PERCEPTION AND ATTITUDE OF ADOLESCENT MOTHERS ATTENDING HEALTH FACILITIES IN IBADAN SOUTH-EAST LOCAL GOVERNMENT AREA TOWARDS THEIR RE-ENROLMENT INTO SCHOOLS

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CERTIFICATION

This is to certify that this study was carried out by Folasade Tunrayo FADAYOMI of the Department of Health Promotion and Education, Faculty of Public Health, under my supervision.

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DEDICATION

I dedicate this work to my Father, my King, the eternally faithful God, for seeing me through the MPH programme. I appreciate you Lord and I know I couldn't have made it this far without you.

Thank you daddy!!!

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ABSTRACT

In many developing countries, adolescent pregnancy has been one of the major hindrances to the education of girls. In Nigeria most girls who become pregnant in schools are expelled and fail to return to school after delivery. Others who are fortunate enough to continue schooling face numerous problems. Few studies have documented the perception and attitude of adolescent mothers towards re-enrolment into schools. This study therefore, examined perception and attitude of adolescent mothers towards re-enrolment into schools in Ibadan South-East local government area.

A descriptive cross-sectional survey was conducted among randomly selected 298 consenting adolescent mothers attending health facilities in Ibadan south-east local government using a two-stage sampling technique. A pretested structured interviewer-administered questionnaire which contained 13-point perception and 5-point attitudinal scale was used for data collection .Scores between 0-7 was categorized as poor perception while scores >7 was categorized as good perception. Attitudinal scores of 0-2 and >2 were categorized as negative and positive attitude towards school re-enrolment respectively. Data was analyzed using descriptive statistics and Chi-square at $p<0.05$ level of significance.

Mean age of participants was 20.4±1.2 years and 73.5% were Christians. A large number (64.1%) of the respondents had good perception towards their re-enrolment into schools while 35.9% had negative perception towards school re-enrolment. Majority (82.2%) of the respondents agreed with the statement that they will return to school if their teachers are willing to support them as most of them believe that they might be abused by their teachers. Most of the respondents (88.9%) agreed that coming back to school will make them learn from their mistakes (getting pregnant). Majority (95%) of the respondents indicated that they would return to school if there are re-entry policies.

Majority of the respondents (79.9%) had positive attitude to their re-enrolment into schools. A large number (79.2%) agreed that they can combine their academic work with caring for their baby. Most of the respondents (88.9%) said they prefer to re-enroll in another school if

they are given the opportunity. More than half (51.0%) indicated that they are not afraid to meet their teachers. Perceived barriers affecting respondent's re-entry into school were parent's financial status (97.3%), Stigmatization (76.8%), school re-enrolment policy (65.1%), lack of husband's support (66.4%), early marriage (56%) and lack of school support (43.6%). A significant association was found between the respondents' age and their perception towards school re-enrolment, No significant association was found between the religion of respondents and their perception towards school re-enrolment. A significant association was found between the respondents' marital status and their perception. There was no significant association between the respondents' level of education and their perception about school re-enrolment.

The perception and attitude of adolescent mothers towards school re-enrolment in the study area was good, but there exist several barriers to the actualization of this. Health promotion strategies such as advocacy and training would be useful in addressing this problem.

Keywords: teenage pregnancy, school re-enrolment, attitude, perception
Word count: 471

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ABBREVIATIONS

UNFP:	United Nations Population Fund
WHO:	World Health Organization
UNICEF:	United Nations Children's Education Fund
STIs:	Sexually Transmitted Infections
SPSS:	Statistical Packages for Social Sciences
NDHS:	Nigeria Demographic Health Survey
MDGs:	Millennium Development Goals
FAWE:	Forum for African Women Educationists
NDHS:	Nigeria Demographic health survey
UNESCO:	United Nations educational, scientific and cultural organization
MESTEVEE:	Ministry of Education, Science, Vocational Training and Early Education
AAP:	American Academy of Pediatrics

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

WHO identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to19 (WHO 2015). Adolescence stage is also categorized according to age-sets. These include early adolescence (10-14 years), middle adolescence (15-16years) and late adolescence (17-21 years) (Spano, 2004). It is the transition period between the end of childhood and the beginning of adulthood. Adolescent marks the onset of sexual maturity. Adolescence is a time of great change for young people. It is a time when physical changes are happening at an accelerated rate. There are also numerous developmental issues that just about every teen faces during the early, middle and late adolescent years (AACAP, 2003). But adolescence is not just marked by physical changes—young people are also experiencing cognitive, social/emotional and interpersonal changes as well (Spano, 2004). Adolescent's body is not as developed as that of adult women in terms of childbearing (Williamson, 2013). Thus, they often face certain complications during pregnancy which might result into death (Ogori, Shitu, and Yunusa, 2013). The focus of the 2013 World Population Day on July 11, was on "Adolescent Pregnancy". This indicates that teenage pregnancy has global effects and implications.

Adolescent pregnancy is a public health concern for both the developing and developed countries due to the observed negative impacts on the child and mother. Also, the unfriendly and uncaring dispositions of nurses and those in the medical institutions and facilities who are supposed to provide care create additional horror and hurdles to the teenage mothers. The world wide incidence of premature birth and low birth weight is higher among adolescent mothers. (Ekefre, Ekanem, and Ekpenyong, 2014). In every region of the world, girls who are from low income households or, live in the rural areas, and are illiterate or poorly educated are more likely to become pregnant than their counterparts that are well educated and wealthier in urban areas(Williamson ,2013) . In eight African countries, over nine out of ten young women in rural areas have not completed lower secondary school (UNESCO 2015). There are about 580 million adolescent girls in the world. A large number

(One-third) of these African adolescents live in Nigeria. Majorities (95%) of adolescent births in most part of the world occur in developing countries and nine (9) in ten (10) of these births occurred among married adolescents or a union. About7.3 million births occur in adolescent girls under 18 every year , two million of these births occur in girls under 15 while 20,000 girls give birth every day (Williamson, 2013)

According to the United State Centers for disease control and prevention, United States has the highest adolescent birth rate among developed countries as 329,772 births were recorded among adolescents between 15 and 19 in 2011. Nineteen (19) per cent of young women in developing countries become pregnant before age 18 (UNFPA, 2013). According to estimates for 2010, 36.4 million women in developing countries between ages 20 and 24 reports having had a birth before age 18. Among developing regions, West and Central Africa have the largest percentage (28 per cent) of women between the ages of 20 and 24 who reported a birth before age 18 and 6% of reported births before age 15, while Eastern Europe and Central Asia account for the smallest percentage (0.2 per cent). One girl in 10 has a child before the age of 15 in Bangladesh, Chad, Guinea, Mali, Mozambique and Niger(Williamson, 2013) .

There are several factors that determine the rate of teenage pregnancies in different countries of the world. In Nigeria and other developing countries, poverty, illiteracy , lack of sexuality education, mass media and internet, lack of parental guidance, peer group influence, child/early marriage, sexual abuse/violence, drug abuse among others tend to be glaring indicators that determine the rate of teenage pregnancies(Ogori et al., 2013). Several studies have reported high rate of pre-marital sexual activities among Nigerian adolescents and incidence of teenage pregnancy in the society is increasing gradually every year.(Ogori et al, 2013, Aderibigbe et al 2011). Girls that become pregnant should not be denied their access to education. One review found that only about one in three adolescents who left school because of pregnancy ever returned, while those who return to school suffer from stigmatization, ridicule, and abuse from both teachers and other learners, (Williamson, 2013). According to UNFPA (2013), girls who remain in school are less likely to become pregnant because education prepares them for jobs and livelihoods, raises their self-esteem and their status and further gives them more say in decisions that affects their lives. Birth rates among women with low or no education are higher than those with secondary or tertiary education.

Education could play a significant role in developing self-confidence, increasing age at first sexual intercourse and delaying marriage (Acharya, Bhattaria, Poobalan, Van Teijlingen, and Chapman, 2010).

1.2 Statement of the problem

According to UNICEF (2008), worldwide every 5th child is born to teenage mother and approximately 90% of the teenage births occur in developing countries. Globally, each year 13 million births occur to girls younger than 19 years (Williamson 2013). Worrisome is the fact that teenage pregnancy is a 'high -risk' pregnancy due to its association with various adverse maternal and fetal outcomes which results in increased mortality and morbidity of the mother and the child. Unless experienced medical hands and advice are available, adolescents run a high risk of pregnancy induced health problems because complications arising from pregnancy and childbirth are the leading causes of death in teenage girls in developing countries.

It is estimated that 70,000 female teenagers die each year because they are pregnant before they are physically mature enough for successful motherhood and as such indicated that teenage pregnancies and births are considered as risky (Yasmin, Kumar, and Parihar, 2014). To further potentiate the problem, in sub-Saharan Africa and other developing countries, girls are losing the battle for equal access to education (Williamson 2013). Specifically, in Nigeria, nearly (23%) of adolescent women age 15-19 are already mothers or pregnant with their first child and women with no education are much more likely to have begun childbearing before age 20 than women with secondary or higher education (NDHS 2013).

The Nigerian National Statistics shows that the percentage of teenage mother aged 15-19years who have had children or are currently pregnant was 22.9% in 2008 with an estimated adolescent population of over 23million in Nigeria. (Envuladu, Agbo, Ohizie and Zoakah, 2014) In 2013, the National Population commission reported that teen pregnancy in Nigeria might spike up to 60 million by the year 2015. Studies have shown that most of these pregnant young mothers do not return to school after giving birth. Few of them who decide to go back to school face a lot of challenges. They are despised and stigmatized by their teachers, colleagues /friends at school and even their parents (Williamson 2013). Education

can be seen as a veritable tool towards curbing the menace of teenage pregnancy. Strategically, education occupies the minds of the teenage girls as it makes them busy. Girls who remain in school longer are less likely to become pregnant (Williamson, 2013) . Over 90 percent of children in developing countries are out of school (UNESCO, 2011). Sub-Sahara Africa had the highest prevalence of teenage pregnancy in the world in 2013 (United Nations population Fund, 2013) and birth to teenage mothers account for more than half of all the births in this region. Approximately 95% of teenage pregnancies occur in developing countries with 36.4 million women becoming mothers before age 18. (United Nations Population Fund, 2013). According to NDHS 2008, Nigeria's adolescent fertility topped other African countries with 121 live birth per 1,000 compared with other African countries (5.8 per 1000 in South Africa and 63 per 1,000 in Ghana).

A report by United Nations Population Fund (2013) on Motherhood in childhood stated that one in three girls in developing countries is married before the age of 18 and 50 million girls are at risk of being married before 15 between now and 2020. This implies that if these current trends continue the number of girls under 15 having babies in this region is projected to increase from 1.8miliion in 2010 to 3 million over the next 17 years. This would take the estimated total number of under-18 giving birth in Sub-Sahara Africa to rise from 10.1million in 2010 to more than 16million by 2030. Several reports have shown that unintended pregnancy is one of the main reasons why young girls leave school. A survey on the re-entry of pregnant girls in primary and secondary schools in Uganda, found out that in 2012, 34% of girls dropped out of school due to early pregnancy and 11% due to early marriage (Forum for African Women Educationalist, FAWE 2011). In many developing countries, adolescent pregnancy has been one of the major hindrances to the education of girls. Adolescent girls who become pregnant should not be denied access to education; they should be given a second chance to complete their schooling. In a study conducted by Onyeka and Miettola (2011) on unintended pregnancy and termination of studies among secondary school students in Anambra state, Nigeria reveals that following the students delivery of their babies a larger percentage of the students mostly in Public schools discontinued their studies.

In Nigeria, there is no legal or policy position that prohibits pregnant girls or adolescent mothers from discontinuing their education, yet the practice is that most girls who

become pregnant in schools are expelled and adolescent mothers fail to return and complete their education after delivery. Others, who are fortunate enough to continue with school, are faced with numerous problems. Inadequate/ lack of mechanisms to ensure pregnant girls/ adolescent mothers complete education, denies them the right to education (FAWE 2011). Many research works have been done on the causes, effect and consequences of adolescent pregnancy but little or less work has been done on the attitude and perception of adolescent mothers towards re-enrolment into secondary school.

1.3 Justification

The results of this study will be useful in shedding light on the attitude and perception of adolescent mothers attending health facilities in Ibadan south-east local government towards their re-enrolment into secondary schools. The findings of this study will help in providing enough information in order to make recommendations mainly to policy makers as well as other implementing partners and stakeholders in addressing this problem and come up with effective interventions to help in the re-enrolment of adolescent mothers hence reducing adolescent drop-out rates in schools.

1.4 Research questions

This study provided answers to the following questions:

1. What are the attitudes of adolescent mothers towards their re-enrolment into schools?
2. What are the perceptions of adolescent mothers towards their re-enrolment into schools?
3. What are the perceived-barriers affecting re-entry of adolescent mothers into schools?

1.5 Broad Objective

The broad objective of the study was to investigate the attitude and perception of adolescent mothers attending health facilities in Ibadan South east local government towards the re-enrolment into schools

1.6 Specific Objective

The specific objectives of this study were to

1. Determine the attitude of adolescent mothers towards re-enrolment into schools

2. Assess the perception of adolescent mothers towards the re-enrolment into schools
3. Identify the perceived-barriers affecting the re-enrolment of adolescent mothers into schools.

1.7 Hypothesis

The following hypotheses were tested by the study

Ho 1: There is no significant association between age of adolescent mothers and their perception towards re-enrolment into schools

Ho 2: There is no significant association between religion and the perception of adolescent mothers towards re-enrolment into schools

Ho 3: There is no significant association between marital status of adolescent mothers and their perception towards re-enrolment into schools

Ho 4: There is no significant association between level of education of adolescent mothers and their perception towards re-enrolment into schools

CHAPTER TWO

LITERATURE REVIEW

2.1 Prevalence of adolescent pregnancy in developing countries

Precise data on adolescent pregnancies in developing countries is scarce. This is because most pregnant adolescents do not go for /cannot access antenatal care. Most adolescents do not go for antenatal care (ANC) because of the stigma and shame of being pregnant while some do not have access to quality antenatal cares especially those in the rural areas. Reports from Nigeria Demographic Health Survey (NDHS 2013) show that there are large differentials in antenatal care coverage. Proportion of women who reported that they receive antenatal care from a skilled provider is high in South East and South West and low in the North West and North East.

Similarly, rural women and less educated women are less likely than others to receive assistance from a skilled provider during delivery and deliver in a health facility than urban and educated mothers. In Chad, Ethiopia, Mali, Niger and Nigeria, fewer pregnant adolescents received antenatal care from a skilled provider and delivered with the help of a skilled attendant. (Kothari et al., 2012). Pregnancies that end in miscarriage and abortion are often absent from most national databases. Therefore, most adolescent pregnancies may go undocumented in developing countries.

Between 2009-2013, the schooling system In Zambia has recorded a total of 76,567 school girls' pregnancies among children in primary and secondary schools. About 86% of school girls' pregnancies occurred in rural areas among learners in grades 1-9. (Mesvtee, 2013)

In Zambia, there were 3,663 teenage pregnancies rose from 3,663 in 2002, to just under 15,000 school going teenage pregnancies between 2010 and 2014. (Mesvtee Statistical Bulletins, 2013).

Several studies have reported high rate of pre-marital sexual activities among Nigerian adolescents. In more than 30 countries, 10 percent of adolescents have had sexual intercourse at the age of 15,with rate as high as 26% in Niger (Williamson, 2013). In Nigeria,

the incidence has been determined by researchers to lie between 26% and 28% of all pregnancies.(Oriafo, 2012).

2.1.1 Factors contributing to adolescent pregnancy

2.1.2 Child/Early Marriage

Adolescent birth rates are highest where child marriage is most prevalent (UNFPA, 2013). Child marriage is a human right abuse (UNFPA 2012). Despite laws against it, the practice remains widespread. Choosing when and who to marry is one of life's most important decisions. No one else has the right to make that decision for someone else. The decision to marry should be a freely made, informed decision that is taken without fear, coercion, or undue pressure. It is an adult decision and a decision that should be made, when ready as an adult. Child marriage is the violation of article 16(2) of the universal declaration of human right and article 16 on the elimination of all forms of discrimination against women (CEDAW) (UNFPA, 2012).

Child or early marriage is defined as a formal marriage or informal union entered into by an individual before reaching the age of 18 (UNICEF, 2011; Nour, 2006),the World Health Organization(WHO) defines child marriage as marriage before the age of 18 which applies to both boys and girls, but the practice is far more common among young girls. Child marriage occurs when at least one of the partners is under age 18.The Child Rights Act bill passed in 2003, raised the minimum age of marriage for girls to 18.

The practice of child marriage is widely spread across Sub-Saharan Africa and South Asia with many children marrying at a far younger age than 18. Death rates among women giving birth before the age of 19 are twice those who give birth at 20 while for girls giving birth at the age of 15 or younger they are five times higher. (Brown, 2012). About thirty nine percent of all females in Nigeria between the ages of 20 and 24 were married before the age of 18years by 2011 (Walker, 2013).

In Northern Nigeria, girls are married as early as 12 years of age. Over half of the women in the North are married by the age of 16.A Survey by Mercy Corps 'Adolescent Girls Opportunity Fund(2013) on the adolescent girls in Northern Nigeria shows that among three northern states (Katsina,Jigawa And Kano) 27% of the girls were married . Majority of the girls married between the ages of 15 and 17 while some married before age 15.Early

marriage, has been noted as a reason why many girls do not complete school in Northern Nigeria. (Mercy Corps, 2013)

2.1.3 Lack of Parental care

Teens whose parents supervise them and monitor their behavior including the selection of their friends and role models raise children who are more likely to avoid early sexual activity, pregnancy, and parenthood than those parents who do not (Albert, 2007).

Study conducted by Thobejane (2015) on the factors contributing to teenage pregnancy in Matjitjileng Village, South Africa revealed that most of the teenagers fell pregnant at the age of 16 and 19 years because of lack of parental guidance and role model and were influenced by their peers who fell pregnant at an early age and were ignorant about contraceptives. Parents do not have enough time to sit with their children and talk about sex. Teenagers, especially girls, who experience body changes, find it difficult to discuss these changes with their parents (Bezuidenhout 2008).Some children may be living with their parents but are not able to enjoy maximum parental care because of lack of basic needs.
The estimated number of orphans in Nigeria was 7.8 million children in 2007 and this was projected to increase to 8.2 million orphans by the year 2010.

2.1.4 Peer group Influence

Recent study shows that peer pressure is one of the main reasons for engaging in sexual activities among adolescents (Aji et al., 2013).Peer plays a role in the social and emotional development of adolescents. Youths who resist engaging in sexual activity tend to have friends who are abstinent as well while youths who are sexually active tend to believe that most of their friends are sexually active as well (Advocates for Youth, 1997).

Their influence begins at an early age and increases through the teenage years. Peer pressure is the influence on a peer group that encourages others to change their attitude, values or behaviors. It is natural, healthy for children to have friends and rely on friends as they grow. A Peer can influence the behavior of an adolescent positively or negatively. Peer pressure is commonly associated with adolescent risk taking such as delinquency, drug abuse, reckless driving and sexual behaviors. Teenagers prefer to go with their peers rather than with their parents due to strong peer pressure. Among the adolescents, peer pressure is a

major factor that encourages the teenage boys and girls to indulge in sexual activities (Pogoy, Verzosa, Coming, and Agustino, 2014) . Many adolescents report feeling pressured by their peers to have sex before they are married.

2.1.5 Poverty

Those teens living in neighborhoods beset by poverty, unemployment, and high crime rates are more likely to start having sex early, fail to use contraception, and become pregnant or cause a pregnancy(Albert,2007) Poverty as a factor can also lead young people who are trapped in it to end up being victims of sexual trafficking. Teenagers who are born and have grown up into the circle of poverty may end up into prostitution as a way of compensating the salaries of their parents (Theobejane 2010). Studies in Bida local government in Nigeria by Odimegwu, Solanke and Adedokun (2002) revealed that adolescents whose parents were poor are more likely to engage in premarital sex which can lead to adolescent childbearing than adolescents whose parents were middle to high income level. Some girls are sexually active at an early age because of lack of financial assistance. Teenage girls whose parents face significant hardship have limited resources available to meet their basic needs, such as feeding, clothing, shelter, health care and education are likely to become pregnant than those who come from a wealthy family. Women in urban areas marry four years later than rural women (NDHS, 2013).

2.1.6 Mass media and Internet

The images that pervade the media (television, music videos, the Internet, and the like), are increasingly more explicit in sexual content. More than half (56 percent) of all television shows contain sexual content—averaging more than three scenes with sex per hour (Kaiser Family Foundation, 1999). The mass media and the internet have their advantages in terms of providing necessary information for young people on sexual heath and relationships but studies have shown that mass media negatively influences teens and their sexual behaviour.Studies by Asekun-Olarinoye et al have also shown that exposure to radio, television, newspapers, magazines, internet and watching of pornography is a key correlate to onset of early sex. Those who spend more time watching television and those who used the internet more frequently were more likely to be sexually active (Asekun-Olarinmoye , Adebimpe and Omisore, 2014)

2.1.7 Lack of knowledge on sex and sexuality education

Women and men in Nigeria tend to initiate sexual activity before marriage. Nearly one-quarter of women age 25-49 have had sexual intercourse by age 15 and more than half by age 18 (NDHS 2013). It is also estimated that 75 percent of the world population, younger than 15 years has no access to information regarding sexuality and reproduction (Bezuidenhout 2008).Sexuality education is more likely to have a positive impact when it is comprehensive and knowledgeable about human sexuality, understand behavioural training and are comfortable interacting with adolescents and young people on sensitive topics. The curriculum should focus on clear reproductive health goals, such as preventing unintended pregnancy, and on specific risk behaviors and protective behaviors that lead directly to the achievement of those health goals (Kirby, 2011).

Curriculum-based programmes are more effective if they also develop life skills, address contextual factors, and focus on the emerging feelings and experiences that accompany sexual and reproductive maturity. To be effective in preventing pregnancy and sexually transmitted infections, sexuality education should be linked with reproductive health services, including contraceptive services (Chandra-Mouli et al., 2013).

In many instances, adolescents have inaccurate or incomplete information about sexuality, reproduction and contraception (Presler-Marshall and Jones 2012). For example, a study in Uganda found that one in three adolescent males and one in two females did not know that condoms should be used only once(Presler-Marshall and Jones 2012) .Another study in Central America found that one in three adolescents did not know a pregnancy could occur the first time a girl had sex. (Remez et al 2008). Sexuality education must be comprehensive. This is the use of an age-appropriate and culturally relevant approach to teach about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information. Parents and educators sometimes fear that sexuality education will encourage adolescents to have sex. But research shows that sexuality education does not hasten the initiation of or increase sexual activity (UNESCO, 2009). Lack of sexual knowledge had big impact on some adolescents who engaged in early sexuality.

Teenagers, especially girls, who experience body changes, find it difficult to discuss these changes with their parents (Bezuidenhout 2008).Research has shown that adolescents want to constantly receive sexual information from their parents and teachers but parents are

shy to discuss sex-related issues with their adolescent children or they think the discussion would encourage them to indulge in sexual activities (Aji et al, 2013). In some cases teenage mothers are not well educated about sex and thus this leads to lack of communication between the parents and the children. A study on the sources of sexual information in Niger State, Nigeria reveals that 18.3% of the adolescents got information about sexual issues from their parents while others got information from their friends and peer group and physicians. A similar study among in-school adolescents in Nnewi, Anambra State Nigeria shows that 10.4% of adolescents got information about sexual issues from their parents while in United States, it was found out that 59% of adolescents learnt about sexuality from their parents (Aji et al, 2013).

