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SCHOOL OF PUBLIC HEALTH
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UNIVERSITY OF GHANA

SOCIAL SUPPORT AND PREGNANCY EXPERIENCES OF WOMEN IN AN URBAN SLUM IN ACCRA

BY
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DECLARATION

I hereby declare that except for ideas and references to other people's work which have been duly cited, this dissertation submitted is my own work, produced from research under the supervision of my academic supervisor. I also declare that this dissertation has not been submitted in part or in full for a degree in any higher institution.

.....21st July, 2021.....

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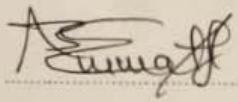

.....21st July, 2021.....

DR. EMMANUEL ASAMPONG — DATE

(SUPERVISOR)

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DEDICATION

This work is dedicated to all pregnant and nursing mothers in the various slums in Accra, particularly those in the Brigade slum community. Their tenacity and determination are admirable. This work hopes to bring their side of reality to the world.

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ABSTRACT

Background: Pregnancy can be described as a sensitive and delicate period for women, accompanied by diverse physiological and psychological changes which can bring stress, depression and anxiety on the expectant mothers. Social support during pregnancy is widely recognized for reducing feelings of anxiety and stress associated with pregnancy and can act as a buffer by providing other coping resources for women. Living conditions in urban slums are acknowledged as harsh and unhygienic, yet dwellers, including pregnant women, reside in these areas. This study, thus, sought to explore the social support received by women in the Brigade slum, an urban slum in Accra, and the relationship it has with their pregnancy experiences.

Methods: This study was a qualitative phenomenological study. Sixteen respondents were purposively sampled in the Brigade slum community in the Ayawaso West Municipality of Accra. Data collection was done through in-depth interviews with the aid of an interview guide. Interviews were transcribed verbatim and manually analysed using thematic analysis.

Results: The study revealed that all women received some form of social support during their pregnancy though not in equal measures. Assistance with household activities like sweeping, washing and water fetching were the commonest type of support received. Monetary support was however the greatest unmet need of support. Husbands, siblings and mothers of respondents were the main providers of social support. Respondents faced numerous challenges in the slum such as spontaneous evacuations and violence, great sources of worry during their pregnancy.

Conclusion: The women registered a need for social support during pregnancy. Support received served as immense protective and buffering resource during pregnancy in the slum.

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LIST OF ABBREVIATIONS

ADD	Acute Diarrhoea Diseases
ANC	Antenatal Care
ARI	Acute Respiratory Infections
CS	Caesarean Section
ECG	Electricity Company of Ghana
ERC	Ethical Review Committee
GHS	Ghana Health Service
GSS	Ghana Statistical Service
GRIDCo	Ghana Grid Company
ILO	International Labour Organization
IOM	International Organization for Migration
ISSER	Institute of Statistical, Social Services and Economic Research
JHS	Junior High School
LMIC	Low- and Middle-Income Countries
MMDAs	Metropolitan, Municipal and District Assemblies
PPD	Postpartum Depression
SEM	Social-Ecological Model
SHS	Senior High School

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UN-Habitat	United Nations Human Settlements Programme
UNICEF	United Nations International Children's Emergency Fund
UNIDO	United Nations Industrial Development Organization
WHO	World Health Organization
y/o	years old

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CHAPTER ONE

INTRODUCTION

1.1 Background

Pregnancy is generally considered as a sensitive and delicate period for women (Edmonds, Paul & Sibley, 2011). It is a significant life-changing journey which comes with major physiological, psychological and social changes for the mother-to-be (Klobucar, 2016). While some experience pregnancy/childbearing as positive, wonderful and strengthening, to others, it is a negative experience, associated with anxiety and stress (Buultjens, Murphy, Robinson & Milgrom, 2013). Pregnancy is an eventful period that, when successful, inevitably transits one to be a mother. Bäckström (2018) discovered that the thought of motherhood alone contributes to the stress and anxiety women experience during pregnancy. Mothers' inability to adjust suitably to the bodily, psychosocial and emotional changes that accompany pregnancy, tends to pose a risk to them and the unborn. While some mothers have expressed satisfactory preparations and positive expectations during and after childbirth, others express unpreparedness, fear and anxiety (Bäckström, 2018).

Research depicts that social support is essential to the health and general wellness of expectant mothers during the 9-month-long pregnancy journey (Dunkel Schetter, 2011). Social support during pregnancy and the gradual and steady transition to motherhood is also known to contribute to the reduction of the anxiety and stress the women face (McLeish & Redshaw, 2017). The effects of social support transcend beyond the pregnancy period (Williams, Sarker & Ferdous, 2018). Trivette, Dunst and Hamby (2010) reported that the quantity and quality of social support that the mother receives influences the parental functioning and the child's development. Social support serves as a significant resource to individuals who are worn out by the stress and abrupt transitions

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the vicissitudes of life bring, thus, Habel, Feeley, Hayton, Bell and Zelkowitz (2015) acknowledged that considering the physiological, psychological and biological changes and stress expectant mothers go through social support is all the more essential. Some research works have proven the significance of social support in decreasing and buffering physical and psychological stress and depressive symptoms accompanying pregnancy and even improving pregnancy outcomes (Detres, 2018; Loomans et al., 2011). Access to social support is also known to aid mothers to maintain a healthy psychological life during pregnancy which has positive health implications to the unborn child. Also, it motivates mothers to indulge themselves in positive health behaviours and lifestyle patterns and good dietary habits (Elsenbruch et al., 2007; Loomans et al., 2011). For instance, in a work done by Elsenbruch et al. (2007), mothers with low support who resorted to smoking (34%) were more than smoking mothers who receive high support (17%). Risk of pregnancy and complication at birth such as poor neonatal status, low birth weight and prematurity, poor labour progress and intrauterine growth retardation is reportedly decreased with decreased emotional distress such as depression and anxiety (Edmonds et al., 2011; Elsenbruch et al., 2007). A factor of these risks in pregnancy has been associated with lack of social support (Elsenbruch et al., 2007). Despite the complexity of the association between social support, psychological stress and pregnancy outcome, it has been documented that psychosocial resources, such as emotional and instrumental support, provide a source of protection for the women from the life of stress as a pregnant woman (Hetherington et al., 2015). Social support can thus be defined as an action or care that is given willingly to someone from others.

Social support is reflected in material or instrumental support (such as financial support, help with house chores), emotional support (such as care, love and empathy), informational support (such as advice and suggestions on healthy diets to eat) and appraisal support (that is, affirmative and

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reassuring words that assist in self-evaluating) (House, 1981 as cited in Bäckström, 2018). These are the four known social support. Most pregnant women frequently receive social support from their mothers and their babies' fathers; other sources include friends and peers (Edmonds et al., 2011; Logsdon, Gagne, Hughes, Patterson, & Rakestraw, 2005).

In Ghana, urban slums serve as home to many internal and international migrants. Characteristics of such settlements include overcrowding, unhygienic conditions, unsafe buildings, deprived access to basic facilities such as health services, sanitation and clean water (Owusu, Agyei-Mensah & Lund, 2008). Urban slums are mostly dwelled by migrants who move to urban cities, mainly in search of better economic opportunities. Others may have been evicted from their previous places of residence (often slums). They end up residing in slum communities as they re-cope their lives in the cities. Many come on their own to make a living and send proceeds to their families back at their native homes. Among these migrants include women and the youth, and they are subjected to the harsh environmental and societal conditions of informal settlements or slums (Beguy, Mumah & Gottschalk, 2014).

1.2 Problem Statement

Globally, about 54% of the world's population lives in urban areas, a billion of whom are estimated to be living in slum settlements (UN-Habitat, 2016). According to the International Organization for Migration (2015), 61.7% of people in sub-Saharan Africa are slum dwellers. This statistic represents more than half the populace in the sub-region living in slums. In Ghana, the slum population has increased steadily. As of 2001, it was estimated that around 4.5 million Ghanaians reside in informal settlements or slums. This number has increased by 1.83% per annum. In 2010, the population of slum dwellers reached 4.9 million and 5.3 million in 2014 (UN-Habitat, 2016).

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The capital city, Accra, is the most populous city and the most rapidly urbanized in Ghana (World Population Review, 2019). The rapid urbanization has also led to the fast development of slums and informal settlements in the city. Next City (2013) reports about 43% of the urban population in Accra live in slums. This represents close to half of the populace in Accra.

Settlers in these areas, including pregnant women, have to constantly deal with insecurity of land and evacuations, lack or unavailability and inaccessibility to basic services and amenities such as electricity, potable water, disposal site and lavatories (United Nations Industrial Development Organization [UNIDO], 2018). This is very similar to anecdotal reports by settlers at the Brigade slum in the Ayawaso West Wuogon Municipality in Accra, for instance. Threats of evacuation were persistent in Brigade due to the erection of electrical pylons, of which the inhabited land is intended for. This insecurity of land is a constant nightmare to inhabitants. In addition, the presence of the huge tension poles poses daily hazard of radiation and potential collapse of these pylons to dwellers in the slum. Violence and strife seem like a daily affair in slums. Despite these, the risk factors associated with pregnancy including stress and depression (Hetherington et al., 2015) are not exclusive to women who reside in harsh environments like slums. Women have these added worries to the physiological, emotional and psychological changes that accompany pregnancy (Bäckström, 2018). Habel et al. (2015) admitted that individuals who are worn out by the stress and abrupt transitions of life, like those in slums, are worthy of support. Social support is known to decrease and buffer physical and psychological stress (Detres, 2018). For pregnant women, research suggests social support as a protective measure during pregnancy (Edmonds et al., 2011). Pregnant women residing in slum areas are deserving of social support due to the double burden of being pregnant and living a slum.

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While the situation could be perilous to the lives of pregnant women in slums, very little work has been done in urban slums to assess how social support, a buffering resource, can influence the expectant woman's pregnancy condition and experience, be it in the positive light or negative more especially in a slum in the demanding streets of Accra.

Studies on social support have been largely quantitative with fewer concentrating on social support for pregnant urban slum dwellers in the city of Accra. These limit the understanding from the perspective of the mothers in urban slums on the issue of social support and pregnancy, thus the need for this study.

1.3 Rationale of the Study

Social support has proven to be beneficial to pregnant women due to the role it plays in reducing stress and anxiety associated with pregnancy and the steady transition to parenthood. In addition, life in a slum is known to be harsh and uncivil especially when it comes with eviction and demolition of the structures put up by dwellers. This study seeks to probe if postnatal mothers in Brigade slum, a slum community in Ayawaso West Municipality, Accra, had access to any form of social support during their most recent pregnancy and how it had an influence on their childbearing process. It will also help to identify if residing in a slum contributed positively or negatively to their pregnancy experience. Information from this study will provide invaluable knowledge for decision making by policymakers, families and healthcare workers and other providers of social support.

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1.4 Research Questions

(i) What is the role of social support in the pregnancy experiences of the women?

(ii) What type of social support did the women receive?

(iii) Who were the providers or sources of social support to the women?

(iv) How does the living setting (the slum) play a role in in the pregnancy experiences of the women?

1.5 General Objective

To explore the social support women in an urban slum in Accra received and its influence on their pregnancy experiences.

1.6 Specific Objectives

(i) To explore the role of social support in the pregnancy experiences of the women.

(ii) To identify the types of social support the women want and have access to.

(iii) To identify the providers of social support to the women.

(iv) To determine how the living setting (the slum) plays a role in the pregnancy experiences of the women.

1.7 Operational Definition of Key Terms

The study makes use of some key terms and such terms are being defined as used in the study:

- **Pregnancy experience(s):** this refers to incidences encountered during the pregnancy journey of the respondent, with respect to the quality of life of the mother during pregnancy and her perceived health of the unborn child. Interest in experience spans from pregnancy to the time of delivery/childbirth.

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- **Providers/Sources of support:** anyone (or anything) that provides any form of help/support during pregnancy
- **Social support:** any kind/form of assistance and help the women received during pregnancy up to childbirth/delivery
- **Postnatal mothers:** the term, as used in the study refers to mothers who have recently delivered within one year.

1.8 Theoretical Underpinning

This study is based on the social-ecological model of social support as an environmental resource developed by Bronfenbrenner (1979). The model states that human behaviour is affected by several environmental factors and at multiple levels, namely, micro-system, mesosystem, exo-system and macro-system levels. The micro-system level refers to the face-to-face influences in a particular setting that the individual interacts. It could be the individual immediate family, workgroup or other members of other social networks. The mesosystem level refers to the interrelation among the various settings in the micro-system in which the individual is involved. The exo-system refers to the forces within the larger system that the individual is embedded while the macrosystem refers to the cultural beliefs and values that influence all other levels.

In line with the above social-ecological model, the study considers four levels that influenced the mothers' access to social support during pregnancy: the individual level (micro-system level), the interpersonal level (mesosystem level), organizational level (exo-system) and community levels (macro-system level).

The intrapersonal level refers to the mother's own demographic, social, and psychological characteristics that may influence social support. The interpersonal level extends to her social

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networks of family, friends, co-workers, and peer groups as sources of social support. At the organizational level, the mothers may receive support from health workers at the health facility, whilst the mother's community may influence the kind and adequacy of support provided.

The study postulates that the experiences and support structure of the women can be affected by individual factors, family and social network structure, organizational factors and community factors from the health facility. At the individual level, factors such as mother's age, marital status, economic status, education may influence how mothers experience social support during pregnancy. The mother's social network of family, friends, and significant others may influence her access to social support and lived experiences of her pregnancy. At the organizational level, support received from health workers at antenatal clinics may contribute to the pregnancy experience of the mother. Family support, financial status can influence the experience of mothers positively or negatively. At the community level, mother's environment may influence their pregnancy experience which may influence the overall support the mother will need and actually receive.

There are two main perspectives on how social support works to affect health outcomes such as maternal and child health. The first, Cohen and Hills (1985) postulate that social support influences health outcomes through acting as a buffer to stress that enables individuals to re-adjust their usual behaviour in response to challenging demands such as the birth of the first child. The second, by O'Reilly (1988) explains that social support is an existential human need and directly affects health outcomes. In this sense, the absence of social support can produce stress. Both theoretical perspectives are considered in this study.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature done in relation to the topic of social support and pregnancy experiences of women in an urban slum in Accra. **The chapter has been organised under the following sub-headings:** the pregnancy experience and its challenges, viewpoints of social support as explored by researchers, the types or kinds of social support, the sources or providers of social support and the living conditions in urban slums.

2.2 Pregnancy Experience and Its Challenges

Childbearing or pregnancy is a challenging part of life (Edmonds et al., 2011); a journey which transits mothers into another phase of life – parenthood. To some nulliparous mothers, it comes with excitement (Bäckström, 2018), and to many, pregnancy comes as a surprise and the genesis of challenges. Either way, pregnancy comes with its biological, emotional, physiological and psychological changes (Klobucar, 2016).

When expecting a child, the expectant mothers often worry about the well-being of the unborn child, the childbearing process and the changes motherhood will bring to their lives. The mother carrying the unborn, developing child experiences physiological, psychological and even social contextual changes (Bäckström, 2018). Psychologically, the expectant mother goes through many different stages/phases during the pregnancy. Bäckström helps give a good perspective about the pregnancy journey of women:

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In the first trimester of pregnancy, the thought that fills the mother's mind is fear of miscarriage, or abortion if she is contemplating one. In this early phase of pregnancy, she is also overly concerned about the health of the baby, which can leave her very stressed and anxious. In the second trimester of the pregnancy, the middle phase, the mother starts to notice foetal movements and can make a distinction between herself and the baby. A sense of joy is often lit when these movements can be felt and can be reassuring about the health status of the child. The absence or irregular frequency of foetal movements may, however, leave her worried and disturbed, dominated by fear about the health status of the unborn child. In the last phase of pregnancy, the third trimester, the anxiety pangs resume where the mother worries about the forthcoming birth and her capacity to manage with labour and birth. Despite these anxieties, she longs to meet her unborn child. During these phases, the mother gets the opportunity to bond with her unborn infant. Undoubtedly, the changes and thought patterns during these phases has its way of bringing in feelings such as anxiety, stress, worry and depression and all these have a way to negatively influence the mother-baby bonding as discovered by Brodén (as cited in Bäckström, 2018) and even the development of the child when he/she is born. In addition, the stress greatly affects the quality of life of the mother (Loh, Harms & Harman, 2017).

For some times past, becoming a parent (mother) has been described as one of the most evolving changes that take place in the lives of most people (Barimani, Vikström, Rosander, Forslund Frykedal & Berlin, 2017b). This is often because, this transition involves some form of changes in one's identity, behavioural patterns or role relations (Meleis, Sawyer, Im, Messias & Schumacher, 2000). Here in Ghana, one's identity changes hugely when one bears a child. If the person was known as barren, pregnancy is an unmistaken sign that the person is not. In addition, the birth of a new child adds up to the number of children the woman or couple has and increases their societal

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status. The transition to being a parent (again) also involves a change in habits of mind (Klobucar, 2016). Schumacher & Meleis (as cited in Bäckström, 2018) added that this transition brings in some apprehension to the mother since it is influenced by expectations (from self and others), levels of skills and knowledge she is perceived to acquire, social contextual circumstances and her emotional and physical well-being. Also, when mothers get access to satisfactory knowledge of the pregnancy journey and what to expect, it assists in reducing stress and anxiety associated with pregnancy and childbirth/labour. Acquiring knowledge and perceiving childbearing and parenthood as normal incorporates into the mother, the feeling of preparedness, and together with social support and sometimes professional support like enrolling in a parental education class, pregnancy and parenting are less to be feared (Bäckström, 2018). Barimani et al. (2017b) studied that when the reverse is done, that is unrealistic expectations, a feeling of unpreparedness, stress and loss of control as well as a lack of support, just to mention a few, obstruct transition process.

Also, McLeish and Redshaw (2017), and Bayrampour, McDonald and Tough (2015) revealed that mothers who have high perceived stress, low social support or partner tension, are more likely to experience anxiety and depression during pregnancy. Many a time, the thought of being a parent puts enough parental stress on the expectant mothers which also affects their quality of life (Loh et al., 2017). This indicates that childbearing is a vulnerable time in terms of the mental health of the mothers (Redshaw & Henderson, 2013).

Antonovsky (as cited in Bäckström, 2018) stated that a person's ability to maintain health is connected to the person's sense of coherence, that is, sense of coherence is the person's ability to cope with stressors in life and they perceiving life as comprehensible, manageable and meaningful. Other researchers have studied and also shown that high levels of sense of coherence are connected with better pregnancy well-being (Ferguson, Davis, Browne & Taylor, 2014). In addition to that,

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more support is experienced (Ferguson, Browne, Taylor & Davis, 2016), uncomplicated delivery (Ferguson et al., 2016; Oz, Sarid, Peleg & Sheiner, 2009) and willingness among women to deliver without epidural analgesia (Jeschke et al., 2012). Epidural analgesia is a technique used at or around the time of an operation to manage pain, injected anywhere along the vertebral column as a treatment for labour pain (Silva & Halpern, 2010). Conversely, low sense of coherence is associated with pregnancy-specific distress (Staneva, Morawska, Bogossian & Wittkowski, 2017), depression, anxiety and posttraumatic stress disorder (Ferguson et al., 2014). From the antenatal to the postnatal period, Ferguson et al. (2016) claimed that a mothers' sense of coherence increases and is assumed to be affected by positive maternal experiences (Habroe, Schmidt & Holstein, 2007), as well as by social support (Wolff & Ratner, 1999).

Another aspect of pregnancy that requires support is due to postpartum depression (PPD). Postpartum depression is a public health concern that has raised an alarm due to the adverse effects on mother's perinatal wellbeing; affecting even the child's physical and cognitive wellbeing and development (Azad et al., 2019). The prevalence of PPD among mothers worldwide ranges from 0.5% to 60.8% (Halbreich & Karkun, 2006). PPD is a common, non-psychotic mood or a mental disorder characteristically manifesting in mothers within one year of delivery (Halbreich & Karkun, 2006; Stewart, Robertson, Dennis, Grace & Wallington, 2003). In a work done by Tronick and Reck (2009), women in developing countries showed higher rates of PPD than women in developed countries. Gavin, Gaynes, Lohr, Meltzer-Brody, Gartlehner (2005) in a systematic review conducted revealed that in 28 developed countries the prevalence of PPD symptom was 6–13% among women in high-income nations. For low- and middle-income countries (LMIC), an independent systematic review found the prevalence of postpartum common mental disorder was approximately 20% (Fisher et al., 2012). And for urban slums, in a qualitative study which sought

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to explore the cultural attitude towards PPD in an urban slum in Dhaka, Bangladesh, 17 women of the 36 women interviewed, were suffering from PPD (Williams et al., 2018). In this study, women reported that lack of practical social support, among others such as financial crises, adverse life events and intimate partner violence were causes of daily emotional distress and sadness during the postpartum period (Williams et al., 2018). Globally, strong predictors of PPD among women reported by other researchers include preterm or low birth-weight infants, unemployment, socio-economic deprivation, poor social or emotional support, housing problems, first-born child, childcare stress, low self-esteem, negative attitude towards pregnancy, antenatal depression or anxiety, previous history of depression, poor marital relationship, history of domestic abuse, major adverse life events in preceding one year, neuroticism, perfectionism and level of daily hassles are (Norhayati, Hazlina, Asrenee & Emilin, 2015; Vigod, Villegas, Dennis & Ross, 2010). Taking a critical look at these predictors, they could be grouped into the lack of the four kinds of social support that is, lack of appraisal support, as in the instance of low self-esteem, lack of instrumental support as in the childcare stress and level of daily hassles, lack of emotional support as in domestic abuse, and lack of informational support such as little information and knowledge about what to expect during the various phases of pregnancy, and labour. This was no different from risk factors identified in the rural areas of low- and middle- income countries (Surkan et al., 2017; Islam, Broidy, Baird & Mazerolle, 2017).

According to the WHO Alma Alta Declaration (World Health Organization, 1978) and the Ottawa Charter (World Health Organization, 1986), health has been defined as the state of complete physical, mental and social well-being, and not just the absence of infirmities. With this, professionals are often challenged to have positive wellbeing and health in focus, instead of the absence of illness, viewing cases from a health and well-being perspective instead of an illness

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perspective. To exemplify this, and the challenges these perspectives bring, Bryar and Sinclair (2011) have presented pregnancy and childbirth through two different models. In the first model, pregnancy is addressed as a normal life event and as a period of growth for women. In the second model, pregnancy is treated as an illness and women are encouraged to view themselves as patients (Bryar & Sinclair, 2011). The danger with viewing things from the second model is that some normal life events, such as pregnancy, may be classified as potential sources of ill-health. Ferguson et al. (2014), spelt it out that a focus on risk during pregnancy and birth does little to boost the confidence of women, who hope to achieve normality. He added that it does nothing to help the expectant parents to manage stressors linked to childbearing, nor mobilize resources required to prepare for the changes that come with pregnancy.

A study conducted by Azad et al. (2019) presented that in urban slums in Bangladesh, postpartum depression among the women of urban slum could not be associated with respondent age and wealth. However, it was prevalent amongst mothers who were employed compared to mothers who were not. Also, mothers who worked before, but due to the pregnancy had to leave their jobs had a higher chance of being depressed. This could imply that the lack of instrumental support could be detrimental to the health of a working mother, more so when pregnant, which to some people is seen as a sickness (Bryar & Sinclair, 2011). This perspective of pregnancy could result in the loss of the job of expectant mothers. Comparing uneducated women to educated women (those who have completed secondary or a higher level of education), uneducated group of women were more prone to depression than educated women, and a good number of those in urban slums may have less than a secondary education certificate.

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2.3 Viewpoints of Social Support

Social support is a network-/kinship-/friendship-based social phenomenon, and has widely become the pinnacle of research attention in the last three decades (Song et al., 2016), and is considered a complex and multi-faceted concept. This has been shown in the diverse media the concept has been operationalized. Logsdon & Koniak-Griffin (2005) for instance, pioneers who worked on social support considered social support as the interaction with other to meet the social needs of affection, esteem, approval, sense of belonging, identity and security.

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 et al., 2015; Sampson, Villarreal & Padilla, 2015). This concept has not changed much in the past decades. In 1976, Cassel (as cited by Song et al., 2016) defined an aspect of social support as protective factors that buffers or cushions people from the physiological and psychological effects of exposure to any kind of stressor situation. In the same vein, Cassel continued that while one hand of social support protects health, another side can produce diseases. For instance, getting false information from a relative or friend.

Despite the side of the coin social support plays, a direct relationship has been established between social support and the health of individuals especially the pregnant mothers (Bäckström, 2018; Khresheh & Barclay, 2010). This can be grouped into formal and informal social supports. Formal or professional support describes medical services such as antenatal and postnatal services and pregnancy education classes, and other assistances 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 (Bäckström, 2018; Lin, Mingang, Xiaofang & Wu, 2010).

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Due to the benefits to the individuals who receive them, informal support is considered as cost-effective and readily available (Ryser & Halseth, 2011). Generally, informal supports are mostly offered by family, friends, and neighbours and are unpaid (Thanakwang & Soonthorndhada, 2011). Informal supports may come in varied forms including affection, advice, companionship, assisting the pregnant girl with transportation and nursing care (Alexandre, Labronici, Maftum & Mazza, 2012). The informal as well as formal support give the expectant mothers a sense of inclusion rather than neglect and helps to prevent depression that she might go through.

2.4 Types of Social Support

McVeigh (1995, p. 41) refers to social support as what is "done to or for an individual believed to be in need of support, and also the extent to which the individual is connected or attached to the social network", where social network is the web of social relationship that surround individuals.

Social support can be categorized in different ways, under different interest focus. In terms of its content, for example, House (1981) divided social support into emotional support (such as liking, love, empathy); instrumental support (such as goods and services); informational support (such as information about the situation or phenomenon); or appraisal support (information relevant to self-evaluation). This has been one of the major ways of categorizing the different types of social support. In terms of its degree of subjectivity, earlier workers dichotomized social support into perceived support and objective or actual support (Caplan, 1979). In terms of the role relationship between the recipient and the donor (Thoits, 1982), social support could be kin-based (e.g., parents, spouses, children, siblings, other relatives) or nonkin-based (e.g., friends, neighbours, co-workers).

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In terms of its contexts, social support could be routine support within an ordinary situation or nonroutine support within a crisis (Lin, Dean & Ensel, 1986).

For this subheading, social support will be viewed in terms of its content, that is, what is contained in that kind of social support, what does one get or what type of support is available to one from a particular social support. This leads to the popular four types of social support: emotional support, instrumental support, informational support and appraisal or affirmative support (House, 1981; Logsdon & Koniak-Griffin, 2005). Schaefer, Coyne & Lazarus (1981), on the other hand, identifies five different types of social support: emotional, esteem, network, informational and tangible social supports.

Emotional support is the provision of empathy, love, care trust and intimate exchange with spouses (Song et al., 2016). It promotes a sense of security, safety and belonging. Even though it does not directly solve the challenges, it is described as most essential if one claims to have a positive experience of support and it goes ahead to have a positive impact if the support is rendered (Mander, 2001) and buffers negative effects of stress (Glanz et al., 2008). For expectant mothers, when providers of the support lend a listening ear to the grievances, pains and needs of their pregnancy journey and anxiety of the upcoming parenting, it strengthens them (Bäckström, 2018).

Affirmative or esteem support help in self-evaluation and promotes reassurance of the individual's ability and competence in a situation they may find themselves in. through communication and interaction, esteem support boosts the individual's self-esteem and ability to handle an issue, endure a situation or confront the problem at hand. Pregnant mothers should be reassured of their ability to handle the challenges that come with childbearing and the next stage of child-rearing or parenting. All these are known to enhance confidence which aid in a smooth pregnancy journey (Bäckström, 2018).

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Informational support involves offering information to help solve the actual problem. This includes advice and suggestions. Informative support regarding the pregnancy must consist of adequate, practical information about pregnancy, the expectations during the journey, preparing for childbirth, as well as parenting or nursing (Bäckström, 2018; Glanz et al., 2008).

Instrumental support is also referred to as practical or tangible support. It is a practical help in solving the actual problem (Mander, 2001). With this kind of support, a person is given physical assistance to help buffer the stressful event. It could be material goods like food or money or it could be actions. In the case of pregnant women, some instrumental support may include help with the household chores, washing, fetching water, doing the groceries and babysitting the other children (Edmonds et al., 2011).

Network support gives a person a sense of belongingness. By the patterns of communication that ensues, a person is reminded of the support from the network.

The different acts of support may not be uniquely different or independent. For instance, in a study done by Azad et al. (2019), provision of both practical/instrumental support and emotional support, especially from the partners or spouses (when women sharing their personal feelings with their spouse) reduces the chances of the women to be depressed. Mothers can benefit from the different types of support, in their preparations for childbirth and parenting. Expectant mothers could be strengthened through support and this contributes to their understanding and feeling of preparedness for childbirth and parenting (Bäckström, 2018).

In certain instances, support needs to be requested or asked for; for example, informative support without having to ask for it may not lead to the desired effect of reducing feelings of stress (Uchino, 2003). For some people, however, asking for support might be difficult because the act of asking

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can instil a sense of incompetence in the actual situation (Hodnett, Gates, Hofmeyr & Sakala, 2013; Uchino, 2003).

2.5 Sources or Providers of Social Support

Social support can come from different sources. These are often those of their social contacts and include romantic partners or spouses, family friends, community and colleagues at the workplace or marketplace. The sources could be formal, for instance, support from health institutions, professionals or healthcare workers (Taylor, 2011) or natural or informal, such as friends and family members. Supports from natural sources are great contributors to the well-being of individuals (Song et al., 2016).

In a work done by Jackson (as cited by Song et al., 2016), spousal support reduces the effects of depression of five kinds of stressors, namely, marital strain, parental strain, work strain, economic strain and physical health strain, while friend support is effective for only three of the stressors, that is, marital strain, economic strain and physical health strain. The moment two people make that decision to have a child, they stand to be the most important support system to each other in facing the challenges that come with that decision during the transition to parenthood. Several studies suggest that particular members of the mother's social network may be important in providing the necessary social support during pregnancy such as the father of the baby and the woman's mother (Edmonds et al., 2011). In fact, it is proposed that a good relationship and partnership with the father of the baby reduces the chance of delivering a preterm infant (Hetherington et al., 2015). When expectant fathers are involved during pregnancy and childbirth, it is strengthening for the expectant mothers which lead to positive health outcomes for the mother and new-born child (Martin, McNamara, Milot, Halle & Hair, 2007; Buist, Morse & Durkin, 2003). Though in reality it may seem that fathers are negligent of their roles as a father and a

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husband or partner, some research work has it that fathers wish to be more involved during pregnancy (Widarsson, Engström, Tydén, Lundberg & Hammar, 2015; Hildingsson, Haines, Johansson, Rubertsson & Fenwick, 2014) and childbirth, howbeit, they find it difficult to understand what exactly is expected of them (Bäckström & Hertfelt Wahn, 2011). Bäckström (2018) strongly argues that partners should be involved in the pregnancy journey of their spouses and should be equally well-versed in the expectations and phases of pregnancy. A work by Loomans et al. (2011) revealed that most women who at least live with their partners during the pregnancy period, recorded low depression and anxiety, among other factors like being highly educated and not smoking and drinking alcohol. Mothers themselves describe pregnancy as a sensitive period of their lives (Bäckström, 2018). During this period, they are compelled to discuss certain intimate things to their partners, which besides the pregnancy, they would not have discussed. This communication skills and abilities bring the couple closer and have been found to increase the confidence of the woman during the journey and even of the father. Support from partners contribute to the feelings of calm and security during childbirth and the parenting (Edmonds et al., 2011).

Not only do expectant fathers or spousal partners play a significant role in providing support but support from the woman's mother and even mothers-in-law and sister-in-law, have shown to be instrumental especially with the informative support, that is with advice and suggestions; and instrumental support, that is, help with routine house activities) (Edmonds et al., 2011).

The feelings of calm and security during pregnancy are not only facilitated by their partners but non-kin-based relationship, such as friends, colleague workers, neighbours and especially other expectant mothers of similar age groups. Sharing of experiences strengthen the mothers. However, at times, the sharing could instil fear in the mother especially if the experience is being shared by

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one who had a negative childbirth experience. In this case, social support may be seen as negative like Cassel (as cited in Song et al., 2016) tried to project. Such 'horror stories' are mostly shared by the expectant mother's mother, friends, relatives, colleagues or unknown people who they may have come into contact with at a function or even via the Internet. Of these non-kin-based relationships, neighbours have been found to provide substantial emotional, esteem (Edmonds et al., 2011) and emotional supports (Hetherington et al., 2015). Song et al. (2016), also observed that religious participation and support its linkage to health and reception of more support is substantial.

Husbands and maternal mothers were identified to have provided the highest instrumental, appraisal and emotional support to mothers. Leahy-Warren (2005) study revealed a positive and statistically significant relationship between appraisal and informational support to the confidence of the mother in infant care practices. Freund (2007) also indicated that the child's father offered great emotional support to the mother.

In this technology era, mothers also use the Internet to obtain information about childbirth. They experience the Internet as the fastest way to obtain information. Not only does the Internet have an upper hand for its speed but its diversified sources of information as well as availability to go anonymous. Expectant mothers' express needs for different types of information such as pregnancy-related questions like Braxton Hicks contractions or "false labour" pains and foetal movements); what they needed to purchase and prepare at home before the arrival of the baby; childbirth-related questions (how to recognize the beginning of labour) and questions about parenting. These set of information may be obtained from various reliable sources such as midwives, nurses and obstetricians during their antenatal visits or by just calling the health centres or by using the Mobile Midwife technology, a mobile technology that sends timely messages to

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expectant and nursing client mothers concerning their health and pregnancy (Entsieh, Emmelin & Pettersson, 2015). Satisfactory information facilitates the mothers' understanding of childbirth and parenting. On the other hand, when the information varied in content or was overly exaggerated, especially those from the Internet, it could cause confusion or uncertainty among the expectant mothers.

With this, another source of reliable support especially the informative support is that from nurses, midwives, community health workers and doctors. This kind of professional support is offered by professionals and often limited to professional knowledge. Midwives, for instance, possess priceless knowledge about the normality and healthiness of pregnancy and childbirth and have a natural role in blending the medical and reality perspective in aiding in the childbearing period of mothers (Bäckström, 2018). Support from these more formal institutions can include the pregnancy schools and antenatal and postnatal services. Childbearing involves many challenges for the expectant parents and several researchers have shown that parents and their infant benefit from expert support. Professional support is shown to decrease the number of pre-term births (Ickovics et al., 2007) during pregnancy, increase parental knowledge, better prepare mothers for childbirth (Barimani, et al., 2017a; 2017b; Svensson et al., 2009) and infant care (Manant & Dodgson, 2011). As well as increase partner involvement (Ferguson et al., 2013). Community health research workers, for instance, contribute significantly to the health information and advice expectant mothers receive (Edmonds et al., 2011).

Bäckström (2018) who studied elaborately on professional support, made several observations. The results of her work showed that the expectant first-time mothers perceived that professional support contributed to their mental preparedness for childbirth and parenting. By 'mental preparedness', the mothers meant knowing what could happen and how they could respond to

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anything that happened, as well as feelings of being relaxed or safe. On the other hand, when the mothers perceived lack of professional support, it negatively influenced their mental preparedness. Professional support contributes to mental preparedness and is one of the topmost contributions to supporting pregnant women. The reliability of the information provided by professionals increased when the mothers could trust the health-care professionals throughout the whole chain of antenatal and labour-ward care. Bäckström continued that, professional support could also be reassuring (i.e. affirmative) and emotional, according to the mothers' perceptions; this included the midwives listening to, confirming or meeting the individual needs of the mothers. When the midwives created a relaxed atmosphere, the mothers perceived that this provided the opportunity for them to express their experiences and releases anxiety which then led to feelings of security. On the other hand, lack of reassurance (i.e. affirmative) or emotional support could hamper the mothers' ability to trust themselves and, in their capacity, to give birth. Mothers who did not have other friends who were pregnant or who had had children had someone to share and contribute and relate to during antenatal services or pregnancy education class. Not having the opportunity to participate in an antenatal education class was perceived as unsatisfactory by the mothers. However, Johnson, Kirk, Rooks, & Muzik (2016) showed that some African American mothers in Southeast Michigan indicated their distrust of the information and recommendations provided by healthcare workers regarding breastfeeding and therefore relied more on their peers and families.

The professionals could include the partner's role by providing information about how partners could help and support the mothers during labour. This information could include massage and breathing techniques, or the best ways to help the mothers cope with labour pains using mental strategies. However, the partners perceived there was a lack of information concerning the following: childbirth complications (Caesarean birth, breastfeeding complications etc.); economic

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issues; parental leave; baby-related items that they needed to purchase and finally how to meet the baby's needs.

With all these, however, some individuals have limited personal capital of their network members. When encountering undesirable life events, they are expected to use social capital to help reduce the negative health effects of stressful life events (Song et al., 2016). When mothers have limited personal capital, they have fewer people to fall on for help during those unpleasant vicissitudes of pregnancy life.

2.6 Living Conditions in Urban Slums

UN-Habitat (2010) characterizes slum communities as places that lack of basic infrastructure, poor schooling facilities, high risk of sexual and gender-based violence, high levels of substance abuse and poor livelihood opportunities, all of which negatively impact the health and wellbeing of residents. Besides, there is overcrowding, marginalization, harmful environmental exposure, social disadvantage and insecurity of land in slums.

Sub-Saharan Africa is growing faster in its population than anywhere else in the world, and the strains of population growth are progressively felt in the urban areas (UN-Habitat, 2010). The increase in population is attributed to rapid rural-urban migration leading to the quick development of informal settlements. In Accra for instance, 60% of the population live in informal settlements (Van Rooijen, Spalthoff & Raschid-Sally, 2008).

Of this migratory movement, young people account for the majority of migrants (Awumbila et al 2015; Msigwa & Mbongo, 2013) and one-eighth of migrant workers are the youth in that age range of 15-24 who move primarily for improved economic conditions (United Nations Children's

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Emergency Fund [UNICEF], 2014). The International Labour Organization (ILO) (2014) further indicated that a lot more young men and women are eager to relocate to other countries. This was revealed in data collected in 150 countries. Even though other age groups migrate, the desire among young people to move from their rural areas to the urban cities for better non-agricultural employment opportunities is high (Ginsburg et al., 2014).

In most cases, however, the social status of slum dwellers is very poor (Singh, 2016). Most slum dwellers live in downgraded sections of society that contain poorly- built structures made of plywood, or cardboard or roofing sheets and thatch. In these places, access to the basic amenities of life such as potable water, sanitation and electricity is difficult. Slum-dwellers often engage in low-level economic activities such as tailoring, construction, alcohol retailing, cleaning of houses, auto driving, rickshaw pulling, herding of cattle and fowls and some illegal activities (Singh, 2016). Others also engage in street hawking to make ends meet. This, coupled with the high illiteracy rate makes it difficult for the slum dwellers to earn a meaningful income. Existing evidence suggests that most slum residents in low and middle-income countries are not satisfied but have to stay in slums (Mudege & Zulu, 2011) and struggle with the insecurity of the tenancy.

It is believed that health is wealth and that healthy people are capable of building healthy nations. However, the health situation among slum residents depicts a different picture. The inability to consume healthy and nutritious foods contributes to a high level of malnutrition among women slum occupants and their children (Goswani & Manna, 2013). Overcrowding in housing units is associated with communicable diseases such as respiratory infections and tuberculosis (Arku, Luginaah, Mkandawire, Baiden & Asiedu, 2011; Krieger & Higgins, 2002), which is very common in slums. The lack of potable water and poor waste disposal both contribute to diarrhoea transmission infections. According to Rahman (2006), there is a sturdy link between

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environmental conditions and diarrhoea outbreak. For instance, among the urban poor of Aligarh City, India, the incidence of diarrhoea was reported to be 96% with the main contributory factors being open defecation, buying prepared cheap food from vendors and the use of manual latrines. Similarly, children in slums with diarrhoea were found to be 32% higher compared to 13% in the whole of Nairobi and 17% in rural areas (Kimani, Zulu & Undie, 2007). Studies specify that the lack of sanitation amenities is more common among slums and deprived poor communities compared to towns and cities in most parts of Ghana (Institute of Statistical, Social Services and Economic Research [ISSER], 2010-2011). In most slums of Nairobi Province, malaria has been cited as a common epidemic (Yazoume, Kimani, Kebaso & Mugisha, 2007). In profiling diseases among slum dwellers, Riley, Ko, Unger and Reis (2007) record that there is also evidence of chronic non- communicable diseases like hypertension, diabetes, injuries, rheumatic and heart diseases among slum dwellers.

2.7 Conclusion

Though some research works have tried to address and account for social support, conditions of pregnant women specifically in urban slums and the bearing it had on their pregnancy here in Ghana, and Accra to be specific, has been insufficiently researched on. Slums are on the rise in Accra and vulnerable pregnant women inhabit in these areas. Dwellers in the Brigade slum community acknowledge that the number of people and shack buildings keep increasing and more (pregnant) females especially adolescents are resident there. This work sought to bridge the knowledge gap by conducting an in-depth interview to understand how social support is related to pregnancy experiences of pregnant women in this urban slum in Accra from a qualitative point of view. From the research, recommendations made as to how best to make pregnancy manageable

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for these women even in a seemingly inhumane living condition are offered. A qualitative method was appropriate for this study so the views and thoughts of the women can be expressed and made known.

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CHAPTER THREE

METHODS

3.1 Introduction

This chapter **presents** the method plan of the study. It outlines and describes the study design, study area, target population, sample procedure for the study, ethical considerations as well as data analyses process that was used. The data collection techniques and instruments are also shown in this chapter.

3.2 Study Design

This was a qualitative study that used a phenomenological approach. Phenomenology seeks to describe the lived experiences of the people directly involved in the phenomenon of study (Creswell, 2013). It probes into an individual's beliefs and knowledge, seeking to describe their experiences about a particular phenomenon as perceived by them. It is consequently necessary and suitable when a researcher seeks a deeper understanding of experiences that are common to a group of individuals (Creswell, 2013). The study design permitted participants to give in-depth information about the subject matter through open- and closed-ended questions as well as allowed flexibility for the researcher to probe responses from participants for clarity. Through these, responses that were never anticipated by the researcher (Mack, Woodsong, MacQueen, Guest & Namey, 2011) on social support and pregnant women in urban slums were brought to bear and discussed.

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3.3 Study Area

The study was conducted in the Brigade slum community, located in the Ayawaso West Municipal Assembly in the Greater Accra Region of Ghana (Figure 1). It is named "Brigade" by settlers there due to its proximity to a military barracks some kilometres away. Some also call the place Yutees, after a security company on that stretch of road. The slum is close to other notable governmental and private organizations such as the office of the Ghana Chamber of Mines, the Nursing and Midwifery Council, Community Water and Sanitation Agency, the Department of Feeder Roads and Wild Gecko Handicrafts on the Gulf Street, Shiashie-Accra.

At the Brigade slum community, dwellers report that majority of the inhabitants (60%) are from the Volta Region or Togo, the Ewe ethnic group. The second-largest ethnic group that inhabit there are the Guans (25%). The remaining 15% is made up of other ethnicities like Akans, Northerners and Gas. Anecdotal states that there are about 700 slum residents with about 450 makeshift structures/kiosks made primarily of wood, plywood and aluminium roofing sheets. The inhabited land originally belongs to the Ghana Grid Company (GRIDCo) and the Electricity Company of Ghana (ECG) for the mounting of high-tension electrical poles to serve electrical power to surrounding homes and offices. This makes it highly unsafe for people to reside there and thus residents face constant evacuation threat from GRIDCo and ECG. Most of these dwellers are former slum dwellers who were evicted from dwellings. Others came from other regions chiefly the Volta Region in addition to the Oti, Bono, Eastern and Western regions. Some also came from neighbouring Togo. Job search and economic challenges were the main reasons settlers resided in the slum. The slum sits on a land space of about five (5) acres. There are no recognized leadership in governing the residents in the slum. They have potable water and electricity but no lavatory.

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The Ayawaso West Municipal is one of the 260 Metropolitan, Municipal and District Assemblies (MMDAs) in Ghana, and forms part of the 29 MMDAs in the Greater Accra Region. The Ayawaso West Municipal Assembly was carved out of the Ga West Municipal Assembly as one of the 38 newly created and upgraded districts assemblies in 2018. It was inaugurated on March 15, 2018, alongside other 37 newly created districts (Ghana Districts, n.d.). Before this, Ayawaso West was a sub-metro of Accra Metropolitan Assembly (Ghana Statistical Service [GSS], 2012). Statistics from GSS (2012) reveals that Ayawaso West Municipality has an expansive geographical area is deemed to be the least densely populated area with population 70,667, representing 1.8% of the populace in the Greater Region of Ghana. The population of males is 37,065 as against 33,602 females, with a population of 18 years and older for both sexes being 53,616. There are 14,909 number of households and the population in households is 51,997 with a house-hold size of 3.5.

Ayawaso West is regarded as cosmopolitan and comprises of people with diverse ethnic backgrounds, diverse educational background as well as economic and religious backgrounds. All dwellers in Ayawaso West Municipal Assembly reside in urban sites. There are no rural communities in the municipality (Ghana Statistical Service, 2012). Ayawaso West is home to most of the luxurious residences in Ghana located in areas such as East Legon, Airport West, Abelenkpe, Dzorwulu, Roman Ridge, and South Legon. However, there appear to be a growing number of slums developing in certain portions of this constituency, especially in areas such as the Gulf House (Shiashie), Bawaleshie and areas along the Tema Motorway (The World Bank, 2010). With this, in Ghana, makeshift dwelling units such as tents, kiosks, containers and attachment to shops or offices together constitute 2.0% of the housing structures. However, in Greater Accra, the proportion of makeshift structures is 6.2%, which is exceptionally higher than in all regions, which

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is less than 1%. Second to Greater Accra is Ashanti Region (1.8%) (Ghana Statistical Service, 2012).

The Ayawaso West Municipal begins from the Nsawam road of the N1 Highway to East Legon, through to the Tetteh Quarshie Roundabout through to the 37 Military Hospital roundabout and then follows the Obasanjo Highway.

3.3.1 Rationale for Choice of Study Area

Ayawaso West Municipal Assembly is known for its luxurious residences and offices. However, over time, several slums and informal settlements have quickly sprung up. Unlike other slum communities such as those at Agbogbloshie which is not sited in luxurious areas, the Brigade slum community is. The presumption is that life in a developed, deluxe and busy urban area like Ayawaso West must come with its unique challenges, especially psychologically and financially, and a study of the state of social support to pregnant women who have settled in that slum community has not been done. According to settlers, the Brigade slum has quickly sprung up and grown and is estimated to have about 200 makeshift structures there. These reasons act as a propellant in the choice of the study area.

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Figure 1. Map of Ayawaso West Municipality (Map of Ayawaso West Municipality (a projected location of the Brigade slum indicated with the red indicator)

Sources: Sagoe et al., 2019 and GoogleMaps, 2020

3.4 Study Participants

Sixteen postpartum mothers who reside at Brigade slum were enrolled into the study and interviewed to have privy of their social support system during their recent pregnancy and the bearing it had on their pregnancy experiences. The participants fulfilled the following inclusion criteria:

3.4.1. Inclusion criteria

1. Mothers who have delivered within one year as at the time of the study.
2. Postnatal mothers who carried the pregnancy for at least 6 months in the slum.

The latter criterion was to ensure that the experiences the mothers share will be reflective of their stay in the slum, which is a key objective of this study. The former criterion is to control for recall bias without placing a lot of limitation on who can be enrolled for the study.

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3.4.2. Exclusion criteria

Mothers who were ill either due to pregnancy or other factors.

3.5 Number of Study Participants

According to Boyd (2001), two to ten participants are sufficient to reach saturation in a qualitative work. Again, Guest, Bunce and Johnson (2006) stated that after 12 interviews, 92% of saturation was reached. Saturation was reached upon interviewing the 16th respondent. Thus, interviews were concluded at this point.

3.6 Selection of Study Participants

A non-probabilistic purposive sampling technique was utilized in selecting participants. In order to get participants who were suitable to furnish the data for the desired phenomenon in question, participants were enrolled based on the inclusion criteria. In order to get such participants, a contact person in the slum community helped the researcher identify eligible participants. This contact person was a resident of the slum, with about 6 years-experience of stay in the slum, as at the time of the study. She was the first person to receive the researcher, and upon explaining the purpose of the study to her, led the researcher to the first eligible participant. After interviewing each participant, snowballing was used to identify other respondents who meet the inclusion criteria. One disadvantage with snowballing is the possibility of getting similar characteristics due to the close-knit of contacts (Blanken & Treatment, 2016). In view of these, the researcher, guided by the inclusion criteria, was also conscious in enrolling participants with disparate characteristics such as age group, marital status and educational level from the various contacts. This ensured that fairly diverse respondents were selected for the study. These techniques helped to avoid getting

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participants of similar characteristics by factors such as age group, marital status and educational level.

3.7 Data Collection Method

The data was collected from the mothers through face-to-face in-depth interviews. On average, interviews lasted for about 30 to 45 minutes and was done primarily in the Twi and Ewe languages. Some interviews, however, in addition, had a mix of English and Ga. Sundays were the most available and suitable days for the dwellers at Brigade, thus four Sundays spanning from July to August were used to collect the data. All interviews were recorded upon permission from respondents, who were made aware of the purpose of the study and their right to withdraw from the study at any point they deemed fit. Signed informed consent was acquired after the voluntary agreement of respondents. The data was collected by the principal investigator and two research assistants. Field notes were taken to augment the audio recording. The participants were free to take a break or engage in any household duty once it was not a distraction to them. Follow-up interviews, where necessary were done on phone with the respondents due to the COVID-19 pandemic, and where convenient at the study site also.

3.8 Data Collection Tools

Research tools such as interview guide, field notebooks, mobile phone digital voice recorders and camera were used in the data collection process.

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The interview guide was divided into these sub-sections: Respondents profile, Pregnancy experience and Types of social support received, Sources/Providers of support, and the Living setting and pregnancy. Further questions were asked based on the responses and feedback obtained from respondents.

3.9 Pilot Study

Before the actual data collection in the study area, a pilot study was conducted in a slum setting in Okponglo-Bawaleshie in the Ayawaso West Wuogon Municipality of Accra, to test the interview guide for quality and efficiency (Karimi, 2015). The pilot study brought to bear some of the challenges likely to be faced in the field and thus preparations made. The pilot study was conducted with two mothers to ascertain the clarity of the questions. This gave way for rephrasing of questions and addition of follow-up questions and possible probes to get detailed data on the phenomenon.

3.10 Data Storage and Usage

Data obtained from respondents including audio recordings, images, transcription of interviews were stored electronically on computers and mobile devices, with a password known only to the principal investigator/research assistants.

Codes and pseudonyms were given to the interviewed participants. For the production of this report, the given pseudonyms are used. All files of the research stored on the computer were password-protected. Both soft and hard copy data will be kept by the principal investigator for a

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maximum of 5 years to allow for publication of the research, after which it will be destroyed permanently by formatting electronic devices completely and burning hard copy data.

3.11 Data Analysis

Interviews conducted in the local dialects (Twi, Ewe and Ga) were translated and transcribed into the English Language. To check for accuracy, some of the transcripts were translated back into the local dialect. The transcribed and verbatim translated recordings were entered into the computer using Microsoft Word. The transcripts were read and re-read to detect for differences and similarities while listening to the original voice recording. The six thematic analysis procedures described by Braun and Clark (2006) was used for the analysis of the data collected. First of all, the researcher continually familiarized with the data/transcript during transcription and by constant review of the completed transcripts. Secondly, initial codes were generated from the transcripts. Coding and recoding were done and patterns organised into themes. Themes which had a strong relationship to the study objectives were identified, reviewed, defined and named. This process was manually done. Themes such as spousal support, evacuation and violence, came up in response the various objectives. Finally, the results were produced and reported. This process was iteratively done, particularly between the stage of generation of codes and themes from the transcript. The thematic analysis was manually done employing both a deductive and inductive analysis (Creswell, 2009).

3.12 Quality Control

To achieve a high level of quality and trustworthiness, several methods were incorporated in the process as suggested by Lincoln and Guba (1985). First, to ensure credibility, interviews were very

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engaging, giving sufficient time for participants to provide more information on the phenomenon. Data obtained from participants were confirmed with them to ensure accuracy and resonance of what was shared. The study made use of data triangulation by utilizing transcribed interviews, field notes and audio recordings. To ensure transferability, 'thick' and detailed description of respondents' experience with social support and their pregnancy was used. Lincoln and Guba (1985), the study incorporated external audits to evaluate if the findings and interpretations were consistent with the data. Again, a reflection at the limitation of study further contributed to attaining confirmability through reflexivity.

3.13 Ethical Considerations

Ethical clearance was sought from the Ghana Health Service Ethical Review Committee with approval number GHS-ERC 025/01/20. Since there **was** no recognizable leadership at the Brigade slum at the time of the study, oral permission was sought and granted by each respondent. All the participants signed the informed consent after a summary of the purpose of the study, potential risks and benefits and utility of the data was explained to them. The consent documents were read and translated by the principal investigator/research assistants into a language the respondents understood (Twi/Ewe/Ga). A family member served as a witness to the agreement. In cases where no family member was available, the community contact person served as a witness with approval from the respondents. Permission was obtained to record the interview as well as take pictures of their living setting.

There are no foreseen physical risks involved in the study, nevertheless, in instances where participants were emotionally and psychologically disturbed in the process of answering a question, respondents had the decision to decline from answering the question. In instances were respondents expressed some willingness to answer, the questions were rephrased or asked at a later

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time when they were sober. Participants were given the freedom to abandon the interview process at any time they deem fit without any penalty. Such participants had their data completely erased.

To ensure confidentiality, codes were issued and pseudonyms have been used in the production of this document. Contact details of principal investigator/research assistants and the respondents were exchanged. The GHS-ERC administrator's contact details were made available on the information sheet.

3.14 Conflict of Interest

There was no conflict of interest as far as this study was concerned.

3.15 Coronavirus (COVID-19) Preventive Measures

To protect participants from the global coronavirus pandemic, study participants were required to the use of alcohol-based hand sanitizer before, and where needed during the interview process. All participants were advised, provided for and required to wear face masks during the entire data collection. This provision will be at no cost to the study participants. Physical/social distance was ensured as much as was possible. In instances where it could not be ensured, both researcher(s) and participants were well-adorned with face masks.

These measures applied to the researching team. Wearing of gloves were mandatory for the research team.

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CHAPTER FOUR

RESULTS

4.1 Introduction

The study was aimed at exploring the social support pregnant women in the Brigade slum community in the Ayawaso West constituency had and its influence on their pregnancy experiences or journey. This chapter presents the findings from the study, elucidating the characteristics of the respondents, their pregnancy experiences and social support, the type of social support received, the providers of the social support and the role of the living setting (the slum) to their pregnancy experiences.

4.2 Characteristics of Respondents

Sixteen participants were involved in the study. These women were all postpartum, nursing mothers who recounted their pregnancy experiences with social support concerning their most recent (just-ended) pregnancy. Majority of the participants (9) were aged 20-29 years. Six of the respondents were aged 30-39 years and only one participant hit the 40-age mark. Most of the women were married (8). However, this number was closely followed by the cohabiting women (7) with one single (unmarried/uncohabited) respondent, a schoolgirl. The highest educational level attained was the tertiary level by just one (1) participant who had completed nursing training college. Primary and Junior High School (JHS) leavers where the majority (9) with one participant still attending junior high school. Senior High School leavers formed the minority (2). Four (4) participants, however, did not have any form of formal education. At the time of pregnancy, the majority of the participants (11) were self-employed mainly trading in cooked food like rice, *waakye*, *kenkey* and roasted plantain. There were two (2) apprentices (dressmaking and ceiling designer) and one (1) student in junior high school. Of these numbers, eight participants were able

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to fully work during pregnancy. This number was however closely followed by those who either stopped working permanently or temporarily due to the pregnancy (6). Two participants were not engaged in any form of economic activity while pregnant. Majority of the respondents (8) had stayed in the slum for about 3 to 5 years. Five participants had lived there for between 1 to 2 years and only three (3) participants had lived there for more than 5 years. All the participants had carried the pregnancy in the slum for at least 6 months of the pregnancy period. Two participants were primiparous mothers, 5 respondents had their second birth and the remainder 9 had three or more children. The highest number of births per respondent was five. A fewer proportion of the respondents (6) attended ANC regularly while the remaining participants (10) went inconsistently during pregnancy. All participants delivered naturally by vaginal delivery, except for one participant who delivered through caesarean section. Respondents' characteristics are summarized in Table 1.

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Table 1. Characteristics of Participants

CHARACTERISTICS	Number of Participants
Age (years)	
20-29	9
30-39	6
40-49	1
Marital Status	
Married	8
Single	1
Cohabiting	7
Educational level	
No education	4
Primary/JHS	9
Senior High/Technical School	2
Tertiary	1
Resident with spouse/partner (during pregnancy)	
Yes	13
No	1
Not stable	2
Working during pregnancy	
Yes	8
No	2
Stopped/Unstable	6
Type of Work	
Self-employed	11
Apprentice	2
Student	1
No work	2
Duration of stay at Brigade slum	
1-2years	5
3-5years	8
5years+	3
Duration of stay at Brigade with the pregnancy >6months	16
Pregnancy type	
Planned pregnancy	7
Unplanned pregnancy	9
Type of delivery	
Vaginal delivery	15
Caesarean section	1
Gestational age	
Term birth	11
Pre-term birth	3
Post-term birth	2
Total number of children	
1	2
2	5
3+	9
Age of recent child	
<3months	2
3<6 months	5
6<9 months	4
9<12months	5
Antenatal visits:	
Consistent attendance	6
Inconsistent attendance	10

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4.3 Pregnancy Experience and Social Support

The first objective of the study was to explore the role of social support on the women's pregnancy experiences. To appreciate their experience with the support, it was necessary to understand their varied experiences with their most recent pregnancy. The themes that aided to conceptualize this objective were (a) Experiences of pregnant women and (b) Impact with or without social support. The first theme sought to understand the respondents' experience or journey through pregnancy. The second theme, which will be addressed in a different section of this chapter, sought to know the role social support had on the women who had support, and on those who did not have any or insufficient support.

4.3.1 Experiences of Pregnant Women

The women had varied experiences with their pregnancy. Some reported being sick throughout their entire pregnancy journey while others reported sickness at certain stages of their pregnancy. This sickness, termed as 'pregnancy' sickness by the respondents was characterized by fatigue, headaches, feverishness, vomiting and spitting.

Here are some experiences of participants with regards to pregnancy/morning sickness in the following quotes:

> *"This pregnancy I suffered. I really suffered. Anytime I am pregnant I fall sick. I fall sick anytime I get pregnant. You'll see that, there are [times] that my head will be burning me continuously... every time I am pregnant, my head will be burning me continuously. So my hair, unless I cut it before I will be able to, I will be ok"* ***(Baaba, 26 y/o, Married, Parity: 4)***

> *"The first three months, it was like, it felt like small small malaria, pregnancy sickness. [the seventh month] I was vomiting! As for that one, unless I didn't. Any type of food...*

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When I was going to the eighth to ninth months and the vomiting stopped" ***(Cynthia, 30 y/o, Married, Parity: 2)***

A few other participants had anaemia, which contributed to their sick status. Emefa was one of such participants who shared her experience in the quote:

"I felt normal just that I wasn't strong enough to work. It was only blood problem (anaemia) I was having. When I was 3 month they told him (husband) to come and donate blood so when I got to my 7th month I went and they said my blood now ran to 6.0 so that way they will not allow me to go home otherwise something may happen to me." ***(Emefa, 27 y/o, Married, Parity: 2)***

Some experienced various mood swings and narrated being irritated easily:

"Sometimes when you are pregnant it is not easy, you can see someone, your partner and be angry at them" ***(Enyonam, 38 y/o, Cohabiting, Parity: 3)***

"When it happens [with pregnancy], your temp pressure (temper) is high. Any small thing then you will be angry" ***(Evelyn, 29 y/o, Cohabiting, Parity: 2)***

Some also reported having a change in appetite. Nelly recalled having increased appetite for different kinds of food:

"Hmm it [pregnancy] is not easy.. sometimes the food that you want to take you won't be happy with it, you want to eat something else ...for this one I used to eat a lot." ***(Nelly, 23 y/o, Married, Parity: 2)***

The pregnancy had some economic effects on the women as most of them had to abrogate their work completely whereas others stopped temporarily and resumed when they got enough strength.

For Baaba, being pregnant meant, a pause in from any economic activity:

"The very moment I got pregnant I stopped. Any time I get pregnant I fall sick. It has continued for the third time. I always fall sick. So I am not able to sell things... I used to sell things, I cooked rice and sell and all" ***(Baaba, 26 y/o, Married, Parity: 4)***

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Getty too was badly hit and had to stop selling kenkey until she gained enough strength:

> *"I couldn't do anything for the nine months. Unless I give birth before I am able to do something. Even the kenkey that I prepare I am not able to. For me unless, I get six months before I get enough strength"* ***(Getty, 34 y/o, Married, Parity: 3)***

In the case of Gina, even though she was well and not plagued with any sickness, the nature of her work, as a ceiling design apprentice, made her retire, until after the pregnancy:

> *"When I got to about the 5th to 6th month, because I was working with machines, they said after I deliver, then I can resume, so since then I haven't gone to the workplace"* ***(Gina, 32 y/o, Cohabiting, Parity: 4)***

Some participants could however work during their pregnancy. Yama was an example and though admitted that pregnancy was tough, she was able to work:

> *"For pregnancy the beginning is hard. For the first 3 months, I was strong. From 4 months to 6 months too I was strong and working alright. From 6-9 month I couldn't work because of COVID-19. If not, I will still be working until the delivery time."* ***(Yama, 30 y/o, Married, Parity: 3)***

Though these experiences were irrespective of age, marital status or parity, few of the participants, however, went through the pregnancy calmly, without any sign or hint of sickness. Afi and Gina were such examples and recounted their trimester journey:

> *"Ei, my pregnancy journey I took it so calmly ((laughs)) I took it so calmly...for me all my pregnancy I don't vomit, I don't fall sick. I am normal...I don't spit around."* ***(Afi, 34 y/o, Married, Parity: 4)***

> *"Oh, when I took seed, I knew it. I didn't vomit, I didn't fall sick. Nothing happened to me"* ***(Gina, 32 y/o, Cohabiting, Parity: 4)***

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4.4 Types of Social Support

Considering the diverse experiences with pregnancy, the study was keen on knowing what form of social support the women received and identifying the support they were deficient of.

4.4.1. Types of Social Support Received

Instrumental support

Instrumental or tangible support seemed, by far to be the most received support by the women while pregnant. This type of support ranged from monetary support, assistance with household work including sweeping, fetching of water, washing of clothes and cooking, provision of food, care for existing children, running of errands and assistance with the running of one's business. Every participant reported having at least this kind of support in a way or another.

Cynthia highlighted the kind of instrumental support she received while pregnant:

> *"When he [husband] goes to fetch water, he can also sweep. When he goes to work too, on his return, he can buy something for us. So maybe a day my mind will not be there then he will buy them. The baby's things everything then he bought them. When he goes and come, the baby's bucket and bowl, he alone did, he didn't tell me anything all I realized was that when he returned from work, he had bought them. As for him. "* ***(Cynthia, 30 y/o, Married)***

Beatrice also recalled the support she had, also with household chores:

> *"The eldest [child] among them is now nine years. So that time just him, when he takes a bucket, he will go and fetch water. And his sister will sweep.. even if I would bath, they will fetch water and put it in the bathroom. Then they will sweep. Even if it is some food, they will cook it and they will eat."* ***(Beatrice, 28 y/o, Cohabiting)***

Beatrice, like others, also had help in running their areas of businesses. She shared how her younger sister helped her as a *waakye* seller:

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"My sister who was staying with me, she was a little matured so she knows how to cook and sell.... it was my sister that was supporting me small, small. So even if I am lying down, when I see she has prepared it (the 'waakye')" ***(Beatrice, 28 y/o, Cohabiting)***

Emefa shared how her husband and uncle supported her financially:

"My uncle used to send me money..... He [my husband] was the one giving me money" ***(Emefa, 27 y/o, Married)***

Emotional Support

Emotional support also ranged from everything regarding the offering of empathy, concern, affection, love, encouragement and care to the respondents. It also involved giving a listening ear to them, conversing and laughing with them.

Cynthia expressed the love and pampering her husband offered her during pregnancy:

"He was the one who comforted me, and pampering me, everything...he can hold my tummy and place his hand on it. playing with it" ***(Cynthia, 30 y/o, Married)***

Yama also got a listening ear and attention from her husband:

"He (husband) listens to me and gives me the necessary attention when I need it.." ***(Yama, 30 y/o, Married)***

Beatrice, for instance, went through some relationship crisis with her boyfriend which was greatly affecting her physical and mental states during her pregnancy. She shared the kind of emotional support she had from her little sister who resided with her at the slum:

"My sister, [who] was supporting me like that. (chuckles) The child to acting all grown-up (chuckles). Some times are there she will say, "Sister stop crying ok, it will be well." Then she will be saying some things that are funny for me. So, she is the person I will say was

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with me, who really helped me. She wasn't grown but when she saw the way I was, she could encourage me and all." ***(Beatrice, 28 y/o, Cohabiting)***

Appraisal Support

Appraisal support mainly had to do with the women getting some kind of encouragement and motivation to persist with the pregnancy, especially when situations became difficult. Most of the women who received this support had abortive thoughts due to the struggles with pregnancy sickness, among other factors like financial challenges. Evelyn was a benefactor of this support and narrated her experience with appraisal support:

"Because of where the situation had gotten to, things were very difficult - it was both the sickness and the money. Like I needed someone to help me, but since I was not getting any helper, like I said I will go and abort the pregnancy. It was my pastor (who) advised me a little. That is what made me stop. The time my pastor told me that I should be patient, I shouldn't abort it, I became patient and remembered that if you abort it is not good. That is why I got some kind of faith and I didn't take it out." ***(Evelyn, 29 y/o, Cohabiting)***

Beatrice also narrated how receiving appraisal support from a nurse prevented her from conducting an abortion. With her case, the sour relationship with her partner propelled her abortive intents:

"I wanted to abort the child then our [I and the boy] relationship would have been apart so she (nurse) gave me advice, that the child that is coming I don't know what he is coming to do for me. It is true that I have given birth to some already but every child and his own. So I should stop and see what God will do. So when she calls me, as for advice, she gave me a lot, she gave me a lot." ***(Beatrice, 28 y/o, Cohabiting)***

Enyonam had mood swings during her pregnancy and was easily annoyed by her partner and mother whom she lived with. She narrated being frustrated and tempted to abort anytime she encountered those mood swings and anger. She recounted the appraisal support her mother provided:

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> *"Sometimes when you are angry you say this pregnancy if I get I will terminate it or if your husband annoys you, you feel like getting rid of the pregnancy or killing yourself. My mother tells me that it's not doing those things that is the life. It is the future that matters"* ***(Enyonam, 38 y/o, Cohabiting)***

Emefa was dejected when she was diagnosed with anaemia. She feared that death was imminent and had a very negative talk. Her neighbour appraised and encouraged her:

> *"The woman (neighbour) helped to change my mindset. When I went to the hospital and they said I wasn't having blood, it was headache so I was always complaining that I might lose my life. So this woman said I should stop talking about that, that God will help me"* ***(Emefa, 27 y/o, Married)***

Others also found appraisal support needful during labour:

> *"...the time labour set in. For that one, it was the nurses who will be saying that "Oh be patient, in a little time". Maybe "Sit down" ... So little by little they persuaded us until I delivered the child. It was painful but if, it was painful but, if they say force yourself, you will have to put in some determination. And the thing to you can't also cry"* ***(Cynthia, 30 y/o, Married)***

Those who were not beleaguered by pregnancy sickness or have abortive tendencies, like Fati did not receive and were not in great need of such appraisal supports:

> *"As for me that things I didn't go through so I didn't get such things (appraisal support)"* ***(Fati, 25 y/o, Married)***

Spiritual Support

Spiritual support also came up as a very common support type the respondents received. They mainly came in the form of prayers and spiritual directions from pastors, church members, neighbours or directly from God when the women prayed.

Here is Cynthia's experience with spiritual support:

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"I was really going to church and prayers. So that one, when I go, when the pastor sees something, then he will let me do some directions. When I do those directions then that will be it." ***(Cynthia, 30 y/o, Married)***

For Evelyn, beside the prayer support she received from her pastor, shared how her church members supported her spiritually:

"Like if I am at home then they [church members] will come and visit me and ask me if I am feeling well or not, then they will pray for me. All of that contributed. It helped me" ***(Evelyn, 29 y/o, Cohabiting)***

Afi did not have a lot of people supporting her during her pregnancy. Towards delivery, she recalled clinging to and receiving spiritual help directly from God to deliver safely:

"The date I had to deliver had passed so I was disturbed. So in the night, I didn't sleep. Because I was praying and telling God that I didn't want forced labour ...God also heard my prayer so just by the next morning labour set in" ***(Afi, 34 y/o, Married)***

Informational support

Informational support received spanned from anything relating to advice about pregnancy. Dietary advice was the most received form of informational support during the women's pregnancy. Some also had advice as to how to take care of themselves during pregnancy. Health workers, some family members, neighbours and even strangers provided this kind of support to the respondents.

Emefa, who had anaemia during pregnancy, recounted the kind of informational advice she received from health workers:

"The support I had was that when I went to the hospital, they said my blood is low so they advised me to be eating vegetables and they also told me to be using 'koensusua' to do any soup I am doing. I should add it. They kept advising me to take my medicine." ***(Emefa, 27 y/o, Married)***

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In terms of general wellbeing, Enyonam received some counsel as to activities to avoid to keep herself safe during the pregnancy:

> *"They (health workers) tell us (pregnant) women to avoid lifting heavy objects because not everyone's blood is strong. Some things are there, like carrying water from the ground to your head can have an effect on the baby in your womb."* ***(Enyonam, 38 y/o, Cohabiting)***

4.4.2 Areas of Need for Social Support during Pregnancy

With all these being said, there were some gaps of support the respondents needed or wanted that they did not receive or were not sufficiently provided for.

Monetary support

Most of the women, even those who received much support recounted that finances were still a huge challenge. During pregnancy, the women needed the money to partake in the antenatal care services, purchase items for their expectant child, deliver in health facilities, run their businesses and attend to their personal upkeep needs.

One prime need for monetary support came when ANC was due. Majority of the respondent (11) were not able to consistently attend ANC. This was mainly due to financial challenges. Their story was very similar to that of Grace:

> *"I needed money to go for check-up at the hospital but he [partner] wasn't having it so I couldn't go."* ***(Grace, 40 y/o, Cohabiting)***

Evelyn took time to recount her varied need for financial support during each stage of pregnancy, which was insufficiently provided:

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"(1st trimester) I needed money to go to the hospital. I was sick. I was sick so I couldn't do anything. I couldn't eat. (but) I didn't get it [money], so we kept borrowing from people like that... (Second trimester) I needed it [money] to work. There was no help coming from anywhere. So it was only tears that I was shedding and I used it to go and sell pure water. (Third trimester) too I needed money that I would use to deliver but that one too I didn't get. All of that contributed to why God made me deliver in the house." ***(Evelyn, 29, Cohabiting)***

Provision of food

Some of the women also stated a need for food supply during pregnancy and especially after delivery. Beatrice narrated her harrowing ordeal of not getting even '*Lipton*' to drink after her caesarean section.:

"They operated on me Tuesday. So the Thursday that they told us that we can drink Lipton. "So everybody should go and buy Lipton and sugar". And everybody called their husbands. When I called this boy (boyfriend), he said he is working he cannot come. That was the day that I became sad and my brother is here (in Brigade slum), I called him on phone that I beg him, they said today we can drink Lipton so he should come and take and go and buy sugar and Lipton for me. From here to there 2 cedis. Even if he won't get when he comes I have 5 cedis I will give it to him to (to board a car). Sister, my brother used, "I am coming I am coming". Now I was dizzy. I was shaking...The people there asked me "why don't I have family members?" I couldn't talk. That day is when I was really saddened it was not easy. It was like I didn't have any family member." ***(Beatrice, 28 y/o, Cohabiting)***

Baaba has a similar experienced but eventually had something to eat. Her husband, the main supporter, had a work schedule which made it difficult to be present all the time:

"If you give birth, they will call you that someone should bring food for you... but I didn't get anyone except after my husband closed from work. I sat there in the hunger for a while. It gave me a bit of a problem because I got hungry. I got very hungry in the hospital... My husband, he had to ask permission from work to come and buy food for me. So when he

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came, he bought a lot of food and placed them there so that, when he leaves, I won't feel hungry." ***(Baaba, 26 y/o, Married)***

Emefa emphasized that it is problematic not getting food during pregnancy.

"The only thing is that if you are pregnant and you don't get food to eat that is the problem" ***(Emefa, 27 y/o, Married)***

Assistance with housework and errands

Effects of pregnancy/morning sickness made it difficult for some women to engage in their household chores and run simple errands. This was one of the supports some of the respondents needed but insufficiently received. Baaba and Evelyn expressed their need for assistance with household chores and errand going respectively:

"Someone is there when they get pregnant, they don't fall sick so they can do everything of theirs. But for me, it would have been better that someone will come and help me. So that they will help me with the sweeping and things like that. All of these it is only my daughter (11-year-old) who did them" ***(Baaba, 26 y/o, Married)***

"If I want to send someone, that one too I wasn't getting help. Like if I want something, I don't get someone to send them but that one too I needed help ...I wanted someone who would like buy something for me, or I want to send the person to the market but I didn't get it. I didn't get it that one." ***(Evelyn, 29 y/o, Cohabiting)***

Emotional comfort

A few others like Baaba expressed their need for some comfort particularly during their experience with pregnancy/ morning sickness.

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"An example is like how I was sick. So like if someone was close to me, I could have got some comfort" ***(Baaba, 26 y/o, Married)***

With all this, instrumental support came up as the type that most respondents received, and at the same time, the type that they needed the most, particularly with financial support. Emotional, spiritual and informational support also frequented in the type of support they had. Appraisal support was particular to those who had severe health challenges like anaemia or those who had abortive tendencies. Nonetheless, those who were not in peculiar challenges received this support considering the regular challenge with morning sickness.

4.5 Providers of Social Support

Among the list of people who provided some form of social support to the women were their husbands/partners, siblings, Pastors and church members, Neighbours, community friends, health workers, colleague workers, strangers and the media.

Support from Husbands/Partners

Husbands/partners were the main providers of social support to the women while pregnant. This was mainly because, Brigade was considered a no-man's-land. Because inhabitants were settlers from various parts of the country, most inhabitants kept to themselves and avoided any trouble. Thus, one's partner was the only, most reliable source of help. Every respondent received some form of support from their husbands/partners either instrumental support, especially with assistance with household work and financial support; emotional support, encouraging and showing acts of love to their wives/partners; and a few provided appraisal support.

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Cynthia who had unflinching support from her husband described his varied instrumental support towards her:

> *"As for my husband every time he could do anything for me. He goes to fetch water for me, he does everything for me. Some times when I even vomit, he goes to pour it out for me. With every medicine, every month he gives me money to go to the hospital. Those times I could tell a lie to him that I am going to conduct a scan and he will give me, maybe I couldn't even take the scan but even that he will still give me money. As for him. He is the very one who gives me money. My in and out, food, everything. Even the items for the baby he bought them. He bought them."* ***(Cynthia, 30 y/o, Married)***

Emefa also stated provision of money and assistance with housework as the support she also received from her husband:

> *"He was the one giving me money. He would come back (from work) and do the house chores when I not back from work."* ***(Emefa, 27 y/o, Married)***

Enyonam also took turn in narrating how supportive her partner was with housework:

> *"No one gave me this (instrumental) support apart from my partner. He cooks for me, takes care of the kids and sometimes fetches water"* ***(Enyonam, 38 y/o, Cohabiting)***

For many of the respondents, their spouses' financial incapability was a challenge. They were, however, appreciative of the little they supported with and understood their situation. Most of the spouses of the respondents where handymen: especially carpenters and masons and so were easily laid off once their services had expired.

Evelyn's partner was a construction worker and at the time of her pregnancy, the husband was redundant. She, however, appreciated the effort the husband put into providing financial resource to seek medical attention:

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"Then the (construction) work had gone down... I needed money from him to work but he too he wasn't working, he was at home...during the time (1st trimester) that I was sick and there was no money, he really forced and got a loan so he really did well with it" ***(Evelyn, 29 y/o, Cohabiting)***

Grace expected much financial support from her spouse. She, however, demonstrated a strong belief in her partner's willingness to support should he have been financially capable:

"I expected much from my partner but he does not have the means so I do not blame him. If he had the means he would have provided it". ***(Grace, 40 y/o, Cohabiting)***

Husbands/partners also provided emotional comfort and support to their spouses.

Emefa, made it known that her husband was her central provider of emotional support, giving her attention and showing her love and care during her pregnancy:

"He (husband) has been encouraging me. He is the only person I have and listens to me. ((Laughs)) Sometimes if he comes home from work and he cooks and if I don't want to eat, he will be putting the food in my mouth." ***(Emefa, 27 y/o, Married)***

Cynthia also shared the kind of emotional comfort she got from her husband:

"He [husband] can hold my tummy and place his hand on it...playing with it. As for him, I won't ever speak evil of him" ***(Cynthia, 30 y/o, Married)***

In a few instances, partners also provided appraisal and informational advice. Sela got pregnant while still in school and wanted to abort it but her boyfriend supported her and prevented her from committing that act:

"My boyfriend. Like the day I realized that I was pregnant I told him that I was not ready to have a child and he said as far as I am pregnant, I have to carry the baby. That's why I carried the pregnancy. If not for my boyfriend I would have terminated the pregnancy." ***(Sela, 23 y/o, Single)***

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Cynthia's husband also provided some informational guidance to her with regards to her eating, while pregnant:

> *"...When I finish eating and I vomit at that moment, and I say I want this, immediately he will buy it for me...So maybe he will tell me, "Don't eat it too much. If you eat it too much you will vomit o?" and I will be like, "Yes, I hear you". So little by little."* ***(Cynthia, 30 y/o, Married)***

Support from Mothers of Respondents

Mothers of the respondents also came up as providers of social support to their daughters. Though most respondents did not receive support from their mothers as they hoped, few did, with the mothers mainly providing instrumental support, particularly assistance with housework, provision food and in some cases, financial support. They also provided some emotional support, appraisal support and informational support. Mothers of respondents who provided support for their daughters either lived with their mothers in the slum or they within Accra.

Enyonam was like such a person and received various support from her mother:

> *"My mother lives here with me. [She] gives me all the support because sometimes when I go to the roadside to sell, she cooks and brings it to me. She also encourages me...That [pregnancy] time my husband lost his job. If I don't have money to go to the hospital, I go to her and inform her that it's time to go to the hospital so she should give me money to go to the hospital."* ***(Enyonam, 38 y/o, Cohabiting)***

Enyonam's mother was also a provider of informational advice:

> *"My mother tells me to do this, don't eat this, this thing is not good for a pregnant woman to do. Fine, I understand this thing is not good for a pregnant woman."* ***(Enyonam, 38 y/o, Cohabiting)***

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Sela was also a recipient of support from her mother, with whom she lived with as a schoolgirl. Her mother was her main source of support:

> *"I only got enough support from my mother ...My mother helped with the house chores ...I always get support from her."* ***(Sela, 23 y/o, Single)***

Cynthia's mum lived in Accra. She used to stay with her before moving to the slum to join her husband. She visited her mother often during her pregnancy and even moved to stay with her when her delivery time was close, due to the proximity to her health facility. She also recounted the instrumental and informational support she received from her mother.

> *"When I go home it is my mother. She also helped me. Like when she goes to the market and she sees things like that, baby things like that, she will buy them. She shows me (things I should do)"* ***(Cynthia, 30 y/o, Married)***

Old age, sickness and distance were some limiting factors to the respondents' receiving support from their mothers.

Beatrice for instance expected much emotional support from her mother but she was sick. She believed her relationship with her boyfriend displeased her mother and contributed to the unwillingness to support her:

> *"For the pregnancy, it was my mother ...I called her that she should come and stay with me so that it will help me to get this, but she told me that she was sick so she couldn't come."* ***(Beatrice, 28 y/o, Cohabiting)***

Baaba could not receive support from her mother because she stayed far. She noted this in the quote below:

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"My mother like this if she takes a car and embarks on a long journey right now, she will be sick right then before she returns." **(Baaba, 26 y/o, Married)**

This was a similar reason for in-laws, particularly mothers-in-law who were not present to help. Baaba continued to express this in the quote below:

"...If your husband's mother is close by like that, like they, if anything...they can come and help you. My husband's mother and family they are from Kintampo so none of them came... whether I am pregnant or I have delivered they could have come because it is their grandchild. They would have come but because they are far, that's why they cannot... If they were close by...as for foodstuff they have. So like if they could bring some to you that "Take it and eat it and use it to take care of the child" but because where they are is far, they could not bring me anything" **(Baaba, 26 y/o, Married)**

Despite this, there was one respondent whose mother sent her food items from her village, and received monetary support from her uncle:

"My family are not here but my mum used to send foodstuffs. My uncle used to send me money." **(Emefa, 27 y/o, Married)**

Support from Sisters of Respondents

Another group of people whose support was unflinching were the siblings, particularly the sisters of the respondents. They also contributed their support tangibly, mainly with assistance in household chores like sweeping, fetching of water and cooking. Some also supported financially while others helped them manage their businesses/trade. Sisters were also a source of emotional comfort, rendering advice and encouragement to their sisters (respondents) and keeping them company.

Beatrice's little sister, though young, was a very resourceful source of instrumental and emotional support. This is what Beatrice, a *waakye* seller, had to say about her sister's support:

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"She (sister) was the one who stayed with me and helped me. She is 13 years..., she was a little matured so she knows how to cook and sell... So even if I am lying down when I see she has prepared it (the 'waakye') ... Some times are there, she will say "Sister stop crying ok, it will be well". Then she will be saying some things that are funny for me ...she could encourage me and all...she washes clothes for me and all." ***(Beatrice, 28 y/o, Cohabiting)***

Sela's sister performed simple errands for her:

"I only got enough support from my mother, sister...My sister used to buy food for me when I send her." ***(Sela, 23 y/o, Single)***

Support from sisters was accessible because they resided with the respondent at the slum. Some though lived within Accra and could visit home and receive assistance from some family members, particularly mother or sister. Cynthia for instance got assistance from her younger sister in performing some domestic chores as well as run errands for her any time she frequented her maternal home. Cynthia noted this in the excerpt below:

"When I go home it is (my mother or) sister who does it for me .. she also helped me with the washing of clothes and cooking. Small small like that. When I want to go and buy something, she will go and buy it for me" ***(Cynthia, 30 y/o, Married)***

Support from Pastors and Church Members

Interestingly, pastors came up as great sources of support, particularly with spiritual support. Emefa and Sela, for instance, received prayer support from their pastors:

"My pastor was praying for me always." ***(Emefa, 27 y/o, Married)***

"In terms of prayers, my pastor was praying for me." ***(Sela, 23 y/o, Single)***

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Evelyn's pastor also played a key role in reassuring her when she contemplated abortion due to some challenges she was plagued with, as well as provided her informational and emotional support"

> *"It was my pastor…he advised me a little. That is what made me stop… the time my pastor told me that I should be patient, I shouldn't abort it, I became patient and remembered that if you abort it is not good. That is why I got some kind of faith and I didn't take it out… Pastor too prays for me …for him, he advises me, the pregnancy and life and all, and he prays for me also"* ***(Evelyn, 29 y/o, Cohabiting)***

Her church members also came to pray for her:

> *"They (church members) came to pray for me. Like if I am at home then they will come and visit me and ask me if I am feeling well or not, then they will pray for me. All of that contributed, it helped me"* ***(Evelyn, 29 y/o, Cohabiting)***

Support from Health Workers

Health workers provided respondents with informational support particularly advising them to eat well and taking their medication.

> *"The nurses they will tell you that, 'Your medicines, take your medicines. The medicine you were given take them. Do eat well.' That one too is a help."* ***(Baaba, 26, Married)***

> *"The support I had was that when I went to the hospital, they said my blood is low so they advised me to be eating vegetables and they also told me to be using 'koensusua' to do any soup I am doing. I should add it."* ***(Emefa, 27 y/o, Married)***

In some peculiar case, nurses, for instance, gave some emotional and appraisal supports. Beatrice for instance had some relationship issues with her boyfriend and received immense help from a nurse:

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"Erh, usually, the way that when I go to the hospital I will be sitting there quietly, so one nurse came to take my number with which she was asking me questions and I explained things to her so when it is there, she will call me. She will call me on my phone and tell me that I shouldn't be overthinking... so she is the person that gave me a bit of comfort. She was giving me advice. I wanted to abort the child then our [I and the boy] relationship would have been apart so she gave me advice, that that child that is coming I don't know what he is coming to do for me. It is true that I have given birth to some already but every child and his own." ***(Beatrice, 28 y/o, Cohabiting)***

Afi, however, reported having a bad experience with the nurses who attended to her delivery:

"Oh no. my sister when you get there, they'll check the things you came with, when you bring it, instead that you that you are in pains they will help you,... they'll be like "Bring out the rubber! Bring out the cloth, lay it on the bed after laying it, lie on it" (said in a disgusted tone). While the person is in pains. We don't talk like that. As a nurse they have employed you. They are there because of us." ***(Afi, 34 y/o, Married)***

Support from Neighbours and community friends,

On the whole, the general community folks were very unsupportive due to the individualistic mentality/lifestyle there. However, one's neighbours or close community friends rendered some services.

Evelyn's community friend for instance offered her assistance in fetching water for her:

"For the fetching of water, I got someone to help me little by little. She (my neighbour) helped me in fetching water ...If it was not for the person like I would have been going. [so] I was a little bit ok" ***(Evelyn, 29 y/o, Cohabiting)***

Emefa's neighbour also showed her love and care by providing food for and supporting her in the temporal absence of her husband. She called that neighbour as her only friend and companion:

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"And this woman (neighbour) was helping me. The beginning she was the one that was cooking and giving me food to eat. By then my husband went for the father's funeral. ...She was the one that was cooking for me. Sometimes, when she even cooks and I say I cannot eat, she will let me drink the soup and she would take the food... She (neighbour) is the only friend I have." ***(Emefa, 27 y/o, Married)***

Grace's community companion, also termed as a friend, provided informational support and counsel to her:

"I use to eat white clay a lot during my pregnancy period but someone (neighbour) told me to stop eating it. So I stopped eating it. When I was pregnant, I use to say "If I die during the delivery is that not all". But my friend stopped me from saying those things." ***(Grace, 40 y/o, Cohabiting)***

Cynthia explained why fellow slum dwellers were generally unsupportive. Her explanation resonated with the rest of the participants:

"As for this area, everybody, everybody is minding their own business oo ((chuckles)) everyone is in their kiosk. Because no one wants problem for themselves." ***(Cynthia, 30 y/o, Married)***

Support from Colleague Workers

Though colleague workers did not frequent the list of support providers, those who did also played their little role in supporting. Yama a roasted plantain seller got some informational advice from s colleague trader:

"For me, I sell at the roadside so when I am about to eat there is someone older than me (trader) that advises me to go and hide myself before eating. She always says I shouldn't put myself down like that because not everyone passing by is a human being...but because within that (pregnancy) period I hide myself, the person wouldn't see and destroy things on me." ***(Yama, 30 y/o, Married)***

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Efe was also an apprentice of dressmaking. Her colleagues from work greatly encouraged her while learning the skill with the pregnancy.

> *"I was learning the work with the pregnancy so it wasn't easy for me. But my colleagues at work were always encouraging me."* ***(Efe, 25 y/o, Cohabiting)***

Support from Strangers

Interestingly, strangers and passers-by also made the list of providers of support, though not for many respondents.

Beatrice was a benefactor of the spiritual support of a stranger. Her support greatly benefitted her as she narrated how it protected her from death:

> *"A madam, a certain madam that came, she came to share a prayer with me like for some three days. As for her, like, she is a herbalist so as I was going, she saw me and like she said that this is what she has dreamed about (the unborn child) so she wants to pray with me for some three days...The day they were doing the c-section, the light that shone on my womb for the section, immediately they finished then ((foi))[light out]. The number of operations that they had conducted that when it got to my turn. The lights too it wasn't everywhere too oh. My place, just there, where they just operated me...So I can see that the madam's prayers it helped a lot.."* ***(Beatrice, 28 y/o, Cohabiting)***

Sela also received informational advice on pregnancy and eating from someone stranger to her:

> *"One day I went to the market to buy foodstuffs and I was told by one of the market women to avoid eating in public."* ***(Sela, 23 y/o, Single)***

Enyonam also recalled getting some financial support from a passer-by customer while selling.

> *"Some people are generous. Because sometimes I don't have money but you will see someone who will ask you to come for money."* ***(Enyonam, 38 y/o, Cohabiting)***

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Teacher

The only school-going respondent also reported receiving unflinching support from her teacher.

> *"I got it (emotional support) from my teacher(madam). She (teacher) was the one encouraging me and caring for me when I was pregnant... In terms of going to the hospital. She was the one that encouraged me to go to the hospital for ANC...My teacher also advised me to keep coming to school...I got financial assistance from my teacher.... [she] was the one who paid my hospital bills."* ***(Sela, 23 y/o, Single)***

4.6 Role of Support and Pregnancy Experiences

The presence or absence of social support gave each respondent a different narrative of the pregnancy experience of the respondents. The role of support, whether present or absent, was very significant and respondents did not hold back on sharing how their pregnancy journey was impacted by the presence or absence of social support.

4.6.1 Pregnancy experiences and the presence of social support

Social support received by the women contributed to the narrative of their pregnancy experience. Positive impacts of the support received were shared by the respondents. The respondents associated those positive experiences/outcomes to the varied support they received.

Survival/Endurance during Pregnancy

As presented in section 4.3.1, pregnancy came with great difficulties, needs and discomfort to most respondents. Social support received during pregnancy helped some respondents survive the difficult journey of pregnancy.

Enyonam admitted that receiving social support from people helped her endure and survive the arduous journey of pregnancy:

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"As for pregnancy it's not easy so I think I wouldn't have survived without their support." ***(Enyonam, 38y/o, Cohabiting)***

Sela had provision of food which helped her endure her pregnancy period as noted in the quote below:

"It [social support] helped me to survive. I needed food during my pregnancy experience and they provided it so it was okay." ***(Sela, 23 y/o, Single)***

Emefa received financial support from her husband when she had to stop work during pregnancy. She admitted how resourceful it was to her and the difficulty it would have posed in the absence of it:

"He was the one giving me money...It helped because I stopped working when I was pregnant so I needed financial support. Things would have been difficult for me if not for my husband's support." ***(Emefa, 27 y/o, Married)***

Good Health of Mother and Baby

Respondents associated the good health they experienced to the informational support received. They believed it also helped the unborn child, then, to be healthy and strong.

Emefa stated that the nutritional advice provided by healthcare workers helped her to be healthy during pregnancy particularly since she was diagnosed with anaemia. She believed the health of her unborn child was good because of this support as expressed in the excerpt below:

"From eating the fruit and vegetables I was healthy and the baby in my womb too was healthy." ***(Emefa, 27 y/o, Married)***

Grace also got some directions of activities to disengage from which she believed led to the good health of her unborn child:

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"They advised me to stop lifting heavy things so that it doesn't affect the baby in the womb." ***(Grace, 40 y/o, Cohabiting)***

Joy, Hope and Pride

Emotional and instrumental support received, in particular, gave respondents a high sense of joy, pride and hope. Cynthia shared how the company of her husband for ANC visits made her feel happy and gave her a sense of pride.

"It was nice for me. I was feeling proud that I also have someone who is helping but there are some men who don't have time. ...They don't have time but for this one." ***(Cynthia, 30 y/o, Married)***

The emotional support Enyonam received made her have a very optimistic perspective amidst financial challenges at home

"(I) had people in my life that loved me so I was full of hope. I wasn't that worried although there was no money." ***(Enyonam, 38 y/o, Cohabiting)***

Improved mental/psychological health

Emotional and instrumental support, in particular, provided helped the women to manage thoughts of worry, fear or anxiety and other negative emotions like anger during pregnancy. This helped improve their mental/psychological health.

Enyonam for instance battled with mood swings during pregnancy. Emotional support received helped her to manage the raging emotions she had:

"I got love from the two of them... It helped me because sometimes when you are pregnant it is not easy, you can see someone, your partner and be angry at them. So when you have someone you can have a conversation with, you can forget those things." ***(Enyonam, 38 y/o, Cohabiting)***

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In some cases, the provision of support created no room for such thoughts. Yama received emotional support from her husband. It made her worry-free and even admitted that a lack of this support can be evident during hospital check-ups:

> *"My husband was showing me love. He listens to me and gives me the necessary attention when I need it... I was okay throughout my pregnancy ...My husband was very supportive so I wasn't worried about anything... My husband wasn't causing me pain. My BP was always normal during the pregnancy. Yes, if you are pregnant and your husband is not giving you peace it will show when you go to the hospital..."* ***(Yama, 30 y/o, Married)***

For those who were contemplating suicide, social support received, particularly appraisal support, caused such respondents to rescind their decision. Evelyn was contemplating abortion in the absence of sufficient financial support. With the appraisal and reassuring support and advice of her pastor provided, she abstained from doing that:

> *"Like I needed someone to help me, but since I was not getting any helper, like I said I will go and abort the pregnancy...yes, I was going to abort the pregnancy and then I will be free. Because I needed money to sell things but I wasn't getting it ...my pastor told me that I should be patient, I shouldn't abort it, I became patient and remembered that if you abort it is not good. That is why I got some kind of faith and I didn't take it out."* ***(Evelyn, 29 y/o, Cohabiting)***

Emefa's neighbour helped her have a more positive perspective about her pregnancy since she was beleaguered of the thought of death when diagnosed with anaemia during her pregnancy. She expressed this in the quote below:

> *"The woman (neighbour) helped to change my mindset. When I went to the hospital and they said I wasn't having blood, it was headache so I was always complaining that I might*

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lose my life. So this woman said I should stop talking about that ...I started thinking positive because of the woman (neighbour)." ***(Emefa, 27 y/o, Married)***

Safe delivery

Majority of the respondents associated their safe delivery with the spiritual support they received from pastors, church members and even strangers during their pregnancy, as well as the informational support that was provided to them.

Beatrice for instance had a very dramatic experience with the electricity supply going off just after her emergency caesarean section. She recounted that the prayers of a passer-by who gave her spiritual insight to a possible perilous delivery saved her life:

> *"A madam, a certain madam that came, she came to share a prayer with me like for some three days. As for her, like, she is a herbalist so as I was going, she saw me and like she said that this is what she has dreamed about (the unborn child) so she wants to pray with me for some three days...The day they were doing the c-section, the light that shone on my womb for the section, immediately they finished then ((foi))[light out]. The number of operations that they had conducted that when it got to my turn. The lights too it wasn't everywhere too oh. My place, just there, where they just operated me ...So I can see that the madam's prayers it helped a lot... When they just cut me open, then the lights went off. If God hadn't come in then I don't believe that I would have come back"* ***(Beatrice, 28 y/o, Cohabiting)***

Emefa also received some spiritual directions from her pastor of which she believed helped her to give birth successfully:

> *"The only support I got was that I went to church and my pastor asked me to buy an apple and come and he will bless it for me and water.... I can say (it supported) because I was able to give birth successfully."* ***(Emefa, 27 y/o, Married)***

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Sela for instance hinted that the support she received from health workers during her ANC helped her deliver successfully:

> *"Through hospital checkups till the time I delivered. It has helped me to deliver successfully."* ***(Sela, 23 y/o, Single)***

Informational support provided to Beatrice in the form of dietary advice of her anaemic state saved her also from having any further complications with delivering:

> *"They said the way my blood is small I cannot deliver with it otherwise unless we come and buy blood. But when they told me that when I come I should be eating that abeduru, kontonmire and all that. It even made the blood, when I went back, they didn't need it again...so I saw that it helped me a lot in that advice that they gave me."* ***(Beatrice, 28 y/o, Cohabiting)***

Yama also received tremendous support from health workers during her ANC visits. Even though she delivered two weeks before her due date and had a low birth weight baby, she did not associate the outcome to the support received:

> *"They see to me well when I go for ANC visit so I think it's my baby's nature that is smallish. Maybe it is because I gave birth earlier than the date given to me that's why."* ***(Yama, 30 y/o, Married)***

4.6.2 Pregnancy experience and the absence/insufficiency of social support

Some respondents had little to no support during their pregnancy. Their pregnancy journey proved to be more challenging due to the absence/insufficiency of support.

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Tiredness

A lack of support, particularly instrumental support made some respondent exclusively tired during their pregnancy. Baaba, for instance, lacked sufficient support with household work. She recounted needing support to aid her rest a little but lacked that support:

> *"You know when you are pregnant, doing things around is all on you. Household work, fetching water and all that...like someone will come and help me with my things and me too my hands would have relaxed."* ***(Baaba, 26 y/o, Married)***

When it came to running of little errands, Evelyn reported that the absence of support in that manner bothered her and she often embarked on those errands herself:

> *"If I want something I don't get someone to send them but that one too I needed help. It disturbed me...the way it disturbed me was like if I got, like the person will go and buy something for me and I didn't get the person. That is why it disturbed me...So I had to go little by little."* ***(Evelyn, 29 y/o, Cohabiting)***

Worry

Respondents who did not receive social support reported having to worry or think a lot. Cynthia explained some thought patterns that fill the minds of pregnant women which can leave them very troubled:

> *"Some are like, 'Will you give birth to the child in this way?' You see they say when you are going to deliver a, the child, maybe you wouldn't get the child and maybe you the mother too (indistinct). So it is like you will be thinking and praying small small small."* ***(Cynthia, 30 y/o, Married)***

Lack of financial support was another source of great worry to respondents. Gina, for instance, had insufficient financial support. Even though her sister offered her money, she was troubled

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about her inability to repay her particularly since she had been sent home from work on the advent of her pregnancy.

> *"What made it difficult was that I couldn't go to work to get the money to pay her, up to now. ...I think about it a lot ..throughout while I was pregnant it was there. Like I am at home, I am no longer going to work, and I went to take it [the money]. In which way can I work again to repay her."* ***(Gina, 32 y/o, Cohabiting)***

Irregular ANC visits

During the pregnancy, majority of the respondents (10), experienced the inconsistent attendance to ANC due to financial challenges. Grace, like the majority, lacked financial support which limited regular attendance to ANC:

> *"I attended ANC but because of financial problems so I only went once... I needed money to go for check-ups at the hospital but he wasn't having."* ***(Grace, 40 y/o, Cohabiting)***

Home delivery

Lack of financial support made some respondents experience home delivery against their will. Gina's partner was not financially proficient. She, thus, had to compromise for home delivery. She expressed herself in the quote below:

> *"There is no money so I cannot insist on going to give birth in a hospital. Because if I give birth in a hospital, he (partner) to he doesn't have money ...that is why I gave birth at home."* ***(Gina, 29 y/o, Cohabiting)***

4.7 Living Setting

The study asked the participants how life was at the slum and how it affected their pregnancy if it did. Interestingly, there was very little benefit that could be derived from staying at Brigade slum.

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Besides the sheer advantage of proximity to one's workplace, there was nothing positive to write about, with staying at Brigade slum.

The slum was a very difficult terrain for the respondents not only during pregnancy but generally as well. Their stay in the slum contributed to their pregnancy experiences which they spoke about.

Generally, the setting was described as difficult, inhabitable, or simply "management". The words Emefa, Afi and Grace summarizes respondents' description of the setting:

> *"Here is not a staying place. We are just managing here"* ***(Emefa, 27y/o, Married)***
>
> *"If you look at the area it is a hustling are"* ***(Afi, 34y/o, Married)***
>
> *"Life is very difficult here"* ***(Grace, 40 y/o, Cohabiting)***

4.7.1 Challenges in the slum and pregnancy experience

Respondents listed the following factors as reasons that made living in Brigade slum difficult and the contribution it made to their varied pregnancy experiences:

Evacuations

Almost every respondent had something to say about the issue of evacuation. Even though they knew the evacuations were on justifiable grounds – due to the mounting of electrical poles on that land – it brought several challenges to them while pregnant and even after childbirth. Some of the excerpts from participants are shown below:

> *"When the pregnancy was six months, they came to demolish our structure so we slept outside for a long time before moving to this new structure. It worries a lot."* ***(Yama, 30 y/o, Married)***

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"For here, here is not safe like that because small thing then they will come. GRIDCo people will come that everyone should leave this place... You see they said under the high tension is not good for us, for people to stay here, and here too is not safe like that." ***(Cynthia, 30 y/o, Married)***

"The problem here is that those who demolish our structures they normally come to demolish ... Then we will be sleeping outside with the children. This my child when I gave birth to him, in exactly the first month they came to break down the place and I slept outside with the child like that ...they demolished all this side so we used [mosquito] net as a [tent] to sleep in, till we were able to construct this one [our current structure]. You see, there is no money to go and rent a place so when they break our structures the then we (are stranded) ... Yes. They bring us a lot of problems. Because they said this is land they have mounted high tension poles so we should leave here. But then there is no money to go and rent a place. So what can we do." ***(Baaba, 26 y/o, Married)***

"For this place, they can evacuate us at any time. This is not our own land" ***(Evelyn, 29 y/o, Cohabiting)***

Unsupportive Slum Dwellers

Dwellers of Brigade slum were also noted to be very unsupportive. Respondents often contrasted these areas to previous places of stay:

"Some areas when you give birth or you are pregnant people give you gifts. It depends on the area you are. But here every one is suffering so if you are pregnant you are pregnant for yourself." ***(Yama, 30 y/o, Married)***

Though Cynthia, received sufficient support from her husband in the slum, she admitted that life in the slum is difficult, particularly without any support as the slum residents kept to themselves often. She expressed this in the note below:

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"For that one, if you don't get anyone to help you then you will see that it is difficult. But if you get someone helping you, supporting you a little you will see that it will be a little easy for you. But if it is only you, so like, it is a bit of tiring...if you want to buy something and you can't, if you have someone there, "oh, buy this for me". As for here everyone is in their kiosk...everyone is in their kiosk. Because no one wants problem for themselves." ***(Cynthia, 30 y/o, Married)***

Again, respondents believed that dwellers in the slum contended with pregnant women spiritually and could even influence outcomes of pregnancy. This is an excerpt of what Beatrice said on that:

"The little thing that I have studied here in Brigade. They carry evil eyes. So you the person if you are not careful, you will give birth and you'll see that it is a problem that you've brought upon yourself." ***(Beatrice, 28 y/o, Cohabiting)***

Beatrice added that such attitude even affected businesses, making life in the slum more challenging:

"Here one thing that is here, if you have a little work, because of what I told you earlier, envy and all. You will see that then someone will fight against you then you will your (business) will decline." ***(Beatrice, 28 y/o, Cohabiting)***

Evelyn also admitted the spiritual contention experienced in the slum and added that dwellers argued and often had a conflict with her while pregnant. Surprisingly, their relationship restored after delivery. She hinted some spiritual connotation to these behaviours.

"Apart from spiritual eh, physically somebody is there they like arguing ..they will fight with you and then like they will no longer be on talking terms with you...For that I really got some a lot. But when I delivered, we were fine...the problem here is maybe, you and your friend will be at loggerheads. That is the problem that is normally here." ***(Evelyn, 29 y/o, Cohabiting)***

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Violence and inappropriate lifestyles

Violence and inapt lifestyles such as theft, drunkenness, smoking and noise-making were frequent occurrences in the slums. For some participants had learned to live with these occurrences and avoid places where these were common. For some others too it disturbed them greatly.

Afi narrated the frequency of violence in the slum:

> *"Eiii! If they don't fight in the morning they'll fight at dawn if they don't fight at dawn they'll fight in the afternoon, if they don't fight in the afternoon in the night or 12 midnight they'll fight. Here, it is like they have cursed this place."* ***(Afi, 34 y/o, Married)***

Beatrice narrated some of these occurrences in the slum. Due to the frequency of this event, she had become conversant with the events and thus, avoided such scenes to avoid being affected when she was pregnant. She noted it in this quote:

> *"They like fighting and the boys boys who smoke wee, they too they steal things. For that one, if you leave your gate open right now, when you will return they would have taken the little things that you have. They will take them away... They will be fighting but for me, I don't go near it at all. All it is is that I will be at my somewhere and I will be thinking of myself."* ***(Beatrice, 28 y/o, Cohabiting)***

Grace, in particular, recounted experiencing sharp abdominal pains when these fighting and disturbances occur.

> *"There is a lot of violence here. When there is violence in the area it affects my pregnancy. Thus I feel a sharp pain in my abdomen when there is violence in the form of fighting and shouting. I feel so cold that I have to sit down"* ***(Grace, 40 y/o, Cohabiting)***

Sela also reported of some rape incidences within the slum. She also indicated that the smoking was unsafe for pregnancy:

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"Drunkards, smokers and others are here. I hear of rape but I don't know who has been doing that. ...I heard that some people rape their girlfriends...If you are pregnant and someone who is passing by smoking, it can affect the pregnancy." ***(Sela, 23 y/o, Single)***

Some of the respondents expressed particular concern for their children being born and brought up in such an environment:

"For children you know the children if you want to bring them up you don't have to bring them up in a rough area like this. Do you understand? You have to raise them in a place where they'll be decent. Do you see? For them, you have to bring them up in a decent area. But here is not where to raise your children. So as a mother, a mother, the children when they see any paper on the ground they will take they don't know if it is and they will take it and put it in their mouth. Cigarette too they leave it on the floor and the children they don't know what it is and the person will take it, do you see. So this area is a rough area" ***(Afi, 34 y/o, Married)***

Noise pollution also made it difficult to get some rest in the slum. Gina some of such instances:

"There is a man here they have painted his house ash, like mine...he can play the music loudly like that. If you're in the house, then the house is shaking shaking...for that one, it worried ...like the time that I have to sleep I am tired or I am back from work, I am tired, I have to sleep, I should relax myself, I cannot so I take it like that." ***(Gina, 32 y/o, Cohabiting)***

Financial Challenges

Respondents resonated the financial challenges that were characteristic in the area in the following quotes:

"There is hardship in (Brigade). An example is like, when it comes to money issues, challenges [suffering] will come because here, everyone they go to work the work they do is government work. So if you have some financial challenges and you go to someone to ask for a loan if you are not careful you will not get. You will not get. They will tell you

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that the month hasn't ended, so they haven't paid them. And for selling things, over here if you sell something and you hawk with it around here you will see that, it, it is a problem... here, if you (sell your food on the road out, you will just bring them back) because they people know their hometown folks more and even here, it is a quiet, here is very quiet. When you sell something, you would realize that your money issues will just be messed up. You see this place is not close to town." ***(Baaba, 26 y/o, Married)***

"There is hardship here, there is hardship here (ahokyer3). So you'll see that because of that, the girls girls. They will be following the boys boys, then they'll go and get pregnant. I said yesterday, I gave someone a loan. If I didn't go and discharge her, like who. She doesn't have anybody. And the boy too, a small boy and she followed him and impregnated her. And that is what yesterday- hmmm. It is a problem oo" ***(Beatrice, 28 y/o, Cohabiting)***

Unhygienic living conditions

Brigade slum lacked a lavatory and a proper disposal/waste management system. This made the place very filthy and uncomfortable. Yama described the hygienic situation with repugnance:

"As for rubbish it's a lot. Did you pass the area? There is a lot of rubbish here." ***(Yama, 30 y/o, Married)***

Some respondents admitted the unsanitary nature of the slum. They, however, made sure that their personal space was kept clean:

"It not neat here at all but I keep the front of my house." ***(Emefa, 27 y/o, Married)***

Respondents admitted defecating openly in the bush which came with great discomfort:

"There is no toilet here so when you are pregnant and you go to the bush and see things or the scent if you are feeling to ease yourself, you wouldn't even know how to go there." ***(Yama, 30 y/o, Married)***

The lack of any toilet facility also makes dwellers, particularly the women, at risk of rape, as stated in the quote below:

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"They do rape here. If you are not careful and you are going to the toilet in the bush, the guys hide there so if you're not careful they will rape you. So you have to be careful when going to the bush." ***(Enyonam, 38 y/o, Cohabiting)***

External Environment

Brigade slum is located in Ayawaso West \Municipality, which is thronged with many luxurious edifices and a plush of opulence. The study was set on exploring the role these beautiful environments affected them psychologically during pregnancy, particularly in contrast with their shanty environment. Respondents reported how their exterior deluxe environment affected them during pregnancy:

"It does affect me psychologically. I ask myself when I would also live in such big houses and feel relaxed." ***(Grace, 40 y/o, Cohabiting)***

"I get worried. I ask myself that am I not a human being. But you have to believe that you would also get there one day so you don't take it so seriously." ***(Yama, 30 y/o, Married)***

Some respondents were not psychologically disturbed. There was however a longing and hope for a better place, as expressed in the following quotes:

"And that it is not like affect. So let us take it like maybe me too I will say that if I get money, I will build some of the house, or I will buy a land and build a house." ***(Gina, 32 y/o, Cohabiting)***

"It doesn't affect me. It's not yours. Where you find yourself, you have to appreciate it. Because by now those who will stay in those big big houses wish to get pregnant but they don't. You don't know if you find yourself in those big houses you might also not get a child." ***(Emefa, 27 y/o, Married)***

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4.7.2 Reason for migration to the slum

Respondents gave reasons to why they resided in the slum. Some of them had been expelled from previous settlement mostly slum:

> *"We were at Kumordzi before we came here. It is a government land so we were expelled from it."* ***(Grace, 40 y/o, Cohabiting)***

Others came in search of job opportunities:

> *"We were living at Aveme in the Volta region before we moved here because of job."* ***(Yama, 30 y/o, Married)***

Some also came to join their husbands/partners who resided in the slum:

> *"I was at my mother's place so he came to get this place before he brought me."* ***(Cynthia, 30 y/o, Married)***

There were a few others like Sela who had some family/relationship issues and thus moved to this area:

> *"Hmmm, the reason why we moved here is because of my father. He wants to kill us. He wants to kill my mother. He has been drinking and smoking. When he drinks a lot of alcohol, he abuses my mother physically."* ***(Sela, 23 y/o, Single)***

For Beatrice, a disapproved relationship during her youthful days caused her father to drive her out of their house. Coupled with financial challenges that plunged her, she moved to the slum:

> *"My father too said the boy he warned me but I didn't listen so he sacked me from the house. Someone who had given birth 3 weeks. So only me and the child. So I was suffering. So it was friendship that I called my friend that ...I beg if she will get any work for me to do and when I said it she said a madam is calling for some work but a day is 5 cedis ...The*

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person was selling waakye. So I will get up and help her. That is what made me land here." ***(Beatrice, 28 y/o, Cohabiting)***

Notwithstanding their motivation to settle at Brigade slum, most participants expressed vehemently their decision to leave. Financial challenges were, however, was the main reason participants were still staying in the slum. Below are quotes from some respondents:

"For this place, for me honestly, if I got the chance I would leave here because when they break down the place it really disturbs. Maybe the man doesn't have money to rent a place so we will be in it like that." ***(Baaba, 26 y/o, Married)***

"But for here, it is like because we don't have money to rent a place that is why we are staying here. Nobody can say that, "Because I have money I would come and stay here, in a kiosk or something". They would go and rent a place. Because there is no money that is why we are here." ***(Beatrice, 28 y/o, Cohabiting)***

Others like Yama and Efe were not regretful of their decision to reside. They, however, hinted that they would certainly leave the place, sooner or later

"I don't regret coming here because as for life it starts from somewhere before going somewhere...Here is not a dwelling place. We are just managing here till life get better for us to move from this place." ***(Yama, 30 y/o, Married)***

"I don't regret moving to the slum. I will leave but it will take some time." ***(Efe, 25 y/o, Cohabiting)***

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CHAPTER FIVE

DISCUSSION

5.1 Introduction

The study sought to explore if postnatal mothers in slums had access to any form of social support during their most recent pregnancy and how it had an influence on the childbearing process. It will also help to identify if residing in a slum contributed positively or negatively to their pregnancy experience. To achieve this objective, it was necessary to know the types of social support the women needed during their time of pregnancy and what they received and how it influenced their pregnancy experience. Also, the providers of the various forms of support were identified and finally the role the living setting (slum) influenced their pregnancy experiences and receipt of support. Based on the social-ecological model (SEM), it was expected that women will receive support from interpersonal level (such as family and friends), organizational level (such as health facilities, churches) and community levels (that is the slum community). Individual level, factors such as mother's age, marital status, economic status, education may influence how mothers experience social support during pregnancy. This section seeks to discuss the key findings in relation to the objective of the study.

5.2 Pregnancy Experiences

As noted in the literature, pregnancy was accompanied by varied physiological, psychological and psycho-social changes (Klobucar, 2016). Participants went through health ailment predominantly morning sickness which was characterized by vomiting, spitting, feverishness, headache and fatigue. Some mothers had anaemia due to pregnancy. Some experienced mood swings and an increase in appetite. Experiences of pregnancy particularly sickness led to some mothers abrogating their work either permanently until after the pregnancy or temporarily until they gained

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enough strength to work. Most of the working mothers were self-employed, thus could determine when to go to work or not. Besides, the nature of work, often trading, made it possible for then to resume or absent themselves from work when feeling unwell. However, one participant, for instance, who did not have any kind of pregnancy-related sickness who worked with machines, was made to stay at home to safely go through the period and resume after delivery. This was congruous with work by Bryar and Sinclair (2011). These temporal or permanent abrogations of work brought significant financial challenges to them, with which some had some financial support, while others did not. From findings by Bryar and Sinclair (2011), it was implied that instrumental support was beneficial for working pregnant women, and a lack of it could be detrimental to their health.

Besides the morning sickness, some women's pregnancy journey was characterized by mood swings which tend to affect the social relations, particularly with family and neighbours close by. Such mothers were easily irritated and quarrelled quite often with people they love such as their spouses and mothers. These include the various thought patterns Brodén (as cited in Bäckström, 2018) described as a characteristic during the pregnancy phase.

Some women also had appetite variations, particularly with a heightened sense of appetite. This feature is also associated with pregnancy. Support in gratifying this need was very much anticipated.

Anaemia also came up us one of the predicaments that were associated with the pregnancy of some women. The biological challenge not only affected the women physically, in terms of being fatigue but psychologically as well as the news of shortage of blood and the consequent health risk if unaddressed disturbed the mental state of mothers.

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These varied experiences were characteristic to the women notwithstanding age, parity or level of support received, these experiences. Older multiparous mothers (>28 years) and primiparous mothers all experienced either one of these. It can be said, thus, that age or number of pregnancies does not exempt anyone from some ailments associated with pregnancy. Nevertheless, three participants who reported no sickness during their just-ended pregnancy were all multiparous mothers on at least their fourth birth.

Edmonds et al. (2011) stated categorically that pregnancy was a sensitive and delicate period for women. It thus comes with its major physiological, psychological and social changes for the mother-to-be (Klobucar, 2016). These changes were very much experienced by the women in their trimester journey. Backstrom (2018) asserted that the first trimester of pregnancy was most challenging with numerous physical and hormonal changes leading to what was termed as 'pregnancy sickness'. This was mainly characterized by fatigue, headache, etc. Most women recalled going through this phase especially in the first trimester of their pregnancy consistent with Backstrom (2018). This was common among both multiparous and nulliparous mothers. For some women, they experienced the pregnancy illness throughout the pregnancy while others experienced it in the first and last trimesters of the pregnancy. The experiences were very severe and intense among some women which required medical intervention, while others did not need such care.

Consistent with Azad et al. (2019), most women either had to truncate their working schedule or bring their work to a complete halt especially at the stage of pregnancy where illness or fatigue is most severe. This decision also contributed and significantly ameliorated the financial challenges they already may have been.

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5.3 Types of Support Received and Needed

The respondents made known the types of social support they received. They ranged from instrumental support to emotional support to informational support, appraisal and spiritual support, commonly mentioned though not initially considered during desk study. These various types of support impacted /influenced the women differently concerning their pregnancy and experience.

With instrumental support, the main forms received included were assistance in household chores such as fetching of water, washing of clothes, sweeping and cooking. Other forms mentioned included monetary support, assistance with the care of other children, running of errands and purchasing of items for the expectant child. These were among the most common form of instrumental support received by pregnant women (Edmonds et al., 2011; House, 1981).

Most participants also received emotional support. This came in the form of keeping them company and conversing with them, rendering them some advice about life and other challenges they may have been going through besides the pregnancy and showing them care and love. During pregnancy, several thoughts overwhelmed mothers. To the participants, such thoughts included their safety and that of their unborn child, especially towards delivery. Others were worried about other daily events of life. To some, their relationship with their partners or family had hit hard rocks and thus it was a source of worry and frustration to them. Bäckström (2018) found these thoughts of anxiety reflective of pregnant women. Redshaw and Henderson (2013) emphasized that mothers mental health is vulnerable during pregnancy. The respondents reported that receiving emotional support reduced those worrying thoughts and brought them some sense of joy and happiness.

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As important as this support seems, some respondents got little to no form of emotional support. Such respondents reported that, during the experience of pregnancy sickness, the sheer company of people to comfort them during the sickness would have been enough. Emotional support was seen as a humane act and was only necessary that people be there for one another. Many of the respondents who did not have access to this support had to think about their problems, particularly financial challenges. Some were in dire need of advice about life and some relationship issues they found themselves in.

Appraisal support included affirming the women of their potency to sail through the pregnancy period. This was a critical type of support that was particularly beneficial to the women who were contemplating abortion. All recipients of this support stated how beneficial it was to them in preventing them from committing an act they may have regretted later since they came to terms that the pregnancy could be a source of blessing to them. Some mothers were filled with negative thoughts of death especially when diagnosed with anaemia or by the mere thought of the delivery day. During labour, some women found it reassuring when they were offered this support. Bryar and Sinclair (2011) stated that mothers can see pregnancy either as a normal life event or as a period of illness. Ferguson et al. (2014) however asserted that focusing on the risk during pregnancy and birth does little to boost the self-confidence of women, who hope to achieve normality. Appraisal support helped reassure the women during the entire pregnancy period and led to successful deliveries.

Another support which was not expected in the study, but came up as very important was spiritual support, mainly prayers and spiritual directions. Congruous with findings from Song et al. (2016), respondents who received this support stated that it helped them during delivery and protected them and their unborn child from "evil eyes" and intents. Those who had no much support from

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people stated that prayer was their form of comfort when things were most difficult for them during their pregnancy journey, particularly during delivery.

When it came to informational support, the women reported receiving advice on the pregnancy, particularly nutrition advice, foods to eat and those to avoid, like white clay. Food recommendation came very beneficial as some of them were unaware of threats to their pregnancy, particularly for those who were diagnosed with anaemia during pregnancy. Again, some received advice about practices to engage in such as walking about (exercising) and others to avoid during pregnancy, such as with lifting of buckets or heavy loads as it could affect the health of the unborn child.

Notwithstanding all these supports that were recorded, mothers reported that other forms of the supports were either absent or insufficiently provided for. Chief among the list was financial support. Though some had some financial assistance, an overwhelming majority (even among those who reported having this support), still stated a grave need for financial assistance. This support was primarily needed by the women to attend their ANC sessions and other healthcare needs, deliver in a health facility, purchase items for their unborn child, financial support for their business and trade to cater for their upkeep needs.

Another lacking support need to some participants was the provision of food. The women made it clear that regular provision of food was key to their survival which some lacked and had inadequate supply during pregnancy and to some after delivery. Their heightened need for food could be a result of the consequential increase in appetite, a prime physiological change associated with pregnancy. Some others needed help in running short errands around. When it came with assistance with housework, though it was adequately supplied for to some respondents, few women were deficient with it. This was among married/cohabiting women whose partners' work took them out of the house often, and had to depend on their younger children for this support.

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5.4 Providers of Social Support

According to Edmonds et al. (2011) and Logsdon et al (2005) pregnancy women frequently receive support from their husbands or babies' father, the women's mothers, peers and friends, consistent with findings of the study. Based on the socio-ecological model, as postulated, women receive support from interpersonal level (such as family and friends), organizational level (such as health facilities, churches) and community levels (that is the slum community).

Support from Husbands/Partners

Husbands/partners were the primary sources of support to most of the respondents in one way or the other. This highlighted support from the interpersonal level, according to the SEM. Husbands were known to provide particularly instrumental and emotional support. In some cases too, they were the providers of appraisal support to their spouses. Instrumental support was mainly in the form of assistance in household chores like fetching water and cooking. Women who received such help from their partners were very elated and heightened the sense of love from their partners. Again husbands/partners were the main providers of monetary support during pregnancy. Husbands/partners also gave great appraisal and emotional support to their partners. Partners encouraged and rendered listening ears to their partners during pregnancy. This was particularly useful when the respondents felt discouraged and fatigued due to pregnancy. Findings by Azad et al. (2019) revealed that practical/instrumental and emotional support from partners reduces the chance of women being depressed, consistent with, the result of the study. The respondents made it apparent that due to the individualistic nature of residents of Brigade slum, it was only one's partner that was a sure source of social support. Findings from Freund (2007) and Hetherington et

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al. (2015) also reported partners as strong support for mothers. According to the respondents, most partners were willing or at least demonstrated some effort to support them. They undoubtedly their sure source of support. Inhibitions came as a result of the type of work the man was involved in which may keep him away from the house often. However, when they returned, they made efforts to support their partners where necessary. Another challenge to the partners helping was financial difficulties. The respondents' partners were mainly handymen: carpenters, masons, electricians. Thus, when there was no need for their service in a project, they had no work doing and thus no income. The women reported that this put their spouses in a difficult position to help, worsening their financial plight especially when there was no other person to feel this gap. Jackson (as cited by Song et al., 2016) stated that once a couple decides to have a child together, they become each other's most important support system in whatever challenge that decision may bring to them. Spouses of the respondents largely lived up to this mandate during their wives/partners' pregnancy.

Support from Mothers/ In-laws

For mothers, even though some researches show that they are very supportive of their pregnant daughters (Edmonds et al., 2011), in Brigade, this fact was not much realized. Since most of them were temporary settlers from different parts of the city and country, they stayed apart from their family members. Most of the respondents admitted that their mothers were old and could not embark on long journeys to be with them and support them. Respondents, however, expressed the grave need for the support of their mothers but due to distance and their old age it was impossible. It was however interesting to note that, when the women delivered, they stated that their mothers made some effort to visit them. Similar reasons were made for their in-laws and other family members. Aunties and grandmothers also became helpful for those women who ended up delivering at home, mainly due to financial challenges. According to the respondents, most of them

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stayed far off and thus could not come to support the respondents. Notwithstanding, some respondents were desirous of some support from them, particularly instrumental and emotional support.

Those who happened to receive support from their mothers were either living in the slum with their mothers or their mothers stayed within Accra and thus were able to visit their mothers from time to time. In the cases where mothers were accessible to those respondents, they reported their mothers a huge source of support besides their partners. Consistent with findings by Edmonds et al. (2011), mothers played a significant role in supporting the respondents with household work particularly with cooking and general running of the home. They were a strong financial backbone for them particularly if the respondent's partner was financially strained. Mothers were also a source of love and comfort to the respondents with their presence and provision of encouragement and in some cases appraisals. Respondents who had maternal support also reported the informational advice they received from their mothers. This was a contribution to the immense work of healthcare workers in providing informational support in the form of advice and suggestions on pregnancy, particularly dietary advice to respondents, consistent with Edmonds et al.'s (2011) findings. Here again, it was evident the worth of support coming from the interpersonal level of respondents. No in-law was reported to provide any form of support during respondents' pregnancy period. Some, however, were available and supportive after delivery. In one rare case, though the respondent's mother lived far-off, she was able to regularly send foodstuff to the respondent in Accra. Again, only one participant received financial support from an uncle. Research can be done to ascertain from providers, particularly kin-based providers, the reason for being more supportive after delivery than during pregnancy.

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Support from Siblings

Siblings, particularly the sisters of the respondents also came up as great sources of social support to the respondents. Siblings showed their support instrumentally, emotionally and provision of informational support. This was consistent with findings from Edmonds et al. (2011). Sisters, in particular, assisted the respondents in carrying out household chores like sweeping, fetching of water, cooking, and in the care of the other children as well as helping them run their businesses. Where capable, some sisters also provided monetary support to the respondents which were very useful. It was however clear that siblings who supported either stayed with the respondent or stayed in Accra came from with those whose siblings stayed afar off were not able to support the respondents much. Some of the sisters were themselves married and could not leave that responsibility to support the respondents which the women had to come to terms with. Some women also visited their family home once in a while during their pregnancy which allowed their siblings to support them whilst there. Sisters also gave informational support to respondents particularly dietary information on pregnancy.

Support from Health workers

Health workers also played a critical role in providing support to the respondents. They represent the organizational level of providers of social support to mothers in this study. This was mainly exhibited in the provision of informational support as expected (Bäckström, 2018; Edmonds et al., 2011). In a few cases, however, health workers also provided appraisal support to labouring mothers and to some respondents who were trodden by life activities when they visited the hospital for antenatal care. Respondents reported of the positive influence the support of the health workers were to them, particularly their advice on nutrition as some could recount how it saved them from complication due to anaemia and ensured the general health of the mother and baby during

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delivery. These were congruous with Bäckström (2018) who admitted that health workers had priceless knowledge about the normality and healthiness of pregnancy and childbirth. In some cases too, the health workers, particularly the nurses and midwife were very unsupportive to some respondents during labour, yelling on them and being unfriendly and impatient with them. This experience was however reported by one respondent, an older multiparous mother (>30 years).

Support from Pastors and church members

The role of pastors as a provider of social support came very much as a surprise to the study. Some women recounted how pastors and other spiritual figures provided immense spiritual support in the form of prayers and spiritual directions which the recipient respondents admitted saved them, particularly during delivery. Again, pastors provided great encouragement and reassurance to some respondents who were contemplating abortion. Through their godly counsel, the women refuted their decision to abort being convinced that their life could even be better with the birth of that child coupled with the fact that they believed it was not a right act. The women reported that this support helped them greatly during those contemplative stages. Song et al. (2016) listed that support from religious bodies play a significant role in the health of individuals. According to the SEM, this support falls under the organizational level.

Support from community members and neighbours

In Brigade community, it was apparent that if you did not have family or friends with you, you would be deluded of any support. Brigade community could be termed as a place where it is 'every man for himself'. The women were quite vocal about the unsupportive nature of fellow residents in the slum. This level of influence is the community level based on the SEM, and support from this level was very low. It was however apparent that those who had friends in the slum (though