Social Support and Access To Prenatal Health Services Among Pregnant Teenagers

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ABSTRACT

The study examined the impact of access to social support on pre-natal health seeking behavior of a Selected group of pregnant teenage girls in Lagos, Nigeria. A random sample of 170 pregnant teenage Girls and older mothers were selected from antenatal clinic registers of three Maternal and Child Health Clinics in Lagos. An interview schedule was administered to seek information on initiation of pre-natal visits, socio-demographic characteristics, living arrangements and access to social support. Multiple regression analysis of the data indicated access to social support was a significant predictor of early initiation of prenatal care, irrespective of socio-demographic background and living arrangements of the group of mothers studied. The results showed that a teenage mother-to-be with inadequate social support and living in a poor household is the standard profile of a poor initiator of early prenatal care. While the results are not very different from those obtained in other studies, notably, in the United States, the implications may be more serious in a developing country like Nigeria, where teenage childbearing is occurring in the context of inadequate health services, poor State sponsored social services and widespread poverty.

KEYWORDS: Teenage Pregnancy; Social Support; Pre-Natal Clinic Visits; Pregnancy Outcomes.

INTRODUCTION

Adolescent reproduction has long been recognized as an important issue in maternal and child health in Nigeria, as in many parts of the world. This concern is underlined by the attention accorded to adolescent reproductive health issues by successful governments of Nigeria, International Organizations, and non- governmental organizations. One key medical and health issue of adolescent reproduction is its association with poor pregnancy outcomes for the mother and child. Compared to women of more mature age, pregnancy and child bearing during the teen years have been observed to present much higher risks of low birth weights, neonatal mortality, infant mortality and pregnancy-related medical complications.(Babson and Clarke, 1993). In Nigeria, findings from the most Demographic and Health Survey(2012) revealed that births to young mothers (under age 20 years) continue to be at a higher risk of dying than those of older mothers.

Explanations of Teenage Pregnancy Outcomes

Two factors have been advanced to explain the observed link between young maternal age and the risk of adverse birth outcomes. First, births to teenagers are considered high risk due to the physical immaturity of their reproductive system, which may not be able to withstand the strains of pregnancy and childbirth (Nortman,1994). Contrary to this biological explanation, it has been argued that the poor pregnancy outcomes associated with adolescent reproduction are due more to the disproportionate number of teenage mothers who live in poverty. According to this perspective, the

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effect of age on pregnancy outcomes is confounded by socio-economic factors such as education and income (Geronimus,2006).

These explanations are based largely on the experience of developed countries, especially the United States. It is therefore not clear if similar situation exists in less developed countries. As a biological process embedded in socio-cultural milieu, teenage pregnancy occurs in different social contexts and It is plausible that the age and socioeconomic effects on pregnancy outcomes may also vary across cultures. Infact, when it comes to adolescent fertility, the western model which defines early child- bearing in terms of out-of-wedlock births is less useful in sub-Saharan Africa, where early marriage remains common and lineage support for parenthood is still relatively strong; childbearing and childrearing in traditional African societies are rarely the exclusive concern of the biological parents (Page,1999). For example, family members and kin, particularly mothers, grandmothers, and in-laws, have traditionally provided extensive social support for pregnant and lactating mothers (LeGrand and Mbacke,2003). At the same time, most African societies have traditionally used social support in the form of moral, social, and economic sanctions to discourage premarital teenage pregnancy (Christensen, 1954) in order to ensure, among other things, that the mother and child have extensive social network for future support.

Although most adolescent childbearing in sub-Saharan African societies have traditionally occurred in the context of marriage and under the protection of the family, kin and community support, we are now witnessing births to teenage girls outside the protection of marriage, as a result of socio-demographic transformations such as increasing mobility of the youth, rapid urbanization, education and training which have not only lengthened the gap between menarche and social adulthood for adolescent girls but have also eroded the traditional strictures on adolescent sexuality. Furthermore and at the same, these often socially stigmatized premarital pregnancies are occurring in the context of a much weakened informal supportive networks of family and kin, as well as conjugal support (Oppong,1991). Thus, unlike the developed countries, there are two configurations of adolescent fertility in sub-Saharan African societies; one occurring under the protection of socially approved relationships and the other condemned and less supported outside such relationships(Bledsoe and Cohen,2003).

This paper argues that in the context of the social dynamics of adolescent reproduction in sub-Saharan African societies, it may be access to prenatal support, and not necessarily maternalage and/or socioeconomic status, which determines pregnancy outcomes. The idea that the social context is important for health outcomes is not new and is clearly related to the sociological literature on social integration and isolation as first formulated by Durkheim (1954) in his classic study in his classic study of suicide. Durkheim has demonstrated that the individual's social tie in the fabric of society is critical to his or her health. Persons without social ties experience a state of anomie or the feeling of isolation and loneliness which adversely affect their well-being. Contemporary social scientists have confirmed Durkheim's hypothesis by linking absence of social network and support to a variety of health outcomes (Cohen and Syme,1986), including pregnancy outcomes (Norbeck and Tilden ,1983;Oakley,1990; Williamson and Leferve,1992).

Theoretical Framework

Two theoretical perspectives have been suggested in the literature regarding the specific mechanism through which social support influences health outcomes. The first is the buffering hypothesis which posits that that social support exerts its effects on health outcomes by protecting people from the negative consequences of stress (Cohen and Wills, 1985). Stress here refers to any environmental, social, or internal demand that requires the individual to re-adjust his/her usual behavior patterns, such as the birth of the first child or divorce. In this sense, social support has meliorating influence on the underlying stressor or stressors. With regard to health outcomes, social support may motivate individuals to adopt health promoting behaviors such as proper nutrition, exercise, accessing health care and complying with treatment recommendations. The second is the direct

effect hypothesis which argues that social support is an existential human need and that the absence of it may be a stressor in itself (O'Reilly,2008). Social support, therefore, promotes good health, irrespective of the level of stress. Both direct and indirect effects of social support on health outcomes have been demonstrated in empirical research that have used various types of social support measurements. (Berkman,1985). Direct effects tend to be found when social support is measured by the degree to which individuals are integrated within social networks, while the buffering effects tend to be shown when support is measured by the availability of resources that help one to cope with stressful events.

This study makes use of both theoretical perspectives to try to understand the relationship between social support and access to health services. The study posits that maternal stress is an aetiological factor in poor pregnancy outcomes (Oakley,1990). But the problem is likely to be intensified in adolescent pregnancy, especially if occurs outside social recognized bounds (Omololu,1994). Social support influences pregnancy outcomes by eliciting a positive prenatal health behavior (buffering hypothesis) and/or by directly acting as a buffer to the stress of pregnancy (direct effect hypothesis). A pregnant girl's access to prenatal health care services is hypothesized to be a function of her access to social support which is conditioned by her socio-demographic characteristics and her social network structure. These in turn are influenced by the wider socio-cultural context of values and belief systems regarding social support, as well as changes in supportive networks as a result of demographic and socio-economic factors such as migration, urbanization, wage employment and individualism.

The objective of the paper is to assess the impact of the presence or absence of social support on prenatal health seeking behavior of a group of pregnant adolescent girls in Lagos in the light of a substantial body of research findings which indicates that access to adequate prenatal care may mitigate the effect of young maternal age on adverse birth outcomes (Leppert,2006).

The study is undertaken in the context of mounting evidence that the traditional structure of families, the basic systems of social support for adolescents and other family members, is undergoing rapid changes in Nigeria, as in other parts of the world, with extended family networks of relatives being lost and customary patterns of social support being weakened.

METHOD OF DATA COLLECTION

The study was undertaken in October 2012 in Lagos. The social survey research method was used to collect data for the study. The target population of interest to the study was pregnant teens aged 15 to 19. However, older mothers between 20 to 24 years were included as a control group.

The survey population was drawn from antenatal clinic of three Maternal and Child Health Clinics in Lagos. These were the University of Lagos Maternal and Child Health Unit; Lagos State University Maternal and Chlid Health Unit and Lagos Island Maternity Hospital. The health facilities were strategically located to act as catchment areas for women attending antenatal and postnatal health care within Lagos and its environs.

The combined list of the antenatal attendance registers from the clinics was used as the sampling frame. The sampling frame contained information of client identification number, name of mother, age of mother and home address. On the basis of information provided in the sampling frame, a random sample of 170 each of teenage mothers and older mothers were selected for the study.

The Survey Instrument

The main instrument of data collection was the questionnaire which sought to collect information on the following topics: socio-demographic background of respondents and those of their

husbands/partners; maternity history; characteristics of current pregnancy; housing condition; and social support providers and resources.

The survey instrument was pre-tested to ascertain whether the concepts and language used were understood by respondents. The exercise also offered opportunity to find out about the flow and logical sequencing of questions. The pretesting was undertaken at the antenatal unit of the University of Jos Teaching Hospital which was not among the health facilities selected for the study.

The administration of the instrument was of the canvassing type where respondents were visited at their homes for the interview. Two problems related to the location of respondents for interview were encountered during field work. First, poor numbering of dwelling made the location of some respondents for interview difficult. The numbering of houses in some areas were not sequential and rain had washed part of some of the house numbers. A strategy adopted to locate respondents was by probing residents of adjacent homes . Guided by the names on the sampling lists, inquiries were made in these houses about any teenage girl who has recently been attending any of the selected antenatal clinics. Since such information is generally public knowledge in most Nigerian communities, it was possible to locate some respondents in this manner.

Another problem was related to the proper identification of respondents at their given addresses. This was because some of the teen mothers gave incorrect addresses and/or registered at the clinics with names that were different from those by which they are called at home. Unknown to their household members, some of the teen mothers have adopted European names which are known only to friends and school mates. Armed with this knowledge, the strategy of snowballing was used to identify and locate respondents. By this method, teen mothers who had been successfully interviewed in a locality were used, through probing, to help locate other adolescent mothers in their area who were on the sample list. The identification number on a clinic registration card was cross-checked with that on the sample list to be certain of the true identity of a respondent who was located in this manner. The strategy proved effective and all 340 respondents sampled for the study were successfully interviewed.

MEASUREMENTS AND ANALYTICAL MODEL

A multiple regression model is employed to assess the effect of social support on prenatal health care behavior. The key assumption underlying this model is that access to social support directly affects the likelihood of a mother initiating an early prenatal visits, irrespective of her socio-demographic and household characteristics.

Dependent Variable

The dependent variable of interest is the timing of initiation of prenatal care. It is measured at two levels as early prenatal care(defined as prenatal visit after the first trimester of pregnancy). An early visit may be a better and more exogenous indicator of differentials in prenatal behavior than a late visit because an early visit is less likely to be compromised by pregnancy-related problems that may necessitate seeking health care (LeGrand and Mbacke,2003) as well as cultural factors that may delay a visit.

Independent Variables

There is extensive literature on the socio-demographic, institutional and attitudinal barriers to prenatal care. The independent variables included in this study are maternal age (Moss and Hensliegh,1990),maternal education(Caldwell,1979;Elo,1992), marital status(McCaw-Binns,1995), religious and cultural beliefs (Brown,2006), socioeconomic status, living arrangements and access to social support (Caper and Logan,1990).

Measurement of Social Support

The concept of social support was introduced into the literature in the 1970s (Cassel,1976;Cobb,1976). Since then, there has been tremendous increase in the number of publications that have dealt with the subject in such diverse disciplines as social psychology, sociology and health. Despite the increased interest in social support, the precise definition and measurement of the concept has eluded mostresearchers (Brown,2006;Oakley,1990).

Most investigators, however, agree that social support usually refer to the provision of instrumental, informational   and emotional assistance to individuals by significant others such as the family,friends, church members, and co-workers (Vaux,1988).

In this study, social support is conceptualized as perceived support. To measure access to social

support, the women were asked (1) about their social network resources; (ii)kinds of assistance received (cash, clothing, food, transport, help with household task, accommodation, and emotional support) (iii) and their satisfaction with the assistance received in the two weeks before being interviewed. They choose any of two options for each type of assistance (a) as much as I would like (b) much less than I would like. A Liker-type index of satisfaction with social support was then constructed from the responses.

Specification of Model

In the multiple regression equation, initiation of prenatal visit is modeled as an outcome of access

to social support, individual socio-demographic characteristics and household characteristics during

pregnancy. The dichotomous nature of the dependent variable is suited for use in a logistic regression

model (Morgan and Teachman,1988; Hanushek and Jackson,1977). The specification of the model to

be estimated is as follows:

Log [Pi/(1-Pi)]={ B0+BkXk,

where Pi is the probability that an expectant mother,I, would initiate an early prenatal visit; Bo is the

intercept representing the likelihood of initiating an early prenatal visit when all coefficients are set

to zero;   Bk is the regression coefficient for each independent variable and measures the extent to

which a particular independent variable contributes to the likelihood of initiating an early prenatal

visit; and Xk is the independent variable whose effect is being estimated.

RESULTS

Table 1 reports on the distribution of the timing of prenatal health care visits by selected independent

variables. Chi-square tests were performed to ascertain statistically significant relationships between

the independent variables and the timing of prenatal visits at the 0.05 level of significance. Information

in the table indicate that maternal age, marital status, education and living arrangements are all

significantly associated with the likelihood of initiating an early prenatal visit. The percent use of early

prenatal care is significantly lower among teenage mothers and mothers in consensual union as well as

those with no education. Although not statistically significant, we note that mothers-to-be who are

living with partners are better initiators of early prenatal visits than those living with parents and relatives. Similarly, pregnant school girls and those in apprenticeship training have the highest

percentage of early visit by work status. One would expect these groups of pregnant adolescents to be the more likely the hide their pregnancies and report late for antenatal care. The work status of

other groups of women shows little variation with early prenatal visit; similar proportions of women

reported an early visit among those in agriculture and the unemployed, while those in petty trading are

only slightly more likely to report an early visit. Religious affiliation seems not to be significantly

associated with timing of first prenatal visit.

Table 2 presents the results of three logistic regression estimates. Model 1 examines the impact of

maternal age and marital status on the probability of occurrence of an early prenatal visit. Model 2

 is an extension of the model to include the social support variable to examine whether its impact

can account for variations in prenatal visits by maternal age and union status. Model 3 presents

estimates of the likelihood of seeking early prenatal care, after controlling for other socio-economic variables.

Overall, the results from the three models are consistent with the hypothesis that social support

is significantly associated with prenatal health care behavior, although the effect of maternal age

persists in all the models. Each of the model is discussed in turn.

Model 1: Results in model 1 confirm previous findings that being a teenager and being unmarried

are both significantly related to poor prenatal health seeking behavior (Brown,2009). Pregnant

unmarried women and pregnant teenagers are statistically less likely to seek prenatal care in the

first trimester of pregnancy compared to older and married women.

Model 2: In this model we examine whether social support, rather than the age of the mother or

her marital status, accounts for the observed variations in prenatal behavior in Model 1. The

introduction of the social support variable in the model significantly improved the fit of the model.

The statistical significance of the R2 test of model fit (p< 0.0.05) indicates that to understand the

prenatal health seeking behavior of the pregnant women in our sample , it is important to know

their access to prenatal social support. Results in this model demonstrate the strong and positive

effect of instrumental social support on the likelihood of initiating prenatal care early in pregnancy.

We further note that the significant effect of marital status on prenatal behavior observed in Model 1

disappears after controlling for social support in Model 2. This can be interpreted to mean that it is

social support and not marital status per se that influence early prenatal visit. In other words, when

it comes to making an early prenatal visit, it does not matter if a woman is married or not as long as

she receives adequate social support. However, contrary to expectation, it does matter if the mother

is a teenager. This is because the expected non-significance of the effect of maternal age on early

prenatal visit, after accounting for social support in this model did not appear. This suggests that

there is something about being an expectant teenager that acts as barrier to seeking prenatal care early in pregnancy, once marital status and social support are accounted for. A possible explanation may be that in traditional Nigerian societies it is regarded immodest for a pregnant woman, especially a

primipara, to publicly disclose her early pregnancy status. Thus this behavior may have more to do

with socio-cultural reasons than maternal age. Another probable reason may be the fear of disclosure

of pregnancy to significant others (Brown,2009), particularly if the pregnancy occurred outside socially

approved context.

Model 3: The model shows that the significant effects of maternal age and social support on the timing of prenatal health care visit persist after controlling for potential rival covariates. The only other

significant factor that affects early prenatal behavior in this model is the socioeconomic status of the

household of which the pregnant woman is a member. Women from poor households (measured by

raffia roofing) are significantly less likely to report for early prenatal care than their sisters living in

high income households (measured by aluminum/tile roofing). This result is expected as poverty is often

associated with low education and low income both of which are also associated with poor health seeking behavior.

Maternal education, work status, religion, ethnicity, and living arrangements were poor predictors of

early initiation of prenatal care. Infact an R2 test of model fit indicated that including these variables

did not significantly improve the fit of the model (p=0.153). This suggests that a model without these

covariates explains the variance in prenatal care behavior just as well as a model with these

covariates.

CONCLUSIONS

As a group, pregnant adolescent girls are more likely than older women to receive inadequate

prenatal health care services (Leppert,2006). These behaviors have been hypothesized to lead

to poor birth outcomes for adolescent mothers and their children (McCaw-Binns,1995). In this

paper, we examined, through multivariate analysis, the possibility that social support influences

in part the observed the observed poor access to prenatal health care in teenage pregnancy.

Specifically, the analysis focused on whether social support independently influences prenatal

health care behavior in pregnancy. The analysis identified three factors that acted as barriers to

the initiation of early prenatal care among the prospective mothers studied. These were young maternal age, lack of social support and poverty. The analysis revealed that a teenage mother with inadequate social support and living in a poor household is the standard profile of a poor initiator of early

prenatal care in the group studied. While the result is not very different from those obtained in other

studies, notably in the United States(Geronimus,2006), the implication may be more serious in a

developing country such as Nigeria, where teenage childbearing is occurring in the context of

inadequate health services, weak state sponsored social welfare services and widespread poverty.

Table 1: Percent Initiating Prenatal Care By Timing Of Visit and Selected Independent Variables

Variables	Early Visit	Late Visit	Total No.
----Age*			
15-19	27.6	72.4	170
20-24	41.9	58.1	170
Marital Status*			
Married	43.0	57.0	128
Consensual	29.4	70.6	151
Never Married	31.1	68.9	61
Education*			
None	27.4	72.6	73
Primary	39.4	60.6	104
JHS and Above	35.2	64.8	163
Work Status			
Farming/Fish Seller	30.6	69.4	36

Commerce	35.6	64.7	147
Apprenticeship	46.4	53.7	28
Student	37.5	62.5	32
Unemployed	30.9	69.1	97
Religion			
Catholic	28.6	71.4	70
Protestant	38.6	61.4	125
Other Christians	38.8	61.2	49
Moslem	36.5	63.5	63
Traditional	24.2	75.8	33
Ethnicity			
Yoruba	64.3	35.7	200
Ibo	62.4	35.6	74
Hausa	28.0	72.0	66
Living Arrangement*			
Live with Parents	28.2	71.8	151
Live with Partner	42.2	57.8	83
Live with Relatives	35.7	64.3	56

Note:* Statistically Significant for x2 test at p<0.05

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Table 2: Logistic Regression Results Describing The Relationship Between Social Support and Early Initiation of Prenatal Visit.

Independent Variable	Model 1		Model 2		Model 3	
	Coef.	Z	Coef.	Z	Coef.	Z
Marital Status						
Consensual	-0.51*	-1.99	-0.39	-1.50	-0.42	-1.37
Never Married	-0.29	-0.82	-10.19	-0.56	-0.17	-0.47
Age						

15-19	-0.57*	-2.35	-0.60*	-2.46	-0.47*	-1.98
Social Support						
Instrumental			0.26*	2.10	0.28*	2.08
Education						
No education					-0.21	-.06
Primary					0.23	0.80
Work Status						
Farming/Fishing					-0.13	-0.32
Student					0.30	0.86
Unemployed					-1.10	-0.34
Ethnicity						
Yoruba					0.29	0.92
Religion						
Catholic					0.01	0.02
Protestant					0.58	1.17
Other Christian					0.40	0.73
Moslem						
Living Arrangement						
With Parents					-0.20	-0.68
With Partner					-0.19	-0.52
SES						
Dwelling raffia/thatched Roof					-1.58*	-3.02
CONSTANT	-0.09	-0.45	-0.15	-0.76	1.07	0.19
Pseudo R2	0.026		0.037*		0.087	

Note: Reference category for union status is married, for age is older mother, for education is JHS, for work status is commerce, for ethnicity is non-Yoruba, for religion is traditional, for socioeconomic status

(SES) is high.*P<0.05.

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