

Resilience Levels Among Perinatal Teenage Girls Accessing Services in Selected Maternal Child Health (MCH) Clinics in Nairobi County, Kenya

Lunar Odawa*¹

¹United States International University – Africa,
Department of Psychology; P. O. Box 49773 00100
Nairobi, Kenya

Dr. Stella Nyagwencha (PhD)²

²United States International University – Africa,
Department of Psychology P. O. Box 49773 00100
Nairobi, Kenya

Dr. Michael Kihara (PhD)³

³United States International University – Africa;
Department of Psychology P. O. Box 49773 00100
Nairobi, Kenya

Corresponding Author:- Lunar Odawa*¹

Abstract:-

➤ Background

Resilience is considered to be a protective factor for mental wellbeing for all ages. Perinatal teenage mothers experience a myriad of challenges that affect their mental health, resilience can help them manage, adjust and thrive despite the challenges of early pregnancy and therefore protect them from common mental disorders like depression and anxiety. This study was conducted to examine the levels of resilience among perinatal teenage girls between age 10-19 years who were accessing maternal child health (MCH) services during pregnancy and one year post delivery. Non-probability purposive sampling technique was used to identify four health care facilities offering MCH services where the participants were selected purposively. A brief resilience scale (BRS) questionnaire was used to collect data from a sample population of 175 perinatal teenage mothers alongside a Socio-demographic questionnaire. Data analysis was done using Statistical Package for Social Sciences SPSS (SPSS®) Version 28.

Results from the study indicated that majority (97.2%) of the respondents had low to normal resilience levels; 45.1% had low levels of resilience, 52% had normal resilience levels and 2.9% had high resilience levels.

➤ Conclusion:

Majority of the perinatal teenage mothers may experience common mental disorders due to minimal ability to adapt, cope and even thrive when they experience teenage pregnancy and therefore policies and strategies need to be put in place to equip the perinatal teenage girls with resilience enablers for better mental health and life.

Keywords:- Resilience Perinatal Teenage Girls, Teenage Pregnancy, Maternal Child Health.

I. INTRODUCTION

Resilience has been described as the ability to adapt, cope with adversity and thrive despite experiencing difficult circumstances and therefore a person is able to recover from challenges and maintain or regain mental health balance.[1]. Resilience can help in managing a challenging situations and preventing heightened stressor levels as studies indicate that individuals with high resilience have low stress levels[2,3] Perinatal mental health in teenage has been overlooked especially in the low middle income countries despite the existing evidence that early pregnancy-related challenges increase the risk of mental health disorders like suicidal behavior and depression which are associated with impaired functioning.[4,5] Several studies point to resilience playing an important role in adapting, coping, overcoming challenges that could apply to perinatal teenage girls. For example, resilience has been described as a protective factor for depression [6,7] and postpartum resilience is helpful in coping with challenges of teenage motherhood after delivery [8]. A study on resilience for perinatal HIV affected adolescent girls described some high resilience level despite stressors. The resilience was characterized by a strong belief system, acceptance of the changed circumstances, appreciation of individual strengths and a high self-esteem [9]. Evidently, social support system and self-esteem are resilience enablers and they probably deter mental health conditions during perinatal period [10]. Literature on resilience theory indicate that individual's resilience levels can significantly be enhanced through the improvement of personal skills including using effective coping mechanisms, enhancement of problem-solving skills, emotional control, and self-efficacy [11]. Resilience can be equally enhanced by cultivating positive perceptions of towards familial and community support resources [12] Development of personal

skills and/or assets together with supportive resources comprise two important elements in resilience building that have been found to either to remove or reduce the negative effects of challenging and stressful situations [13]

II. METHODOLOGY

The study used a quantitative method design in four study sites that were selected using non probability purposive sampling. The four sites were public health facilities in Nairobi County that offer MCH services.; Lang'ata Health Clinic, Pumwani Maternity Hospital, Mama Lucy Kibaki Hospital and Kangemi Health Centre. The study was conducted between April 2023 and August 2023

III. RESEARCH INSTRUMENTS

➤ *The Data was Collected Through the use of Two Tools.*

- *Researcher Designed Socio-Demographic Questionnaire:*

The researcher formulated a questionnaire for collecting demographic information which included; participant's age, highest level of education, religion, marital status, and current pregnancy status.

