SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

SOCIAL SUPPORT AMONG PREGNANT ADOLESCENTS IN ADAKLU DISTRICT IN THE VOLTA REGION

BY

SETH KWASI FRIMPONG ADJEI

(10638229)

THIS THESIS/DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF PUBLIC HEALTH DEGREE.

JULY 2018
DECLARATION

I do hereby declare that apart from references to other people’s works which have been duly acknowledged, this dissertation is the result of my own independent work done under supervision. I further declare that this dissertation has not been submitted for award of any degree in this institution or other universities elsewhere.

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SETH KWASI FRIMPONG ADJEI DATE
(STUDENT)

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PROF. PHILIP BABA ADONGO DATE
(SUPERVISOR)
DEDICATION

I dedicate this work to God our Heavenly Father, to my lovely wife Gloria Adjei and children (Spencer, Kimberly and Arianna) for the support given to make this work possible.
Acknowledgement

First and foremost, I would like to thank God our Heavenly Father who made this thesis a reality.

I wish to express my sincere appreciation to my supervisor Professor Philip Baba Adongo of Department of Social and Behaviour Science, School of Public Health for his guidance, supervision, objective criticisms, suggestions and corrections, which contributed immensely to the completion of this work.

I would like to thank the staff of Adaklu District Health Directorate and the pregnant adolescents who availed themselves to participate in this research. Also, to thank my research assistants Kisses Johnson and Lynda Buatsi for their time and contributions to this study.

I thank Mr Kwadwo Asante Afari, for his contribution and encouragement which kept me focused in achieving this success.

I wish to acknowledge my parents, (Francisco and Sarah), my siblings (Zola and Joseph) and their families, for their prayers, support and encouragement through this process.

My deepest gratitude also goes to my darling wife for always being my source of strength, for her understanding and emotional support.

To God be the Glory.
ABSTRACT

Adolescent pregnancies continue to pose a challenge to many developing countries including Ghana. In Ghana, it is estimated that the contribution of adolescent to the total fertility rate is quite significant. Despite this, pregnant adolescents continue to face challenges such as physical, emotional and psychological effects.

The aim of the study is to explore the kinds of social support received by pregnant adolescents and how it lessened their challenges. The study adopted a qualitative approach and purposively selected participants from Adaklu District of the Volta Region. One-on-one in-depth interview with an interview guide was the main data collection instrument used.

The study revealed that pregnant adolescents are faced with challenges including drop out from school, verbal abuse, emotional, financial, health amongst others. The study also revealed that pregnant adolescents received emotional support from parents, especially mothers and other family members. Instrumental support, mostly provision of material and financial assistance was also received from family members and partners who were working. Informational support such as shared experience, medical advice and relevant information on pregnancy were received from family members and health care workers.

The study established that social support had both positive and negative impacts on the pregnant adolescent. Positively, social support promoted the physical well-being of the pregnant adolescent who received them. On the other hand, some few individuals felt they had lost their respect in the society because they were seen as deviants who could not grow to be giving out for marriage.
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LIST OF ACRONYMS

ANC   Antenatal Care
CHAG  Christian Health Association of Ghana
CHPS  Community-Based Health Planning and Services
DHIMS District Health Information Management Systems
GDHS  Ghana Demographic and Health Survey
GHS   Ghana Health Service
GSS   Ghana Statistical Service
IDI   In-depth Interview
JHS   Junior High School
NGOs  Non-Governmental Organisations
TFR   Total Fertility Rate
UNFPA United Nation Population Fund
WHO   World Health Organisation
CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Pregnant adolescents often turn to informal support networks for help, especially in dealing with adolescent pregnancy related issues and parenthood. The social network provides support including provision of instrumental, emotional, appraisal, and financial support. Conversely, it is significant to recognize that social networks may include both positive and negative interactions, with resultant health impacts (Berkman, 2009). In literature, social support has appeared as a key factor which has the likelihood to reduce depression in pregnancy and subsequent parenting (Smith-Battle, 2012), brings about improvement in child development. (Bell, Zimmerman, Almgren, Mayer & Huebner, 2006). Some authors have argued that social support, especially from the family, is vital for the maintenance of the individual’s mental health and capacity for coping with stressful situations (Habel, Feeley, Hayton, Bell & Zelkowitz, 2015). According to Peter et al., (2017), emotional or practical support from the family and/or friends in the form of companionship, affection, information and assistance, makes individuals feel valued, loved and secured.

According to Logsdon, Gagne et al., (2005) social support can be categorised into two. These are formal which is obtained from formal institutional programmes including governmental and religious institutions. Informal support on the other hand, are all forms of support that are received from friends, family and other social ties. In the view of Logsdon, Gagne et al., (2005) social support may include providing materials, giving information and expressing empathy and love. The benefits of social support are mainly
to make the pregnant adolescent less stressful and bring about improvement in the health of both the mother and the child (Smith-Battle, (2012); Edwards et al., 2012).

It is estimated that about 16 million adolescents aged 15 to 19 become pregnant each year, accounting for 11% of all births globally (WHO, 2016). Although it is established that adolescent fertility is decreasing globally in recent times (McCall et al., 2014; Guttmacher Institute, 2014), teen pregnancies and births outcomes present serious difficulties in many countries. Complications during pregnancy and childbirth are noted to be the second cause of death among girls aged 15 to 19 years old (WHO, 2016).

Babies of teen mothers are 50% more likely to be stillborn, die early, or develop severe and long-term health complications. In addition, there is a higher risk of young girls who become pregnant to lose their education (Rosenberg et al., 2015), and thus limited economic prospects (UNFPA, 2016). These and other negative outcomes of early childbearing of young mothers and their children have brought about heightened international efforts to identify sources of risk and protective factors and to reduce adolescent pregnancy (WHO, 2016; UNFPA, 2016).

Furthermore, unstable conjugal relationships may result in the onset of the pregnancy and emotional disorders are often worsened by the family’s reaction and treatment meted out to the adolescents. The lack of family support contributes to the risk of psychiatric disorders during pregnancy, especially anxiety disorders, the most common psychiatric disturbance in females of reproductive age (Kessler, Petukhova, Sampson, Zaslavsky & Wittchen, 2012). It is opined that social support received by a pregnant woman and for that matter a pregnant adolescent boosts her self-esteem and also guides against depression in pregnancy. Social support is also critical after delivery and this has a positive influence on the mother and the newborn, while lack of it could increase
the negative outcomes in the pregnant adolescent (Coffman & Ray, 2002). Per the reviewed background so far, it could be deduced that pregnant adolescents are faced with numerous challenges. These challenges make them vulnerable and creates lots of problem to them.

1.2 Problem Statement

Adolescent pregnancy is considered one of the reproductive challenges globally. It is estimated that about 16 million girls who are aged between 16 and 19 years and about 1 million girls below age 15 years conceive and give birth annually (United Nations Population Fund (UNFPA, 2016). It is projected that by 2035, births among adolescents will rise to 20 million making the situation one of the key public health challenges (Fleming, Driscoll, Becker et al; 2015).

The 2014 Ghana Demographic and Health Survey (GDHS) showed that the Total Fertility Rate (TFR) was 4.2 (GSS, 2014). The contribution of adolescents to the total fertility rate (TFR) between 1988 and 2008 has increased from 9.7 percent in 1988 to 10.8 percent in 1993, it has however since seen a gradual decline to 8.2% in 2008 (GSS, 2010).

Maternity during adolescence has been perceived as a challenge and this has been looked at from different perspectives. In the area of public health, adolescent pregnancy is considered a major problem due to the perinatal risks. Adolescent pregnancies may be considered high risk, especially that of adolescents under the age 15 years and below (GSS, 2014).

In developing countries such as Ghana, the leading causes of hospitalisation and death among adolescent women is child-health and complications (Kirbas, Gulerman &
Daglar, 2016; GHS, 2016). Anaemia, preeclampsia and postpartum hemorrhage may occur among adolescent pregnant girls (GHS, 2016). Preterm birth, low birth weight, low Apgar score and perinatal mortality are also common among the children of adolescents (Kirbas, Gulerman & Daglar, 2016). By 2015, the percentage of adolescents who attended antenatal services in the country was 12.09%, 11.84% in 2016 and by half year 2017, the total percentage of adolescents who were registered at antenatal clinics was 12.08% (District Health Information management system 2 (DHIMS2, 2017). Regional data showed that Volta Region topped (15.14%) in the number of adolescents who became pregnant and attended antenatal in 2015. In 2016 the proportion of girls who became pregnant and attended ANC increased to (15.32) and by half year 2017, the region had recorded 14.66% (DHIMS2, 2017). Adaklu is one of the key Districts in Volta Region that was noted for high and consisted adolescent pregnancies. In 2015 for example, the District recorded 23.2% of its total ANC attendance being adolescents. After deliberate efforts such as health education by the health directorate, the proportion of adolescents who became pregnant and showed up at ANC reduced to 17% in 2016. However, the proportion of girls who attended ANC by half year 2017 has shot up to 19% which is higher than the national average of 12.8% (DHIMS2, 2017). Some of these teenage girls were married and this was influenced by place of residence (rural/ urban). For example, the 2010 population and housing census revealed that males aged 12 - 14, constituted a relatively higher proportion of married people (5.6%) compared to females (5.2%) who were reported married. Again, 9% percent of adolescent females aged 15-19 years were married compared to about 5% of their male counterparts. Twice the proportion of married females aged 15-19 years lived in rural areas compared to their counterparts who dwelled in urban areas.
These indicate the importance of social support in the overall health and well-being of the pregnant adolescents. Li, Ji & Chen (2014) indicated that higher degree of social support is associated with a lower risk and ensures better well-being for recovery from depression and other health crises among pregnant adolescents. A search for literature on the phenomenon in the country indicated that much has been done on adolescent-related issues, however; there was no information on social support and adolescent pregnancy-related issues. This forms the basis for this study in the Adaklu District in the Volta Region of Ghana where adolescent pregnancy has been very high for the past five years.

