# "If I have work and can take care of my children, I will become happy."

A study to understand mental well-being and well-being enhancement among young married and single mothers in rural Eastern Region, Ghana

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# Abstract

Within international development circles, early marriage and associated early pregnancy are predominantly framed as a health concern. While the effects on girls' education, and sexual and reproductive health are well documented, the lived realities of young married women and young mothers appear to be little researched. Research around early marriage and adolescent pregnancy highlights the physical well-being of young women, while little is known about their mental well-being. For these reasons, this study focuses on the mental well-being of young married women and – given their prevalence – single mothers. The study took place in rural communities in Ghana's Eastern Region. The research acknowledged that the participants' state of mind existed of emotional, psychological and social well-being, and was influenced by economic, physical and spiritual factors. In addition, this study examined the ways in which these girls and women enhance their well-being in their daily lives. Data were gathered by doing participant observation in community meetings, conducting focus group discussions and in-depth interviews, and having informal conversations.

The data indicate that in the research communities coming to a marriage agreement uplifts the status of a woman, whereas failing to reach a marriage agreement lowers the status of a woman. Community norms prescribe that fathers are in the position to decide whether they desire to finalize a customary marriage and/or claim their children. Financial instability and community stigmatization are major factors for adolescent mothers in feeling unhappy and dissatisfied with their lives, and desiring to be self-sufficient and independent. The adolescent girls taking part in the study tried to secure or enhance their mental well-being by adapting their aspirations to their reality, improving their spiritual well-being, and involving themselves in farming, work and leisure activities. Moreover, The Hunger Project-Ghana, the church, female family members, husbands and current boyfriends offered these young women different types of support. These results clarify the importance of addressing the current contextual needs of young married and single mothers for policy and practice.


*Key words*: early marriage; adolescent pregnancy; mental well-being; well-being enhancement; support; community norms; stigmatization; mental health; Ghana

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## Abbreviations

FGD: Focus Group Discussion

HC: Her Choice

JHS: Junior High School

MHS: Maternal Health Survey

SRHR: Sexual and Reproductive Health and Rights

THP-Ghana: The Hunger Project-Ghana

UN: United Nations

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

UvA: University of Amsterdam

WHO: World Health Organization

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# 1. Introduction

## 1.1. Problem statement, relevance and research aim

The United Nations Children's Fund (UNICEF, 2014) estimates that all over the world more than 700 million women alive at that moment have entered into marriage before turning 18. In the Global South specifically, in nine out of ten cases in which adolescent girls of the age 15-19 bear children, marriage has preceded childbirth (Loaiza & Wong, 2012). A study focused on sub-Saharan Africa states that more than one third of girls get married before the age of 18 in more than half of the countries examined (Koski, Clark, & Nandi, 2017). Even though early marriage is starting to occur less in a large part of this area; striking in this study is that the prevalence of marriage is decreasing among girls between 15 and 17 years old, whereas in more than half of the countries no relevant progress was made towards diminishing the prevalence of marriage among girls under 15 years of age. This lack of improvement suggests that there is resistance to postponing marriage among the youngest girls (Koski et al., 2017).

Early marriage and child marriage are often used interchangeably (Archambault, 2011). This thesis prefers the use of early marriage and elaborates further on the meaning of these terms in the theoretical framework. Within international development circles, early marriage is predominantly framed as a health issue. Studies have shown that marriage has unfavourable effects on the well-being of girls (Nour, 2009; Raj, 2010). Much research and development initiatives focus on the *prevention* of early marriage, the lived realities of married girls and young mothers receiving less attention. Better understanding of these young women's experiences of marriage and motherhood is needed in order to more fully comprehend, among other issues, the effects of working a 'second shift' (when girls work in and outside of the home), the intergenerational effects of early marriage, the access of married girls to health services (beyond contraceptive services), connections with the community, and the mental health consequences for married girls (Hodgkinson, Koster, & Miedema, 2016).

As the effects of marriage and childbearing on girls' educational attainment and their physical well-being are well documented (Greene, 2014), research gaps address the mental well-being of young married and single mothers. Svanemyr et al. (2015) also point out that mental health is less studied in comparison to reproductive health outcomes. For the reasons highlighted above, this study focuses on the mental well-being consequences of early marriage and adolescent pregnancy in order to develop greater understanding of young women's realities. The study is expected to be useful for policy and practice geared towards long-term efforts to prevent early marriage and shorter-term efforts to support young mothers, whether married or not. I build on previous research of Brittany Haga who focused on the overall well-being of married girls in rural Eastern Region in Ghana (Haga, 2018). In order to grasp the ways in which the girls seek to enhance or secure their mental well-being I draw on their own perspectives. This means looking into their past experiences, daily life, support systems and future aspirations, among other things.

## 1.2. Literature around early marriage, well-being and support

This section presents a brief review of academic literature around topics that are particularly useful for my research: the unfavourable well-being consequences of early marriage and the support systems that can enhance the well-being of married girls.

### 1.2.1. Adverse well-being outcomes for married adolescent girls

The World Health Organization (WHO, 2017) acknowledges that adolescence is characterised by rapid physical, social and mental development. Health-related factors that limit this growth inhibit the capacity of young people to thrive and reach their full potential, which therefore can have implications for their state of well-being. Early marriage has been clearly connected with adverse well-being outcomes for girls and women all over the world (Raj, 2010; WHO, 2017). Young married women are disadvantaged compared to others, since they are more likely to experience less educational opportunities, unfavourable consequences for their sexual and reproductive health, domestic violence and limited freedom (Greene, 2014; Irani & Latifnejad Roudsari, 2019). Due to the changing environment, which often includes new homes, new roles, new husbands and pressure to reproduce, married girls were also found to experience feelings of rejection, isolation and depression (Nour, 2009). In addition, when girls are married they are at increased risk for suicide attempts, which is largely related to different forms of gender-based violence (Raj, 2010). Studies have shown as well that early marriage is linked to self-immolation (Svanemyr et al., 2015). These harmful well-being consequences underpin why Greene (2014) suggests that the reasons for wanting to end early marriage lie in upholding girls' rights and working towards the achievement of health and development goals.

### 1.2.2. Support systems for married adolescent girls

Marriage brings extra responsibilities for girls that do not always have sufficient support or resources to deal with this (Greene, 2014). Some girls embrace the new environment that marriage has brought and prove their fertility as a survival technique, while others do not (Nour, 2009). Muhanguzi, Bantebya-Kyomuhendo and Watson (2017) call for developing a framework on how social institutions – including school, health and legal services, local government, and religious institutions – enhance the resilience of girls, which can be understood as their capacity to respond to challenges that stand in the way of their well-being (on the latter, see Bracke, 2016). Family and school have proven in particular to nurture the resilience of adolescent girls to early marriage. With the family laying foundations and the school providing support, these institutions play a crucial role in improving the capacities, skills and well-being of children. Female support figures, such as teachers, mothers and aunts, are considered as potential game-changers in building resilience around early marriage (Muhanguzi et al., 2017). In addition, Santhya and Erulkar (2011) promote interventions aimed at creating social support networks for married girls.

## 1.2. Involvement of Her Choice and The Hunger Project

This research adds to existing in-depth qualitative research that is conducted within the realms of the Her Choice (HC) programme. The programme works towards reducing the occurrence of early marriage. HC is a Sexual and Reproductive Health and Rights (SRHR) alliance that consists of the following Netherlands-based organisations: Stichting Kinderpostzegels Nederland, International Child Development Initiatives, The Hunger Project (THP), and the University of Amsterdam. HC works together with 30 partner organisations in 10 countries in South Asia and sub-Saharan Africa (Bangladesh, Benin, Burkina Faso, Ethiopia, Ghana, Mali, Nepal, Pakistan, Senegal and Uganda) who seek after building child-marriage free communities (Koster et al., 2019). Various studies of the alliance have guided me in the beginning stages of this research.

In order to conduct the research I needed the help of gatekeepers to provide me with access to potential respondents and a research location. Within the network of the HC alliance, THP-Ghana gave me the chance to conduct my research around the epicenter of Boti in Ghana's Eastern Region, through which I experienced the implementation of the HC programme. The Epicenter Strategy of THP unites multiple villages around an epicenter that reaches approximately between 10,000 and 15,000 people with its services. The strategy is said to have thus far reached over 1.6 million people across the sub-Saharan African continent, and strives for the empowerment of communities in meeting the basic needs of its members, with the emphasis on strengthening the position of women (THP, 2018).



*Figure 1: THP-Ghana Boti epicenter (author's own, 2019)*

## 1.3. Thesis outline

This thesis has started with introducing the problem statement, relevance and aim of the research, as well as the involvement of HC and THP-Ghana in enabling this research. Chapter 2 provides specific information about Ghana's historic and current context, the prevalence of early marriage and adolescent pregnancy in Ghana, and how mental health is framed in Ghana.

Chapter 3 details theories behind the following concepts: early marriage, adolescent pregnancy, mental well-being and well-being enhancement. Subsequently, Chapter 4 elaborates on the research methodology. Chapters 5 and 6 consist of empirical data, examining community norms around and experiences of sexuality education, early marriage, and adolescent motherhood; and the mental well-being of and well-being enhancement among young married and single mothers. Lastly, Chapter 7 answers research questions, discusses findings, theoretical insights, recommendations and suggestions for further research, and concludes this thesis with final remarks.

## 2. Context

This chapter provides contextual information that elaborates on Ghana's conditions in the fields of history, politics, economics, religion and education (2.1), the relations between early marriage and adolescent pregnancy in Ghana (2.2), and how mental health is framed in Ghana (2.3). These sub-sections pave the way for understanding participants' experiences.

### 2.1. Ghana's historic and current context

The medieval kingdom of Ghana, which did not share the same location as present-day Ghana, has given the country its name. Attracted by Ghana's gold, and other natural resources Europeans began to trade with local people, and later to participate in the enslavement and trade of local people. After the abolishment of the slave trade, the British established the Colony of the Gold Coast at the end of the 19th century. Colonists exploited the region for hundreds of years (Gocking, 2005). Under the leadership of Kwame Nkrumah and the Convention People's Party, a nationalist movement led to the nation's independence in 1957. After independence, Ghana faced times of political instability, including military coups. In 1993, the Fourth Republic of Ghana was established and paved the way towards the constitutional democracy Ghana has known since (Gocking, 2005). Ghana's multi-party system has strongly influenced the stability of the country (BBC, 2018), and the country is defined by its freedom of speech and the press (World Bank, 2019). Apart from cocoa and gold, the more recent discovery of oil helped the country's economy boom (BBC, 2018). The accelerated economic growth reduced the national poverty rate significantly and led to Ghana's status of lower middle income country in 2011 (World Bank Group, 2018).

Ghana's population is currently estimated to be around 30.2 million people (Worldometers, 2019). The country knows various ethnic groups, languages and religions. In 2010, 71.2% of the population indicated to be Christian, 17.6% Muslim, 5.2% Traditionalist and 5.3% non-religious (Ghana Statistical Service, 2013). The current president, Nana Akufo-Addo, is attempting to deliver on the promises he made during the peaceful elections of 2016, including the ones on free high school education (World Bank, 2019). Even though the tuition fees for public schools have been abolished[1], there are still many costs associated with attending school, such as school uniforms, textbooks, transportation (Adu Boahen & Yamauchi, 2018; Akyeampong, 2009) and printing fees for exams[2] (Alicia, 17-years-old, single, interview 17).

### 2.2. Early marriage and adolescent pregnancy in Ghana

The Republic of Ghana has prohibited child marriage by law. The Ghanaian constitution of 1992 states that a child is "a person below the age of eighteen years" (Republic of Ghana, 1992: 21). The Children's Act of 1998 supports this statement and has set the minimum legal age of marriage for both boys and girls at 18 years old (Republic of Ghana, 1998). Nevertheless, the

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[1] In 1996, Ghana has implemented the Free and Compulsory Universal Basic Education programme which focused, among other things, on abolishing tuition fees for public basic schools, including primary schools and junior high schools (Adu Boahen & Yamauchi, 2018).
[2] Even though Alicia (interview 17) reported that the government can help pupils out with school uniforms, textbooks and bicycles, she still had to drop out of school due to existing printing fees.

Ghana Maternal Health Survey (MHS) of 2017 has found that 20.5% of women aged 20-24 was first married by the age of 18, whereas 4.9% was married at 15 years old (Ghana Statistical Service, Ghana Health Service, & ICF International, 2018: 34). Men generally enter into marriage later than women in Ghana, and the Ghana Demographic and Health Survey of 2014 found that the prevalence of child marriage for boys was much lower (Ghana Statistical Service, Ghana Health Service, & ICF International, 2015). In addition, for girls, there seem to be more costs attached to marrying very early, which is defined as marriage before the age of 15 (Stevanovic Fenn et al., 2015), since it is more likely that very early marriage will have negative consequences for their level of schooling, employment opportunities, earnings potential, health and well-being (Nguyen & Wodon, 2012).

On average, women start marrying later when they have enjoyed more education and wealth. Women from rural areas in Ghana marry approximately three years earlier than their counterparts from urban areas. In Eastern Region, women aged 25-49 have been found to have the median age of 21 for marrying for the first time, which is just a little below the median age of all women from this age group (Ghana Statistical Service et al., 2018: 31-34). These findings illustrate why several authors associate early marriage in Ghana and neighbouring countries with rural areas, less wealth and less education (Malé & Wodon, 2016; Stevanovic Fenn et al., 2015).

Comparing the median age of first marriage (21.5 years) with the median age of first sexual intercourse (18.1 years) among Ghanaian women aged 25-49, suggests that a large share of women have sex before entering into marriage (Ghana Statistical Service et al., 2018: 31). In this way, marriage and sexual activity express to what extent women are prone to the risk of getting pregnant (Ghana Statistical Service et al., 2018). Remarkable is that the median age of first birth among women in this age group in the country also lies at 21.5 years, compared to 21.3 years in Eastern Region. The age at which childbearing starts influences the cumulative fertility of women directly. Especially when contraceptives are not or minimally used, early childbearing can result in a longer reproductive period, higher fertility, and increased health risks related to the pregnancy or childbirth (Ghana Statistical Service et al., 2018: 40).

Moreover, the 2017 Ghana MHS measures teenage childbearing as the percentage of Ghanaian women within the age group of 15 and 19 who are pregnant with their first child or have given birth. The results show that 14% of these women have started childbearing, among which those aged 15 made up 3% of these women, and those of 19 years old 32%. Similar to early marriage, adolescent childbearing seems to correlate with factors like urban/rural residence, education and wealth (Ghana Statistical Service et al., 2018: 40). Figure 2 visualizes that in Eastern Region, for example, 13% of women aged 15-19 have started childbearing.
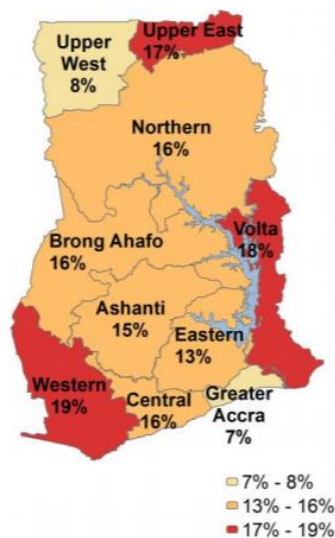
*Figure 2: Adolescent pregnancy per region (Ghana Statistical Service et al., 2018)*

Several studies that focus on unintended pregnancy – mistimed or unwanted – in Ghana call for the need for improvement in family planning programmes, including more access to contraceptive methods and information on family planning (Ameyaw, 2018; Eliason et al., 2014; Nyarko, 2019). The 2017 Ghana MHS found that one in ten women with the age of 15-19 uses contraceptive methods, most of whom make use of a modern method of contraception (such as injectables or the pill) instead of a traditional one (such as rhythm or withdrawal). The percentage of married women and sexually active unmarried women in this age group that uses these methods is 27.6% and 35.6% respectively (Ghana Statistical Service et al., 2018: 51).

## 2.3. Mental health in Ghana

Even though Ghana passed a progressive Mental Health Act in 2012 – which is still to be implemented – the country does not have a record of prioritizing mental health (Fournier, 2011; Ofori-Atta, Read, & Lund, 2010; Walker, & Osei, 2017). Fournier (2011) argues that this lack of priority stems from the preference for physical health over mental health, the low fatality of mental illness, and the longstanding stigma of mental illness. Tawiah, Adongo and Aikins (2015) encountered that mental health patients and their families deal with stigma and discrimination. Women in particular face more stigma than men, according to the psychiatric nurse, Regina (interview 18). Ghanaians are found to opt for treatment from traditional healers in an attempt to solve a mental problem before going to a psychiatric hospital (Fournier, 2011). Regina (interview 18) indicated that her clients often refused to take medicine for their mental conditions and generally found clarifications for unusual behaviour in spiritual beliefs. In addition, she highlighted that the lack of money for health insurance usually forms a major obstacle for Ghanaians who are dealing with poverty to make use of official health services. Those that do have health insurance would rather visit a health facility for their physical health than for their mental health.

Having worked as a psychiatric nurse for years, Regina (interview 18) was of the opinion that Ghanaians do not understand mental health due to a lack of education on this topic. She emphasized how even mental health nurses deal with the feeling of not being taken seriously in their work by other health workers. This example shows how, in Ghana, mental health caregivers usually deal with stigma, just like their clients (Tawiah et al., 2015). When Regina (interview 18) talked about mental health in schools, she also came across pupils' misconceptions regarding mental health, and noted that at times a language barrier hindered her in addressing mental health properly. For that reason, she felt that mental health should be included in the health classes that schools offer, which requires more collaboration between teachers and health workers. Her views align with those of Tawiah et al. (2015) who argue that more and better education on mental health, especially at the community level, could help Ghanaians deal with mental health-issues.

## 2.4 Concluding remarks

This chapter presented contextual information in order to create better understanding of the experiences of adolescent girls and other participants. The chapter provided historic and current conditions of Ghana, expanded on the practices of early marriage and adolescent pregnancy in Ghana, and emphasized the lack of attention for mental health in the country. The next chapter discusses theories that underpin the research.

# 3. Theoretical Framework

This chapter details my theoretical framework, starting with a framework around early marriage (3.1) and adolescent pregnancy (3.2). Sections 3.3 and 3.4 respectively discuss the notions of mental well-being and well-being enhancement. Lastly, I provide the original conceptual scheme in section 3.5.

## 3.1. Early marriage

The international community defines child marriage as a marriage in which one or both of the spouses is below the age of 18 (Hodgkinson et al., 2016; Nour, 2009). The Universal Declaration of Human Rights states in Article 16 that men and women must be of full age when they marry, and that the full and free consent of the spouses is necessary for this union (UN General Assembly, 1948). In international development circles, marriage before the age of 18 is thus perceived as a human rights violation (Nour, 2006; Raj, 2010). However, contradicting the idea behind child marriage is the actual definition of a child according to the Convention on the Rights of the Child, which refers to a "human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier" (Sexual Rights Initiative, 2013: 1). That is to say, if the national law of a given country dictates that its citizens attain majority at a lower age than 18 or lets marriage determine majority, then there cannot be a universally accepted definition of child marriage. Therefore, this definition leaves room for interpretation and brings a loophole that is worth mentioning with it (Greene, 2014; Sexual Rights Initiative, 2013).

It could be argued that the term 'early marriage' is more inclusive than child marriage. While some authors and institutions use these terms interchangeably, others suggest that early marriage includes child marriage and marriages in which one or both of the spouses are below 18 but are no longer treated as children by law. The spouses can even be above the age of 18 and, therefore, their age does not make the marriage necessarily early. Factors such as level of physical, sexual, emotional, psychosocial and educational development, and not being aware of one's life options could restrain the readiness of a person to fully and freely consent to marriage. That is why early marriage is related to evolving capacities which recognizes that the right of children to make decisions should be a reflection of their own maturity and abilities (Sexual Rights Initiative, 2013).

