I will hear tells she is full and satisfied [... She giggled]'' ¬PD 5; 18 years with 5months female child.

Another participant expressed this:

''...My baby most at times will pour out the subsequent breast milk from the mouth and this shows my baby is satisfied...'' ¬PD1; 17 years with 2 weeks baby.

To corroborate this statement, a teenage mother aged 17 years noted that:

> *‘‘…[Usually] when my baby is satisfied I will see that the breast milk that is in her mouth start coming out of her mouth and I will clean it, when this continues for about three or four times I will know that my baby is satisfied and I will stop feeding at that time…’’* ¬PD5; 17 years 3 weeks.

It was further added:

> *‘‘…When I breastfeed my baby fully I will see that for some minutes, the baby will sleep and stop touching my breast…’’* ¬PD 13; 18 years with 3 months child.

Child bathing and Cleaning Practices

Babies need to be kept warm during the cold weather and to be dressed in light cotton clothing when the weather is hot (GHS, 2011). Ghana Health Service revealed that a child may need only one bath a day and it is advisable to use very mild soap and fine sponge to prevent bruising. The report further indicated that care must be taken not to expose the baby for too long during bath time. Teenage mothers mentioned the things they use to bath their infants, the number of times and the bathing position they employ to bath their babies with the help of the pictorial guide.

Nearly all of the participants mentioned that they get initial support and guidance when bathing their babies from their mothers/parent, mothers-in-law, grandmothers and relatives. Some of the participants had this to say:

> *‘‘For the first three months going, I had to observe my mother doing it because I did not have the confidence [akokodul] to bath my baby so she asked me to look carefully anytime she*

was bathing the baby. After sometimes, my mother helped me do it. But, nowadays I do it by myself. I even bath my baby twice in a day, one in the morning, one in the evening and I do it very well. Yes, I gently place the baby in the rubber bowl like the one in picture 4 (in pictorial guide)'' ¬PD29; 19 years with 15 months child.

Another teenage mother mentioned this:

''...[At the initial stage], my mother in-law used to bath my baby on her lap, but I have fear to do so I bath my baby in rubber bucket, but I make sure I guide her not to fall or use any part of the body to hit anything or the rubber. Yes the same way in the guide picture 4 [she related]...'' ¬PD 16; 19 years female child.

Some of the participants mentioned some of the challenges they face when bathing their babies. They included; fear/less confidence and/or not skilful enough in cleaning some of the important parts of the body. Some of the participants had this to say:

''...I am always careful because I am afraid the soap will enter my baby's eyes, mouth or nose...'' ¬PD8; 19 years with a female child.

Another teenage mother aged 18 years with a baby aged three months further added:

''...I think the little problem I face when bathing my baby is when I want to clean her vagina and it is very difficult for

me because I become not too sure whether her vagina is clean or not…’’ ¬PD 7; 18 years with 3 months child.

In relation to child bathing and cleaning practices, teenage mothers were asked to share how they clean their baby’s umbilical cord. Almost all participants mentioned that their guardian, parents, in-laws and traditional birth attendants Traditional Birth Attendants [TBAs] assist them at the initial stage. Teenage mothers mentioned they have been using substances such as methylated spirit and cotton wool, medicine mixed with powder, palm kernel oil, and shea butter to the cord stump while others use just hot stones and wet towels on the cord. One participant said this:

> *‘‘When I returned from the hospital my mother was the one bathing and cleaning my baby’s umbilical cord for me. She sometimes uses palm kernel oil mixed with some medicine like ash and black colour...I don’t know the name and she rubs it around the chord. She said it removes the pains and help the wound [ekul] to go fast’’* ¬PD22; 18 years with 2 weeks child.

However, some of the participants who gave birth in the hospital indicated that the baby’s cord was kept dry and only wiped with cotton wool soaked lightly in methylated spirit. One had this to say:

> *‘’…My mother cleans my baby’s umbilical cord for me. She uses spirit and cotton wool to clean it…’’* ¬PD1; 17 years with 2 weeks child.

This further corroborated by a teenage mother aged 17 years:

> *‘‘…my mother in-law has been bathing and cleaning my baby for me. She uses methylated spirit to clean the umbilical cord. When she baths my baby she keeps the cord dry and after that she uses the spirit to clean it well…’’* ¬PD 5; 17 years with 3 weeks child.

On the other hand, some participants who gave birth at home revealed that Traditional Birth Attendants [TBAs] used hot stones and a wet cloth to clean the baby’s umbilical cord. One participant who gave birth at home said this:

> *‘‘…I did not clean it myself, the woman [TBA] who helped me to give birth did it for my baby. She puts stone in a fire and after removing it, she put a wet cloth/towel on the hot stone to make bit warm and apply it on the cord…’’* ¬PD 14; 17 years with female child.

Accommodation/Sleeping Strategies of Teenage Mothers

Hanna and Saa-Touh (2014) allude to the fact that the homelessness among teenage mothers is explained by variety of factors, including teenage pregnancy, pregnant girls escaping abuse and teen mothers leaving home due to conflict with parent and family members or feeling unloved, homeless teenage girls or mothers are therefore those who spend night at lorry parks, kiosk, stay in abandon buildings (Hanna, 2001; Saa-Touh, 2014). The majority of teenage mothers in this study were found to be living in a poor household or environment and had poor sleeping arrangements or accommodation strategies. During the interviews, participants were asked to describe where they sleep with their babies and the participant reported different accommodations such as an extended family house, wooden and metal container structure, some with the mothers who lived in the rented single rooms, some have their own family apartment, some with their boyfriends/baby's father. The majority of the participants mentioned that they slept on a mat, mattress, folded cloth/blanket, while others sleep on bed. Very few participants indicated that they slept under a mosquito bed net. Some of the participants said this:

> *''I was sleeping with my friend at Esuakyire [name of an area] but when I gave birth I decided to come home and stay with my mum. We all sleep in a single room. I have a mat [pointed at the picture 6 in pictorial guide] that I and my baby sleep together on it. I put rubber under the baby's cloth to avoid urine penetration the mat when the baby urinates on it. I will say it is ok for me and my baby but I wish we slept on good bed and sleep under the mosquito bed net''*. ¬PD 10; 19 years with 20 months child.

Another teenage mother who moved from the mother's home after childbirth to stay with the baby's father had this to say:

> *''…I used to stay with my mother, but when I gave birth to my baby, I have come to stay with my boyfriend mother's home so ever since I have been with him even after child birth, he has a bed (pointed at picture 8 in the pictorial guide). Normally, I and the baby sleep on the bed and he sleeps with a big cloth on the floor…''* ¬PD 12; 19 years with 6 months child.

Another teenage mother aged 18 with a baby aged 5 months who wanted to prevent malaria slept under mosquito treated bed net. She had this to say:

> *‘‘....Hmm! Where I stay there are a lot of mosquitoes because of the big gutter there, so I always put my baby under a mosquito net. I sleep under it too. Oh yes, like picture 7 in the pictorial guide. I know it’s good to sleep under mosquito treated bed net…’’* ¬PD 3; 18 years with 5months child.

Another teenage mother who slept on mat had this to say:

> *‘‘Hm [...] we sleep together on the mat on the floor like picture 6 in the pictorial guide. The floor as well as the mat is hard and I don’t have a big cloth, but the small cloth that I have, I put it under my baby to sleep and I sleep on the bare mat like that so when I wake up I feel some pains but now I am used to it’’.* ¬PD 23; 18 years with 17 months child.

Major Postnatal Challenges Encountered by Teenage Mothers

The consequences of teenage childbirth affect both mothers and children, and ultimately the family regardless of the motivation for teen childbearing (Gyesaw & Ankomah, 2014). Studies have concluded that, early childbirth may pose risks or complications for teen mothers and infants (Hanna, 2001; UNFPA, 2015; WHO, 2018). Teenage mothers are also less competent care givers, have fewer resources, and unable to meet their competing demands on their time (Timms as cited in Bah, 2016). Teenage mothers (13 to 19 years) mentioned a number of challenges they face after childbirth. The study observed both health and socio-economic challenges such as postpartum complications, inaccessibility to health care services, financial challenges, educational challenges, family and baby's father's rejection, denial and irresponsibility**.**

Challenges Associated with Childbirth

As part of the challenges, observations were made by teenage mothers from the day they gave birth. Teenage mothers noted that postpartum complications were memorable experiences as far as childbirth was concerned. A number of childbirth complications were mentioned by teenage mothers, including, postpartum haemorrhage or vagina bleeding, preterm births and other neonatal problems. Some of the participants noted that they were disappointed and dissatisfied about experiencing such complications, although they were much concerned about their own survival and that of their babies. These were some of the views of the participants:

> *''...Yes, hmm! When I gave birth I experienced similar things [reflecting on those in the pictorial guide: picture 9...], I had a lot of blood coming from my vagina for some days, it was really bad because I could not sustain the pains at first, but when I came home the pain has gone down…''*
>
> ¬PD3; 18 years with a female child.

Another participant who experienced caesarean birth, thus, when the baby was delivered through a cut [incision] had this to say:

> *'' ... I was scared when the nurse told me they have to cut me [incision], because my child was big, so they did it before*

I was able to deliver safely…'' ¬PD 19; 19 years with 6 months female child.

Another participant who experienced bleeding from vagina or haemorrhage had this to say:

''…When I gave birth, hmm […], it was a tough condition for me at that time. I bled a lot [pointed at picture 9 in the pictorial guide] and had severe pains as well. This continues, for some time, but now it is gone is only when I am having sex that I feel the pain small…''. ¬PD 6; 18 years with a female child.

A 19 year old teenage mother who experienced preterm birth/low weight baby had this to say:

''…My baby was too small when I saw him, yes [participant pointed at picture 10 in the pictorial guide]. I felt disappointed and I was so scared. I delivered at 8th months, and I was dissatisfied with this because I did not want them to retrieve my baby, until my full nine months but he could not have stayed in my womb. I even asked myself so many questions that, was my child going to die in my stomach? Because I was surprised and concerned about my health and the well-being of my baby…'' ¬PD 17; 19 years.

Some of the participants also experienced various feelings such as pain, tiredness/dizziness, and hunger at the same time. These feelings were initially negative and they were shocked and scared that some of these things were happening to them. Some of the participants had this to say:

''... I gave birth successfully, but for sometimes now I have had problems with my waist. I feel pain and sometimes get scared when I want to have sex…'' ¬PD10; 19 years with 20 months child.

Corroborating the negative feeling [pain] of the teenage mother, another participant aged 18 years noted.

''... I feel dizzy and I sometimes feel pain in my upper right belly…'' ¬PD 23: 18 years.

Another participant aged 19 years, who perceived sudden lose weight had this to say:

''...I get tired any time I walk and I become hungry but I know it is because of the sudden loss of weight and energy...'' ¬PD 16; 19 years with female child.

