

Health and Social Problems of Teenage Pregnancy and Future Childbearing in Amassoma Community, Bayelsa State, Nigeria

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Abstract: This study examined the health and social problems of teenage pregnancy and future childbearing in Amassoma community. Three hundred pregnant and breastfeeding teenagers (150 pregnant teenager and 150 breastfeeding teenage mothers) whose ages averaged 15.36 years participated in the study. The study is aimed at exploring the health and social problems of teenage pregnancy and future childbearing. A descriptive study designed with self-structured interview guide and observations were used for the purpose of data collection and analysis. The result indicated the pregnant teenagers and breastfeeding teenage mothers complained of high poverty rate, misconception about contraceptives use, sexual harassments, ignorance, low education, marital instability, early marriage, sexual abuse, modernization, religion, culture among other things as causes while medical problems reported include poor eating habits, difficulty in child birth, anaemia, depression, threatened abortion, premature delivery, vesico vaginal fistula, high blood pressure, maternal and child mortality and haemorrhage. Furthermore low level of education, unstable marriage, poverty, financial dependency, neglect, lack of job skills are among the social problems as well as health outcomes of teenage pregnancy. It was found that pregnant teenagers/breastfeeding teenagers who married received good psycho-social support and good health than single/divorced pregnant/breastfeeding teenage mothers. The result also showed that health education significantly influenced their knowledge about contraceptives. Similarly, breastfeeding teenage mothers who had good psycho-social support and better health status were more than pregnant teenagers without psycho-social support hence poor health. It was also deduced that the health status of the pregnant teenagers and breastfeeding teenage mothers are related to age, hence as the teenagers get older, their health get improved and there is reduction in pregnancy complication. It was revealed that the pregnant teenagers and breastfeeding teenage mothers' accessibility to nursing care and health care facility enhanced their health status. Furthermore, it was revealed that a proportion of pregnant teenagers/breastfeeding teenage mothers in low socio-economic status spent higher proportion of their live in poor health with little economic support from the household. Similarly, health education significantly enhanced pregnant teenagers' level of coping with the stress of teenage pregnancy.

Key words: Health status, psycho-social condition, teenager, teenage pregnancy, menarche, contraceptives, ovulation

INTRODUCTION

Teenage pregnancy is defined as a teenager or underage girl (usually within the age of 13-17) becoming pregnant (Treffers, 2003). Teen periods are between 13-19 years which are the ages at which reproductive organs becoming functionally active. In some psychological literature, it is often described as a time of crises, a crucial stage of lifespan developed when individual struggles with the transition from childhood. This stage is usually filled with psychological, emotional

and cognitive changes (Erikson, 1968). Teenage pregnancy in everyday speech usually refers to women who have not reached legal adulthood which varies across the world who becomes pregnant. The average age of menarche in United States is 12.5 years old, though this figure varies by ethnicity and weight (GI, 2005). It is said that early menarche or fertility leads to early pregnancy but this depends on a number of factors both societal and personal. Worldwide, the rate of teenage pregnancy ranges from 143 per 1000 in sub-Sahara African countries to 2.9 per 1000 in South Korea (UNICEF, 2001). Majority

of teen pregnancies are unintended and unplanned, half of these pregnancies occur within the 1st 6 months of initial sexual intercourse and are usually outside of marriage thus carrying a social stigma in many communities and cultures. According to Slatter (2000), teenager may lack knowledge of or access to conventional methods of preventing pregnancy, as they may be, too embarrassed or frightened to share such information. In other case, contraception is used but proves to be inadequate.

The social stigma that once attended out of wedlock pregnancy may have diminished however the risks of serious health consequences remain for babies born to mothers still in their teens. Children of teenagers are more likely to have low birth weights and to suffer the associated health problems. The risk of pregnancies and childbirth among adolescents are numerous. It includes damage to the reproductive health organ, maternal mortality and infertility, complication during pregnancies and childbirth and obstetric fistula (Tinuola, 2006).

About one-fourth of youths report first intercourse by age 15. In most continental Western European countries, there exists a very low teenage birth rate. This is varyingly attributed to good sex education and high level of contraceptive use, traditional values and social stigmatization (UNICEF, 2001). Conversely, however in other countries and cultures, particularly in the developed world, teenage pregnancy is usually within marriage and does not involve a social stigma. Sub-Sahara Africa for instance has the highest rate of teenage pregnancy in the world and this is because women tend to marry at an early age (Treffers, 2003).

Teenage pregnancy is often both a cause and a consequence of social exclusion. Risk factors include poverty, being in care, low educational attainment and mental health problems. Pregnant teenagers and young mothers often live of low incomes and poor housing conditions (Stodemire *et al.*, 1986). In some societies, early marriage and traditional gender roles are important factors in the rate of teenage pregnancy. For example in some Sub-Sahara African countries, early pregnancy is often seen as a blessing because it is proof of the young women's fertility. However in Nigeria, some cultures forbid teenage pregnancy that occur out of wedlock because of high level of traditional values and social stigmatization while some cultures and communities accepts sexual relationship among teenagers but provides incomprehensive and unbalanced information about sexuality (Tinuola, 2006). But whether teenage pregnancy is accepted or not, the fact remains that when teenagers

get pregnant, the potential harm to the mother, the child and society at large can be very far-reaching, especially because their bodies are not fully developed to meet challenges of carrying the pregnancy and child birth. Teen pregnancy and motherhood affects the entire family members. Teenagers' parents are thrust into the role of raising two children the teenager and her child. Furthermore, parents find themselves stressed emotionally and economically at a time when they expect their children to become self-reliant and self-dependent (East, 1996).

