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SOCIAL CAPITAL AND ADOLESCENT GIRLS' RESILIENCE TO TEENAGE PREGNANCY IN BEGORO, GHANA

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Summary. This study focuses on how older adolescent girls access and utilize social capital to develop resilience against teenage pregnancy in Begoro, Ghana. A survey of 419 non-pregnant girls aged 15–19 years, selected using a multi-stage cluster sampling technique, was conducted in 2012. Qualitative data were gathered through in-depth interviews with ten girls purposively selected from the survey respondents. Parents, relatives, teachers and religious groups were found to be important sources of social capital for the non-pregnant girls in developing resilience against teenage pregnancy. In addition, resilient girls tended to rely on multiple sources of social capital. It is recommended that stakeholders and policymakers in Ghana ensure that these significant sources of social capital in adolescent girls' sexual experience are equipped with the right information to help girls decrease the risk of teenage pregnancy.

Introduction

In recent times, adolescent sexual and reproductive health has received much attention. However, the focus has been on teenage mothers or pregnant teenagers to the neglect of those who are not pregnant. Studies of pregnant teenagers and teenage mothers are useful since they identify the problems adolescents face in their sexual and reproductive behaviour and how they can be helped by policy intervention. However, lessons can be learnt from adolescent girls who are able to avoid, or have protected, sexual intercourse and therefore escape unintended pregnancy. This includes how they are able to overcome, avoid or positively adjust to the threats associated with their sexual and reproductive experience by appropriating the available resources in their social environment.

Social resilience is an individual's ability to access resources to adjust to, cope well with and search for or create options that help him/her to overcome a threat

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(Obrist *et al*., 2010). Research from a resilience perspective usually focuses on competencies and positive outcomes rather than negative ones (Obrist *et al*., 2010). As such, the resilience of a person is often explained in relation to his/her exposure to risk, protective factors and the positive outcomes (Carey *et al*., 1998; Luthar, 2006; Obrist *et al*., 2010; Masten, 2011). Risks include factors that expose individuals to negative outcomes; protective factors are the various resources that support people to reduce the effects of adversity, which then culminates in positive outcomes. In child development psychology and human development research, protective factors have been identified as stemming from an individual's disposition, relationship with 'significant others' as well as the social environment (Luthar, 2006; Masten, 2011). Thus, an individual's resilience is reflected in how he/she positively adapts to, or reduces, the effect of risk in a specific context (Masten, 2011). Resilience is significant in the study of adolescent girls' sexual and reproductive experiences since studies have shown that adolescents are predisposed to sex and teenage pregnancy (Henry & Fayorsey, 2002; Awusabo-Asare *et al*., 2004; Hindin & Fatusi, 2009).

This article discusses how non-pregnant adolescent girls in Ghana utilize their relationship with significant others to avoid and overcome the risk of premarital sex and teenage pregnancy. It focuses on adolescent girls who were not pregnant or had not had any live birth at the time of the study. For analytical purposes, a non-pregnant girl refers to a girl between the ages of 15 and 19 years who may have had an abortion or a miscarriage.

Social capital as a protective factor

Social capital is not a new concept within sociology. It can be traced back to Durkheim, who 'discovered' the importance of social integration in society, although he did not label it as such (Durkheim, 1964). Durkheim postulated that when individuals are well integrated into society it serves as a protective cover and benefit for them. In recent times, Bourdieu (1986), Coleman (1988) and Portes (2000) have given this protective phenomenon a more modern interpretation, with the development of the social capital concept. Social capital is said to encompass the benefits that individuals or groups access from a 'significant other' because of an existing relationship (Bourdieu, 1986; Coleman, 1988; Portes, 2000). For individuals to have access to social capital they must have social relationships that allow them to access resources possessed by their associates or groups. An individual's participation in family, church, school and community activities provides a source of social capital on which she/he can rely to her/his advantage. To have social capital, a person must be in a social relationship and be participating in social activities with people or groups who generate resources that can serve significant purposes in their lives. Those who generate the significant resources become the source of an individual's social capital.

From the diverse literature, three main sources of social capital available to the individual can be identified, namely the family, social networks and organizations. These three sources provide social capital to the individual in the form of social support and serve as social control mechanisms on the individual, group or organization (Coleman, 1998; Portes, 2000). Social control emanates from the norms that govern people's behaviour in a community. They are norms that are shared by all. As Durkheim (1964) put it, all human associations give rise to expectations of patterns of conduct such that as

people interact, relationships develop that bring about common ways of doing things. These new patterns of values and perceptions and actions give rise to expectations and constraints on how people should act. Thus, relationships tend to influence people's behaviours and actions either by 'constraining' or by 'obliging' them to act in normative ways. From this perspective, social capital in the form of social support emerges within families as members interact and create norms and expectations that define behaviour, and the same holds for members in communities because they feel it is obligatory to help each other (Durkheim, 1964; Coleman, 1988). Social networks develop by virtue of individuals being members of society. For example, by going to school or church and by residing in a community, one is exposed to an array of people who may be a source of their social capital at a point in time. In Ghana, sources of social capital for adolescent girls include parents, older siblings, friends, religious groups, schools and the community members who serve as social control mechanisms and provide social support and other benefits.

Accessing social capital as a whole generates trustworthiness, networks and institutions that are important for collective actions (Ostrom & Ahn, 2003). In as much as social capital is important for collective actions, individuals also rely on it for their own benefit, which in the end serves the interest of the community. The collective action is, however, of less significance in this study, as it focuses on individual adolescent girls' ability to avoid pregnancy. Participation in various institutions has the potential to decrease the rate of teenage pregnancy in a community when individual adolescent girls rely on their access to resources from a significant other to avoid pregnancy. Social capital is seen as an individual's protective factor involving an adolescent girl's 'proactive' behaviour such as success at making friends with significant people and taking the initiative to avoid, overcome and successfully cope with issues about sex and pregnancy (Wolin & Wolin, 1993; Jenson & Fraser, 1994; Alvord & Grados, 2005). For example, having a supportive family rather than a non-supportive one can be a protective factor for adolescent girls against risk. Adolescents who come from non-supportive families are disadvantaged. Studies show that supportive families, where parents take the initiative, reduce children's exposure to risk (Jenson & Fraser, 1994; Alvord & Grados, 2005). In the social environment, the kinds of support available to adolescent girls with regards to their sexual and reproductive life are the norms and values of the community, peers, school and churches. These can serve as a source of social support and a social control mechanism for girls to overcome, avoid and/or adjust positively to risk (Jenson & Fraser, 1994; Majumdar, 2006; Kumi-Kyereme *et al*., 2007). The main interest here is on how individual adolescent girls use their access to resources (social capital) possessed by a significant other to build resilience against teenage pregnancy. Hence, the manifestation of social capital is measured at the individual level, focusing on the benefits that girls derive from the relationship they have with significant others.

Methods

Study population

The study was conducted in 2012 in the Fanteakwa District of the Eastern region of Ghana, which has one of the highest rates of teenage pregnancy (16%) in the country (Ghana Demographic and Health Survey, 2007). The study population constituted

non-pregnant older adolescent girls between the ages of 15 and 19 years living in the district capital, Begoro. This cohort of girls was selected because they contributed to the national fertility rate (Agyei-Mensah, 1997; Ghana Demographic and Health Survey, 2008). This included all girls aged 15–19 years who were contacted in their homes.

Sampling procedure

A multi-stage cluster sampling technique was used because the study population was scattered and it was impossible to compile a list of all the older adolescent girls in the study area. The study area was first organized into geographical clusters and then individuals were randomly sampled from within the selected clusters. An enumeration area list obtained from the Ghana Health Service (GHS) in the district was used to identify the different clusters in the Begoro community. In the first stage, all the outreach sites in the enumeration area list from the GHS in Fanteakwa district were used. In all, four outreach areas, namely Belco, Odumase, Akwansrem and Obuasi, were randomly selected for the study. In the second stage of the sampling, the four selected communities were used as the cluster for the selection of the final sample of respondents, out of which the study sample was obtained. In these four communities, and using the saturation technique, every home in the cluster was visited to select respondents. When saturation was attained, 419 non-pregnant girls were interviewed.

Data collection and analysis

The study utilized a mixed-methods approach allowing for the use of both quantitative and qualitative methods. This was because the study was interested in both the socio-demographic characteristics of the respondents and their stories. The approach allowed the researchers to locate the relevant respondents for the study after conducting the survey. Questionnaires were used to collect data from the survey respondents. The questionnaires had mainly closed-ended questions, although some questions allowed for multiple responses. The rationale for providing multiple-choice responses was to enable respondents to provide uniform answers for easy coding and analysis. The questionnaires elicited data on socio-demographic characteristics, pregnancy status, social environment, personal knowledge and skills as well as the personal experiences of the adolescents. In addition, the questionnaires accessed data on the resilience level of each respondent. To categorize adolescent girls as high or low resilience, a resilience scale constituting eight sets of questions was included in the survey questionnaire to measure the competence of girls to avoid pregnancy. The scale was used to measure the various resources available to girls, their success at accessing these resources and their success in using them to avoid teenage pregnancy. As such, girls who had an average mark and above were classified as high-resilience and the rest as low-resilience girls. Since most of the questions in the questionnaire were pre-coded, only the open-ended questions were coded after the collection of data. Data were coded, analysed and entered into the computer using Epi Info Version 3.5.4 software for quantitative data analysis.

For the qualitative part of the study data were collected using the interview guide, which further probed the survey results. This afforded the respondents the opportunity

to tell their stories about how they developed resilience to teenage pregnancy. The respondents were interviewed in their homes with their parents' consent. This reduced anxiety and facilitated free discussions. The respondents' own consent was also sought. After going through the pleasantries with parents a private space was selected for the one-to-one in-depth interviews. In all only ten adolescent girls were selected for in-depth interview; these girls were from the 419 survey respondents and were purposively selected based on their resilience scores in the survey. This group of girls was selected to give a detailed explanation and insight into how they developed resilience against sex, teenage pregnancy and motherhood. Since the in-depth interviews were conducted in the local language, Twi, the audio-recorded responses were transcribed into English and typed into Microsoft Word for analysis.

Results

Table 1 shows the sources of social capital reported by the survey participants. The survey data reveal that 85% of the non-pregnant girls believed they had the ability to establish and maintain relationships with people they could ask for advice on sexuality and teenage pregnancy. Girls had access to social capital from various sources. They received such support from relevant sources such as parents, other relatives, teachers or religious leaders to avoid or overcome the risk of sex and teenage pregnancy. Parents stood out as the main source of social capital for non-pregnant girls, with other relatives (24.1%) being the second highest. The study found that 15% and 9.8% of the adolescent girls identified their peers and boyfriends, respectively, as a source of social capital. Only 17.2% of the non-pregnant girls mentioned their teachers as providing them with social support through advice and encouragement on sexual and reproductive health matters; 11.5% cited their religious groups as a source of social capital. The least identified source of social capital for adolescent girls was nurses/doctors (2%).

The role of familial support

The results show that 74.6% of the high-resilience non-pregnant girls and 38.6% of the low-resilience non-pregnant girls identified their parents as a source of social capital (Table 1). Parents provided social support for their daughters through advice and social control mechanisms and served as people girls could trust and rely on for social support. The following narratives confirm this:

> All my siblings are girls so my mother occasionally sits us down and advises us to abstain from sex and be careful with boys or else we will end up with teenage pregnancy. (Yaayaa, high-resilience non-pregnant girl, in-depth interview, Begoro)

> My parents advise me to concentrate on my studies and they provide me with whatever I need. My father has threatened to disown me if I become pregnant because I am not matured enough to have a baby. (Frema, high-resilience non-pregnant girl, in-depth interview, Begoro)

> If you have someone like your parents to advise you on teenage pregnancy, it can help you to stay away from men. (Kuukua, low-resilience non-pregnant girl, in-depth interview, Begoro)

Table 1. Sources of social capital reported by non-pregnant adolescent girls, Begoro, Ghana, 2012

Source of social capital	Total sample *n* (%)	High-resilience girls *n* (%)	Low-resilience girls *n* (%)	*p*-value
Number of girls	419	209	210	
Parents	237 (56.6)	156 (74.6)	81 (38.6)	<0.001
Other relatives	101 (24.1)	60 (28.7)	41 (19.5)	<0.001
Teachers	72 (17.2)	45 (21.5)	27 (12.9)	0.028
Peers	63 (15.0)	24 (11.5)	39 (18.6)	ns
Religious group	48 (11.5)	37 (17.7)	11 (5.2)	<0.001
Boyfriends/partners	41 (9.8)	21 (10.0)	20 (9.5)	ns
Others	19 (4.5)	14 (6.7)	9 (4.3)	ns
Nurses/doctors	11 (2.0)	9 (4.2)	2 (1.0)	ns

ns, non-significant.

From the narratives presented above, it can be seen that parents often educated their daughters about abstinence from sex and cautioned them against being in a relationship with the opposite sex. The findings suggest that girls who were resilient to teenage pregnancy had parents who provided social support and served as a social control mechanism against risky sexual behaviours that could lead to pregnancy.

Apart from parents, other relatives such as older siblings sometimes gave their younger sisters advice on sexual behaviour and teenage pregnancy. The survey data revealed that 28.7% and 19.5% of the non-pregnant girls who identified other relatives as a source of social capital had high and low resilience scores, respectively (Table 1). For instance, Adwoa, a high-resilience girl who identified her elder sister as providing her with social support, observed:

> I have an older sister who is a hairdresser; she always advises me to stay away from men when I visit her or when she comes to visit us. I ask her questions related to teenage pregnancy and she answers them. (Adwoa, non-pregnant high-resilience girl, in-depth interview, Begoro)

Kuukua, a low-resilience girl, also explained:

> Anytime my sisters see me talking to the opposite sex, they call me and advise me to be careful with them [boys] or else I will end up pregnant in my teenage years. As for one of my sisters, she keeps advising me that if I have sex with a man, I will contract HIV/AIDS… (Kuukua, high-resilience non-pregnant girl, in-depth interview, Begoro)

From the in-depth interviews, it was observed that the majority of the non-pregnant adolescent girls identified their sisters as a source of advice. Other relatives, specifically older siblings, provided social support to younger ones through advice to help them avoid sex and teenage pregnancy. This supports previous studies that show that older siblings have an influence on the sexual behaviour and experience of younger siblings (Widmer, 1997; Kowal & Blinn-Pike, 2004).

Statistically, there was a significant relationship ($p < 0.001$) between parents and other relatives as a source of social capital and the resilience of a girl against sex and

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teenage pregnancy (Table 1). This suggests that girls who have access to social support and social control from their parents and older siblings are more likely to avoid risky sexual behaviour and teenage pregnancy. This calls, therefore, for the empowerment of parents and older siblings on how to educate girls since they play an important role in the sexual behaviour of their children.

The role of adolescent girls' networks

In the study, 11.5% of the high-resilience and 18.6% of the low-resilience girls identified their peers as a source of social capital. Thus peers are not a major source of social capital for adolescent girls in their quest to overcome their sexual and reproductive health problems. Peers mainly provided social capital in the form of trust, thus providing advice and suggestions to each other on avoiding risky sexual behaviours. From the in-depth interviews, it was observed that peers provided information on types of family planning programmes available, literature on sexual and reproductive health issues and even assistance on where to get more information about how to avoid teenage pregnancy. Obaa Yaa explained:

> A friend of mine advised me to go and buy 'Life Guide' … It is a book that teaches on how to avoid teenage pregnancy. She [friend] also advised me to go and get a tablet [emergency pill] and it really helped me to protect myself from pregnancy. (Obaa Yaa, high-resilience non-pregnant girl, in-depth interview, Begoro)

In addition, peers who were already pregnant or mothers also provided support in the form of advice to their non-pregnant friends. Asor, who benefited from advice from her peers who were mothers, observed:

> … some of my friends who have babies sometimes shared their experiences of teenage pregnancy and motherhood with me and advise me to be wary of men. My parents and sisters used to advise me to avoid entering into sexual relationship with the opposite sex. It has been a while now, but I usually ask my friends … we discuss it when we meet. (Asor, high-resilience non-pregnant girl, in-depth interview, Begoro)

This notwithstanding, the majority of the non-pregnant girls shared their sentiments on why they rarely discussed issues of sex with their peers. Mansa stated:

> I have many friends both at school and at home. Well we never talk about sex; I think we do not have to discuss such things when we meet … As for me, though I have knowledge on sex and pregnancy I keep it to myself or else my friends will think I am having sex with boys … (Mansa, low-resilience non-pregnant girl, in-depth interview, Begoro)

Peers have an influence on adolescents' sexual and reproductive experiences (Nabila & Fayorsey, 1996; Awusabo-Asare *et al.*, 2004; Sieving *et al.*, 2006). They develop relationships with people in their age bracket at home, in school, at church and in the community at large. Nonetheless, this study found no significant relationship ($p = 0.581$) between peers as a source of social capital and resilience of non-pregnant girls (Table 1). This indicates that peers were not a major source of social support in adolescent girls' resilience against sex and teenage pregnancy. However, if peers are equipped with the right information they could have a positive impact on the sexual behaviour of their friends and colleagues.

Statistically, there was no significant relationship between boyfriend/partner as a source of social capital and resilience level (Table 1). However, those who identified their boyfriend/partner as a source stated that they sometimes supported them by using condoms when they had sexual intercourse. According to Asor, a high-resilience girl, her boyfriend was supportive in their sexual relationship because he encouraged her to buy condoms and even gave her money to do so. Asor explained:

> He [boyfriend] has no problem with us using condoms during sex; sometimes he even gives me money to buy them [condoms]. (Asor, high-resilience non-pregnant girl, in-depth interview, Begoro)

Asor relied on advice and information she received from various sources, especially those who had experienced childbirth, and used condoms to prevent pregnancy. In Asor's case, her boyfriend accepted the use of condoms, which made it easier for her to protect herself from teenage pregnancy and sexually transmitted infections.

The role of organizations

There were no specialized institutions for adolescent sexual and reproductive health in the study area. However, educational, religious and health institutions in the community provided social support and sometimes served as a social control mechanism for the adolescent girls who associated with them. Teachers provided advice on how girls should relate to the opposite sex, both in and out of school, to avoid pregnancy. In addition, teachers taught adolescent girls how to avoid pregnancy and sexually transmitted infections as part of the school syllabus. Thus, 21.5% of the non-pregnant girls who identified their teachers as a source of social capital had high resilience scores, whereas 12.9% had low resilience scores. Adwoa and Yaa, who had high resilience scores, illustrated how their teachers supported them in the following narratives:

> They [teachers] teach us those things [sexual and reproductive health] at school. The teachers teach us how to use condoms to protect ourselves and how to access family planning. They also teach us that we can buy medicine at the pharmacy shop to prevent pregnancy. (Adwoa, high-resilience non-pregnant girl, in-depth interview, Begoro)

> They [teachers] teach us that if we have sex we can get pregnant or a sexually transmitted infection. They also make time to teach us how to avoid teenage pregnancy and they advise us to concentrate on our studies … (Yaayaa, high-resilience non-pregnant girl, in-depth interview, Begoro)

The low-resilience girls also corroborated this:

> I am in JHS 1. Sexual and reproductive health is part of our science syllabus … We were taught in our science class that if you want to avoid teenage pregnancy you could use a condom or take a pill. (Mansa, low-resilience non-pregnant girl, in-depth interview, Begoro)

Sexual and reproductive health education is part of the school syllabus and therefore it is expected that because a large number of the respondents were in school, they would

identify their teachers as a source of social capital on sexual and reproductive health issues. This notwithstanding, teachers still contributed to non-pregnant girls' resilience, since 21.5% of girls with high resilience scores compared with 12.9% of those with low resilience scores gave teachers as a source of social capital. Statistically, teachers as a source of social capital was significantly ($p = 0.028$) related to adolescent girls' resilience to sex and teenage pregnancy (Table 1). This suggests that girls who received social support in the form of advice and encouragement from teachers were more likely to avoid the risk of sex and teenage pregnancy than girls who did not.

The study found that of the non-pregnant girls who gave religious group as a source of social capital, 17.7% had high resilience scores and 5.2% had low resilience scores (Table 1). Religious leaders preach chastity before marriage, which probably helps adolescent girls overcome the risk of sex and pregnancy. Those girls with access to social capital from their religious groups indicated that they were educated about how to live a life of chastity. Yaayaa, who was a member of the Ladies' Wing of her church, shed light on how the teachings and advice from her religious group helped her to avoid pre-marital sex, and for that matter teenage pregnancy:

> We have a Ladies' Youth wing headed by the pastor's wife and she teaches us on these things [premarital sex and teenage pregnancy] … I am a member of the Ladies' Wing of my church and our leader admonishes us against premarital sex. Because of this, I always strive to maintain a good reputation ... and we have specific days that we meet for these teachings. (Yaayaa, high-resilience non-pregnant girl, in-depth interview, Begoro)

On the other hand, Akosua, a low-resilience girl, observed that although she was a member of the youth wing of her church, she did not receive advice or teachings on sex and teenage pregnancy from the leaders of her church. She said:

> I am in Junior Youth at my church but they do not teach us these things. Our leaders are silent on issues about sex and pregnancy. (Akosua, low-resilience non-pregnant girl, in-depth interview, Begoro)

However, Frema summed up the views of the other girls, and why only 11.5% identified religious leaders as a source of advice:

> The leaders sometimes try to advise us at the mosques, but they do not do it frequently otherwise, the pregnant teenagers will complain that the elders just want to condemn them. (Frema, high-resilience non-pregnant girl, in-depth interview, Begoro)

Although girls may be affiliated to religious groups, not all religious leaders give advice on sex and teenage pregnancy. The narratives of the adolescent girls explain why, despite 72.0% of the non-pregnant girls asserting that religious beliefs helped them to avoid pregnancy, only 11.5% identified their religious group as a source of social capital (Table 1). Statistically, religious leaders' advice is significantly ($p < 0.001$) related to non-pregnant girls' resilience against teenage pregnancy (Table 1). This suggests that girls who receive support in the form of teachings and advice from their religious groups on abstaining from sex are more likely to avoid the risk of sex and teenage pregnancy.

Although health professionals had information and should have been one of the major sources of social capital for non-pregnant girls, they were the least likely source from which girls received support on their sexual and reproductive life. In all, only 2% of

the non-pregnant girls identified nurses/doctors as a source of support (Table 1). Yaa explained:

> I ask … some of the nurses who are my friends about some of the medications that can help me avoid pregnancy and they teach me the side effects of such medications. (Yaayaa, high-resilience non-pregnant girl, in-depth interview, Begoro)

According to Yaayaa, she relied on her friendship with some nurses to seek information on how to protect herself from becoming pregnant. Thus, those who got support from health professionals were those who had a relationship with them through either family ties or friendship. This can be attributed to the normative culture of the Ghanaian society that does not expect children to ask questions about sex, let alone procure sex-related materials like condoms (Adomako Ampofo, 2001). This suggests that non-pregnant girls only sought the services of health professionals at health centres.

Discussion

In this study's analysis parents stood out as the largest source of social capital for non-pregnant adolescent girls in this region of Ghana. Society expects parents to perform their roles as primary agents of socialization by inculcating in their children the norms and values of a society. As such, parents, by performing their 'expected' duties, provide their children with access to social capital, which depends on the relationship between adolescent girls and their parents. Adolescents from supportive families will have greater access to social support from their parents than those from 'dysfunctional' families (Alvord & Grados, 2005; Jenson *et al.*, 2011). Other relatives such as aunts, uncles and grandparents have been the focus of most studies in Ghana on the influence of other family members on adolescent sexual and reproductive health. The present study highlighted the role of sibling relationships in protecting adolescents from risky sexual behaviour. However, sibling relationships seem not to have received much attention in Ghana, although the current findings suggest that they might have the potential to reduce risky sexual behaviour (Widmer, 1997; Kowal & Blinn-Pike, 2004; Kumi-Kyereme *et al*., 2007). Adolescent girls tend to feel more comfortable asking their siblings questions on sex-related matters than speaking with their parents (Kowal & Blinn-Pike, 2004). This is because siblings are seen to be less critical or punitive and the relationship is more informal and cordial. Thus, where older siblings have a healthy sexual life, the tendency for their siblings to follow that path is high. Older siblings have an influence on their younger siblings based on familial ties as well as the normative value of respect for older people. Sibling relationships become functional in adolescents' sexual behaviours depending on the quality of relationship in terms of trust, respect and familiarity. The social environment enables the quality of the relationship; younger siblings look up to older siblings on matters such as sex-related issues. This supports previous findings that adolescents are connected more with family than non-family members (Awusabo-Asare *et al*., 2004; Kumi-Kyereme *et al*., 2007).

However, this contradicts Kumi-Kyere *et al.*'s (2007) finding in Ghana that adolescents communicated more with non-family members on sex-related matters. This study found that, despite the limited communication of adolescents with their parents on sex-related matters, parents' interest in their daughters' lives serves indirectly as a source

of social control, which prevents risky sexual behaviour. Family members also provide social support and other services for adolescent girls that have the potential to reduce their exposure to sex-related risk. When parents show an interest in their daughters' lives, it prevents them from engaging in risky sexual behaviours because they do not want to bring shame to their parents (Majumdar, 2006). Adolescent girls, in their bid to meet the expectations of their family, may abstain from sex or use contraception to protect themselves from unwanted sexual outcomes (Coleman, 1988; Portes, 2000; Majumdar, 2006; Kumi-Kyereme *et al*., 2007; Biddlecom *et al*., 2009).

This study found, as have other studies, that parents only communicate a little with their daughters on sex-related issues, and then only on abstinence, which can expose adolescent girls to risky premarital sex (Adomako Ampofo, 2001; Awusabo-Asare *et al*., 2004; Kumi-Kyereme *et al*., 2007). Though such one-sided (abstinence only) sex education can leave girls with superficial knowledge about their sexuality, and perhaps partially informed about how to avoid risky sexual behaviours (Hindin & Fatusi, 2009), parents' interest in the well-being of their children provides social support and control that discourages risky sexual behaviour. This suggests that family background and resources influence adolesents' sexual and reproductive life.

By participating in institutional activities, adolescents widen their networks and develop relationships that can be beneficial or otherwise to their sexual and reproductive lives. Adolescents are prepared to discuss or seek advice on sexual and reproductive health issues from their peers because they 'understand' them better and are ready to listen without being judgemental (Kumi-Kyereme *et al*., 2007). However, when peers' influence was narrowed down to best friends, Madjumar (2006) observed that they provide social support that protects adolescent girls from risky sexual behaviours. Though the present study did not specifically look at the influence of best friends, but at friends in general, similar findings were found. Peers who had experience provided social support in the form of advice to shelter them from a variety of undesired outcomes. The results of some studies indicate that peers who were pregnant or mothers sometimes had a negative influence on their non-pregnant peers (Arai, 2003; Domhnaill *et al*., 2011). The present study found that such associations were helpful when such peers had the right information; non-pregnant girls sometimes received advice from teenage mothers on how to avoid pregnancy. Adolescent girls who had experienced childbirth and were facing challenges were good peer counsellors.

Although in their study in Burkina-Faso, Ghana, Malawi and Uganda Bankole *et al*. (2007) identified teachers as the major source of information for adolescents on sexual and reproductive health issues, this was not the case in the present study. According to Agyei *et al*. (2000), teachers make sex education lessons abstract, resulting in girls not being able to reconcile what is taught with real-life experience. The quality of the resources accessed from one's source of social capital is key to developing resilience (Bourdieu, 1986). Teachers have the potential to be a good source of social support for adolescent girls since they have the opportunity to teach both abstinence and protection in sexual relationships.

Membership of a religious group allows girls to participate in, and benefit from, teachings on abstaining from sex before marriage, which served as a social control mechanism that helped girls to avoid teenage pregnancy. The small number of adolescent girls who identified nurses/doctors as a source of social capital was expected

because this group of respondents were not pregnant and therefore had little or no interaction with nurses and doctors. Thus, girls who identified these health workers as a source of support had an existing relationship with them and appropriated the resources to their advantage.

In conclusion, familial ties and membership of religious and educational institutions make social capital accessible to non-pregnant adolescent girls. These associations become a source of social support and social control for girls. Thus, high-resilience adolescent girls rely on their access to social capital in the form of social support and social control from their relationship with parents, older siblings, teachers and religious groups to avoid the risk associated with premarital sex. Exposure to these risks is avoided or adjusted to in two ways: either by abstinence or by the use of contraceptive pills or condoms. Those who abstain from sex in order to avoid risk are able to do so because of the interactions they have with their parents, older siblings, teachers and religious leaders.

Parents and religious leaders provide social support as well as serving as a social control mechanism for girls to avoid risky sexual behaviours. Parents tend to advise their daughters to stay away from sexual relations to avoid pregnancy, which does not usually include advice on the use of contraceptives to protect them in case they do engage in sexual activities. This is because parents belong to older generations that hold on to traditional values in most Ghanaian societies, where girls are expected to remain chaste until marriage. Thus, teaching adolescent girls how to use condoms may suggest encouraging them to engage in premarital sexual relationships, and this is against the values and norms of the society (Glover *et al*., 2003; Morhe *et al*., 2012). Teachers and older siblings, on the other hand, do not limit their advice on sexual behaviour to abstinence, but extend it to the use of protection during sex to avoid sexually transmitted infections and pregnancy. Since teachers do not focus solely on abstinence, girls are able to use their advice to protect themselves when they have sex.

The non-pregnant girls in this study did not rely on just one source for social capital, but accessed it from different sources. It is recommended that for adolescent girls to benefit more from their relationship with their parents on sexual and reproductive health issues, parents should be encouraged to teach their daughters not only about abstinence but also about how to use protection. Furthermore, since teachers tend to play a key role in adolescent girls' sexual and reproductive life, they should be trained to handle such topics well in order to influence adolescents' sexual behaviour. Teachers, nurses/doctors, siblings and peers must be empowered to disseminate such information on abstinence and protective sex in ways that would benefit adolescent girls.

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