Many international and national laws prohibit marriage below the minimum legal age of 18 (Hodgkinson et al., 2016; Loaiza & Wong, 2012). However, international legal frameworks often lack mechanisms for their enforcement, and the implementation of these laws can be challenging at the national level (Hodgkinson et al., 2016; Koski et al., 2017). There are different explanations for the fact that national laws against child marriage are often not enforced. First of all, families and girls may be unaware of the laws against early marriage (Hodgkinson et al., 2016; Loaiza & Wong, 2012). These laws are frequently in conflict with traditional practices, especially among those that consider marriage as part of the transition to adulthood. In certain countries, the age of menarche is leading in determining when a girl is ready to marry, for example (Hodgkinson et al., 2016).

Many countries allow exceptions to the laws that refer to the minimum legal age of marriage when consent is given by parents or judicial/religious authorities (Hodgkinson et al., 2016; Koski et al., 2017; Loaiza & Wong, 2012). Loaiza and Wong (2012) discuss that, in practice, these exceptions have an effect on females younger than 18. Research shows that girls are disproportionately affected by marriage, which is how many organisations justify their focus on women within the field of early marriage (e.g. UNICEF, 2014). Gender inequality and discrimination against girls become apparent through early marriage. Marriage among girls occurs everywhere in the world, but is most common in the regions of South Asia and sub-Saharan Africa (UNICEF, 2014).

Other reasons why laws against child marriage are not always enforced lie in the actual possibility of enforcement in practice. Customary and religious marriages may occur without being legally registered, but still enjoy the same status and obligations as legal marriages. Since the ages of the brides and grooms to be are often not determined due to the lack of birth registration, the law cannot offer them any protection. There are also religious leaders who forge registration documents in order for girls to be able to get married without having reached the legal age of marriage. This may occur in the case of pre-marital pregnancy in a given country where registration documents are required for a wedding to take place (Hodgkinson et al., 2016). Laws against child marriage are also difficult to enforce in rural areas, especially when officials have large areas under their care and are not able to intervene adequately. The enforcement of these laws is highly dependent on the judicial system, political will, and the will of those who are supposed to protect the nation's citizens (Hodgkinson et al., 2016, Loaiza & Wong, 2012).

## 3.2. Adolescent pregnancy

In the literature, adolescent pregnancy and teenage pregnancy are often used interchangeably. This research prefers using the term adolescent pregnancy, as the term that is associated with 'teen moms' seems to carry stigmatization (on the latter, see Greenblatt, Cockrill, & Herold, 2015). WHO (2004: 5) defines adolescent pregnancy as "pregnancy in a woman aged 10-19 years", acknowledging the difference between younger adolescents and adolescents that are 15 years or over. It has been estimated that throughout the world there are around 16 million adolescent girls that are 15 years or older and two million young adolescent girls who get pregnant each year (Blum & Gates, 2015). While adolescent pregnancy occurs all over the world, some of the highest rates are found in sub-Saharan Africa, showing substantial variation within the continent (Blum & Gates, 2015; WHO, 2004). WHO (2018, para. 4) states: "adolescent pregnancies are more likely to occur in marginalized communities, commonly driven by poverty and lack of education and employment opportunities". In other words, chances are higher for the poorest girls with little or no education to become adolescent mothers than girls who are better off regarding their financial and educational background (Blum & Gates, 2015).

Pregnancy intent distinguishes between intended and unintended pregnancies. Whereas most research assumes that adolescent pregnancy is unintended and in need of preventing, adolescents also want and plan for childbirth to happen. In this way, intended pregnancies could

bring positive attitudes towards childbearing at an early age (Macutkiewicz & MacBeth, 2017). Where social norms dictate adolescents, in particular girls, to marry early and start childbearing early, adolescent pregnancies are more likely to be intended than in regions where these norms are not prevalent (Sedgh et al., 2015). According to the United Nations Population Fund (UNFPA), "90% of adolescent births among 15-19 year olds occur within marriage" (Blum & Gates, 2015: 8). Nevertheless, there are many adolescent pregnancies and childbirths that are unplanned and unwanted. It is estimated that the unmet need for modern contraception has resulted in that half of the pregnancies that occur among adolescent girls with the age of 15 or over in the Global South are unintended (WHO, 2018). Unintended pregnancies can also present themselves when adolescent girls may not be in the position to prevent unwanted or coerced sex which is usually unprotected. Chances are higher for girls to experience unintended pregnancy in societies that condone violence against women (WHO, 2018).

Adolescent mothers have a higher risk of nurturing children that become adolescent mothers themselves and being negatively affected by poverty, low educational attainment, low income, difficulties with housing, conflicts in the family and social isolation (Cook & Cameron, 2017). The sudden withdrawal of friends, as a result of pregnancy, is found to strain the coping ability of adolescent mothers (Ellis-Sloan & Tamplin, 2019). Their maternal health is associated with being exposed to poorer general health and nutrition which increases the chance of foetal, perinatal and maternal disability and death (Blum & Gates, 2015). Moreover, pregnant adolescent girls are often late for prenatal care due to lack of knowledge and access, fear and stigma (Leftwich & Alves, 2017). They are at risk of anaemia, pre-eclampsia and delivery related consequences such as preterm delivery, stillbirth, low birth weight and higher caesarean rate (Arai, 2009; Karataşlı et al., 2019; Leftwich & Alves, 2017). Young adolescent girls that are below the age of 15 while pregnant also run a higher risk than others of placental tears, obstetric fistula, obstructed labour and death (Blum & Gates, 2015). Adolescent pregnancy has furthermore been found to have negative impact on young mother's mental health, leading to depression for example (Arai, 2009; Leftwich & Alves, 2017).

Arai (2009) notes that adolescent motherhood is often considered 'problematic', framing this largely in relation to negative outcomes of early pregnancy, such as those detailed above. However, adolescent mothers can experience motherhood positively despite facing difficulties, as well as being aware that adolescent pregnancy is often frowned upon. Arai's (2009) research shows that many young mothers focus on being a good mother and consider becoming a mother as positively transforming. Especially when supported and accepted by their families, adolescent girls are found to cope well with transitioning to motherhood. Moreover, another way of looking at adolescent motherhood is that young mothers would experience more freedom in the future, in comparison to older mothers, and that children could strengthen the family bond. Authors such as Arai (2009) and Kane and colleagues (2019) thus assert that rather than problematising adolescent pregnancy, social and health policies should work towards a better understanding of the experiences of adolescent mothers in order to support their well-being.

## 3.3. Mental well-being

Within existing international development literature, there is a lack of attention for the meaning of mental well-being. The concepts of mental well-being and mental health seem to be used interchangeably, making it difficult to envision a general academic consensus on mental well-being, as distinctively different from mental health. That being said, the definition of (mental) health does help in arriving at a definition on mental well-being, for which I will be drawing on explanations of WHO but mostly on the research of Keyes (2002, 2005, 2007), as mentioned below.

WHO (2005: 2) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This holistic approach suggests that mental health relates to physical health, behaviour and fitness rather than the absence of mental illness. Defining mental health is quite complex, since having average mental health is strictly speaking not the same as being healthy. Being healthy also depends on differences in history, culture, geography, class, gender and a person's general or temporary state (WHO, 2005). Despite these complexities in measuring someone's health, WHO (2005: 2) arrived at the following definition of mental health: "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". This definition shows that mental health provides the basis for the well-being and effective functioning of individuals and communities.

More specifically, Keyes (2002: 208) operationalizes mental health in contrast to mental illness, defining mental health as "a syndrome of symptoms of an individual's subjective well-being". Comparing the definitions offered by respectively, Keyes (2002) and the WHO (2005), suggests that mental health is seen as reflective of an individual's subjective or mental well-being, showing that these types of well-being are quite synonymous. Mental well-being is thus best measured through examination of subjective well-being, which entails: "individuals' perceptions and evaluations of their own lives in terms of their affective states and their psychological and social functioning" (Keyes, 2002: 208). For the sake of practicality, I use Keyes' definition of subjective well-being in researching mental well-being.

Before proceeding to the explanation of mental well-being, it is of importance to further clarify the difference between the concepts of mental health and mental well-being. Keyes (2006: 1) states: "The quality of an individual's life can be assessed externally and objectively or internally and subjectively." Objectively, people judge other people's lives using certain criteria. Subjectively, people assess the quality of their own lives based on their own evaluations. In other words, according to Keyes (2006), mental health is measured by someone else, a social group or society; whereas mental well-being is evaluated by the person in question, based on own experiences.

The concept of mental well-being is constructed to exist of emotional, psychological and social well-being (based on Keyes, 2005; Keyes, 2007). Emotional well-being revolves around positive emotions and links 'hedonism' to happiness, which refers to the minimization of pain and the maximization of pleasure in life (Franken et al., 2018). That is why emotional well-being aims at positive affect, the absence of negative affect and life-satisfaction (Keyes, 2002).

Both psychological and social well-being reason from a 'eudaimonic' perspective with an emphasis on positive functioning. This perspective strives towards the fulfilment of one's (true) potential (Keyes, Shmotkin, & Ryff, 2002). According to Ryff (1989), psychological well-being consists of six variables that focus on optimal functioning and self-realization which are self-acceptance, personal growth, purpose in life, environmental mastery, autonomy and positive relations with others. In Keyes' (2005) view, psychological well-being is about how individuals thrive in their private lives, whereas social well-being is about how individuals thrive in their public lives reflected in optimal functioning within society and social groups. Keyes (1998) identifies five variables of social well-being, that is, social acceptance, social actualization, social contribution, social coherence and social integration.

| Mental well-being reflected in 13 dimensions | | |
| --- | --- | --- |
| *Emotional well-being (positive emotions)* | *Psychological well-being (positive psychological functioning)* | *Social well-being (positive social functioning)* |
| Positive affect Avowed quality of life | Self-acceptance Personal growth Purpose in life Environmental mastery Autonomy Positive relations with others | Social acceptance Social actualization Social contribution Social coherence Social integration |

*Table 1: Overview of mental well-being dimensions that show mental health as flourishing, based on Keyes (2007)*

That being said, these theories around mental well-being (emotional, psychological and social well-being) were developed in the West and the relevance of the proposed variables will be examined in the context of rural Ghana. In addition to these theoretical insights, I feel that physical, economic and spiritual factors play a big role in determining someone's mental well-being as well. These factors seem to be particularly prevalent when people are suffering physically, economically or spiritually. That is why these factors are relevant to data around mental well-being and are examined in this study.

## 3.4. Well-being enhancement

Various studies in the field of psychology and psychiatry have demonstrated that patients regard well-being as a relevant outcome of treatment and that well-being can be promoted in clinical populations (Franken et al., 2018). However, scientific advances in this field have focused more on establishing and validating interventions aimed at managing identified illnesses as compared to well-being, and typical health workers will have more knowledge on treating illnesses than on promoting well-being. This shows the focus on illness-oriented services and the need for health services that make use of the science of well-being (Slade, 2010). According to WHO (2005), an effective promotion of mental health must approach mental health positively and aim at building strengths, empowerment, community, resilience, and resourcefulness. The WHO thus urges governments to focus on building healthy public policy, strengthening community action, creating supportive environments, reorienting health services and developing personal skills. Mental health promotion should include policies, strategies and

activities that are formulated by communities instead of the usual 'experts' and take into account cultural values (Lahtinen et al., 1999; WHO, 2005).

Scholars such as Fava and Ruini (2002) have argued that true well-being, or wellness, has to do with being aware of one's well-being, and can be improved by realizing one's true potential and being completely engaged with others. This entails a process of self-realization. These authors assert that well-being is not to be equated with positive emotions and subjective happiness, since the latter do not produce improvements nor developed personality in the long run (Fava & Ruini, 2002). Therefore, eudaimonic theories of well-being show the importance of engaging in meaningful endeavours in contrast to hedonic theories, as stated before. Research suggests that 'doing good' might be a way of creating a significant and satisfying life (Steger, Kashdan, & Oishi, 2008). People create resources by maintaining healthy relationships or having a purpose in life, for example. Well-being is also achieved by performing activities and pursuing meaningful goals that correspond with strengths, characteristic traits, personal values and aspirations, or that provide competence, autonomy and relatedness (Steger et al., 2008).

Even though doing something just for pleasure corresponds with satisfaction in the short term (Steger et al., 2008), positive emotions have proven useful in terms of serving as a buffer against stress. Various positive coping strategies, such as giving positive meaning to regular events, are related to positive affect and increases in psychological well-being. A growing body of evidence suggests that there are differences in the abilities of individuals to have effective control over their own emotional lives, leading some to effectively manage and regulate their emotions in situations that are perceived as stressful. High-resilient individuals have the capacity to learn from setbacks in life – marked by adversity, loss and hardship – and use this to guide their thoughts, actions and strategies in order to prevent negative emotional life experiences. Positive emotions can be evoked strategically through relaxation techniques, optimistic thinking and humour (Tugade & Frederickson, 2004). Various behavioural interventions, including well-being therapy (Keyes et al., 2002) and problem-solving therapy (Rosenberg, 2019), aim at enhancing psychological well-being (Weiss, Westerhof, & Bohlmeijer, 2016).

## 3.5. Conceptual scheme

This conceptual scheme is my own interpretation of a functional model of mental health, as presented by Lahtinen et al. (1999: 31). The experiences of early marriage shape a person's emotional life events, mental health (which expresses itself in individual resources) and present social context, leading to a lower, unchanged or higher level of mental well-being. A person's well-being can be enhanced by working with these emotional life events, individual resources and social support. To provide the context of the research, the scheme visualizes the main target group, that is, young women and girls within Ghanaian society and culture. It is important to note that the concept of adolescent pregnancy does not feature in this scheme as its importance only became apparent in later stages of the research.
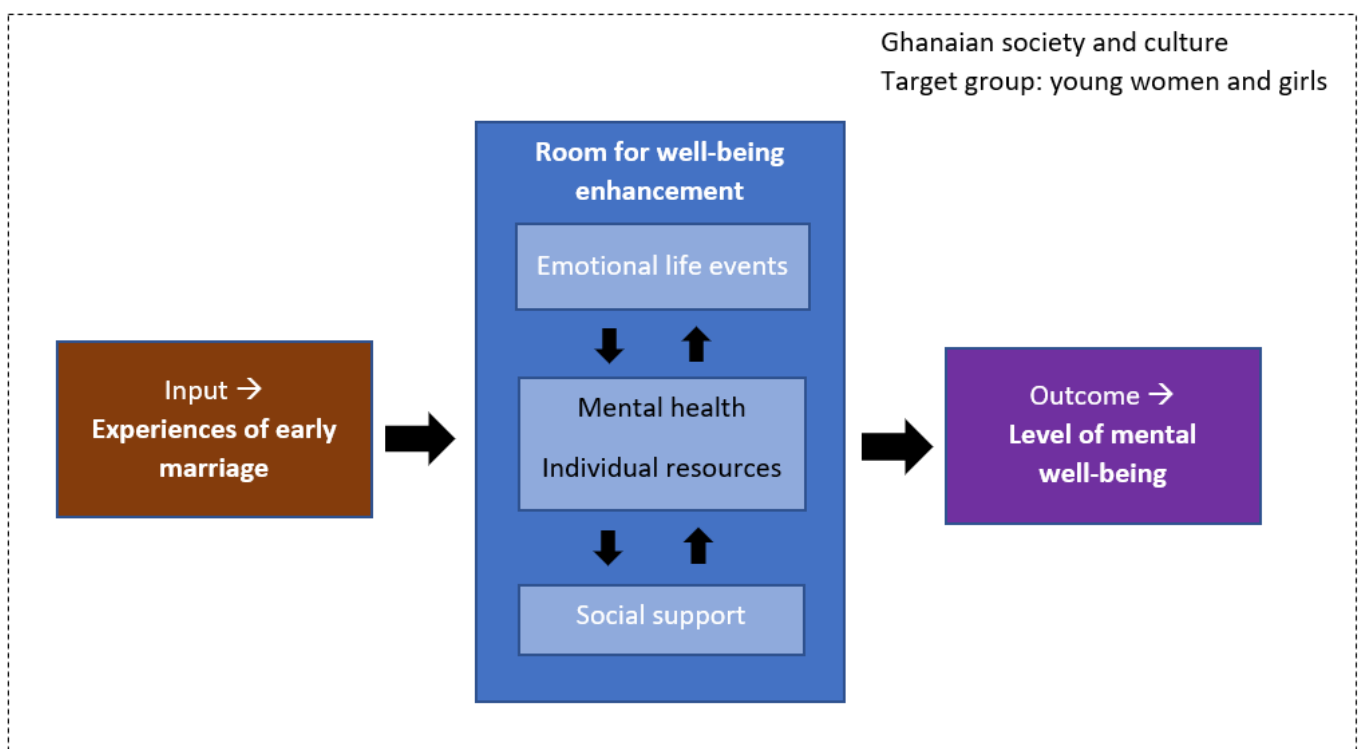
*Figure 3: Preliminary conceptual scheme*

## 3.6. Concluding remarks

This chapter has presented the theories that underpin my research. In preventing early marriage, one must consider why national laws against the practice are often not enforced. Literature around adolescent pregnancy alternates between a focus on preventing related well-being outcomes for adolescent girls, and supporting current well-being needs of adolescent mothers. The mental well-being of an individual reflects own experiences of emotional, psychological and social well-being. Strategic efforts can improve this individual's well-being in the short or the long run, given the value of both outcomes. Finally, the preliminary conceptual scheme was provided. The next chapter delves into the research methodology.

# 4. Research Methodology

This chapter details my research methodology. Section 4.1 states my main research question and sub-questions that have guided me through this research. Subsequently, I present the research location (4.2), unit of analysis, sampling methods (4.3), methods of data collection (4.4) and data analysis (4.5), which elaborate on how I have focused, conducted and analysed my research. Section 4.6, 4.7 and 4.8 reflect on research quality criteria, ethical challenges, limitations and how I have sought to deal with these.

## 4.1. Research questions

Taking the knowledge gap around the mental well-being of young married and single mothers into consideration, the main research question guiding this study is:

- ❖ How do adolescent pregnancy and early marriage affect the mental well-being of young women in rural Eastern Region, Ghana, and in what ways do they seek to secure or enhance their well-being?

The underlying sub-questions are:

1. What are the dominant community norms around motherhood and marriage, and how do these norms relate to the prevalence of adolescent pregnancy and early marriage in the community?
2. How do married girls and adolescent mothers perceive their own mental well-being?
3. What means do married girls and adolescent mothers use to enhance their well-being, and how do different actors support them in their everyday life?

## 4.2. Research location

The research was conducted in rural Eastern Region in Ghana, which is one of the 16 administrative regions that Ghana has[3]. More specifically, the research took place near the regional capital of Koforidua, where one of the regional offices of THP-Ghana is located. Informal research was done in Koforidua (shown in figure 4), but the main research area was located in and around Boti in the adjacent Yilo Krobo District where the population for 2018 was estimated to be 104,888 people (Ghana Statistical Service, 2019). I regularly commuted from Koforidua by car to the research communities, approximately at 23 kilometres distance. Travelling could be quite challenging due to the condition of the roads. Usually I went to the epicenter of Boti – a community centre set up by THP-Ghana – to attend meetings or meet participants for interviews or FGDs. This epicenter reached community members from eight

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[3] 6 administrative regions were recently added in order to "end decades of petitions calling for the formation of the regions" according to the following source: https://www.modernghana.com/news/916140/ghana-now-has-16-regions.html.

neighbouring communities who could go for THP-related meetings or a visit to the clinic or the bank. In other cases I went to the homes of the participants.