Teenage mothers are less likely to gain adequate weight during their pregnancy leading to low birth weight. Low birth weight is associated with several infant and childhood disorders and a higher rate of infant mortality. Teenage mothers receive regular parental care less often than older women. In Niger Delta region, particularly in rural areas like Amassoma of Bayelsa State, Nigeria, teenage pregnancy and sexual relationships among teenagers are widely accepted. In fact, early pregnancy is seen as norm, a god-given gift and proof of the young woman's fertility. Therefore, cohabitation among sexually active is widely practiced and highly condoned. This has led to an increased rate of teenage pregnancy in Amassoma leaving the community with a lot of children and teenage mothers. Women exposed to abuse, domestic violence and family strife in childhood are more likely to become pregnant as teenagers and the risk of becoming pregnant as a teenager increases with the number of adverse childhood experiences becoming pregnant as a teenager does not appear to raise the livelihood of long-term negative psychosocial consequences (Tamkins, 2004).

Health and medical problems: Maternal and prenatal health is of particular concern among teens that are pregnant or parenting. The worldwide incidence of premature birth and low birth weight is higher among adolescent mothers (NCPTP, 2003). Research indicates that pregnant teens are less likely to receive prenatal care, often seeking it in the third trimester if at all (Makinson, 1985). The possibility that teenage pregnancy is bad for health in the longer term is particularly significant for the primary care team, given that social attitudes towards teenage pregnancy and motherhood are generally negative and there is empirical evidence indicating that teenage pregnancy is most often unplanned (Finlay *et al.*, 1995).

The GI (2005) reports that one-third of pregnant teens receive insufficient parental care and their children are

more likely to suffer from health issues in childhood or be hospitalized than those born to older women. Many pregnant teens are subject to nutritional deficiencies arising from poor eating habits and suffer from significant anaemia and other complications of pregnancy which may result in the deaths of such teen girls. Young mothers and their babies are also at greater risk of contracting HIV (Makinson, 1985). Children of teenager parents are at increased risk of low birth weight, delay in cognitive development, school problems, behavioural disorders and becoming teenage parents themselves (Kessler *et al.*, 1994). The world health organization estimates that the risk of deaths following pregnancy is twice as great for women between 15 and 19 years than for those between the ages of 20 and 24. The maternal mortality rate can be up to five times higher for girls between 10 and 14 than for women about 20 years of age. There is greater risk of medical complications of teenage pregnancy because of under development of the pelvis which can lead to damage of the reproductive organs or lead to difficulty in childbirths or cause obstructed labour, obstetric fistula, infertility, infant mortality, maternal mortality, death, depressive disorders and sexually transmitted diseases (UNICEF, 2001).

Joners and Battle (1990) add that teenage mothers experience poor emotional health and well being and are three times more likely to suffer from post natal depression and poor mental health. And that the teenager mother and their children are at increased risk of living in poverty. Contributing to this, Irvine states that most teenage mothers are economically and materially disadvantaged. It is reasonable to expect a higher rate of post-partum depression and stress-related illness among teenage mothers than among adult mothers (Irvine *et al.*, 1997). Furthermore, he states that teenage period is a crucial stage of lifespan development when individual struggles with transition from childhood to adulthood. Therefore, the teenager who is pregnant must cope with the crisis of adolescence and the crisis of pregnancy. Such physical and mental upheavals, together with new responsibilities and the stress of adjustment to parenthood could affect the health of the teenage mother (Scafeer *et al.*, 1978).

Psycho-social outcome: Life outcomes for teenage mothers and their children may vary considering the economic status of the family and the social support available. Some pregnant teenagers are too ashamed to talk about their situation; thereby loosing contact with friends and becoming socially isolated, some feel shocked and common reactions include anger, guilt

and denial (Irvine *et al.*, 1997; Cutrona, 1984). They have problems with their relationship e.g., partnership break ups, parental separation and lack of community and family support.

Studies have also indicated that teenage girls are often in abusive relationships at the time of their conceiving and are likely to be beaten by their child's father and abandoned. They have a much greater chance of divorce (Meadows and Downson, 2007). Poverty is one of the causes of teenage pregnancy. Therefore, early childbearing further compounds the poverty level. Most of these teenagers are single parents and lacks who would contribute to the household income. These teen mothers often live on low incomes and poor housing conditions (DHSSPS, 1992). Furthermore, there is evidence to suggest that risk to the well-being and development of the children of teenage mothers may be exacerbated if the teenage mother lacks supports (Shapiro and Mangelsdorf, 1994). However, some evidence has been presented that indicates that insufficient prenatal care is related to complications and suggests that prenatal medical and social care could improve the health of the teenage mother and the outcome of her pregnancy (Konje *et al.*, 1993; Mahfouz *et al.*, 1995).

Aims of the study: Less attention has been paid to the health and psycho-social problems of pregnant teenagers and future childbearing in Amassoma. The aim of the study was to explore some of the ailments, psycho-social problems of pregnant teenagers and breastfeeding teenage mothers and their coping strategies.

Hypotheses:

- The health status of majority of pregnant teenagers/breastfeeding teenagers will vary with their level of social support
- Easy accessibility to nursing care will affect the health status of majority of pregnant teenagers/breastfeeding teenagers
- There will be no significant difference in the social support received by pregnant teenagers and breastfeeding teenagers
- Giving health education to the majority of pregnant teenagers/breastfeeding teenagers of Amassoma will significantly influence their knowledge about contraceptives
- The health status of majority of the pregnant teenagers/breastfeeding teenagers will vary with level of income
- The health status of the majority of the pregnant teenagers/breastfeeding teenagers will vary with their age
- Health education will significantly enhance the ability of majority of pregnant teenagers to cope with stress of teenage pregnancy

MATERIALS AND METHODS

The setting of the study: The research was conducted in Amassoma community in Wilberforce Island. It is the largest community in Southern Ijaw Local Government of Bayelsa State, Nigeria where Niger Delta University is situated. The community is made up of 23 compounds commonly called Pele or Ama. It is accessible by land from Yenagoa the state capital city. The major languages are Izon (Ijaw) and Pidgin English. Like every Izon town, people of Amassoma are characterized by a similar cultural system, norms and values. In Amassoma, there is only one existing general hospital with a non-functional health center. Culturally, early marriage is a norm between the ages of 12-28. Polygamy and concubinage are widely practiced while cohabitation among the sexually active is widely condoned and encouraged. There is an annual cultural festival called Se-igben featuring, wrestling competition, boat regattas and fishing contest among others. This festival gives room for loosed conducts, illicit and indiscriminate sexual relationships among the sexually active population, giving way to increased rate of teenage pregnancy.

Research design and participants: The study adopted descriptive study designed to reveal the health and social problems of teenage pregnancy and future child bearing in Amassoma community, Bayelsa State of Nigeria. The target population of this study are the pregnant teenage girls and all breastfeeding teenage mothers in Amassoma with age 13-19 years irrespective of their level of education. A simple random sampling technique was used to select 15 compounds (Pele or Ama) from the 23 compounds in Amassoma community. A total of 300 respondents who were available at the time of study were purposefully selected (150 pregnant teenagers and 150 breastfeeding teenage mothers) ages average 15.36 years with a range of 13-19 years. Three hundred teenagers (pregnant teenagers and breastfeeding teenager mothers) were randomly selected from each of the 15 compounds and they were interviewed.

Random samplings were used to select the compounds by casting of lots to pick the selected ones and the same method was used to select among the pregnant teenagers and breastfeeding teenage mothers per each of the selected compounds. About 54 (18.0%) were married, 27.67% had secondary education, 70.66% of the respondents had only primary education. Majority 276 (92) were Christian, 9.1 engaged in farming and fishing, 9.66 were traders, tailor and hairdresser while majority 71.67% were students. More than three-quarter 76.1% of the respondents source their income by depending on their parents while 17.66% sourced their income through

self-employment. The 74% were from polygamous family. About 6 (2%) were widowed while 36.33% were separated, divorced or abandoned.

Instrument: Data was collected with the use of observation and a structured interview guide. The questionnaire consisted of 4 sections. Section A consists of 13 items designed to explore the socio-demographic characteristics of the respondents. Section B consists of 14 items designed to explain the health problems and social affect of teenage pregnancy. Section C had 16 items that assessed the causes and perception of teenage pregnancy as well as the coping strategies. Section D comprised 15 items which evaluated the roles of government, the effectiveness of nursing services available for the teenagers and the effects of teenage pregnancy towards future childbearing. The questionnaire was translated to Pidgin English for less educated respondents. Six subjects' experts (SMES) assessed the extent to which the instrument tapped the variables of interest. The 89% of the SMES agreed that the instrument was valid. The questionnaire comprised 58 items all together.

Procedure: Permission was obtained from the chief of the community, community development committee, women leader and from head of the household. Consent was obtained verbally from the individual respondents and confidentiality was assured before embarking on data collection. The interview guide was used and the fieldwork lasted for 10 weeks. The field work was done by the researcher and two trained and experienced nurses who could speak the local Ijaw language to the illiterate respondents to ensure that problems that arose in the field were given prompt attention in order to minimize errors and to ascertain co-operation. Each interview session lasted between 15-25 min with an average of 20 min. Every one of them was interviewed separately with a short introduction about the purpose of the interview. The interview day and time was dictated by each respondent through the family head.

Data analysis: The numbers and percentages of the respondents in each group and response category were determined. Furthermore, Pearson's χ^2 -test was used to assess whether the numbers of respondents in the categories were significantly different with respect to health and social variables.