- *The Brief Resilience Scale (BRS)*

This is a six-item measure of resilience [14] that focuses on the capacity to bounce back from stress and adversity. On a 5-point Likert scale, responses are scored from Strongly Disagree (1) to Strongly Agree (5). The respondent is deemed to be more resilient the higher the mean BRS score. To prevent social response bias, half of the items have their scores reversed [15] Cronbach's alpha was reported [15] to range from .80 to .91 for four samples. In order to prevent the desirability response bias (Cronbach, Cronbach alpha) suggested reversing items 2, 4, and 6 in all studies.[15] To reduce response bias, the BRS is a short, single-factor instrument with three items that are positively and three that are negatively written [15] The Brief Resilience Scale [15] was one of the measures with the most favorable psychometric qualities, according to [16]. BRS is a self-administered tool where the respondent is asked to respond by ticking or circling one answer per row how strongly they agree with the statements. Items 1, 3, and 5 are positively worded, and items 2, 4, and 6 are negatively worded. The BRS is scored by reverse coding items 2, 4, and 6 and finding the mean of the six items.

- *For Questions 1, 3, and 5:*

✓ 1. Strongly Disagree, 2. Disagree, 3. Neutral, 4. Agree, 5. Strongly Agree

- *For Questions 2, 4, and 6:*

✓ 5. Strongly Disagree, 4. Disagree, 3. Neutral, 2. Agree, 1. Strongly Agree

Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered

- *BRS Score Interpretation:*

- ✓ 1.00-2.99 Low resilience,
- ✓ 3.00-4.30 Normal Resilience,
- ✓ 4.31-5.01 High resilience

- *Sample Size*

175 perinatal teenage girls were used in this study. The sample size for this study was derived using Fisher's formula with a precision /absolute error of 5% and a type I error of 5% [17]. Purposive sampling method was used to select respondents from the selected health care facilities [14]. The target population for this study was perinatal teenage girls between ages 10-19 years who were either pregnant or had given birth in the past one year. The participants were recruited from the selected health facilities where they were accessing antenatal and postnatal care services.

The perinatal teenage girls included were conversant with English or Kiswahili and had no any serious health conditions or cognitive impairments (from past medical history) that would have limited their participation in this study.

- *Procedure*

The researcher obtained all the requisite approval documents to facilitate the process of data collection. An approval letter was obtained from IRB-USIU-A (Institutional Research board United States International University Africa) to enable the researcher acquire research permit from the National Commission of Science Technology and Innovation (NACOSTI) and the Nairobi County Council. The researcher used contextually validated tools which are reliable and standardized for the purposes of testing. The tools were then be printed in preparation of the pre-test and later for the main study.

Armed with the research permit and the Nairobi City County research authorization, the researcher visited the MCH centers to discuss about the study with their leadership. This was aimed at creating awareness of the study within the MCH centers and secure the goodwill from management to carry out the study with the perinatal girls seeking MCH services in their clinics. Upon being granted the permission, the researcher was introduced to the administrators of the respective clinics who introduced to the respective persons in charge of the services offered to the perinatal teenage girls.

The first step was to identify eligible respondents from the clinic's register with the help of the nurse in charge and the research assistant. The eligible respondents were teenage mothers who had given birth and were attending postnatal services in the clinic and those who were pregnant and were attending prenatal clinic. Before collecting any data, informed consent was obtained from each participant. The consent form explained the purpose of the study, the procedures involved, and the rights of the participant. Respondents were informed that their participation was voluntary and they had the right to withdraw at any time.

Perinatal teenage girls were considered as emancipated minors by virtue of being pregnant or had given birth and could therefore give consent.

The questionnaires were administered to respondents using the fill and pick approach. demographic data such as age, educational level, marital status, and socio-economic status was collected from each participant. The data was collected using a separate questionnaire or by including demographic questions in the survey instruments. Respondents had adequate privacy and confidentiality during the data collection process. Respondents were given a private and quiet space to complete instruments. The researcher checked the questionnaires upon being filled and

collected to ensure the collected data met the study requirements. The duly filled and collected data was stored securely and protected from unauthorized access.