Figure 4: Map of Ghana (Africa Today, 2008)
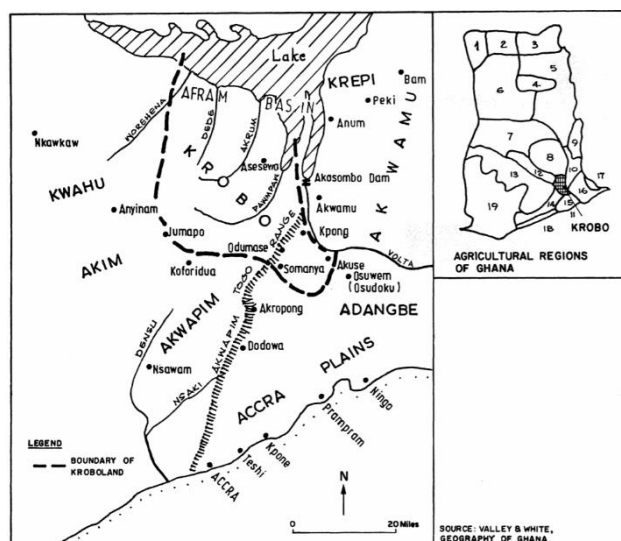
Figure 5: Map of Kroboland (Bedele, 1988)

The main ethnic group in the research communities was Krobo, belonging to the Dangbe ethnic groups. The participants spoke the language Krobo, were Christian and referred to their land as Kroboland. The second map above highlights how Kroboland is situated in relation to natural resources. In addition to the THP-Ghana sign of Boti, figure 6 shows what the research area looks like.



Figure 6: THP-Ghana sign of Boti (author's own, 2019)

The agrarian sector has long been of substantial importance for Ghana's economy (Akobeng, 2017), and especially for the Krobo people who are mainly farmers. The sector is dependent on the weather, since heavy rainfall can influence the conditions of the roads and the access to local markets. On the other hand, as my research took place at the end of dry season, quite some farmers stated that they were in need of rain for their crops. The weather thus affects the incomes of farmers and others in rural areas (Akobeng, 2017). Most Krobos live off growing crops such as cassava, yams, maize and cabbage. Selling small items such as food is often done to earn a little money, but is usually not profitable enough to being referred to as a proper job. The families that live in the research communities are mostly dealing with poverty in regards to their perceived level of financial suffering. In general, women perform the household tasks and fetch water. Men usually go through more schooling, which gives them a head start in the field of speaking English and employment opportunities.

## 4.3. Unit of analysis and sampling methods

The main unit of analysis is the mental well-being of married girls, pregnant girls and adolescent mothers that were between 12 and 24 years old, as the HC alliance works with married girls (ages 12-17) and women who were married as children (currently aged 18-24). Another group of key informants existed of male and female community leaders, including a church elder, chief, queen mother (female authority figure), teachers, and nurses. In regards to the group of parents, the sample consisted of women only given I sought to develop a more thorough understanding of female perspectives on adolescent pregnancy and early marriage.

Regarding the sampling methods I made use of opportunistic sampling through which I could take opportunities to collect relevant data for my research as they arose. This method falls within purposive sampling approaches which allowed me to strategically obtain my research participants (Bryman, 2012). A THP-Ghana staff member ('animator') usually arranged for me to meet up with the participants. Due to constraints in the availability of the girls I followed what THP-Ghana deemed possible in regards to the FGDs: grouping girls who were from the same communities in order to facilitate easy access to the meeting place, and to make the girls feel more comfortable in talking about sensitive topics.

## 4.4. Data collection methods

In order to answer my research questions, I collected data through qualitative research methods as I desired to fully grasp the experiences of adolescent girls. Therefore, the emphasis was on the content of conversations rather than the quantity of participants (Bryman, 2012). During the fieldwork period I collected data by doing participant observation in community meetings, conducting FGDs and in-depth interviews, having informal conversations, and writing field notes.

### 4.4.1. Participant observation in community meetings

I started my fieldwork by attending community meetings with the purpose of introducing myself in a formal way to the communities, and getting an understanding of what these regular meetings entail. The customary introductions in particular paved the way for me to get to know the community, and vice versa. As a participant observer according to the definition of Bryman (2012: 432) I immersed myself in these community meetings in which I not only observed the behaviour of the participants, but also listened to and asked about conversations being held with community members, THP-Ghana employees and me. These participant observations helped me to find out what was of importance within the research communities and how the talks of the animators of THP-Ghana were received. I further explored the topics of these meetings in FGDs and interviews.



*Figure 7: Community meeting at the Boti epicenter (author's own, 2019)*

### 4.4.2. Focus group discussions

To become familiar with the general reception of my research topic, I started from the beginning of my research with conducting FGDs. In total I conducted four FGDs: two with (16) adolescent girls (aged 17-24), one with (10) community leaders and one with (8) female parents. Prior to the actual discussions, verbal consent was received for the audio recording of all the FGDs. The FGDs lasted approximately an hour and a half, with the exception of the FGD with community leaders, which ended up taking two and a half hours due to the extensive answers that were given. After each FGD I provided the participants with refreshments, such as snacks and drinks, to thank them for their participation in my research.

*Figure 8: FGD with adolescent girls (provided by local supervisor, 2019)*

The FGDs were semi-structured for which I made use of an FGD guide. I started the FGDs with an association game in order to break the ice, feeling that the participants would be supported in gathering and expressing their thoughts in a way that suited them. I asked the participants what they associated with certain words, after which they could say whatever came into mind. By letting them be in charge of the direction of the conversations they were given the opportunity to be in control about what was being said. My intention for the rest of the discussions was to go into major emerging themes when they would appear. The participants were asked to elaborate through follow-up questions. Especially in the FGD with community leaders, we naturally deviated from the main questions. For three out of four FGDs I made use of translators who participated occasionally in the conversation to do additional explanations, respond to experiences that they recognized and make jokes in order to make the participants feel more comfortable. Other than that I took on the role to facilitate the discussion and elaborate on certain questions when necessary.

The table below summarizes background information on the participants from both FGDs with adolescent girls that were conducted. More information about these participants can be found in the appendices.

| FGDs with adolescent girls | | Boti epicenter (n=16) |
|---|---|---|
| Marital status | Single mothers | 10 |
| | Married | 6 |
| Age at first child birth | First child before 18 | 8 |
| | First child from 18 | 8 |

| Education[4] | Primary School | 4 |
| | Junior High School | 11 |
| | Senior High School | 1 |
| Occupation | No occupation | 14 |
| | Occupation | 2 |

*Table 2: Background information on the participants of the FGDs with adolescent girls*

## 4.4.3. In-depth semi-structured interviews

In-depth interviews were particularly relevant for acquiring information about how individual girls perceived their experiences of pregnancy, motherhood and marriage. I conducted in-depth interviews with 17 adolescent girls (aged 16-24) whose background information I have summarized in table 3. The girls gave their verbal consent to the recording of the interviews, which lasted between an hour to an hour and a half. These interviews were semi-structured since this was both convenient for me as a researcher and for the translators who needed a moment at times to translate questions into Twi or Krobo. I used an interview guide to lead my way through the conversation. Regarding the few interviews in which I could converse with the girls in English, I could deviate more from the interview guide and ask more follow-up questions. After each interview I expressed my gratitude by giving the adolescent girls sanitary pads – and drinks and biscuits if available – as previously discussed with my local supervisor. Towards the end of the field work period I realized that the point of saturation was reached, as the general gist of what was being said in the interviews tended to be quite similar.

| Interviews with adolescent girls | | Boti epicenter (n=17) |
| --- | --- | --- |
| Marital status | Single girls | 1 |
| | Single mothers[5] | 12 |
| | Married | 4 |
| Age at marriage | Not married (before 18) | 13 |
| | Married before 18 | 4 |
| Age at first child birth | No children | 1 |
| | Pregnant | 4 |
| | First child before 18 | 10 |
| | First child from 18 | 2 |
| Education[6] | No education | 2 |
| | Primary School | 2 |
| | Junior High School | 13 |
| Occupation | No occupation | 17 |

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[4] Education refers to the highest level of education of the adolescent girls. However, this does not assume that they have finished this type of education.
[5] Single mothers include three girls with boyfriends who did not consider themselves as married, and four mothers to be who were pregnant at the time of the interviews.
[6] Education refers to the highest level of education of the adolescent girls. However, this does not assume that they have finished this type of education.

| | Occupation | 0 |
| --- | --- | --- |

*Table 3: Background information on the participants of the interviews with adolescent girls*

In addition, I conducted one interview with a psychiatric nurse who was affiliated with the clinic of the Boti epicenter. The interview lasted almost an hour and a half, and was recorded with permission. For this interview I had prepared an interview guide, but I ended up deviating enormously from this as the conversation in English flowed nicely. Our conversation, in which she expanded on her views related to her work activities, tied my research together in the area of mental health.

### 4.4.4. Informal conversations and field notes

The rest of the data were gathered through elaborate field notes about informal conversations I had with my local supervisor, translators, THP-Ghana animators and other Ghanaians throughout Ghana, but specifically in Koforidua, Boti and neighbouring communities. These conversations were essential to support data triangulation. When it came to certain superstitions and misconceptions I used my field notes to see if Ghanaians outside of the research communities also believed in the same things. In addition, I talked with quite some Ghanaians about the education system of Ghana. It came to my attention that public education was supposed to be free, even though many of the adolescent girls I spoke to dropped out of school because of financial reasons.

### 4.5. Data analysis

I started the process of transcribing FGDs and interviews in the field, which helped me in later interviews with where to focus on. This way I could identify key themes and apply them in later data collection techniques. After returning to the Netherlands, I finished transcribing the FGDs and interviews, while adding some preliminary codes to the transcripts in my word documents. For every transcript I put together the main ideas of participants, including the reasons for and process of the marriages, and pregnancies. Additionally, I analysed the data manually by inductively drawing from the data through initial and selective coding, according to Charmaz (2006). Through initial coding I produced as many codes as I deemed necessary, while selective coding provided me with more common and analytical codes. I organised these codes in word documents. As indicated earlier, my fieldnotes served as a means to triangulate my data. The themes that emerged from the data analysis will be addressed in empirical chapters of the thesis (Chapters 5 and 6), corresponding with the established sub-questions.

### 4.6. Reflections on research quality

Building on Guba and Lincoln's (1994) work on evaluating the quality of qualitative research, I use the use the criterion of trustworthiness. Trustworthiness exists out of the following sub-criteria: credibility, transferability, dependability and confirmability (Bryman, 2012: 390). Regarding the credibility of the research, I have taken steps to determine that my observations fitted with the actual reality of the respondents by checking with them and my translators

directly whether I understood the answers of the respondents correctly. In order to give as full an account as possible, I used a variety of sources for me to understand the reasoning behind these answers. I made use of triangulation by checking my initial findings with respondents from different target groups, informal conversations with Ghanaians outside of my target groups, and documents with historical information related to Ghana. I also talked with my local supervisor and fellow classmates who were doing research on similar topics.

Transferability focuses on whether my findings would hold in other contexts or times (Bryman, 2012). As the findings were specific to the research area and its population (rural setting in the South of Ghana with people from the Krobo ethnic group), the transferability of the research can be questioned. However, by making rich descriptions of cultural aspects that I am using for contextualization, I enlarged the possibility of transferring my findings to other contexts. Therefore, I feel that one can learn lessons from my findings that can be relevant in other settings.

Dependability is concerned with the reliability of the research. I have kept all records of the phases of the research process (Bryman, 2012), such as preparations for fieldwork, field notes, interview transcripts and documents during data analysis. I changed my interview guide a few times because I had to adapt my questions to the reality of the adolescent girls who took part in my study. I also tried to be consistent with my research methods and reflected on them with my local supervisor from time to time.

Confirmability stresses the importance of objectivity while realizing that one is always subjective (Bryman, 2012). My own subjectivity played thus a role in the research. For instance when the girls were not talkative, I would have to give them examples of answers to the questions. Even though this affected the research, I chose to do this because at times it would be my best chance of getting an answer. They still had the option to not answer the question. In other situations, when respondents would make me feel uncomfortable by emphasizing my Western background or emotional by sharing difficult experiences, I usually tried to not let this influence my further questions. I was always keeping in mind that I had to go into every interview and FGD with open eyes and make the participants feel as comfortable as possible.

## 4.7. Ethical considerations

This section reflects on the ethical considerations and challenges I have dealt with during my fieldwork. As mentioned before, as gatekeepers the animators of THP-Ghana usually selected the participants. In seeing to it that the research was carried out in a responsible manner, it was of importance to thoroughly explain to the respondents the nature of the research and their rights. To ensure that the respondents received enough information in order for them to make an informed decision regarding their participation in my study (Bryman, 2012) I worked with verbal instead of written consent, since written forms could make the participants uncomfortable according to THP-Ghana. At the start of every interview and FGD I would go through an introductory text containing information about me, the goal of my research, and informed consent regarding participation and audio recording.

Asking participants about their personal experiences with early marriage and pregnancy may have revived painful memories. In addition to the topic being sensitive, I also recognized that I would be speaking to participants – possibly below the age of 18 – that were dealing with stigma within their communities. The interviews often took place at the homes of the respondents through which family members occasionally walked past or stayed nearby, possibly listening to the questions. In other places, I would wait with posing further questions until the people who stopped to listen would be gone. During interviews and FGDs I focused on the body language of the respondents. Especially when the adolescent girls who took part in my study seemed shy about certain questions, I would go on to the next question in order to make them feel more comfortable. I would also offer them twice the possibility to receive the contact details of someone trustworthy. Regarding the safety of the participants, I made sure that the collected data were password-protected, and that the participants could not be identified by their names or other significant information. The girls were assigned pseudonyms that are used in the discussion of the data in Chapters 5 and 6.

Another aspect of ethics focuses on the position of the researcher in comparison to the position of the participants. This issue, often referred to as positionality, indicates that the researcher must recognize and take into account these different positions when conducting research (McDowell, 1992). As a young western woman who was doing research with THP-Ghana, the community members referred to me as Madam which gave me a certain level of respect, since a Madam is usually considered as someone who holds a high position. Therefore, it was not complicated to talk to male community leaders. In an attempt to reduce the distance between me and the adolescent girls I usually tried to find common ground as young women, for instance, through our shared interest in dance. Even though I was seen as the foreign researcher who did not speak the local languages, in certain instances I emphasized my Afro-European biracial background in an effort to create some degree of trust. Besides my appearance, my role as a researcher came in when girls and women approached me for financial assistance. In these situations I emphasized that I was a researcher who did not work for THP and was not in a position to give out money. I also informed these respondents as best I could about the programmes of THP-Ghana.

## 4.8. Limitations

In order to make the research more reliable it is important to show transparency regarding the research process. Therefore, I will describe three key limitations that influenced my research.

### 4.8.1. Overburdening of communities

In 2018, another student from the master International Development Studies, Haga (2018), also did research around the epicenter of Boti, among other communities. Even though the focus of our research was different, the scope of our research has been quite similar, that is, around well-being of married and single mothers. Despite my request to do the research in a different area, THP-Ghana had assigned Boti to me due to the proximity of the epicenter to Koforidua, and the psychiatric department that the clinic offered. As Clark explains the notion of research

fatigue, which can present itself "when individuals and groups become tired of engaging with research" (2008: 955), I did not want to burden community members with having to participate again in similar research. The idea for my research sample was thus to find respondents, especially for the individual interviews with the adolescent girls, who had not already participated in Haga's research. Finding them was quite difficult for THP-Ghana, but worked out to the best of my knowledge.

Clark (2008: 956) argues that research fatigue can occur when "the experience of an earlier engagement begins to act as a barrier to future involvement". In regards to my research, participants were dealing with a foreign researcher (again) without direct financial improvements coinciding with my arrival. As a consequence, the participants could be less appreciative of the outcomes that they associate with participating in research in the future. Even though the overburdening of my specific research communities does not necessarily have to do with the fact that I was the second researcher the community members had seen in two years, I discussed with my local supervisor that in the future THP-Ghana should send prospective students to different communities, preferably different regions. The latter would also help THP and HC with collecting data using participants from various regions in Ghana. In this way, the members from the communities, where my classmates and I have been researching in, should not have to go through the process of having to receive a foreign researcher and talk about similar topics again.

### 4.8.2. Beyond my control

After discussing the plans for the research period with my local supervisor, I realized that some things would be beyond my control. As stated before, THP-Ghana provided me with access and was therefore in control of the research location, free and prior informed consent, and informing the participants on the nature of my research. Their involvement influenced the times I could go into the field, and the expectations the community members had of a foreign researcher. Regarding the actual data collection, THP-Ghana arranged for the specific time and location for the interviews to take place. Sometimes the adolescent girls had to wait some time before it was their turn to partake in the interview. After trying one interview with two girls at the same time, in which one girl just repeated everything the other girl said, I clearly stated that I wanted to conduct individual interviews and tried to go to the homes of the girls or arrange for different meeting times.

Towards the end of the research, occasionally I would realize upon arriving at the research location that the arrangements for that day had not been made. In certain instances the data collection method of the day would depend on the availability of adolescent girls in the community where I was. For conducting the second FGD with adolescent girls I had to make use of the opportunity in which I could gather the girls who had come to the epicenter of Boti to attend a community meeting. Moreover, once I had to employ a new translator on the spot whom I could not inform thoroughly about the specific questions of my interview guide before the interview would begin. This unexpected change influenced the answers I received, but it

might have expanded the scope of my research in a positive way as I was able to do more follow-up questions and rephrase certain questions on the spot.

### 4.8.3. Language barrier

Even though English is the official language of Ghana, there are many recognized national languages from which Twi is the language that is the most widely spoken. The mother tongue of the research participants was usually Krobo, to which some could add Twi and/or English as their spoken languages. Therefore, I had to employ translators. Even though a number of conversations, a few interviews and parts of FGDs were in English, for most of my data collection I worked with translators. One of them was my local supervisor who communicated with the community members in Twi. Most of my interviews and FGDs have been attended by a woman, named Ernestina, who was from the area and helped me translate my questions into Krobo. At the end of the research period, I worked with another woman, Esther, who was from a community further away from the Boti epicenter. She was familiar with the girls and could often clarify when I did not completely understand their answers.

Certain words, especially related to mental well-being, did not translate well in either Twi or Krobo. This might be part of the explanation why at times the questions concerning the mental aspect of well-being were not fully understood. Therefore, I resorted to using synonyms in these type of questions. The language barrier also limited the possibility to use certain participatory methods such as creating a problem tree, drawing a time-line, and using diaries. My local supervisor and I agreed that these methods would not be feasible, since the adolescent girls and other community members could be illiterate, not comfortable with writing in general and/or not have enough knowledge of the English language. Carrying out these methods would have been very difficult, as they require reflecting on what has been created. Instead, I chose to use an association game as an ice-breaker.

### 4.9. Concluding remarks

This chapter has outlined my research methodology, including information about the research location and its population for additional contextualisation. The provided research questions, sampling methods, and techniques for data collection and analysis helped me to conduct the research in a feasible manner. In order to offer more transparency, I have explained the measures I took to overcome quality, ethical and other dilemmas. The next chapter starts the empirical discussion.

