KNOWLEDGE AND PERCEPTION OF HEALTH RISKS ASSOCIATED WITH TEENAGE PREGNANCY AND CHILDBEARING AMONG ARTISAN ADOLESCENTS IN IBADAN SOUTH EAST LOCAL GOVERNMENT, OYO STATE

BY

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ABSTRACT

Adolescent pregnancy and childbirth are social and public health concerns with a wide range of physical, psychological, social and economic consequences for the adolescent girls, their babies, families and communities. Despite the increasing prevalence of adolescent pregnancy and its complications,few literatures exists that have systematically explored artisan adolescents' knowledge and perception on the health risks associated with teenage pregnancy and childbearing. Therefore, this study investigated the knowledge and perception of artisan adolescents on health risks of teenage pregnancy and childbearing.

The study design was a cross-sectional study. A multistage sampling method was used to select 350 artisan adolescents across the 12 wards in Ibadan south east local government area. Quantitative instrument (semi-structured questionnaire) was used for data collection. The questionnaire included socio-demographic characteristics of respondents, a 44 point scale to measure the knowledge of adolescents on the health risks associated with teenage pregnancy and childbearing, a 19-point scale to assess respondents' perception on the health risks associated with teenage pregnancy and childbearing and factors predisposing artisan adolescents to the health risks associated with teenage pregnancy and childbearing. Knowledge scores ≤15 were categorised as poor knowledge, >15 ≤ 30 were categorised as fair knowledge and >30 as good knowledge. Perception scores ≤8 were categorized as negative perception and scores >8 were categorised as positive perception. The data were analysed using descriptive statistics, Chi-square and multiple regression at $\alpha_{0.05}$.

Respondents' mean age was 17.0 ±1.5 years and 66.6% were females. Majority (76.6%) had fair knowledge score. 24.0% of the respondents stated that pregnancy can occur from the age of 12 years while majority (72.0%) agreed that female adolescents are at higher risks of health problems associated with pregnancy. Depression, STI, Abortion, premature labour and poor nutrition were the most common health risk of teenage pregnancy highlighted by respondents. Majority, (60.0%) of the respondent had a positive perception on the health risks associated

with teenage pregnancy and childbearing. The overall mean score for the perception of respondent on the health risks associated with teenage pregnancy was determined at 12.6±3.2. There was significant association between age of respondents and knowledge on health risk of teenage pregnancy (R Square = 0.16; $p<0.05$). There was also a significant association between the level of knowledge of respondents and the level of perception of health risk associated with teenage pregnancy and childbearing (R Square = 0.025; $p<0.005$), indicating that respondents' knowledge has a 2.5% influence on their level of perception.

Results from this study indicate that there is a huge gap in the knowledge of respondents on health risks involved in teenage pregnancy and childbearing. However, the work place of artisan adolescents is a good setting for education, capacity building intervention aimed at increasing adolescents' knowledge on health risks associated teenage pregnancy and childbearing which will assist in the control and mitigating the prevalence of adolescent pregnancy.

Keywords: Health risk, Teenage pregnancy, Knowledge, Perception.
Word count: 472

DEDICATION

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CERTIFICATION

I certify that this work was carried out by Adebisi Mistura IYANDA under my supervision in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria.

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LIST OFABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
IBSE	Ibadan South-East
LGA	Local Government Area
NDHS	Nigerian Demographic Health Survey
NPC	National Population Commission
STI	Sexually Transmitted Infections
SPSS	Statistical Packages for the Social Sciences
WHO	World Health Organization

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OPERATIONAL DEFINITION OF TERMS

Adolescents: A developmental phase between the age of 10 and 19 characterized by human growth and development that occur after childhood and before adulthood. Because pregnancy requires physical development, this study included adolescent age 15-19 years of age. 'Adolescent' was simultaneously replaced by teenager in some paragraph but they mean the same.

Childbearing:This refers to the reproductive period in a woman's life. This is the time during which she is physiologically able to conceive children.

Knowledge: Defined as the facts, information and skills acquired through experience or education. Thatis, the awareness or familiarity gained by experience or a fact, or a situation

Artisan adolescents: Adolescents age 15-19 years who are not attending school (i.e. not receiving any formal education) and may therefore includes adolescents who have dropped out of school, unemployed or participate in non-formal school programs.

Perception: It is an interpretation that bases on previous knowledge and experiences to understand the environment. It is built on the environment and kept information from the past. Perception in this study is about the feelings of the study respondent on how they understand the statements in the questionnaire.

Pregnancy: It refers the period that begins after conception and it occurs at fertilization before childbearing.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Adolescents constitute a substantial proportion – 30 million of the country's population, it has been projected that by 2025, the population of young people in Nigeria will exceed 57 million of which a large proportion are adolescent (Advocacy for youths, 2018). Alcohol and substance abuse, juvenile delinquency, teenage pregnancy, susceptibility to and transmitting sexually transmitted infections (STIs)/HIV, vulnerability to risks associated with early sexual activity and child marriage, and unemployment are some of the challenges faced by youths in the Nigeria(Jessica Morris and Hamid Rushwan, 2016; World HealthOrganization, 2016). Adolescents are at a critical stage of life which presents them with special needs especially that of their sexual and reproductive health.

Adolescents pregnancy and subsequent childbearing to females younger than 18 years old continually poses to be a public health challenge affecting over 16 million girls and young women globally (WHO, 2014). The rate of adolescent birth occurring yearly ranges from 0.29% in South Korea to 14.3% in sub-Saharan African countries (WHO, 2014). In Nigeria, the incidence of teenage pregnancy are reported to range from 1.7% to 11.8% (Osaikhuwuomwan and Osemwenkha, 2013). The 2013 National DemographicHealth Survey documents the proportion of teenage pregnancy to be highest in the North-west and lowest in the South Western part of Nigeria(36% and 8% respectively).The high rate of teenage pregnancy occurring in Nigeria has been linked to factors which include: poor knowledge of sexuality education, peer group influence, poor knowledge and ineffective use of contraceptives, low socioeconomic status, child marriage and cultural permissiveness (Osaikhuwuomwan and Osemwenkha, 2013). Outcomes of adolescent pregnancy are often of adverse psychosocial, socioeconomic and health effects (Sedgh, Finer, Bankole, Eliers and Singh, 2015). In comparison with older women, the negative health and socioeconomic consequences associated with adolescent pregnancy is worrisome (WHO 2016). Health complications include: anemia, hypertension, eclampsia, premature labour, postpartum

hemorrhage, low birth weight, cognitive and behavioral difficulties. In addition, adolescent mothers are also at higher risk of psychological problems because they experience higher levels of stress, depression, low self-esteem, sense of personal failure and suicidal attempts (Case, Hoyt, Canfield and Wilkinson, 2015; Timur, Kokonali and Yakut, 2016).

Through the past decades, adolescent's sexual and reproductive health concerns have increasingly been on National agendas due to the high burden of HIV/AIDS and sexually transmitted infection among young people, however, this concerns has not been transformed into actions (WHO, 2014). The reproductive health of young people including adolescents remain poorly understood and under-served worldwide (Olumide, Oluwatosin, Franklin and Obafemi, 2016). Several interventions have been recommended to help mitigate the incidence and ill-effects of teenage pregnancy (Haman, 2001). Some notable recurring ones in literature include: education on sexuality, provision and utilization of contraceptives, effective and accessible family planning methods for adolescents. In Southern Nigeria, Oronsanye *et al.,* (2001), advocated sex education, systematic dissemination of information for planned and conscious parenthood as well as free availability of contraceptives to deal with the issue of adolescent pregnancy that has been pervasive throughout Nigeria. However, the problem still persists in the country, perhaps due to some key factors that influences adolescent behaviour in the 21st century such as declining age at menarche, early sexual debut, poverty and inadequate contraception (Oni and Alabi, 2017).

More than half of the 22% of Nigerian adolescents dwell in rural areas, with a majority being out-of-school teenagers (National Population Commission, 2016) and only minimal efforts have been made to address their concern and provide them with the required sexual and reproductive health service (NPC, 2016). Owing to the reason that there is a paucity of information regarding how these group of people perceive adolescent pregnancy and the context in which it occurs, this research seeks to yield results that can inform reproductive health programs to cater for the specific needs of these out-of-school adolescents by developing salient and socially appropriate measures for preventing unintended pregnancies.

1.2 Statement of problem

Research shows that adolescent years are the most stressful and confusing times of life. During this period, adolescents are expected to acquire education and skills needed for adulthood in the future. On the contrary, many teenagers engage in risky behaviours and premarital sex which exposes them to the risks of STIs/HIV and adolescent pregnancy. Adolescent pregnancy remains a major contributor to maternal and child mortality and to the intergenerational cycles of ill-health and poverty in Nigeria(NPC, 2016). Pregnancy and childbirth complications are the leading cause of death among 15 to 19 year old globally with low and middle income countries accounting for 99% of global maternal deaths of women ages 15to 49years (WHO 2016).

Pregnancy occurring during adolescence is mostly unwelcomed and unwanted especially when it occurs out of wedlock, thusaffecting the individual's life adversely. Adolescent mothers face the higher risks of eclampsia, puerperal endometritis and systemic infections, preterm labour, obstructed labour, anemia, poor maternal nutrition and poor breastfeeding that women aged 20-24 years.In addition to health problems, the adolescent suffer from physical, psychological andsocial problems. Sometimes, teenager pre-plan pregnancy but they are still at higher risks for health problems than the females who delay childbearing.

Babies delivered by teenagers have several risks factors: Prematurebirth, birth of underdeveloped child, delivering a baby with low birth weight, blood pressure problems, low iron level in blood, threat of sexually transmitted diseases and hypertension are risks factors regarding teenage pregnancy.

The prevalence of teenage pregnancy over decades in Nigeria has increased as more efforts have been channeled towards reducing the prevalence without any imminent success in sight. WHO factsheet (2016) reported the prevalence of HIV amongst 15- 24 years old was 4.5% with 1.33% among malesand 3.3% among females. Adeyinka et al., (2010) from a case control study conducted in southwestern Nigeriafrom January 2007 to November 2008 reported the proportion of adolescent pregnancy to be between 1.1% and 2.2%. The study also reported the overall complications resulting from teenage pregnancy to be 44.44% compared to 22.22%among the control. Olurinola (2016) reported the incidence of adolescent pregnancy

in the South West Nigeria to be low but rising (4% in 2008 to 6% in 2013).Prevalence rate continues to increase despite efforts of the government and other stakeholders through campaigns, interventions and the establishment of youth friendly services.

Out-of-school adolescents are at higher risks of pregnancy and childbearing as studies have shown that sexual activity are less likely to occur during school periods because of the structured and well supervised environment provided in schools (Molley, Audrey and Williams, 2015).This research therefore seeks to unveil the knowledge and perception of health risk of teenage pregnancy and childbearing among apprentice adolescents. The rationale of this research being that having a clear understanding of this component of health behavior (knowledge and perception) from the adolescents' perspective will help reveal information as to why there has been an increase in the prevalence of teenage pregnancy and its complications.

1.3Justification

Despite the increasing prevalenceof adolescent pregnancy and its complications, very little literature exists that have systematically explored artisan adolescents'knowledge and perceptionon the health risks associated with teenage pregnancy and childbearing. Whereas a plethora of studies (Adedokun et al., 2016; Oladepo and Oluwasanu,2011), have investigated the attitude, perception and sexual risk behaviours of adolescents among in-school adolescents in Nigeria.

Although these studies have shown that adolescents engage in risky sexual behaviours that can lead to pregnancy and childbearing, very little is known about their knowledge and perception on the health risks and complications associated with pregnancy.This research contributes to the literature on adolescents' knowledge, perceived susceptibility, perceived severity to health risks of pregnancy and childbearing.

In addition, this research provides credible evidences to the factors influencing artisan adolescent knowledge and perception on the health risks associated with pregnancy in Nigeria that will in-turn raise awareness on necessary actions to be taken by concerned parties to help modify the adolescents negative perception and to reinforce theirpositive perceptions.

The findings from this research will also serve as grounding for evidence based public policies. It will call the action of policy planners and organizers to the needs of artisan adolescents in other to take them into consideration when formulating policies and planning programs designed to sensitize adolescents on the implications/complications of teenage pregnancy.

1.4 Research Questions

The study was guided by the following research questions:

1. What is the knowledge of artisan adolescents on the health risks associated with teenage pregnancy and childbearing?
2. What is the perceptionof artisan adolescents on the health risks associated with teenagepregnancy and childbearing?
3. What are thebehaviours predisposing artisan adolescents to the health risks associated with pregnancy and childbearing?

1.5 Objectives

Broad objective

To explore the knowledge and perception of health risks associated with teenage pregnancy and childbearing among artisan adolescents in Ibadan South East Local Government area, Oyostate

Specific Objectives

The specific objectives are to:

1. Assessthe knowledge of artisan adolescents on the health risks associated with teenage pregnancy and childbearing
2. Determine the perception of artisan adolescents on the health risks associated with teenage pregnancy and childbearing.
3. Identify the behaviours predisposingartisan adolescents tothe health risks associated with pregnancy and childbearing

1.6 Research Hypotheses

The following null hypotheses (Ho)were tested for this study:

There is no significant association between

1. Age of respondent and knowledge of health risks associated with teenage pregnancy
2. Sex of respondent and knowledge of health risks associated with teenage pregnancy
3. Level of education and knowledge of health risks associated with teenage pregnancy
4. Age of respondent and perception of health risks associated with teenage pregnancy
5. Sex of respondent and perception of health risks associated with teenage pregnancy
6. Level of education and perception of health risks associated with teenage pregnancy
7. Respondent's knowledge of health risk and respondent's perception of health risk associated with teenage pregnancy

CHAPTER TWO

LITERATURE REVIEW

2.1Introduction

Adolescent pregnancy and subsequent childbearing is a major public health challenge worldwide.Research indicates that 70,000 adolescents die from pregnancy and childbirth related complications every year (UNFPA, 2013). Three million estimated unsafe abortions are from adolescents. Other health impact of adolescent pregnancy includes risk of illness and disability, including obstetric fistula, STIs, including HIV and health risk to infant including preterm birth (UNFPA, 2013).

2.2 Adolescence

Adolescents have received considerable research attention in the last decade primarily because of their sheer size and the fact that adolescents are affected by several reproductive morbidity including HIV/AID. A major feature of adolescence is sexual and reproductive growth and development. Many adolescents are involved in sexual activities that increase their risk to several reproductive health morbidity including unwanted pregnancies, abortion and sexually transmitted infections (Titiloye and Ajuwon, 2017). Research confirms that adolescent lack basic knowledge on reproductive biology and prevention methods and preconception care, as they rely majorly on mass media and peers as the source of information on sexual and reproductive health, unfortunately, these sources are either false or incomplete (Nzioka, 2001).

The age range of adolescence as defined by WHO is10 to 19 years (Emmanuel, Joseph, Jeffery and Clement, 2013). This has been adopted by Nigeria's Ministry of Health. The national demographic health survey of 2018 in Nigeria indicated that adolescent formed 16% of the total population of 186 million (National Demographics Profile 2018). All adolescents are not alike, they differ in demographic and social background. In study of sexual behaviour among four sub-Saharan African countries including Ghana, findings indicated that adolescents have levels of awareness but little in-depth knowledge about pregnancy and HIV

prevention Emmanuel, Joseph, Jeffery and Clement, 2013).While studies have shown that adolescents engage in sexual practices, only few sexually active adolescents use contraceptives methods such as hormonal contraceptives and condoms. For example, among sexually active Ghanaian adolescents age 15-19 years, 80% of girls and 63% of boys were not using any contraceptive method in their last sexual encounter (Kumi-kyereme, Awusabo-Asare and Biddlecom, 2007).

Addressing the high rate of teenage pregnancies and non-contraceptive use in Africa requires a context-specific understanding of the high prevalence of adolescent pregnancy while a significant group does seems to manage to prevent getting pregnant (Krugu, Meviasen, Prisen and Ruiter, 2016). Previously identified barriers to contraceptive use among adolescents in sub-Saharan Africa include inadequate sexual knowledge and risk perception, lack of skill to negotiate safer sex options, ambivalent attitude towards sex, lack of access to educational and health services and negative social norms around premarital sexual activity and pregnancy (Mushwana, Monareng, Muller and Ritcher, 2015). Other reports also indicate that young girls engage in unsafe sex because they have not considered contraception, are afraid of possible side effects (Abiodun and Balogun, 2009), are more worried about the safety of the contraceptive than preventing an unintended pregnancy or are not adequately informed about the risk of pregnancy or disease posed by unsafe sex (Adedimeji, Omololu and Odutola, 2007).

2.3 Prevalence of adolescent pregnancy

Adolescent pregnancy and childbirth is a social and public health concern with a wide range of physical, psychological, social and economic consequences for the adolescent girls, their babies, families and communities (Papri, Khaman, Ara and Pamna, 2016). Adolescent pregnancy in most regions and countries have declined in the past decade. There is an increase of age at first marriage and adolescents are more often using contraceptives than the past two decades (WHO, 2016). The policy of education for all has been implemented in many countries which has led to an increased number of educated boys and girls. This education as so far contributed to the reduction of early childbearing in some countries.

Vincent and Alemu (2016) reported that about 16 million of adolescent girls aged between 15 to 19 years give birth every year. The prevalence of female under 15 years that give birth every year are majorly from low and middle-income countries (WHO, 2016). About 10 percent of girls in low and middle-income countries give birth before attaining the age of 16 and are most prevalent in sub-Saharan African, South-Central and South Eastern Asia with sub-Saharan African has the highest rate habitually associated with early marriage where more than 30% of girls marry before the age of 18, 14% of girls marry before the age of 15(WHO, 2016) and 25% of girls have given birth by the age of 18 (Vincent and Alemu 2016).

Majority of studies concentrated on unintended pregnancies which led to personalized designs of various programs to the needs of women. Though adolescent pregnancy is associated with various fatal effects, it has been proven that a significant proportion of theses pregnancies are wanted and even planned (Mushwana, 2015). It is beneficial for adolescent pregnancy to be intended so as to have positive pregnancy outcome of both the mother and the child. The adverse effects of unintended pregnancies often times have lesser effect on the father since he is less likely to be involved in the care of the child when this happens (WHO 2016).

2.4 Childbearing among adolescents

Teenage childbearing has been associated with negative outcomes for teen mothers and their offspring. Teen mothers experience lower self-esteem and are at higher risk for depression, substance abuse and living in poverty relative to their same age peers who delay childbearing (Lipman, 2011). Additionally, they have lower educational attainment(Flahery,2011). Pregnant and parenting teens experience high levels of intimate partner violence, both as victim and as perpetrator(Perper, 2012). Children born to teen mothers are at higher risk for abuse and neglect than their peers who are born to adult mothers (Lipman, 2011). They also demonstrate inferior language skills and tend to score lower on tests of cognitive ability (Sue, 2011). These deficits persist, and often expand, through childhood (Sue, 2011). As adolescents, they are at higher risk of becoming teen parents themselves (Brown, 2012). Adult children of former teen mothers have lower educational attainment; have lower income levels; are at higher risk of mental illness and substance abuse; and disproportionately enter the

prison system (Brown, 2012). Inferior environmental and social factors; maternal stress and depression; ignorance of and unrealistic expectations surrounding child development; maternal egocentric developmental stage; and negative parenting behaviors all likely contribute to these disparities (Sue, 2011). Although perhaps less obvious, teenage childbearing has a high societal cost as well. It is estimated that, in 2008, US taxpayers incurred $10.9 billion in costs related to teenage childbearing (Sue, 2011). The average annual public sector cost per mother younger than 18 is over $4000. These costs are related to healthcare, welfare and other public assistance, lost taxes and incarceration, among other factors (Barnet, 2010). However, recent literature suggests that the negative impact on teen mothers may not be as dismal as previously reported (Barnet, 2010).

Improved outcomes are probably in part attributable to the fact that contemporary investigators control for environmental factors that make teens more likely to become pregnant in the first place. It is likely that the social, economic and environmental factors that promote teenage childbearing also create many of the negative outcomes previously attributed to maternal age (Lipman, 2011). In fact, the outcome gaps between teenage and older mothers, and their respective offspring, are narrowed or even eliminated in many studies that control for the mothers' childhood environment(Lipman, 2011). Regardless of root cause, however, it remains clear that teenage mothers and their offspring remain at high risk for numerous negative outcomes. The impact of adolescent childbearing is compounded with repeat births (Barnet, 2010). Nearly 20% of all births to mothers under the age of 20 represent a repeat birth (Brown, 2012). A second birth within 24 months of the first occurs in 23% of African–American, 22% of Hispanic and 17% of white adolescent mothers. Past interventions to reduce these numbers have been geared toward increasing contraception use among teen mothers and providing further education and social support opportunities.

Success of these programs has been mixed, and studies have often measured surrogate outcomes, such as rates of contraception use, rather than the true outcome of repeat pregnancy (Perper, 2012). A 2007 meta-analysis conducted by Corcoran and Pillai,(2010) included 16 programs aimed at decreasing repeat pregnancy rates and found overall success up to at least

19 months following the intervention, but the programs were quite varied, with no one clear model leading to success(Perper, 2012).

2.5 Knowledge of adolescents on pregnancy

Based on the interviews with the adolescents, knowledge of sexuality are understood in the sense of gender and sexual choice, thus shown through sexual behavior and attitudes with each other. Sexuality can be understood as the desire for contact, warmth, affection, or love, and sexuality is a phenomenon of human existence, present in the life of adolescents. In the family, the dialog about sexuality and sex is still a taboo in general. Adolescents acquire this information mostly from friends, magazines, movies, television, and the Internet, and less often from teachers and health professionals. Parents in many cases transfer the responsibility of sex education to schools. In this context, the school and the government should be in contact to provide education that addresses this theme in all its dimensions. Parents should not delegate to others their task of talking to their children about sex; also important isknowing the most appropriate way to address this subject (Freitas, 2016).

According to the results of this study, the adolescents recognize that the family and the school should share the responsibility of informing them. Having the father as a source of information about sexuality, pregnancy, STI/AIDS prevention, and contraception, and being comfortable talking about sex with the mother are positively associated with the consistent use of contraceptives (Freitas, 2016). The teacher is the first choice among adolescents as a source of STI information, confirming the importance of teachers in the natural role of sexual educator in the school environment (Bretias, 2010). Regarding the harm caused by the lack of information, STIs are still a serious public health problem, especially in adolescence, and it may leave curable or incurable issues, such as infertility, ectopic pregnancy, genital cancer, chronic liver disease, among others. Then, preventive actions based on the understanding of how young people perceive and lead their sexual lives should be developed, because the lack of this understanding has led to prevention strategies that either use a metaphorical language, making it difficult to understand or, in other cases, vulgarize the theme, instigating different types of prejudice (Bretais, 2010). A study (Moura, 2011) conducted to describe sources of information on sexuality and contraception used by adolescents showed that more than 85% of adolescents had some information about how to avoid having children and STIs before

becoming pregnant. About 55% said they had someone to talk to about this subject. In the preference scale, friends came first with 36.3%, followed by the mother with 25.5%, and the partner with 16.6%. Adolescents generally know that condoms prevent illness and pregnancy, but they find them difficult to use. Adolescents do not know their own bodies and were unable to recognize the symptoms of STIs and the transmission methods of AIDS. They believed that an apparently healthy person cannot be infected, which raises the chances of acquiring an STI (Dias, 2010). Or they simply did not believe in the existence of the risks of pregnancy and diseases during the first sexual intercourse, considering themselves indestructible and fully protected in their magical thinking(Olivera, 2013). This thought was displayed in this study when adolescents did not take the risk seriously because they believed an unwanted pregnancy would never happen to them. The most familiar type of STI among young people is AIDS, often referred to as HIV. They presented insufficient characterization of the disease and its causative agent, and they showed a lack of knowledge about these infections, which is a point of concern, because studies show adolescence is the period with the highest incidence of the disease (Freitas, 2016). Another study conducted with young people showed that 50% of the students knew about the male condom, and 56% said they had not started their sex life. Regarding the knowledge of STIs, 90% only knew AIDS, and condoms were mentioned as the prevention method.

However, another study (Moura, 2011) showed that a high percentage of adolescents did not know any transmission method of STI, showing that, despite the dissemination by social information vehicles, such information has not effectively reached the population. The percentages of adolescents who did not know the signs and symptoms were even higher regarding the lack of knowledge of transmission methods. In this study, the adolescents mentioned condoms and other contraceptives, as well as family guidance as prevention methods. The use of preventive and contraceptive methods is not directly related to the knowledge of adolescents, but it may be related to other factors that may influence their sexual behavior, such as their thoughts and attitudes as determined by their perceptions, values, beliefs, and feelings, which condition the proper and regular use of condoms (Moura, 2015).

2.6Health risks associated with adolescent pregnancy and childbearing

Pregnancy during adolescence is often associated with poor maternal and child outcomes. Childbearing in adolescence is also associated with social and psychological problems such as isolation, poverty, low levels of education and unemployment (Cook and Cameron, 2015). The impact of maternal age on obstetrics and neonatal outcome has been studied worldwide and are with variable results. A WHO multi-country study including 29 low-income and middle-income countries found adolescent mothers to be at a higher risk of several adverse health outcomes including low birth weight, preterm delivery, eclampsia and infections compared with mothers age 20-24 years (Ganchimeg, Ota and Morisaki, 2014).

Similarly in high-income countries, health outcomes are also less favourable for younger mothers. Babies born to adolescent mothers have been shown to be at higher risk of preterm birth, low birth weight, high rate of stillbirth and neonatal mortality (Tyberg, Blomberg, Kjolhede, 2013). However, adolescents have been consistently shown to experience lower rates of caesarean and instrumental delivery (Blomberg, Brich and Tyrberg, 2014) and therefore are at lower risks of complications associated with assisted births. It is not currently clear by literature as to what extent differences in birth outcomes between adolescent and adults mothers are predicted by age alone (Katie, Karen, Victoria and Jane, 2018).

Gibbs, Wendt and Peters, 2012 assessed the relationship between early first childbirth and increased risk of poor pregnancy outcomes and found that there was considerable evidence to suggest that at a very young maternal age, (less than 15 years or less than two years after menarche), there is negative effect on both maternal and fetal growth and also infant survival. It also suggest that young women who are still themselves growing are likely to compete with the fetus for nutrient which may in turn cause impaired fetal growth and result in low birth weight babies or babies who are small at gestational age. The study also found increased risk of anemia. Premature birth and neonatal mortality associated with young maternal age.

Difference in pregnancy outcomes have also been linked with demographic and behavioural characteristics. Lifestyle and socio-demographic factors such as smoking, alcohol use and deprivation have all been shown to contribute to poor pregnancy outcomes. Research has also established that adolescent mothers in high income countries are at high risk of exhibiting these characters (Blumenshine, Egerter and Barclay, 2010; East and Fellice, 2014).

While education is linked to socioeconomic class, data shows it influences behavior and utilization of health services, studies have shown that women who have higher levels of education are more likely to have higher number of ante-natal clinic visits and deliver in a health facility compared to unschooled women (Fawole, Shah, Fabanwo, and Adegbola, 2012). The level of educational attainment enhances the chances of a woman to overcome negative cultural norm, enhance her skill to bargain for autonomy within the family and community structure and ultimately take appropriate health related decisions compared to her illiterate counterpart (Mekonnen, Mekonnen, 2003). Research in India (Patra, 2016), Kenya (Ferre, 2009) demonstrated that delaying child bearing until the females are between the age of 20-30 years would have a fourfold lower risk of dying from pregnancy related complication compared to those less than 20 years old.

2.7 Adolescent perception of pregnancy

Risk perception is defined as people's judgments and evaluation of risks they are likely to be exposed to (Funicane and Holup, 2006).Risk perception plays a central role in in many health behavior theories including Health Belief Model (Bayrampour, Heaman, Duncan and Tough, 2012). A greater perception of health risk increases the protected motivation and it is also important to help understand how people perceive health risks, how accurate these perceptions are and how risk information are received (Jackson, Allum, and Gaskell, 2006). Perception of risk is a factor which strongly influences the care that high risk women receive before and during pregnancies and their decision about prenatal care.

