

UNIVERSITY FOR DEVELOPMENT STUDIES

**FACTORS CONTRIBUTING TO TEENAGE PREGNANCY IN THE WEST
MAMPRUSI DISTRICT**

ESTHER TANI GOMNAH



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MAMPRUSI DISTRICT**

BY

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**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY
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DECLARATION

Student

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere:

Candidate's Signature

20/9/16

Name: Esther Tani Gomnah

Date

Supervisor

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies

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Date



ABSTRACT

Investing in teenage girls today will unleash their full potential to shape humanity's future. However, the distorted transitioning of girls into womanhood as a result of early pregnancy ought to be seen as a significant economic loss. This study sought to ascertain the factors determining teenage pregnancies in the West Mumprusi District. The study was cross-sectional in design with both qualitative and quantitative data used. A total of 196 teenage mothers were sampled for the study and data analysed using SPSS version 21. The mean age of the study participants was 16.6 ± 1.4 with a minimum and maximum age of 12 and 19 years respectively and a median age of 17 years. Majority of the study participants had never been to school and most (61.7%) of them still depended on their parents for their daily survival. The data revealed that, 19.4% of the teenage girls interviewed were pregnant at the time of the study. Contraceptive use ($p=0.01$) and level of freedom from home ($p=0.04$) were identified as important intrapersonal and interpersonal factors respectively in determining teenage pregnancy in the study area. Most (65.3%) of the study participants were aware of family planning or modern contraceptives while very few (35.2%) were aware of comprehensive abortion care. In conclusion, both intrapersonal and interpersonal factors were identified as determinants of teenage pregnancy. However, only contraceptive use and level of freedom from home were identified as important intrapersonal and interpersonal factors respectively in determining teenage pregnancy in the study area. Communities and families should therefore be sensitized about adolescent sexual health and steps should be taken to enroll back teenage mothers to school to prevent or reduce multiple teenage pregnancies.



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DEDICATION

I dedicate this work to my parents (Rtd. Rev. Solomon Nyabah Gomnah & Mrs. Dorcas A. Gomnah), husband (Dr. John W. Abenyeri) and sons (Isaac Abenyeri Weseh & Jesse Sulemana).



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LIST OF ABBREVIATIONS

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ATR	African Traditional Religion
CAC	Comprehensive Abortion Care
CHPS	Community – Based Health Planning Services
DHMT	District Health Management Team
FGDs	Focused Group Discussions
GDHS	Ghana Demographic and Health Survey
GDHS	Ghana Demographic Health Survey
GSS	Ghana Statistical Service
GYRHS	Ghana Youth Reproductive Health Survey
HDA	Housing Development Agency
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IOM	International Organisation for Migration
JHS	Junior High School
NGOs	Non-Governmental Organisation
NRC	Norwegian Refugee Council
PPAG	Planned Parenthood Association of Ghana
SHS	Senior High School
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund



VVF	Vesico-Vaginal Fistulae
WHO	World Health Organization



CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Teenage is a transitional stage of physical and psychological human development that generally occurs during the period from puberty to legal adulthood. According to the World Health Organization [WHO], (2014), there are about 580 million teenage girls in the world of which four out of five of them live in developing countries. The World Bank (2012) reported that, investing in teenage girls today will unleash their full potential to shape humanity's future. However, the distorted transitioning of girls into womanhood as a result of early pregnancy ought to be seen as a significant economic loss.

A report by the United Nations Population Fund [UNFPA] (2014) stated that about 16 million teenage girls become pregnant worldwide which translates into 11% of all births worldwide. The report further stated that ninety-five per cent of these births occur in low- and middle-income countries. The average adolescent birth rate in middle income countries is more than twice as high as that in high-income countries, with the rate in low-income countries being five times as high. In another report by the UNFPA (2013), it was reported that teenage pregnancies are very high in sub-Saharan Africa which accounts for more than 50% of all teenage pregnancies in the world whilst about 2% occur in China, 18% in Latin America and the Caribbean. The statistics from the UNFPA further indicate that; in low- and middle-income countries, almost 10% of girls become mothers by age 16 years, with the highest rates in sub-Saharan Africa and south-central and south-eastern Asia.





Niels-Hugo (2011) found that the proportion of women who become pregnant before age 15 years varies enormously even within regions – in sub-Saharan Africa, for example, the rate in Rwanda is 0.3% versus 12.2% in Mozambique. In Ghana, it was found that teenage mothers formed 18% of all births in Ghana (GDHS, 2008).

Teenage pregnancies create anxiety and desperation among the victims and therefore desperate measures are adopted to try to get rid of it. In relation to this desperate measures being adopted by teenage girls, the WHO (2013) found that fourteen percent of all unsafe abortions in low- and middle-income countries are among teenage girls and about 2.5 million adolescents have unsafe abortions every year. Adolescents are more seriously affected by complications of unsafe abortions than older women.

In Ghana, there are regional variations in the rates of teenage pregnancies with the Northern and Central regions having the highest rates as reported by the Ghana Health Service in 2014 (GHS, 2014). Teenage pregnancies affect the health, education, and earning potential of millions of girls especially those from low-income countries. In most cases their children are born to fathers who are not responsible enough to take care of these children. Teenage pregnancy is intertwined with issues of human rights. Sometimes these pregnant girls are pressured or forced to leave school, for example, is denied her right to education (UNFPA, 2013).

Factors leading to teenage pregnancies are multifaceted and may differ from country to country and region to region. These factors may be related to the parents of the girls, friendship with their peers, economic status of the parents and societal perceptions about fertility. The West Mamprusi District is one of the districts in the Northern region with low quality of life and due to low level of education and the reliance on subsistence farming (GSS, 2012). These are fertile conditions precipitating

the occurrence of teenage pregnancies. The aim of this study is therefore to assess the factors influencing the occurrence of teenage pregnancies in the West Mamprusi District.

1.2 Problem Statement and Justification

Sexual and reproductive health is one area of chief concern during the period of adolescence (WHO, 2006). This is because adolescents encounter a lot of problems regarding their sexuality and reproductive lives. Some of these problems are teenage pregnancy, inaccessibility of contraceptives, early initiation in to sexual activities. Also, health workers are often unfriendly towards adolescents who seek various kinds of assistance at health outfits (GSS, 1994; Henry and Fayorsey, 2002; Awusabo-Asare et al., 2007). Each year, more than 350,000 teenage girls globally die after falling pregnant – one every two minutes. Out of this figure, more than 50% of these deaths occur in Africa whilst over 30% occur in other developing countries especially Asia (UNFPA, 2014). The World Bank (2014) also estimated that more than 40% of students who are teenagers drop out of school due to teenage pregnancies in Africa. They drop out because they either get pregnant or make someone pregnant. Statistics from the Ghana Health Services (2014) has revealed that about 750,000 teenagers between the ages of 13 and 19 became pregnant in Ghana of which majority of them were from the Central and Northern regions.

A baseline survey conducted by the Planned Parenthood Association of Ghana [PPAG], (2014) in the Northern and Upper East regions of Ghana revealed that 52.4% of all antenatal care registrants in all the Districts, Metropolis and Municipalities in these two regions were teenagers or within the age group of 13-19 years. The report further showed that 89% of these teenagers said that their pregnancies were unplanned





or unintended. This was attributed to the low knowledge and use of available contraceptives which was found to be 8.2%. The Annual report of the West Mamprusi District Health Directorate for 2013 showed that 15.6% of ANC registrants were teenagers. This was found to be the highest number of teenage pregnancies ever recorded in the district.

Teenage pregnancy has serious implications to the individuals/victims, their families and the society as a whole. Since majority of teenage pregnancies are unintended; they are more likely to lead to induced abortion. A report by WHO (2012) indicated that, deaths during the first month of life are 50–100% more frequent if the mother is younger than 20 years and also stillbirths and death in the first week of life are 50% higher among babies born to this same group of mothers compared to babies born to older mothers. Deaths during the first month of life are 50–100% more frequent if the mother is an adolescent versus older, and the younger the mother, the higher the risk. Kolbila (2008) also reported that the rates of preterm birth, low birth weight and asphyxia are higher among the children of adolescents, all of which increase the chance of death and of future health problems for the baby. Again, his study found that teenage mothers are sometimes forced to deliver the babies via caesarean section because their pelvises are not yet developed and in many case they struggle to deliver naturally because their pelvises are still small. This increases the risks of hemorrhaging and puts their lives at risk.

Teenage pregnancies affect the health, education, earning potential and entire future of the victim and may trap her in a lifetime poverty cycle, exclusion and powerlessness. Many teen moms are compelled to quit their studies in order to take care of their infants. In addition, sexual activity by teens raises the risk of HIV

infection in light of apparent widespread promiscuity and the practice of unprotected sexual intercourse. Complicating matters is the propensity of teenage girls to engage in illegal abortion due to their desperation to get rid of the pregnancy. Maternal mortality is reported high among teenage mothers. Even though studies have been conducted to espouse the causes and factors leading to teenage pregnancies, few are dedicated at finding reasons for its persistence (WHO, 2014). This study seeks to contribute to addressing this gap in the literature.

1.3 Research Questions

The study seeks to answer the following specific questions;

- i. What are the factors that are associated with teenage pregnancies in the West Mamprusi District?
- ii. What is the level of knowledge use of contraceptives among teenage girls in the West Mamprusi District?
- iii. What is the level of knowledge of teenage girls in the West Mamprusi District on Comprehensive Abortion Care?

1.4 Objectives of the Study

This study has a main objective and specific objectives as follows:

1.4.1 Main Objective

The main objective of the study is to investigate the factors leading to teenage pregnancies in West Mamprusi District of Ghana.

1.4.2 Specific Objectives

1. To identify the intrapersonal and interpersonal factors contributing to teenage pregnancies in the West Mamprusi District.



2. To assess the knowledge and use of contraceptives among teenage girls in the West Mamprusi District
3. To assess the knowledge of teenage girls on Comprehensive Abortion Care (CAC) among teenage girls in West Mamprusi District

1.5 Significance of the Study

Teenage pregnancy is a social and health problem to both the victim and her society. It affects the entire life of the victim and her child which perpetuates a vicious cycle of poverty. The Northern region has a high dependency ratio which has impoverished majority of the populace in the region. It is anticipated that the findings of this study would contribute to the prevention of teenage pregnancies through the provision of vital information on the causes of teenage pregnancies for policy makers, donors, and other relevant stakeholders to use. The provision of information will help to direct resources and energies towards tackling those specific factors leading to teenage pregnancies.

Again, since the study will also assess the knowledge of teenage girls on contraceptives and Comprehensive Abortion Care, it will be useful to health care service providers to devise ways of reaching teenagers and making the services available and accessible to them in order to curtail the menace of teenage pregnancies.

The findings of the study will also contribute to existing literature on teenage pregnancy for future research works and for readers who would like to study on teenage pregnancies.



1.6 Organization of Thesis

This thesis has been presented or organized into five chapters which was structured based on the general components of a research, that is, the introduction, methodology, results and discussions and conclusion and recommendations.

Chapter one focuses on the introduction of the study, background of the study, the problem statement, the study objectives, and the significance of the study and the ethical considerations of the study.

The second chapter reviewed the relevant literature in relation to the study. Literature was reviewed on the burden of teenage pregnancy, the prevalence of teenage pregnancies, knowledge of teenagers on sexual and reproductive health services (specifically contraception and abortion care), factors that influence teenage pregnancy and the recommendations' that have been given to teenage pregnancies. The methodology of the study, which is made up of the study design, study type, study variables (independent and dependent variables), data collection instruments, sampling procedure and sample size, study population, sources of data, data collection methods, quality control measures, and limitation(s) of the study was presented in the third chapter.

Results and discussion of the study were presented in chapter four and five respectively. The results was presented or sectioned based on the specific objectives of the study. The summary of key finding, conclusion and policy recommendations were presented in chapter six.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews literature on teenage pregnancy; its causes, the health and social implications of teenage/adolescent pregnancy. The review draws generally from worldwide sources but with a focus on Ghana.

2.1 Teenage Pregnancy

Teenage pregnancy is a global issue and a key challenge to the development of teenagers (WHO, 2009). The causes and consequences of teen pregnancies have seen considerable research, policy and program discussion, and debate. Some studies argue that teen pregnancies compromise women's educational prospects and economic opportunities. On the contrary other works point out that teen pregnancies are a marker of such conditions, rather than an underlying cause of them. There, however, seems to be consensus that teen pregnancies are associated with poor social and economic conditions and prospects. A greater proportion of intended teen births are in developing countries. This is because many women still marry early (WHO, 2006). However, even intended pregnancies to young women in low income countries are of policy and public health relevance due to the risks associated with them. For example young adolescents are more likely to experience obstructed labour, fistula, and premature delivery. They may also give birth to low weight babies than older women (UNICEF, 2008).

Teenagers between the ages of 15-19 consists about 15 million globally and they are responsible for more than ten percent of the babies born every year (WHO, 2008).



According to UNICEF (2008) the number of children born to both married and unmarried adolescent girls within the ages of 15 to 19 is about 14 million.

According to the World health Organisation (2008) about 16 million adolescent girls aged 15-19 give birth each year consisting of roughly 11% of all births worldwide. Almost 95% of these births occur in developing countries. The worldwide adolescent fertility rate was estimated to be 55.3 per thousand for the period 2000-2005 (WHO, 2008). This meant that on average about 5.5% of adolescents gave birth each year. In the less developed countries Adolescent birth rates are more than twice as high compared to rates in more developed countries. About 90% of births to adolescents occur within marriage in the developing world. This proportion is nearly 100% in Western Asia/Northern Africa, Central Asia, and South-Central and South-Eastern Asia, but it is between 70-80% in South America and in sub-Saharan Africa (WHO, 2008). The pregnancies may be "intended" as a result of social and cultural norms, or due to unmarried young women seeing it as a means of establishing identity. Throughout the world, births to unmarried adolescent mothers are far more likely to be unintended while those outside marriages are more likely to result in abortion. A small but significant proportion of adolescent pregnancies occur through nonconsensual sex. Recent studies of coerced first sex show rates between 10% and 45% of girls who had their first sex before age 15 (WHO, 2008).

The pregnancies occurring in unmarried adults are usually unplanned. Several factors account for teenage pregnancies. Although a range of factors that influence risky sexual behaviour have been identified, the weight that can be assigned to any single factor (Kirby, 2002) or how factors interact or act in cumulative fashion to increase risk is not fully understood (Meade and Ickovics, 2005 in WHO, 2006). Thus



behaviour change programmes have shown success in little, localised contexts but what is not clear is how to achieve radical behaviour change among a meaningfully large numbers of people at risk (Abe and Zane, 1990), and eventually, teenage pregnancy, STIs and HIV.

In Africa, in the early 1990s pregnancy was much more welcomed, especially among young women and their families. This indicated a sign of 'love, womanhood and fertility' and potential bride wealth, and that men felt pride in bearing a child as a sign of their masculinity (Abiodun and Balogun, 2008). But a changing socio-economic landscape has brought about changes in the aspirations of young people, particularly in urban areas. This, in turn, has altered cultural expectations of some young women and also men. Over two thirds of adolescents who have ever been pregnant in Sub-Saharan Africa (2003-2004) report their pregnancies as unwanted (Abiodun and Balogun, 2008). Along the lines of increase in opportunities and aspirations for education and pervasive unemployment, now most African adolescents do not welcome early pregnancy (Abiodun and Balogun, 2008). A 1996 study of Sub-Saharan African adolescents reported that a greater majority of girls did not want to have a child until they finished school and obtained the financial ability to care for a child (Ahiadeke, 2001). In South Africa, in 1998, young African mothers in Soweto mentioned the difficulty of accepting and dealing with an early pregnancy, dealing with negative parents and societal perception and treatment, and the trauma associated with weighing options regarding the continuation of the pregnancy, who to inform and whether to continue education (Ahiadeke, 2001).

According to UNICEF (2008), the causes of teenage/adolescent pregnancy include poverty, sexual abuse like rape, incorrect/non-use of contraception, low self-esteem,



low educational goals, lack of knowledge about sexual and reproductive health, risky adolescent sexual behaviour, as well as customs and traditions that lead to early marriage of adolescents (WHO 2008).

2.2 Factors accounting for Teenage Pregnancies

Teenage pregnancy is directly related to Adolescent Sexual and Reproductive Health (ASRH) which refers to the physical and emotional well-being of adolescents. This includes their ability to be healthy and remaining free of early or unwanted pregnancy, unsafe abortion, sexually transmitted diseases such as HIV/AIDS and sexual violence or coercion (UNFPA, 2002).

2.2.1 Intrapersonal factors

Individual or interpersonal factors are those attributes of an individual that increases his/her likelihood of engaging in risky behaviour by influencing how he/she interacts with the other contexts, and the influence that those contexts bring to bear on him/her (WHO, 2006). This includes sexual experience, number of Sexual partners, age mixing. The use of contraceptive and knowledge and experiences of HIV/AIDS and other STIs

2.2.2 Sexual experience

The sexual behaviour of adolescents has the potential to confer significant risk to adolescents experiencing early pregnancy and contracting STIs and HIV. When teenagers initiate sexual intercourse early in life they place themselves at higher risk for early pregnancy, STIs and HIV (Kirby, 2007). Early sexual acts remain an area of intractability in adolescent sexual behaviour. Ghanaian adolescents are considered to be highly sexually active. They also often begin sexual activity at an early age. The 1998 GDHS shows that about 17% of adolescents within the age bracket of 15-19 had



their first sexual intercourse at age 15. In the 2003 version of the survey (GDHS, 2003), 9.0% of women and 4.0% of men reported having sexual intercourse by age 15. Also 48.0% of women and 25.0% of men have had their first sexual intercourse at age 18. The figures not only show how early adolescents in Ghana start having sex but also suggest that many people have sex before marriage. The 2003 GDH Survey also shows that at national level, some 14.0% of 15-19 years old adolescents are pregnant or are already mothers. The GDHS (2008), shows that 9.9% of 15-19 years old adolescents had at least one child. This indicates a decrease in teenage pregnancies from the 1998 to 2008. The GDHS (2008) further shows that 69.0% of all births to 15-19 year olds were either unwanted or mistimed. This implicates the low level of contraceptive usage and likely low resilience of teenagers to sex by males.

2.2.3 Number of Sexual Partners

Data shows that 17% of sexually experienced 15–19-year-old males had two or more partners in the 12 months preceding the survey (GDHS, 1998). The 2008 GDHS data showed that, 19.4% of 15–19-year-old adolescents who had experienced sex had two or more partners in the 12 months prior to the survey (GDHS, 2008). Tweedie and Witte (2000) also report that 79% of females and 68% of males aged 12–24 in the 1998 Ghana Youth Reproductive Health Survey (GYRHS) had one current sexual partner while 3% of females and 10% of males reportedly had two or more sexual partners within the three months prior to the survey. Also, among those who had experienced sex before, 60% of females and 39% of males reported one lifetime sexual partner, 38% of females and 53% of males had two to three lifetime partners, and 1% of females and 5% of males reported four or more lifetime sexual partners

(Tweedie and Witte, 2000). Having more than one sex partner potentially increases the exposure to sexually pregnancies and sexually transmitted diseases.

2.2.4 Age mixing

When young people have sex with partners that are older than themselves they expose themselves to increased risk of engaging in more sexual activity and also having sex without contraception. This could then expose them to STI and pregnancies (Kirby, 2007; Ahiadeke, 2001). In South Africa for example, the 2003 RHRU survey reported that for young men the average age of sexual partners was a year younger than they themselves were, but for females, their partners were on average four years older. This trend causes significant risk for HIV. The study showed that when young women's partners were within a five year age range, HIV prevalence was 17.2 percent. The study adds that HIV prevalence almost doubled (29.5%) in instances that partners were five years older than themselves.

2.3 The Use of Contraceptive

According to Ahmed et al. (2006) avoiding conception has come to be defined as part of female sexual respectability and attractiveness. Generally, it is agreed that women hold responsibility for contraception in the relationship although there is little space for open discussion about contraceptive choices with male partners. Although many participants in the study supported contraceptive use, it is still a stigmatised and has negative social connotation of being promiscuous. Also women have little room to suggest condom use as it is considered inappropriate and indicative of sexual permissiveness (WHO, 2006). At an organisational level, in spite the increasing availability of condoms the negative and moralising attitude of some health staff in the limited access and few young people have the financial ability to buy condoms. At



the structural level, pervasive poverty also forced some young women to engage in sexual relationships in exchange for lifts home from school, and gifts and money daily subsistence.

Studies showed that, the youth in Ghana are aware of and are using contraceptives. However, the level of awareness and utilisation varies spatially and gender wise. Research shows that among young people in South Africa condom use in the context of an HIV epidemic has identified a complex interplay of factors that determine its use (Ajzen and Fishbein, 1980). At the individual level, most young people did not use condoms because they did not perceive themselves to be at risk of HIV infection. At a relational level, young men in particular have internalised the frequently reported negative attitudes shown by peers towards condom use. Condom use has also come to be negatively associated with trust, respect and fidelity within steady relationships, but is generally accepted within casual encounters. In fact, Albert (2004) showed that, young people who were married or in a relationship lasting six months or longer were less likely to use condoms. Young people erroneously evaluate trustworthiness within relationships based on subjective criteria (appearance and reputation of the partner), rather than on objective criteria (a negative HIV test and discussion of sexual history). Worryingly, 31 percent of youth in the 2003 RHRU survey still believe that using a condom is a sign of not trusting one's partner. Power imbalances also play a very important role in women's ability to negotiate safe sex (Aldaz-Carroll and Moran, 2001). Also, in a context of high levels of sexual coercion, women rarely have the strength and power to negotiate sex or condom use in relationships. Males often trick women into having sex, lying about using condoms (Amoateng et al., 2007).



Data from GYRHS showed that, in Ghana 76% of females aged 15–19 and 88% of males the same age were aware of at least one modern family planning method (GYRHS, 1998). Among those aged 12–14, 33% of females and 6% of males were aware of at least one modern family planning method. The condom was the commonest known method of contraceptive. About 77% of males and 66% of females were aware of this method.

In the 2008 GDHS, reported that the proportion of both males and females aged 15–19 who were aware of at least one modern method was a little over 80%. The results of the 1998 GDHS and that of the 2008 version are not much different. But the results from the 1998 GDHS show marginal improvement over that of the 1998 one. Tweedie and Witte (2000), however, won that adolescent's knowledge of some specific methods is superficial. They exemplify this by referring to the fact that 21% of females and 46% of males who know the method do not know that it has to be taken daily to achieve effectiveness (Tweedie and Witte, 2000). The conclusions of the authors can also be interrogated with reference to the type of people questioned. Those questioned were not necessarily people who were had earlier used the method or were currently using it. Rather the question was open. So it cannot be expected that common knowledge of a method among people who have not used it before be so good they. If the respondents had had involved in the use of the contraceptive they would probably have known have that they had to take the tablet daily for it to be effective.

The very fact that contraceptive awareness among adolescents is high in Ghana is a good thing. What is rather surprising is that the use of contraceptives is low as opposed to it knowledge among adolescents. According to the Ghana Statistical



Service, thirteen percent of all 15–19-year-old females and 35% of married females had ever used a modern family planning method as of 1998 (Ghana Statistical Service, 1999).

2.3.1 Knowledge and Experiences of HIV/AIDS

The knowledge and consequently effort to avoid STDs can also influence teenage pregnancy (WHO, 2006). Abstaining from sex or unprotected sex can prevent STDs as well as have a by-effect of preventing teenage pregnancies. The 2008 GDHS has it that 97.6% of adolescents aged between 15 and 19 years have knowledge of HIV/AIDS. This can be said to be very high. This may be the result of decades of education on the subject by government and NGOs. The Ghana Health Service in their 2002 report on STI attendees at clinics estimated the prevalence of syphilis to be 0.6% among 15–24-year-olds (Ghana Health Service, 2003). The challenges in obtaining accurate data about STIs are myriad. First people are afraid to report STI symptoms for fear of being labelled promiscuous (Anon, 1991). Also STIs are likely to be underreported because such infections may not be considered to be major problems. There are also misconceptions about STIs that result in poor reporting. For example, Antwi (2009) in a study in the streets of Accra report that 51% of males and of 37% females of females stated that one could get an STI through witchcraft, "juju" (voodoo) as punishment for adultery.

Similarly, Antecol and Bedard (2007) also found out that some people thought that females could get STDs as from eating lots of sweets. Through an indirect means of determining the prevalence rate of STIs among young people Tweedie and Witte (2000) asked adolescent respondents to mention the number of people they knew who



currently or previously had an STI. The results showed that 27% percent of males and 22% of females reported that they knew one or more people who ever had an STI.

The GDHS (1998) showed that, after HIV/AIDS, the most commonly known STI among adolescents is gonorrhoea. The study showed that 41% of 15–19-year-old females and 46% of males are aware. The next commonly known STI was syphilis; about one in 10 adolescents were aware of it.

Arai (2003) also note that 74% of adolescents had heard of gonorrhea while 51% had heard of syphilis. Similarly Ashcraft & Lang (2006) also found that in 1993 97% of males and 94% of females aged 15–24 had heard of at least one STI. Out of this number, 29% of the males and 5% of the females reported ever contracting STI. In another study among street youth aged 8–19, 59% Anarfi (1997) reported that hardly knew of any STD besides AIDS. Results from another study of street youth showed that 98% had heard of a least one STI (Anarfi and Antwi, 1995).

Young people are generally aware of the existence of formal medical services for STI diagnosis and treatment but the same cannot be said of their attendance to health facilities when they when they are confronted with an STI; a great majority use other services (GYRHS, 1998). In the 1998 GYRHS, Tweedie and Witte (2000) observed that 94% of both males and females mentioned the hospital or clinic as a place access treatment for STI, followed by drugstore (27% of males and 19% of females). The authors (Tweedie and Witte) also observed that of those who ever had sex and ever had an STI, 75% of males and 57% of females sought treatment. The common sources for treatment were drugstores (41% of males and 16% of females), hospitals/clinics/health posts (39% of males and 49% of females) and pharmacies (19% of males and 21% of females).



Tweedie and Witte (2000) found that the major reason for not seeking professional medical treatment for an STI was the perceptions of the youth that the infection was not serious and that they could still go on with their normal business. In a study 1,147 street youth in Accra, Anarfi (1997) found that, of those who ever contracted an STI (58 males and 27 females), 43% of the males and 15% of the females self-medicated while 35% of the males and 22% of the females sought treatment from a druggist and only 18% went to a formal health institution.

2.3.2 Interpersonal factors

The everyday social environment in which young people live their lives can also have a significant effect on their sexual behaviour. The players in this social environment include parents, partners, peers and schools. These among others play a significant role in the identity, formation and decision making for and by teenagers (IOM, 2005).

Families:

Family life can have a great influence on teenager's exposure to and behaviour at having sex. Many aspects of family life can exert substantial influence on adolescents' sexual behaviours and pregnancy risk (Miller, 2002). Some of this are socio-economic status, family type, parental values and role-modeling, parental style, monitoring and support and parent-child communication.

Family type: Family structural characteristics play a vital role in understanding and determining teenage sexual behaviour including pregnancy. Many studies have revealed that family structure has a strongly correlation with teenage pregnancies (Miller *et al.*, 2003; Langille *et al.*, 2004). For example growing up in a single-parent home (Kirby, 2002; Bonell *et al.*, 2006) or without any parents exposes adolescents to higher risk of early pregnancy (Bankole *et al.*, 2007). Also, when family factors



associated with father absence are controlled for, the association between mothers' single parenting and daughters' early pregnancy is still strong (Bandura, 1986). Teenagers who are raised in larger families are also at increased risk of earlier sex than those who are not. This results from little attention from parents and also teenager's replicating their siblings' sexual behaviour (East and Shi, 1997; East and Jacobson, 2001). The association between family structure and youth sexual behaviour has been linked to single or divorced parents more permissive sexual attitudes and values, inadequate parental supervision and monitoring and the parents' own dating activity (Bastien et al., 2006).

Household Characteristics: In addition, household characteristics including family sources of income and maternal employment may be linked with both poor parenting and family structure which, in turn, affects adolescent sexual behaviour (Berglas et al., 2003). Poverty can cause distant parent-child relationships to affect behavioural and personality attributes of adolescents (Bell et al., 2008). This may then increase the likelihood of association with deviant peers and risky sexual behaviour.

2.3.3 Parental Values and Role-modeling

The family can have a very early and lasting impact on an adolescent's beliefs, systems and values, and therefore on their behaviour (Gordon, 1996). Consistent parental values is very important as it acts as a vital factor in influencing later sexual debut and also decreases the risk of unintended pregnancies (Bhorat and van der Westhuizen, 2008). Those parents who are clear and straight about the value of delaying sex are more likely to have their adolescents have sexual intercourse at an early age (Bhorat and van der Westhuizen, 2008). Parents' values against adolescent sexual intercourse have the capability to decrease the risk of adolescent pregnancy.



On the other hand, parents with permissive attitudes concerning sex or premarital sex, or those that have negative attitudes about contraception are more likely to have teenagers who are more likely to have unsafe sex and becoming pregnant (Kirby, 2002).

More so, family members serve as role models to their children and children may learn to replicate their behaviours. So teenagers are more likely to initiate sex and experience pregnancy if it is that their parents or other family members had sex outside of marriage, or are cohabitating with a romantic or sexual partner or have had a child outside of marriage (Kirby, 2001). Having a mother or sister with a history of teenage pregnancy who is strongly associated with a teenager herself falling pregnant (Bhorat and van der Westhuizen, 2008).

2.3.4 Parental Style, Monitoring and Support

The nature and quality and extent of the relationship between an adolescent and their parents can be an important factor influencing the decisions that they make about sex. It has been found out that teenagers whose parents provided a warm, loving, and nurturing environment were less likely to engage in sex (Bissell, 2000). Many studies have shown that the presence of parent-child connectedness (support, closeness, and parental warmth) reduce the risk of adolescent pregnancy by influencing adolescent sexual and contraceptive behaviours (Bissell, 2000). On the contrary, those parents who were overly strict and authoritarian were associated with a greater risk of teen pregnancy among their children. A failure to share a close relation with adolescents usually elevates the influence of peers on sexual activity. This could result in poor or distant parent-child relationships and risky adolescent sexual behaviour (Bissell, 2000). Adolescents who consider their relationships with their parents as coercive are



more likely to be involved with deviant peer groups, and then their peers become more important and influential.

Conversely, adolescents whose parents pursue authoritative parenting styles are more likely to join a peer group that encourages them to engage in sex (Albert, 2004). Parental practices influence both the emotional and social development of adolescents. It is found that parents who set and enforce rules, monitor behaviour and provide needed support can have a positive influence on sexual behaviour. Some studies have shown that parental regulation through house rules, supervision and monitoring can delay sexual debut, reduce the number of partners, increase contraceptive use and decrease pregnancy risks among teenagers (Albert, 2004).

2.3.5 Parental Communication

Parental communication with adolescents is another major factor determining teenage pregnancies. Among the various dimensions of family social support, parent – adolescent communication on issues of sexual behaviour and childbearing has received a lot of attention (WHO, 2006). Positive, free, open and constant family communication about sex is associated to postponement of sexual activity, increased contraceptive use and fewer sexual partners. In a similar vein, parent-child communication is crucial for the prevention and reduction of teenage pregnancy (WHO, 2006). According to Albert (2004), many adolescents agree that it would have been easier for them to avoid teen pregnancy if they were able to have more free and honest conversations about sex topics with their parents. Parent-child communication about sex increases the likelihood that sexual risk will be talked about with partners. This has the potential to mediate negative peer norms about sexual behaviour. In spite of the importance of parent-adolescent communication about sexual behaviour, the



CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Teenage is a transitional stage of physical and psychological human development that generally occurs during the period from puberty to legal adulthood. According to the World Health Organization [WHO], (2014), there are about 580 million teenage girls in the world of which four out of five of them live in developing countries. The World Bank (2012) reported that, investing in teenage girls today will unleash their full potential to shape humanity's future. However, the distorted transitioning of girls into womanhood as a result of early pregnancy ought to be seen as a significant economic loss.

A report by the United Nations Population Fund [UNFPA] (2014) stated that about 16 million teenage girls become pregnant worldwide which translates into 11% of all births worldwide. The report further stated that ninety-five per cent of these births occur in low- and middle-income countries. The average adolescent birth rate in middle income countries is more than twice as high as that in high-income countries, with the rate in low-income countries being five times as high. In another report by the UNFPA (2013), it was reported that teenage pregnancies are very high in sub-Saharan Africa which accounts for more than 50% of all teenage pregnancies in the world whilst about 2% occur in China, 18% in Latin America and the Caribbean. The statistics from the UNFPA further indicate that; in low- and middle-income countries, almost 10% of girls become mothers by age 16 years, with the highest rates in sub-Saharan Africa and south-central and south-eastern Asia.



Niels-Hugo (2011) found that the proportion of women who become pregnant before age 15 years varies enormously even within regions – in sub-Saharan Africa, for example, the rate in Rwanda is 0.3% versus 12.2% in Mozambique. In Ghana, it was found that teenage mothers formed 18% of all births in Ghana (GDHS, 2008).

Teenage pregnancies create anxiety and desperation among the victims and therefore desperate measures are adopted to try to get rid of it. In relation to this desperate measures being adopted by teenage girls, the WHO (2013) found that fourteen percent of all unsafe abortions in low- and middle-income countries are among teenage girls and about 2.5 million adolescents have unsafe abortions every year. Adolescents are more seriously affected by complications of unsafe abortions than older women.

In Ghana, there are regional variations in the rates of teenage pregnancies with the Northern and Central regions having the highest rates as reported by the Ghana Health Service in 2014 (GHS, 2014). Teenage pregnancies affect the health, education, and earning potential of millions of girls especially those from low-income countries. In most cases their children are born to fathers who are not responsible enough to take care of these children. Teenage pregnancy is intertwined with issues of human rights. Sometimes these pregnant girls are pressured or forced to leave school, for example, is denied her right to education (UNFPA, 2013).

Factors leading to teenage pregnancies are multifaceted and may differ from country to country and region to region. These factors may be related to the parents of the girls, friendship with their peers, economic status of the parents and societal perceptions about fertility. The West Mamprusi District is one of the districts in the Northern region with low quality of life and due to low level of education and the reliance on subsistence farming (GSS, 2012). These are fertile conditions precipitating

the occurrence of teenage pregnancies. The aim of this study is therefore to assess the factors influencing the occurrence of teenage pregnancies in the West Mamprusi District.

1.2 Problem Statement and Justification

Sexual and reproductive health is one area of chief concern during the period of adolescence (WHO, 2006). This is because adolescents encounter a lot of problems regarding their sexuality and reproductive lives. Some of these problems are teenage pregnancy, inaccessibility of contraceptives, early initiation in to sexual activities. Also, health workers are often unfriendly towards adolescents who seek various kinds of assistance at health outfits (GSS, 1994; Henry and Fayorsey, 2002; Awusabo-Asare et al., 2007). Each year, more than 350,000 teenage girls globally die after falling pregnant – one every two minutes. Out of this figure, more than 50% of these deaths occur in Africa whilst over 30% occur in other developing countries especially Asia (UNFPA, 2014). The World Bank (2014) also estimated that more than 40% of students who are teenagers drop out of school due to teenage pregnancies in Africa. They drop out because they either get pregnant or make someone pregnant. Statistics from the Ghana Health Services (2014) has revealed that about 750,000 teenagers between the ages of 13 and 19 became pregnant in Ghana of which majority of them were from the Central and Northern regions.

A baseline survey conducted by the Planned Parenthood Association of Ghana [PPAG], (2014) in the Northern and Upper East regions of Ghana revealed that 52.4% of all antenatal care registrants in all the Districts, Metropolis and Municipalities in these two regions were teenagers or within the age group of 13-19 years. The report further showed that 89% of these teenagers said that their pregnancies were unplanned



or unintended. This was attributed to the low knowledge and use of available contraceptives which was found to be 8.2%. The Annual report of the West Mamprusi District Health Directorate for 2013 showed that 15.6% of ANC registrants were teenagers. This was found to be the highest number of teenage pregnancies ever recorded in the district.

Teenage pregnancy has serious implications to the individuals/victims, their families and the society as a whole. Since majority of teenage pregnancies are unintended; they are more likely to lead to induced abortion. A report by WHO (2012) indicated that, deaths during the first month of life are 50–100% more frequent if the mother is younger than 20 years and also stillbirths and death in the first week of life are 50% higher among babies born to this same group of mothers compared to babies born to older mothers. Deaths during the first month of life are 50–100% more frequent if the mother is an adolescent versus older, and the younger the mother, the higher the risk. Kolbila (2008) also reported that the rates of preterm birth, low birth weight and asphyxia are higher among the children of adolescents, all of which increase the chance of death and of future health problems for the baby. Again, his study found that teenage mothers are sometimes forced to deliver the babies via caesarean section because their pelvises are not yet developed and in many case they struggle to deliver naturally because their pelvises are still small. This increases the risks of hemorrhaging and puts their lives at risk.

Teenage pregnancies affect the health, education, earning potential and entire future of the victim and may trap her in a lifetime poverty cycle, exclusion and powerlessness. Many teen moms are compelled to quit their studies in order to take care of their infants. In addition, sexual activity by teens raises the risk of HIV



infection in light of apparent widespread promiscuity and the practice of unprotected sexual intercourse. Complicating matters is the propensity of teenage girls to engage in illegal abortion due to their desperation to get rid of the pregnancy. Maternal mortality is reported high among teenage mothers. Even though studies have been conducted to espouse the causes and factors leading to teenage pregnancies, few are dedicated at finding reasons for its persistence (WHO, 2014). This study seeks to contribute to addressing this gap in the literature.

1.3 Research Questions

The study seeks to answer the following specific questions;

- i. What are the factors that are associated with teenage pregnancies in the West Mamprusi District?
- ii. What is the level of knowledge use of contraceptives among teenage girls in the West Mamprusi District?
- iii. What is the level of knowledge of teenage girls in the West Mamprusi District on Comprehensive Abortion Care?

1.4 Objectives of the Study

This study has a main objective and specific objectives as follows:

1.4.1 Main Objective

The main objective of the study is to investigate the factors leading to teenage pregnancies in West Mamprusi District of Ghana.

1.4.2 Specific Objectives

1. To identify the intrapersonal and interpersonal factors contributing to teenage pregnancies in the West Mamprusi District.



2. To assess the knowledge and use of contraceptives among teenage girls in the West Mamprusi District
3. To assess the knowledge of teenage girls on Comprehensive Abortion Care (CAC) among teenage girls in West Mamprusi District

1.5 Significance of the Study

Teenage pregnancy is a social and health problem to both the victim and her society. It affects the entire life of the victim and her child which perpetuates a vicious cycle of poverty. The Northern region has a high dependency ratio which has impoverished majority of the populace in the region. It is anticipated that the findings of this study would contribute to the prevention of teenage pregnancies through the provision of vital information on the causes of teenage pregnancies for policy makers, donors, and other relevant stakeholders to use. The provision of information will help to direct resources and energies towards tackling those specific factors leading to teenage pregnancies.

Again, since the study will also assess the knowledge of teenage girls on contraceptives and Comprehensive Abortion Care, it will be useful to health care service providers to devise ways of reaching teenagers and making the services available and accessible to them in order to curtail the menace of teenage pregnancies.

The findings of the study will also contribute to existing literature on teenage pregnancy for future research works and for readers who would like to study on teenage pregnancies.



timing, frequency, content, developmental, appropriateness and quality may mediate the outcomes of communication (Anon, 1991).

2.3.6 Partners

A gender power inequity is an important factor in women's vulnerability to early and unprotected sex and pregnancy (WHO, 2006). Sexual and physical violence against women is rather common in developing countries where law enforcement agencies lack the human capital and logistical capacity to arrest crime. Coerced sex is often accompanied by physical assault resulting in various degrees of injury. Adolescents are often forced or tricked into having sex for the first time, usually involving physical violence to ensure acquiescence, and this pattern characterises their sexual relationships well into the future.

In rural areas particularly, the practice is so common to the extent that peers reinforce it as a normative and accepted practice. Some women have also come to believe that the beatings are meant to show love. Some studies have in fact reported that most women do not consider forced sex as rape when it involves a boyfriend (WHO, 2006). It is asserted that men use violence to ensure the sexual availability of women. Some partners also refuse to discuss contraceptives and use the threat of violence or of rejection to deter women from bringing up the topic is a significant deterrent to discussing contraceptive use. Although the extent of violence experienced is sometime high in relationships, few affected people consider leaving due to societal norms and stigmas of been divorced (WHO, 2006).

Also, because women are relatively poorer than men, they tend to stay in relationships even when they involve sexual and physical violence. Such women may see staying in the relationship as the only or most important means of securing success and self-





esteem in life. More so, although not recognised as transactional sex, relationships, some of them do afford particularly very poor women material gains that would otherwise not be accessible to them. In this circumstance where sexual and physical violence has become a social construct of relationships, individually-focused interventions that merely promote 'choice' among women are unlikely to achieve much success (Bissell, 2000).

2.3.7 Peer Group Influence

Peers are an important factor in teenage pregnancy. When children make the transition from childhood to adolescence and engage in the process of identity formation, their dependence on parents and siblings as the sole or main sources of influence and decision making begins to decline. Increasing interaction with other role models - best friends, peers, teachers and community members, begin to increase their sphere of influence. But some of these sources have negative deeds and actions. Peer attitudes, norms and behaviour as well as perceptions of norms and behaviour among peers begin to suffix and do have a have a significant influence on adolescent sexual behaviour. Some studies have shown that teenagers are more likely to have sex when they believe that their friends are having sex, and when a positive perception about condom and contraceptives use is held they also tend to use condoms (Kirby, 2002).

The World Health Organisation (2006) explains that while constructions of femininity require women to be chaste and adhere to sexual fidelity, girls often feel pressure from their friends to have multiple sexual partnerships as a means to gain peer group respect. Also, Bissell (2000) report that girls who did not have experience with sex were excluded from friendship circles when issues of sexuality were been discussed because they were regarded as 'children'. Also among men sexuality has also come to

be an important factor in been a successful man. This has led to young men engaging in sexual activity very early in life (Bissell, 2000).

2.3.8 Sexual Coercion

Sexual coercion is an important contributing factor to teenage pregnancies. The common thing is males coercing teen girls into having sex (WHO, 2006). During coerced sex, a male may not have the time to put on a condom. It is also likely that condoms may tear or puncture due to the stressful nature of the sex thus exposing the teen girl to pregnancies and STDs. A study by Nabila et al. (1997) among adolescent traders in Accra indicated that 2% of males and 12% of females reported that their first sex was the result of coercion. According to the 1998 Ghana Youth Reproductive Health Survey, 2% of males and 12% of females were forced to have sex the first time while 0.5% of males and 0.6% of females reported having their first sexual intercourse with a family member (Tweedie and Witte, 2000).

In a study among young people aged 12–24 in junior secondary, senior secondary and university in the Central Region, Awusabo-Asare et al. (1999) observed that among 415 adolescents who claimed to have had sex, 19% reported that they were forced into it. Also, among the 211 who had had sex with schoolmates, 13% reported that they were forced. Of the 234 who had sexual intercourse with their neighbours, 13% claimed to have been coerced. Of those who had sex with teachers, 6% reported having been forced into the act.

It is crucial to recognise the difficulties involved with identifying forced sex instances in Africa (WHO, 2006). Culturally women are not expected to agree to men's proposal verbally before sex. Such a woman may be perceived as a prostitute. So it is common for a male to struggle a bit with a female before the first sexual intercourse.



Thus the perception of men about female's concern to sex is that they like it. Males in Ghana have the perception that women do not really mean it when they say 'no'. According to the GYRHS survey approximately two-thirds of both males and females aged 12–24 in the 1998 GYRHS who had ever had sex stated that most girls did not really mean "no" when they said "no" to sex. Most males often go with the tradition of men putting a little pressure on females to have sex. But even traditionally, extreme force is unacceptable (Awusabo-Asare et al., 2004). Beyond the first sex, females are still exposed to forced sex with their boyfriends. Tweedie and Witte (2000) for example report that 13% of males and 14% of females who had ever had sexual intercourse stated that it was acceptable for a boyfriend to beat his girlfriend when she does not provide sex. This is not only against the rights of the girl but could expose her to pregnancies and STDs.

2.3.9 Communities Influence

The socio-economic situation of communities particularly the sense of social cohesion is crucial for informal social control as well as the role modeling offered by adult members. Role modeling of adults of a community can have a significant bearing on the sexual behaviour of adolescents. In the situation of social disorganisation, high levels of disadvantage and poor achievement of members within a community young people are more likely to have an increased opportunity of engaging in sex earlier and having early pregnancies (Kirby, 2002). For example low levels of education, income and employment in addition to high rates of crime in the community are risk factors for early pregnancy.

On the other hand when community members are high achievers in terms of income and employment and education, and avoiding teenage pregnancy, teenage pregnancy





rates are likely to be low (Kirby, 2002). In a situation when young people don't finish school and struggle to find work and see few opportunities for economic security, they are likely to ignore the costs of pregnancy, HIV and display a willingness to take greater risks (Bissell, 2000). Higher opportunity for education, income and participation in sport among girls has been found to decrease their likelihood of having sex early in life thereby reducing the chances of teenage pregnancy.

However, in an environment of fast social and cultural change social connectedness can be disrupted due to the lack of or weak common values and goals. It is asserted that tensions between political and traditional community leadership has dampened the spirit and willingness of community members to act in the interest of all of its children (Bissell, 2000).

2.3.10 Institutional factors

The staff of public health outfits can have a major impact on young people's sexual behaviour. It is asserted when quality health care services are provided by well trained professionals devoid of judgment and respect for the confidentiality of adolescents coupled with respect for their human dignity, they are more likely to make use of these services (WHO, 2006). Also, if services that are free and also convenient in terms of open times, do not come along with long queues and are free or at least within their economic reach, are more likely to attract more young people (WHO, 2006). This is an important factor in teenage pregnancy worldwide. According to the World Health Organisation (2014) across the world studies have indicated that when young people require health services, the public sector is often the last resort. Other factors that may affect health seeking is the physical distance, poor quality of clinical

services, lack of privacy and respect, high costs and a culture of shame that surrounds certain conditions that are reinforced by health care workers (WHO, 2006).

2.4 Comprehensive Abortion Care

Abortion among teenagers in Ghana is on the rise and is done through both orthodox and unorthodox means. Those who go through unorthodox abortions risk the chance of dying or getting complications. The unorthodox means is used for reasons such as ignorance, the lack of capital and fear been identified (WHO, 2006). The Ghana Youth Reproductive Health Survey (GYRHS, 1998) show that 11% of males and 16% of females aged 12–24 who ever had sexual intercourse reported that they have at one time or another been involved ever being in terminating a pregnancy. Among these, 77% of females and 72% of males aborted just one pregnancy. The majority of them were not married (67% and 86%, respectively). The report considered abortion to be generally high at a rate of 58% of females who ever had sex.

Data from the 1998 GYRHS reveals more than half of adolescents who reported ever being involved in an abortion stated that the last abortion was at a hospital or clinic (64% of females and 58% of males) and about a third stated their last abortion was at home (30% of females and 39% of males). The high percentage of abortion in the hospital could be misleading. Therefore one should not simply accept that most abortions are carried out at the hospital (Tweedie and Witte, 2000). Rather, the question at what time in the abortion process does youth go to the hospital should be raised. Tweedie and Witte, 2000 argue that among those who reported going to a hospital or clinic for the last abortion may have included those seeking treatment for complications resulting from abortions performed out of main stream orthodox places or means.





Ahiadeke (2001) also shows that, in southern Ghana between 1997–1998, 38% of pregnant teenagers sought help from a pharmacist and 11% had self-medicated, while only 12% had obtained an abortion from a physician (Ahiadeke, 2001). These findings are somewhat contrary to the GYRHS findings. While Ahiadeke (2001) found that only about 12% relied on a physician for abortion the GYRHS found that more than half its respondents went to the hospital or clinic.

Although Ahiadeke (2001) does not clearly indicate whether physicians necessarily conducted the abortions in clinics or hospitals, the results are still comparable as physicians are expected to use similar or same orthodox means of abortion whether in their homes or clinics. Kwankye (2005) also observe that some young females use harmful but inexpensive methods to abort pregnancies. These strategies sometimes result to complications which may then be sent to the clinic or hospitals.

Reasons for aborting pregnancies include the want continue education, inability to cater for the child, men's denial of paternity and social stigma (WHO, 2006). Most educational institutions in Ghana do not accept pregnant girls during pregnancy and after delivery as opposed to a recent Ghana Education directive to have such girl back when they have delivered. This results in teenagers considering abortion so as to continue their education. The financial ability to cater for children is another contributory factor. This is especially the case when the male denies the pregnancy and therefore also the responsibility to cater for the girl and the baby.

The social environment may also lead to abortion as some cultural situations place cultural restrictions on girls who have become pregnant at a younger age. This accompanied by the social stigma of some sort of shame is sometime seen by the pregnant teen as something that will be unbearable (Kwankye, 2005).



2.4.1 Health and Social Implications of Teenage pregnancies

Notwithstanding the downward trend in adolescent pregnancy it still remains very prevalent in the poorest countries. Adolescent childbearing has a negative impact on the health of the adolescents and their infants; individual social and economic effects; and societal level impacts.

Teenage pregnancies pose a lot of problems to the bearers. These problems and their implications range from health, social, economic and religious. This section shall discuss the health, and social implications. Thus while child birth is supposed to bring happiness, teens who give birth rarely experience it. This is more so when the pregnancies are unplanned.

Adolescent girls face lots of health threats during pregnancy and childbirth. It is estimated that such girls account for about 15% of the Global Burden of Disease for maternal conditions and about 13% of all maternal mortality. Due to their low level of preparedness in all fronts as compared to adults, adolescents are usually more likely to die in childbirth than adult mothers (WHO, 2006).

A survey in Latin America revealed that maternal death rates for adolescents under 16 are 4 times greater than for women in their 20s. Although some of this risk can be attributed to other factors besides young age such as giving birth for the first time, lack of access to care, or socioeconomic status – there seems to be an independent effect of young maternal age on pregnancy risk to the mother (WHO, 2008). The age of the girl thus the biological readiness is usually the most common factor. Also, these girls often have lower level of education, social status and use of medical facilities (WHO, 2006).



Some of the health challenges faced by pregnant teenagers include hypertension, anaemia, obstructed labour and vesico-vaginal fistulae (VVF). Thus in the absence of good maternal care these young people stand a higher risk of these situations translating into complications. The situation of some of these teenagers is often complicated by their refusal to attend maternal care early where it is available. One reason for this is the shame or stigma often attached to their situation. Also, some health workers are unfriendly to these teenagers (WHO, 2006).

Maternal mortality, morbidity and injury are common among teenage mothers. Of every young woman who dies in childbirth, 30-50 others are left with an injury, infection or disease (HAD, 2003). Adolescent mothers are more likely to have less than average weight babies, at risk of malnourishment, poor development or death. Also, infant and child mortality is highest amongst children delivered by adolescent mothers.

The rate of new born deaths is about 50% higher to adolescent mothers versus mothers in their 20s (GDHS, 2008). There are also health risks to mothers. A combination of physical and socioeconomic factors place babies of youngest mothers at higher risk of dying. There is an independent adverse effect of early pregnancy on new born health, even after controlling for a range of other factors (Conde-Agudelo et al 2005; WHO, 2007). In the United States of America the World Health Organisation found a 55% higher risk of neonatal death to babies of mothers aged 10-15, a 19% higher risk in babies of 16-17 year-olds, and a 6% higher risk in babies of 18-19 year-olds. The adverse impact of poor new born health resulting from adolescent pregnancies can lead to inter-generational effects and also long term effects leading to adulthood disease (WHO, 2008).



Adolescents who get pregnant also stand the risk of missing schooling and opportunities for employment. Many girls who become pregnant in the developing world often have to drop out of school. Most of these girls with little or no education have fewer skills and opportunities to find a job. This can also have economic cost implications for a poor country losing out on the annual income a young woman would have earned over her lifetime, if she never had an early pregnancy.

In most developing countries pregnant teens are sent home from school upon the realisation that they are pregnant. Mostly, they are not given pregnant or maternal leave but a sack from school. Thus this sometimes practically ends the opportunities for schooling among some girls. Also after delivery some schools do not accept teen mothers back to school and this could end the education of some girls (HDA, 2003).

In addition, teenagers who experience pregnancies are also likely to have the cycle repeating itself (WHO, 2006; GDHS, 2008). This means that their entire lives could be messed up if they are unlucky not to have good social support. Their situation could be even more worse if they bear children for different males and if the fathers of the children are also young.

The psychological implications of teenage pregnancies can also be rife. Teenage mothers stand the risk of experiencing negative short, medium and long term mental health outcomes (HDA, 2003). Teenage mothers could experience shocks during or after pregnancies that could result in mental instability leading to mental illness. Also, stress borne by teen mothers could derail them from normality and put them in mental illness situations. Sometimes, even where social help is available, it is difficult to recognise these mental situations. This is because the victims may not manifest the symptoms in public or even external. For some of them these remain intrinsically

and gradually wear them up through constant thought of their situation. These could have implications for how they cater for their young ones as well (HDA, 2003).

2.4.2 Adolescent Childbearing

In some cases adolescent pregnancy and childbirth are planned but for the majority they are not. Adolescent pregnancies are more likely to occur in poor, uneducated and rural communities. In some developing countries, particularly in Africa becoming pregnant outside marriage is not uncommon. By contrast, some girls may face social pressure in the community to marry resulting in children. More than 30% of girls in low- and middle-income countries marry before they are 18; around 14% before they are 15 (WHO, 2013).

Yet some girls do not have the knowledge of how to avoid getting pregnant. This is mainly because sex education is lacking in many countries. Some of them feel too inhibited or ashamed to seek contraception services. Also, contraceptives may be too expensive or not widely or legally available. More so when contraceptives are widely available, sexually active adolescent girls are less likely to use them than adults. In addition girls may be unable to refuse unwanted sex or resist coerced sex, which usually results unprotected sex.

According to Ghana Statistical Service (1999), between 1988 and 1998 the age-specific fertility rate among 15–19-year-olds reduced from 124 births per 1,000 women to 90 births per 1,000 women. This reduction was part of a general fertility decline in Ghana, and teenage fertility still represented nearly 10% of total fertility in 1998, as it did in 1988. The 1998 GDHS shows that 14% of 15–19-year old females were either pregnant or have had a child before. Tweedie and Witte (2000) also state that from the 1998 GYRHS 22% of females aged 12–24 who had ever had sex had



experienced at least one pregnancy, and 40% of males who ever had sexual intercourse stated that they had made someone pregnant.

Agyei et al. (2000) report that teenage pregnancy was high among adolescents in the Eastern and Greater Accra Regions. Out of a sample of 829 unmarried females in these two regions more than one out of every three adolescents who ever had sexual intercourse had become pregnant at least once. They also found that the incidence of pregnancy was higher in urban than in rural areas.

In 1990, the University of Ghana Medical School found that in the urban Ablekuma sub-district of Accra of 1,307 adolescent females and males aged 13–19 showed that 120 of the women were pregnant at the time of the survey. The study also found that, 27% of the pregnant teenagers had complications such as general weakness, bleeding and anaemia. In a quasi-experimental study of problems associated with adolescent pregnancy in Ghana, Adjei and Ampofo (1996) using a sample of 198 of females who had gotten pregnant before age 20 and the same number of respondents who became pregnant after age 20 as a control group, it was found that 60% did not want their pregnancy, compared to 38% of those in the control group.

Also they found that half of the partners of the females in the main study did not want the pregnancies as compare to only 31% of the partners of those in the control group. But 41% of those who were pregnant before age 20 had had an abortion before as compared to 57% of those in the control group.

Generally, childbearing varies by demographic characteristics such as age, residence and education. In the 1998 GDHS, it was found that 15% of females aged 15–19 in rural areas had ever had a delivery compared to only 7% of females the same age in urban areas. Higher education is also associated with the delay in childbearing. A



study conducted by Awusabo-Asare et al. (2004) shows that in 1998, 16% of 15–19-year-old females who had less than seven years of education had ever given birth as compared to about 9% of those with seven or more years of education.



CHAPTER THREE

METHODOLOGY

3.0 Introduction

This Chapter is devoted to a brief background of the study area and the research methodology employed in carrying out the study. The research methodology includes: the research design, sources of data, and tools for data collection, sampling procedure, and techniques of data analysis, as well as ethical consideration and limitation of the study.

3.1 Description of the Study Area

This was focused on location and size, population and housing characteristics, vegetation and drainage, culture and ethnicity, economic activities and health care in the district.

3.1.1 Location and Size

The study was conducted in the West Mamprusi district. It is located within longitudes 0°35'W and 1°45'W and Latitude 9°55'N and 10°35'N. The total land area is 5,013 km² and shares boundaries with eleven districts and two regions – Upper East and West. It has its District capital as Walewale. The district shares boundaries with six (6) districts after the creation of the Mamprugu Moaduri District. To the North is the Talensi and Builsa districts. It is bordered to the East by the East Mamprusi district, on the South the district shares borders with Savelugu\Nantong district. On the Western part, the district is bordered by Mamprugu Moaduri district.



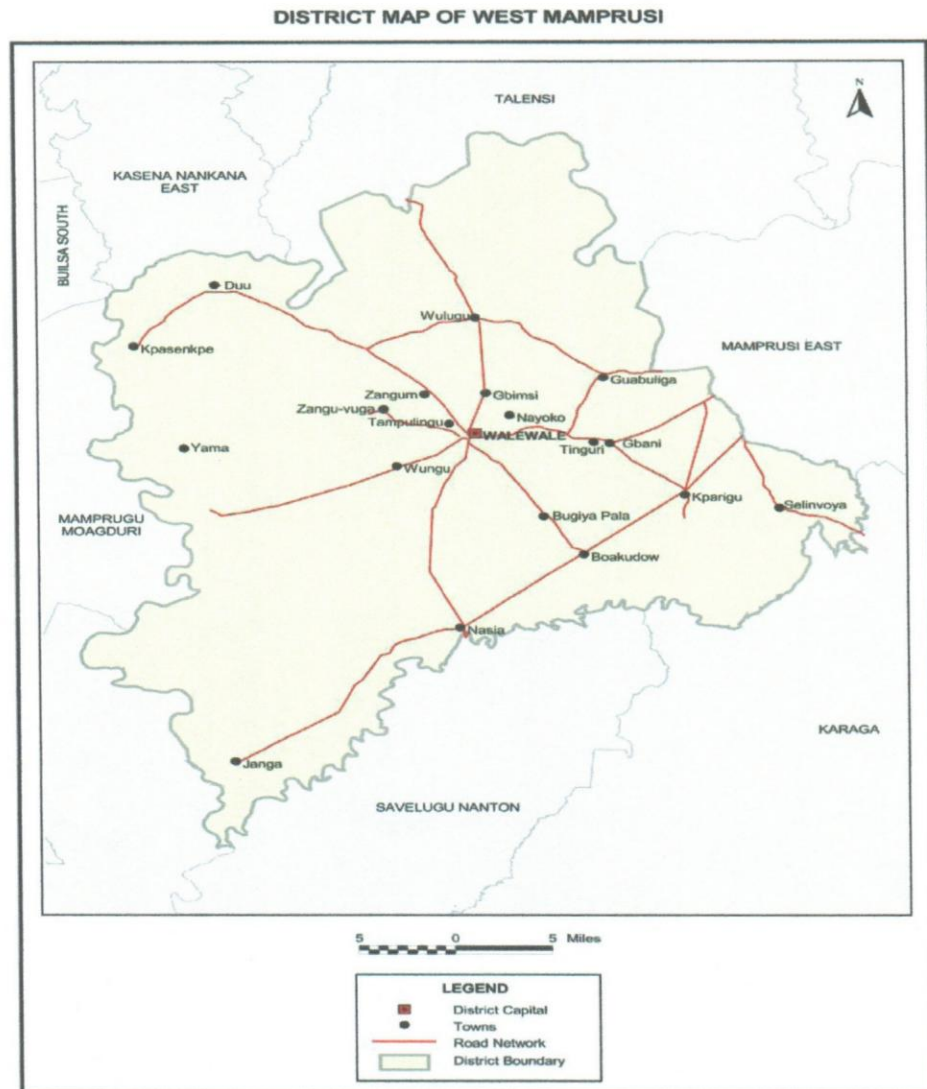


Figure 3.1: Map of the West Mamprusi District

Source: Ghana statistical service, 2010

3.1.2 Population and Household Characteristics

The results of the 2010 Population and Housing Census put the district population at 157,187 people. Out of this, 49.7% are males and 50.13% are females. The district has annual population growth rate of 2.7%. The urban population in the district is 18% (GSS, 2010).



The district has an average household size of 8 with a dependency ratio of 1:12. The district thus, has a population density of about 24 person/km² compared to 16 in 1984. The population growth pattern has shown an increase of 100% between 1970 and 1984, 75% between 1984 and 2001.

The population is concentrated in and around Walewale the district capital, of within 10 to 15km radius. There are other pockets of relative concentration in and around Janga in the southern part of the district, the area of relative concentration is Kpasenkpe-Duu area. The rest are either very sparsely concentrated or unsettled at all. There is therefore a very vast land of unoccupied land mass in the district.

The district is predominantly a rural one, with majority of the population living in rural areas. It is reported by the West Mamprusi District Assembly (2014) that only 5 settlements have a population from 5,000 and above. Sixteen settlements were found to be in the range of 2,000 to 5,000. The district capital Walewale, alone accounts for 12% of the districts population (18,880).

The majority of people in the district live in huts built of mud and roofed with straw. The general state of housing in the district is poor with a lot of houses marked by cracked walls, leaking roofs and weak foundations. The poor state of housing indicates the high degree of poverty in the district. There is, however, an increasing trend of new houses being roofed with aluminum sheets.

3.1.3 Vegetation and Drainage

The district is characterised by a single rainy season, which starts in late April with little rainfall, rising to its peak in July-August and declining sharply and coming to a complete halt in October-November.

The area experiences occasional storms, which have implications for base soil erosion depending on its frequency and intensity especially when they occur at the end of the dry season. Mean annual rainfall ranges between 950 mm - 1,200 mm.

The dry season is characterized by Hamattan winds. These winds, which blow across the Sahara desert, are warm and dry causing significantly daily temperatures and causing the soil to lose moisture rapidly. Maximum day temperatures are recorded between March-April of about 45°C while minimum night temperatures of about 12°C have been recorded in December-January.

The district is drained by the White Volta and its tributaries the Sissili and the Kulpawn rivers. Flooding by the White Volta is an annual problem caused mainly by the numerous small rivers, which flow into it especially below Pwalugu. Occasional flash floods have also been caused by spilling of waters from streams further upstream in Burkina Faso.

The prevailing rainfall and the nature of the underlying rock formations determines to a large extent the ground and surface water potential for the district. The present combination of heavy run-off, high evaporation and transpiration and low infiltration rates to recharge aquifers in some areas in the district, contribute to water deficiencies especially to the west of the White Volta, the south around Fio area and eastern parts around Shelinvoya.

The natural vegetation of the district is classified as Guinea Savannah Woodland, composed of short trees of varying sizes and density, growing over a dispersed cover of perennial grasses and shrubs. The climatic conditions, relief features and soil texture which foster water logged conditions (especially in the area west of the White



Volta) in the rainy season and draughty soils in the dry season tend to develop a characteristically hardy tree vegetation adapted to long periods of dry spells.

The existence of dense woodlands and forests along river valley (especially areas along the basin of the White Volta and its tributaries) is gradually beginning to change due to the influx of people into these areas as a result of the successful control of river borne diseases (e.g. Onchocerciasis). The vegetation is also annually affected by bush fires, which sweep across the savannah woodland each year.

3.1.4 Culture and Ethnicity

The Mamprusis are the major ethnic group in the district who co-exist peacefully with other minor ethnic groupings including the Akan, Frafras, Kassinas, Bimobas, Fulanis, and the Ewes. The Ewes are mainly settler fishermen who have settled along the major rivers especially the White Volta – to engage in fishing. The Fulanis are also settled in the area and are herdsmen for the indigenous people.

3.1.5 Economic Activities

Total land area in the District is 5013 km², with 45,781 hectares being put to cultivation. The average farm size is between 0.5 – 2.4 hectares. Land is normally acquired either by inheritance, from the chief or family heads. The principal land uses reflect the almost total rural base of the district economy. About 77.4% of the people depend on agriculture for their livelihood. Large amounts of land are therefore put to the cultivation of major crops like maize, millet, guinea corn, groundnuts and cotton. Important minor crops cultivated include legumes, cassava and yams. There are a lot of good lands for tree crops and large scale mechanized Agriculture.





The economic base of the West Mamprusi District is agriculture with an average of 80% of the economically active population engaged in something to earn a living. Agricultural activities in the district include crop production, livestock and fisheries. Only 54.7% of the 80% however farm as a major activity. Agriculture is basically on a subsistence level with smallholder farmers representing the main users of agricultural land. The average farm sizes vary from 0.5 hectares to 2.4 hectares.

Primary Processing of agricultural produce is done in the district though not on a large scale. Mostly it simply involves transforming farm produce into another form for local consumption. Sheanuts processing for exports is however picking up in the district. Some of the processed produce is groundnut oil, parboiled rice, Shea butter, smoked fish and Dawadawa spice.

3.1.6 Health Care in the District

The West Mamprusi District Health directorate is administratively divided into five (5) sub-districts; Walewale, Janga, Kpasenkpe, Kubori and Yikpabongo sub-districts. The district health system is made up of one (1) Hospital in Walewale, one (1) polyclinic in Janga, three health centers in Kpasenkpe, Kubori and Yikpabongo, six (6) clinics (Nelson Mandela and Our lady of Rocio (Walewale), PPAG Kparigu, Yizesi, Yagaba and Logri), four (4) CHPS compounds (Gbeo, Nasia, Yama and Kukua). It is made up of 212 communities.

The West Mamprusi District has a total population of one hundred and fifty nine thousand one hundred and eighty two (159,182) (Ghana Statistical Service Population and Housing Census, 2010).

3.2 Methodology

This study used both secondary and primary data. The secondary data for the study was gotten from books, reports, journal articles on adolescents in Ghana, particularly in the Greater Accra region. Also, district assembly documents were accessed for the purposes of understanding the area. The primary data was sourced from the respondents using questionnaire, observation, focus group discussion and In-depth interviews.

Mixed methods have several advantages. It helps the researcher compensate for the apparent limitations of each individual method; that is quantitative and qualitative (Barbour, 2008). The study made use of the quantitative and qualitative methods. A questionnaire was designed using the literature, which helped to capture a lot of information including characteristics of the respondents and to locate teenagers who had experienced pregnancies before. There were also qualitative questions in which respondents were made to speak their minds on the issues of sexual and reproductive issues in adolescent girls. Quantitative techniques help one to easily generalise and obtain patterns about a sample population (Babour, 2008). The weakness of this method, however, is that it does not give detail understanding of the issues or even fails in some cases to point or give clues about the likely causes (Thagard, 2003). This study compensated for the weaknesses of the quantitative method by adding a qualitative portion.

Qualitative methods in social research have many advantages that make them suitable for use together with quantitative methods. Some of the most important differences from quantitative methodology are according to Thagaard (2003) that qualitative method uses analysis of text instead of numbers, it includes proximity and closeness





to the informants as opposed to distance to respondents, and one has small (and often carefully chosen) selections of informants or object of study. While quantitative studies often have a linear process, qualitative methodology often goes in a cyclical process. Analysis and interpretation are activities that are ongoing throughout the research process, because the researcher will reflect and interpret the data while trying to get the overview. The research moves through different phases, and these overlap to a certain extent. The flexibility that lies in the qualitative research process can also give the researcher possibilities to change strategy during the process, and the process itself goes back and forth between theory, methodology and data (Thagaard, 2003).

There is no single accepted way of doing qualitative research. The researcher's view on ontology, epistemology, goal of research, the research participants and audience for the research are amongst the factors that influence the research that is carried out. In terms of the characteristics of this method, there is a consensus that qualitative research is a naturalistic, interpretive approach concerned with the meanings which people attach to phenomena within their social worlds (Snape and Spencer, 2003). Certain data collection methods have also been associated with this type of research, such as observation, in depth interviewing, group discussion and narratives. It also involves using methods of data generation that which are flexible and sensitive to the social context in which the data are produced. Close contact between the researcher and the people being studied is also a key element in the nature of the data generation. In terms of outcomes, or nature of outputs, there are several important elements. Producing detailed descriptions based on or an interpretation of the perspectives of 50 the participants in the social setting is one aspect, while answering 'how', 'why' and 'what is' is another. Particularly important for my research is also consideration of the influence of the researcher's perspective. In sum, the aim of qualitative research is

generally to provide an in depth and interpreted understanding of the social world, by learning about people's social and material circumstances, experiences, histories and perspectives (Snape and Spencer, 2003).

According to McCracken (1990) in Antwi Bosiakoh (2009), in-depth interviews give an advantage of helping us enter the thoughts of the respondents and experience the world just like they do. It is appropriate for addressing sensitive issues which respondents may not feel free to discuss in public settings. Also the interviewer can observe the physical environs and also use non-verbal cues like grimaces (Neuman, 1997). The demerits of this technique include interviewer bias. For instance, the tone of voice or wording of questions can affect the respondent (ibid). In-depth interviews are appropriate for this study because after dealing with views of adolescents as a group, the study finds it proper to isolate various cases which tell the stories of resilient adolescents from the perspective of individual adolescents. The use of this technique will ensure that the views of those respondents are highlighted and that access is gained to certain sensitive but important information which respondents will otherwise not share.

3.3 Study Design

The study was descriptive cross-sectional in design with both quantitative and qualitative data collected using structured questionnaire, interview guide and focused group discussion guide. The Data collected included socio-demographic characteristics, factors contributing to teenage pregnancy, practice and use of contraceptives and comprehensive abortion care

3.4 Sample Size Determination

The sample size of the study was determined using the following statistical formula for sample size determination $N = z^2 pq / d^2$ (Snedecor and Cochran, 1989), where N is the required sample size, z is the z-score corresponding to a 95% confidence level which is estimated to be 1.96, p is the prevalence rate of teenage pregnancy in the study area = 15% (0.15) (West Mamprusi District Health Directorate's Report, 2014), q is the proportion of teenage girls who are not pregnant = $1 - p = 1 - 0.15 = 0.85$, d is the precision or margin of error = 5% (0.05).

$$N = \frac{(1.96)^2 \times (0.15)(0.85)}{(0.05)^2}$$

$$N = \frac{3.8416 \times 0.127}{0.0025}$$

$$N = 195.28 = 196$$

Therefore a final sample size of One Hundred and Ninety-Six (196) was used in the study.

3.5 Sampling Technique

Purposive sampling and snow-balling technique were used to enroll 196 teenage mothers into the study.

By this, teenage nursing mothers and teenage girls who were pregnant were purposively identified and enrolled into the study. Also, teenage girls who have been pregnant before were identified through the snow-balling technique, as they were identified and enrolled through the help of others.



3.6 Data Collection

Two sources of data were used to collect data for this study; these were both primary and secondary sources. In the collection of the primary data both quantitative and qualitative methods of data collection were employed. The quantitative data were collected by the use of structured questionnaires. These were categorized into sections that will enable the researcher achieve her objectives. They were then sectioned according to the stated objectives. on socio-demographic characteristics, demographic characteristics of parents, knowledge of contraceptives, use of contraceptives and factors that influence the high rates of teenage pregnancies. The questionnaires were administered in one-on-one interaction with the respondents which is appropriate for the sensitive issues such as teenage pregnancy.

The qualitative method involved the use of Focus Group Discussions (FGDs) among the teenagers and parents and interview of teenagers and parents. The FGDs and interviews were organized to elicit information on the factors that influence the occurrence of teenage pregnancies. The knowledge of the discussants on the consequences of teenage pregnancies was also discussed.

3.7 Data Processing/Analysis

Quantitative data collected was entered into SPSS version 21.0 and analyzed in order to draw valid and reliable conclusions. The data collected were coded before entering them into the SPSS software.

Simple frequencies were established or found for socio demographic characteristics, parental information, and knowledge of contraceptives and use of contraceptives. Bivariate analyses or cross tabulation were performed for the quantitative data. Chi square values of these bivariate analyses were considered to be statistically significant



with $P < 0.05$ and a confidence level of 95 %.The essence of the cross tabulation was to determine the factors that are significant contributors to teenage pregnancy.

The qualitative data was analyzed by transcribing the recorded tapes of the FGDs. Thematic and content analyses were performed by extracting the main themes of the discussions and supported with some directed quotations from the discussants.

3.8 Quality Control Measures

To ensure the quality and genuineness of the data, the questionnaires were self-administered by the lead/principal investigator. This made the questioning to be uniformed. The questionnaires were pre-tested in two facilities before the final administration. Ten people were interviewed during the pre-testing and it helped in restructuring the questionnaires.

3.9 Ethical Considerations

Permission was sought from the District Director of Health Services of the West Mamprusi District before embarking on the study. The questionnaires were approved by the District Director before they were administered.

The consent of the respondents was sought through a written and an informed consent. The aim of the study was explained explicitly in the consent form. Respondents were not compelled to take part in the study but rather it was voluntary.

Anonymity and confidentiality of the actual source(s) of information obtained from the study was assured, by not indicating the names of facilities and individuals who took part in the study. Names were not provided on the data collection tools and therefore no clues were provided for someone to trace the source of information.



CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter captures the results of the study which were presented in tables and charts. The chapter is structured in accordance with the research objectives. First the socio-demographic characteristics of respondents, followed by factors associated with teenage pregnancies, knowledge level on contraceptive use and respondents' knowledge on comprehensive abortion care.

4.1 Demographic Characteristics

Relevant background information of respondents is presented in this section.

The mean age of the study participants was 16.6 ± 1.4 with a minimum age of 12 years and maximum age of 19 years. The median age was found to be 17 years with a range of 7. Most of the study participants (81.1%) were above 16 years. Majority of the study participants (44.9%) have not had any form of formal education while only 3 (1.5%) had tertiary education. Most (87.2%) of the respondents were Muslims and the least (2.6%) practiced African Traditional Religion. One hundred and eleven of the respondents (56.6%) were married while 1 (0.5%) was widowed. More than half (59.2%) of the study participants did not have any occupation while only 14.3% of them were working as at the time of the study. Most (61.7%) of the respondents still depended on their parents for their daily survival (main source of income) (Table 4.1).



Table 4.1: Demographic and general information

Indicator	Frequency	Percent
Age group (years)		
12-15	37	18.9
16-19	159	81.1
Total	196	100
Educational status		
Primary	34	17.3
JHS/middle school	41	20.9
SHS	30	15.3
tertiary/college	3	1.5
None	88	44.9
Total	196	100
Religion		
ATR	3	1.5
Christianity	20	10.2
Islam	173	88.3
Total	196	100
Marital status		
Divorced	29	14.8
Married	55	28.1
Single	111	56.6
Widowed	1	0.5
Total	196	100
Occupation		
Head porter	2	1.0
Farmer	28	14.3
Seamstress	8	4.1
Trader	20	10.2
Student	22	11.2
None	116	59.2
Total	196	100
Current working status		
Working	28	14.3
Not working	168	85.7
Total	196	100
Main source of income		
Other relatives	13	6.6
Own job	22	11.2
Parents	121	61.7
Spouse	40	20.4
Total	196	100

Source: field Survey, 2015



4.2 Family background of respondents

Almost one-third (29.6%) of the study participants were single parented (Table 4.2).

Table 4.2: Family background of respondents

Are you a single parent daughter	Frequency	Percent
No	138	70.4
Yes	58	29.6
Total	196	100

Source: field survey, 2015

4.3 Teenage pregnancy status of respondents

Table 4.3 below shows the teenage pregnancy status of the respondents. Almost one-quarter (19.4%) of the study participants were pregnant as at the time of the study and the remaining (80.6%) had been pregnant or given birth before.

Table 4.3: Pregnancy status of respondents

Pregnant	Frequency	Percent
Not pregnant	158	80.6
Pregnant	38	19.4
Total	196	100

Source: field survey, 2015

4.4 Factors that influence teenage pregnancies

This section looks at some of the factors that influence teenage pregnancy, which has been grouped into two; the intrapersonal and interpersonal factors. The study gathered data about the respondents to ascertain the current situation of teenage pregnancy and the characteristics of victims with the help of interviews and focus group discussions.



4.4.1 Intrapersonal factors

The intrapersonal factors that were identified include; age of teenager, level of education, occupation, working status, source of income, religion, and the use of contraceptive. However, only modern contraceptive usage was found to significantly ($p=0.013$) associate with current pregnancy status.

Majority of the study participants who were pregnant at the time of study were within the ages of 12 and 15 years although not statistically significant (24.3% versus 18.2%, $p=0.399$). Majority of the study participants who were pregnant at the time of the study had higher education (SHS and tertiary) although not statistically significant (27.3% versus 17.8%, $p=0.209$). Majority of the study participants who were pregnant at the time of study were Muslims although not statistically significant. Respondents were asked about contraceptive use. Most of the respondents who were pregnant at the time of the study were reported to have used any modern contraceptive before (30% versus 14.7%, $p=0.013$) (Table 4.4.1).



Table 4.4.1: Pregnancy status and intrapersonal factor

Variable	N (%)	Pregnancy Status		Test Statistics	
		Not Pregnant n (%)	Pregnant n (%)	Chi-square (χ^2)	p-value
Age					
12-15	37	28(75.7)	9(24.3)	0.711	0.399
16-19	159	130(81.8)	29(18.2)		
Total	196(100)	158(80.6)	38(19.4)		
Educational status					
Low education	163	34(82.2)	29(17.8)	1.579	0.209
High education	33	24(72.7)	9(27.3)		
Total	196(100)	158(80.6)	38(19.4)		
Religion					
ATR	3	3(100)	0(0.0)	2.073	0.355
Christianity	20	18(90.0)	2(10.0)		
Islam	173	137(79.2)	36(20.8)		
Total	196(100)	158(80.6)	38(19.4)		
Contraceptive use					
No	136	116(85.3)	20(14.7)	6.231	0.013
Yes	60	42(70.0)	18(30.0)		
Total	196(100)	158(80.6)	38(19.4)		
Working status					
Not working	168	138(79.8)	34(20.2)	0.544	0.461
Working	28	24(85.7)	4(14.3)		
Total	196(100)	158(80.6)	38(19.4)		

Source: field survey, 2015

4.4.2 Interpersonal factors

The interpersonal factors considered in this study include; marital status of teenagers, communication with teenagers, freedom of teenagers in family, financial support and abuse in home, and family background. Only level of freedom was found to significantly associate with current pregnancy status among the study participants.

Majority of the study participants who were pregnant at the time of the study were widowed or divorced although not statistically significant. Majority of the study participants who were pregnant at the time of the study had partial freedom in their homes. Although not statistically significant, most of the teenagers who were pregnant did not have financial support from their homes (20.8% versus 17.9%,



p=0.608). Majority of the study participants who were pregnant at the time of the study were not from abusive home although not statistically significant (20.1% versus 16.7%, p=0.615). Although not statistically significant, majority of the study participants pregnant at the time study were from single parent homes (20.7% versus 18.8%, p=0.765) (Table 4.4.2).

Table 4.4.2: Pregnancy status and interpersonal factors

Variable	N (%)	Pregnancy Status		Test Statistics	
		Not pregnant n (%)	Pregnant n (%)	Chi-square (χ^2)	p-value
Marital status					
Divorced	29	21(72.4)	8(27.6)	6.979	0.073
Married	55	48(87.3)	7(12.7)		
Single	111	89(80.2)	22(19.8)		
Widowed	1	0(0.0)	1(100.0)		
Total	196(100)	158(80.6)	38(19.4)		
Level of freedom					
Absolute	78	66(84.6)	12(15.4)	6.570	0.037
Partial	64	45(70.3)	19(29.7)		
Restricted	54	47(87.0)	7(13.0)		
Total	196(100)	158(80.6)	38(19.4)		
Financial support for Teenagers					
No	101	80(79.2)	21(20.8)	0.263	0.608
Yes	95	78(82.1)	17(17.9)		
Total	196(100)	158(80.6)	38(19.4)		
Abused					
No	154	123(79.9)	31(20.1)	0.253	0.615
Yes	42	35(83.3)	7(16.7)		
Total	196(100)	158(80.6)	38(19.4)		
Parenting					
Both parents	138	112(81.2)	26(18.8)	0.089	0.765
Single	58	46(79.3)	12(20.7)		
Total	196(100)	158(80.6)	38(19.4)		

Source: filed Survey, 2015

4.5 Knowledge on Contraceptive Use/Family Planning

Majority of the teenagers who were pregnant at the time of the study had ever heard of family planning although not statistically significant (20.3% versus 17.6%, p=0.653) (Table 4.5).



Table 4.5: Pregnancy status and knowledge on family planning

Variable	N (%)	Pregnancy Status		Test Statistics	
		Not pregnant n (%)	Pregnant n (%)	Chi-square (χ^2)	p-value
Heard of family planning					
No	68	56(82.4)	12(17.6)	0.202	0.653
Yes	128	102(79.7)	26(20.3)		
Total	196(100)	158(80.6)	38(19.4)		

Source: field Survey, 2015

Figure 4.1 shows the source of information about family planning among study participants. Majority (42.2%) of the study participants who ever heard of family planning were reported to have heard of it from friends while very few (3.9%) heard from parents. Respondents were asked their source of information on contraceptives.

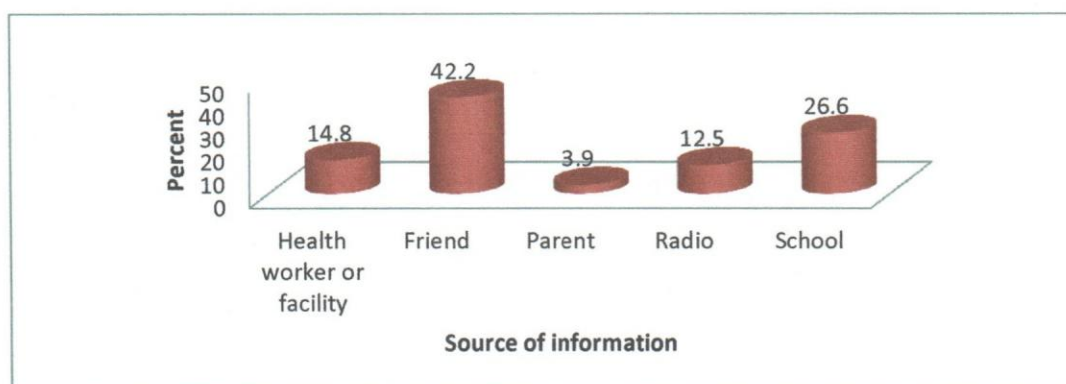


Figure 4.1 Source of information about family planning

Source: field survey, 2015

4.6 Knowledge on Comprehensive Abortion Care

Majority of the study participants who were pregnant at the time of the study were not aware of comprehensive abortion care although not statistically significant (19.7% versus 18.8%, $p=0.886$) (Table 4.6).

Table 4.6: Pregnancy status and knowledge on comprehensive abortion care

Variable	N(%)	Pregnancy Status		Test Statistics	
		Not pregnant n(%)	Pregnant n(%)	Chi-square (χ^2)	p-value



Awareness of comprehensive abortion care					
No	127	102(80.3)	25(19.7)	0.020	0.886
Yes	69	56(81.2)	13(18.8)		
Total	196(100)	158(80.6)	38(19.4)		

Source: field survey, 2015

The study participants who were reported to have had some knowledge about comprehensive abortion care were further asked about its affordability. Most (61.2%) the respondents indicated that comprehensive abortion care was not affordable (Figure 4.2).

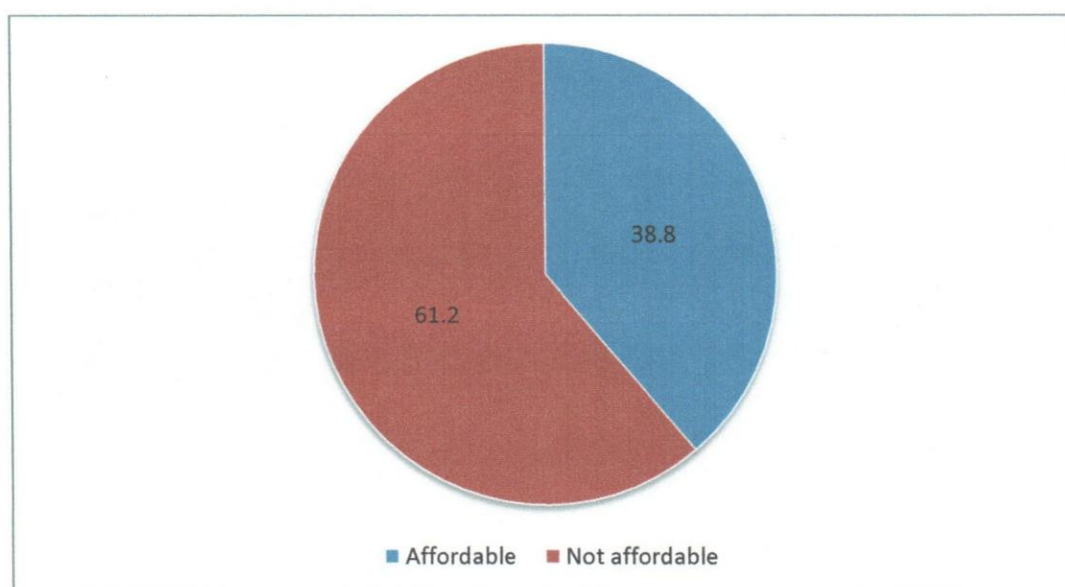


Figure 4.2: Affordability of Comprehensive Abortion Care

Source: field survey, 2015

4.7 Factors attributed to persistent teenage pregnancy in the study area (Participant perspective)

The issue of teenage pregnancy in this area is attributed to several factors. Paramount among them is parental neglect, introduction of mobile telephone and the issue of “record dance” (modern dance). In an in-depth interview with the chief of Lugri, the following were revealed:



"The young girls of today, like money, they want to have things that their parents cannot afford. The men will not even come to the house, they will stand somewhere and call them on their mobile phone. The mobile telephony has spoiled all our girls and when they girls become pregnant you don't even know who is responsible because the man will never come to the house for you to see him. They talk on phone and do all their arrangement and final meet at a point".

Source: In-depth interview with the chief of Logri, 2015.

4.8 How to deal with teenage pregnancy

The study inquired about strategies to help address teenage pregnancies in the study area. It appeared that study participants were more interested in parental care and punitive measures.

In an in-depth interview, an elder pointed out the following:

"When a child is in school and get pregnant, the teachers should be queried. But when the child is in the home (house) and gets pregnant, the mother of the child should be the one to be queried. Why am I saying the mother should be queried? When a child is in the house, she must eat that which is provided by the household. She must comport herself to the mother. When a student is staying in the dormitory of a school and yet come to town in the night to meet boyfriends, - some of the teachers are involve in this nefarious activity. This is my humble contributions".

Similarly another respondent stated that:

"What I have to say is what Yakubu (referring to the immediate respondent) has already pointed out to. This unnecessary travels, occasions and entertainments is what makes the children not to listen to the truth. In the evening when you go towards the township, you will see that there are intimate interaction between young girls and boys; the money for a man is not spent for free. While this is undoing they get pregnant. You the one that is pregnant cannot escape from this menace and yet you have not got any money to care for yourself and your unborn child. As this happens, burden is then placed in the mother and father. Put our plight to the elders to also help us. Whatever they can do to bring a change in our community is welcomed. This is also my humble contribution".



There was also the opinion that the needs of teenage girls should be given priority as explained by a victim of teenage pregnancy below:

"Like I have already intimated. Some of these pregnancies results due to the lack of your basic needs. What I think our parents should do is that they should make sure we have enough while we are in school. And some time some of our parents too they just don't care. In the night they do not care if the girl child is in the home or not. They should monitor for the girls in the night. If the girl is not there, but they should know where she is. And make sure that where she is safe".

Discipline in schools was also considered an important means of reducing teenage pregnancies as reported by one of the key informants:

"Like I said, schools like this they should make sure that there is discipline, like some of the girls will just leave school and say they are going home but will not reach their house, they will remain elsewhere. So school authorities should monitor their movements".

4.9 Focus Group Discussion

Findings from the focus group discussions indicates that contraceptive use was rare due to lack of knowledge and financial means but generally not accepted for teenage girls to use them since they are not allowed to have sex. Also, the discussions mentioned that women feared men in asking for their daughters to use contraceptives and men too feared their wives in helping their daughters get this. This was captured in a statement below:

"As we are saying, if you the man is the one discussing family planning with your daughter, your wife will ask you if that is your wife for you to be discussing such with. For the educated, they can have such discussions with their children but we the locals cannot have such discussions for our wives cannot even phantom that. If your wife ask you such questions what will be your justifications?"



Another elderly man in a focus discussion explained the interaction of financial support in the following words: *"What I have to say is that some of the girls are more interested in material and immediate gains. Some of these girls you will realise that within their household, their parents are able to provide their basic needs like food, shelter, and clothing and even care for her in school. Because these children are interested in material gains, they still go above all this and seek for these things from boys and young men in the streets. While the child keep begging men for this resources and coins, if she is not also morally up right, you will realise that she pays it back through sex. Look as am sitting here, I caught some small children just at the back here engaged in sexual activity. I have actually monitored those small children and I believe they were engaged in such activity for long until I eventually caught them. Imagine if these small girls are engage in this and get pregnant, will they be able to care for themselves. Their parents were in the house while they engaged in this activity. While she has brought shame to her family for getting pregnant, when she birth, who is going to take care of this child. Here is the case the mother cannot be able to work to take care of a child. When a woman is to deliver, she is expected to have some resources like ingredient, cloths and baby cloths to care for the child. If she just deliver without all this, pressure is then set on the teenagers mother to provide all this resources putting undue pressure on the already dwindle resources".*

Among the issues concerning factors contributing to teenage pregnancy, a 62 year old man pointed at single parenting as one of the main factors in a statement as below: *most of the blame can be attributed to the mothers of the children. This is more serious with those who already have no fathers. These children are result of the very problem we are discussing so there is no man to cater for children. The reason is that girls sleep with their mothers. When you the man even realise that the girl does not sleep accordingly in the house, the mother may even insist that the girl sleep in the room. When the child does not eat that which is cooked by the household, the mother insists she does. When the girl go out and comes back late, the mother insist the girl was already in the room. You the man may even know the mother is lying to defend the girl. In some instances the girl may even be sleeping in two houses or in two rooms and the mother may even know this. When you the man want to reprimand the girl, the mother insist you want to tarnish her image. So talking about teenage pregnancy, some mothers ignorantly defend their girl child leading to the occurrence of the pregnancies within our communities. Sometimes when you keep on disciplining*



these girls, their mothers jump to their defense saying it is like that everywhere. Intimating it is because you hate the girl- your strict monitoring role. Sometimes even make your own child to hate you, indicate you do not like her but the mother. So for me, yes we and their mothers discuss the menace but if the mother does not seem to support entirely what you are saying, the child is likely to stick to that which is said by the mother. Since the child finds pleasure in what she is doing, she adheres to that said by the mother. The time the child will realise that she was wrong in the choices she made, then she is already in trouble. By then, she is pregnant and there is no turning back. So we the men we talk and advice, but the mothers also spoil some of the girls for us. The mother will not listen insisting you are bringing her name in to disrepute.

4.10 In-depth Interview

In an individual interview with Amina, 18 year old teenage girl reported the following as why she is not in school:

"Hmmm! I am not in school because of the pregnancy, my parents and the teachers asked me to stop the school because I was pregnant. I was in the SSSI at the Wulugu secondary when I became pregnant. Now am dropped out because I don't think I can continue after I deliver my baby".

As reported by Malia, a 17 year old teenage mother at Lugri:

"I was not married to him, he only made me pregnant and my parents asked me to move to his house to deliver, after the delivery and the outdooing he said I should go back to my house until such a time that he is ready to pay the dowry. I have been here receiving all kinds of insults from my parents and peers. Hmmm had I know is always at last".



CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This chapter discusses the results on the findings of the research as depicted by the data and analysis presented in chapter four (4).

5.1 Socio-demographic characteristics

The socio-demographic characteristics of teenagers according to World Health Organization (WHO) are crucial in determining their exposure and vulnerability to teenage pregnancies (WHO, 2006). The current study found this to be fundamental in understanding teenage pregnancies in the study area although with weak relationships.

The ages of respondents in this current study ranged from 12 to 19 years. This is in line with WHO standards, which defines adolescents as people between the ages of 10 and 19 years.

The current study found about eight in ten of the study respondents to be Muslims with Christians and others making up the smallest minority. This is not surprising as the Population and Housing Census report (Ghana Statistical Service, 2010) report that the West Mumprusi district is dominated by Muslims. In terms of religious affiliation, this present study observed that most of the parents of teenagers who were pregnant at the time of the study were Muslims although not statistically significant. According to Nukunya (2003), communities in Ghana with high concentration of Muslims are far more likely to experience teenage pregnancies than Christian dominated communities. He explains that Christian communities were far more likely to discuss sex issues and educate children better at sex related issues due to their relatively higher levels of education (of parents). More so children in Christian



communities were more likely to be enrolled in formal school than those of Muslim communities.

More than half of teenage mothers studied were found to be single. This evidently supports the argument that, though sex outside marriage and especially amongst teenagers may be frowned upon by society, the practice still goes on and one of the resultant effect is teenage pregnancy. More so, in Ghana, child marriage is not common (Nukunya, 2003), thus it is less surprising that most teenagers who get pregnant are not married away early.

The family background is reported as an essential factor in influencing teenage pregnancy (WHO, 2006) and for that matter, the current study inquired about the parental status of the teenage mothers studied and the study found that more than one-quarter of the study participants were from single parent homes.

5.2 Factors that influence teenage pregnancy

The discussion under this subject was divided into two; intrapersonal and interpersonal factors that influence teenage pregnancy.

5.2.1 Intrapersonal factors

Individual or interpersonal factors are those attributes of an individual that increases his/her likelihood of engaging in risky behaviour by influencing how he/she interacts with the other contexts, and the influence that those contexts bring to bear on him/her (WHO, 2006).

Age is an important determinant of an individual's sexual activity and therefore pregnancy (Sowah, 2009). In the present study, more participants in the early or lower teenage (12-15 years) were found to be pregnant compared to those in the upper teenage (16-19 years) although not statistically significant. This trend could also be



attributed to the fact that girls in the lower age group could be more likely to engage in sex due to the physiological and physical body changes experienced at this stage which may make them think they are matured and ready for sex. This is contrary to the findings of WHO where they found teenage pregnancy to be higher among the upper teenage group. They attribute it to the physical maturation and higher exposure to social life outside of the home (WHO, 2006).

Teenager's level of education was another important intrapersonal factor considered, with a look at its importance in influencing teenage pregnancy. Data from the current study revealed that, more of the participants who were pregnant at the time of the study had higher educational status although not statistically significant. This could partly be due to partial freedom enjoyed at that level of education.

Contraceptive use among teenagers could lead to control of pregnancies (Kwankye, 2005, 2007; Kirby, 2008). Ironically, in this present study majority of those who were pregnant at the time of study were reported to have used modern contraceptive before. This could be due to their partial knowledge about modern contraceptives and curiosity for its usage as partial knowledge could be more dangerous than no knowledge at all.

5.2.2 Interpersonal characteristics

The everyday social environment in which young people live their lives can also have a significant effect on their sexual behaviour. The players in this social environment include parents, partners, peers and schools. The intrapersonal factors affecting teenage pregnancy considered in this study included parent's marital status of teenagers, communication with teenagers, freedom of teenagers in family, financial support and abuse in home, and family background. According to NRC and IOM



(2005) such interpersonal factors amongst others, play a significant role in the identity, formation and decision making for and by teenagers.

In the present study, only level of freedom was found to significantly associate with current pregnancy status among the study participants. The level of freedom that a teenager has in her life is significant in determining teenage pregnancy (USAID, 2004). Majority of those who were pregnant were found to enjoy partial freedom from their homes. The partial freedom could have led to partial knowledge and limited education about dangers of pre-pubertal sex and sex education. Curious teenagers may want to practice or try the little they know which could have resulted in the pregnancy.

Although not statistically significant, majority of the study participants who were pregnant at the time of the study were widowed or divorced which raises concern about the age at which girls get married in the study area. Girls are reported to be married out early to men for chieftaincy benefits or royal lineage in Northern Ghana and this could be evident in the present study. The study suggests that, not only are sexual activities high among teenagers in the study area but a substantial level of low knowledge or lack of access to pregnancy preventive measures.

Although not significant, most of the study participants who were pregnant at the time of the study were found not to have received any financial support from their parents and other family members. WHO in one of its reports (WHO, 2006) indicated that, when the needs of teenagers are not met by the family they are more likely to look elsewhere including boyfriends who could expose them to sexual activities at an early age and then the likelihood of teenage pregnancy becomes high. This assertion is affirmed by other studies (Nicholson and Ayers, 2004; Sowah, 2009) where they



reported the importance of financial support to teenage girl and its absence as a determining factor for teenage pregnancy.

Although not statistically significant, most of the teenagers who were pregnant at the time of the study were from homes that abuse were not reported. This is contrary to the findings of other studies (Makiwane, 1998; Maharaj, 2006; Makiwane, 2007) where they reported abusive homes to be an important factor in determining teenage pregnancy.

In the present study, majority of the study participants who were pregnant at the time of the study were found to come from single parent homes. It is a popular notion that when children live under the care of both parents and are jointly brought up by them, the possibility of sexual experimentation and teenage pregnancies declines (WHO, 2010). Other studies report teenage pregnancy as being an incident mostly associated with broken homes or unstable homes. HAD (2003) observed that, teenage mothers are more likely to come from families with some crises. This includes issues concerning single parenting, broken homes, and financial crises among others. The family can have early and lasting impact on an adolescent's beliefs, systems and values, and therefore on their behaviour (Gordon, 1996). Consistent parental values are reported to be very important as it acts as a vital factor in influencing later sexual début and also decreases the risk of unintended pregnancies (Berglas et al., 2003). However, single parent homes are less likely to succeed in enforcing the right values. Those parents who are clear and straight about the value of delaying sex are reported to be more likely to have their adolescents have sexual intercourse at an early age (Blum and Rinehard, 1998). Parents' values against adolescent sexual intercourse have the capability to decrease the risk of adolescent pregnancy (Miller et al., 2001). On the other hand, parents with permissive attitudes concerning sex or premarital sex,



or those that have negative attitudes about contraception are more likely to have teenagers who are more likely to have unsafe sex and becoming pregnant (Kirby, 2002).

More so, family members serve as role models to their children and children may learn to imitate their behaviours. For that matter, teenagers are more likely to initiate sex and experience pregnancy if their parents or other family members are reported to have sex outside of their marriages, or are cohabitating with a romantic or sexual partner or have had a child outside of marriage (Kirby, 2001). Having a mother or sister with a history of teenage pregnancy was found in other studies to strongly associate with teenage pregnancy (East and Jacobson, 2001; East et al., 2006).

5.3 Knowledge on contraceptive Use

About six in ten of the study participants had ever heard of family planning or modern contraceptives. This is in line with the findings of Ghana Youth Reproductive Health Survey (GYRHS, 1998) where 76% of females aged 15–19 and 88% of males the same age were reported to be aware of at least one modern family planning method. Although not statistically significant, majority of the teenagers who were pregnant at the time of the study had ever heard of it. Knowledge on contraceptives is reported to be an important factor that can help teenagers avoid pregnancies (GDHS, 1993; Blum and Rinehard, 1998; Elhag, 2003). Knowledge on modern contraceptives or family planning is a good indicator for efforts to encourage its use. According to Ahmed et al. (2006) avoiding conception has come to be defined as part of female sexual respectability and attractiveness. The findings from the current study could be



attributed partially to curiosity or partial knowledge about the family planning methods and hence inappropriate use or application.

5.4 Knowledge on Comprehensive Abortion

In the present study, none of the study respondents reported ever aborting a pregnancy while more than two-thirds of them did not know about comprehensive abortion. The abortion status of teenagers in the present is contrary to the findings of the Ghana Youth Reproductive Health Survey (GYRHS, 1998) where 11% of males and 16% of females aged 12–24 who ever had sexual intercourse reported of ever terminating a pregnancy.

Although not statistically significant, majority of the study respondents who were pregnant at the time of the study were not aware of comprehensive abortion care. This could partly be due to low or no reproductive health education in the study district. More so, most of the study participants who were reported to have heard of comprehensive abortion care think it is expensive and beyond their economic reach. However, in other studies (Blum and Nelson-Mmari, 2004; Borat and van der Westhuizen, 2008), abortion is reported to be a theoretical option for those who do not want to deliver their babies and as such, the question of affordability should not overshadow compliance. The same cannot be the case for the study since illiteracy is high and many are yet to come to terms with issues concerning comprehensive abortion care.

These findings in the present study could be the reason for the high level of teenage motherhood in the study area.



CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents summary of the main findings, conclusion and recommendations. The summarized main findings bothered on factors determining teenage pregnancies, and respondent's knowledge on contraceptives and abortion were presented.

6.1 Summary of Key Finding

The study found a number of interesting findings and some of which are as follows:

The mean age of the respondents was 16.6 ± 1.4 with a minimum age of 12 years and maximum age of 19 years.

Majority of the respondents (44.9%) have not had any form of formal education. Making the illiteracy rate to be very high in the area thereby contributing to high number of teenage pregnancy and teen mothers in the area.

More than half (59.2%) of the respondents reported not have any meaningful employment while only 14.3% of them were working in the informal sector as at the time of the study.

Most (61.7%) of the respondents still depended on their parents for their daily survival (main source of income). Thereby bringing hardship to those who were pregnant and also they pregnant and nursing mothers find it difficult to have access to good nutrition and diet and reported by some of the respondents.

Almost one-quarter (19.4%) of the respondents were pregnant as at the time of the study while the remaining (80.6%) had given birth and were nursing their babies at the time of the study.



The respondents who were pregnant at the time of the study were reported not to have used any modern contraceptive before (30% versus 14.7%, $p=0.013$).

Majority of the respondents who were pregnant at the time of the study were those who reported that parental negligence was the major factor that led to their situation.

Majority of the teenagers who were pregnant at the time of the study had ever heard of family planning although not statistically significant (20.3% versus 17.6%, $p=0.653$), but it supported the view that family planning education is important and should be conducted in most of the rural area including the west Mamprusi district where this study was conducted.

Majority of the respondents who were pregnant at the time of the study were not aware of comprehensive abortion care although not statistically significant (19.7% versus 18.8%, $p=0.886$) but it shows that comprehensive abortion care education was poorly conducted in the area.

Some of the respondents who were aware of comprehensive abortion care reported that it was expensive and beyond the reach of the poor. They indicated that it was meant for the rich and the educated elites in the society and not the poor in the rural communities.

6.2 Conclusion

In conclusion, age, level of education, occupation, working status, source of income, religion, and the use of contraceptive were identified as intrapersonal factors while marital status of teenagers, communication with teenagers, freedom of teenagers in family, financial support and abuse in home, and family background were identified as interpersonal factors. However, contraceptive use and level of freedom from home



were identified as important intrapersonal and interpersonal factors respectively in determining teenage pregnancy in the study area.

Awareness of family planning or modern contraceptive among the study participants was found to be high whereas awareness of comprehensive abortion care was relatively low.

6.3 Recommendations

The study makes the following recommendation to assist stakeholders and policy makers in reducing the incident of teenage pregnancy in the study district and Ghana as a whole especially those in the hinterlands.

The Ministry of Education in collaboration with the Ghana Education Service should include school-based sex education, peer education, as well as sexual and reproductive health programmes in its curriculum at the basic level and continue it to the secondary level in our educational institutions.

The District Health Management Team should organise programmes periodic health education on adolescent sexual and reproductive health through the local radio station, posters in the local language to educate community members about the advert effects on teenage pregnancy and other related effects.

The Health Promotion Unit of the Ghana Health Service and the Reproductive and Child Health Unit of the District Health Management Team (DHMT) should team up to sensitize and educate all community members about family planning and the right contraceptive use. Especially the men in the communities.



The DHMT in collaboration with the Ghana Education Service should sensitize and educate parents about girl child care and responsible parenting. This can be done through Parent Teachers Association meeting, health education fora and joint community fora on health and education. In this regards assembly members and traditional rulers in the various electoral areas should be involved.

Adolescent-friendly corners should be set up at all clinics in the district by the DHMT to provide reproductive health education to the youth in the area.

The Ghana Education Service should initiate programmes to re-enroll teenage mothers back to school after delivery.



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APPENDICES

Appendix A:

Questionnaire Teenage Mothers

FACTORS CONTRIBUTING TO TEENAGE PREGNANCY IN THE WEST MAMPRUSI DISTRICT.

INFORMED CONSENT

I am a student from the University for Development Studies, conducting a study on “So Many Teen Mothers in My Village”; Factors Contributing To Teenage Pregnancy in The West Mamprusi District. This study is part of my Master of philosophy degree thesis hence I will be most grateful if you assist me by answering the following questions. All information given would be confidentially treated.

Section A: Socio –Demographic Characteristics of Respondent:

1. Age
2. Marital status
 - A. Married
 - B. Divorced
 - C. Single
3. Educational level
 - A. Basic
 - B. JHS
 - C. SHS/Second cycle
 - D. Tertiary
4. Are you currently working?
 - A. Yes
 - B. No
5. Occupation
6. Parity
7. What is your main source of income?
 - A. Own job
 - B. Spouse or partner
 - C. Parents
 - D. Other relatives



- E. Partner's parents
- F. Helping others for a fee

8. Husband's age if any

9. Husband's educational level

- A. Primary
- B. JHS
- C. SHS/Second cycle
- D. Tertiary
- E. No formal education

10. Where do you live?

- A. Alone
- B. With own mother (include step mother)
- C. With own father (include step father)
- D. With baby's father
- E. With baby's father's father and mother
- F. With other relatives
- G. With friends
- H. In a foster home
- I. Incarceration

Section B: Sexual Activity of Respondent

11. Have you ever had sexual intercourse before

12. At what age did you have your first sex?

13. How did it happen?

14. Did you ever have sex education?

A. Yes

B. No

15. If yes, where did you receive this sex education?

- A. School
- B. Church/mosque
- C. TV
- D. Radio
- E. Social media
- F. Friends

16. What type of sex education was given to you?

17. Did you discuss sex issues with your parents? If yes which of your parents

18. If no why are they not discussing issues of sex with you?

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19. Have you ever been a victim of sexual molestation?

- A. Yes
- B. No

20. If yes who was the perpetrator?

- A. Your partner/boyfriend
- B. A previous partner/boyfriend
- C. Your date
- D. Your father
- E. Your step-father
- F. Another relative
- G. Friend
- H. Neighbour
- I. An acquaintance
- J. Someone known to you from work or school/college/university
- K. Person in a position of trust or authority (not at work, school or university)
- L. A stranger
- M. Don't know/can't remember
- N. Don't wish to answer

Section C: Factors Causing Teenage Pregnancy

21. Whom were you living with when you were growing up?

- A. Both parents
- B. Mother alone
- C. Father alone
- D. Other relatives
- E. Was a house help to someone

22. Are they able to provide you with the basic needs like food, shelter, clothing etc.?

23. Have you been pregnant before?

24. If yes what do you think was the main cause of you been pregnant?

25. What do you think were the other reasons for you becoming pregnant at this time in your life?

- A. Unprotected sex (but not planning baby)
- B. Contraceptive failure
- C. Desire for a child
- D. Ignorance about sex
- E. Partner wanted a child

Section D. Parental Responsibilities

26. Were you living with your parents before your pregnancy?

- A. Yes
- B. No

27. Do you still live with your parents?

- A. Yes
- B. No

28. Were you sleeping under the same roof with your parents?

- A. Yes
- B. No

29. If no, why?

- A. My parents do not have a house of their own
- B. The rooms were inadequate
- C. We were too many
- D. There was no mattress for us
- E. My parents never cared about me

30. Were you eating from your parents' house?

- A. Yes
- B. No

31. If no, why?

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32. In your own assessment, do you think your parents provided or performed their responsibilities as parents?

- A. Yes
- B. No

33. If no, why?

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34. In your opinion, how should a pregnant teenager handle the situation?

- A. Terminate the pregnancy
- B. Have and keep the baby
- C. Give the baby up for adoption
- D. No opinion, each case is individual

35. In your opinion, whose responsibility it is if a girl becomes pregnant?

- A. Girl herself
- B. Boy's
- C. Both but more of the boy's
- D. Both but more of the girl's
- E. Both equally
- F. Parents'

36. To what extent do you agree that it is girl's responsibility only to take care of the contraception to avoid pregnancy?

- A. Strongly agree



- B. Agree
- C. Disagree
- D. Strongly disagree

37. To what extent do you agree that contraception should be available for young people under the age of 16 without parental consent?

- A. Strongly agree
- B. Agree
- C. Disagree
- D. Strongly disagree

38. To what extent do you think that teenage pregnancy is a problem which needs to be tackled?

- A. Strongly agree
- B. Agree
- C. Disagree
- D. Strongly disagree

39. To what extent do you agree with the statement that sex education encourages underage sexual activity?

- A. Strongly agree
- B. Agree
- C. Disagree
- D. Strongly disagree

40. To what extent do you agree that the availability of birth control and abortion is a major cause of increased sexual activity among teenagers?

- A. Strongly agree
- B. Agree
- C. Disagree
- D. Strongly disagree

41. To what extent do you agree or disagree with the following statements on teenage mothers?

- A. Teenage mothers are less likely to finish their education
- B. Less likely to find a job
- C. More likely to end up as single mothers
- D. More likely to bring up their children in poverty

Section E. Knowledge of Family Planning and Abortion Care

42. Which type of contraceptive and family planning methods do you know?
/multiple response allowed read from the list and mark all that apply/

- 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/calendar

43. Have you ever used any contraceptive method?

- A. Yes
- B. No

44. If yes, which method have you ever used?

- 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

45. Do you think abortion is acceptable?

- A. Yes
- B. No

46. Have you ever aborted a pregnancy before?

- A. Yes
- B. No

47. In your opinion, what prevents young girls from aborting an unintended pregnancy?

- A. Fear of stigmatization
- B. Fear of the parents
- C. No money
- D. Don't know where to go for abortion
- E. Fear of complications and death
- F. Others (specify).....

48. Where can you go for an abortion?

- A. Hospital
- B. Health centre
- C. Pharmacy shop
- D. Traditional herbal centre
- E. Any available local expert
- F. Others (specify).....



Appendix B: Focus Group Discussion Guide

FOCUS GROUP DISCUSSION GUIDE

1. Why do you think teen pregnancy continues to occur in this community?
2. Do you know about family planning methods?
3. What is the level of usage of contraceptives among teenagers in this village?
4. What are the reasons for nonuse of family planning among teenagers?
5. What are the causes of teenage pregnancy in this community?
6. What are the consequences of teenage pregnancy to the mother and her child?
7. What are parental responsibilities to prevent the occurrence of teenage pregnancies?
8. Is abortion acceptable among teenagers?
9. What are the barriers to seeking abortion services among teenage girls?
10. How do you think teenage pregnancy can be prevented?



Appendix C: Interview Guide for Respondents

INTERVIEW GUIDE FOR TEENAGERS WHO HAVE EXPERIENCED PREGNANCIES

1. Could you explain how it happened that you got pregnant?
2. Did you get pregnant at your first sex or after?
3. How many sex partners did you have at the time you got pregnant?
4. What was your knowledge on contraceptive and condom use before you got pregnant?
5. Were you using any contraceptive just before you got pregnant? Why?
6. Did your boyfriend accept the pregnancy?
7. How did your parents treat you when you got pregnant?
8. Can you describe how life was after you got pregnant?
9. Did it affect your education? How?
10. Are you back in school after delivering your baby? (for those who have delivered)
11. If still pregnant: Do you intend to go back to school after delivering?
12. Do you think that the school authorities will take you back?
13. What do you think account for teenage pregnancies among other colleagues of yours?
14. What do you suggest can be done by government and parents and school authorities to prevent teenage pregnancies?