# 5. Community norms around and experiences of sexuality education, early marriage, and adolescent motherhood

## 5.1. Introductory remarks

This chapter examines the sexual and reproductive knowledge of girls. Section 5.2 looks into what is taught to them around family planning in the formal education system, the home and the community. It is paramount to consider these teachings in the light of their transitioning towards womanhood. Subsequently, 5.3 provides an insight of the views on, and experiences of, marriage and motherhood through the lens of adolescent girls. The sub-sections cover types of marriage, their perceptions on being married and mothers, and the processes around their early marriages and adolescent pregnancies. As mentioned before, relevant to understanding the data is that the population of Boti and neighbouring communities primarily identified as belonging to the Krobo ethnic group.

## 5.2. Sexual and reproductive knowledge of girls

This section addresses the education on family planning that girls taking part in this study reported they received in schools, at home, and through communal traditional rites.

### 5.2.1. Education on family planning

As family planning is broadly recognised as supporting the prevention of unplanned pregnancies among adolescents, I deemed it useful to find out about the ways girls could get their education on family planning.

***Family planning within the education system***

Within the formal education system pupils start to learn about health related topics in Junior High School (JHS). In an FGD with community leaders, I asked teachers how family planning matters are usually taught. One teacher explained his point of view:

> [Family planning methods] are integrated in integrated science and social studies. Before they get to form 3 [of JHS] they know almost all these things. It depends on the teacher, on the particular teacher who is handling that subject. (…) The strategy I normally use is after taking them through all the methods, there are so many methods and we all role play and then simulate it into our real life and choose the best. So in conclusion the majority will come out with the abstinence. That is the best. Usually with the condom you are not secured. Even biblically it's not even good. So we use the Bible to condemn the use of condom. So the best thing is to abstain from sex. And it's a sensitive area which Africans [usually agree upon]: their chastity. We normally teach that one also to support abstinence. (FGD 3)

The extract highlights how teachers are in control over the specific strategy they use to teach their pupils the topic of family planning, and over the preferred method they will bring forward to their pupils. As this teacher also showed his negative attitude towards other birth control methods – such as the use of pills, injections or implants – and would discourage his pupils from going to health centres to get on birth control, the majority of his pupils will likely retain

that abstinence is the best method. In addition, linking the practice of chastity to Africans could add to biblical reasons and thus strengthen the argument for abstinence. The education of these kind of views can help explain why a number of adolescent participants appeared to have no intention of using birth control.

Since the adolescent girls received different levels of education, they also had different accounts of knowing about family planning methods. Taylor (23-years-old, single mother, interview 15) explained that JHS taught her about abstinence, sexually transmitted infections, and how and when girls can get pregnant. She explicitly stated: "They advise us about not taking a boyfriend, so they won't advise us to take any medicine."[7] This quotation supports the view that for girls the starting point for teachings on family planning is to avoid getting a boyfriend – which would promote abstinence – and not to protect oneself with 'medicine', i.e. the birth control pill. The idea is that pupils should not be having (premarital) sexual relationships, which would prevent difficult situations on its own. Contrary to this view is what Gabriella (16-years-old, pregnant, interview 3) was taught in school for using birth control methods: "You do [family planning] to protect yourself from boys, like boyfriends." This quotation highlights an argument for using family planning that is based on the acknowledgement that girls could be having sex.

An adolescent mother referred in an FGD to being vaguely taught about family planning methods in school: "If you use it, you don't become pregnant. I've forgotten the rest" (FGD 2). Not being able to recount what else she had learned supports the view of Paige (22-years-old, single mother, interview 14) who emphasized the need for more and comprehensive formal sexuality education in JHS and Primary School. She argued: "The school should teach more about these matters, so that you'll understand it." This quotation underlines how a number of girls who have reached JHS seemed to not have learned adequately about the existing family planning methods in school, which could have been a factor in their adolescent pregnancies.

What is also important is the need for more informal education on family planning. Even though several of the adolescent girls indicated to know about birth control methods by hearing about them through the television or someone in their close environment, girls with no or limited education in particular could not be informed about these methods through the formal education system. Elisa (24-years-old, single mother, interview 16) who had not been able to go to school explained that before becoming pregnant she did not realize the consequences that pregnancy would have for her: "At that time I didn't understand what would happen if I got pregnant." This comment again highlights the lack of knowledge young women had on critical SRHR-related topics.

*Family planning within the home*

In order to understand parental sexuality education, I spoke with community leaders and parents. The data highlight that mothers in particular reportedly educate their daughters to not have sexual relationships with boys. The following excerpt from an FGD with community leaders illustrates the cautious nature associated with this type of education:

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[7] Quotations that had to be translated have been altered from the third person to the first person, as they were mostly translated into the third person.

> If the child is able to go through the formal education system, then the family planning issue is solved there. But in the home we only talk about abstinence. We use abstinence as our only method of family planning. (…) In the home, mothers shy away from issues relating to sex, among other things, because our tradition doesn't allow us to mention the name of [reproductive] organs to a child. We feel it is naïve to talk about [reproductive] organs with a child. If you do that the child will not respect you. (FGD 3)

As the excerpt reveals, mothers are expected to talk about abstinence only. The view that mothers do not like to speak about issues relating to sex is supported by the preference of female participants for using euphemisms such as 'being patient' over mentioning sex explicitly, when addressing abstinence. In addition, a mother explained in an FGD with parents that fellow mothers would certainly not bring their daughters to a health facility for birth control (FGD 4). The idea behind this being that the use of birth control would result in 'following boys' more, increasing the chance that their daughters would engage in premarital sexual relationships.

One of my translators, Ernestina, referred to another reason why mothers do not approve of family planning: "They don't, because the mothers don't practice it. So they won't teach it" (FGD 4). This quotation alludes to the uncertainty of not knowing exactly what will happen with girls who use birth control for a long time, which appeared to hamper its use by young women in the research communities. Echoing this view, an adolescent mother stated in an FGD: "People think or there is a perception that when you do family planning you wouldn't be able to give birth" (FGD 1). This quotation highlights the misconception and distrust of (modern) contraceptive methods, which causes the adults to consider it safer to stick with the method of abstinence which also aligns with their Christian beliefs. These arguments for 'abstinence only' resonate with the study of Kohler, Manhart and Lafferty (2008) that has found that birth control methods were linked to their perceived ineffectiveness.

Juliette (17-years-old, pregnant, interview 8) spoke of receiving the following advice from her mother and other relatives with regard to sexual relations:

> I should not rush myself in following boys. I should rather be patient and concentrate on what I am doing. Because when you have found work and start working yourself, then you can get better men than you would get following these boys.

Juliette's recollection of the advice highlights the idea that a girl can get 'better men' when she waits with having sex and finds a job. The idea behind this view is that engaging into sexual relationships with 'boys' will lead girls into trouble, whereas 'men' are presumably more fit for marriage. Mothers taking part in FGDs reported that they believed that girls should 'abstain from boys' completely, as it was commonly believed that boys would impregnate girls without taking responsibility for the pregnancy later on (FGD 1, 2, 3, 4). As a female community leader also stated: "Nowadays the young boys they deceive you and impregnate you. They won't cater for you" (FGD 3). This quotation highlights the female perspective of the seemingly misleading behaviour of boys when they refuse to support adolescent girls once the baby is conceived.

### 5.2.2. Towards womanhood

Krobo communities of Ghana are accustomed to the tradition of yearly performed puberty rites which focus on the transition of girls from girlhood to womanhood, as researched by Adinku

(2016). In an FGD, a community leader brought up these puberty rites to emphasize its importance for Krobo society:

> The girl starts menstruation, they send her to a selected old woman who performs the rites for the young girls. So you send her to the selected old woman, they keep her for one week and then take her through social life, especially childbearing, childrearing, housekeeping for one week. (…) So after one week they'll bring her out and then perform social celebration for her and she has become an adult to get into marriage. In these days that thing [puberty rites] has been watered down. (FGD 3)

Even though the puberty rites have been 'watered down', the excerpt underlines that the informal education that the puberty rites provide leads girls into adulthood, preparing them for the next stage of their lives, that is, marriage and motherhood. This view is supported by the idea that female Krobos are ready to start (sexual) relationships, once the initiation is over. A male community leader strengthened the argument by referring to the situation a girl who has recently become a mother finds herself in: "Now you have become an adult, you can care for yourself. Your mother will not give you money to buy food for yourself and your baby" (FGD 3). In this way, parents can legitimize why they no longer support their adolescent daughters financially, as mothers are considered adults and adults should be able to provide for themselves.

## 5.3. Girls' views on and experiences of marriage and motherhood

This section addresses common marriage types; the importance, meaning and purpose of marriage and motherhood; and the processes around early marriage and adolescent pregnancy.

### 5.3.1. Types of marriage

The girls involved in my study have not performed marriages that are legally registered by the state, making the enforcement of Ghanaian laws against child marriage complicated, as Hodgkinson et al. (2016) indicate. In practice, many participants expressed divergent ideas about the various forms marriage can take. A few girls brought up in an FGD that they considered a relationship as an informal marriage[8], in which a man and a woman engage themselves in sexual relationships without living together or having performed customary rites (FGD 1). This view seemed to blur the boundaries of the perception of marriage. Nevertheless, the adult community members do not see this type of commitment as marriage, and will rather refer to it as 'friendship'.

***Cohabitation: "without performing the rites you can be married"***

In the Boti communities, certain living arrangements can indicate marriage. A man and a woman living together is recognized by the community members as a type of marriage and referred to as cohabitation. A community leader referred to common reasons for this type of marriage:

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[8] Even though a number of participants indicated that a relationship can be considered informal marriage, adolescent mothers with boyfriends did not consider themselves married unless they were cohabitating.

> Mainly they do cohabitation. So, let's say about 60% of marriages in Ghana are cohabitation. Cohabitation because the man has no money to come and perform the customary rites. You have also given birth, you can't cater for the child, and you want the man to help you cater for the child. So you go and stay with him and you'll be providing food and then you become husband and wife. When he is going to the farm, you go with him. Being the first back at the house, you cook and then you eat. (FGD 3)

This excerpt clarifies why it is usually more beneficial for men and women to live together, when children are involved and money is lacking for an official marriage. It appeared that couples involved in cohabitation often did not have the financial means to perform the customary rites in order to be in a formally recognized marriage. In the words of an adolescent mother: "without performing the rites you can be married" (FGD 1). This statement adds to the experiences of the adolescent girls who were cohabitating and considered themselves married. They were promised the official marriage rites in the future as well. Participants clarified in conversations that formal marriages are often preceded by cohabitation, as it takes time to prepare for the customary marriage rites.

### *Customary marriage*

The official type of marriage is the customary marriage which focuses on the performance of the customary marriage rites. A community leader clarified this process:

> The man has to consult the parents of the woman, and the two families will come together, and there are some items he has to present to show that he is demanding the hand of the woman. And if it is accepted then it is guaranteed. That is the customary marriage. (FGD 3)

This excerpt highlights that before the customary rites are performed in the Boti communities, the families have to negotiate for the relationship of their children. Once the parents have discussed and agreed upon the marriage and bride price, the process can continue. Participants explained that the transfer of gifts usually existed of a number of drinks, including alcoholic beverages. If money permitted, the marriage could be followed with a ceremony and refreshments in church. Genevieve (18-years-old, married, interview 2) was the only girl that I interviewed who had experienced the official customary marriage rites. Even though her husband had not finished all the rites, she indicated that he paid her parents some amount of money and gave them drinks.

In the research communities, customary marriages had also been arranged by the parents of the spouses. At the time of the study, however, this arrangement was not common. A community leader stated: "Only one out of hundred marriages will be arranged by the parents" (FGD 3). Another community leader spoke of her own experiences with arranging a customary marriage for her son. She emphasized that those that do occur are voluntary and have to be agreed upon by the girl involved. In her case, the girl had consented to the marriage before introductory rites were performed and the girl moved in with the family (FGD 3).

### 5.3.2. "Marriage glorifies a woman": perceptions of marriage and motherhood

***Importance of being married and a mother***

In order to inquire about marital statuses I asked FGD participants what 'being single' meant to them. The importance of getting married for women became particularly clear in an FGD with community leaders who distinguished between unmarried men and unmarried women, when referring to single adults. A community leader stated:

> Being single, definitely you are going to be a spinster or a bachelor. Somebody who doesn't marry as a man is a bachelor and someone who doesn't marry as a woman is a spinster. (FGD 3)

This response highlights an unequal approach to naming unmarried adults from different genders. According to the online Cambridge English Dictionary (n.d.), the word 'bachelor' refers to "a man who has never married", whereas the word 'spinster' refers to "a woman who is not married, especially a woman who is no longer young and seems unlikely ever to marry". The meaning of spinster explicitly elaborates on the woman's perceived age-group and likelihood of getting married, which was not implied in regards to the meaning of bachelor. The negative connotation of the dictionary definition of spinster seemed to correspond with the reality of women in the research communities who saw great value in being married. Supporting this view were parents' statements as to suggesting that a single woman was associated with being in an unfavourable state for which she could be pitied (FGD 4). This idea again seems to indicate gender inequality in terms of how unmarried men and women are viewed.

In general, the data highlight that for participants partaking in the study marriage was the norm, as was having children. Fabienne (18-years-old, married, interview 9) stated: "You will get children from a marriage. When you are getting married, that means you want (more) children or you already have a child." Fabienne's remarks indicate that marriage is supposed to bring forth and/or support children. A community leader referred to the kind of comments the community usually makes towards a woman who has reached a certain age and has not started childbearing:

> When a woman turns 25, 26, 30 years in a community without a child, it tends to be a mockery to the whole society: 'Oh, an old fool who is not having a child.' (…) When the children are coming [of age] and then 20, 21, 22, you see the parents even quarrelling with them: 'Ah, you haven't even given birth.' We have that. (FGD 3)

This excerpt shows the importance of having children for women in the research communities in order to be taken seriously and earn the respect of the community. In addition, another community leader stated that women have an 'expiration date', clarifying that reaching menopause without having given birth was considered expiring (FGD 3). This view also adds to the idea that women are not completely valued if they have not produced children at one point in their lives.

More specifically, the data highlight that for the woman in particular marriage can uplift her social status. A parent explained in an FGD that marriage comes with respect: "When you are a married woman, you are respected because nobody will come and deceive you in any way, since you are having a man to cater for you" (FGD 4). Or as a young mother stated during an

FGD: "Marriage glorifies a woman" (FGD 1). Marriage thus appeared to fulfil a critical function in women's lives, that is, as a powerful institution that could upgrade their lives. Failing to reach an (official) marriage agreement after getting pregnant, on the other hand, was perceived as lowering the status of a woman. Fabienne (18-years-old, married, interview 9) supported this view:

> As the pregnancy forced me into this marriage [cohabitation], I will make sure to stay with the boy and [officially] marry him. He will come and perform the marriage customs.

This quotation resonates with the idea that marriage can be the result of women's livelihood strategies (Boehm, 2006; Kaur, 2010).

### *"Marriage is helping each other": meaning of marriage and motherhood*

During the research, participants defined marriage as a union between a man and a woman, and as entailing a mutual understanding between two people. In an FGD, an adolescent mother explained:

> In my view, how I see marriage is that marriage is an understanding, an understanding between the two partners. Even if there is a disagreement; you will not quarrel outside, you will settle everything inside. And in marriage you also take very good care of your kids, so that your kids grow up to be responsible. (FGD 1)

This response highlights that marriage does not just refer to a state of being but also to a process that brings the ones involved closer to each other by working towards a common goal, namely raising responsible children. Genevieve (18-years-old, married, interview 2) knows out of experience: "marriage is helping each other." This thought was further elaborated in an FGD with female parents who agreed upon the idea that both parties can improve their well-being, when they agree to help each other out the best as they can, for example, in working together at the farm (FGD 4).

The essence of motherhood was indicated by the participants to be about having given birth and caring for the child(ren). An adolescent mother stated: "A mother takes better decisions [concerning the children] than the father of the children" (FGD 1). This quotation suggests that women were deemed the better caregivers, and childrearing was thus primarily considered the task of a woman. In addition, Elisa (24-years-old, single mother, interview 16) explained what motherhood means to her: "As a mother, you are able to take care of your children, provide for their needs. That is why they will call you a mother." This quotation shows how mothers are expected to know how to care for their children, being concerned about their needs.

### *Purposes of marriage*

The data highlight a distinction between the male and the female perspective on the purposes of marriage. In general, the men involved in the study seemed to rely upon the Bible for their desire to marry. The following excerpt is illustrative of these views:

> [Marriage] is an ordinance from God which serves as a union between a man and a woman for the purpose of multiplying or for the purpose of bringing forth to replace themselves in the future. (community leader, FGD 3)

This view on marriage explains how reproducing comes to the core of what marriage is about. A number of participants justified reproducing at an early age by invoking the prospect of death, as dying young without children would stop the lineage. An adolescent mother referred to the importance of the ability to produce children:

> Some of these guys also say that they want to have given birth with you before they will come and marry you, because they think that when they marry you straight away you may not be able to produce children. (FGD 1)

According to this young woman's experiences with 'guys', having children that are born out of wedlock can be justified when this proves a woman's fertility.

On the other hand, the female view on the purpose of marriage that came forward in the study had more to do with the financial support a husband can offer. A female community leader stated: "As a woman, at some stage you have to find a man to marry who will care for you and will provide for you" (FGD 3). Community norms seemed to perpetuate the idea that this remark illustrates, which is that women (and their children) need to be provided for by their husbands.

In interviews and FGDs, participants agreed upon the idea that having children in itself serves another purpose that will present itself in the future. A community leader referred to the future benefits of having children:

> In Africa, it's the child, that same child that you are giving birth to who will be the right person to come and cater for you in your adulthood at an older age. So if you don't have any child, whether you have a husband or not, you must have a child to come and take care of you in your old age. That is the motive behind it. Am I not clear? You can't say: 'Whose child will come and help me?' (FGD 3)

This excerpt highlights the expectations people have of their children who are supposed to care for their parents when they have reached an older age. In that way, children can serve as a safety net for when the elderly, for instance, are short of money or have fallen ill.

### 5.3.3. "I am pregnant because when I was going to school nobody supported me": processes leading up to early marriage

*Drivers of early marriage*

The data highlight that in the Boti communities early marriages were usually the result of a lack of finances, pregnancy or a combination of the two. Explaining these underlying drivers was the lack of alternatives that the girls had experienced before their marriage, that is, in certain cases girls saw no other option than get married. Married girls indicated in interviews and FGDs having 'forced' themselves into their marriage. The prospect of bearing a child without secured financial support was certainly a reason for adolescent girls to enter into marriage. Because of economic motives Fabienne (18-years-old, married, interview 9) got together with a man who could provide for her, as her mother was not around to do that. She explained: "I did not have the intention of getting married, but because of the pregnancy I forced myself into this marriage." Echoing this experience, Paulina (18-years-old, married, interview 12) indicated as

well that her pregnancy had led her into her marriage, since raising a child would require financial help from somewhere.

In addition, the data highlight that the explanation for the persistent practice of early marriage could be found in the lack of opportunities to girls, as explored by Hodgkinson et al. (2016). This applied to the educational and job opportunities the girls had had in their lives[9]. Brianna (17-years-old, married, interview 6) had not been able to go to school, which affected her chances of getting a job directly. She explained how she was staying with her grandmother who could not care for her anymore. As she could not find work to do, she had to resort to marriage. This experience speaks to her lack of alternatives, which was also reflected in the experience of Genevieve (18-years-old, married, interview 2). After her father had passed away, she needed financial help to be able to continue her education. In order to secure her educational opportunities, she engaged in unprotected sex with her boyfriend, leading to her being pregnant. Upon finding out about her pregnancy, she remembered telling her sister: "I am pregnant because when I was going to school nobody supported me." Seeing no alternative to resolving the situation she was in, she entered customary marriage when she was 17 years old.

