

Perceived Social Support and Psychological Well-being among Unmarried Teenage Mothers in Ilorin Metropolis, Nigeria

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doi: <https://doi.org/10.37745/bjpr.2013/vol14n24959>

Published October 03, 2026

Citation: Abdul-Baki M.A., Anyebe E.E., Adewara O.I., Abore E.O., Salami M.F., Ibrahim A.O., Danzaki S.O., Obe O.A. (2026) Perceived Social Support and Psychological Well-being among Unmarried Teenage Mothers in Ilorin Metropolis, Nigeria, *British Journal of Psychology Research*, 14(2),49-59

Abstract: *Unmarried teenage mothers in Nigeria face stigma, interrupted schooling and economic hardship, yet little is known about the support available to them and how that support*

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relates to their psychological well-being. To assess the types, levels and perceived adequacy of social support available to unmarried teenage mothers in Ilorin Metropolis, their psychological well-being, the factors that enhance or hinder support, and the relationship between support and well-being. A cross-sectional survey was conducted in three primary health care centres (Pakata, Balogun Fulani and Okelele). Of 226 eligible teenage mothers, 180 were recruited by proportionate allocation and 168 returned usable questionnaires (response rate 93.3%). Data were collected with a structured questionnaire incorporating an adapted Multidimensional Scale of Perceived Social Support (Cronbach's $\alpha = 0.85$) and analysed using descriptive statistics, multiple linear regression and Pearson correlation at $p < 0.05$. Healthcare support ($M = 3.79$) and family support ($M = 3.62$) were rated high, whereas community support was moderate ($M = 3.31$). Support was perceived as adequate overall ($M = 3.82$). Psychological well-being was moderate ($M = 3.00$), with low confidence in caring for the child ($M = 2.24$). Supportive family members ($\beta = .276$, $p = .001$) and educational opportunities ($\beta = .245$, $p = .007$) positively predicted perceived support, whereas financial constraints ($\beta = -.178$, $p = .028$) and limited access to healthcare ($\beta = -.212$, $p = .011$) were negative predictors ($R^2 = .202$). Perceived social support had a weak, significant positive correlation with psychological well-being ($r = 0.18$, $p = 0.02$). Unmarried teenage mothers in Ilorin receive meaningful healthcare and family support, but community support is weaker and its association with psychological well-being is modest. Adolescent-friendly services, economic empowerment, school re-entry pathways and community anti-stigma programmes are needed.

Keywords: Adolescent mothers; Social support; Psychological well-being; MSPSS; Primary health care

INTRODUCTION

Adolescent pregnancy, defined by the World Health Organization as pregnancy among girls aged 10–19 years, remains a major global health concern because of its health, social, economic and psychological consequences for young mothers and their children (World Health Organization [WHO], 2024). Most adolescent births occur in low- and middle-income countries, and pregnant adolescents in these settings remain underserved by health interventions (Sabet et al., 2023). Sub-Saharan Africa records the highest adolescent fertility globally, and the drivers of teenage pregnancy in the region include poverty, limited education and weak access to reproductive health information (Asmamaw et al., 2023; Gunawardena et al., 2019; Odimegwu & Mkwanaenzi, 2016).

In Nigeria, 19% of women aged 15–19 years have begun childbearing (National Population Commission [NPC] & ICF, 2019), and teenage pregnancy is concentrated among girls from poorer households (Okoli et al., 2022). Although early marriage explains much adolescent childbearing in the north, pregnancies outside marriage are increasingly visible in urban centres. Qualitative evidence from south-western Nigeria links them to poverty, poor parental supervision, peer influence and limited contraceptive knowledge (Esan et al., 2022). Adolescent mothers face higher risks of obstetric complications and adverse neonatal outcomes

Publication of the European Centre for Research Training and Development -UK (WHO, 2024). They also face elevated risks of depression and other mental health problems (Hodgkinson et al., 2014), and early motherhood frequently interrupts schooling and entrenches poverty (Akella & Jordan, 2014; Bunting & McAuley, 2004). For unmarried adolescents, these burdens are compounded by stigma and weakened family and community ties (Gbogbo, 2020; Mangeli et al., 2017).

Social support can buffer the effects of stressful life events on psychological health (Cohen & Wills, 1985). For teenage mothers, support from parents and relatives provides emotional stability, childcare and financial help, and is consistently associated with better parenting and educational outcomes (Bunting & McAuley, 2004). Peer and community networks can reduce isolation and stigma; in Zimbabwe, a community-based peer support intervention lowered depressive symptoms and improved perceived support among adolescent mothers (Tinago et al., 2024). Health workers are a further source of support. Adolescent-friendly services improve service uptake (Omobowale et al., 2023), whereas judgmental or inaccessible services discourage young people from using care (Abubakari et al., 2020).

Despite this evidence, few Nigerian studies have examined family, community and healthcare support together, or linked perceived support to psychological well-being among *unmarried* teenage mothers, a group whose marital status exposes them to additional social sanction. Evidence from North-Central Nigeria, including Ilorin, a city with strong religious and cultural norms around marriage, is particularly limited. This study therefore assessed (i) the types and levels of support available to unmarried teenage mothers in Ilorin Metropolis; (ii) their perceived adequacy of that support; (iii) their psychological well-being; (iv) the enhancers of and barriers to perceived support; and (v) the relationship between perceived social support and psychological well-being. The null hypothesis tested was that there is no significant relationship between perceived social support and the psychological well-being of unmarried teenage mothers.

MATERIALS AND METHODS

Study design and setting

A cross-sectional survey design was adopted, as it allows the status of variables to be described at a single point in time without follow-up (Setia, 2016). The study was conducted in three primary health care centres (PHCs) in Ilorin Metropolis, Kwara State, one in each of the three metropolitan local government areas (LGAs): Pakata PHC (Ilorin West), Balogun Fulani PHC (Ilorin South) and Okelele PHC (Ilorin East). The centres were selected because they provide antenatal, postnatal and child health services and serve socio-culturally diverse populations.

Population, sample size and sampling

The target population comprised 226 teenage mothers attending the three centres during the three-week data collection period (Pakata = 79; Okelele = 94; Balogun Fulani = 53). The sample size was estimated with the Kish formula for a single proportion (Kish, 1965), $n = z^2pq/d^2$, where $z = 1.96$, $p = 0.12$ (prevalence of teenage motherhood reported in Port Harcourt by Onwubuariri and Kasso, 2019), $q = 0.88$ and $d = 0.05$. This gave $n = 162$, which was adjusted for 10% non-response to 180. The sample was allocated proportionately (80% of each centre's

Publication of the European Centre for Research Training and Development -UK population): Pakata, 63; Okelele, 75; and Balogun Fulani, 42. Within each centre, eligible mothers were recruited consecutively as they attended until the allocation was filled.

Eligible participants were unmarried teenage mothers aged 10–19 years who had delivered at least one child and consented to participate. Married teenage mothers, primigravid pregnant teenagers with no prior delivery, and those too unwell to participate were excluded.

Instrument

Data were collected with a five-section structured questionnaire covering (A) socio-demographic characteristics; (B) types and levels of social support; (C) perceived adequacy of support; (D) psychological well-being; and (E) enhancers of and barriers to support. Section B was adapted from the 12-item Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988), with four items each on family, community and healthcare support. The original "friends" and "significant other" subscales were contextualised to community members and healthcare providers. Sections C–E were developed from the literature. Items were rated on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Mean scores for support and well-being were classified as low (1.00–2.49), moderate (2.50–3.49) or high (3.50–5.00); adequacy was classified as inadequate (1.00–3.00) or adequate (3.01–5.00).

Validity and reliability

Three experts assessed face and content validity, and the instrument was translated into the local language and back-translated to ensure equivalence. A pilot test at Eromo PHC, Ilorin, which was not included in the main study, yielded a Cronbach's alpha of 0.85.

Data collection and analysis

Two trained research assistants administered the questionnaire and retrieved it on the spot; it was interviewer-administered for participants who could not read. Data were analysed with frequencies, percentages, means and standard deviations for demographics and research questions 1–3. For research questions 4 and 5, a multiple linear regression model was fitted in which ten enhancer and barrier items were entered simultaneously as predictors of the composite perceived-support score. The hypothesis was tested with Pearson's product–moment correlation. Significance was set at $p < 0.05$.

Ethical considerations

Ethical approval was obtained from the University of Ilorin Ethical Review Committee (UERC/ASN/2025/3251). Participants received information about the study, gave informed consent, and were assured of confidentiality and of their right to withdraw without penalty.

RESULTS

Characteristics of respondents

Of the 180 questionnaires distributed, 168 were returned complete (response rate 93.3%). Most respondents were aged 19 years (64.3%), followed by 16–18 years (29.8%) and 13–15 years (6.0%). The largest educational group had incomplete tertiary education (32.1%), followed by completed secondary education (23.2%); 10.1% had no formal education. As shown in Table

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1, most respondents were students (37.5%), lived with their parents (45.2%) and had one child (73.2%).

Table 1. Socio-demographic characteristics of respondents ($n = 168$)

Variable	Frequency	%
Occupation		
Student	63	37.5
Apprentice	46	27.4
Unemployed	25	14.9
Trader	21	12.5
Others	13	7.7
Living arrangement		
With parents	76	45.2
With partner	34	20.2
With relatives	26	15.5
Alone	26	15.5
Others	6	3.6
Number of children		
One	123	73.2
Two	34	20.2
More than two	11	6.5

Types and levels of support

Healthcare support was rated highest ($M = 3.79$, $SD = 1.04$), followed by family support ($M = 3.62$, $SD = 1.25$); both were in the high range. Community support was moderate ($M = 3.31$, $SD = 1.23$) (Table 2). Within family support, reliance on family during emergencies ($M = 3.76$) and emotional support ($M = 3.74$) were high, while family support for educational decisions was only moderate ($M = 3.42$). All community-support items fell in the moderate range; approachability of community leaders scored lowest ($M = 3.19$). Access to affordable healthcare services was the highest-rated item overall ($M = 3.93$).

Table 2. Types and levels of perceived support ($n = 168$)

Statement	SA	A	N	D	SD	Mean	Std. dev.	Remark
Family support								
My family provides me with emotional support	54 (32.1)	50 (29.8)	39 (23.2)	17 (10.1)	8 (4.8)	3.74	1.15	High
My family assists me with childcare responsibilities	36 (21.4)	62 (36.9)	41 (24.4)	19 (11.3)	10 (6.0)	3.57	1.13	High
My family supports my decisions regarding my education	62 (36.9)	26 (15.5)	22 (13.1)	36 (21.4)	22 (13.1)	3.42	1.49	Moderate
I can rely on my family during emergencies	59 (35.1)	49 (29.2)	32 (19.0)	17 (10.1)	11 (6.5)	3.76	1.22	High

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Statement	SA	A	N	D	SD	Mean	Std. dev.	Remark
<i>Composite</i>						3.62	1.25	High
Community support								
Community members treat me with respect	31 (18.5)	50 (29.8)	37 (22.0)	33 (19.6)	17 (10.1)	3.27	1.26	Moderate
I have access to community programmes that support teenage mothers	38 (22.6)	51 (30.4)	46 (27.4)	19 (11.3)	14 (8.3)	3.48	1.20	Moderate
Community leaders are approachable when I need assistance	27 (16.1)	56 (33.3)	32 (19.0)	27 (16.1)	26 (15.5)	3.19	1.32	Moderate
I feel accepted in my community despite being a teenage mother	28 (16.7)	42 (25.0)	58 (34.5)	29 (17.3)	11 (6.5)	3.28	1.13	Moderate
<i>Composite</i>						3.31	1.23	Moderate
Healthcare support								
Healthcare providers treat me with dignity	27 (16.1)	86 (51.2)	37 (22.0)	10 (6.0)	8 (4.8)	3.69	0.98	High
I receive adequate information about maternal health services	45 (26.8)	74 (44.0)	29 (17.3)	10 (6.0)	10 (6.0)	3.80	1.09	High
I feel comfortable discussing my health concerns with healthcare workers	42 (25.0)	66 (39.3)	42 (25.0)	12 (7.1)	6 (3.6)	3.75	1.03	High
I have access to affordable healthcare services	51 (30.4)	79 (47.0)	21 (12.5)	9 (5.4)	8 (4.8)	3.93	1.04	High
<i>Composite</i>						3.79	1.04	High

Values are *n* (%). SA = strongly agree; A = agree; N = neutral; D = disagree; SD = strongly disagree. Decision rule: 1.00–2.49 = low; 2.50–3.49 = moderate; 3.50–5.00 = high.

Perceived adequacy of support

Respondents rated the support they received as adequate overall (composite *M* = 3.82, *SD* = 1.23) (Table 3). The adequacy of healthcare services in meeting maternal health needs was rated highest (*M* = 4.08), followed by satisfaction with family support (*M* = 3.86). The positive effect of community support on well-being was rated lowest, although it remained within the adequate range (*M* = 3.63).

Table 3. Perceived adequacy of support (*n* = 168)

Statement	SA	A	N	D	SD	Mean	Std. dev.	Remark
The support I receive meets my emotional needs	66 (39.3)	36 (21.4)	41 (24.4)	9 (5.4)	16 (9.5)	3.76	1.29	Adequate
The assistance provided helps me manage my responsibilities effectively	59 (35.1)	52 (31.0)	32 (19.1)	11 (6.5)	14 (8.3)	3.78	1.23	Adequate
I am satisfied with the overall support from my family	72 (42.9)	43 (25.6)	25 (14.9)	14 (8.3)	14 (8.3)	3.86	1.29	Adequate

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Statement	SA	A	N	D	SD	Mean	Std. dev.	Remark
Community support has positively impacted my well-being	56 (33.3)	37 (22.0)	47 (28.0)	12 (7.1)	16 (9.5)	3.63	1.28	Adequate
Healthcare services have addressed my maternal health needs adequately	80 (47.6)	39 (23.2)	34 (20.2)	12 (7.1)	3 (1.8)	4.08	1.06	Adequate
<i>Composite</i>						3.82	1.23	Adequate

Values are *n* (%). Decision rule: 1.00–3.00 = inadequate; 3.01–5.00 = adequate.

Psychological well-being

The composite psychological well-being score was moderate ($M = 3.00$, $SD = 1.30$) (Table 4). Respondents frequently reported feeling overwhelmed by their responsibilities ($M = 3.46$), trouble sleeping because of stress or anxiety ($M = 3.17$), sadness or hopelessness ($M = 3.14$) and isolation or loneliness ($M = 3.01$). Confidence in their ability to care for their child was low ($M = 2.24$).

Table 4. Psychological well-being of respondents ($n = 168$)

In the past month, I have...	Mean	Std. dev.	Remark
Felt overwhelmed by my responsibilities	3.46	1.26	Moderate
Had trouble sleeping due to stress or anxiety	3.17	1.19	Moderate
Experienced feelings of sadness or hopelessness	3.14	1.28	Moderate
Felt isolated or lonely	3.01	1.36	Moderate
Felt confident in my ability to care for my child	2.24	1.39	Low
<i>Composite</i>	3.00	1.30	Moderate

Decision rule: 1.00–2.49 = low; 2.50–3.49 = moderate; 3.50–5.00 = high.

Enhancers of and barriers to perceived support

The regression model was significant, $F(10, 157) = 3.98$, $p < .001$, and explained 20.2% of the variance in perceived support (adjusted $R^2 = .152$) (Table 5). Supportive family members ($\beta = .276$, $p = .001$) and educational opportunities ($\beta = .245$, $p = .007$) were significant positive predictors. Limited access to healthcare ($\beta = -.212$, $p = .011$) and financial constraints ($\beta = -.178$, $p = .028$) were significant negative predictors. Community programmes, peer support groups, community stigma, lack of information about resources, lack of family support and access to healthcare services were not significant.

Table 5. Multiple linear regression of enhancers and barriers on perceived support ($n = 168$)

Predictor	β	<i>t</i>	<i>p</i>
Enhancers			
Supportive family members	.276	3.484	.001*
Educational opportunities	.245	2.722	.007*
Access to healthcare services	.072	0.878	.381
Peer support groups	.009	0.107	.915
Community programmes	-.044	-0.470	.639

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Predictor	β	t	p
Barriers			
Limited access to healthcare	-.212	-2.581	.011*
Financial constraints	-.178	-2.216	.028*
Lack of information about available resources	.112	1.423	.157
Stigma from community	.007	0.083	.934
Lack of family support	-.016	-0.209	.835

β = standardised coefficient. Model: $F(10, 157) = 3.98, p < .001; R^2 = .202$; adjusted $R^2 = .152$. Significant at $p^* < .05$.

Relationship between perceived social support and psychological well-being

Perceived social support had a weak but significant positive correlation with psychological well-being ($r = 0.18, p = 0.02$); the null hypothesis was therefore rejected (Table 6).

Table 6. Pearson correlation between perceived social support and psychological well-being

Variable	n	Mean	SD	r	p	Decision
Perceived social support	168	42.85	9.87	0.18	0.02	H_0 rejected
Psychological well-being	168	15.02	4.04			

DISCUSSION

This study examined the social support available to unmarried teenage mothers in Ilorin Metropolis and its relationship with their psychological well-being. Healthcare providers were the most highly rated source of support, followed by family, with community support lagging behind. The prominence of healthcare support probably reflects the recruitment setting, since all participants were already engaged with PHC services. Mothers who do not attend facilities may have a very different experience. Adolescent mothers elsewhere have described health workers as an important but inconsistent source of help (Mangeli et al., 2017, 2018). The present finding suggests that PHCs in Ilorin are an accessible entry point for psychosocial as well as clinical care.

Family support was high for emotional and emergency needs, but only moderate for educational decisions. This gap matters because returning to school is one of the strongest protective factors for teenage mothers and their children (Bunting & McAuley, 2004). South African school-going teenage mothers similarly reported that practical family help rarely extended to sustained support for their education (Amod et al., 2019). Community support was the weakest domain, and no community item reached the high range. This is consistent with reports from Ghana and Iran that adolescent mothers experience gossip, exclusion and diminished standing in their communities (Gbogbo, 2020; Mangeli et al., 2018), particularly when pregnancy occurs outside marriage.

Although support was judged adequate overall, psychological well-being was only moderate. Many respondents felt overwhelmed, sad, lonely or sleepless, and confidence in caring for their child was low. These patterns mirror the emotional distress and sense of role inadequacy described by adolescent mothers in Iran and Ghana (Gbogbo, 2020; Mangeli et al., 2017), and

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they reinforce calls to address the mental health needs of pregnant and parenting adolescents directly rather than assuming that general support will suffice (Hodgkinson et al., 2014). Low parenting self-efficacy is modifiable. Nurse home-visiting programmes have produced lasting improvements in maternal outcomes among young, low-income mothers (Olds et al., 2004), which points to a practical nursing response.

Supportive family relationships and educational opportunities predicted higher perceived support, whereas financial constraints and limited healthcare access predicted lower support. This pattern is consistent with the economic and educational disadvantage that characterises teenage motherhood in Nigeria (Esan et al., 2022; Okoli et al., 2022). It also suggests that interventions addressing poverty and schooling may strengthen support more than awareness activities alone. Peer support groups and community programmes did not predict perceived support, possibly because such structures are scarce in Ilorin. Where peer groups have been deliberately established, as in Zimbabwe, they have reduced isolation and depressive symptoms (Tinago et al., 2024).

The weak positive correlation between social support and psychological well-being ($r = 0.18$) indicates that support explains only a small share of variation in well-being. This is consistent with the stress-buffering model, in which the protective effect of support depends on whether it matches the stressor (Cohen & Wills, 1985). Emotional and practical help at home may do little to offset stigma, financial insecurity and disrupted education. The finding suggests that the quality and fit of support matter as much as its availability, and that support should be combined with targeted mental health and economic interventions.

Strengths and limitations

This study assessed three sources of support simultaneously in a population that is rarely studied in North-Central Nigeria, and it achieved a high response rate. However, the cross-sectional design precludes causal inference, and self-reported data may be affected by social desirability, particularly given the stigma attached to unmarried motherhood. Recruitment from PHCs over three weeks may have over-represented mothers already connected to services and limits generalisability to more marginalised mothers and to married teenage mothers. The well-being and enhancer/barrier items were researcher-adapted, and peer and digital sources of support were not examined in depth.

CONCLUSION AND RECOMMENDATIONS

Unmarried teenage mothers in Ilorin Metropolis perceive high support from healthcare providers and family but only moderate support from their communities, and their psychological well-being is moderate, with low parenting confidence. Family support and educational opportunities enhance perceived support, while financial constraints and limited healthcare access undermine it. The association between support and well-being, though significant, is weak. The following actions are recommended:

1. PHCs should integrate routine psychosocial screening, counselling and parenting-skills education into postnatal and child-health services for teenage mothers, and nurses should be trained in adolescent-friendly, non-judgmental care.

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2. Government and non-governmental organisations should provide economic empowerment, including vocational training, conditional cash support and scholarships, to reduce financial barriers.
3. Education authorities should enforce school re-entry policies and offer flexible or alternative education for teenage mothers.
4. Community and religious leaders should be engaged in anti-stigma campaigns, and structured peer support groups for teenage mothers should be established and evaluated.
5. Family-focused counselling should help parents support their daughters' continued education, not only their immediate childcare needs.

Future research should use longitudinal and mixed-methods designs, include teenage mothers outside formal health services, compare unmarried and married mothers, and examine peer and digital sources of support.

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