1.3 Conceptual Framework

![Conceptual framework showing the challenges of pregnant adolescents that attracts social support.](source: Researcher’s own construct (2018).)

**Fig. 1:** Conceptual framework showing the challenges of pregnant adolescents that attracts social support.

**Source:** Researcher’s own construct (2018).
The conceptual framework alludes that adolescent pregnancy is associated with several risk factors which have been broadly categorized as medical, psychological, social among others which may compromise the healthy development of both mothers and their fetus. Importantly, social support may offset the potential risks associated with adolescent pregnancy and parenthood. It must be recognized that social support may come in different forms and varied sources. When the pregnant adolescent receives social support, the challenges may be minimised and the result will be quality of life for both the mother and the fetus.

1.4 Objectives of the Study

The general objective of the study is to explore the social support received by pregnant adolescents in Adaklu District.

1.4.1 Specific Objectives are to;

1. Identify the challenges faced by pregnant adolescents
2. Assess the social support pregnant adolescent girls receive in the community
3. Explore the types of social support available to pregnant adolescents
4. Examine the satisfaction of pregnant adolescents on the social support services they receive

1.4.2 Research Questions

1. What challenges do pregnant adolescents face?
2. Do pregnant adolescents receive any social support?
3. What kind of social support do pregnant adolescents receive?
4. Are pregnant adolescents satisfied with the type of social support they receive during pregnancy?
1.5 Significance of the Study

The study is useful as it has the tendency to shape social and cultural conditions as well as public discussion on adolescent pregnancy.

The study will also inform policymakers, corporate organizations, NGOs and other entities to plan social support for the pregnant adolescents since they become vulnerable during this period and may need help. Typical of this will focus on empirical and theoretical findings concerning social support and adolescent pregnancy.

Finally, the study aims to contribute to the literature on social support and adolescent pregnancy in the country.

1.6 Organization of the Study

The whole study has been presented in five main chapters. Chapter one describes the general introduction of the study, the main problem under investigation, the main objective and the specific objectives. It further states the rationale and how the whole study is organized.

Chapter two is dedicated to the review of relevant literature on the phenomenon, models and theories of social support. The third chapter gives a brief profile of the study area. This includes location and size, social services and the economy. It also contains the research design adopted, the data collection tools employed, the data requirement and the sources of the data, the sampling technique, the key data variables and the framework for data analysis and reporting. It also provides a guide as to the conduct of the field survey. Chapter four presents the results from the field work whiles chapter five provides a discussion on the study conducted. The last chapter describes a summary of the main findings, conclusion and recommendations based on the findings.
1.7 Justification

Though extensive studies have been done on adolescent health and especially adolescent pregnancies globally, not much has been done on the subject of social support among pregnant adolescents in Ghana. Specifically, no study has been done at the Adaklu District where adolescent pregnancy is high. Again, as vulnerable as pregnant adolescents are, if social support is not extended to them, they may end up taking wrongful decisions that could affect them and the unborn child. It is therefore key to explore the social support among pregnant adolescents. Findings from the study will be used for planning and decision making in the area of adolescent health in the Volta Region.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction
This chapter examined and discussed literature related to the research study. Among the specific areas that were considered in the discussions are, challenges during pregnancy, types of social support, sources of social support, models and theories of social support.

2.2 Adolescent Pregnancy Situation
Adolescent pregnancy is considered one of the reproductive challenges globally. It is estimated that about 16 million girls who are aged between 16 and 19 years and about 1 million girls below age 15 years conceive and give birth annually (UNFPA, 2016). It is projected that by 2035, births among adolescents will rise to 20 million making the situation one of the key public health challenges (Fleming, Driscoll, Becker, et al., 2015). The babies born to these adolescents constitute approximately 11% of all births worldwide. Out of this, 95% occur in developing countries or low-middle income countries (WHO, 2015). A survey carried out from mid-1990s to early 2000s in 51 countries indicated that about 10% of girls were mothers before the age of 16 years with the highest rate emerging from Sub-Saharan Africa and the South Central and South-Eastern Asia (Miller, Sate & Winward, 2005).

Adolescent births in the lower and middle-income countries are twice higher compared to that of more developed countries (WHO, 2015). The rate ranges from 1% in Japan and the Republic of Korea to as high as 20% in the Democratic Republic of Congo. The WHO has reported that of the total 15 countries with the highest rate of adolescent pregnancy (30% or greater) worldwide, 14 are found in Africa. It further stated that one
out of ten adolescent girls have a child before attaining 15 years in Chad, Guinea, Mali, Mozambique and Niger where there is a high rate of child marriage (Mangiatera, Pendse, McClure & Rosen, 2008). UNFPA has also reported that 18 African countries constitute the top 20 countries with high rate of adolescent pregnancy worldwide, with Niger having the highest rate of 51% of women delivering before age 18 years every year (UNFPA, 2013).

The UNFPA in the State of World Population report stated that West and Central Africa account for the highest percentage (6%) of reported births before age 15 years among developing countries. The report also made claims that the West and Central African regions account for 44% of the unsafe abortion among adolescents who are between 15 and 19 years in developing counties in the world which excludes East Asia (UNFPA, 2013). There is a projection that there will be an increase in adolescent pregnancy from 10.1 million in 2010 to 16.4 million in 2030 in Sub-Saharan Africa. That is from 2 million adolescent births per year in 2010 to 3.3 million adolescent births per year in 2030 (UNFPA, 2013). There has been variation in the birth rate of adolescent girls between the ages of 15 and 19 years in Sub-Saharan Africa in recent years. The variation ranges from 37 births per 1000 girls in Mauritius to 229 births per 1000 girls in Guinea. This rate is compared to that of worldwide which is 65 births per 1000 girls. In North Africa and the Middle East, the average birth rate is around 56 births per 1000 girls varying from 7.5 births in 1000 girls in Tunisia to 122 per 1000 girls in Oman. However, the rate in these regions fell substantially between the 1970s and early 1990s. The rates in Asia are not different from that of some part of the world. The rate for Central Asia varies from 27.7 per 1000 girls in Azerbaijan to 152 per 1000 girls in Afghanistan. In East and South Asia and the Pacific, the rate varies from 3.6 per 1000 girls to 115 per 1000 girls in Bangladesh. Birth rate however has fallen since the mid-
1970s in these regions. Latin America has an average of 78 per 1000 girls varying from 48.3 per 1000 girls in Cuba to 149 per 1000 girls in Nicaragua. There was a notable increase in some countries of this region from the mid-1970s to early 1990s (Bearinger, Sieving, Ferguson & Sharma, 2007).

In Europe, the average rate is 25 per 1000 girls with varying range of 5.4 per 1000 girls in Switzerland to 40.4 in Bulgaria. There is a considerably varying incidence rate of adolescent pregnancy in Europe. The United Kingdom (UK) has the highest rate in Western Europe. This rate is however, lower to that of Bulgaria, Russia and Ukraine in the whole of Europe (Tripp & Viner, 2005). There was a significant fall in the rate of teenage pregnancy throughout most countries in Western Europe during the 1970s, 1980s and 1990s. The rates of the United Kingdom however, remained above the level of the early 1980s (Tripp & Viner, 2005). There has been a significant decrease (25%) in the rate of teenage pregnancy in the United States of America (USA) from 2007 to 2011. Notwithstanding this reduction, United States of America still has the highest rate of adolescent pregnancy among developed countries (Kost & Henshaw, 2014). The teenage pregnancy rate for the USA as of 2010 was 57.4 pregnancies per 1000 women. There was a record reduction in the rate of teenage pregnancy from 116.9% in 1990 to 57.4% in 2010. Between 2008 and 2010 the teenage pregnancy rate dropped by 15%, from 67.8% in 2008 to 57.4% in 2010 (Kost & Henshaw, 2014). One factor that determines the level of fertility in any given population is the age at first birth.

In Ghana, adolescents between the ages of 12 and 19 years contribute 6.6% of the total fertility (GSS, 2013). Also, as much as 12% of adolescent girls between the ages of 15 and 19 have had a child. It is estimated that 1 out of every 10 births occur among adolescent girls in Ghana (Awusabo-Asare & Abane, 2004). About 13% of women
between ages 15 and 19 years have already given birth to their first child in Ghana. The highest childbearing rate (23%) is in the Central and Northern regions of Ghana with the lowest rate (7%) occurring in Western and Greater Accra regions (GSS, 2009). It was identified that women with little or no education were likely to begin childbearing at an early age whilst women who have attained secondary education or more, less likely to start childbearing early (31% compared to 1%) (GSS, 2009). The 2014 GDHS reports that 14% of adolescents between the ages of 15 and 19 years have already started childbearing, 11% have given birth to their first child and 3% were pregnant during the survey (GSS, 2014). The report also indicated that the proportion of adolescents who have begun childbearing increases with age; 1% at age 15 to as high as 31% at age 19. The regions with the highest childbearing rate as indicated in the report were the Volta, Brong Ahafo and the Central regions (GSS, 2014).

2.3 Challenges Associated with Adolescent Pregnancy

Pregnancy constitutes a period of vital life changes that demands total psychological adjustments and, in some cases, mothers may experience stress and anxiety (Liran et al., 2012). It is argued that when pregnant women are not able to adjust psychosocially and emotionally, health challenges are likely to occur. For example, Liran et al., (2012) opined that depressed mood during pregnancy has been identified as a predictor of postpartum depressed mood. Again, studies have established that emotional distress, particularly symptoms of depression and anxiety, may increase the risk of pregnancy and birth complications, poor neonatal status, low birthweight, prematurity and intrauterine growth retardation (Kawakita et al., 2016;).

Social support refers to the voluntary action that is directed from one person to the other which may lead to positive response (Mermer, Bilge, Yucel & Ceber, 2010); this
voluntary action comes from varied sources, such as the family, friends, community or spouse (Backstrom, Larsson, Wahlgren, Golsater, Martensson & Thorstensson, 2017); and it comes in various forms such as physical and emotional (sympathy, love, care), verbal and financial aid or assistance (Mermer, Bilge, Yucel & Ceber, 2010). In pregnancy, social support and healthy behaviours during pregnancy (Capponi et al., 2014) quality of life, depression (Xie et al., 2010), during labour and delivery (Khresheh & Barclay, 2010), in young and vulnerable women are among the topics investigated in some research.

The role of social support as a resource against stress and psychological and physical symptoms is well researched in literature. For instance, the importance and influence of social support on promoting the health of mothers and newborns (Khresheh & Barclay, 2010) and on prevention of many diseases and an increase in life expectancy and decrease in postpartum depression and better results in pregnancy outcomes (Figueiredo, Pacheco & Costa, 2007), perceived support from family. It has been proposed that effective psychosocial resources, particularly social stability and social participation providing emotional and instrumental support, are protective by buffering the impact of life stress on the emotional well-being of the mother (Glazier et al., 2004).

Evidence from population-based epidemiological and clinical studies found that in addition to the effects of other established socio-demographic, obstetric and behavioral risk factors, women reporting higher levels of psychological stress during pregnancy are at significantly increased risk of preterm birth (Wadhwa, Entringer, Buss & Lu, 2011). Stress at the beginning of pregnancy has been identified as one of the main causes of disorders during delivery (Dunkel & Tanner, 2012).
2.4 Pregnant Adolescents and Health

Early child bearing has been found to be associated with many health glitches including anaemia, mental illness (puerperal psychosis), malaria, unsafe abortion, and obstetric fistulae (Mouli, Camacho & Michaud, 2013).

Most girls after realising they are pregnant resort to any means possible to terminate the pregnancy. Some go to the extent of undergoing unsafe abortion which even if they survive leaves permanent mark or adverse effect on their reproductive life. This usually occurs in developing countries where abortion is not legalized. About 2-4 million adolescents practise unsafe abortion every year in developing countries (WHO, 2011). Adolescent pregnancy contributes immensely to maternal mortality, perinatal mortality and infant mortality. In 2008, WHO stated that adolescent pregnancy contributed to 13% of all deaths and 23% of all disability adjusted life years (WHO, 2008). Adolescent pregnancy was also found to contribute to rancorous cycle of ill-health and poverty (WHO, 2008 & WHO, 2011).

Pregnancy related deaths are found to be the leading cause of mortality among adolescent girls who are between the ages of 15 and 19 years worldwide (Isa et al., 2012). However, recent studies have shown a decline in the rate of deaths in all regions globally, especially in South-East Asia where mortality rate has reduced from 21 to 9 deaths per 100,000 girls since the year 2000 (WHO, 2014). It is in view of this that the UN Secretary General launched The Global Strategy for Women’s and Children’s Health in September 2010 to address the issues concerning the health and welfare of adolescent girl. This was also to achieve the Millennium Development Goal -5 which is related to reduction of maternal mortality (WHO, 2011). The WHO also reported that perinatal deaths among infants born to mothers who are below the age of 20 are...
50% higher compared to infants born to mothers who are above 20 years (WHO, 2011). Babies who are born to adolescent mothers also have the likelihood of developing childhood health problems than babies born to older mothers (Ganchimeg, Ota, Morisaki, Laopaiboon, Lumbiganon, Zhang et al., 2014). The adverse effect of poor new born health resulting from adolescent pregnancy can have inter-generational effect and also long-term effects which may result in adulthood diseases (Foetal Origins of Adulthood Diseases) (WHO, 2014). In Ghana, it has been revealed that birth to adolescent mothers between the ages of 15 and 19 years have the highest rate of infant and child mortality (GSS, 2010).

There are some girls that get pregnant because they are afraid of visiting clinics, where they will get some contraceptives. The reason why teenagers are afraid is the nurses’ attitudes towards giving teenagers contraceptives. Some nurses were uncomfortable about providing teenagers with contraceptives, as they felt they should not be having sex. They responded to request for contraceptives in a manner that was highly judgmental and unhelpful. The girls describe it as harassment (Yidana, Ziblim, Azongo & Abass, 2015).

2.5 Pregnant Adolescents and Social Challenges

Young adolescents who become pregnant may face stigma and lower educational attainments and, in some cases, drop out of school. For example, it is projected that between 5% to 33% of girls who fall within the ages of 15 to 24 years drop out of school due to early pregnancy or marriage (World Bank, 2017). Absenteeism from formal education among pregnant adolescents may truncate their desire to fulfil their future goals as many of them may not have the opportunity to complete their education mostly due to stigmatization and the time they spend in the care of their child (Timur, Kokanal,
Topçu et al., 2016). Despite the aforementioned risks, there is also the possibility of adolescent encountering social risk linked to the physical, emotional, economic, and social dependency issues (Timur, Kokanal, Topçu et al., 2016). There is also the tendency of these adolescent girls facing risks of violence from their peers and the immediate family since they may not have the opportunity of making their own decision related to nutrition, social and medical care among others.

They are likely to have lower socioeconomic status because they may not be gainfully employed and in some cases experience violence with their families, partners and the families of their partners (Jutte et al., 2010). For instance, it is assumed that teenagers who become pregnant are expected to experience violence within marriages if they should enter with their partners or the family of the partners due to misunderstanding and immaturity (UNFPA, 2013). The situation put the adolescent mother into adversity which unceasingly impact on the lives of their unborn babies (DeSocio et al., 2013). Poverty can either be a cause or a consequence of adolescent pregnancy and parenting and fewer job opportunities (UNFPA, 2013). This could be attributed to lower skills and educational attainments. Generational consequences have been found to persist across socioeconomic status and thus potentially affect all adolescent births (Jutte et al., 2010).

According to Dole et al., (2003), the type of neighbourhood one grows in contributes to maternal stress of the pregnant adolescent. Adolescents raised in poor neighbour may experience discrimination, low socio-economic status households, lower education and may not achieve their educational goals. The adolescent is thus prone to sexual promiscuity in addition to poor sexual education resulting in pregnancy. (Talashek, Alba & Patel, 2006).
Additionally, separation and or divorce from partner, recurrent pregnancy, poverty, interruption in career and limited career opportunities are likely to be associated with teenage pregnancy (Klein & American Academy of Paediatrics Committee, 2005). Maternal health status and behaviours are likely to be the influential effect of social and environmental factors (Dole et al., 2003).

2.6 Adolescent Pregnancy and Violence

Gender power inequalities play a significant role in women’s vulnerability to early and unprotected sex as well as pregnancy. On many occasions, young women have less power over their own bodies than men, and often required to be more accountable for their actions than young men. Recent research has shown that both a history of physical abuse by a partner and current involvement in a physically abusive relationship was associated with becoming pregnant (Hodgkinson, Beers, Southammakosane & Lewin, 2014).

2.7 Conceptualisation of Social Support

Social support is considered a complex and multi-faceted concept. This has been shown in the diverse medium the concept has been operationalised. For instance, some pioneers who worked on social support considered social support as how person's basic social needs-for affection, esteem, approval, sense of belonging, identity and security—are met by interacting with others (Logsdon, 2005). Another school of thought perceived social support to act as a barrier to stress and have therefore considered social support as an interaction that is perceived by the recipient to enhance coping and support in responding to stress (Habel, Feeley, Hayton, Bell & Zelkowitz, 2015). Social support has also been viewed as a multiple construct which works as a means of
meeting basic needs and a means of buffering stress (Sampson, Villarreal & Padilla, 2015). It has also been shown that there is a direct relationship between social support and the health of individuals especially the pregnant adolescent (Khresheh & Barclay, 2010). This can be grouped into formal and informal social supports.

According to Lin & Wu, (2010), formal support describes medical services and other assistance that are received from healthcare providers, while informal support describes the kind of support given to an individual by family members, friends and other close allies. The benefits of informal support in the lives of individual’s especially pregnant adolescents have been well researched. Due to the benefits to the individuals who received them and because it is considered as cost-effective and readily available (Ryser & Halseth, 2011). Generally, informal supports are unpaid and are mostly offered by family, friends, and neighbours (Thanakwang & Soonthorndhada, 2011). It has also been observed that informal supports may come in varied forms. These may include: affection, advice, companionship, assisting the pregnant girl with transportation and nursing care (Alexandre, Labronici, Maftum & Mazza, 2012). Informal support, for example, communication, is believed to play a key role in providing instrumental support to the pregnant adolescent which in the end may boost their competency, self-esteem and/or autonomy. The informal support gives the pregnant adolescent a sense of inclusion rather than neglect and helps to prevent depression that she might go through.

2.8 Sources of Social Support

Social support can come from different sources: family, friends, romantic partners, pets, community ties, and co-workers. Sources of support can be natural (e.g., family and friends) or more formal (e.g., mental health specialists or community organizations)
(Taylor, 2011). The support of friends especially age mates, colleagues from work and playmates have been found to be contributing factors to a persons’ well-being. Friendship can provide instrumental support and allies. Support from a romantic partner is associated with health benefits, particularly for men (Kiecolt-Glaser & Newton, 2001).

Apart from friendships, families also play a key role in helping loved ones especially the adolescent to adjust to life. This could be done through constant visits and spending quality time discussing family related issues. Li, Ji & Chen (2014) posit that families form an active and powerful interpersonal foundation for adolescents and their well-being.

2.9 Types of Social Support

Types and sources of social support vary among researchers. Four main categories of social support have been identified: emotional, appraisal, instrumental and informational (Logsdon, 2005). On the other hand, Schaefer, Coyne & Lazarus (1981) identifies five different types of social support: Emotional, Esteem, Network, Informational and Tangible social supports. Emotional support which expresses empathy, love trust and care. This is the kind of communication that meets the affected person’s needs or feelings. These are expressions of concerns and do no directly solve the challenges of the affected. They rather heighten an individual’s hope and mood. This type of support is what we most often think of when we hear the term social support.

Another type of social support, Informational support, is the information that provides useful or needed information, this includes advice and suggestions and instrumental
support which describes tangible aid and service. An individual just diagnosed with a condition often needs more information and this can be supported by those who provide useful information (Logsdon, 2005).

Esteem support describes communication that boosts an individual’s self-esteem and the ability to handle the problem at hand or perform a needed task. This encompasses an individual’s ability to convince a fellow who has a challenge that he/she has the ability to confront the problem at hand.

Network support refers to communication that affirms individuals belonging to a network or reminds them of support from the network. In other words, it reminds people that they are not alone in whatever situation they are facing. Members of a network may offer many types of support but the concept of network support emphasises that a network is available to provide social support.

Tangible support is any physical assistance provided by others. In some situations, individuals need material goods or actions to help them in challenging situations.

Social support is synonymous to the concept of social network where families and friends provide help needed by the individual.

2.10 Theories of Social Support

Various theories have been used to describe the concept of social support. One of the central theoretical standpoint in social support field has been the stress and coping theory (Sampson, Villarreal & Padilla, 2015). According to this theory (Folkman & Moskowitz, 2004), stress ensues when people conversely interpret situations (i.e., negative appraisals) and stress leads to health problems, as long as people do not employ adequate coping responses (e.g., problem solving, emotion regulation). Social
support promotes health by protecting people from the adverse effects of stress (i.e., stress buffering; Sampson, Villarreal & Padilla, 2015). It does so by promoting more adaptive appraisals, more effective coping or both. In principle, social support is supposed to promote appraisals and coping to the extent that the particular type of social support matches the demands of the stressor (the optimal matching hypothesis; Sampson, Villarreal & Padilla, 2015). Social integration, perceived support and enacted support play somewhat different roles in the stress and coping model of social support. An individual’s perception of support should reflect her/his history of the receipt of effective enacted support, and this perception should directly reduce negative appraisals of stressors.

2.11 Effects of Lack of Social Support

Social support is an important factor that may promote the physical and well-being of individuals. For example, in a study of 707 older adults, it was established that there was a positive relationship between social support and recovery from illness (Hay, Steffens, Flint, Bosworth & George, 2001). In another instance, social support was found to moderately reduce the effects of health-related strain on mental health (Morikawa et al., 2015). According to Leahy-Warren, McCarthy & Corcoran (2012), the absence of social support has been linked to a decline in cognitive function of people who are stressed. Social support, social exchange and social network promote well-being in the pregnant adolescent as they reduce stress or depression.

Again, Maharlouei (2016), in a study of the importance of social support among pregnant women identified varying benefits of social support. As the study identified that decrease in social support over a year was found to be associated with increased
psychiatric symptoms, including depression. Also, it was found that quality, not quantity, of the support, was key to the health and well-being of people. For example, Adams et al, (2004), noted that receiving fewer visitations from close allies, and having less extensive social network predicted loneliness. Again, it was found that persons with less social relationship results in reduced immunological functioning (Morikawa et al., 2015).

Lowdermilk, Perry & Cashion (2011) suggest that unbalanced social exchanges contribute to changes in living conditions. In a similar study, it was ascertained that social support including conversations have been acknowledged as impacting immunological functioning (Morikawa et al., 2015). Others have argued that social support provides a sense of belongingness to one’s social ties, which brings about we-feeling and well-being.
CHAPTER THREE

METHODOLOGY

3.1 Introduction

The structure of this chapter shows a framework that presents the methodological plan of the study. It outlines and describes the study design, study area and the source of data for the study. The instrument used for data collection, sampling and sampling procedure, sample size and technique of pretesting of instruments and data analyses are also shown in this chapter.

3.2 Study Design

A qualitative study was used to explore the social support received by pregnant adolescents in Adaklu district. The study used the phenomenology approach. Phenomenology probes an individual’s beliefs, knowledge, perceptions and experiences about a particular phenomenon. It is concerned with the lived experiences of the people who are directly involved in the phenomenon under study (Creswell, 2013). In phenomenological research, respondents are asked to describe their experiences as they perceive them. It is therefore applied when there is the need for deeper understanding of experiences that are common to a group of individuals (Creswell, 2013). This method allowed me to identify and understand the issues pertaining to social support to these pregnant adolescents in the Adaklu District.

3.3 Study Area

The study was carried out in Adaklu District of the Volta Region. Adaklu district is one of the 25 Administrative districts in the Volta Region with its capital located at Adaklu Waya. The district is about 802 square kilometres and shares boundaries with Ho
Municipal to the North, Agortime-Ziope District to the East, Central Tongu District to the South, and Ho West District to the West.

The district has 13 electoral areas with a population of 42,323 which is mostly rural and covers 68 communities excluding numerous farming communities and Fulani settlements. The District is predominantly inhabited by Ewes and some few Ga-Damgbe and Fulani settlers.

Socio-cultural and religious norms in the communities of the district vests most authority in the hands of chiefs, religious leaders and clan heads who are mostly males. The predominant religion is Christianity. There are however a number of traditional religious practitioners and few Moslems.

Health service provision is mainly by the Government through the Ghana Health Service and supported by the Christian Health Association of Ghana (CHAG). The District has no District Hospital as such health services are delivered by Adaklu-Helekpe Health Centre, Adaklu-Waya Health Centre, Sofa Clinic (CHAG), Ahunda Health Centre, Torda CHPS zone, Ahunda CHPS zone and Kordiabe CHPS zone. The District epidemiological profile shows a concurrent significant prevalence of diseases including Malaria, Upper Respiratory Tract Infections, Intestinal Worms, Diarrhoea and Rheumatism/Joint Pains. The district has Total Fertility Rate of 2.4 births per woman and a General Fertility Rate of 71 births per 1,000 women aged 15-49 years. The District can boast of a number of first and second cycle schools with no tertiary institution. The road network in the area is relatively good. Majority of the inhabitants are farmers who grow to feed their families.
3.4 Data Source

Data for the study was mainly obtained from the primary source. Primary data were obtained directly from respondents through the use of interviews which comprised open-ended and probing questions.

3.5 Target Population

The target population were adolescents between the ages of 15-19 years old who were pregnant. This was achieved by making personal contacts with the target group in their homes and health facilities where they accessed health services. This was done after an
introductory letter from the School of Public Health of the University of Ghana which narrated the purpose of the study was explained to the respondents.

3.6 Sample and Sampling Procedure

The sampling technique adopted for the study was the non-probability method and purposive sampling technique. The logic behind this decision was to gain an in-depth understanding of the experiences of the adolescent pregnant girls. Considering the very personal nature and population under study, purposive sampling was used to reach out to the participants. This was achieved by making a personal contact with the respondents.

3.7 Sampling Size

Boyd (2001) suggests 2 to 10 participants as sufficient to reach saturation whiles Creswell (2003) asserts that between five and twenty-five interviews will suit this purpose. Based on the various assumptions fifteen (15) pregnant adolescents from Adaklu District were selected for the study.

3.8 Tools for Data Collection

Research tools such as interview guide, were prepared in consultation with the School of Public Health, University of Ghana for the purposes of data collection.
3.9 Training of Research Assistants

Two research assistants were recruited and trained by the principal investigator for data collection. The recruited research assistants were trained to develop a practical understanding of the research problem and the rationale of the study, along with an understanding of the timeframe of scheduled activities. The assistants were made up of personnel who could read, write and speak both Ewe and English languages fluently. Again, the team was trained on informed consent procedures and skills in conducting in-depth interviews, using interview guides and in conformity to ethical issues involved in data collection. Further, the research team was trained to strengthen their interviewing skills while interacting with respondents from different backgrounds. The training provided guidelines and strengthened the skills of the research assistants for the documentation of interactions and maintaining a daily account of events in the field. Finally, the training hinged on how to audio-tape interviews and the importance of revisiting and completing interviews whenever there was a break to address gaps during the transcription processes.

3.10 Data Collection

A face-to-face in-depth interview with clients who met the age criteria and are pregnant was carried out using a semi-structured interview guide.

3.11 Data Collection Procedure

The face-to-face interview technique was used to obtain information from participants by using Ewe and English language. Before the start of each interview session, information about the study, the use of the data being collected, and an estimated timeframe of the interview was made known to participants. Participation in
the study was completely voluntary, and participants were duly informed about their right to withdraw from participating in the interview at any point in time if they wish. Confidentiality of respondents and their information was maintained throughout the study by conducting the interviews at the convenience of respondents and also keeping data out of the public. Prior consent was sought from participants for audio documentation of the interview. Upon agreement, participants and the Principal Investigator and/or the assistants signed the inform consent form and a copy of the form given to participants for keep. In a situation where the participants were unable to read and write, research assistants read and interpreted in Ewe for full understanding. Anonymity was ensured by maintaining codes during data entry instead of names, contact numbers and other cues that could lead to the identification of participants. The essence of these measures was to ensure that respondents participate in the study willingly without any form of coercion and also ensure that information obtained is kept safe.

3.12 Data Management

Data obtained from the research participants including audio recordings, transcripts of interviews were stored electronically on a hard drive with a password known only to the Principal Investigator.

3.13 Interview with Pregnant Adolescents

Adolescent pregnancy is defined as getting pregnant in the teenage or adolescent period which is between the ages of 10 and 19 years. However, in this study, adolescent pregnancy will be defined as a pregnancy in female adolescents who are between the ages of 15 and 19 years.
Persons who met the criteria of the target population of the study (pregnant adolescent girls who are between ages 15-19 years) were interviewed at their own convenient time in their homes. The interview guide was mainly divided into four sub-sections: demographic characteristics of respondents, challenges faced, types of social support received and the sources of the kinds of social supports they received. On the whole, the interview lasted for about 45 minutes and all respondents were asked the same question. Further questions were asked based on the responses and feedback obtained from respondents.

3.14 Ethical Considerations

Increased concern about ethical conducts especially in the study of human behaviour through research has attracted the formulation of guiding principles by Universities, professional bodies and governments that clearly define the rights and privileges of research participants (Kumar, 2005). In order not to flout these principles and to ensure the proper conduct of the study, the following ethical principles were adhered to.

First, due processes were followed to obtain ethical approval from the Ghana Health Service Ethical Review Committee. Secondly, approval was sought from the School of Public Health, University of Ghana. Further, approval was sought from the District Director of Health services for Adaklu who gave permission for the research team to visit health facilities within the district.

Despite obtaining permission for the fieldwork from the above bodies, other ethical principles were followed in order to protect research participants. One of these ethical principles was to obtain informed consent from respondents. This particular principle was adhered to by explaining to participants the nature and purpose of the study, type
of questions to be asked, the sensitivity of questions and the consequences thereof before they took part in the study. Participants were informed that the interview proceedings would be audio tape recorded. Upon agreement, the Principal Investigator or the assistant signed the inform consent form with respondents who were 18 years and above and a copy of the form was given to the respondents for keep. This principle made participation in the study voluntary and without any form of compulsion. Also, permission was sought and an assent form completed by parents and guardians of respondents who were below the age of 18 years.

3.15 Possible Benefits
Participants in this study may not benefit directly however; finding from the study may influence policy perspectives on social support for the pregnant adolescents in the country. Findings may also influence State institutions and other organisations to explore approaches to providing social support to pregnant adolescent since they may be classified as a vulnerable group.

3.17 Data Storage
Data obtained from respondents including audio recordings, transcription of interviews were stored electronically on a hard drive with a password known only to the Principal Investigator. The hard drive with data were kept under lock by the principal investigator.

3.18 Compensation/Cost
There was no compensation/cost either in cash or kind for respondent’s involvement in this study.
3.19 Confidentiality

Information provided was protected to the best of my ability. Respondents were not named and any information that could lead to their identification was not presented in the study. Where there was the need to quote statements verbatim, anonymity was ensured.

3.20 Data Analysis

To accomplish this task, interviews conducted in the local dialects were closely and accurately translated and transcribed into the English language. Gaps identified during this process were filled by making reference to field notebooks and interview tapes whenever the need arose. All voice recordings from the interviews were transcribed and translated into English by research assistants. To check for accuracy, some of the transcripts were translated back into Ewe. The research team then compared the Ewe and English versions for differences and similarities while listening to the original voice recording. After verification of accuracy in translation, each transcript was then read aloud by a research assistant while the other team members listened to the corresponding voice recording for consistency. The transcribed and verbatim translated recordings were entered into the computer using Microsoft Word. The textual data were imported into NVivo 11, a qualitative data analysis tool, using both predetermined codes, following the main topics included in the IDI guide. The codes and the data located under them were collated into potential themes and reviewed to ensure that they were coherent and reflected the content of the dataset. The names of the final themes were then determined.
CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of the study. Specifically, the demographic characteristics of respondents, challenges faced by pregnant adolescents, source of income for ANC Services, the types of Social Support received by adolescents and where such supports came from have been discussed. The chapter further presents the benefits derived from the received social support and whether or not the received support impacted on respondent adversely. The chapter ends with a brief summary of the results.

4.2 Demographic Characteristics of Respondents

In this study, fifteen (15) respondents were interviewed. Information on their demographic characteristics indicated that five (5) respondents were 19 years, three (3) were 18 years, four (4) were 17 years and two (2) being 16 years. Only (one) 1 adolescent girl was 15 years. Three (3) of these number had no formal education, whiles five (5) had only primary education. Respondents who had Junior high education were six (6), whiles one (1) person had a senior high education. The religious affiliation of the respondents indicated that thirteen (13) were Christians whiles two (2) were Muslims. None of these girls had been formally married. Only one (1) respondent had started a hairdressing apprenticeship. The rest were not working. Majority (11) were living with their parents whiles four (4) were living with their supposed partners because they had been sacked from home.
One would have thought that adolescents who had no formal education could have been the majority but adolescents with Junior high education were found to be the majority of pregnant girls.

4.3 Challenges Faced by Pregnant Adolescents

Teenage pregnancy, resulting in teenage motherhood has been a social and health problem in many countries. Adolescents by virtue of their stage are confronted with numerous challenges which stem from health, financial, abuses and violence. From the results, challenges faced by pregnant adolescents included: drop out from school, verbal abuses, stigmatization, rejection, financial difficulty and other health implications. Respondents narrated how they were unable to socialize with the rest of the community and their own classmates:

“I am always at home because of the fear of stigmatization. I can’t go out to socialise because I was warned by my family and other people in the community about my relationship with this particular boy but because of love, I did not listen. My teachers also warned me and because of the pregnancy, I am unable to go to school. I cannot even call my classmates because I am shy...” (Respondent 3)

“...I quite remember one evening they were playing night jam and I went there, then the people around were pointing fingers at me, they said pregnant women do not come here so I should leave here....” (Respondent 4)

“...I remember one afternoon I met three of my friends at the market and when I called them one told the others not to come close to me because when they do
"I will teach them how to get pregnant, can you imagine mmh....” (Respondent 1)

Other respondents expressed how difficult the situation was when they realized that they were pregnant and had to stop schooling:

"I was always thinking about the termination of my school. I stopped the schooling myself because classmates and other friends were laughing at me. My teachers did not also ask me why I stopped schooling maybe because they are aware of my pregnancy” (Respondent 12)

"I sometimes feel sorry for myself, seeing my colleagues going to school and I am at home.” (Respondent 8)

"I got pregnant when I was in JHS 2 and I have since stop because that is the rule in the school and also for example if I were to be in JHS 3 then I will say I will try and finish it by writing the final exams but in this case, I was in JHS 2” (Respondent 7)

In most cases, parents and family members feel disappointed when their wards become pregnant. As a result, most parents out of anger and disappointment abuse their wards verbally. The narrations below are examples of how pregnant adolescents were abused:

"My father always reigns insults on me for getting myself pregnant, he even goes further to tell me how useless I am. It really hurts me but I can’t do anything about it, I just have to be quiet and it gets me depressed on some occasions.” (Respondent 2)
“My biggest challenge during my first three months pregnancy was when my mother was unhappy with me and always deny me food. She told me she will punish me till that baby comes out” (Respondent 15)

Partners who were also not prepared for the pregnancy also felt disappointed, insulted and sometimes denied responsibility. A respondent narrated how she was abused by the partner:

"As for that hmmm...my partner always abuses me verbally calling me names such as a foolish girl, good for nothing, and so on"... (Respondent 11)

Pregnant adolescents are mostly confronted with emotional challenges due to the situation they find themselves in. Among these challenges are depression, fear, anger and sadness which influence the mood and life style. The narrations below express how respondents felt emotionally:

“For some time now, I have been examining my life, I went to stay with someone with a vision of becoming somebody in future and here I am pregnant. Anytime I think about it, I feel depressed and lonely. I have been rejected by the person I went to stay with so am back living with my mother.” (Respondent 13)

“I sometimes regret getting myself pregnant and that makes me depressed and lonely.” (Respondent 5)

“I have been thinking a lot about my situation but I just have to forget sometimes and hope God will provide. One thing I don't understand is that before my pregnancy I was very close to my partner and he treats me well but ever since I became pregnant his attitude has changed and he now even doesn’t pick up my calls.” (Respondent 10)
Emotionally, girls who became disturbed had thought of aborting their pregnancies especially when they were mocked by their classmates or whenever they were abused verbally at home. Some girls shared their experiences:

“My friends have been laughing at me since I got pregnant and as a result, I keep to myself and always at home, during those hard times I usually think of aborting the baby” (Respondent 14)

“I always think about it and I feel like terminating the pregnancy but I have been warned by the midwives that I will die if I try to abort the pregnancy.” (Respondent 6)

“Anytime I do something and it offends my mother, then she would start her rant on me...and that she has sent me to school to become somebody better in future and I went to get myself pregnant.... whenever this situation arises I usually feel sad, depressed and begin thinking.” (Respondent 9)

Adolescent pregnancy, which results in teenage motherhood is social and health problem in many communities. Especially because at this age most of these girls are not working and as a result, find it extremely difficult to raise funds for themselves and their babies. Financial challenge was a major problem faced by these young girls. Some respondents shared their frustrations on how difficult it was to raise funds for food, personal belongings and antenatal care:

“I am facing a lot of difficulties with regards to money, you know I am not working, my mother is a Gari seller, so if she does not do enough sales and if my partner too doesn’t send money it is not easy at all.” (Respondent 8)
“I am facing some difficulties with money issues, even if I am hungry and ask my partner money for food he will tell me he does not have so if my mother does not support me at that particular moment I will be hungry till we cook in the evening.” (Respondent 11)

“One of the biggest challenge I am facing now has to do with money, ..."I remember last month when I visited the hospital, I was told I am over stressing myself"... that is true because there is no place I can get money” (Respondent 1)

Most pregnant adolescents are confronted with health challenges which may lead to complications during deliveries and in some cases may contribute to maternal and child mortalities. Conditions such as vomiting, malaria, stomach pains were reported by adolescents as some of the forms of health challenges. Some respondents had this to say on the health challenges they are going through:

“My pregnancy is a very difficult one, I got very ill some time ago and was rushed to the hospital, when I came I was given some medicines to take and that really helped me. The nurses told me it was malaria and I was not admitted too. I also suffered from the disorders of pregnancy, vomiting, headaches and Stomach pains.” (Respondent 10)

“Almost every day I feel like vomiting, that is anytime I eat, I always vomit. I also suffered from malaria, became very ill and was admitted.” (Respondent 6)

“Sometimes I don't want to come to the hospital because I am afraid of needles and when I went to Adidome, the nurses shouted at me. For example, when they say something and I don’t understand then they will scream at me because
I am a teenager so sometimes I don't feel happy about coming to the hospital.” (Respondent 3)

4.4 Source of Funds for ANC Services

Funds for ANC was crucial for pregnant adolescents. Mostly, monies came from parents of girls whilst supposed partners who were employed also supported them with monies for ANC.

“I try to come for ANC visit anytime I am scheduled. Almost every month I come. The cost depends on whether I am going alone or I go with my mother. If I am alone the transport is 6.00 cedis. But if I am scheduled to go to Ho for laboratory services or scan I spend more and all these bills are paid by my parents. I also have NHIS which I use when I visit the facility.” (Respondent 7)

“My mother is the one who caters for me, from feeding to T&T for health care in the hospital. Because of financial difficulties this is my third visit to the hospital. There are times I don't have money and will have to walk from the village to the health facility although the distance is far.” (Respondent 5)

“I don't spend much in attending hospital because my dad has a motor bike so my little brother brings me on anytime I am scheduled for ANC.” (Respondent 9)

Partners who were working provided their supposed partners with money to attend ANC:

“My child’s father is a taxi driver. He gives me money to go to the hospital and to get my medications. He even sometimes sends me himself.” (Respondent 2)
4.5 Types of Social Support

Pregnancy is a critical period in the life of every woman especially the adolescent pregnant girl. During this period, social support when obtained calms the nerves of the girls. However, it is also a period for psychological and physiological challenges. Social support in most situations affect the lives of these pregnant girls significantly because they may obtain the needed support to cope with. Three main types of supports were received: emotional, instrumental and informational

Emotionally, the girls had the following expressions:

“My mother is my bedrock, she always shows me love even though am pregnant, giving me food and encouraging me to eat, she gives me money for my hospital bills and a lot other.” (Respondent 3)

“My brothers and sisters are my sources of encouragement, they make sure I am not lonely or find myself thinking alone. As for my mother, she always refers me to what she has told me prior to my pregnancy that I should stop following the guy and that he will impregnate me and will reject me. I feel very sorry for myself now.” (Respondent 12)

“My child’s father has been very supportive. He is the one I have always been talking to. He tells me that everything will be ok. He has promised to assist me to learn a trade after my delivery. Was also encouraged that I can go through the pregnancy successfully” (Respondent 13)

Instrumentally pregnant adolescents received the following supports:

“My mother is the main support during this pregnancy, she provides support including, money for food, my own clothing because I could not wear my other
cloth they became small, to my baby's clothing among others. My partner also supports but not as much as my mother." (Respondent 4)

“My mother is very helpful when it comes to buying of baby items, just yesterday she bought some baby clothing, some few additional soaps and pomade for me.” (Respondent 15)

“My child's father is providing me with some money to buy few items prior to my delivery.” (Respondent 14)

Informationally pregnant girls received from some few people including nurses and other close family members who had delivered before:

“My mother really provides me with information...I remember my mother telling me anytime I want to sleep I should sleep sideways not just anyway...” (Respondent 7)

“I am the only one left at home with my mother and she is the one who has been advising me.” (Respondent 13)

### 4.6 Sources of Social Support

Different sources of support were relevant to adolescent pregnant girls. Support from parents, family members and other supports from partners or partners’ family were related to good health. Parents of pregnant girls even though were not happy with their daughters getting pregnant, they formed the main sources of social support. Respondents re-counted how their parents supported them:
“My major source of income during this pregnancy is my mother, I believe she gives me this support because I respect her a lot. She has also bought some few items for me which will aid me in my delivery.” (Respondent 6)

“For now, the person I really count for everything, if I am depressed, upset, feeling generally down and weak is my mother. And now that I am very close to delivery she is really taking care of me and I am happy for that love she is showing me.” (Respondent 4)

“My child's father does not care about me anymore, he now sees me as a burden on him although I do not stay with him. My mother is now the only person looking after me and she has also delivered not too long ago” (Respondent 14)

Family members especially grandmothers who had delivered also provided support to the girls:

“I received some items such as cloth, fish and money from my grandmother and other people. My grandmother was the one I can really count on during my pregnancy because she does not insult me and she also sometimes encourages me.” (Respondent 2)

“I will say my grandmother is the one I can really count on when it comes to advice, when and how to relax when I am tensed or depressed...She once told me that pregnant women do not fight because when you do that, it is either your baby will die during delivery or die after delivery... so I should not engage myself in that.” (Respondent 3)
“I received some items from my uncle, he bought me cloth and gave me money when he visited.” (Respondent 6)

Informational support which came from the religious groups of respondents also benefitted pregnant adolescents:

“One other support I received is from my church, few of the members got to realise I was pregnant so anytime I go for church services they usually talk to me to calm me down...I think they are part of the reason why I did not go for an abortion... They told me I should not consider an abortion because I don't know who the child will become one day in future.” (Respondent 1)

4.7 Benefits of Social Support

Social support brought physical and emotional benefits to pregnant adolescents. It essentially helps individuals to have a network of family and friends that provide support in times of need. It also urges people up during times of stress and often provides them with the needed strength to sail through challenges. Experiences are shared below:

“It really helped me, for example, when my partner told me to go for an abortion, I told my mother and she advice not to do it and it really help me......It has really helped me in taking care of myself, coming to the hospital and my daily upkeep....” (Respondent 8)

“If not for the help I am receiving I would have considered aborting the baby so it has really helped me. The other time when one of my church member passed by she prayed with me and gave me GH₵5.00 to buy food, as a matter of fact that particular day I had no money on me. Other members also brought me some few items so am grateful to all of them. Our church pastor’s wife told
me never to abandon church service because during this time a lot of evil spirits usually go around so I should make a point to always come to church so I have since been regular at church service not only on Sundays but weekdays as well.” (Respondent 5)

“I will continue my education after delivery God willing … I have been informed about family planning. When I deliver I will opt for it to prevent further unplanned pregnancy… I have really plan to become someone very important in future, I wanted to join the military or become a footballer.” (Respondent 1)

4.8 Adverse Impact on Social Support.

This respondent had this to say on how she has been adversely affected:

“My Aunty, she will give you something and insult you in addition. That is not nice. Example …one time my mother was not home and I was hungry so my mother said I should go and borrow some money from her such that when she returns she could and pay. But after she gave me the money she stated passing very bitter words on me. She said young teenagers of this days when you send her to school she will come back with a big stomach…” (Respondent 11)
CHAPTER FIVE
DISCUSSION

The study revealed that pregnant adolescents are confronted with varied constraints mostly because such pregnancies are unintended and unplanned, forcing the young girls to drop out of school for the fear of being stigmatized by classmates. Stigmatisation did not only come from classmates but also from the community. The neighborhood and community stigmatization have been identified to affect maternal stress (Dole et al., 2003) and preterm birth (Bell et al., 2006). On the other hand, other studies on neighborhood and pregnancy have yielded varied results of effects on pregnant women (including adolescents), however, this is dependent on the nature of interaction that existed among the social group (Bell et al., 2006). Whiles quality neighborhood promoted togetherness and acceptance, poor neighborhood quality, such as discrimination and stigmatization were observed as potential concerns associated to adolescent pregnancy and maternal stress (Talashek, Alba & Patel, 2006).

Further, most girls faced emotional challenges because they felt that they had disgraced themselves and their families, unpreparedness to have babies and regrets. Others believed that their lives had come to an end because they may not be able to achieve their dreams of schooling. These conditions could affect adolescent pregnant girls to acquire proper healthcare (Hall, Moreau & Trussell, 2011). In some cases, girls threaten to abort the pregnancy because they could not bear the shame and also do not have the resources to take care of themselves and the unborn babies.

Girls were abused verbally by their parents and the immediate families for the disappointment and disgrace they have brought to them. The effects of pregnancy faced by adolescents can be very significant because they are more likely to have various
medical and obstetric complications such as unsafe abortions, pregnancy-induced hypertension, and pre-term delivery (Kawakita et al., 2016). Many of these adolescents tend to have insufficient antenatal care due to emotional, anxiety and economic problems, failure to avail themselves for antenatal services and it increases their risk of complications during childbirth (Kawakita et al., 2016). Similarly, Liran et al., (2012) opined that depressed mood during pregnancy has been identified as a predictor of post-partum depressed mood. Again, studies have established that emotional distress, particularly symptoms of depression and anxiety, may increase the risk of pregnancy and birth complications, poor neonatal status, low birthweight, prematurity and intrauterine growth retardation (Kawakita et al., 2016). Smith-Battle, (2012) asserted that young mothers may have mental health challenges which may affect the well-being of her child. Anxiety and stress are reported to have resulted in the disturbances of development of the babies born to teen mothers (Edwards et al., 2012).

Furthermore, subsequent children born to teen mothers may suffer the same adverse medical and social outcomes. For example, a study revealed that children born to teen mothers may experience mortality rates two to four times higher than children born to aged mothers (Jutte et al., 2010). Another study concluded that the rates of neonatal admissions and childhood hospitalization were comparatively higher for children of adolescents than that of adult mothers (Fleming, Driscoll, Becker et al; 2015).

The relevance of Antenatal Care (ANC) services to ensuring the health and well-being of young mothers and newborn is very crucial and as noted ANC should be started in the first trimester of pregnancy (WHO, 2018). However, the study revealed that most pregnant girls were Junior High School pupils who are not working and therefore require money for the payment of transport and other charges. The study showed that
parents of girls offered their wards money for expenses on their ANC. Partners of the pregnant girls who were mostly older and working as traders, commercial drivers also provided money for their ANC services. Supposed parents’ in-law also offered financial support to their supposed in-laws when their sons are not able to provide the financial needs of the girls. According to Jutte et al., (2010) social factors such as family structure may influence the state of health of a young mother and her child. This could also mean that poverty can also influence adolescent pregnancy outcome. Hall, Moreau, and Trussell (2011) reported that pregnant adolescents who were not financially sound economically showed lower utilization of ANC and other reproductive health compared to their counterparts who could afford the cost of ANC. This finding could propose that deficiency in obtaining reproductive and sexual health information may result in complicated pregnancy and subsequent delivery (Hall, Moreau & Trussell, 2011).

Adolescent pregnancy and social support are positively related. This is because social support involves an act that intends to bring help that will impact positively on recipients. Results from the study showed that different kinds of support were received by the adolescents of which some could be described as formal (as coming from formalized institutions and organizations example, churches Government programs etc.) and informal (family, friends, peers etc) (Edwards et al., 2012). Specifically, Emotional support dominated all other forms or types of support. The emotional support came in the form of advice, giving them a listening ear, encouragement not to abort the pregnancy and offering sympathy to the pregnant girls. Pregnant girls sourced emotional support mainly from parents and other family members. Another form of support that was received by pregnant adolescent was instrumental. These came in the forms of money, clothing and food items which were received from parents and the
supposed partners and their families. Informational support came from grandmothers, mothers and healthcare providers. The support provided by the mothers and grandmothers included pregnancy related experiences while health workers provided information on their health and medical needs. This finding supports the notion that social support can be considered as a multifaceted concept which may include social network, emotional support, informational, instrumental support and mutual assistance from different sources: family, friends, romantic partners, pets, community ties, and co-workers (Taylor, 2011). Empirical data confirmed that friendly, attachment relationships occurred within family members, therefore they are often considered as the first choice of social support (Li, Ji & Chen, 2014).

The impact of social support in the lives of pregnant girls was evident from the results of the study. The mental health issues of a young pregnant adolescent such as depression is reduced drastically when social support is available (Smith-Battle, 2012). Social support helped the pregnant girls to secure financial and other resources for their hospital treatments. This relieved them of the stress and depression that accompanied their lack of resources for food and medical treatment. The emotional support brought joy and happiness to them as they interacted with family, friends and neighbours.

In a similar study, Cornwell et al., (2008) indicated that age is negatively related to the size of the social network while it is positively associated with interaction with neighbours, participation in religious activities and other forms of social volunteering activities.

In another study conducted on the vulnerable including pregnant adolescents, social support was found to act as mediator, and its absence was related to psychological stress and other related issues (Boen et al., 2012). In a recent study conducted on Indian
sample, social support networks were found to be positively related to the vulnerable including pregnant adolescent (Mathur, 2014). It has also been revealed that social support has a significant role in promoting the well-being of individuals (Li, Ji & Chen (2014). Again, people with good networking seem to be more confident and healthy as they nurture a feeling that someone is there for them to rely on. It has a bigger impact on their psychological well-being and vice versa (Wadhwa, Entringer, Buss & Lu, 2011).

The quality of social support obtained by pregnant adolescents has an influence on their mental health and the development of their unborn babies (Morikawa et al., 2015). Logsdon, Gagne, Hughes, Patterson and Rakestraw (2005) described social support as a pivot on which the well-being of a pregnant adolescent and her child centres. In a study among African American pregnant adolescents, social support was identified to have had a positive influence on women who received them (Capponi et al., 2014).

Social support from family networks, compared to non-family support, have been identified as beneficial to the well-being of young pregnant girl (Smith-Battle, 2012). Supportive relationships with partners and parents have also shown to be effective in dealing with depressive symptoms and talking with other teen mothers can boost their self-esteem and increase their sense of belongingness (Smith-Battle, 2012).

This means that lack of social support on the other hand, could result in negative outcomes for pregnant women. This may include anxiety which may bring about increased emotional and social factors that may influence outcomes (Coffman & Ray, 2002).
Although the purpose of social support was to bring about happiness and relieve from stress and other health related issues, some were adversely affected. For example, some pregnant girls who received support either from the family felt that they had become dependent, hence, a burden to the family. Others who received social support from friends and neighbours but not families felt dejected by their families. These findings corroborated the debate on the three potential explanations for negative associations with social support and the recipients. First, the support might undermine the recipients' self-worth. Second, the receipt of support could simply be a reaction of the social environment to an increased stress level (i.e., low well-being) of an individual. Third, the support received might not meet the needs of the recipient (Li, Ji & Chen (2014).

5.1 Conclusion

In this chapter, pregnant adolescent received mainly emotional support. Instrumental support was also received. The range of this support may have prevailed due to the monitored difficulties and needs faced by pregnant adolescents. With regard to informational support, participants acknowledge guidance from mothers, grandmothers and healthcare providers. In some cases, the lack of support resulted in school dropouts, social isolation and relationship problems with partners and family members. There is therefore, the need for a careful monitoring of pregnant adolescents by parents and health professionals during pregnancy and postpartum periods, so their demands are met in order to avoid social and health challenges associated with teen pregnancies.
CHAPTER SIX
SUMMARY OF MAIN FINDINGS, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

All over the world, adolescents’ pregnancy has been common and this poses a lot of challenges to the individual, families and the entire country. Due to these challenges, social support has been thought of as a way relieve to teens who find themselves in this undesirable situation. The present study was undertaken to identify challenges faced by pregnant adolescents, assess the type of social support, explore the sources of social support and ascertain the impact of social support on the health of pregnant adolescents. Related literature was reviewed to examine the scope of the study. Consequently, qualitative approach underpinned the study where in-depth interviews were used to gather information. The study utilised thematic analysis in coming out with the findings. This chapter highlights the key findings, conclusions, and recommendations.

6.2 Main Findings

1. Results from the study revealed that pregnant adolescents are faced with numerous challenges. These challenges include financial, emotional, health and other forms of abuse especially from family members. Furthermore, pregnant adolescents are deeply distressed by various difficulties such as drop out of education, depression accompanying their new state, disappointment from the family, shortcomings in obtaining medical treatment due to shyness and abuses from the medical staff.

2. Social support plays critical role in the lives of pregnant adolescents. It becomes an extremely significant resource to pregnant adolescents and their
unborn babies. Social support also contributes toward well-being even in the presence of high level of stress. It generates the sense of self-worth and positive influence.

3. The types of social support the pregnant adolescent receive included instrumental which came from partners, parents and in some cases close family members. Another form of support that was recoded was emotional which mostly came from mothers and close family members. Informational support in the form of advice on seeking medical care such as antenatal care, proper dietary, birth preparedness and family planning was also received by the pregnant adolescent.

4. Sources of social support to the pregnant adolescent predominantly came from parents especially mothers. Other sources from where the pregnant adolescent received support included partners, family members and in some few cases neighbours in the community.

5. The study established that social support had both positive and negative impacts on the pregnant adolescent. Positively, social support promoted the physical well-being whiles some few individuals felt they had lost their respect in the society.

6.3 Conclusion

The main aim of the study was to explore the social support received by pregnant adolescents in Adaklu district. The study sought to identify the challenges, types and sources of social support and the effect of receiving social support on pregnant adolescents. The types of social support the pregnant adolescents received included instrumental which came from partners, parents and in some cases close family
members in the form of money and other material items such as clothes and food items. Emotional support which mostly came from mothers and close family members in the form of encouragement and assurance of support to the pregnant girl during the period. This stabilized the girls and boosted their self-esteem. Also, informational support in the form of advice on seeking medical care such as antenatal care, proper dietary, birth preparedness and family planning was also received by the pregnant adolescent.

6.4 Recommendations

Based on the main findings of the study, the following recommendations are made.

1. The study recommends that, given the vulnerable nature of the pregnant adolescents, a policy should be made by the Ministry of Gender, Women, Children and Social Protection to provide support to pregnant adolescents in the country. This support can be in the form of counselling centres which could be attached to health facilities where pregnant adolescents seek antenatal care services.

2. It is recommended that Ghana Education Service provides a possible means of enrolling adolescent mothers back to school after delivery.

3. Special provision should be made by the Ghana Health Services to provide pregnant adolescents with special ANC services, including counselling, and birth preparedness.

4. Governmental and Non-Governmental organizations are to come up with programmes to provide support to these pregnant adolescents.
REFERENCES


APPENDICES

Appendix 1: In-Depth Interview Guide for Pregnant Adolescents

UNIVERSITY OF GHANA, LEGON
SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF SOCIAL AND BEHAVIOUR SCIENCES

Topic: Social support among pregnant adolescents in Adaklu district in Volta Region

In-depth interview guide for pregnant adolescents

Introduction

Thank you in advance for taking time to participate in this interview. We shall have a short discussion to obtain your experiences as a pregnant adolescent. Your answers will remain anonymous and confidential. Data obtained from you will be used solely for academic purposes (This conversation will be recorded for the sole purpose of analysis). This recording will not be made public. Please share with me your experiences.

QUESTIONNAIRE GUIDE FOR PREGNANT ADOLESCENTS

Section 1

Respondents’ profile

1. Profile of respondents
   Age
   Religion
   Educational background
   Occupation
   Income
   Marital Status
   Duration of marriage
   Place of residence
   Gestational age

Section 2

Challenges

What are the challenges you go through as a pregnant adolescent? Probe on challenges such as:

   I. Emotions/psychological
   II. Monetary
III. Health  
IV. Accommodation  
V. Physical  
VI. Companionship  
VII. Abuses  
VIII. Loneliness/depression

Section 3

Source of income for ANC services
How many times have you been to the hospital? How much do you incur per a visit to the hospital? Probe further to find out how she settles the cost. Find out whether there is any payment package, support (insurance, discount etc) for pregnant adolescents

Section 4

Types of social support
Do you receive any form of social support? What are the types of social support you receive as a pregnant adolescent? Probe on the following forms of social supports:
- Emotional Support
- Instrumental Support
- Informational Support
- Socializing Support
Others

Section 5

Where do you receive social support from and why? Probe further on the following and find out why those mentioned were the source of social support

I. Whom can you really count on to be dependable when you need help?
II. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?
III. Who accepts you totally, including both your worst and your best points?
IV. Whom can you really count on to care about you, regardless of what is happening to you?
V. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?
VI. Whom can you count on to console you when you are very upset/depressed?
Section 6

How has the social support you received helped you to cope with life as a pregnant adolescent?

Probe on specific areas where support has helped.

Probe to find out whether they are satisfied with the kind of support they receive.

Section 7

**Negative impacts of social support**

Is there any negative implication as a result of the support you receive? Probe on the negative impact on the relationship with:

I. Family
II. Siblings
III. Friends
IV. Colleagues
V. Classmates
VI. Spouse/Partner
VII. Religious body etc

Section 8

Is there any experiences about support/social support that have come your way that you will like to discuss with me?
Appendix 2: Respondent Information Sheet

General information

**Project Title**: Social support among pregnant adolescents in Adaklu District in Volta Region

I am Seth Kwasi Frimpong Adjei (Principal investigator), a student of the Department of Social and Behavior Science in the School of Public Health, University of Ghana Legon pursuing a Master of Public Health Degree Programme.

Contact: 0244774304/0209461623. E-mail: sethofms@yahoo.co.uk

I am here with my research assistants to carry out a research to find out about social support among pregnant adolescents in Adaklu District. This is purely for academic purposes and forms part of the requirement for the award of Master of Public Health Degree.

**Procedure**

To find answers that will meet the study objectives, I invite you to take part in this research. If you accept, you will be required to participate in an interview with the principal investigator (Seth K. F. Adjei) or a representative. Your selection into this interview is purposive given your experience as a pregnant adolescent. You are assured that any information you provide will be kept strictly confidential and anonymous and will used for the purpose of this study.

**Benefits and Risks**

There will be no monetary or material compensation for the study. There are also no known risks associated with this study and I am always available to assist with any questions.
Confidentiality

No name will be recorded. Your name and identity are not needed in the study. However, the information you are going to provide will be recorded and will be treated strictly confidential. You are assured of total confidentiality to the information you will give. Apart from the researcher and supervisor of this research, no one else will have access to information provided whether in part or whole. Data collected will be stored under lock and key then destroyed after a minimum of three years as per research protocol.

Right to refuse

Your participation in this study is voluntary. You therefore have the right to withdraw from the study at any point in time. If you wish to withdraw, you may have to inform the interviewer and your request would be granted. Nonetheless, your full participation is highly encouraged.

Dissemination of results

Findings and recommendations would be available at the School of Public Health and it will also be disseminated through a meeting with different stakeholders at the end of the study.

Before Taking Consent

Do you have any questions you wish to ask about the study? Yes/No

If yes, please indicate the questions below

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
If you have any question(s) or further clarification concerning this study and/or the conduct of the primary investigator and research assistants, please do not hesitate to contact the following; Seth Kwasi Frimpong Adjei, School of Public Health, University of Ghana, Legon sethofms@yahoo.co.uk. Tel: 0244774304/0209461623; Prof. Philip Adongo, School of Public Health, University of Ghana, Legon, adongophilip@yahoo.com Tel: 0244806015 and; Mrs. Hannah Frimpong (Administrator), Ghana Health Service Ethical Review Committee Secretariat, Accra. Tel: 0507041223 / 0243235225
Appendix 3: Informed Consent

INFORMED CONSENT
I have read the information given above, and I understand. I have been given a chance to ask questions concerning this study and questions have been answered to my satisfaction. I now voluntarily agree to participate in this study knowing that I have the right to withdraw at any time without it affecting my current or future use of health care services.

Signature/Thumb print: …………………………… Date: ………………………

Contact detail: ………………………………………

I, the undersigned, have explained this consent to the respondent and that she understands the purpose of the study, procedures to be followed as well as the risks and benefits of the study. The participant has fully agreed to participate in the study.

Signature of interviewer…………………………….. Date: ………………………

Contact detail: ………………………………………
Appendix 4: Letter of Assent

LETTER OF ASSENT

I am Seth Kwasi Frimpong Adjei (Principal Investigator), a student of the Department of Social and Behavioral Science in the School of Public Health, University of Ghana Legon pursuing a Master of Public Health Degree Programme.

I am conducting a research on Social support among pregnant adolescents in Adaklu District. In particular, I am interested in exploring the social support received by pregnant adolescents in Adaklu district.

As a parent/guardian, your child will be helping to explore the kinds of social support received by pregnant adolescents and how it cushions them. The study is expected to inform policy makers, corporate organizations, NGOs and other entities to plan social support to help pregnant adolescents who form part of the very vulnerable population in Ghana.

No penalties or negative consequences will result from withdrawal from the study. All responses will be treated as confidential as no names will be placed on the interview guide; neither will it be shown to anyone without you and your child’s permission. I hope that you allow her to participate fully since her views on the subject is important. If you want to ask anything more about the study, I would be ready to answer.

Please confirm the participation of your child by ticking in the box below.

☐
By ticking in the box, I give my informed consent for my daughter to be interviewed, with full awareness of the purpose, terms and conditions of the information given.

Signature………………………………………… Date………………………………

P.I./Research Assistant’s Name: …………………………………………………

Signature: ……………………… Date………………………………………………
Appendix 5: Ethical Clearance

Ghana Health Service Ethics Review Committee

My Ref. GHS/RDD/ERC/admin/App
Your Ref. No.

Seth Akwasi Frimpong Adjei
University of Ghana
School of Public Health
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

<table>
<thead>
<tr>
<th>GHS-ERC Number</th>
<th>GHS-ERC: 122/12/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Title</td>
<td>Social Support among Pregnant Adolescents in Adaklu District in the Volta Region</td>
</tr>
<tr>
<td>Approval Date</td>
<td>27th December, 2017</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>26th December, 2018</td>
</tr>
<tr>
<td>GHS-ERC Decision</td>
<td>Approved</td>
</tr>
</tbody>
</table>

This approval requires the following from the Principal Investigator:

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol.

SIGNED: .......................................................... Dr. Cynthia Bannerman (GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra