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INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH (ISSER)

UNIVERSITY OF GHANA, LEGON

**ADOLESCENTS' KNOWLEDGE, ATTITUDES AND PERCEPTIONS REGARDING
SEXUAL AND REPRODUCTIVE HEALTH AND TEENAGE PREGNANCY IN LA,
GREATER ACCRA REGION**

BY

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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MA
DEVELOPMENT STUDIES DEGREE.**



DECEMBER, 2018

DECLARATION

I, **Abdul-Hamid Ibrahim**, hereby declare that this thesis titled “Adolescents’ knowledge, attitudes and perceptions regarding sexual and reproductive health as well as teenage pregnancy in La, Greater Accra Region” is a product of my research carried out at the Institute of Statistical, Social and Economic Research (ISSER) of the University of Ghana under the supervision of Dr Ama Fenny. With the exception of references that were made to other people’s scholarly works which were duly acknowledged, I declare that this dissertation has not in part or whole been submitted for the awarding of a degree in Ghana or elsewhere.

.....

Date.....

Abdul-Hamid Ibrahim (Student)

.....

Date.....

Dr. Ama Pokuaa Fenny (Supervisor)

DEDICATION

This work is dedicated to the almighty Allah and my family who have been my support all along.

ACKNOWLEDGEMENT

There are some key individuals who have contributed immensely to the completion of this dissertation with the first of them being my lecturer and supervisor, Dr Ama Pokuaa Fenny. Her immense guidance and patience from the onset of this dissertation writing to the very last day of its submission is one that I really appreciate and cannot ever forget. For this, I say a big thank you and may God bless you beyond measure. The other persons whom I need to acknowledge again are my lecturers at the Institute of Statistical, Social and Economic Research (ISSER) who have supported me in diverse ways aside imparting me with knowledge. Finally, I will also acknowledge a lot of my good friends both on and off campus who continuously helped me in their own small ways to complete this dissertation.

ABSTRACT

This study came about as a result the identification of the persisting problem of teenage pregnancy in La. The study sought to assess adolescents' knowledge, perception and attitudes of sexual and reproductive health (SRH) in the La community. To achieve this purpose, 386 teenagers (15-19 years) living in La were purposively selected from schools as well as some key informants (counsellors and peer educators) through a multi stage sampling technique. Data was gathered from the students through the use of a structured questionnaire whilst data was obtained from the key informants through the use of interviews. The data that was gathered was analysed using inferential and descriptive statistics. Results from the study showed that majority of the respondents did not have much knowledge about modern family planning methods, how to use contraceptives and the menstrual cycle. Majority of them had begun consuming alcohol, watching pornographic films, engaging in sexual activities as well as not using contraceptives whilst having sex. Also, most of the respondents had the perception that becoming pregnant or impregnating someone was a way of proving one's fertility. They also had the perception that their families would support them in case they either got pregnant or impregnated someone. In relation to the teenage pregnancy situation in La, it was found that there was an association between teenage pregnancy and the adolescents' knowledge of STDs/STIs, how to prevent STDs/STIs, knowledge of contraceptives, entering into sexual relationships, engaging in sex, not using contraceptives whilst having sex and the perception that pregnancy proves one's fertility. A probit regression that was run further showed that sex of the respondents, educational backgrounds of the respondents and living with non-relatives all had marginal effects on the teenage pregnancy situation in La. It also showed that there was a positive relationship between teenage pregnancy in La and the risky sexual behaviour exhibited by the teenagers of La.

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LIST OF ABBREVIATIONS

ADHD	National Adolescent Health and Development Programme
AIDS	Acquired Immune Deficiency Syndrome
CD	Compact Disk
CEDPA	Centre for Education and Development of Population Activities
ECP	Emergency contraceptive pills
EU	European Union
GHS	Ghana Health Service
GSS	Ghana Statistical Service
GUNSA	Ghana United Nations Students Association
HIV	Human Immune Virus
ISSER	Institute of Statistical, Social and Economic Research
JHS	Junior High School
KAP	Knowledge, Attitudes and Perception
LADMA	La Dade-Kotopon Municipal Assembly
MFCS	Muslim Family Counselling Services
NaRCIE	National Resource Centre for Inclusive Education
SHS	Senior High School
SRH	Sexual and Reproductive Health
UN	United Nations

UNFPA	United Nations Population Fund
WHO	World Health Organization
YMCA	Young Men Christian Association
YWCA	Young Women Christian Association

CHAPTER ONE

1.1 BACKGROUND OF THE STUDY

Globally, sexual and reproductive health have been given a lot of attention due to the numerous implications it has on the state of the world in terms of population growth, economies of countries as to how and where to allocate most of their resources, planning for these populations and individuals' decision making and expenditure (Hadi, 2017). The population of the world in 2017 stood at 7.5 billion with the population of the youth being 1.2 billion people (Kenada & Dupuis, 2017). On a world wide scale an average of 16 million girls in their late adolescence give birth annually accounting for 11% of all births with the majority of these births coming from low and middle income countries (UNICEF, 2010). This notwithstanding, pregnant teenage girls stand a higher chance of having difficulties during pregnancy and the children born to them also stand a greater chance of falling sick or dying (Ghana Demographic and Health Survey, 2014).

Data from the World Bank in 2015 indicated that adolescent birth rates for sub-Saharan Africa was 100 births per every 1,000 women in their late adolescence making it the highest in the world (World Bank, 2016). Twenty thousand girls below age 18 give birth daily in developing countries resulting into 7.3 million births per annum (United Nations Population Fund [UNFPA], 2018). The rate of adolescent births per 1000 women aged 15 to 19 in 2015 stood at 21% for America, Canada (9%), China (7%), Ethiopia (56%), Costa Rica (56%), Mexico (62%) and 10% in Qatar (World Bank [WB],2016). In Ghana, data from the demographic and health survey (2014) indicated that 14% of women between the ages of 15 to 19 years had begun childbearing with childbirth among teenagers in rural areas (17%) being higher than that of their counterparts in the urban areas (12%) (Ghana Statistical Service [GSS], 2015, pp. 69-70.).

The adolescent stage is a crucial period in the lives of human beings (Mirghafourvand, Charandabi, Sharajabad & Sanaati, 2016). In some cultures, this is the period in which the individual is gradually ushered into adulthood. It therefore marks a transition of physiological, emotional and psychological wellbeing (Shore & Shunu, 2017). The age at which the transformation begins, however, varies significantly among individuals (Stang & Story, 2005), mostly due to differences in nutrition and genetics/hereditary factors (McCauley, Salter, Kiragu & Senderowitz, 1995).

Historical data from Europe and the United States of America indicates that since the 19th century, the age of menarche has in every 10 years reduced by 2 to 3 months (Wyshak & Frisch, 1982). According to Chen et al. (2007), this resulted in a reduction of up to 3 years in the age at which adolescents in America and Europe began to menstruate. This reduction in age of menarche was said to be influenced by improvement in nutrition and healthcare (McCauley, Salter, Kiragu & Senderowitz, 1995). The adolescence stage happens to be one of the most precarious for such young teenagers who are exposed to many dangers that can adversely affect their lives (National Research Council, 2011). Their desire to be free from parental control and curiosity often lead them to unhealthy lifestyles (Eccles, Midgley, Wigfield, Buchanan, Reuman, Flanagan & Mac Iver, 1993). For example, some teens learn how to smoke and drink alcohol during this period (Simons-Morton et al, 2001) while others adopt promiscuous lifestyle and begin to engage in sexual activity which ultimately lead to teenage pregnancy, drug addiction, alcoholism and even deaths (Smart & Fejer, 1972; Arain et al, 2013; Acharya et al, 2010).

On a global level estimates show that 214 million women from developing countries are unable to meet their family planning needs due to cost or poverty (Guttmacher Institute, 2017). For example, a study showed that as of 2014 the cost of providing services related to modern contraceptives, maternal and new-born health care, health care for HIV among pregnant

women and their new-born babies as well as treatment for four common STIs totalled \$18.7 billion in developing countries alone (Singh, Darroch & Ashford, 2014). According to the World Health Organization sexual health is not just the absence of disease, dysfunction or ill health but it includes the state of physiological, emotional, psychological and social well-being in relation to sexuality. It encompasses being able to have a healthy sex life that is not forced or discriminated against (WHO, 2006).

Reproductive health on the one hand includes a state of total physiological, psychological and social well-being in relation to the reproductive system and the function it plays (WHO, 2006). Due to the importance attached to teenage sexual and reproductive health globally, attempts were made by the United Nations (UN) to give it some legal backing and ensure it was factored into the health care needs and plans of the health care sectors of various countries (Guttmacher Institute 2017; Singh, Darroch & Ashford, 2014). Therefore, the UN General Assembly Special Session on Children in 2002 decided to formulate and enforce adolescent health programs and policies that would promote their overall wellbeing (Morris & Rushwan, 2015). It is no disputable fact that risky sexual behaviours have multiple negative implications, both on the individual and the family or relatives of the individual involved. According to Mirzaei et al, (2016), such implications may include negative outcomes that affect others other than the individual engaged in it such as break ups of relationships, family disputes, constitutional redress and monetary challenges (Mirzaei et al, 2016). This kind of behaviour can be as a result of peer influence, bad parenting, alcohol and substance abuse, unavailable information to the adolescents, watching of pornography or even living arrangements in their homes (Ugoji, 2014; Doku, 2012; Cooper, 2002; Oluwatoyin, & Modupe, 2014; Ritchwood et al, 2015; Shore & Shunu, 2017).

With respect to the above, there has been an intensive drive to create more awareness about the need to place more importance on sexual and reproductive health issues among people from

various backgrounds, race, religions, occupations and nationalities (Shand et al, 2017; UNICEF, 2012). This has been championed by international organizations, non-governmental organizations, faith based organizations, academics, governments and individuals (Cameron & Bond, 2002; PPAG, 2016).

In Ghana, promoting issues of sexual and reproductive health remain a priority agenda of the Ghana Health Service, Ministry of Health, Planned parenthood association of Ghana, Human rights advocacy centre, Marie stopes international Ghana, USAID among other private organisations (Cameron & Bond, 2002). As such, a lot of work has been done in several parts of Ghana particularly in the rural areas regarding sexual and reproductive health (Aninanya et al. 2015; Gyesaw & Ankomah, 2013; Rondini & Krugu, 2009). Most existing studies have examined issues of family planning, contraceptive use, ante natal and post-natal care, mother-child mortality, exclusive breast feeding and adolescent health programmes (Guttmacher Institute, 2017; Singh, Darroch, & Ashford, 2014; Darroch et al, 2016).

Others (Acharya et al, 2010; Mirzaei et al, 2016; Ritchwood et al, 2015; Shore & Shunu, 2017; Ugoji, 2014) have studied the causes and effects of risky sexual behaviour and its link with teenage pregnancy. What this study seeks to do is therefore to examine how the knowledge and perceptions the teenagers of La have about sexual and reproductive health could make them engage in risky sexual behaviours that can ultimately lead to a negative outcome such as teenage pregnancy.

1.2 Problem statement

Teenage pregnancy is a phenomenological problem that thwarts individual, societal and national progress due to its associated social, economic, emotional, psychological and health problems. Besides exposing perpetrators to sexually transmitted diseases and infections it has

the tendency to induce maternal and under-five mortality (Daniels, 2015; Loaiza & Liang, 2013; Gyesaw & Ankomah, 2013). Though teenage pregnancy has been researched into in different parts of Ghana, especially in rural and indigenous communities, by many scholars (Keller, Hilton & Twumasi-Ankrah, 1999; Gyan, 2013; Gyesaw & Ankomah, 2013; Krugu et al, 2016; Sowah, 2016) with poverty being cited as one of the major causes of pregnancy, this study will rather like to look at the teenage pregnancy situation in La (an indigenous community) by looking at the knowledge and perceptions teenagers there have about SRH and how this may lead them to engaging in risky sexual behaviours which could ultimately lead to pregnancy. Information available from the 2010 population and housing census on the La Dade-Kotopon municipality showed that as far back as 2010 the municipality had a high teenage pregnancy rate of 568 births in that year alone (GSS, 2014). Information obtained from the District Health Information Management System (DHIMS 2) showed that the rate of teenage pregnancy in the municipality had over the years been decreasing till 2017. In 2014, 2015 and 2016, a figure of 445, 384 and 282 teenage pregnancies were recorded respectively. However, in 2017, the figure increased to 303. Amongst adolescents (10-14 years) there were 16 cases recorded and 287 cases recorded for adolescents (15-19 years). The information available at the municipal health directorate of the La Dade-Kotopon municipality as well as the La General hospital showed that most of the teenage pregnancy cases have consistently over the years come from the indigenous suburbs of south La such as Agbawe, Apaapa, Burkina, Abafum and Kojo Abesse. This point was also reiterated in a brief discussion with one of the officers of the social welfare department of the municipal assembly and an officer at the municipal health directorate who both expressed concerns that despite the numerous programs embarked on by the municipal assembly over the years in those communities in La to address the issue of teenage pregnancy, the problem still persists. Therefore, the question that comes to mind is why is it mostly teenagers from the indigenous suburbs of La who have

over the years consistently fallen victim to teenage pregnancy than their counterparts in other areas within the municipality such as Burma camp, Labone, Cantonment or South La estate? With the known dangers associated with teenage pregnancy on the teenagers, their families and the community as well as the efforts being made to drastically reduce it by the Ghana Health Service, the La Dade-Kotopon municipal assembly and other non-governmental organizations, it is quite worrying that teenage pregnancy has persisted over the years in the southern part of La. This warranted the need to conduct this research to investigate the knowledge and perception gaps among teenagers to understand their views on SRH and how it leads them to engaging in risky sexual behaviours which could ultimately lead to pregnancy.

Table 1.0 Trend of teenage pregnancy in La Dade-Kotopon

YEAR	AGE DISTRIBUTION			REGISTRANTS	ATTENDANCE
	10-14	15-19	20-24		
2014	12	433	1947	8793	44381
2015	12	372	1424	7600	49267
2016	9	273	1150	6662	44093
2017	16	287	1073	5640	39578

Source; District Health Information Management System (DHIMS 2) of Ghana

1.3 Research questions

1. What knowledge and perceptions do adolescents in La have about sexual and reproductive health?
2. What are the attitudes (risky sexual behaviours) that these teenagers in La exhibit?
3. Does their knowledge, perceptions and attitudes about sexual and reproductive health help reduce incidence of teenage pregnancy?

1.4 Research objectives

1.4.1 General objective

The general aim of the study is to assess adolescents' knowledge, perceptions and attitudes of sexual and reproductive health (SRH) and its linkage with teenage pregnancy in the La community.

1.4.2 Specific objectives

More specifically the study is meant to:

- Ascertain the knowledge and perceptions of sexual and reproductive health among adolescents in La.
- Examine sexual and reproductive health attitudes among adolescents in La.
- Identify other factors contributing to teenage pregnancy in La.

1.5 Hypothesis

Ho: there is no relationship between the knowledge, perceptions and attitudes towards sexual and reproductive health (SRH) and teenage pregnancy in La.

1.6 Rationale of the study

There have been several studies such as that of Chen et al., (2007) and Goonewardene & Deeyagaha Waduge (2005) that have highlighted the many negative effects of teenage pregnancy on the individual, the family, community and nation as a whole. It is a problem that is continuously being addressed by bodies such as the World Health Organization, the Ghana Health Service, the La Dade-Kotopon municipal assembly and many non-governmental organizations in the country. Even though teenage pregnancy is high in the La Dade-Kotopon

municipality, most of the cases recorded come from the indigenous suburbs of south La. This according to the municipal health directorate of the La Dade-Kotopon municipality has been the trend for some years now. Though the municipal assembly has organized some programs to address teenage pregnancy in the municipality, there has not been a comprehensive research in La that looks at the knowledge, perceptions and attitudes exhibited by the teenagers towards SRH and how this could ultimately lead to teenage pregnancy. Therefore, this study will try to provide reliable micro data to inform policy on ways to check sexual reproductive behaviours among adolescents. This will also have bearing on reducing the hardship and other effects that accompany irresponsible sexual and reproductive behaviours as the country seeks to improve the lives of the youth in all aspects. The study will also inform parents, religious and traditional leaders within La of the need to pay more attention to sexual and reproductive health education.

1.7 Organization of the study

The organisation of the study follows the institutional standard. In all, the study contains five chapters.

Chapter one presents the background to the study, and highlight the problem statement and relevance of the study. Chapter Two reviews related literature and presents a working conceptual framework for the study. Chapter Three presents the study methodology. Chapter Four will cover the presentation and discussion of results. Chapter Five will present the summary of findings, conclusion and recommendations based on the findings of the study.

1.8 Definition of terms

Adolescence: it is a phase in the life of an individual that is seen as a transition from childhood to adulthood and is usually between the ages of 10 to 19 (Darroch, Woog, Bankole, & Ashford, 2016).

Sexual health: it is a state of physiological, emotional, psychological and social well-being in relation to sexuality and not merely the absence of disease, dysfunction or ill health (WHO, 2006).

Reproductive health: it is a state of total physiological, psychological and social well-being in relation to the reproductive system and the function it plays. It stresses the need for people to have good and safe sex as well as reproduce in any way they want out of their own volition (WHO, 2006).

Teenage pregnancy is defined as a teenaged or under aged girl usually within the ages of 13 to 19 becoming pregnant (WHO, 2006).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature in the area of sexual and reproductive health as well as teenage pregnancy. This will be done based on the first three specific objectives as themes. There is a section on the knowledge and perceptions of sexual and reproductive health, risky sexual behaviour and other factors leading to teenage pregnancy.

2.2 Knowledge and perception of sexual and reproductive health

This section seeks to review literature on the knowledge and perceptions adolescents have about sexual and reproductive health from all parts of the world. It will be divided into three parts with the first part looking at the global picture, followed by the African context and finally the Ghanaian context.

The National Resource Centre for Inclusive Education (NaRCIE) of Belize in partnership with the United Nations Population Fund (UNFPA) in 2010 conducted a study among hearing impaired adolescents and adults to determine their knowledge, attitudes and practices concerning sexual and reproductive health as well as HIV/AIDS in the country. One hundred and twenty hearing impaired persons were selected for the study and a mixed method was used for collecting the data. Results from the study showed that there was a gap in these adolescents' knowledge of STIs and HIV/AIDS, high incidence of early sexual debut as well as a high rate of forced sex among both sexes. It was also observed that drug and alcohol use contributed to risky sexual behaviour amongst the respondents. Findings on their knowledge of sexual and reproductive health showed that out of the 72 people interviewed, about 80% of them were not aware of any of the STDs they were questioned on with 62.5% of them not knowing how HIV

is contracted. About 70% of the respondents actually believed that HIV could be transmitted through mosquito bites, hugging an infected person or eating from the same plate of an infected person. More than half of the respondents did not also know how to access preventive methods as well as sexual and reproductive health services (Ysaguirre, 2010).

Similarly, Agampodi, Agampodi and Piyaseeli (2008) emphasized in their study conducted in Sri Lanka that knowledge on sexual reproductive health services was lacking among adolescents especially boys. The few girls who had some knowledge about sexual reproductive health however did not know that they could seek service from a youth centre in the public health facility (Agampodi et al., 2008). Villalobos et al. (2017) revealed that one way to improve knowledge about reproductive health among adolescents is through counselling services. This is reflected in the views held by Hull, Hasmi and Widyantoroc (2004) who stated that in Indonesia, knowledge about adolescent reproductive health had improved significantly through counselling services by the Indonesian AIDS Foundation.

Johnson et al. (2015) explored the perceptions of adolescents on family planning in Boston and found that even though 90% of the adolescents interviewed knew of how to use condoms, 50% of them did not know how other contraceptives worked. Also, 65% of the respondents had misconceptions about the timing of pregnancies and the menstrual cycle. The few who had some understanding admitted they received such education from their schools and parents. Shanbhag et al. (2012) in their study tried to assess the perceptions and practices regarding menstrual hygiene among some selected teenage high school girls in Bangalore, India. They found that out of the average teenage high school girl who begins menstruation at age 15, only 28.7% actually had knowledge regarding how to manage themselves during such period. Of those with some knowledge, 57.9% acquired such knowledge before their first menstrual cycle with only 44.1% of them using sanitary pads during their periods. Mothers were the number one source of information regarding menstruation to these adolescents' whilst there was a lot

of ignorance, unsafe practices and false perceptions about menstruation among these teenage girls largely fueled by existing cultural factors (Shanbhag et al., 2012). In another study by Houston et al. (2006) among some selected urban adolescent females in the United States of America, the findings showed that the teenage girls were more concerned about premenstrual syndrome, menstrual disorder, dysmenorrhea, excessive bleeding and lengthy menstrual periods. Even though information on menstruation was given by the various healthcare providers only 2% of the teenagers attempted seeking this information from them.

In a related study, Skrzeczkowska et al. (2015) indicated that many adolescents in Poland began their reproductive health life unaware of the negative outcomes of irresponsible sexual behaviour. Consequently, 52% of sexually active adolescents in the study lacked adequate knowledge on menstrual cycle and contraceptive usage (Skrzeczkowska et al., 2015). The study further revealed that even though various contraceptives exist, the most frequently patronized contraceptive among the adolescents was the condom (Skrzeczkowska et al., 2015). Drawing from another study in Sweden by Aneblom et al. (2002), it was found that 83% of the women sampled knew of the existence of emergency contraceptive pills (ECP). However, the study indicates that more teenagers than those aged above twenty years had heard of it. This means that per the study knowledge of ECP decreased with age as evidenced by the fact that those above 30 years of age had the least knowledge. Further findings pointed to the fact that 22% of the sample had ever used an emergency contraceptive pill with teenagers being more frequent users than women over the age of twenty. Further, most of the women got to know of ECP through their friends and the media. The results however showed that even though 83% of them were aware of emergency contraceptive pills (ECP), only 15% of them used it to prevent pregnancy. This was clearly manifested when close to half of the respondents (43%) admitted undergoing at least one legal abortion prior to the study.

Across Africa, some empirical studies have been conducted to ascertain sexual and reproductive health knowledge. In 2013, Feleke, Koye, Demssie and Mengesha conducted a study in Gondar, Ethiopia and investigated reproductive health service utilization and associated factors among adolescents. The findings revealed that majority of adolescents in Gondar Town (93.4%) had knowledge about family planning services but only 79.5% of the adolescents utilized family planning services. (Feleke et al., 2013). It was indicated that 68.1% of the adolescents utilized contraceptive methods during sexual intercourse with condom being the most used contraceptive (Feleke et al., 2013). Further interesting observation by Feleke et al. (2013) showed that adolescents with secondary education highly understood and utilized family planning methods than those without secondary education. Additionally, voluntary counselling and testing services emerged as key sources of knowledge (Feleke et al., 2013). The findings reflected similar observation by Tilahun et al. (2012) which showed that 80% of the sample in Ethiopia gained similar knowledge through counselling services about sex, family planning and contraceptive usage. Among the adolescents who utilized family planning services were those who had knowledge about family planning and its usage as well as those who frequently had sex (Ansha et al., 2017). Contrary to the above view held by some of the teenagers in Ethiopia concerning family planning services, it had been observed that there had been under utilization of sexual reproductive health services in Eastern Ethiopia among adolescents due to circumstances such as misconceptions, fear, lack of adequate services, lack of school based reproductive health education and traditional practices (Ansha et al., 2017).

In Burundi, Moise et al. (2017) pointed out that across health facilities, adolescent reproductive health services included distribution of educational print materials such as pictures and posters, adolescent examination as well as community outreach on sex education within schools and

communities. These youth friendly services were provided by the Ministry of Health of Burundi (Moise et al., 2017).

Given that many adolescents become pregnant despite the existence of different forms of modern contraceptives, Hounton et al. (2015) assessed modern contraceptive usage among adolescents in Burkina Faso, Ethiopia and Nigeria. The study revealed that adolescents in junior high schools or upper primary residing in urban areas used modern contraceptives as compared to their peers at the upper primary or junior high school level residing in rural areas. In addition, the authors emphasized that modern contraceptive usage was less for adolescents who had been in child marriage with unintended pregnancies (Hounton et al., 2015). With respect to adolescent knowledge on SRH services and organizations engaged in SRH services in Ethiopia, Hounton et al (2015) pointed out that adolescents were provided services relating to implant contraception. According to the authors, the Government of Ethiopia formed the Community Health Extension Workers Program to render services on modern contraception to improve knowledge.

Rondini and Krugu (2009) conducted a study that looked at the knowledge, attitudes and practices of reproductive health of 219 adolescent senior high school students between the ages of 15-24 years in Bolgatanga in the Upper East region of Ghana. The students were selected from Bolgatanga Secondary School (Bigboss), Bolgatanga Technical Institute (Botech), Bolgatanga Girls Senior Secondary School (Bogiss), Zuarungu Senior Secondary School (Zuss) and Zamse Secondary Technical School (Zamsetech). The researchers collected data on their perception of adolescence, male-female relationships, family planning, STIs and HIV/AIDS and vulnerability to sexual violence. Results from the study showed that 20% of the adolescent students did not know much about how HIV/AIDS was transmitted whereas 82.1% of females and 74.7% of the males had not used any family planning methods which they believed exposed them to sexual infections and unwanted pregnancies. They attributed the

situation to low infrastructure and poor accessibility to that part of the country which meant that fewer reproductive education programs were being directed to that part of the country. In concluding they argued that the general awareness and fear of STIs, HIV/AIDS and unwanted pregnancies amongst the students did not necessarily lead to protective behaviour among them since it was found that there was a significant difference between the knowledge that the adolescent students had and the practices that they were engaged in.

Again, Dako-Gyeke and Ntewusu (2012) in their study revealed that some adolescents in Tamale received and perceived as helpful, sexual and reproductive health services such as counselling, family life education, communication and contraceptive use. In addition, adolescents were also engaged in sexual and reproductive health outreach programs (Dako-Gyeke & Ntewusu, 2012). Furthermore, with regards to knowledge and perception of reproductive health services and abortion, it was reported that some of the adolescents lacked knowledge about contraceptive usage and family planning measures and resorted to self-induced abortions or services from unqualified practitioners (Dako-Gyeke & Ntewusu, 2012).

In their exploration of the reproductive health programs for adolescents in Ghana, Cameron and Bond (2002) revealed that some organizations that provided reproductive health services for adolescents in Ghana included the Centre for Education and Development of Population Activities (CEDPA) which collaborated with other non-governmental agencies such as the Ghana United Nations Students Association (GUNSA), the Muslim Family Counselling services (MFCS), the Young Men Christian Association (YMCA) and the Young Women Christian Association (YWCA). These organizations provided reproductive health services such as peer sensitization and education, HIV testing and outreach programs to young adolescents who perceived such services as beneficial (Cameron & Bond, 2002).

Furthermore, it had been suggested by Tabong et al. (2018) that among the reproductive health services provided for adolescents in urban Accra, health education, delivery of sanitary pads to students and counselling services were readily identified by the study participants. In the Western Gonja District in Northern Ghana, lack of knowledge and negative perception about reproductive health service had led to some adolescents risking their lives as shown by Kyilleh et al. (2018) that some adolescents in school as well as those out of school had minimal or no knowledge about sexual and reproductive health compared to those who were in school

On the issue of sexual and reproductive health services in Ghana, the National Adolescent Health and Development Programme (ADHD) had sought to improve adolescent health for young Ghanaians between the ages of 10-24 years by providing them with promotive, preventive, rehabilitative and clinical health care (Ghana Health Service, 2016). Its main objective was to ensure that health care was made available, affordable and accessible to young people wherever they found themselves.

In this vain, Aninanya et al (2015) in their work aimed at assessing the impact of a social learning intervention (that integrated the environment, education, motivation and self-productiveness to change behaviour) on the usage of sexual and reproductive health services among 2,664 adolescents aged 15–17 years from 26 randomly selected communities in the Kassena-Nankana district in the Upper East region of Ghana over a period of 3 years. Some of the twenty-six selected communities were given an intervention consisting of school- based curriculum, out-of-school outreach, community mobilisation, and health-worker training in youth-friendly health services and were compared with the other communities that only had community mobilization and health-worker training in youth-friendly health services. At the end of the research, it was found that participants from the communities that were given intervention had twice the odds of using STI services, 89% greater odds of using perinatal services and 56% greater odds of using antenatal services as compared to the other

communities without the intervention. As such, it was established from the study that to increase the use of sexual and reproductive health services by young people in the selected communities from the Kassena-Nankana district there was the need to use targeted school based and outreach activities in community mobilisation as well as including people engaged in youth-friendly services provision.

From the literature reviewed above on the knowledge and perceptions of adolescents on sexual and reproductive health, it clearly shows that adolescents from different places across the world have little knowledge on contraceptives and its usage, modern family planning methods, sex, the menstrual cycle as well as STDs/STIs and how to prevent them. Some of these have been shown in different studies (Oluwatoyin & Modupe, 2014; Ysaguirre, 2010; Thato et al., 2008) to be link with risky sexual behaviours. This study sought to find if this was the case in La.

2.3 Risky sexual behaviour

This section reviewed literature on some of the risky sexual behaviours that adolescents engaged in that led them to becoming pregnant or impregnating someone else. There were studies that showed the link between risky sexual behaviour and teenage pregnancy such as the works of Oluwatoyin & Modupe (2014), Kotchick et al. (2001), Shore & Shunu (2017), Shelton (2009), Kanku & Mash (2010), Mothiba & Maputle (2012) and Mirzaei et al. (2016). This section showed some of the risky sexual behaviours that adolescents engage in which lead to teenage pregnancy looking at the international, African and Ghanaian scenarios.

Early sexual debut, coital debut or intercourse debut as some call it is one of the factors that is spoken about and attributed to risky sexual behaviour that can easily lead to teenage pregnancy and contracting sexually transmitted diseases among adolescents (O'Hara et al., 2012). Early sexual debut is influenced by several factors. O'Hara et al. (2012) through their study in U.S.A

on the subject matter identified that early exposure of a child to sexual content in movies had a greater chance of leading them into early sexual activity in their adulthood. It was shown that sexually explicit content in movies changed the individual's sensation seeking behaviour by increasing it during their adolescence.

Kastbrom et al. (2015) tried to find out how having sex before the age of 14 could affect some aspects of the lives of adolescents by the time they turned 18. The study involved 3,432 Swedish high school students. At the end of the study it was found that early sexual intercourse was correlated with risky sexual behaviours like having multiple sexual partners, engaging in oral and anal sex, alcohol and drug abuse, smoking as well as anti-social behaviours like stealing, running away from home, lying and exhibiting violent traits (Lansford et al., 2010; Price and Hyde, 2009; Cavazos et al. 2010). The girls in the study experienced more sexual abuse than the boys whereas the boys were more prone to experiencing low self-esteem, poor mental health and weak sense of coherence and physical abuse than the girls by the time they turned 18 years.

Having multiple sexual partners is one of the risky sexual behaviours engaged in by adolescents which have many negative consequences on them and others (Shelton, 2009; Vasilenko & Lanza, 2014). This particular behaviour is one that is exhibited by different people across the world where an individual may either have concurrent or sequential multiple sexual partners (Kelley et al, 2003). Having multiple sexual partners among sexually active adolescents has been shown through many studies to increase their risk of contracting sexually transmitted diseases or infections such as chlamydia, HIV/AIDS and human papilloma virus (HPV) infection leading to cervical cancer (Kann et al, 1995; Mosure et al, 1997; Vaccarella et al, 2006; Kalichman et al, 2007).

Substance abuse is also one factor that has been shown to influence teenage pregnancy by many studies. Vosburg et al. (2015) in their pilot study involving 31 adolescents recovering from opioid addiction tried to look at the development of prescription opioid abuse, its addiction and transition to heroin abuse among adolescents from some Massachusetts Recovery High Schools. Data was collected from them using a self-report questionnaire and statistical tests were then run on the acquired data. Results from the study showed that the substances that were first abused by the respondents before their use and addiction to prescription opioid were alcohol, cannabis and tobacco. The average age for the initiation of prescription opioid abuse was 15 years with 58% of the respondents admitting that they were addicted to some prescription opioid drugs. 72% of those addicted said they were already using marijuana before they started using these drugs with the major reasons that was given by the adolescents for first using these drugs were curiosity and peer influence. These drugs were however obtained from their friends either by buying or stealing them as well as through legal prescriptions. Once acquired, 67% of them admitted that the preferred mode of intake of the drugs was through crushing and sniffing of the drug with 80% of them later becoming addicted to heroin as a result of them altering the use of the opioid drug. Among the 13 identified prescription opioid drugs abused by these adolescents include codeine and tramadol which have now caught the attention of the entire country and is of major concern to all due to the wide spread media reportage of its growing abuse among the youth of Ghana. As such, these two drugs will be part of the substances that the respondents will be questioned on to find out if the adolescents of La were abusing them as well.

In addition, Vasilenko and Lanza (2014), conducted a study among some youth in America from 80 high schools and middle schools in which they tried to find out how the association between depression, substance abuse (tobacco, marijuana and alcohol) and multiple sexual partners changes from mid adolescence to young adolescence. A clustered sampling method was used to select the respondents to ensure that it was representative of the various

racess, ethnicities and regions in America. At the end of the study the results showed that the chances of having multiple sexual partners increased during their teenage years to their early twenties but the association between depression, substance abuse and having several sexual partners reduced with age.

Non-use of contraceptives before, during or after is another risky sexual behaviour that adolescents exhibit in many parts of the world. This was explored by Kimo and Makuria (2017) whom upon exploring the views of some adolescents in Ethiopia on contraceptive use, had their findings revealing that being unmarried and sexually inactive (73%), lack of knowledge (8.3%), religious reasons (6%) and the fear of complications (2.8%) associated with using contraceptives were the reasons given by the adolescents for not patronizing contraceptives. For adolescents who had engaged in abortion before, they did not rely on modern methods, rather they resorted to the traditional methods (Kimo & Makuria, 2017).

Another study by Glynn et al. (2010) sought to look at age at menarche, schooling, and sexual debut in Karonga district of Malawi among 15,570 individuals with results showing that women who had an early menarche (below 14 years) had an early sex debut, dropped out of school earlier and got married earlier than those who did not have an early start of menstruation. The average age of sexual debut for the men was 18.8 and 17.5 for women in this study. Available data in Ghana showed that 32% of young men and 47% of women in the country had their sex debut at age 18 (Ghana Statistical Service, 2015b).

Fatusi and Blum (2008) also found through their study conducted using 2,070 Nigerian adolescents (15-19 years) from the northern and southern parts of Nigeria that factors such as their religiosity, demographic and psychosocial factors influenced their age of sexual debut. Their findings showed that due to religiosity the females had a lesser rate of intercourse debut (Nonnemaker et al, 2003; Rew and Wong, 2006; Rostosky et al, 2004). The perception of both sexes about condom access and use, alcohol use and issues relating to the opposite sex increased their chances of having sexual intercourse at an early age (Gore and Bracken, 2005;

Sampson et al, 2001). Also, adolescents from the northern part of the country (12.1% of males and 13.1% females) had a lower rate of intercourse debut as compared to their counterparts from the south (24.3% males and 28.7% females).

One of the risky sexual behaviours among adolescents involve having multiple sexual partners. This resonates with the immediate question of why do people choose to have multiple sexual partners even when they know the dangers associated with it? There have been different studies done in trying to provide an answer to this question. Some studies investigated and found interesting but multiple answers including reasons like sexual dissatisfaction, lack of affection and financial support from a partner, assault and lack of communication (Parker et al, 2007; Taruberekera et al, 2009; Tawfik and Watkins, 2007; Swidler and Watkins, 2007; Leclerc-Madlala, 2003). Some other reasons identified in the literature include the fact that multiple sexual partners served as a form of collateral whilst others simply considered the act as a source of pleasure (Jana et al., 2008; Taruberekera et al, 2009; Swidler and Watkins, 2007). Peer pressure and the abuse of substances such as marijuana, alcohol and tobacco have also been shown to increase the chances of a person having multiple sexual partners among adolescents and young adults (Baskin-Sommers and Sommers, 2006; Cavazos-Rehg et al, 2011; Graves and Leigh, 1995).

In Ghana, Kyilleh et al (2018) in their study tried to explore adolescents' knowledge of reproductive health, the choices they make and the factors that influenced these choices in northern Gonja. Their findings showed that the teenagers considered contraceptives such as condoms used during sexual intercourse unattractive whereas others considered the act of having sex as a sign of love and affection for the partner as well as a way to prove one's fertility. With regards to abortion services, adolescents in Northern Gonja lacked the knowledge on how to access abortion care and therefore used very crude methods to induce abortion such as drinking concoctions and inserting herbs into the vagina (Kyilleh et al., 2018).

Glover et al. (2003) in their desire to assess adolescents' knowledge, attitudes and behaviours related to a wide range of gender and reproductive health issues conducted their study using 704 unmarried youth from Tamale, Sunyani and Takoradi. The respondents were either students, apprentices or unaffiliated working youth. At the end of the study it was found that 25% of the sexually active females indicated their first time of having sex involved the use of coercion or rape as compared to the 5% males. The men were those who largely used force to get sex from their partners and this increased with an increase in their age. Over 73% of the respondents also agreed that it was okay to be violent towards women in a relationship. The results further showed that the respondents had a high knowledge of contraceptives but did not know how to use them. Also, being aware of the dangers of STDs did not prevent them from engaging in unprotected sex subsequently leading to undesired pregnancies and abortions.

Based on what was reviewed above, this study sought to look at factors such as early sex debut, substance abuse, having multiple sexual partners and non-use of contraceptives as some of the possible risky sexual behaviours that the teenagers of La could possibly be engaging in which result in teenage pregnancy.

2.4 Other factors leading to teenage pregnancy

This section of the review looks at some other factors that lead to teenage pregnancy aside the adolescents engaging in risky sexual behaviours. This is necessary because there could be more than one factor that is causing the teenage pregnancy situation in La. In this section, some of these factors will be looked at from the international, African and Ghanaian level.

Acharya et al. (2010) conducted a study in some selected countries in South Asia to identify the risk factors associated with teenage pregnancy in South Asian countries. They did this by searching the EMBASE, MEDLINE and CINAHL electronic databases to identify some works

that had been done on the subject matter between 1996-2007 based on the following themes; knowledge of sexual health, attitudes and behaviours, utilization of health services and consequences of teenage pregnancy. The studies that were selected were mainly done in India, Bangladesh, Sri Lanka and Nepal. Some of the risk factors that had a significant link to teenage pregnancy and were identified at the end of the study were the family structure, culture, educational attainment and socio-economic status of the respondents (Brennan et al., 2005; Ganatra & Hirve, 2002; Goonewardene & Deeyagaha Waduge, 2005; Khandait et al., 2000; Rashid, 2006; A K Sharma et al., 2001; Arun K. et al., 2002; Shrestha, 2002; Weerasekera, 1997). For their knowledge on sexual health, behaviours and attitudes it was found out that most teenage girls in the region had learnt of at least one contraception method from their friends or peers but very few of them had ever used contraceptives (Goonewardene & Deeyagaha Waduge, 2005; Arun K. Sharma et al., 2002; Shrestha, 2002). At the time, this was attributed to their ignorance of how conception takes place and the dangers of unplanned pregnancies among majority of the teenage girls (Goonewardene & Deeyagaha Waduge, 2005). On the issue of utilization of health services, it was found out that a good portion of the teenagers (17-19 years) made less use of ante natal care compared to adult mothers largely due to socio economic challenges which led to the difference in accessibility of health services among the teenage mothers (Goonewardene & Deeyagaha Waduge, 2005; Weerasekera, 1997).

A look at the consequences of teenage pregnancy showed that complications such as low birth weight, still birth, pregnancy induced hypertension, pre-term delivery, birth asphyxia, foetal distress and anaemia were common among pregnant teenagers (Brennan et al., 2005; Ganatra & Hirve, 2002; Goonewardene & Deeyagaha Waduge, 2005; Khandait et al., 2000; Rashid, 2006; A K Sharma et al., 2001; Arun K. Sharma et al., 2002; Shrestha, 2002; Weerasekera, 1997). The social consequences on the other hand included higher rates of divorce, premature death, barrier to higher education, unhealthy children, single motherhood and population

growth (Ganatra & Hirve, 2002; Goonewardene & Deeyagaha Waduge, 2005; Rashid, 2006; Shrestha, 2002).

Part et al. (2013) however conducted a study among female adolescents between the ages of 15-19 years in 21 European Union member states to find cross country and regional variations as well as trends in reported cases of teenage pregnancy paying particular attention to the legislations as well as sexual and reproductive health services in Europe. Comprehensive statistical information about teenage live births, abortion legislation, induced abortions as well as youth friendly sexual and reproductive health services were compiled for each of the EU countries relying on national and international secondary data sources.

At the end of the study, it was observed that on the whole there had been a decline in the rates of teenage pregnancy in the European Union. However, there was a significant difference among the individual member countries. Northern Europe (Denmark, Estonia, Finland, Ireland, Latvia, Lithuania, Sweden and the United Kingdom) had the highest decline in teenage pregnancy rates whilst Eastern Europe (Bulgaria, Czech Republic, Hungary, Poland, Romania and Slovakia) saw the lowest decline (Haldre, Part & Ketting, 2012). The rate of teenage child births and teenage mothers were highest in Eastern Europe with countries like Romania, Slovakia and Bulgaria seeing this growth. However, Latvia, Estonia, Hungary and Lithuania witnessed a decline in teenage childbearing since the year 2000 which was attributed to an increased allocation of funds to sexual and reproductive health education, increased use of contraceptives, free or subsidized contraceptive distribution and the intensification of sexual education in schools (Bearinger, Sieving, Ferguson, & Sharma, 2007; Haldre, Part, & Ketting, 2012). Estonia saw the highest decline of teenage pregnancies in Europe (Haldre, Part & Ketting, 2012). In the case of Poland where as a legislation, adolescents had to seek for parental consent before they could visit a centre to address issues of their sexual and reproductive health, there was a high rate of teenage pregnancy (The Family Federation of Finland, 2012).

Another factor known to lead to teenage pregnancy among the adolescents is anticipated family support should they get pregnant. Furstenberg & Crawford (1978) in their study on helping teenage mothers to cope through family support among some teenagers in America came out with findings which showed that the nuclear family and siblings gave more support to adolescents in different ways such as providing them with free accommodation as well as helping with child care. This support was more if the adolescent was still living with the parents than if the adolescent was living alone or with other people. The results further showed that this support helped improve the chances of the teenage mother returning to school after giving birth as well as the overall health of the baby. The flip side of this was the situation where adolescents were neglected or maltreated by their parents and care givers which forced them to engage in certain behaviours that eventually lead to teenage pregnancy. This was looked at in a study by Haydon et al. (2011) in the United States of America among some selected adolescents in 80 high schools with the aim of finding out if there was any association between parental neglect or maltreatment during childhood and adolescence and outcomes of STD in their young adulthood. Findings from this study showed that among the females there was a positive association between them reporting of a current STD and having been sexually abused, physically neglected, not getting enough supervision or being physically abused in their childhood or adolescence. The results further showed that there was a significantly high chance of a female who has gone through some physical neglect in their childhood testing positive for an STD in their young adulthood. In a similar study by Wilson & Widom (2008) that sought to examine the link between child maltreatment and risky sexual behaviour as well as contracting HIV in their adulthood, it was found that child maltreatment was associated with an early sex debut (15 years) and prostitution among the victims. The rate of contracting HIV was double among the victims of child maltreatment than those in the control group.

In Ethiopia, Kanku and Mash (2010) conducted their study in the rural town of Taung among teenagers to understand their attitudes and perceptions of teenage pregnancy, contraception and sexuality. This was to help identify the factors that these teenagers saw as contributing to teenage pregnancy. A qualitative method was used in which 13 in-depth interviews and 3 focus group discussions were used. The three focus groups were made up of 11 males (18-23 years), 14 teenage girls (16-19 years) and 10 women (19-25 years) who had children during their teenage years whereas the interview involved 13 pregnant teenagers. Results from the research showed that teenage pregnancy in the town was influenced by several factors such as unemployment, peer pressure, poverty, alcohol abuse by teenagers and their parents, no constructive activities to engage them during holidays, availability of child support grants to pregnant mothers, transgenerational sex, sexual coercion, poor understanding of reproductive health, the menstrual cycle and use of contraceptives, low self-esteem, poor sexual negotiation skills, pregnancy seen as socially desirable, the need to prove one's sexuality or simply trying to please their boyfriends.

There had also been several studies that tried linking teenage pregnancy to parenting. One such study was that of Boyce (1999) who tried to examine the link between parenting and risky sexual behaviour among white junior and senior high school teenagers. Parenting behaviours such as physical and psychological support, communicating on matters related to sex as well as behavioural controls were examined. At the end of the study, it was revealed that the sexually active female children had a greater chance of taking sexual risks if they were under some form of psychological control from their parents. It was also observed that high risk taking among both male and female adolescents was greatly reduced by parental monitoring.

In Ghana, Gyesaw and Ankomah (2013) also conducted a qualitative study in which they explored the experiences of teenage mothers between the ages of 14-19 years during pregnancy, child birth and child care from a suburb of Accra. The data was collected through

8 focus group discussions and 9 in-depth interviews involving 54 respondents. At the end of the study, it was found that some of the reasons given by the teenage mothers for becoming pregnant included transactional sex, experimenting with sex, the desire to be a teenage mother, sexual abuse and lack of sex education. The study also revealed that the reaction of the parents to the news of the pregnancy was different among the fathers and mothers. Whereas the mothers reacted to the news in an immediate, sharp and usually vocal manner, the fathers were rather very moody, deeply hurt and troubled by news of the pregnancy. Again, it was found that the teenage mothers faced the challenge of fending for the new born baby as well as themselves. Besides getting support from their partners and family, they also desired the support of their peers who could better understand them and accept their new situation as mothers (DeVito, 2010). The teenage mothers also claimed that taking care of a new born baby was one of their toughest challenges so far (Nystrom and Ohrling, 2004). Another key finding of the study was that the topmost concern of these teenage mothers was the fact that they were dropping out of school as a result of the pregnancy with many of them having the hope of one day returning to the classroom (Kumi-Kyereme et al., 2007).

In many studies such as the one above, the researchers most often tried to find out the effect teenage pregnancy has on the mother whilst some studies tried to find out the cause of the pregnancy. Gyan, 2013 sought to do this in addition to finding out how teenage pregnancy affected the education of the teenage girls in Chokor, Accra. Through the use of focus group discussions and interviews, he was able to arrive at the conclusion that the major cause of teenage pregnancy among the girls in Chokor were poverty (94%), poor parenting (90%) and peer pressure (74%).

In a similar study involving 481 teenagers in the Ejisu-Juabeng district of Ghana by Morhe et al. (2012) to examine the factors associated with teenage pregnancy involvement it was found that the gender of the respondents, the age at which they became sexually active and dropping

out of school was significantly associated with teenage pregnancy in the district. Asibey (1998) in his research in the Nkwanta district in the Volta region of Ghana equally tried to find out what was causing the teenage pregnancy situation in the 12 selected communities as well as the effects this had on them. At the end of the research he found that child betrothal, poor girl child education and reliance on peers for information on sexual and reproductive health were the major factors that were contributing to the teenage pregnancy situation in the selected communities. Also, the punishment given by the chiefs to men who impregnated teenagers was usually directed at teenage pregnancy that occurred out of wedlock.

The review above shows that there are several other factors that could lead to teenage pregnancy aside the adolescents' knowledge and the risky sexual behaviours they may be engaged in. As such, some of these factors such as anticipated family support in times of pregnancy, having sex as a test of one's fertility, anticipated financial gain and parental neglect among the teenagers of La will be looked at.

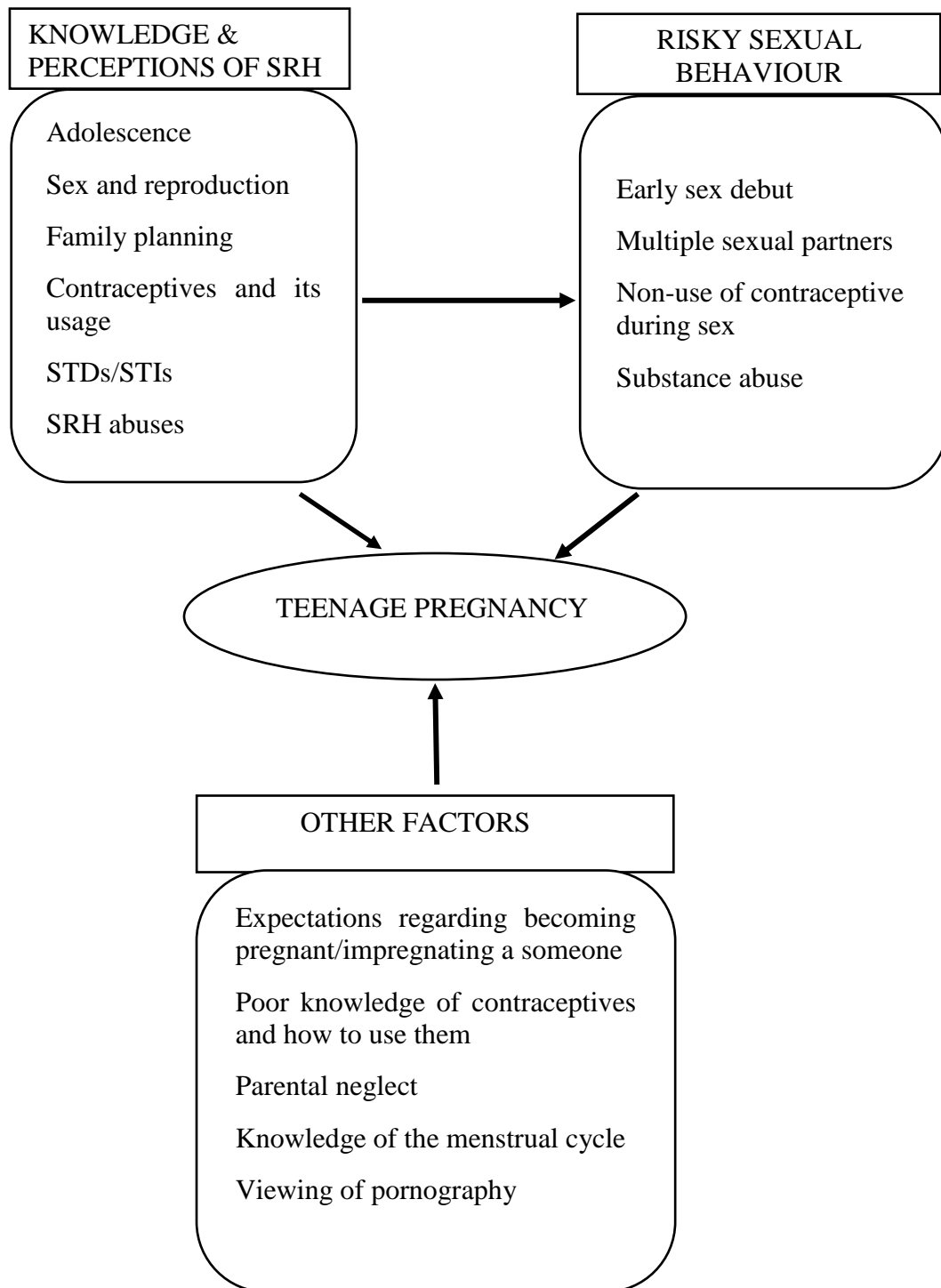
2.5 Theoretical framework of the study

The reasoned action theory propounded by Acek Ajzen and Martin Fishbein in 1975 was used in this study. It is a theory that has been used to predict and explain several health behaviours. The assumption of this theory states that a person's decision to engage in any behaviour is based on his or her intentions and the results that he or she expects to get from the behaviour be it positive or negative (Gillmore et al., 2002). These intentions are formed based on the norms and beliefs that the person is exposed to. For instance, a person's decision to have sex or not may be based on their beliefs and the norms regarding sex as well as a desired anticipated positive outcome such as pleasure or intimacy or a negative outcome such as pregnancy, diseases, injury, chastisement or neglect. For a teenager to become pregnant or impregnate someone he or she must first have sex. Engaging in sex, which is the behaviour, will then be

said to be an act that one decides to engage in after thinking about certain factors based on their beliefs (such as the need to use a contraceptive) and anticipating an outcome once that thought is put into action.

In this study, the theory informed how the beliefs of the adolescents (based on their knowledge and perceptions of sexual and reproductive health) may or may not form their intentions to either engage or not engage in risky sexual behaviour that could ultimately lead to teenage pregnancy even though they may or may not be aware of the societal norms regarding teenage pregnancy.

2.6 Conceptual framework



Source; Author's construct derived from literature, 2018.

The conceptual framework is derived from literature and divided into four parts; the identified problem (teenage pregnancy), knowledge and perceptions of sexual and reproductive health,

risky sexual behaviour and other factors that could lead to teenage pregnancy. The variables listed under knowledge and perceptions of sexual and reproductive health are supposed to either lead or not lead the adolescents into engaging in risky sexual behaviour. This has been demonstrated in studies such as that of Shelton (2009), Ugoji (2014), Rondini & Krugu (2009) and Zhang et al. (2016). Engaging in the listed risky sexual behaviours have been shown to ultimately lead to or influence teenage pregnancy in different studies across different parts of the world (Oluwatoyin & Modupe, 2014; Kotchick et al., 2001; Shore & Shunu, 2017; Shelton, 2009; Kanku & Mash, 2010. Mothiba & Maputle, 2012; Mirzaei et al., 2016). Aside risky sexual behaviour, there could also be the possibility that there are other factors that might be leading to teenage pregnancy among the adolescents in La. As such, there will be the need to look at the variables listed under ‘other factors’ that could also lead to teenage pregnancy.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section looked at the background profile of the study area, La as well as the La Dade-Kotopon municipality in which it is situated. Following the background profile was a description of the study design sampling method/procedure, sample size calculation as well as the instruments for data collection and analysis.

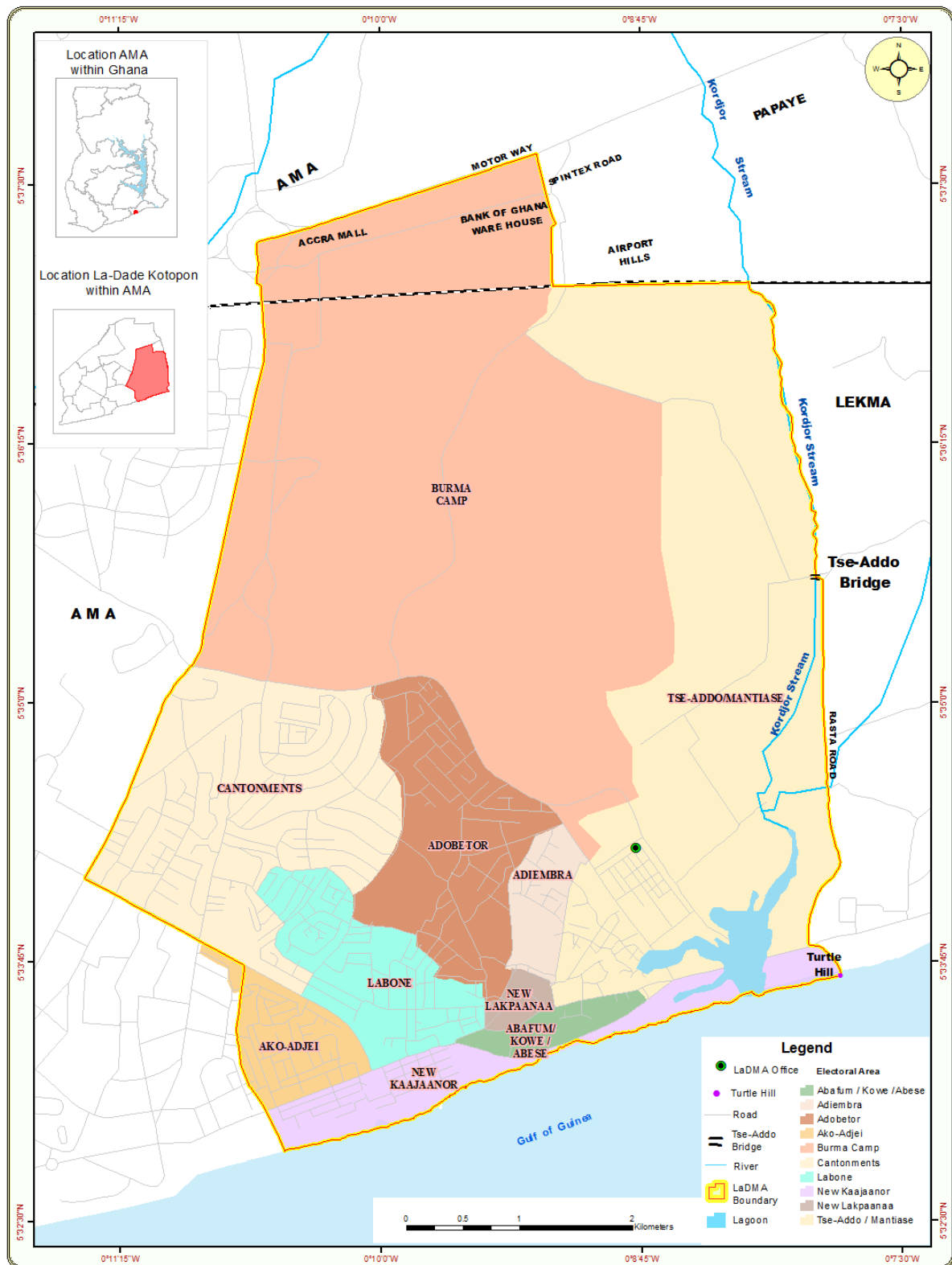
3.2 Area of study

La Dade-Kotopon with a total population of 183,528 is situated in the South Eastern part of the Greater Accra Region. It is diagonally located between Latitudes $5^{\circ}32'50''$ N and Longitudes $0^{\circ}11'15''$ W and Latitudes $5^{\circ}38'0''$ N and Longitudes $0^{\circ}7'50''$ W. It has a total land area of about 36 square km, which represents almost 1.1% of the total land size of the Greater Accra Region. The La Dade-Kotopon Municipal Assembly was carved from the Accra Metropolitan Assembly in 2012 and inaugurated on 28th June, 2012. Some major settlements in the municipality are Cantonments, Labone, Burma Camp, Kaajaanor, Ako Adjei, Abufum, Kowe, New Lakpanaa, Tse-Addo, Adiembra and Adobetor (Fig. 3.1).

The study was conducted in the municipal capital, Labadi (La), which had a 2017 projected total population of 117,303. La township is located at the southern part of the Municipality close to the shore and bordered by communities such as Teshie, Osu, Burma camp and Labone. It is an indigenous patrilineal community that has been in existence for several centuries. The inhabitants of La are largely Ga-Adangbe with a small percentage of the people living there being Akans, Ewes, Dagombas among other ethnic groups. The language widely spoken in La is Ga and the people of La celebrate the Homowo festival every August. In terms of climate La is in the Coastal Savannah zone and has two rainy seasons. The first begins in May to mid-July

while the second season begins in mid-August to October. Though majority of the inhabitants of La are largely Christian, there is a proportion of them who practice African traditional religion and Islam. Traditionally, the La mantse is the traditional head of La but his traditional powers and jurisdiction extends beyond La to as far as Madina and Adenta. The La Mantse is assisted by eight clan sub-chiefs in the traditional administration of the area. There are 77 family houses that fall under the umbrella of eight clan houses, headed by sub chiefs who represent their people in the traditional council. They also assist the paramount chief in the traditional administration of the Municipality. The settlement in La can be divided into two. The first being the indigenious La community characterized by a lot of compound houses and family houses where the extended family system is practiced. The other part is made up of the new settlements that sprung up as a result of the influx of businesses to the area such as the south La estate. These settlements are well planned and mostly occupied by nuclear families. La is well noted for the businesses dotted along its coast as well as the beaches there. Some of these include the La Palm Beach hotel, Jokers, Labadi beach, Tawala beach and the Ghana international trade fair centre. La does not have a lot of vegetative cover since land has become a very scarce commodity in the area which sometimes trigger conflict among individual or families. The biggest hospital in the municipality, the La general hospital is situated in La and serves all the adjoining communities.

Fig 3.1 Electoral Area Map of La Dade-Kotopon Municipal.



Source: La Dade Kotopon municipal assembly, 2018.

In this study, the target population was late adolescents of ages between 15 and 19 who were schooling and resident in La with a projected 2017 population of 10,649 adolescents between this age ranges. It was important to use the projected 2017 populations of people living in La as well as adolescents between the ages of 15-19 years in La because the official data available for them were captured in the 2010 population and housing census of Ghana which by now would be at least seven years old. The 2010 figure for the total population of La was 98,683 whilst that of the teenagers (15-19 years) was 8,959 (Ghana Statistical Service, 2014). It was necessary to use teenagers between 15-19 years because it is in this age range that teenagers usually experienced most of the physiological, emotional and psychological changes that came with adolescence. For the study, I purposively selected the sample from schools for some reasons. First, student exhibit similar characteristics as learners and therefore constituted the desired sample. Second, they were easier to select from schools than from households and third, the majority persons within the desired age bracket of 15-19 years were in school, hence, representation was a key factor. As such, this is where it would be easy to find many schooling adolescents within the age bracket of 15-19 years during the day to solicit for information on the set objectives.

3.3 Design of the study

For this study, the mixed method approach was used. This approach has both the qualitative and quantitative features that are necessary for obtaining in depth information from the respondents that could be used in arriving at broad and strong conclusions. The research was meant to take a critical look at the teenage pregnancy situation in La by finding out the knowledge and perceptions the adolescents there had about SRH. Aside this there was the need to examine some risky sexual behaviours or attitudes that the teenagers might be exhibiting. The quantitative aspect was meant to find out how much knowledge the teenagers of La had

about SRH as well as some of the attitudes that they may exhibiting. Since some of the issues concerning SRH were quite sensitive to the respondents, many of them wouldn't have felt comfortable answering questions on them in an interview situation. As such, there was the need to use a questionnaire that offered the respondents the privacy and secrecy they required to be able to answer certain personal SRH questions. After this, there was the need to probe further to find out if there was any link whatsoever between the knowledge, perception, attitudes and the teenage pregnancy situation in La. The quantitative part helped in addressing all these and was again useful in testing of the hypothesis which said that there was no relationship between the adolescents' knowledge, perceptions, attitudes and the teenage pregnancy situation in La. The qualitative aspect of the mixed method was also used in obtaining extra information from the key informants (counsellors and peer educators) who were expected to have more knowledge of SRH as well serve as the immediate contact in school that these teenagers went to when they wanted to talk about certain issues bothering them including issues of SRH. The qualitative aspect of the mixed method design also gave the researcher the chance to come up with his own interpretation as well as make inputs on the quantitative figures generated in the study for easy understanding. In all, both the qualitative and quantitative sides of the mixed method approach were to help the researcher provide answers to his research questions and objectives.

3.4 Sampling

3.4.1 Sampling Procedure/ Method

I adopted a multi-stage sample technique which included a simple random sample and a purposive sampling technique. A simple random selection was used in selecting the schools in La from which the sample of adolescents were taken. This was done by obtaining the list of JHS and SHS schools in La from the education directorate of LADMA and then writing the

names of each of the schools on a piece of paper. All the papers were put in a container and shaken for them to mix up. Without looking in the container, the researcher put his hand in container and randomly selected the schools to visit. This was done to give an equal chance for selection to each of the schools. Purposive sampling was then used in the selection of the key informants and students in the schools who were resident in La. In a case, where the selected school did not have a counsellor but had a peer educator, the peer educator was interviewed and vice versa. If the school had both, they were both interviewed. For the students, only those of them from La were asked to avail themselves by the teacher and then those of them between the ages of 15-19 were selected as part of the sample. In a situation where the required sample size was not obtained from the school, a simple random sample was used to select another school to visit and get more of the sample size needed. Purposive sampling is a qualitative research technique where the researcher chooses specific people within the population to use for a particular study or research project (Palys, 2008). Unlike random studies, which deliberately include a diverse cross section of ages, background and cultures, the idea behind using purposive sampling is to concentrate on people with particular characteristics who will better be able to assist with the relevant research whom in this case are teenagers (15-19 years), schooling and resident in La. This was done to help find their knowledge and perceptions about sexual and reproductive health (SRH) and how that could be linked to risky sexual behaviours that the teenagers in La might be engaged in that could ultimately lead to the teenage pregnancy situation in the community.

3.4.2 Sample Size Calculation

In trying to determine the sample size of the population there was the need to find the current population from which the sample size would be taken. The 2017 sample population of adolescents between the ages of 15-19 years in La (10,649) was a projected figure calculated using the 2010 population growth rate (2.5%) and 2010 population of adolescents 15-19 years

in La (8,959) both obtained from the 2010 population and housing census of Ghana. In calculating for the 2017 projected population, the 2010 population of adolescents 15-19 years in La (8,959) was multiplied by the population growth rate (2.5%) to find the anticipated increase in population (223.98). This figure was then added to the 2010 figure (8,959) to obtain the projected population for the year 2011. The figure for 2011 was then used to calculate that of 2012 using the same procedure and this was done until I arrived at the 2017 projected total population of adolescents (15-19 years) living in La (10,649).

Below is the formula that was used to determine the sample size of the population;

$$n = \frac{Z^2 (1-P)(n)}{e^2}$$

$$= \frac{2^2 (0.25)}{(0.5)^2}$$

$$= 400$$

The sample size was 400 but it was however short by 14 but within the statistically appropriate limit. The research was therefore conducted using 386 adolescents (15-19 years) from La chosen from some selected schools in La. According to Enders (2003) it is normal to find psychological and educational studies having a missing rate of 15% to 20%.

3.5 Data Collection Tools

The study made use of the knowledge, attitudes and practices (KAP) survey instrument. It is one of the tools used in investigating health behaviour as well as gaining information on health seeking practices the world over (Hausmann-Muela et al. 2003, Manderson and Aaby 1992). The use of the KAP tool for data collection in La attempted to give insight regarding the

knowledge and perceptions adolescents had about sexual and reproductive health, their attitudes towards sexual and reproductive health (risky sexual behaviour) as well as other factors and how these could be leading to teenage pregnancy in the La community. The KAP tool was designed to reflect the research design, objective and research questions.

The KAP was used in designing the semi-structured questionnaire and interview guide to solicit information from the respondents. Before the questionnaires could be issued or interviews done, an introductory letter from the institute for social, statistical and economic research was shown to them to seek and get their approval first. The questionnaires were then personally issued with the help of four other persons to adolescent students in the selected schools within La whilst the interview guide was used in soliciting for information from key informants including counsellors or peer educators within the selected schools. Permission was sought from the interviewee and the interview was recorded using a recorder. The questionnaire was divided into three thematic areas based on the research objectives which included the sections on knowledge and perception of sexual and reproductive health, risky sexual behaviours and other factors leading to teenage pregnancy. The data collection instruments were a reflection of the KAP tool designed purposely to elicit data on knowledge and perception of SRH as well as risky sexual behaviours among the adolescents (15-19 years) of La. The questions asked in the questionnaire included both open ended and closed ended questions. At the end of each session with the students, the questionnaires were collected and kept in a file to be analysed later. Each questionnaire distributing and answering session lasted for at least thirty minutes but in some instances the session had to be cut short since the students were in their exams period. The interview session on the other hand usually lasted for twenty minutes each. In all, it took 3 weeks to collect the data. For sources of data, theoretical and analytic literature were reviewed on the subject of this study. Towards this regard, various scholarly works from different sources such as books, journals and the internet were reviewed and analysed to give

an in-depth understanding to the problem of teenage pregnancy by looking at factors like sexual health, reproductive health and risky sexual behaviours at the global, continental (Africa) and national level.

Table 3.1 Number of respondents obtained from the selected schools

School	Level	Number
School A	JHS	131
School B	SHS	117
School C	SHS	138

Out of the 398 adolescent (15-19 years) students from La that were needed from the study, 131 of them were first obtained from school A which is a JHS, 117 were then obtained from school B which was a SHS and the final 138 students were obtained from school C which was also a SHS. The list of JHS and SHS was obtained from the La Dade Kotopon municipal assembly. The names of these schools were written on pieces of papers, placed in a basket and randomly selected. School A was the first to be randomly selected and 131 adolescent students between the ages of 15 to 19 from La were obtained to whom the questionnaires were administered. The process was repeated for school B and C until the desire sample number was obtained. The names of the schools are not however made known in the work for ethical reasons.

3.6 Data Analysis

Once the quantitative data was collected from the field using the questionnaires, it was coded, entered into a computer, processed and analysed using Stata which has the capability of analysing and presenting data in a very easy and accurate manner. Responses obtained from the key informants interviews were also transcribed and relevant portions that were used in

parts of the analysis were duly quoted or paraphrased as the respondent gave it during the interview. The analysis began with a brief introduction and presentation of the demographic characteristics of the respondents which looked at their mean age, religious affiliation, educational level, living arrangements and guardians' occupation which were all tabulated based on their sex.

Objective 1; Knowledge of sexual and reproductive health among adolescents of La.

In ascertaining the knowledge and perception, answers obtained regarding respondents' knowledge about modern family planning methods, STDs/STIs, contraceptives, how to use contraceptives, SRH abuses, what sex is to them were included in the analyses. A summary table was drawn to highlight their responses and the proportions of the teenagers that gave those responses. Where there was the need to add pictures to make the analysis better that was done. Their knowledge on SRH abuses was also ascertained and a separate table was created for it. It was also analysed based on their sex, educational level, living arrangements and guardians' occupation.

Objective 2; Examine sexual and reproductive health attitude among adolescents in La.

In analysing this objective, certain attitudes such as abusing of substance, entering into sexual relationships as a teenager, engaging in sex, non-use of contraceptives during or after sex and having multiple sexual partners were analysed based on their sex, educational level, living arrangement and guardians' occupation. A summary table was used to show the responses given.

Objective 3; Identify other factors contributing to teenage pregnancy in La.

An analysis was done on some other factors that could be contributing to the teenage pregnancy situation in La which included the perceptions (pregnancy as sign of fertility and anticipated family support in times of pregnancy), knowledge of the menstrual cycle, viewing of

pornography and parental neglect. A summary table was drawn for the results and the above factors were analysed based on the sex, educational background, living arrangements and guardians' occupation of the respondents.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the analysis of results obtained from the data gathered from the field. The chapter is organised into sections based on the study objectives.

4.2 Demographic characteristics of respondents

Table 4.1 presents a brief summary of the demographic characteristics of the 386 respondents consisting of 179 males (46.4%) and 207 females (53.6%). The average age of the total respondents was 17.5 years.

The majority of the respondents (78.8%) were Christians while the remaining 21.2% were Muslims. The majority of the sample (66.1%) were in SHS while the remaining 33.9% were in JHS.

A look at the living arrangements of these teenagers showed that slightly more than half of them (51.3%) were living together with both parents while approximately 22% of them were living with single parents. Among the male respondents, approximately 50% of them were living with both parents, 25.1% with single parents, 18.4% with relatives and the remaining 7.3% of them living with other people they were not related to. The situation is a bit different among the female respondents with 53.1% of them living with both parents, 18.9% living with single parents, about 25.1% living with relatives and the remaining 2.9% living with other people they are not related to.

Data from the field also showed that majority of the teenagers had their parents working in the informal sector (59.3%) whilst only 40.7% of them had their parents working in the formal

sector. This is reflective of the labour force distribution within the La Dade Kotopon municipality in Ghana where approximately 60% of the working population were employed in the informal sector (GSS, 2014). This finding is also in tandem with the findings in the national employment report of Ghana which showed that 59.9% of workers were engaged in work considered to be informal whilst the remaining 40.1% were working in establishments considered as formal (GSS, 2015). For the male respondents, approximately 62% of them had their parents working in the informal sector as against 57% for females and about 40% working in the formal sector as against that for females which is 43%.

Table 4.1 Demographic characteristics of respondents

	Sex		
	Male	Female	Both
Mean age (years)	17.7	17.4	17.52
Religion			
Proportion of Christians	77.65%	79.71%	78.76%
Proportion of Muslims	22.35%	20.29%	21.24%
Educational level			
Proportion in JHS	32.40%	35.27%	33.94%
Proportion in SHS	67.60%	64.73%	66.06%
Living arrangements			
Both parents	49.16%	53.14%	51.30%
Single parent	25.14%	18.84%	21.76%
Relatives	18.44%	25.12%	22.02%
Others	7.26%	2.90%	4.92%
Guardians' occupation			
Formal sector	37.99%	43.00%	40.67%
Informal sector	62.01%	57.00%	59.33%

Source: Author's field survey, 2018

4.3 Knowledge of sexual and reproductive health among adolescents of La.

4.3.1 Knowledge or understanding of what sex is

One objective of this study was to ascertain respondents' knowledge on a number of issues indicated in Table 4.2. Findings from the survey showed that more than half (54.6%) of the sample perceived sex as a biological function. Thus, they believed it was something natural that any human being has the right to engage in either for pleasure or reproduction. A little above 18% of them saw it to be a human right which meant that they were entitled to it naturally by law and could therefore seek legal redress if they were denied this right. Approximately 12% of the respondents viewed sex as a source of pleasure. In particular, this view was reiterated by one of the peer educators in school A who said,

One major thing that has drawn a lot of my colleagues' attention to sex is the stories they hear about how enjoyable sex is. Many of them are just curious and anxious to find out how enjoyable it is. The media is also not helping since today there are so many adverts on T.V, particularly Adom T.V that create the impression that sex is a very pleasurable activity and to enjoy it well you must take in some drugs to help boost you. (Interview, 2018).

About 11% of the teenagers were however of the view that sex was an obligation that they had to perform so long as they were in a relationship with the opposite sex. As such, being in a relationship with either a boyfriend or girlfriend meant that they had to have sex as an integral part of that relationship. Overall, only 5.5% of the teenagers in the study regarded sex as something that was of no relevance to them at this point in time of their lives and as such did not really care about knowing what it was. The results further showed that more of the males discussed issues concerning SRH with their friends (75.4%) as compared to the females (68.6%). However, more females (13.5%) than males (8.9%) discussed SRH issues with their parents. This finding is corroborated by Chowa, Masa & Osei-Akoto, (2012) in their work

concerning youth and their health in Ghana where it was equally found that a lower number of youth discussed sensitive issues like SRH with their parents.

In terms of their educational background, more than half of those in JHS (52.0%) and SHS (55.7%) saw sex to be a biological function. Again, more people in SHS viewed sex to be a right (20.6%) as compared to those in JHS (13.0%). The situation was similar for those who thought of sex as an obligation where those in SHS were 11.4% as compared to 7.0% of the respondents in JHS. For those who took sex to be a fun activity, those in JHS (13.0%) happened to be more than those in SHS (11.0%).

Of the total number of respondents who had their parents working in the informal sector (59.3%), 18.1% of them saw sex to be a right, 9.6% said it was an obligation whereas more than half (55.8%) of them viewed sex to be a biological function. Only 11.6% of them said it was a fun activity whilst 5.0% of them said sex was of no relevance to them. Amongst the rest of the teenagers whose guardians were working in the formal sector, about 52.7% of them viewed sex as a biological function, 18.6% said sex was a right to them, 10.9% of them were also of the view that sex was an obligation whereas 11.6% were of the view that sex was a fun activity to them. The remaining 6.2% of them saw sex to be irrelevant to them.

Table 4.2 Knowledge of sexual and reproductive health among adolescents of La.

		Knowledge of sexual and reproductive health among adolescents of La (Percent)										
		Sex		Educational level		Living arrangement			Guardians' occupation		All	
		Male	Female	JHS	SHS	Both parents	Single parent	Relatives	Others	Formal	Informal	
What is sex to you?	A right	23.8	13.1	13.0	20.6	12.4	28.6	18.2	31.6	18.6	18.1	18.3
	An obligation	8.8	11.3	7.0	11.4	13.6	8.6	6.5	0.0	10.9	9.6	10.1
	A biological function	55.0	54.2	52.0	55.7	61.7	37.1	54.6	57.9	52.7	55.8	54.6
	A fun activity	10.0	13.1	13.0	11.0	7.4	14.3	18.2	10.5	11.6	11.6	11.6
	Irrelevant	2.5	8.3	15.0	1.3	4.9	11.4	2.6	0.0	6.2	5.0	5.5
Family planning	Yes	40.8	42.0	13.0	56.1	41.4	33.3	51.8	31.6	52.9	33.6	41.5
	No	59.2	58.0	87.0	43.9	58.6	66.7	48.2	68.4	47.1	66.4	58.6
Contraceptives	Yes	54.2	57.5	30.5	69.0	61.1	33.3	64.7	63.2	58.6	54.2	56.0
	No	45.8	42.5	69.5	31.0	38.9	66.7	35.3	36.8	41.4	45.9	44.0
Contraceptive use	Yes	19.6	17.4	1.5	27.1	23.7	13.1	5.9	42.1	19.8	17.5	18.4
	No	80.5	82.6	98.5	72.9	76.3	86.9	94.1	57.9	80.3	82.5	81.6
STDs/STIs prevention	abstinence using	62.6	73.0	61.1	71.8	72.2	64.3	67.1	47.4	72.0	65.5	68.1
	contraceptives	14.0	9.2	7.6	13.3	9.1	13.1	12.9	21.1	8.9	13.1	11.4
	Avoid contact with infected person	16.2	14.5	22.1	11.8	14.1	14.3	16.5	26.3	14.0	16.2	15.3
	Being faithful	7.3	3.4	9.2	3.1	4.6	8.3	3.5	5.3	5.1	5.2	5.2
STDs/STIs	Yes	78.2	83.1	61.1	91.0	79.8	72.6	91.8	79.0	79.6	81.7	80.8
	No	21.8	16.9	38.9	9.0	20.2	27.4	8.2	21.1	20.4	18.3	19.2

Source: Author's field survey, 2018

4.3.2 Respondents' knowledge of modern family planning methods.

Another thing that had to be looked at in this study in an attempt to find out respondents' knowledge of SRH was their knowledge on modern family planning methods. Of the total respondents, about 59% of them did not know of any modern family planning method. Likewise, 59.2% and 58% of the male and female respondents did not know of any modern family planning method. Further analysis showed that most of the respondents in JHS (87%) did not know of any modern family planning method as compared to their counterparts in SHS (43.9%). It was also found that a higher percentage of those who had their parents working in the informal sector (66.4%) did not have knowledge of any modern family planning method as compared to those whose parents worked in the formal sector (47.1%).

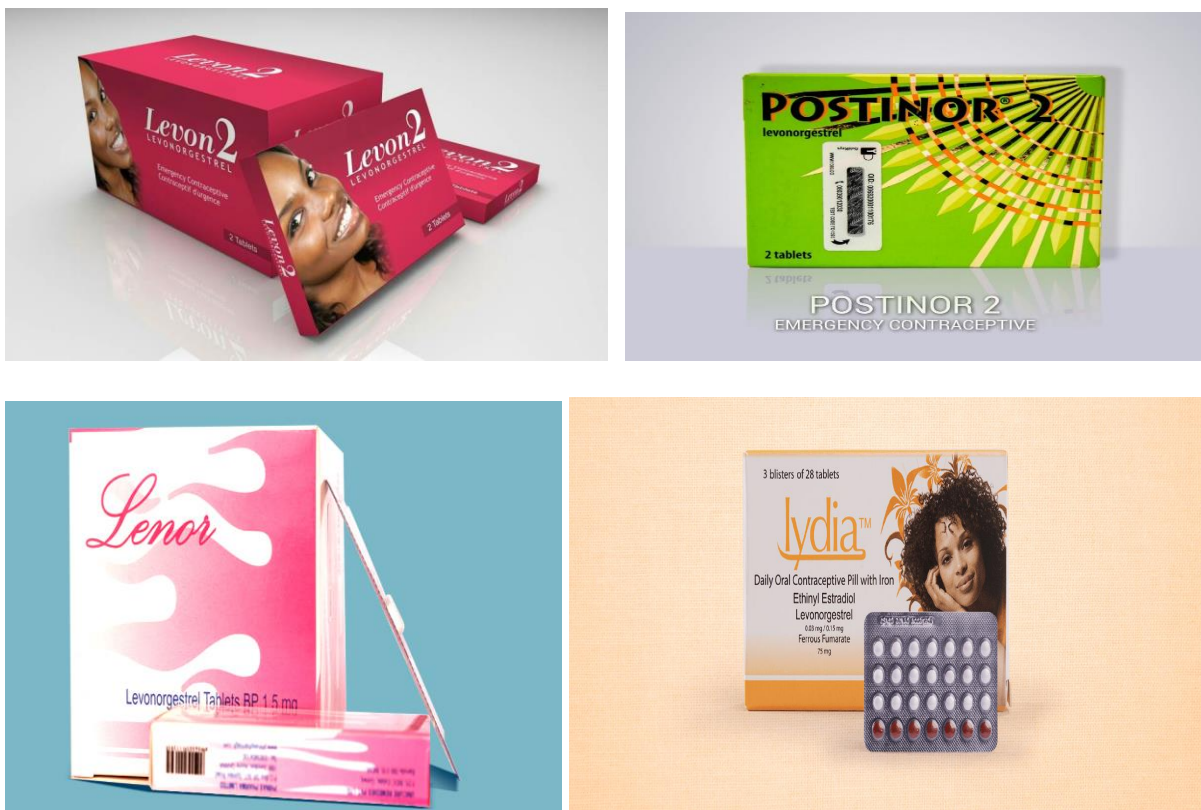
Overall, only 41.5% knew of modern family planning methods. Of this proportion, those who knew about contraceptives were 66.25%. Approximately 13% of those in JHS knew of some family planning methods whilst 56.1% of the total number of respondents in SHS admitted knowing at least one family planning method. This finding is similar to a study by Feleke et al. (2013) which found that adolescents with secondary education highly understood and utilized family planning methods than those without secondary education in Gondar, Ethiopia.

About 52.9% of the respondents whose parents worked in the formal sector knew of at least one modern family planning method compared to 33.6% of those whose parents worked in the informal sector.

Most importantly, 56% of the total respondents knew of at least one contraceptive with the most identified contraceptives being the condom (48.4%) and the oral contraceptive (51.6%). Comparatively, this awareness level was lower than the 99.7% found in the Ga East Municipality by Aryeetey, Kotoh & Hindin (2011). Some of the oral contraceptives that were

readily identified by the teenagers were the Levon 2, Postinor 1&2, Contra 72, Lenor, Secure and Lydia contraceptives. Over all, the results show that those in SHS (69%) who had some knowledge of contraceptives were twice of those in JHS (30.5%). Likewise, those living with both parents and had knowledge of some contraceptives (61.1%) were more than those living with single parents (33.3%). Also, those who had their parents working in the formal sector and knew about contraceptives (58.6%) were slightly more than those whose parents were working in the informal sector (54.2%).

Fig 4.1: Images of contraceptives readily identified by the teenagers





Source: Google images, 2018.

Knowledge on contraceptive usage was also ascertained. The results showed that over 81.6% of the respondents did not know how to use contraceptives. Regarding living arrangements and knowledge on contraceptive use, a greater proportion of those living with their relatives (94.1%) did not know how to use contraceptives followed by those living with single parents (86.9%), both parents (76.3%) and non-relatives (57.9%). It was also observed that most of those who did not know how to use contraceptives had more of their parents working in the informal sector (82.5%) than those in the formal sector (80.3%).

4.3.3 Respondents' knowledge of STDs/STIs.

Results on knowledge of STDs also showed that more of the females knew of STDs/STIs as compared to the males. The STDs/STIs that were readily identified include HIV/AIDS

(41.5%), Gonorrhoea (33.1%), Syphilis (23.2%), Candidiasis (1.1%) and Chlamydia (1.1%). This finding differs from that of Rondini & Krugu, (2009) where gonorrhoea and syphilis were the two most identified STDs. In this study, over three quarters of those in SHS (91%) knew of STDs/STIs as compared to those in JHS (61.1%). A greater portion of those living with relatives (91.8%) knew more of STDs/ STIs than those living with both parents (79.8%), single parents (72.6%) and non-relatives (79%).

4.3.4 Respondents' knowledge of how to prevent STDs/STIs (HIV/AIDS)

When respondents were asked of the ways in which STDs/STIs particularly HIV/AIDS could be prevented, close to 68.1% of them thought that the best way to do that was abstinence from sex. Although this was in tandem with findings by Rondini & Krugu, (2009), the proportion of the sample who inclined knowing abstinence could prevent STDs/AIDS was lower compared with 90.2% of those found in Bolgatanga by Rondini & Krugu, (2009).

4.3.5 Respondents knowledge and perceptions of sexual and reproductive health abuses

Another key area that had to be looked at was the knowledge and perceptions the teenagers had of some selected sexual and reproductive health abuses. Amongst the listed abuses, those that were readily identified by majority of the respondents (more than 50%) as abuses were forced sex (84.5%), groping (75.5%), refusal to sell condoms to a teenager (57.8%), receiving sexually suggestive messages from somebody (51.8%), forced marriage (78.5%), non-consensual sex with partner (64.14%) and aborting a pregnancy without the consent of your partner (62.8%). This finding is similar to the results of Yendaw, Martin-Yeboah & Dagah, (2015) in which refusal to sell condoms to a teenager, forced sex, forced marriage and groping were equally identified as SRH abuses by adolescents (15-19 years) in Yamoransa in the Mfantseman municipality of Ghana.

When asked if forced sex was an abuse, approximately 85% of them responded that it was an abuse with 82.9% and 85.6% of the males and females agreeing to this respectively. If you analyse it based on their educational levels, 79.6% of those in JHS understood that forced sex was an abuse whilst 87.01% of the respondents in SHS equally agreed that it was an abuse. When the teenagers were questioned if unwanted sexual touching or groping by others was a sexual abuse, close to three quarters (72.54%) of them agreed that it was an abuse with more males (76.8%) agreeing to this than females (69.37%) Those in JHS and SHS who identified with this act being an abuse were 76.5% and 70.5% respectively.

The case was however different when they were asked if being spoken to in a sexually suggestive manner on phone or in person was a form of sexual abuse. Less than half (43.26%) of the respondents saw this to be a sexual abuse meaning over 55% of them did not regard this act as a form of sexual abuse. Only about 41.5% of the males and 44.6% of the females saw this act to be an abuse. However, over 62% of those in SHS did not regard this to be a form of sexual abuse as compared to the over 56% of respondent in JHS who agreed it was an abuse. This simply meant that more of the respondents in SHS (62%) did not think being spoken to in a sexually suggestive manner on phone or in person was an abuse as compared to the adolescent students in JHS (44.7%).

On the contrary, a little over half (57.8%) of the respondents identified refusal to sell a condom or oral contraceptive to them at a pharmacy by a pharmacist as a form of sexual and reproductive health abuse. More than half of both the male (57.9%) and female (57.7%) respondents identified this as an abuse with over half of the respondents in JHS (56.1%) and SHS (58.7%) agreeing to this. Interestingly however, about 54% of the respondents did not regard exposing parts of your body to others in a sexual manner as a form of sexual abuse with more than 51% of the females agreeing to this and over 55% of the males equally taking this stance. It also happened that 40.2% of those in JHS saw this to be some form of sexual abuse

as compared to majority of those in SHS (50.4%) who equally regarded that act as a form of sexual abuse. When the respondents were asked if being sent sexually suggestive text messages, pictures and videos was a sexual abuse to them, over 51% of them said yes with more females (54.05%) than males (48.9%) agreeing to this. Analysing this based on their educational level, more of those in SHS (61.02%) saw such an act to be a form of sexual abuse as compared to those in JHS (34.1%). With the issue of forced marriage, more than three quarters (78.50%) of the respondents identified it as an abuse with the proportion of males being 76.8% and females being 79.7%. Again, more than 74% of those in JHS and 80.7% of those in SHS identified forced marriage as a sexual and reproductive health abuse.

Another thing that many of the respondents (64.1%) identified as a sexual and reproductive health abuse was having sex with your partner without their consent. 61.6% of the males and approximately 61% of the females agreed to this. Those in JHS who acknowledged that this was an abuse were 65.2% whilst those in SHS were 59.1%. Majority of the respondents (62.9%) however did not regard an individual not having a say as to the number of children to have with their partners as a reproductive health abuse. Only about 36% of the males and 37.8% of the females saw it to be an abuse whereas 46.2% of those in JHS and 32.3% of those in SHS identified it as a reproductive health abuse.

The last thing that the teenagers were questioned on concerning sexual and reproductive health abuses was the issue of one partner deciding to abort a pregnancy without the consent of the other partner. Here, over 62% of them responded in the affirmative. Out of this proportion were 54.3% of the males and 68.02% of the female respondents. Looking at this outcome based on their educational levels, more of those in SHS (63%) understood this to be a reproductive health abuse as compared to those in JHS (60.6%). Overall, among all the abuses that the respondents were questioned on, the top three sexual and reproductive health abuses that they identified the most were forced sex (84.5%), forced marriage (78.5%) and groping (72.5%). Those that they

least identified as abuses include sexually exposing parts of your body to others (46.97%), being spoken to in a sexually suggestive manner on phone or in person (46.9%) and not having a say as to the number of children to have with your partner (37.05%).

Table 4.3: Knowledge and perceptions of sexual and reproductive health abuses

	Knowledge of sexual and reproductive health abuses						
	Sex		Level of education		Frequency	Percent of responses	Percent of cases
	Male	Female	JHS	SHS			
Forced sex is an abuse.	82.93%	85.59%	79.55%	87.01%	326	14.18%	84.46%
Unwanted sexual touching by others is a sexual abuse.	76.83%	69.37%	76.52%	70.47%	280	12.18%	72.54%
Being spoken to in a sexually suggestive manner on phone or in person is a sexual abuse.	41.46%	44.59%	55.30%	37.01%	167	7.26%	43.26%
Refusal to sell a condom or contraceptive to you at the pharmacy shop is an abuse.	57.93%	57.66%	56.06%	58.66%	223	9.70%	57.77%
Sexually exposing parts of your body to others is sexual abuse.	44.51%	48.65%	40.15%	50.39%	181	7.87%	46.89%
Receiving sexually suggestive text messages and pictures is sexual abuse.	48.78%	54.05%	34.09%	61.02%	200	8.70%	51.81%
Forced marriage is a sexual and reproductive health abuse.	76.83%	79.73%	74.24%	80.71%	303	13.18%	78.50%
Having sex with your partner without their consent is a sexual and reproductive health abuse.	61.59%	60.81%	65.15%	59.06%	236	10.27%	64.14%
Not having a say as to the number of children to have with your partner is an abuse.	35.98%	37.84%	46.21%	32.28%	143	6.22%	37.05%
Deciding to abort a pregnancy without the consent of your partner is an abuse.	54.27%	68.02%	60.61%	62.99%	240	10.44%	62.18%
Total					2299	100%	595.60%

Source: Author's field survey, 2018

In sum, it is observed that the teenagers from La did not really have much knowledge concerning sexual and reproductive health. Aside the majority of them knowing about contraceptives, STDs/STIs and how to prevent them and some SRH abuses, they largely did not know of modern family planning methods and how to use the contraceptives that they readily identified.

4.4 Risky sexual behaviours/attitude among adolescents in La

The second objective of this study was to find out the SRH attitudes among adolescents. The result based on the sample indicates that approximately 29% of the respondents have engaged in substance abuse. This proportion is much lower than that of a similar study conducted in 2015 at Haramaya Secondary and Preparatory School in East Ethiopia where 44.6% of the teenagers in that school inclined to have engaged in substance abuse. Of those who admitted taking alcohol consisted of 60% of the students in JHS and about 53% of those in SHS. The school counsellor in school B buttressed this point when he said,

“I am aware that some of the students in this school consume alcohol. But I must be quick to add that they do not do this whilst on campus since they know it is against school rules and they will be suspended if caught doing so” (Interview, 2018).

More than half of those living with both of their parents (55.7%), relatives (66.7%) and non-relatives (62.5%) admitted ever taking alcohol. The results also showed that more of those whose parents were working in the informal sector (55.6%) used alcohol than those whose parents work in the formal sector (53.2%). The second highest substance that was abused by these teenagers was shisha (18.2%) which was done by over 17% of both the males and females with majority of these abusers being SHS students. Those who had their parents working in the formal sector abused more of shisha (23.4%) than their counterparts whose parents were working in the informal sector (14.3%). Most of the shisha abusers were living with single parents (26.1%). The least abused substances were marijuana (8.2%), cigarette (7.3%), codeine

(7.3%) and tramadol (4.6%). In analysing the abuse of the listed substances, the results showed that more of the male respondents smoked cigarette and marijuana than their female counterparts. They also consumed codeine than the females. However, more females (65.4%) than males (44.8%) admitted to taking alcohol.

Beside substance abuse, the study sought to know about respondents' attitude towards sexual relationships. It was observed that 44.6% of respondents were either in sexual relationships or have had one in the past. Close to half (48.2%) of the total number of respondents admitted having sex before. It was however striking to find nearly double the proportion of males (63.7%) admitting to having sex before as compared to the 34.8% of female respondents. Of this proportion that admitted to having sex before include 54.5% of the total number of respondents in SHS. Again, those who were living with both parents (48.5%) were more engaged in sexual relationships than those living with single parents (33.3%). There was a follow up question to find out if these teenagers were in multiple sexual relationships and just a small fraction of the total number of respondents (8.8%) admitted to having multiple sexual partners with just 8.4% of the males and 9.2% of the females making up this proportion. Few of those in JHS (5.3%) as compared to those in SHS (10.6%) had multiple sexual partners with a large portion of them being those living with non-relatives (26.3%).

Also worth noting was the fact that more than half of the adolescent students in SHS (57.7%) admitted to have had sexual intercourse compared with 29.8% of those in JHS. More than half of those living with single parents (52.4%) and those living with their relatives (55.3%) had engaged in sex at one point. It was worrying to find that most of those who had engaged in sexual intercourse were 15 years old, which is against the constitutionally mandated age of 16 years (Constitution, 1992).

When asked on how they ended up having sex, 47.5% of those who admitted to have had sex before said there was a mutual consent between them and the people they had sex with. Approximately 28% of them said they were pressured to have sex whilst 20% said they were forced to have sex. The remaining 5% said they were drugged. The results further showed that a larger portion of the males (57.14%) had sex based on mutual consent as compared to the females (40%). Collectively however, more females (53.34%) than males appeared to have either been forced or pressured to have sex than their male counterparts (40%). This finding is similar to that which was conducted in Tamale, Sekondi and Sunyani by Glover et al. (2003).

Respondents' attitude towards contraceptive use was also assessed. Results from the data gathered showed that a majority of them (81.6%) did not use any form of contraceptive to protect themselves whilst having sex. This outcome is quite high when compared to the findings of Oluwatoyin & Modupe (2014) who conducted a research into risky sexual behaviour among secondary school adolescents in Ibadan North local government area in Nigeria and found 45.1% of the respondents had engaged in unprotected sex.

In sum, it was observed that a slight majority of the teenagers in La had begun consuming alcohol with the larger portion being the female respondents (65.4%). Again, only 44.6% of the respondents admitted being in sexual relationships with a corresponding 48.2% of the entire number of respondents stating they were sexually active with most of them being the male respondents. Though some of them were sexually active, only 18.4% had ever used any form of modern contraceptive with only 8.8% having multiple sexual partners.

Table 4.4 Risky sexual behaviour among adolescents in La

		Risky sexual behaviour among adolescents in La (Percent)										
		Sex		Educational level		Living arrangement			Guardians Occupation		All	
		Male	Female	JHS	SHS	Both parents	Single parent	Relatives	Others	Formal	Informal	
Substance abuse	Alcohol	44.8	65.4	60.0	52.9	55.7	39.1	66.7	62.5	53.2	55.6	54.6
	Cigarette	8.6	5.8	16.0	4.7	8.2	13.0	0.0	0.0	6.4	7.9	7.3
	Marijuana	12.1	3.9	4.0	9.4	11.5	0.0	5.6	12.5	0.0	14.3	8.2
	Codeine	10.3	3.9	4.0	5.9	3.3	13.0	16.7	0.0	6.4	7.9	7.3
	Tramadol	5.7	3.9	12.0	5.9	4.9	8.7	0.0	0.0	10.6	0.0	4.6
	Shisha	19.0	17.3	8.0	21.2	16.4	26.1	11.1	25.0	23.4	14.3	18.2
Sexual relationship	Yes	44.1	44.9	25.2	54.5	48.5	33.3	48.2	36.8	41.4	46.7	44.6
	No	55.9	55.1	74.8	45.5	51.5	66.7	51.8	63.2	58.6	53.3	55.4
Have you had sex before?	Yes	63.7	34.8	29.8	57.7	39.9	52.4	55.3	84.2	50.3	46.7	48.2
	No	36.3	65.2	70.2	42.4	60.1	47.6	44.7	15.8	49.7	53.2	51.8
Contraceptive use	Yes	26.3	11.7	7.6	24.0	11.2	21.4	9.5	57.9	11.5	23.1	18.4
	No	73.7	88.4	92.4	76.0	82.8	78.6	90.5	42.1	88.5	76.9	81.6
Multiple sexual partners	Yes	8.4	9.2	5.3	10.6	9.1	7.1	5.9	26.3	8.3	9.2	8.8
	No	91.6	90.8	94.7	89.4	90.9	92.9	94.1	73.7	91.7	90.8	91.2

Source: Author's field survey, 2018

4.5 Other factors that could be linked to teenage pregnancy among adolescents in La.

Table 4.5 summarises result on other factors considered by respondents as precursors for teenage pregnancy. It shows that overall, anticipated family support (55.4%), misconception about teenage pregnancy as a sign of fertility (50.5%), lack of parental supervision (61.1%) and viewing of pornography (56.7%) were likely risk factors that could trigger high incidence of teenage pregnancy among adolescents. Also, about 57% of the respondents did not have much

knowledge of the menstrual cycle with majority of them being the male respondents (60.9%).

The difference between male and female who were viewing pornography was worth noting since 64.3% of the males were watching pornographic films as compared to the 50.2% of females equally watching pornographic videos.

Table 4.5 Other factors that could be linked to teenage pregnancy among adolescents in

La.

		Other factors that lead to teenage pregnancy among adolescents in La (Percent)										
		Sex		Educational level		Living arrangement			Guardians Occupation		All	
		Male	Female	JHS	SHS	Both parents	Single parent	Relatives	Others	Formal	Informal	
Anticipated family support	Yes	57.0	54.1	42.8	62.0	55.1	56.0	56.5	52.6	52.9	57.2	55.4
	No	43.0	45.9	57.3	38.0	45.0	44.1	43.5	47.4	47.1	42.8	44.6
Pregnancy proves your fertility	Yes	53.1	48.3	33.6	59.2	47.5	42.9	64.7	52.6	46.5	53.3	50.5
	No	46.9	51.7	66.4	40.8	52.5	57.1	35.3	47.4	53.5	46.7	49.5
Knowledge of the menstrual cycle	Yes	39.1	47.3	30.5	50.2	47.5	27.4	52.9	31.6	44.0	43.2	43.5
	No	60.9	52.7	67.2	49.8	52.5	72.6	47.1	68.4	56.1	56.8	56.5
Viewing of pomography	Yes	64.3	50.2	61.1	54.5	53.5	63.1	57.7	57.9	58.6	55.5	56.7
	No	35.8	49.8	38.9	45.5	46.5	36.9	42.4	42.1	41.4	44.5	43.3
Parental supervision	Yes	57.0	64.7	67.9	57.7	67.7	47.6	60.0	57.9	59.2	62.5	61.1
	No	43.0	35.3	32.1	42.4	32.3	52.4	40.0	42.1	40.8	37.6	38.9

Source: Author’s field survey, 2018

4.6 Testing of hypothesis

In an attempt to identify a link between teenage pregnancy and knowledge, perceptions and SRH attitudes, a chi square test was run on teenage pregnancy and each of the six variables

listed under knowledge. It was also run for each of the six variables under attitudes and the two variables under perceptions. The results showed that becoming pregnant or impregnating someone as a proxy measure of teenage pregnancy significantly related to respondents' knowledge on STDs/STI, contraceptives and its usage. In terms of attitude, the study observed that sexual intercourse, non-use of contraceptives and engagement in sexual relationships were significantly related to teenage pregnancies. Likewise, perception of teenage pregnancy as a sign of fertility was found to have statistically significant relationship with teenage pregnancy (Table 4.6).

Table 4.6 Chi square analysis measuring the level of association between teenage pregnancy, knowledge, attitudes and perception

Becoming pregnant or impregnating someone.	Pr<0.05	Chi square value
KNOWLEDGE		
Modern family planning methods	0.075	3.1631
STDs/STIs	0.003*	8.8205
How to prevent STDs/STIs	0.053	7.6975
Contraceptives	0.033*	4.5534
How to use a contraceptive	0.004*	8.2707
The menstrual cycle	0.642	0.2158
ATTITUDE		
Use of substances	0.084	2.9762
Non-use of contraceptives during or after sex	0.000*	30.7372
Watching of pornography	0.084	2.9824
Entering into a sexual relationship	0.000*	14.3213
Engaging in sex	0.000*	91.7508
Having multiple sexual partners in relationship	0.102	2.6804
PERCEPTION		
Becoming pregnant or impregnating someone proves one's fertility.	0.001*	11.6362
Anticipated family support should they impregnate someone or become pregnant	0.236	1.4024

Source: Author's field survey, 2018

Following the chi square analysis, I generated a new knowledge, attitude and perception index from the above listed variables in table 4.6 to be used in running a probit regression. The new knowledge index was generated by combining the six variables listed above in table 4.6 under knowledge and then divided by six to form the AllKnowledge2 index. In creating the Attitudenew2 index, I combined the six variables listed above in table 4.6 under attitude and divide it by six to obtain the AllAttitude2 index. For the AllPerception2 index, the two variables listed under perception in table 4.6 were added and divided by two to create it.

Table 4.7 Regression analysis for teenage pregnancy in La.

4.7.1 Probit regression reporting the marginal effects of some selected independent variables on the teenage pregnancy situation in La.

Probit regression, reporting marginal effects Number of obs = 386
LR chi2(9) = 176.09
Prob > chi2 = 0.0000
 Log likelihood = -99.143064 Pseudo R2 = 0.4704

HEBPIS~w	dF/dx	Std. Err.	z	P> z	x-bar	[95% C.I.]
Sexnew*	-.2079648	.0467919	-7.45	0.000	.536269	-.299675	-.116254	
Educat~w*	.1295689	.038767	3.99	0.000	.660622	.053587	.205551	
L_sing~a	.0066246	.0115235	0.58	0.562	.435233	-.015961	.02921	
L_rela~s	-.0011689	.0070336	-0.17	0.868	.660622	-.014954	.012617	
L_nonr~s	.0196224	.0112245	2.03	0.043	.196891	-.002377	.041622	
Age	.0117068	.0101717	1.13	0.258	17.5155	-.008229	.031643	
AllPer~2	-.0140438	.0235539	-0.59	0.552	.529793	-.060208	.032121	
AllAtt~2	.1498446	.0507981	3.97	0.000	.342401	.050282	.249407	
AllKno~2	-.0404906	.0433065	-0.94	0.346	.400259	-.12537	.044389	
obs. P	.1891192							
pred. P	.0373822	(at x-bar)						

(*) dF/dx is for discrete change of dummy variable from 0 to 1
 z and P>|z| correspond to the test of the underlying coefficient being 0

Source: Author’s field survey, 2018

Table 4.7 above shows the results of the probit regression.

The regression model used was as follows:

$$\text{Teenage pregnancy (HEBPISBnew)} = B_0 + B_1 \text{Sexnew} + B_2 \text{Educationnew} + B_3 L_* + B_4 \text{Age} + B_5 \text{AllPerceptions2} + B_6 \text{AllAttitudes2} + B_7 \text{AllKnowledge2} + U_i.$$

In the model, teenage pregnancy was the dependent variable, B_0 was the constant, B_1 to B_4 were the control variables, B_5 - B_7 were the independent variables and U_i was the error term assumed to have a zero mean and constant variance. B_1 to B_3 were made dummy variables. B_1 Sexnew was the sex of the respondents, B_2 Educationnew was the educational level of the respondents and B_3 L_* was the living arrangement of the respondents which included living with both parents, single parents, relatives and non-relatives. B_4 Age was the age of the respondents. B_5 AllPerceptions2 was the perceptions the teenagers have concerning SRH, B_6 AllAttitudes2 was the risky sexual behaviours/attitudes exhibited by the teenagers whilst B_7 AllKnowledge2 was their knowledge of SRH. The AllPerceptions2 index was made up of the variables anticipated family support in times of pregnancy and pregnancy as a proof of fertility. The AllAttitudes2 index was made up of these six variables; substance abuse, watching of pornography, entering into sexual relationships, engaging in sex, non-use of contraceptives during sex and having multiple sexual partners. The AllKnowledge2 index consists of six variables; knowledge of family planning methods, STDs/STIs, how to prevent STDs/STIs, knowledge of contraceptives, the menstrual cycle and how to use contraceptives.

The probit regression output showed the Prob> chi2 value (0.0000), the Pseudo R2 value (0.4704), LR chi2 [9] (176.09), the Number of obs (386) and the coefficients for the control and independent variables ("dF/dx" column). The Prob> chi2 value (0.0000) was significant. The Pseudo R2 value (0.4704) represented the proportion of variance in the dependent variable that could be explained by the independent variables. Therefore, for this study, 47% of variation in the dependent variable (teenagers becoming pregnant or impregnating others) was being explained by the independent variables in the model that looked at the knowledge and perceptions of SRH as well as the attitudes of the teenagers in La.

The results of the regression showed that there was a negative relationship between teenage pregnancy in La and the sex of the respondents. The results suggested that switching from male

to female reduced the likelihood of a female adolescents in La becoming pregnant by 20% than their male counterparts impregnating someone. This was statistically significant (0.000) at a 5% significance level. Also, there was a positive relationship between teenage pregnancy in La and the educational level of the adolescents. The results showed that switching from JHS to SHS increased the teenagers' chance of either becoming pregnant or impregnating another person by 12%. This was statistically significant (0.000) at a 5% significance level. The results again showed that there was a positive relationship between teenage pregnancy and the living arrangements of the adolescents in which a unit increase in adolescents living with non-relatives increased their odds of impregnating someone or becoming pregnant by 19% than those living with both of their parents, single parents and relatives. This was statistically significant (0.043) at 5% significance level. Finally, the regression results showed that an increase in the Attitude index (substance abuse, watching of pornography, entering into sexual relationships, engaging in sex, not using contraceptives during sex and having multiple sexual partners) among the teenagers of La increased their chances of becoming pregnant or impregnating others by 14.9%. This was statistically significant (0.000) at a 5% significance level. This indicates that there was a positive relationship between teenage pregnancy and the risky sexual behaviours exhibited by the teenagers in La. Therefore, it could be said that the teenage pregnancy situation in La was likely to increase by almost 15% should there be an increase in watching of pornography, entering into sexual relationships, engaging in sex, not using contraceptives during sex and having multiple sexual partners among the teenagers of La.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter puts across the major findings of the study and draws conclusions from it. Based on the findings, some recommendations were also presented and indicated areas that the study could not cover and should possibly be looked into by future research.

This study sought to assess adolescents' knowledge, perceptions and attitudes of sexual and reproductive health (SRH) in the La community. A sample of 386 students living in La were purposively selected from one junior high school and two senior high schools in La. These schools were randomly selected. There was a criteria employed in the study to help get answers to the three research questions, objectives and hypothesis. The objectives were to; ascertain the knowledge and perceptions of sexual and reproductive health among adolescents in La, examine sexual and reproductive health attitude among adolescents in La and identify linkages between teenage pregnancy and knowledge of SRH

5.1 Summary of key findings

Knowledge and perceptions of SRH among adolescents in La.

In assessing the knowledge and perceptions the teenagers of La had about sexual and reproductive health, it emerged that the majority of the sample (58.6%) did not know of any modern family planning method. Fifty-six percent of the teenagers however knew of at least one contraceptive but in terms of contraceptive usage, almost 82% of the respondents did not know how to use contraceptives. There was further evidence that showed that more than two-thirds of the sample knew of at least one STD/STI with the commonest among them being gonorrhoea, syphilis, chlamydia and HIV/AIDS. In terms of how to prevent such STDs/STIs,

more than half the sample believed that the best way was through abstinence. Knowledge of SRH abuses were linked mostly to forced sex, groping, refusal to sell condoms to a teenager, receiving sexually suggestive messages from somebody, forced marriage, non-consensual sex with partner and abortion without the consent of a partner.

Risky sexual behaviours exhibited by the adolescents of La

It emerged from the finding that more than half of the respondents had already commenced consumption of alcoholic beverages while a little below fifty percent have begun active sexual lifestyle. The gender difference was however striking with close to 64% of the male respondents admitting to being sexually active as compared to 34.8% of the females. It was also interesting to find about same proportion engaged in active sexual lifestyle were also into risky sexual relationships despite some of them knowing the consequences it poses on their SRH. Most importantly, it was common to find that a significant number of the sample engaged in sexual activities without using contraceptives either before or after sex.

Other factors that could be linked to teenage pregnancy

Of the other factors that could lead to teenage pregnancy, the study found that anticipated parental support was a crucial drive or motivation factor. This was because, more than half the sample indicated that they were likely to get pregnant or got someone pregnant only if they knew they could get parental support for their action. More interestingly, it was odd to find that approximately half the respondents getting pregnant at adolescent age thought this was a sign of fertility that must be encouraged.

Findings from the study show that becoming pregnant or impregnating someone as a proxy measure of teenage pregnancy was significantly related to respondents' knowledge on STDs/STI, contraceptives and its usage. In terms of attitude, the study observed that sexual intercourse, non-use of contraceptives and engagement in sexual relationships were

significantly related to teenage pregnancies. Likewise, perception of teenage pregnancy as a sign of fertility was found to have statistically significant relationship with teenage pregnancy

The regression results showed that switching from male to female reduced the likelihood of a female adolescents in La becoming pregnant by 20% than their male counterparts impregnating someone. This was statistically significant (0.000) at a 5% significance level. Furthermore, it was observed that switching from JHS to SHS increased the teenagers' chance of either becoming pregnant or impregnating another person by 12%. This was statistically significant (0.000) at a 5% significance level. Again, a unit increase in adolescents living with non-relatives increased their odds of impregnating someone or becoming pregnant by 19% than those living with both of their parents, single parents and relatives. This was statistically significant (0.043) at 5% significance level. Finally, the results showed that an increase in the Attitude index (substance abuse, watching of pornography, entering into sexual relationships, engaging in sex, not using contraceptives during sex and having multiple sexual partners) among the teenagers of La increased their chances of becoming pregnant or impregnating others by 14.9%. This was also statistically significant (0.000) at a 5% significance level.

The regression results showed that there was a positive relationship between teenage pregnancy in La and educational level, living arrangement and risky sexual behaviours exhibited by the teenagers (15 to 19 years) of La. It again showed that there was a negative relationship between teenage pregnancy and the sex of the adolescents in La (15 to 19 years).

5.2 Conclusion

The findings from the study showed that the teenagers from La did not really have much knowledge concerning sexual and reproductive health. Aside the majority of them knowing about STDs/STIs and how to prevent them, contraceptives and some SRH abuses, they largely

did not know of modern family planning methods and how to use the contraceptives that they readily identified. This is evident in the risky sexual behaviours that some of them were exhibiting especially in the situation where over forty-eight percent of them had already begun having sex with more than eighty-percent admitting to not using any form of contraceptives before or after sex even though they were aware of the dangers associated with such action. Also, it was observed that the majority of the teenagers (57%) at the time of the survey were already exposed to watching pornography which could further increase their desire to have sex. However, only a small percentage of those already in sexual relationships with others were having multiple sexual partners they were in relationships with at the time of the survey. Though this may seem minute, it is not something that can be overlooked since this greatly increases their chances of contracting STDs/STIs as well as becoming pregnant or impregnating someone. The danger is that they may end up spreading it even further especially when many of these teenagers (53.6%) have the perception that they cannot go into a pharmacy to buy contraceptive or visit the hospital for counsel because they would be ridiculed.

Most importantly, the perceived notion that parental support was a motivation for risky sexual behaviour should be considered a worrying development and a threat to adolescent sexual reproductive health. Though the chi square test results showed that there was a relationship between teenage pregnancy and the respondents' knowledge of STDs/STIs, knowledge of contraceptives, knowledge of how to use contraceptives, entering into sexual relationships, engaging in sex, not using contraceptives during or after sex and the perception that impregnating or becoming pregnant to prove one's fertility, results from the probit regression analysis rather showed that it was the variables under the attitude index that when increased would result in a 14.9% increase in teenage pregnancy in La. Again, the results further showed that sex of the respondents, educational backgrounds of the respondents and living with non-relatives all had marginal effects on the teenage pregnancy situation in La.

5.3 Recommendations

Based on the findings from the study, the study recommends the following:

❖ **Extension of SRH education and services into the communities in La by the La general hospital.**

In view of the fact that close to half the respondents lacked courage to consult pharmacists and other health professionals in times of need in relation to their sexual reproductive health means that more community health outreach programmes need to be organised by healthcare professionals to raise awareness on the need for adolescents to seek professional counsel. Particularly, the La General Hospital should take it upon itself to organize frequent community outreach programs to the residents. This will afford them the chance to meet the adolescents and gradually help take away the apprehensions they have about going to the hospitals for SRH related issues. With a cordial relationship gradually established between the teenagers of La and the health workers, they will begin to feel comfortable opening up to them and having their fertility checked if they desire. With this, the adolescents will gradually let go of the erroneous perception many of them have that they have to either impregnate someone or become pregnant to prove their fertility.

❖ **Paying of critical attention to the teenagers by counsellors and their guardians**

Results from the study has shown that there is the need for intense monitoring by both the counsellors in the schools and the guardians of the teenagers at home. With the results showing the kind of risky sexual behaviours that the teenagers are engaging in and the link that it has with increasing the teenage pregnancy situation in La, much effort will be needed from counsellors and guardians to know the kind of friends that the teenagers hang around with. These friends have been shown from the findings to be those they mostly discuss issues of SRH with and easily listen to. With effective monitoring and guidance from both the counsellors and

guardians, the teenagers can avoid being lured into some of such risky sexual behaviours that can lead to teenage pregnancy.

5.4 Limitations of the study

One major challenge faced during the research was that the municipal assembly did not have a comprehensive profile on La and this made it very difficult getting specific demographic data for my study area. There was also the issue of financial and time constraints. At some point in time when the data was being collected, school examinations had started and this hampered the rate at which the data was collected. Also, the study focused on only adolescents in school to the neglect of those who were not schooling. Therefore, future studies can research into the area by either focusing on adolescents out of school in La or those receiving education in private schools to help fill that gap.

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APPENDIX

UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH

Dear Sir/Madam,

This questionnaire is designed to collect data from adolescents between the ages of 15-19 for academic purposes only with the topic of the research being, **“Adolescents’ knowledge, attitudes and perceptions regarding sexual and reproductive health and teenage pregnancy in La, Greater Accra region”**. Due to the sensitive nature of the topic and some of the questions, any response you give to the questions below will be treated with utmost confidentiality. Respondents must do well to answer all questions.

Demographic characteristics

1. Age.....
2. Sex; a. Male b. Female
3. Religion; a. Christianity b. Islam c. African traditional religion d. Atheism
e. Other religion (indicate).....
4. Educational level; a. Primary b. JHS c. SHS
5. Living arrangement; a. Both parents b. Single parent c. Relatives d. Others
6. Parents’ work/job;

Knowledge and perception of sexual and reproductive health

7. Which of the following do you consider yourself to be at this stage in life?
a. A Child b. An adolescent c. A young adult d. Don’t know
8. Have you heard of sexual and reproductive health before?
a. Yes b. No
9. What is the source of your knowledge on sexual and reproductive health?
a. School b. Peers c. Parents d. Media
e. Other (specify).....

10. What is sex to you?
a. A right b. An obligation c. A biological function d. A fun activity
e. Irrelevant f. Don't know
11. Who do you feel comfortable discussing matters of sex with?
a. Friends b. Parents c. Teachers d. Siblings e. Others
(specify).....
12. Do you know of any family planning method?
a. Yes b. No
b. If yes, name any.
13. What changes are you experiencing in this period of life?
a. Physical changes g. I am not sure
b. Sexual feelings/wet dreams
c. Emotional changes
d. The desire to be with the opposite sex
e. Increased desire to have sex.
f. More problems
14. What are you afraid of in this period of life?
a. HIV/AIDS, STIs
b. Pregnancy
c. Dropping out of school
d. Uncertain future
e. Drug abuse
f. Bad peer influence
g. Menstruations
h. Sex
i. Nothing
j. Behaving badly
k. Don't know
15. Is HIV/AIDS a matter of concern for you?
a. Yes b. No
16. Do you know of any sexually transmitted diseases or infections (STDs/STIs)
a. Yes b. No

If yes, name any of them.....

17. What can you do to prevent HIV/AIDS and other STIs?

- a. Abstinence b. Using contraceptives c. Avoid contact with infected people
- d. Being faithful

18. Do you know of any contraceptives?

- a. Yes b. No

19. If yes, name any.....

.....

20. Do you know how to use a contraceptive?

- a. Yes b. No

21. This section tries to find out the perception you have about sex and reproductive health.

Read each of the sentences and tick whether you agree strongly agree (SA), agree (A), neutral (N), disagree (D) or strongly disagree (SD) with each of them.

a) There is an increase in sex-based messages, programs, music and adverts in the media today.

SA	A	N	D	SD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) It is a taboo to talk about sex and reproduction openly

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

c) Sex and reproduction is the business of adults

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

d) My religious beliefs make me feel engaging in sex is very bad.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

e) I am supposed to find out issues about sex and reproduction on my own.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

f) Having sex with your boyfriend/girlfriend is a normal thing.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

g) So long as you are receiving gifts from your boyfriend/girlfriend you should also give him/her sex in return.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

h) Having sex with your boyfriend/ girlfriend shows how much you love him/her.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

i) If I go into a pharmacy to buy a condom I will be seen as a bad boy/girl.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

j) I can't go to the hospital to talk to them about my sexual issues.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

k) Abortion is a bad thing.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

l) Using contraceptives can have an effect on your health

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

- m) Giving birth early is dangerous for your health.

--	--	--	--	--
- n) So long as you use a contraceptive you will not get pregnant.

--	--	--	--	--
- o) Health professionals show negative attitude towards adolescents seeking sexual and reproduction health services in the facility

--	--	--	--	--

22. The following are abuses in sexual and reproductive health. Read each of them and if you think it is an abuse to you, tick in the box []. If it isn't, just move on to the next sentence.

- a. Forced sex []
- b. Unwanted sexual touching by others (Groping) []
- c. Being spoken to in a sexually suggestive manner on phone or in person []
- d. Refusal to sell a condom or contraceptive to you at the pharmacy shop []
- e. Sexually exposing parts of your body to others. []
- f. Receiving sexually suggestive text messages and pictures. []
- g. Forced marriage []
- h. Having sex with your partner without their consent []
- i. Not having a say as to the number of children to have with your partner []
- j. Deciding to abort a pregnancy without the consent of your partner []

Risky Sexual Behaviour

- 23. Do you enjoy any form of supervision from your parents?
 - a. Yes b. No
- 24. If yes, in what ways?
- 25. Have you ever used any of the substances listed below (number 27) before?
 - a. Yes b. No (If no, skip to question 29)
- 26. If yes, which one(s),
 - a. Alcohol b. Cigarette (Tobacco) c. Marijuana d. Codeine e. Tramadol f. Shisha
- 27. How did you obtain it?
 - a. Friends b. drug store c. pub d. Street vendor
 - e. Other (specify).....
- 28. Why did you use it?
 - a. Peer pressure b. Curiosity c. Forced to use it

c. Other reason (specify).....

29. Do you watch pornographic videos (porn)?
a. Yes b. No (If no, skip question 31)

30. Where do you usually obtain them?
a. Online using my phone/laptop b. On TV c. From friends d. From CD sellers in the neighbourhood.
e. Other.....

31. Are you in a sexual relationship (boyfriend/girlfriend)?
a. Yes b. No

If no, skip to question 33.

32. Do you have multiple sexual partners that you are in a relationship with?
a. Yes b. No

If yes, how many and why do you choose to have that number?
.....
.....

33. Have you had sex before?
a. Yes b. No

If no, skip to question 37.

34. If yes, at what age did you first have sex?

35. If yes, why did it happen?
a. There was mutual consent to have sex
b. You were pressured
c. You were forced
d. You were under the influence of alcohol or other substance
e. Other reason(s).....

36. Have you ever used any contraceptive before?
a. Yes b. No

Teenage pregnancy

37. Are you aware of any danger that teenage pregnancy poses to the adolescent girl during and after pregnancy?
a. Yes b. No

38. If yes, name any.
.....
.....
.....

39. Have you ever been pregnant or impregnated someone before?
a. Yes b. No

40. Do you know the menstrual cycle very well?

- a. Yes b. No

41. Becoming pregnant or getting someone pregnant proves your fertility.

- a. Yes b. No

42. If you get a girl pregnant or become pregnant your parents will help you take care of the child.

- a. Yes b. No

43. If you get a girl pregnant or become pregnant you will get extra income from your partner or your parents to take care of the pregnancy.

- a. Yes b. No

44. Have any of your teenage friends become pregnant?

- a. Yes b. No

45. If yes, what reason did they give for becoming pregnant?

.....
.....

Thanks for your participation.