RESULTS AND DISCUSSION

The socio-demographic characteristics showed that majority of the respondents (66%) were between the ages of 15 and 17 years, 23% were between 18 and 19 years and 11% were between 12 and 14 years. Table 1 showed that

Table 1: Frequency distributions showing the probable causes of teenage pregnancy

Possible factors	Frequency	Percentage
Perception of people towards teenage pregnancy		
As gift from God	152	50.67
Proof of female fertility	79	26.33
Something to be discouraged	24	8.00
Acceptance of illegitimacy	17	5.67
It is culturally acceptable	28	9.33
Total	300	100.00
Lack of knowledge about sexual activity/low education		
Ignorance about sexual matters	173	57.67
Ignorance about family planning devices	33	11.00
Aware of the consequences of sexual matters	94	31.33
Total	300	100.00
Contraception		
Lack of knowledge about	126	42.00
Incorrect use of	63	21.00
Too ashamed to use	35	11.67
Misconception	76	25.33
Total	300	100.00
Age discrepancy in relationship		
12-14	125	41.67
15-17	93	31.00
18-20	82	27.33
Total	300	100.00
Childhood environment		
Father not married to mother	96	32.00
Parents are separated	65	21.67
Encouraged to have boyfriends	27	9.00
Rape	14	4.66
Older siblings are doing it	51	17.00
Imitating peer group	47	15.67
Total	300	100.00
Poverty		
Financial assistance	210	70.00
Poor food	37	12.33
Mother encouraged me to	32	10.67
For satisfaction	21	7.00
Total	300	100.00

50.67% of the respondents perceived teenage pregnancy as a blessing and gift from god, 26.33% perceived it as a proof of the woman's fertility, 9.33% perceived teenage pregnancy as a phenomenon that is culturally acceptable while 8.% saw it as a mistake needing correction. Finding reveled further that 53% had no knowledge of contraceptives or had never used them before, 25.33% had misconception about contraceptives while 21.0% either forgot to use oral pills or used condoms incorrectly.

Table 1 further shows that 41.67% of the respondents between age 12 and 14 claimed being in a relationship with older men. Childhood environment situations can lead to teenage pregnancy with 32.9 and 21.67% from broken homes, 17 imitating their older siblings doing it, 15.67 respondents imitating peer group, 9 were encouraged to have boyfriend (s) and 4.66% of the respondents come to term with the harassment from the male in the community as a contribution factor to the increasing rate of teen pregnancy in the community. Furthermore, it was revealed from this study that, 70% of teenagers involved in sex as a result of financial assistance, 12.33%

Table 2: Frequency distribution of social and health problems of teenage pregnancy

Social factors	Frequency	Percentage
Education		
Dropped out of school	206	68.67
Continued after child birth	31	10.33
Wish to continue if assisted	63	21.00
Total	300	100.00
Marriage instability		
Married	54	18.00
Single	131	43.67
Abandoned	102	34.00
Divorced	7	2.33
Widowed	6	2.00
Total	300	100.00
Job opportunity/occupation		
Housewife	19	6.33
Dependent on parents	228	76.10
Petty trader	25	8.33
Employed (low paid job)	28	9.33
Total	300	100.00
Depression/anxiety		
During pregnancy	82	27.33
After pregnancy	177	59.00
After childbirth and now	41	13.67
Total	300	100.00
Following childbirth		
Was pregnant again	189	63.00
Was not	61	20.33
Will pregnant soon	50	16.67
Total	300	100.00
Health factors		
Complications during pregnancy		
Anaemia	154	51.33
Pregnancy-induced hypertension	35	11.67
Convulsion	16	5.33
Haemorrhage	32	10.67
Threatened abortion	32	10.67
None	31	10.33
Total	300	100.00
Complications during delivery		
Obstructed labour	95	31.67
Prolonged labour	78	26.00
Eclampsia	18	6.00
Excessive bleeding	37	12.33
Death of babies	32	10.67
None	40	13.33
Total	300	100.00
Mode of delivery		
Spontaneous vaginal delivery	222	74.00
Caesarian section	78	26.00
Total	300	100.00
Baby alive after 6 months		
Yes	232	77.33
No	68	22.67
Total	300	100.00
Weight of the baby (kg)		
1.5-2.0	173	57.67
2.1-2.5	112	37.33
2.6-3.0	14	4.67
3.5 and above	01	0.33
Total	300	100.00

for food, 10.67% respondents were encouraged by their mothers while 7% engaged in sex for satisfaction. Table 2 shows the frequency distribution of social and health problems of teenage pregnancy. Among the social

factors, it was deduced that 68.67% of the respondents dropped out of school, 21% wish to continue if assisted while 10.33% continue after childbirth. About 43.67% of the respondents were single, 34% were abandoned, 18% married 2.33% divorced while 2% were windowed. Furthermore, 76.1% depends on their parents economically, 9.33% were employed (low paid jobs), 8.33% were petty traders while 6.33% were full time house wife.

Table 2 also shows that 59% suffered post-natal depression and experienced poor mental health up to 2 years after childbirth. About 27.33% experienced high rate of depression and anxiety during pregnancy. Also 63.0% of the respondents became pregnant repeated thereafter again, 20.33% were not while 16.67% claimed they would pregnant soon. Among the health factors, it was deduced that >51.33% had significant anaemia probably because of poor eating habits. The 11.67% had pregnancy induced hypertension, 10.67% had hemorrhage, another 10.67% had threatened abortion while 5.33% had convulsion and 10.33% remained healthy throughout pregnancy.

Table 2 further showed that during delivery, 31.67 had obstructed labour, 26.0% had prolonged labour, 12.33 excessive bleeding and 10.67% had still birth while 13.33% suffered no complication during delivery. In the mode of delivery, 74% reported spontaneous vaginal delivery while 26% were through caesarian section. About 77.33% of the respondents reported that their babies were alive after 6 months of delivery while 22.67% reported that they lost their babies within the first 6 months of delivery. Furthermore, 57.67% babies desired by respondents weighed between 1.5-2 kg and only 0.33% weighed 3.5 kg and above.