A number of participants indicated their experiences of giving birth as natural and painful but it 'worth it'. They saw the benefits in terms of feeling more physically resilient and better able to give birth easily without any complications. Most of them were positive (self-confident) and were determined to have successful delivery. Majority of the teenage mothers put all their faith and hope in God during labour even though some of them knew they were young to give birth at that time. Some of the participants had this to say:

''…Ooh, I thank God I had a successful delivery. I gave birth to my child naturally and did not experience any birth challenges, but it was a bit painful especially my last push…'' ¬PD 20; 18 years with 3 months child.

Corroborating the positive [self-confident] of the teenage mothers, another participants aged 19 years indicated:

> *‘‘...It was successful and happened just like that. I realised my baby was out and crying…’’* ¬PD 27; 19 years with a female child.

Additionally, some participants also identified postpartum challenges linked to their health and children’s health. For this age group, they had to make strict and hard decisions to stay home and take care of their children when they were sick. Most of them took their children to hospital for weighing and vaccination. There were also challenges teenage mothers faced in accessing postnatal care. Some participants indicated they have to walk a long distance; some lacked money to go the hospital for a check-up and weighing, and some attitudes of nurses were the reasons they did not visit health facilities as often as possible after childbirth. These were some of the views of the participants:

> *‘‘I used to go to the hospital for weighing but now my baby is not sick so I do not go unless maybe my baby is sick […]. I think it is not a problem and another thing is that from where I stay in the hospital is also far and getting money to go is a problem’’* ¬PD 10; 19 years with a male child, completed JHS.

Another participant who based on the attitude of the nurses decided not access hospital had this to say:

> *''…. the way the nurse talked to me was bad, so I also overacted so since then I do not feel happy to go to the hospital again…''* ¬PD15; 19 years with a female child.

Some participants indicated that they had once been to the hospital even though they gave birth at home. They do not access postnatal care including weighing and other services after childbirth. Some had this to say:

> *''…Oh, I have been in the hospital for just once for baby's injection and vaccination. I even gave birth at home and my mother and grandmother have been taking care of me and my baby since …''* ¬PD 21; 19 years with 9 months male child.

To corroborate this statement, a teenage mother aged 19 years indicated that:

> *''…I don't go to the hospital often […]. I remember I have been there for once for weighing and vaccination apart from that there is an old lady [TBA] just at the back of the road, and she takes care of my baby when something is wrong with me or my baby I just go to her…''* ¬PD 24; 19 years with a female child.

Financial Challenges

Moore *et al.*, (as cited in Bah, 2016) observed that, because of low educational attainment and low marital stability, coupled with poverty to young parenthood. Teenage mothers have lower incomes and face problem of getting financial assistant from their family, and young fathers of their children. Financial problem or challenge was one of the major challenges teenage mothers encounter/face. The majority of the participants indicated how they were struggling with the cost and resources of raising/taking care of their babies. Most of them were not working before getting pregnant and lost significant income support for their families. The main family income was generally from fishing and farming such as growing maize and cassava, vegetables and fruits. Any extra income comes mostly from baby's fathers, relatives and friends. Having a baby not only increased the cost of living, but also reduced the labour force within the family. Those who got pregnant when they were schooling were, therefore, assisted by their mothers who often had to quit their own time of working hours and business travelling just to help care for the babies, thus creating further financial strain. Financial support seemed crucial to being able to provide good care for their child as a teenage mother. Participants talked about their financial challenges and how they get financial support to take care of themselves and their babies. Some participants had this to say:

> *''I take care of my baby[...], but I stay with my mother so she has been providing some of my needs and gives me food because we cook together, but she doesn't give me money unless I'm sick, hmm[...], but It would be nice if I could get some help with formula, baby's nappies and some money to pay for the baby's expenses from my baby's father or his parents, I don't even hear from him [the boyfriend] so I am there like that''* ¬PD2; 19 years with a male child.

To corroborate this statement, another teenage mother aged 19 years related:

> *‘‘Hmm […] getting support is a big problem I am facing now. I need some help with my baby expenses. It really worries me. No one in our family has a permanent job to earn good income. Some work day by day while the cost of living has increased every day since I had a baby things have become tough for me’’.* ¬PD8; 19 years with 10 months child.

On the other hand, one mother who received support from the family said:

> *‘‘…Oh, I take care of my baby, but my mother, brother and sister help as well. But what I get is not enough so I am planning to do something to get money to buy some of the things that my child will need myself…’’* ¬PD7; 18 years with 3 months female child.

Nearly, all participants expressed interest in schooling. Being a pregnant/teenage mother student was a challenge for most people we interviewed. Teenage mothers indicated that they would like to go back to school, but they realized that it would be very difficult and it will even take some time for them to go back because they have to wait for their babies to grow up while others see themselves as mothers ‘grown up’ and thinking they cannot be in school. These were some of their views:

> *‘‘…I wish I could go back to school, but not now because I have to take care of my baby to grow and see if I can continue with school. It would be nice if my family will provide support me then I can go back to the normal schools*

but for now nobody is asking me and want to help me …''¬PD5; 17 years.

This further corroborated by a teenage mother aged 19 and completed JHS:

> *''...Yes, I would like to continue my education, but I have planned to be enrolled to get the senior high certificate when my child gets to three years old, I will go to school because now SHS is free so I will go…''.* ¬PD17; 19 years completed JHS.

Another participant related:

> *''...Hmm! I wish but it is difficult [she sighed]. Who will look after my baby if I go back to school, I have to sit home and take care of my baby…''* ¬PD16; 19 years.

In the same vein, some participants said that others judged them, gossip about them, stared at them and see them as spoilt girls. They reported that their lives have changed since they got pregnant and after giving birth others look down upon them. Some of the participants had this to say:

> *''Ooo […]. I am not sure I can go back to school [SHS]. The school authority asked me to leave when I got pregnant. And nobody will give me money, food or dress even if I say I want to go back to school, but I wish I could go to school in a different place when my child grows…''* ¬PD 7; 18 years.

Another participant who felt disappointed because her friends gossip about her and think she is a spoilt girl had this to say:

> *''...I was getting hate from other friends who gossip when I got pregnant and now I feel disappointed and regret because*

my friends see me as spoilt because I got pregnant so I don't think I can go back to school, I will make sure I work to get money to take of myself and have a good future like other friends who are going to school …'' ¬PD 23; 18 years with 17 months child.

Baby's Fathers Attitude, Denial and Irresponsibility

Teenage mothers were asked on how supportive or caring their baby's fathers (boyfriends) were. This question was asked because studies have revealed that teenage fathers are irresponsible. They are more likely to deny pregnancy and have nothing to do with their children and abandon their pregnant girlfriends (Rickel as cited in Bah, 2016). Majority of participants (teenage mothers) mentioned some attitudes of their baby's fathers (boyfriends) toward them as a major challenge they encountered. For most participants, the first person they told of their pregnancy was the father of their baby. Some of these the baby fathers were students/teenage and workers/adult men. However, some had been in a relationship with the father, but had broken up before finding out they were pregnant. Some of the participants had this to say:

''My baby's father was in [SHS] but after school we broke up because of the issues concerning the pregnancy. Initially I was thinking he was in school so I didn't want to mention his name to the family to get disappointed because he told me not to tell the parent about it so I tried to mention somebody that nobody knew to cover him for some time. This caused a lot of problems for me because he also stood on it

to deny me for mentioning the other person's name. Hm! What he did really pains me and because of that I'm not even in good terms with him '' ¬PD 12; 19 years.

Another participant who planned to do an abortion had this to say:

''My boyfriend was schooling [SHS] and not working so when he got me pregnant we were both scared and afraid about that so we were all thinking to do abortion. He later brought me some medicine in bottles I drunk all but still the pregnancy was there, although I had some pains and blood came so I thought that was that, [aborted] but in about some months later my stomach became big and everybody saw it so I decided to give birth [...] He is working now, every month he gives me something [money]'' ¬PD 14; 17 years.

This further corroborated by a teenage mother aged 19 years.

''...My baby's father did not care. I asked him if he wanted me to keep the baby or wanted me to have an abortion and he chose the latter [abortion]. I was not happy to be with him anymore. Not long after that we broke up. He is not a good guy...'' ¬PD19; 19 years with 6 months child.

According to some teenage mothers, fathers of their babies were in school studying and had no resources with which they (the baby fathers) could care for them and their babies. Most relationships were not approved of by the parents of the baby's father. Both teenage mothers and fathers also risked being expelled from school if the fact that they were living in a relationship was discovered. Unsurprisingly, many of these fathers just denied and ignored being the fathers of the baby because they had nothing then to care, support and provide for the teenage mother and her baby. These were some of the views of the participants:

> *‘‘... He denied […] so we are no more koraa,[totally] he had already broken up with me…’’* ¬PD1; 17 years.

Some of the teenage mothers later understood why they were denied but after giving birth, the boyfriends were welcomed since they started showing care and supporting them. Some of the participants had this to say:

> *‘‘…We were not in good terms when I got pregnant, he denied me, but I latter welcomed him [he is my baby's father] so when he came back to me […], now he has been providing my needs, he gives me money, and he buys me things that I asked for…* ¬PD 8; 19 years with 10 months child.

To corroborate this statement, a teenage mother aged 19 with 10 month baby also indicated:

> *‘‘...Oh, nowadays he is good, in beginning that I was pregnant he was not minding me, but after I gave birth to his baby, he visits me, he buys things for me and my baby, I say God bless him to continue like that…’’* ¬PD 17; 19 years with 10 months child.

Another participant mentioned how her baby's father helped when the child needed blood:

> *‘‘...Since school time my boyfriend was helping me because my parent did not have money to help me and did not like it*

too. But he gives me everything. He even donated his blood to my baby meanwhile my father and my mother were all there they did not allow the blood sample to be taken for my baby when she needed blood […] Hm […][she sighed her frustration]…'' ¬PD 22; 18 years.

Teenage Motherhood and Coping Strategies

Most of the childbirths in this study were unplanned. Regardless of whether the childbirths were desired or not. Most of the teenage mothers had less preparation to cope with the roles of parent/mother. Their ability to cope with the stresses of teen motherhood and their limited knowledge of appropriate childcare skills affected their wellbeing and that of their babies (Bah, 2016; Clemmens, 2002). Teenage mothers had numerous responsibility to perform such as providing care and meeting the needs of their child. Rearing a child was a big task, especially for new teenage mothers since they were not prepared; yet, they faced it with resilience and courage. Teenage mothers were likely to adapt and cope with the new maternal role.

Coping as a Teenage Mother

Childrearing promotes the relationship between mother and baby. The majority of the teenage mothers expressed how they were coping with life after childbirth. Some of the participants mentioned how they coped regarding motherhood for the benefit of their babies. Some of the participants had this to say:

''…My mother has been helping me and even told me to see myself as a mother like those adult and handle my baby as

an adult person…'' ¬PD11; 19 years petty trader with 4 months child.