➤ *Statistical Analysis*

The data was analyzed using quantitative data analysis approaches based on the research questions. The first step in quantitative data analysis was to describe or summarize data using descriptive statistics. Descriptive statistics were used to summarize data into tables and figures, and the results were presented in frequencies, percentages and confidence intervals. The Statistical Package for Social Sciences (SPSS®) Version 28 was used analyze the data.

IV. RESULT

Table 1 Levels of Resilience among Respondents

Measure	Category	Frequency (N=175)	Percentage	95% Confidence Interval	
				Lower	Upper
Resilience Levels	Low Resilience	79	45.1	37.7	52.0
	Normal Resilience	91	52.0	45.1	59.4
	High Resilience	5	2.9	0.6	5.7

From the results, respondents with low resilience were 45.1%, 95% C.I ,37.7 to 52.0, normal resilience was 52.0% ,95% C.I, 45.1 to 59.4 and high resilience 2.9% 95% C.I 0.6 to 5.7. A majority of the respondents had normal resilience.

The low and normal resilience levels that 97.1% of the adolescent mothers in the current study is not enough for them to deal with the new challenges that come with motherhood. It implies that the adolescent mothers lacked sufficient personal resources that could protect them from the effects occasioned by responsibilities of motherhood [19,20]. Mental stressors in pregnancy such as shame, hopelessness, & embarrassment lower pregnant and postpartum adolescents’ resilience to overcome depression and hence the adolescents learn to cope by isolating themselves, socializing with other pregnant adolescent mothers, and finding solace in alcohol, drugs, and risky sexual behaviors [22] High resilience levels are required to effectively deal with the challenging situations brought about by adolescent motherhood and hence preventing heightened stressor levels [20] Individuals with high resilience have low stress and anxiety levels.[1,2] Hence, high resilience is considered a protective factor for depression.[19,20] Having high resilience brings about positive outcomes even when faced with adversity.[21]

highly resilient and hence effective in coping with life stressors and challenges. It there means that the perinatal girls in this study lacked a strong personality, had low self-esteem and self-efficacy and most importantly lacked social support. This finding aligns with those of similar studies which established those perinatal teenage girls had low levels of resilience. In reference to the attachment theory, the study concludes that the perinatal teenage girls in this study had an insecure attachment and hence have a flawed sense of self-worth which extends to having emotional states that are unstable, suffering from feelings of powerlessness and helplessness concerning their past and present situations all of which predispose them to mental challenges. Secure attachment style is linked to greater resilience characterized by a stress-resistant mindset. Resilient individuals are able to better cope with extreme stressors than others who suffer the same experiences.

RECOMMENDATIONS

The current study was limited to perinatal girls in Nairobi, a city location where better healthcare and support services are presumed to exist. For comparative purposes, it will be important to carry out a similar study with perinatal girls from a rural setting.

Future studies may focus on investigating the precise mechanism of psychological resilience against depression and anxiety

V. CONCLUSION

A majority of the respondents (97.1%) had normal and low levels of resilience. From this finding, the study concludes that the perinatal teenage girls accessing services at selected Maternal Health clinics (MCH) in Nairobi County lacked sufficient personal resources that could protect them from developing depression and anxiety occasioned by the new challenges that come with motherhood and it takes a strong personality, self-esteem, and sense of mastery, self-efficacy and social support to be

REFERENCES

- [1]. Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). What is resilience? *The Canadian Journal of Psychiatry*, 56(5), 258–265.
- [2]. Hjemdal, O., Vogel, P. A., Solem, S., Hagen, K., & Stiles, T. C. (2011). The relationship between resilience and levels of anxiety, depression, and obsessive-compulsive symptoms in adolescents. *Clinical Psychology & Psychotherapy*, 18(4), 314–321.
- [3]. Olajubu, A. O., Omoloye, G. O., Olajubu, T. O., & Olowokere, A. E. (2021). Stress and resilience among pregnant teenagers in Ile-Ife, Nigeria. *European Journal of Midwifery*, 5, 88-90.
- [4]. Musyimi, C. W., Mutiso, V. N., Nyamai, D. N., Ebuanyi, I., & Ndeti, D. M. (2020). Suicidal behavior risks during adolescent pregnancy in a low-resource setting: A qualitative study. *PLoS One*, 15(7), e0236269.
- [5]. Palfreyman, A., & Gazeley, U. (2022). Adolescent perinatal mental health in South Asia and Sub-Saharan Africa: A systematic review of qualitative and quantitative evidence. *Social Science & Medicine*, 5, 115413.
- [6]. Edward, K. (2005). Resilience: A protector from depression. *Journal of the American Psychiatric Nurses Association*, 11(4), 241–243.
- [7]. Ziaian, T., de Anstiss, H., Antoniou, G., Baghurst, P., & Sawyer, M. (2012). Resilience and its association with depression, emotional and behavioural problems, and mental health service utilisation among refugee adolescents living in South Australia. *International Journal of Population Research*, 5(5), 125-128.
- [8]. Birkeland, R., Thompson, J. K., & Phares, V. (2005). Adolescent motherhood and postpartum depression. *Journal of Clinical Child and Adolescent Psychology*, 34(2), 292–300.
- [9]. Woollett, N., Cluver, L., Hatcher, A. M., & Brahmabhatt, H. (2016). To be HIV positive is not the end of the world: Resilience among perinatally infected HIV positive adolescents in Johannesburg. *Children and Youth Services Review*, 70, 269–275.
- [10]. Van Haeken, S., Braeken, M. A. K. A., Nuyts, T., Franck, E., Timmermans, O., & Bogaerts, A. (2020). Perinatal resilience for the first 1,000 days of life: Concept analysis and Delphi survey. *Frontiers in Psychology*, 11, 563-564.
- [11]. Coulombe S, Pacheco T, Cox E, Khalil C, Doucerain MM, Auger E, Meunier S. Risk and Resilience Factors During the COVID-19 Pandemic: A Snapshot of the Experiences of Canadian Workers Early on in the Crisis. *Front Psychol*. 2020 Dec 3;11:580702. doi: 10.3389/fpsyg.2020.580702. PMID: 33343455; PMCID: PMC7744587.
- [12]. Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., Bruffaerts, R., De Girolamo, G., De Graaf, R., & Gureje, O. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet*, 370(9590), 841–850.
- [13]. Wang, J.-L., Zhang, D.-J., & Zimmerman, M. A. (2015). Resilience Theory and its Implications for Chinese Adolescents. *Psychological Reports*, 117(2), 354-375.
<https://doi.org/10.2466/16.17.PR0.117c21z8>
- [14]. Smith BW, Dalen J, Wiggins K, Tooley E, Christopher P, Bernard J. The brief resilience scale: assessing the ability to bounce back. *Int J Behav Med*. 2008;15(3):194-200. doi: 10.1080/10705500802222972. PMID: 18696313.
- [15]. Cronbach, L. J. (1950). Further Evidence on Response Sets and Test Design. *Educational and Psychological Measurement*, 10, 3-31.
<https://doi.org/10.1177/001316445001000101>
- [16]. Windle, G., Bennett, K.M. & Noyes, J. A methodological review of resilience measurement scales. *Health Qual Life Outcomes* 9, 8 (2011).
<https://doi.org/10.1186/1477-7525-9-8>
- [17]. Bernard, R. (2010). Fundamentals of biostatistics. Duxbury Press visiting program. *American Journal of Orthopsychiatry*, 86(1), 61.
- [18]. Edward, K. (2005). Resilience: A protector from depression. *Journal of the American Psychiatric Nurses Association*, 11(4), 241–243.
- [19]. Ziaian, T., de Anstiss, H., Antoniou, G., Baghurst, P., & Sawyer, M. (2012). Resilience and its association with depression, emotional and behavioural problems, and mental health service utilisation among refugee adolescents living in South Australia. *International Journal of Population Research*, 5(5), 125-128.
- [20]. Birkeland, R., Thompson, J. K., & Phares, V. (2005). Adolescent motherhood and postpartum depression. *Journal of Clinical Child and Adolescent Psychology*, 34(2), 292–300.