CHRISTIAN SERVICE UNIVERSITY COLLEGE

DEPARTMENT OF NURSING

TEENAGE MOTHERHOOD AND ITS PSYCHOSOCIAL EFFECTS ON TEENAGE MOTHERS ATTENDING POSTNATAL / CHILD WELFARE CLINIC AT TAFO GOVERNMENT HOSPITAL

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OCTOBER, 2014

DECLARATION

Students` Declaration

We hereby declare that this project is our own work carried out at the Department of Nursing of Christian Service University College, Kumasi in partial fulfilment for the award of BSc. Degree in Nursing. All references are acknowledged

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Supervisor`s Declaration

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ABSTRACT

Teenage motherhood is associated with increased risk for child and maternal mental health and social problems. Researches in many countries also have confirmed that teenage mothers and their families are often at a disadvantage compared with those whose children are born in their twenties or thirties.

The present study examines the relations between adolescent motherhood and the impact it has on the young mother and her child's psychosocial status at Tafo Government Hospital.

A purposive sampling under the non-probability method of sampling with questionnaires was used to select and seek for information from the respondents. In all 80 teenage mothers out of the total teenage mothers in Tafo Government Hospital were used. The results showed that, most (72%) of the teen mothers were single and also 58% of them ended their education at the senior high level and could not attain higher education hence increasing their rate of unemployment. The findings of the research suggested that, teenage mothers should be encouraged to continue their education if possible or to learn a trade. They should also be counselled on contraceptive use as well as choice of job they want by health counsellors to reduce unemployment.

Finally it was highlighted that, these mothers should be trained and taught good parental practices in raising their children and this should be done by experienced midwives to help prevent these young mothers and the children from several forms of psychosocial problems.

DEDICATION

We dedicate this work to God Almighty who made this project work come into reality.

ACKNOWLEDGEMENTS

Our first and foremost gratitude goes to the Almighty God for good health, strength, commitment and protection throughout the completion of this project work.

The next appreciation goes to the Ag. Head of Nursing department of the Christian Service University College, Mrs. Ernestina Armah and to our supervising tutor, Miss Cynthia Akuoko through her competent guidance and knowledgeable supervision which made this project work come to a conclusion successfully. We appreciate her sensitive and objective editing, recommendations and insight into our work.

Our warmest gratitude goes to the staff of Tafo Government Hospital and respondents for availing themselves and co-operating throughout this research work. We also acknowledge all the lecturers of the Christian Service University College for their immense knowledge impacted into us throughout this study. All we say is, we salute u all.

We are also grateful to all authors and publishers whose work we consulted, either on the internet, from books and journals.

Our gratitude also goes to our colleagues and friends who in diverse ways contributed to this study and all others who were of great help towards the successful completion of this work.

Finally, we say thanks to our family for the moral support, encouragement, concern and financial support shown towards the successful completion of this work.

Almighty God blesses you all.

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INTRODUCTION

1.1 BACKGROUND

The transition from childhood to adulthood may be referred to as adolescence or teenage which has been defined by the World Health Organization (2014) as the period between 10 – 19years.

According to United Nations Population Fund (UNFPA, 2008), teenage pregnancy is defined as teenage girl, usually within the ages of 13-19, becoming pregnant. The term in everyday speech usually refers to girls who have not reached legal adulthood, which varies across the world and become pregnant. Teenage pregnancy and the consequent teen motherhood are among the major societal problems confronting the contemporary global community.

Globally, about 16million teenage girls become mothers every year (World Health Organization, 2014). The United Kingdom (UK) has the highest rate of teenage pregnancies in the Western Europe (United Nations Children's Fund, 2001). Babies of teenage mothers, tends to have a lower than average birth weight and infant mortality in this group is 60% higher than for babies of older women (Social Exclusive Unit, 2009). There is also evidence that the children of teenage mothers are more likely to become teenage parents themselves (Bloating et al, 1998; Kiernan, 1995).

According to Save the Children Campaign in UK (2012), teenage mothers under 15years are five times more likely to die in their 20s whiles babies born to younger mums are also at far greater risk and around 1million babies born to adolescent girls die every year. Babies are 60% more likely to die if their mother is under 18years (Save the children, 2012).

For the United States, teenage pregnancy and childbirth are disproportionately common among poor people of all races because a report by the United States National Research Council (1987) suggests that while large numbers of teenagers of all classes and races are

sexually active, most poor teenagers may be initiated into sex at a slightly younger age than the non-poor (Farley, 2005).

In Ghana, for example, Xinhua News Agency in 1996 reported that an estimate of nearly one-third of the childbirths recorded in public hospitals occurred to women under 19 years of age and this situation is even more dramatic in the rural areas as well as small to medium-sized towns which are often under-represented in the hospital birth statistics (Twumasi-Ankrah et al, 2000).

A survey conducted by the UN Regional Institute for Population Studies (2003) reported that one out of three girls aged 15 to 19 living in Ghana's Central Region has had a child. The area's fertility rate is 5.6 %, compared to the national rate of 5.5 % (Xinhua News Agency, 2006).

According to the World Bank (2010) report on Ghana reproductive health as an indicator, it report that percentage of women ages 15 – 19 who have had children or are currently pregnant in Ghana was reported at 13.30%.

The prevalence of teenage pregnancy has become very common in the Ghanaian society, especially among youth who are at the Primary and Junior High School (JHS) levels of education (Kunateh, 2009). Teenage pregnancy is caused by lot of factors. According to Amoako (2005), the major contributing factor to teenage pregnancy is poverty. Many children in Ghana are victims of teenage pregnancy just because their parents do not have enough money to support their education or even provide three square meals for the family. Based on this, the teenagers are forced to engage in premature sex to earn money to support their education or even provide three square meals for the family. Many other children also involve themselves in premarital sex because of curiosity. It is a common knowledge that teen years present such a person with various challenges relation to sex. A few teenagers are able to overcome the challenges but in most cases, many of them fall into it (Amoako, 2005).

In most Ghanaian communities, children are not allowed to discuss sex issues openly, unlike the olden days when they received sex education through the performance of puberty rites. In contemporary times due to urbanization and industrialization, these rights are seldomly performed in addition to lack of parental guidance. At present, the only form of education these teenagers have from their parents or guardians is a warning to refrain from sex while the required parental guidance and discipline of adolescents is relinquished to teachers at school (Keller et al, 1999)

1.2 PROBLEM STATEMENT

Teenage pregnancy and the consequent teen motherhood are among the major societal problems confronting the contemporary global community and Ghana is no exception (Akunu, 2005). World Health organisation Statistics for 2014 indicates that about 16 million girls aged 15 to 19 give birth each year, representing 11% of all birth worldwide where 95% of these births occur in low and middle – income countries (WHO, 2014). The average adolescent birth rate in middle income countries is more than twice as high as that in high – income countries with the rate in low-income countries being five times as high. These proportions of birth that take place during adolescence are about 2% in China, 18% in Latin America and the Caribbean and more than 50% in Sub-Saharan Africa (WHO, 2014).

In Sub-Saharan Africa, the issue of teenage pregnancy is very worrying. The regional average rate of birth per 1000 (females 15 – 19 years of age) is 143, ranging between 45 in Mauritius to 229 in Guinea. This is very high compared to the world average of 65. In some Sub-Sahara African countries, including Mauritius, Guinea, Ghana, Democratic Republic of the Congo, Ethiopia and Nigeria, one in five adolescent females gives birth each year. In some African countries, 30 – 40% of all adolescent females experience motherhood before the age of 18 (Senanayake & Ladjali, 2004).

In Ghana, statistic conducted by the Ghana Health Service (GHS) in 2012 revealed that about 750,000 teenagers between the ages of 15-19 became pregnant.

In 2013, it was reported that 21,171 teenagers at various health centres were detected to be pregnant whilst 20,720 cases of teenage pregnancy were recorded in 2012 (Ashanti Regional Directorate of Health, 2013).

From the above statistics provided, it indicates that teenage pregnancy and teenage motherhood has been of high prevalence in the Ashanti Region, the country as a whole (WHO, 2014).

It is in the light of this that this research is undertaken to investigate the effects of teenage motherhood and its impact on the mother and child's psychosocial status in the Tafo township in the Ashanti region of Ghana..

However, less attention has been given to its psychological and social effects on both the mother and the child. Only a few have explored the psychosocial effects on the children as well as the teenagers in relation to pregnancy, delivery, and early motherhood. Teenage motherhood is associated with increased risk for child and maternal mental health and social problems such as unemployment, school dropouts, inability to practice exclusive feeding, bad upbringing of the infant etc. This study is to examine the relations between adolescent motherhood and the impact it has on the young mother's psychosocial status.

1.3 RESEARCH OBJECTIVES

1.3.1 Main Objective

The goal of the study is to determine the psychosocial effects that affect teenage mothers during pregnancy, delivery and afterwards.

1.3.2 Specific Objectives

1) To determine the psychological and social status associated with teenage mothers.
2) To determine the type of parental practices given by most teen or adolescent mothers.
3) To find out whether teenage motherhood has negative or positive impact on the young mother and the child's psychosocial status.
4) To analyse the relationship between early motherhood and the psychosocial status of the mother and child.

1.4 RESEARCH QUESTIONS

1. What are the psychological and social statuses associated with teenage mothers?
2. What parental practices are offered by the teenage mother to their children?
3. What are the negative or positive impact of teenage motherhood on the psychosocial status of the mother and the child?
4. What relationship exists between early motherhood and the psychosocial status of the mother and child?

1.5 SIGNIFICANCE OF THE STUDY

The purpose of this study is to identify the exact impact early motherhood among teenagers has on the young mother and child.

This study would help to educate the teenagers on the consequences of early motherhood relating to their psychosocial state. In this review, the study would explain how teen parenting can affect their state of mind and their behaviour in caring for the baby and training the child when he or she is older. Another significance of the study is to reveal most of the psychosocial problems teen mothers and their children go through as a result of early motherhood. This will identify whether it has affected

their state of mind or their relationship with other people. Therefore, these results would assist any psychologist or care giver to give proper diagnoses for appropriate treatment, thus, if medical treatment, supportive or psychological therapy is given accordingly.

1.6 LIMITATION OF THE STUDY

The study was challenged due to time constraints and financial resources.

1.7 DEFINITION OF TERMS

Teenager or adolescent: Is a transition from childhood to adulthood aged between thirteen (13) and nineteen (19).

Mother: this refers to a female parent of a person.

Motherhood: this is a state or condition of being a mother by protecting, nurturing and catering for a child.

Teen motherhood: this is a state where a teenager gives birth and begins to adopt the duties of a mother.

Status; it is the level of importance of a particular discipline.

Psychology: psychology is the scientific study of the human mind and their behaviour.

Sociology: this is the systematic study of the social behaviour and human groups. Thus the study of the inter relationship between individuals in a particular society.

Psychosocial status: this is the state of a person with respect to kind of behaviour displayed towards others or himself and his/her ability to interact and relate normally with one another at a particular time

CHAPTER TWO

LITERATURE REVIEW

2.1 OVERVIEW OF TEENAGE MOTHERHOOD

Teenage motherhood is the state where a teenager assumes the responsibilities of a mother, thus going through the process of pregnancy and delivery, and thereafter begins to cater for the baby through growth and development. It is difficult to define exactly what constitutes teenage motherhood because of inconsistencies in defining its age limits, but studies focusing on the causes and consequences of teen motherhood typically include young women 15 - 19 years old. Although births occur among adolescents younger than fifteen, they are often included only in aggregate national statistics. Childbearing among children under age fifteen is considered socially problematic in almost all industrial cultures.

Teenage mothers and their families have also been shown to experience social disadvantage on such measures as education, housing, employment and family income. In practice, the medical and social problems are probably not as independent as they may seem, since the medical problems may be associated as much with low levels of care as with any straightforwardly physiological difficulty associated with early conception (SEU 2009).

UNICEF (2001) Innocenti Research Centre has been conducting a major review of teenage motherhood. A key component of the enquiry is a comparison between western countries in the risk of teenage motherhood, in the disadvantages for mothers and for children associated with early parenting, and in the policies adopted to address the issue. Although the outcomes of teenage motherhood have been well-studied within various countries, each research project has been carried out independently to find out the results. Consequently, several authors have concluded that a mother's age at her first birth influences her child's cognitive and psychosocial development and eventual adult adjustment.

A research by Boden et al (2008) elaborated that, early motherhood was associated with higher levels of mental health disorders, higher levels of welfare dependence, lower levels of workforce participation, and lower income. Their findings suggest that early motherhood puts young women at risk for educational underachievement and poorer economic circumstances. The linkages between early motherhood and later mental health difficulties can largely be accounted for by childhood, family, and related circumstances that occurred prior to parenthood.

Perhaps the most obvious correlate of adolescent childbearing is privation: teenage mothers are twice as likely to be impoverished as adults (Hoffman et al, 2000) and more likely to receive welfare (Moore et al, 2003), although the extent to which these adverse social outcomes are a product of adolescents' disadvantaged background, versus the pregnancy itself, is debated (Geronimus & Korenman, 2004).

Children of teenage mothers are at higher risk of developing mental health disorders such as anxiety disorders and depression (Moore et al, 2003) Adolescent childbearing was not significantly associated with elevated mental health problems for children born later in a mother's life. This finding is consistent with Grogger (2007), who found that male children born to adolescent mothers had higher incarceration rates than their later born siblings. Again Turley (2003) found that maternal age at first birth was more predictive of later born children's cognitive test scores than maternal age at children's own births. Jaffee et al (2001) also found that maternal age at first birth significantly predicted early school leaving, unemployment, early parenthood, and violent criminal offending in young adult offspring, above and beyond maternal age at offspring's' own birth.

There is an essential difficulty in resolving the extent to which adolescent childbearing causes offspring psychopathology: Adolescent mothers differ from adult mothers in many respects other than age. Obviously, one cannot randomly assign children to be born to

adolescent versus adult mothers. Moreover, many of the "upstream" variables at play in a teenage woman's life before her pregnancy predict both her age at first birth and also her children's functioning, and thus may account for the relation between adolescent motherhood and child psychopathology. For example, impoverished women are more likely to give birth as adolescents (Geronimus, 2004), and poverty is associated with increased risk for antisocial behaviour in childhood and adolescence (Christ, et al., 2000).

A research by UNICEF innocent research centre (2001) confirms that families with a teenage mother were indeed worse off in several respects than families whose mother has had her first child in her twenties or thirties. Thus a high risk of poverty, for example, is an 'outcome' of teenage motherhood. Is this a 'consequence' of teenage motherhood? Can we be confident that the same women would have had a lower risk of poverty if they had decided to delay their family until, say in their late twenties? Suppose women from disadvantaged backgrounds were much more likely to become pregnant in their teens, they might have had a high risk of eventual poverty, even if they had not had a child so early. If so, their poverty should be ascribed to their background, rather than to their early parenthood. It also emphasized that, Teenage mothers were more likely to experience disadvantageous outcomes than other women, even after the influence of family background had been taken into account. In fact most of the apparent difference in risk was attributable to the age at which the woman had her first child, rather than to her childhood experiences.

2. 2 QUALITIES OF ADOLESCENT MOTHERS' PARENTING

The quality of adolescent mothers' parenting has been the focus of much research especially by Brooks-Gunn & Furstenberg, (2006). They focused on adolescents' behaviour in the context of mother-infant interactions and compared adolescent mothers to adult mothers. Regarding the latter trend, the general conclusion of these studies is that, adolescent mothers, when compared to adult mothers, are reportedly less sensitive, less verbal, and less

responsive to their infants' interactional cues. However, most studies do not control for the socioeconomic factors associated with early child-bearing. When such controls are implemented, few differences emerge between the parental behaviour of teenage mothers and adult mothers (Brooks-Gunn & Furstenberg, 2006).

Moreover is important to recognize that not all adolescent mothers parent are alike. Some teenagers lack the maturity and sense of responsibility to adequately nurture their children, whereas others adjust well to the stresses of parenting and provide favourable care giving. The other trend ascribed to the studies of adolescent mothers eliminate that of examining exclusively their behaviours and overlook the importance of the psychological components of parenting, such as adolescents' parenting attitudes and values perceived.

To summarize the qualities of adolescent mothers' parenting, the aetiology of depression and how early and unplanned onset of parenthood may impact the course of depression and child neglect. Again due to the early child bearing, the mother experience lack of knowledge, inexperience, and resources that may impede individuals from acting. Again becoming an adolescent mother often takes the teen off society's normative life trajectory. The adolescent is no longer able (or as able) to participate in age-typical social events and sports, nor is she able to date as easily. The early onset of parenthood often inhibits the development of stable relationships and in many cases; the adolescent mother often faces the daunting responsibility of being a parent with minimal or no support from a partner (Brooks-Gunn & Furstenberg, 2006).

As with an older mother, an adolescent's attitude toward parenting influences her parenting style; mothers who place inappropriate expectations on the child are likely to use harsh and rejecting discipline strategies. Such strategies are linked with child anger, low self-esteem and social withdrawal. Furthermore, mothers with intense feelings of inadequacy and failure

in the parenting role tend to withdraw emotionally and physically from the infant. This withdrawal has been linked to angry and resistant infant behaviours and troubled mother-child relationships (Brooks-Gunn & Furstenberg, 2006).

To add more, even though adolescent mothers assume a great deal of adult responsibility by becoming a mother, they are still children themselves and the grandparents continue to have an obligation to meet their daughters' needs. Further, it is often the case that adolescent mothers are the children of adolescent mothers themselves, who may not have adequate time, energy, and resources to provide support to their daughters. These combined factors often place the adolescent mother in an environment where there is little support for her needs, which in many cases, may translate into the adolescent mother becoming depressed and not being able to, or wanting to, provide for the needs of her new-born child.

2.2.1 Emotional Effects

A teenager will experience intense emotions as soon as she has realized she has missed a period. Her emotions may start out as confusion, fear, excitement, frustration, and resentment. As she tries to figure out how she feels about being pregnant, how she will tell her parents, and what she will tell the father of the baby, she will naturally be very overwhelmed. There are many choices to make early on in pregnancy that she will need to face such as ending the pregnancy, giving it up for adoption, or keeping the baby. These are big questions that many young women are not ready to face. All of this intense emotional upheaval interferes with her education and completing assignments and tests in school. Some pregnant teens are so overwhelmed they may contemplate suicide, dropping out of school, or running away rather than face their parents or deal with these life-changing decisions (Donna, 2006).

2.2.2 Physical Effects

Once you are pregnant, there is no easy way out physically. The options you have when you are pregnant are the same, whether you are an adult or a teenager. The Morning after Pill, also known as Emergency Contraceptive can be taken up to five days after having unprotected sex and this can make you sick for several days. However, is considered safe and effective. It has to be used immediately following intercourse. Using it after you already know you are pregnant is too late (Donna, 2006). Abortion as a means to end a pregnancy has psychological and emotional consequences of which some are more intense depending on your belief system. Some states require parental permission to undergo an abortion. There are physical risks to abortions, but most in-clinic abortions are considered safe (Donna, 2006).

2.2.3 Giving Birth/ child birth

Pregnancy and giving birth to the baby is another option you have when you are pregnant. You still need to decide if you will keep the baby or give it up for adoption. Pregnant teen girls may have a normal, healthy pregnancy if they are healthy before becoming pregnant, go to the doctor for pre-natal visits, avoid drugs and alcohol, and eat healthy food. Morning sickness, being tired, and just being pregnant in general may interfere with school, work, and social activities. A teenager who does not go to her prenatal visits and does not take good care of herself is at greater risk for: Fatal death, High blood pressure, Anaemia, Labour and delivery complications, Low-birth weight infant (Donna, 2006).

2.2.4 Too-Early Childbearing Often Harms the Health of Both Mother and Child.

According to Yinger Sherbinin and Ochoa (2002) early childbearing may be life-threatening to both the mother and the child. Mothers younger than 17years face an increased risk of maternal mortality because their bodies are not yet mature enough to bear children. These young women may not recognize the symptoms of pregnancy or may not wish to

acknowledge a conception, delaying prenatal care and endangering the health of the child and mother.

2.2.5 Delivery Effects

Teenage mothers are generally regarded to be at increased risk of instrumental delivery (Konje et al., 2002; Bacci et al., 2003) and Caesarean section (Moerman, 2004; Khwaja et al., 2006), yet the reason for the high incidence of operative deliveries has not been satisfactorily explained. It has been suggested that the physical maturity of the teenage mothers was the underlying factor (Moerman, 2004). However, teenage pregnancies are also associated with increased incidence of complications such as preterm labour (Zhang and Chan, 2005; Fraser et al., 2005) and low birth weight (Naeye, 2008) could also be associated with increased Caesarean section rate. A high operative and Caesarean delivery rate could therefore be the consequence of these complications rather than of the physical maturity of teenage mothers (Bacci et al., 2003; Zhang and Chan, 2005), and foetal growth retardation (Elster, 2004; Fraser et al., 2005), all of which could have been indications not only for instrumental and Caesarean delivery, but also for induction of labour.

2.2.6 Post-Term Deliveries Effects

The higher frequency of occurrence of low-birth weight babies in the teenage-group than control is the most common reason in such cases. The teenage mothers had a significantly higher number of preterm deliveries compared to the adult mothers while the reverse was noted in post-term deliveries. Such a high incidence of preterm labour leads to higher risks for neonates. Many authors from developed countries have reported an association between teenage pregnancy and preterm delivery (Gilbert et al., 2004)

Low birth weight is a key predictor of malnutrition and an important determinant of child mortality (Kushwaha et al., 2003). One of the most detrimental outcomes of low birth weight is growth retardation, and if the new-born happens to be a girl, it perpetuates a vicious cycle

of female malnutrition throughout adolescence and adulthood. This process gives rise to a condition of intergenerational transmission of physical (small mothers have small babies), social and economic disadvantages into the next generation (Mehra & Agrawal, 2004).

2.3 PSYCHOSOCIAL RISKS TO THE ADOLESCENT MOTHER

Adolescent parents and their children represent populations at increased risk for psychological, developmental, and social problems which include Poverty, mental and behavioural disorders, lack of education, and inadequate family, any children live with their adolescent parents alone, or as part of an extended family (Geronimus et al, 2004). According to Turley (2003), teenage motherhood places both the young mother and her child at predisposition for various problems, including low educational attainment, high unemployment, greater dependency on welfare, parents, relatives and lower levels of psychological functioning for mothers. Hence most teenage mothers add up their financial problems to their parents' or families and therefore increase the constraints at the home which makes them susceptible to all forms of psychosocial problems (Turley, 2003).

The employment status of mothers varies according to many circumstances. Women who had their first births as teenagers are less likely to be in employment than women in all other age-at-first-birth categories.

For the lone parents, the mother may be the only source of earnings. In couples, there are two potential earners, and the mother's earnings may not be seen to be so crucial. Nevertheless, there are issues to be resolved: between the traditional belief that women with children should remain at home or have minimal participation in the workforce, on the one hand; and the need to increase the family income and maintain a sense of personal economic independence, on the other (Pogarksy, & Farrington, 2007).

A study by Furstenberg et al, (2007) focus that, teenage mothers are less likely to be employed than other mothers. Their overall analyses suggested that, early childbearing

decreased the likelihood of a woman being in employment, and that it was not necessarily having a baby as a teenager that put her at a disadvantage. They have shown that, young parenthood is associated with curtailed educational attainment and increased likelihood of lone parenthood, which, taken together, help explain why women who had their first birth at a young age were less likely to be in employment.

The correlation between earlier childbearing and failure to complete high school reduces career opportunities for many young women (National Campaign to Prevent Teen Pregnancy, 2002). A study by Coley and Chase-Lansdale (2008) found that, 60% of teenage mothers were impoverished at the time of giving birth. Additional research by National Campaign to Prevent Teen Pregnancy, (2002) found that nearly 50% of all adolescent mothers sought social assistance within the first five years of their child's life. A study of 100 teenage mothers in the United Kingdom by Social Exclusion Unit (2009) found that only 11% received a salary, while the remaining 89% were unemployed. Most British teenage mothers live in poverty, with nearly half in the bottom fifth of the income distribution (Elster et al, 2004).

It should be noted that, employment dropped among women who had children later than their early thirties, however, and this may represent a cohort effect in which earlier generations of women were less likely to combine work and motherhood.

2.4 PSYCHOSOCIAL RISKS TO THE INFANT

Children of teen mothers had increased risks for poor health, and social outcomes nearly equal to those seen in children of teen mothers. Combined, these relatively few children experienced a large share of the negative outcomes occurring among young people (Jutte et al., 2010). The results suggest the need to expand the definition of risk associated with adolescent motherhood and target their children for enhanced medical and social services (Jutte et al, 2010).

Early motherhood can affect the psychosocial development of the infant. The occurrence of developmental disabilities and behavioural issues is increased in children born to teen mothers. A study by Hofferth and Reid (2002) suggested that adolescent mothers are less likely to stimulate their infant through affectionate behaviours such as touch, smiling, and verbal communication, or to be sensitive and accepting toward his or her needs. Another study by Crockenberg (2007) found that those who had more social support were less likely to show anger toward their children or to rely upon punishment.

The adolescent mothers compared with older mothers of similar parity and socioeconomic status, adolescent mothers tend to vocalize, touch, and smile at their infants less, to be less sensitive to and accepting of their infants' behaviour, and to hold less realistic developmental expectations. Deficits in cognitive and social development in the children of adolescent mothers may persist into adolescence. Adolescent mothers who have more social support exhibit less anger and use less punitive methods of parenting than adolescent mothers with fewer social supports. The adverse effects of adolescent motherhood for offspring mental health may be more evident as offspring themselves transition into adulthood, as it has been previously suggested by Brooks-Gunn & Furstenberg (2007).

Adolescent mothers may not be trained in appropriate stimulation techniques and may be coping with stress in their own lives, on-going education and support by the paediatrician and other nurturing adults is imperative to help prevent negative sequel in their offspring. Children of adolescent mothers who continue to have close ties with the child's biological father with good employment status have better education, employment less depressed, and are at less risk of becoming adolescent parenting themselves. However, children of adolescent parents, without paternal involvement, remain a group at risk, with a high rate of school dropout, incidence of depression and incarceration as well as risk of adolescent parenthood.

CHAPTER THREE

METHODOLOGY

3.1 STUDY AREA

Tafo is a town in Kumasi Metropolitan District in the Ashanti region of Ghana near the regional capital Kumasi. Tafo is the thirtieth most populous settlement in Ghana, in terms of population, with a population of 60,919 people recorded in 2012. Because of the town's population and housing development in recent years, it is debatable whether Tafo is still regarded as a separate town, or already a suburb of Kumasi which is the capital of the Ashanti Region. The town is near Kumasi, with a distance of approximately 3.3 kilometres to the centre of a similar name sounding village named New Tafo and must be distinguished from Tafo. Tarkwa is located just 4.6km away from Tafo. The city centre of Kumasi is located approximately 9.8kilometers. Tafo is one of the urban constituencies of the Kumasi Metropolitan Assembly.

Tafo serves as the regional headquarters of the Ashanti – king in history with its chief as Tafohene. There is an important Cocoa Research Institute at Tafo which was opened in June 1983 with 1,000 former employees. Now, there are about 200 employees who perform essential research and monitoring activities in the area of cocoa cultivation.

With healthcare, Tafo Hospital is a major hospital in Tafo which serves as a health care institution for the local population and also plays a major role in the overall well-being of the Town's population.

3.2 STUDY DESIGN

A descriptive cross sectional study was used for this research. The design for this study falls under quantitative research design. It involves the investigation of the phenomenon in a rigorous and controlled design using precise measurements (Polit and Beck 2006). This study utilised non-experimental because some human characteristics are not subject to experimental

manipulation because of ethical implication (Polite and Beck, 2006). The descriptive method under non experimental research design was further be used in this study. It was used to obtain information about the characteristic of phenomena within a particular field of study. The purpose of using on descriptive design is to provide a true picture of the situation as they naturally happen by observing, describing and documenting. The design was expected to yield a true picture of teen motherhood and how it can influence the mothers and their children psychosocial status in Tafo.

3.3 STUDY POPULATION

The study population comprised of teenage mothers from age 13-19, attending the Postnatal and Child welfare Clinic at Tafo government hospital.

3.4 TECHNIQUES/ INSTRUMENTS FOR DATA COLLECTION AND ANALYSIS

Questionnaires and interviews were used to collect information for the research work. The questionnaires were constructed in such a way that information gathered can cover the research objectives. The questionnaires were administered among the respondents and those who could not read and write were assisted by reading and interpretation of the questions but the literates were given the chance to answer the questions by themselves. The questionnaires consist of closed ended and opened ended questions. Collected data were collated and presented in tables and graphs using Epi Info Version 7.

3.5 SAMPLING AND SAMPLING TECHNIQUES

Purposive sampling was used to arrive at the sample size because the respondents have common characteristics. The teenage mothers were fished out from the entire attendants during clinic days using the postnatal registration book to answer the questionnaires.

This was done because the teenage mothers form the main target group and are relevant to the topic. The sampling technique was used to select 80 respondents from the Postnatal and Child welfare Clinic.

3.6 ETHICAL CONSIDERATIONS

The purpose of the study and its benefit, including aspects of privacy, anonymity and confidentiality were explained to participants and informed that they can refuse to participate in the study or discontinue their participation at any stage. Oral consents were again sought from the teen mothers before the administration of the questionnaire as they accepted to participate in the study.

3.7 VALIDITY AND RELIABILITY

The questionnaire was clear and structured according to the respondents understanding. The questionnaire was given to statistician to go through to ensure validity. To ensure reliability, some pretest questions were given to respondents with same characteristics at the Maternal and Child Health Hospital, Adum.

Ambiguities and errors were corrected before the final administration of the questionnaires.

CHAPTER FOUR

ANALYSIS OF THE RESEARCH DATA

4.1 SECTION A: DEMOGRAPHIC DATA

This section sought to identify the age, educational status, marital status, religious background, employment status, spouse employment status, main source of income, whom the respondent live with and type of accommodation of respondents.

Table 1.DEMOGRAPHIC DATA

Ages of Respondents		
Age	**Frequency**	**Percentage**
13-15	17	21
16-19	63	79
Total	**80**	**100**
Educational Status of Respondents		
SHS	45	57
JHS	25	31
Primary	5	6
Non Formal Education	5	6
Total	**80**	**100**
Marital Status of Respondents		
Single	57	72
Cohabitating	14	17
Married	9	11
Total	**80**	**100**

Religion of Respondents		
Christianity	57	71
Islamic	20	25
Traditional	3	4
Total	**80**	**100**
Employment Status of the Respondents		
Employed	16	20
Unemployed	64	80
Total	**80**	**100**
Employment Status of the Respondents Spouse		
Employed	6	67
Unemployed	3	33
Total	**9**	**100**
Main Source of income of Respondents		
Own employed	11	14
Husband	8	10
Mother	48	60
Other Relatives	13	16
Total	**80**	**100**
Whom the Respondents Live with		
Parent	59	74
Spouse	10	13
Alone	6	7
Friends	5	6

Total	**80**	**100**
Type of Accommodation of the Respondents		
Compound house	41	51
Flat	6	7
Self-contain	10	13
Single room	23	29
Total	**80**	**100**

Source: Field work 2014.

Out of eighty (80) respondents, 21% of the mothers gave birth to their first child within 13 to 15 years whilst 79% mothers also gave birth from 16 to 19 years.

Majority 57% had completed senior high school (SHS) whilst 6%being least for primary level as well as those with non – formal education level. As to the reasons for stopping school, 40% of the respondents attributed their reasons as a result of pregnancy whilst 3% indicated that they have deferred but will continue later after delivery.

About 72% of the respondents were single with none of them being divorced.

A large percentage of respondents being 71% were Christians and the least 4% being traditionalists.

With the employment status of the respondents, 80% of them were unemployed and the remaining 20% were employed and out of those who were employed, 18.75% indicated that they were porters.

Also, out of the 9 married teenagers 67% of them have their spouse employed whilst 33% were unemployed.

The respondents were asked of their main source of income and 60% stated that they are dependent on their parents (mothers) and 10% asserting their husbands as their main source of income.

Approximately, 74% of the respondents live with their parents and 6% of them with their friends. Among these respondents, 51.25% being majority asserted that they lived in a compound house against 7.50% that lived in flats.

4.2 SECTION B: OBSTETRICS DATA

Table 2: **Obstetrics Data I**

Number of Children by Respondents		
	Frequency	**Percentage**
1	69	86
2	11	14
Total	**80**	**100**
Ages of Children		
0 – 1year	38	42
1 ½ year – 2years	23	32
2½ years – 4years	13	18
4½ years and above	6	8
Total	80	100
Gestational Age in Months of Respondents		
8 Months	7	9
9 Months	65	81
Above 9 Months	6	7
Below 7 Months	2	3
Total	**80**	**100**

Table 2 above, 86% respondents had one child whilst 14% had 2 children at their ages.

The respondents were asked for the ages of their children and out of the 80 respondents, 42% said their children were within 0 – 1year, whiles the least 8% falls within 4 ½ years and above.

The Table further indicates that, 81% of the respondents conceived for 9 months till they delivered whiles minimum of 2% conceived below 7 months as premature babies.

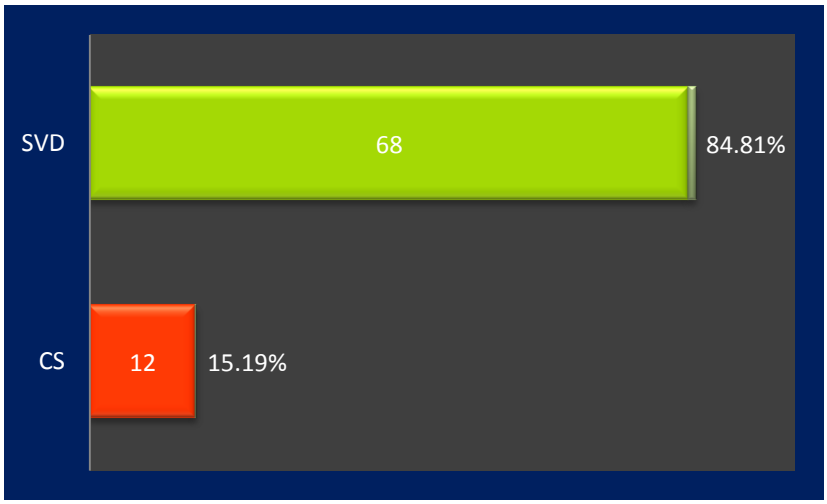

Figure 1: Mode of Delivery

The respondents were asked the mode by which they delivered and out of the total teenage mothers 80, 15% of them delivered through caesarean section (CS). And 85% the rest delivered by spontaneous vaginal delivery (SVD).

Table 3: Obstetrics Data II

Abnormality after Delivery		
	Frequency	**Percentage**
Present of abnormality	3	4
Absent of abnormality	77	96
Total	**80**	**100**
Immunizations		
All immunization received	72	90
Immunization not fully received	8	10
Total	**80**	**100**
Childhood Diseases		
Present of childhood disease	4	5
Absent of childhood disease	76	95
Total	80	100
Exclusive Breastfeeding		
Exclusive breastfeeding done	50	63
Exclusive breastfeeding not done	30	37
Total	**80**	**100**

From the above table, 96% of the respondents claimed that their children had no abnormality after delivery whilst 4% admitted that their children had few abnormalities.

On the immunizations of the children, 90% of the mothers stated that their children have had the full course of immunization but 10% said they have not completed.

Prior to that, 95% of the mothers confirmed that, none of their children suffer from any childhood disease but rather 5% of them said their children did suffer some diseases like measles, whooping cough and kwashiorkor.

Sixty - three percent (63%) of the respondents being the majority did practice exclusive breastfeeding whiles 37% did not exclusively breastfeed their children with most attributing their reasons to insufficient breast milk production and least of them indicating lack of knowledge on it as well as others not in support by their nannies.

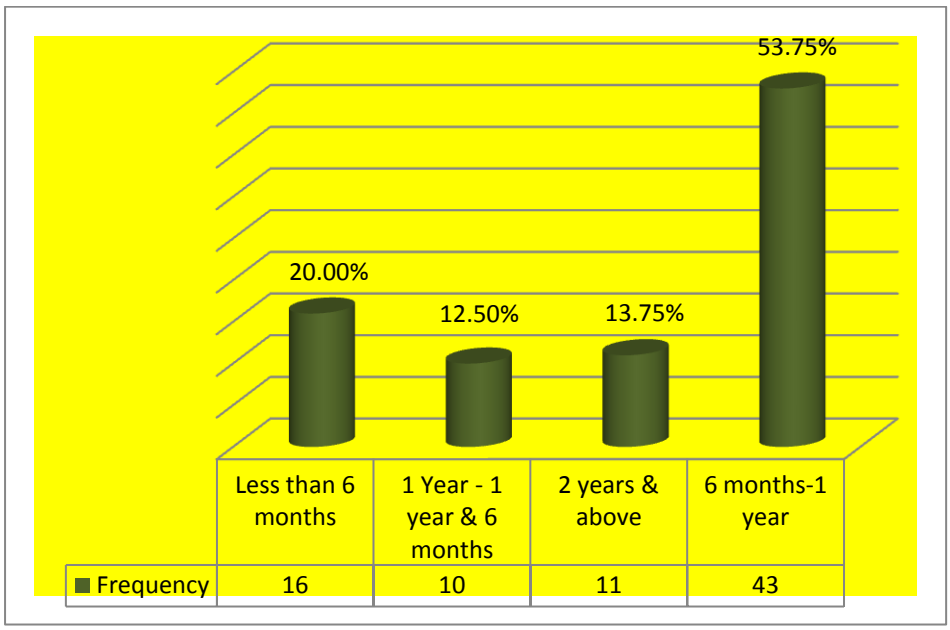

Figure 2: Length of Breastfeeding

A question was asked as to how long the respondents breastfed their children and the figure above denotes that, 53.75% of the teenage mothers breastfed their children from 6 months to 1 year, and 12.50% of them breastfed from 1 year to 1 year &6 months.

4.3 SECTION C: CHILD'S DEVELOPMENTAL DATA

Table 4: Child's Developmental Data

Commencement of School		
	Frequency	**Percentage**
Child has started schooling	30	38
Child has not started schooling	50	62
Total	**80**	**100**
Academic Performance of the Children		
Average	7	23
Excellent	3	10
Good	14	47
Very Good	5	17
Weak	1	3
Total	**30**	**100%**
Child's Behaviour in the Mix of Age Mates		
Aggressive towards others	2	3
Isolate him/herself quietly	5	6
Plays freely &happily	63	79
Total	**70**	**100**
Mother's Interaction with Child		
Always	31	39
Most of the time	32	40
Not at all	2	3

Sometimes	15	18
Total	**80**	**100**
Mother's Reaction when Child Misbehaves		
Beat him/her	41	51
Calm & talk to him/her	21	27
Ignore him/her	18	22
Total	**80**	**100**

According to the 80 respondents, 62% of them said their children haven't started schooling while 37% of them had their children already in school.

Out of the 30 mothers who said their children had begun schooling, 46% asserted their wards were academically good whiles 3% was weak.

With children's behaviour in the mixed of their peers, 78% of the mothers said their children play freely with others whilst 2% indicated that their children are aggressive towards others.

The mothers were enquired as to how often they play or interact with their children and out of the 80 respondents, 40% indicated that they play with their children most of the time whiles 3% of them do not play with them at all.

With the mother's reaction when the child misbehaves, 51% of them usually beat their children when they misbehave whiles 23% choose to ignore them.

4.4 SECTION D: MOTHER'S PSYCHOSOCIAL STATUS

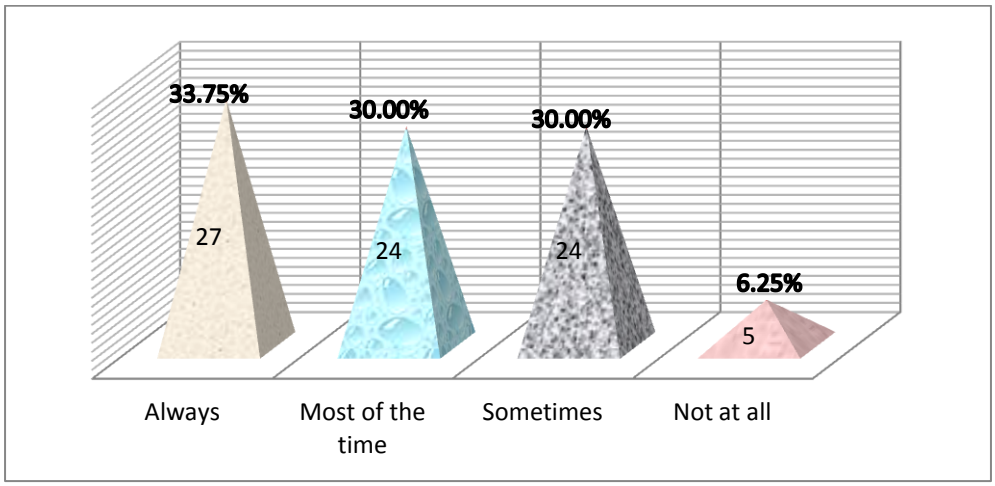

Figure 3: Relationship with family members

Approximately 34% of the teen mothers have a good relationship with their family members always but 6% do not have good relationship with their family members at all.

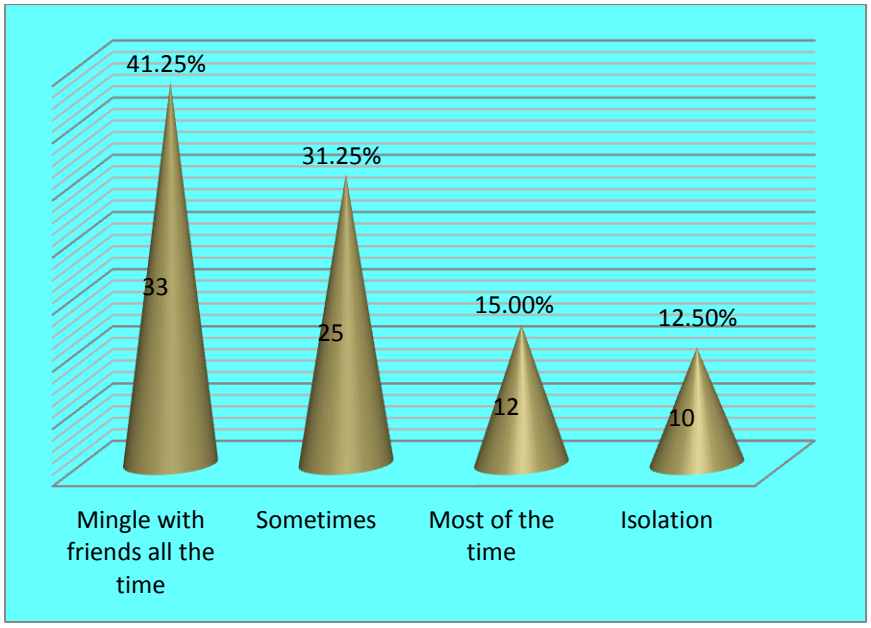

Figure 4: Mothers relationship with friends

From the above figure, 41.25% of the teenage mothers mingle with friends all the time whiles 12.5% isolate themselves from their friends after childbirth.

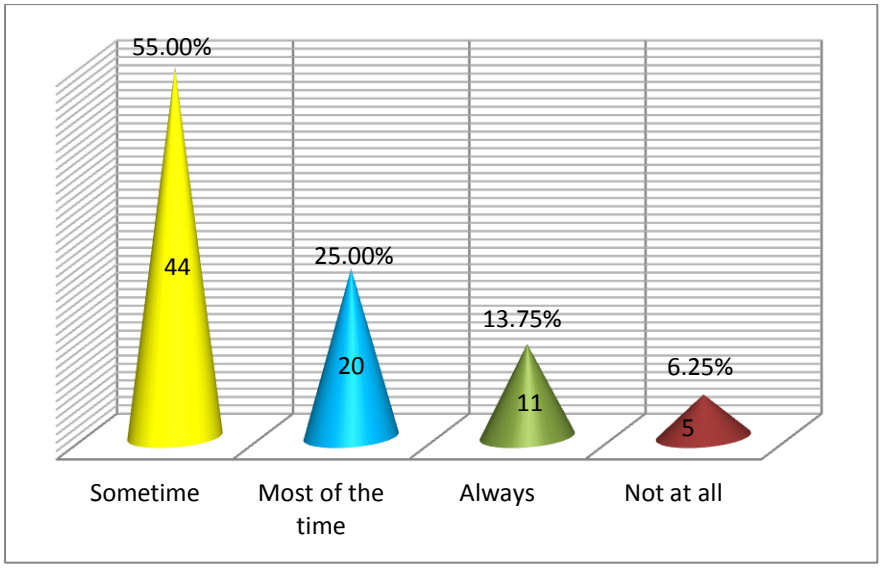

Figure 5: Support from Family Members

The respondents were asked whether they get any support from their family and the figure indicates that, 55% of the mothers do get support from their family sometimes however 6.25% had no support from their family. As to the kind of support the respondents get from their family members, 71% of mother claimed that they get financial support whilst approximately 14% have support in the care of their babies.

Table 5: Mother's Psychosocial Data

Tuition on Baby Care		
	Frequency	**Percentage**
Taught how to care for baby	50	63
Not taught how to care for baby	30	37
Total	**80**	**100**

Changed in Lifestyle		
Had a change in lifestyle	60	75
Had no change in lifestyle	20	25
Total	**80**	**100**
Teenage Mothers' Advice		
Advice in support of teen motherhood	8	10
Advice against teen motherhood	72	90
Total	**80**	**100**
Plans to go back to school / learn a trade		
Plans for advance	70	88
No plans for advance	10	12
Total	**80**	**100**

Respondents were asked whether they were taught on how to nurture and care for their babies and 63% of them confirmed that they were taught whiles the remaining 37% of them said they were not taught. Out of those who were taught, majority (40%) said they were taught by the midwives at the antenatal clinic with few by their friends.

Again, 75% of the teen mothers responded that early motherhood had really changed their planned life whiles 25% of them said it hadn't changed theirs. Majority of the respondents suggested that it is very stressful for being a teenage mother and life become difficult to handle.

The respondents were again asked if they will advise their friends to give birth at their age and out of the 80 respondents, 90% of the respondents' advice against teen motherhood but 10% of them said they would encourage others to give birth at their teenage age than to go for an abortion.

Finally, 87.50%of the respondent wish to either go back to school or learn a trade whilst the remaining 12.5% had no plan in advancing their education nor learn a trade. However, majority of them prefer schooling to trading.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

With demographic characteristics of respondents, age, educational level, religion, marital status, and employment status considered, it was revealed that majority, 79% of respondents were between the ages of 16 – 19 years and Senior High School leavers who are Christians, singles as well as were unemployed in either formal or informal sector. This revealed that, most of the teen mothers delivered in their late teen ages than those in their early teens whilst still dependent on their parents or other relatives for their basic needs including that of their children. This affirmed the findings by Boden et al., (2008) which elaborated that, early motherhood was associated with lower levels of workforce participation and lower income. In support of the above findings, Turley (2003) also came out that, teenage motherhood places the mother and the child at greater dependency on welfare. Hence most teenage mothers add up their financial problems to their parents' or families and therefore increase the constraints at the home which makes them susceptible to all forms of psychosocial problems.

With regards to the obstetrics data collated, 84.81% of the teen mothers had one child each via spontaneous vaginal delivery (SVD),whiles 15.19% had caesarean section during delivery at their ninth month of gestation with 42.47 % of the children between age 0 – 1 year. This implies that, the antenatal services in Ghana have improved and therefore making these teen mothers beneficiaries which has helped in reducing maternal and child mortality rate in the country in accordance with the Millennium Development Goals 4 and 5 (MDG 4 &5).

This is in conformity with Brooks-Gunn & Furstenberg (2006) findings which revealed that, when early, frequent and quality obstetrical care is available or received, it reduces the risks of pregnancy related complications in terms of the health of infants as well as the teenage

mothers. Moreover, larger portion of the respondents (96%) said their children never experienced any abnormality or infection after delivery and 90% also completed their full course of immunizations. Hence most of their children (95%) did not encounter any of the childhood killer diseases. This was made possible due to improved maternal health care system in Ghana. This will help in the normal development of the children since immunizations are very essential in the child's life and prevents childhood diseases like whooping cough, diphtheria, poliomyelitis, neonatal tetanus etc.

Under the child's developmental data which is in conjunction with parental practicing of the adolescent mother, 62.5% of the total respondents said their children had started schooling and play freely and happily in the midst of their peers. Out of this percentage, 46.62% of them confessed that their children were good in respect to academic performance. The next greater portion (23.31%) also said their wards were average whilst 16.65 were very good, 9.99% indicated that their wards perform excellently and 3.33% being weak academically. Furthermore, 40% of the teenage mothers elaborated that, they mostly interact with their children. This study therefore disputes the literature by Lahey, & Burgess, (2004) which stated that adolescent mothers, when compared to adult mothers, are reportedly less sensitive, less verbal, and less responsive to their infants' interactional cues. Despite all external pressures, the teen mothers still have good relationship with their children. On the contrary, 51% of the total mothers confessed that, they usually beat their children as a form of correcting them when they misbehave and this agrees with McAnarney et al, (2006) that, adolescent mothers who have more social support exhibit less anger and use less punitive methods of parenting than adolescent mothers with fewer social supports. An adolescent's attitude toward parenting influences her parenting style; mothers who place inappropriate expectations on the child are likely to use harsh and rejecting discipline strategies. It

presumes that, teenage mothers are sterner or strict on their children as compared to older mothers

On the aspect of exclusive breastfeeding practice by the teen mothers, the information gathered denoted that, the majority of teenage mothers (63%) were able to practice that for not less than 1year whilst 37% admitted that they never practiced exclusive breastfeeding due to several reasons. Such reasons include; insufficient production of breast milk for the babies, lack of knowledge on exclusive breastfeeding, time constraints due to schooling and work schedules as well as nannies including mothers and grannies not in support of exclusive breastfeeding. Therefore, resorts to other complementary feeds at a very tender age of the baby mostly at the first week where the baby's digestive system is not well developed. This leads to the impaired maturity / development of the babies' brains, predisposing them to low intelligence quotient and poor academic performance when grown. This further supports the study by Horwood et al (2001) which analysed that, breast feeding has long term benefits for child's cognitive development. Hence cognitive development and maturation may be impaired if child is not exclusively breast fed during infancy which may lead to the risk of psychological problems later in life.

With regards to the teen mother's psychosocial status, majority of the teen mothers have good relationship with their family members as well as their friends and gets some form of support from them sometimes. This result is not in support of the literature of Berthoud and Robson (2001) which confirms that, families with teenage mothers are indeed worse off in several respects than families whose mothers had their first child in their twenties or thirties. It summarizes that, the relationship between the teenage mothers and families are not interrupted but do not receive enough support from them as 71.25% indicated that they get financial support from their family members with the rest indicating food, clothing and caring of the baby as their support from their family members. The greater percentage of 63

confirmed that, they were taught how to care for their babies indicating midwives, relatives and friends as their advocates' whiles 37% said they were not taught and therefore they were inexperienced in grooming and nurturing babies. This was supported by East et al (2001) who stated that some teenagers lack the maturity and sense of responsibility to adequately nurture their children, whereas others adjust well to the stress of parenting and provide favourable care giving. Hence they usually need assistance from experienced relatives like their grandmothers and mothers but when these help are not forth coming, then raising children becomes a problem predisposing them to several vices. Personally, most of the respondents revealed that, teen motherhood is a very stressful task to undertake. It becomes extremely difficult when there is no or less support from others either financial or material support. This is further supported by Berthoud & Karen (2001) which analysed that, teenage mothers are more likely to experience disadvantageous outcomes than other women, even after the influence of family background had been taken into account. Again, 51.25% of the respondent strongly believe that life has becomes difficult after child birth and therefore most of the teenage mothers finally declared they would never advice other teenagers to give birth at that stage.

In conclusion, the teen mothers and their children are susceptible to different kinds of psychosocial problems such as financial difficulty, school dropout, depression etc and hence measures should be put in place to help curb the menace.

5.2 CONCLUSION

The study indicated that, majority of the teenage mothers experienced depression, anxiety and becomes school dropouts without employment to earn an income to cater for themselves and their children leading to total dependent on their families.

The study also revealed that most of the teen mothers do have good relationship with their children, friends and family members.

Also the study indicated that majority of the respondents use much punitive measures in correcting their children when they misbehaved.

Furthermore, the research indicated that teenage motherhood has negative impact on both mother and child.

Lastly, the research revealed that majority of the teenage mothers become school dropouts leading to high rate of unemployment among the youth in the country.

5.3 RECOMMENDATIONS

Based on the findings from the study the following recommendations are enumerated in order to improve nursing practice and administration.

1. Organization of school health program / outreach with much attention on the Adolescent reproductive health as well as contraceptive use to reduce the prevalence of teenage pregnancy and sexually transmitted infection among teenagers in the country.
2. Family planning unit at the various health institutions should be environmentally friendly to the teenagers for easily accessibility.
3. Separate antennal and postnatal services should be organized for pregnant teenagers with experienced midwives who can understand them for easily detection of pregnancy related conditions / complication.

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APPENDIX

QUESTIONNAIRE

Introduction

Dear participants, we are final year students of the Christian Service University College and conducting a research on the effects on early motherhood and its impact on the mother and child's psychosocial status in Tafo - Kumasi.

The information provided is for academic purpose only and all will be handled confidentially.

Your safety throughout this study is assured

Your co-operation is therefore highly solicited.

INSTRUCTION: please tick, underline or complete where appropriate.

Section A: Demographic Data

1. Age

a) 13-15 [ ]

b) 16-19 [ ]

2. Education level

a) Primary [ ]

b) J.H.S [ ]

c) (c) SHS [ ]

d) Non – formal education [ ]

3. If had stopped schooling, state reasons for leaving school

.....

.....

.....

4. Religion.

a) Christianity [ ]

b) Islamic [ ]

c) Traditional [ ]

d) Other, specify …….

5. Marital status?

a) Married [ ]

b) Cohabiting [ ]

c) Single [ ]

d) Divorced [ ]

6. Employment status

a) Employed [ ]

b) Non-employed [ ]

7. Specify the type of employment if any?

.....

8. If married, what is spouse's employment status?

a) Employed [ ]

b) Non employed [ ]

9. Specify main source of income.

a) Husband [ ]

b) Mother [ ]

c) From own employment [ ]

d) Other relatives [ ]

e) Others specify.....

10. Which type of accommodation do you live in?

a) Flat [ ]

b) Self contain [ ]

c) Single room [ ]

d) Compound house [ ]

e) Other, specify……

11. Whom do you live with?

a) Spouse [ ]

b) Parents [ ]

c) Friends [ ]

d) Alone [ ]

e) Other, specify.....

Section B; Obstetrics data

12. How many children do you have? ……

13. Specify the age(s) of your child (ren).....

14. How many months did you get before first delivery?

a) Below 7 months [ ]

b) 8 months [ ]

c) 9 months [ ]

d) Above 9 months [ ]

15. Mode of first delivery;

a) Caesarean section (CS) [ ]

b) Spontaneous vaginal delivery (SVD) [ ]

16. Did you or the child have any infection or abnormality after delivery?

a) Yes [ ]

b) No [ ]

17. Did the child receive all the immunizations?

a) Yes [ ]

b) No [ ]

18. Did the child suffer any childhood disease?

a) Yes [ ]

b) No [ ]

19. If yes, specify the type of disease.....

20. Did you practice exclusive breastfeeding?

a) Yes [ ]

b) No [ ]

21. If no, state the reason.....

.....

22. For how long did you breastfeed?

a) Less than 6 months [ ]

b) 6months-1 year [ ]

a) 1 year - 1year & 6months [ ]

c) 1 year&6 months-2 years & above [ ]

Section C; Child's developmental data

23. Have your child started schooling?

a) Yes [ ]

b) No [ ]

24. What is the academic performance of your child?

a) Weak [ ]

b) Average [ ]

c) Good [ ]

d) Very good [ ]

e) Excellent [ ]

25. How does your child behave in the mix of his/her age mates, that is if he

a) Plays freely and happily [ ]

b) Isolate him/ herself quietly. [ ]

c) Aggressive towards others [ ]

d) Other, specify…….

26. How often do you play and interact with your child?

a) Always [ ]

b) Most of the time [ ]

c) Sometimes [ ]

d) Not at all [ ]

27. What is your reaction when your child misbehaves or causes any trouble?

a) Beat him/her [ ]

b) Calm and talk to him/her [ ]

c) Ignore him/her [ ]

d) Other, specify.....

Section D; Mother's psychosocial data

28. Do the family members relate to you and your child in a good manner?

a) Always [ ]

b) Most of the time [ ]

c) Sometimes [ ]

d) Not at all [ ]

29. How do you relate to friends?

a) Isolate [ ]

b) Mingle with friends all the time [ ]

c) Sometimes [ ]

d) Most of the time [ ]

30. Do you get any support from your family members?

a) Always [ ]

b) Most of the time [ ]

c) Sometimes [ ]

d) Not at all [ ]

31. Describe the kind of support.....

.....

32. Were you taught on how to nurture and cater for a baby?

a) Yes [ ]

b) No [ ]

33. If yes, identify who did and describe what she taught you.

.....

34. Have early motherhood changed your normal lifestyle?

a) Yes [ ]

b) No [ ]

35. If yes, describe the changes.

.....

.....

36. Personally, how does it feel like to be a mother by that time? Describe briefly.

.....

.....

37. How do you feel / think about life after birth?

……

…….

38. Would you advice your friends to give birth at your age?

a) Yes [ ]

b) No [ ]

39. Do you have any plan of going back to school / learning a trade?

a) Yes

b) No

40. Please state your reason …….

Thank you!