UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL BASED SEX EDUCATION: PERSPECTIVES OF TEACHERS AND STUDENTS IN SENIOR HIGH SCHOOLS IN THE TAMALE METROPOLIS

AUGUSTINA DECHEGME ACHIGIBAH

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BY

AUGUSTINA DECHEGME ACHGIBAH (B.A. POLITICAL STUDY)

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FEBRUARY, 2018

DECLARATION

Student:

I hear by 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:…….…… Date:……

Augustina Dechegme Achigibah

Supervisor:

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

Supervisor's Signature:…….…… Date:……

Dr. Evam Kofi Glover

ABSTRACT

The purpose of the study was to assess the perspectives of teachers and students in Senior High Schools in the Tamale Metropolis on school-based sex education. Provision of sexuality education in schools has been identified as a key strategy in promoting the sexual and reproductive health of adolescents as it equips them with the knowledge, skills and efficacy to make informed decisions about their sexuality and lifestyle in the mist of numerous and conflicting messages about their gender and sexuality. Though sex education was introduced in the curricula of pre-tertiary schools in Ghana, little is known about the perspectives/views of teachers and students on this school-based sex education. The study was cross sectional descriptive that employed both qualitative and quantitative methods. A total of 403 students in six senior high schools were selected using multi-stage sampling method. Teachers who handled sex education in schools were purposively sampled. Data were collected through a questionnaire, focus group discussions and interview guide. Quantitative data was analyzed using SPSS version 16.0 whilst data from the focus group discussions and interview were analyzed manually. Both teachers and students favored the school-based sex education but were not fully satisfied with the provision of only knowledge on contraceptives, STIs/HIV/AIDS without skills acquisition on how to handle risky sexual situations. Lack of training for teachers on adolescent reproductive health, culture and religious factors were identified as some of the challenges associated with teaching sex education in schools. There is the need to constantly train teachers, especially those who handle sex-education on adolescent reproductive health issues. There is the need for the designers of the sex-education program to look into ways of mitigating the negative influence of the Ghanaian culture and religious beliefs on school-based sex education.

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DEDICATION

I dedicate this work to my mother (Paulina Bayiwasi)

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immuno-deficiency syndrome
FGD	Focus Group Discussion
GSS	Ghana Statistical Service
HIV	Human Immune deficiency virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MICS	Multiple Indicator Cluster Survey
NORSAAC	Northern Sector Action on Awareness Center
PPAG	Planned Parenthood Association of Ghana
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
SPEEK	Supporting Peers and Encouraging Empowerment
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Policy
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The highest levels of adolescent pregnancy are in Africa implying a highly youthful population that is sexually active. Retrospective data from Sub-Saharan Africa showed that more than a quarter of women (20–24) and between 27-35% of men (20–24) reported that they had sex before age 15. Between 0-10% of women (20–24) reported a birth before age 15 and 4-46% reported births before age 18(Chandra-Mouli et al., 2014).In Ghana, 14% of women aged 15-19 had begun childbearing in 2014 (GSS 2014).

These unwanted pregnancies occur because sexually active youth has a high unmet need for sexuality information and contraception. They also reflect a failure to provide a safe environment that supports young girls to reach adulthood with education, prospects and hope (WHO, 2006). Young people need access to comprehensive, age-appropriate and accurate sexuality education sexual and reproductive health information and services so they can use contraception, prevent unintended pregnancy and decide if and when to have children. At the same time, these investments allow young people—especially girls—to take advantage of education and employment opportunities. Effective sex education programmes have been shown to reduce misinformation, increase the use of contraception to prevent unintended pregnancies and sexually transmitted infections and promote positive attitudes and behaviours (UNFPA, 2012).

School based sex education programs evolved in response to concerns about high rates of teen pregnancy and increasing rates of sexually transmitted infections (STIs), including

HIV/AIDS in most second circle schools of most countries of the first World. According to Meschke, Bartholomae &Zentall (2002) industrialized countries such as the United States of American recorded the highest pregnancy rate among teenagers between ages 15-19. Henshaw et al., (2006) established that, out of every 1000 pregnancies, 76.4% were among 15-19 adolescent girls, majority of which are unintended pregnancies. Adolescents are more often than not at the greatest risk of contracting STIs. In line with this, majority of parents, including health professionals and a cross section of the public advocated the inclusion of sexual health education in schools (Meschke et al., 2002).

However, according to the Public Health Agency of Canada (2008), mere inclusion of sex education in educational curriculum is not an antidote to reducing the rate of teen pregnancies, but rather access to effective, broadly-based sexual health education. This is regarded as an essential component in reproductive health and a strong measure to reducing teen pregnancies among the growing population of the world. It is against this backdrop that, school-based sex education programs are considered very essential avenues for providing sexual health education to young people. Sawyer et al. (2012) are of the view that, developing countries have the greater proportion of the youthful population because of high fertility rates. Sawyer and his colleagues contend that for a healthy population therefore, authorities in the health care sector and school administration should establish effective school-based sexual health education.

The rationale for providing sexual health education to young people is to equip them with the requisite knowledge and values regarding responsible sexual life. Knowledge on responsible sexual life, will inform young people concerning choices about their sexual and social relationships and to prevent them from contracting STIs and unplanned

pregnancies (UNFPA, USAID, UNICEF, 2009). The assertion made by UNFPA, USAID, UNICEF implies that, inadequate knowledge on the use of modern contraceptives among adolescents can affect their reproductive health.

Sub-Saharan Africa remains the region that is most affected by STIs particularly the HIV epidemic, despite positive signs that HIV prevalence is declining among young people in the sub-region (Hervish et al., 2012). The high numbers of new infections among young people in the sub-region remains a serious concern to governments and policy makers. It is estimated that nearly eighty-percent (80%) of young people in Sub-Saharan Africa are living with HIV/AIDS (UNAIDS, 2016). The high STIs prevalence among adolescents and young people in the sub region is attributed to inadequate knowledge on sexual and reproductive health services. Common practices such as early sexual debut, high primary school dropout rates and low transition to secondary school, as well as weak adolescent health services combine to create a daunting challenge in reproductive health among adolescents (UNAIDS 2012).

Global and regional commitments and policy declarations have come from both the education and health sectors to promote the roll-out of comprehensive sexual health education and creating full access to the necessary SRH services (UNESCO 2009). The programme of action developed at the International Conference on Population and Development (ICPD) in 1994 underscores the importance of sexuality education 'both in and out of school' as part of the basic life skills that all young people require. However, the situation is quite complex in the Ghanaian context. Among other things, the cultural and religious factors of Ghana create a sensitive environment where issues of sexual and reproductive health have remained highly taboo (Mack, 2011 as cited from Nyarko et al.,

2014). The mere mention of "Sex" seems to evoke uncomfortable feelings among both the young and old. Adults in the Ghanaian Society have usually refrained from discussing sexual matters with the young making it very difficult for teenagers to ask questions relating to sexual issues as they would be seen as "disrespectful", "disobedient" and sometimes "immoral". Hence issues on sexuality are seen as topics for adult discussions only (Nyarko et al., 2014)

Some religious groups in Ghana are opposed to sex education. They associate sex education with encouraging immorality among adolescents. In fact, it is argued that sex education would make adolescents and young people want to carry out sexual experimentation (Ankomah, 2001 as cited from Nyarko et al., 2014). The influence of social and religious factors on young peoples' sexuality explains the ambivalent attitude of the government and schools towards sexual health education though it is officially part of the school curricula (Osei, 2009 as cited from Nyarko, et al., 2014). Sexual health education became part of the curricula of pre-tertiary educational institutions with the publication of the Adolescent Reproductive Health Policy in 1996. The rationale for introducing sexual health education was because majority, nearly 90% of children and young people were enrolled in schools (Awusabo-Asare et al., 2006). The government again in 2000 published a new Adolescent Reproductive Health Policy with the aim of equipping young people with the knowledge and skills to make informed decisions and utilize available Sexual and Reproductive Health facilities optimally. To achieve this, the policy seeks to strengthen the teaching and learning related to sexual reproductive health in the school curriculum for in-school adolescents (Adolescent Reproductive Health

Policy, 2000). This presupposes also the need to strengthen the capacity of teachers to provide the necessary support to students on the subject matter.

1.2 Problem Statement

According to the 2010 population and housing census, 31 per cent of Ghana's population of 24.4 million consists of young people (aged between 10 and 24 years). This indicates that a good number of the Ghanaian population is within the youthful age. These groups of young people, according to Melanie Croce-Galis (2004) are at risk and some already facing the challenges of unplanned pregnancy and sexually transmitted infection (STI) as a result of indulging in risky sexual behaviors and inadequate knowledge on STIs prevention.

The 2008 Ghana Demographic Health Survey showed that by age 15 most young people have had their first sexual experience. According to the report, 8.2% of females and 3.6% of males have had their first sexual experience by age 15 years. Early sexual intercourse is a risk factor of unplanned pregnancy and may contribute to high numbers of STIs and HIV infections especially because of the vulnerability of these young people. In 2012, young people between the ages 15-24 contributed 28% to all new HIV infections in the country. The prevalence among the 15-19 and 15-24 age groups was also 0.7% and 1.3% respectively (Ghana AIDS Commission, 2014)

Adu-Gyamfi (2014) established that, unplanned pregnancies among young people mostly lead to the termination of schooling especially among girls. Adu-Gyamfi's study in Upper Denkyira on pregnant adolescents revealed that 96.25% of the respondents had to stop schooling due to pregnancy. The study also revealed that unplanned pregnancies by the school dropouts were largely due to limited knowledge and access to quality sexual and

reproductive health care services. The situation is not different in the northern parts of Ghana especially that the Multiple Indicator Cluster Survey (MICS) report of 2011 shows an adolescent birth rate of 73 births per 1000 women in Northern Region. The high rates of teenage pregnancies resulting from limited knowledge of young people on their sexual and reproductive health calls to question the existence and effectiveness of the School-based Health Education Programme, especially from the perspective of teachers as primary implementers and the students as the end-users.

1.3 Justification

Although sex education is often discussed and evaluated in terms of its role in reducing adolescent pregnancy and STI rates, those in favour say its primary goal is broader: to give young people the opportunity to receive information, examine their values and learn relationship skills that will enable them to prevent unprotected intercourse and to help them become responsible, sexually healthy adults, (Donovan, 1998). Donovan's view is however not accepted by all. There are some strong religious views that oppose sex education for young people. The Roman Catholic Church is one of the major opponents of 'group sex education'. Following from the publication by the Church (The Education of the Redeemed Man, December, 1921) and a decree of the Holy Office on March 21, 1931, by Pope Pius XI said that "no approbation whatever can be given" to group sex education (cf. Dolan, 1984). Indeed Pope Paul VI, in an address on September 13, 1972, classed sex education along with erotic literature and pornography as one of the evils of the day (cited from Dolan, 1984).

Religious and cultural views are that sex education among young people could lead to sexual experimentation. There are however dissenting views from some quarters of society with some parents choosing to have their wards educated on their sexuality.

Agencies in favour of sex education say it has positive implications for the well-being of young people generally. Comprehensive Sexual Health Education as described by IPPF for example seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and within relationships. It is a culturally relevant approach that teaches young people about issues related to sex and relationships. It also provides opportunities to explore one's own values and attitudes and to build decision- making, communication and risk reduction skills about many aspects of sexuality (IPPF, 2009).

It is argued that the individual-level sex education may not produce the effect that is needed for the good of young people generally and the society at large. The point is made that intervention programmes that target only individual-level factors in isolation provides a limited perspective on the complex issue and, furthermore, precludes a more in-depth understanding of how higher level variables (e.g., family, peers, school, community, and society) that may be independently associated with sexual risk behaviors in the presence of these other individual level factors (Di Clemente et al., 2007). Thus, even though individual-level approaches are seen as useful and essential, there is substantial evidence indicating that their intervention effects tend to diminish over time (Pedlow et al., 2004 as cited in Di Clemente et al., 2007). For behavior change to be meaningful, it must be enduring. As individual-level interventions lack sufficient impact to sustain behavioral change, there is therefore the need for interventions like school-based sexual education

which aims at providing life-long values and decision-making skills to take cognizance of impact of higher level variables that shape young people's behavior.

The debate has brought divisions in tackling the problem in Ghana. Thus even though officially accepted in Ghana, the sex education programme continues to face some challenges especially among individual teachers (as frontline implementers of the policy) may reject the programme on the basis of their individual moral/faith grounds.

Despite this challenge, the government policy on sex education for young people continues to be implemented. Several NGOs including the Northern Sector Action on Awareness Center (NORSAAC), Savanna Signatures, Marie Stoppes, and the Planned Parenthood Association of Ghana (PPAG) are making frantic efforts to educate young people on their sexual health. Programme managers are aware of the fact that more innovative approaches are needed to meet the challenges that impede the realization of the goal. The need for area specific assessment of the programme as a measure towards remedial efforts for meeting the objectives cannot be overemphasized. It is against this background that this study as an area specific assessment of the sexual health education programme becomes important. Indeed, despite the fact that the school-based sexual health programme has been on-going for many years, there is to date no systematic evaluation especially among senior high school students in the Tamale Metropolis. It is obvious that there is the need for regular assessment of the programme to ensure the realization of its objectives. It is within this domain that this study seeks to investigate school-based sexual health education among senior high school students in the Tamale Metropolis in the Northern Region of Ghana.

A number of questions continue to agitate the mind of the public in relation to the implementation of this programme and its effectiveness as planned. The major questions include: What are the views of both teachers and students on school-based sex education? What are students' knowledge, attitudes and practices on sexual and reproductive health issues? Do students have access to reproductive health services? What are the challenges associated with school-based sex education and how should these challenges be addressed? It is believed that finding answers to these questions will contribute towards improving the programme generally.

1.5 Objectives of the Study

1.5.1 General Objective

The general objective was to assess the perspectives of SHS teachers and students on school –based sex education in the Tamale Metropolis.

1.5.2 Specific Objectives

1. To assess students' knowledge, attitudes and practices on sexual health issues

2. To describe students accessibility to sexual health care services

3. To describe teachers and students' perspectives on school-based sexual health education

4.To outline the challenges associated with school-based sexual health education and how these challenges can be addressed.

1.6 Significance of the Study

The importance of sex education is made manifest with the implementation of the school-based sex education as part of the curriculum of the Ghana education service. This is to

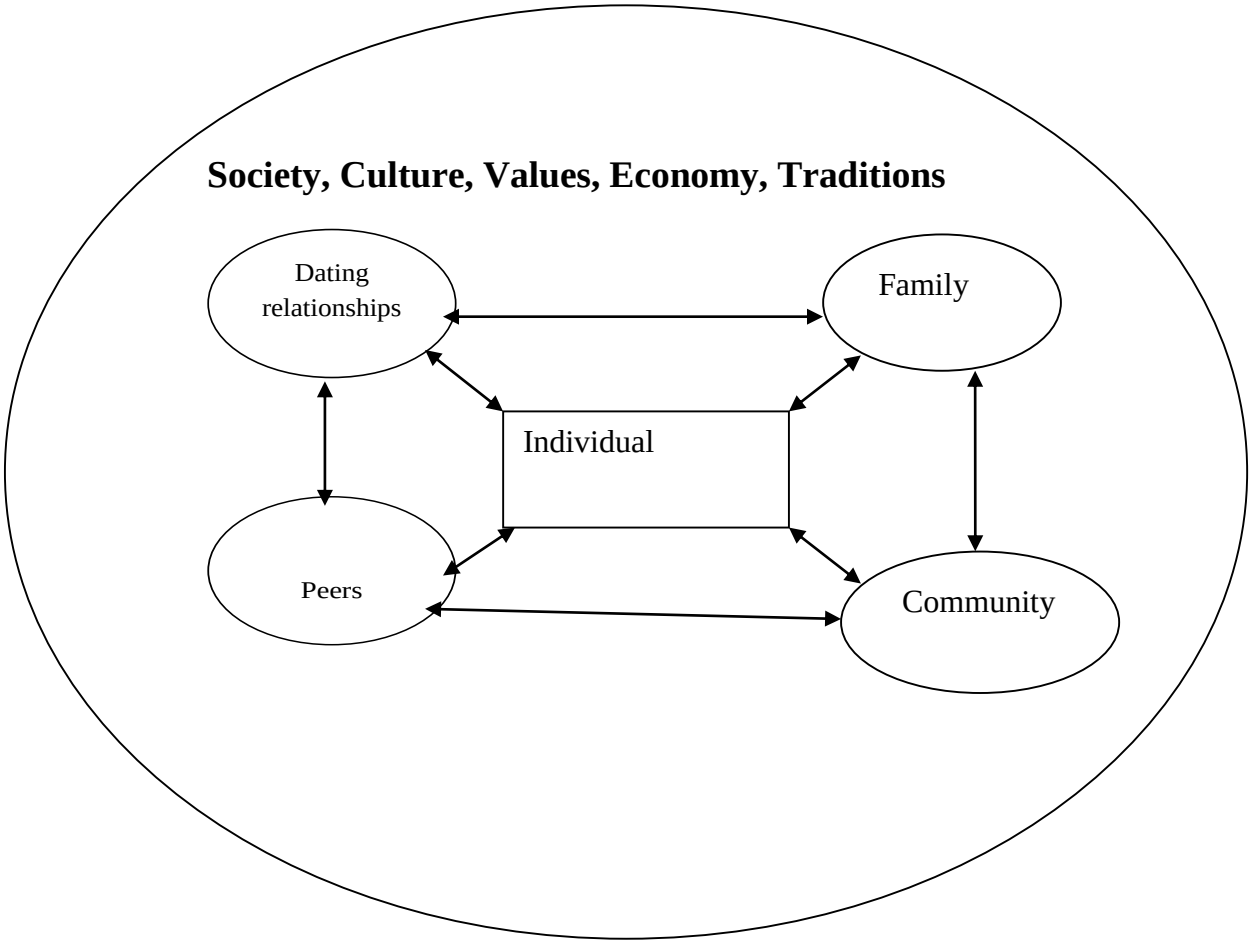
equip young people with requisite knowledge, skills and values to make informed decisions and choices regarding their sexual and reproductive health. Adequate knowledge of the youth on sexual and reproductive health will help reduce the incidence of STIs including HIV.

The findings of the study will help enlighten most parents, especially in West Africa and Ghana in particular on the essentials of educating young people about their sexual health. This will help parents who shy away from communication connected to sex to embrace the reality of sex education in our contemporary times. The study again will most likely unravel the intricacies about young peoples' sexual life and that can serve as a policy directive document for stakeholders on reproductive health care services including NGOs and Ghana Health Service in the design of their sexual health youth friendly programmes.

1.7 Scope of the Study

The study was limited to the Tamale Metropolis in the Northern Region of Ghana as it has the highest number and diverse forms of Senior High Schools in the region and also due to resource and time constraints.

1.8Conceptual Framework



Source: Diclementi, 2007

The conceptual framework seeks to conceptualize perspectives on school-based sexual health education using the Ecological Model. It discusses the mechanism through which various factors interact to influence young people's sexual behavior. The model designed by Bronfenbrenner (1979) defined this social ecology of human development as involving the study of mutual transactions between human beings, and the properties of the environmental systems in which they interact. The goodness-of-fit between the person and the environment influences whether outcomes are successful or strained. He identified four system levels:

(a) The Microsystem—the roles and characteristics of the developing individual

(b)The Mesosystem—the settings with which the developing person interacts, thus the school, family and peers. This level describes the interactions between the individual, the school, the family and peers and how they work for the good of an individual.

(c)The Exosystem— settings with which the individual does not interact but nevertheless have an effect on the persons' development. For example how the parent's experience at work may influence his interaction with a child.

(d)The Macrosystem—cultural values and larger societal factors that influence the individual.

This model recognizes the importance of diverse arrays of factors that represent a web of causality including personality traits, parental monitoring and support, peers, media, cultural and societal norms, influence young people's sexual behavior. Given this web of causality, any effort to effect changes in young peoples' sexual behavior like school-based sexual health education, would have to address both the proximal and distal environmental factors that interact to influence young people's decision making process (Maton, 2000 cited from Di Clemente, et al., 2007).

Interactions within several social spheres such as the family, peers, school, definitely have an influence on shaping a young person's sexual behavior or attitude. The use of an ecological approach provides a broader perspective for critically looking at numerous leverage points of long-term behavior change that school based sexual health education seeks to achieve. For the purpose of this study therefore, the ecological model becomes important as a guide in my analysis of data.

This is against the background that young people are exposed to diverse sources of influence transecting different levels of causation. To adequately prevent and reduce the likelihood of adopting sexual risk behaviors, intervention programmes should be designed to address these myriad levels of causation as described by Bronfenbrenner (Di Clemente et al., 2007)

Applying an ecological approach to young peoples' sexual behavior and attitudes is consistent with the growing tendency of health promotion programmes to be based on expansive theoretical models that greatly exceed constructs that comprise the individual level (Di Clemente, et al. 2002 Di Clemente et al., 2007).

Figure 1.1 above illustrates the individual embedded within the proximal context of an environment defined by peers, community, family, school and sexual and dating relationships. The figure illustrates how these proximal influences are embedded within the distal influences of society such as economics, tradition, norms, laws, and mores. In essence, the distal elements influence the proximal elements, which mutually influence each other as well as the young person thereby making him the victim or the benefactor of these larger influences. To provide holistic information to young people therefore, sexual health education programmes must adopt a complementary approach that addresses these proximal and distal spheres as well as the interactions that occurs among them. The conceptual framework as a tool promises to enable a critical look at, not only the influences within the social setting concerning attitudes and practices, but also how school-based sex education programme helps young people to cope with these myriad influences on their knowledge, attitudes and practices. It is believed that sex education would inform the necessary knowledge, attitudes and behavior of young people about life situations so that

young people who benefit from the programme would show better understanding, attitudes and behavior patterns than those who do not benefit from the programme.

1.9 Operational Definition of Terms

Access: Ability and capacity to acquire and utilize information and services

Attitudes: Relatively enduring organization of beliefs around an object or a situation that predisposes one to respond in some preferential manner

Contraceptive: A device or a drug used to prevent pregnancy, sexual transmitted diseases and other health related problems

Health: Health is the social, economic, cultural, spiritual and political wellness of the individual in a particular period of time.

Sexual health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence

Sexuality: Feelings, thoughts and behaviors of being a female or male, being attractive and being in love as well as being in relationships that include sexual intimacy and physical sexual activity

Sexual behavior: Constitutes a person's sexual practices

Sexual health education: process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy

Sexual health knowledge: A person's awareness and understanding of issues related to his or sexuality.

Sexual Practice: Activities engaged in with regards to sexuality

1.9Organization of the study

This thesis is organized into six (6) chapters, with the following respective captions, Introduction, Literature Review, Methodology, Results and Analysis, Discussions, and Conclusion/Recommendations.

Chapter One contains introduction to the study covering a brief background to the study, the problem statement, justification, objectives, relevance of the study, scope of the study and conceptual frame work, as well as the organisation of the study.

Chapter Two has to do with literature review where works of other scholars and authorities relating to the research topic were looked at.

Chapter Three had to do with methodology of the study, which contains the study design, description of the study area, sample size, sampling technique, study variables, data collection techniques, research instruments, data processing and analysis, quality control and ethical considerations.

Chapter Four contains the findings of the study which were discussed under Chapter Five.

Chapter six contains the conclusions and recommendations based on the key findings of the study.

CHAPTER TWO

LITERATURE REVIEW

This chapter focuses on the review of literature related to the topic of the study. The review will be organized under the following subheadings

1. Young people's sexuality

2. The knowledge, Attitudes and Practices of adolescents on sexual health.

3. Access to sexual health services

4. School-based sexual health education and its challenges.

2.1 Young People' Sexuality

Young people are experiencing a time of transition, full of physical, psychological, emotional and economic changes as they leave childhood and enter adulthood. The decisions that are made during this period of life affect not only the individual wellbeing of the young person, but also the wellbeing of entire societies. Ensuring that young people can successfully go through this phase of life will help break the cycle of poverty and produce benefits for individuals, communities and nations (UNFPA 2012).

A young person as defined by WHO (year) is a person between the ages 10-24 whilst adolescents are those aged 10-19 years. Population figures from UNFPA (2014) shows that there are currently more young people in the world today than ever before. According to the report, this an unprecedented 1.8 billion young people alive today with Sub-Saharan African countries having a proportionally large cohort of young people . Sub-Saharan Africa's population is consists of more than one-third of young people between the ages

10-24 (Hervish et al., 2012). In Ghana, the 2010 census conducted indicates that young people formed 22.4% of the total population of 24,658,823 (GSS. 2012). This large population of young people represents an opportunity for accelerated economic growth and poverty reduction, yet their vulnerabilities and challenges, which mostly lead to morbidity and mortality, have made it quite impossible for them to make any meaningful contribution to the socioeconomic development of their country.

The greatest challenge probably facing young people today has to do with sexual and reproductive ill health resulting from risky sexual behaviors. Sexual activities among young people have seen a rise in recent years and rapidly becoming an issue of public health concern across the globe. This has largely been attributed to the growth of secondary sexual organs, changes in hormonal secretion, emotional, cognitive and psychosocial development during the stage of adolescence. The adolescence stage presents a period of curiosity, experimentation and most often than not exploration of one's sexuality and sexual life. This however, if often characterized by risk taking behaviors resulting in negative sexual outcomes. (Steinberg, 2008Steingber, 2008 cited in Krugu, 2016)

Sexuality as defined by WHO (2006) is "a central aspect of being human throughout life encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships". A young person's sexuality refers to sexual feelings, interactions, behaviors values and attitudes during the transitional period of his human life. Though sexual development in every person begins earlier in life, it becomes very overt during transitional period to adulthood.

The sexual behaviors, values and attitudes of young people are largely shaped by social and culture norms within which the adolescent finds himself.

2.2 Knowledge, Attitude and Sexual Practices

2.2.1 Sexual Health Knowledge

Knowledge on sexual health which encompasses information related to sexuality, sexual and reproductive health care problems and sexual and reproductive health care services can be said to be a protective factor against risky sexual behavior and its attendant consequences by young people. Knowledge on sexual health issues therefore empowers young people to make informed decisions concerning their sexual lives thereby reducing their risk for unplanned pregnancies, abortions STIs and HIV/AIDS (WHO, 2006). Though studies on young people's knowledge of their sexual health indicate an appreciable level of knowledge of young people on their physiological changes as they transit from childhood to adulthood, their knowledge of contraceptives, STIs/HIV and conception is still considerably low.

Though there has been mass media education and school based programmes on sexual and reproductive health in Ghana for over two decades, depth of students' knowledge is still inadequate even as majority of them are afraid to get pregnant. Among young people aged 15-19 years, only 28% of females and 21% of males had detailed knowledge about how to prevent pregnancies; were aware of a woman's fertile period and were familiar with at least one modern method of contraception. Moreover, knowledge on proper use of the male condom, which is the most common method of protection among young people, is also very limited (Awusabo-Asare et al, 2006).

With the exception of the male condom, most young people know little about other methods of contraception (Boamah et al., 2014). Awareness of contraceptives can be described as limited to the male condom with few young people knowing the other modern methods of contraception like IUD, diaphragm and the traditional methods. In their study exploring the socio-cultural determinants of contraceptive use among adolescents in Northern Ghana, Yidana et al., (2015) found that 74.8% of respondents had knowledge of the male condom as compared to 3.3% of respondents who had knowledge of tubal ligation.

Knowledge on contraception is most often than not negated by perceptions of links between some modern family planning methods and infertility, still births menstrual side effects. Among young women, the fear of side effects and personal opposition to family planning are among the commonest factors undermining uptake. A study on sexual health experiences of never-married youths in three Ghanaian towns including Tamale found that 98% of the sample of urban youth knew the existence and spread of sexually transmitted infections, especially HIV/AIDS and gonorrhea. However, only few valued the need for effective contraception. This may be associated with the high incidence of unintended pregnancies, unsafe abortions, and maternal deaths (Eliason et al., 2014 cited in Averiyire 2015).

In addition, perceptions of young people regarding the use of contraceptives also affect their contraceptive use. Where girls and boys who use contraceptives are perceived as bad, as reported by Hagan et al., (2012), contraceptive use tends to be low even among the sexually active. Their study also reports that perceptions that contraceptives are for only adult married persons also affects young people's contraceptive use.

In spite of the reported cases of high incidence and prevalence of STIs infections among today's young people than decades past, knowledge level on STIs, modes of transmission, symptoms and treatment is still considerably low among them. A study by Savanna Signatures (2014) among Junior High School pupils in Northern Region of Ghana showed that though majority (52%) believed that HIV/STI is a threat, a significant 37% were unsure or did not even know they could get infected with HIV/STIs. Twenty percent of the respondents held the belief that they could not be infected by STIs through unprotected sex. Another study by Alwyn et al., (2001) also showed that majority of young people have more knowledge on HIV/AIDS than other STIs as 80% did not know that vaginal discharge is a common symptom of an STI infection in women. Also, 60% were ignorant of the fact that a person may not present any symptoms when infected with some STIs.

Moreover, most young people hold certain myths and misconceptions on their sexual health that also predisposes them to negative health outcomes. These misconceptions mostly stem from the seeming inconsistent information received from divergent sources. Young people have been identified to possess insufficient knowledge with respect to pregnancy. Some practice the withdrawal method whilst some females also choose to track their "safe" periods within their menstrual cycle as a pregnancy preventive method without knowing the risks associated with the methods (van der Geugten et al., 2017)

A study in Ethiopia also revealed that some young people hold the view that it is not possible for a young girl to get pregnant from a single act of sexual intercourse. Among the female respondents between the ages 15-19, only 44% knew that a woman could still get pregnant if she washed herself after sex with 35% indicating that they were unsure of that (Abajobir et al., 2014). Such misconceptions lead to non-use of contraceptives and

ineffective STIs protective measures and treatment when infected. However, although accurate knowledge on STIs and other sexual health issues alone is not necessarily a protective factor against risky sexual behavior, it has been found to be a necessary component in the change process for individuals who have misconceptions about behaviors that prevent STI infection (Anwar et al., 2010).

2.2.2 Sexual Practices

Risk-taking sexual practices have become a common practice among young people. It is not uncommon to find them engaging in sexual intercourse at an early age, having multiple sexual partners, unprotect sexual intercourse and unsafe abortions (Ogbada, 2013).Risk taking behaviors is a characteristic of the adolescence phase of life, a normal phase of human development characterized by heightened curiosity, experimentation and exploration of the ideals of life which includes sexuality (Steingber, 2008 cited from Krugu, 2016)

Young people are confronted daily with choices about whether or not to have sex and if they do, whether or not to use contraceptives and many factors have being identified to affect these choices that young people make regarding their sexuality. Mores, values, cultural norms play critical role in shaping the kinds of sexual behaviors that young people engage in. To influence or change sexual behaviors therefore, parents or interventions must consider shaping these factors that affect sexual behaviors of these young ones. These factors according to literature consist of biological, family, school, peers and community. The factors have been categorized into risk factors; which include those factors such as early sexual debut, multiple sexual partners that encourage behaviors that might lead to

pregnancy or STIs. Protective factors have been described as those that encourage behaviors that prevent pregnancies or contracting STIs (Kirby et al., 2005)

Age and physical development have a dramatic effect on sexual behavior. The older young people get, the more likely they are to have sex. They are also likely to initiate sex early they mature physically at an early age and also begin menarche at an early age. The age at which adolescents begin sexual debut is of significant public health importance, as it has been found to expose them to potential risky outcome both in the short and long term (Sanfort et al., 2008 cited from Ogbada, 2013).

Globally, the age at which young people commence sexual initiation is said to be decreasing (Rose et al., 2005).This age varies widely in countries and depends on the acceptable cultural practices which may have negative influences on their sexual behaviour. In Ghana, though the median age the median age of sexual debut for women and men between the ages of 20-24years is reported to be 18.4years and 20years respectively, 11.8% of girls in the 15-19 age group initiated sex at age 15 as compared to 9.3% of males (GSS-DHS,2015). Early sexual activity leads to a long period of premarital sexual activity during which partner changes are relatively common, resulting in development of higher risk sexual orientations (Bongaarts & Watkins, 1996 cited from Ogbada, 2013). Early sexual debut has also been found to be associated with sexual intercourse with casual partners and multiple sexual partners and a higher risk for STIs infection (Harrison et al., 2005 & Pettifor et al., 2004)

Varied reasons have been reported for why young people engage in sexual activity. These reasons range from pleasure to peer pressure to financial reasons. In a study of three districts in Ghana, Sallar reported that 38% of adolescents had sex for the first time for

pleasure while 23% of males and 24% of females had sex because of peer pressure (Sallar, 2001)

Family characteristics such as educational level of parents, family income, and family structure are very important in determining sexual behavior. Living with both parents decreases the likelihood of initiating sex early or having multiple sexual partners. However, parental separation or divorce puts adolescents at risk of initiating sex early. Moreover, the presence family connection in the form of support, security and direction is less likely to put young people at risk for pregnancy and STIs (Kirby et al., 2005).Communication between parents and children on sex and contraception is also likely to delay if they children are not yet sexually active and if they are, contraceptive use may increase. Communication includes the interactions and discussions that parents, other adults and peers have with young people on issues that are of interest or pertinent to one or both parties involved, as well as the content, nature and timing of the action (Kumi-Kyereme 2007).Effective communication between mothers and daughters is an important factor in shaping the sexual behavior of daughters in the long term. It increases the rates of reliable contraception as well as decreases the rate of elective abortion among girls (Palatnik et al., 2012).

Generally, peers play a role in shaping the sexual behaviors of their colleagues. Young people tend to forge their identities and behavior patterns through a process of socialization and acceptance by peers. Perception of peers on sexual behaviors is an important normative predictor of intention to begin sexual relations. Perceiving one's peers as sexually active, favorable to one-night stand is linked to a positive attitude toward sexual relations and engaging in one-night stands sex (Potard et al., 2008). However, where peers perceive their

colleagues to have a support toward contraceptive use, they are also likely to use contraceptives to prevent pregnancy and STIs Schools have also been identified to protect young people from indulging in risky sexual behaviors. It has been established that staying in school, feeling connected to school and earning good grades is associated with developing plans for higher education which in turn helps to delay sexual initiation among young people (Kirby et al., 2005).

The media landscape is evolving at a startling pace, and a greater diversity of content, new types of media, and new platforms for delivering messages are constantly emerging with a limitless variety of content on the internet. Media content can now be viewed or used on computers, MP3 players, handheld video players, and cell phones, as well as on television sets. This new portability makes it possible to use media in a variety of new settings and, conceivably, throughout the day (Collins et al., 2010) And Young people have become the earliest adopters of information and communication technology on these media platforms. The ease of access to all these forms of information makes the youth to be readily prone to the positive and negative influence which may make or mar the adolescent‘s future depending on the type of message been carried (Ogbada, 2013).

According to most theories of media effects, the influence of media depends largely on the content it contains. Much of the research linking media and sex—particularly studies of attitudinal effects—has focused on television. Television viewing remains the most common medium and platform, and it makes up the largest chunk of adolescents’ media use, accounting for 4.5 hours of media time out of nearly 11 total hours spent with media daily 30 (Rideout el al., 2010 cited from Collins et al., 2010)

A content analysis of 1,154 programs representative of the content airing between 6 a.m. and 10 p.m. Mountain Standard Time on 10 channels in the 2004–2005 television season in the US found that 70 percent of programs contained sexual content. Among those with such content, there were an average of five scenes with sex in each hour of programming.31 Thus, there is great opportunity for television to influence adolescents' developing views about sex (Kunkel et al., 2005 cited from Collins et al., 2010). The majority of sexual content in the media depicts risk-free, recreational sexual behavior between non married people. Media programming rarely depicts negative consequences from sexual behavior, and depictions of condom and contraception use are extremely rare (L'Engle et al., 2006 cited from Ogbada, 2013).

Unfortunately, risky taking behaviors among young people often results in negative health outcomes for this cohort and financial strain on families and governments as they are compelled to commit resources which could have been used to boost development to provide health care services to mitigate the consequences of such risky behaviors. Early sexual debut especially among girls which is a risk taking behavior is often linked to coerced sex(Kastbom et al.,2015) and the such girls are also more likely to engage in multiple and in most cases intergenerational unprotected sexual relationships(Moore et al., 2007 cited from Krugu, 2016).

Early and coerced sexual debut is often associated with a higher risk of HIV and other STI infections and unplanned pregnancies (Stockl et al., 2013 cited form Krugu, 2016).Globally, it has been reported that the negative consequences of young people's sexuality such as STIs and early and unplanned pregnancies, STIs and HIV/AIDS, and unsafe abortions poses a threat to the health and social life of this cohort than any other

group. Estimates from UNAIDS (2012) show that approximately 2.2 million adolescents aged 10–19 are living with HIV with 80% of them living in Sub-Saharan Africa whilst those within the age categories 15-24 accounted for 42% of all new HIV infections. Ghana is one of the countries in sub-Saharan Africa confronted with HIV/AIDS and its devastating. Of all new HIV infections for 2012, Young people aged 15-24 contributed 28% with a prevalence of 1.3% (Ghana AIDS Commission, 2014).

Sexual risky-behaviors of a majority of young people do not only put them at risk of STIs infections but also unplanned pregnancies especially those between the ages of 15-19. WHO (2014) statistics show that in spite of the decline in global adolescent birth rates since 1990, adolescent girls still account for 11% of all births worldwide with a majority of these births occurring in low and middle income countries. UNFPA (2013) report also shows that 14 million pregnancies occur across sub-Saharan Africa with nearly half of these pregnancies occurring among girls aged 15-19 years. The Multiple Indicator Cluster Survey (2011) put the adolescent birth rate in Ghana at 60 per 1000 women with 12% of young people between ages 15-19 beginning childbearing whilst 16 percent of those between ages 20-24 also having a live birth before age 18. The 2015 DHS report also revealed that14 percent of women aged 15-19 had begun child bearing in 2014.

Pregnancy to young girls are mostly unplanned and remains a major contributor to maternal and child mortality. Health risks for mother and baby are strongly associated with child birth at an early age. Many of these risks are also associated with giving birth for the first time

Young mothers compared to older mothers face high risks during pregnancy and childbirth. Infant and child deaths are higher young mothers between the ages 15-19 as compared to older women, (Ringheim et al., 2010). Factors including poverty, malnutrition, immature reproductive tract, child marriage, and gender inequities act to compromise the health of pregnant adolescents especially those living in poor communities in developing countries, putting them at a greater risk of death (WHO, 2006). Babies born to such mothers tend to be preterm with low birth weight and hence at risk of neonatal and perinatal mortality (WHO, 2006).

Unplanned pregnancy contributes to social deprivation and the vicious cycle of poverty among young mothers and the society as a whole. Pregnancy and childbirth which often leads to stigmatization, social pressure and expulsion from schools among in-school girls marks the beginning of poverty for the adolescent girls as she is denied the opportunity to empower herself and her child (WHO, 2006). Young mothers are therefore more likely to be poor as adults and also more prone to having children who when compared to children born to adult mothers, have poorer educational, behavioral and health outcomes over the course of their lives. (Cook et al., 2015, as cited in Krugu, 2016).

To avert the public stigmatization and health consequences that are mostly associated with unplanned pregnancies, a majority of these pregnancies to young people end up in abortions and mostly unsafe abortions. Young women most often cite a desire to continue their education, but the lack of financial means to support a child or their male partner's denial of paternity as the main reason for having an abortion (Croce-Galis, 2004). Though issues of abortions are often shrouded in secrecy, reports and studies have shown that young people still cause abortions despite its legal implications.

The Ghana Youth Reproductive Health Survey report (2000) indicated that 11.2% of males and 15.7% of females who are sexually active between the ages 12-24 years were reported to be involved in terminating a pregnancy. Most of these abortions unfortunately do not take place under conditions that meet medical standards (WHO, 2011). Of 19 million illegal abortions globally each year, 2.2 to 4 million are on adolescents, who tend to seek abortion later in pregnancy. The later in pregnancy women undergo abortion, the greater the health risk (Olukoya et al., 2001 cited from WHO, 2006).Croce-Galis (2004) also reports that 30% of women and 39% of men between the ages of 12–24 were involved in abortions that took place at home. And to delay seeking care in the event of complications.

Despite these findings however, there are still some young women who would carry pregnancies to full term and the reasons for such decision includes the fact that the extended family system that still prevails to some extent provides support for them (ACDEP , 2008).

Studies suggest that the high rates of unplanned pregnancies to young people stem from their limited knowledge on the menstrual cycle and how pregnancy occurs. In a study in Ethopia, only 14% knew that pregnancy could occur in the middle of the cycle, with 31% not knowing when it could occur within the cycle, (Abajobir et al., 2014). In Ghana, a 2006 study by Awusabo-Asare et al., (2006) indicated that most young people, both male and female did not know that a girl in the adolescent stage could get pregnant the very first time she has sexual intercourse. Also, though a majority (67%) of the older adolescents reported knowing the fertile period within the menstrual cycle; only 26% knew the specific time such a girl could get pregnant within the menstrual cycle (Awusabo-Asare et al., 2006).

A menstrual cycle begins on the first day of a period and ends the day before the next period begins. A normal cycle length is between 24 and 35 days. Though no two menstrual cycles are the same for any woman, it has been established that ovulation usually occurs every month, about two weeks before the next period starts. During the average woman's menstrual cycle there are six days when intercourse can result in pregnancy; “fertile window” which comprises the five days before ovulation and the day of ovulation itself. However, just as the day of ovulation varies from cycle to cycle so does the timing of the six fertile days (Wilcox et al., 2000).

According to GDHS 2014 report, 14% of youth adolescents have begun children bearing implying that young people are engaged in sexual activity.

2.2.3 Contraceptive Uptake

High rates of teenage pregnancies in Sub-Saharan Africa and Ghana indicates high rates of unsafe sexual practices among young people including non-use of contraceptives (Bearinger et al., 2007 cited from Krugu, 2016).The lack of knowledge about contraceptives, STIs and pregnancy have been identified as a factor that influences the protected or unprotected sexual behavior of young people particularly their condom use (van der Geutgen, 2017). Overall, rates of contraceptive use remain very low in all regions in sub-Saharan Africa among 15-to-19-yearold and 20-to-24-year-old women including those married (UNFPA, 2012). Studies in Ghana have documented high knowledge level of contraceptives among young people. Kumi Kyeremanteng et al. (2006) indicated that a majority (90%) of young people were reported to have heard of at least one modern contraceptive method with male and female condoms being the most commonly known. Similarly, an overwhelming majority (87.7%) of adolescents in Kintampo Districts

demonstrated high levels of knowledge of modern contraceptives, (Enuameh et al., 2015). In Northern region, a considerable number (58%) of young people also demonstrated knowledge of contraceptive methods with the pill being the most known among this cohort (ACDEP, 2008).

Though some studies (Awusabo-Asare et al., 2006 & Abdul-Rahman et al., 2011) have documented a considerable increase in the number of young people using contraceptives especially in Ghana, other studies have also shown that there is generally low uptake of contraceptives among the same cohort which has been attributed to lack of knowledge on usage (Ohene and Akoto2008). The 2008 Ghana Demographic and Health Survey (GDHS) report showed that 23% of never married women in the 15–19 age category and 59% in the 20-24 age category had had sexual intercourse in the 12 months preceding the survey. Notwithstanding this high level of sexual activity, condom use was reported to be generally low; it was reported to be at first sex and was found to be uncommon as only 25% of females and 32% of males used condom the first time they had sex. It was also reported that 74% of women aged 15-19 indulged in higher risk sex in the 12 months preceding the survey and only 24% used condom.

The 2010 Population and Housing Census Summary made available in 2012 also reported a low contraceptive uptake especially among the 15-19 age group with only 19.5% of females and 14.7% using any contraceptive method (GSS, 2012). In review of family planning needs of adolescents, in Kintampo, Enuameh et al. (2015) reported a low uptake of contraceptives among sexually active respondents. Out of a total of 2,128 respondents, only 17.9 percent of females and 6 percent males were reported to have used any form of contraceptive method. For those who used contraceptives, the male condom was indicated

as the most preferred method among male respondents with females preferring injectable and pills.

Several factors have been cited for this low uptake of contraceptives among young people. Among such factors at the individual level include low risk perception, insufficient knowledge needed to make informed choices opposition from male partners and perceived adverse effects (Yidana et al., 2015 & Hagan et al., 2012). The low levels of utilization also reflects the both the limited capacity health systems and the frameworks within which contraceptive services are delivered especially in developing countries.

In a study investigating the antecedents of young peoples' intentions to use condoms, Krugu et al., 2016 reported that perceived susceptibility towards STIs, perceived behavioral control toward condom use and the injunctive norm toward condom use were the strongest correlates of condom use intentions among young people in Ghana. Intentions not to use condoms was associated with having no sex experience, having negative feelings toward carrying condoms and not strongly perceiving that peers believe condom use is always a good idea. The study also revealed that where young people perceive higher risk toward STIs and unintended pregnancies have positive attitudes toward condom use, they were more likely to use condoms.

In a systemic review of qualitative research on limitations to contraceptive use among young women, Williamson et al., (2009) also reported geographical barriers to health services, fear of negative reception from clinic staff, lack of guidance on how to use contraceptives as some barriers to contraceptive uptake. The study also showed that the

fear of side effects associated with some hormonal methods; menstrual disruption and fertility fears, discourages young girls from using contraceptives.