The cost and reward implication of adolescent childbearing indicates diverse perception in adolescents. A study by Smith and colleagues (2012) to describe the perception of teen motherhood in adolescent females from Austria revealed that the rewards of childbearing were perceived by some adolescents as becoming an adult with full independency and with a

transformative experience that foster personal growth. Theseadolescents believes childbearing changes their life by becoming strong and growing faster. In contrast, the implication of adolescent childbearing was viewed as a decreasing social life and social isolation, it causes multiple demand and inhibits opportunity for personal development (Childs, Knight and White, 2015).

Another study conducted by Lebese and colleague (2015) in South Africa showed that adolescent childbearing was perceived as both positive and negative by school students. The student perceived adolescent pregnancy to be positive if planned by sexual partners and that they were going to work to make end meets and also plan to get married or if the said female student was already married and has the full support of the husband and/or both parents. On the other hand, adolescent pregnancy was perceived to have negative effects on the student parent and the unborn child if he is rejected by the sexual partner who got her pregnant, the factor may also have emotional and psychological effect.

A number of studies indicates that there are positive aspects of adolescent pregnancy and birth, namely improved family relationships, family support, increased focus on educational goals, maturity, becoming more responsible, being loved, and having someone to love (Herrman and Waterhouse, 2011). Many of these positive perceptions of adolescent births have been elicited from pregnant or parenting adolescents in qualitative studies. Herrman and Nandakumar, (2012) found that residing with one parent, living in poverty, and/or having a parent or sibling who gave birth during adolescence were associated with adolescents having more positive views on adolescent pregnancy(Herrman and Waterhouse, 2011). Several studies also pointed to the transformative power of adolescent pregnancy and parenting in the lives of adolescents that became more focused and responsible as a result of the experience (SmithBattle, 2013). Geronimus (2003) noted that adolescent pregnancy was normative and protective, specifically in African-American impoverished communities where adolescents had a multigenerational family and community support system in place to help them succeed as parents. In a similar study, young adult African American women reported feeling pressured by peers and boyfriends to get pregnant during adolescence because it was the expected social norm (Martyn and Hutchinson, 2001).

In a study involving adolescent parents and never pregnant adolescents, findings showed they were aware of the changes that giving birth during their adolescent years would require in their lives, and most did not desire the additional responsibility, or were concerned about the response of their family and friends (Herrman, 2008). In a similar study, findings revealed pregnancy-related stigma, putting personal goals on hold, lack of financial and educational preparation, and having to miss out on the adolescent years to be among the negative consequences associated with adolescent pregnancy (Rosengard et al., 2006). Collectively, findings from these studies suggest that adolescents have varying opinions about adolescent pregnancy ranging from it being an expectation to it being a hindrance to future aspirations.

2.8 Theoretical frame work – Health Belief Model (HBM)

The HBM was originally developed as a systematic method to explain and predict preventive health behavior. It focused on the relationship of health behaviors, practices and utilization of health services. HBM has been revised in later years to include general health motivation for the purpose of distinguishing illness and sick-role behavior from health behavior. Originated around1952. It is generally regarded as the beginning of systematic, theory-based research in health behavior.

Health Belief Model (HBM) is one of the most widely used conceptual frameworks in health behavior research, both to explain changes and maintenance of health-related behaviors and as a guiding framework for health behavior interventions. It addresses the likelihood of taking recommended health action as influenced by specific health beliefs related to the health problem and recommended health actions. These beliefs are the individual's perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy). The core constructs of the model include;

1. Perceived susceptibility - one's subjective perception of the risk of contracting a health condition
2. Perceived severity feelings concerning the seriousness of contracting an illness or leaving it untreated

3. Perceived benefits - the believed effectiveness of strategies designed to reduce the threat of illness and risk
4. Perceived barriers feeling nuisance as someone who takes particular health actions or results from the actions. These factors can influence individual perceptions and indirectly, health related behaviors. The variables which include under modifying factors are; demographic, socio-psychological, and structural (Glanz et al., 2008).

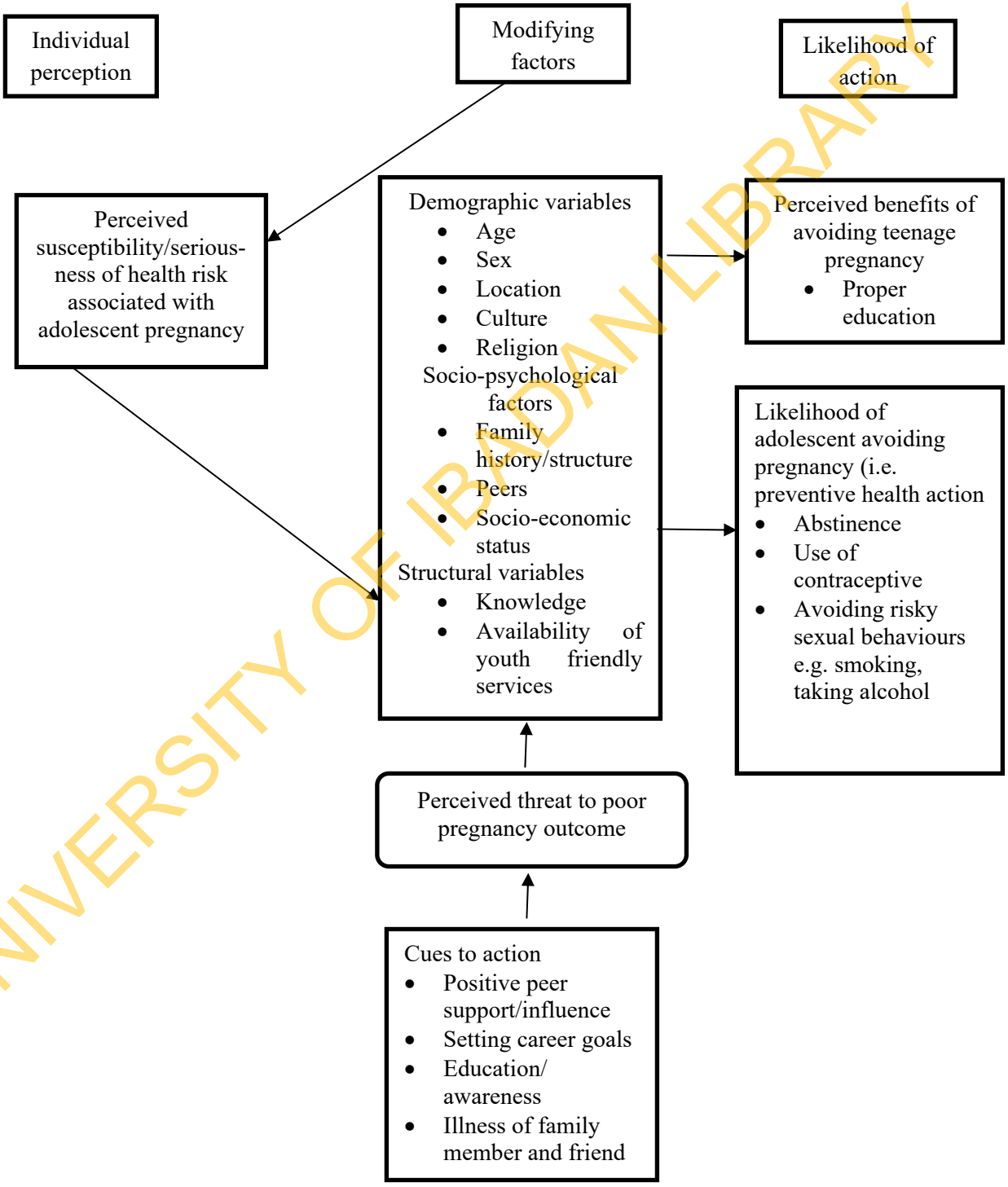


Figure 2.1: Theoretical framework (Health Belief Model)

CHAPTER THREE

METHODOLOGY

3.1 Study design

This study was a cross-sectional study aimed atinvestigating the knowledge and perception of health risks associated with teenage pregnancy and childbearing among artisan adolescents in Ibadan South East Local Government area, Oyo state.

3.2 Study Site

This study was carried out in Ibadan South East Local Government area of Oyo state, Nigeria. Ibadan south east local government is one of the 33 local governments in Oyo state. The local government was created on the 27th of August 1991. It was carved out of the defunct Ibadan Municipal Government.It is located in the inner core of the metropolis which has high density population. The local government is dominated by the Yorubatribe. Adults and young people are observed to be engaging in differenttype of artistry activities including: hair dressing/hair barbing, auto mechanic, tailoring, aluminum work, carpentry/upholstery andwelding. The population in the area as of 2006 census was 266,457. The population density of the local government was calculated to be 2,832 persons per square kilometer. The local government consists of 12 wards which is represented in table 3.1.

Table 3:Wards in Ibadan South East Local Government area

Ward	Areas
1	Mapo, part of Oronyan, Oja Oba
2	Part of Idi Arere, Isale Ijebu
3	Part of Kobomoje, part of Oronyan
4	Part of Kobomoje
5	Agbongbon, Ita Ege
6	Eleta Idi Aro
7	Oniyere, Olubadan
8	Odinjo, Owode
9	Omilabu
10	Kudeti, Olunloyo
11	Odo Oba, Elere, Ile tuntun
12	Boluwaji, Ajet, Adeyemo, Sanyo

3.3Study Population

The study population wereartisan adolescents aged 15-19 years, who wereartisans in Ibadan South EastLocal Government area of Oyo state, Nigeria. These group of people consisted of adolescents who were not currently receiving any formal education but participates in non-formal school program.

3.4 Sample size determination

The sample size for this study was estimated to be 350respondents using Kish's formula.

$n = \frac{Z_\alpha^2 pq}{d^2}$ (Kish, 1965)

Z_α: Standard normal deviation set at 1.96 at 95% confidence interval

d: the level of precision set at 5% (0.05)

p: (estimate of target population) = 0.28% (NPC, 2013)

q: 1-p

$$n = \frac{1.96^2 \times 0.28(0.72)}{(0.05)^2} = 310 \text{ adolescents}$$

Non response assumed rate of 10% of 310was added to the sample size to give341adolescents.

To improve accuracy of the study, sample size was rounded up to 350 respondents.

3.5 Sampling procedure

A multi-stage sampling technique involving four (4)stages was used in selecting respondents for the study

Stage 1: Simple random technique was used to select 5 wards out of the 12 wards in the LGA

Stage 2: Convenience sampling of six major artisan associations was identified for the research in each ward. Artisan association selected included: hairdressing, barbing, auto mechanic, tailoring, shoe making andsales assistants (traders).

Stage 3: From each selected artisan group in each ward, proportionate sampling was used to determine the number of respondents (see table 3.2).

Stage 4: Artisans who gave consent to participate in each shop visited were interviewed

Table 3.2 Proportionate selection of respondents

S/N	Artisan group	Total population	Sample size
1.	Hairdressing	273	78
2	Barbing	88	25
3	Tailoring	438	125
4	Trading	301	86
5	Welding	70	20
6	Shoe making	56	16
Total		1226	350

3.6 Inclusion criteria

Criteria for inclusion in this study were:

- All artisan adolescents age 15–19 years old in Ibadan South East Local Government area.
- Artisan adolescents who gave their consent to participate in the study

3.7 Exclusion criteria

Criteria for exclusion in this study were:

- Artisan adolescents aged 10- 14 in Ibadan South EastLocal Government area.
- In-school adolescents in Ibadan South East Local Government area.
- Artisan adolescents who do not give their consent to participate in thestudy.

3.8Methods and instrument for data collection

A semi-structured interviewer-administered questionnaire was used to obtain information from the research respondents. The questionnaire was developed based on the set objectives, review of literature and guidance from the research supervisor. The questionnaire was translated to the local language (Yoruba language) for ease of administration. The questionnaire consisted of four sections.

Section A determined the socio-demographic characteristics of the respondent.Section B determined the knowledge of health risks associated withpregnancy and childbearing among artisan adolescents. Section Cdetermined the perception of health risks associated with pregnancy childbearing among artisan adolescents. Section D determined the factors

predisposing artisan adolescents to the health risks associated with teenage pregnancy and childbearing.

The questionnaire included two scale measurement generated from in-depth review of relevant literature, review from research supervisor and other expert in the field and pretest of the research instrument. The scales included a knowledge scale to the measure the knowledge of respondent on the health risks associated with pregnancy and childbearing;a perception scale to measure the perception of respondent onhealth risks associated with pregnancy and childbearing.

The knowledge scale was a 44-point scale consisting of a 40 items related to the health risks associated with teenage pregnancy. The knowledge score was calculated for each respondent and score ≤15 was considered poor knowledge, >15≤30 fair knowledge and >30 good knowledge. A 19 point perception scale consisting of 19 items was used to investigate the perception of adolescents on the health risk associated with teenage pregnancy. A perception score of <8 and ≥8 was considered negative and positive perception respectively.

3.9 Validity of the instrument

Validity of the instrument was ensured through consultation of relevant literatureand subjection of draft questionnaire to critical review by the research supervisor and colleagues. Validity was also ensured by translating the questionnaire to the local language of the community to ensure clarity of the questions in the research instrument.

3.10 Reliability of the instrument

To ensure reliability, the instrument was pre-tested among 10% of the sample size using artisan adolescents in Ibadan North Local Government area of Oyo state. The Cronbach's alpha for the data obtained was analysed, giving a reliability coefficient of 0.75 indicated a strong internal consistency of the instrument.

3.11 Data Collection Procedure

Four trained research assistants who had previous experiences on data collection and were proficient in Yoruba language were recruited and trained to ensure viable collection of data.

Research assistants were trained on good communication skills, good interpersonal relationship,purpose of the research and respect for persons.

Questionnaires wereadministered to respondents by the researcher and other trainedresearch assistants after obtaining a valid informed consent from therespondents.Data were collected at respondents' workshops after the close of work in the evening. Accent was sought from the different heads of the workshops before data were collected. Survey questionnaire was interviewer-administered. Respondents were allowed to be interviewed wherever it pleased them. Copies of questionnaires were retrieved immediately after completion and werecross checked for completeness.

3.12 Data management and analysis

The quantitative data collected through the use of questionnaires were checked for completeness and accuracy on the field. Serial numbers were to each questionnaire for ease of identification and for correct data entry. Knowledge and perception scores were assigned individually to each of the questionnaires. The knowledge score was calculated for each respondent and score ≤15 was considered poor knowledge, >15≤30 fair knowledge and >30 good knowledge. A perception score of <8 and ≥8 was considered negative and positive perception respectively. The data was input into IBM/SPSS statistical tool, Version 21.0 for analysis. Descriptive statistics like frequencies, percentages was used to summarize variables while Chi-square and Multiple Regression was used to test for associations between demographics and the dependent variables.The hypotheses were tested for significance at 0.05 level using t-test and analysis of variance.

3.13Ethical Consideration

Ethical approval was obtained from Oyo state ethics review committee to ensure the study met all the principles and guidelines in research involving human participants. Permission was obtained from the heads of the artisan association within the local government area to carry out the study. Informed consent was sought from each respondent using an informed consent form. Confidentiality was ensured through the protection of data collected from the respondents.

3.14 Study limitation

- The study was limited to Ibadan South East LGA, therefore, the findings cannot be generalized to other areas in Ibadan.
- The sample consisted of only adolescents aged 15-19 who were artisans. Younger adolescents (10-14 years) and adolescents who are in-school were excluded from the study which could have given a wider perspective of the phenomenon.

CHAPTER FOUR

RESULTS

4.1Socio-demographic characteristics of respondents

There were three hundred and fifty respondents (350) recruited for this study aged between 15 years and 19 years old with a mean age of 17.02 ± 1.546 years, additionally, the highest percentage of the respondents (24.6%) were aged 15 years old, followed by 19 years olds (23.7%). There were more female respondents (66.6%) for this study than male respondents (33.4%). The highest level of education recorded by respondents was senior secondary school (84.6%). More than half of the respondents were of Christian religion background compared to Islam (40.6%). Respondents were predominantly of Yoruba ethnicity (91.4%) while small proportions were of Igbo ethnicity (6.3%) and Hausa ethnicity (0.3%). It was shown that slightly more than half of the respondents (57.7%) had Oyo as their state of origin, followed by Osun and Ogun state (13.1% and 6.9% respectively). Majority of the respondents were single (89.7%) while 2.6% of the respondents were married, still, 5.1% of the respondents have had children (Table 4.1a).

There were six identified artisan occupation by the respondents, most of the respondents nevertheless were tailors (35.7%), followed by traders (24.6%), hairdressers (22.3%); shoemakers were however the least with 4.6% of the respondents. Most of the respondents earn less than 5,000 naira monthly (87.4%), additionally, most of the respondents (84%) were living with their parents. The family size of respondents ranged from 2 to 17 with a mean family size of 4.97 ± 1.656. In addition, more than half of the respondents (58.3%) were brought up in urban locality while 65.4% currently live in urban locality (Table 4.1b)

Table 4.1a: Socio-demographic characteristics of respondents (N =350)

Variable	Frequency (№)	Percentage (%)
Age (years)		
15	86	19.7
16	41	19.1
17	69	23.7
18	67	19.1
19	83	23.7
Sex		
Male	117	33.4
Female	233	66.6
Level of education		
Primary	8	2.3
Junior secondary	46	13.1
Senior secondary	296	84.6
Religion		
Christianity	208	59.4
Islam	142	40.6
Tribe		
Igbo	22	6.3
Hausa	1	0.3
Yoruba	320	91.4
Others	7	2.0
State of origin		
Oyo	202	57.7
Osun	46	13.1
Ogun	24	6.9
Ondo	19	5.4
Others	59	16.9
Marital status		
Single	314	89.7
Married	9	2.6
In a relationship	27	7.7
Number of children		
0	332	94.9
1	13	3.7
2 and above	5	1.4

***Others:** Bayelsa, Edo, Imo, Kogi, Delta, Kastina, Ekiti, Kwara, Anambra, Abia, Lagos, Akwaibom, Enugu.

Table 4.1b: Socio-demographic characteristics of respondents (N =350)

Variable	№	%
Occupation		
Hairdressing	78	22.3
Barbing	25	7.1
Tailoring	125	35.7
Trading	86	24.6
Welding	20	5.7
Shoe making	16	4.6
Monthly income		
0 ≤ 5000	206	87.4
>5000 ≤ 100000	25	7.1
>100000 ≤ 150000	5	1.4
>150000 ≤ 200000	4	1.1
>200000	10	2.9
Person living with		
Parents	294	84.0
Relative	34	9.7
Friend	6	1.7
Lover	16	4.6
Family size		
2 -5	233	66.1
6 -9	114	32.6
10-13	1	0.3
14-17	3	0.9
Locality of upbringing		
Rural	100	28,6
Peri-urban	46	13.1
Urban	204	58.3
Locality currently living in		
Rural	57	16.3
Peri-urban	64	18.3
Urban	229	65.4

4.2 Respondents'knowledge on how pregnancy occurs

Respondents were asked how pregnancy occurs and majority of them (81.7%) answered through sexual intercourse while 3.1% answered sexual intercourse, ejaculation into vagina, fusion with egg and fertilization (Table 4.2a). in addition, when asked from what age can pregnancy occur, majority of the respondents selected ages 12 (26%) and 13 years (24.9%) (Table 4.2b).

When defining teenage pregnancy, less than half of the respondents (45.1%) defined it as pregnancy between 9-18 years while some (13.7%) of the respondents defined it as pregnancy that is unwanted (Table 4.2c).

Furthermore, when asked what are the health challenges of a teenager becoming pregnant, respondents identified depression, lack of care of mother and child, premature birth, anemia, severe bleeding, shame, rejection, poor nutrition, suicide, HIV/STI, financial struggle, hypertension, drop out of school, death of mother, small vagina opening causing severe pain, morbidity, abortion leading to womb damage and complication/operation during delivery as health challenges.

Table 4.2a: Respondents' knowledge on how pregnancy occurs (N=350)

Variable	№	%
Through sexual intercourse	286	81.7
Sexual intercourse and ejaculation into vagina	8	2.3
Sexual intercourse, ejaculation into vagina, and sperm fuses with egg	7	2.0
Sexual intercourse, ejaculation into vagina, fusion with egg and fertilization*	11	3.1
Intercourse without protection	9	2.6
No response	21	6.0
Wrong answer	8	2.3

***Correct answer**

Table 4.2b: Respondents' knowledge on what age can pregnancy begin to occur (N=350)

Variable	№	%
7 years	1	0.3
9 years	6	1.7
10 years	11	3.1
11 years*	23	6.6
12 years*	91	26.0
13 years*	87	24.9
14 years	36	10.3
15 years	45	12.9
16 years	13	3.7
17 years	6	1.7
18 years	12	3.4
19 years	2	0.6
20 years	5	1.4
23 years	1	0.3
25 years	5	1.4
26 years	1	0.3

***Correct answers**

Table 4.2c: Respondents' knowledge on what is teenage pregnancy (N=350)

Variable	№	%
Pregnancy between 11-19 years*	158	45.1
Pregnancy that is unwanted	48	13.7
No response	144	41.1

*Correct answer

4.3 Knowledge of respondents' on health risks associated with teenage pregnancy and childbearing

Table 4.3 shows the level of knowledge of respondents on selected statements. Majority of the respondents (90.9%) selected yes for the statement that a teenager of my age can become pregnant/impregnate a female, also, the statement that teenage pregnancy is a problem to my country was believed to be true by majority of the respondents (88.3%). More than half of the respondents (67.1%) disagreed that at my age, I can become pregnant/impregnate a female. More than half of the respondents (57.4%) reported that becoming pregnant/impregnating a female poses me to some health challenge to be true. Most respondents (72%) agree that female adolescents are at higher risks of health problems associated with pregnancy than women of older reproductive age is true. Likewise, the statement that foetus in an adolescent mother is at higher risks of health problems than foetus of older women was believed to be true by more than half of the respondents (67.1%). Engaging in sexual practices does not pose health challenges to male teenagers was believed to be false by less than half of the respondents.

More than half of the respondents (55.1%) stated that a female within age 20-35 suffer pregnancy related health challenges than females age 15-19 is false. A female must consider her height and weight before becoming pregnant was considered trued by more respondents (45.4%) while most respondent (80.9%) believed that a male should consider his financial ability before impregnating a female. Early marriage (between 13- 19 years) cannot cause ill heath to the mother and child was believed to be false by more than half of respondents (56.6%) while more respondents (44.3%) showed it is false that teenage pregnancy health problems can be aggravated if the mother visits the hospital/attends ante-natal clinic. Finally, the statement that the use of contraceptives (family planning) can help reduce the prevalence teenage pregnancy was reported to be true by majority of the respondents (74%).

Table 4.3: Knowledge of respondents on the health risks associated teenage pregnancy and childbearing (N=350)

Variables	Yes	No	I don't know
A teenager of my age can become pregnant/impregnate a female?	318 (90.9%)*	25 (7.1%)	7 (2.0%)
Teenage pregnancy is a problem to my country	309 (88.3%)*	28 (8.0%)	13 (3.7%)
At my age, I can become pregnant/impregnate a female	100 (28.6%)*	235 (67.1%)	15 (4.3%)
Becoming pregnant/impregnating a female poses me to some health challenge	201 (57.4%)*	81 (23.1%)	68 (19.4%)
Female adolescents are at higher risks of health problems associated with pregnancy than women of older reproductive age	252 (72.0%)*	37 (10.6%)	61 (17.4%)
Foetus in an adolescent mother is at higher risks of health problems than foetus of older women	235 (67.1%)*	37 (10.6%)	78 (22.3%)
Engaging in sexual practices does not pose health challenges to male teenagers	116 (33.1%)	165 (47.1%)*	69 (19.7%)
A female within age 20-35 suffer pregnancy related health challenges than females age 15-19	92 (26.3%)	193 (55.1%)*	65 (18.6%)
A female must consider her height and weight before becoming pregnant	159 (45.4%)	129 (36.9%)*	62 (17.7%)
A male should consider his financial ability before impregnating a female	283 (80.9%)*	31 (8.9%)	36 (10.3%)
Early marriage (between 13- 19 years) cannot cause ill heath to the mother and child	89 (25.4%)	198 (56.6%)*	63 (18.0%)
Teenage pregnancy health problems can be aggravated if the mother visits the hospital/attends ante-natal clinic	136 (38.9%)	155 (44.3%)*	59 (16.9%)
The use of contraceptives (family planning) can help reduce the prevalence teenage pregnancy	259 (74.0%)*	36 (10.3%)	55 (15.7%)

*** Correct answers**

4.4Respondents knowledge on health risks associated with a teenage pregnant mother

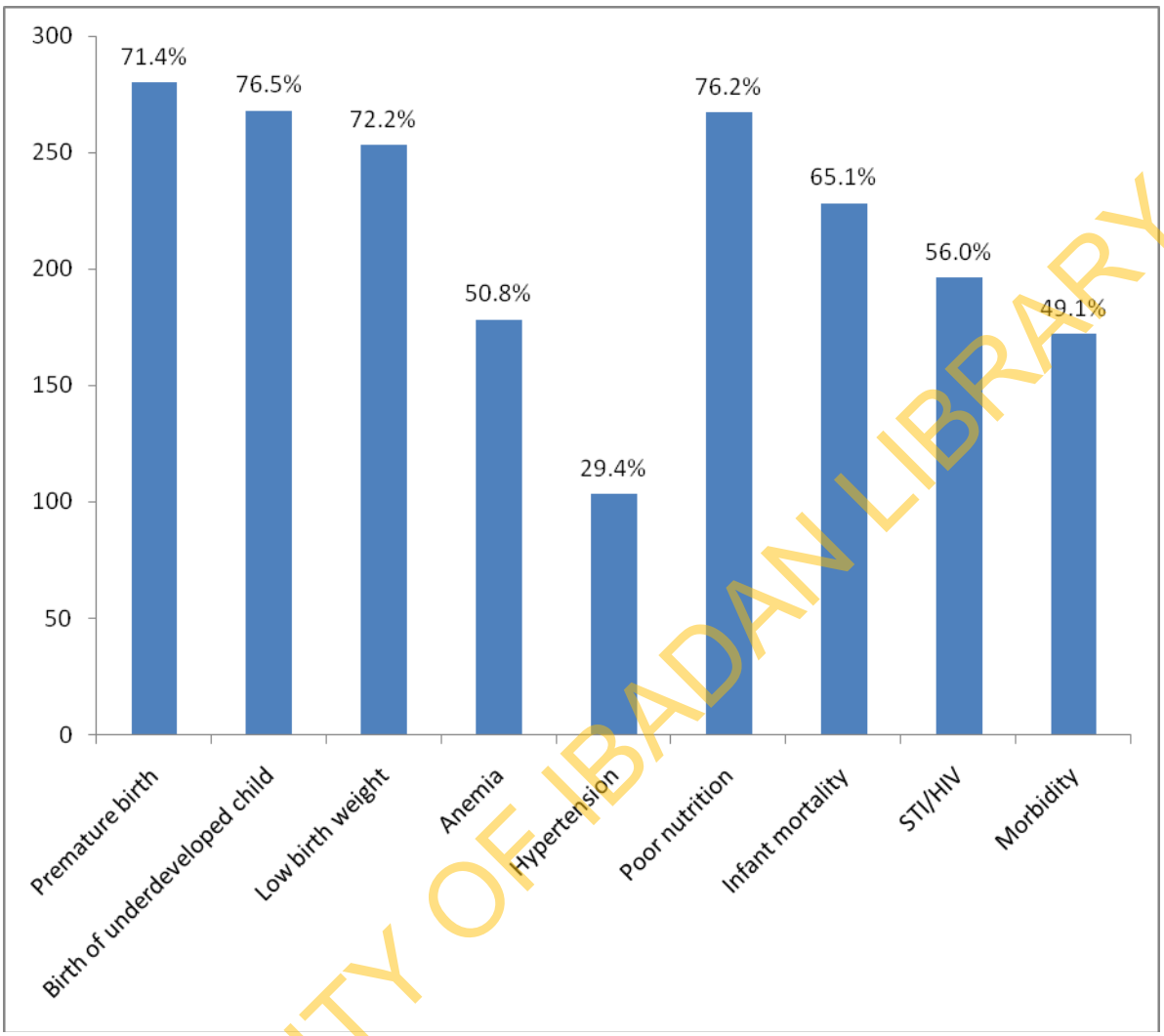
Figure 4.1, shows the health risk associated with a teenage pregnant mother, it revealed that depression (73.1%), STI (73.1%),abortion (72.2%), premature labour (72.2%) and poor nutrition (71.7%) were the highest rated health risk a teenage is exposed to by respondents. Nonetheless, monkey pox, rabies, conjunctivitis and asthma were reported not to be high risk threat to teenage pregnant girl (see results in figure 4.1).

Figure 4.2 shows the health risk for teenage pregnancy as known by respondents. It shows that premature birth had the highest number of respondents' count (80.0%), followed by birth of underdeveloped child (76.5%) and poor nutrition (76.2%), it was evident that most respondents do not believe that hypertension (29.4%) is an health risk of teenage pregnancy, likewise morbidity (49.1%) and anemia (50.8%).

Overall level of knowledge of respondents was determined to be at a mean score of 11.29 ± 2.79 from a possible score of 44 (25.7%). Furthermore, majority of the respondents (76.6%) had fair knowledge of the health risk associated with pregnancy while 10.6% and 12.9% had poor and good knowledge respectively (Table 4.4).

***Multiple responses**

Figure 4.1: Respondents knowledge on health risks associated with a teenage pregnant mother



***Multiple responses**

Figure 4.2: Respondent s knowledge on health risks for a child born by a teenage mother

Table 4.4: Respondents distribution of knowledge (N=350)

Knowledge variable	Score	№	%
Poor	0 ≤15	37	10.6
Fair	> 15 ≤30	268	76.6
Good	> 30	45	12.9

4.5 Perception of respondents on the health risks associated with teenage pregnancy and childbearing

Becoming pregnant as an adolescent is not a problem was disagreed to by more than half of the respondents while the statement that I don't think there is any problem associated with having multiple sexual partner was also disagreed to by most of the respondents (75.7%). More than half of the respondents (63.1%) disagreed to the statement that I think engaging in sex with or without the use of condoms isn't a bad idea. Furthermore, Terminating an unwanted pregnancy in order to save my career isn't a bad idea was disagreed to by most of the respondents (70%). Additionally, majority of the respondents (62.6%) disagreed that I believe I can bear the burden that comes with pregnancy regardless of my age. More than half of the respondents (52.3%) agreed that I can still progress well in my career despite becoming pregnant or having a child at a tender age while 57.1% of the respondents disagreed that Pregnancy related complications is not an issue to female teenager. The use of herbal concoctions to terminate an unwanted pregnancy does not pose any health risk was disagreed to by most of the respondents (75.4%).

The statement that childbearing at a tender age isn't any big deal to me was disagreed to by 71.4% of the respondents. More than half of the respondents (64.3%) agreed that adolescent mothers are at higher risk of pregnancy complication than older women. Although, more of the respondents (69.4%) disagreed that childbearing at a tender age isn't a big deal to my family. The statement that adolescent females bear the larger burden of pregnancy than their male counterpart was agreed to by 71.7% of the respondents. About one third of the respondents (60%) disagreed that it is good to have ones children at adolescence rather than at an older age. In addition, more than half (58.9%) of the respondents disagreed to thinking is less risky to have children at adolescence than at an older age while most respondents (75.7%) disagreed that they can abort a pregnancy and it won't cause them any harm. More than half of the respondents (59.2%) agreed that becoming pregnant/impregnating a female at tender age poses me to some health risk.. the statement that I can advise my friend to abort pregnancy was disagreed to by most of the respondents (79.1%). Most of the respondents (70.6%) agreed that adolescent pregnant comes with some health challenges. Finally, the

statement that I don't think I can ever become pregnant as an adolescent /impregnate a female was agreed to by 65.5% of the respondents).

The overall perception of respondents was determined at a mean score of 12.66 ± 3.24 from a possible score of 19 (66.63%). Majority of the respondents (60%) had positive perception of health risk associated with pregnancy while 10.3% and 29.7% had negative and fair perception respectively (Table 4.5c).

Table 4.5a: Perception of respondents on health risks associated with teenage pregnancy (N=350)

Variable	Agree	Undecided	Disagree
Becoming pregnant as an adolescent is not a problem	100 (28.6%)	26 (7.4%)	224 (64.0%)*
I don't think there is any problem associated with having multiple sexual partner	48 (13.7%)	37 (10.6%)	265 (75.7%)*
I think engaging in sex without the use of condoms isn't a bad idea	87 (24.9%)	42 (12.0%)	221 (63.1%)*
Terminating an unwanted pregnancy in order to save my career isn't a bad idea	67 (19.2%)	38 (10.9%)	245 (70.0%)*
I believe I can bear the burden that comes with pregnancy regardless of my age	82 (23.4%)	49 (14.0%)	219 (62.6%)*
I can still progress well in my career despite becoming pregnant or having a child at a tender age	183 (52.3%)	38 (10.9%)	129 (36.9%)*
Pregnancy related complications is not an issue to female teenager	73 (20.9%)	77 (22.0%)	200 (57.1%)*
The use of herbal concoctions to terminate an unwanted pregnancy does not pose any health risk	51 (14.6%)	35 (10.0%)	264 (75.4%)*
Childbearing at a tender age isn't any big deal to me	67 (19.2%)	33 (9.4%)	250 (71.4%)*
I think adolescent mothers are at higher risk of pregnancy complication than older women	225 (64.3%)*	55 (15.7%)	70 (20.0%)
Childbearing at a tender age isn't a big deal to my family	65 (18.6%)	42 (12.0%)	243 (69.4%)*
I think adolescent females bear the larger burden of pregnancy than their male counterpart	251 (71.7%)*	54 (15.4%)	45 (12.9%)
It is good to have ones children at adolescence rather than at an older age	79 (22.6%)	61 (17.4%)	210 (60.0%)*

Table 4.5b: Perception of respondents on health risks associated with teenage pregnancy (N=350)

Variable	Agree	Undecided	Disagree
I think is less risky to have children at adolescence than at an older age	90 (25.7%)	54 (15.4%)	206 (58.9%)*
I can abort a pregnancy and it won't cause me any harm	38 (10.9%)	47 (13.4%)	265 (75.7%)*
Becoming pregnant/impregnating a female at tender age poses me to some health risk	207 (59.2%)*	49 (14.0%)	94 (26.9%)
I can advise my friend to abort pregnancy	38 (10.9%)	35 (10.0%)	277 (79.1%)*
I believe that adolescent pregnant comes with some health challenges	247 (70.6%)*	55 (15.7%)	48 (13.7%)
I don't think I can ever become pregnant as an adolescent /impregnate a female	229 (65.5%)*	46 (13.1%)	75 (21.4%)

***Correct answers**

Table 4.5c: Perception distribution of respondents on the health risks associated with teenage pregnancy and childbearing (N=350)

Knowledge variable	Score	№	%
Negative	0≤ 8	36	10.3
Positive	>8	314	89.7

4.6 Reactions of respondents to getting pregnant

Table 4.6showed the resultson the reactions of respondents peradventure they found out they were pregnant or have impregnated someone. It was revealed that majority (64.9%) of the respondents stated that they will keep the baby, while 12.3% stated that they are so sure they cannot become pregnant at a teenage age. Very few of the respondents 0.6% and 0.9% stated that they will seek medical help and kill themselves respectively.

Table 4.6: Reaction(s) of respondents to getting pregnant (N=350)

Variable	№	%
I am so sure I cannot become pregnant	43	12.3
Have an abortion	21	6.0
Kill myself	3	.9
Seek medical help	2	.6
Keep the child	227	64.9
Run away	15	4.3
No response	13	3.8
I don't know	26	7.4

***Multiple responses**

4.7 Respondents reason(s) for reactions to getting pregnant

Table 4.7 showed the reasons given by respondents for the reaction if peradventure they found themselves pregnant or impregnated someone. Respondents reported that 'keep the child because abortion too risky' (24.6%) was the most identified reason for their reaction, followed by 'abortion is a sin' (15.7%), other reasons identified included: 'I cannot face the consequences because am still young' (10.3%)and 'To save the child's life because he/she may be destined for greatness' (12%).

Table 4.7: Respondents reasons for reaction to getting pregnant(N=350)

Variable	№	%
I don't engage in risky sexual behaviours	20	5.7
Having a baby isn't bad	5	1.4
Abortion because I don't like the father/mother of the child	9	2.6
Keep the child for love sake	6	1.7
Have the baby to save my life because abortion can lead to death or damage my womb	16	4.6
Keep the child to save the child's life because he/she may be destined for greatness	42	12.0
Abortion is a sin	55	15.7
Keep the child because that may be the only child destined for me	7	2.0
I can't become pregnant because I cannot face the consequences/because am still young	36	10.3
I can't become pregnant because my parent/guardian will be disappointed	12	3.4
Keep the child because abortion is risky	86	24.6
To continue my career	10	2.9
I don't know	35	10.0
No response	11	3.2

***Multiple responses**

4.8 Respondents perceived health challenge(s) associated with teenage pregnancy and childbearing

A larger proportion of the respondents (46.3%) did not know any health challenge associated with their reaction to becoming pregnant as a teenager, while 13.1% believed that they are not prone to any health challenge. However, for those who felt exposed to health challenges, financial struggle (7.7%) and depression (7.4%) were the most prominent (Table 4.8).

Table 4.8: Respondents perceived health challenge(s) associated with teenage pregnancy andchildbearing (N=350)

Variable	№	%
Depression	26	7.4
Anemia during pregnancy	5	1.4
Set back in my career during pregnancy/childbearing	9	2.6
Shame	14	4.0
Abortion may lead to damage to the womb/reproductive organ	17	4.9
Am not prone to any health challenge	46	13.1
I don't know	162	46.3
No response	30	8.6
Depression and financial struggle	4	1.1
Financial struggle	27	7.7
Not applicable	10	2.9

***Multiple responses**

4.9 Behaviours predisposing respondentsto the health risks associated with pregnancy and childbearing

There were 40.9% and 40.3% who have had sex before and weresexually activerespectively(Figure 4.3).The age of sexual debut for respondents ranged from 5 years to 20 years with a mean age of sexual debut at 11.83 ± 5.170. It was also found that more than half of the respondents (58.8%) have only one sexual partner, however 16.2% of the respondents have had more than three sexual partners. Contraceptive use however was very low at 27.7% although most of the respondents (62.6%) have never attended parties before. Alcohol consumption was also low at 20.6% with majority (78.6%) never had it and only 1.7% drink weekly (Table 4.9).

It was also revealed that half of the respondents have adolescent friends who have had children. While 24.9% of the respondents feel pitiful and sorry for them, another 24.0% stated that I have no bad feelings towards them. There were 295 (84.3%) respondents who agreed that their parents frown against risky sexual behaviour and also 72.6% disagreed that their community encourages sexual behaviour. Majority of the respondents (67.7%) see themselves becoming parents in the next 10 years. Club membership among respondents was low (24.9%) and reproductive health information sharing within the group was equally low (19.7%).

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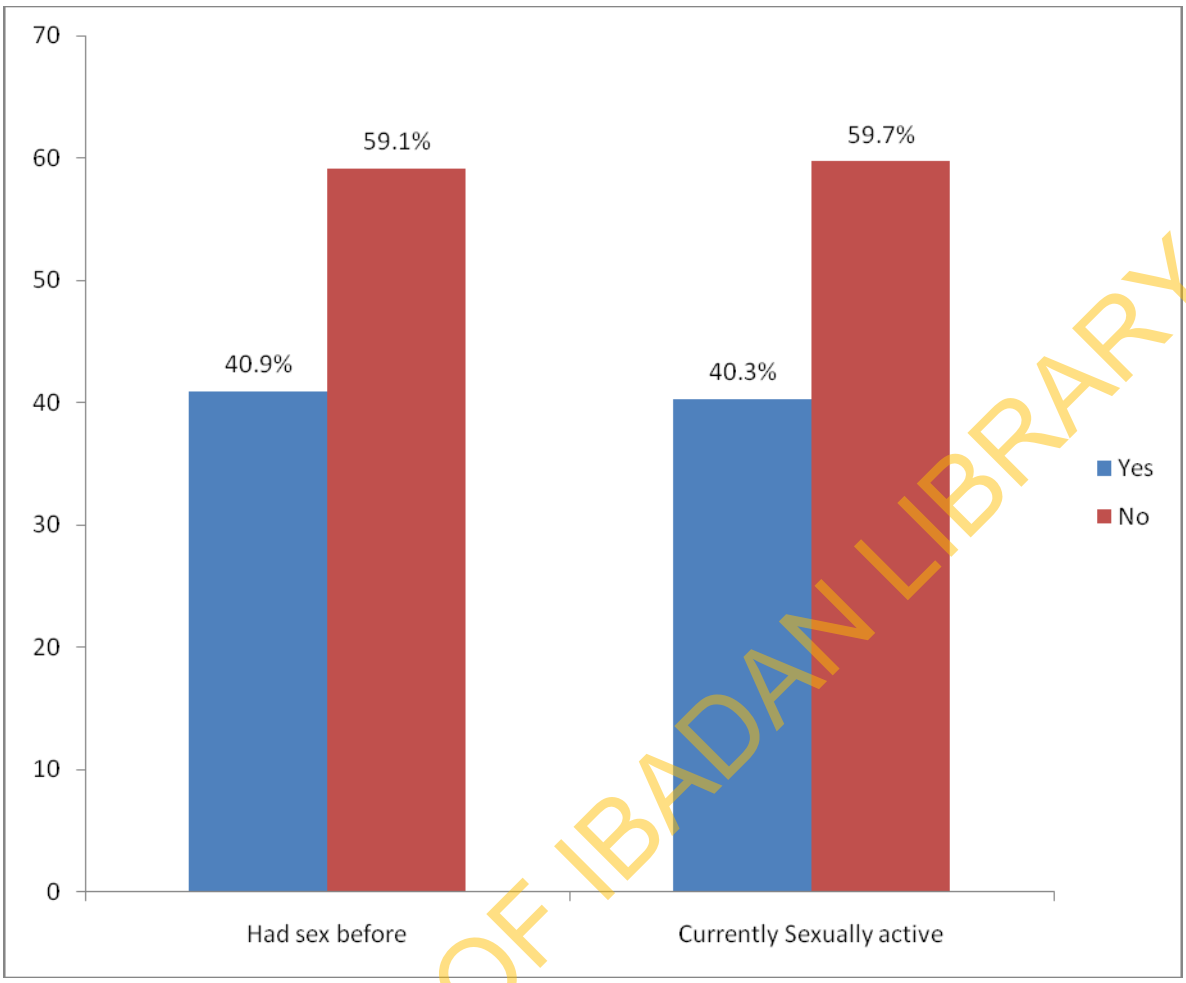

Figure 4.3: Respondents' sexual history

Table 4.9a: Behaviours predisposing respondents to the health risks associated with teenagepregnancy and childbearing (N=350)

Variable	№	%
Age of sexual debut (N = 144)*		
5 years – 11 years	41	28.5
12 years – 17 years	88	61.1
18 years – 20 years	15	10.4
Number of sexual partners (N = 136)		
One	80	58.8
Two	22	16.2
Three	12	8.8
More than three	22	16.2
Contraceptive use		
Yes	97	27.7
No	253	72.3
Parties attendance frequency		
Never	219	62.6
Often	42	12.0
Occasionally	58	16.6
Seldom	31	8.9
Alcohol consumption		
Yes	72	20.6
No	278	79.4
Alcohol consumption frequency		
Never	275	78.6
Weekly	6	1.7
Seldom	28	8.0
Often	19	5.4
Occasionally	22	6.3

* Mean age = 11.83 ± 5.170

Table 4.9b: Behaviours predisposing adolescent to the health risks associated with pregnancy and childbearing(N=350)

Variable	№	%
Adolescent friends who have children		
Yes	177	50.6
No	173	49.4
Feelings towards them		
I feel sorry and pitiful	87	24.9
I am ashamed of them	13	3.7
I have no bad feelings towards them	84	24.0
Parents frown against risky sexual behavior		
Yes	295	84.3
No	55	15.7
Community encourages sexual behavior		
Yes	96	27.4
No	254	72.6
How soon do you want to be a parent		
1 year to 10 years	237	67.7
11 and above	94	26.9
Club membership		
Yes	87	24.9
No	263	75.1
Reproductive health information in club		
Yes	69	19.7
No	73	20.9

4.10 Hypotheses Testing

The following null hypotheses were tested for the study

4.10.1Hypothesis I

There is no significant association between age of respondent and knowledge of health risks associated with teenage Pregnancy:correlation analysis was used in testing for significant association between the age of respondents and their level of knowledge, the association was found at a ratio of 1:0.128 at p-value of 0.018, indicating a positive association at 12.8% in knowledge with age (Table 4.10.1a).

Linear regression analysis was used to predict the strength of the association with the age of respondents as the independent variable while the knowledge of respondents as the dependent variable. Statistical analysis showed a significant association between the age of respondents and their knowledge on health risk of pregnancy (R Square = 0.016; $p < 0.05$). This indicated that the age of respondents has a 1.6% influence on their level of knowledge on health risk associated with pregnancy. The null hypothesis is hereby rejected (Table 4.10.1b).

Table 4.10.1a: correlation analysis of significant relationship between the age of respondents and their level of knowledge

Correlations			
		Age of respondents	Knowledge of respondents
Age of respondents	Pearson Correlation	1	.128*
	Sig. (2-tailed)		.018
	N	350	343

*. Correlation is significant at the 0.05 level (2-tailed).

Table 4.10.1b: Linear regression analysis between age of respondents and knowledge on health risks of pregnancy

Model		Sum Squares	ofdf	Mean Square	Sig.	R Square	Null hypothesis
1	Regression	43.614	1	43.614	0.018	0.016	Rejected
	Residual	2620.812	341	7.686			
	Total	2664.426	342				

4.10.2 Hypothesis II

Test of significant relationship betweensex of respondent and knowledge on health risks associated with teenage pregnancy: chi-square test was used. Statistical analysis showed no significant association between the sex of respondents and their knowledge on health risk of pregnancy X_2 (2, N = 350) = 3.478, p = 0.176. The null hypothesis is hereby retained (Table 4.10).

Table 4.10.2: Test of significant relationship between respondents' sex and their knowledge of health risks of teenage pregnancy

Sex	Knowledge of health risk of teenage pregnancy			Chi Square test		
	Poor	Fair	Good	Value	Df	p-value
Male	15 (40.5%)	92 (34.3%)	10 (22.2%)	3.478	2	0.176
Female	22 (59.5%)	176 (65.7%)	35 (77.8%)			
Total	37	268	45			

4.10.3Hypothesis III

Test of significant relationship between level of education and knowledge of health risks associated with teenage pregnancy: Chi-square test was used. Statistical analysis showed no significant association between the level of education of respondents and their knowledge ofhealth risk of pregnancy X_2 (4, N = 350) = 6.596, p = 0.119. The null hypothesis is hereby retained (Table 4.10.3).

Table 4.10.3: Test of significant relationship between respondents' level of education and their knowledge of health risks of teenage pregnancy

Level of education	Knowledge of health risk of teenage pregnancy			Fisher's exact		
	Poor	Fair	Good	Value	Df	p-value
Primary	0 (0.0%)	8 (3.0%)	0 (0.0%)	6.596		0.119
Junior secondary	8 (21.6%)	36 (13.4%)	2 (4.4%)			
Senior secondary	29 (78.4%)	224 (83.6%)	43 (95.6%)			
Total	37	268	45			

4.10.4 Hypothesis IV

Test of significant association between age of respondent and perception of healthrisks associated with teenage pregnancy: Chi-square was used in testing for significantassociation between the age of respondents and their level of perception, the association was found not to be significant, with a negative association at -8.1% reduction in perception with age. The null hypothesis is hereby retained (Table 4.10.4).

Table 4.10.4: Test of significant relationship between the age of respondents and their level of perception

Correlations			
		Age of respondents	Perception of respondents
Age of respondents	Pearson Correlation	1	-0.081
	Sig. (2-tailed)		.130
	N	350	347

4.10.5Hypothesis V

Test of significant relationship betweensex of respondent and perception of health risks associated with teenage pregnancy: Chi-square test was used. Statistical analysis showed nosignificant association between the sex of respondents and their perception of health risk of pregnancy X_2 (2, N = 350) = 1.777, p = 0.411. The null hypothesis is hereby retained (Table 4.10.5).

Table 4.10.5: Test of significant relationship between respondents' sex and theirperception of health risks of teenage pregnancy

Knowledge	Perception		Chi-square		
	Negative	Positive	X^2	df	p-value
Poor	2 (5.6%)	35 (11.1%)			
Fair	27 (75.0%)	241 (76.8%)	2.191*	2	0.313
Good	7 (19.4%)	38 (12.1%)			

4.10.6Hypothesis VI

Test of significant relationship between respondents'level of education and perception of health risks associated with teenage pregnancy: Chi-square test was used. Statistical analysis showed a significant association between the level of education of respondents and their perception of health risk of pregnancy X_2 (4, N = 350) = 9.222, p = 0.041. The null hypothesis is hereby rejected (Table 4.10.6).

Table 4.10.6: Test of significant relationship between respondents' level of education and their perception of health risks of teenage pregnancy

Level of education	Perception of health risk of teenage pregnancy			Fisher's exact		
	Poor	Fair	Good	Value	Df	p-value
Primary	0 (0.0%)	6 (5.8%)	2 (1.0%)	9.222		0.041
Junior secondary	7 (19.4%)	9 (8.7%)	30 (14.3%)			
Senior secondary	29 (80.6%)	89 (85.6%)	178 (84.8%)			
Total	36	104	210			

4.10.7Hypothesis VII

Test of significant relationship betweenrespondent's knowledge of health risk and respondent's perception of health risks: Chi-square test was used. Statistical analysis shows that there is no significant association between the level of knowledge of respondents and their perception of health risk of pregnancy X_2 (4, N = 350) = 3.229, p = 0.518. The null hypothesis is hereby retained (Table 4.10.7)

Table 4.10.7: Test of significant relationship between respondents' level of knowledge and their perception of health risks of teenage pregnancy

Knowledge	Perception		Chi-square		
	Negative	Positive	X^2	Df	p-value
Poor	2 (5.6%)	35 (11.1%)			
Fair	27 (75.0%)	241 (76.8%)	2.191*	2	0.313
Good	7 (19.4%)	38 (12.1%)			

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter focuses on the major findings of the study. It is organized into the following sub-sections: Socio-demographic characteristics; Respondents' knowledge on the health risks associated with pregnancy and childbearing; respondents perception of the health risks associated with pregnancy and childbearing and behaviours predisposing respondents to the health risks associated with pregnancy and childbearing. Other sub-sections are the implications of the findings for health promotion and education, conclusion and recommendations.

5.2 Socio-demographic characteristics of respondents

There were 350 respondents for this study and they were aged between 15 years and 19 years with a mean age of 17.02 ± 1.546, with the most of the respondents being 15 years old. Majority of the respondents are female with a ratio of 2 females to 1 male respondent. Literacy level among respondents was very high as all of them had a form of formal education from primary education to senior secondary school; majority of respondents however had senior secondary school education. More than half of the respondents were Christians and there were more respondents of Yoruba ethnicity than any other ethnic groups reason linked to the geographical location of the study. Furthermore, it is not unexpected that majority of the respondents have Oyo state as their state of origin, followed by Osun state, Ogun state, Ekiti state and Ondo state; these states are neighouring state to the study state of Oyo state, therefore the high number of respondents from this state will not be an aberration. Majority of the respondents were not married which expectedly reflected in the high number of respondents without children.

There were six occupations taken up by respondents: hairdressing, barbing, tailoring, trading, welding and shoe making. Tailoring had the most number of respondents, an occupation

predominantly common among female adolescents. Almost all of the respondents earn considerably less amount than the Nigerian minimum wage, this may not be alarming as most of the respondents still live with their parents and do not have any financial responsibilities. Interestingly, it was found that while most respondents were brought up in the urban region, there was an increase when comparing to respondents currently living in the urban region, likewise, there was a reduction in number of respondents currently living in rural region than the number of respondents brought up in rural region, this is an indication of a rural-urban migration.

5.3 Knowledge of respondents on the health risks associated with teenage pregnancy and childbearing

Understanding the knowledge on reproductive health is an important facet in the lives of out-of-school artisans with a direct implication on completion of apprenticeship and progression to fecund adults. The findings indicated a deficiency in knowledge regarding the health risks associated with teenage pregnancy among artisan adolescents meaning that there was inadequate knowledge on various reproductive health matters relating to the health of the teenage mother and the baby born by the teenager.The lack of knowledge makes them vulnerable to unsafe reproductive health behaviour and inappropriate choices. Some of these choices may have detrimental effects on their reproductive health and future. For example, a wrong choice can lead to unplanned pregnancy or STI infection (Harden, 2009). In another study, it was found that lack of knowledge on reproductive health was associated with early initiation of coital relations and of unwanted pregnancies (Minnick, 2014). The effects of these unplanned pregnancies are multifarious with some capable of lasting for a lifetime. These potential human resource and future leaders end up as school dropouts due to unplanned pregnancy and other attendant complications. Additionally, a good number of adolescents who indulge in early sexual debut may contract HIV and other STIs (Idele, 2014). These have health social and economic implications for their households and the nation as whole as funds will be required to provide lifetime medication for people with HIV and may even affect their line of generations yet unborn

Respondents' knowledge on how pregnancyoccurswas assessed.Result showed that majority did not have a comprehensive knowledge on the subject as they described that pregnancy occurs through sexual intercoursewhile not acknowledging the biological aspect of ejaculation into vagina, fusion with egg and fertilization, this is similar to findings of Herman *et al.* (2011).

However, respondents showed a good level of knowledge on thehealth challenges of a teenager becomingpregnant. Some of the identified health challenges include, lack of care of mother and child, premature birth, anaemia, severe bleeding, shame, rejection, poor nutrition, suicide, HIV/STI,etc. Some of the identified health risks were reported by Cool *et al.* (2015). Majority of the respondents agreed that female adolescents are at higher risks of health problems associated with pregnancy than women of older reproductive age which conforms with report by Ganchimeg *et al.* (2014) where it was noted that adolescent mothers to be at a higher risk of several adverse health outcomes including low birth weight, preterm delivery, eclampsia and infections compared with mothers age 20-24 years.

Majority of respondents believed that foetus in an adolescent mother is at higher risks of health problems than foetus of older women.This results were similar to study by Tyberg *et al.* (2013) who reiterated that babies born to adolescent mothers have been shown to be at higher risk of preterm birth, low birth weight, high rate of stillbirth and neonatal mortality, a view also shared by Gibbs *et al* (2012).

Nevertheless, the overall knowledge of respondents of respondents on the health risks associated with pregnancy and child bearing was poor as also reported by Lebese (2015).

5.4 Perception of respondents on the health risks associated with teenage pregnancy and childbearing

In regards to respondents' perception towards health risk associated with teenage pregnancy, it was found that becoming pregnant at adolescents was viewed as a problem by most respondents, this was however contrary to an Austria study where adolescents believes childbearing changes their life by becoming strong and growing faster although there were some implications highlighted such as decreasing social life and social isolation and inhibition of personal development (Childs *et al.*, 2015).

From this study, it emerged that respondents had a negative perception that the use of some local preparations and herbs are effective abortifacients. A study in southern Ghana negates this finding as there was the widespread notion amongst adolescents that ingestion of panacin and cafalgen (painkillers) before sex had some contraceptive effects (Adongo, 2014). Washing of the vagina and vulva with soap and water which is another local practice to avoid pregnancy after unprotected sex has implications on the reproductive health of adolescents.
According to Lebese *et al.* (2015), adolescents perceived adolescent pregnancy to be positive if planned by sexual partners and that they were going to work to make end meets and also plan to get married or if the said female student was already married and has the full support of the husband and/or both parents, however, adolescent pregnancy was perceived to have negative effects on the student parent and the unborn child if he is rejected by the sexual partner who got her pregnant, this might be applicable to respondents as majority of the respondents did not believe they can bear the burden that comes with pregnancy.

In light of the previous points made, more than half of the respondents believed that it is good to have ones children at adolescence rather than at an older age, reason for this statement might be improved family relationships, family support, increased focus on educational goals, maturity, becoming more responsible, being loved, and having someone to love as identified by Herman *et al.* (2011). This expectedly may play significant role in the decision of most of the respondents to keep the baby if they get pregnant or impregnate someone, coupled with the thought of getting an abortion being too risky and protecting the unborn child.
While in developed countries, adolescent pregnancy is a social norm (Martyn *et al.* 2001), respondents in this study believed it to be very risky. Additionally, majority of the respondents believed they can never become pregnant as an adolescent /impregnate a female, this may be due to the fear of stigmatization, putting personal goals on hold, lack of financial and educational preparation, and having to miss out on the adolescent years (Rosengard *et al.,* 2006).
Overall, respondents' perception towards health risk associated with pregnancy and childbearing was favourable, which is similar to findings byHerrman, 2008.

5.5 Behaviours predisposing respondents to the health risks associated with teenage pregnancy and childbearing

Majority of the respondents have not had sexual intercourse before, reducing the risk of teenage pregnancy by half among respondents, however, among the sexually active respondents, age of sexual initiation was between the ages of 5 to 11, while although more than half have only had a sexual partner, a significant amount have had multiple sexual partners while also engaging in risky sexual behaviourslike not using contraceptives to prevent pregnancy. It was also found that reproductive health information sharing was low among respondents(Mushwana, Monareng, Muller and Ritcher, 2015).

Most artisan adolescents are reliant on their peers who are in-school and the mass media for information on reproductive health. These sources make them vulnerable to misinformation. In that case, they will be making decisions based onincorrect information which can negatively affect them. Parents who could be the most appropriate source of information are inhibited by socio-cultural barriers that prevent them from discussing reproductive health issues with their children as has been reported by Owusu, Blankson & Abane (2011).

The findings of this study underscore the need for innovative ways to expand access to reproductive health education and services to both in-school and out-of-school adolescents. School-based approaches which are linked to the community have been found to be effective in other countries (Denno, 2015). These approaches could be adopted for Nigerian adolescents as a community-related strategy intervention.

The study found that having a sexual partner was a common practice among adolescents in the community, and is widely viewed as an acceptable practice. Among adolescents, this is done to conform to peer norms and a way of demonstrating that one had what it takes to be a woman or man. The act of engaging in sexual practice among adolescents has been widely reported across the sub-Saharan African region, with about 25% reporting having sexual contact before attaining 15 years of age (Saggurti, 2013). This study also found that having multiple partners was a common practice. Similar findings were reported among adolescents in Tanzania (2011). Despite the fact that many adolescents reported having multiple partners,

the use of condom was reportedly low during sexual encounters. This is a challenge to public health workers involved in sensitizing the population against risk of STIs and HIV among Nigerians. The use of condom is one of the key strategies employed by the National AIDS Control Programme (NACP) to reduce the burden of unwanted pregnancy,HIV and STIs.

5.6 Implications to health promotion and education

The health promotion and education implication of this study is discussed below:

Work place health promotion: from this study, it is evident that thereis a huge gap in the knowledge of respondents on the health risks associated with adolescent pregnancy and childbearing. The workplace however poses as a good setting in improving the knowledge of artisan adolescents on risks of teenage pregnancy through health education strategies. The work place of artisans are organised and has an authority that is spoken for, with this, artisan adolescents can be easily reachable and sustainability will also be ensured.

Skill acquisition to improve self-efficacy for abstinence, and condom use: One of the major interventions in the control of adolescent pregnancy is abstinence. This strategy has been found to help in the control of HIV in Uganda (Green, Halperin, Nantulya and Hogle 2006), a disease profoundly contracted through sexual intercourse. There is need for a capacity building intervention aimed at increasing adolescents' self-efficacy and confidence in practicing abstinence and use of contraceptives such as condoms which will help in the control and reduction of adolescent pregnancy.

5.7 Conclusion

This studyexplored the knowledge and perception of health risks associated with teenage pregnancy and childbearing among out-of-school adolescents in Ibadan South-east Local government area, Oyo state. Findings showed that respondents had an overall poor knowledge of health risks associated with teenage pregnancy and childbearing, however they were able to mention at length the health risk teenage mothers are exposed to. The respondents' perception however was favourable. Findings further showed that about half of the respondents engage in sexual activity, though there was a very low contraceptive use, indicating that sexual risky behaviour is high

5.8 Recommendations

From the findings from this study, the following are recommended:

1. Policy makers

Policy advocacy should be made to bodies in charge of reproductive health to integrated sexual and reproductive health services reaching all young people in both in and out of school. With comprehensive sexuality education is key to preventing unwanted pregnancy, HIV/AIDS and other STIs to meet SDG target 3.1.

2. **Non-governmental organizations (NGOs)/community based organizations (CBOs)**

There is need for a wide range of comprehensive educational intervention aimed at improving the knowledge of adolescents on the health risk associated with adolescent pregnancy.The range of comprehensive interventions should focuson sexual health education, counseling, consistent birth control methods promotion and provision so asto preventand control the adverse outcomes related to risky sexual behaviours.

3.Parents/guardians

Parents should be the primary source of reproductive health educators to adolescents and young persons. Parents should be sensitized on the significance of providing a helpful home environment for their children so as to sustain a strong relationship while giving them necessary and correct information on sexual health issues according to their age. This in turn will create stronger bonds within the family that will effect positive changes in adolescents sexual behaviours.

4. Heads of artisan association

There is also need to collaborate with each of the artisan groups to train and educate the artisan heads in providing correct information to the adolescents. Artisan heads would serve as other sources of information from which these adolescents receive counseling and information regarding sexual and reproductive health.

5. There is need for further studies on qualitative exploration on the knowledge and perception of health risks of artisans.This would give a broader perspective on the subject which would help designinterventions programs necessary to increase knowledge and reinforce positive perceptions of the adolescents.

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APPENDICES

APPENDIX I

INFORMED CONSENT FORM

IRB research approval number:

This approval will elapse on:

Title of research: Knowledge and Perception of Artisan Adolescents on The Health Risks Associated with Teenage Pregnancy and Childbearing in Ibadan South East Local Government Area, Oyo State

Name of Researcher: This research is being conducted by Iyanda Adebisi Mistura who is a postgraduate student in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan.

Purpose of Research: The purpose of this research is to investigate the Knowledge and Perception of Artisan Adolescents on The Health Risks Associated with Teenage Pregnancy and Childbearing in Ibadan South East Local Government Area, Oyo State

Sample size and procedure for data collection: A total of 367 respondents would be recruited for this study using multi-stage sampling procedure to select eligible respondents.

Expected duration of research and participant(s) involvement: The process of this study will last for two months. The expected time to spend with each participant in filling the questionnaire is ten to fifteen minutes. You are to provide answers to the questions contained in the questionnaire.

Risk(s): There are no physical risks in participating in this study. Also, each participant will be given privacy to fill questions perceived to be sensitive.

Cost to participating or joining the research: Participation will cost nothing financially to you as participants. It will however take a little of your time.

Benefit: At the end of the research, findings will be useful in the design of an intervention which would assist in empowering artisan adolescents on sexual issues and reduce their risk taking behaviours.

Confidentiality: All information collected in this study will be given coded numbers. Names of participants will not be written on the questionnaires. In addition, any identifier will not be used in any publication or report emancipating from this study.

Voluntariness: Your participation in this research is entirely voluntary.

Consequences of participant's decision to withdraw from the research and procedure for the termination of participation: You can choose to withdraw from the research at any time without penalty. Please also note that some of the information that might have been obtained about you before you choose to withdraw may be used in reports and publications.

Statement of Person Obtaining Informed Consent

I have fully explained the nature and scope of the research to _____and have provided sufficient information to him/her which is needed by him/her to make informed decision.

Date _____

Signature _____

Name _____

Statement of Person Giving Consent

I have read the description of the research and the research has been explained to me in a language I understand. I understand that my participation is voluntary. I know enough about the purpose, method, risk and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. Finally, I have received a copy of this consent form and additional information sheet to keep for myself.

Date _____

Signature _____

Name _____

Detailed contact information including contact address, telephone, fax, email and any other contact information of researcher(s), institutional HREC and head of the institution:

This research has been approved by the Oyo State Research Ethical Review committee and the chairman of this committee can be contacted at ministry of Health, Secretariat, Ibadan.

In addition, if you have any question about your participation in this research, you can contact the principal investigator.

Date _____

Signature _____

Name _____

Name: Iyanda Adebisi Mistura Department: Health Promotion and Education

Phone: 09060551728 Email: iyandadebisi@gmail.com

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT

APPENDIX II

CONSENT FORM (YORUBA LANGUAGE)

FOOMU IFOHUNSI TISALAYE IMO AATI IRO AWON ODO OMODO LORI EWU TO JOMO OYUN NINI ATI OMOBIBI NI AGBEGBE ILU IBADAN

Nomba itewogba IRB:

Itewogba yii yoo koja ni:

Akole iwadi: imo aati iro awon odo omodo lori ewu to jomo oyun nini ati omobibi ni agbegbe ilu ibadan

Oruko oluwadi: Iwadi yii yoo waye nipase Iyanda Adebisi Mistura ti o nse omo ile-eko giga ti Ibadan ni Eka Igbelaruge Ilera ati Eko.

Idi iwadi: Idi iwadi yi ni lati ko alaye jo nipa imo aati iro awon odo omodo lori ewu to jomo oyun nini ati omobibi ni agbegbe ilu ibadan

Ilana fun gbigba data: Lapapo orinleloodunrin o din kan odo ti ko si ni ile-iwe ni ijoba agbegbe Egbeda ni yoo kopa ninu iwadi yii pelu lilo ilana oni ipele lati fi mu awon ti o le kopa.

Akoko ti a ye fun iwadi: Ilana yii yoo sise fun osu meji. O ni lati pese idahun si ibeere ti o wa ninu iwe ibeere. Yio gba o ni iseju mewa si meedogun lati dahun awon ibeere naa.

Ewu: Kosi ewu ninu kikopa ninu iwadi yii. Sibesibe , igbalaye wa lati dahun awon ibeere ti o ko ba fe so sita fun ra re.

Awon ohun ti iwadi yii yi o gba lowo re: Kikopa ninu iwadi yii ki yio na o ni ohun kohun, sibesibe, yio gba die ninu akoko re.

Anfaani: Ni opin iwadi yi, awon awari wa yoo wulo lati ro awon odo ti ko si ni ile-iwe niagbara ti o ye nipa imo ti o je mo iwa ibalopo ati latifi mo irufe eto ti a le gbe kale lati fi ko ju ija si iwa ibalopo to lewu.

Asiri: Gbogbo awon alaye ti a o gba ni iwadi yii ni a o fun ni nomba. Awon oruko eniyan ti o dahun kii yoo wa lori awon ibeere. Ni afikun, a ko ni lo awon ami idanimo miiran ni eyikeyi lori iwe tabi iroyin.

Iyonda: Kikopa re ninu iwadi yii o je atinuwa

Ipinu awon olukopa lati yo kuro ninu iwadi ati liana fun yiyokuro: O le yan lati kuro ninu iwadi yii ni igba kigba laisi ijiya Kankan. Jowo mop e die ninu awon alayeti a gba lati odo re saaju ki o to yan lati kuro ni a le lo ninu awon iroyin ati awon iwe ase.

Gbolohun eni ti o fe iyonda

Mo ti se alaye kikun ti o niise pelu didara po fun iwadi yii fun _____ ati wipe mo ti pese alaye ti o to fun.

Ojo _____

Ibuwolu _____

Oruko _____

Gbolohun ti Eniyan ti o fe se iyonda

Mo ti ka apejuwe iwadi yii, atipe won ti se alaye re funmi ni ede ti o ye mi. Mo mo wipe ikopa mi je atinuwa. Mo mo nipa idi, awon ona, ewu, ati awon anfani ti o wa ninu iwadi yii, mo si ti pinu lati kopa ninu re. O ye mi p emo le ko lati tesiwaju ninu iwadi yii. Ni akotan, mo ti gba foomu iwadi itewogba ati iwe ifowosi fun ara mi.

Ojo _____

Ibuwolu _____

Oruko _____

APPENDIX III

QUESTIONNAIRE (ENGLISH LANGUAGE)

Code number _____

Knowledge and Perception of Health Risks Associated with Pregnancy and Childbearing among artisan Adolescent

I voluntarily wish to partake in this study? Agree ( ) Disagree ( )

For the questions in the sections, please tick (V) in the box where your responses apply or complete the blank spaces provided

Part A: Socio demographic characteristics of Respondent

Please tick (V) any of the responses that apply to you in the options or complete the blank spaces provided as applicable

1. Age at last birthday: _____ years old
2. Sex: Male ( ) Female ( )
3. Highest educational level obtained: Primary ( ) Junior school ( ) Senior school ( )
4. Religion: Christianity ( ) Islam ( ) Traditional ( ) Others ( )
5. Tribe: Igbo ( ) Hausa ( ) Yoruba ( ) Others ( )
6. State of Origin: _____
7. Marital Status: single ( ) Married ( ) Separated ( ) Widowed ( )
8. Number of children you have: _____
9. Occupation/Trade: _____
10. Monthly income: _____
11. Who do you live with: Parent ( ) Relative ( ) Friend ( ) Lover ( )
12. Family size (No of persons eating from the same pot): _____
13. Locality of upbringing: Rural ( ) Peri-urban ( ) Urban( )
14. Kind of locality currently living in: Rural ( ) Peri-urban ( ) Urban ( )

Part B: Knowledge of artisan adolescents on the health risks associated with pregnancy and childbearing. .

Please write your answers in the spaces provided

15. How does pregnancy occur?

_____

_____

16. From what age can pregnancy occur?

_____

17. What is teenage pregnancy?

_____

18. List three health challenges of a female becoming pregnant as a teenager?

i. _____

ii. _____

iii. _____

Please tick (V) where the option apply to you

S/N		Yes	No	I don't know
19.	A teenager of my age can become pregnant/impregnate a female?			
20.	Teenage pregnancy is a problem to my country			
21..	At my age, I can become pregnant/impregnate a female			
22.	Becoming pregnant/impregnating a female poses me to some health challenge			
23.	Female adolescents are at higher risks of health problems associated with pregnancy than women of older reproductive age			
24.	Fetus in an adolescent mother is at higher risks of health problems than fetus of older women			
25.	Engaging in sexual practices does not pose health challenges to male teenagers			
26.	A female within age 20-35 suffer pregnancy related health challenges than females age 15-19			
27.	A female must consider her height and weight before becoming pregnant			

28.	A male should consider his financial ability before impregnating a female			
29.	Early marriage (between 13- 19 years) cannot cause ill heath to the mother and child			
30.	Teenage pregnancy health problems can be aggravated if the mother visits the hospital/attends ante-natal clinic			
31.	The use of contraceptives (family planning) can help reduce the prevalence teenage pregnancy			

Please tick (V) where the option apply to you

32. The following are health risks likely associated with a pregnant adolescent

S/N		Yes	No	I don't know
a.	Anemia			
b.	Abortion			
c.	Asthma			
d.	Typhoid			
e.	Conjunctivitis			
f.	Measles			
g.	Tsetse fly			
h.	Food poisoning			
i.	Monkey pox			
j.	Sexually transmitted infections			
k.	Premature labour			
l.	Poor nutrition			
m.	Rabies			
n.	Depression			

33. The following are health risks for babies born by adolescents' mothers

S/N		Yes	No	I don't know
a.	Premature birth			
b.	Birth of underdeveloped child			
c.	Low birth weight			
d.	Anemia			
e.	Hypertension			
f.	Poor nutrition/breastfeeding			
g.	Infant mortality			
h.	STI/HIV infections			
i.	Morbidity			

Part C: Perception of artisan adolescents on the health risks associated with teenage pregnancy

Please tick (V) where appropriate.