Another participant indicated how she provided for herself and her baby:

''...After I gave birth I did my best to find something to do so I can now provide for myself and my child, I don't need anything from anybody so I am managing and doing my best as a mother…'' ¬PD4; 19 years with 19 months child.

A Sense of Being a Teenage Mother

Sense of becoming a teen mother or longing to have a baby was also highlighted as a way of gaining attention and legitimate attempt for teenage mothers to see themselves as adults or grown-ups. Some teenage mothers were happy; others were not happy about having a baby at this early stage. Although some of the pregnancy occurred accidentally or was not planned for, more than half of the teen mothers choosing to have babies could be the fact that they wanted to be mothers since most of them have already been taken care of their younger siblings (brothers and sisters) so didn't have any problem giving birth and having the sense of becoming mothers after we asked them about how they feel as mothers. These were the views of some participants:

''Ooh! Hm...I regretted when I became pregnant. I was not happy initially, I told my friend and she also told me that those giving birth are not better than me so since then I also made up my mind as a mother to prove to others friends that I can take care of the baby. So I didn't see anything wrong with becoming a mother because I am only my

mother's child so becoming a mother was a good thing''. ¬PD1; 17 years.

To infirm this statement, another teenage mother aged 18 years said:

''...I did not have any regret becoming a mother because I wanted to let my friends and the friends of the baby's father know that I can be a good mother and take care of my baby even if he doesn't support me, for now I cannot say I am sad ooh no[...]. I am ok paaa...'' ¬PD13; 18 years with 3 month child.

It was further added by a teenage mother aged 18 years who noted that being a mother means she is blessed:

''I did not regret having a baby, the reason is that My boyfriend was working so he gave me the hope and told me he will take care of me so I could take good care of myself and my baby so from day one I was blessed to become a mother''. ¬PD6; 18 years.

The participants' sense of being a mother arose from acknowledging and realizing the maternal role as well as feelings of happiness and healthy mother or unhealthy or sad mother. The majority of the teenage mothers expressed that they received happiness from their boyfriends, babies and relatives when they became mothers. When we asked them how they feel as teenage mothers, some participants described feeling content as caring about their new-borns. Some had this to say:

''...Being a mother, I will say I am happy and feel good because I am blessed with a child, but I have to do the best

things for my baby to be happy as well. Although I am too young to have a baby, I wanted to be a good mother. I had to get up early to prepare everything for my baby before she wakes up... ¬PD23; 18 years with 17 months child.

This further corroborated by a teenage mother aged 18 years:

''... I do not feel like I am young, I feel like I am getting old. I feel like I'm a mother, a woman and I like it... [Her hardest struggles included the baby's crying and not getting sleep], *in the morning, and at night I don't get much sleep when the baby cries. When I wake up, I don't really feel fine because I get so tired...''* ¬PD7; 18 years with 3 months child.

Another teenage mother described why she has regretted and not happy having a baby since she became a mother. She had this to say:

''...I have regretted papa hmm [...], I am not happy anymore because I don't party [go out with friends] as many as I used to, and I don't hang out with my friends again. I don't have money now because of my baby and even if I want to go somewhere, I can't leave my baby and that is what I don't like about having a baby now. I have got to stay at home and can't go anywhere meanwhile at first if I go out I get money from my friends...'' ¬PD11; 19 years with 4 month baby.

Another participant had this to say:

''I will not say I have regretted having a baby at this time, neither will I say I am happy this is because since I had my baby, I tried not to associate myself with too many people,

even my close friends so I don't feel happy and I think once you have a baby your mind-set should change, and I don't want to hang around and do something and get myself into trouble so I spend most of my time with my boyfriend or my baby'' ¬PD2; 19 years with 3 weeks child.

Other teenage mothers also expressed that their experiences as a sense of feeling happy and healthy as mothers. Although they face other challenges, they believe having a child is more important than any other thing. One participant had this to say:

''…Ooh yeah, when I gave birth to my baby my life has changed and I am very happy because I found myself like not wanting to do things that I know that I should not be doing. I always like to think before I do something. It makes me a lot more careful in what I do because I see myself as a mother now…'' ¬PD9; 17 years with 7 months child.

Most of the teenagers struggle after becoming mothers. They stay idle at home, which resulted in conflicting family relations and perceived dwindling of personal support and relationship with the baby's father. Some teenage mothers expressed how they are/were struggling to provide support for their babies. One of them had this to say:

''… [Because] of my child I don't go anywhere, always idle at home. I don't do anything and I don't have money[…]hmm […] but want my child to be in day care but nobody is helping me, my baby's father has ignored me so I have to find work and get money so I can do it on my own

and will not have to rely on anybody else. But I just love being a mother. I have changed a lot, but it was for the betterment of my child…'' ¬PD14; 17 years.

Accepting Responsibility as a Teenage Mother

The teens' new maternal role/responsibility as a mother is very complicated as compared with other important roles as unborn teenager. Some participants reported the challenges they faced integrating motherhood (as responsibility) with being a mother (new maternal role) they play as mothers. Some of the teenage mothers, therefore, had to force to or juggle their multiple roles. The teenage mothers identified other key challenging roles linked to their children: they had to make difficult decision whether to stay home or take care of their children when they wanted to do something else like going to church, going to school, and going to sell. Some participants had this to say:

''… Every day I am with my baby […] even when I wanted to go for church programs, my church has a lot of activities they do. They always have a program going on. I really want to go but I sacrifice not going, because I know I have a baby. So, instead of going for the program, I stay home even though sometimes I don't want to…'' ¬PD1; 17 years with a male child.

To corroborate this statement, another participant noted the following:

''…Hmmm! Sometimes I had to decide that I am not going anywhere because of my baby […] I will stay home the whole day and look after my child, and meanwhile I wish to go and

sell something to get money to feed ourselves...'' ¬PD7; 18 years.

Some of the participants felt that it is their responsibility to take care of their babies; however, they felt they were too young to be mothers. But most often, they tried to be good and loving mothers. One participant said this:

''I felt I had more responsibility when I had a baby to take care of [...] I was glad when I saw my baby for the first time. My baby was a healthy and complete [nothing happened to my baby] baby after birth I loved my baby so I will make sure I take care of my baby well, even though I am young I can still be responsible'' ¬PD9; 17 years with 7 month child.

Other teenage mothers also expressed their interest in combining motherhood roles with other things, for instance, with the motive of continuing their education, getting employment and/or family obligations as challenging. Some of the participants had this to say:

''... It's going to be hard, because I am still producing breast milk for my child [breast feeding], I would have to wait for may be some years before I can continue with my education ...'' ¬PD13; 18 years.

Another participant expressed how she feels whenever she meets her school mates:

''... I feel bad especially when I meet my friends going to school or when I even meet them as girls' girls talking about things that happen in their schools...'' ¬PD15; 19 years.

Another participant who struggled to sell something to support herself [petty trader] had this to say:

> *''It is difficult for me because if I don't work I will not get money to take care of myself and my mother. My mother keeps my baby when I go to sell things. My child is growing, so he eats a lot and my boyfriend fails to give me money unless I tell her the child is sick and he will bring small money so when I receive the money I add some to it and buy fruits and sell to get more money.''* ¬PD10; 19 years with a 20 months male child.

Social Support for Teenage Mothers

According to Cronenwett as cited in Bah (2016), social support can be defined through four categories of support. Two of the categories were emotional and instrumental. According to Cronenwett, emotional support is characterised as those acts that provide care, love, trust and concern, whereas instrumental support referred to access to direct help when the person is in need such as money, aid in kind, labour and time. Social support was highlighted as a critical factor in helping teenage mothers in coping and adapting to the situation of becoming mothers. It was revealed by the participants that the primary source of social support was given by their family. More than half of the participants indicated that their families were very supportive; others also indicated that their families/relatives were a bit supportive as well as their baby's fathers.

One participant whose family knew that the boyfriend was a student noted the following:

''Immediately that I came back from the hospital my mother bought me some of the things I would need to help me, my big sister also bought clothes for my child when she heard that I have given birth. My Uncle has been giving me money because they know my baby's father is a student and not working. So far my family supports me very well.'' ¬PD14; 17 years.

To corroborate this statement, a teenage mother aged 19 years mentioned that:

''My mother gives me a lot of support especially when I gave birth, she taught me how to take care of my stomach so that it doesn't become big. She also taught me how to take care of my body neat and keep my baby neat as well. She most at times holds my baby and sings for my baby to sleep whenever my baby cries so hard.'' ¬PD8; 19 years with female child.

Another participant who received support from the baby's father had this to say

''...My baby's father [husband] has been taking care of us. He gives me little money and take care of the basic things my child needs as well. It is very hard for him but I know it because I am not working [...] Hmm...'' ¬PD 17; 19 years with 10 months child.

A teenage mother aged 19 years who received a massive support from the father when the mother got angry and ignored her had the following to say:

''I get support from my father when I gave birth my mother got angry with me so I went and stayed with my father [separated with the wife]. He was the one giving me money to buy food, clothes and medicine for my baby. He makes sure I breast feed and bath my baby well. At night when the baby cries my father takes the baby and walk in the room till the baby sleeps. My father also speaks with my boyfriend to give me money and visit the child so when he is coming he also brings some things like diapers, and provisions as well.'' ¬PD11; 19 years.

Teenage Mother's Future Plan

About half of the participants indicated that, in the next five years, they would want to plan to study or go back to either a nursing school or university after they get the opportunity to finish the senior high school. These participants reflected that higher education will provide them with greater opportunities to help them take care of themselves and their babies very well. Others also indicated to do their own business because some were already learning sewing (seamstress), hairdressing, and other business like mobile banking, and some petty trading/selling. Some of the participants had this to say:

''Hmmm […] may be I will go back to school and study, one of my results is not good so I have to write the paper again I will go to remedial classes because I want to go to the University. I want to work in an office or good company to get more money to take care of my baby. Without a good

education I will not be able to get a good job so I am praying to get money to start the classes''. ¬PD 4; 19 years, completed SHS.

This further corroborated by a teenage mother aged 19 years who wanted to be a nurse:

''...I want to be a nurse so I will go to school again when my child is two years, my brother says he will support me since he's working now...'' ¬PD10; 19 years, completed SHS.

Another participant who wanted to do business had this to say:

''...I want to do my own business in next five years.it is not easy for now but I will start with small selling of things as I do now to save more money to open my business…'' ¬PD 9; with 7 months child, completed JHS.

To corroborate this statement, another teenage mother aged 13 years indicated:

''...I want to be my own madam or master [seamstress] in a few years to come…'' ¬PD 13; 18 years, completed primary.

