Research Article

Antenatal Education on Pregnant Adolescents in Turkey: Prenatal Adaptation, Postpartum Adaptation, and Newborn Perceptions

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S U M M A R Y

Purpose: This clinical trial study was planned in order to evaluate the effect of antenatal education on antenatal and postpartum adaptation and newborn perceptions among adolescent pregnant women.

Methods: A research assistant met with pregnant adolescents in a Family Health Center and at the participants' homes. The sample included 70 pregnant adolescents (35 in experimental group, 35 in control group) chosen through simple random sampling. The experimental group received antenatal education, whereas the control group merely had routine surveillance. As for data collection tools, the Prenatal Self Evaluation Questionnaire (PSEQ), the Postpartum Self Evaluation Questionnaire (PPSEQ) and the Newborn Perception Scale (NPI) was used.

Results: We found that the experimental group who received antenatal education had a lower mean total PSEQ score (133.94 ± 15.62) compared to the control group (159.86 ± 17.83). In the comparison of the two groups, we found that the experimental group had lower mean total PSEQ scores on the first postpartum day, first postpartum week and second postpartum week compared to the control group did, indicating higher levels of postpartum adaptation (p = .017, p = .009, p = .029).

Conclusion: We determined that the level of prenatal adaptation was higher in the experimental group, which received antenatal education, than in the control group and that levels of postpartum adaptation was significantly higher in the experimental group on the first postpartum day and the first and second postpartum weeks but not on the fourth postpartum week. There were no significant differences between the experimental and control groups in terms of NPI results.

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Introduction

Adolescent pregnancies are among the most important health and social issues of the 21st century. The World Health Organization defines adolescent pregnancy as pregnancies occurring in girls aged between 10 years old and 19 years old [1]. The rate of women who become mothers prior to the age of 20 is a measure of adolescent fertility, which is accepted to be an important health and social issue in numerous countries [2,3]. Throughout the world, 16 million adolescents aged between 15 years and 19 years give birth per year, while 3 million adolescent pregnancies end with unsafe miscarriages and approximately 60.0% of babies of adolescents die [4]. Additionally, 200 girls die worldwide every day due to early pregnancies that occur during adolescence [5].

The worldwide incidence of adolescent pregnancies is 5.3% and is related to various social, cultural, and economic factors such as age at marriage, traditional attitudes, family structure, education, economic status, and family planning [6]. One of the most important problems of Turkey, which is mainly populated by young people, is early marriages. Early marriages have strong cultural and social norms including having children straightforward. Due to such reasons, pregnancies occur at an early age. Getting pregnant at an early age negatively affects one's educational level and social life as well as one's physical health [7]. In Turkey, the rate of fertility is 30.5 in 1,000 in the 15–19 years age group [8].

Due to the natural processes that occur during pregnancy, various structural and functional changes take place in a woman’s body. Both the mother and the infant are negatively affected by pregnancies that occur before the mother reaches physical,
psychological, and social maturation [9]. The adolescent, who struggles to achieve development, tries to adapt to the changes that occur in her body on one hand, and faces the psychology of motherhood on the other hand; the exposure to such processes puts the individual at risk [10–14]. The impact of pregnancy increases as the age of the adolescent decreases [7]. During adolescent pregnancies, provision of special care that is different from that in adult pregnancies is required. However, when such needs are met, one can adapt to pregnancy and childbirth, and provide support and care for the baby. Therefore, antenatal care services should be provided for pregnant adolescents in order to protect and promote maternal and infant health.

In Turkey, where the prevention of adolescent marriages and pregnancies seem improbable in the near future, one of the main roles of nurses is to protect and maximize maternal and infant health in the context of public health services. It is of crucial importance that pregnant women who are in this risk group receive support during the antenatal period so that they go through a healthy pregnancy process, avoid complications during childbirth and give birth to a healthy child, and during the postpartum period, establish a positive mother-infant relationship.

The purpose of the present study is to evaluate the effect of antenatal education on antenatal adaptation, postpartum adaptation and newborn perceptions among adolescent pregnant women.