Culture and religion has been identified as a major barrier to contraceptive use. Culture and religion of a society determines what information is given on sexuality. Talking about SRH-related issues to young people is still a cultural taboo in almost all Ghanaian cultures. This is encouraged by traditional and religious ideology that abstinence is an important way to avoid unprotected sex and its adverse consequences (van de Geutgen et al., 2017). These beliefs therefore prohibit young people from having anything to do with contraceptives hence a low uptake of contraceptives though majority of this cohort are sexually active (Lebese et al., 2013).

2.2.3 Sexual Health Attitudes

Given the impact of the negative health outcomes arising from risky sexual behaviors on their future health and development, one would expect very positive attitudes toward their sexual health and wellbeing, yet this cannot be said for a majority of young people. According to Rokeach (1968) cited from (Stone et al., 2012) attitude sare relatively enduring organization of beliefs around an object or a situation that predisposes one to respond in some preferential manner. Placing young people in the context of this definition implies that the beliefs they hold concerning their sexual health and wellbeing determine their choices on matters related to their sexual lives. The attitude and behavior of young people regarding buying and possessing condoms as well as their attitude toward actual condom use influences their decisions to have protected or unprotected sex.

Some research has revealed that not all young people are worried about contracting STIs. In one of such studies in Zimbabwe, whereas the young women had little knowledge of the signs and symptoms of STIs, getting infected with an STI, was regarded as a symbol of manhood and something to be very proud of among the young men, (ZNFPC, 1996 as cited in Dehne et al., 2005). In another study in Zambia, boys held the belief that girls were the main carriers of STIs, and that it was normal for a boy to get STIs as part of growing up (Zambezi et al, 1996, cited in Dehne et al., 2005). Thus, where young people regard STIs as a normal thing during that stage in life or believe they are less at risk for STIs, they are less likely to use condoms during sexual intercourse.

Moreover, young people also hold varied reasons for not using contraceptives during intercourse ranging from it making sex unpleasurable to it being a sign of infidelity. Two studies in Ghana revealed attitudinal barriers to condom use among young people. Glover et al., (2003) reported that 62% of their respondents cited shyness to purchase a condom as a challenge to condom use. Also, respondents were reported to view possessing a condom as a sign of promiscuity especially for women hence majority (78%) thought it was inappropriate for women to carry a condom. Azeez (2011) also reported similar findings such as infidelity associated with condom use, religious leaders classifying condom usage as a sin and promotion of immorality.

Cultural taboos are also a major obstacle to informed discussions about sexual and reproductive health issues, particularly with regard to young people (Cobb, 2010 cited from Lebese et al., 2013). Cultural norms related to sexual health issues form a barrier to open discussions about issues related to sexual health and consequently contraception. According to Lebese (2013) in rural areas, there is silent disapproval for contraceptives use

amongst adolescents which often result to the use contraceptives without the knowledge of parents. They often hide the pills from their parents making them to forget to take them which mostly leads to unwanted pregnancy.

Poor health education by service providers has also been reported by as another factor that contributes to low uptake of family planning by young people. The busy schedule of service providers sometimes makes it difficult for them to spend quality time with young people to effectively teach them about their choice of contraceptives. This lack of information is often the contributory factor to the discontinuation of contraceptive methods, because young people often do not have information related to the side effects and how to deal with them(Lebese, 2013).

In a systematic review of qualitative literature on limits to contraceptive use by young women, Williamson et al., (2009) indicated that concerns over experienced and perceived side effects of hormonal contraceptive methods, particularly fear of infertility and menstrual disruption, were central to young women's non-use of these methods. In their study assessing the Trend of Contraceptive Usage among Ghanaian Female Adolescents, Abdul-Rahman et al., (2011) also reported that the main concern for not intending to use contraceptives was related to side effects of the methods. Fertility related reasons were said to have accounted for about 11% and 12% of the reasons for not intending to use contraceptives in 2003 and 2008 respectively. Other reasons cited were interference with normal body function and inconvenience associated with using some methods.

2.3 Access to Sexual Health Services

Adolescents, in general, are experiencing a relatively healthy stage of their lives, having survived infant and childhood vulnerabilities and illnesses. But they are also moving

through a phase that brings dramatic physical and emotional changes, as well as new risks. A move toward greater independence and decision making along with experimentation with new lifestyles and activities creates a different set of health risks more closely connected to behavior. With increased sexual activity among young, unmarried people and the emergence of the HIV/AIDS pandemic, greater health challenges have developed. At the same time, better health delivery systems have developed, methods to prevent pregnancy and STDs have improved, and communications to transmit vital information have become better. However, because of social discomfort in accepting the reality of adolescent sexual activity, unwillingness exists to put these services at the disposal of the young people who need them (Senderowitz, 1999). Access to sexual health services by young people has always been a problem and still continues to be a challenge to their sexual well-being especially in less developed countries across Africa. The transition from childhood to adulthood has come to be associated with risky sexual behaviors yet many young are excluded from services that would reduce the risk and consequences of such behaviours.

The Government of Ghana has worked to support adolescents through Adolescent Reproductive Health Policy (2000) and National HIV/AIDS and STIs Policy (2001) initiatives, while Ghanaian health services (GHS) promote youth-friendly policies (Aninanya et al., 2015). Evidence however suggests that Ghanaian adolescents still avoid SRH services, particularly due to stigma around premarital sex, regardless of reports of STI prevalence and high birth rates among this group, 750,000 births annually.(12 & 13 Health intervention in northern Ghana). Two in every three young women and 4 in 5 young men with STI symptoms do not seek treatment, while approximately half of unmarried

sexually-active female adolescents and over one-third of sexually-active male adolescents do not use contraceptives (Awusabo-Asare et al., 2008). Surveys have also shown that 5.2% female and 3.4% male adolescents have contracted STIs with HIV and syphilis prevalence among Ghanaian adolescents being 1.9% and 5.5% respectively (GSS, 2009 & NACP/GHS, 2009 cited from Aninanya et al., 2015)

The three regions of Northern Ghana(Northern, Upper East and Upper West regions) have poorer economic and health outcomes than the national average, as geographical, historic, and socio-cultural factors have excluded the north from much of Ghana's economic growth[17]. Research in Ghana's Upper East Region showed 32% of out-of-school adolescents experienced difficulties accessing HIV testing services [18]. Qualitative research found adolescents were particularly deterred from accessing health services by costs and negative provider attitudes (Koster et al., 2001).

Young people avoid using existing RH services for a variety of reasons operational barriers, lack of information, and feelings of discomfort. The operational policies or the environment of facilities in many cases reduce access of services even in situations where service programmes may not intend to bar young people from using services. Being young constitutes a stage where one constantly learns new information about one's sexuality and development. Most often than not, friends are usually the source of this information. Relaying on friends for information on sexuality makes a majority of them poorly informed or even misinformed about such matters. This situation, coupled with a insufficient knowledge of pregnancy and STI risks and available reproductive health limits access and thus utilization of services (Senderowitz, 1999).

Perhaps, the most widespread explanation for young people's avoidance of clinics and service providers is their discomfort with real or perceived clinic conditions and hostile or judgmental attitudes of providers. Most young people, who suffer from sexual or reproductive health problems, including STIs, fail to use mainstream health services as these are not tailored to meet their specific needs but rather that of adults and children (Dehne et al., 2001). Such perceptions sometimes result from their own experiences, second-hand information from peers, or a general reputation about the services (Senderowitz, 1999).Coupled with these constraints are financial constraints, geographical inaccessibility, shame and guilt associated with seeking for medical attention for some sexual health problems like STIs. Most of these young people often experience feelings of guilt and shame when they realize that they have contracted an STI or have become pregnant and because they usually do not have the skills needed for telling someone that they have a sexual health problem, confiding in someone becomes a challenge for them (Brabin, 1998 as cited in Dehne et al., 2001). It is therefore not uncommon to find some presenting false and hazy reports on their sexual health problems when they do visit a health facility.

It has been reported that closely linked to feelings of shame and embarrassments are fears relating to confidentiality of services (Zabin et al., 1991 as cited in Dehne et al., 2001). Access to confidentiality at health care centers is of major concern to seeking health care services for sexual health problems by young people. Dehne et al (2001) intimated that where there are even assurances that clinic information would remain confidential, anxiety often remains that parents or other older adults would get to know their sexual health problems.

To prevent STIs and unplanned pregnancies, young people must resort to the use of contraceptives. Yet the fear and embarrassment associated with obtaining them puts most of these young ones away. In nationally representative household surveys among 12- to 19-year-olds in Burkina Faso, Ghana, Malawi, and Uganda, it was found that a large proportion of sexually-experienced respondents did not know how to obtain contraceptive methods due to embarrassment, fear and the financial costs (Biddlecom et al., 2006). As a result of these fears and concerns a majority of them resort to using natural methods of contraception like withdrawal method which have been reported to be less effective in preventing pregnancy and STIs.

Being able to access and reproductive health services improves utilization of these services by young people. A health intervention in Upper East region of Ghana showed positive attitude toward service utilization. Reported usage of STI services increased from 3% to 17% among intervention adolescents versus 5% to 8% among comparison adolescents. The intervention also saw an increase in HIV counseling and testing. This increased from 3% to 13% among intervention versus 4% to 11% among comparison adolescents (Aninanya et al., 2015).

Promoting the sexual health of young people is thus very critical to their well being and there requires more than just the right information but access to quality sexual and reproductive health services that responds to their unique and special needs. For preventing, treatment and rehabilitation of sexual health problems like STIs, unplanned pregnancies and complications from unsafe abortions.

2.4 School-Based Sexual Health Education

In Ghana, as elsewhere in Africa and the developing world, schools form a perfect setting for imparting important health information and other life issues to young people. With a majority of Ghanaian young people now enrolled in secondary schools, the school setting has become an important venue for transmitting information and skills needed to protect these young people against risky behaviors. School-based sexual health education has become one of the most important and widespread ways to help young people improve their sexual and reproductive health especially if well designed and implemented effectively (Rosen et al., 2004). Among youth who attend school, most start schooling before initiating sexual intercourse whilst others get enrolled at the time they are already sexually active. Therefore, schools provide an opportunity for interventions to achieve high coverage of young people before or around the time they become sexually active. Schools also offer the opportunity to encourage young people to delay the onset of sexual activity and increase their use of contraceptives after sexual initiation (Ross et al., 2006)

Sex education or family life education has been described as a lifelong process of acquiring information and forming attitudes, beliefs and values about identity and intimacy. It therefore encompasses sexual development, reproductive health, interpersonal relationships and affection, intimacy, body image and gender roles (SIECUS, 2004 cited from IPPF, 2009). It has also been defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexual health education provides opportunities to explore one's own sexuality, values and attitudes and to build decision- making, communication and risk reduction skills about many aspects of sexuality. The primary goal

of sexuality education is to equip young people with the knowledge, skills and values to make responsible choices about their sexual and social relationships (UNESCO, 2009). According to Kirby (2011) such programs strive to delay the initiation of sex, increase condom or other contraceptive use and sometimes reduce the number of sexual partners.

Notwithstanding the importance of sex education in young people's lives, the implementation of school based sex education is challenged. Mckee (2008) contends that key to successful school-based sex education is training and attitude of teachers. Unfavorable attitude of teachers toward sex education impedes the delivery of the right information on sexuality to young people at the right time. Studies have proven that untrained teachers and sometimes improperly trained teachers often avoid discussions on sexuality matters with young people due to their lack of confidence and knowledge on the subject matter (Iyaniwura, 2004).

Sex education has also often been resisted by school authorities because of fear of overcrowding the school curriculum and also because fear of taking on additional responsibilities without any form of motivation (McCauley et al., 1995 cited from Rosen et al., 2004)

Another challenge that has been identified as facing school-based sex education has to do with opposition from conservative religious sections of society. Though schools are recognized as an appropriate avenue for addressing sexual health threats, these conservatives who view themselves as the repository and transmitters of their communities' values and beliefs are often found at the forefront of opposition to sexuality education in schools. (Rosen et al., 2004)

2.4.1 Policy Environment

Recognizing young people as potentials of future development, Global commitments have been made to help address sexual health needs of this group. International conferences and agreements such as the 1989 Convention on the Rights of the Child, the 1994 International Conference on Population and Development (ICPD), the U.N. World Program of Action for Youth to the Year 2000 and Beyond, and the 2001 U.N. General Assembly Special Session on HIV/AIDS have all affirmed the needs of young people for information, counseling, and quality sexual and reproductive health services (Rosen et al., 2004). Being a signatory to most of these international commitments, governments of Ghana have also formulated some policies to support young people's sexual health needs. These policies include:

•Adolescent Reproductive Health Policy in 1996. The rationale for introducing sex education was because majority, nearly 90% of children and young people were enrolled in schools.

Adolescent Reproductive Health Policy, 2000 with the aim of equipping young people with the knowledge and skills to make informed decisions and utilize available Sexual and Reproductive Health facilities optimally.

Though research measuring the impact of schools upon adolescent sexual is quite limited, there is still some good measure of evidence to support the fact that programs that effectively decrease school dropout and improve attachment to school, school performance, and educational and career aspirations are likely to either delay sex, increase condom or contraceptive use, or decrease pregnancy and childbearing, (Kirby, 2002). Thus,

being in school can serve as protective factor against sexual risk-taking behavior with greater attachment to school associated with less sexual risk-taking. This results from the fact that the school structure and programs certainly do have an impact upon a young person's plans for the future and their motivation to avoid childbearing.

A wide variety of explanations have been offered by educators and researchers studying young people's sexual behavior on how schools help in reducing risky sexual behaviors among in-school young people. They suggest that:

1. Schools structure students' time and limit the amount of time that students can be alone and engage in sex.

2. Schools increase interaction with and attachment to adults who discourage risk-taking behavior of any kind (e.g., substance use, sexual risk-taking, or accident producing behavior). More generally, they create an environment which discourages risk-taking.

4. Schools can increase belief in the future and help young people plan for higher education and careers. Such planning may increase the motivation to avoid early childbearing thus positively associated with contraceptive usage.

5. Schools can increase students' self-esteem, sense of competence, and communication and refusal skills. These skills say claim, may help students avoid unprotected sex, (Kirby, 2002).

In addition to the positive effects of just being in school to young people, Kirby et al., (2007) posit that a well-designed written curriculum on sexual health education intervention programs that is well implemented in schools where large numbers of young

people can be reached provides a better opportunity of reducing sexual risk behaviors among in-school young people. This is because among young people who attend school, many start schooling before they initiate sex and others are enrolled whilst already sexually active. When such intervention programs are implemented, they encourage those who are not yet sexually active to delay the onset of sexual activity, encourage the use of contraceptives, and also help to reduce the number of sexual partners of sexually active young people. Thus, school-based sexual health interventions provide an opportunity for interventions to reach young people before or around the time they become sexually active, (Kirby, 2011).

Several studies have also documented the positive impacts of school–based sexual health education on young people across both developed and developing countries. In a review of 83 studies from both developed and developing countries measuring impact of curriculum-based sex and HIV education programs on sexual behavior such as initiation of sex, frequency of sex, number of sexual partners, condom use, contraceptive use in general, and composite measures of sexual risk-taking among young people under 25 years, it was found that two thirds of the programs significantly improved one or more of such sexual behaviors. For instance, out of 52 studies that measured impact initiation of sexual activity, 22 representing (42%) of such programs significantly delayed the initiation of sex whilst 48% of 54 studies measuring impact on condom use also showed an increase in condom use among beneficiaries of the programs, (Kirby et al., 2007).

A study evaluating the effect of a sex education programme on at-risk sexual behaviour of school-going young people in Ilorin, Nigeria, reported positive changes in attitude regarding the belief that multiple sexual partners are not hazardous to health. The study

also reported increase in sexuality knowledge and a relative decrease in at-risk activity among the experimental group than the control group (Esere, 2008).

In another evaluative study ('The World Starts with Me"), a sexual health education in schools in Uganda, students from the intervention schools scored significantly better than the comparison students at the post-test when it came to wrong beliefs concerning pregnancy, like "a girl cannot get pregnant the first time she has sexual intercourse." With regard to attitude toward condom use and self-efficacy to use condoms, there was once again a significant difference between the intervention and control group with the intervention group demonstrating a positive attitude toward condom use and stronger self-efficacy to use condom (Rijsdijk et al., 2011).

In a randomized control trial of a Ghanaian school-based and peer led sex education programme, Supporting Peers and Encouraging Empowerment (SPEEK), short term effects showed encouraging results. Students who went through the SPEEK programme were significantly better to explain how to use a condom and also had a positive attitude toward carrying condoms with them especially when going out for social activities where they were most likely to engage in sexual activities. Students in the intervention arm were also able to explain how pregnancy occurs and how to conduct STI test as compared with the control group. Moreover, they developed a high risk perception of contracting STIs if they had sex without using condoms as compared with students in the control arm. The results of the SPEEK programme showed that rather than increasing the risk of sexual activity, young people who receive comprehensive sex education have lower risk of pregnancy than those who receive no sex education or abstinence-only education (Krugu et al., 2016).Another study in Nigeria, revealed significant differences between

experimental and control groups on knowledge of transmission and prevention of AIDS. Knowledge of indiscriminate sex, transfusion with infected blood, use of unsterile instruments, transplacental transmission and sharing needles and syringes as modes of transmission were significantly higher among experimental group as compared to the control group. Whereas 94% of the intervention group knew that HIV could be transmitted from mother-to-child, only 42.8 % of the controls knew this. Also, when compared with the control group, 53.7% and 20.4% of the intervention group reported using condoms during their last sexual intercourse and consistent use of condoms respectively, whilst only 42.5% and 12.8% of students in the control group reported using condoms and consistent condom use. (Fawole, 1999).

Kaushal et al. (2015) contends that sexual health education does not only improve the knowledge and attitude of young people on sexuality issues but can also positively improve the knowledge and attitude of teachers towards the subject given the important role they play in the lives of young people. In their study on the "Impact of Health Education on the Knowledge and Attitude of Teachers Regarding Reproductive Health of Adolescents", it was reported that teachers' knowledge and attitude toward sexual/reproductive health had greatly improved after the education. Before the training, only 33 (21.3%) out of a total of 155 sampled teachers, had adequate knowledge about different STIs whilst 54 (34.8%) of teachers had adequate knowledge about routes of transmission and prevention of AIDS respectively. The number of teachers with adequate knowledge about STIs after the intervention increased to 68(43.9%) and the number of teachers who had adequate knowledge about prevention of HIV/AIDS also increased significantly to 89 (57.4%).

A process evaluation of a school-based sex education programme in Tanzania also showed that teachers' attitudes towards teaching about condoms improved significantly after training. Trained teachers, compared with their untrained counterparts were reported to be much more receptive to teaching primary school pupils in their last year about condoms. They were also found to be less likely to associate teaching sex education with initiation of sexual activity. Results also revealed improved self-efficacy and confidence of teachers to handle teach sex education as well as other subjects. Trained teachers, as well as head teachers and ward coordinators reported to have increased their use of participatory teaching methods both in MEMA kwa Vijana classes and other lessons (Renju, 2010).

2.4.2 Challenges of school-based sexual health education

Implementation of interventions in schools in developing countries is constrained by the availability of teachers and curricular materials as well as teacher training; access to other financial, material and technical resources; and the culture and norms of both the local communities and the schools themselves (James-Traore et al., 2004).

The effectivenes of sex education has been identified to be dependent on the content of the program and the level of implementation. It has been established that programs that are implemented with sufficient completeness (quantity of the program) and fidelity (implementation according to the program guidelines) may result in positive health outcomes (Kalafat, 2007).implementation of curriculum sex education refers to performance of the actual use of the programme regarding how completely it has been taught (quantity) and also how the programme has been implemented as intended by its developers (quality or fidelity) (Paulussen et al., 1994 cited from Schutte et al., 2014,), . Thus incomplete or incorrect implementation has the potential of undermining the

effectiveness of a sex education intervention. The impact of school-based health education programs is also most often than not attenuated by inadequate teacher implementation (Schutte et al., 2014).

In spite of the obvious importance of sexual health education to both young people and teachers, school-based sexual health education has had its share of challenges. Although many societies recognize the threats to young people's sexual health and the importance of schools in addressing these threats, upholding traditions and beliefs, including the expectation that young people abstain from sexual activity until marriage. This makes it very difficult for society especially traditional and religious leaders including parents to whole heartily endorse school-based sexual health education as they are often in the forefront of opposition to sexual health education in schools (Rosen et al., 2004).

Studies have shown that a combination of factors from the environment work to affect school-based sexual health education especially in Africa. Successful Implementation of sex education not only requires specific attributes of the teacher such as knowledge, attitudes and skills but also support from colleagues or appropriate authorities such as the school director and the society.

Religion has been proven to be the major barrier to discussing issues on sex and sexuality at home and in schools. Jerves et al. (2014) contends that traditional religious views of sexuality acted to skew parents understanding of sex education; parents were said to regard sex education as a morally and physically dangerous activity. Though tradition and culture also played a role in shaping people's understanding of sexuality, religion (Catholic and Evangelical), was reported to play a fundamental role in setting the parameters of behavior in the areas of sexuality. In a similar study in Tanzania, however, Muslims were hesitant

on the introduction of sexual health education to young people. Nonetheless, culture and traditional values also restricted any form of communication on sexuality with young people (Mbonile et al., 2008). Another study in Ghana also reported a social censor on discussions on matters related to sex and sexuality hence restricting open and free communication on the subject with young people. This social censor acted to instill fear in children to even approach parents to ask anything bothering on their sexuality (Asampong et al., 2013).

These religious and cultural influences therefore act to shape parents, teachers and other guardians understanding of sexuality and what should be taught young people as part of their sexual health. Religious and cultural beliefs reserve discussions on sex and sexuality as business for especially only married adults. This has promoted fear in parents and teachers that sexual health education would encourage promiscuity among young people. Adolescents in a study (name of study) reported that parents did not talk with them about sexuality issues because doing that would be considered as giving their children the permission to be having sex. The high value placed on virginity before marriage constitutes a barrier to open communication on sexuality as society believes doing that would encourage premarital sex. (Lebese et al., 2013)

In Ghana, parents were reported to have a negative attitude towards teaching sexual health to their wards which made it impossible for teachers to impart sexual health information to students. Parents' opposition resulted from their perception that young people would engage in premarital sex if they are introduced to sexual health topics in school (Kumi-Kyereme et al., 2014). Teachers have likewise been found not in favor of teaching of

sexual health especially on issues like contraceptive usage for fear of students becoming promiscuous (Iyaniwura, 2004).

Implementation of sex education is in most cases influenced by the curriculum-related beliefs of the teacher which include attitudinal, normative and self- efficacy beliefs. Attitudes of teachers toward implementing sex education is subject to the personal benefits the curriculum has for them and also the practicality of program, that is, in relation to how acceptable the intervention is from a practical point of view. Self-efficacy which refers to teachers' perceived ability and control over the teaching and management strategies of sex education has also been identified to be a strong predictor of the implementation of curriculum based sex education (Schutte et al., 2014).Findings from a school-based sex education programme in the Netherlands revealed that completeness and fidelity of a sex education programme correlates significantly with teacher benefits, instrumentality, subjective norms, social support and self – efficacy and student response. Teachers from the study were seen to more likely to implement sex education programme if they saw benefits in its use for themselves, if they found the program practical to use, if they believed that others appreciate and support the delivery of sexual education and if they believed they are capable of delivering lessons. They were also more likely to implement it completely if students responded positively to the programme (Schutte et al., 2014).

In addition to teachers' motivation to teach sex education that has been identified as a challenge, the students' motivation to learn has also been identified as something to be considered in designing and implementing sex education programmes as it is important for the success of such programmes. Students' motivation to learn depends on the design of sex education programmes according to their preference. A study by Henk et al (2007)

reported that a higher preference of students for an independent course on HIV/AIDS was significantly related to a positive motivation to learn. Thus, the needs of the highly motivated adolescents seem to be best served by the independent curriculum design option (Henk et al., 2007). The independent or separated course approach curriculum describes a design of a sex education programme has a standalone course in the broader school curriculum. Though this approach may ensure sufficient emphasis from teachers, its success especially in a crowded school curriculum depends on stronger commitment from policy makers, school authorities and teachers (Mathews et al., 2006). Another approach as described by Craig et al., (2004) is the carrier course approach where sex education or HIV/AIDS programme is integrated into an existing course like integrated science or social studies as its currently the case in Ghana. However, this approach challenges with success as more sensitive topics are less likely to be taught.

An evaluation of a CSE in Uganda revealed that the course was taught in an irregular and unscheduled manner. This resulted from leaving the programme in the hands of teachers to be fixed into school timetables as they saw fit. The haphazard teaching method made students unsatisfied with what they had been taught as they complained of not learning all they would have liked to learn. Students expressed a strong interest to learn about condoms, specifically how to use them. To meet their expectations and needs, students indicated that the programme be incorporated into the curriculum and made examinable in order to improve its implementation (Kinsman et al., 2001).

Another challenge that has also been found to inhibit school-based sexual health education has to do with the lack of training on young people's sexuality for teachers who handle

subjects related to sexuality. Teachers under such circumstances have reported feeling less confident when discussing or teaching issues related to sexuality with students.

According to WHO (2004) inadequate levels of training and the prevalence of didactic teaching methods implies the inability of teachers to use participatory, student-centered techniques that are effective for effective skills building.

Literature on teachers attitude toward sex education have shown that teachers generally appear more favorable toward the teaching of puberty related topics such menstruation, personal hygiene and the dangers of STIs than discussing contraceptive use and abortion with students (Aransiola et al., 2013). Nonetheless, when compared with non-trained teachers on young people's sexuality, teachers who have received some form of training tend to show favorable attitudes toward young people's sexuality and contraceptive and are even more comfortable discussing with and counseling young people on sexuality challenges (Iyaniwura, 2004).

Iyaniwura (2004) therefore maintains that a key issue to be considered for successful school-based sexual health programs is the training and attitudes of teachers. Untrained or improperly trained teachers on young people's sexual health most often than not have an unfavorable attitude towards discussing sexual matters with students especially on more sensitive topics like contraceptives. Training of teachers has a positive influence on their curriculum-related beliefs, subjective norms perceived social support and self-efficacy. Where teachers are trained, they tend to exhibit more favorably attitudes towards teaching students on sexual health matters. Trained teachers tend to have mastery over implementation, exhibiting confidence in controlling student behavior during sex

education and also in directing lessons in which students practice the use of condoms on an artificial penis. (Wiefferink et al., 2005). A study in Ile Ife, Nigeria also reported a favorable disposition of teachers towards teaching sexual health education in schools after undergoing training on sexual health education. The study reported that at pre-training the percentage of those who were in favor of it was just 17.9% but after training, it significantly increased to 45.2%. The study also reported a significant increase in the percentage of teachers who supported the use of contraceptives by students at post-training assessment (69.0%) as compared to pre-training assessment (25.0%) (Adegbenro et al., 2006).

Teaching and Learning Materials on sexuality are very crucial to effective school-based sexual health education as they promote participatory and practical teaching and learning. The lack of these in schools therefore implies abstract teaching where students do not relate to what is taught. For most developing countries, the only available material for sexual health education in schools has been just text books. Students' access to comprehensive sexuality information is therefore very limited as they are not exposed to other relevant sources of information (Pokharel et al., 2006).

Owning to teachers inability to effectively deliver sex education lessons as a result of lack of training, the use of health workers, who mostly more knowledgeable about the sexual topics , more comfortable discussing such topics and more comfortable using interactive learning methods, have been reported to be favored by some people. , using health-workers or other trained adults to discuss sensitive matters, such as condoms, in schools may help teachers avoid the internal conflicts mentioned above and may allay fears of community censure. Nevertheless, resource constraints could prevent health-workers from teaching intensively about sexuality (Ross et al., 2005).

CHAPTER THREE

METHODOLOGY

This chapter provides the profile of the research community as well as the methods used in collecting and assembling the data to answer the research questions and objectives. It also highlights the nature of methodological issues involved and covers the study design, data source, populations and units of enquiry, sampling procedures, techniques for data collection, pre-testing, data collection (field work), data processing and analysis.

3.1 Description of the Study Area

3.1.1 Profile of Tamale Metropolis

The Tamale Metropolitan Assembly is located at the centre of the Northern Region. It shares common boundaries with Savelugu/Nanton District to the north, Tolon/Kumbungu District to the west, Central Gonja District to the South - West, East Gonja District to the south and Yendi District to the east. The Tamale Metro occupies approximately 750 sq km. which is 13 percent of the total area of the Northern Region (GSS, 2014).

3.1.2 Demographic characteristics

The population of Tamale Metropolis, according to the 2010 Population and Housing Census, is 233,252 representing 9.4 percent of the region's population. Males constitute 49.7 percent and females represent 50.3 percent. The proportion of the population living in urban localities (80.8%) is higher than that living in rural localities (19.1%) of the metropolis. The population of the metropolis is relatively youthful; almost 36.4% of the population is below 15 years depicting a broad base population pyramid which tapers off with a small number of elderly persons (60 years and older) representing 5.1 percent.

3.1.3 Education

According to Ghana districts (2010), 8 Public and 11 registered Private Senior High schools in the Tamale metropolis. Among those currently attending school, 15.1 percent are in nursery, 18.2 percent in JSS/JHS, 12.5 percent in SSS/SHS and the largest proportion (40.0%) is in primary. Only 5.7 percent of the population 3 years and older in the metropolis are currently attending tertiary institutions (GSS 2014). The Tamale Metropolis has nineteen (19) Senior High Schools; eight (8) Public and eleven (11) Private schools.

3.1.4 Ethnicity and Culture

The Metropolis is a Cosmopolitan area with Dagombas as the majority. Other minority ethnic groupings are Gonjas', Mampurisi, Akan, Dagaabas, and tribes from the Upper East Region. The area has deep rooted cultural practices such as festivals, naming and marriage ceremonies (GSS 2014).

3.1.5 Religion

About 90.5% of the populations in Tamale Metropolis are Muslims with 8.8 % constituting Christians population. About 0.2 percent has no religious affiliation. Among the Christians, the Catholics have the highest proportion of 3.0 percent, followed by Pentecostal/Charismatic (2.4%) and Protestants (2.4%). The proportion of Traditionalists in the Metropolis is 0.3 percent (GSS 2014).

3.2 Study Design

The study employed the descriptive cross sectional study design. Leedy & Ormrod (2010) view descriptive survey as a design that collects information about the characteristics, opinions, attitudes, practices and experiences of individuals or groups by asking questions.

Cross sectional studies involve collecting information from a representative sample that has been selected from a population at a given point in time (Orlsen & Marie, 2004). The design is consistent with this study as it seeks the perspectives and views of students and teachers on school based sexual health education in the Tamale Metropolis. It is also consistent with the study as relevant data were collected within a specific period. This research design was preferred to a longitudinal study design mainly because of the limited time at the disposal of the researcher. As a descriptive cross-sectional survey, it was to provide information about the prevailing picture to facilitate the development of interventionist policies. The study may also provide benchmark data for subsequent trend studies.

3.3 Sampling

This section captures the sample size determination and the sampling technique.

3.3 .1 Sample Size Determination

The sample of the study was determined using the following statistical formula;

$$N = \frac{Z^2 \times pq}{e^2}$$ (Cochran, 1963)

Where, N is sample size, Z is t-value (1.96) corresponding to 95% confidence level, e is the desired level of precision (0.05), p is the estimated proportion of the SHS students hat is present in the population estimated to be 50% (0.5) and q is 1-p (1-0.5) = 0.5

This implies;

$$N = \frac{1.96^2 \times 0.5(0.5)}{0.05^2}$$

$$N = \frac{3.8416 \times 0.25}{0.0025}$$

$$= \frac{0.9604}{0.0025}$$

$$= 384.16 \approx 384$$

With a 5% non-response rate on 384 (0.05×384) = 19.2, resulted in the final sample size of 384+19.2 = 403. Therefore a sample of 403 students was enrolled in the study.

To enable comparative analysis, an equal number of respondents were selected from each of the six schools. Sixty–eight students (segregated by sex) were therefore randomly selected from the 4 respective mixed-sex schools as well as from each of the 2 single-sex schools. Thus, 408 sets of questionnaire were administered but only 403 as the desired sample size were captured for the data analysis.

A total of 6 teachers were purposively selected from the six selected schools for in-depth interviews.

3.3.2 Sampling technique

Multistage random sampling technique was employed to arrive at the Senior High Schools and their students/counselors. Fisher et al., (1983) advised that in drawing samples from diverse populations, the technique most commonly used is multistage sampling.

At the first stage, the list of schools from the Tamale Metropolitan Office of GES was put into two groups (clusters): Private and Public. The private schools are 11 in number whilst the public schools are also 8 in number giving a total of 19 SHS. The quota system was used in determining the number of schools to be included in the study.

Thus:

Number of Public Schools

8/19×100 = 42%

42% of 8

42/100×8= 3.36

Therefore, the number of public schools to be included is 3

Number of Private Schools:

11/19×100 = 58%

There 58% of 11

58/100×11 = 6

Therefore number of private schools to be included is 6.

In total, 9 schools were to be selected for the study but due to resource constraints, the researcher reduced the number of schools to 6.

To enable comparative analysis, 3 schools each were selected from the Private and Public clusters. In selecting the public schools, two schools were outstanding as they are Single Sex schools and were therefore automatically selected for inclusion. The remaining one school was then randomly selected from the rest of the Public schools.

The second stage of the sampling involved the selection of respondents from each of the six (6) selected schools. Specific to the study sample, the study population was second year students in the selected Senior High Schools in the Tamale Metropolis. This is as a result of the fact that, at the time of administering the questionnaire, the third–year students had

already completed and the first year students were only at the beginning of their second term with relatively little exposure to the sexual health education programmes.

In order to sample individual students from within each of the schools, a list of second year students in the respective schools was obtained from the various School Administrations. In recognition of the comparatively limited number of girls in Senior High Schools generally, the list of students from each SHS was further segregated by sex (except for two single-sex schools). The number of males and females to be included in the study was then proportionately determined based on the number of students within each sex. Random sampling using the lottery approach was then used in selecting individual respondents from each of the sexes for this study. This was deemed important in order to ensure that the views of both male and female students were adequately captured. Respondents were sampled from a general assembly of all form two students. Students who picked a paper with 'include' written on it were considered for the study. These students were then made to answer the questionnaire in one big class room.

In the case of school counselors, GES School Counselors at all the randomly selected Senior High Schools in the Tamale Metropolitan District were purposively selected for inclusion in the study population. In this sense, all school counselors related to aspects of sexual health education in selected Senior High schools in the Metropolis were included. Among other things, the essence was to assess the knowledge and attitudes of teachers designated as counselors. This is important because meeting the goals of the programme, among other things depend largely on the quality of teaching generally. Exploring the challenges facing school counselors would also help in recommendations towards remedial measures for effective sexual health interventions in senior high schools.

3.4 Study Variables

This section describes the research sample, instrument, setting, and data analysis employed in the study. The outcome (dependent) variable of the study is perspectives of teachers and students on school-based sexual health education and this was measured by:

1. Students' evaluation of sexual health education in school

2. Students' assessment of teachers

3.Teachers' and students' view on how sexual health education should be handled

The independent variables include the following; socio-demographic characteristics such as age, sex, religion, type of school, and student status.

3.5 Research Instrument

A self-administered questionnaire was used to obtain quantitative information from student respondents. The questionnaire was structured to solicit information on sexual health knowledge and practices, and assessment of school-based sexual health education by students. Focus group discussion guide prepared was used to obtain qualitative information on students' accessibility to sexual health information and services, attitude of teachers towards sexual health education and also challenges of sexual health education. An in-depth interview guide was used to solicit information from teachers on; the strengths, weaknesses, opportunities and threats of sexual health programme in schools; students' sexual behavior and their perspectives on school-based sexual health education.

3.6 Data Collection Techniques

A self-administered questionnaire was used to collect quantitative data from students. The questionnaire was prepared using questions adapted from the standard Ghana Demographic

and Health Survey (GDHS, 2008) instruments. Further questions (knowledge, attitude and practices) related to sexual health of young people were adapted from the works of Adamchak et al., (2000) and pre-tested. In addition, two separate Focus Group Discussions (FGDs) were held respectively with both female and male Senior High School students. Respondents who answered the questionnaire satisfactorily after going through the retuned questionnaires were selected for FGDs. A total number of four FGDs were held with forty students, ten for each FGD. Qualitative findings were used to complement the quantitative findings.

3.7Quality Control

To ensure quality control, research assistants were trained. This was done before pre-testing the data collection tools. The aim of the training was to ensure that research assistants understood the research topic, objectives and the sensitivity of issues related to sexuality and need for confidentiality.

3.8 Pre-testing of Research Instruments

Pre-testing of research instruments was done in Dabokpa Vocational/ Senior High School. This school was selected for the exercise because it was one of the non-selected senior high schools in the survey. The pre-testing exercise aimed primarily at ascertaining the consistency, appropriateness and reliability of the research instruments. The exercise helped in making the necessary corrections on the draft instruments and in producing the final instruments used in the study.

3.9 Data Processing and Analyses

The Statistical Package for the Social Sciences (SPSS), version 21.0 was used to analyze quantitative data whilst qualitative data was analyzed manually. Descriptive statistics as well as chi-squared tests were employed in the quantitative data analysis. FGDs were audio-recorded and transcribed verbatim and analyzed manually. Findings from FGDs were used principally for supplementing and complementing the findings from the survey.

3.10 Ethical Considerations

Permission was first sought from the regional GES office and the introductory letter obtained helped to access the various schools. At the respective schools, informed consent was sought from the teachers and students. The study protocol was usually made known and respondents assured of confidentiality. Only respondents who agreed to have understood the study protocol and voluntarily accepted to participate in the study were administered the questionnaire.

CHAPTER FOUR

DATA PRESENTATION

This chapter presents the findings of the study, obtained from both the quantitative and qualitative data analysed. Four Focus Group Discussions for males and females held in two of the selected schools.

The chapter is divided into 5sections; socio-demographic characteristics, sexual health knowledge, attitudes and practices of students, students access to sexual health care services, teachers and students perspectives on school-based sexual health education and challenges with school-based sexual health education.

4.1 Socio Demographic Characteristics of Respondents

4.1.1 Sample and Response Rate

In all, a total of Four Hundred and Two (402) students in six Senior High Schools in the Tamale Metropolis were sampled for the study. In addition, a total of six (6) School counselors representing the main counselor from respective study schools were self-selected for interviews. A total of four hundred and two (402) questionnaires were returned, implying an approximately 98% response rate. The study uses tables and charts in presenting quantitative results. Findings are then interpreted and discussed in the context of the study's objectives and research questions.

4.1.2 Background Characteristics of Respondents

Data on socio-demographic characteristics of respondents in this study included: sex, age, religion, school type and student status (Boarding Student or Day Student). These

characteristics are regarded as important variables against which the knowledge, attitudes and behavior related to sexual health as measured by selected indicators could be pitched for analysis.

Table 4.1: Socio-demographic characteristics of respondents

Variable	Frequency	Percentage
	Sex	
Male	187	46.5
Female	215	53.5
Total	402	100
	Age	
15-19	319	79.4
20-24	83	20.6
Total	402	100
	Religion	
Islam	299	74.4
Christianity: Protestant	64	15.9
Christianity: Catholic	39	9.7
Traditional	0	0
Total	402	100
	Student Status	
Day	170	42.3
Boarding	232	57.7
Total	402	100

Source: Field Data (2015)

As depicted by Table 4.1, student respondents comprised 54% females and 46% males. The average age of respondents was 18 years with a standard deviation of 1.6 indicating a normal distribution of respondents in relation to age. The age group that emerged with the highest frequency was 18 representing nearly a third of the respondents (29%). The highest age within respondents was 24 years while the minimum age was 12 years. This is in consonance with age specifications for SHS levels in Ghana. On the average, by age 6, the child should be in class one. By 12 years therefore, all things being equal, the child should be in the Junior High school. By this trajectory, by age 16, the child should be in the final

year of the Senior High school. It is however not surprising that the average age is 18. This could be attributed to late entrance into school by some young people and also because some students repeat the same class for various reasons.

The vast majority of respondents, 299 (74%) were Muslims. This is to be expected since Islam is the major religion in the Northern region. Christians in the study constituted 25.6%. However, on denominational basis, Christian protestants were 64 (16%) with 10 percent being Roman Catholics. On student status, more than half (57.7%) were Boarding students whilst the remaining 42.3 percent constituted Day students.

4.2 Knowledge, Attitude and Practices

4.2.1. Sexual Health Knowledge

Adolescence is a period of diverse social, psychological and physiological changes. Knowledge of adolescents on sexuality, among other things, is crucial to making informed decisions and choices for enhancing their sexual and reproductive health. In this context, understanding bodily changes including menstruation and the production of sperms, how and when conception occurs, as well as related knowledge on contraceptives especially modern contraceptives, knowledge about sexually transmitted infections and issues relating to peer pressure cannot be ignored. In this study therefore, efforts were made to assess knowledge on some sexual health issues. Three broad categories were assessed; (1) Knowledge on bodily physical changes during adolescence ;(2) Knowledge about pregnancy, and (3) Knowledge about contraceptives.

The findings indicate that knowledge about physical bodily changes during adolescence was almost universal. An overwhelming majority (about 96%) of student respondents were

able to correctly list at least three physical bodily changes associated with adolescence in both boys and girls. This is not surprising when we read this outcome with findings garnered through FGDs. During FGDs, participants were found to be very knowledgeable about indicators especially for knowledge on bodily physical changes during adolescence. A further probe reveals that perhaps its popularity is related to the fact that this subject matter permeates discussions in almost all subject areas including even the physical sciences. One FGD participant noted that:

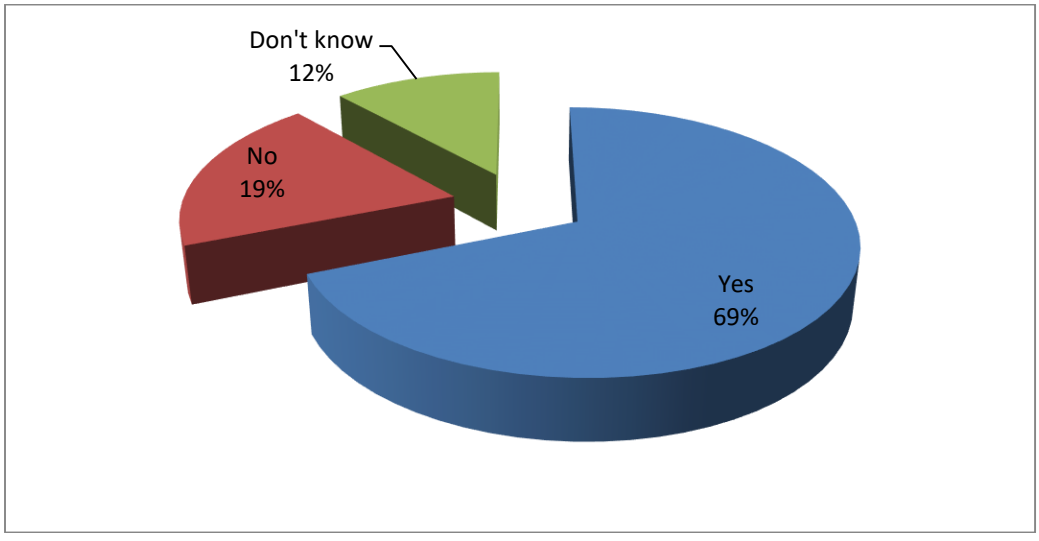
> *"Even during math's classes, sometimes the teacher talks jokingly about what he calls 'adolescent qualms and quirks'. He makes people laugh and laugh. Then teacher would talk about bad boys and bad girls, peer pressure and temptations with drugs and sex. Those issues are his favourites. Then he would bring in things like the devil and God … judgment day and hell waiting."*(Female student, (Girls FGD 2)

Another participant (male) from another school (school C) observed that his Physics master deviates into discussing such moral issues and actually makes a great impact on individuals. The participant observes that young school youths are quite observant and would listen to a teacher who is seen as a model in both his work as a teacher (where students make very good grades in his subject especially in the external exams) and as a good parent. Apart from supportive teachers, the discussions however show that some male teachers are seen as double-dealers who abuse the opportunity by sexually harassing and exploiting female students for sexual favours. Participants noted that some female teachers on the other hand are seen as being unnecessarily severe and quite judgmental. In this sense, even though such teachers chip in thoughts on the subject during teaching, their seeming

derogatory stance is seen as rather inadvertently empowering adventure into the unknown. Some students as individuals or as small groups consciously plan strategies for rebelling against teachers perceived as being judgmental by doing exactly contrarily to the expected. Thus FGDs suggest that even though other teachers create space for discussions related to sexuality issues, such issues were usually heavily couched in morality, religion and hell fire. In this stance, there is the consensus during FGDs that the moral lesson hardly goes down well with students because it is usually one sided and hardly allows for open communication on the issue.

Another indicator for knowledge about SRH issues relates to proportion of respondents who could mention that a girl who has experienced menarche could become pregnant even the first time she has unprotected sex. Figure 4.1 gives a summary of the findings in relation to knowledge about pregnancy.

Fig 4.1: Can a girl who has experienced her menarche get pregnant the very first time she unprotected sex?



Source: Field Work (2015)

As shown by Figure 4.1 31%of respondents lacked knowledge as to whether a girl who has experienced menarche could get pregnant the very first time she has sex. Whilst more than 68.9% were able to correctly answer that such a girl could get pregnant the very first time if she engages in unprotected sex. Nonetheless, FGDs revealed that most young people hold several misconceptions regarding how pregnancy could occur. As one male student at the FGDs noted;

"I heard that during sex the girl would only get pregnant when she lies flat but when she stands or uses the 'bend-down-and-collect' style she will not get pregnant." (Male student, Boys FGD 2)

"I was told that after sex the girl could drink plenty of water or milk to prevent pregnancy" (Female student, Girls FDG 1)

"When a girl drinks a glass of Guineas after sex, she will be safe from getting pregnant" (female student Girls FDG 2)

The above findings are some misconceptions mentioned during FGDs. A further probe in relation to possible sources of misconceptions about sex was traced to unprecedented access to pornographic material in different forms. Easy internet accessibility especially associated with the proliferation of cell phones was linked to engendering open individual access to pornographic material generally. The emergence of new communication links like Whatsapp and Facebook were noted, among other things, as adding new impetus to easy distribution of videos, pep talks and images around the world even with complete strangers including spreading of false information. Participants of FGDs for example mentioned the internet as the major source of information about physical postures during

sex. The associated rumor that some postures during the sexual act could prevent pregnancies wide spread. It is interesting that when cross tabulated by sex of respondent, the findings suggest that more girls (53. 7%) than boys (46.2%) indicated that a girl, once she has experienced her menarche could still get pregnant the very first time she has sex notwithstanding the posture assumed during unprotected sex or the use of withdrawal as a method of contraception.

4.2.2 Knowledge on Contraceptives

The professionals assume that knowledge about an object may lead to attitude formation about that object and may affect practices in relation to the said object. Experts have therefore pointed out three basic components of this relationship: Informational, Emotional, and Behavioral (Smelser and Baltes (1967). In this study, efforts were made to measure these different components respectively among respondents. In the first place, the informational component (knowledge) has been gauged through asking respondents to mention at least three modern contraceptives they are aware of. Knowledge on contraceptives is deemed essential to developing unwanted pregnancy prevention programmes. Such knowledge is also thought to invariably shape positive attitudes and therefore positive contraceptive behavior of adolescents. The logic is that adolescents with misinformation regarding contraception may unwittingly engage in risky sexual behavior. Exploring the knowledge, attitudes and behavior patterns of adolescents regarding contraception could be useful in developing innovative programmes to meet the sexual needs of this cohort.

In the first place therefore, the study sought to find out the knowledge of respondents on contraception. Findings (Table 4.2) show that seventy percent (70%) of respondents could

mention at least one method of contraception whether modern or traditional. The most known method by respondents was the condom specifically the male condom (98.8%) with the least known method being the Norplant (30.1%). In the same regard, the overwhelming majority of respondents (87.8%) could mention that the condom prevents both pregnancy and STIs.

Table 4.2: Student's knowledge of contraceptives

Contraceptive Method	Frequency	Percentage (%)
Pill	238	59.2
IUD	170	42.3
Diaphragm/jelly/foam	223	55.5
Female condom	365	90.8
Male	397	98.8
Norplant	121	30.1
Emergency Pill	202	50.2
Vasectomy	186	46.3
Tubal Ligation	192	47.8
Natural Method	177	44.0
Withdrawal	275	68.4
Total	402	100

Source: Field Work (2015)

The FGDs suggest that the popularity of the condom among respondents is a natural consequence of peculiarities of the target population under study. In-school young people may be sexually active but by natural sequence of things, may and are largely not interested in 'family planning' at this point in their lives. The FGDs suggest that the concern at this point in time is basically acquiring wide-ranging knowledge about life including contraceptives generally. For students who are however sexually active at this point in their lives, individuals have choices that go beyond knowledge per se to practice/use of contraceptives. In this milieu, young people are biologically mature to have sex but may be socially and economically immature to have children. In this context then, Family

Planning is not the issue at stake rather the prevention of unplanned pregnancy becomes a critical concern for those young people who are sexually active. There are other equally important issues that come into the equation as noted by one female participant:

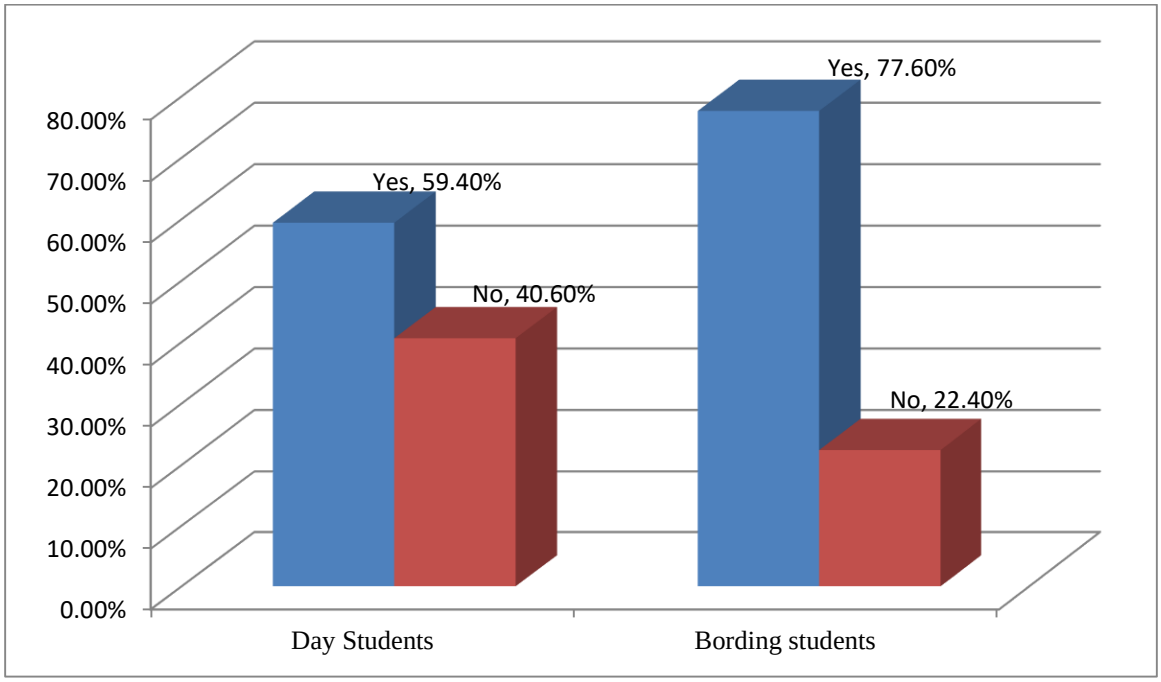
"My father is a pharmacist and he said contraceptives like the Family Planning pills are not good for the young girl as it can make her fat."(Female student, Girls FDG 1).

Another said;

"They say the pills and injectables are not good for young girls. They are meant for married women" (Female student, Girls FDG 2).

One major concern of this study was to ascertain the knowledge of respondents in relation to contraceptives. The question naturally emerges as to which category of students would absorb this knowledge better. There is the supposition that those students who are in the boarding facility are comparatively protected from the larger society and its sex related pressures and temptations for students. In terms of this, it is argued that Day students are more likely than Boarding students to be sexually exposed and/or sexually active. The assumption is therefore that Day students would be comparatively more interested and knowledgeable than their counterparts in relation to contraceptives. Figure 4.2 gives a summary of findings in this regard.

Figure 4.2: Student status and Knowledge of contraceptives



Source: Field data (2015)

Contrary to the assumptions, Figure 4.2 shows that students in the Boarding facility were comparatively more knowledgeable than Day students in relation to contraceptives. Whereas59.4% of day students had knowledge of contraceptives, 77.6% of boarding students possessed knowledge of contraceptives. In all, 69.9% of the student population demonstrated knowledge of contraceptives. There was a significant relationship between the status of a student and his knowledge of contraceptives (p value=0.000). The boarding students demonstrated more knowledge of contraceptives than day students.

Table 4.3: Pearson chi –square test on Student status and knowledge of contraceptives

			Student status		
			Day	**Boarding**	**Total**
Do you know of any contraceptives	Yes	Count	101	180	281
		Percentage	59.4%	77.6%	69.9%
	No	Count	69	52	121
		Percentage	40.6%	22.4%	30.1%
Total	Count		170	232	402
	Percentage		100%	100%	100%

Chi-square test

	Value	Df	P-value
Pearson chi square	15.403	1	0.000

Source: Field Data (2015)

4.2.3: Religion and knowledge about contraception

Some religious traditions have presented recurring obstacles to open discussion about contraceptives among young people. The Roman Catholic Church is for example opposed to artificial contraception including any orgasmic acts outside the context of marital intercourse. There is however the anecdotal evidence that religious denomination or doctrine may not necessarily influence knowledge choices and practices of individuals. In

this study therefore, efforts were made to find out whether religious affiliation of the adolescent affects knowledge on contraception (Table 4.4).

Table 4.4: Pearson Chi-Square Test on Religion and knowledge of contraceptives

		Religion			
		Moslem	**Protestant**	**Catholic**	**Total**
Knowledge of contraceptives	Yes Count	200	50	31	281
	Percentage	66.9%	78.1%	79.5%	69.9%
	No Count	99	14	8	121
	Percentage	33.1%	22.9%	20.5%	30.1%
Total	Count	299	64	39	402
	Percentage	100.0%	100.0%	100.0%	100.0%

Chi-Square Test

	Value	df	P-value
Pearson Chi-Square	5.049	2	0.080

Source: Field Data (2015)

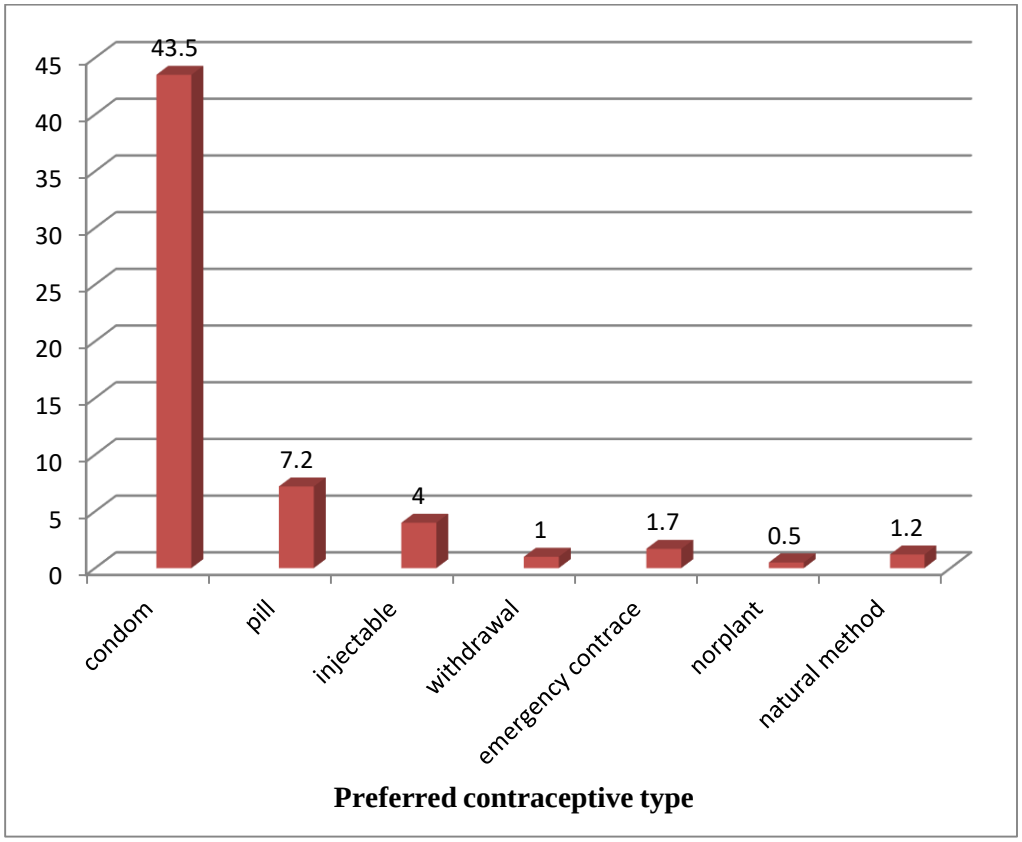
Out of the 299 Moslem respondents, 66.9% confirmed knowing some contraceptives. Seventy- eight percent (78%) of the 64 Christian Protestants also knew of contraceptives whilst that of Catholics was 79.5% of the 39 Catholics respondents. There existed no significant relationship between a student's religion and his/her knowledge of contraceptives (p value = 0.080).It was therefore concluded that religious affiliation has no direct influence on the knowledge of respondents on modern contraceptives.

4.2.4 Sexual Health Attitudes

Apart from investigating the knowledge (informational aspect), efforts were also made in this study to find out the emotional component of attitudes (Smelser and Baltes, 1967) of respondents towards contraceptives. The emotional component (attitudes) was assessed through asking respondents to indicate their opinion about whether they would ever consider using contraceptives personally. In this wise, the question seeks to explore feelings of the respondent about the object. These feelings could be positive, negative or neutral.

The findings show that even though a majority of respondents have knowledge about contraceptives, this knowledge does not seem to translate into a favorable attitude toward contraceptives generally. Only 59.2% of respondents considered using any contraceptive method. For those who would use any contraceptive in the future, the most preferred method was the condom (43.8); the pill (7.3); and the injectable (4.0%). Figure 4.3 presents the findings.

Figure 4.3: Preferred contraceptive type



Source: Field work (2015)

For the 40.8 percent respondents who have never considered using any contraceptive, the desire to remain chaste came up strongly in FGD as a reason; *"I prefer staying chaste until I marry and when am married, there is no need of me using it."* (Female Student, Girls FDG 2)

This reason reflects the strong influence religion has on decisions young people make with regards to their sexuality. All the religious denominations in Ghana preach chastity. Young people are expected to stay chaste till they marry. A young person who is therefore seen possessing or using contraceptives is usually regarded as immoral or promiscuous. Various

reasons were given by respondents who had no intentions of ever using any contraceptive. These include the following;

"I prefer staying chaste until I marry and when am married, there is no need of me using it." (Female Student 1)

But yet another respondent considers the issue in relation to his religious background. A Muslim participant had this to say:

"I think Family Planning is a good thing generally. However, it depends on the reason for using a contraceptive method. In fact, we Muslims embrace the use of contraceptives as a way of spacing our children so as to comfortably take care of them. The religion says contraception is only meant to space children and not terminate an individual's fertility."

The perceived side effects of some modern contraceptive methods also emerged as reasons for not intending to use contraceptives. The fear of becoming infertile emerged as a major obstacle to contraceptive use;

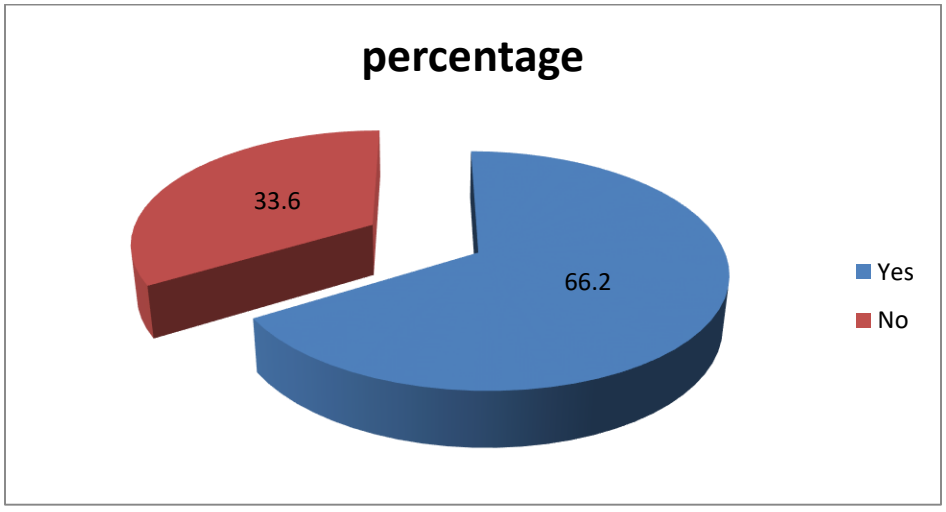
"Some of the contraceptive actually are harmful because they can lead to permanent infertility and several miscarriages." (Female Student, Girls FDG 2)

The personal statements above register some basic challenges. In the first place abstinence from sexual intercourse is certainly a preferred safer-sex approach. However, the assertion that "when am married there is no need of me using it' raises questions about ensuring that the knowledge acquired through the programme is broadened to be inclusive of the importance of contraceptives for both spacing and limiting childbearing (Family Planning). The view held by some participants that since contraceptives may be "harmful" (have some

side-effects), there is the need to avoid using any completely smirks of misconception about contraception generally. Finally, the belief that contraceptives are not meant to terminate an individual's fertility brings in the religious view related to Islam and the avoidance of permanent contraception. In this view, more permanent methods of contraception like sterilization are not acceptable to Muslims.

Another important component of attitudes towards contraceptives among respondents was measured through asking them to indicate their opinion on the issue of whether contraceptives could be made accessible to sexually active unmarried adolescents. In spite of the seemingly less favorable attitudes toward future contraceptive use, it is quite interesting that majority of respondents think it is important to allow sexually active unmarried young people have access to the devices. As the figure 4.4 shows, 66% said young people who are sexually active should be allowed to have access to contraceptives whilst 33.6 percent said no.

Figure 4.4: Attitudes toward sexually active unmarried young people use of contraceptive



Source: Field work 2015

The fact that more than half (66.2%) favored making contraceptives accessible to sexually active young people presupposes that respondents appreciate the reality of sexual activity among young people and its associated risk of unplanned pregnancies and STIs. FGD with students revealed reasons for such favorable attitudes:

"Because some young people are there who are not married yet are sexually active and cannot abstain. So in order to avoid teenage pregnancy, there is the need to let have access to contraceptives." (Male Student, Boys FDG 2)

Another explanation was that:

"Looking at the way things are going on campus, at times you can see a girl and 'fall' for her and she will also 'fall' for you and when you are finally with her in corner, you become unconscious and can have unprotected sex but if you have a condom in your wallet at that emergency moment, you can protect yourself." (Male Student, Boys FDG 2)

For respondents who were not in favor of this, religious and moral prohibitions emerged as major reasons why students thought unmarried but sexually active young people should be denied access to contraceptives. Indeed the major concern for this group is the moral implications of sex outside marriage, a religious demand

"This method is illegal because Islam (Allah) does not allow unmarried people to engage in sex." (Male Student, Boys FDG 1)

"It is not allowed to have sex as unmarried young people. Christianity and even society frowns on it." (Female Student, Girls FDG 1)

Table 4.5 gives a summary of the findings related to opinion of respondents (students) on the issue.

Table 4.5: Pearson Chi-Square Test on Religion and young peoples' access to contraceptives

		Religion			Total
		Moslem	**Protestant**	**Catholic**	
Should sexually active unmarried young people have access to contraceptives?	Yes Count	188	48	30	266
	Percentage	62.9%	75%	76.2%	66.2%
	No Count	111	15	9	135
	Percentage	37.1%	25%	23.8%	33.8%
Total	Count	299	64	39	402
	Percentage	100.0%	100.0%	100.0%	100.0%

Chi-Square Test

	Value	**df**	**P-value**
Pearson Chi-Square	11.567	4	0.021

Source: Field Work (2015)

Table 4.5 attempts to bring some more meaning into the situation. The Table explores attitude of respondents (students) by religious affiliation on the issue of making contraceptives accessible to sexually active unmarried young people. As shown by Table 4.5 two-third (62.9%) of Moslems held the view that young people should be allowed to have access to contraceptives. Out of a total of 39 Catholic respondents, about four-fifth (76.9%) showed a favorable attitude toward young people's access to contraceptives. The percentage of Christian Protestant who favored young people's access to contraceptives

was also 75 percent. Chi-square test revealed a significant relationship exist between the religion of a respondent and his/her attitude toward young people's access to contraceptives (p value = 0.021). The religion of a respondent therefore influenced his/ her attitude toward making contraceptives accessible to sexually active unmarried young people

Apart from students, opinions of teachers on the issue were sought. It is quite interesting that the far majority of teachers (83%) interviewed felt strongly that unmarried young people should not allowed access to contraceptive information; where to get them and how to use them.

One teacher was of the opinion that:

*"I would not recommend that students be given in-depth information on contraceptives because of the fear of experimentation … Indeed the purpose of contraception is limited to family planning. Once they are not making families now then do you expect them to have access to contraceptives? Of course, they can be told what contraceptives are but they are not to use until they are ready. If you allow access then you are in effect shouting; 'go and practice' … the license to have sex."(*School Counselor, In-depth Interview)

But another teacher believes that the advent of HIV/AIDS and other sexually transmitted infections make the situation a formidable one. With global trends and the powerful drive of social media, many have become more pragmatic about the issue. He observed that the challenge especially of some girls with ambition (materialism, career, or higher education) where parents and relatives cannot afford - means relying on some men who could afford to support. These men in turn sometimes seek sexual favours for the support given. The challenge is that even though religious groups generally help in diverse ways, they are limited in providing the needs of especially young girls. This cohort therefore may be attracted to the alternative prospect and the opportunity cost associated. The role of

Guidance and Counseling in schools become all the more crucial in determining what could be done – the client is empowered to make an informed choice.

Table 4.6: Pearson Chi-Square Test results on attitude toward contraceptives use

		Religion			Total
		Moslem	**Protestant**	**Catholic**	
Would ever consider using any modern contraceptive method	Yes Count	170	41	27	238
	Percentage	56.9%	64.1%	69.2%	59.2%
	No Count	129	23	12	164
	Percentage	43.1%	35.9%	30.8%	40.8%
Total	Count	299	64	39	402
	Percentage	100.0%	100.0%	100.0%	100.0%

Chi-Square Test

	Value	Df	P-value
Pearson Chi-Square	2.931	2	.231

Source: Field Work (2015)

Another level of indulgence related to access to contraceptives by sexually active students was measured by asking respondents to indicate whether they would 'ever consider using any modern contraceptive method'. Cross-tabulated with the religious affiliation of respondents, an interesting pattern emerges. Table 4.6 also shows a cross-tab of religion and student's attitude toward contraceptive use (personal use of contraceptives). Less two-thirds (56.9%) of Moslems showed a favorable attitude toward future contraceptive use, 64.1% of Protestants indicated their intentions toward future contraceptive and 69.25% of Catholics also showed a favorable attitude toward contraceptive use. Chi square results showed that religion had no influence on student's intentions toward contraceptive use. (p

value= 0.231). Also, more than a half (59.2%) of all respondents showed a favorable attitude toward contraceptive use

As part of assessing attitudes of students, respondent's views bordering on abortion were also sought. The purpose of this was to re student respondent's perception on abortion and the decision they would take when faced with an unplanned pregnancy.

In almost every cultural setting in Ghana, abortion appears to be a very sensitive and contentious topic associated with stigma and criticisms. It carries with it religious, moral, cultural and political dimensions and viewing it from the religious and moral lens a sin against God and crime against society as the laws permits abortion only in the case of rape or defilement or a threat to the health of the mother or child. It was therefore not surprising that the mention of abortion during the FDG generated strong and uncomfortable reactions from the girls indicative of the sensitive nature of the topic. Girls were reserved to talk about it probably because of the stigma and how sinful it is considered in our society. One female student finally intimated that:

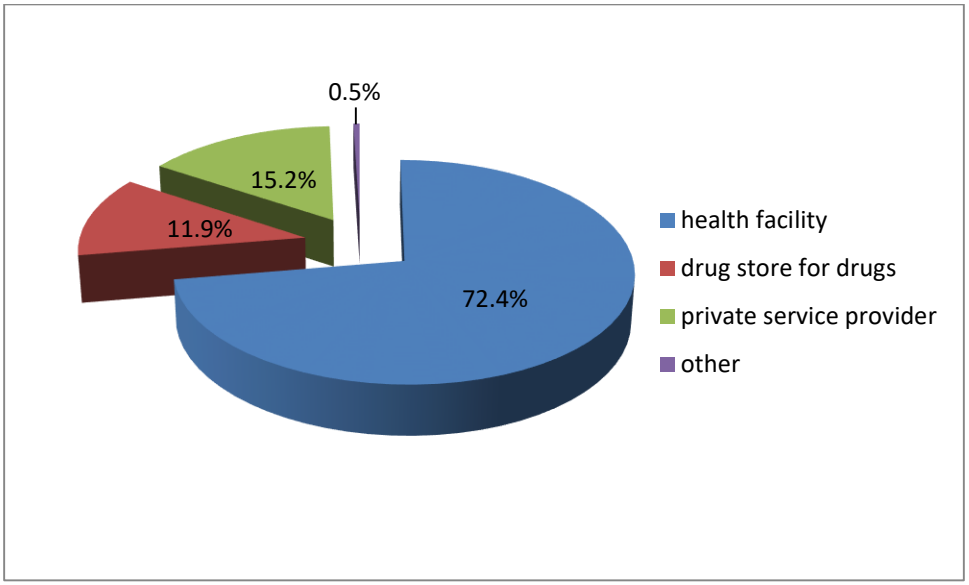
"During one of our monthly moral talks, our teacher told it is a sin against God and that it is not good for us as one can die from it."(Female Student, Girls FDG 1).

Results from quantitative data also revealed that 24% of respondents had intentions of seeking for abortion when confronted with an unplanned pregnancy. Less than half (40.3%) also were of the view that they would quit school and keep their pregnancy. About thirty-six (35.6%) had no idea of what to do when confronted with an unplanned pregnancy.

Answering the question on where to seek abortion services, the majority of respondents (72.4%) cited the health facility as the place to seek for abortion care if ever they want to

terminate a pregnancy. The table below shows the places where respondents intend seeking for an abortion in case of an unplanned pregnancy.

Figure 4.5: Place to go for an abortion



Source: Field Work (2015)

Despite citing the health facility as the place to seek for abortion, responses from FGD results also showed that some young people still use some crude methods like grinded bottles, over the counter drugs and other local concoctions.

"Some girls use broken bottles to cause abortion. Others also use 'Trimol' (Tramadol) (a burst of laughter) or Paracetamol. Some people also say that you can mix malaria drugs and Amoxicillin and take it to cause abortion."(Female Student, Girls FDG 1)

4.2.5 Sexual Practices

It is undeniable that young people globally engage in sexual activity with some even engaging in very risky sexual practices like, group sex, multiple, sexual partners unprotected sexual intercourse. As part of assessing the sexual practices of young people,

the study sought to proportion of respondents who identified themselves as sexually active, the proportion of sexually active respondents who use contraceptives and the proportion of sexually active respondents who have ever been pregnant or gotten a girl pregnant.

The survey shows that more than a third (35.6%) of respondents said they have ever had sex. Of this, 26.6 percent fell within the 16-20 age group. Focus Group Discussion participants (students) revealed that almost all individual participants said they could point out at least 5 colleagues (students) who they were aware as friends who ever had sex or are sexually active. Even though questions during FGDs were not personalized, the general consensus was that a sizeable number of students at the SHS level have ever had sex or are sexually active. Participants at FGDs agree about the moral implications of sex outside marriage as well as the risk in unprotected sex.

Furthermore FGDs also revealed that a major concern for adolescent boys especially has to do with the challenge of wet dreams. Many participants associate the situation with demonic attacks. A 16 year old participant noted that:

"I was very surprised when my male friend who is a strong born-again confessed that he was also often sexually induced in his dreams by some girl for sex. He confessed that when this happens, he feels spiritually exploited. He has fasted and prayed over the situation several times but to no avail. Other friends also experience the same situation and are very worried about it because it draws funny maps on beddings. Everyone says it is the devil at work."(Male Student, Boys FGD 1)

Another FGD participant was concerned not only about premature ejaculation but also about whether oral sex could have negative effects:

"My friend said he was involved in having group sex with other friends and when it got to one guy's turn, as soon as he got on top of the girl, he 'released' prematurely on top of her. The girl was bullied to give a blow job to revive him… I don't know if this will bring disease to the girl." (Male Student, Boys FGD 2)

The several issues raised during FGDs go to register varied challenges facing adolescents generally. Even though some level of sex education is ongoing, participants agreed that students hardly get the opportunity to raise personal questions and also to have one-to-one counseling on such delicate issues including wet dreams, masturbation, premature ejaculation, or abortion. These are said to verge on morality and as such have social sanctions attached. One male student retorted when asked why he did not approach the school counselor on such nagging issues as follows:

"But how could I … I just don't know how…It is very private and I don't want people saying I am bad or that I have some devil inside me …"(Male student, Boys FGD).

The impression gleaned from FGDs suggests that for many participants, the sex education programme seems to be scratching barely the surface of expressed needs of the target group.

Among those who have ever had sex, the most used contraceptive method to prevent pregnancy and STIs was the male condom (15.9%) with just 6.2 percent ever using a female condom. Among modern contraceptives, the emergency contraceptive came up as the second most used method (7.2) whilst the Norplant was the least used method (1.0%) probable due to the effects of its prolonged use. Comparing gender preference for contraceptives, more males (54.8%) than females (34.1%) preferred to use the condom.

However, females also indicated preference for other methods like injectables (5.6%) and pills (11.2%). With a p value of 0.00, there was a significant relationship between the gender of respondents and their preference for a contraceptive method. (p value = 0.00). The study also revealed that for sexually active respondents, 3.2% reported that they ever experienced pregnancy or gotten a girl pregnant.

Apart from exploring issues related to sources of information on sex questions, participants at FGDs were agreed that many of their age mates were sexually active. For some, being sexually active is a natural consequence of current events and challenges. Attractions like widespread pornography, and the fact that some in-school girls get social and economic capital from men for sexual favours have made sex outside marriage the in-thing. Sex and emotional issues seem to gradually emerge as a common focus for the unmarried. To be romantic is to be civilized. It is also no longer a huge embarrassment to be sexually active outside marriage. Indeed some even think the more you practice before marriage the better the preparation for marriage: *"practice makes man perfect. If young people abstain from sex, when we marry, your first night will be war for you because you can't do it properly"* (Male Student, Boys FGD 1).

For others too, having sex was seen as a means of relieving tension from studies. The impression was that they had read from the internet that having sex makes one feel relaxed and able to be sharp;

"Our teachers are always saying a student who is sexually active may find it conflicting with studies. But then, some students believe sex satisfies deep emotional needs especially for those from homes where parents do not give such emotional support. It is a good

sensation to feel loved by someone. It is also a way around stress. I even read this on the internet and one of my colleagues wrote the link on the blackboard for all to go and verify. So some use this approach in studying…" (Male Student, Boys FGD 2)

Others also intimated that having sex was a means of making them academically smart as they had read from the internet that having sex makes one feel happy and able to memorize things;

"Our teachers are always saying that we should stop the sex but we are also of the view that when you have sex, it makes you an A1 student, makes your mind sharp to understand things, it also takes away stress. I heard this through the internet. So with all these importance we don't see the negative aspect of sex."(Male student, Boys FDG 2)

Further probes revealed that FDGs revealed that girls who find themselves in relationships with the opposite sex, in most situations are compelled to have sex with their partners as prove of their love and commitment to the relationship.

"It is not as if we bad, but sometimes our boyfriends ask us to have sex with them to show that we love them and because we don't want to lose the boys, we do it."(Female student, Girls FDG 2)

Participants, especially female participants indicated that girls often engage in sexual activity with so called 'responsible' male partners to get financial support for themselves whilst in school since most of them have their families living far away from Tamale.

4.3 Access to Sexual Health Information and Services

Access to sexual health services is also a key indicator of the sexual health of young people. This includes; access to information, counseling services, and for those sexually active, counseling on contraceptives, as well as STI screening and treatment among others. Access to information is to produce a positive attitude towards healthy sexual practices. In this study, access was measured in terms of geographical distance, financial ability, attitudes of parents and health workers.

4.3.1Attitudes and Gender of health workers

There was a general consensus among participants of FGD from both schools that the attitude of some health workers is a barrier to accessing sexual health care. Lack of confidentiality and scornful statements from health workers were cited as major issues to deal with when visiting a health facility for health care.

"Sometimes we are scared to go to the health facility for help because some of the doctors are not kind. They will insult and bully you, especially the old ones." (Female student, Girls FGD 2)

Another student also intimated that

"Sometimes our colleagues go and they are insulted; 'young girl like you and you have started having sex and you are now pregnant and you are now bringing it for us to do abortion for you' Because of this many young people would rather let friends direct them the crude way rather than face such disgrace-concoctions with sugar, malt, coffee or broken bottles to abort."(Female student, Girls FDG 2).

Though students unanimously agreed that some health workers' attitude constituted a barrier to accessibility, there was however divergent views as to whether this negative attitude came primarily from the young ones or the old ones. There were others who thought the younger health workers are friendlier than the older ones and vice versa.

On the issue of confidentiality, a student intimated: *"Some doctors especially the female doctors can't keep secrets because women in general talk too much. If the female doctor should know you, one day she will just sit somewhere and spit it out."*(Male student, Boys FGD 1)

Apart from the attitudes of health workers being a barrier, the sex of the health worker also came up as barrier to students accessing sexual health care. Almost all participants of the FGD expressed the view that the sex of the health worker whom they go to meet for health care sometimes determines their ability to confidently explain their condition. Both boys and girls expressed the view that they would prefer to seek attention and treatment from health workers of the same sex. Seeking medical attention from a health worker, who is of the same sex they said, would make them more comfortable to openly talk about issues bothering them.

" *When you are guy and you visit the hospital and it's a female doctor, you just have to change the topic but when it's a male, you go ahead and tell him the real problem"* (Male student Boys FDG2)

Another male student corroborated;

"We would prefer that when we got to hospital with sexual health problems, we speak to male doctors." (Male Student, Boys FDG 1)

"If ladies come to take pills or other methods they feel shy when a male health worker is inside and because of that they go back. But if a lady were to be inside they would go in"(Female, student, Girls FGD)

These unwelcoming attitudes of health workers according to the students make them very uncomfortable and shy whenever they have to seek health care from health facilities. It was therefore not surprising that 157 representing 39.1% indicated a preference for obtaining contraceptives from a drug store with 106 representing 26.6 preferring the health facility. Sixty-seven (67) representing 16.7% cited peer educators as people from whom they could comfortable obtain a contraceptive.

4.3.2Attitude of parents

Parents' attitude to their wards seeking medical attention for issues related to their sexual health also came up as barrier to accessing health information and services. This opinion was strongly expressed by students from both schools. However, whilst some expressed the view that their parents would allow them to access information on their sexual health: *"I will describe my parents as the best. My parents usually want me to get access to sexual health care so they teach me a lot and even tell me to go the internet and learn more to get the knowledge to teach them* (Male Student, Boys, FDG 1*)*,others also said their parents' attitude was not encouraging:

*"I won't even venture to tell my parents I want to go the hospital. If they know you are pregnant, they will be treating you as if you are not their daughter. Some will even send you the hospital for abortion and other will send you packing to the boy who got you pregnant."(*Female Student, Girls FDG 2*).*

Mothers were seen to be quite understanding when it came to accessing sexual health care from health facilities or when an unplanned pregnancy should occur; *" We trust our mothers on such issues because she is a lady, the way she carried your pregnancy, she knows how it is to be pregnant. That is why if you have such a problem and you talk to your mother she will mind you. But your father will be insulting you a bad girl."(*Female Student, Girls FDG*).*This attitude of some parents, insisting on going to health facility with their children and showing a hostile attitude to their health challenges makes they said, often makes them afraid and shy to seek the necessary attention they need for their sexual health.

4.3.3 Financial constraints

Though some participants of the FGD did not regard the cost of seeking health care as a barrier to accessing health care because of the National Health Insurance, majority of participants expressed the view that financial cost associated with seeking health care concerning their sexual health is still a big challenge regardless of the health insurance. The cost of getting screened and treated of STIs, for instance was mentioned as expensive since it wasn't covered by the NHIS.

"Some screenings are very expensive so if they can reduce the cost of screening and treatment so that we can all access them." (Female Student, Girls FDG 1)

Another student corroborated;

"Hmmm, if you go to seek for treatment and it's expensive, you will have nothing to do than to harm yourself. Those things they have to reduce the prices for us like the

contraceptives and seeking for treatment because we can't afford them" (Female Student, Girls FDG 2)

"The cost of seeking attention is a problem because nowadays if you are you are using health insurance you may go around 5am and you can be there till 2pm without saying a doctor but if you go with money, they will give you the appropriate medicine. In this case if you don't have money, you wouldn't be given the right medicine." (Male Student Boys FDG 2)

4.3.4 Geographical Barriers

Participants expressed varied views on this theme. For those students who found themselves living in the urban towns, geographical distance to a health facility was not really a barrier but for those students who came from rural communities having access to health information and services is becomes a challenge when they are on holidays considering the distance from their communities to the nearest health facility; *"sometimes going to the health facility looks expensive. Some of us our houses are far from the health facilities and you have to pay for transportation to go there. I wish they will bring it to our door steps otherwise some of us will not get the chance to go there and if anything happens, we will keep it and it will harm us."*

(Male Student, Boys FDG 2)

The distance from the schools to a health a facility also emerged as a barrier especially for those who were in the boarding house; *"geographical barrier is a big challenge. This school for instance, we don't have a school bus so when you are going to the hospital you*

have to foot or you have to pay for your own transportation."(Female Student, Girls FDG 1)

4.3.5 Student status (day student and boarding student) as barrier

Another issue that emerged as a barrier to students accessing sexual health information had to do with the student status. For those in the boarding house, accessing health information was a challenge since schools neither had efficient ICT centers nor allowed students to possess phones on campus where students could go online and read on their sexual health.

"When am on campus, actually I don't get all the information concerning my sexual health but when am in the house, I always watch programmes on TV where they talk about these things. I also have a phone in the house and go to the net, but here there's nothing like that. And when you go to the ICT center, they will tell you come back during break time, when we have to eat. And when you even go later, they will close the WIFI and tell they don't have credit."(Male Student, Boys FDG 2)

Another student added;

"When we come to school, we don't get the right information but if you are at home, you get the practical aspect of it, you listen to radio discussions and watch TV shows on the topic. We are not allowed to have phones in school and our phone boots are not also having internet and facebook so you can't access good information."(Female Student, Girls FDG 1)

4.4: Teachers and Students Perspectives on School-Based Sexual Health Education

Table 4.7: Students Assessment of Sexual Health Education in School

Item	Disagree N (%)	Agree N (%)	Undecided N (%)
I have received information on the emotional changes related to adolescent development.	146 (36.4)	159 (39.6)	97 (24.1)
I have received information on the physical changes that occur during adolescence	18 (4.4)	380 (94.5)	4 (1.0)
I have received information on where STIs/HIV counseling and testing services are provided	154 (38.3)	131 (32.6)	117 (29.1)
I have received information on the various types of contraceptives	194 (48.3)	169 (42.1)	39 (9.7)
I have received information on how to effectively use some contraceptives	283 (70.4)	66 (16.4)	53 (13.2)
I have received information on the side effects of some contraceptives	293 (72.3)	70 (17.4)	39 (9.7)
I have received information on where to acquire contraceptives	81 (20.2)	292 (72.4)	29 (7.2)
I have received information on the consequences of unplanned pregnancy on my education	46 (11.5)	320 (79.6)	35 (8.7)
I have received information on the consequences of unplanned pregnancy on my health	61 (15.2)	308 (76.6)	33 (8.2)
I have been educated on the need to refuse unprotected sex	56 (14)	312 (77.6)	34 (8.5)
I have been educated on the effects of negative peer pressure on risky sexual behavior	53 (13.2)	312(77.6)	37 (9.2)
I am satisfied with what I am taught in sexual health education	325 (80.8)	55 (13.7)	

Table 4.8: Student's assessment of teachers on sexual health education

Item	Disagree N (%)	Agree N (%)	Undecided N (%)
Teachers in this school take teaching sexual health education seriously	132 (32.8)	187 (46.5)	83 (20.6)
Teachers motivated me to learn about my sexual health	167 (41.6)	153 (38)	82 (20.4)
Teachers motivated me to access valid sexual health information and services	182 (45.3)	122 (29.9)	100 (24.9)
The teaching strategies used in sexual health education helps me to understand what is taught.	307 (76.4)	49 (12.2)	

Source: Field Work 2015

This survey also sought to determine students' assessment of schools based sexual health education and their teachers. As indicated in Table 4.7, whereas an overwhelming majority (94.5%) received information on the physical changes that take place during adolescence, the same cannot be said for receiving education on the emotional changes that comes along with the physical changes. Educating young people these emotional changes and how to cope or handle them is very crucial to helping to manage emotional feelings that mostly drive some of them into unhealthy or risky sexual behaviors.

It is contradictory that though majority of respondents mentioned being informed of the effects of unplanned pregnancies on their education and health (79.6%) and (76.6%), less than half of them received information on where to access contraceptives (42.1%) and how to effectively use the contraceptives (16.4%).In depth interviews with teachers confirmed this fact. Though teachers acknowledged the fact that some of their students were sexually active, yet they were of the view that information on how to practice safer sex, that is, contraceptive usage should be withheld from students.

"I will not recommend that students be given in-depth information on sexual health issues like contraceptives because those things are called family planning and once they (students) are not making families, then they are not to have access to them. If you tell them where and how to get them, then we are giving them the license to have sex."(Science teacher, In-depth Interview, School D).

In their opinion, doing so would imply giving students the free license to engage in sex. Teachers expressed the view that exposing students to the details of sexuality education would do harm to them as some would be tempted to engage in sex.

"We should be economical on making sexual health education practical in the sense that young people have curious minds and as you teach them these things, they would go behind the school authorities and experiment and this may lead to something else." (School Counselor, In-depth Interview, School B)

The fear of being branded a bad teacher by students or getting into trouble with parents for taking about sex to pupils was also a reason for teachers unfavorable attitude toward a comprehensive and holistic sexual health education;

"Telling students about these things could also bring problems for the teacher. When a problem arises students would say it was their teacher who taught them."(Science Teacher, In-depth Interview School C).

Two- third of teachers (66%) were of the view that students should just be educated on the menstrual cycle, the reproductive system, and personal hygiene especially for girls and how to deal with their relationships with the opposite sex.

Notwithstanding teacher's opposition to teaching sexual health education, students were of the opinion that sexual health education was of importance to them as people growing into adults. Participants of the FDG mentioned that since their parents hardly talk to them on issues related to their sexuality, school-based sexual health education would help them to learn, understand and cope with changes, especially, emotional changes associated with puberty. Female participants also mentioned that teaching them about menstruation, the menstrual cycle could help dissipate the fear and embarrassment they sometimes feel when they start menstruating. It could also be a means of helping them cope with the emotional changes that occur during in the menstrual period.

"Learning about our sexuality and health is very important to us as young people. We growing up and so we need to know the changes that are occurring in our bodies." (Male student, Boys FDG 2)

"As girls, we are often not educated much on menstrual issues so most of us are not able to cope with changes, especially the pains and anger that occurs during that period." (Female student, Girls FDG 1)

"I think that if we are taught more on menstruation, some of us wouldn't be shy and embarrassed when we menstruating. Learning about the menstrual cycle could also help some of us to prevent unplanned pregnancies."(Female Student, Girls FDG 1)

4.4.1 Availability of sexual health education in schools

Both students who participated in FDG Teachers interviewed expressed the opinion that school based sexual health education is relevant for young people to improve their knowledge regarding their sexual and reproductive health. This in their opinion will

contribute to the reduction of unplanned pregnancies and STIs in young people. In spite of the fact that both teachers and students recognized the relevance of sexual health education to young people, both interviews with teachers and FDG with students revealed that there's not a well-designed sexual health education within the curricula. What is currently taught in schools dwells on just the reproductive system, its functions and process, physical changes during adolescence and parental care without in-depth information on other issues related to young peoples' sexual health like contraceptives, skills development in handling relationships, emotional challenges associated with growing up and how to handle such issues.

"We don't have lessons on sexual health. It is only in science they taught us the reproductive system but those regarding their sexual health, no" (Female Student, Girls FDG 1)

A teacher reiterated this;

"The only thing we teach related to sexual health is when it comes to topics on the reproductive system and the excretive system as it has to do with the genitals and infections. Once a while, something of that sort can come up. Apart from that, I think there's nothing like that in the curriculum."(Science Teacher, In-depth Interview School F)

Another teacher added;

*"We teach Social Studies and in that subject there's a topic known as sexual reproduction and health. And in Integrated Science we also have topics related to sexual health and reproduction."(*School Counsellor, In-depth Interview School A)

There was a general consensus among teachers and students that what is taught as part of their sexual health was not enough to address most of the challenges are currently facing. As some teachers said;

"What we teach them doesn't address their sexual health problem. Even the little that you teach, some of them feel shy to ask questions that will lead to clarifications. So what the curriculum prescribes is what we teach and if nobody asks questions on that, we leave it as it." (Science Teacher, In-depth Interview School E)

"I don't think what they are taught is enough for students because most of what is taught is done in abstract terms so they just see it as something to read and answer questions during exams. Students see them as theories because these topics cannot be practicalized."(School Counsellor, School A).

A teacher intimated that sexual health education in schools is not given much attention because it is not an examinable subject in final WASSCE examinations but rather concerns the individual personal health hence teachers mainly concern themselves with teaching students to pass examinable subjects. This is not surprising as the Ghanaian educational system is academically oriented and highly competitive. The major concern of school authorities and teachers is to make student pass well in order to get a good name for their schools.

"Ghanaian school system is about passing exams and if you want to take your time and teach those things your students will go and fail and they will say you are a bad teacher. If you want to make a name for your school, you put those things aside and concentrate on the examinable things." (Science Teacher, School F)

Due to the apparent limited education on sexual health in school, students said they mostly have to rely on friends, the media and some Non-Governmental Organizations to find answers to most of the issues bothering them on their sexual health. There appeared a general consensus among FGD participants that most of the information they currently received on their sexual health was from 'NOYAWA', a reproductive health programme for young people.

It is therefore not surprising that an overwhelming majority 80.8 percent of student respondents indicated that they were not satisfied with they are taught about them in sexual health education and also gave a poor assessment of their teachers on sexual health education.

Despite the stand of some teachers not to give comprehensive sexuality education to students and some teachers, nonetheless expressed the opinion that students should be educated on their sexual health as would help them to make right choices thereby avoiding the consequences of negative sexual behaviours;

"We should embrace sexual health education and teach students on the consequences of engaging in sexual intercourse early. I therefore recommend that schools teach sexual health education." (Science Teacher School D)

"I have often have often said it is because of knowledge that my people perish. You will see them as small boys and girls but what they know, you might not probably know. So why don't we teach them so they know. But if you mention certain sexual parts, they will frown and some parents might come to accuse us of teaching their wards sexual styles." (School Counselor, School A)

For sexual health education to be comprehensive and holistic, a teacher intimated that the culture, society and family should also open up and talk to children on the topic as it would be very difficult for teachers alone to handle it;

"I think the curriculum should include comprehensive sexual health education. But where the culture doesn't permit that, when they come to school and you teach them, they will have a bad perception about you. When you teach them in school and the family doesn't compliment it, it will not help."(Science Teacher, School C).

4.4.2 How Sexual health education should be handled

Teachers in general indicated that they would prefer health professionals whether from Non-Governmental Organizations and the government sector to take over the teaching of sexual health educations as they have the knowledge to answer most of the questions bothering students on sexual health issues. Students, from the FDG, however, specifically said they would prefer health professionals especially those from NGOs to handle sexual health education as they thought NGOs would better handle the subject than even health professionals from the government sector. There was a general preference for 'NO YAWA' a Marie Stoppes Ghana sexual and reproductive health programme for young people.

A teacher said;

"I think professionals should handle it because there are certain dicey issues teachers cannot handle especially when it comes to demonstrations. So I would encourage that professional like the doctors and nurses should be made to visit schools once a while to give lectures to students." (School Counselor, School B)

Another teacher also said;

"If the government can make professionals handle it, there would be in-depth knowledge on the subject. The understanding will be more when professionals teach them than we the students." (Science Teacher, C).

"We prefer the 'NO YAWA' people; they held a drama to teach us on our sexual health. They can explain things better for us to understand than teachers because teachers do it as part of their job but won't teach us fully for us to understand."(Male student, Boys FDG 2)

Another student opined;

"I prefer the NGOs to the doctors because I once went to a government hospital for an HIV test but the nurse couldn't have time to explain things to me; the importance of having the test. She gave me the test without giving me the counseling regarding what to do about the outcome of the test. I think if it were an NGO, they would have briefed me on those things."(Female student, Girls FDG 1)

4.5 Challenges to School-Based Sexual Health Education

4.5.1 Cultural challenges

Cultural was regarded as a major challenge to sexual health education in schools. The influence of tradition and culture on the socialization of the individual made it difficult for both teachers and students to openly discuss sexuality topics in class.

As a teacher noted;

"Our society and cultural upbringing frowns on those who mention sex, or sexual organs. That is why parents feel shy to talk about sex with their children. The issue of sex and

reproductive health is not allowed in society so even when such things are shown on TV, parents feel uncomfortable when children are around."(Male teacher, Ambariya SHS)

A student said;

"Sex education is not our culture, we are learning from somewhere. It doesn't conform to our culture and so if a master is teaching sex education it will be as if he is going against the doings of Ghanaians and I don't think he will put his culture aside and do something different. This limits the masters from teaching it" (Male student, Boys FDG 2)

Some teachers because of this cultural influence expressed shyness in explicitly mentioning sexual organs by their names and often resorted to using euphemisms;

"Even though we are taught the reproductive system in Integrated Science, some of the teachers find it difficult to mention the male and female organs during lessons; they only say the 'something', when you 'fire'. So they have to mention everything so we know." (Male student Boys FDG 1)

Whereas teachers found it difficult opening up with students, most students equally found it difficult to ask questions or make contributions in class during lessons for fear of being tagged as immoral since society regards anyone who openly talks about sexuality as immoral. This ideology of tagging people as immoral for discussing sexuality resulted in some students tagging some teachers as immoral for trying to be explicit when discussing issues on sexual health;

"Sometimes we the students discourage the teachers by giving them bad names for talking about sex and other things. So sometimes they don't feel like saying those things."(Female student)

"At times when the masters talk about these things, most of us especially the girls think badly of the master. They tarnish the image of that master so it makes it difficult to talk about these things." (Male student, Boys FDG 2)

4.5.2 Religious challenges

Results from interviews and FDGs revealed varied views on the influence of religion on school-based sexual health education. Whereas some participants expressed the view that religion especially Islam which is the dominant religion in the study area, does not support teaching students on issues related to their sexuality, the most of the respondents who were Muslims also indicated that religion (Islam) does not prohibit the teaching of sexuality but rather encourages it as the Quran encourages parents to teach their children on issues of sexuality before marriage.

"We are living in a Muslim dominated environment and it's like there's a frown on mentioning of sex and sexual organs so when you mention it they see you as a bad person. For instance if you enter the class and mention vagina, you hear 'Alhamdulilai', and 'haram.'(Male teacher, Kalpohin SHS)

" One master ever asked students to write things they don't like about him and a student wrote that whenever he comes to class, he talks about sex issues which is 'haram' in their religion. So master stopped talking about those things." (Male student)

Sexual health is in Islam. The prophet says in one of the hadiths that when your daughter is of age , prepare her for marriage and the preparation here means teacher what entails in the family home; how to take care of herself, her body and that of her husband. So in effect, in Islam, sexual health education is there. But most of Imams don't teach it because of the fear of experimenting and also because of the difficulty in interpreting what the Prophet says. (Male teacher, Success College)

"In Islam for instance, the prophet said we should always go for knowledge where ever it is. Sex education is knowledge, so we can go ahead and learn it. What Islam is against is practicing what is learnt when not married."(Female student, Girls FDG 2).

Because of the intertwined nature of culture and religion especially in Islam, people often criticized sex education through their cultural lens making appear as though it is religion prohibiting the teaching of sexual health education to young people.

4.5.3 Limited time and Lack of teaching materials for sexual health education

Though an overwhelmingly majority (92.3%) said sexual health education was of relevance to them, there appeared to be very limited time for teaching sexual health education. as 82.8%of students indicated that the allocated time for teaching sexual health education was not enough. This possible was due to the fact that sexual health education is not a subject on its own for which time should be allocated. Also, text books (Integrated Science) were cited as the main material used for sexual health education in schools (99.3%)

CHAPTER FIVE

DISCUSSION

This chapter presents the summary of findings, discussion, conclusion and recommendations of the study. The conclusions were drawn out of the data analysis and the objectives of the research. The general objective of this study is to assess the perspectives of SHS teachers and students on school–based sex education in the Tamale Metropolis. Specifically, the study aimed at: assessing students' knowledge, attitudes and practices on sexual health issues; examining the accessibility of students to sexual health care services; examining the perspectives of teachers and students on school-based sexual health education and finally examining the challenges associated with school-based sexual health education and how these challenges can be addressed. The chapter is organized according to the objectives of the study.

5.1 Knowledge Attitude and Practices

This study sought to explore the knowledge, attitudes and practices of young people. The importance of assessing the knowledge of young people on their sexual health cannot be overemphasized. Indeed knowledge on the subject matter is critical to reducing, if not eliminating, lifelong consequences of engaging in unhealthy sexual practices.

Results from this survey reveal that the far majority of respondents have knowledge on different aspects of the issue. For example, nearly almost all respondents (95.8%) had knowledge on physical changes associated with puberty. This is not surprising especially because findings revealed that discussions related to physical bodily changes are diffused

in subject areas including Biology and Social Science and sometimes in discussions outside the classroom environment.

It is interesting however that knowledge on the occurrence of pregnancy was very limited and especially clouded with misconceptions. Eighty percent of respondents did not know that a girl who has experienced her menarche could get pregnant even when the withdrawal method is used. Findings from FDGs revealed that young people's minds are clouded with misconceptions on how pregnancy occurs. The style or posture assumed during sexual intercourse was said to be a function of the occurrence of pregnancy. A woman or young girl according to FDG participants could get only pregnant when she assumes the missionary position during sex. Pregnancy in their opinion was not likely to occur if the 'bend down and collect' style is used during sex. These findings concur with the findings of Awusabo-Asare et al. (2006), and van der Geugten (2017) argue that most young people do not have accurate knowledge concerning the occurrence of pregnancy. Their findings show that a majority of respondents believed that the withdrawal method prevented pregnancy and also a girl could not pregnant if she has sex standing up.

These misconceptions highlight the urgent need for young people to be given correct and reliable information on every aspect of their sexuality. To prevent unplanned pregnancies and the risk of unsafe abortions among young people, it is important for them to be thoroughly educated on the menstrual cycle and when a young girl could get prevent within the course of the cycle. It is not just enough for them to know about the changes that occur in their bodies as they grow. Education on how to cope and manage the urge to have sex imposed by the hormonal transformations in their bodies must be given to young people.

The findings of the study also showed that 69.9% of respondents demonstrated knowledge of contraceptives with the condom being the most known method (98.8%) followed by the pill (59.2%). The finding however is not surprising especially because of the national campaign associated with the ABC against HIV infection. Awusabu-Asare et al. (2006) found that over 90% of young people had heard of at least one modern contraceptive, with the condom being the most known modern contraceptive by young people. However, to the other modern methods as well as some traditional methods such as Tubal Ligation, Vasectomy and Natural method were not commonly known to respondents. This result is similar to Yidana et al., (2015) who found that just 3.3% and 3.8% young people had knowledge of tubal ligation and vasectomy respectively as well as Hagan et al., (2012) who also reported little knowledge of young people on sterilization (male/female), intrauterine device (IUD), and diaphragm.

Similar to other studies on contraceptive use by young people in Ghana (Abdul Rahman et al., 2011), information from friends and family on the possible side effects of some modern methods was the popular reason for both limited knowledge and use of contraceptives like the pill, and injectables among respondents.

Comparing knowledge of the boarding students to that of day students on contraceptives, more boarding students (77.6%) demonstrated knowledge of contraceptives than day students (59.4%). The constant interaction that occurs with peers on issues related to their sexuality especially during non-school hours, which day students lacked, probably accounted for more day students having knowledge of contraceptives than day students. One would have expected more day students to possess this knowledge than their counterparts given their exposure to information from the media and closeness to family at

home but this finding shows the limited access to information on their sexuality especially from the family.

In this study, though (66.2%) favored making contraceptives accessible to sexually unmarried young people, less than that percentage (59.2%) actually had intentions toward contraceptive use. This disparity in their responses is perhaps attributable to the perceptions they have developed toward contraceptive use. Studies have reported a general feeling of embarrassment associated with contraceptives use by young people. Glover et al 2003 study on "Sexual Health Experiences of Adolescents in Three Ghanaian Towns" showed that shyness and embarrassment about purchasing contraceptives served as a significant barrier to contraceptive use. Another study in the Central region of Ghana also reported that 40% of respondents indicated that young people or adolescents who use contraceptives are bad boys and girls (Hagan et al., 2012). The fear of being regarded as promiscuous could thus have contributed to less than a third of respondents of this study showing any intentions toward contraceptive use.

For the 40.8% respondents who had intentions toward contraceptive use, the male condom emerged as the most preferred followed by the pill and injectable. Results also showed that more females had preference for injectables and pills by females than their male counterparts. This finding corresponds with findings from other studies (ACDEP 2008, Enuameh et al, 2015). Literature suggests the situation could be attributed to the discreetness in the use of these methods considering the fact that society frowns on young people being sexually active.

Results also indicated that the religion of a respondent had no influence on his/her knowledge of contraceptives, but it however had influence on a respondent's attitude toward making contraceptives accessible to young people. In religious groupings, 62.9% of Moslems were of the view that contraceptives should be made accessible to sexually active unmarried young people whilst 76.9% Catholics and 75% Protestants favored access to contraceptives by young people.

According to respondents who didn't have any intentions toward contraceptive use, premarital sex was regarded a sin against God, a position held by both Christianity and Islam and they were therefore expected to abstain from sex till marriage. Contrary to this abstinence philosophy, the study, like other studies in Ghana (Ogbada 2013 and Awusabu-Asare et al. (2006) revealed that young people are sexually active. In this study, 35.6% of respondents were sexually active with some engaging in very risky sexual practices such group sex where several guys have sex with the same girl interchangeably within the same period.

For sexually active respondents, 15.9% used the male condom with 6.2% using the female condom and 7.2% using the emergency contraceptive. The likely effects, infertility, disruption of the menstrual cycle, of some modern contraceptives came up as a reason for some respondent's especially female's intentions not to use some specific modern contraceptives. Information received from society on the effects of contraceptives such as pills and injectables appeared to have negatively influenced respondents, especially girls' perception of these methods. Focus Group discussion revealed that some respondents perceived these methods to be exclusively for married women and was therefore a no go area for them. This corroborates with the findings of Williamson et al. (2009) and Hagan

et al., (2012) who also reported similar findings. However the difference in this study is that young women did not report any barriers to condom use which is thought to be more accessible and more attractive than hormonal contraceptives. In Williamson et al. (2009) study, use of condoms by women was limited by their association with disease and promiscuity and greater male control.

The low level of contraceptive utilization is been cited to be a function of both the limited capacity of health system and the framework within which these services are offered. Other hindrances found to be associated with this challenge are risk perception (the lower the risk perception to acquiring STIs and pregnancy, the lower the use of contraceptives), insufficient knowledge with which to make choices regarding contraceptives and also opposition from male partners (PRB, 2008 cited from Hagan et al., 2012).

Among young people, feeling comfortable to with carrying condoms and their availability are important prerequisites for condom use. Sexual and reproductive health interventions aiming at increasing the use of condoms may have good chance of success if they include teachings on how to obtain condoms from public stores and how to carry them about without feeling embarrassed. Initiatives that support the supply of free condoms in places such as the wash room have higher chances of breaking barriers to condom use especially among young people with high risk sexual behavior (Krugu et al., 2016)

Also, respondent's misconception and limited knowledge about how conception occurs influenced non use of contraceptives. Conception was associated with the position assumed during sexual intercourse; pregnancy was said only likely to occur when partners assumed the missionary position during sexual intercourse. This misconception about conception

and poor attitudes toward contraceptive use raises the need for comprehensive sexuality education to equip them with the right information, values and attitudes to make the right decisions.

5.2 Access to Sexual Health Services

FDGs with students revealed that attitudes of health workers and parents were found out to be an obstacle to accessing sexual health services. The environment of most health facilities creates a lack of confidence for young people to access the services they require. Coupled with this was the judgmental attitude of some health personnel. This finding agrees with the results of a number of earlier studies. Tilson et al. (2004) for example found that that the lack of privacy at clinics constituted a barrier to seeking treatment for STIs by young people. In the same vein, even though Kumi-Kyereme et al. (2014) agrees that judgmental attitude and turning away of clients who seek STI treatment by health care providers creates a barrier between the provider and the client but they also point to the fact that the approaches sometimes adopted by the providers in the treatment of STIs are in line with the protocol of the Ghana Health Service in dealing with treatment of STIs. Treatment protocol for gonorrhea for example demands that the person seeking treatment should come along with his or her partner for both to be examined and treated.

In addition to the judgmental attitudes the lack of privacy at health centers, participants also indicated that they sometimes do not trust health workers, especially women, to keep sexual health complaints a secret. Female health workers were seen as talkative and divulging confidential issues to third party including parents of students.

The sex of the health worker was also identified to have an influence on young people accessing health services. FGD respondents revealed that they would prefer to be attended

to by health workers who are of the same sex as them. Male respondents especially expressed the need for this as they usually feel uncomfortable talking to female health workers and are most likely to change the story and give a different complaint when being attended to by a female health worker.

To make health facilities more accessible to young people, such facilities must be youth friendly. The settings must be comfortable and appropriate for them. In this regard, separate spaces and special time must be created for young clients. Youth friendly services should also meet the needs of clients and should also include follow-up strategies to retain their clients.

Having specially staff that is trained to work competently and sensitively with young people is often considered the single most important condition for establishing youth-friendly services. Trained staff must possess knowledge and familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity. Moreover, they must also possess interpersonal skills so that young people can be at ease and comfortably communicate their needs and concerns. Youth clients been reported to feel more at ease to openly discuss issues where service providers are of the same sex or age with the young clients (Senderowitz, 1999).

Privacy and confidentiality which rank extremely high among young people must also be ensured. Though young people must feel confident that their important and sensitive concerns are not retold to other persons including their parents., it has however been established that common fear expressed by young people is that the nurse will tell their mothers that they came to the clinic for RH care (Marie Stoppes 1995 cited from Senderowitz, 1999).

Even though consistent with other studies (Kumi-Kyere et al., 2014, Mbonile et al., 2008) parental attitude was generally found not to be encouraging when the need to seek sexual health services arose, this study however found that, mothers were considered to be more understandable than fathers in dealing with sexual health challenges like unplanned pregnancies.

Though the National Health Insurance Scheme subsidizes the cost of some health services, the cost of seeking medical attention and treatment for certain sexual health related diseases and problems still remains a challenge for our young people who are especially dependent on parents for their livelihoods. In most cases, the full cost of seeking medical attention in these areas is borne by the patient without any form of subsidy. The need for subsidizing the cost of treatment of sexual health ailments or even the provision of some form of routine screening and treatment for young people in and out of school is very important. This could help prevent life time damages to those who might be engaged in risky sexual behaviors.

For those within the boarding house system, the distance and cost involved in visiting a health facility for medical attention appeared to be a challenge. Respondents therefore called for the construction of school clinics within campuses where they could easily seek the needed attention.

5.3 Perceptions of School-Based Sexual Health Education

School-based sexual health education was recognized by both teachers and students as very important for providing the knowledge, values and attitudes needed to make informed decisions in matters related to sexual health. Yet the findings of the study suggest that the sexual health education component of the program within Senior High Schools is far from

being comprehensive. What is currently available on the program has to do with lessons on the reproductive system within Integrated Science where emphasis is on academic interest and in Religious and Moral Education where the concept of sin limits discussions on the issue. Despite acknowledging the importance of sexual health education to young people, teachers in this study were not in favor of including topics such as contraceptives use and comprehensive abortion in the school curricula. Teachers rather favored students with biology-focused pubertal related information to students. Results also indicated that both teachers and pupils are more concerned with subjects that are examinable in final WASSCE and not sexual health education which is non-examinable. This is however contrary to a number of studies (Rijsdijk et al., 2011, Kirby et al., 2007) that argue that Comprehensive/Interactive and participatory based learning is effective for the development of the right values and attitudes enabling them to question and form their own values and attitudes (IPPF, 2009). The mere integration of some aspects of sexual health into Biology and Integrated Science may not be sufficient to give students the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality.

The findings also point to the fact that the current method of sexual health education in Senior High Schools has the challenge of availability of adequate class time allocation as well as the appropriateness of the class setting for achieving the desired results. Studies (Aransiola et al., 2013, Kirby, 2002) found that programs aimed at attitudinal and behavioral changes must not just be theoretical but have effective and comprehensive counseling components which are characteristic of being responsive to the practical issues confronting sexual and behavior challenges of young people. This type of environment

provides the opportunity for counselors to help solve personal issues of students that cannot be disclosed within the classroom setting.

The unfavorable attitude of teachers toward comprehensive sexual health education was found to be triggered by the fear that young people who are not sexually active now, out of curiosity, may end up being enticed into experimentation with sex once they have knowledge about sex. Educating young people about contraceptives and where to acquire them was considered an encouragement for them to be sexually active. During FGD discussions, participants noted that religious leaders also use the Holy Books to renounce sex education for unmarried young people. They accept however that the situation is already beyond control with many young people becoming sexually active outside marriage even within Faith groups. Notwithstanding this, they still hold that giving unmarried people knowledge about contraceptives may urge on the tide of destruction - eroding values further. Indeed this finding may explain the very recent dilemma presented by the mass media of one pastor canning adolescents who were supposedly engaged in 'fornication' - sex outside marriage (GhanaWeb 18/08 2016, article 463436). The situation has raised a divided front among society with many arguing for the right of the individual under human rights precepts against others using the Holy Books to justify the action.

FGDs further reveal that discussions about sexuality in Ghana and many other African cultures is seen as a taboo, giving the responsibility of discussing sexuality related topics with young people to grandparents and aunties. Ceremonial/puberty rites like "dipo" are also occasions usually used to educate young people about their sexuality. This is largely quite limited to moral injunctions, dos and don'ts. It was the consensus of FGD participants that the society has advanced beyond just giving moral instructions. The sensitivity

surrounding sexual talk to young people today has therefore compelled parents and other family members, teachers and society as a whole to give very limited information to young people on sexuality. The study showed that a combination of cultural and religious prohibitions made it difficult for teachers to openly teach students about sexual health. Teachers were afraid of being criticized by parents for teaching their wards about sexuality in an environment where discussions on sex and sexuality is considered a taboo or "haram". Teachers were said to be quite shy, very cautious and often using awkward euphemisms when referring to sexual organs and other sexual-related issues which in most cases leave students more confused. Under such circumstances, students, for fear of being regarded as profane or loutish find it difficult asking questions. The desire of Teachers to protect their image therefore creates the objection to teaching certain sensitive topics in sexual health. The literature Iyaniwura (2004) suggests that teachers should be educated on why it is important to discuss sexuality related topics with young people as sexuality does not necessarily encourage. In addition, she also suggests that teachers be trained to develop effective communication skills to put them in a better position to teach sexuality education. Implementation of school-based sex education programmes should also include community sensitizations to educate parents and community members on the importance of sex education to their children's well-being. Doing so would prevent the situation where parents tag or violently confront school authorities for talking about sex with their children.

Owning to the inability of teachers to confidently discuss sexuality topics with students, it is not surprising that a majority (70.4%) of student respondents were unsatisfied with what they are taught in school as part of sexual health education. Students indicated their preference for personnel from NGOs to handle Comprehensive Sex Education in schools

registers their unmet need. Findings therefore suggest that students did not perceive that sexual health education was given the needed attention in schools. Student's personal, health and social development was considered secondary to their academic success. More attention was given to examinable subjects and how to prepare students to pass exams.

There was a general desire by students for in depth information about their sexuality, sexual health challenges during that stage in life and how to address such challenges and also information on how to handle sexual relationships with the opposite sex. Findings showed that the sexual and reproductive health education program (NO YAWA) for young people initiated by Marie Stoppes International for example was very popular with students.

5.4 Challenges to School-Based Sexual Health Education

Discussions about sexuality in Ghana and many other African cultures is seen as a taboo, giving the responsibility of discussing sexuality related topics with young people to grandparents and aunties. Ceremonial/puberty rites rights like "dipo", are also occasions usually used to educated young people about their sexuality. The sensitivity surrounding sexual talk has therefore compelled parents and other family members, teachers and society as whole to give very limited information to young people on sexuality. The study showed that a combination of cultural and religious prohibitions made it difficult for teachers to openly teach students about sexual health. Due to these prohibitions, teachers often emphasized the moral aspects of sex and sexuality thereby condemning sex before marriage, the use of contraceptives and abortion on moral grounds.

The morally sensitive nature of sexuality was identified as something scaring teachers from discussing this topic with students for fear of being criticized by parents for teaching their

wards about sexuality in an environment where discussions on sex and sexuality is considered a taboo or "haram." Effective delivery of CSE by teachers requires support from school authorities, colleagues and communities. A clearly stated school policy on sex education facilitates implementation of sex education (Schutte et al., 2013). Where school policy and social support from communities are lacking, teachers are constrained to deliver quality CSE to students.

Moreover, teachers were reported of being shy and often resulted to the use of euphemisms when referring to sexual organs and other sexual-related issues which in most cases leave students more confused owing to the lack of understanding of such euphemisms. Under such circumstances, students, for fear of being regarded as spoilt or promiscuous find it difficult asking for further explanations.

If teachers who function as instructors and role models are to empower young people in their care with life-saving knowledge and skills on sexual and reproductive health, they must be competent, confident and comfortable to offer comprehensive sexual education. To be competent and confident therefore implies that teachers must be trained to acquire participatory teaching skills that would enable them to discuss sensitive without shyness and also in a non-judgmental and rights-based. The development and sustainment of teachers' capacity and effectiveness is therefore critical to the delivery of good quality (UNESCO, 2005). Shyness on the part of teachers that result to use of euphemisms when discussing sexuality in class implies lack of training for teachers and ineffective sex education in Ghanaian schools. The failure of society as well as teachers in openly communicating with young people about their sexuality has implications for society as a whole. Young people

would not be able to make informed decisions regarding their sexuality due to the lack of a comprehensive education on their sexuality and health.

Studies have shown that a well-structured programme curriculum is a prerequisite for a successful implementation of sex education. The curriculum provides procedural guidelines for implementation thereby ensuring thorough completeness and fidelity of programmes. Unlike other studies(Schutte et al., 2014 &Renju et al., 2009) that had curriculum and other supportive teaching materials as well as a specified time for teaching sex education,, this study reported inadequate teaching materials and insufficient time for lessons on sexual health. Besides the Integrated Science and Biology text books, there appeared to be no other form of teaching and learning materials in the schools despite respondents' desire for educational materials that are interactive and that which give real live experiences. The content and level of implementation of the curriculum is also an important element of successful sex education programmes. Only programs delivered with sufficient completeness (quantity of the program) and fidelity (implementation according to the program guidelines) may result in positive health outcomes.

Though the current study found no specific allocated time for teaching sexuality education, the only time frame within which students get to learn about their sexuality was during Science and this lessons was said to be woefully inadequate as issues bothering sexuality only come up only sporadically. There was therefore a general consensus among FGD participants for the allocation of a specific days and time period for teaching sexuality education to enable them acquire the knowledge, skills, attitudes and values required to make informed decisions. Giving a specific time on time tables for sex education would ensure that such programmes are delivered according with completeness and fidelity.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The overall objective of this study was to assess the perspectives of Senior High School teachers and students on school-based sexual health education in the Tamale Metropolis. The findings from the study showed that majority of students have adequate knowledge about the physical changes that take place during puberty. This common knowledge of students on these changes was attributed to the fact that discussions on the subject permeate almost all subject areas including even the physical sciences. Though students had this knowledge, their understanding of when and how conception takes place. The study showed that young people hold several misconceptions on how pregnancy could occur. To most of them, the pregnancy was associated with the position assumed by the woman during sexual intercourse. The missionary position was associated with woman getting pregnancy.

Young people in this study also expressed good knowledge on contraceptives with a considerable proportion using contraceptives. However, the fear of the negative effects of some modern contraceptives appeared as a barrier to their use especially by females.

In spite of demonstrating considerable good knowledge of physical changes associated with puberty and contraceptive, Respondents nonetheless expressed dissatisfaction with current education they receive in school on their sexuality.

The study also revealed the current challenges confronting the discussion of sexuality issues with students in school. Teachers are not able to freely communicate with young

people on topics related to their sexuality. Students on the other hand are also afraid to talk openly or ask questions on sexuality for fear of being tagged as being promiscuous. Religious and cultural beliefs were raised as barriers to the teaching and learning of sexuality education in the schools.

It was also found that schools also lack the necessary teaching and learning materials to facilitate sexuality education. Apart from the Integrated Science and Social Studies text books, there are no other educative materials for young people to learn from. In effect, the knowledge, skills and attitude these young people need to make decisions concerning their sexual life is woefully limited.

6.2 Recommendations

6.2.1 Recommendation for a National Sexuality Education Policy

There is the need for the formulation of national policies and standards for sexuality education and a system for monitoring sexuality education programs to ensure the attainment of high standards and uniformity in SHS. The policy should come along with a well-structured curriculum and supportive teaching materials.

In the development of national policies, stakeholders from the religious denominations, Ghana Health Service and NGOs in sexual and reproductive health should be involved. There is the need for parents to be informed of sexuality education curriculum to generate their support for such a program

In addition to the above, a national policy should also be put in place that would ensure the provision of adolescent friendly clinics at campuses of Senior High Schools to address the

sexual and reproductive health problems of pupils. If this is put in place, students would find it easy and comfortable to visit such clinics for health care.

For effective development and implementation and monitoring of school curriculum sex education programmes, it is critical that teachers be properly trained to teach the subject. It is also important that such training be extended to those who develop the curriculum, who train, support and manage teachers.

6.2.2 Recommendations for NGOs in Health

Non-Governmental Organizations should dedicate more resources for Sexuality Education for young people especially for those in Second Cycle schools as it is in these schools that most get influenced negatively to adopt risky sexual behaviors. Civil Society actors on Sexual and Reproductive Health must also invest in research to come out with evidence-based sex education programmes for young people and also. Building knowledge and expertise would also better position civil society actors to advocate for SRHR for young people.

6.2.3 Recommendations for classroom sexual health education

There is also the need to make available high quality and professional teaching resources that meet the needs of young people and such materials should be interactive, realistic, more visual and less text. Visual materials could be on the male and female reproductive organs and pictorial representations of symptoms of some STIs like gonorrhea, syphilis, genital warts among others. This would help students better appreciate lessons delivered and also the consequences of indulging in risky sexual behaviors.

From the study it was found that integrated science teachers who are mostly males are responsible for teaching young people about their sexuality with little room for female teachers. Conscious efforts should therefore be made to involve female teachers in teaching sex education especially in the teaching of topics like the menstrual cycle, contraceptives and issues related to pregnancy.

Teachers need to also adopt a teaching style that is interactive, participatory and pupil centered. During lessons, students must have the opportunity to freely ask questions and make contributions without intimidation. Schools should also create more opportunities for young people to learn from experts in areas related sexuality and relationships.

6.2.4 Recommendations for professional development

There should be a national policy for teacher trainees to be educated on young people's sexuality. In addition to this, they should also be trained to develop their interpersonal skills in order to become effective communicators with young people. These would enable them to become effective sexuality educators to young people.

6.2.5 Recommendation for further research

This study revealed the dissatisfaction of young people with what is taught in school as sex education. Future research should explore the challenges facing young people in relation to their sexuality. This would help inform what needs to be included in the syllabus of school-based sexuality education. Future research should also be geared towards assessing parental attitude and support for school-based sexuality education in the Tamale Metropolis. There is also the need to research into evidence-based sex education

programmes to inform the design of appropriated interventions in Ghana that would give young people the needed information and education on their sexuality.

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APPENDICES

Appendix 1: Questionnaire

Thesis Tile: School-based sexual health education, Perspectives of teachers and students in senior high schools Tamale Metropolo /Sagnerigu District.

SECTION 1: SOCIO-DEMOGRAPHIC DATA

1. Sex

1. Male

2. Female

2. Age …… (years)

3. Religion:

1. Moslem
2. Christian (protestant)
3. Traditional religion
4. Christian (catholic)
5. Others (specify)……..

4. Type of school: ……

5. Status of student

1. Day student
2. Boarder

SECTION 2: Students' Sexual Health Knowledge and Practices

6. As girls grow and mature, certain physical changes occur in their bodies. List three of these changes

1 ……..

2 …….

3 ……..

7. Certain physical changes occur in the bodies of boys as they grow into adulthood. List three of these changes

1……

2……

3……

8. When girls mature, they start to menstruate. At what age did you have your first menstrual period? …… (Years).

9. How did you feel when you experienced your first menstrual period?

1) Shy 2) Normal 3) Embarrassed 4) Scared

10. Did you receive any education on menstruation before you started menstruating?

1) Yes 2) No

11. If yes in 9 above, from which source did you receive such education?

1) Mother 4) School

2) Father 5) siblings

3) Friends 6) Other (specify)……..

12. Can a girl get pregnant even before her first menses?

1. Yes 2. No 3. Don't know

13. Can a girl who has experienced her menarche get pregnant the very first time she has sex?

1. Yes 2. No 3. Don't know

14. In the process of unprotected sexual intercourse between a boy and a girl, is it possible for the girl to get pregnant if the boy withdraws before ejaculation?

1. Yes 2. No 3. Don't know

15. Do you know of any contraceptives?

1. Yes 2. No

The table below contains a list of contraceptives. Answer question 16 and 17. Then proceed to answer question 18 if your answer to 17 is YES.

LIST OF METHODS	Q.16) Have you ever heard of method?	Q.17 Have you or your partner ever used method	Q.18 The last time you used this method from where did you obtain it?
PILL: Women should take every day	1. Yes 2. no	1. yes 2. no	……
IUD: a coil or loop placed in the womb by a doctor or nurse	1. yes 2. no	1. yes 2. no	……
INJECTABLE (DEPO): injection which prevents women from becoming pregnant	1. yes 2. no	1. yes 2. no	……
DIAPHRAGM/FOAM TABLETS/JELLY: women place insert before sex	1. yes 2. no	1. yes 2. no	……
FEMALE CONDOM: rubber sheath women insert in the vagina before sex	1. yes 2. no	1. yes 2. no	……

MALE CONDOM: rubber sheath men wear on the penis during sexual intercourse	1. yes 2. no	1. yes 2. no	……
NORPLANT (JEDELLE): small rods placed under the skin of the left upper arm	1. yes 2. no	1. yes 2. no	……
EMERGENCY CONTRACEPTIVE: Pill taken by women within 72 hours after unprotected sex	1. yes 2. no	1. yes 2. no	……
VASECTOMY: Cutting of the sperm cords and tying them to prevent the flow of sperm(permanent method)	1. yes 2. no	1. yes 2. no	……
TUBAL LIGATION: Cutting and tying the fallopian tubes to prevent fertilization (permanent method)	1. yes 2. no	1. yes 2. no	……
NATURAL METHOD; Billings' method, menstrual cycle method	1. yes 2. no	1. yes 2. no	……
WITHDRAWAL METHOD: withdrawal of the penis before ejaculation	1. yes 2. no	1. yes 2. no	……

19. Among the methods of contraception you know, which method prevents both sexually transmitted infections and pregnancy? ……

20. Should sexually active unmarried young people be allowed to have access to contraceptives?

1. Yes 2. No

21. Explain your answer to 20 …….....

……

……

……

Young people have sex for various reasons - love, because they feel like it, because they are forced or tricked.

22. Have you ever had sex?

1. Yes 2. No

23. If you ever had sex, how old were you?

…….. Years

24. Have you ever been pregnant or impregnated a girl?

1. Yes 2. No

25. How old were you when you became pregnant or impregnated a girl?

…… Years

26. What would you do if you were pregnant or your partner was pregnant?

1. Stop schooling and keep the pregnancy

2. Get an abortion and continue schooling

3. Don't know

27. Do you know what girls sometimes use to cause abortion? If you do, name some of these materials.

……

……

28. If you were pregnant or impregnated a girl and wanted to get an abortion where would you go?

1. Go to health facility 2. Go to drug store for drugs 3. Go to private service provider

3. Go for local medicine 4. Other (specify)……

29. Would you ever consider using any contraceptive method?

1. Yes 2. No

30. If yes, which of the contraceptive methods would you prefer to use?

.....

31. If no, why wouldn't you want to ever use a contraceptive?……

……

……

……..

32. From which of the following sources can you comfortable request for a contraceptive if you wanted one?

1. Drug store
2. Health facility
3. Local community seller
4. Peer educators
5. Friends
6. Other(specify)…….

33. What do you know to be the possible side effects of some modern contraceptives? Name those contraceptives and give the side effects……

……

……

34. Have you ever experienced any of the following symptoms in the table below? Tick(√) as many as apply

SIGN	yes	No
White (Candida)		
Painful urination		
Swelling of the scrotum(boys only)		
Itching around the genitals		
Vaginal discharge (girls only)		
Discharge from the penis(boys only)		

35. If you have ever experienced any of these signs and symptoms what did you do?

1. Did not seek for treatment
2. Treated myself with local medicine
3. Went to the health facility
4. Went to drug store for treatment

36. What would you do if you start experiencing symptoms of STIs?

1. Go to the health facility for treatment
2. Go to the drug store for medicine
3. Leave it to go on its own
4. Treat it with local medicines

The following questions are to determine whether you have received adequate information on sexual health, STI and HIV/AIDS from school.

37. In the table below, provide information about whether you agree or disagree on the statements given. Tick (√) **Agree, strongly agree, undecided, disagree or strongly disagree**.

Item	Agree	Strongly agree	Undecided	Disagree	Strongly disagree
I have received information on emotional changes related to adolescent development					
I have received information on the physical changes that occur during adolescence					
I have information on where STIs and HIV counseling and testing services are provided					
I have had information on various types of contraceptives					

I have received information on how to effectively use some methods of contraceptives					
I have received information on the side effects of some contraceptives					
I have received information on where to acquire contraceptives					
I have received information on the consequences of unplanned pregnancy on my health					
I have been educated on the need to refuse unprotected sex					
I have been educated on the effects of negative peer pressure on risky sexual behavior					

I am satisfied with what I am taught in sexual health education					

The following questions seek your assessment of your teachers regarding the teaching of sexuality education. To what extent do you agree with the following statements?

ITEM	Agree	Strongly agree	Undecided	Disagree	Strongly disagree
Teachers in this school take teaching sexual health education seriously					
Teachers motivated me to learn about sexual health					
The teacher motivated me access valid information and sexual health services					
The teaching strategies used in school helped me learn how to practice safer sex					

38. Which of the following teaching aids are used during sexual health education? (tick all that apply)

1. Audiotapes 2. Textbooks

3. Newspapers and magazines 4. Video tapes

5. Pregnancy, HIV/AIDS, and STIs prevention materials such as posters, pamphlets, pictures

39. Do you think the time allocated for teaching sex education is enough for you?

1. Yes 2. No

40. Do you think sex education is relevant to you as a young person?

1. Yes 2. No

41. Explain your answer to the above question

……

……

……

Appendix 2: In-depth Interview Guide for Teachers

1. As we live in an era of technological evolution with so much social media such as face book, whatsapp, viber, etc, how would you describe the sexual behavior of your students?

Probe for

i. Whether (students) are sexually active

ii. Cases of girls becoming pregnant in this school

2. In your opinion do you think a girl can get pregnant even before her first menses?

3. In the process of unprotected sexual intercourse between a boy and a girl, do you think it is possible for the girl to get pregnant if the boy withdraws before ejaculation?

4. In your view does sexual health education program address all that students need to know about their sexuality?

What areas of young people's sexual health are taught as part of sexual health education? (Probe if it includes; understanding of their sexuality, contraceptives, abortion, development of skills related to sexual relationships; negotiation and assertive skills)

5. From your experience as a teacher, how do you think sexual health education program should be organized? Should sexual health education include the details such as the menstrual cycle and pregnancy, contraceptive usage and abortion services?

6. Would you say you have been given the necessary training to teach students on their sexual health?

7. How would you describe students' attitude to sexual health education lessons?

8. What would you say are some of the challenges associated with school-based sexual health education?

Probe for i. Allocated time for teaching the subject ii. Teaching aids iii. Social and cultural iv. Religious factors

Appendix 3: Focus Group Discussion Guide for Students

1. In your view does sexual health education program address all that you need to know about your sexual health as young people?

2. What information do you wish to know about your sexual and reproductive health that you are currently not being taught? Why would you consider that information important?

3. Apart from what you receive from school, what other alternative sources do you get information from in relation to your sexual health? (Probe for whether they receive sexual health education from health workers or NGOs)

4. Considering the current methods of teaching sexual health education in this school, how do you think it should be done to meet your expectations?

5. How would comprehensive sexual health education have impact on your attitudes to sexual health? (Probe if it would help them delay sex till marriage, empower them to use contraceptives if sexually active, seek screening and early treatment for STIs)

6. How would you describe teachers' attitude to teaching sexual health education?

7. As a second cycle institution, guidance and counseling services are very important for the emotional health of the students. How can you describe the nature of providing these services in your school especially in relation to your sexual health?

8. Access to information on the sexual health has been a challenge to most young people. Would you say you have access to the appropriate sexual health information and sexual health care services as young people? (Financial, geographical, attitude of providers and parents)

9. What would you say are the barriers that make it difficult for you to access information and sexual health care services?

10. What in your opinion are some of the challenges that make teaching of sex education in schools difficult?

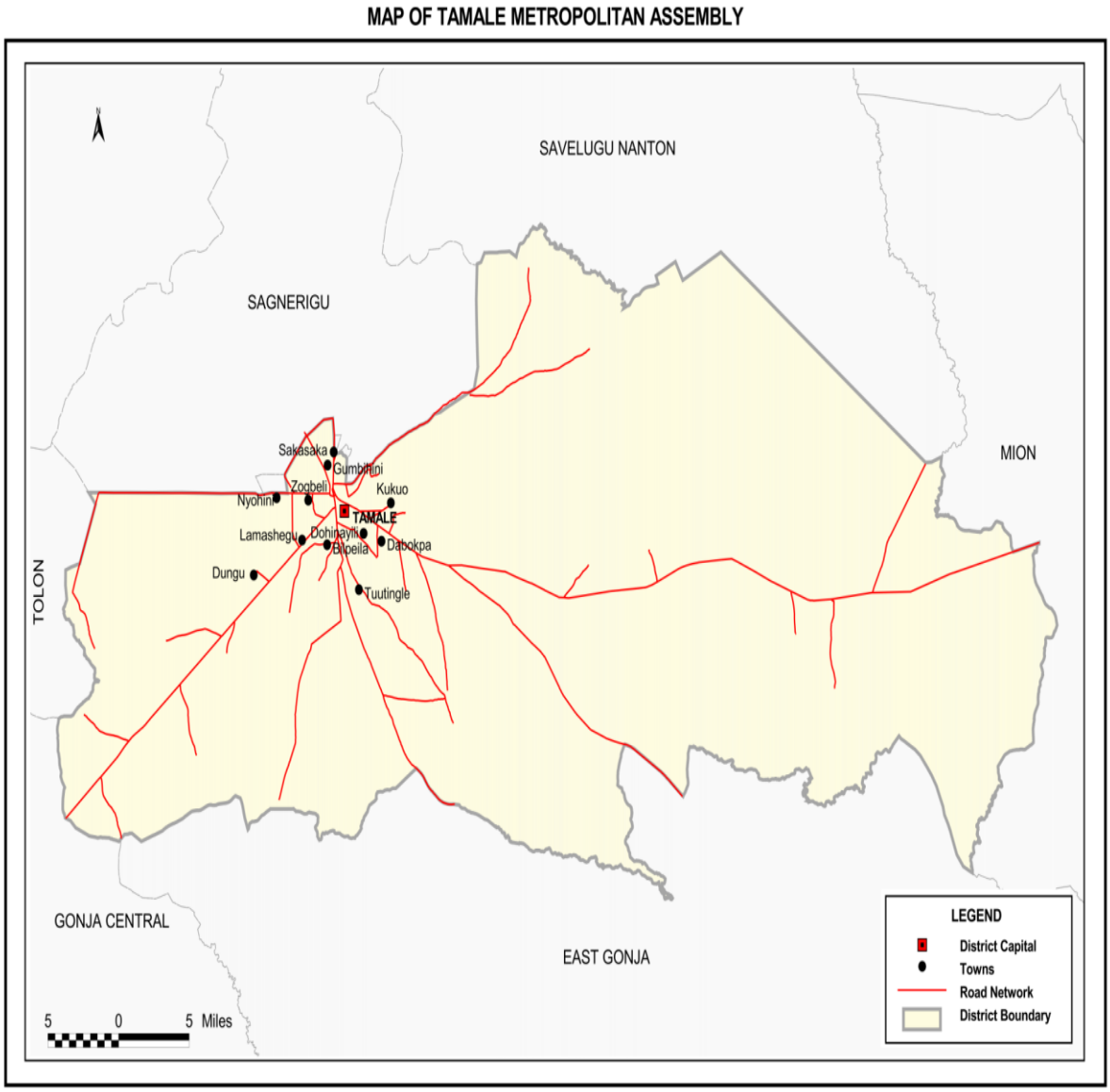
i. Social and cultural barriers

ii. Religious barriers

iii. Teaching aids

How can these challenges be addressed to improve the teaching of sex-education in schools?

Appendix 4: Map of Tamale Metropolis



Source: Ghana statistical service (2010)