### *Role of the girl in the early marriage decision-making process*

In the research communities, the families of both spouses to be play a big role in the process of getting married, which resonates with Dolphyne's (1991) statements. According to traditional customs, the boy or man has to ask for the hand of the girl in marriage, after consulting with his family. Both families first have to agree to the marriage which could be preceded by trying to find out if the person in question will be hardworking and, therefore, a desirable candidate for marriage. After the family of the girl has agreed to the marriage, the girl can respond by accepting or declining the proposal. Having experienced the customary marriage rites, Genevieve (18-years-old, married, interview 2) stated: "I was in agreement with the process and I was also part of it. My mother and siblings were all part of the process." This experience seems to indicate that arranging a marriage is a family affair in which the girl has a say. In the words of Gabriella (16-years-old, pregnant, interview 3): "I can disagree with my parents if they are forcing me to marry. I can say no." This quotation supports what the adolescent girls partaking in the study indicated about having the opportunity to decline a marriage request, even when their parents would press for the marriage.

In general, girls seemed to have less power in the process leading towards marriage than their male counterparts. Several girls and women indicated that boys and men often make promises of marriage before pregnancies occur, to go back on their word immediately after these pregnancies having no intention of marrying the mother of their future children. The girls and women perceived this turn of events as misleading, as they felt like they had been lied to by their boyfriends. Elisa (24-years-old, single mother, interview 16) spoke of such an experience with the father of her four children:

> When the guy came, he would be saying that he would marry me. After the pregnancy he didn't do the marriage customs. So I realized that he was deceiving me. That's why I broke up with him.

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[9] Parents and other caregivers have a major influence on a girl's educational and job opportunities. As mentioned in FGDs, pressure from parents and being an orphan are also considered drivers of early marriage.

Her response underlines how girls in the research communities have a rather passive role in the process of getting married, as their partners are the ones who have to actively perform the customary rites and, therefore, decide if the marriage will happen or not. In this way, the final decision of getting married is made by boys and men who are in the position to consider whether they desire and can afford a marriage.

### 5.3.4. Processes around adolescent pregnancy

*Pregnancy intent*

In order to clarify the occurrence of adolescent pregnancy it is important to look into the 'intendedness' of pregnancies among girls, as Macutkiewicz and MacBeth (2017) argue. The adolescent girls that experienced intended pregnancies were either married or promised marriage in the future. Ella (17-years-old, pregnant, interview 7) explained her frustrations with the promises of her boyfriend:

> I don't know the mind of the boy. Before this pregnancy he told me that he would marry me, but when the pregnancy came he didn't want to accept it.

This excerpt highlights how girls could have engaged in intended pregnancies expecting the young man in question to accept the child and marry them.

The majority of the adolescent girls partaking in the research did not plan for their pregnancies to happen. The data seemed to highlight that a number of girls knew about the risk of getting pregnant, but still engaged in unprotected sex[10]. Taylor (23-years-old, single mother, interview 15) explained that, in need of money for school supplies, she had been taking the risk of a possible pregnancy. Representative of grasping unintended pregnancy was what Elisa (24-years-old, single mother, interview 16) expressed: "It just happened like that". This quotation clarifies how getting pregnant does not have to be an active decision, but can just happen to girls when they do not take precautions or abstain. Paige (22-years-old, single mother, interview 14) indicated: "Before I was pregnant, it was worrying me. I was not planning to get pregnant, but unfortunately the pregnancy came." This quotation illustrates again how the girls with unintended pregnancies did not necessarily plan on being pregnant and might have thought about the possibility, but still took their chances.

*Claimed ownership of the pregnancy*

The data highlight that Krobos maintain a tradition in which inheritance is based on patrilineal descent when the customary pregnancy rites have been performed. Tradition prescribes that a father has to claim ownership of a pregnancy before the child is legitimately his. Claiming ownership of a pregnancy occurs by performing customary pregnancy rites either before or after the pregnancy, as I have been informed that Ghanaians consider it disrespectful to do this during the pregnancy. The pregnancy rites involve the gathering of the family of the child's father and mother, in which the family members will establish that he is the one that impregnated her and, therefore, has to look after the child in the future. When these rites have not been performed on

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[10] As discussed earlier in this chapter, the lack of sex education explains why some girls do not know enough about risks of unprotected sex or the existence of contraceptive methods.

a given child by the parents or other relatives of the father of the child, the child will belong to the family of his or her mother. In that case, it will be up to a maternal uncle – instead of the father – to care for the child.

Officially claiming a pregnancy includes bringing gifts, which usually exist of drinks for the family and cloth for the pregnancy. The family members of the girl will serve the drinks in order to express their approval. A few adolescent mothers indicated having received additional items such as soup, cosmetics, baby dresses, sandals and a headwrap. Others reported that their child was claimed without having experienced the proper pregnancy rites. However, the majority of the single mothers indicated that the father of their children had not accepted their pregnancies, offering him a way to get out of his responsibilities to contribute financially to the life of his child. "Then when your child is grown, he just resurfaces and comes and claims the child," an adolescent mother observed (FGD 1). Young women thus suggested that fathers in the research communities could choose if and when they want to claim their children.

## 5.4. Concluding remarks

Throughout this chapter it was shown that community norms strongly influenced girls' experiences on sexual relationships, marriage and motherhood. In promoting abstinence, both teachers and parents relied on biblical, cultural and traditional arguments, and the uncertainty around modern contraceptive methods. The experiences of young mothers underlined the need for more (in)formal comprehensive sexuality education. Because of unequal gender norms, failing to reach or coming to a marriage agreement impacted the girls' social status. Pregnancy, financial reasons, and the lack of educational and job opportunities were major drivers in the marriages of girls. In the processes around marriage and pregnancy, girls were dependent on their current or former partners, who were in the position to decide if and when they desired to engage in customary marriage or claiming their children. Therefore, the girls themselves were found to play a rather passive role in these processes. Building on these findings, the next chapter addresses the direct consequences of marriage and motherhood for the mental well-being of girls.

# 6. The mental well-being of and well-being enhancement among young married and single mothers

## 6.1. Introductory remarks

This chapter elaborates on the mental well-being of adolescent mothers in section 6.2, while intertwining the impact of finances, pregnancy and motherhood. Combining key themes in girls' emotional (6.2.1), psychological (6.2.2) and social well-being (6.2.3) provides insights in their mental well-being. It must be said that these elements of mental well-being are interlinked and complement each other. Section 6.3 examines well-being enhancement strategies, and points out support figures and institutions for adolescent girls.

## 6.2. Mental well-being of adolescent mothers

The data suggest that the mental well-being of adolescent girls is mostly influenced by economic factors, this being a matter they raised most frequently and consistently throughout conversations and interviews. Most girls saw a difference in their mental well-being before and after becoming a mother, as the birth of their children required them to stop the continuation of their education and to redistribute their financial resources. An adolescent mother spoke in an FGD about the emotional weight of her situation:

> Before I had delivered, it was like when I sleep, I sleep. But now when I sleep I still think about my daughter, because when I wake up I am thinking about what she will eat the next day. (FGD 1)

This extract highlights the post-pregnancy state of adolescent mothers who do not just have to figure out how to meet their own needs, but also those of their children. Therefore, the data underline the relevance of the economic situation of single and married adolescents to their mental well-being.

Table 4 confirms what is stated above by clarifying whether the interviewed adolescent girls who have experienced pregnancy and/or marriage find their mental well-being to be negative or positive.[11] The majority of the girls, thirteen girls, experienced their mental well-being to be negative, whereas only three girls could say that their mental well-being felt positive. The latter indicated that the situation they were in had improved as a consequence of marrying their husbands. Their partnership had coincided with a level of financial stability. The other girls, on the other hand, were worried about their economic situation on a daily basis.

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[11] For the sake of feasibility, the binary terms of positive and negative have been used to express the mental well-being of the adolescent girls. In reality, grasping one's mental well-being would rather fit on a spectrum.

| Mental well-being | Negative | Positive |
|---|---|---|
| 1. Camilla (single) | X | |
| 2. Genevieve (married) | | X |
| 3. Gabriella (single)[12] | X | |
| 4. Danielle (single) | X | |
| 5. Olive (single) | X | |
| 6. Brianna (married) | | X |
| 7. Ella (single) | X | |
| 8. Juliette (single)[13] | X | |
| 9. Fabienne (married) | | X |
| 10. Maya (single) | X | |
| 11. Melanie (single) | X | |
| 12. Paulina (married) | X | |
| 13. Delilah (single) | X | |
| 14. Paige (single)[14] | X | |
| 15. Taylor (single) | X | |
| 16. Elisa (single) | X | |

Table 4: Participants' overall indication of their mental well-being

## 6.2.1. Emotional well-being

Guided by Franken et al. (2018) and Keyes (2002), emotional well-being focuses on positive emotions and rejects negative emotions. Regarding this element of mental well-being, the girls that took part in the study spoke about their emotions and the perceived quality of their lives. Even though negative emotions were emphasized time and time again, most girls could recount times at which they experienced positive emotions as well (see section 6.3). Furthermore, concerning the emotional well-being of the participants, the data highlight a distinction between the experiences of single mothers (to be) and married girls.

***Single motherhood: unhappiness and dissatisfaction with life***

Pregnancies influenced the adolescent girls not just physically but also emotionally. They spoke of their pregnancy as challenging, mentioning nausea, vomiting and pains throughout their bodies. Feeling less strong than before their pregnancies, many girls reported to be less active as a result. Juliette (17-years-old, pregnant, interview 8) explained:

> How I used to do things at first, now it's not like that. I used to go to the farm with my mother, but now I can't do it anymore.

This quotation highlights how girls' pregnancies impaired their ability to do their daily work at home or at their parents' farm. For single girls, this inability seemed to be emotionally demanding in particular, as it caused more reason to worry about their finances.

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[12] The marital status of this participant is single, despite having a boyfriend.
[13] See footnote 12.
[14] See footnote 12.

Unwed adolescent mothers felt that their emotional well-being was highly impacted by their economically dire situation. Many girls stated that they experienced more financial difficulties after having become a mother. Due to a lack of income and less willingness of their parents to give them spending money, or food in certain cases, their lives had become financially unstable. Young mothers often emphasized having to share the same amount of money they usually received, or even less, with their children. An adolescent mother referred to the effect her economic difficulties have on her daughter's education:

> I am praying that God will help me to get money to cater for my daughter. They have even resumed for school, but because of financial problems she is still at home. (FGD 1)

This quotation clarifies how becoming pregnant at a young age can reinforce problems given young mothers are less able to financially provide for their children, particularly when they are single. Moreover, a number of girls indicated that they experienced difficulties when they or their children fell sick, as they could not afford to pay for hospital services.

In explaining the emotional weight of their situations, single adolescent mothers felt more restricted in their actions, as compared to the time before they had given birth. Camilla (16-years-old, single mother, interview 1) explained:

> Before I gave birth, I was happy because I was having some small small money to support myself. But as of now, I am not happy at all because I don't have [money].

This excerpt highlights why young mothers often reported feelings of unhappiness. Some even stated that they never experienced happiness, as they only felt brief moments of joy. These unhappy feelings were mostly explained by worrying about meeting the needs of themselves and their children in terms of food and health. Elisa (24-years-old, single mother, interview 16) stated: "I don't have money, so I'm not happy. If I have work and can take care of my children, I will become happy." Her remarks reflect that struggles with financial difficulties are causing negative emotions to dominate in the lives of single mothers. Besides unhappiness, concerns about their own economic situations expressed themselves in sadness, anger, annoyance and discomfort.

Regarding their perceived quality of life, single mothers and pregnant girls reported not being satisfied with their lives. This dissatisfaction with life stemmed from regretting their early pregnancies, not being able to find a job and struggling with providing for their children. In the words of Maya (18-years-old, single mother, interview 10): "I'm not satisfied with my life. If I would get some work to do, my life could be improved." This quotation was a common response in interviews that reflects the strong desire for self-sufficiency (see psychological well-being).

*Married motherhood: financial stability and satisfaction with life*

The economic situation of married girls appears to be better than that of their single counterparts, as the former enjoyed some level of financial stability. Brianna (17-years-old, married, interview 6) explained how her situation had certainly seen improvements since marriage: "When I was depending on my parents, there were some needs I couldn't get. As of now, my husband can provide for my needs." This response not only illustrates the financial stability a husband can offer, but also that husbands are expected to support their wives

financially, making the necessity of having a job for married mothers less urgent than for single mothers. Married girls referred to the relative ability to spend money freely, as the married girls that took part in the study were dependent on their husbands' earnings. Fabienne (18-years-old, married, interview 9) and Paulina (18-years-old, married, interview 12) indicated that at times they needed additional financial support from their family members on top of what they were receiving from their husbands. Paulina in particular seemed more negatively affected by her financial difficulties than the other married girls, making her feel less comfortable in general, as reflected in table 4.

Married girls generally did better in the area of positive affect, or rather, the absence of negative affect. As they did not have to worry as much as single mothers, they experienced less negative emotions. Advancing their state of mind was knowing that their husbands would provide food or be supportive of their plans for the future. Nevertheless, husbands could also be the cause of negative emotions for the girls. Genevieve (18-years-old, married, interview 2) explained that she experienced positive emotions when she was living happily with her husband. However, these would turn into negative emotions when he became upset: "If I don't do what my husband wants, then that is where the problems will come." Not doing what he wanted her to do, such as doing tasks in the household that are expected of wives, would have negative consequences for her.

In addition, married girls involved in the study were generally or at times satisfied with their lives, as they reaped the benefits of some level of financial stability. They still indicated, however, that a job could improve the way they are feeling. Fabienne (18-years-old, married, interview 9) explained: "[My satisfaction with life] depends on the situation. When I would get some job to do, my situation could be improved." This quotation highlights how the married girls that participated in the study, just like the single participants, considered a job a necessity.

### 6.2.2. Psychological well-being

With regards to the definition of psychological well-being I use the definition that Ryff (1989) proposed, which revolves around the prosperity of individuals in their private lives (Keyes, 2005). The key themes that were brought up by the adolescent girls that took part in the study are reduced mobility, aspirations, independence and self-sufficiency.

***Reduced mobility and aspirations***

Giving birth impacted strongly on the mobility of the adolescent girls that took part in the study. Many girls indicated that their life was free and flexible before child birth, whereas their life had changed significantly after child birth. An adolescent mother explained in an FGD:

> In my family as soon as you give birth to even one person, they say: 'Okay, stay home. Don't go anywhere again.' So your education and your whole life become a standstill. (FGD 1)

This excerpt highlights how various families in the area of Boti did not expect their daughters to finish school after childbearing, as they were supposed to stay home to care for their children. Being confined to the home influenced their psychological well-being greatly, putting a stop to

any plans – such as plans regarding further education and employment – they might have had. In practice, when young mothers go somewhere they often bring their children with them, as many girls reported experiencing difficulties with finding people who want to look after their children.

In general, the girls involved in my study expressed having come to the realization that they were too young to get pregnant and/or married. An adolescent mother explained how her situation had impacted her vision:

> The reason why most of us are not happy is that some people had a vision, but because of the situation they now sit back and think: 'Will I be able to achieve this vision?' (FGD 1)

This excerpt clarifies how her inability to pursue her life goals had negatively affected her emotionally, linking her emotional well-being to her psychological well-being. Regarding their aspirations, young women referred to the desire to get a job either in selling provisions, hairdressing or sewing, aware of the necessity to get into an apprenticeship for the last two professions. Supporting their vision, several girls indicated that an official job would correspond with becoming somebody. Olive (18-years-old, single mother, interview 5) stated: "When I change my mind, get handwork to do, am patient and do it well, then in the future I will have become somebody." This quotation highlights not only the importance of finding a job, but also the reachability of finding a job. In similar ways, young women showed an optimistic attitude towards their future.

### *Independence and self-sufficiency: "We have become a big burden to our families"*

In the area of autonomy, the adolescent girls seemed to be hindered in making independent decisions. They desired to be self-sufficient in order to be able to provide for themselves and their children, as opposed to being provided for by parents or partners. Brianna (17-years-old, married, interview 6) spoke of her direct needs: "I am thinking of having my own handwork. That will help me and not all the things that I have to ask my husband." This quotation emphasizes the reality for the girls that participated in the study, as they were dependent on their families in terms of food and money. An adolescent mother explained how she felt about this reality in an FGD: "We have become a burden. We have become a big burden to our families" (FGD 1). This response refers to the emotional and psychological burden girls often felt from constantly having to rely on their families' (limited) economic resources. In their personal struggle for independence, most girls had arranged financial assistance through their boyfriends at one point in the past, and were at the time of the study looking for apprenticeships or jobs.

### 6.2.3. Social well-being

In measuring social well-being, the third and final element of mental well-being, I use Keyes' (1998) definition that refers to the prosperity of individuals in their public lives which is visible in society and social groups (Keyes, 2005). The key themes that came to light in this area were relationships with friends, community stigmatization and social exclusion.

### Relationship with friends

Most girls seemed to be interested in having a social life – whether they had one or not – as being socially active could generate valuable connections and distractions. Seven girls indicated that they were close with their friends. As they were staying in the same environment as their friends, they had the opportunity to see them regularly without having to travel far. Some participated in farming activities together or received some small amount of money from their friends in order to meet the needs of their children.

In contrast, two girls reported that they did not have friends at the time of the study. Brianna (17-years-old, married, interview 6) emphasized that her lack of friends had coincided with her lack of education:

> I haven't attended school at all, so I don't feel like having friends. I was staying at home. My sister was married to a man here in this town. I came here before, and then the man saw me and then asked of me, that he wanted to marry me. So in the light of this, I don't like chatting with friends and playing with them.

This excerpt refers to how Brianna considered the school an environment where friendships arise. Even though friendships can originate in many different places, it seemed likely that she had less opportunities of making friends than girls who were exposed to the school environment.

The remaining girls pointed out that their social life had changed once they discovered they were pregnant or gave birth. They indicated that their relationships with various community members, such as family or friends, had changed into negative relationships over time. The separation of friends can be explained by diverging life paths, resulting in the withdrawal *of* or *from* friends. Reasons for this separation are the relocation of friends, the hindrance of childbearing to meeting friends and the disapproval of the adolescent pregnancy. Paige (22-years-old, single mother, interview 14) referred to the latter:

> I don't have any friends because if I make a friend, it's not good for me. At times they would be angry with me. When I was pregnant they would fight with me. They didn't agree with my pregnancy. That's why I don't make friends.

As the stigmatized conception of adolescent pregnancy had resulted in the withdrawal from friends in this example, these findings resonate with the findings of Ellis-Sloan and Tamplin (2019) who have found that most young mothers in their study indicated that their pregnancies have led to a drastic reduction in their circle of friends.

### Community stigmatization and social exclusion

Most girls that took part in the study reported feeling comfortable within their community, but not supported by their community. The lack of support from community members in particular seemed to stem from judgements and social exclusion. Most girls were aware of the (negative) views their community had of them because of their early marriages and/or pregnancies, indicating that most people think that married girls and single mothers have disobeyed their parents by not taking their advice at heart (see Chapter 5). Because the adolescent pregnancies of these girls brought extra difficulties to the family, community members had spoken badly of

them. An adolescent mother stated in an FGD: "They think we are useless. People see us as nobody" (FGD 1). As premarital pregnancies reportedly stigmatize girls more than boys, the girls had to deal with being called useless, recalcitrant, promiscuous, uncivilized and deviants. This name calling was perceived as insulting at times and could enhance the feeling of exclusion. Danielle (21-years-old, single mother, interview 4) explained why she experienced social exclusion: "People will think that when they are including you in certain things, you will bring your burden to them. So they will exclude you." This quotation highlights how the community members excluded adolescent mothers from social activities out of unease with being asked for financial support.