Method

Study design and participants

This clinical trial study was planned in order to evaluate the effect of antenatal education on antenatal adaptation, postpartum adaptation and newborn perceptions among adolescent pregnant women. Sample size was calculated with the G-Power program (version 3.1.7) using data from a previous study [15], where α = .05, and effect size is 0.77. The power analysis method determined a minimum sample size of 28 people with 80% power. Taking into consideration that the participants may discontinue the study due to various reasons since they belong to a risk group. Therefore, the sample of the study consisted of 35 pregnant women in the experimental group and 35 pregnant women in the control group who were selected with simple random sampling. At the end of the study, we found that the effect size for the Prenatal Self Evaluation Questionnaire (PSEQ) in each group with a sample of 35 people was 1.55 and that power was 0.99.

Sample inclusion criteria were as follows: pregnant women aged 15–19 years, being between 12th and 17th gestational weeks (because miscarriages are more common during the first trimester), being registered to a family health center, being at least literate, not having a communication problem, having a healthy newborn (Appar score of ≥ 7, weighing ≥ 2,500 g), not having developed any antenatal or postpartum complications that require hospitalization, having mothers that were still alive (because there were subscales that measure one's relationship status with her mother in both instruments), living with one's husband (because there were subscales that measure one's relationship status with her husband in both instruments), not having participated in other antenatal education programs, and giving oral and written consent to participate in the study. Nine adolescent pregnant women in the sample were excluded from the study since they did not meet the inclusion criterion regarding complications.

Because of complications including premature birth (n = 3), abortion (n = 3), Down syndrome (n = 1) and neonatal asphyxia (n = 2) occurring during the process, instead of nine adolescent pregnant, who dropped out, nine women had been selected according to the sample selection criteria.

Data collection

The study was carried out between August 10th, 2011 and October 24th, 2013. Among all pregnant women aged 15–19 years and were registered to 12 Family Health Centers (FHC) located in Usak, Turkey, those who agreed to participate in the study and met the inclusion criteria were assigned to the experimental group or the control group. A simple random numbers table was used for randomization and pregnant women who were registered to FHC with odd numbers (1, 3, 5, 7, 9, 11) were assigned to the experimental group, whereas those who were registered with even numbers (2, 4, 6, 8, 10, 12) were assigned to the control group. The inclusion of different FHC in the experimental and control groups ensured that the participants could not interact with each other.

Ethical consideration

In order to conduct the study, ethical board approval (dated and numbered 03.08.2011-4) was obtained from the MU Institute of Health Sciences Clinical Research Preliminary Evaluation Commission Headship. For the FHC where the study was conducted, an approval (dated and numbered 14.11.2011-34340) was obtained from the Family Doctorship Education and Logistics Branch Office, which is affiliated with the Turkish Ministry of Health Basic Health Services Directorate. In addition, the identity of the researcher, researcher’s institution, aim of the study, how acquired data will be used, and the right to reject answering questions were explained in detail to the participants. The reason for selecting the participants was also explained. The study began after taking oral and written consent from the participants. Consent was obtained from the husbands of married participants under the age of 18 and from the legal guardians of single participants.

Measurements

Data was collected using the information form on sociodemographic and childbirth- and newborn-related characteristics, the PSEQ, the Postpartum Self Evaluation Questionnaire (PPSEQ), and the Neonatal Perception Inventory (NPI).

The PSEQ was developed by Lederman in 1979 in order to evaluate adaptation to motherhood in antenatal women, and was adapted into Turkish by Beydag and Mete, The PSEQ has a 4-point Likert scale with 79 items and 7 subscales that evaluate adaptation to pregnancy. Each subscale contains 10–15 items. The subscales are acceptance of pregnancy, identification of a motherhood role, relationship with her mother, relationship with her husband, preparation for labor, fear of helplessness, and concern for the well-being of self and baby. Total scores range from 79 to 316. Lower subscale scores indicate that adaptation to pregnancy is better compared to higher scores [16].

The PPSEQ was developed by Lederman and Weingarten in 1981 in order to evaluate adaptation to motherhood in postpartum women, and was adapted into Turkish by Beydag and Mete. The PPSEQ uses a 4-point Likert scale, and contains 82 items and 7 subscales that evaluate a mother’s postpartum adaptation. Each subscale includes 10–13 items. The subscales are quality of partner relationship, perception of partner’s participation in child care, gratification from labor and delivery experience, satisfaction with life circumstances, confidence in ability to cope with tasks of motherhood, satisfaction with motherhood and infant care, and support for maternal role from family and friends. Total scores...
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