On the other hand, some teenage girls become mothers because they didn't have any direct plan for their future lives and because they lack parental control and had issues of broken homes. Some teenage girls relied on their boyfriends for support and motivation, which ended some of them in early childbearing. Some of the participant said this:

''Hmm! I don't have any plans for now. I decided to give birth because I realized that my boyfriend can take care of

me and my baby but after I gave birth he doesn't give me money always so I think I have to look for some job or go and sit at someone's shop to get money to feed myself and my baby''. ¬PD15; 19 years.

This further corroborated by a teenage mother aged 18 with a female child:

''...Hmm, May be to help my boyfriend in his business. I was always helping my boyfriend and he was taking care of me so I did not have any future plan apart from helping my boyfriend to sell phones accessories, but now I will start and sell something to get more money to take care of myself and my baby and open my own business in the next few years..'' ¬PD 6; 18 years with a female child.

Plan for the Child's Future or Aspirations

For most of the teenage mothers interviewed, childbirth was unintentional or unplanned. However, overwhelmingly, they were positive about their experiences of being a mother and have aspirations for themselves and their children. Many indicated that being a mother had changed them for better. Some reported the plans they have for their babies/children to grow up without the negative experiences they [teenage mothers] had faced from childhood through to motherhood. These were some of the views of the participants:

''... I want my baby to grow up very well and become somebody better than I do, I will help my baby to go to school and become a great person in future…'' ¬PD 21; 19 years with a male child.

To buttress this quotation, another participant indicated that:

> *‘‘…I want my baby to go to the university, get a good job and become a better person in life. …’’* ¬PD 9; 17 years with 7 months child.

Further observation was made:

> *‘‘..I want my baby to have a bright future and take care of me when I am old…’’* ¬PD 3; 18 years.

Self-motivation and Advice for Teenage Mothers and Non-mothers

“There is a saying that experience is the best teacher”, teenage mothers mentioned in the form of advice based on their experiences to other teenagers (who had given birth and those without a child). They advised and encouraged other teens to achieve their goals in life and also fuel their intention to prove other people wrong that getting pregnant and giving birth does not mean it is over with their lives. Some of the participant had this to say:

> *‘‘…I will say that it is not easy to give birth so they [other teenage girls] should concentrate on their education and not have babies at this time like me and they should also assess their boyfriends well before giving them to them because some of the boys are very bad and may reject you when you get pregnant…’’* ¬PD 1; 17 years with a male child.

Another participant had this to say:

> *''My advice for other friends [teenage mothers] is not to see childbirth as a burden. They should not lose hope, but they should start doing something profitable to take care of themselves and their children''*. ¬PD 17; 19 years with female child.

Another teenage mother aged 19 years, who was of the view that having a child at teen age is more profitable because your child can grow up early and also start taking care of you:

> *''[My little advice]… is that we should not give up [as teenage mothers] because we have given birth, it is even good to have a child at this time, so that my child can grow up so quickly and become my friend…at least when I get to some age my child can also take care of me. I will just make sure I take good care of my child…''* ¬PD 8; 19 years with 10 months child.

Another participants who was of the view that bearing a child is a gift God had this to say:

> *''My advice is that, as teenage mothers, we should know that the child is a gift from God so we don't have to say it is a bad thing […], we have to do business or sell things in bits to make sure we take care of the child, but I will tell other teenagers to avoid having sex at this age even though they can be in a relationship…''* ¬PD 14; 17 year.

This further corroborated by a teenage mother aged 18 years:

> ‘‘*...other teenagers who are not yet pregnant should focus on their education and avoid boyfriends and sex…’’* ¬PD 6; 18 years with a female child.

DISCUSSION

The interviews were performed with teenage mothers (13 to 19 years) with babies two years or less. The study explored the lived experiences of the participants while they were experiencing the phenomena. This provides an empirical account of the lived experiences of the teenage mothers. The findings of the study are discussed according to the main themes (parent nodes) that emerged during the data analysis within the context of the literature. Furthermore, the ecological systems theory was conceptualized as a framework to guide the present study by looking at the smaller environment (the exo and the micro systems) and followed by the broader environment (the chrono and macro systems) and help in understanding and discussing childbirth experiences of teenage mothers within their context. The framework places the teenage mothers at the centre, exploring their lived experiences and how they interact with, and relate to, various systems. In line with the theoretical and conceptual issues underpinning this study, the following discussions are presented based on the research questions/objectives of the study.

Teenage Mothers' Childcare Practices

Results of the study revealed that most of the teenage mothers appear to have knowledge on proper positioning and/or attachment of their babies. For instance, when breastfeeding their babies, but have low confidence (inexperienced) in other childcare practice like child bathing and umbilical cord care. Although they had learned to do so and had some experience from mothers, relatives and mother in-laws (Kridli, llori & Verriest, 2013). Others who, despite having given birth for the first time, noted that they had already cared for their younger siblings and had some experiences in child care practices. These experiences were based on the use of 'popular' practices that were part of their family and community culture instead of scientific-based practices given by health professionals when caring for their babies (Tomeleri, & Marcon, 2009). Moreover, it was observed that certain proportion of teenage mothers used methylated spirit and cotton, while others used 'traditional substance', for instance, medicine mixed with powder, palm kernel oil, Shea butter, hot or heated stones and wet towels were applied to the cord stump as a common way of cleaning and caring for the child's umbilical cord. This findings of the present study go in line with (WHO, 2008), where application of a harmful traditional substance, such as cow dung, to the cord stump in neonatal mortality setting.

Furthermore, it was observed that teenage mothers struggled or faced a number of challenges when performing some of the childcare practices. For instance, child bathing and umbilical cord cleaning. Hence, most of them mostly depended on their parent, mother in-laws, and guardians, TBAs for support. This helps them to cope in light of the challenges that they encountered in their 'maternal role' or care for their babies. This finding goes consistent with those found in the study conducted by Gee and Rhodes (2003) on adolescent mother's relationship with their children and found that adolescent mothers struggle to cope with their new maternal roles.

The results of the study identified a relatively varied means through which teenage mothers acquired knowledge on breastfeeding. Teenage mothers noted that knowledge, skills and experiences of breastfeeding are very important as way of ensuring good breastfeeding practices especially with the exclusive breastfeeding [EBF]. A similar results found by previous studies in Ghana (Gyampoh, Otoo and Aryeetey, 2014). A contradiction was observed, where fewer mothers lacked knowledge of feeding practices. The finding of the current study corroborates with those found in a study on knowledge of breastfeeding practices in Ghana (Mogre, Dery & Gaa, 2016), that teenage mothers were observed practicing exclusive breastfeeding successfully irrespective of the associated challenges and other unpleasant situations. This is because teenage mothers know the benefits of breastfeeding their babies. This finding is comparable to that of Wambach and Cohen, (2009), noted that sufficient breastfeeding knowledge is one element needed to successfully breastfeed.

Result of the study on complementary feeding revealed that teenage mothers reported a general use of koko (porridge) as first complementary food and other foods which are made from cereals based flour such as maize, rice, cassava etc. These food are not nutritious and it is even difficult to digest when given to infant. This finding corroborates those found in a study on young child feeding practices and nutrition status in rural Ghana by Nii and Lartey (2007), which reported a general use of 'unfortified koko' (low nutrient porridge) as a first complementary food among 65% of mothers while only 27% of the respondents studied had fortified their complementary food with legume flour and groundnut paste. Similar observations were also made by Fjled et al., (2008), where the common complementary food that is introduced from six months to age two is maize flour porridge often fortified with vitamin A, salt, and pounded groundnut.

Meanwhile, complementary food or weaning food should, under ideal circumstance, be clean, contain high energy and protein and easy to digest, culturally appropriate, and locally available as concurred by (Arora et al., 2000).

Results of this study revealed a number of challenges associated with breastfeeding practices. Closely, all of the teenage mothers indicated that breastfeeding was interrupted and unpleasant from initial stage because they suffered from nipple problems, stomach pains when the baby sucks for long and lacked the experience and confidence to control or overcome these challenges. This finding seems to contradict those found in the study conducted by Ahmed (2008), which identified support for mothers of infants immediately after delivery as a way of overcoming breastfeeding problems and enhancing confidence. However, the teenage mothers indicated that they needed their mothers, guardians, and open-minded healthcare providers that are willing to listen to them and provide help on breastfeeding problems, share knowledge about childcare, and provide specific education aimed at teenage mothers to develop confidence. This is evident in the previous study conducted by Kridli, Ilori, and Verriest (2013), which revealed that the family, mothers, mothers-in-law, and sometimes, female relatives, play a primary role in supporting the mother in taking care of herself and her new-born after birth.

Results on the accommodation/sleeping strategies of teenage mothers in the KEEA municipality revealed that, the majority of the teenage mothers were homeless and slept in wooden and metal container structure (kiosk), some with their boyfriends (baby's fathers) in wooden structure.

Most of them were found to sleep on mat, student mattress, and folded cloth/blanket. These findings corroborate with those found in the previous studies (Hanna 2001). Hanna alludes to the fact that the homelessness of teenage mothers is explained by a variety of factors, including teenage pregnancy, pregnant girls escaping abuse and teenage girls leaving home due to conflict with parent, family members or feeling unloved, homeless teenage girls or mothers are therefore those who spend night at lorry parks, kiosk and stay in abandon buildings. The findings of the current study also affirm those found in a study by McArthur and Winkworth (2013), where the authors explored the hopes and dreams of young mothers in receipt of income support and found that homelessness or having poor condition is common for young mothers.

Postnatal Challenges Teenage Mother's Encounter

Results of the study on postnatal challenges teenage mothers encounter after childbirth in the KEEA Municipality showed that the majority of teenage mothers (13 to 19 years) faced a number of challenges after childbirth. The results of the study emerged that teenage childbirth is associated with adverse health outcomes for both the teenage mother and the child. Several maternal risk factors and birth complications such as vagina bleeding or postpartum haemorrhage, waist pains, low birth weight, depression, loss of weight, and other neonatal problems were found to be common among teenage mothers in the KEEA Municipality. The findings of the current study go in line with those found by (Gilbert, Kumar, Singh, Rai & Singh, 2013; WHO, 2018), that childbirth among teenagers is associated with poor health outcomes (childbirth complications) such as preterm delivery, eclampsia, puerperal endometritis, postpartum haemorrhage, and neonatal deaths.

Results of the study emerged that teenage mothers know the importance of accessing postnatal (PNC) healthcare. Most of the teenage mother accessed postnatal care (PNC) for services such a vaccination, weighing, medical care etc. for first postnatal contact even when birth was at home (WHO, 2008). However, the findings of the present study observed that, subsequently, certain proportion of the teen mothers intermittently access or visit health facility for postnatal care due to financial reasons, attitude of nurses or health workers, and distance of the facilities. This findings corroborate that of (Darroch, Woog, Bankole, & Ashford, 2016), but seems to contradicts to the recommendations made by (WHO, 2013), that postnatal care and practices were made for all mothers [including teenage mothers] and new-borns to make additional post natal contact on day three (48-72 hours), between 7-14 days after birth and six week after.

Results of the study on the financial challenges teenage mothers face after childbirth emerged that majority of the teenage mothers were struggling with the cost and resources of raising a baby. Some of the teenage mothers interviewed were not working before getting pregnant and lost significant income support from their families. The main family income was generally from primary economic activities such as fishing and farming such as growing maize and cassava, vegetables and fruits. Any extra income came mostly from baby's fathers, parent and relatives. The findings of the present study affirm those found in the previous study by Ahorlu, Ady-Gyamfi, Pfeiffer, and Obrist (2013), that three most important sources of financial support were from parent, relatives and partners (baby's fathers) when they conducted a study to examine the coping with teenage pregnancy and child birth in Ghana. Teenage mothers having a baby did not only increase the cost of living, but it also reduced the labour force within the family and even created a further financial strain (Weston & Soriano, 2006).

This segment of the results reveals the emotional and psychological aspect of the teenage mothers' experiences with childbirth. It emerged in this study that, about half of the teenage mothers noted that they had been in a good relationship with their baby's fathers, while some of them revealed they had broken up before finding out they were pregnant or have given birth. Besides, most of these fathers, according to teenage mothers, denied them and their babies which affected most of them emotionally and psychologically after childbirth. These findings corroborate with Ahorlu *et al*. (2013). They observed that partners may be a source of stress and conflict for the teenage mothers. However, the findings in the present study appear to contradict that of (Bah, 2016), who noted that pregnant and parenting teenagers most frequently cite their boyfriend as major sources of support emotionally and psychological. Similarly, few of the teenage mothers noted that little financial supports were obtained from partners (fathers of their babies). This finding corroborates with those found in the previous studies by (Badasu 2004).

Teenage Motherhood and Coping Strategies

Results from the study on how teenage mothers cope with the situation of becoming mothers in light of the challenges they face in the KEEA Municipality emerged that almost all of the teenage mothers required support from their parents, close relative/peers, fathers of their babies.

These support help them to cope as teenage mothers. The finding of the study is in line with those that have been conceptualized in the ecological systems theory by Bronfenbrenner (1979). Where parent, peers, relatives and families are part of parenting or motherhood environment embedded within the society that provide care and support for teen mothers.

Similarly, findings of the study by Ungar et al. (2007) seem to support those found in the present study that social support facilitates access to material resources such as food, clothing and shelter, and to educational, medical and employment assistance is also important to overcoming adversity. The finding further corroborates with previous study by (Badasu, 2004) where support offered by parents, peers and teachers has been recognized to play an important role in the emotional and psychological well-being of young teenage mothers. This means that coping is an important construct in understanding how teenage mothers react to the stresses and adjustments they experienced in their lives supported by (Garcia, 2010).

Results of the study on accepting responsibility as a teenage mother revealed that teenage mothers faced challenges with meeting the needs of their babies as well as seeking ways to satisfy their own needs as new mothers. Some of the teenage mothers indicated that they have to sell (petty trading) and juggle with their multiple roles, and make strong decision as responsible mother. Although, the teenage mother were able to identify the key challenging roles and develop coping strategies to overcome those challenges. This finding goes consistent with those found in the previous study conducted in a suburb of Accra by Gyesaw and Ankomah (2013), revealed that adolescent mothers face numerous challenges that place demands not only on the young mother's stage of adolescent development, but also on their ability to adapt to the obligations of parenthood and accepting responsibility as teen mothers.

In a similar vein, support obtained from the fathers of their babies is equally found to be very useful in helping teenage mothers to cope in light of the challenges regarding motherhood. This corroborates that of Neamsakul, (2008), that fathers who have much contact with their children, who are responsible in child caring, and who encourage and support teen mothers from transition to parenthood were claimed to assist in releasing teen mothers' stresses which otherwise would have resulted to emotional and psychological challenges such as stress and depression.

The results of study on sense of being a teenage mother emerged that bearing a child as a teenage mother in the KEEA Municipality was perceived as a challenge for these young mothers and their families. Most of the teenage mothers initially regretted giving birth at this early stage but, were subsequently happy having a child. This finding deputes that of Oweis, (2009), where teenage mothers were unhappy with their childbirth because they were scared and had no control. In this study, Teenage mothers claimed to be good mothers and ensure that they (teen mothers) together with their babies become successful in their life course transition irrespective of the challenges they encounter. This finding corroborates with those found in the previous studies conducted by Awumbila (2008), who found that adolescent mothers face numerous challenges that place demands not only on the young mother's stage of adolescent development, but also on their ability to adapt to the obligations of parenthood and becoming successful in life. Further supported by (Gyesaw & Ankomah, 2013).

In this study, nearly, all teenage mothers had future plans or have good intention of building new dreams/plans for themselves and their children at least for the next five years. It emerged that teenage mothers were more probable to have hope and plans to continue their lives in spite of the challenges they face. Additionally, the teenage mothers began to build new dreams for themselves and their babies. They also saw themselves as adult and believed to be stronger, more conscious, and wiser this time. All of them were convinced that everything happens for a reason. Through all the ups and down in their lives, they still managed to adapt and cope with the circumstances. The findings of the present study go in line with the resilience theory explained by Ledesma (2014), where a person has the capacity to adapt, recover from or remain strong in times of hardship and move on to face the next level of his/her life. The current findings corroborate that of (Badasu, 2004).

The results from this study also indicate that almost all the teenage mothers did not give up (regretted) having babies at such early stage but had plans for their future. Their future plans or aspirations border on education and business (vocational type). The majority of them showed resilience and had positive plans for their future and that of their babies. The findings of current study affirm those found in previous studies by Alemayehu, Haidar and Habte (2009), that a person has the capacity to adapt, recover from or remain strong in times of hardship to ensure successful outcomes. The study also revealed that teenage mothers were confiding in themselves to hold on to their future plans and ensure that they achieve those future plans successfully. This finding corroborates that of Luthar, Cicchetti and Becker (2000), where young mothers showed resilience and the ability to bounce back from adversity, frustration, and misfortune. The findings further Support (Ledesma, 2014), that teenage mothers exhibit resilience and manage to satisfy their own developmental needs as well as those of their children.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents the summary of the study, the conclusion drawn based on the findings and recommendations. It also provides suggested areas for further studies.

Summary

The main objective of the study was to explore teenage mothers' experiences with childbirth in the Komenda-Edina-Eguafo-Abrem Municipality of Ghana. The study was undertaken to:

i. Investigate teenage mother's child care practices.

ii. Evaluate postnatal challenges teenage mothers encounter after childbirth; and

iii. Explore coping strategies of teenage mothers in light of the challenges they face regarding motherhood.

The literature identified provides a background and foundation to the aims and objectives and research questions posed by this study. Health belief model, resilience theory, and ecological systems theory were reviewed and discussed to provide robust theoretical and conceptual basis for discussing and interpreting the experiences of teenage mothers in relation to childbirth. A qualitative descriptive phenomenological research. In-depth interview (IDIs) and pictorial guide were used as a tool to gather data from 30 participants from the five sub-municipal communities in the KEEA Municipality to achieve the aims and objectives of this study.

Summary of the Major Findings

This section provides a summary of the major findings that were obtained from the study.

Findings from the study emerged that teenage mothers (13 to 19 years) experienced postpartum challenges and risks of child birth complications, including postpartum haemorrhage, preterm, low birth weight, and other neonatal conditions. However, nearly about half of the teenage mothers had safe delivery or childbirth without any complications.

The finding on the child care practices revealed that most of the teenage mothers were inexperience. Even though they seem to have knowledge on proper positioning and/or attachment of their babies. Most of them adopted 'popular' child care practices that were part of their family, community culture and beliefs in the KEEA Municipality. Finding suggested that health care professionals need to identify beliefs and practices of teenage mothers to plan quality care for mother-child. Teenage mothers required knowledge, skills and adequate child care information. They also need social support to meet their basic needs to ensure that proper and appropriate materials are being provided for their babies and ensure good, healthy and well-being of their children.

Furthermore, it was observed that teenage mothers had knowledge on feeding practices especially exclusive breastfeeding. However, some of them reported challenges associated with breastfeeding, which included insufficient breast milk, nipple sore, abdominal pain, nipple tickling and other unpleasant situation when breastfeeding. In addition, Teenage mothers who were doing complementary feeding also reported a general use of porridge (koko) as first complementary food 'popular practice' and other foods which are made from cereals based flour such as maize, rice, and cassava. Apart from the formulae (NAN milk), studies have noted that these food are not nutritious and it is even difficult to digest when given to infants or babies.

The majority of the teenage mothers were found to be accessing Postnatal care (PNC) for the first time after childbirth and noted that they benefited from accessing health care services for weighing, immunization and vaccination, medical check-up. Thus, highlighting positive experiences with regards to postnatal services. However, some of the teenage mothers were also reluctant and showed negative feelings in their attempt to access PNC due to some negative attitudes of the health care professionals (nurses) and distance of the health facility, financial reasons. Notwithstanding that, they were found to cope and adapt strategies in controlling and managing childbirth complications and other neonatal challenges. With help of the family and relatives, teenage mothers showed self-confidence and ability to cope with their lives.

Results on accommodation/sleeping strategies commonly used by the teenage mothers were found to be risky. Thus, teenage mothers were more likely to be exposed to disease such as malaria because of where they live and sleeping pattern adopted by the teen mothers. Few of them were observed to be sleeping under treated mosquito bed net. While the majority of them were found accommodated around big gutters, kiosk, containers and other wooden structure. Additionally, teenage mothers were found to be sleeping on mat on bare floor with their babies. Teenage mothers who were using some of these sleeping pattern reported body pains, and body weakness.

The finding of the study revealed that more than half of the teenage mothers expressed their pain of being denied by their boyfriends or baby's fathers. This, therefore, affected most of them emotionally, psychologically and physically. Notwithstanding that, teenage mothers indicated how they can cope regarding their motherhood transition.

The majority of them also showed resilience as a coping strategy by establishing key factors/things such as the opportunity to find work/job, earning income, their abilities and confidence, faith in God and attempt to work hard to meet their unmet needs and ensure that they achieve their future plans and that of their babies for a healthy lives and become good, happy and responsible mothers for their children. In addition, it was observe that most teenage mothers get financial support to take care of themselves and their baby from their families and parents. However, few of them noted that they receive little supports from the fathers of the babies after childbirth.

Again, the findings revealed that some of the teenage mothers were not connected to the institution in the exosystems such as education, Even though most of the teenage mothers regretted being out of school because of the unplanned pregnancy or childbirth, they still showed interest to further their education and even have future plans of providing good education for their children.

The finding of this study revealed that the teenage mothers have no intentions of giving up for giving birth, although they noted some signs of regretting (feeling sad) because of early childbirth. However, it was observed that most of teenage mothers had their own future plans or aspirations which bordered on education and business (vocational type).

Closely, all of the teenage mothers, irrespective of their background, mentioned amazing aspirations for their baby's future as well. These aspirations included educating their baby to become businessmen, good person, have bright future and get good job to take of their mothers when they grow up. They motivated themselves to take their time in life and having hope in God. Also Building strong abilities and capability to cope and make sure they work hard to ensure a successful future for themselves and for their babies. These were linked to the coping strategies.

Conclusion

The study represents the phenomenological perspective of teenage mothers. It also sought to gain a holistic view of teenage mothers' experience during and after childbirth and how the supporting systems played a role in their lives in the KEEA Municipality. The ecological systems theory was utilised where teenage mothers are placed at the centre of their social and health context, and their lived experiences with childbirth were explored. In this study, an in-depth interview and a pictorial guide were used to investigate childcare practices, perceived postnatal challenges and the coping strategies adopted in light of the challenges facing teenage mothers after childbirth in the municipality.

Childbirth complications and maternal implications for teenage mothers are numerous. With WHO (2018) strategies targeted to reduce maternal and child mortality rates and achieving the Sustainable Development Goals (SDGs 3), ensure healthy lives and promote well-being for all at all ages, and the new global strategy for women's, children's and adolescents' health (2016 to 2030) agenda to ensure that women and their babies survive labour complications and reach their full potentials for health and life, it is crucial that attention is given to teenage mothers during and after childbirth. Mitigating childbirth complications is paramount in having less complicated and safe delivery and it requires concerted effort and a shared responsibility of the teenage mothers, family and healthcare professionals (nurses and midwives) and, perhaps, the traditional birth attendance.

In this study, it emerged that teenage mothers know the importance of accessing postnatal (PNC) healthcare but most of them have negative attitudes toward accessing facilities or healthcare services due to financial reasons, attitude of nurses or health workers, distance and proximity of the facilities. Meanwhile, most of the postnatal challenges facing teenage mothers observed could be addressed if they make little effort to have a regular visit or access healthcare services. The community health workers should collaborate with the communities and provide support network through the provision of public health information and community based-strategies to address some of the challenges facing teenage mothers in the municipality.

All teenage mothers in this study required support, knowledge and skills on child care practices. They use 'popular' practices that were part of their family and community culture instead of scientific-based practices given by health professionals when caring for their babies. These practices included using cross-breastfeeding, and unfortified food (raw maize, cereals etc.) as complementary feeding, medicine mixed with powder, palm kernel oil, Shea butter, hot or heated stones and wet towels were applied to the cord stump. Health care professionals must be aware of the 'popular' child care practices and beliefs of teenage mothers in order to plan quality care for new young mothers in the KEEA Municipality. Health care providers (nurses) should recognise and contribute to changing these popular child care practices and provide them with scientific knowledge. Furthermore, teenage mother should exhibit competent skills and confidence, to cope with the new maternal roles and accepting 'motherhood'. The new mothers may need assistance in assuming the maternal role and successfully attaching to their new-borns and provide them with their interventions and modern childcare practices to ensure their total wellbeing and that of their babies.

Teenage mothers identified a need for self-development, continuing education needs and a support system while adjusting to motherhood. GHS, working through the municipality project initiatives with the GES, could establish support systems that focus on teenage mothers. It emerged that teenage mothers were more likely to go back to school (training and vocational) if given the opportunity and the necessary support. Teenage mothers also showed resilience by establishing key factors such as the opportunity to find work/job, earning income, and work hard to meet their unmet needs.

The use of the ecological systems theory allowed for a holistic view into the perspective. It emerged that teenage mothers or participants were well not fully connected and satisfied with the support they receive from the micro system. Therefore, all teenage mothers need to be strongly connected to the micro-system, including the family, parent, relatives, peers, neighbourhood and baby's fathers to require social and financial support (welfare) from the exo-systems such as education, religious affiliations, community and healthcare and social services. In addition, the connection with these systems shall create a friendly environment to have equal access and discuss teenage pregnancy risk and other related sexuality issues to help reduce high prevalence of teenage childbirths in the municipality.

Much attention should be drawn to the municipal assembly, NGOs and the government towards the creation of jobs/employment opportunities for the young people and improving access to quality and affordable healthcare services, and effort at empowering teenagers on Comprehensive Sexuality Education and ASRHR. Competent-based education programs and vocational skill training should be implemented particularly for teenage mothers in the KEEA Municipality. Besides, availability of programmes, resource and interventions aforementioned will help to reduce the high prevalence rate of teenage childbirth in the municipality. In all, the findings presented in this study may have implications for future policies (adolescent reproductive health), maternal and child health, health service provision and other agencies dealing with teenage mothers in the municipality.

Recommendations

Based on the findings and conclusion of the study, the following recommendations are made:

Individual, Family and traditional level

1. Parents need to be encouraged to have strict rules and regulations within the family of teenage girls, but should also create the freedom

within the family for teenage girls to discuss issues related to sex, sexuality and responsible adulthood. Additionally, families in the KEEA Municipality should show much interest in their wards' education and development.

2. Families, the chiefs and the municipal heads (health, schools, churches, NGOs) should review policies and set up by-laws and practices to punish older men who take advantage (impregnate) teenage girls and refuse to take care of them. This will help the teenage girls in the municipality to stop depending on older men in exchange of money and fish for sex to reduce the prevalence cases of teenage pregnancy and childbirth.
3. Training and seminars/workshops should be organised by the Municipal Health Directorate to help educate the TBA's, parents and guardians in the KEEA Municipality on the substances and traditional practices in dealing with childbirth complications, childcare practices that are probable to put young mothers and the babies at a higher risk of dying and encouraging the use of treated insecticides mosquito bed net for teenage mothers.
4. Municipal Health and Education Directorates should educate the chiefs, families and parents to review and eliminate some cultural practices (superstitions), myths and beliefs surrounding breastfeeding and certain foods that can negatively affect both maternal and child health.

Policy level

5. GHS, NHIS should provide massive education on maternal and child health (affordable health care services) for teenage mothers in the KEEA Municipality by ensuring and providing affordable high-quality maternal and childcare services. Nursing mothers should be well informed, supported and encouraged on breast feeding practices to counter negative socio-cultural practices or beliefs.
6. Interventions (scientific-based-knowledge) and programmes that are targeted to support breastfeeding/childcare practices should be recognized by stakeholders, including nurses, especially public health and community health nurses, TBAs at the grass root to ensure implementation of breast feeding policies and practices, aimed at reducing underweight, stunting, malnourished infant, infant morbidity and mortality through recommended feeding practices by WHO and GHS.
7. Effort should be made by all stakeholders, including the Government of Ghana (GoG), the KEEA Municipal Health Directorate (MHD), the family, community and organisations in the municipality to make adequate support, create opportunities and encourage comprehensive sexuality education (CSE) and Reproductive Health and Right (ASRH) and make services available to all teenage girls and expand funding for programmes that evidence shows reduce teen pregnancy and early childbirth.
8. Pictorial guide is also recommended in qualitative data gathering because it helped in reducing limitation of information and also help

to gain at least some modicum and easily access sensitive occurring event whose meaning can be explored in the interview. It also serves as a memory aid and a way of accessing the past and current situations, experiences, emotions, and insight of the participant's experiences during the interview.

Suggestions for Further Research

Although a number of studies relating to teenage pregnancy and teenage mother have been conducted in Ghana, there are still gaps. The following are further suggestions to better understand the social and health context of this category (teenage mothers aged 13 to 19 years) of the population.

First of all, more longitudinal studies can be done to follow up the event and the life course of these teenage mothers and their babies. Such studies can explore the factors associated with positive and negative health outcomes of the teenage mothers and their babies.

Subsequently, a study may look at the correlation of teen perceptions and traditional beliefs associated with childcare practices, exploring the translation of attitudes to behaviour in the promotion of responsible teen motherhood.

It is advisable to conduct a number of different studies on the same subject to help find more solutions, especially to determine the causes of disease, for instance, diarrhoea, malaria in children born to teenage mothers living in poor environmental communities. Longitudinal study researches to inform decision-makers for planning of evidence based programmes for the vulnerable, especially children under two years, which is important for child survival.

Future research can be done to hear the voice of teenage fathers (example, Swartz & Bhana, 2009), as their experiences have been neglected in the KEEA Municipality. Such studies could examine their background and attitude towards teenage girls, sexual behaviour, knowledge of contraceptives, because it was highlighted in the present study that one of the major challenges teen mothers face is that teenage boys have been impregnating them but rejecting and denying their own babies and also introducing them to abortion.

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APPENDIX A

UNIVE RSITY OF CAPE COAST

DEPARTMENT OF POPULATION AND HEALTH

INTERVIEW GUIDE FOR TEENAGE MOTHERS

This interview guide is designed to elicit information from teenage mothers (13 to 19 years) with a child two years old or less in the KEEA municipality. The information provided will be strictly used for academic purposes. The information provided will be given the confidentiality it deserves. Please kindly tick in here **[ ]** if you agreed to participate in the study. Thank you for agreeing to participate.

SECTION A

SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. Age (in completed years)

   1. 13 [ ] 2. 14 [ ] 3.15 [ ] 4. 16 [ ] 5. 17 [ ]

   6. 18 [ ] 7. 19 [ ]

2. Educational level attained?

   1. Primary Level [ ] 2. J.H.S [ ] 3. S.H.S [ ] 4. Tertiary [ ] 5. Other, please specify………………………………….

3. Religious affiliation

   1. Christian [ ] 2. Islamic [ ] 3. Traditionalist [ ] 4. Other, please specify…………

4. Marital Status

   1. Never married/single [ ] 2. Married [ ] 3. Divorced [ ] 4. Separated [ ] 5. Widow [ ] 6. Other, please specify ……………………………….

   6. Current occupation ……………………………………

SECTION B

Thank you for agreeing to speak with me today, as you will remember from the things I told you earlier, if you have any question or concerns during our conversation today, please kindly feel free and let me know ok!. [Notes to interviewer: Probe questions are those bulleted]

Warm up questions

Tell me about your child.

- What is your child's name, is your child a male or female, how old is your child, is your baby big or small, etc.?
- What do you like about your baby?

Objective 1: Assess teenage mother's child care practices

We are going to talk about some child care practices

1. Do you breastfeed your child? *What do you see in the picture (show the pictorial guide)?*

- Can you show me how you hold/position your baby when you breastfeed?
- Why do you think it is important to position your baby this way when you breast feed?
- How do you know if your child is hungry and/or satisfied after breastfeeding?
- Please describe to me any uncontrollable and/or unpleasant experiences when you breast feed your child? Probe for views on *how* and *why* this happened!

2. Do you breastfeed your baby exclusively? *Why*?

- What do you know about exclusive breastfeeding?
- Why do you think it is beneficial to your child?

3. Do you give your baby complementary food? *Why*?

- What do you think about complementary feeding? *What do you see in the picture (Show the pictorial guide)*
- Can you show me how you give complementary feeding?
- Why do you think providing other liquid or formulas does for your baby?
- Why do you give your baby formulas apart from breast milk? Tell me more.

4. What are the challenges you face when breastfeeding your child? For example, nipple sore, tickling, insufficient milk etc.?

- How do you address this problem(s) you have mentioned
- *Ask this in relation to the problem mentioned*

5. Do you bath your child? *What do you see in the picture (show the pictorial guide)*

6. Can you show me how you hold or position your baby when bathing him or her?

7. Which of the child bathing position *(in pictorial guide)* do you think is the best (safe) practice? Why?

- What are the things you use to bath your child and how many times do you bath your child in a day? *Why*?
- What are the challenges you face when bathing your child?
- How did you address that challenge? *Ask this in relation to the challenge mentioned*
- How did you care for your child's umbilical cord? For example, Things you use, how you use it?
- Who else help you to clean it? *interview the person's views on how and whether the things they use is clean or appropriate*

8. Please can you describe where you and your baby sleep?

- *What do you see in the picture (show the sleeping arrangements in the pictorial guide)*
- Which sleeping arrangement do you have/use?
- Why do you think (this one) is appropriate than the others?
- *Ask this in relation to the particular sleeping arrangement preferred/chosen*

9. Apart from you who else takes care of your baby? (*interview the person shortly if available*)

- Please can you tell me about the things you do to support the teenage mother and why? *(probe)*

SECTION C

Objective 2: <u>Examine postnatal challenges teenage mothers encounter</u>

We are going to talk about some PNC challenges that you face/facing after childbirth

1. Please would you describe what happened the day you gave birth to your child?

- Did you experience any postpartum haemorrhage/vagina bleeding, low birth weight child and any complications? *(show the pictorial guide)*
- What happened? *Ask in relation to the complication mentioned*
- Have you been going for postnatal care? (*show pictorial guide) that teen mother visiting PNC*
- Why do you think it is important to access/visit postnatal care (PNC)?

2. How often did you visit the hospital after childbirth?

- What kind of health care services do you access? Family planning, weighing, etc.

3. What major challenges do you face after giving birth to your child (social, health, economic/financial and psychological or any)? Tell me more

4. How did you overcome/address the challenges you have mentioned?

- *Ask this in relation to the challenges mentioned*
- Is there anybody who helps you to address your unmet needs?
- Please tell me some of the things the person does to meet your basic needs?

SECTION D

Objective 3: Explore coping strategies of teenage mothers in light of the challenges they face regarding motherhood

We are going to talk about how you cope or address the challenges you face as a teenage mother

1. What are the major challenges you encounter now as a mother?

- For example, financial problems, sickness, schooling, emotional or psychological, boyfriend or family attitudes toward you etc. Tell me more

2. How do you address the challenges you face as a teenage mother?

- *Ask in relation to each of the challenges mentioned.*

3. How do you take care of your child?

- Please tell me what you do to support your living?
- What kind of support do you get from:
- *Your family,*
- *Your friends,*
- *The father of your child?*
- How do you get sufficient support? *Ask in relation to each of the support mentioned*

4. What can you say or feel about being a teenage mother now? *(show the pictorial guide) that teenage mother is either healthy and happy or unhealthy and sad/regret childbirth*

- Can you show me when a mother is healthy/sad and unhealthy/happy?
- What will you say about your current situation? For example, have you regretted giving birth at this age? Why?
- Can you say you are healthy and happy having a baby at this age? Why?

Ask with the aid of the pictures in the pictorial guide

5. What will you say about your baby's father?
6. What is your plan for your child's future?

- How are you going to ensure that? *Ask in relation to the said future plan(s)*

7. How do you want to see yourself in the future?

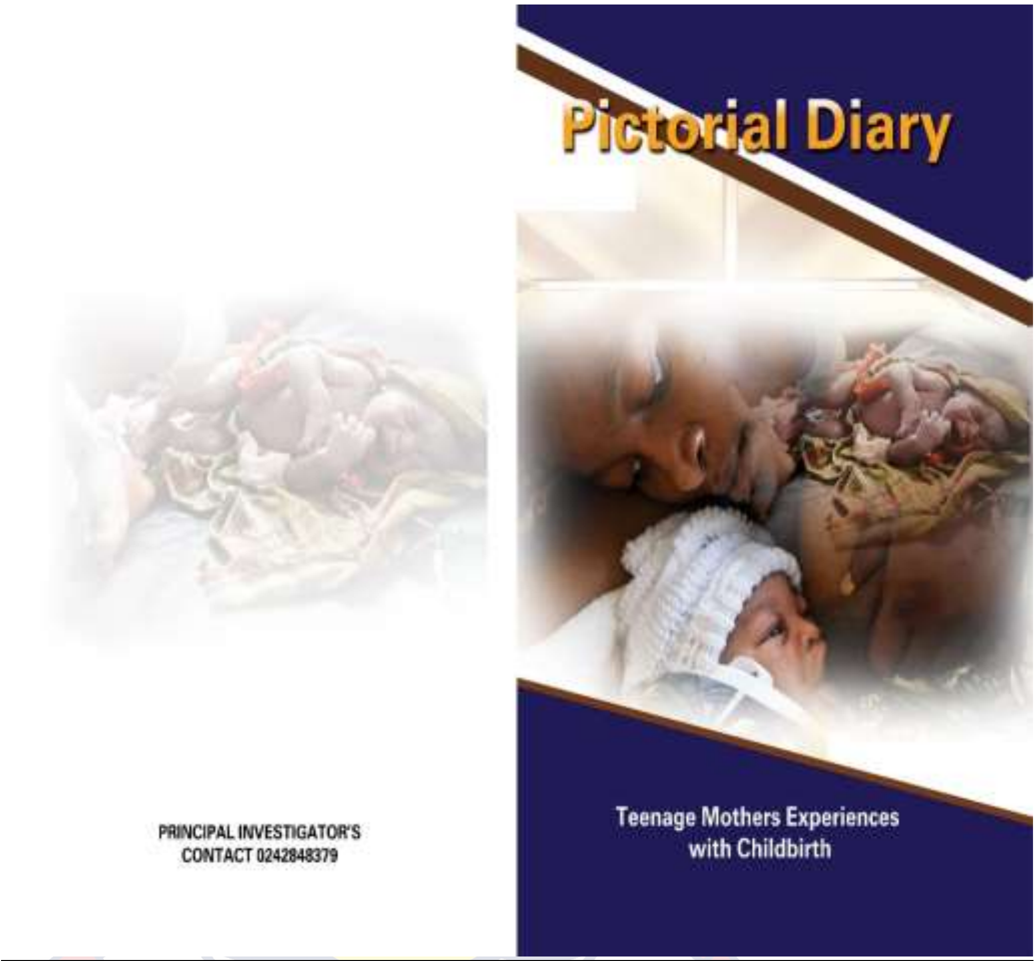
- What do you want to do in five years' time as a teenage mother?
- How can you ensure that you achieve that future plans?
- *Ask in relation to each of the plans mentioned*

8. What advice would you give to teen mothers and other teenage girls who have not yet given birth?
9. Is there anything that you would want to say about the things we have discussed today?

Thank you for your time and participation. I wish you well and have a nice day.

APPENDIX B

PICTORIAL DIARY INTERVIEW GUIDE



PICTORIAL GUIDE FOR TEENAGE MOTHERS' EXPERIENCES WITH CHILDBIRTH

FEEDING POSITIONING AND ATTACHMENT

PICTURE 1 * MOTHER LYING AND BREASTFEEDING
PICTURE 2 * MOTHER SITTING AND BREASTFEEDING
PICTURE 3 * COMPLEMENTARY FEEDING

COMMON CHILD BATHING PRACTICES

PICTURE 4 * SAFE BATHING PRACTICE
PICTURE 5 * RISKY/ UNSAFE BATHING PRACTICE

4

5

COMMON SLEEPING ARRANGEMENT

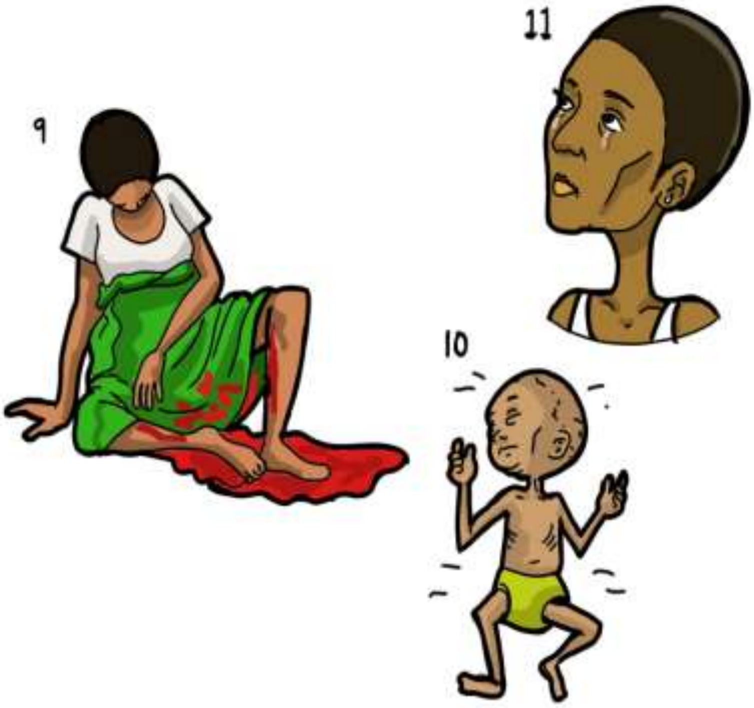
PICTURE 6 * SLEEPING ON MAT
PICTURE 7 * SLEEPING UNDER INSECTICIDE TREATED BED NET
PICTURE 8 * SLEEPING ON MATRESS

COMPLICATIONS OF TEENAGE CHILDBIRTH

PICTURE 9 * POSTPARTUM HAEMORRHAGE / VAGINA BLEEDING

PICTURE 10 * PRETERM/ LOW BIRTH WIGHT/ WEAKLY SICKLY BABY

PICTURE 11 * SIGN OF OTHER RELATED PAIN AFTER CHILDBIRTH/ ABDOMINAL PAIN



MANAGEMENT OF CHILDBIRTH COMPLICATIONS

PICTURE 12 * TAKING PRESCRIBED DRUGS
PICTURE 13 * REPORTING PROMTLY AND REGULARLY TO PNC / HOSPITAL FOR TREATMENT AND ADVICE.

12

13

TEENAGE MOTHER'S CURRENT SITUATION/ COPING MOOD

PICTURE 14 * UNHEALTHY / SAD MOTHER AND BABY
PICTURE 15 * HEALTHY HAPPY MOTHER AND BABY

THANK YOU FOR YOUR TIME AND PARTICIPATION.

I WISH YOU WELL

APPENDIX C

ETHICAL CLEARANCE (LETTER)

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
E-MAIL: irb@ucc.edu.gh
C/O Directorate of Research, Innovation and Consultancy
OUR REF: UCC/IRB/A/2016/370
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

30TH APRIL, 2019

Mr. Reuben Foster Twinoh
Department of Population and Health
University of Cape Coast

Dear Mr. Twintoh,

ETHICAL CLEARANCE – ID: (UCCIRB/CHLS/2019/09)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled **Teenage Mothers' Experiences with Child Birth in the KEEA Municipality, Ghana**. This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

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

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date: 02/05/19

APPENDIX D

INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
COLLEGE OF HUMANITIES AND LEGAL STUDIES
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF POPULATION AND HEALTH

Telephone: 03321-32440/4 & 32480/3 Direct: 03321-30416
0547380265
Fax: 233-34072,UCC, GH
Telex: 2552,UCC, GH
Telegrams & Cabels: University, Cape Coast
Email: pop.health@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DPH/L8/145

23rd January, 2019

Your Ref:

The Chairman
Institutional Review Board
University of Cape Coast
Cape Coast

Dear Sir,

LETTER OF INTRODUCTION

Mr. Reuben Foster Twintoh is a second year MPhil student of the Department of Population and Health, Faculty of Social Sciences, College of Humanities and Legal Studies, University of Cape Coast. His research topic is titled: **"Teenage mothers experiences with child birth in the Komenda-Edina-Eguafo-Abrem Municipality, Ghana".**

We would be very grateful if ethical clearance is granted to enable him conduct his research

Thank you.

Yours faithfully,

Prof. Augustine Tanle
HEAD

Mobile: 0503280195/0243604141

APPENDIX E

IN-DEPTH INTERVIEW GUIDE FOR TEENAGE MOTHERS

"PARTICIPANTS CONCEPT"

Introduction

Good Morning/Afternoon! My name is …………… I am a student of the UCC. I am here, to have a discussion with you about how you take care of your baby and cope as a teenage mother. I would want us to discuss about your experiences with child birth, what you know about breast feeding (exclusive and complementary), talk about postpartum challenges and how you adapt and cope with those challenges you face after child birth. This kind of conversation is between you and me only and I will be visiting other teenage mothers in the municipality in their homes to do the same discussion with them like we are doing today. I will not refer to you by your name because I do not want to associate your name in our discussion. I will use code (ID 1, 2, 3…) to identify you so kindly feel free to express yourself and tell me everything I need to know. However, if there is any particular question you cannot answer just tell me so that I will move to the next question. I would like to write/record this conversation, but with your permission, so that I will be able to capture all the important information and also for the sake of time so that you can have time to continue with your other important things. The recordings will be deleted/erased from the tape recorder/ phone after writing a report out of it for my work. This discussion is solely for academic purposes, but it may help the KEEA municipality, health management, and social welfare to inform policy and practices later after I have written it out/published. I promise not to take more than 60 minutes of your time with the aid of the pictorial guide.

If you agree to participate, I would like you to press the red bottom of the phone or tape recorder and say "YES" I agree (*in Fante, Twi, or English)*

Do you agree to participate in this interview?

PARENT ''PARTICIPANT CONCEPT''

Good Morning/Afternoon!

My name is …………… I am a student of the UCC. I am here, to have a discussion with you about your daughter and her baby. I would want us to discuss about your daughter's experiences with childbirth, I would like to know some of the things that you do to support her when she gave birth. This kind of conversation is between you and me only. I will not refer to you by your name because I do not want to associate your name in our discussion. I will use code (ID 1, 2, 3...) to identify you so kindly feel free to express yourself and tell me everything I need to know about your support for your daughter. I would like to write/record this conversation but with your permission, so that I will be able to capture all the important information and also for the sake of time so that you can have time to continue with your other important things. The recordings will be deleted/erased from the tape recorder/ phone after writing a report out of it for my work. This discussion is solely for academic purposes. I promise not to take more than 10 minutes of your time.

Do you agree to participate in this interview?

If you agree to participate, say "YES" I agree (*in Fante, Twi, or English)*

APPENDIX F

UNIVERSITY OF CAPE COAST

INFORMED CONSENT FORM

TITLE: TEENAGE MOTHERS' EXPERIENCES WITH CHILDBIRTH IN THE KOMENDA-EDINA-EGUAFO-ABREM MUNICIPALITY, GHANA

Principal Investigator: Reuben Foster Twintoh

Address: University of Cape Coast

College of Humanities and Legal Studies

Faculty of Social Sciences

Department of Population and Health

Cape Coast

General Information about Research

The main objective of the study is to explore teenage mothers' experiences with childbirth in the KEEA municipality. Specifically, the study strives to answer the following questions: How do teen mothers take care of their babies (childcare practices) in terms of breastfeeding, bathing, etc.? What are the challenges teenage mothers face after childbirth? How do teenage mothers address the challenges they face regarding motherhood?

Komenda-Edina-Eguafo-Abrem municipality in the Central Region of Ghana has been confronted with a high prevalence of teenage pregnancy and early childbirth. Research suggests that teenage mothers face various forms of challenges during and after childbirth. These challenges have significant consequences or implications on personal, family, society, national as well as global levels and also have a potentially negative demographic and social consequences, and births to teenage mothers have been found to have the highest infant and child mortality. But to understand the incidence or occurrence of teenage childbirth, some of the problems or contributing risk factors should be understood. These factors may vary from social, economic as well as the cultural and psychological background. However, much work has not been done and knowledge and understanding of this young mothers' experiences with childbirth in this context continue to be elusive or difficult to be rarely seen. Therefore, this study seeks to explore teenage mothers' experiences with childbirth in the KEEA Municipality. The study will use a qualitative research design. An in-depth interview guide will be used to gather data for the study. Averagely, each interview section is expected to last for about 50 minutes. Teen mothers would be expected to answer questions relating to their lived experiences with childbirth. Informed consent would be sought from the parents/guardian and participants themselves before they will be included in the study.

Procedures

To find answers to the questions this study seeks to address, we invite you to take part in this research project. If you accept, you will be required to: participate in an one-on-one interview that would be conducted by myself and the field assistants. You are being invited to take part in this study because we feel that your experience as a teenage mother can contribute much to this discussion. The type of questions that are likely to be asked touches on aspects such as your experiences with childbirth, your assessment of the childcare practices, postnatal challenges you encounter after childbirth and, the coping strategies you have adapted or addressing in light of the challenges you faced a teenage mother?

If you do not wish to answer any of the questions posed during the interview, you may say so and the interviewer will move on to the next question. The interview will take place at home, and no one else but the interviewer will be present. The interview will be recorded for recall sake. The information recorded is considered confidential, and no third party will be privy is this conversation except with your express consent. The expected duration of the interview is between 30 and 75 minutes.

Possible Risks and Discomforts

There would be no realistic predictable risks or discomforts to the participants. However, any form of discomforts (psychological or emotional trauma or distress) that may come up as a result of the sensitive nature of the questions. There will be a professional or qualified counsellor to advise you on the issues or the situation and ensure that the participant is sound or healthy (physically, mental/psychologically and socially). This professional or counsellor is a female nurse who works in the Elmina hospital in this municipality and has more experience in maternal and child care services. She has been talking to and advising teenage mothers and other adults who give birth in the facility when there are any possible risks or discomforts. She will keep all the information about you confidential and anonymity will be ensured.

Possible Benefits

Findings from this research have the potential to contribute to health policies and interventions aimed at improving maternal and neonatal health care and help address issues of maternal and child morbidity and mortality and strengthen and ensure good childcare practices in the country. It is also envisaged that the findings will contribute to the existing knowledge of maternal and child health. Findings from this study will again serve as reference material for students, and researchers who are interested in issues of teenage childbirth. Again, the findings from this study will point out areas for future research. The study would be of benefit to the KEEA Municipality as well as Municipal Health Directorates and Health Management Team, Non-Governmental Organisations, Policy Makers and Health Planners for better policy and planning practices.

Confidentiality

The information you give during this interview will be kept confidential and you are assured that we will protect information about you to the best of our ability. The interviews, will be transcribed and soft copies would be kept safe with the aid of '*my dropbox app'* application software. The hard copies (field notes) will be hidden from sight or unauthorized access. After data analysis, the data will properly be destroyed by burning. Data will be kept by the principal investigator. Again, anonymity of respondents will be ensured by using pseudonyms where necessary, instead of the real names.

Compensation

There will be no compensation package in cash to be offered for participation during the interviews but for the appreciation of time, and any inconvenience that we may cause during the interview, you will be given a bar of key soap or baby soap at the end of your participation in the study to show our appreciation. This offer will be made after the data collection because most of the teenage mothers have an idea what the investigators take their information to do so they normally ask for gifts. Nevertheless, this will help and motivate the teenage mothers to open up for the interviews to get more in-depth information to ensure data quality.

Voluntary Participation and Right to Leave the Research

Having to record entries regularly over time may lead to participant fatigue and attrition. The investigator has no control over the participant. Therefore, Participation is solely voluntary and you can choose to exit from the participation at any point in time when you feel uncomfortable with the questions being asked without any penalty.

Contacts for Additional Information

In case you have further questions regarding this study, please contact:

Reuben Foster Twintoh (Mr.): +233 (0)242848379.

Eugene K. M. Darteh (Prof): +233 (0)243717014

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of University of Cape Coast (UCCIRB). If you have any questions about your rights as a research participant, you can contact the Administrator at the IRB Office between the hours of 8:00 am and 4:30 p.m. through the phones lines 0558093143/0508878309/0244207814 or email address: irb@ucc.edu.gh

VOLUNTEER AGREEMENT

The above document describing the benefits, risks, and procedures for the research (Teenage mother's experiences with childbirth in the KEEA Municipality) have been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_______________ ______________________

Date Name and signature or mark of volunteer

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

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

_________________________ _______________________

Date Name and signature of witness

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

_____________________ ___________________________

Date Name and signature of person who obtained consent

INFORMED CONSENT FOR PARENT

Statement of obtaining informed consent

I have fully explained this research to ___________________ and have given sufficient information about the study, including the procedures that on, risks and benefits, to enable the participant make informed decision to or not to participate.

_______________________   ______________________________

Date   Name and signature of parent

Statement of parent or guardian giving consent/accent:

I have read the information on this study/research or have had it translated into a language I understand. I have also talked it over with the interviewer to my satisfaction. I understand that my participation is voluntary (not compulsory). I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it. I understand that I may freely stop being part of this study at any time without having to explain myself.

_______________________   ______________________________

Date   Name and signature of parent

APPENDIX G

EVIDENCE OF NVIVO 12 PRO QUALITATIVE ANALYSIS SOFTWARE

This section presents evidence of the data in the software during the analysis.