2.1.8 Alcohol and Drug Use

There is equally the role drugs and alcohol use play in the increase of teenage pregnancy. Drugs and alcohol that removes inhibition can easily trigger and encourage unintended sexual activity**.** Adolescents who engage in high risk behaviors such as smoking or using alcohol and other drugs are more likely to be sexually active therefore, at risk for teenage pregnancy. Alcohol use and intoxication is also significantly related to the perpetration of sexual violence (The Higher Education Center for Alcohol and Other Drug Prevention, 2002). Victims may be sexually assaulted after knowingly ingesting illegal drugs, such as marijuana, heroin, and cocaine, they may also be unknowingly drugged Once ingested, a person becomes disoriented, confused, and may be rendered unconscious for several hours, therefore, alcohol and drug use has been cited as one of the major risk factors for both experiencing and perpetrating sexual victimization.

2.1.9 Sexual Abuse/Violence

The World Health Organization (WHO 2002), in their World Report on Violence and Health defined sexual violence as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting, including but not limited to home and work. Sexual violence may include attempted and/or completed rape, sexual coercion and harassment, sexual contact with force or threat of

force, and threat of rape. According to the American Academy of Pediatrics (AAP, 2001), adolescents are more likely to experience sexually violent crimes than any other age group. The National Crime Victim Survey (2000) noted that adolescent females age 16-19 are four times more likely than the general population to report sexual assault, rape, and attempted rape. Often this violence occurs within the context of dating or acquaintance relationships, with the female partner the likely victim of violence and the male partner the likely perpetrator. In Nigeria, One-quarter of ever-married women have suffered from spousal abuse, whether physical, emotional, or sexual at some point in their life (NDHS, 2013).

The Facts on Adolescent Pregnancy, Reproductive Risk and Exposure to Dating and Family Violence (2010) reported that In a qualitative study of 53 sexually active young women age 15 to 20 with a history of intimate partner violence, one in three (32 percent) became pregnant while in an abusive relationship and more than half (59 percent) of those who became pregnant within an abusive relationship reported that those pregnancies were unwanted. Also, In another qualitative study of 53 sexually active young women age 15 to 20 with a history of intimate partner violence, one in four (26 percent) young women reported that their abusive male partners were actively trying to get them pregnant. Twenty to twenty-five percent of pregnant teens reported physical or sexual abuse during pregnancy.

2.2 Impact of adolescent pregnancy on Health

Adolescent pregnancy carries several health risks to both the mother and the baby. Complications during pregnancy and childbirth are the second cause of death for 15-19 year-old girls globally(WHO, Fact sheet 2014) Adolescent who becomes pregnant within 2 years of menarche or when her pelvis and birth canal are still growing are likely to have health problems (World Health Organization, 2004). Stillbirths and newborn deaths are 50 per cent higher among infants of adolescent mothers between the ages of 20 and 29 (World Health Organization, 2012a). Williamson (2013) added that about 1 million children born to adolescent mothers do not make it to their first birthday. Infants who survive are more likely to be of low birth weight, and be premature than those born to older women in their 20's. Adolescents in low and middle-income countries especially sub-Saharan Africa and South Asia have double the risk for maternal death and obstetric fistula than older women (Blum et al, 2013).

"About 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth" (UNICEF, 2008). "Complications of pregnancy and childbirth are a leading cause of death for older adolescent females" (World Health Organization, 2012).

A study by the World Health Organization shows that girls who become pregnant at 14 or younger are more likely to experience premature delivery, low infant birth weight, perinatal mortality and health problems in newborns (World Health Organization, 2011). Studies in Ethiopia, Malawi, Niger and Nigeria show that about one in three women living with obstetric fistula reported developing it as an adolescent (Muleta et al., 2010) . Therefore, adolescent pregnancy remains a major contribution to maternal and child mortality and to the cycle of ill-health and poverty thereby hindering the accomplishment of the fourth Millennium Development Goals (reducing child mortality and improving maternal health) by 2015.

2.2.1 Unsafe Abortion

Major medical dictionaries defined Abortion is the spontaneous or induced termination of a pregnancy when the fetus is not viable. World Health Organization (WHO) and the National Center for Health Statistics, the Centers for Disease Control and Prevention (CDC) define abortion as" pregnancy termination prior to 20 weeks gestation or fetus bore weighing less than 500g". It can be induced through a pharmacological or surgical operation or may be spontaneous (also called miscarriage).It is estimated that one-third of teen pregnancies end in abortion (WHO 2012). A pregnant adolescent may be stigmatized by an early pregnancy and decided to seek abortion which is illegal, unsafe and can be distratous to the health. Adolescent girls between the ages of 15 and 19 account for as many as 3 million unsafe abortions annually in developing countries (WHO Fact sheet ,2014). Almost all (98%) of unsafe abortion take place in developing countries where abortion is illegal and unsafe abortions account for almost half of all abortions. (Sedgh et al, 2012, Shah and Ahman, 2012). Thirteen percent (13%) of maternal deaths representing about 67000-80,000 women and other serious complications are as a result of unsafe abortion. Abortion is illegal in Nigeria, the abortion law prohibits induced abortion except for medical reason in order to save the life of the woman.Inspite of the law, it has been estimated that 610,000 induced abortions occurs yearly in Nigeria. (UN, 2008, WHO, 2003)

Shah and Ahman (2012) revealed from their study that in developing world excluding East Asia, Sub-Sahara Africa accounts for 44% of all unsafe abortions between the ages of 15-19 while Latin America and the Caribbean account for 23%. Complications from unsafe induced and spontaneous abortions pose a serious threat to the woman's health and life. In countries where there are no re-entry policies such as Nigeria, school girls who do not want to face embarrassment of official school expulsion had to resort to unsafe abortion in order to remain in school which may lead to several consequences such as death.

2.2.2 Out of school adolescents

As the 2015 deadline for the United Nations Millennium Development Goals (MDGS) approaches, new data shows that the world is still unlikely to fulfill one of the most modest commitments which is to get every child in school by 2015. According to UIS data (UNESCO institute for statistics data base) there were 57 million out-of-school children of primary school age in 2011; more than one-half of the worlds out of school children live in Sub-Sahara Africa. In African countries such as Burkina Faso, Cote d'voire, Ethiopia, Kenya and Nigeria more than one million children are out of school. In 2011, 69million young adolescents around the world were not attending primary or secondary school, South and West Asia has the biggest share of this population with 31million out-of school young adolescents while in sub-Saharan Africa, 22million adolescents are out-of school. (UNESCO institute for statistics, fact sheet 2013). Studies have shown that teenage pregnancy is one of the reasons that lead to termination of studies at a tender age (Fawe, 2011).Teen pregnancy and childbirth contribute significantly to drop out rates among high school females.

2.2.3 Attitude and perception of adolescent mothers towards their re-entry into secondary schools

The right to education is a fundamental human right (UNESCO, 2014). Every individual, irrespective of race, gender, nationality, ethnic or social origin, religion or political preference, age or disability, is entitled to equitable and successful completion of education (FAWE, 2011).

However at primary and secondary school level, most of the children who enroll do not realize their right to full basic education as most of them drop out. Globally, out of 104

million children aged 6-11 that are out of school each year, 60 million are girls. Nearly 40% of these out of school children live in Sub-Saharan Africa while 35% live in South Asia (UNESCO, 2014).In Sub-Saharan Africa; more than half of the girls (54%) do not complete primary education.

A survey conducted by FAWE (2010) shows that girls' education still faces an uphill task as there are noted cases of girls dropping out of school especially as they progress to higher classes as a result of getting pregnant while they are still in school and failure to re-enter school after delivering. Most times school careers of many girls are cut short because of pregnancy. Challenges of high dropouts and teenage pregnancies have continued to disrupt and affect girls' education thereby blocking the celebrated achievement of increasing female enrolment in schools. Pre-marital pregnancy among girls is stigmatized both in school and in communities (Williamson, 2013). In many situations, in most schools pregnant girls and child mothers are suspended or expelled, they often fail to return and complete their education while most of them do not wait to be identified by the school administration, they chase themselves and there is no system for follow up and monitoring in schools. At the community level, pregnant girls are often rejected at home and sent away, they may go with the men responsible and get married, they are labeled as useless, a burden, perceived as sinful, abominable, outcasts, a waste; they are isolated and denied assistance even when the family has resources while others are assisted by parents to abort. (FAWE, 2010)

Several sub-Saharan Countries such as Zambia, Botswana, South Africa, Tanzania and Kenya have have policies in place to ensure re-entry of pregnant girls into schools. Reports from surveys show that adolescent mothers fail to re-join school because of certain challenges such as the lack of their parent's support. They are isolated and denied assistance at home even when the family has resources. Most of the girls are chased away by their parents and they end up either marrying the father of the child or looking for odd jobs to look after their babies as teen mothers. Some of these girls end up doing odd jobs such as housemaids, hotel or bar attendants, saloon maids etc. Other challenge includes the stigmatization by peers, friends/classmates, community and schools. This leads to outright fear and the perception that such girls are spoilt and not fit to be in school. This makes such girls not to return to school.

Report from a researcher on the experience of young school-going mothers in high schools at Leribe district of Lesotho (2011) shows that adolescent mothers experience undue pressure from teachers, peers/ classmates and the community they live in. They also suffer discrimination and exclusion at school and from society largely because of the perception that the immorality of teenage mothers would teach other students this bad behavior and encourage others to become pregnant. Young mothers are, thus, marginalized and excluded from their peers. For this reason some girls decide to leave school and have the fear of coming back to school. (Arlington Public school, 2004). Adolescent mothers' poor performance in their academics also contributes to their decision to leave school. Research conducted by Samuel, 2002 reveals that adolescent mothers always have to struggle to catch up in their classes. They have to split their time between their classes and their babies and sometimes they have to miss class or examinations. This result in most teen mothers lagging behind in their school work resulting in their failure. For this reason and many others, teen mothers lose interest and decide to leave school.

2.2.4 Challenges of Teenage Motherhood

Education plays a pivotal role in the social and economic development of any country in enhancing the quality of lives of its citizens (UNESCO, 2010). Teenage pregnancy has militated against the educational success of girls especially in developing countries. Statistics show that there are 580 million adolescent girls in the world. Four out of five of them live in developing countries. Education is important for these girls in order to break the poverty cycle in which most of them are trapped. These girls must be allowed to return to school after becoming mothers and few of them who try to go back to school face many challenges in trying to balance motherhood and the demands of schooling.

Several Studies have also shown that teen mother faces a lot of challenges in trying to complete their education which may serve as a hindrance towards their willingness to come back to schools. They have difficulties in combining their roles as a mother with their academics. Managing to care for an infant and devoting time to school work is a great challenge for adolescent mothers counseling and child care facilities to the young teen mothers on their return to school may lessen their challenges and therefore, being able to concentrate and perform well in their academic work.

Several studies have also reported a number of complaints received from adolescent mothers in several African countries, concerning some forms of discrimination which include schools not allowing pregnant girls/ adolescent mothers to complete their schooling/ return to school after delivery for the fear that they might contaminate other girls and encourage them to become pregnant. A newsletter from the UNICEF Caribbean Area Office (UNICEF/CAO, 2003) on the issue related to child development and protection in the Caribbean expressed the opinion of some teen mothers about going back to school. The girls decided not to go back to school because the principal of the school did not allow them. (UNESCO 2003) stated that it may be illegal to refuse pregnant girls an opportunity to complete their schooling since education is their human right.

Chigona and Chetty (2007) revealed from their study on Girl's education in South Africa that teen do not succeed in their education when they return to school as they do not have enough time to do their homework and to study. In most cases, teen mothers cannot afford child-care facilities and families do not offer much help in taking care of the babies. This is worsened when they have to miss class due to the illness of their babies. Unfortunately, their teachers do not have the means of helping the mothers catch up with the missed lessons. This result in most teen mothers lagging behind in their school work resulting in their failure. There is need for adequate support to prepare them for schooling and mothering as this is a big responsibility for a teenager who is still developing psychologically. This also concur with the findings by Molapo (2011) which indicated that that young mothers lack child care assistance at home because no one is willing to help or provide care for the baby. One of the teen mothers in the study commented that there is no one to help her look after her baby when she is in school. Furthermore, she gets no encouragement at home in relation to school work because when she gets home, she has to do a lot of work for the whole family and also cook for her baby…… There is no time for school work at home. For this reason and many others, teen mothers lose interest and decide to leave school.

Teen mothers also stated that they are stigmatized, victimized and alienated by their peers, and sometimes by their teachers some of the teachers pass bad remarks concerning the mothers in the presence of other learners and this have direct and indirect negative impact on the self-esteem of the teen mothers. This negatively affects them by their feeling of out of

place, (low self-esteem) resulting in poor performance in school. There are no strong policies to deal with any mockery, teasing or marginalizing young teen mothers in schools. These remarks may affect the comfort of adolescent mothers and may force them to drop out of school. Teen mothers lack academic support and encouragement from their teacher. The report is similar to the study by Molapo (2011) which reveals that young mothers experience numerous problems at high schools which manifest in poor performance and high dropout rate. The young mothers have a tough time at school because they experience negative attitudes from their teachers. The impact of this rejection imposes stress and young mothers who lack resilience or cannot manage these frustrations simply leave school without achieving anything. In some of the schools, teachers do not go back to explain what was covered when the young mothers were absent, but for other learners they do so. To them it is like wasting time.

Angeline, Rustica, Nerlie and Ronalissa (2014) submitted that adolescent mothers have less possibility to finish their studies after engaging in early pregnancy. Taking care of the baby and providing financial assistance are challenges they encountered and tried to cope up with. Some of the adolescent mothers interviewed in the study had no plans to go back to school because of lack of physical, social and financial support. The result of the study also shows that the academic performances of teenage mothers had slightly influenced their decision in dropping-out of school after pregnancy. High performing students had greater impetus to precede their studies only if they have financial capabilities. The academic performance, the financial status and support of the family of teenage mothers determines if they can pursue their studies and achieve their dreams in life.

2.2.5 School Re-Entry Policies

The Constitution of Nigeria grants every child the right to education, yet a girl's access to education is denied when she becomes pregnant or gives birth. Several sub-Saharan African countries have revised and reformed their policies and practices for pregnant school girls to return to school after delivery. The Sub-Saharan Africa (SSA) region is characterized by high school dropout rates in the world. Teen pregnancy is the major constraint in the elimination of gender disparity in education and the achievement of the Millennium Development Goals of universal primary education and gender equity in education by 2015

(UNESCO, 2003).For example, In 1994, The government in Kenya came up with a re-entry policy guidelines allowing the re-entry of girls to schools after giving birth unconditionally. In Malawi, the government reviewed the policy that allows readmission of pregnant school girls after delivery and guaranteed childcare (UNESCO 2003). In South Africa, the 1996 policy allows logistical and financial support to pregnant and mothering teens to continue with schooling. In Namibia, a pregnant student is allowed to be in school until she is about to deliver, after delivery the baby is given to a responsible adult to take care of , and the girl has the right of readmission in the same school within twelve months from the date she left school . (Namibia MBESC 2001c). Contrarily, in Zimbabwe, a pregnant student must drop out of school and re- applies after two years, provided there is availability of space in the school.

In Madagascar, new mothers could return to school immediately after delivery if they wished while in Cameroon, girls have the right to negotiate the duration of their maternity leave with their school management, and can arrange for extra classes so that they do not lag behind in their school work during the agreed period of absence from school.

In October 2009, Tanzania adopted a new policy under the pressure from UNICEF and other civil organizations to change her 1995 educational policy on pregnant students to allow them to continue with studies during pregnancy and after giving birth (Media Global 2010). Pregnant students were allowed to sit for the national examinations in primary and secondary schools .New guidelines such as (timeframe, which school to be readmitted to, and the care for the baby) were developed that would assist teenage mothers in returning to school after delivery. In Jamaica, a "Policy on the Re-Integration of Adolescent Mothers into the Formal Education System" was approved by the Cabinet in May 2013 with the support of the Women's Centre of Jamaica Foundation, Ministry of Education and UNFPA which allow all school-aged mothers to continue their education after the birth of their child. The new policy went into effect in September 2013, and teenage mothers no longer face the risk of being denied entry back to school. Schools are now mandated to accept adolescent mothers back into the formal education system after they give birth. They also have the choice to choose either to attend new school or to return to the one they left. According to a study by Fawe (2011) on best practices on the re-entry for adolescent mothers in Zambia, Girls in co-educational school prefer to go to different schools after having a baby because they suffer

more teasing and taunting than those that attend all-girls schools. Only few of the co-educational schools receive their own girls back.

In September 1997, government announced the re-entry policy in Zambia which gives chance to girls who fall pregnant while in school to reclaim their school place and continue their education.

Table 2.1 Incidence of adolescent pregnancy and the number of girls re-enrolled between 2009 and 2013 in Zambia

Year	No of pregnancies	No of girls re-enrolled
2009	15,497	6,679
2010	15,586	6,067
2011	15,707	6,030
2012	14,849	6,001
2013	14,928	5,829

(Source – Ministry of Education, Science, Vocational Training and Early Education, MESVTEE Statistical Bulletin 2013)

In spite of the policies, in some countries, pregnant and mothering students are still expelled from schools while some are struggling to continue with studies under difficult situations. Some school heads do not want to give teenage mothers space in their schools, there believe is that giving a chance of education to teenage mothers will encourage more girls to become pregnant.

Reports from the study conducted by Maluli and Bali (2014) on Exploring Experiences of Pregnant and Mothering Secondary School Students in Tanzania reveals that 99% of the respondents are aware of the existence of re-entry policy for adolescent mothers but further stated that the policies are political but not practical as it opens door to corruption and favoritism. Some pregnant students are still expelled, while some school heads re-admitted young mothers due to kindness or family relationship, others had to pay some amount of money". It is not done officially; it is based on who you know.

Readmission of pregnant students and adolescent mothers is still a major problem in schools in Nigeria. The common practice, is the expulsion of pregnant girls from school which violate girl's child rights to education as stipulated in the UN Convention on the Rights of the Child (1989), and the Universal Human Rights .School girls who become pregnant in Nigeria have to face official school expulsion and most girls never return to school to complete their education after birth.

2.3 Theoretical Framework

The ecological model of change which was developed by McLeroy and colleagues (1988) was used for the study. The theoretical framework presents a systematic way of understanding events or situations. It is a set of concepts, definition, and propositions that explains or predicts events or situations by illustrating the relationship between variables (National Cancer Institute [NCI] 2005). In this study Ecological Model was adopted to provide a clear explanation of the important variables linked to the study which should be assessed.

Ecological models of health are comprehensive health promotion frameworks that are multifaceted, which focus on environmental change and its influence on behavior, and structural interventions such as policies that help individuals make healthy choices in their daily lives (Lemerle, 2005). The common thread linking the ecological models of health is their focus on those intangible assets within human systems (such as organizations and communities), which in many subtle ways determine health outcomes.

2.3.1 The tenets of the ecological model includes:

1. Individual or intrapersonal factors: This involves the attitude, general perceptive, self-concept, motivation and past experience of adolescent mothers about school re-enrolment which could be a determinant factor on whether they will return to school or not. This study examines the effect of interpersonal factors on the re-enrolment of adolescent mothers into schools.

2. Interpersonal factors: This addresses the influence of significant others including family, friendship and peers network, spouse, parents that provide social identity, on their re-

enrolment to school or not. In this study the role of significant others having capabilities of influencing behaviors positively or negatively was investigated. This is possible because in most instances adolescents tend to act in accordance with what they learn or hear from significant others.

3. Community: The culture, norms and tradition of people towards the re-enrolment of adolescent mothers' into schools. Attitude and perception of the community can affect student's re-entry into schools. Some communities see adolescent mothers as an outcast and do not want them in schools because they see them as a bad influence to others.

4. Institutional factors: These are institutional or organizational characteristics such as rules and regulations, policies, in schools which may constrain or promote recommended behaviors. In Nigeria, there should be formulation and implementation of re-entry policies in schools that will encourage the affected students to come back to school. Schools should be willing to reabsorb the affected girls during pregnancy or after delivery. Schools should also be equipped to effectively cater for pregnant and/or lactating girls. This study also investigated the influence of institutional factors towards adolescent's school re-enrolment.

5. Societal Or Public Policy Factors: The fifth level looks at the broad societal factors such as Local, state, federal policies and laws that regulate or support retention policies, early detection of pregnancies, control, and management must be in place to ensure that girls that are pregnant have access to education and the health of pregnant and lactating student is safeguarded at all the time.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

The study was a descriptive cross sectional one and it examined the perception and attitude of adolescent mothers attending primary health care center in Ibadan South East Local Government Area.

3.2 Study variables

The independent variables in this study were the socio-demographic characteristics such as age of the respondents, educational level, marital status, ethnic group of the respondents, religion, parent's financial status, family status and occupation of the respondents. The dependent variables included perception and attitude of adolescent mothers attending primary health care centers, South East Ibadan.

3.3 Study Setting

Ibadan South-East Local Government Area.

Ibadan South East Local Government Area has thirteen (13) primary health care centers located in community. The study was conducted in all the primary health care centers located within the community in Ibadan South East Local Government Area.

Ibadan South-East Local Government Area was created on the 27th August, 1991 and it is the smallest urban Local Government Area and contains some of the core slum areas in Ibadan. The administrative headquarters of the Local Government Area is situated at the center of Ibadan on the top of Mapo hill. Ibadan South-East Local Government Area is bounded in the North by Ibadan North Local Government Area, in the east and south by Ibadan North East and Oluyole Local Government Areas respectively and bounded on the West by Ibadan South-West Local Government Area. It covers an area of about 893 hectares and has a population of 266,046. There are 12 wards in the Local Government Area and numerous tourist sites including Mapo Hall, Olubadan's palace and the Central Mosque, Oja'ba (Adijolola, 2014).

3.4 Study Population

The study population consists of adolescent mothers attending Primary Health Care Center in Ibadan South East Local Government Area, Oyo State. These adolescent mothers included married and single adolescents.

3.4.1 Eligibility criteria

- **Inclusion Criteria**

The inclusion criteria include adolescent mothers that are within the range of (10-21) years that have given their consent to partake in the study and attend health facilities in Ibadan South-East local government area of Oyo State

- **Exclusion Criteria**

Adolescent mothers that were younger than 10years of age or older than 21 years, mothers who refused or not willing to participate in the study and do not attend health facilities in Ibadan South-East local government area of Oyo State.

3.5 Sample Size Determination and Sampling procedure

3.5.1 Sample size

The sample size (n) will be determined by using **Fischer et al (1991)** sample size formula:

$$n = \frac{Z^2 p(1-p)}{d^2}$$

Where n=minimum sample size required

Z= confidence limit of survey at 95% (95% CI)

P= Prevalence is estimated to be 22.9% (Amoran 2012)

d=absolute deviation from true value (degree of accuracy) = 5%

$$n = \frac{1.96^2 \times 0.229 \times (1-0.229)}{0.05^2} = 271.3$$

A non-response rate of 10% was added to calculated sample size to make (271+ 27.1) =298.This is done in order to address any possible case of incomplete response.

3.5.2 Sampling Procedure

Table 3.1 estimated total monthly antenatal attendance of pregnant women attending primary health care in Ibadan South East Local Government

S/N	Names of Primary Health Care	Total ANC Attendance	Proportionate sampling of respondents	Interval used= total no of willing participants/ required no of participants per PHC
1	Agbongbon	789	$\frac{789 \times 5576}{298} = 42$	$\frac{120}{42} = 3$
2	OritaAperin	377	$\frac{377 \times 5576}{298} = 20$	$\frac{55}{20} = 3$
3	Balaro	53	$\frac{53 \times 5576}{298} = 3$	$\frac{20}{3} = 7$
4	Boluwaji	1313	$\frac{1313 \times 5576}{298} = 70$	$\frac{150}{70} = 2$
5	Elekuro	119	$\frac{119 \times 5576}{298} = 6$	$\frac{60}{6} = 10$
6	Lanioka	64	$\frac{64 \times 5576}{298} = 3$	$\frac{25}{3} = 8$
7	Mapo	89	$\frac{89 \times 5576}{298} = 5$	$\frac{38}{5} = 8$
8	Molete	377	$\frac{377 \times 5576}{298} = 20$	$\frac{60}{20} = 3$
9	Odinjo	1654	$\frac{1654 \times 5576}{298} = 88$	$\frac{120}{88} = 1$
10	Oranyan	665	$\frac{665 \times 5576}{298} = 36$	$\frac{60}{36} = 2$
11	Owode	11	$\frac{11 \times 5576}{298} = 1$	$\frac{5}{1} = 5$
12	Challenge	29	$\frac{29 \times 5576}{298} = 2$	$\frac{18}{2} = 9$
13	Eyin grammar	36	$\frac{36 \times 5576}{298} = 2$	$\frac{25}{2} = 13$
Total		5576	298	

Source: Oyo State Ministry of Health Records (2015)

Sampling method: A two (2) stage sampling method was used for the selection of respondents.

STAGE 1: a proportionate sampling technique was used for the selection of respondents from each PHC.

STAGE 2: A systematic sampling technique was used to select the determined number of respondents per PHC that met the inclusion criteria and was willing to participate in the study.

The interval was determined based on the number of willing participants in each PHC and the required number of participants per PHC.

Simple random (balloting) selection was done between the first and the second respondent and the interval was thereafter used in selecting the participants.

3.6 Instrument for data collection

An interviewer- administered questionnaire which was developed in English Language and translated to Yoruba was used for the research. The questionnaire contained close ended questions under the following section.

A. Socio-demographics characteristics
B. Perception of adolescent mothers towards their re-enrolment into schools
C. Attitude of adolescent mothers towards their re-enrolment into schools
D. Perceived barriers affecting the re-enrolment of adolescent mothers into schools

3.7 Validity of instrument

The validity of the instrument was authenticated by the following number of steps:

The instrument was reviewed by the researchers' supervisor, mentor, lectures, co-researchers and the validity of the research instrument were ensured through the development of draft instrument by consulting relevant literatures, subjecting the draft to independent peer and expert reviews particularly expert in public health. The validity of the research instrument was also ensured by carrying out pre-test among adolescent mothers attending primary health care center in Ibadan north local government area, Oyo State.

3.8 Reliability of instrument

The reliability of the questionnaire was calculated using Cronbach's Alpha coefficient analysis. The Cronbach's alpha coefficient is a model of internal consistency based on the average inters item correlation. Instrument are said to be reliable when it shows correlation coefficient of 0.5 and above. The Cronbachs alpha coefficient gotten after the reliability analysis of the instrument for this study was 0.77.

3.9 Pre-test of instrument

Ten (10) percent of the total sampling size was pre-tested. The pre-testing of the instrument was done in different primary health care center with similar characteristics. The pre-testing was done in Ibadan North Local Government Area.

3.10 Data collection procedure

The researcher visited the matron of each PHCs centres for consents of the respondents. Four (4) trained female research assistants were recruited to administer the questionnaire under the supervision of the investigator and were trained for data collection using a quantitative tool for two days. During the training session, goal and objectives of the research were carefully explained to the research assistants, so that they would understand the goal of the research and their responsibilities as research assistants. The process of data collection took three weeks. The training focused on: the rationale and study objectives, sampling techniques and methodology of study, how to obtain verbal formal consent from respondents and proper administration of research instrument (questionnaire).

3.11 Data Management and Analysis

The copies of the questionnaire were serially numbered for control and recall purposes, and the data collected were checked for completeness and accuracy on a daily basis. The numbering of the questionnaire was to ensure easy identification and recall of any instrument with problems. The data were sorted, edited and coded manually by the investigator with use of coding guide. The data were imputed into the computer while the analysis was carried out using the SPSS statistical tool software version 20. A frequency count was run to detect missing cases while the data also undergo cleaning. Descriptive

statistics and inferential statistics (chi-square) were used for the analysis and the data were presented in tables and charts. The copies of the questionnaire were stored in a place where unauthorized person would not have access to them.

The socio-demographics variables were analyzed with the use of frequency distribution tables and cross tabulations of categorical variables (Sociodemographics) against the outcome variable (perception of adolescent mothers towards their re-enrolment into schools).The perception of the respondents towards school re-enrolment was assessed using 13-points scale. Data on perception was analyzed by assigning one (1) point to each correct answer and zero point for incorrect answers provided by the respondents. Respondents with 0-7 points were regarded as having poor perception about their re-enrolment into schools while those who score above 7(>7) were regarded as having good perception.

Also a 5- point's attitudinal scale was used in assessing the attitude of adolescent mothers towards their school re-enrolment. Data on attitude was also analyzed by assigning I point to each correct answer and zero point for incorrect answers provided by the respondents. Respondents with 0-2points were considered as having negative attitude towards school re-enrolment while those greater than 2 points were considered to have positive attitude.

The data was subjected to descriptive (mean) and inferential statistics (chi-square test) .Chi-square was used to test the hypotheses, p-value of 0.05 or less was considered to be significant for the chi-square test.

3.12 Ethical considerations

This study followed the ethical principles guiding the use of human participants in research. Ethical approval was obtained from Oyo State ministry of health Ethical Review Committee. The purpose of this was to ensure that this study is conformed to the generally accepted scientific principles and international ethical guidelines related to human subject researches. Permission was obtained from Oyo State Ministry of Health before copies of the questionnaire were distributed. Four research assistants were trained to assist in administering questionnaires.

3.13 Confidentiality of data

Absolute confidentiality was fully assured. No identifier such as name of respondents was required and all information provided was kept confidential. Completed copies of the questionnaire were kept in secured setting where no other persons can have access to the information gotten from the respondents. All information was used for the purpose of the research.

3.14 Non-Maleficience

The research did not in any way inflict harm on the participants and every other participant was treated equally as much as possible.

3.15 Voluntariness

At any point in time any participant who wishes to withdraw was free to do so.

3.16 Translation

The questionnaire was translated into Yoruba for easy understanding by Yoruba speaking respondents. See appendix II for more details.

CHAPTER FOUR

RESULTS

4.1 Socio-Demographic Characteristics

Table 4.1 shows the basic socio-demographic characteristics of the respondents. A total of 298 females aged 10-21years participated in the study. The mean age of participants was 20.4±1.2 years. Majority (90.6%) of the respondents were married while 9.4% reported that they are single. A large number (73.5%) of the respondents were Christians while 26.5% were Muslims. More than half (67.4%) had secondary education while 32.6% had primary education.

Table 4.1: The Socio-demographic characteristics of participants N=298

SOCIODEMOGRAPHIC	N (%)
Age(yrs)	
15-18	131(44)
19-21	167(56)
Religion	
Christianity	219(73.5)
Islam	79(26.5)
Marital status	
Single	28(9.4)
Married	270(90.6)
Ethnic group	
Yoruba	270(90.6)
Igbo	9(3)
Hausa	19(6.4)
Present occupation	
Trading	135(45.3)
Tailoring	105(35.2)
Hairdressing	58(19.5)
Level of education	
Primary	97(32.6)
Secondary	201(67.4)
Family type	
Monogamy	125(41.9)
Polygamy	173(58.1)
Parent's marital status	
Married	179(60.1)
Divorce	107(35.9)
Widow	9(3.0)
Widower	3(1.0)

4.2: Perception of respondents' towards re-enrolment into schools

Some questions were asked to examine the perception of respondents towards their re-enrolment into schools. In answering the questions, some of the respondents had positive and negative perception towards re-enrolment into schools. One hundred and eighty-eight adolescent mothers (63.1%) believed that they might be abused by their teachers and peers in the classroom while 109(36.6%) respondents disagreed with the statement. One hundred and ninety one respondents (64.1%) agreed to the statement that they won't be able to concentrate well in my studies if they return back to school while 107 (35.9%) respondents disagreed with the statement .One hundred respondents (33.6%) believed that many schools may not be willing to accept them back in school because the schools might believe that they might influence others negatively thereby destroying the image of the school while 166(55.7%) respondents disagreed with this statement. One hundred and eighty respondents (60.4%) concurred to the statement that no one will be willing to help them take care of their baby while they are in school, nevertheless 108(36.2%) disagreed with it.

One hundred and ninety four (65.1%) respondents believed that they are too old to return to school while 103(34.6%) respondents disagreed with the statement. More than half of the respondents (203, 68.1%) agreed that their parents may not support their going back to school while (85, 28.5%) disagreed with the statement. Majority of the respondents (245, 82.2%) agree with the statement that they will return to school if their teachers are willing to support them while (50, 16.8%) respondents disagreed with this statement.

Majority of the respondents (265, 88.9%) agreed that coming back to school will make them learn from their mistakes while (31, 10.4%) respondents disagreed with the statement .More than half (208, 69.8%) of the respondents concurred to the statement that they prefer to learn a trade to coming back to school, one quarter (29.5) of the respondents did not agree with the statement while two respondents (0.7%) chose don't know. See table 4.2 for more details

Table 4.2: Perception of respondents towards re-enrolment into schools

Perception statement	Yes (%)	No (%)	I don't know (%)
I think I might be abused by my teachers and peers in the classroom	188(63.1)	109(36.6%)*	1(0.3)
I think I won't be able to concentrate well in my studies	191(64.1)	107(35.9)*	0(0.0)
I feel coming back to school make me learn from my mistake	265(88.9)*	31(10.4)	2(0.7)
I prefer to return back to school if there are re-entry policies and the school is willing to accept me	283(95.0)*	15(5.0)	0(0.0)
I will return to school if my teachers are willing to support me	245(82.2)*	50(16.8)	3(1.0)
Many schools will not be willing to accept me because they believe I might spoil the image of the school	100(33.6)	166(55.7)*	32(10.7)
Schools may not be able to look after their babies	162(54.4)	105(35.2)*	31(10.4)
My parents may not support my going back to school	203(68.1)	85(28.5)*	10(3.4)
My fellow mates will laugh at me and call me names	162(54.0)	114(38.6)*	22(7.4)
I think am too old to return to school	194(65.1)	103(34.6)*	1(0.3)
My parents are not happy and unwilling to send me back to school	156(52.3)	132(44.3)*	10(3.4)
No one is willing to help me take care of my baby while am in school	180(60.4)	108(36.2)*	10(3.4)
I prefer to learn a trade/work than coming back to school so that I can earn money to take care of my baby	208(69.8)	88(29.5)*	2(0.7)

4.3: Perception score of respondents

Figure 4.1 show that a large number of the respondents (64.1%) had good perception towards their re-enrolment into schools while 35.9% had poor perception towards school re-enrolment.

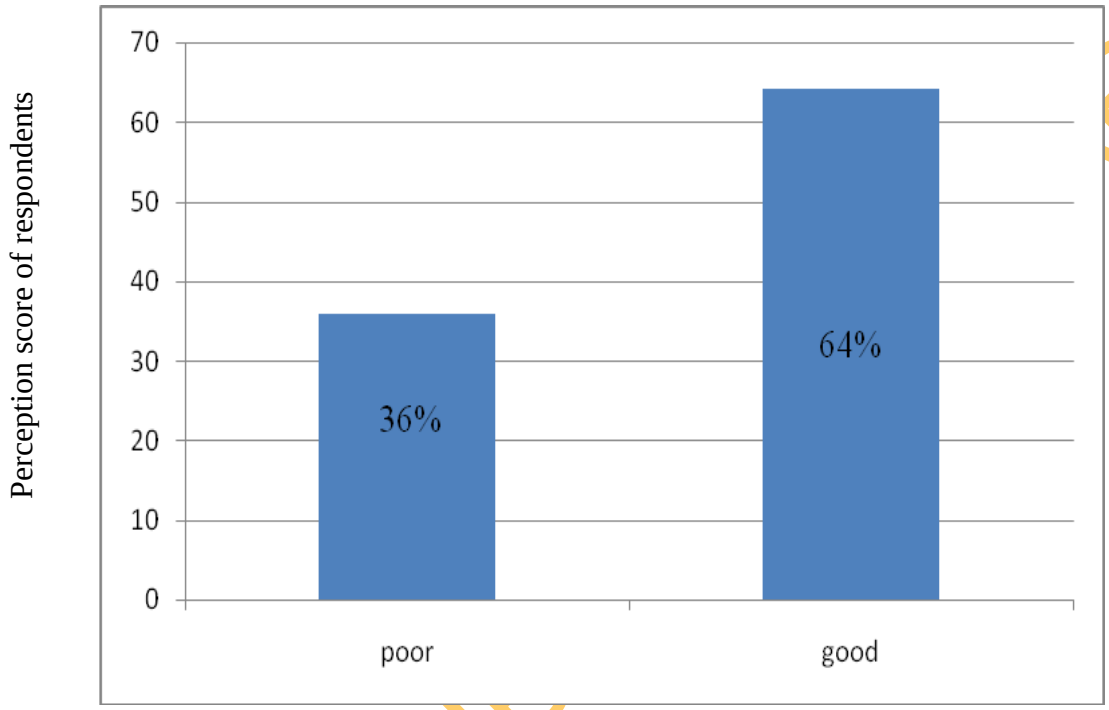

Figure 4.1 perception score of respondents on school re-enrolment

4.4 Respondent's attitude towards re-enrolment into schools.

The attitude of the adolescent mothers towards school re-enrolment was assessed by requesting the respondents to give response to set of outlined indicators with respect to school re-enrolment. Respondents showed positive and negative attitude towards their re-enrolment into schools. Majority of the respondents (79.2%) agreed that they can combine their academic work with caring for their baby while few of the respondents (19.5%) disagreed with it. Four respondents (1.3%) indicated 'don't know' as their option.

Majority of the respondents (88.9%) said they prefer to re-enroll in another school if they are given the opportunity as opposed to 33 (11.1%) who disagree with that. One hundred and twenty five (41.9%) respondents reported that they are afraid to meet the school authority while a slight high percentage of respondents (57%) disagreed. One hundred and three (34.6%) respondents reported that they will prefer to re-enroll in the same school if they are given opportunity to come back to school while a large number of respondents (65.1%) disagreed. Almost half of the respondents (45.6%) also agreed that they are afraid to meet their teachers while more than half (51.0%) disagreed with that. See Table 4.3 for details

Table 4.3: Attitude of respondents towards re-enrolment into schools

Attitudinal statement	Agree (%)	Disagree (%)	Undecided (%)
I can combine academic work with caring for my baby	236(79.2*	58(19.5)	4(1.3)
I prefer to re-enroll in another school if am giving the opportunity	265(88.9)	33(11.1)*	0(0.0)
I am afraid/shy to meet with my teachers	136(45.6)	152(51.0)*	10(3.4)
I will prefer to re-enroll in the same school if am giving the opportunity	110(36.9*	186(62.4)	2(0.7)
I am afraid/shy to meet with the school authority	128(43.0)	170(57.0)*	0(0.0)

*Correct response

4.5: Attitudinal Score

The result of the findings from this study shows that majority of the respondents (79.9%) had positive attitude to their re-enrolment into schools while few of the respondents (20.1) had negative attitude towards their school re-enrolment. See figure 4.2 for full details.

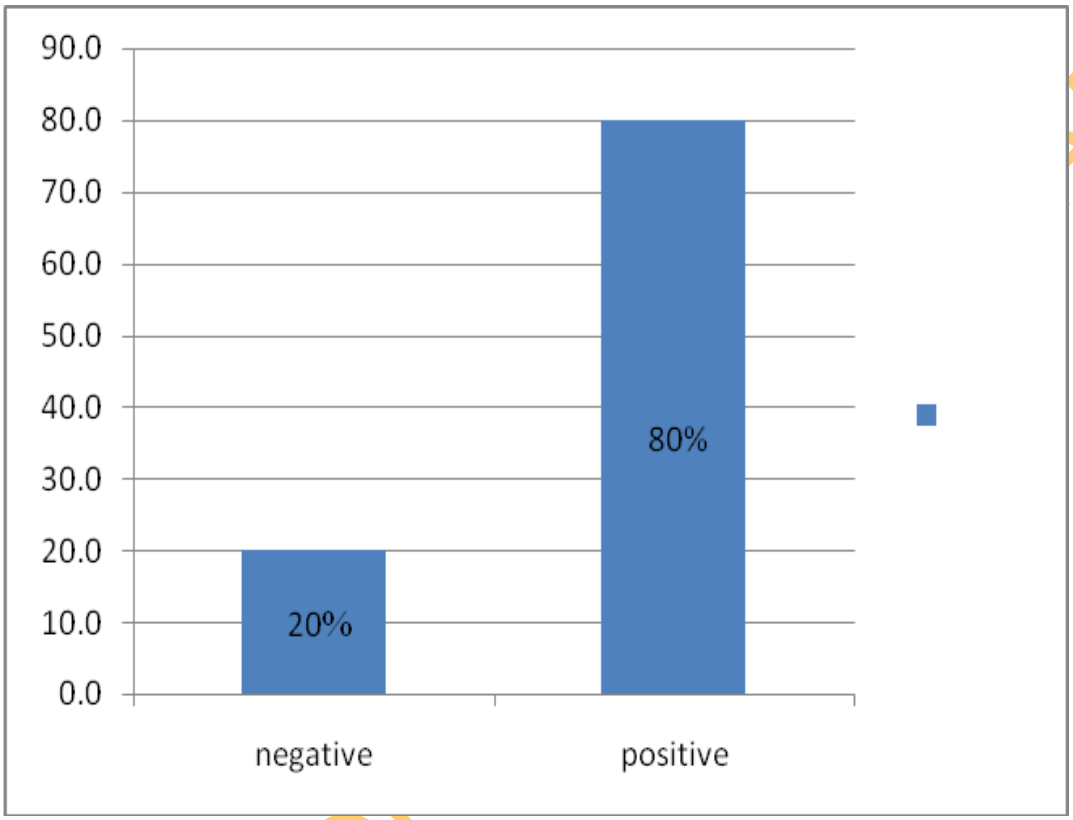

Fig 4.2 Attitudinal score of respondents on school re-enrolment

4.6 Perceived barriers affecting re-enrolment of respondents into schools

In reporting the perceived barriers affecting school re-enrolment, parent's financial status was identified by majority of the respondents (290, 97.3%) as a major factor affecting school re-enrolment while only eight respondents (2.7%) disagreed with that. A slightly high percentage of respondents (56%) reported that early marriage is a major factor affecting school re-enrolment while (44%) opposed that. Two hundred and twenty nine (76.8%) respondents concurred to the statement that stigmatization affects their re-enrolment into schools while fifty seven respondents (19.1%) disagreed. One hundred and ninety-eight respondents (66.4%) reported that lack of boyfriend/husband's support will affect their re-enrolment into schools while ninety-eight respondents (32.9%) disagreed. Twenty two respondents (7.4%) reported that lack of friends support (attitude of their friends) will serve as a barrier to their re-enrolment while majority of the respondents (91.9%) disagreed with the statement. Thirty respondents (10.1%) agreed that lack of teachers support (attitude of their teachers) affects their re-enrolment into schools while Two hundred and sixty-four respondents disagreed. More than half of the respondents (65.1%) reported that school re-enrolment policy affects their re-enrolment into secondary schools while 31.9% opposed. One hundred and twenty-six (42.3%) agreed that lack of school support affects school re-enrolment while a slight high percentage (53.4%) disagreed. See Table 4.4 for more details

Table 4.4: Perceived barriers affecting re-enrolment of respondents into schools

Perceived barriers	Yes (%)	No (%)	I don't know (%)
Lack of school support	130(43.6)	160(53.7)	8(2.7)
Parents' financial status	290(97.3)	8(2.7)	0(0.0)
Stigmatization	229(76.8)	59(19.8)	10(3.4)
Early marriage	167(56.0)	131(44.0)	0(0.0)
Lack of boyfriends'/ husbands' support	198(66.4)	98(32.9)	2(0.7)
Lack of teachers' support	30(10.1)	264(88.6)	4(1.3)
School re-enrolment policy	194(65.1)	95(31.9)	9(3.0)
Lack of friends' support	22(7.4)	274(91.9)	0(0.7)

4.7 TEST OF HYPOTHESES

Ho 1- there is no significant association between the age of adolescent mothers and their perception towards re-enrolment into secondary schools.

The result showed that there is a significant association between the respondents' age and their perception towards school re-enrolment (x^2= 7.210, df = 1, p-value = 0.007), thus we reject the null hypothesis (Ho) which states that there is no association between the respondents' age and their perception towards school re-enrolment ($p<0.05$).

Table 4.5: Association between the age of respondents' and their perception towards re-enrolment into schools.

Age of respondents	Poor perception N (%)	Good perception N (%)	Total (100%) N (%)	x^2 value	df	p-value
15-18	71(23.8)	96(32.2)	167(56.0)	7.210	1	0.007
19-21	36(12.1)	95(31.9)	131(44.0)			
Total	107(35.9)	191(64.1)	298(100)			

Ho 2- there is no significant association between the religion of adolescent mothers and their perception towards school re-enrolment.

The result showed that therefore there is no significant association between the respondents' religion and their perception towards school re-enrolment (x^2=0.200 df = 1, p-value = 0.655), thus the null hypothesis (Ho) which state that there is no association between the religion of adolescent mothers and their perception towards school re-enrolment is accepted (p> 0.05).

Table 4.6: Association between the religion of respondents' and their perception towards school re-enrolment

Religion of respondents	Poor perception N (%)	Good perception N (%)	Total (100%) N (%)	x^2 value	df	p-value
Christianity	77(35.2)	142(64.8)	219(100)	0.200	1	0.655
Islam	30(38.0)	49(62.0)	79(100)			
Total	107(35.9.)	191(64.1)	298(100)			

Ho 3- there is no significant association between marital status of adolescent mothers and their perception towards school re-enrolment.

The result showed that therefore there is significant association between the respondents' marital status and their perception towards school re-enrolment (x^2= 10.815, df = 1, p-value = 0.001), thus we fail to accept the null hypothesis (Ho) which state that there is no association between marital status of adolescent mothers and their perception towards school re-enrolment ($p< 0.05$).

Table 4.7: Association between adolescents' marital status and their perception towards school re-enrolment

Marital status of respondents	Poor perception N (%)	Good perception N (%)	Total (100%) N (%)	x^2 value	df	p-value
single	18(64.3)	10(35.7)	28(100)	10.815	1	0.001
married	89(33.0)	181(67.0)	270(100)			
Total	107(35.9.)	191(64.1)	298(100)			

Ho 4- there is no significant association between the level of education of adolescent mothers and perception about their re-enrolment into schools.

The result showed that there is no significant association between the respondents' level of education and their perception about school re-enrolment (x^2=2.256, df = 1, p-value = 0.133), thus the null hypothesis (Ho) which state that there is no association between the level of education of adolescent mothers and perception about their school re-enrolment is accepted (P>0.05).

Table 4.8: Association between respondents' level of education and their perception towards school re-enrolment

Level of education of respondents	Poor perception N (%)	Good perception N (%)	Total (100%) N (%)	x^2 value	df	p-value
primary	29(29.9)	68(70.1)	97(100)	2.256	1	0.133
secondary	78(38.8)	123(61.2)	201(100)			
Total	107(35.9.)	191(64.1)	298(100)			

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study accessed the perception and attitude of adolescent mothers towards re-enrolment into secondary schools. In this chapter, explanations are given regarding the results presented in the previous chapter. The demographic characteristics of the respondents, their perception and attitude towards re-enrolment into schools, and the perceived barrier that can affect their re-enrolment were also emphasized. Conclusions and recommendations were made at the end of this report.

5.1 Socio-Demographic Characteristics

All the respondents were females. The mean age of participants was 20.42±1.196 This age. However, this is different from the study conducted by Aderibigbe et al (2011), on teenage pregnancy and prevalence of abortion among adolescents in north central Nigeria where the mean age of respondents was15.63±2.11. Majority of the respondents belonged to the Yoruba ethnic group .This could be traced to the fact that the study location is situated in the South-western part of the country where the Yoruba's are the predominant ethnic group. The findings that most of the respondents were married could be attributed to the fact that that young mother marry as soon as they realize that they are pregnant or suspected to be pregnant London (2008).

5.1.1 Perception of adolescent mothers towards re-enrolment into schools

More than half of the respondents are of the perception that they might be abused by their teachers and peers in the classroom while less than half of the respondents disagree with that. Teenage mothers who return to school after the birth of their children, experience intimidation and marginalization and lack of support from educators (Chigona and Chetty, 2008).A Study by Byron Brown (2013) on the social experiences of ex-drop outs re-enrolled in secondary school in south Africa shows that negative social labeling and teasing were persistent force in the lives of ex-drop out at school. The study revealed that re-enrolled dropouts experience teasing, negatively labeling, ostracism and the feelings of isolation from their teachers and peers at school which prevents them from having a sense of belonging in

the school community. Thus, the reaction towards the ex-dropouts may be pleasant and welcoming, or it may be hostile. Hostile social treatment may manifest in various forms, including stereotyping, prejudice, discrimination, scapegoating, rejection, and isolation (Briffa, 2010). Arlington Public School (2004), Pillow (2004), Wolpe, Quinlan & Martinez (1997) also concur to this finding by disclosing that young mothers experience undue pressure, discrimination, stigmatization from teachers, peers and the community they live in and are also isolated by their school mates.

More than half (64.1%) of the respondents said that they won't be able to concentrate well in their studies if they come back to school. This corroborates with the findings by Samuel (2002) in Molapo (2011) who found that teenagers who leave school to deliver their babies always have to struggle to catch up in their classes as they have to split their time with their classes and their babies. They might as well fall behind in their class work or sometimes miss examinations. London (2008) concur with this finding by indicating that student mothers must survive a very stressful time after their babies are born as they are torn between the demands of the family, home, school, father of their children and the outside world.Nzama (2004) buttresses this findings by stating that childbearing affects the teen mothers' work at school as teen mothers have to rush home after school and do not have time to go for study sessions like other learners.

More than half (54%) of the respondents perceived that they will be laughed at by their fellow mates and call names if they return to school. According to Molapo (2011), most of the young mothers after returning to school face the challenges of stigmatization by educators, other learner and friends.

A large number of the respondents reported that their parents may not support their coming back to school. Similar to the findings of this study, Mkhize (1995) in Molapo (2011) reported that young mothers encounter less support or much- needed help when resuming their student roles and this is the main reason why teen mothers fail to perform well in school after delivery of their babies which makes it very difficult for teen mothers to complete their education. Chigona and Chetty(2007) also concur to the finding by stating that those young mothers who experience more hardships in returning back to school are those who do not receive help from their parents.

Majority of the respondents (82.2%) agreed that they will return to school if their teachers are willing to support them.Masuku (1998) states that teen mother gets humiliated by their teachers. This is supported by Molapo (2011) who concurred to the findings by stating that teachers have negative attitudes towards young mothers. Some of the teachers humiliate teen mothers in the classrooms and they do not give them chance to learn as they give to other learners. Teachers say words that pass bad impression to young mothers at assemblies which other learners also learn from. This result also concur with the findings of various authors which reveal that young mothers lack support.(London,2000,Dench & Bellis,2007,Tayler-Ritzler and Balcazar,2007).

More than half (54.4%) of the respondents agreed that schools may not be able to look after their babies. This corroborates with findings by Molapo (2011) who noted that it is evident that some teen mothers have no one to look after their babies when they are in school. Sometimes they had to be late or absent from school in other to look after their sick child. Nzama (2004) in Molapo (2011) also point out that young mothers have no support .They have the burden of taking their children to clinics for check-ups and have to care for them when they are sick.

More than half (52.3%) of the respondents also agreed that their parents are not happy and unwilling to send them back to school.Nzama (2004) agree with this findings and reveals that teenage pregnancy and motherhood causes tension in the girl families Teenage pregnancy and motherhood are regarded as a taboo and teen mothers are rejected mostly by their fathers.(Molapo 2011). Fawe (2011) also attest to this finding by indicating that parents chase their daughters away when they are sent away from school due to pregnancy.

According to Fawe (1994), school careers of many girls are cut short because of pregnancy by either the girl withdrawing themselves from school or through the national policies that ensure that pregnant girls are expelled from the education system with little or no chance of re-entry after delivery. This could explain why most of the respondents (95%) are of the perception that they prefer to return back to school if there are re-entry policies. At the school level, some of the practices that exist regarding how to address cases of girls who gets pregnant include public send off, suspension and automatic expulsion which results in pregnant girls running out of school especially when the school have not noticed her, aborting and re-appearing in school, giving birth and re-joining different school while few

rejoin the same school. This acts as a preventive measure to deter others from getting pregnant and to save innocent ones from being caught by the same trap (Fawe 2011). Even though only few of the respondents (33.6%) in the study are of the perception that most schools may not be willing to accept them, but literature supports this view because schools believe that they might serve as a bad example to others.

According to Fawe (2011) it is normally hard for the parents to look after the girl and the baby. Most of the girls result in looking for odd jobs to look after their babies as single teen mothers. This can better explain why 69.8% of the respondents in this study prefer to learn a trade to coming back to school.

Majority of the respondents(88.9%) agreed that coming back to school makes them learn from their mistakes.Fawe(2011) concur with this findings by indicating that girls should be allowed re-entry because they would have gained good experience never to repeat the mistake of getting pregnant.

A large number of respondents agree that no one is willing to help them take care of their babies while they are in school if they return to school. Tayler- Ritzler and Balcazar (2007) shares a similar perspective by stating that teenage mothers who drop out of schools reported that they lack support at home. The support they lack at home included lack of child care assistance, for example no family members, friends, or boyfriends were willing to provide child care.

5.1.2 Attitude of adolescent mothers towards their re-enrolment into schools.

According to Fawe (2011) there are few girls who re- joins the same school because of stigma and fear of teachers and the pupils .This is because generally, pregnancy is seen as shameful and such girls hardly return to school. This explains why majority of the respondents (88.9%) prefer to re-enroll in another school while only few of the respondents (36.9%) prefer to re-enroll in the same school if they have the opportunity of going back to school. Some of the adolescent girls are discriminated against by their teachers and peers. They are also isolated by their mates. This revealed why about half (49%) of the respondents said they are afraid or shy to meet with my teachers and the school authority.

5.1.3 Perceived barriers affecting the re-enrolment of adolescent mothers

About half of the respondents agreed that lack of school support as one of the barriers affecting their re-enrolment into schools. Majority of the respondents chose stigmatization and lack of teacher's support as a barrier. Tayler- Ritzler and Balcazar (2007) share a similar perspective by stating that teenage mothers who drop out of schools reported that they lack support and at home. Teen mothers lack encouragement which is related to school, maternal interference with their school enrolment and refusal to sign school enrolment forms. Teen mothers lack support at school because teacher did not provide caring relationships and a lack of academic support. In many situations, almost all schools expel pregnant girls and as child mothers, they often fail to return and complete their education. (Fawe, 2011) There are also significant challenges with peers such as threat of violence and ridicule. A large number of respondents also indicated lack of husband's support as a barrier affecting school re-enrolment. This finding is similar to that of Joseph Rowntree foundation (2007) which stated that adolescent mothers experience lack of support from young fathers who simply neglect their paternity responsibilities. Teenage mothers lack support from their boyfriends after the birth of their children. Freeman and Rickels (1993) added to this by giving example of teenage mothers who revealed that after two years they were no longer in a relationship with their boyfriends(fathers of their children).

Many of the respondents agree that they would return to school if there are re-entry policies. No clear policies exist on how cases of pregnancies in schools can be handled or assisting girls who would want to re-join school after giving birth.(Fawe 2011) Similar to the findings of this study, Fawe (2011) also stated in their report on the survey on "re-entry of pregnant girls in primary and secondary schools in Uganda" that most times school careers of many girls are cut short because of pregnancy either by the girls withdrawing themselves from school or through expulsion with little or no chance of re-entry after delivery. The situation is worsened by an absence of a coherent national policy on pregnancy in school and on re-entry after delivery. This is supported by Molapo (2011) in their findings on the "experiences of young school-going mothers in high schools at Leribe district of Lesotho" which shows that legislation to allow teen mothers to return to school has not been accompanied by enabling policies and support instruments to make the legislation work at school level.

In this study, almost all the respondents indicated that lack of parental financial support was a barrier affecting their re-enrolment. Some families are too poor to assist young mothers financially and as a result children are abandoned. The parents are usually poor and they sacrifice to send their children to school and once the child gets pregnant, it become difficult too hard for the parents to comprehend. Parents may result to chasing the daughter away or not taking proper care of her even if they have the resources (Fawe 2011).

More than half (56%) of the respondents chose early marriage as one of the perceived barriers that affect their re-enrolment into school. Girls rejected at home and sent away run to men responsible for the pregnancy and get married. Another common practice is the families of the pregnant girl and the man responsible agree to marry off the two in other to keep the image of the two families (Fawe, 2011).This corroborates with the findings by London (2008) which reveals that young mother marry as soon as they realize that they are pregnant or suspected to be pregnant or feared to have lost their virginity and drop out of school immediately.

5.2 Implications of the findings for health promotion and education

Teen pregnancy is a major public health issue because it directly affects the immediate and long-term well-being of mother, father and child. “It is a common saying that “educate a girl and you educate a nation”; the role of education in the lives of women cannot be undermined because of many benefits that come with it. An educated girl will grow to be financially, mentally and socially empowered; hence will be enabled to take control of issues that not only borders around her health but that of her family. Since one’s level of education to an extent determines one’s income and capacity, it is expedient, therefore, that girls get education for better contribution to their families, society and world (Eweniyi and Usman 2013).

Health education is the combination of learning experiences designed to facilitate voluntary adaptation to behavior conducive to health(green and kreuter,1991).It is concerned with reinforcing or changing knowledge,attitude,practice and behaviors of people through effective time-tested strategies, with the aim of helping them to ensure an optimum well being. These strategies can therefore be used to addresss the attitude, perception and barriers

affecting the re-enrolment of adolescent mothers into schools. Identified strategies are advocacy and training.

Advocacy can be conducted to the government using lobbying as a strategy. This is to ensure the formulation and implementation of re-entry policies for adolescent mothers. Also media advocacy can be employed to reach the community and religious leaders on the importance of school re-entry of adolescent mothers. Media such as newspapers, television, radio, billboards can be used to educate people on the consequences of dropping out and stigmatization of adolescent mothers and the benefits of school re-enrolment.

Training as a health promotion strategy could be conducted for school principals and teachers on the care and support of adolescent mothers and the consequences of stigmatization of adolescent mothers. It could be in form of workshop,in-sevice training and on-the job training. This training could be facilitated by health promoters from the unit of school health in the state ministry of health. Training curriculum will be developed to facilitate the program. Training methods such as lecture, discussion, questions and answers can be used. The training could be evaluated using pre-and post test assessment.

5.3 Conclusion

This study is aimed at investigating the attitude and perception of adolescent mothers towards re-enrolment into schools. The result of this finding shows that the perception of adolescent mothers towards school re-enrolment was good. A large number of the respondents had a positive perception towards school re-entry which are willingness to return to school if the school, teachers peers and parents are willing to support them, willingness to return to school if there are re-entry policies, readiness to continue and believe that they have the potential to perform well in their studies, not been shy of being discriminated against.
Also respondents' attitude towards school re-enrolment was good. Majority of the respondents had positive attitude towards their re-enrolment into schools which include willingness to combine school and caring for the baby and re-enrolment in the same school or another school if they are giving the opportunity to re-enroll.

The study revealed that the respondents have good perception towards their re-enrolment into schools but there are some factors which serve as a barrier deterring them from coming back to school. Some of these factors are: stigmatization, early marriage, lack

of boyfriends'/husbands' support, school re-enrolment policy, parent's financial support, lack of school ,friends and teacher's support.Therefore,some recommendations were made to assist in providing solutions to these barriers.

5.4 Recommendations

1. Advocacy should be conducted to the government to sensitize them on the importance of formulation and Implementation of the re-entry policy so that girls who drop out due to pregnancy can re-enter.
2. In-service training programme for the school heads, teachers and students should be provided in order to mitigate stigma so as to create a condusive learning environment for teen mothers in schools
3. Sex education should be taught in schools and parents should be encourage to talk to their adolescents about sexuality and other topics to keep adolescents informed in order to help them reduce unwanted pregnancy
4. Government and policy makers should formulate and enforce laws and policies that would encourage re-enrolment of adolescent mothers into schools

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Appendix I

QUESTIONNAIRE

PERCEPTION AND ATTITUDE OF ADOLESCENT MOTHERS ATTENDING HEALTH FACILITIES IN IBADAN SOUTH-EAST LOCAL GOVERNMENT TOWARDS THEIR RE-ENROLMENT INTO SCHOOLS

Dear Respondent,

I am a postgraduate student of the Department of Health Promotion and Education in the Faculty of Public Health, College of Medicine, University of Ibadan. I am carrying out a study on "PERCEPTION AND ATTITUDE OF ADOLESCENT MOTHERS ATTENDING HEALTH FACILITIES IN IBADAN SOUTH-EAST LOCAL GOVERNMENT TOWARDS RE-ENROLMENT INTO SCHOOLS". This research is part of the requirement for the award of Masters in Public Health (Health Promotion and Education).Please note that you are not required to write your name on the questionnaire. Kindly feel free to express your opinion and be rest assured that your responses will be kept confidential. Your honest and sincere response to the following questions will be highly appreciated.

Thank you.

Section A: Socio- Demographic data

Instruction: Please tick (√) in correct information appropriately

1. Age in years as at last birthday…….
2. Religion: 1.Christianity ( ) 2.Islam ( ) 3. Traditional ( ) 4.others specify( )
3. Adolescent's Marital Status: 1.Single ( ) 2. Married ( ) 3. Divorce ( ) 4.living with husband ( ) 5.widow ( )
4. Ethnic group: 1.Hausa ( ) 2.Igbo ( ) 3.Yoruba ( ) 4.others specify ( )
5. Highest level of education: 1.primary ( ) 2.secondary ( ) 3.others specify ( )
6. Parent's marital status: 1.Married ( ) 2.Divorce ( ) 3.Widow ( ) 4.Widower ( ) 5. others specify ( )

7. Family type : 1.Monogamy ( ) 2.Polygamy ( )
8. Adolescent's present occupation: 1.Trading ( ) 2.Tailoring ( ) 3. Hairdressing ( ) 4.others specify ( )

VARIABLES UNDER STUDY

Section B: Perception of adolescent mothers towards the re-enrolment into schools.

Please tick in correct column that best suit your response to each statement

S/N	Statement	agree	disagree	undecided
10	I think I might be abused by my teachers and peers in the classroom			
11	I think i won't be able to concentrate well in my studies			
12	I feel coming back to school makes me learn from my mistakes			
13	I prefer to return back to school if there are re-entry policies and the school is willing to accept me			
14	I will return to school if my teachers are willing to support me			
15	Many schools will not be willing to accept me because they believe i might spoil the image of the school			
16	Schools may not be able to look after our babies			
17	My parents may not support me to go back to school			
18	I think am too old to return to school			
19	My fellow mates will laugh at me and call me names			
20	My parents are not happy and unwilling to send me back to school			
21	No one is willing to help me take care of my baby while am in school			
22	I prefer to learn a trade than coming back to school so that I can earn money to take care of my baby			

SECTION C: Attitude of adolescent mothers towards the re-enrolment into schools

S/N	Statement	yes	no	I don't know
23	I can combine academic work with caring for my baby			
24	I prefer to re-enroll in another school if am giving the opportunity			
25	I am afraid to meet with my teachers			
26	I will prefer to re-enroll in the same school if am giving the opportunity			
27	I am afraid to meet with the school authority			

SECTION D: Perceived barriers affecting re-enrolment of adolescent mothers

What are the barriers that you perceive will affect your re-enrolment into schools?

	Barriers	Yes	No	I don't know
28	Lack of school support			
29	Parent's financial status			
30	Stigmatization/Shame			
31	Early marriage			
32	Lack of boyfriends'/ husband's support			
33	Lack of teacher's support			
34	School re-enrolment policy			
35	Lack of friends support			

Appendix II

INFORMED CONSENT FORM

Dear respondent,

My name is Fadayomi Folasade T. I am a student in the Department of Health Promotion and Education, Faculty of Public Health, College of medicine, University of Ibadan, Ibadan, Oyo state.

The purpose of this research is to assess the attitude and perception of adolescent mothers in Ibadan South-east local towards their re-enrolment into Schools. This questionnaire contains questions which would be easy to answer and strict confidentiality would be assured as there is no way of identifying your responses because no information to personally identify will be collected. If you decide not to participate in this study, you will suffer no discrimination or any harm.

Your completion of this questionnaire is totally voluntary, however, should you decide to participate, I appeal that you complete all questions as accurately and truthfully as possible as your honest answer will help to assess your attitude and perception towards your re-entry into schools.

Thank you for your kind co-operation.

Yours sincerely,

Fadayomi Folasade T.

Respondent's confirmation

Having read the above, I do wish to participate in the study.

Signature: …….

Date: ……..

APPENDIX III

IBEERE

IWA ATI EROAWON ABIYAMO TO JE ODOLANGBA TI OHUN LO ILE ISE ETO ILERA IJOBA NI ILU IBADAN, AGBEGBE IJOBAIBILE GUSU-ILAORUNLATI PADASI ILE IWE GIRAMA LEHIN TIWON BATIBIMON TAN.

Eyin oludahun wa nitoto,

Oruko mini....., Akeko ile iwe giga ti unifasiti ti ilu ibadan Eka ti Igbelruge ati eko eto ilera, ile iwe imo iwosan, ti ilu Ibadan. Mo je ikan lara awọn egbe ti ohun gbe igbese lati se iwaadi kan ti akole re je "ìwa ati eroawon abiyamo to je odolangba ti ohun lo ile ise eto ilera ijoba ni ilu ibadan, agbegbe ijobaibile gusu-ilaorunlati padasi ile iwe giram lehin tiwon batibimon tan".

Awon olukopa ninu iwadi yi ni ao yan ni ipele, ni ipele isapẹrẹ ilana. Awọn ọna ti data gbigba jẹ nipasẹ ati ni-ijinle Ìfọrọwánilẹnuwò.Iwadi yi se pataki fun gbigba iwe eri ti ojogbon ninu eto ilera gbogbogboo (Eka ti Igbelruge ati eko eto ilera). Ejowo ako nilo oruko yin ninu iwe ibeere yi. Gbogbo ohun tia abaso ninu ibeere yi ni yio wa ni pipamo laarin wa, Inu wa yiodun pupo ti ebele dara pomonwa ninu iwadi yi tokan-tokan ati nitooto.

Ese pupo.

Ipin A: Awon nkan idanimon nipa yi (**SOCIO-DEMOGRAPHIC INFORMATION)**

Atoka: Jọwọ, samisi [√] ninu awọn apoti ti a pese (bi yẹ)

1. Ejowo omo odun melo ni ese ni ojo ibi ti ese kehin.....(Odun)
2. Elesin woni yin 1. Kristiani **( )** 2. Musulumi **[ ]** 3. Elesin Abalaye **[ ]** 4.Imiran eso pato
3. ipo wo ni ewa nipa igbeyawo? 1. Motigbeyawo ( ) 2. Motigbeyawori( )
   3. Nko ti gbeyawo ri ( )
4. Omo eya wo ni yin? 1. Yoruba ( ) 2.Igbo ( ) 3.Hausa ( )
   4.imiran eso pato……(edaruko)_____
5. Ejowo eka to iwe melo ( ) Ile eko girama ( ) Ile iwe aloko bere ( ) imiran

6. ipo wo ni awon obi yin wa nipa igbeyawo? Wontiigbeyawo ( ) Won kotigbeyawori ( )
   Igbeyawo won ti tuka ( ) Imiran (Eso pato)
7. Eto inanwo awon obi yin : owo wan ko gbe peli rara ( ) won gbowo gidi die ( )
   won gbowo to gbe pali gaan ( )
8. Eto igbeyawo : Oniyawo kan( ) Oko kan iyawo kan ( ) Ile olorogun ( ) Opo ( )
9. Ise obi awon odo: Oloko owo( ) Aso riran ( ) Oni diri ( ) Imiran Eso pato ( )

Ipin B: ERO AWON ODO ALABIYAMO LORI PIPADA SI ILE IWE GIRAMA LEYIN OMOBIBI

ATOKA: Ejowo ese amin si ibi tioba ye

S/N	IBEERE	BEENI	BEEKO	NKOMO
10	Molero pe awon oluko ati awon ore mi yio ma bumi ninu ile iwe			
11	Mo lero pe awon oore mi yio yera funmi ni toriwipe won yio lero wipe apeere buruku ni wa fun awon odobirin.			
12	Molerope pipada si ile iwe yio je kin kogbon lati ara asise mi			
13	Otemi orun kin lowa ise kin le se itoju omo mi			
14	Moni fesi lati pade si ile iwe, ti ofin ba wa lati fayegba ipada awon odo tin obati bimon ri.			
15	Maa pada si ile iwe ti awon oluko mi ba se setan lati se iran lowo funmi?			
16	Opolopo ile iwe koni fegbami nitori wipe moleje apere buruku fun awon odobirin ni ile iwe nan.			
17	Awon ile iwe le maale boju to awon omo wa?			
18	Awon obimi lema fowo si wipe kin pada si ile iwe?			
19	Awon oore mi yio maa fimi se yeye?			
20	Inu awon obimi kodun si, won kosi fara mon wipe kin pada si ile iwe?			

21	Kose eni ti ose tan lati ran milowo lati bojuto omo mi nigbati moba wa ni ile iwe?			
22	Mo lerope moti dagba ju lati pada si ile iwe?			
23	Otemi lorun lati lo ko ise ju lati pada si ile iwe lo?			
24	Awon obimi ko lowo lati ran mi losi ile iwe pada?			
25	Otemi lorun kin lo se igbeyawolo ju kin pada si ile iwe lo?			

Ipin C: Iwaodo alabiyamo lori pipada si ile iwe girama leyin omobibi

ATOKA: Ejowo ese amin si ibi tioba ye

S/N	Ibeere	Mofara mo	Nko faramo	Nko mo
25	Nko le farada itiju ti yio waye nigba ti mo ba pada si ile iwe?			
26	Mole maa sise, kin malo si ile iwe kin sima bojuto omo mi leekan na			
27	Otemilorun lati losi ile iwe imiran ti oyato pata pato ti mo ba ri anfani lati pada si ile iwe?			
28	Eru kobami lati pade awon oluko mi?			
29	Maafe lati pada si ile iwe kan naa ti mo ba ri anfani imiran lati losi ile iwe?			
30	Eru awon ijoba ile iwe nbami			
31	Nko nile gbaju mon ekoo mi daradara?			

Ipin D: Awon ohun idena ti ohun se idiwo fun awon odo birin abiyamo lati padasi ile iwe giramaa.

Awon ohun idena wo ni elero wipe olese ohun idiwo fun yi lati pada si ile iwe girama?

	Ohun idiwo tabi ideena	Beeni	Beeko	Nkomo
32	Alaini oluran lowo			
33	Eto inan wo awon obi			
34	Ituju ati esin			
35	Igbeyo pajawiri			
36	Aini iran lowo lati odo awon obi			
37	Aini iran lowo lati odo awon oluko			
38	Airi iran lowo lati odo awon elegbe akeko			
39	Agba dida			
40	Ofin ipada si ile iwe fun awon odobirin ti obati bimon ri			
41	Aini iran lowo lati odo awon ore?			

Modupe pupo fun dìdáhùn àwọn ìbéèrè won yi tọkàntọkàn, Olorun abukun yin o.

APPENDIX IV

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

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/ 479/1604

29th January, 2016

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

Attention: **Fadayomi Folasade**

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

This is to acknowledge that your Research Proposal titled: "Attitude and Perception of Adolescent Mothers Attending Health Facilities in Ibadan South East Local Government Towards Re-enrolment into School" has been reviewed by the Oyo state Review Ethical Committees.

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.

Signature & Date

(Dr) Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee