UNIVERSITY FOR DEVELOPMENT STUDIES

SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS: THE ROLE OF PLANNED PARENTHOOD ASSOCIATION OF GHANA (PPAG) IN THE WEST MAMPRUSI DISTRICT, GHANA.

ALIU AWUDU

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BY

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A DISSERTATION SUBMITTED TO THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL OF ALLIED HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT

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DECLARATION

I, Aliu Awudu hereby declare that this submission is my own work towards the award of Masters of Science Degree in Community Health and Development and that, to the best of my knowledge it contains no materials previously published by another person nor material which has been presented for the award of any degree of the University, except where due acknowledgement has been made in the text.

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ABSTRACT

Adolescence constitutes a transitional period between child psychism organization and the result of an adult, mature personality. During this evolutionary phase, the psychic balance is unsettled and the personality is characterized by fluidity. This study was conducted to assess sexual and reproductive health services (SRH) among adolescents: the role of Planned Parenthood Association of Ghana (PPAG) in the West Mamprusi District in the northern region of Ghana. Three research objectives were formulated to serve as a guide to the study. Descriptive cross sectional survey design was used to conduct the study with purposive sampling technique used to sample the schools and PPAG Clinic from the study area. In all 300 respondents were sampled from the study area. Results from the research showed that 88% of the respondents knew that PPAG Clinic was available in the study area and was providing sexual and reproductive health services to people including adolescents. Results also showed that 65.7% respondents stated that they knew about the comprehensive abortion services provided by PPAG clinic at the study area. From the results also, 88% respondents stated that ASRH services being provided by PPAG Clinic were readily available to adolescents. About 95% respondents knew the male condom as a family planning method whilst 36.3% respondents knew IUD as a family planning method. Key informants from the PPAG Clinic identified challenges confronting PPAG in providing ASRH services and information to the people in the study area to include; inadequate finance in carrying out outreach programs often, lack of commitment from adolescents and religious barriers. Advocacy on mass media awareness about the importance of ASRH services would be an ideal choice especially at the study area.

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May the Almighty Allah bless you all abundantly.

DEDICATION

I dedicate this thesis to the Almighty Allah, my family, friends and my supervisors.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AIDs	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ASK	Access, Services and Knowledge
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
HIV	Human Immune deficiency Virus
ICT	Information and Communication Technology
IUD	Intra-Uterine Device
LAM	Lactational Amenorrhoea Method
LDP+	Leadership Development Programme
NSAM	National Survey of Adolescent Males
NSFG	National Survey of Family Growth
PPAG	Planned Parenthood Association of Ghana
PNC	Postnatal Care
STDs	Sexual Transmitted Diseases
SRHR	Sexual and Reproductive Health Rights
UNFPA	United Nation Population Fund
YRBS	Youth Risk Behaviour Survey

CHAPTER ONE

1.1 Introduction

This chapter contains the background of the study, the problem statement and the research objectives with the corresponding research questions formulated. The significance of the study and brief background of PPAG are included in this chapter.

1.2 Background of Study

According to the United Nations Population Fund (UNFPA, 2002), adolescent sexual and reproductive health (ASRH) refers to the physical and emotional well-being of adolescents. This includes their ability to be healthy and remain free from early or unwanted pregnancy, unsafe abortion, sexually transmitted diseases including HIV/AIDS and sexual violence or coercion. The term “Sexual and Reproductive Health” has gained global recognition and popularity since the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt (Anochie and Ekpeme, 2013). The holistic definition of reproductive health which also included sexual health was devised in the ICPD programme of action (Anochie & Ekpeme, 2013). This definition was endorsed by 179 participating countries and also they expressed commitment to promote sexual and reproductive health in their respective countries. Since then ASRH programmes had been implemented with high priority in different countries and substantial progress had been achieved since that time (Anochie & Ekpeme, 2013). The essential ASRH services include: Family planning, antenatal care (ANC), safe delivery and post-natal care (PNC) services, Prevention and appropriate treatment of infertility, sexually transmitted infections (STIs), Human Immune Virus (HIV) and Acquired Immune deficiency

Syndrome (AIDs), Prevention of abortion and management of its consequences, Prevention and surveillance of violence against women as well as care of survivors, Strengthen referral system for further diagnosis and management of above problems, Promotion of human sexuality and reproductive health using appropriate methods like information, education and counselling.

In Sub-Sahara Africa, for example, a woman's lifetime risk of dying from preventable or treatable complications of pregnancy and childbirth is (1 in 39) as compared to (1 in 3800) in the developed regions according to Benson et al (2011).

The life of younger adolescence defined as ages from 10 to 19 years are characterized by profound biological, cognitive, emotional and social changes associated with the passage of puberty (Darroch, Singh & Frost, 2014). Age-related and gender-related risks and opportunities in families, communities and societies interact with individual developmental processes to create the conditions for both positive and negative health outcomes (Dela & Cruz, 2013). These formative years offer an ideal window of opportunity for building foundations for sexual and reproductive health and rights for young adolescents and for preparing them to make safe, informed and voluntary sexual and reproductive and other decisions in their lives (Dela & Cruz, 2013). The period of early adolescence is especially challenging for the provision of information and health services enabling adolescents to “deal in a positive and responsible way with their sexuality”, as recommended in international agreements (Glynn, 2015). Overlaying the enormous diversity of young adolescents’ lives based on socio-economic, cultural and family and community characteristics are individual and group variations in the timing and sequencing of girls’ and boys’ sexual and reproductive maturation and cognitive

capacities, particularly those relating to critical thought and impulse control (Jejeebhoy, Shah & Yount, 2013). These variations are reflected in differences in young adolescents' sexual curiosity and in their quest for information and experiences (Jejeebhoy, Shah & Yount, 2013).

From all stages of the adolescent's growth is the intensity of sexual drive resulting in the new and often mysterious emotions and thoughts accompanying them according to (Mathur, 2014). One important issue for both boys and girls at this stage is to manage to reconcile sexuality with the other sides of self-perception which is developing without conflicts and stress. This is not so easy in modern societies, where the roles of the sexes are changing all the time and a strange mixture of freedom and prudishness has spread (Lamas and Bissell, 2015). Biologically, the immature reproductive and immune systems of adolescent translate to increased susceptibility to STIs and HIV transmission (Mofenson & Munderi, 2014). In addition to biological vulnerability, cultural and socioeconomic factors particularly social inequality and exclusion, as well as having older partners increase their susceptibility (Mofenson & Munderi, 2014). Adolescents face serious threats to their lives and health in the form of HIV/AIDS and other sexually transmissible infections (STIs), early pregnancy, and unsafe abortion. Reproductive health information and services, which can avert these threats or mitigate their impact on adolescents' lives are thus vital components of the rights to life and health. It is estimated that every year five million unsafe abortions are performed on adolescents in low-income countries (Mathur, 2014).

1.3 Problem Statement

Young people are currently the group most severely impacted by HIV/AIDS in Africa (Mathur, 2014). In 2011, young people aged between 15 and 24 years accounted for 41% of all new HIV infections globally but severe in Africa and it is also estimated that globally, there are five million young people (15–25 years) living with HIV according to World Health Organization (WHO, 2012). Most of these young people live in Sub-Sahara Africa with majority being women who do not know their status according to (WHO, 2012). Globally, adolescent make up of more than 60% of all young people living with HIV, and in Sub-Sahara Africa that rate jumps to 72% (Rehan, Mah and Balal, 2011) with prevalence among adolescents girls in some countries five times higher than among adolescents boys (Mathur, 2014). Rates of STIs also show the highest prevalence among 19-20 year olds, followed by 15–19 year olds, again often with adolescent bearing the higher burden (Nguyen, 2012).

Data from the Tamale Metropolitan Health Directorate indicates that family planning practice is very low (11%) in Northern Region. This is even on the basis that very intensive programme have been put in place to intensify education and thereby improve the general acceptability of family planning use, the trends in the Metropolitan Health Directorates depicts a reduction in a population of 202,317 in 2008 only 18% utilized family planning services. The figure even reduced to 16% in 2009 and in 2010 estimated populations of 203, 076 and 203,962 respectively (Tamale Metro-Health Report, 2011). The Annual report of the West Mamprusi District Health Directorate for (2013) showed that 15.5% of ANC registrants were teenagers. This was found to be the highest number of teenage pregnancies ever recorded in the District and second in the region among all the 26 Districts. The first district in the region is the Zabzugu-tataale District which

recorded the highest in 2015. The Ghana Health Service has for many years supposedly provided youth friendly sexual health services to all. Much has been done to make these facilities youth friendly. Some health related Non-Governmental Organisations (NGOs) including Planned Parenthood Association of Ghana (PPAG) have been complementing or supplementing these efforts over the years. However, data from the West Mamprusi District Health Directory annual report of the (2013) and (2014), showed that Sexual Health Services and information for young people is poorly served. Even though the existence of PPAG clinic in the study area ideally is supposed to provide ASRH services and information to these people. The study is therefore designed to examine sexual and reproductive health services for adolescents: the role of Planned Parenthood Association of Ghana (PPAG) in the West Mamprusi District.

1.4 Research Questions

The following research questions guided the study.

1) What is the level of awareness of adolescents about the ASRH services being provided by PPAG in the study area?
2) What factors account for ASRH services utilisation among adolescents in the Kparigu sub-District?
3) What are the challenges confronting PPAG in the delivery of ASRH services to adolescents in the study sub-District?

1.5 Objectives of the Study

1.5.1 Main Objective

The main objective: To examine sexual and reproductive health services for adolescents: the role of Planned Parenthood Association of Ghana (PPAG) in the West Mamprusi sub-District, Kparigu of Northern Region of Ghana.

1.5.2 Specific Objectives

The specific objectives are as follows:

1. To assess the level of awareness of adolescents about the ASRH services being provided by PPAG in the study area.
2. To determine what factors account for the utilisation of ASRH services among adolescents in the study area.
3. To examine the challenges confronting PPAG in the delivery of ASRH services to adolescents in the study area.

1.6 Significance of the Study

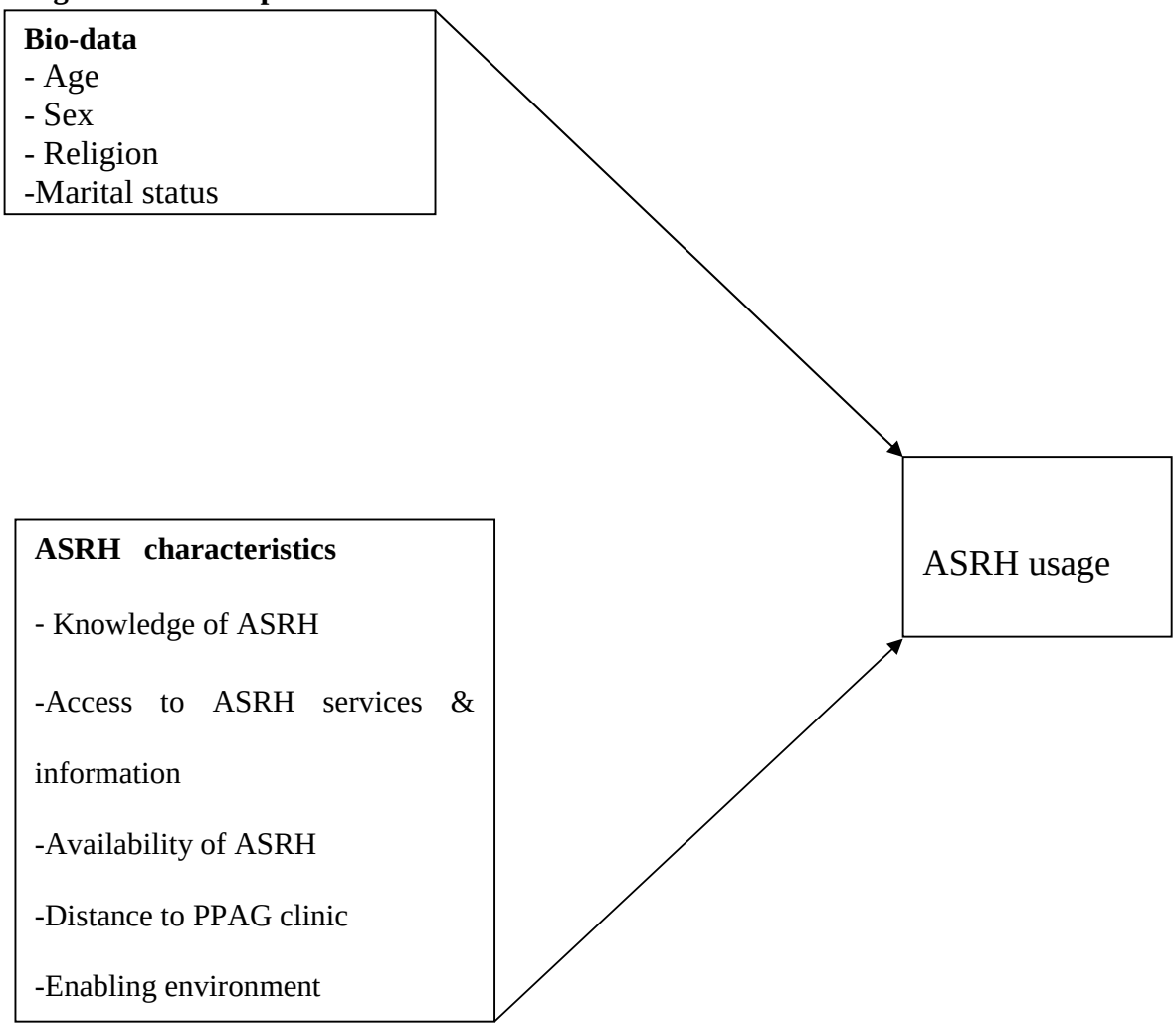
Information generated by the study would be useful for designing interventions and formulating policies aimed at improving the uptake of ASRH services in the West Mamprusi District especially for adolescents. There is an array of family planning services but people have their choices therefore, the results of this study would be helpful in assisting health workers, PPAG workers and peer educators to identify the preferred methods of family planning services for clients so that more resources would be committed in promoting those services. The findings of this study when published would serve as resource material for future research works.

1.7 Definition of Terms

- **Adolescents**: These are persons aged between 10 and 19 years. This shall be the working definition in the research work.
- **Abortion:** The deliberate termination of a pregnancy, usually before the embryo or foetus is capable of independent life.
- **Adolescent-Friendly Services:** These are Sexual and Reproductive Health services delivered in ways that are responsive to specific needs, vulnerabilities and desires of adolescents.
- **Sexuality:** It is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

1.8 Conceptual Framework

Figure 1.1: Conceptual Framework



(Source: Adopted from Boyd, 2014)

The conceptual framework establishes the relationship between respondents' bio-data characteristics, ASRH characteristics and access to ASRH services and information. The conceptual framework explains that the age, sex, religion and marital status which serve as bio-data of respondents influence respondents use of ASRH services and information.

From the conceptual framework also, knowledge of the availability of ASRH, access to ASRH, enabling factors among others influence use of ASRH services and information.

ASRH use is influenced by accessibility based on the extent to which staff attitude, education and campaign programmes, cost and service points distribution are planned to promote the service. Poor accessibility could therefore lead to low use of ASRH whereas the contrary would lead to an increase in use. Further accessibility characteristics, which are connected and influenced by social issues include religion, distance to health centre, education, taboos that are local, and decision making power at home among prospective users could influence ASRH usage. Poor social perspective on ASRH due to religion, education, moral or cultural factors may limit ASRH acceptability and up-take. In addition, economic status of users could empower their decision-making and further suppress negative social perspective of ASRH hence, increase its use. However, unemployment which leads to economic dependency may affect one's decision making on birth control and therefore use or non-use of contraceptives methods.

Finally, knowledge and use of ASRH information, has a direct and indirect influence on ASRH use. Directly, a more enlightened person on ASRH may use it but the less enlightened, may doubt its potency and its benefit and therefore may not find it attractive to use.

1.9 Background of PPAG

According to Planned Parenthood Association of Ghana (PPAG) report **(2015)**, reproductive health issues have been identified as a cause of ill health and death among adolescents and women of childbearing age. Women, especially those living in deprived

areas, suffer exceedingly from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, gender-based violence, and other problems which are related to their reproductive system and sexual behaviour.

Planned Parenthood Association of Ghana (PPAG) was set up in 1967 to provide family planning services to the people of Ghana. Over the years, its work has expanded to cover a whole range of sexual and reproductive health (SRH) services. Today, in addition to basic family planning support, PPAG provides maternal and child health care, infertility management, and voluntary counselling and testing (VCT) for sexually transmitted infections (STIs) including HIV/AIDs. It also provides other SRH services (for example, programmes for the management of erectile dysfunction).

National Partnership towards improved sexuality education in schools (2014) PPAG Report*;*

As part of PPAG's commitment to ensuring that young people in Ghana have access to comprehensive sexuality education, the Association partnered with the Ghana Health Service and the Ghana Education Service to further develop and strengthen the in-school adolescent development and reproductive health education. As part of the partnership, PPAG will provide technical assistance in terms of content development and provision of youth facilitators or resource person to help in coordination and delivery of programme within the schools. PPAG is also exploring the possibilities of using the platform to spread its Leadership Development Programme (LDP+) within the school system by engaging the management of the junior and senior high schools to adopt the LDP+ programme to improve their school infirmary. Through this initiative, PPAG will also support the national efforts to address the knowledge and information gap on

comprehensive sexuality education as facilitated by the Ghana Health Service with support from the Ghana Education service.

PPAG continued to implement the project "Reducing Maternal Mortality and Morbidity in Ghana". Queen Mothers were identified and trained in this initiative to help reduce maternal mortality in some selected communities in the Eastern Region, to increase access, quality and comprehensive abortion services and expand the provision of abortion related services as an integral part of sexual and reproductive health services. The Queen Mothers were tasked to conduct community durbars, sensitization meetings to educate young people on the dangers of unsafe abortion and the availability of comprehensive abortion care services. To ensure direct access to services, the project activities were linked to trained midwives from the Ghana Health Service who provided the health based education and safe abortion services to clients.

Host of the Ghana Access, Services and Knowledge (ASK). Sexual and Reproductive Health Rights (SRHR) Alliance programme;

PPAG is the host of the Ghana SRHR Alliance for Young People, a Coalition of eight (8) local NGOs which are currently implementing the Access, Services and Knowledge – ASK Programme. The ASK Programme contribute to government's efforts towards improving the sexual and reproductive health of young people in Ghana. The Alliance is currently made up of Planned Parenthood Association of Ghana – PPAG; Hope for Future Generations – HFFG; Northern Sector Awareness and Action Centre – NORSAAC; Simli Aid; Presbyterian Health Services – North; Curious Minds and Theatre for a Change and Savannah Signatures.

Working Teams were created to provide leadership for the Alliance and facilitate some alliance building by jointly implementing activities called joint activities. PPAG chairs the National Governing Body.

The PPAG has a Family Health Clinic sited at Kparigu in the Northern Region of Ghana, in the West Mamprusi District, since 1997. In pursuit of making SRH services more accessible, PPAG had implemented projects, which include Ensuring Mothers and Babies' Regular Access to Care (Project EMBRACE) in the Northern Region and Community-Based Contraceptive Services Project (CBCSP), elsewhere in Ghana. Others are adolescents and youth-related services established in Sunyani and the implementation of Comprehensive Adolescent Sexual Reproductive Health and Rights (CASRHR) in Accra, Sogakope, Mepe and Bomso.

1.10 Organization of the Thesis

This thesis is organized into six chapters. Chapter one comprises the background of the study, the problem statement, research questions, the study objectives, the significance of the study, definition of terms, conceptual framework, background of PPAG and Organization of the thesis. Chapter two is made up of a review of relevant literature in relation to the study. The methodology is presented in Chapter three comprising the study area, study design, data collection tools, sampling procedure and sample size determination, study population, sources of data, data collection methods and ethical considerations. Results of the study are presented in chapter four whilst the discussion of the results and findings of the study is done in chapter five. Chapter six comprises of the conclusion and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A literature review is an objective, critical summary of published research literature relevant to a topic under consideration for research. Its purpose is to create familiarity with current thinking and research on a particular topic, and may justify future research into a previously understudied area (Kalanda, Verhoeff and Chimsuku, 2013).

2.2 Teenage Pregnancy

Adolescent pregnancy is a complex phenomenon associated with economic and social factors, as well as sexual behaviour. It has come to be considered an important public health problem due to its prevalence in recent decades (Boyd, 2014; Adenike and Omoboye, 2013). According to World Health Organisation (WHO 2014), about 16 million girls aged 15 to 19 and some 1 million girls under 15 give birth every year, most in low and middle income countries. Complications during pregnancy and childbirth are the second cause of death for 15-19 year-old girls globally. Every year, some 3 million girls aged 15 to 19 undergo unsafe abortions. Babies born to adolescent mothers face a substantially higher risk of dying than those born to women aged 20 to 24.

The (2014) World Health Statistics indicate that the average global birth rate among 15 to 19 year olds is 49 per 1000 girls. Country rates range from (1 to 299) births per 1000 girls, with the highest rates in sub-Sahara Africa. Adolescent pregnancy remains a major contributor to maternal and child mortality, and to the cycle of ill-health and poverty.

Nationally, according to Ghana News Agency (2013), it is estimated that 750,000 teenagers between 15 to 19 years become pregnant in Ghana annually, and about 14,000 teenagers became pregnant in the Central Region alone.

Also, a total of 762 teenagers in the Gomoa West District in the Central region became pregnant in (2012) and 17 of them were aged between 10 and 14 years.

Regional assessment of teenage pregnancy in Ghana shows that the Upper East, Volta, Brong Ahafo, Central and Eastern regions have the highest regional rates of 14 per cent and above according to Ghana Demography and Health Survey (GDHS) report (2014). Of these regions the Upper East region has the highest national prevalence rate of teenage pregnancy of 15 per cent whilst the Northern region has the lowest prevalence rate of 4.4 per cent and is followed by Greater Accra with 6.6 per cent.

It is significant to note that no region has shown an annual decreasing trend in the prevalence of teenage pregnancy in Ghana over the last few years.

The rate of teenage pregnancy in Ghana is high, of all births registered in the country in (2014), 30 per cent were by adolescents, and 14 per cent of adolescents aged between 15 and 19 years had begun childbearing, according to graphic.com (2016). The growing numbers of pregnant adolescents shows that addressing adolescent sexual and reproductive health issues is vital in Ghana. According to graphic.com (2016), in Ghana, females represent 51.2 per cent of the entire population of almost 25 million whereas adolescents represent 22.4 per cent of the total population.

The consequences of sexual behaviour of adolescents are an enormous burden on themselves and the society as a whole (Eugene, 2014; Finer and Fine, 2013). These are

due mainly to little or no preparation and guidance they have on how to develop responsible sexual behaviour (Lamas and Bissell, 2015; Graham, 2014; Kaufman, De Wet and Stadler, 2013).

Developmentally, adolescents reach physical maturity before they are cognitively able to appreciate the consequences of their behaviour and their primary source of information regarding sexuality is their peer group. Most parents shy away from this responsibility (Lamas and Bissell, 2015). Many object to giving adolescents the capacity to delay parenthood while unsuccessfully imploring them to delay sexual activity (Lamas and Bissell, 2015; Mittal, 2014).

2.3 Awareness Level of ASRH Services

Teenage pregnancy is one of the unfavourable and usually unplanned outcomes of adolescent sexual activity. According to Mayor (2014), about 20% of pregnant teenagers conceive during the first sexual exposure and 50% within the first 6 months. It has also been revealed that the younger the age of initiating intercourse, the greater the likelihood of pregnancy among adolescents (Langer, 2011; Miller, Lesser & Reed, 2013). Approximately 15 million 15 to 19 year-old adolescents worldwide give birth every year, which represents more than 10% of all births (Creatsas, 2013; Adenike and Omoboye, 2013). At least 1.25 million adolescents become pregnant per year in the 28 members nations of the Organization for Economic Co-operation and Development (Kalanda, Verhoeff and Chimsuku, 2013). Of these, about half a million seek an abortion.

The number of abortions among 10 to 19 year-old adolescents dropped 22.4% from 2010 to 2013. The total drop was of 34.6% over that decade and such a reduction is attributed

to campaigns directed to adolescents and increased access to adolescent sexual and reproductive services and information (Adelakun, 2014; Görgen, Maier & Diesfeld, 2014). The adverse effects of unsafe abortion on the health of adolescents' girls are the result of restrictive laws, stigma, poverty, gender inequalities, and lack of access to adequate health care (Adelakun, 2014).

Access to modern adolescent sexual and reproductive health services is a key element for the reduction of unwanted pregnancies and the need for abortions (Adelakun, 2014). For many reasons, however, not all pregnancies can be prevented and societies should guarantee the right to quality care for all adolescents who decide to terminate their unwanted pregnancies (Anochie & Ekpeme, 2013). In almost all developing countries adolescent's access to safe abortion is restricted by the law, which results in high rates of preventable complications and premature deaths (Adelakun, 2014). Unsafe abortion continues to be a global *"persisting, preventable pandemic"* (Anochie & Ekpeme, 2013; p43) and its consequences have been a serious concern of international organizations. The World Health Organization (WHO, 2012; p23) defines unsafe abortion as *"…a procedure for terminating an unwanted pregnancy carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both"*. Unwanted pregnancy is the most common cause of induced abortions in all societies (Bali & Mahabal, 2012).

Unwanted pregnancies are those that occur at an inopportune time, as a result of unfavourable circumstances or among women who do not want to become pregnant or to have more children (Adenike and Omoboye, 2013). A study conducted in Colombia with 3,575 adolescents concluded that approximately one in each three participants presented

risky sexual and/or reproductive behaviours, including experiencing an unplanned pregnancy (Benson, Andersen and Samandari, 2011). An unplanned pregnancy that is also an unwanted pregnancy may pose a severe problem for the sexual and reproductive health of adolescents and young individuals.

Sexually active adolescents are at increased risk of contracting HIV infection and other sexually transmitted diseases (STDs). The HIV prevalence rate for adolescents aged 15-19 was almost similar for young women (1.1%) and young men (0.9%), while adolescents living in urban areas had higher HIV prevalence rates (2.2%) compared to their rural counterparts, 0.5% (Creatsas, 2013). In a cross sectional study conducted by Jejeebhoy, Shah and Yount (2013) among adolescents, findings revealed that for those who reported first sex before 15 years, HIV prevalence was 5.3 percent among young women and 0.3 percent among young men. Overall, adolescents between the ages of 10 and 19 years represented about nine percent of persons living with HIV and 13 percent of all HIV-related deaths in Kenya.

It is reported that HIV testing rates for Kenya are lowest among adolescents between 15-19 years (49.8%), with only 23.5 percent reporting awareness of their status. Forty-nine percent of young women aged 15-19 and 60 percent of those aged 20-24 had comprehensive knowledge of HIV, while 58 per cent of young men aged 15-19 and 71 per cent of those aged 20-24 had comprehensive knowledge of HIV; 53 percent of female adolescents and 34 percent of their male counterparts reported condom use during their sexual debut compared to 70 percent of females and 65 percent of males aged 15 and above (Jejeebhoy, Shah and Yount, 2013). Among never-married adolescents, girls were less likely to have used a condom during their last sexual encounter (42%) compared to their male counterparts (55%) (Jejeebhoy, Shah and Yount, 2013).

An association has been shown between maternal viral load and the risk of transmission from mother to child postnatal (Adelakun, 2014; Berer, 2012).

The presence of other STDs (such as syphilis, gonorrhoea, and chlamydia) with local inflammation may increase viral shedding, thereby increasing the risk of transmission during labour. Maternal antiretroviral therapy during pregnancy can reduce transmission, mainly through the reduction of viral load. However, combination therapy throughout pregnancy is expensive and not generally available in developing countries where it is most needed (Berer, 2012). In many countries, particularly in sub-Saharan Africa, adolescent girls are potentially doubly affected by HIV because they are vulnerable to infection and often act as caregivers. Adolescents, especially girls, are often vulnerable to HIV infection because of their lack of social status and their economic vulnerability (Mathur, 2014).

In some instances, adolescents are responsible for providing care to HIV-positive kin, a role that may turn them into de facto heads of household (Mathur, 2014). This situation may increase their own susceptibility to infection if they begin seeking income from unsafe sources (e.g., sex work) or engage in trading sex for food or school fees. In some settings in sub-Saharan Africa there is emerging evidence that early marriage brings increased vulnerability to HIV infection (Creatsas, 2013). A married adolescent may have frequent sexual relations with her husband who is often older and sexually experienced (Clark, 2014).

Majority of adolescents normally discuss sexual issues with their parents, but there is some variation according to topic and gender (Miller, Lesser & Reed, 2013). In most cases where adolescents discuss sexual issues with their parents, majority of them normally discuss about AIDs and, to a lesser extent, STDs (Kaufman, De Wet and

Stadler, 2013). According to the 1995 National Survey of Adolescent Males (NSAM), 57% of young men between the ages of 15–18 have ever discussed AIDs with their parents and 43% have ever talked about STDs. Studies by the Planned Parent Association of Ghana (Anonymous, 2012) have shown that family planning reduces maternal deaths by between 20 and 30 per cent in Ghana. Again, a multi sentinel survey conducted by Ghana Health Service in (2011) revealed that the use of modern contraceptives stood at only 23 per cent. This shows that despite the almost universal knowledge about family planning (over 90 per cent), practice of contraception remains low in Ghana.

At first intercourse, three-quarters of teenage girls in 2010 in Zambia reported using a contraceptive method (Jejeebhoy, Shah and Yount, 2013). Majority of them reported having used the condoms (63%), followed by the pill (8%) and other methods (4%). However, one-quarter used no method (Jejeebhoy, Shah and Yount, 2013). Other studies in Ghana, reported that most teenagers mentioned that they were not aware of the abortion services being provided by health centres (Anonymous, 2010). In Osun State, Nigeria, most adolescents were not aware of sex education services at health centres (Adenike and Omoboye, 2013). However, in Uganda, most adolescents reported high awareness of ASRH knowledge (Clark, 2014).

2.4 Challenges faced in delivering ASRH Services

A series of multifaceted barriers currently prohibits good sexual and reproductive health for adolescents (Lamas and Bissell, 2015). At the political level, ASRH is low priority and there are often restrictive laws and policies in place (Juma, 2012). Various societal, cultural, and religious factors create an inhibitive environment for discussion of ASRH as many societies hold a deeply embedded sense of disapproval of adolescent sexual

activity; this is often demonstrated through the stigmatization of sexual health concerns, in particular STIs/HIV (Mayor, 2014). Judgemental attitudes about sexual activity abound, especially for those out of marriage and sexually active girls and women (Miller, Lesser and Reed, 2013). In some regions, accepted practices of early marriage and childbearing, age differences between partners, and societal pressure prohibiting use of contraceptive methods may also exist.

Poor ASRH can be further confounded by conflict, migration, urbanization, and lack of schooling (Lamas and Bissell, 2015). With regard to service-related barriers, poor health systems for sexual health, family planning, and maternal health are common, with unmarried adolescents ignored in some cases, married adolescents in others, and an overall deficiency of youth-friendly services (Miller, Lesser and Reed, 2013). Lack of integration is seen where services that might address counselling and family planning fail to include HIV/STI care. Services may also be hampered by corruption and lack/erratic availability of supplies and equipment (Miller, Lesser and Reed, 2013). Economic and physical accessibility restrict adolescents' access to services where they do exist.

On a personal level, young people's care-seeking behaviour may be restricted because of fear (of people finding out and other confidentiality issues that may result in violence), embarrassment, lack of knowledge, misinformation and myths, stigma, and shame (Mofenson and Munderi, 2014). A range of people have an influence on adolescents' access to information and services, including peers, parents, family members, teachers, and healthcare workers. Some argue that the single most important barrier to care is provider attitude (Okezie, Ogbe and Okezie, 2010). Many healthcare workers deter adolescents from using services because of their attitude. The above patterns of sexual

relations make young girls extremely susceptible to STDs, in particular infections with HIV in regions with a high prevalence of the virus.

In particular, the fact that older and experienced men seek sexual relations with young girls without using barrier contraceptives leads to the transmission of these diseases (Rehan, Mah and Balal, 2011). In countries with a high prevalence of HIV some men even purposely have sex with young girls in an attempt to avoid becoming infected with HIV. In South Africa, one in five pregnant adolescents is infected with the virus (Rehan, Mah and Balal, 2011). Unprotected sexual intercourse is the risk behaviour common to both unintended pregnancy and HIV infection (Okezie, Ogbe and Okezie, 2010). Under these circumstances young girls at the beginning of their reproductive lives are at highest risk of HIV infection and relatively often a pregnancy in a young adolescent will be combined with a recent infection and high viral load (Rehan, Mah and Balal, 2011).

Adolescent pregnancy, whether intended or unintended, increases the risk of maternal mortality and morbidities including complications of unsafe abortion, prolonged labour, delivery and post-natal period (Okezie, Ogbe and Okezie, 2010). A number of factors have been associated with adolescent pregnancies. While many adolescents may choose to get pregnant, many pregnancies occur in the context of human rights violations such as child marriage, coerced sex or sexual abuse (Okezie, Ogbe and Okezie, 2010).Broader socio-economic factors such as poverty, lack of education and limited economic opportunities among girls may also contribute to adolescent pregnancy rates (Rehan, Mah and Balal, 2011). Furthermore, lack of reproductive healthcare services for adolescents particularly a lack of contraceptive education and affordable, available contraceptive commodities means contraceptive use among married and unmarried adolescents is generally low in developing regions (Rehan, Mah and Balal, 2011).

Millions of women in developing countries have an unmet need for modern contraception, which means that they want to avoid pregnancy but are using ineffective methods such as withdrawal and periodic abstinence or any method (Miller, Lesser & Reed, 2013; Mathur, 2014). In 2012, the number of sexually active women aged 15-49 years, both married and unmarried, who were in this condition was 222 million. Globally, the unmet need for modern contraception decreased slightly between 2008 and 2012, but increased in most of Africa reaching 53%, and in some sub-regions of Asia, Latin America and the Caribbean where the figures were 21%, 25% and 22% respectively (Miller, Lesser and Reed, 2013; Kalanda, Verhoeff and Chimsuku, 2013). In addition, adolescents may not use modern contraceptives for different reasons including concerns about their side effects or health risks, infrequent sex, rejection from their partners, or religious beliefs (Kalanda, Verhoeff and Chimsuku, 2013).

In Nepal, most teenagers stated that contraceptives for teenagers were available at all the times (Jejeebhoy, Shah and Yount, 2013). In Ghana, teenagers mentioned that location of places where adolescents could get contraceptives was a challenge to them compelling them to feel reluctant to use contraceptive. In Ghana, most (57%) adolescents stated that poor attitude of nurses at health centres was making it difficult for them to acquire commodities at certain times (Jejeebhoy, Shah and Yount, 2013). In Uganda, adolescents mentioned religious beliefs as a major problem affecting adolescents from using contraceptives (Kalanda, Verhoeff and Chimsuku, 2013). In Kenya, similar studies were reported by the Kenya National Bureau of Statistics (2014), where adolescents mentioned religion as a major factor affecting access to ASRH services.

2.5 Knowledge of Adolescents concerning ASRH

The term "adolescent" is often used synonymously with "teenager". In this sense "adolescent pregnancy" means pregnancy in a woman aged 10–19 years. In most statistics the age of the woman is defined as her age at the time the baby is born. Because a considerable difference exists between a 12-or13-year-old girl, and a young woman of say 19, others sometimes distinguish between adolescents aged 15–19 years, and younger adolescents aged 10–14 years. Birth rates and pregnancy rates are counted per 1000 of a specific population (Clark, 2014). Statistics comparing the incidence between countries often give rates per 1000 adolescents aged 15–19 years (Darroch, Singh and Frost, 2014). Sometimes statistical data on pregnancies and births among younger adolescents are also available. The pregnancy rate includes pregnancies ending in births and also pregnancies ending in abortion; the abortion rate is the number of (induced) abortions per 1000 women of a specific age (Boyd, 2014). The abortion ratio is the percentage of pregnancies ending in (induced) abortion (Barker and Rich, 2012).

Concern about the increase in unmarried adolescent pregnancy has been expressed throughout Africa (Barker and Rich, 2012). There is consensus that this is a phenomenon with detrimental effects for African society. The observed consequence include contributions to higher infant mortality (Eugene, 2014), potential barriers to the development of the woman, increased maternal morbidity and mortality (Barker and Rich, 2012) and the spread of sexually transmitted diseases (De Bruyn and Packer, 2014). It is contributing substantially to overall fertility in Sub-Sahara Africa. Taken as a region, the countries of Sub-Sahara Africa have the highest level of early child bearing in the world (Boyd, 2014; Creatsas, 2013; Berer, 2012). The problem of the morality of abortion is one of the most complex and controversial in the entire field of applied ethics.

It may therefore appear rather surprising that the most popular proposed "solutions" to it are extremely simple and straightforward, based on clear-cut universal rules which typically either condemn abortion severely in virtually every case or else deem it to be morally quite unproblematic, and hence permissible whenever the mother wishes (De Bruyn and Packer, 2014). This polarised situation in the theoretical debate, however, is in clear contrast with the abortion law in many countries (including Britain), where abortions are treated very differently according to the stage of pregnancy at which they are carried out, so that early abortions are permitted relatively easily, whereas very late abortions are sanctioned only in exceptional cases (Görgen, Maier and Diesfeld, 2014).

It seems likely, taking account of the time of an abortion, the law genuinely reflects the weight of public opinion there may be no overall consensus on the underlying moral issues, but it does appear to be part of "common sense" morality to accept that, whatever the ultimate rights and wrongs of abortion in general may be, at any rate abortion early in pregnancy is morally greatly preferable to late abortion according to (Eugene, 2014; Glynn, 2015). Young people are currently the group most severely impacted by HIV/AIDS. In 2009, young people aged between 15 and 24 years accounted for 41% of all new HIV infections among adults over the age of 15 and it is estimated that worldwide there are five million young people (15–25 years) living with HIV (Dela and Cruz, 2013). Treating STIs is essential because they can facilitate the transmission of HIV as well as causing lasting damage. Only a minority of adolescents have access to any acceptable and affordable STI/HIV services. In most countries, comprehensive and accurate knowledge about HIV is low and HIV testing in this age group is rare (Dickson, Sporle and Rimene, 2013). Outcomes for young people with HIV are poor; while a recent analysis estimated a 32% decrease in AIDS-related deaths among non-adolescents (aged 0–9 years and aged

20 and older) between 2005 and 2012, among adolescents (aged 10–19 years) there was a 50% increase in AIDS-related deaths, especially among boys (Dickson, Sporle and Rimene, 2013).

The World Health Organization estimates that globally more than 2 million adolescents are living with HIV (WHO, 2012). Over 35% of all reported cases of HIV are among young people of age group 15 to 24 years. Although the overall number of HIV related death is down by 30% since last decade, estimates suggest that HIV death among adolescents is still at rise. This increase which has been mostly in the Africa region may reflect the fact that although more children with HIV survive into adolescence, to prevent the transmission and maintain good health, they still lack proper care and support (United Nations Education Fund, 2012). Among adolescents, certain sub-groups for instance street adolescents and slum dwellers are most vulnerable to HIV (United Nations Education Fund, 2012). In India, where 22% of total population constitutes adolescents, fifty percent of the girls are married by 18 years of age. Unmet need of contraception among the age groups of 15 to 19 years is 27% and 40% of the adolescents' start taking drugs between the age of 15 and 20 and become victim of substance abuse (Okezie, Ogbe and Okezie, 2010).

Sexually transmitted infections (STIs), especially those that are ulcerative, are associated with an increased risk of HIV infection and have significant implications for reproductive health outcomes (Okezie, Ogbe and Okezie, 2010). Among Kenyan adolescents aged 15-19, only one percent of girls and 0.3 percent of boys self-reported an STI (Kenya National Bureau of Statistics, 2014). Among those aged 20-24, 1.9 percent of girls and 1.9 percent of boys self-reported an STI. However, these estimates are likely to be under reported due to lack of knowledge of common symptoms of these conditions as well as

routine clinical monitoring of STIs especially among young people (Langer, 2011). In across sectional survey conducted by Görgen, Maier and Diesfeld (2014) in Uganda it was showed that all the adolescents who were sampled for the survey said they have ever heard of ASRH services before and by extension had considerable knowledgeable.

Similarly, Dela and Cruz (2013) reported that adolescents had a very good knowledge concerning ASRH but felt reluctant to use it during sexual intercourse. In a cross sectional survey carried out by De Bruyn and Packer (2014) in rural Kenya among adolescents, it was reported that most of the respondents could not mention one example of family planning method but only stated that it was against their religious beliefs. In some instances society may not accept contraceptives due to cultural, religious and economic reasons, coupled with poor provider attitude and cost of service (Graham, 2014; Benson, Andersen and Samandari, 2011; Anochie and Ekpeme, 2013; Alubo, 2014; Bali and Mahabal, 2012).

Similarly, a cross sectional descriptive survey by Bali & Mahabal (2012) on adolescents perception of family planning issues revealed that adolescents in Kenya perceived family planning as bad because it has the tendency of promoting unnecessary sexual activities among young people. On the contrary, knowledge of adolescents who were sampled for interview on contraceptives use in Uganda was found to be very low (Anochie and Ekpeme, 2013). It was revealed by the report that most of the adolescents mostly from the rural communities mentioned that they were prevented from discussing contraceptives openly even among their colleagues for fear of being reported to their parents. Similarly, knowledge gap was discovered concerning adolescents in rural Tanzania on contraceptive regarding risks, benefits and side effects in several key areas, but was increased by counselling (Barroso, 2010).

The report indicated that 77% of the females and 85% of the males who were sexually experienced adolescents had never used any contraceptive method and 64% of the females and 74% of the males had never used a modern contraceptive method before (Barroso, 2010). In a cross-sectional survey in rural communities in Nigeria, condom was the most widely known modern contraceptive method since it was cited by 43% of women; the Pill was by only 28%, Injectable 16.2%, IUD 8%, spermicidal foam 2%, and the diaphragm by less than 2% (Becker, 2013). In a study conducted by Becker (2013) concerning adolescents knowledge on what method of contraceptive they considered all the time to use, most (51%) mentioned the male condom, 30% of the adolescents mentioned periodic abstinence, whilst 19% adolescents mentioned Norplant.

In a similar study, findings made by Bali & Mahabal (2012) revealed that 45% adolescents mentioned pills as their preferred choice, 34% adolescents mentioned spermicidal, 15% adolescents mentioned sterilization whilst 6% adolescents mentioned injectable (Depo-Provera). However, adolescents in Uganda did not know any method of contraceptives that were available for them to use (Bali and Mahabal, 2012). In Nigeria, adolescents were not using any method of contraceptive according to (Adenike and Omoboye, 2013). It was revealed that most (67%) adolescents were not using contraceptives whilst 33% adolescents were using contraceptives at the time of the research (Adenike and Omoboye, 2013).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The methodology that was used in conducting this study is presented in this chapter. The subsections in this chapter include the study design, a description of the study area, the study population, sample size determination, sampling procedures, data collection procedures and analyses, quality control measures and ethical considerations.

3.2 Study area

The research was conducted in the Kparigu sub-District in the West Mamprusi District of Northern Region of Ghana. The West Mamprusi District was created in 1988 under Legislative Instrument (LI) I 1448 which was later in 2012 replaced with LI 2061 following the creation of the Mamprugu Moagduri District. The District is located within longitudes 0°35'W and 1°45'W and Latitude 9°55'N and 10°35'N. It has a total land size area of 2610.44 sq km and shares boundaries with East Mamprusi and Gushiegu Districts to the east; North Gonja, Savelugu and KumbunguDistricts to the south; Builsa, Kassena-Nankana East Districts and Bolgatanga Municipality (Upper East Region) to the north and; to the west, Mamprugu Moagduri District.

The West Mamprusi District is one of the 26 administrative assemblies in the Northern Region of Ghana with Walewale as its capital. Administratively, the District lies within the Northern region, although it has strong economic and functional linkages with some major settlements in the Upper East Region like Bolgatanga and Fumbisi. The West Mamprusi District has a population of 121,117 (GSS, 2010). About 50.8% of the District's population is made up of females while 49.2% constitutes males. There are 86

communities in the District including some fishing and farm camps. The District is predominantly rural, with a population of 76,503 living in rural settlements. Urbanization in the District is centred in Walewale, which is the dominant urban centre having many social amenities.

3.2.1 Water and Sanitation

The principal sources of water supply in the District are small town water supply systems in Walewale, Wulugu, Nasia white volta and Guabuliga. There is water point sources fitted with hand pumps and hand dug wells. The main agencies facilitating access to water and sanitation services in the West Mamprusi District are Community Water and Sanitation Agency (CWSA), NGOs including World Vision Ghana, New Energy and European Union RWSP.

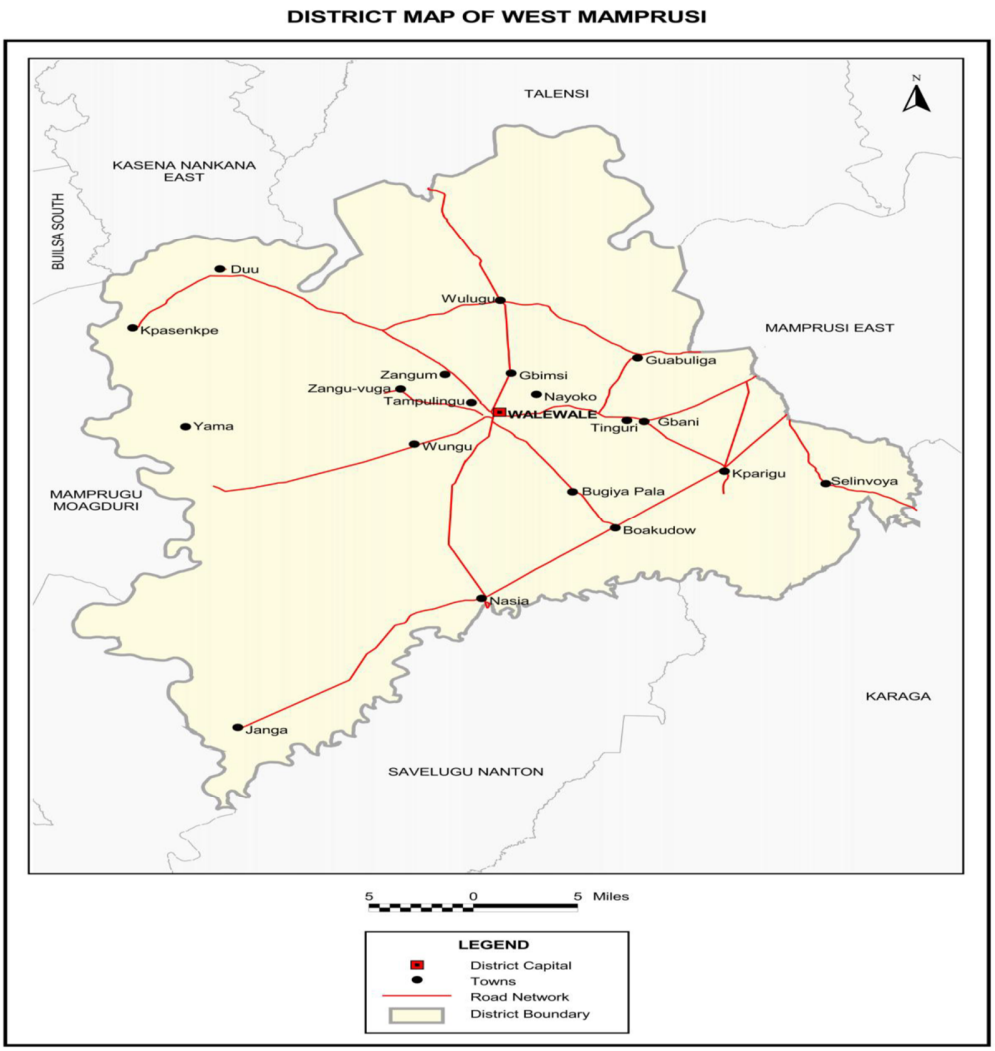
3.2.2 Health

Health facilities in the District are few and woefully inadequate. The highest level of health delivery systems in the District is the Walewale District Hospital which serves as a referral centre. There are four other private and public health facilities in the District. These are the Janga Polyclinic, Kpasenkpe Health Centre, Kparigu PPAG clinic, Mandela and Our Lady of Roccio private clinics in Walewale. Other health facilities are the Community Health Planning Services (CHPS) compounds at Gbeo, Nasia, and Guabuliga.

3.2.3 Culture and Ethnicity

The West Mamprusi District is largely inhabited by the Mamprusi who constitute about 75 per cent of the total population of the District. This dominant ethnic group coexists harmoniously with minority groups such as the Builsa (4.7%), Frafras (2.7%), Kasena (2.2%), Dagomba (1.8%), and some other ethnic groups in Ghana. The main traditional festivals celebrated in the District are the Bugun (fire festival) and Damba festivals. The main dominant religions are Islam (79.4%), Christianity (15.6%) and the Traditionalists (3.7%) (West Mamprusi District Assembly, 2012; 2013).

Figure 3.2: Map of West Mamprusi District



(**Source: West Mamprusi District Assembly, 2012; 2013**)

3.3 Research Design

. A cross-sectional descriptive study design was used. This study design provides a comprehensive summary of a phenomenon in everyday language and is ideal when direct descriptions of the phenomenon are desired (Creswell, 2003). It is used as a need assessment tool to provide information on which to base sound decisions and to prepare

the background for more constructive programme of health research. Both qualitative and quantitative approaches were employed.

Table 1: Study Population and Sample Size

POPULATION SIZE (P)=532			STUDY PARTICIPANTS (N) =300		
FORMS(J.H.S) 1, 2 & 3.	BOYS	GIRLS	TOTAL	PROPORTION TO SAMPLE	
FORM 1	124	94	218	70+53=	123
FORM 2	91	106	197	51+60=	111
FORM 3	59	58	117	33+33=	66
GRAND TOTAL	274	258	P=532	154+146=	(N)=300

The study population involved only adolescents aged (10-19) years, that is early adolescents (10-14) and late adolescents (15-19) years who were students in the schools selected in the study area. The sample size involved 300 adolescents from a total of 532 study population. This sample size was determined from the study population using the sample size to proportionate approach. In the various classes, the number of pupils by sex was expressed as a percentage of the total number and from the results a figure was obtained. In Form one class, 70 adolescent boys were proportionately sampled from the total of 124 whilst 53 respondents were selected from the total of 94 adolescent girls in that class. In Form two classes 51 adolescent boys were selected from a total of 91 whilst 60 adolescent girls were selected from a total of 106. In Form three classes 33 adolescent boys were selected from a total of 59 whilst 33 adolescent girls were also selected from a

total of 58. This was due to the fact that most of the Form three students were not available at the time of the study.

3.5 Sampling Criteria

Sampling criteria is the essential characteristics of the target population (Creswell, 2003). Sampling criteria refers to inclusion and exclusion criteria which help to control extraneous variables. It ensures homogeneity and provides a guideline for sample recruitment (Creswell, 2003). For production of credible results, extraneous variables which could interfere with measurement will be controlled. Inclusion criteria refer to the specific characteristics the investigator wishes to include in a study (Creswell, 2003). Whereas exclusion criteria refers to characteristics not wanted in the study (Creswell, 2003).

3.5.1 Inclusion Criteria

- Only adolescents who were considered as pupils in the selected Junior High schools in the study area.
- Only adolescents who were willing to be used as study participants.

3.5.2 Exclusion Criteria

- Adolescents who were in Primary school at the study area.
- Any adolescent in the study area.
- Adolescents who were not willing to be used as study participants.

3.6 Sampling Technique

Non-probability sampling technique was used to select the institutions of study, thus PPAG Clinic and Kparigu L/A J.H.S and study participants, thus key-informants, teenagers and Service providers (sexual and reproductive health needs providers) in Kparigu sub-District. Neuman (2007) has noted that, purposive sampling is used to select cases that are especially informative and when a researcher wants to identify particular types of cases for in-depth investigation. Moreover, the purpose is less to generalize to a larger population, but rather to gain a deeper understanding of the issues under consideration. Kumekpor (2002) has also opined that purposive sampling is useful in studies evaluating the causes of success or failure of projects. In such cases, projects which are known to have failed or succeeded are studied to identify causes or factors of failure or success.

A non-probability sample technique specifically the purposive sampling method was used to select the PPAG Clinic as it was the only one serving in Kparigu sub-District for the study. The selection of the school was informed by the fact that it serves a double stream with a population of 532 pupils for seven communities within the study area. These communities included: Boamasa, Nabulugu, Senvoya, Moatani, Zaalari, Guakudow and Kparigu. Simple random sampling technique was however, used in the various classrooms with the assistance of some teachers to select the study participants. Simple random sampling technique was used to give each adolescent in the classroom an equal chance of being selected for the study.

3.7 Data Collection Tools

Face-to-face interviews using structured questionnaire was used to collect primary data from the study participants. The questionnaire consisted of closed and opened ended questions. The secondary data was obtained from the review of relevant literature. A qualitative method using an interview guide to elicit additional relevant information on ASRH and challenges confronting PPAG among health staff at the study area was developed and used. This complemented the quantitative information gathered using the structured questionnaire. All the data gathered from the key informants with the interview guide were put into common themes based on the study objectives.

3.8 Assumptions of the Study

For the purpose of this study the following assumptions were made by the researcher:

(i) The study assumed that all the study participants provided accurate information to the responses.

(ii) The study assumed that PPAG has provided ASRH information and services to study participants.

(iii) The study assumed that study participants had the right to access ASRH information and services.

3.9 Limitations of the Study

This research work is not without limitations. The process of selecting respondents randomly from a sample was challenging as every adolescent wanted to take part in the research work in the classroom. Also, some selected study participants were very reluctant to respond to the questionnaire. The survey relied upon adolescent self-

assessment of ASRH information and services. The reliance on self-recall of how study participants responded to certain questions is a big challenge. There was also inadequate research articles on the study topic directly as much was yet to be done about it. Insufficient funds was another challenge. Nonetheless, these limitations did not influence the interpretations of the findings.

3.10 Data Processing and Analysis

The completed questionnaires were crossed checked for completeness and accuracy. The data were summarized in (MS Excel 2013) and where appropriate, the data was coded for subsequent descriptive analysis. Descriptive statistical tools used included tables, pie charts and bar graphs. The qualitative data were analysed manually and responses grouped into themes (content evaluation).

3.11 Ethical Considerations

The study was approved by the University for Development Studies. All participants gave prior informed consent. The respondents were made aware that they reserved the right to withdraw any time they had a change of mind. Completed questionnaires were structured to ensure confidentiality of the respondents.

CHAPTER FOUR

RESULTS

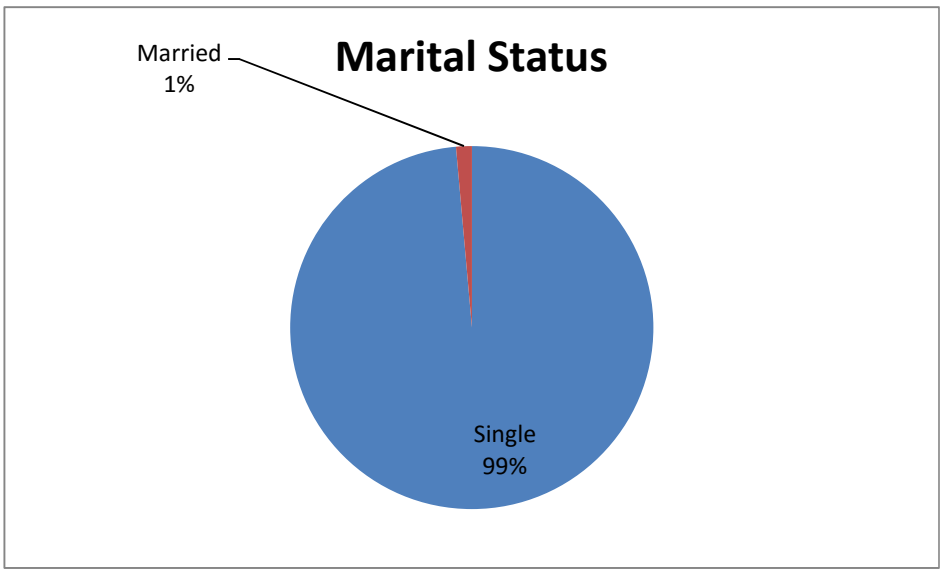
4.1 Introduction

This chapter presents the findings and analysis of the data that was collected from the respondents. The Microsoft excels 2013 was used to analyse the primary data. The results are presented in the form of simple frequency and percentage tables, pie charts and bar charts.

4.2 Demographic Characteristics of Respondents

The demographic background of the respondents is shown in Table 4.2 under the following headings; age, gender, marital status, form and religion.

Figure 4.1 Marital Status



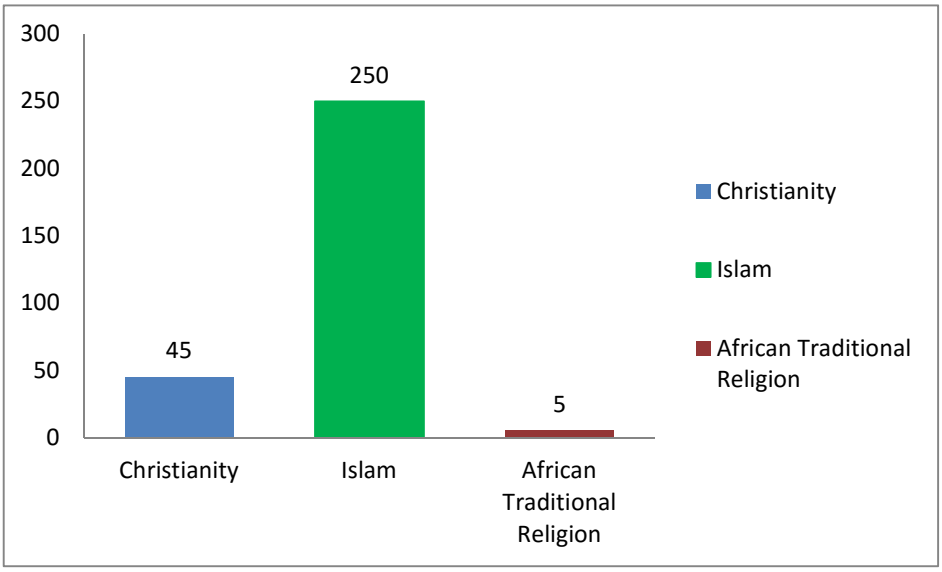
The pie chart above shows the marital status of respondents at the Junior High School level, indicating that some young adolescents are involved in early marriage which may affect the quality of their education. This is also indicated in the table below.

Table 4.1: Socio-demographic characteristics of respondents

Variable	Frequency(N=300)	Per cent (100%)
Age		
10-14	126	42.0
15-19	174	58.0
Gender		
Male	154	51.3
Female	146	48.7
Marital Status		
Single	296	98.7
Married	4	1.3
CLASS		
Form one	135	45.0
Form two	91	30.3
Form three	74	24.7
Religion		
Christianity	45	15.0
Islam	250	83.3
ATRs	5	1.7

Source: Field survey, 2016

Figure 4.2 Religious Denomination



The bar chart above indicates both boys and girls in their various faith; that Islam Religion dominate within the study area followed by Christianity and African Traditional Religion who co-habit peacefully.

From Table 4.2, the mean age of the respondents were 12.4 ± 0.494 (mean ± SD). More than half 174 (58%) of the respondents were between the ages of 15-19 years while 126 (42%) of the respondents were aged between (10-14) years. A very high proportion 296 (98.7%) of the respondents said they were single but in a consensual relationship whilst 4 (1.3%) of the respondents claimed they were married. From Table 4.1, 135 (45%) were in form one, 91 (30.3%) in form two whilst 74 (23.7%) were in form three. From the results also, 250 (83.3%) respondents were of the Islamic faith with only 45 (15%) respondents and 5 (1.7%) respondents being Christians and Traditional worshippers respectively. Analyses also revealed that 274 (91.3%) respondents said they were living with their parents whilst 22 (8.7%) respondents indicated that they were not living with their parents. Additionally, study participants responded to the following issues as; 278

(92.7%) respondents said they were living with parents whilst 22 (7.3%) respondents said they were living with their extended relatives.

From the results, 67.7% respondents said they found it easy to discuss sex-related issues with their friends whilst 22 (7.3%) respondents found it easy to discuss sex related issues with their parents. This may be due to the fact that parents are now beginning to see the importance of educating their adolescent children on their reproductive and sexual rights to prevent unwanted pregnancies on the part of adolescents' girls who may indulge in sex without any contraceptive method.

4.3 Awareness Level of ASRH Services being provided by PPAG

Table: 4.3 Awareness of PPAG Services

Variable	Yes	No
Ever heard of PPAG clinic	265 (88.0%)	35 (12.0%)
Activities of PPAG	262 (87.3%)	38 (12.7%)
Contraceptives services of PPAG	238 (79.0%)	62 (21.0%)
Counselling services of PPAG	180 (60.0%)	120 (40.0%)
Abortion services of PPAG	197 (65.7%)	103 (34.3%)

Source: Field survey, 2016

From Table 4.3, respondents were asked whether they have ever heard of PPAG clinic before and 265 (88%) said yes whilst 35 (12%) said they have never heard of PPAG clinic. This may be due to the fact that this category of respondents came from one of the communities' far from the study area and perhaps may not be informed of PPAG Clinic. Among respondents who said they have ever heard of PPAG clinic indicated their

sources of information. And from the results, 86 (32.5%) of the respondents said they heard of PPAG clinic from a community forum, 80 (30.2%) respondents said they came into contact with the clinic face to face interaction, 52 (9.6%) respondents mentioned the media, 25 (9.4%) respondents said they heard of the clinic from peer educators whilst 22 (8.3%) respondents said they heard of PPAG clinic from a health facility. From the table also, 87.3% respondents said they knew the activities of PPAG in the study area whilst 12.7% respondents said they do not know what PPAG does in the study area.

Respondents were asked whether they were aware of the contraceptives services offered by PPAG clinic and 238 (79%) said they were aware of the contraceptives services offered by PPAG clinic whilst 62 (21%) respondents were not aware of the contraceptives services offered by PPAG clinic in the study area. Respondents were asked on the counselling services provided by PPAG clinic and from the results 60% respondents were aware of the counselling services whilst 40% respondents were not aware. Analyses showed that 156 (52%) respondents said they were aware of the sex education services provided by PPAG clinic whilst 144 (48%) respondents said they were not aware of the sex education services provided by PPAG clinic at the study area. With regards to awareness of comprehensive abortion services provided by PPAG clinic, 197 (65.7%) respondents said yes they were aware of the comprehensive abortion services provided by PPAG clinic whilst 103 (34.3%) said they were not aware of the comprehensive abortion services provided by PPAG clinic. When probed respondents stated that they have never been there for such services before

4.4 Challenges faced by PPAG Clinic in delivering ASRH Services

Interaction with key informants at the study area identified challenges confronting PPAG at the study area.

'I think the Islamic ideology was a big challenge here as most Muslims find it very difficult to access ASRH services and information as they perceived it to be against their faith'. (source: 62 year old medical assistant of PPAG clinic and 35 old midwife, 2016).

'There is also high illiteracy rate here too. Most people are still not informed of the importance of the PPAG Clinic especially on ASRH services and information being provided to people'(source: 62 year old medical assistant of PPAG clinic and 35 old midwife, 2016).

'There is inadequate finance to scale up more sensitisation programs for adolescents at the study area and the neighbouring communities'. (source: 62 year old medical assistant of PPAG clinic and 35 old midwife, 2016).

'We also have logistic constraints making it difficult sometimes to work in this place'. (source: 62 year old medical assistant of PPAG clinic and 35 old midwife, 2016).

'The staff also woefully inadequate in this clinic to serve all the needs of the people, especially adolescents on ASRH services'. (source: 62 year old medical assistant of PPAG clinic and 35 old midwife, 2016).

Table: 4.4 Challenges in accessing ASRH.

Variable	Yes	No
ASRH General Services	174 (58.0%)	126 (42.0%)
Usefulness of ASRH Services	276 (92.0%)	24 (8.0%)
Availability Of The Services	264 (88.0%)	36 (12.0%)
Accessibility of ASRH services	264 (88.0%)	36 (12.0%)
Ability to purchase ASRH services	235 (78.0%)	65 (22.0%)
Location of PPAG clinic	212 (70.7%)	88 (29.3%)

Source: Field Survey, 2016

From Table 4.4, respondents were asked whether they were aware of the general ASRH services being provided to adolescents by PPAG clinic and 174 (58%) said yes they were aware whilst 126 (42%) said no they were not aware of the general ASRH services provided by PPAG clinic. It was also revealed that 276 (92%) respondents said ASRH services provided by PPAG clinic was useful to them whilst 24 (8%) respondents said ASRH services provided by PPAG clinic was not useful to them. According to the 8% respondents, sometimes the services they use do not work and in most cases they end up becoming pregnant. With regards to ASRH services being readily available to respondents, majority of the respondents (88%) said ASRH services were readily available to them whilst 12% respondents said ASRH services were not readily available to them. According to them sometimes they go there only to be told that they have run out of the commodities and refer them to come back another day. It was also revealed that 264 (88%) said ASRH services were accessible to them whilst 36 (12%) said ASRH services were not accessible to them. Among these respondents most of them were

coming from the surrounding communities which are quite far from the Kaprigu community and may not have access to the services at their own will.

Respondents were further asked whether they were able to afford ASRH services and 234 (78%) said “YES”, they could afford the ASRH services whilst 66 (22%) said “NO”, they could not purchase the ASRH services. According to them they are not working and could not tell their parents that they wanted money to go and buy any of the family planning methods; like condoms and pills especially at night. It was also revealed that most of the male counterparts do not buy them and keep in their homes for fear of being called a bad person by their parents. Respondents were asked whether the PPAG clinic was very far from their reach and majority of the respondents 212 (70.7%) said “YES” the PPAG clinic was very far from their reach because they were commuting from the other six communities to Kparigu for their JHS education, whilst 88 (29.3%) said “NO” the PPAG clinic was not far from their reach. With regards to belief or cultural practices that make it difficult for respondents to use ASRH services, 98 (32.7%) said “YES” there were beliefs and practices preventing them from using ASRH services whilst 202 (67.3%) said “NO”, there were no belief and cultural practices preventing them from using ASRH services. Respondents also identified few examples at the opened ended questions to include;

‘Religious beliefs. In explaining the influence of religious belief, one respondent put it succinctly: “I am a Muslim and I do not think my religion permits me to go in for contraceptives”. She explained further that the influence of religion negates the use of contraceptives’. source: respondent (2016).

'Fear of being call a bad girl. One respondent stated that when your friends get to know that you are using contraceptives they will tell your parents and your parents will conclude that you a bad girl', source: respondent (2016).

4.5 Knowledge of ASRH

Respondents' knowledge about the various methods of family planning and contraceptives was assessed. The results showed that knowledge of male condoms was universal in the study sample. All (100%) of the respondents reported that they are aware and know about the male condoms.

Table: 4.5 Family planning methods.

Variable	Yes	No
Pills	212 (70.7%)	88 (29.3%)
Intrauterine device (IUD)	109 (36.3%)	191 (63.7%)
Injectable (Depo-Provera)	53 (17.7%)	247 (82.3%)
Norplant	77 (25.7%)	223 (74.3%)
Condom	285 (95.0%)	15 (5.0%)
Spermicidal	241 (80.3%)	59 (19.7%)
Tubal ligation	60 (20.0%)	240 (80.0%)
Sterilisation	41 (13.7%)	259 (86.3%)
Vasectomy	89 (29.7%)	211 (70.3%)
Periodic abstinence	57 (19%)	243 (81%)
Using any method of contraceptive	57 (19.0%)	243 (81.0%)

Source: Field Survey, 2016

From Table 4.5 respondents were asked to identify the family planning methods known to them and from the results, 70.7% respondents identified pills as a family planning method whilst 29.3% respondents did not know pills as a family planning method. Also from the Table, 109 (36.3%) respondents knew IUD as a family planning method whilst 63.7% respondents said they do not know IUD as a family planning method. It was also showed that, 53 (17.7%) respondents knew injectable (Depo-Provera) as a family planning method whilst 247 (82.3%) respondents did not know injectable (Depo-Provera) as a family planning method. From the results also, 25.7% respondents knew Norplant as a family planning method whilst 74.3% respondents did not know Norplant as a family planning method. From Table 4.3, 95% respondents knew condom as a family planning method whilst 5% respondents did not know condom as a family planning method.

From Table 4.3, results also showed that, 59 (19.7%) respondents said they knew spermicidal as a family planning method whilst 241 (80.3%) respondents said they do not know spermicidal as a family planning method. Analyses showed that 80% respondents said they knew tubal ligation as a family planning method whilst 20% respondents said they do not know tubal ligation as a family planning method. Findings also showed that, 86.3% respondents stated that they knew sterilisation as a family planning method whilst 13.7% respondents said they do not know sterilisation as a family planning method, 29.7% respondents stated that they knew vasectomy as a family planning method whilst 70.3% respondents said they do not know vasectomy as a family planning method, 81% respondents stated that they knew periodic abstinence as a family planning method whilst 19% respondents said they do not know periodic abstinence as a family planning method.

With regards to whether respondents were using any contraceptives, majority of the respondents (81%) said “NO”, when asked to know why, they stated fear of side effects,

fear of being call bad people and fear of parents being informed about it whilst a relatively smaller number (19%) claimed they were using contraceptives methods. It was also revealed that 18% of respondents said they were using Norplant, 17% respondents said they were using pills, 12% respondents said they were using periodic abstinence whilst 10% respondents said they were using condom.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Introduction

This chapter presents the discussion of the results from the research findings. The discussion of these results is based on the specific objectives of this study. Key among the issues is the extent to which findings agree with or at variance with the reviewed literature.

5.2 Demographic Characteristics of Respondents

Reproductive health program and services are commonly targeted to women's reproductive health and offered their services exclusively to women, especially with family planning, prevention of unwanted pregnancy, maternal care during the pregnancy period, risky abortion and the improvement of safe motherhood. But the role of adolescents in reproductive health and ASRH has always been ignored by reproductive health programs. Adolescents are more interested in ASRH issues than often assumed but need communication and services directed specifically at them. Findings from the research revealed that all the respondents were aged between 10-19 years. These respondents were made up of adolescents with formal educational training at the Junior High level.

From the results it was revealed that the age of respondents and knowledge on ASRH and sexually transmitted diseases (STDs), social network and inter-relationship communication have significant association with adolescents' involvement in ASRH issues. It is important to also emphasize that religious beliefs of respondents also affected

how they participated in sexual and reproductive health issues. Since the research involved adolescents aged 10–19 years, it is important that ASRH issues be taken seriously with this category of respondents since findings from the research revealed that respondents have adequate knowledge and information about ASRH except negative attitude towards the usage of ASRH services.

Despite the divergent religious views of respondents particularly with respect to Islam and Christianity, there was still a misconception that sexual and reproductive health adoption among believers of both sects is a violation of their own religious beliefs and practices. As already known, religion forms an essential component of the individual's life and therefore has enormous influence on their decisions, depending on the type of religion they belong to, and the doctrine of their religion.

5.3 Awareness Level of ASRH

Worldwide, one-third of the eligible couples using contraceptives rely on methods such as (vasectomy, condom, withdrawal and periodic abstinence) which require full co-operation of both partners (Creatsas, 2013). Although all adolescents have responsibilities and interest in reproductive health and ASRH, demographic studies on fertility and family planning have overwhelmingly focused on women. In practice, the effect that men have on their own and on women's reproductive lives may be more varied. Results from the study revealed that majority of the respondents representing 79% stated that they were aware of contraceptives issues at the study area. With most of them identifying the health centres, from PPAG clinic that was available to them to access sexual and reproductive health information and services, from their friends and from the media.

This finding from the study supports the study done by Clark (2014) where adolescents in Uganda were aware of sexual and reproductive health information and services being provided to adolescent at health centres. The results also confirm the report of the GHS (2011) where awareness level of contraceptives among Ghanaians was found to be very high. From the results also it was revealed that 87.3% of the respondents despite the existence of the PPAG health clinic at the study area were not aware of the activities of PPAG. This finding could affect adolescents' access to contraceptives services and information especially in time of needs. In line with that only 52% of the study participants knew that sex education was provided at PPAG clinic at the study area. This finding from the study is similar to that of the findings made by Adenike and Omoboye (2013) where teenagers in Osun State, Nigeria did not know that sex education information was provided at health centres in Nigeria.

Concerning whether respondents discuss sex related issues with their parents or not at the study area, it was revealed that majority of the respondents representing 66.3% mentioned that they do not normally discuss sexual issues with their parents. This finding from the study disagrees with the study done by Miller, Lesser and Reed (2013) where adolescents aged 15-18 years stated that they had ever discussed sexual issues with their parents. Majority of the respondents representing 66.7% however, mentioned that they have ever discussed sexual issues with their friends. These findings from the study disagrees with the findings made by Miller, Lesser & Reed, (2013) where study participants, mentioned that they have ever discussed sexual issues with their parents.

Involving adolescents has been a prominent part of the shift from family planning and demographic targets, to the broader reproductive health agenda promoting gender, equality and equity, empowering adolescents and improving family health in society

(Darroch, Singh and Frost, 2014). Adolescents participation has been conceptualised in several ways to enhance their full participation in sexual and reproductive health issues, for instance: (1) adolescents' involvement in decisions about family size and family planning; (2) adolescent' responsibility to reduce risky sexual behaviour and prevent spread of sexually transmitted infections; (3) adolescent's support for sexual and reproductive health and (4) adolescent's own reproductive and sexual health needs particularly in late adolescent period.

5.4 Challenges faced by Adolescent in accessing ASRH Services

There are many challenges confronting adolescents from effectively using sexual and reproductive information and services. Therefore, to exclude adolescents from sexual and reproductive health information, counselling, and services is to ignore the important role adolescent's behaviour and attitudes may play in couples' reproductive and health choices. For example, in some communities in Ghana, societal norms, religious practices, and cultural practices influence adolescents to a great extend over decisions that affect their family's reproductive health. There were notions that the use of modern contraceptive methods encouraged young women to become sexually promiscuous. From the results, both users and non-users expressed the belief that partners of young women who use contraceptives felt that they encouraged the women to be unfaithful.

Findings further revealed that although adolescents have high knowledge on contraceptive, but the actual practice of respondents in using contraceptive was low (19%). From the results 32.7% of the respondents mentioned that beliefs and cultural practices affected the way they access ASRH services and information at the study area. The respondents stated that the major challenge affecting the effective utilisation of

sexual and reproductive health issues among them at the study area. This finding from the study supports the study done by Jejeebhoy, Shah and Yount (2013) where adolescents in Kenya identified cultural and religious beliefs as challenges affecting adolescents from effectively accessing sexual and reproductive health services even if they knew that those services existed.

Another challenge that was identified by respondents was the cost of the commodity. Findings revealed that 22% of the respondents mentioned that sometimes they found it very difficult to purchase sexual and reproductive health commodities. This finding from the study supports the survey carried out by the Kenya National Bureau of Statistics (2014) where economic under-development and poverty are contextual factors identified as determinants of contraceptive use and the uptake of sexual health services among adolescents.

5.5 Knowledge of ASRH

Knowledge provides a foundation for human action. What people know does affect what they do. This is readily seen in daily life. It is also demonstrated by theory and related research. For example, both knowledge and skills are important components of the ability to perform a behaviour (behavioural capability), a central concept in social cognitive theory (Barker and Rich, 2012). Similarly, knowledge is an important factor in other psychological theories such as the theory of planned behaviour. Both of these theories are commonly used as the theoretical basis for effective sex and STD/HIV education programs. Knowledge plays an important role in the stages of change theory, particularly in the consciousness-raising process, which is used in some effective programs (Barker

and Rich, 2012). Examples of the importance of knowledge in sexual behaviour are numerous.

Adolescents may avoid situations that place them at risk of undesired, unplanned or unprotected sexual activity if they do not know ahead of time that those situations are risky. Adolescents will not seek the services of ASRH consistently and correctly if they do not know it exists, how to obtain information may be necessary for its proper use. On the other hand, even though knowledge may provide a foundation, greater knowledge may not necessarily assure responsible behaviour. For example, adolescents may know that drinking alcohol increases their chances of engaging in unintended sexual activity, but may drink alcohol anyway if they are at a party and all their friends are drinking. Adolescents may have considerable information about contraception, but still not consistently use contraception when engaging in sexual activity if their values, attitudes and perceptions of peer norms are not favourable to contraceptive use.

Simply put, while knowledge provides a foundation for human action, knowledge alone is not sufficient. Knowledge may affect behaviour directly. For example, if sexually active young women know they are supposed to take a contraceptive pill every day, they are more likely to take that pill every day. Knowledge may also affect behaviour indirectly by affecting values, attitudes, perception of norms and even perceptions of self-efficacy (Darroch, Singh and Frost, 2014). For example, if youth do not know their parents' values about sexual intercourse among teens, their own values about sexual intercourse may be shaped more by their peers and the media and they may be more likely to engage in sexual activity at an earlier age.

If adolescents do not know that condoms provide considerable protection against pregnancy and STDs, their attitudes towards condoms may be more negative and they

may be less likely to use condoms during sexual activity. If adolescents know how to use condoms or other methods of contraception properly, they are more likely to feel confident using condoms or other methods of contraception and actually use them properly. Specifically, to reduce unwanted pregnancy, adolescents need to delay sex or reduce the frequency of sex and increase consistent and correct use of effective contraception. To reduce STD transmission, young people need to delay sex, have sex less frequently, have fewer sexual partners, avoid concurrent sexual partners, increase condom use, increase the time period between sexual partners, be tested (and treated if necessary) for STDs and be vaccinated against HPV and hepatitis B.

For example, not having sex at a particular time or with a particular person may involve: deciding not to have sex, communicating personal limits about sex, suggesting alternative activities to sex, avoiding situations that might lead to sex and refusing to have sex. Similarly, using condoms may involve: making the decision to use condoms, buying or obtaining condoms, carrying condoms, negotiating their use and using condoms. Associated with each of these more specific behaviours are multiple learning objectives that will affect adolescents s' intention and ability to perform these behaviours.

In this study, all (100%) the respondents had heard of contraceptives before. This finding from the study was not surprising. This finding from the study is consistent with the study done by Görgen, Maier and Diesfeld (2014) where adolescents in Uganda expressed high knowledge concerning family planning and sexual and reproductive health issues. Again this study supports the study done by Adenike and Omoboye (2013) where adolescents said they have ever heard of sexual and reproductive health issues. Results from the study further revealed that all (100%) the respondents knew the male condom as an example of contraceptive method including pills and vasectomy. Adolescents involvement in ASRH

regards adolescents knowledge of reproductive health and family planning, attitudes about the use of contraception, communication with partners about family planning, choices about appropriate contraceptive methods, gives emotional and behavioural support to their partners' to use contraceptives. From the study only 19% respondents reported that they had ever used any form of contraceptive before. This finding from the study supports the study done by Anochie and Ekpeme (2013) where as high as 74% of adolescents stated that they were not using any form of contraceptive at the time of the research work. Although most would now agree that adolescents involvement is important, the introduction of programmes that aim to involve adolescents pose some serious questions about the effects of involving adolescents in areas that have traditionally been considered the preserve of older persons, such as pregnancy and fertility control.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this chapter, highlights of the main results of this study are presented, conclusions drawn from the findings and key suggestions are recommended to assist policy makers in their formulation of programs with regards to ASRH.

6.2 Conclusion

Respondents strongly believe that they are more aware about SRH issues although they do acknowledge that health workers discuss these issues more with older people especially married women than with them. This makes it all the more important for programme planners to ensure that adolescents have complete and correct information concerning ASRH services, for them to make informed choices about SRH decision. The study, however, revealed that knowledge of ASRH services among respondents was high. Therefore, findings from this research confirmed that awareness and knowledge of ASRH information and services do not necessarily translate to use. The main barriers to ASRH information and services uptake among study participants in the study area are myths and misconceptions, with both users and non-users exhibiting lack of factual information on the different contraceptive methods.

The results from this study highlight the social nature of beliefs and behaviours around ASRH. The decision to use or not is primarily influenced by others from within the social network, whose views and perceptions are often more important than an individual's

own. Therefore, ASRH issues campaigns should look beyond the individual to social networks in order to drive demand and remove barriers.

6.3 Recommendations

Based on the findings from the study, a number of recommendations were made to assist (PPAG) and policy makers interested in providing enabling factors for young people to access ASRH services in the study area and Ghana as a whole.

- The Planned Parenthood Association of Ghana (PPAG) should liaise with their sponsors and try to mobilize sufficient funds to scale up their activities of creating awareness leading to knowledge and practises of young people in ASRH services.
- Mobile clinics should be established by government in order to bring ASRH services closer to adolescents' homes or Schools by reducing distances and costs to SRH services.
- PPAG and Ghana Health Service should team up well where the latter train and post adequate healthcare workers to the former such as health surveillance assistants, midwifes and other logistics to improve ASRH services education and up-take in the study area using local languages at specific healthcare centres and community gatherings to help address illiteracy rate.

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APPENDIX I

STUDY QUESTIONNAIRE FOR SCHOOL CHILDREN

UNIVERSITY FOR DEVELOPMENT STUDIES

GRADUATE SCHOOL, TAMALE

INFORMED CONSENT

I am ALIU AWUDU, a student of the University for Development Studies (UDS) offering a Master's Degree Program in Community Health and Development. I am conducting a study on **SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG ADOLESCENTS: THE ROLE OF (PPAG).** I would very much appreciate your participation in this study. This information will help stakeholders in the District to device ways of changing the current circumstances. Whatever information you provide will be kept strictly confidential and will not be shown to any other than the District Health Directorate and the University for a helping hand.

Participation in this study is voluntary, however your views are important for our future welfare. Any clarity needed I am ready for that, thank you.

Respondent agrees (a) Yes ( ) (b) No ( )

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

1. How old are you?.....
2. Which community are you coming from.....
3. What tribe are you? a) Mamprusi b) Bulsansi c) Fulani d) Bimoba e) Others; specify .....
4. What is your religion? a) Islam b) Christianity c) ATR d) Others.....
5. Which form are you in? a).[JHS one] b. [JHS two] c). [JHS three]
6. What is your marital status? a. [Single] b. [married] C. [In a relationship] D. [Divorced] E. Others specify.....
7. How many children do you have?……
8. Do you live with your parents? a) yes b) no
9. Do you live with your relatives? a) yes b) no
10. Which of the following people do you find it easy to discuss sex-related issues with? a) parents b) friends c) teachers d) siblings e) others .....
11. Do your parents discuss sex-related issues with you at home? a) yes b) no

PPAG AWARENESS

12. Have you heard about PPAG clinic? a) Yes b) No
13. How did you hear about them for the first time? a). Face to face interaction b). Community forum c). Radio d). Peer educator e). Visit to the clinic
14. Do you know what PPAG does? a) yes b) no
15. Are you aware of the contraceptive services offered by PPAG? a) Yes b) No
16. Are you aware of the counselling services PPAG provide? a) Yes b) No
17. Are you aware of the of sex education services PPAG provide? a) Yes b) No
18. Are you aware of the comprehensive abortion services PPAG provide?

    a) Yes b) No

ACCESS TO ASRH SERVICES

19. Are you aware about general ASRH services being provided to adolescents by PPAG's clinic? a) Yes b) No
20. Is the PPAG clinic helpful to you? a).Yes b). No c). Somehow
21. Is the PPAG ASRH services readily available? a). Yes b). No
22. Are the ASRH services accessible to you? a). Yes b). No
23. Are you able to purchase the ASRH services? a). Yes b). No c). sometimes

24. Does the service work for you? a).Yes b). No

25. Is the PPAG clinic very far for your reach? a) Yes b) No

26. Name other sources of ASRH services in the community apart from PPAG you Know. A..... B..... C..... D..... E.....

27. Do you have the following problems in trying to access ASRH services in PPAG clinic? *(Circle all if is applicable to you).*

(a) Poor attitude of nurses (b) High cost of contraceptives (c) Not available (d) Very far to reach (e) Cultural taboos.

28. Do you have any belief or practice that makes it difficult for you to use ASRH service? a) Yes b) No

29. If yes to Q 28, what are these beliefs or practice?.....

ASRH KNOWLEDGE

Do you know of the following family planning methods?

30. Pills a). Yes b). No

31. Intrauterine device (IUCD) a). Yes b). No

32. Injectable (depo-provera) a). Yes b). No

33. Norplant (buried under skin) a). Yes b). No

34. Condom a). Yes b). No

35. Spermicidal a). Yes b). No

36. Tubal ligation/female a). Yes b). No

37. Sterilization a). Yes b). No

38. Vasectomy/male sterilization a). Yes b). No

39. Periodic abstinence/calendar a). Yes b). No

40. Do you use any contraceptive methods currently? a). Yes b). No

If yes, which type of contraceptive methods are you using?

I. Pills
II. Intrauterine device (IUCD)
III. Injectable (Depo-Provera)
IV. Norplant (buried under skin)
V. Condom
VI. Spermicidal
VII. Tubal ligation/female
VIII. sterilization
IX. Vasectomy/male sterilization
X. Periodic abstinence

APPENDIX II

INTERVIEW QUESTION GUIDE FOR HEALTH CARE PROVIDERS

1) PPAG was established in which year?
2) What are your catchment areas?
3) What ASRH services do you provide to your clients?
4) Who is your main target?
5) What ASRH services do your clients patronise most?
6) How often do you get in touch with clients?
7) Where do you meet clients for sex education and services?
8) Do parents agree to clients using ASRH services?
9) How do you break socio-cultural barriers to ASRH services utilisations?
10) Is it costly to provide the services?
11) What is your compliance rate?
12) How do you measure your compliance rate?
13) What challenges do you face in providing ASRH care services to your clients?
14) As a service provider, suggest ways for improving efficient reproductive health service delivery to the intended beneficiaries?