In addition, Melanie (22-years-old, single mother, interview 11) indicated that the only time she felt involved in social activities was when the community felt that it was time to clean public spaces, such as the public toilets or the market square. Being involved in this type of communal labour seemed to contribute to a sense of community belonging for young mothers. Moreover, half of the girls reported not feeling excluded from social activities. As nobody would physically stop the girls from going, they were able to go wherever they felt comfortable. In practice, the girls attended weddings, and celebrated public holidays and other festivities. Some girls expressed their involvement in decision-making at home, even though they might not actually be able to make big decisions in the realm of the home.

### 6.2.4. Overview of empirical mental well-being dimensions

The following table summarizes the mental well-being dimensions I have found through empirical analysis:

| Mental well-being dimensions | | |
|---|---|---|
| *Emotional well-being (positive emotions)* | *Psychological well-being (positive psychological functioning)* | *Social well-being (positive social functioning)* |
| Happiness<br>Life satisfaction | Mobility<br>Aspirations<br>Independence<br>Self-sufficiency | Relationship with friends<br>Absence of<br>- Community stigmatization<br>- Social exclusion |

*Table 5: Overview of empirical mental well-being dimensions*

### 6.3. Well-being enhancement among adolescent mothers

This section assumes that young single and married mothers have their own strategies to enhance different aspects of their mental well-being, and rely on the support from institutions and people in their environment to reach this goal. It must be said that these different means for well-being enhancement are often linked to each other.

### 6.3.1. Strategies and activities for well-being enhancement

In securing their mental well-being and possibly their economic well-being, the girls performed their daily activities of maintaining the household, which included sweeping and cleaning the home, cooking for the family, fetching water, and taking care of their children and younger siblings. They made sure to be respectful and humble towards others, and to go to church regularly which would generate appreciation from their parents and community members.

Several girls referred to the strategy of showing exemplary behaviour while asking people in their environment for help. Danielle (21-years-old, single mother, interview 4) explained how she would go about earning the sympathy of her family members:

> When there is a family gathering for a funeral or a wedding, you see, people will come from different places and then gather in the house. So as a girl like me in this situation I have to force myself and do things for these people to get support from them. Maybe there will be a person in the family that will say: 'Oh I like your doings. I appreciate your doings. What do you like to do in the future? I can help you.'

This excerpt highlights how various girls had found their ways of getting some work on the side and/or financial support. Some of this labour included processing food, carrying cabbage and fetching water for someone who would compensate them in return. In addition, most of the girls reported being involved in farming activities at the farm of their parents, and selling cultivated products.

Working towards improving their economic situation on the long run will specifically have a major impact on the psychological well-being of married and single mothers. The data suggest from examining their preferred professions before and after child birth that a number of girls adapted their aspirations of becoming nurses, police-women or soldiers. Ella (17-years-old, pregnant, interview 7) explained what her future plans were before her pregnancy:

> At first I was thinking if I had continued my schooling to [senior high school], then I would be a police-woman. That was what I had in mind before this pregnancy.

She further indicated that she would be happy to learn how to work with clothing or hair, which reflected the positive attitude of most girls towards learning the craft of handwork. After their pregnancies and marriages, half of the girls I interviewed experienced that their predetermined plans appeared to be out of reach and in need of revising. It would be more realistic for them to become hairdressers, seamstresses or traders, as they had not finished their high school education. Therefore, in the quest to find a job, they had adapted their aspirations.

Adolescent girls reported that another strategy to enhance their mental well-being was to improve their spiritual wellness. They indicated that praying, going to church and listening to 'the word of God' could yield positive emotions. The data suggest that for a number of girls being spiritually sound – in one case leading to being baptized recently – was a way of trusting in the greater good, reasoning that the pregnancy happened for a reason and that their situation would improve in the future. An adolescent mother explained in an FGD:

> For me, religion has really contributed to my mental well-being. Before I delivered they were saying 'God is there. There is God', but I didn't experience it. I didn't even know what it was. But after delivering, the kind of things I went through, I knew truly there was a God and it was good. (FGD 1)

This extract highlights that the support religion offers could create hope in adverse situations and could help explain the positive attitudes of the young women towards their future. Olive (18-years-old, single mother, interview 5) explained how praying supported her mentally: "My support is prayers. Those should change my mind, and [make me] focus on what I will do in the future." This quotation clarifies how praying could assist adolescent mothers emotionally and psychologically. Performing religious acts with other people could add a social dimension to religion.

Lastly, the adolescent participants reported undertaking leisure activity as a strategy to enhance their emotional and social well-being, as this type of activity evoked joy and could be done in the company of others. The girls raised listening to music, singing and dancing most frequently in conversations. Maya (18-years-old, single mother, interview 10) indicated: "When I feel sad or unhappy, I sing at home." This response shows how generating joy – even when it is of short duration – can function as a coping mechanism. These activities can be done at home, but also in public, and therefore add a social aspect. Furthermore, a number of girls mentioned that playing sports with friends, watching television and their children play, and reading could also improve their mood directly.

| Well-being enhancement strategy | Type of support |
|---|---|
| Asking for help while showing exemplary behaviour | Financial and social support |
| Farming and other work activities | Financial support |
| Adapting aspirations | Psychological support |
| Improving spiritual wellness | Psychological, emotional and social support |
| Enjoying leisure activity | Emotional and social support |

*Table 6: Overview of well-being enhancement strategies and corresponding support*

### 6.3.2. Support institutions

As the adolescent girls that participated in the study usually associated 'support' or 'help' with financial support, they were often quick to say that they did not get any support from institutions. However, as discussed above, these institutions can offer various types of support.

An institution that promotes employment opportunities for adolescent mothers in the area of Boti would be THP-Ghana which focused at the time of the study on setting up vocational training opportunities for girls in tailoring and hairdressing. The girls partaking in the study emphasized the strong desire to receive help from this organisation or other non-governmental organizations in getting a job, as they felt that the government was not doing enough to help rural citizens with employment. The adolescent mothers (to be) rather focussed on an apprenticeship or a job than on their education because a job immediately yields money, whereas the continuation of their education could postpone income for years. The ones that indicated to also want to proceed with their education dealt with various barriers, such as the perception that the school would not allow them to come back, feelings of shame, a lack of parental support, a lack of day-care facilities in the area, and the payment of several school expenses.

THP-Ghana also supports the health of pregnant adolescents and adolescent mothers. Staff members of the organisation informed girls regularly on health matters such as hygiene and family planning, and provided health services to add to existing services from hospitals, health centres and traditional healers. The THP clinics did check-ups for pregnant women, among others, and could provide community members with medicine and birth control, such as injections, implants, pills and condoms. To make these services affordable, clients were expected to have health insurance, which at times turned out to be an obstacle for girls seeking care.

In addition, the mental aspect of health was definitely an area in which the adolescent girls appeared to need support. As discussed in Chapter 2, because of the stigmatization of mental health in Ghana, the help of mental health professionals is often not accepted nor sought upon by people in need. However, an institution that did seem to support young mothers in their mental well-being was the church. Elisa (24-years-old, single mother, interview 16) explained how advice from the preacher supported her mentally:

> If you have a problem and you go to church, the preacher will advise you. When you come back home, then you become free. You will take advice from it.

This excerpt underlines how young mothers were used to being advised by religious leaders in church, which seemed to lift their burdens a little. They also reported experiencing joy from attending church due to the collective singing, dancing and clapping.

### 6.3.3. Support figures

The adolescent mothers partaking in the study frequently mentioned the lack of support from community members in conversations. As mentioned before, at times the stigmatization of adolescent pregnancy and early marriage caused negative views towards these girls. In contrast, a number of girls reported that they felt supported by their friends, female community members and church elders, being able to voice their issues in confidence from time to time. Two girls reported having received money from their friends, when they were in need to buy food for their children.

The adolescent mothers received various types of support from family members, which would be offered in terms of money, food, advice and pleasure. Most girls reported that their fathers in particular considered them adults for becoming pregnant and entering motherhood, and therefore not deserving of financial support. In this way, many fathers legitimized their decision to no longer finance food for their daughters and their grandchildren. Olive (18-years-old, single mother, interview 5) explained: "My father says that when I ask for food or help, I won't get it because of this situation." Her quotation alludes to how difficult it was for most adolescent mothers that the main breadwinners of their families did not keep supporting them financially. Only in some cases the fathers, uncles or brothers of the adolescents supported them completely or conditionally in terms of money.

The majority of the adolescent girls reported that their mothers offered them financial help. Paige (22-years-old, single mother, interview 14) stated: "If she has some money, she will give it to me." Furthermore, a number of girls alluded to the emotional and psychological support their mothers offered by talking with them about their problems, comforting them when they were sad or bothered, and offering them advice. Danielle (21-years-old, single mother, interview 4) referred to the kind of help she was receiving from her mother:

> As my mother has been caring for my child, if I have got any work now I can go and do it. My child will not disturb me because my mother is caring for him.

This quotation and the one above highlight the crucial role of girls' mothers. Child care was vital for the adolescent mothers in being able to pursue their aspirations. In addition, a number of girls reported that other female relatives, such as their grandmothers, aunties and sisters, occasionally helped out with money and advice.

The data suggest that the fathers of young mother's children were considered support figures, when these were their husbands or boyfriends at the time of the study. This idea corresponds with the dominant community norms that prescribe that these men would be expected to provide for the girls. Regarding emotional or psychological support, one girl indicated she could talk to her husband, whereas another girl would be able to go to her boyfriend when she was worried about something. On the other hand, the single girls who were not in a relationship anymore with the fathers of their children received either no or limited financial support, usually involving the deterioration of the relationship after breaking up or finding out about the pregnancy. Three girls indicated that they would occasionally receive financial support, in case the child had fallen ill, for example.

## 6.4. Concluding remarks

This chapter has illustrated that giving birth had limited the educational and employment perspectives of adolescent girls, influencing their mental well-being considerably. Economic factors were decisive in shaping their mental well-being. Single mothers worried about their financial difficulties on a daily basis, whereas married mothers experienced some level of financial stability which made them feel better emotionally. Remarkable was that both married and single girls reported to be unsatisfied with their level of independence, self-sufficiency, and the way they were stigmatized by the community. Regarding well-being enhancement strategies, the girls reported to show exemplary behaviour; engage in farming and other work activities; adapt their aspirations; improve their spiritual wellness; and enjoy leisure activity. For their economic, physical and mental well-being, they relied on the services of THP-Ghana and the church respectively. Girls also enjoyed the financial and mental support they received from their mothers, female relatives, husbands and boyfriends, and desired these types of support from their community members, fathers and ex-boyfriends. Building on these empirical findings, the next chapter presents a discussion of the research.

# 7. Discussion

This chapter provides a discussion and general conclusions around the main concepts of this research, which are early marriage, adolescent pregnancy, mental well-being and well-being enhancement. Section 7.1 and 7.2 respectively focus on answering underlying sub-questions and the main research question of this study. Section 7.3 presents methodological and theoretical reflections, including a revised conceptual scheme. Subsequently, recommendations (7.4) and suggestions for further research (7.5) are pointed out in order to support policies and practices that promote the mental and overall well-being of young women throughout the world. The chapter ends with final concluding remarks.

## 7.1. Answer to underlying sub-questions

In this section I answer the three sub-questions of this research that feed into the bigger main research question.

### 7.1.1. Community norms, adolescent pregnancy and early marriage

Linking community norms to girls' experiences in Boti and neighbouring communities, this section answers the following sub-question: What are the dominant community norms around motherhood and marriage, and how do these norms relate to the prevalence of adolescent pregnancy and early marriage in the community?

*Sexuality education*

Keogh et al. (2018) acknowledge that for a comprehensive sexuality education program to succeed an enabling environment is necessary, which includes positive cultural norms and backing from the community. This study has found that community norms are hindering sexuality education in schools, as they prescribe that 'abstinence until marriage' is the norm. Even though teachers are supposed to inform their pupils about a whole range of family planning methods, in the research communities they discouraged the use of contraceptives and steered towards transferring the message that abstinence is the best method. The young women partaking in the study reported a lack of comprehensive sexuality education, through which many felt that they did not have a full understanding of the consequences that engaging in unprotected sex could have.

*Marriage and motherhood*

Nyarko (2014) indicates that it is expected of Ghanaians to marry. Unequal gender norms perpetuate discriminatory practices around marriage and motherhood against girls and women (Blum & Gates, 2015; UNICEF, 2014; Watson, 2013). In this study, for a woman, being a single adult – especially without children – has more repercussions than for a man, as she will likely also have to deal with the apparent stigmatization from the community. To the contrary, being a mother within marriage earns her the respect of the community and the family. This study has suggested that coming to a marriage agreement uplifts the social status of a woman, whereas failing to reach a marriage agreement lowers her status. Marriage was thus perceived as a

powerful institution, which resonates with the idea that marriage can be the result of women's livelihood strategies (Boehm, 2006; Kaur, 2010).

The Ghanaian Children's Act of 1998 prohibits child marriage, stating that a child shall not be 'forced' to marry (Republic of Ghana, 1998). The findings of this study highlight that not only are girls below 18 part of informal and formal marriages, the early marriages are also agreed upon by the girls. However, because of their economic needs they often 'forced themselves' into these marriages, seeing no alternative to resolve the situation (on the latter, see also Hodgkinson et al., 2016). The study has shown that the fathers of the children had the final say in marriage and pregnancy processes, as they have to be able to afford customary marriage (or cohabitation) and raising children. This finding aligns with the classic division of roles for males and females in Ghana, dictating that men are supposed to provide for women (Ampofo, 2001). Ironic is that this notion of being provided for is what led the girls of the study into their – intended or unintended – adolescent pregnancies in the first place.

### 7.1.2. Mental well-being

Based on girls' own experiences, this section answers the following sub-question: How do married girls and adolescent mothers perceive their own mental well-being? Guided by Keyes (2005, 2007), their perceived mental well-being was explored by examining emotional, psychological and social well-being.

***Emotional burden***

Several authors argue that marriage and motherhood could lead to girls' experiences of negative feelings, possibly turning towards depression, as they have to navigate new duties as wives, mothers and domestic workers (Arai, 2009; Leftwich & Alves, 2017; Nour, 2009). This study highlights that emotional weight was carried by some more than others. Financial difficulties in particular led single mothers through a whole range of emotions, among which unhappiness, discomfort and dissatisfaction with life. However, married mothers, who mostly enjoyed some level of financial stability, did not seem to worry as much or only occasionally about finances and more about fulfilling the needs of their husbands. These findings underline how married girls, in comparison to single girls, seemed to be more comfortable and satisfied with life in general.

***Psychological burden***

The experiences of girls on being married young and young mothers are associated with less opportunities for education and employment (Blum & Gates, 2015; Mathur, Greene, & Malhotra, 2003). As marriage and childbearing rob girls of their childhood, their psychological well-being can be negatively impacted (Nour, 2009). This study has found that the girls had a vision based on their reduced mobility and aspirations reflected in their goals of becoming working women in the trading, sewing or hairdressing business. This vision highlighted their desire to be self-sufficient in order to provide for themselves and their children. They also felt burdened about being dependent on their own or husband's families, underlining their personal quest for independence.

*Social burden*

Marriage and pregnancy are both found to impose social isolation on girls (Cook & Cameron, 2017; Ellis-Sloan & Tamplin, 2019; Loaiza & Wong, 2012). This study highlighted that most girls were in need of social support. A number of girls could count on their friends to meet up regularly, whereas others did not have friends or lost their friends due to their adolescent pregnancies. Ellis-Sloan and Tamplin (2019) argue that the stigmatizing conception of adolescent pregnancy can lead to a reduced friendship circle, which is likely to increase the burden for young mothers. In addition, the social well-being of adolescent mothers was also affected by stigmatizing views of community members, which led a number of girls to feel excluded within the community.

## 7.1.3. Well-being enhancement

Combining well-being enhancement strategies and activities with support from institutions and individuals, this section answers the following sub-question: What means do married girls and adolescent mothers use to enhance their well-being, and how do different actors support them in their everyday life?

*Strategies and activities for well-being enhancement*

Marriage and childbearing bring extra responsibilities for girls that do not always have sufficient resources to deal with this (Greene, 2014). Showing exemplary behaviour was a strategy for girls to receive financial support from family or community members, or to get the opportunity to engage in small labour in exchange for a compensation. Working on the farm of their parents was also a way of obtaining financial support. Adapting their aspirations to the situations they had found themselves in enlarged their chances of finding a job. These findings seem to resonate with the arguments of Steger, Kashdan and Oishi (2008) stating that well-being is achieved by pursuing meaningful goals that correspond with aspirations. As these strategies create improvements in the long run (see Fava & Ruini, 2002), improving their spiritual wellness and enjoying leisure activity were used as coping strategies to evoke positive emotions in the short run (see Tugade & Frederickson, 2004).

*Support institutions*

Social institutions, including school, health and legal services, local government, religious and ethnic institutions, can enhance the resilience of married and single girls. Providing support, the school can play a crucial role in improving the capacities, skills and well-being of children (Muhanguzi et al., 2017). However, in this study the young mothers dropped out of school and saw various barriers to continuing their education. Girls sought the support of THP-Ghana for vocational training opportunities in tailoring and hairdressing, enlarging their employment chances. The girls also relied on the organisation for their knowledge on health matters, their physical health and birth control. Their mental well-being was directly supported by the institution of the church – not necessarily its members – as they received advice from religious leaders and experienced joy due to the collective singing and dancing.

*Support figures*

Greene (2014) argues that young wives and mothers do not always have sufficient support to deal with their newly received responsibilities. Muhanguzi et al. (2017) argue that the family lays the foundations for enhancing the well-being of girls, and particularly consider female figures, such as teachers, mothers and aunts, as potential game-changers in building resilience around early marriage. The girls involved in the study reported being able to voice their issues from time to time to a small number of community members, including older women, church elders and friends. Regarding their family members, the girls could count on the financial, emotional and psychological support of their mothers and only in some cases on support of their fathers or other relatives. The fathers of their children supported them financially, almost exclusively when these were their husbands or boyfriends at the time.

## 7.2. Answer to main research question

This section provides a final answer to the main research question: How do adolescent pregnancy and early marriage affect the mental well-being of young women in rural Eastern Region, Ghana, and in what ways do they seek to secure or enhance their well-being?

Adolescent pregnancies and early marriages led young women into dropping out of school, which as a result lowered their chances on employment. Single mothers in particular appeared to feel less in control and at times felt misled concerning marriage and pregnancy processes, in which the fathers of their children showed no intention of marrying them or claiming their children. As their lives were often marked by financial instability, they reported feeling unhappy and dissatisfied. Married mothers, on the other hand, enjoyed some level of financial stability which had less of a negative impact on their mental well-being. Both single and married mothers were dependent on their families or husbands, and therefore showed the strong desire to be self-sufficient. Moreover, community stigmatization around premarital pregnancies appeared to affect young women more than young men, leading some young women to experience different forms of social exclusion.

Young mothers appeared to strategize about showing exemplary behaviour, adapting their work aspirations and improving their spiritual well-being in order to improve their well-being and prospects in life. They also performed daily activities to secure or enhance their well-being, which include doing household chores, caring for the children, helping out on the family farm, and participating in work and leisure activities. THP-Ghana responded to their need for employment and nearby access to medication and birth control. Young mothers sought mental support in terms of preaching, advise and joy that the institution of the church could offer. Building on these support systems, young women received financial and mental support from their mothers, other female relatives, husbands and boyfriends, but oftentimes this type of support from their fathers, ex-boyfriends and community fell short.

## 7.3. Methodological and theoretical reflections

This section briefly considers methodological and theoretical reflections, and provides the revised conceptual scheme.

### 7.3.1. Methodological reflections

For a research that desired to fully grasp girls' experiences on marriage, motherhood, mental well-being and well-being enhancement, qualitative research methods were essential. Participatory methods could have added richness to the study, as the girls would have been able to express their feelings in a creative way. Ideally I would have given a group of girls diaries to make notes of daily life experiences, in particular regarding unconscious acts, with the goal of gaining insights into the relationship between behaviour and well-being (Steger et al., 2008). However, these participatory methods ended up being unrealistic. Collecting data by conducting interviews and FGDs were particularly useful to gain substantial insights in girls' lived experiences. Therefore, the methodological decisions made throughout the study were feasible and satisfactory.

### 7.3.2. Theory around mental well-being

As stated in Chapter 3.3, the development literature showed a lack of attention for specifying what mental well-being entails, and clarifying how mental well-being is distinctively different from mental health. In order to be able to examine the mental well-being of adolescent girls, I relied upon the research of Keyes (2002, 2005, 2007). However, the theory around mental well-being as presented by Keyes seemed to have a rather western focus. In the non-western rural area where the study took place, many of the questions Keyes (2005) proposes to ask people regarding their mental well-being seemed out of place. Therefore, I had to adapt this model in the field to what seemed more suitable in a non-western context, keeping in mind that at times the language barrier prevented me from delving deeper into well-being related topics. Striking was that economic difficulties were brought up most frequently throughout inquiries about mental well-being. This made me realize that economic factors should be included in mental well-being models. Even though the framework I used needed to be altered, its contribution was greatly valued as it offered me guidance throughout the study.

### 7.3.3. Revised conceptual scheme

The conceptual scheme has been adapted following data analysis in order to align better with the actual research findings. Within the research I have distinguished a causal relationship between adolescent pregnancy and early marriage. Marrying at a young age after becoming pregnant is displayed as one of the pathways that adolescent girls can take when seeking financial security. On the other hand, pregnancy can also cause a predetermined marriage agreement to fall apart, through which young mothers end up being single. These events affected the mental well-being of young Krobo women who reported experiencing changes in their psychological, emotional and social well-being. Economic, physical and spiritual factors appeared to be crucial in examining their mental well-being. Furthermore, the scheme displays well-being enhancement strategies, activities and support systems that these girls rely on in order to enhance their well-being.
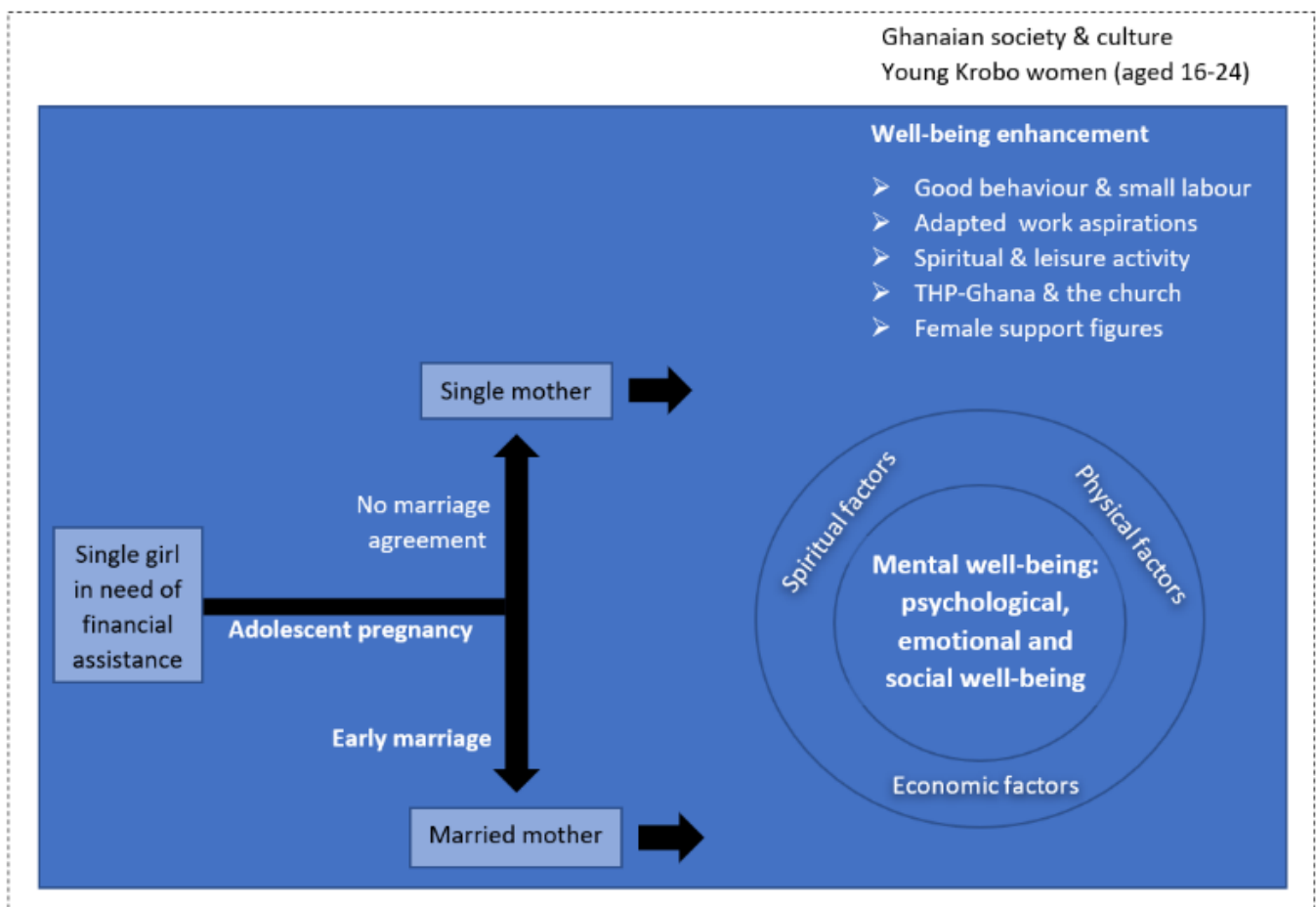


*Figure 9: Revised conceptual scheme*

## 7.4. Policy and practice recommendations

Based on the findings of this research, I present policy and practice recommendations which are specifically intended for governmental and non-governmental organizations such as THP-Ghana in the field of SRHR, early marriage, adolescent pregnancy and (mental) well-being. These recommendations are:

❖ *Provide comprehensive sexuality education in schools*

The data highlighted that in the research communities the current sexuality education is lacking. This was especially prevalent when learning of the misconceptions participants had regarding modern contraceptive methods, such as that those would cause infertility. A number of girls also reported to not have fully understood the risks of unprotected sex in the past. As THP-Ghana is already working with boys and girls clubs that educate pupils on SRHR, the organization should also hold meetings with teachers in order to ensure their work will hold up.

❖ *Provide education on mental health in schools*

The psychiatric nurse involved in the study emphasized that she commonly encountered people with mental health illnesses who do not seek or desire help for themselves. More collaboration between Ghana's Ministry of Education and Ministry of Health could lead to incorporating mental health in schools' health classes and promote conversations around the mental well-being of young people. In that way, young women could be less ashamed in seeking help from mental health professionals and rely better on support figures for the improvement of their mental well-being.

❖ *Promote possibilities for adolescent mothers to continue their education*

A number of girls were under the impression that JHS would not allow them to go back to school after giving birth, the argument being that they would 'spoil' the behaviour of the rest of the pupils. However, schools have to recognize the current needs of adolescent mothers, who often prefer to continue their education over trying to find a job. Schools should thus allow girls to come back after giving birth and eliminate or limit admission fees.

❖ *Create more job opportunities*

The vocational training that THP-Ghana was offering at the time of the study seemed to be vital in creating employment opportunities for adolescent mothers. This would provide the selected girls with training in tailoring and hairdressing. A number of girls also indicated to have the desire to sell provisions and to do handwork in general. The government should respond to this desire, for example, by exploring the art of beadmaking and offering apprenticeships in manual labour.

❖ *Facilitate day care in rural areas*

Adolescent mothers appeared to need someone to care for their young children, when they would choose to continue their education or get the opportunity to pursue employment. In rare cases, they would find someone to look after their children. Small children were usually carried on the back of their mothers. Therefore, day care in the area is highly needed.

❖ *Create more acceptance by strengthening the conversation with (male) community members about the hardships adolescent mothers encounter*

THP-Ghana was leading the way in organising community meetings on the hardships adolescent mothers encounter. The organisation focused on transferring the message that parents, especially fathers, need to keep supporting their adolescent daughters financially upon hearing about the pregnancy, as these girls have to finance feeding themselves and raising a child. Therefore, strengthening the conversation with community leaders and other members is crucial in creating more acceptance and safe spaces for adolescent mothers.

❖ *Set up a buddy system that can support young married and single mothers mentally on a regular basis*

Adolescent mothers reported to be in need of mental support, as they did not always have someone to talk to about their emotional, psychological and social burdens. It may be helpful to have the backing of a buddy who is there in times of need, especially for girls with no or few friends. Therefore, I recommend to implement a buddy system in which buddies meet on a weekly basis for advice and support. These buddies should be peers that have gone or are going through similar experiences. Support groups could carry out problem-solving assignments, as well as go on monthly trips to places such as Koforidua. In this way, young mothers can create social support networks, as discussed by Santhya and Erulkar (2011).

## 7.5. Suggestions for further research

Future research should proceed with working towards a better understanding of the lived realities of married girls and young mothers. Because of the changing contexts and locations in which girls experience marriage and motherhood, an intersectional approach to documenting early marriage and adolescent pregnancy seems useful. The concept of mental well-being deserves more attention in the literature and should be worked out further in models or other tools, in order to analyse girls' mental well-being experiences better. I would urge researchers to use a range of participatory methods for this purpose. Efforts geared at mentally supporting married and single mothers could also focus on evaluating support groups, and well-being and problem-solving therapy in practice.

In addition, more attention should be given to male experiences of early marriage and adolescent fatherhood. Even though girls are disproportionately affected by marriage (UNICEF, 2014), married boys also experience adverse well-being outcomes that deserve to be researched. Crucial would be to gain more insights in male motivations for entering into early marriage, and in what way the mental well-being of young fathers differs from that of young

mothers. Comprehending the role of boys and men in marriage and pregnancy processes could not only help with preventing detrimental practices, it could also support adolescents more effectively.

## 7.6. Final concluding remarks

This study has been relevant to the fields of early marriage, adolescent motherhood and well-being within international development research. The feeling of carrying emotional, psychological and social burdens, as discussed in section 7.1.2, helped with understanding how girls' mental well-being is affected by marriage and pregnancy. By comparing the emotional well-being of married and single mothers in particular, the research recognizes the advantages early marriage can bring. However, this study still disapproves of early marriage, as girls and boys need to develop themselves in many ways, while maintaining some level of playfulness and their educational prospects. In the words of Otiko Afisah Djaba, Ghana's Minister for Women, Children and Social Protection: "Children below 18 should be learning and playing, not getting married or being mothers" (Girls Not Brides, 2017, para. 8). On a final note, I would like to thank the adolescent girls involved in the study for sharing their experiences, views and insights. This research would not have been possible without you.

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# 9. Appendices

## 9.1. Lists of participants

Interviews with adolescent girls

| Respondent number | Pseudonym | Age | Marital status | Age at 1st child birth | Number of children | Community | Education |
|---|---|---|---|---|---|---|---|
| 1 | Camilla | 16 | Single mother | 14 | 1 | Boti | JHS |
| 2 | Genevieve | 18 (husband 19) | Married at 17 | 17 | 1 | Boti | JHS |
| 3 | Gabriella | 16 | With boyfriend | - | Pregnant | Boti | JHS (form 2) |
| 4 | Danielle | 21 | Single mother | 17 | 1 | Osumbio | JHS |
| 5 | Olive | 18 | Single mother | 16 | 1 | Boti | JHS |
| 6 | Brianna | 17 (husband 31) | Married at 17 | - | Pregnant | Boti | - |
| 7 | Ella | 17 | Single mother to be | - | Pregnant | Ponponse | JHS |
| 8 | Juliette | 17 | With boyfriend | - | Pregnant | Boti | JHS (form 2) |
| 9 | Fabienne | 18 (husband 31) | Married at 17 | 17 | 1 | Akko | JHS |
| 10 | Maya | 18 | Single mother | 17 | 1 | Kornya | Primary School (form 6) |
| 11 | Melanie | 22 | Single mother | 19 | 2 | Akko | Primary School (form 6) |

| 12 | Paulina | 18 (hus band 22) | Married at 17 | 17 | 1 | Akko | JHS (form 1) |
|---|---|---|---|---|---|---|---|
| 13 | Delilah | 23 | Single mother | 20 | 1 | Akko | JHS (form 1) |
| 14 | Paige | 22 | With boyfrien d | 17 | 2 | Obusumasua | JHS (form 2) |
| 15 | Taylor | 23 | Single mother | 17 | 1 | Obusumasua | JHS |
| 16 | Elisa | 24 | Single mother | 17 | 4 | Obusumasua | - |
| 17 | Alicia | 17 | Single | - | - | Akobana | JHS (form 2) |

Interview with a psychiatric nurse

| Respondent number | Pseudonym | Age | Marital status | Age at 1st child birth | Number of children | Community | Occupation |
|---|---|---|---|---|---|---|---|
| 18 | Regina | 32 | Single mother | 30 | 1 | Keta, Volta Region | Psychiatric nurse |

FGD 1 (adolescent girls)

| Respondent number | Pseudonym | Age | Marital status | Age at 1st child birth | Number of children | Community | Education/ Occupation |
|---|---|---|---|---|---|---|---|
| 19 | Amanda | 24 (hus band 25) | Married at 20 | 17 | 3 | Osubio No. 1 | JHS/ seamstress |
| 20 | Mia | 24 (hus band 29) | Married at 23 | 23 | 1 | Boti | JHS |
| 21 | Melissa | 17 | Single mother | 16 | 1 | Kornya | Primary School |
| 22 | Rebecca | 23 (hus band 30) | Married at 19 | 19 | 3 | Boti | Primary School |

| 23 | Alexandra | 24 (hus band 26) | Married at 19 | 19 | 3 | Boti | Primary School |
| 24 | Aaliyah | 24 (hus band 26) | Married at 18 | 18 | 2 | Ponponse | Primary School/ Gari processing |
| 25 | Megan | 24 | Single mother | 23 | 1 | Obusio No. 1 | JHS |
| 26 | Tanisha | 21 (hus band 22) | Married at 18 | 18 | 1 | Obusio No. 1 | JHS |
| 27 | Emma | 19 | Single mother | 18 | 1 | Osubio No. 1 | Senior High |
| 28 | Eve | 19 | Single mother | 16 | 2 | Boti | JHS |
| 29 | Hannah | 18 | Single mother | 14 | 1 | Bosotwi | JHS |
| 30 | Rose | 19 | Single mother | 17 | 2 | Osubio No. 3 | JHS |

FGD 2 (adolescent girls)

| Respondent number | Pseudonym | Age | Marital status | Age at 1st child birth | Number of children | Community | Education |
|---|---|---|---|---|---|---|---|
| 31 | Olivia | 19 | Single mother | 15 | 2 | Boti | JHS |
| 32 | Odette | 17 | Single mother | 13 | 2 | Boti | JHS (form 2) |
| 33 | Tasha | 20 | Single mother | 18 | 1 | Osumboa No. 1 | JHS |
| 34 | Serena | 19 | Single mother | 17 | 1 | Boti | JHS |

FGD 3 (community leaders, aged between 40-80)

| Respondent number | Gender | Position in the community | Occupation | Position at THP-Ghana |
|---|---|---|---|---|
| 35 | Male respondent | Honourable | Farmer | Assemblyman/secretary |
| 36 | Male respondent | - | Teacher | Chairman |

| 37 | Male respondent | Elder | Farmer | Animator |
|----|-----------------|-------|--------|----------|
| 38 | Female respondent | - | Trader | Animator |
| 39 | Female respondent | Queen Mother | Farmer | - |
| 40 | Male respondent | Chief | Farmer | - |
| 41 | Female respondent | - | Trader | Financial secretary |
| 42 | Female respondent | - | Nurse | Animator |
| 43 | Male respondent | - | Teacher | HC Representative |
| 44 | Female respondent | - | Teacher | - |

FGD 4 (parents, aged between 30-80)

| Respondent number | Gender |
|-------------------|--------|
| 45 | Female respondent |
| 46 | Female respondent |
| 47 | Female respondent |
| 48 | Female respondent |
| 49 | Female respondent |
| 50 | Female respondent |
| 51 | Female respondent |
| 52 | Female respondent |

## 9.2. Interview guides

This section presents the interview guides I used during data collection in order to guide me during the interviews.

### 9.2.1. Interviews with adolescent girls

Moheé and motsum kaa! I am so grateful that you have agreed to take part in this interview. The reason that I have asked you to do this is because I want to learn more about the experiences of girls and young women from your point of view. I really appreciate that you have taken time off from your daily activities. This interview should not be over two hours.

My name is Samy and I am from the Netherlands and Angola. I am 23 years old and studying at the University of Amsterdam in the Netherlands, in the area of development studies. I am here with …, who works at/with The Hunger Project. In this research I am trying to grasp young women's perceptions on being married at a young age and/or having children at a young age. I am particularly interested to see how this influences your mental well-being, and what you do and have done to improve your well-being. With this information, I would be able to give recommendations to The Hunger Project and Her Choice on how they could improve their programs for adolescent girls. Therefore, it will enrich their data.

In this interview I am going to ask you a certain amount of questions, but know that you do not have to share anything you do not want to share. There are no right or wrong answers, and everything you say is important. In my research I will use the name that you want me to use, which can be a pseudonym so that nobody can trace who you are exactly. Also if you would

like to talk to anyone about health/well-being related issues or anything else, I can provide you with contact details of someone trustworthy that could help out. Furthermore, I would like to audio record this interview, so that I do not have to interrupt you while you are talking in order for me to write everything down. Later I will transcribe the audio tapes without including specific information that can be linked back to you.

Now I would like to ask you the following: Do you consent to being part of this interview? And do you consent to the audio recording of this interview?

| Date: | Husband's age: |
|---|---|
| Name: | Number and age of children: |
| Respondent Number: | Education: |
| Current age: | Occupation: |
| Age at marriage: | Languages spoken: |
| Age at first childbirth: | Tribe: |
| Village: | Religion: |

First I would like to ask you about your current personal situation and past experiences regarding marriage, pregnancy and children.

1. What is your current living situation?
   a. Would you want anything to change about this in the future?
2. Before marriage or being pregnant for the first time, what kind of issues or concerns related to well-being did you experience?
   a. How did you respond to these issues? Did you ask anyone for help or share what you were dealing with to anyone?
3. Have you seen any health service providers? Have you been treated for something?
      i. If so, who decided to go through with this?
      ii. If not, did you feel that your health concerns were taken seriously?
4. Questions for married girls or living together with partner:
   a. Were you part of a legal marriage, traditional/religious marriage or certain living arrangements? Who decided this? Did you want this to happen?
   b. Why did you get married? (Probe: pregnancy, economic reasons incl. dowry/bride price, tradition/culture/religion, protection etc.) Would the marriage benefit you or your family?
   c. What was the process leading up to your marriage like? Do you feel you had a say in the process of getting married? Who was part of the decision-making process? (Probe: husband, parents, other family members, community leaders)

       i.   Were there any marriage rites and/or pregnancy rites performed before living together with your partner? And what do these marriage and/or pregnancy rites entail?

5. Questions for single mothers:
   a. Do you feel like you had a choice in your living situation?
   b. What was the process leading up to your pregnancy/pregnancies like? Had you thought about your future after having a baby?
      i. Were there any pregnancy rites performed?
6. What are your general views on marriage? What does marriage mean to you?
   a. At what age should females get married according to you? And at what age should they have children? Why?
   b. Do you have to get married?
   c. What does it mean to care for your children?
   d. What is good about having a child?
7. With all the experiences you have had, would you have done anything differently regarding your marriage and/or pregnancies?

Next, I would like to ask you questions related to your mental well-being.

**Mental well-being**

1. When you were little, what did you expect from being married and from having children? Was that also what happened in reality?
   a. How have you changed since having children?
   b. Do you think that your mental state has changed since marriage or child birth?
2. Do you have a positive, neutral or negative outlook when thinking of your mental well-being? Why?

Emotional factors

3. Could you explain when you experience positive and negative emotions in your life? Is there some factor that really plays a big role in this?
   a. How have your emotions and feelings changed after marriage or child birth?
4. Are you generally satisfied with your life?
   a. What could be improved?

Psychological factors

5. Do you think you have grown and learned from your actions in the past and challenges in life? How?
6. Could you explain me something about the relationship you have with others, such as your family, friends, partner and community?
   a. Do you trust the people around you?
7. Do you see yourself more as dependent or independent from others? How so?
8. Are you able to influence your personal environment? For example, are you able to disagree on some things with your parents or your partner, so that it suits you (and your child/children) better?
9. Do you have certain goals in life? Things you want to achieve?

<u>Social factors</u>

10. Who would you say is the happiest person in the community? Who has the best life? (for example, think about yourself, someone in your family, someone with a certain job, a Queen mother, a chief etc.)
    a. Who would you say is the unhappiest person in the community? Why?
11. How do people see married girls and adolescent mothers in general?
    a. Do you think people can change their behaviour and way of thinking towards married girls and teen mothers?
12. Could you describe your daily activities? Are these activities useful for your family?
13. Do you feel comfortable and supported in your community?
    a. Are you involved in making decisions in your homes and in the communities? How so?
14. Did your social life change once you were married and/or had children? What changed?
    a. Do you feel you are excluded from certain activities in your community or in your home? Why?
    b. Do you see your friends often? When?

<u>Physical factors</u>

15. What did you know before marriage and/or becoming pregnant about the consequences that marriage and/or pregnancy at an early age would have on your health and well-being?
    a. Did anyone tell you about this in advance? If so, what did they tell you? Were you made aware of possible delivery complications?
    b. Would you have wanted to know more about how your health and well-being would change?
16. During pregnancy, have you made use of any health services, like clinics, hospitals, health centers and/or traditional healers?
    a. Would you have wanted to use these health services more? In what way?
17. Did you experience any changes in your health and well-being when you were pregnant?
    a. Did you experience any labour/delivery complications? If so, what did these entail?
    b. Where did you deliver and how did the delivery go?
18. Do you know about different family planning methods?
    a. If so, how do you know about it and could you explain what methods there are? Do you make use of it?
    b. Do you know about sexually transmitted diseases? Which ones exist and how can you get them?
19. Have you discussed with your partner how many children you want to have in the future?
    a. If so, how many and who decided to have children?
20. Have you ever experienced some form of physical violence or mental abuse? (Probe for threats, hitting, pushing, having sexual relations without consent or mental abuse)
21. Has your physical health suffered after marriage and/or having children?

Economic factors

22. When you experience economic difficulties, how does this influence you emotionally?
23. What has influenced the level and years of education you have received?
    a. Do you think you should have received more years of education?
        i. Did you enjoy going to school?
    b. Are there certain vocational skills you want to learn in the future?
24. Have you ever had a job?
    a. If so, could you tell me some more about this job/these jobs?
    b. If not, what are the reasons for this? Have you had some employment opportunities?
25. Are you able to spend money freely if you want to or does someone else have control over the money?
26. Did your economic state change once you were married and/or had children? What changed?
    a. Do you think that in the future your economic state will improve, deteriorate or stay the same?

Spiritual factors

27. How does religion influence your life? Does religion influence your mental well-being?
    a. Do you enjoy going to church? Why?
28. Did your spiritual wellness change once you were married and/or had children? What changed?

Now I would like to talk about what you do to improve your mental well-being and who offers you support in life.

**Well-being enhancement**

1. What have you done in the past to improve your emotional state in order for you to feel better in life?
    a. What do you do now to feel better when you are sad or unhappy?

Support systems

2. Do you feel like you need support when it comes to your health and well-being?
3. Are there certain social institutions such as school, community and health services that offer you support?
    a. If so, were there certain things that you liked or disliked about it in particular?
    b. If not, do you want support from these social institutions? And what can be improved about the way they offer help?
4. Is there someone you can talk to when you have a problem? If so, who is it you can talk to? (Probe: friends, family, husband, other community members/leaders) How does it help or restrain you?
    a. Do you wish that certain people close to you offer you more support? Who?
    b. Can you think of any role models in your life? (May be someone you aspire to be or someone you look up to)

    c. Have you felt supported by male acquaintances, partners, and authority figures in your life?

5. Are there obstacles in the way of you receiving or asking for support for your health, well-being or children?
6. What are the most fun activities to do when you have time for yourself? What is it you enjoy to do?

Coping strategies

7. Are there specific activities or strategies that improve your emotional state? (Probe: work, cook, household chores, church, care for children, etc.)
8. Do you feel that there is necessary action you have to undertake to improve your mental health? (Probe: going to health services, confiding in family and friends)

**Closing**

1. Do you feel that marriage has had a positive or negative impact on your well-being? How so?
2. Do you feel that becoming a mother has had a positive or negative impact on your well-being? How so?
3. Did you receive from family members advice about marriage including sexual relationships and pregnancies? What did this entail?
    a. What would you advice girls that have not been married yet, have not had sexual relationships yet or have not been pregnant yet?
    b. If you were a teacher, what would you teach young people about having sexual relationships?
    c. What would you advice girls that can't pay their school fees?
    d. Who do you think should help married girls and adolescent mothers with these matters? Girls like you, other community members or people from outside the community?

Thank you so much for your time! If you would like to talk to anyone about certain issues, want to change anything you have said in this interview or wish to receive some follow-up on the research, I can give you the contact details of someone trustworthy now or you can contact The Hunger Project and we will arrange for it to be taken care of.

Motsum kaa!

### 9.2.2. Interview with psychiatric nurse

First of all, thank you for agreeing to take part in this interview. My name is Samy. I am from the Netherlands and Angola. I am 23 years old and I am studying at the University of Amsterdam in the Netherlands, in the area of international development studies.

The reason that I have asked you to do this is because I want to learn more about the experiences of girls and young women from your point of view. In this research I am trying to grasp young women's perceptions on being married and having children at a young age. I am particularly

interested to see how this influences their health and mental well-being, and what they do and could do to improve their well-being. With this information, I would be able to give recommendations to The Hunger Project and Her Choice on how they could improve their programs for adolescent girls. Therefore, it will enrich their data.

In my research I will use the name that you want me to use, which can be a different name so that nobody can trace who you are. Furthermore, I would like to audio record this interview, so that I do not have to interrupt you the whole time in order for me to write everything down. Later I will transcribe the audio tapes without including specific information that can be linked back to you.

Now I would like to ask you the following: Do you consent to being part of this interview and to the audio recording of this interview?

| Name: | Husband's age: |
|---|---|
| Current age: | Number and age of children: |
| Age at marriage: | Education: |
| Age at first childbirth: | Occupation/position: |
| Village: | Religion: |

Clinic/psychiatric department

1. Could you tell me something about the work you do at the clinic?
2. Is the clinic in contact with hospitals in nearby cities?
   a. Is there a possibility for people to being brought to a hospital when there is a big emergency?
3. Which services does this clinic provide?
   a. When married girls and adolescent mothers feel sad or unhappy, is there a possibility to talk to anyone from the clinic?
4. Do you make use of traditional medicine/herbs in the clinic?
   a. If so, for what purpose?
5. Do you see that certain people visit the clinic more often than others? For example men, women, younger people, older people etc.? Why is that?
6. How often do girls below 18 visit the clinic? What are their reasons for coming usually?
   a. Do you think there are any obstacles for them to not come by? (Probe: not having a health insurance, no money, nobody to take care of the kids)
7. Do married girls and adolescent mothers usually come to the psychiatric department of this clinic with concerns? What kind of concerns?
8. How does the clinic offer support to married girls and adolescent mothers?
9. According to you, at what age should females get married and have children? Why?

Physical health

10. What kind of consequences does pregnancy at an early age have for the body of a girl?
    a. Do you think that in general girls know about these consequences?
11. Do you think that getting pregnant and receiving children can be harmful at a certain age?
12. If a girl or a woman has had many pregnancies, does this impact the body?
13. Do labour/delivery complications happen a lot? What are mostly the reasons for this?
14. Do adolescent girls experience different forms of violence such as physical violence, having sexual relations without consent or mental abuse?
15. Does the clinic/epicenter educate people about family planning methods?
    a. What do you usually teach people and is there one method that is better than others?
    b. Are the adolescent girls who come to the clinic usually informed about these methods?
    c. Do you see that girls who have had more education are better informed about family planning methods?
    d. Would you say it is easy for girls to get contraceptives? Do they need some money for that?
16. Have you heard about girls trying to do abortion? How do they usually do it?
17. What do married girls and adolescent mothers do to improve their physical health in order to feel better?

Well-being

18. Before being pregnant for the first time, what kind of issues or concerns related to well-being do married girls and adolescent mothers experience?
19. What kind of issues or concerns related to well-being do married girls and adolescent mothers experience after their first pregnancy?
20. Could you tell me something about the mental well-being of these married girls and adolescent mothers?
21. Do married girls and adolescent mothers report being emotional about certain things?
    a. Do they report certain feelings, such as sexual feelings?
22. Do you think married girls and adolescent mothers are generally satisfied with their lives? Why?
23. How do people see married girls and adolescent mothers in general?
    a. Do you think people can change their behaviour and way of thinking towards married girls and adolescent mothers?
24. Do you think married girls and adolescent mothers feel comfortable and supported in their communities?
    a. Are they excluded from certain social activities?
25. How do economic difficulties influence the adolescent mothers and married girls?
26. Does religion influence the mental well-being of adolescent mothers and married girls? How?
27. What do married girls and adolescent mothers do to improve their mental well-being in order to feel better?

28. What would you advice girls that have not been married yet, have not had sexual relationships yet or have not been pregnant yet?
29. Who do you think can help married girls and adolescent mothers in the best way with these matters? The girls themselves, nurses, other community members, NGOs, the government?
30. Is there anything you would like to add? Any comments or recommendations?

Thank you so much for your time! If you want to change anything you have said in this interview or wish to receive some follow-up on the research, someone from The Hunger Project can let me know and I will arrange for it to be taken care of.

Medaase paa!

## 9.3. FGD guides

This section presents the FGD guides I used during data collection in order to guide me during the FGDs.

### 9.3.1. FGDs with adolescent girls

Moheé and motsum kaa! I am so grateful that you have agreed to take part in this focus group discussion. The reason that I have asked you to do this is because I want to learn more about the experiences of girls and young women from your point of view. I really appreciate that you have taken time off from your daily activities. This focus group discussion should not be over two hours.

My name is Samy and I am from the Netherlands and Angola. I am 23 years old and studying at the University of Amsterdam in the Netherlands, in the area of international development studies. I am here with …, who works at/with The Hunger Project. In this research I am trying to grasp young women's perceptions on being married at a young age and/or having children at a young age. I am particularly interested to see how this influences your mental well-being, and what you do and have done to improve your well-being. With this information, I would be able to give recommendations to The Hunger Project and Her Choice on how they could improve their programs for adolescent girls. Therefore, it will enrich their data.

In this focus group discussion I am going to ask you a certain amount of questions, but know that you do not have to share anything you do not want to share. There are no right or wrong answers, and everything you say is important. In my research I will use the name that you want me to use, which can be a pretend name so that nobody can trace who you are. Also if you would like to talk to anyone about health/well-being related issues or anything else, I can provide you with contact details of someone trustworthy that could help out. Furthermore, I would like to audio record this focus group discussion, so that I do not have to interrupt you while you are talking in order for me to write everything down. Later I will transcribe the audio tapes without including specific information that can be linked back to you.

Now I would like to ask you the following: Do you consent to being part of this focus group discussion? And do you consent to the audio recording of this focus group discussion?

Association game as an ice-breaker:

Which words do you associate with being single?

Which words do you associate with marriage?

Which words do you associate with being a mother?

Which words do you associate with your future? (in 5/10 years)

1. What are your general living conditions?
    a. Would you want anything to change about this in the future?
2. What types of marriages do young girls perform and what are the reasons for these marriages?
    a. What are the processes leading up to marriage like and how are young girls involved?
    b. Were there any marriage rites and/or pregnancy rites performed before living together with your partner? What are these rites and how is the girl involved in the process?
3. What are your general views on marriage? What does marriage mean to you?
    a. At what age should females get married and have children? Why?
    b. Do you have to get married?
    c. What is good about having a child?
4. Did you have different expectations of getting married or having children before and after marriage or child birth?
    a. How have you changed since having children?
    b. Do you think that your mental state has changed since marriage or child birth?
    c. How have your emotions and feelings changed after marriage or child birth?
5. Who would you say is the happiest person in the community? Who has the best life? (for example, think about yourself, someone in your family, someone with a certain job, a Queen mother, a chief etc.)
    a. Who would you say is the unhappiest person in the community? Why?
6. How do people see married girls and adolescent mothers in general?
    a. Do you think people can change their behaviour and way of thinking towards married girls and teen mothers?
7. Do you feel supported in your communities?
    a. Do you see yourself more as dependent or independent from others? When and in what way?
    b. Are you involved in making decisions in your homes and in the communities? How so?
    a. Do you feel you are excluded from certain activities in your community or in your home? Why?
8. Have you been educated on marriage and/or motherhood before you got married/gave birth? (Probe: education on family planning methods)
9. Have you experienced physical violence and mental abuse in your lives?
10. When you experience economic difficulties, how does this influence you emotionally?
    a. Do you think you should have received more education?

i. Did you enjoy going to school?
b. Have you had any employment opportunities?
c. Are you able to spend money freely if you want to or does someone else have control over the money?
11. How does religion affect your mental well-being?
   a. Do you enjoy going to church? Why?
12. What have you done in the past to improve your emotional state in order for you to feel better in life?
   a. What do you do now to feel better when you are sad or unhappy?
13. Which support systems are in place for married girls and/or adolescent mothers? (Probe: school, health facilities, community, church, etc)
   a. Who is it that you can talk to when you are having a problem? (Probe: friends, family, husband, other community members/leaders)
   b. Can you think of any role models in your life?
   c. What are the most fun activities to do when you have time for yourself? What is it you enjoy to do?
   d. Are there obstacles in the way of you receiving or asking for support? (Probe: shame, judgement, male acquaintances)
14. What would you advice girls that have not been married yet, have not had sexual relationships yet or have not been pregnant yet?
   a. If you were a teacher, what would you teach young people about having sexual relationships?
   b. What would you advice girls that can't pay their school fees?

Thank you so much for your time! If you would like to talk to anyone about certain issues, want to change anything you have said in this interview or wish to receive some follow-up on the research, I can give you the contact details of someone trustworthy now or you can contact The Hunger Project and we will arrange for it to be taken care of.

Motsum kaa!

### 9.3.2. FGDs with community leaders and parents

Akwaaba na medaase paa! I am so grateful that you have agreed to take part in this focus group discussion. The reason that I have asked you to do this is because I want to learn more about the experiences of girls and young women from your point of view. I really appreciate that you have taken time off from your daily activities. This focus group discussion should not be over two hours.

Me din de Samy na mefiri Holland, the Netherlands ne Angola. I am 23 years old and studying at the University of Amsterdam in the Netherlands, in the area of development studies. I am here with …, who works at/with The Hunger Project.

In this research I am trying to grasp people's perceptions on being married at a young age and/or having children at a young age. I am particularly interested to see how this influences the mental well-being of young women, and what they do and could do to improve their well-being. With this information, I would be able to give recommendations to The Hunger Project and Her Choice on how they could improve their programs for adolescent girls. Therefore, it will enrich their data.

In this focus group discussion I am going to ask you a certain amount of questions, but know that you do not have to share anything you do not want to share. There are no right or wrong answers, and everything you say is important. In my research I will use the name that you want me to use, which can be a pseudonym so that nobody can trace who you are exactly. Furthermore, I would like to audio record this focus group discussion, so that I do not have to interrupt you while you are talking in order for me to write everything down. Later I will transcribe the audio tapes without including specific information that can be linked back to you.

Now I would like to ask you the following: Do you consent to being part of this focus group discussion? And do you consent to the audio recording of this focus group discussion?

Association game as an ice-breaker:

Which words do you associate with being single?

Which words do you associate with marriage?

Which words do you associate with motherhood?

Which words do you associate with well-being and doing well?

1. What are the general living conditions of adolescent mothers and married girls?
2. What types of marriages do young girls perform and what are the reasons for these marriages?
   a. What are the processes leading up to marriage like and how are young girls involved?
   b. Are there any marriage rites and/or pregnancy rites performed to girls before living together with their partner? What are these rites and how is the girl involved in the process?
3. What are your general views on marriage?
   a. At what age should females get married and have children? Why?
4. Do young girls have different expectations of what marriage or motherhood entails before and after marriage or child birth?
   a. Do you think that their mental state changes after marriage or child birth?
5. How do the emotions of young girls change after marriage or child birth?
6. Do young married girls and adolescent mothers feel unhappy about their situations?
   a. How have they learned from their actions in the past and made changes in their lives?
7. Are young married girls and adolescent mothers usually more dependent or independent from others? When and in what way?
8. How do people see married girls and adolescent mothers in general?
   a. Do you think people can change their behaviour and way of thinking towards married girls and adolescent mothers?
9. Do young married girls and adolescent mothers feel supported in their communities?
   a. Are they involved in making decisions in their homes and in the communities? How so?
10. What does the social life of young married girls and adolescent mothers look like?

a. Are they included in certain activities and excluded from other activities in their communities and in their homes?
11. Are married girls and adolescent mothers educated on marriage and/or motherhood before they get married/give birth? (Probe: education on family planning methods)
12. Do you think the physical health of girls suffers after marriage and/or having children?
   a. Do you think married girls and/or adolescent mothers experience physical violence and/or mental abuse in their lives?
13. Do married girls and adolescent mothers experience any economic challenges?
   a. Do you wish they should be able to receive the maximum level and years of education?
   b. Do they have any employment opportunities?
   c. Do they have a say in how money can be spend or does someone else have control over the money?
14. How does religion affect the mental well-being of married girls and adolescent mothers?
15. What do you think married girls and adolescent mothers do to improve their **mental** well-being in order for them to feel better in life?
   a. Does it differ with what you think they should do?
16. Which support systems are in place for married girls and adolescent mothers? (Probe: school, health facilities, community, church, etc)
   a. Which persons offer them support in their lives? Who is it that they can talk to when they are having a problem? (Probe: friends, family, husband, other community members/leaders)
   b. Can you think of any role models for them?
   c. Are there obstacles in the way of them receiving or asking for support?
17. What would you advice girls that have not been married yet, have not had sexual relationships yet or have not been pregnant yet?

Thank you so much for your time! If you want to change anything you have said in this focus group discussion or wish to receive some follow-up on the research, please contact The Hunger Project and we will arrange for it to be taken care of. Medaase paa!