The result in Table 3 shows that 17.67% of the pregnant teenagers/breastfeeding teenagers who received good psychosocial support also received good health. However, 49.33% of those who had poor psychosocial support also experienced poor health ($\chi^2 (2) = 102.33$, $p < 0.001$). This result supports hypothesis 1. The health status of the pregnant teenagers/breastfeeding teenagers decreases as their psychosocial support decreases and vice versa. The extent to which accessibility to healthcare (nursing care) affected the health status of the pregnant teenagers/breastfeeding teenagers was also evaluated. As

Table 3: Summary of Chi-square showing health status and psycho-social support

Category	F	%	df	χ^2	p-value
Poor health/poor psycho-social support	148	49.33	-	-	-
Poor health/fair psycho-social support	27	9.00	-	-	-
Poor health/good psycho-social support	12	4.00	2	102.33	<0.001
Good health/poor psycho-social support	25	8.33	-	-	-
Good health/fair psycho-social support	35	11.67	-	-	-
Good health/good psycho-social support	53	17.67	-	-	-

shown in Table 4, >55.67% of the respondents reported accessibility to nursing care affected their health status ($\chi^2 (3) = 166.58$, $p < 0.001$).

About 107 (35.67%) of the teenagers that were pregnant experienced poor psycho-social support while 50 (16.67%) of the breast feeding teenagers experienced poor psycho-social support. Also 9.33% of the teenager that were pregnant had good psychosocial support while 19.67% of the breast feeding teenagers experienced good psycho-social support ($\chi^2 (2) = 43.81$, $p < 0.001$) (Table 5). In other to test whether health education would increase the knowledge of pregnant teenagers/breastfeeding teenagers about contraceptives. χ^2 -test was used to evaluate how different the groups were. Table 6 shows that about 86.33% that were influential concerning the influence of health education and knowledge about contraceptives were >13.67% that were influential ($\chi^2 (3) = 367.43$, $p < 0.001$).

Table 7 showed that about 197 (65.67%) of the pregnant teenagers/breastfeeding teenagers that earned low income had poor health status while only 0.66% of the respondents that eared high income had poor health status. About 40 (13.33%) of the pregnant teenagers/breastfeeding teenagers that earned high income had good health status while only 14 (4.67%) of the respondents that earned low income had good health status ($\chi^2 (2) = 155.53$, $p < 0.001$).

Table 4: Summary of Chi-square computation for responses on the effect of accessibility to nursing care on the health status

Category	F	%	df	χ^2	p-value
Strongly affects	167	55.67	-	-	-
Affects	72	24.00	3	166.58	<0.001
Do not affect	36	12.00	-	-	-
Strongly do not affect	25	8.33	-	-	-

Table 5: Summary of Chi-square showing the differences in the psycho-social support of pregnant and breastfeeding teenagers

Category	F	%	df	χ^2	p-value
Pregnant teenager/poor psycho-social support	107	35.67	-	-	-
Pregnant teenager/fair psycho-social support	15	5.00	-	-	-
Pregnant teenager/good psycho-social support	28	9.33	2	43.81	<0.001
Breastfeeding teenager/poor psycho-social support	50	16.67	-	-	-
Breastfeeding teenager/fair psycho-social support	41	13.66	-	-	-
Breastfeeding teenager/good psycho-social support	59	19.67	-	-	-

Table 6: Summary of Chi-square showing the influence of health education on pregnant teenagers/breastfeeding teenagers and their knowledge about contraceptives

Category	F	%	df	χ^2	p-value
Very influential	218	72.67	-	-	-
Influential	41	13.67	3	367.43	<0.001
Uninfluential	23	7.66	-	-	-
Very uninfluential	18	6.00	-	-	-

Table 7: Summary of Chi-square showing the influence of economic status on health status

Category	F	%	df	χ^2	p-value
Poor economic status/poor health	197	65.67	-	-	-
Poor economic status/fair health	26	8.67	-	-	-
Poor economic status/good health	4	4.67	2	155.53	<0.001
Good economic status/poor health	02	0.66	-	-	-
Good economic status/fair health	21	7.0	-	-	-
Good economic status/good health	40	13.33	-	-	-

To test whether age would determine the health status of pregnant teenagers/breastfeeding teenagers. It was shown in Table 8 that majority 51.0% of those with good health status were 15 years and above while 6.67% of those that were <15 years in age had good health status ($\chi^2 (2) = 143.85$, $p < 0.001$). The result in Table 9 showed that 78% that were influential concerning the influence of health education and coping with the stress of teenage pregnancy were >22% that were uninfluential ($\chi^2 (3) = 107.98$, $p < 0.001$). The result in Table 10 shows that 14.33% of the pregnant teenagers/breastfeeding teenagers who married reported good health. However, 60.0% of those who are single/separated experienced poor health ($\chi^2 (2) = 90.47$, $p < 0.001$).

Respondents perceived teenage pregnancy as a blessing and gift from god as a proof of the woman's fertility and as a phenomenon that is culturally acceptable. This was supported by Attar that the fact that in Islam there is no fixed rule as to the age of marriage because they believe that marriage is their tradition and anyone that refuse to marry at a considering age (early age) is rejecting the tradition of Allah. This was also supported by Locoh that among adolescents in some sub-Sahara Africa, early pregnancy is often seen as a blessing from God because it is a proof of the young women's fertility. Tinuola (2006) supported that teenagers were religiously committed to be engaged in pregnancy during teens and many even encouraged some other people to do so probably because they believed that it is divinely supported. And that attempt to act to the contrary was considered anti-God and that pregnancy prior to marriage confirms one's fertility. Contrary to this, Action Health Incorporated indicated that it is something to be discouraged and that teenage pregnancy occurring all over the world and it is constituting one of the major problems in the society and so calls for attention of the general public.

Finding reveled further that majority of the respondents had no knowledge of contraceptives or had never used them before or had misconception about contraceptives. This was supported by Elorn that a sexually active teenager who does not use contraceptives has a 90% chance of becoming pregnant within 1 year. AAP (1999) also reported that contraceptives when used properly are highly

Table 8: Summary of Chi-square showing the influence of age on health status

Category	F	%	df	χ^2	p-value
<15 years poor	77	25.67	-	-	-
<15 years fair	25	8.33	-	-	-
<15 years good	20	6.67	2	143.85	<0.001
15 years and above poor	18	6.00	-	-	-
15 years and above fair	07	2.33	-	-	-
15 years and above good	153	51.00	-	-	-

Table 9: Summary of Chi-square showing the influence of health education on pregnant teenagers and coping with the stress of teenage pregnancy

Category	F	%	df	χ^2	p-value
Very influential	92	61.33	-	-	-
Influential	25	16.67	3	107.98	<0.001
Uninfluential	21	14.00	-	-	-
Very uninfluential	12	8.00	-	-	-

Table 10: Summary of Chi-square computation for responses showing the influence of marital status on health status

Category	F	%	df	χ^2	p-value
Married health status poor	7	2.33	-	-	-
Married health status fair	4	1.33	-	-	-
Married health status good	43	14.33	2	90.47	<0.001
Single/separated health status poor	180	60.00	-	-	-
Single/separated health status fair	26	8.67	-	-	-
Single/separated health status good	40	13.33	-	-	-

effective at preventing pregnancy but despite increasing use of contraceptives by adolescents at the time of first intercourse 50% of adolescent pregnancies occur within the first 6 months.

Furthermore, it was revealed that teenagers involved in sex either as a result of financial assistance for food or for satisfaction. Brown (1991) findings agreed with this that teenage pregnancy occurs as a result of many causes which he highlighted as poverty, early marriage, modernization and development, single parenthood, sexual abuse and non-utilization of contraceptive among teen girls. This was supported by Action Health Incorporated that due to lack of sexuality education 7 out of every 10 Nigerians boys and 5 out of every 10 Nigerian girls attending secondary school are sexually experienced before the age of 10. In addition, apart from the problems associated with limited financial resources, teenage pregnancy is the leading single factor adversely affecting female education in Nigeria.

This study revealed that obstruction labour, prolonged labour and excessive bleeding are common phenomena during delivery. This was supported by NAY (2003). That pregnant girls who are 15 years old and under have a maternal mortality rate 7 times higher than that of women aged 20-24 years old and that girls under 20 years of age suffer more pregnancy and delivery complications such as toxemia, anaemia and premature delivery, prolonged labour than women who are 20 or more year. In

the mode of delivery about 74% reported spontaneous vaginal delivery while 26% were through caesarian section. This was supported by AAP (1999) that a combination of biological and social factors may contribute to poor outcomes in adolescents. This was also supported by NAY (2003) that babies born to mothers under 20 are more likely to die before their first birthdays than those born to mothers' age 20-29 years.

The complications suffered by the respondents revealed by the study which affects the reproductive health of the teen mother and their babies include low birth weight, excessive bleeding which could lead to anemia, sexually transmitted diseases, e.g., HIV AIDS, death of the babies and psychological complications. The pregnant teenagers/breastfeeding teenagers who received good psychosocial support also reported good health. However, those who had poor psychosocial support also experienced poor health. This result supports hypothesis 1. This was supported by Irvine *et al.* (1997) that some pregnant teenagers are too ashamed to talk about their situation, there by losing contact with friend and becoming socially isolated.

The extent to which accessibility to healthcare (nursing care) affected the health status of the pregnant teenagers/breastfeeding teenagers was also evaluated. Thus, the null hypothesis is accepted, this means easy accessibility to nursing and health care facility would affect the respondents health status. This was also reported by Attar that the proper age of pregnancy is 20-30 years, however that the age of mother does not have hazard but the behaviour of mother like quality of parental care is effective on the occurrence of complications. The results showed that the null hypothesis which states that giving health education to the majority of pregnant teenagers in Amassoma will significantly influence their knowledge about contraceptives was accepted because majority that were influential concerning the influence of health education and knowledge about contraceptives were more than those that were uninfluential.

This study revealed that in some relationships, condoms are often used among the teenagers at the beginning of their relationship but are abandoned once the partners consider the relationship stable. It was also supported by WB and TSP (2008) that ignorance about the consequence of sexual activity have much to do in the cause of teenage pregnancy. Some young people lack accurate knowledge about what to expect in relationships and what it means to get pregnant. Based on the above

perceptions, teenagers may lack knowledge of or access to conventional method of preventing pregnancy as they may be too embarrassed or frightened to seek such information. Conventional education and health status are related. Lack of conventional education would lead to lack of opportunities for employment, lack of knowledge about health related issues. This might have instilled some lack of confidence in the respondents and prevent them to face the challenges of teenage pregnancy and its health implications. This was reported by Peaches (1990) that there are limited job opportunities or less stable employment, with her education cut short, the teenage mother may lack job skills, accept low paid jobs and may become financially dependent on her family or on welfare packages. This was also reported by Winter that teen mothers are more likely to drop out of school. Likewise that young mothers are at greater risk of leaving school or attaining a lower level of education and therefore reaching professional dead-ends or missing out on job opportunities. This might led to teenage mothers having a higher rate of depression and anxiety during pregnancy because they may suffer more negative life events which may include difficulties with their partners and lack wider support in the community as well as being lonely.

The level of income of the pregnant teenagers/breastfeeding teenagers is strongly related to their health status and the higher the income, the better their health status. A proportion of pregnant teenagers/breastfeeding teenagers in low socio-economic status spent higher proportion of their live in poor health with little economic support from the household because greater proportion of the higher income respondents participated in social activities with their husbands and parents-in-law in comparison to the low income group. This was also reported by UNFPA that poverty is associated with increased rates of teenage pregnancy. Economically, poor homes have more teenage pregnancies compared with economically rich homes. This was also confirmed by Dryburgh that teenage mothers have higher rate of poor eating habits than older women and are less likely to take recommended daily prenatal multivitamins to maintain adequate nutrition during pregnancy.

When tested whether age would determine the health status of pregnant teenagers/breastfeeding teenagers. It was reported that majority of those with good health status were 15 years and above. The health status of the pregnant teenagers/breastfeeding teenagers are related to age. Hence as the teenagers get older, there is reduction in pregnancy complications and other health problems. This was also reported by Brown (1991) that teenage

pregnancy is a pregnancy that occurs during a girl teenage period or years and occurs as a result of many causes which he highlighted as poverty, early marriage, modernization and development, single parenthood, sexual abuse and non-utilization of contraceptives among the teen girls. Also NAY (2003) stressed it that age of mother at pregnancy is one of the main factors for hazards outcome of pregnancy.

Hypothesis 7 which stated that giving health education to the pregnant teenagers will significantly enhance their coping with the stress of teenage pregnancy is accepted. Since, young people often reach sexual maturity before psycho-social maturity some therefore are sexually matured before they are psycho-socially matured. They are not properly equipped cognitively, emotionally or socially to deal with the difficulties. Pregnant teenagers/breastfeeding teenagers who married reported good health, however those who are single/separated experienced poor health. This was supported by Anda (2007) that boys raised in homes with a battered mother, or who experienced physical violence directly were significantly more likely to impregnate a girl. Ellis *et al.* (2003) also reported it that girls whose fathers left the family early in lives had highest rate of early sexual activity and teenage pregnancy. In such homes, the young girls are missing love and other emotional feelings. Therefore, they might have problems with their relationship ranging from abusive relationships at the time of their conceiving and are likely to be abandoned. They have a much greater chance of divorce hence poor health status.

Result also showed that pregnant teenagers/breastfeeding teenagers who are married received good psycho-social support while those who are single/separated experienced poor psycho-social support hence increased health status. This was supported by Pender that there are two types of individual characteristics and experiences that affects behavioural outcomes. The first is prior related behaviour that an individual possesses. The second is personal characteristics that comprises of biological, psychosocial and socio-cultural outcomes.

Implications for nursing practices: The nurse should see every interaction with consumers of health care especially teenagers as opportunity to promote positive health attitude and behaviours. Teenage pregnancy and motherhood have implication for several different aspects of primary health care. First, the provision of health education and contraceptive services is obviously

relevant to the prevention of unplanned teenage pregnancy. Secondly, appropriate obstetric care should be provided for teenagers who are at high risk of developing complications in pregnancy and childbirth. Thirdly and perhaps even more significantly, there is the implication of care required to deal with longer-term adverse health consequences associated with teenage pregnancy (Irvine *et al.*, 1997).

However, the value and effectiveness of most teenage sexual health interventions have not been adequately evaluated (Oakley *et al.*, 1995). The nurses should introduce teen pregnancy preventing programmes such as abstinence education, knowledge based and clinic focused programmes. These programmes will tend to take a personal approach helping teens understand their own risk and to model out appropriate behaviours provide support to encourage pregnant teens and those who have recently given birth to remain or re-enter educational programmes that will give them the skill to be better parents and provide for their child financially and emotionally without outside assistance.

Therefore, the nurses and the social workers needs to explore the psycho-social factors underlying health promotion behaviours, the impact of lifestyles on health status of the teenagers to avoid early sexual activities or perhaps encourage the use of contraceptives thus creating a supportive environment for health. In addition, the nurses and social workers also need to promote safe and healthy sexual behaviours by offering education-related activity on sexuality, risk behaviours and protective methods. When individuals perceive it as helpful, it can enhance their health and well-being.

CONCLUSION

This study shows that the health and psycho-social problems of teenage pregnancy were low education, poverty, limited job opportunities, difficulty in child birth, haemorrhage, prolonged labour, threatened abortion, maternal and child mortality, anaemia, depression, vesico vaginal fistula and high blood pressure. Care of nurses, health education, conventional education, economic status, age is associated with increased health status and the ability of the pregnant teenagers to cope with the stress of pregnancy. Future studies should compare the health and psycho-social problems of young pregnant teenagers and matured pregnant woman in order to ascertain whether age is really a salient factor in the health and psycho-social status of pregnancy.

REFERENCES

- AAP, 1999. Adolescent pregnancy: Current trends and issues: 1998. *Pediatrics*, 103: 516-520.
- Anda, 2007. Abuse boys, battered mothers and male involvement in teen pregnancy. *Pediatrics*, 107: E19-E19.
- Brown, C., 1991. Medical and social factors affecting early teenage pregnancy. *Am. J. Epidemiol.*, 21: 82-90.
- Cutrona, C.E., 1984. Social support and stress in the transition to parenthood. *J. Abnormal Psychol.*, 93: 378-390.
- DHSSPS, 1992. Health and social well-being: Teenage mother, smoking and pregnancy. <http://www.dhsspsni.gov.uk/smokingyoungmothers.pdf>.
- East, P.L., 1996. Do adolescent pregnancy and childbearing affect younger sibling. *Family Plann. Perspect.*, 28: 148-153.
- Ellis, B.J., J.E. Bates, K.A. Dodge, D.M. Fergusson, L.J. Horwood, G.S. Pettit and L. Woodward, 2003. Does father absence place daughters at special risk for early sexual activity and teenage pregnancy? *Child Dev.*, 74: 801-821.
- Erikson, E., 1968. *Identity, Youth and Crisis*. Wiley, New York.
- Finlay, A., N. Shaw, D. Whithington and M. McWilliams, 1995. Adolescent reproductive behaviour in the Western board area: Report. Western Health and Social Services Board. NI.
- GI, 2005. Sex and relationships. Guthmacher Institute, USA.
- Irvine, H., T. Bradley, M. Cupples and M. Boohan, 1997. The implications of teenage pregnancy and motherhood for primary health care. *Br. J. Gen. Pract.*, 47: 323-326.
- Joners, D.J. and S.F. Battle, 1990. *Teenage Pregnancy: Developing Strategies for Change in the Twenty-First Century*. Transaction Publishers, USA., ISBN: 9780887388187, Pages: 172.
- Kessler, R.C., K.A. Mc Gonagle, S. Zhao, C.B. Nelson and M. Hughes *et al.*, 1994. Lifetime and 12 month prevalence of dsm-111-R psychiatric disorders in the united states. *Arch. Gen. Psychiatry*, 51: 8-19.
- Konje, J.C., A. Palmer and A. Watson, D.M. Hay, A. Imrie and P. Ewings, 1993. Early teenage pregnancies in Hull. *Br. J. Obstet Gynaecol.*, 99: 969-973.
- Mahfouz, A.A.R., M.M. Elsaid, R.A.G. Alerian and A.M. Aamid, 1995. Teenage pregnancy-are teenagers a high risk group? *Eur. J. Obstet Gynaecol. Reprod. Biol.*, 59: 17-20.
- Makinson, C., 1985. The health consequences of teenage fertility. *Family Plann. Perspect.*, 17: 132-139.
- Meadows, S. and N. Downson, 2007. Teenage mothers and their children: Factors affecting their health and development. Graduate School Education, University of Bristol, UK.
- NAY, 2003. Teenage pregnancy: The case for prevention. Nigeria Advocate for Youth, Nigeria.
- NCPTP, 2003. Not just another single issues: Teen pregnancy prevention's link to other critical social issues. The National Campaign to Prevent Teen Pregnancy, USA.
- Oakley, A., D. Fullerton, J. Holland, S. Arnold, M. France-Dawson, P. Kelley and S. McGrellis, 1995. Sexual health interventions for young people: A methodological review. *Br. Med. J.*, 310: 158-162.
- Peaches, A.R., 1990. Teen pregnancy and health. *J. Health Social Behav.*, 31: 43-57.
- Scafeer, D., A. Pettigrew, S. Woldking and E. Zajieek, 1978. Psychiatric aspects of poregnancy in schoolgirls: A review. *Psychol. Med.*, 8: 119-130.
- Shapiro, I.R. and S.C. Mangelsdorf, 1994. The determinant of parenting competence in adolescent mothers. *J. Youth Adolesc.*, 23: 621-641.
- Slatter, J., 2000. Britain: Sex education under fire. The UNESCO Courier.
- Stodemire, A., R. Frank, N. Hedemark, M. Camlet and D. Blazer, 1986. The economic burden of depression. *Gen. Hosp. Psychiatricy*, 8: 387-394.
- Tamkins, T., 2004. Teenage pregnancy risk rises with childhood exposure to family strife. *Prevent. Sexual Reproduct. Health*, 36: 220-228.
- Tinuola, F.R., 2006. Reproductive health issues among adolscentcs in Nigeria. *Bangladesh e-J. Sociol.*, Vol. 3.
- Treffers, P.E., 2003. Teenage pregnancy, a worldwide problem. *Ned. Tijdschr. Geneesk.*, 147: 2320-2325.
- UNICEF, 2001. A league table of teenagers births in rich nations. United Nations Children Found, Inocenti Research Centre, Florence, Italy.
- WB and TSP, 2008. Questions Young People Ask: Answers that Work Watchtower Society of Jehovah's Witness. Vol. 2, Watchtower Bible and Tract Society of New York, New York, USA., Pages: 319.