S/N		Agree	Undecided	Disagree
34.	Becoming pregnant as an adolescent is not a problem			
35.	I don't think there is any problem associated with having multiple sexual partner			
36.	I think engaging in sex with or without the use of condoms isn't a bad idea			
37.	Terminating an unwanted pregnancy in order to save my career isn't a bad idea			
38.	I believe I can bear the burden that comes with pregnancy regardless of my age			
39.	I can still progress well in my career despite becoming pregnant or having a child at a tender age			
40.	Pregnancy related complications is not an issue to female teenager			
41.	The use of herbal concoctions to terminate an unwanted pregnancy does not pose any health risk			

42.	Childbearing at a tender age isn't any big deal to me			
43.	I think adolescent mothers are at higher risk of pregnancy complication than older women			
44.	Childbearing at a tender age isn't a big deal to my family			
45.	I think adolescent females bear the larger burden of pregnancy than their male counterpart			
46.	It is good to have ones children at adolescence rather than at an older age			
47.	I think is less risky to have children at adolescence than at an older age			
48.	I can abort a pregnancyand it won't cause me any harm			
49.	Becoming pregnant/impregnating a female at tender age poses me to some health risk			
50.	I can advise my friend to abort pregnancy			
51.	I believe that adolescent pregnant comes with some health challenges			
52.	I don't think I can ever become pregnant as an adolescent /impregnate a female			

53. What would you do peradventure you become pregnant/impregnate a lady?

_____

54. Why would you take such action(s) as mentioned above?

_____

55. What health challenges do you think is/are associated with this action(s) mentioned above?

_____

Part D: Behaviours predisposing artisan adolescent to the health risks associated with pregnancy and childbearing.

Please tick (V) where appropriate.

Ensure you answer the questions sincerely.

56. Are you sexually active? Yes ( ) No ( )

57. Ever had sex before? Yes ( ) No ( )

58. At what age was your first sexual intercourse? _____ Years old.

59. How many sexual intimate partner(s) do you have? None ( ) One ( ) Two ( ) There ( ) More than three ( )

60. Do you use any contraceptive? Yes ( ) No ( )

61. How often do you attend parties? None ( ) Once a week ( ) At least once a month ( ) More than twice a month ( )

62. Do you drink alcohol? Yes ( ) No ( )

63. If yes, how often do you drink ? Daily ( ) Once a week ( ) At least once a month ( ) more than twice a month ( )

64. My source of reproductive health information is?

a. From friends ( )

b. From family member ( )

c. Older people ( )

d. Internet ( )

e. Hospital ( )

f. Books ( )

g. Health worker ( )

h. School ( )

65. I have adolescent friend(s) who have a child/children? Yes ( ) No ( )

65b. If yes, how do you feel towards him/her? _____

66. My parent frowns at risky sexual behaviours? Yes ( ) No ( )

67. My community encourages risky sexual practices? Yes ( ) No ( )

68. How soon do you want to become a parent? ____ Year(s) from now

69. Do you belong to any club/association? Yes ( ) No ( )

70. If yes, do you receive reproductive health information from this club/association? Yes ( ) No ( )

Thank you for your time and cooperation

APPENDIX IV

QUETIONNAIRE (YORUBA LANGUAGE)

Nomba koodu _____

IMO ATI IRO LORI EWU ILERA TO JOMO OYUN NINI ATI OMOBIBI AWON ODO OMODE LAARIN AWON ODO OMODE TI KO SI NI ILE-IWE

Owu mi lati kopa ninu ifrowanilenuwo yii? Mo gba ( ) Mo yari ( )

Fun awon ibeere onipele, jowo fi ami bayii (V) sinu asuwon to ba ba idahun re mu tabi ki o k idahun re si ibi aye to so fo ti ati pe se

Apa kini: Igbesi aye oludahun

1. Ojo ori e: Omo odun _____
2. Eda: Okunrin ( ) Obirin ( )
3. Iwe kika eri re to ga ju: Ile iwe akobere ( ) Ile iwe gramma akobere ( ) Ile iwe gramma ipele ikeji ()
4. Esin: Onigbagbo ( ) Musulumi ( ) Abalaye ( ) Awon miran (to ka si) _____
5. Eya: Igbo ( ) Hausa ( ) Yoruba ( )
6. Ipinle: _____
7. Ipo igbeyawo: Mo da wa( ) Mo ti gbeyawo ( ) Ati ya pa ( ) Opo ( )
8. Iye omo ti o ti bi: Omo _____
9. Ise ti o n ko lowo: _____
10. Iye owo ti o maa n ri losu: _____
11. Taani iwo n gbe pelu: Obi re ( ) Abatan ( ) Oore ( ) ololufe re ( )
12. Iye yin ninu ebi re: _____
13. Agbegbe ti o gbe dagba: Abule ( ) Ibi to sunmo igboro ( ) Igboro ( )
14. Agbegbe ti o n gbe lowolowo: Abule ( ) Ilu-kekere ( ) Ilu ( )

Apa keji: Oye awon odo omode lori ewu ilera ti o jomo oyun nini ati omobibi.

Jowo, fi ami (V) si ibi ti o dahun ibeere re tabi ki o ko idahun re si ori ila ti a ti fa..

15. Bawo nii oyun nini se n sele?

_____

16. Lati omo odun melo ni oyun le waye?

_____

17. Kini a n pe ni oyun odomode?

_____

18. Daruko ipenija ilera meta ti o le waye ti obirin odomode ba ni oyun

i. _____

ii. _____

iii. _____

Jowo se ami (V) si ibi ti o toka si idahun re

S/N		Beeni	Beeko	Mi o mo
19.	Eni ojo ori mi si le ni oyun tabi fun obirin ni oyun?			
20.	Oyun nini laarin awon odo omode je isoro fun orile ede mi?			
21.	Pelu ojo ori mi, mo si le ni oyun tabi fun obirin ni oyun?			
22.	Oyun nini tabi fifun yan loyun le se ipenija fun ilera mi?			
23.	Ewu to ro mo oyun nini laarin awon odo omode ni ipenija ilera ju awon obirin agbalagba ti o n se abiyamo lo?			
24.	Ole oyun ninu obirin odo omodo ni ewu ilera to poju ti ole oyun ti owa ninu ti abgalabga ti o n se abiyamo lo?			
25.	Biba obirin lopo ko fa ewu kankan nipa ti ilera awon odo omode okunrin?			
26.	Omo obirin ogun odun si maarundin logogi a maa ri ipenija ilera ti o jomo oyun nini ati omobibi ju omo obirin maarundinlogun si okandinlogun lo?			
27.	Obirin gbodo mo iwuwo re ati bi o se ga si ki o to di pe o ni oyun?			
28.	Okunri gbodo ro gabara isuna re ko to di pe o fun obirin ni oyun			

29.	Igbeyawo atetese (laarin odun metala si okandinlogun) ko kin se ohun ti o n so kun fa aisan nipa ilera iya ati omo			
30.	Lilo si ile iwosan tabi ile gbegbi le se akoba fun ilera odo omode obirin ti o ba ni oyun?			
31.	Lilo fifi ito si omo bibi le se iranwo si adinku oyun nini laarin awon odo omode?			

Jowo, fi ami (V) si ibi ti o toka si idahunre

32. Awonyii je ewu ilera fun obirin odomode ti o ba ni oyun

S/N		Beeni	Beeko	Mi o mo
a.	Arun eje oto			
b.	Ki oyun jabo lara obirin			
d.	Iko awugbe			
e.	Iba ponjuponto			
e.	Pipon oju			
f.	Tita			
g.	Kokoro amunisun			
gb.	Majele			
i.	Monkey pox			
h.	Arun ibalopo			
j.	Iro bi nigba ti ko to asiko			
k.	Aijenu kanu			
l.	Ifunpa giga			
m.	Kokoro aja			
n.	Ironu			
33.	Awon ewu ilera fun omo je;			
a.	Bibi om lai to ojo			
b.	Omo ti o gbo lago ara			
d.	Omo to kere ju bo se ye lo			

e.	Arun eje oto			
e.	Ifunpa giga			
f.	Aijeun kanu			
g.	Iku omo ni re we re we			
gb.	Arun ibalopo/ arun ti o gbo ogun			
i.	Ki omo ma se aisan ni gba gbogbo			

Apaketa: Iro awon odo omode lori ewu ti o jomo oyun nini ati omobibi Jowo fi ami (V) ni bi ti o ye.

		Mo gba	Mi o mo	Mi o gba
34.	Oyun nini laarin awon odomode ko kin se isoro kan gbogi?			
35.	Mi o ro pe ewu kankan ro mo nini olubalopo pupo?			
36.	Mi o ro pe ai maloora idabobo fun ibalopo je ohun ti o buuru?			
37.	Si se oyun lati fi gba ju mo eto igbesi aye mi je ohun ti o buuru?			
38.	Mo gbabo pe mo to ko ju gbogbo ipenija to ro mo oyun nini lai fi ti ojo ori mi se?			
39.	Mo si le tesiwaju ninu eto igbesi aye mi bi mo ti le loyun tabi ni omo nigba ti mo si wa ni odomode?			
40.	Ewu to romo oyun nini ko le kan awon obirin odomode lominu?			
41.	Lilo ewe ati egbo lati fi se oyun ko le fa ewu ilera?			
42.	Omo bibi pelu ojo ori mi o je ohun nkan babara si mi?			
43.	Mo ro pe ewu ti awon odomode obirin n ko ni pa ti oyun nini ati omobibi poju eyi ti awon omo okunrin odomode le ko lo?			
44.	Omo bibi pelu ojo ori mi ko je nkan babara si ebi mi?			
45.	Mo ro pe awon odo omode obirin ni ewu ilera pupo lati ko to jomo ti oyun nini ju awon okunrin odo omode lo			
46.	O dara ki a se abiyamo ni igba ewe ju igba ti a ba ti dabga lo?			
47.	Mo ro pe adinku wa fun ewu omo bibi ni igba odo ju igba ti a ba ti dagba lo?			
48.	Mo le se oyun ti ko si ni se ipalara fun ilera mi?			

49.	Oyun nini tabi fi fun yan lo yun ni igba ewe le fa ewu fun ilera mi?			
50.	Mo le gba oore mi ni imoran lati se oyun			
51.	Mo gbagbo pe ipenija ma n wa pelu oyun nini nigba odomode			
52.	Mi o ro p emo le loyuntabi fun yan loyun gege bi odomode?			

53. Kini o ma se ka so pe oni oyun/ fun obirin ni oyun gege bi odmode?

_____

54. Kini idi ti o fi ma gbe igbese yii?

_____

55. Kini awon ewu ilera tio ro pe o wa pelu ibese to ma gbe yii?

_____

Apa kerin: Awon okunfa ti ole mu ki odo omode ni ewu ilera ti o jomo oyun nini ati omo bibi

Jowo se ami (V) si ibi ti o toka si idahun re.Ri pe o si dahun awon ibeere naa ni otito

56. Se o ji pepe nipa ti ibalopo? Beeni ( ) Rara ( )

57. Se o ti ni ibalopo rii? Beeni ( ) Rara ( )

58.omo odun melo ni o nigba ti o koko ni ibalopo? Omo odun _____

59. Olubalopo melo lo nii? Kosi ( ) okan ( ) Meji ( ) Oju meji lo ( )

60. Se iwo maa n lo ifeto si omo bibi kankan? Beeni( ) Rara ( )

61. Bawo ni o se maa n lo si ayeye si? Rara ( ) Ekan ni ose ( ) Ekan ni osu ( ) Oju emeji lo ni osu ( )

62. Se o maa n mu oti lile? Beeni ( ) rara ( )

63. Ti o ba je beeni, bawo lo se maa n mu oti si? _____

64. Nibo ni o ti maa n gba imoran ti o jomo ibalopo ati omobibi?

a. Lowo ore ( )

b. Lowo awon ebi mi ( )

d. Lowo awon eyan to ju mi lo ladugbo ( )

e. Lori ero ayelujara ( )

e. Ni ile iwosan ( )

f. Ninu iwe kika ( )

g. Lowo awn eleto ilera ( )

i. Ni ile-iwe ( )

65. Mo ni awon ore odo omode to ti o ti ni omo/awon omo? Beeni ( ) Rara ( )

65b.Ti o ba je beeni, kini awon erungba re si won? _____

66. Awon obi mi korju si awon iwa ibalopo to le wu? Beeni ( ) Rara ( )

67. Agbegbe mi fun mi ni iwuri lati ma wuwa to jo mo ibalopo? Beeni ( ) rara ( )

68. Igbawo si asiko yii lo wu e lati di obi?Odun _____ si isin

69. Se o wa ninu egbe kankan? Beeni ( ) Rara ( )

70. Se o maa n gba imoran tabi alaye lori ibalopo ati omobibi ninu egbe yii? Beeni( ) Rara ( )

Ose pupo fun askio ati isowopo re.

APPENDIX

ETHICAL APPROVAL LETTER

TELEGRAMS..... TELEPHONE.....

OYO STATE: THE PACESETTER

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting

Our Ref. No. AD 13/479/1059

13th December, 2018

The Principal Investigator,
Department of Health Promotion and Education,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Iyanda Adebisi

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Knowledge and Perception of Health Risks Associated with Teenage Pregnancy and Childbearing among Out-of-School Adolescents in Ibadan South-East Local Government, Oyo State" has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

RESEARCH ETHICAL REVIEW COMMITTEE
MINISTRY OF HEALTH, OYO STATE

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee