UNIVERSITY FOR DEVELOPMENT STUDIES

# SEXUAL BEHAVIOUR OF ADOLESCENTS IN SENIOR HIGH SCHOOLS IN THE EAST MAMPRUSI DISTRICT OF THE NORTHERN REGION

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**BY**

**AZUMAH WAJAK MABALIM (B.A. Population and Family Life)**

**UDS/CHD/0225/15**

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

**OCTOBER 2018**

## DECLARATION

**Student**

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

Candidate's Signature:……...…… Date:…….……

Name: Azumah Wajak Mabalim

**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.

Principal Supervisor's Signature:……

Date:……

Name: Dr. Evam Kofi Glover


## ABSTRACT

The study aimed at assessing the sexual behavior of adolescents in selected Senior High Schools in the East Mamprusi District of Ghana. Cross-sectional descriptive study design was used with multistage sampling technique to sample 405 respondents from two randomly selected Senior High Schools in the East Mamprusi District. The study adopted an integrated mixed-methods approach to data gathering, using questionnaires to gather data from students. Sexual practices were seen as diverse. Generally, penile-vagina penetrative sex was considered the ultimate sex by all respondents. Slightly more than half of respondents (53.1%) have ever had penile-vagina penetrative sex. More females (62.1%) than males (38.8%)) were likely to have reported ever having penile-vagina penetrative sex. Majority of respondents (62.1%) had their sexual debut between ages 14 and 17 years. On the issue of sources of sex information, the data revealed that respondents received sex information from teachers (56.6%); family members (24.4%) and friends (14.1%). Slightly more than half of respondents (54%) consider that sex education by parents is empowering in the delay of sexual debut. On the issue of parent-adolescent communication on sex and sexuality a bivariate analysis of the relationship between parent-adolescent sexual communication and the sexual debut of adolescents shows that there is a statistically significant relationship between sex education provided by parents and the sexual debut of adolescents with a p-value of (0.00). There is some support and recognition of the benefits of comprehensive sex education by students. The researcher therefore recommend the need for a more comprehensive sexual education programme by parents and school authorities across the country.

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my lovely wife Madam Azumah Zaharatu and all my younger siblings for their spiritual, moral and financial support throughout the entire period.

God richly bless you all

## DEDICATION

This thesis is dedicated to my late father Mr Wajak and to my mother Madam Saapoa and all those who might find it helpful to them one day



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## LIST OF ABBREVIATIONS

**AIDS –** Acquired Immune Deficiency Syndrome

**CDC –** Centres for Disease Control

**DHMT –** District Health Management Team

**GARHP –** Ghana Adolescent Reproductive Health Policy

**GHS** – Ghana Health Service

**GSS** – Ghana Statistical Service

**GYRHS** - Ghana Youth Reproductive Health Survey

**HIV –** Human Immunodeficiency Virus

**SSA –** Sub-Saharan Africa

**STIs –** Sexual Transmitted Infections

**UNAIDS**- United Nations Programme on HIV/AIDS

**UNFPA –** United Nations Population Fund

**UNICEF –** United Nations Children's Fund

**WHO –** World Health Organisation

## OPERATIONAL DEFINITION OF TERMS

The following definitions are applicable in this study:

**Adolescent** as used in this study refers to a person between the ages of 10 to 24 years.

**Negative Sexual Behaviour** refers to any sexual activity that increases the likelihood of unwanted pregnancies and contracting sexual transmitted infections (STIs) including HIV.

**Positive Sexual Behaviour** refers to any sexual activity such as sexual abstinence and correct and consistent condom use that promote healthy sexual outcomes.

**Sex** refers to the penetration of the penis into the vagina**.**

**Sexual Intercourse**: the concept of sexual intercourse used in this study is limited to sex in heterosexual relationship (penetrative vaginal sex).

**Sexuality** as used in this study refers to the set of behaviours associated with the ideals, desires, practices and identities linked with sex.

# CHAPTER ONE

## 1.0 INTRODUCTION

### 1.1 Background of the Study

The world is a home to about 1.8 billion adolescents between the ages of 10 and 24. The population of this cohort is increasing at a faster rate in the poorest nations of the world (UNFPA, 2014). The records show that adolescents have some peculiar challenges. For example research has shown that worldwide, more than 2 million adolescents between the ages of 10 and 19 are living with HIV/AIDS - one out of seven of all new HIV infections is an adolescent (UNFPA, 2014). In 2015, about 1.8 million adolescents were living with HIV globally. Out of this number, about 80% live in sub-Saharan Africa region which is the most affected by HIV/AIDS (UNICEF, 2016).

Adolescence represent the critical transition in the human life span which is characterized by rapid growth and development. Besides the physical and sexual maturation, other significant experiences during adolescence include the desire for social and economic independence, the development of self-identity, the development of skills needed to carry out roles and the capacity to develop abstract reasoning (WHO, 2016a). As adolescents go through these transitions, they tend to engage in activities that are risky to their lives now and the future including sexual relationship. This critical period characterized by physical, emotional and psychosexual changes, is also found to correlate with sexual maturity (Awusabo-Asare *et al.*, 2006; UNPFA & Paediatrics Board Review, 2012 cited in Attibu, 2015). In this regard, as adolescence is viewed as a time of opportunities, it also implies a time of considerable risk during which adult guidance and monitoring are

very crucial for the successful outcome of good health including sexual and reproductive health.

Adolescent sexual behaviour is highly relevant to different public health outcomes. These sexual behaviours can either be positive or negative (risky). For example, there is the general notion that positive sexual behaviours such as abstinence from premarital sex or the use of condom correctly and consistently by sexually active adolescents could lead to a healthy sexual and reproductive health outcome. Negative or risky sexual behaviour refers to any sexual activity that increases the likelihood of unwanted pregnancies and contracting sexual transmitted infections (STIs) including HIV. According to Ochieng (2013), common negative or risky sexual behaviours among adolescents include early sexual initiation, unprotected sexual intercourse, inconsistent use of condoms, having high-risk sexual partners (for example injection drug users, survival sex : sex in exchange for money, food, shelter or drugs), or having sex with a partner who has other partners or more than one partner at a time (sexual networking). These negative sexual behaviours expose the adolescent to harmful sexual and reproductive health consequences, both physically and psychologically. These adverse consequences include unintended pregnancy, sexual transmitted infections including HIV, abortion, major depression, post-traumatic stress disorder (PTSD) and suicide tendency (Ochieng, 2013).

The study of adolescents is crucial because decisions made during adolescents do not only affect the wellbeing of the individual adolescent but the wellbeing of the entire society in which they live (UNFPA & PBR, 2012 cited in Attibu, 2015). More specifically, negative sexual behaviours or experiences of adolescents have adverse consequences not only on the development of the individual adolescents but also on the



development of the communities in which they live (Attibu, 2015). More importantly, adolescents are not fully developed psychologically to understand the relationship between behaviour and consequence or the control they have over health decision making including those of sexual behaviour. These inabilities make them (adolescents) more vulnerable to sexual exploitation and high-risk behaviours (WHO, 2016a). Indeed since behaviour patterns for promoting positive healthy living including the values and attitudes established during this period are carried on to adulthood (GARHP, 2000), it is important to understand this cohort and their challenges.

Premarital sexual activities among adolescents lead to several adverse consequences including exposure to sexual transmitted infections (STIs) including HIV/AIDs, unplanned pregnancies, unsafe abortions and other sex related problems. With all these issues affecting the sexual and reproductive health of adolescents, there is there the need for baseline data upon which intervention programmmes could be formulated to help mitigate these adverse consequence of adolescent sexuality.



### 1.2.Problem Statement and Justification

The Ghana Adolescent Reproductive Health Policy (2000) defines adolescence as the period of life between 10 and 24 years. Adolescents account for about 32% of the total population of Ghana (GSS and UNFPA, 2013 p 5). Societal values, attitudes, and behaviour for promoting positive living including those of sexual and reproductive health are formed at this stage. The relevance of this has also been underscored by the Ghana Adolescent Reproductive Health Policy (2000). The policy calls for the education of adolescents and young people on their sexual and reproductive health needs.

Comprehensive sex education, among other things, has thus become an important concern to many stakeholders including parents, teachers, healthcare providers, programme managers, researchers, and the government.

This is especially because there is evidence to show that emerging societies especially developing countries like Ghana are faced with challenges of managing an ever bulging population of adolescents as a new phenomenon. Sub-Saharan African countries including Ghana have a large proportion of adolescents than any other region in the world. Young people between ages 10 and 24 for example account for about 32% of the total population of Ghana (GSS & UNFPA, 2013 p 5). Caring for this category of people in terms of their sexual and reproductive health needs is very crucial to ensure a healthy population for development. However, various studies have shown a disturbing trend of increasing rate of premarital sex and a decreasing age of sexual debut among adolescents. This has a historical trajectory. In much of the traditional society in Ghana for example, young people were given into marriage at puberty to avoid sex/childbirth outside marriage. Formal education combined with the strong influence of Christianity has made an indelible influence over the period of marriage in Ghana. This has culminated in the emerging phenomenon where because of long formal education including acquiring relevant professional training, many young people postpone marriage/childbearing. Even for those sexually active, the easy accessibility and availability of more effective use of modern contraceptives have made the big difference. These have combined to produce the cohort (adolescents) who are "biologically mature to have sex but are generally considered as socially immature for pregnancy and/or marriage" (Glover, 2015). Hence, sexuality has changed over the past few decades with adolescents now reaching physical

maturity earlier and marrying late in life (Tulloch and Kaufman, 2013). The role of parents and other significant others on the life of adolescents in relations to premarital sexual activities including unwanted or unplanned pregnancy, sexual transmitted infections(STIs), sexual violence and sexual coercion has therefore become an issue of public health concern.

A number of studies have been done in the area of adolescent sexuality in sub-Saharan Africa including Ghana. For instance, Glover *et al.*, 2003 in their studies of adolescent sexual experience in Ghana found that about 52% of adolescents in Ghana had had sex. Several other studies (Kumi-Kyereme, Awusabo-Asare & Biddlecom, 2007; Kumi-Kyereme, Awusabo-Asare & Daeteh, 2014) have also shown the varied challenges confronting adolescents. There is evidence for example that adolescent sexuality has many challenges including the upsurge of sexual transmitted infections including HIV/AIDS and unintended pregnancies. It is estimated that almost two thirds of premature deaths and one third of the total disease burden in adult's age can be traced to behaviour patterns that began in their youth days (Fares & Raju, 2007 cited in WHO, 2007).



In Ghana, the rates of teenage pregnancies are high. According to Juliana (2016), 30% of all registered births in 2014 in the country were by adolescents and that 14% of adolescent ages between 15 and 19 years had begun childbearing. This does not auger well for the country since these young people are supposed to be in school. This growing number of unwanted adolescent pregnancy and childbirth implies that addressing the sexual and reproductive health needs of this segment of the society is urgently welcomed.

Related to these adolescent pregnancies is the issue of unsafe abortion. In Ghana, despite the illegal nature of abortion, the issue of unsafe abortion remains common. Even though the issue of illegal abortions is reported among the married in Ghana, the phenomenon is most associated with adolescents. Abortion is reported to be the second common cause of maternal mortality, accounting for about 11 percent of all maternal deaths in the country (Sedgh, 2010).

Data shows that sexual practices of adolescents are much of a risky situation as adolescents are noted for engaging in sexual experimentation. This is especially particular to the female adolescent. Data show that in Ghana, 11 percent of young women and five percent of young men had their first sexual intercourse before the age of 15, while 44 percent of young women and 27 percent of young men had first sexual intercourse by age 18 (GSS, GHS, & IFC International, 2015). In that study, it is reported that nearly all women and men are sexually active by age 25.

There is also evidence that the pressure on young people especially the female to have the necessary financial security especially for paying school fees and also to live comfortably has become a driving force for an emerging era in which permissive sex is becoming of public concern. There is anecdotal evidence that young girls especially target older sexual partners because of pecuniary gains. The Central Regional Health Directorate (Ghana Health Service) for example reports that the major sexual partners of adolescents include teachers, taxi drivers, small scale farmers, and small scale miners (Jonas, 2017). The issues of paying school fees, buying luxurious phones, buying expensive clothing, paying for hairstyle and so many others could be the motivation factors. These demands which

are irresistible to the adolescent are sometimes beyond the affordability of parents yet peer pressure dominates in decision making for most young people to conform.

Even though a lot of studies have been done about adolescent sexuality in Ghana, a critical review of the literature however suggests that the focus of most studies on adolescents in Ghana has been on in-school and out-of-school adolescents and the testing of knowledge, attitudes and practices on contraceptive usage and HIV/AIDS. There have however been no systematic studies in Ghana focusing on the issue of what adolescents consider as sex and sexuality and what type of sexual practices adolescents indulge in.

With reference to the study area (East Mamprusi District), there is anecdotal evidence that a new social order is emerging with the advent of improved social facilities including roads, schools, hospitals, modern religion, business centers and offices. This rapid social change has brought in its wake a new sense of society that is evidenced in significant alterations in the social structure including values and expectations of the people. For example, the phenomenon of urbanization in a hitherto prototypical rural environment is gradually engendering rapid social change with far reaching implications for sexual and reproductive health for especially young people. In recent development efforts, two major towns in the district (Gambaga and Nalerigu) have emerged as host to many educational institutions including the Youth Leadership Training Institute, the College of Nursing and Midwifery, the Gambaga College of Education, Nalerigu Senior High School, Gambaga Girls Senior High School and a host of several basic schools. These institutions attract a high number of adolescent migrants.

The major concerns of local authorities of East Mamprusi District has being the increasing rate of health problems associated with sex and sexuality among young people

in these emerging communities. The District Health Management Team (DHMT, 2015) Report, report of a worrying situation concerning HIV/AIDS in the district (DHMT, 2015). The DHMT report revealed that HIV/AIDS has been increasing sturdily from 14.2% positive cases of all those who voluntarily tested for HIV/AIDS in 2011 to 19.8% positive cases of those who did voluntary counseling and testing for HIV/AIDS in 2013. Modern contraceptive use has been found to be relatively low as new acceptors of family planning rose marginally from 30.9% in 2012 to 34% in 2013 among the people generally. The same report shows that adolescent pregnancies are on the ascendency as the incident increased from 745 adolescents in 2012 to 1034 adolescents in 2015. Related to these adolescent pregnancies is the issue of illegal abortion. The DHMT (2015), revealed that the incidence increased from 34 reported cases in 2011 to 142 cases in 2014. These adverse effects are worrying as these adolescents are the future of the nation.

Urbanism is steadily catching on especially in respect to the two major towns in the district (Gambaga and Nalerigu) as the destination of young migrants from the periphery. This is because, among other reasons, these two towns have become the center of education and also of markets, goods and services seen as the modern trend. Young people applying for college from especially rural societies migrate into these two towns to live and further their education in colleges including: the College of Nursing and Midwifery, the Gambaga College of Education, Nalerigu Senior High School, Gambaga Girls Senior High School and a host of several basic schools. These institutions therefore attract a high number of migrants. With this high number of migrants in and around the communities, there emerges that anonymity which fosters anomie and risky sexual behaviours leading to adverse consequences.

In order to understand the trends, programme managers are aware that there is the need for series of studies that could serve as basis for planning, implementation and monitoring of innovative programmes for the youth.

Even though a lot of studies have been done in the area of adolescent sexuality in Ghana, no systematic empirical work has been carried out to date among this segment of the population in the East Mamprusi District. A number of questions therefore remain unanswered. What activities do adolescents consider as sex? What are the sexual practices among adolescents? What do adolescents see as the strengths, weaknesses, opportunities and threats (SWOT) related to early sexual debut? How does parent-child communication affect sexual behavior of adolescents? These are matters of concern that this current study seeks to investigate.

The purpose of this study therefore is to assess the sexual behaviour of adolescents in Senior High Schools in the East Mamprusi District, Ghana.



**1.3.Research Questions**

i. What practices do adolescents consider as sex?

ii. What are the sexual practices among adolescents of the district?

iii. What are the sources of information about sex for adolescents?

iv. How does parent-child communication about sex affect the sexual behavior of adolescents?

### 1.4.0. Objectives of the Study

#### 1.4.1. Main Objective

The general objective is to assess the sexual behaviour of adolescents in the East Mamprusi District.

#### 1.4.2. Specific Objectives

The specific objectives of the study are to:

1. explore the practices adolescents consider as sex.
2. investigate sexual practices among adolescents.
3. find the sources of information about sex and sexuality among adolescents.
4. investigate parent-child communication patterns and how they affect adolescent sexual behaviour.



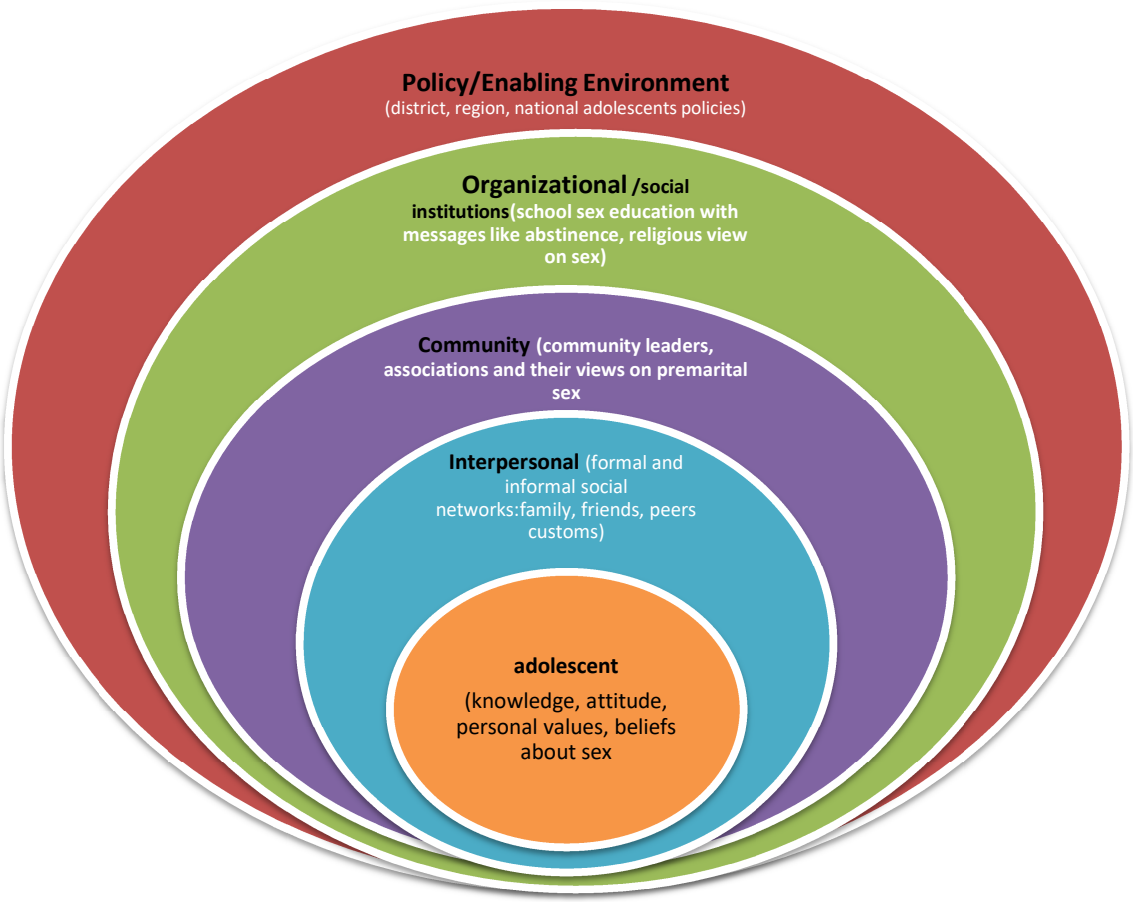
### 1.5. Theoretical Framework (Social Ecological Models)

This study has adapted a modification of the Social Ecological Model in explaining the attitudes and behaviour of adolescents in relation to sexual and reproductive health.

Rimer & Glanz (2005), frames the social ecological perspective as "...the interaction between, and interdependence of, factors within and across all levels of a health problem. It highlights people's interactions with their physical and socio-cultural environments." (pp 10)

The Social Ecological model of health behavior emphasizes the influence of the environment on a person's health behaviour including those of sexual and reproductive health. The model highlights people's interactions with their physical and socio-cultural environments. Two key concepts of the ecological perspective help to identify intervention points for promoting positive sexual health: first, the individual sexual behaviour both affects, and is affected by, multiple levels of influence; second, individual behaviour both shapes, and is shaped by the social environment (reciprocal causation). The model has five hierarchical levels which include: (1) intrapersonal or individual factors; (2) interpersonal factors; (3) institutional or organizational factors; (4) community factors; and (5) public policy factors. These levels are illustrated in figure 1.1 below.






Source: Adapted from the Centers for Disease Control and Prevention (CDC, 2017).

**Figure 1.1. The Ecological Model**

**Intrapersonal/individual factors (the adolescent)**: This refers to characteristics of an individual that may influence behaviour change, including knowledge, attitudes, behaviour, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic/caste identity, sexual orientation, socio-economic status, financial resources, values, goals, expectations, literacy, stigma, and others. These factors may influence adolescent decisions to initiate sex at an early age or not. For instance, the attitude of the

individual adolescent towards sexuality would determine whether he/she would initiate sex or not. Again, it is common knowledge that the knowledge of an adolescent in relation to sexual issues, his/her religious identity, sexual orientation, his values towards sex all affect the individual's decision in relation to sexuality.

**Interpersonal factors (family/parents):** This refers to formal (and informal) social networks and social support systems that can influence individual behaviours, including family, friends, peers, co-workers, religious networks, customs or traditions. The interaction of these contributes to the sexual behaviour of adolescents. For instance, an adolescent living with permissive parents or parents who do not monitor their children's activities can easily fall prey to negative sexual behaviours. Again, the attitude of the adolescent's parents towards sex as well as their perception towards sex may influence the sexual behaviour of the adolescent. This also includes the sexual communication initiated and maintained by parents with their adolescent wards. Thus, permissive parental monitoring and low level of connectedness with the adolescents is associated with negative sexual health outcomes such as early sexual debut, inconsistent use of condom, early pregnancy and its attendant consequences. According to Kumi-Kyereme *et al*. (2007) connectedness describes the nature of relationships that provide the individual with support, security and direction. It also creates an environment within which one grows up and derives support and inspiration. Kumi-Kyereme *et al*. (2007) reports that the more connected adolescents are to other adults, friends and key social institutions (such as religious organizations and social groups), the lower their likelihood of engaging in sexual risk-taking behaviour. A measure commonly used to reflect connectedness between adolescents and family is simply whether a child lives with the mother, father or

parent-figure in the same household. Studies of the relationship between parental co-residence and sexual activity generally show a negative relationship (co-residence is associated with a lower likelihood of being sexually experienced). Parent-adolescent communication includes the interactions and discussions that parents share 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 *et al*., 2007). In the same report, Kumi-Kyereme *et al*. (2007), argued that positive communication between young people and parents, other adults and peers will lead to positive behavioural outcomes, including those on sexual and reproductive health.

**Community:** This refers to the relationships among organizations, institutions, and informational networks within defined boundaries, including neighbourhood associations, community leaders, businesses, and transportation. The views and perception of these organizations on premarital sex can lead to the adolescent adopting either a positive or negative sexual behaviour. The adolescent lives within this network of organization and is influenced by the attitudes and perceptions of these organizations with regards to sexuality. The sexual values projected by these organizations determine the sexual behaviour the adolescent may adopt.

**Institutional and organizational factors**: Organizations or social institutions with rules and regulations for operations affect the behaviour of the adolescent including those of sexual and reproductive health. These institutions include the school system, religious bodies, peer clubs and other related organizations. For instance, if the adolescent attends a school which has a sound sex education programme with messages on abstinence, contraceptive use, assertive skills, and sexual negotiation skills, it is expected that

students in such environment would initiate sex at a later age in life. On the other hand, adolescents who are not exposed to such opportunities in life are likely to exhibit negative sexual attributes such as early sexual initiation, multiple sexual partners, inconsistent use of condom, early pregnancy, abortion and other negative sexual outcomes. The religious beliefs within the social environment of the adolescent could also influence the sexual behaviour of the adolescent. Thus, an adolescent who grows up in an environment with good religious and moral education teaching is likely to initiate sex late compared to their peers without such background.

**Policy/Enabling Environment:** These include local, district, regional, national and global laws and policies, including policies regarding the allocation of resources for adolescent sexual and reproductive health needs. For instance, policies on adolescent sexual and reproductive health, sex education curriculum to be used in educational institutions, sexual and reproductive health protocols used in health facilities in the provision of adolescent friendly services. These policies have profound influence on the quality of service and education on sexuality that adolescents receive which in turn influence the sexual outcome of the individual adolescent.

The environment around the individual may affect the behaviour physically, socially and emotionally. Though individuals have the will or power to make their own decisions, many other factors in the environment have influence on their decision-making process with regard to sexual and reproductive health.

### 1.6. Significance of the Study

To help adolescents transit from childhood to adulthood, there is the need to equip adolescents with sexual knowledge to enable them to abstain from sexual intercourse until they reach adulthood. The findings of this study will thus help lay the foundation for intervention programmes to be made taking into consideration the evidence on the ground as first hand data would be produced. Consequently, this study is geared towards providing relevant and up to date information on the state of sexual behaviour among adolescents. Findings of this study would also help in the design of interventions to improve the flow of communication between parents and their adolescents.

The findings would be useful to policy makers, programme managers, and many institutions that make policies which affect the sexual and reproductive health of adolescents. For example, institutions and departments such as the National Population Council, the Ministry of Health and the Ghana Health Service, and the Ministry of Youth and Employment might find such information useful. Thus, policies would then be made based on the recognition of some of the cultural and social-dimensions in which adolescents find themselves. The data generated in this study would also be used by the government, non-governmental organizations and other stakeholders as baseline for assessing the successes and challenges of the programmes put in place to address the needs of adolescents in relation to their sexual and reproductive health. With little or no information about the current state of sexual and reproductive health of adolescents in this rapidly changing social and economic environment, the outcome of this research is expected to raise awareness on the plight of the Ghanaian adolescent in the rapidly changing social and economic environment. It is expected that the findings of this study



will increase knowledge and add to literature in this academic field and open up issues affecting the sexuality of adolescents' to trigger further research. Finally, this study would build literature on the sexual and reproductive health situation in the District.

### 1.7. Organization of the Chapters

The research work is organized under six chapters. Chapter one contains the introductory chapter which covers the background to the study, statement of the problem, research questions, conceptual framework, objectives of the study, and justification for the study. Chapter two of this research work examines the relevant literature pertaining to the topic stating the subheadings based on the topic and objectives of the study.

Chapter three being focused on the methodology contains detailed elaboration of the methodology used for the research. This includes the study design, research setting/area, units of inquiry/study population, sources of data, sampling procedures (sample design and sample size) and research instruments. The rest are methods of data collection/field work, data processing and analysis, ethical issues involved and how this will be addressed, as well as problems (logistical) and limitations (methods and instruments). Chapter four of the study presents the results and findings. Chapter five is the discussions of the data /analysis. Chapter six covers the summary and conclusions and policy implications. The reference materials and sample of the instrument of data collection are attached at the appendix.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.0 Introduction

This chapter discusses the existing literature and a more focused discussion of the sexual health issues affecting young people generally and specifically in Ghana. The intent is to provide a background against which field data presented in subsequent chapters could be analyzed and discussed. The literature is reviewed under sub-topics including the definition of adolescence; sexual activities adolescents consider as sex; sexual practices among adolescents; sources of sex information and education; and parent-child sexual communication and its implications on the sexual behavior of the adolescent.

## 2.1. Definition of Adolescence and its Implications for Health Outcomes

Adolescence is defined as the period in the human growth and development stage that occurs after childhood and before adulthood: from ages 10 to19 (WHO, 2016c). It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change. The onset of puberty mark the passage from childhood to adolescence. The biological changes during adolescence are almost universal; however, the duration and defining characteristics of this period may vary across time, cultures, and socioeconomic situations (WHO, 2016c). The period of adolescence has revolutionized over the past century including the earlier onset of puberty, increased age at age, urbanization, globalization, and the emerging changing sexual attitudes and behaviours.

According to WHO (2016) besides the biological changes (physical and sexual maturation), other changing experiences during adolescences include movement toward

social and economic independence, and development of identity, the acquisition of skills needed to carry out adult relationships and roles, and the capacity for abstract reasoning. The period of adolescence is also seen as a period of considerable risk taking during which social contexts exert powerful influences on the life of the adolescent. Thus, many adolescents face pressures to use alcohol, cigarettes, or other drugs and to initiate sexual relationships at earlier ages, putting themselves at high risk for intentional and unintentional injuries, unintended pregnancies, and infection from sexually transmitted infections (STIs), including HIV/AIDs (WHO, 2016c). This period is very crucial because behaviour patterns established during this period such as drug use or non-use and sexual risk taking or protection, can have long-lasting positive and negative effects on the future health and well-being of the individual adolescent and the entire society. This is more so because of the inability of adolescents to understand the relationship between behaviour and consequences. This inability may make them particularly vulnerable to sexual exploitation and high-risk behaviours.

The concept of adolescences in the Ghanaian society has multifaceted connotation. According to the GARHP (2000), the adolescent stage is seen as the second decade of life; that is the 10-19 years of age. Demographically, a youth in Ghana is a person aged 15-24 years while socially, the period of adolescence is referred as the period between childhood and adulthood. But for the purpose of this current study, the target population is those aged 10-24 years who are attending senior high school in the East Mamprusi District. The 20-24 group is included because some of them, more specifically those still in school, may have similar reproductive health needs and challenges as 15-19 year olds.

Adolescents are the future leaders of this nation. As the future leaders of the country, it is important to ensure that young people are educated, well informed, and provided with improved health care services and facilities. Creating an acceptable atmosphere for adolescents to learn about the transition to adulthood is one of the central issues in education (GARHP, 2000). According the policy, the values, attitudes and behaviours for promoting positive living, including those on reproductive health, are first formed at the adolescent stage. Therefore, educating adolescents and young adults on sexual and reproductive health has the benefit of contributing to the well-being of the members of the society as well as helping them to develop their potentials.

The emerging changes that accompanies the period of adolescence poses fundamental challenges for adolescents. These sexuality changes include adjusting to the altered appearance and functioning of a sexually maturing body, learning to deal with sexual desires, confronting sexual attitudes and values, experimenting with sexual behaviors, and integrating these feelings, attitudes, and experiences into a developing sense of self (Crockett *et al*., 2003). Crockett *et al*. (2003), argued that the challenge is heightened by the unfamiliar feelings of sexual arousal, the attention connected to being sexually attractive, and the new level of physical intimacy and psychological vulnerability created by sexual encounters.

Adolescents' responses to these emerging challenges are deeply influenced by the social-cultural context in which they live. In many societies worldwide, adolescent sexuality has narrowly been viewed as inappropriate and troublesome rather than as normal and healthy. In one part, this may reflect cultural mores about premarital sexual activity, in

other part it may reflect well-justified concerns about the potential negative consequences of sexual activity (Crokett *et al*., 2003).

In Ghana, cultural proscriptions against premarital sex are counterbalanced by modern permissive attitudes mediated by the media and in the changing values of many adults today. These competing perspectives intertwine, creating a situation where adolescents are exposed to sexual material in their daily life but given inadequate preparation to behave responsibly in sexual situations. The physical changes which heightens the feelings of sexual desire and love collide with societal prescriptions to show restraint, setting the stage for psychological conflict and behavioural inconsistency.



### 2.2 Practices Adolescents consider as Sex and Sexuality

Sexuality is broadly explained as the set of behaviours associated with the ideals, desires, practices and identities linked with sex (Bhatasara *et al*., 2013). Thus the term sexuality describes the whole way a person goes about expressing himself or herself as a sexual being. The literature on sexuality highlights that the most dominant and recognized form of sexuality in the human is heterosexuality. According to Mahcera (2004) cited by Bhatasara *et al*. (2013), in Africa heterosexuality is a more valued status than homosexuality.

The literature on sexuality increasingly highlights the social nature of sexuality. According to Bhatasara *et al*. (2013), sexuality is a product of cultural contexts rather than biological drives and therefore it is mediated by culture. Caplan (1986) cited in Bhatasara *et al*. (2013), argues that sexuality is not biologically given; it is socially and culturally constructed and in constant state of flux. A social constructionist approach to

sexuality that sees biological potentials as essentially mediated by culture has been invoked by a number studies (Vance, 1991 cited in Bhatsara, 2013; Arnfred 2004) cited in Bhatsara, 2013) that point to the existence of multiple sexualities existing in societies. Interrogation of literature thus largely calls for the attachment of meaning and reading of sexuality in its context.



Adolescent sexuality is a debatable concept in almost all human societies. Sexuality is not just about sex (Jimmy-Gama, 2009) but rather is described as the expression of identity through gender (Jimmy-Gama, 2009). Sexuality involves the process that defines and dictates the way in which people negotiate their relationships with others, and in turn, how people's sexual actions impact on them (Options for Sexual Health 2008 cited in Jimmy-Gama, 2009). According to Jimmy-Gama (2009), this conceptualization of sexuality comprises a broad range of behaviours and processes that include those from psychological, social, cultural, political, ethical, moral, legal, religious or spiritual aspects which define morality in various contexts. These behaviours and processes influence values regarding relationships, sexual ethics, sexual culture and psychology in relation to gender and sexual role; physical factors, sexual characteristics, sexual drive, sexual intercourse, sexual activities, and sexual orientation – heterosexual, homosexual and bisexual (Jimm-Gama, 2009). Thus, sexuality involves the way sexual socialization, knowledge, beliefs and values, religion and morals shape the way males and females behave in the society (Jimmy-Gama, 2009).

The conventional view of sex describes it as intercourse between male and female: When people talk about sex they think about male and female. Jaffray (2006) reported that for many people, sex refers to the penetration of the penis into the vagina. Penetrative sex is

thus generally viewed as "natural" or "normal sex" (Richardson 1993). In some traditional or religious societies, particularly among Roman Catholic Church and also among the Moslem, sexuality is only associated with procreation. Sex is only acceptable in marriage for the purpose of procreation only (Phiri, 1998).

There are however disagreements in the conceptualizations of sex among heterosexual partners in some societies. For instance, while female participants in a study in South Africa acknowledged that sex can include other practices such as touching each other, kissing, massaging, exciting each other by touching each other's genitals as well as oral sex (Jaffray 2006), male participants do not understand sex as anything other than sexual intercourse involving penile penetration. Thus, while sex practices can be understood to mean more than penile penetration even among heterosexual females, this notion is not acknowledged by some heterosexual males within one society and this disagreement can affect heterosexual partners' agency to adopt safe sex practices.



According to Jimmy-Gama (2009), sexuality is not just about sex, but also involves what people do with their genitals and who they do it with. Sexuality involves and is shaped by many things including values and beliefs, attitudes, experiences as well as physical attributes.

Thus, sexuality is broader than what one does with another person sexually. It is not only about having sex, or taking part in sexual behaviours but it is also about how the individual feels about the self; how individuals feel as male or female; the way of acting and the feeling about other people and how such factors impact on sexual behaviours (Jimmy-Gama, 2009).

The issue of sex and sexuality among adolescents is a topical issue because of the peculiar challenges it poses for this cohort. The challenges include adjusting to the altered appearance and functioning of a sexually maturing body; learning to deal with sexual desires; confronting sexual attitudes and values; experimenting with sexual behaviors; and integrating these feelings, attitudes, and experiences into a developing sense of self (Crockett *et al*., 2003). These challenges are heightened by the unfamiliar excitement of sexual arousal, the attention connected to being sexually attractive, and the new level of physical intimacy and psychological vulnerability created by sexual encounters. According to Crockett *et al*. (2003), adolescents' responses to these challenges are profoundly influenced by the social and cultural context in which they live. In many societies, adolescent sexuality has typically been viewed as inappropriate and troublesome rather than as normal and healthy. In part, this reflects cultural mores about non-marital sexual activity; in part it reflects well-justified concerns about potential negative consequences of sexual activity. Cultural proscriptions against non-marital sex are counterbalanced by permissive attitudes reflected in the media and in the values of many adults. These competing perspectives co-mingle, creating a situation where adolescents are exposed to sexual material in settings of daily life but given inadequate preparation to behave responsibly in sexual situations (Crockett *et al*., 2003). In this situation therefore, feelings of sexual desire and romantic love collide with social prescriptions to show restraint, setting the stage for psychological conflict and behavioural inconsistency.

In this context, the cultural, social and situational dimensions of sex have made sexuality studies or research very challenging to conduct. In some societies, sexuality is about

heterosexual relationship. More specifically, it is about penetrative vaginal sexual intercourse. Sexuality as a human activity is more encompassing than just penetrative vaginal sex but it may also include non-vaginal sexual intercourse such as kissing, cuddling, masturbation, oral sex, anal sex and so many other sexual practices (Grobbelaar, 2012).

There is dearth of data as to what behaviours adolescents consider to be "sex" and, by the same token, what they consider to be its opposite, abstinence. The tendency to equate "sex" with vaginal intercourse alone represents long-standing cultural norms of acceptable sexual behaviour and certainly applies to adults as well as to adolescents (Remez, 2000; Grobbelaar, 2012). It also reflects a deeply rooted ambivalence about talking about sex. Recent media reports, however, are forcing a reappraisal of the implications of this exclusive focus on coitus for research and data collection efforts, for STI prevention and treatment, and for the framing and interpretation of abstinence and risk-reduction messages (Remez, 2000).



Most studies of adolescent sexuality have focused on vaginal intercourse, thus failing to consider how adolescents perceive the risks, benefits, and prevalence rates of non-coital sex as compared with vaginal sex and the extent to which adolescents view non coital sex as more acceptable than vaginal sex (Halpern-Felsher *et al*., 2005). It is imperative to understand adolescents behaviour, attitudes and perception about non-coital (masturbation, cuddling, kissing, oral and anal sex) sexual practices as compared with coital sexual practices. In a study by Halpern-Felsher *et al*. (2005), on perceptions related to oral versus vaginal sex among adolescents, they found that a significantly greater number of adolescents have had oral sex (19.6%) than vaginal sex (13.5%) and more

adolescents intended to have oral sex in the next 6 months (31.5%) than vaginal sex (26.3%). The results from that study provided important insight into how young adolescents perceive oral sex as compared with vaginal sex, with critical implications for health care providers. Thus, the results revealed that more adolescents have had and intend to have oral sex than vaginal sex. Although limited research has not found evidence for non-coital sexual practices predicting coitus in the future (Smith *et al*., 1985 cited by Halpern-Felsher *et al*., 2005)**,** some researchers have suggested that non-coital behaviours could be predictors for engaging in penetrative vaginal intercourse (Gates *et al.,* 2000). Limited evidence also suggests a relationship between oral sex and intercourse, although it does not specify a predictive order. The results from Halpern-Felsher *et al*. (2005), further indicate that adolescents perceive non-coital sex as less risky, more beneficial, more prevalent, and more acceptable than penetrative vaginal sex.

Another study by Lindberg *et al.* (2007), revealed that non-coital behaviours are common expressions of human sexuality. These non-coital sexual activities, which include mutual masturbation, oral sex, and anal sex, are commonly practiced by opposite sex and same-sex couples as well as adolescents. A number of factors combined to make oral, and to a lesser extent, anal, sex among teens a topic of social, scientific, and political interest. A small but growing body of research demonstrates that substantial numbers of adolescents have had oral sex (Bersamin *et al*., 2006; Boekeloo & Howard, 2002; Brady *et al*., 2007; Schuster, 1996 cited in Lindberg *et al*., 2007) and that the incidence increases with age and ever having had vaginal sex (Gates *et al.,* 2000; Mosher *et al*., 2002; Prinstein *et al*., 2005 cited in Lindberg, 2007). One key concern, highlighted by these literatures was an emphasis on “abstinence” and declining rates of vaginal intercourse among teens and the

perception that adolescents were substituting oral and anal intercourse for vaginal intercourse (Cornell *et al*., 2006 cited in Lindberge, 2007). On the other hand, a variety of clinic and community-based studies suggest that most adolescents do not consider oral and anal sex to be "sex" (Sanders & Reinisch, 1999 cited in Lindberg, 2007) or see oral sex as more acceptable than vaginal sex and less risky in terms of health, social and emotional consequences (Brady *et al*., 2007; Halpern-Felsher *et al*., 2007). Professionals who work with adolescents report an increased concern about oral sex and STIs. Despite a nascent but growing body of research, these professionals also report an inability to separate anecdote from evidence in understanding the extent of non-coital sex and its implications (Remez, 2000). The findings from Lindberg *et al*. (2007), indicated that slightly more than one-half of adolescents have engaged in heterosexual oral sex (55% overall); in fact, higher proportions of teens have engaged in this activity than have engaged in vaginal sex (50%) Substantially fewer (11%) had ever had anal sex. Their study also indicated that adolescents who had ever had vaginal sex were significantly more likely to have had non-coital sex. The overwhelming majority of non-virgin adolescents, 87%, had ever had oral sex, compared to 23% of virgins. From various studies it is important that any discussion about adolescent sex now must recognize that adolescents engage in a wide range of sexual behaviours including coital and non-coital sexual intercourse.

A study of adolescent's sexual attitudes and behaviours of a cohort of adolescents, 15–24 years old, attending a large state university in Manila, Philippines by De Jose (2013), found that male masturbation, necking, and holding hands and kissing were found to be acceptable. This study which was a baseline study also shows that adolescents 15-24

year olds have engaged in intimate kissing (42.8%); masturbation (39.7%); necking (39.5%); petting (31.7%); and oral sex (26.3%). This study also reveals that 47.6% of the respondents strongly believe that a woman should be a virgin at the time of her marriage while 36.1% of the respondents strongly believed that a man should also be a virgin at the time of his marriage. Virginity in this study refers to not having engaged in penetrative sexual intercourse. In another study by Sathe and Sathe (n.d.) on Knowledge, Behaviour and Attitudes about Sexuality amongst Adolescents in Pune, it was found that over two-thirds (62.2%) of the respondents admitted knowing what is masturbation. It was also found that the median age of such activity was 15 years. In that study, nearly half (47%) of the boys reported that they indulged in masturbation and 15% reported doing it every day. This study by Sathe and Sathe (n.d.) also indicated that nearly half of the boys in the study (48.8%) said that they experienced nocturnal emission. In another study by Glover et al. (2003), on the Sexual Health Experiences of Adolescents in Three Ghanaian Towns, they found that non penetrative sexual activity was a means of achieving sexual satisfaction among some adolescents more especially among the sexually active adolescents. In this study, the results indicated that 61% of the respondents agreed that one can get sexual satisfaction with a partner without having penetrative sexual intercourse. In that same study, among those who agreed that penetrative sex is not needed for sexual satisfaction, kissing, fondling and touching were the most frequently mentioned ways of getting such satisfaction (each about 70%); a small proportion of the youth identified practices such as mutual masturbation (17%) or oral sex (5%). This non-coital sexual experience with such intimate contact was almost exclusively the domain of those who had had sex. Among those who agreed that one can get sexual satisfaction

without intercourse, 91% of sexually experienced youth had actually experienced one of the above-mentioned practices, compared with only 10% of respondents who had never had intercourse. The fact that such a small proportion of sexually inexperienced adolescents had had other sorts of intimate contact suggests that youth may take an "all-or-nothing "approach to sexual relations (Erulkar & Mensch, 1997 cited in Glover *et al.*, 2003).

In a study by Awusabo-Asare *et al.* (2006), titled Adolescent Sexual and Reproductive Health in Ghana: Results from the 2004 National Survey of Adolescents, the results show that 77% of females and 72% of males had heard of kissing; 23–24% of females and males who had heard of kissing knew close friends who had done it; and only 4% of females and males who had heard of kissing said they themselves had ever done it. Sixty-six percent of younger adolescent females had heard of fondling compared to 55% of males; about one in three females and males who knew about fondling knew close friends who had done it; and only 7% of females and 8% of males who had heard of it reported that they themselves had experienced fondling in their life time before. While sexual intercourse remains one of the most important experiences to understand, given its direct link to unwanted pregnancy and the transmission of HIV and other STIs, several other sexual behaviours are linked to HIV and other STIs as well. Using anecdotal evidence, some have argued that young women use anal sex as a substitute for vaginal sexual intercourse in order to avoid the risk of pregnancy and/or to preserve their virginity. The survey evidence on anal sex indicates that awareness of the practice varies by age and sex. Some 34% of females and 55% of males aged 12–19 had heard about anal sex. The percentages were higher among 15–19-year-olds of both sexes than among younger

adolescents, and were higher among males than females. One in four 12–14-year-old females said they had heard of anal sex. Among those who had heard of it, 16% of both females and males said they knew close friends who had had anal sex and 2% of females and males said they themselves had ever had anal sex. In the 1998 Ghana Youth Reproductive Health Survey (GYRHS), cited in Awusabo-Asare (2006), 8% of 12–24-year-old males and 5% of 12-24-year-old females who had ever had sex had heard of anal sex. Anal sex is rarely discussed when dealing with sex among young people and the results from both the National Survey of Adolescents and the GYRHS point to the existence of the practice.

In the same study by Awusabo-Asare *et al*. (2006), adolescents were asked a series of questions about their attitudes towards sexuality in general. These included virginity until marriage for females and males and the circumstances under which sex occurs. On attitudes towards virginity until marriage, 88% or more of all adolescents (females and males, older and younger) agreed that young women and young men should remain virgins until they marry. Among those who had ever had sex, the proportion agreeing that young women should remain virgins until marriage was 87% of females and 84% of males while the proportions agreeing that young men should remain virgins until marriage was similar to that of the females (82% of females and 85% of males). The overall results point towards minimal differences in virginity expectations for females and males, and that the "double standard" of expecting young women to be virgins until marriage but to allow young men to have premarital sex is not an attitude held by Ghanaian adolescents in general nowadays.

Odonkor *et al.* (2012), reported in their study of Sexually Transmitted Diseases (STDS) among Adolescents in Second Cycle Institutions in Accra, Ghana: Trends In Sexual Behaviors that of those who have had sex, 24.8% practice vaginal sex, 24.8% said they practice oral sex, 24.0% said they practice kissing, 17.6% said they practice anal sex, 1.2% said they practice lesbianism and only two pupils (0.8%) said they practice homosexuality.

In the same vein, Chukwunonye *et al*. (2015), in their study of adolescents in Senior High School in Nigeria, found that the method of sexual activity practiced by the sexually experienced respondents were vaginal (91.6%), Anal (21.1%) and oral (7.4%). They also found that 30.5% of study participants reported having had homosexual experience. These findings suggest that even though widely frowned upon, homosexuality is practiced in many societies across West Africa contrary to earlier belief and perception that it is only practiced in western countries.

### 2.3. Sexual Practices among Adolescents

The sexual practices of adolescents are issues of public health concern as they have implication for the sexual and reproductive health of the individual adolescent and the entire society (Awusabo-Asare *et al*., 2006; Kumi_Kyereme *et al*., 2007). Initiation of sexual activity whether penetrative vaginal sexual intercourse or non-vaginal sexual activity, are sometimes the defining events in the lives of adolescents because of its implications now or the future (Awusabo-Asare *et al*., 2006; Kumi_Kyereme *et al*., 2007).. The initiation of sex, the type of sexual relationship adolescents engage in, the age of entry into sexual activities, and the number of sexual partners have impact on the sexual health of the individual adolescent and that of the society in which they

live(Awusabo-Asare *et al*., 2006; Kumi_Kyereme *et al*., 2007). Previously, the age at first marriage was often used as a proximate for the onset of women's exposure to the risk of pregnancy (GSS, GHS, & ICF, 2015). However, because some women are sexually active before marriage, the age at which women initiate sexual intercourse more precisely marks the beginning of their exposure to pregnancy as well as exposure to sexual transmitted infections including HIV/AIDS.

In the past, the onset of menstruation for females was interpreted as a sign of maturity and therefore readiness for marriage (Awusabo-Asare *et al*., 2006). Although considerably reduced, there are certain areas in Ghana where the onset of menstruation is still linked to marriage. Under these circumstances, females marry early, leading to the onset of sexual activity and family formation. Currently, changes brought about by formal education, migration and modernization have created conditions for a more significant time lapse between menarche, initiating sex and marriage (Awusabo-Asare *et al*., 2006; Glover, 2015).

The timing of first intercourse is an important indicator of the onset of exposure to risk of both pregnancy and STIs including HIV (Awusabo-Asare *et al*., 2006). Age is very likely to be related to knowledge of risks and means of protection, as well as to the ability to seek and obtain information and services. In this sense, older adolescents are likely to be better equipped than younger ones to deal with problems of sexuality when first intercourse occurs (Awusabo-Asare *et al*., 2006).

The age at first sex is an important indicator when considering the negotiation involved in the decision to have or not to have sexual intercourse. In the study by Awusabo-Asare *et al.* (2006), it was reported that very few adolescents experienced sexual intercourse

before age 13. The differences between males and females begin to emerge around age14 years, when the proportion of females experiencing first sex increases, reaching almost 10% by age 15 and accelerating steeply afterwards to 17% by age 19. For males, the proportion that had experienced sex increases much more gradually and reaches 8% by age 19, about half the proportion among females. As observed elsewhere, females experience first sex far earlier than males (Awusabo-Asare *et al.*, 2006).

Results from the Ghana Demographic and Health Survey (GSS, GHS, & ICF, 2015) show that 11 percent of adolescents have had their first sexual intercourse by age 15, 44 percent by age 18 and 68 percent by age 20. In the same report by GSS, GHS & ICF (2015), the results show that 5 percent of young men have had their first sexual intercourse by age 15, 27 percent by age 18, and 52 percent by age 20. The results also show that 11 percent of women have had their first sexual intercourse by age 15, 44 percent by age 18 and 69 percent by age 20. By age 24, almost all adolescents in Ghana have experienced their first sexual intercourse.

A study by Glover *et al.* (2003), reported that 52% of respondents (adolescents aged 12-24 years) had ever had sexual intercourse and that young women were more likely than young men to be sexually experienced (56% vs. 48%) consistent with that reported by GSS, GHS & ICF (2015). Glover *et al*. (2003), also reported that as would be expected, the proportion who was sexually experienced increased with age: Seven percent of 12–14-year-olds had ever had sex, compared with 29% of 15–17-year-olds, 64% of 18–20-year-olds and 82% of 21–24-year-olds. After adjustment for age, the apprenticed and unaffiliated youth (65% and 59%, respectively) were more likely than those in school (38%) to be sexually experienced.

A study by Attibu (2015), on the sexual behaviour of adolescents in Senior High School in the Tamale Metropolis also revealed that majority of the study respondents (73.1%) had ever been in a relationship with the opposite sex and out of these respondents (58.3%) have had penetrative sexual intercourse; ages 15 to 19 years (34.2%) have had their first sex. The situation is however not peculiar to Ghana alone. A study by Chukwunonye et. al., (2015*)* in South-Eastern Nigeria found that 23.2% of the respondents had their first sexual debut below 10 years of age, 31.6% 31.6% between 10-13years, 36.8% between 14-17years and 8.4% between 18-20 years of age. Mean age at sexual debut was 12 ± 3.6 years. Majority (71.6%) of the sexually experienced respondents admitted that their first sexual exposure was unplanned. 22.1% of them were curious to have sex, 40% were deceived, 3.2% were drugged, 25.3% were forced, 4.2% were raped and 5.3% actually requested for it.

Data on lifetime and current sexual partnerships give an indication of the level of sexual networking, although some studies have raised concerns about the reliability of data on lifetime sexual partnerships and the completeness of reporting on sexual partners (Orubuloye *et al.,* 1995 cited by Awusabo-Asare *et al*., 2004). According to Awusabo-Asare *et al.*(2006), the number of sexual partners one has within a given time period can be used to indicate exposure to HIV and other STIs. In addition, the type of relationship and age difference between partners, the duration of the relationship, exchange of money or gifts, and alcohol consumption at the time of intercourse constitute cofactors of risk of pregnancy and STIs. The result indicated that 78% of females and 60% of males who had ever had sex reported only one lifetime sexual partner. Another 18% of females and 21% of males had two lifetime sexual partners and 4% of females and 19% of males had three

or more lifetime partners. Within the 12 months prior to the survey, 29% of females and 35% of males who had ever had sex did not have sex, and 66% of females and 49% of males had only one sexual partner within the period. The percentage of adolescents who had three or more sexual partners in the 12 months prior to the survey was less than 1% for females and 4% for males. Overall, female adolescents who had ever had sex reported fewer sexual partners than males over their lifetime and within the 12 months prior to the survey, an observation that has been made in other studies in sexual networking and partnerships in West Africa (Awusabo-Asare *et al.,* 2006). Attibu (2015), reported in her study that of those who have had sex, 48.6% indicated that they have had two or more sexual partners within the last three months.

Another sexual practice in which adolescents are involved is the issue of sexual exploitation and coercion. Over the years there have been reported cases of rape, defilement and sexual abuse in the mass media. Evidence from Ghana and elsewhere show that the issue of sexual coercion is a major public health concern for adolescents as well as adults. For young people in particular, sexual coercion has long lasting and profound negative sexual and reproductive health consequences (Tweedie & Witte, 2000). According to Awusabo-Asare *et al.* (2006), 22% of females and 19% of males said that they had ever been touched, kissed, grabbed or fondled in an unwanted sexual way, and twice as many older female and male adolescents than younger adolescents reported this. Sixteen percent of females and 7% of males aged 15–19 years reported that they had ever been physically forced, hurt or threatened into having sexual intercourse. Among females who had ever been coerced into sex, the majority of perpetrators were acquaintances (23%), friends (14%), strangers (14%) and boyfriends (11%). About one in

five female adolescents reported parents, siblings or other family members—particularly uncles—as people who had ever physically forced, hurt or threatened them into having sexual intercourse. Two percent and 4% of females reported teachers and schoolmates, respectively. The results indicate that almost 80% of those who coerced female adolescents were known to the victim. Among males who had ever been sexually coerced, the most common perpetrators were girlfriends (34%), friends (22%) and acquaintances (21%). Three percent reported coercion from a family member. In a study by Ochieng (2013), on Risky Sexual Behaviour among Adolescents Attending Public Secondary Schools in Nairobi, Kenya, he reported that 17% of males and 20% of females said that they were coerced while 12% of males and 16% of females said they were forced in their first sexual debut. Ochieng (2013), also found that majority of the respondents (72% of males and 64% of females) were willing to have sex during their first sexual intercourse. Seventeen percent of males and 20% of females reported that they were coerced in their sexual debut while 12% of males and 16% of females were forced in their sexual debut. Chukwunonye *et al*. (2015), also indicated in their study that majority of students (71.6%) reported that their first sexual experience was unplanned. It was also found that 3.2% of them were drugged, 4.2% were raped, 25.3% were forced and 40% were deceived into having sex.

Another aspect of sexual coercion is the perception among males and even most females that women do not mean what they say when they say “no” to sex. About two-thirds of both males and females aged 12- 24 in the 1998 Ghana National Youth Reproductive Health Survey (GYRHS) who had ever had sex stated that most females did not really mean “no” whey they said “no” to sex (Awusabo-Asare *et al*., 2004). Such perception

and attitudes can translate into an acceptance of sexual violence because a large proportion of adolescent's males do not appear to believe that females really mean what they say and therefore with a little pressure, a girl could be made to change her mind. According Awusabo-Asare (2004), Tweedie and Witte, reported in their study that 13% of males and 14% of females who are sexually experienced indicated that it is acceptable for a boyfriend to beat his girlfriend when she does not provide sex. Glover et al.(2003), in their study found that nearly 25% of sexually experienced female respondents reported that their first sexual experience involved rape or force, and an additional 9% said that they had been enticed or deceived into having sexual intercourse. A smaller proportion of sexually experienced young men (5%) said that rape or force had played a role in their first sexual experience, but a comparable proportion (10%) reported having been enticed or deceived. In addition, one in five males who had had sex admitted to having used some sort of coercion or bribery to get sex, with the most frequent ways being money (10%), gifts (6%) and force (4%).

Related to the issue of sexual coercion is the problem of pressure to go into sexual intercourse. Attibu (2015), reported in her study that 39.9% of respondents of those who have had sex admitted of been pressured to have sex of which 40% of respondents indicated that the main group of persons from which pressure is felt mostly was friends. Abakah (2015), in her study of Sex Education and its influence on sexual behaviour in the West African Senior High School in the Greater Accra Region indicated that more than half (56%) of the respondents reported feeling pressured to engage in sexual activity. She further asserted that majority (53%) of males reported feeling pressure from others to engage in sexual activity with 47% of females reporting same. Her report also indicated

that more than half of the adolescents (51%) said that they felt pressure from friends and classmates, 40% from boy/girlfriends and 9.75% from family.

One other sexual practice which poses a great challenge to adolescents is the issue of transactional sex. Transactional sex, defined as the engagement in sexual activity in exchange for material gifts or money, has been cited by several studies from sub-Saharan Africa as a risk factor for HIV and other STIs (Atwood *et al.,* 2011; Cote *et al*., 2004; Dunkle *et al.,* 2004; Luke N, 2003; Okigbo *et al.,* 2014). Transactional sex increases the risks and prevalence of HIV infection through various ways such as multiple sexual partnerships, sex with older men who are more likely to be HIV infected, and engagement in sexual activity under the influence of drugs and alcohol (Cote *et al.,* 2004; Dunkle *et al*., 2004; Luke N, 2003 cited in Okigbo *et al*., 2014). Transactional sex has also been associated with gender-based violence, substance abuse, and poverty ( Dunkle *et al*., 2004 cited in Okigbo *et al*., 2014). According to Okigbo *et al*. (2014), interventions that address transactional sex will only be successful if the reason for engaging in this behaviour is understood. Males and females have been reported to engage in transactional sex for different reasons; males for sexual gratification and females for financial benefits and access to basic necessities such as food, shelter, and protection. According to a 2011 youth study in Liberia, transactional sex was reported to have emerged during the conflict and post-conflict periods as a source of economic resources (Atwood *et al.,* 2011 cited by Okigbo *et al*., 2014). Some of the youth acknowledged that their first sexual encounter was non-transactional but became transactional when they realized the potential for financial gains. These sexual encounters often took place in entertainment centres such as video clubs that sprang up with the

arrival of the peacekeeping missions during and after the conflict. Okigbo *et al*. (2014), in their study in Liberia found that majority of the respondents (72%) have a history of engagement in transactional sex of which 92.2% of them have engaged in multiple sexual partnerships in their life time.

Frost & Bingenheimer (n.d.) in their study in Southeastern Ghana reported that a substantially smaller proportion of adolescents (8.5%) reported that they had ever been offered money or other gifts in exchange for sex, and an even smaller proportion (1.8%, or just 23 youth) reported actually receiving money or gifts from someone in exchange for sex or for being in a sexual relationship. Likewise, only 2.1% (27 youth) reported that they had ever given anyone money or gifts for sex. However, given that more than half of the survey sample was under the age of 15 (56%) due to the accelerated cohort design, and that respondents may receive (or offer) gifts or money from/to sexual partners without defining this process as a formal exchange, these percentages likely underestimate the prevalence of transactional sex among the adolescent population in the study communities.

To prevent unwanted pregnancies and STI's including HIV, it is important that sexually active people, especially adolescents, should use the various contraceptives especially the condom which serve dual purposes of preventing pregnancy and STIs/HIV.

Acquiring knowledge about contraceptive methods is an important step towards gaining access to family planning services and adopting a suitable contraceptive method (GSS, GHS, & ICF, 2015). Knowledge of any method and of any modern method is almost universal among currently married women (100 percent and 99 percent, respectively) and men (100 percent each). Current use of any method (contraceptives) is 23 percent among

all women, 27 percent among currently married women, and 45 percent among sexually active unmarried women. Among sexually active unmarried women—most of whom are young—the most common methods are the male condom and the pill (8 percent each). In Ghana, GSS, GHS, & ICF Macro (2009), report indicated that contraceptive knowledge is highest among sexually active unmarried women and men (100 percent). Forty-four percent of unmarried women have used a male condom, compared with 19 percent of married women. Ever use of modern contraceptive is also highest among sexually active unmarried (86%). Ochieng (2013), reported in his study in Kenya that 69% of males and 72% of females used contraceptives during their first sexual encounter. In a study by Ncitakalo (2011), on the Socio-Cultural Influences In Decision Making Involving Sexual Behaviour Among Adolescents In Khayelitsha, Cape Town he reported that most of the participants did not use condoms at first sexual intercourse. Participants mentioned some gender dimensions that are linked with contraceptives. It was found out that there were different needs and expectations in terms of choosing a contraceptive method that was mutually beneficial to both parties. Condom use, specifically, predominantly depended on the attitude of male counterparts. Jorgensen (2014), in a study of the Sexual behaviour in the general young population factors associated with sexual risk behaviour reported that about half of both female (53.0%) and male respondents (48.0%) used a condom at sexual debut, but 14.3% women and 15.1% men used neither condom nor non condom contraception. Jorgensen further reported that most respondents used non-condom contraception (women: 39.8%, men: 34.9%) or a condom (women: 31.0%, men: 36.3%) when having a sexual encounter with a stable partner. The proportion of women who had a stable partner and used neither condom nor non-condom contraception was 8.4%

compared to 10.0% of men. Studies by Chukwunonye *et al*. (2015), on the sexual behaviour of adolescents in Nigeria also reported that 74.7% of respondents did not use condom during their first sexual exposure.

A study of street youth in Accra aged 8–19 showed that although 83% of the respondents knew about condoms, only 28% of the sample had ever used condoms and 21% had used condoms in the three months prior to the survey(Awusabo-Asare *et al.*, 2004). In a study in Yilo-Krobo District among males aged 15–24 who had ever had sex, 65% had used condoms at least once and 21% used the condom at last intercourse (Adih & Alexander, 1999 cited in Awusabo-Asare *et al*., 2004). Young males who perceived themselves to be at high risk were more likely to use condoms at their last sexual encounter than those who did not perceive themselves to be at high risk.

Not using contraceptives, particularly condoms, puts adolescents at risk of unwanted pregnancies and STIs, outcomes that have been experienced by a substantial proportion of adolescents. Glover *et al.* (2003), in their study of the sexual experience of adolescents in three towns in Ghana reported that slightly more than a third (35%) of sexually experienced young women reported that they had ever been pregnant. They further indicated that 87% of young women who had experienced a pregnancy said that their last pregnancy was unwanted, and 70% said that they had had or attempted to have an abortion. Among youth who were sexually experienced, greater proportions of apprenticed (45%) and unaffiliated (32%) females than of those in school (6%) had ever been pregnant. All of the pregnancies of in-school women were unwanted, and led to abortions or abortion attempts; for apprentices, 85% of pregnancies were unwanted and

72% led to abortion or abortion attempts, compared with 92% and 62%, respectively, for unaffiliated women.

In a study by Nguyen et al.(2016), on the Prevalence and Factors Associated with Teen Pregnancy in Vietnam: Results from Two National Surveys, they argued that there is a lack of data necessary to draw accurate conclusion of pregnancy among adolescents worldwide (Nguyen *et al.*, 2016). Nevertheless, they asserted that available statistics shows great differences in the rates and prevalence of pregnancy between regions and countries. The average rate of teenage births ranges from the highest in Sub-Saharan Africa (143 per 1000 adolescent females), followed by the Americas (68), the Middle East and North Africa (56), and East and South Asia and the Pacific (56), to the lowest rates in Europe (25) (WHO, 2004 cited in Nguyen *et al.*, 2016). Worldwide there are striking similarities in the negative social, economic, and health outcomes associated with childbearing adolescents. Although adolescents account for about one-tenth of births internationally, they suffer almost one-fourth of the total incidence of poor health outcomes associated with pregnancy and childbirth (WHO, 2016 cited in Nguyen *et al.*, 2016). According to Nguyen *et al.* (2016), adolescent pregnancy and parenthood are not new phenomena worldwide; however, the circumstances in which young women become sexually active, conceive, and give birth, as well as the consequences of these behaviours, have changed considerably over time and across cultures. The results from Nguyen *et al.* (2016), show that the prevalence of pregnancy among Vietnamese teenagers in the national surveys conducted in 2003 and 2008 was stable at 4%, or 40 pregnancies per 1000 adolescent girls aged 14 to 19. Studies in Kenya by Ochieng (2013) revealed that 4.6% of male adolescents attending Public Secondary admitted ever making a girl

pregnant of which 72.7% of them made them pregnant once and 27.3% made girls pregnant twice. He further reported in that study that 6.3% of female adolescents admitted ever being pregnant of which 75% of them got pregnant once and 25% of them got pregnant twice or more. Most (50%) of the girls in that study got pregnant at age 14 years. In some other studies by Attibu (2015), she reported that 14.5% of respondents admitted ever been pregnant or made someone pregnant. A further probe of the outcome of their pregnancies revealed that 69.7% of them resorted to abortion. The age at first pregnancy analysis show that majority of the respondents (78.8%) were between 15 to 19 years old.

Synthesis of literature and research studies that shared reasons for the abstinence of adolescents from sexual intercourse has given a number of reasons. According to Ankomah *et al*. (2011), common among the reasons for sexual abstinence are religious beliefs against premarital sex; STIs and HIV/AIDS prevention; fear of pregnancy and its attendance risks such as dropping out of school, abortion, infertility as a result of unsafe abortions; the fear of bringing shame to the family as a result of pregnancy, lack of sexual partners; and the postponement of sex until marriage. Analysis of literature on reasons for adolescents abstinence from sex as reported by Awusabo-Asare *et al*. (2006), show that the paramount reason given for never having had sexual intercourse by both female and male adolescents was fear of getting pregnant or making someone pregnant (42% of females and 32% of males). The second most common reason for never having had sexual intercourse among females was because they wanted to wait until marriage (40%), while for males it was to avoid HIV/AIDS and other STIs (30%). The third and fourth most frequently reported reasons for the females, respectively, were to avoid HIV/AIDS

and other STIs (18%) and that they were too young (16%). Avoiding sex for the sake of schooling was reported by 6–7% of females and males. Female adolescents, even the 12–14-year-olds, who were abstinent, appeared to be more concerned about avoiding pregnancy than the possibility of contracting HIV/AIDS or other STIs. Male adolescents who were abstinent seem to be equally concerned about pregnancy and HIV/AIDS and other STIs. Attibu (2015), reported in her studies of the outcome of adolescents ranking of the reasons for their sexual abstinence show that respondents not feeling ready to have sex was ranked the most important factor for abstaining from sex with a mean of 2.8. Been afraid of their parents was the second most important factor with a mean of 3.2. The third most important factor according to the rankings was that they never had the opportunity to have sex with a mean of 3.6. The fourth factor was respondents been afraid of contracting HIV/AIDS with a mean of 3.71. Respondents being afraid of becoming pregnant and seeing sex before marriage as wrong were ranked 5th and 6th respectively with means of 3.77 and 3.84.

Choosing to be sexually abstinent may be one of the major challenges facing young people given the widespread exposure to sexually explicit material that to some extent "glorifies" risky sexual behaviour, including multiple sexual partnerships (Blinn-Pike, 2004 cited Kabiru & Ezeh, 2007). Further, the erosion of traditional value systems that dictate acceptable sexual conduct among young people imply that adolescents have to deal with contradictory values and fewer guidelines regarding sexuality (Awusabo-Asare *et al*., 2004 cited in Kabiru & Ezeh, 2007). According to Kabiru & Ezeh (2007), concerns about adolescent sexual health, especially in the face of the HIV/AIDS pandemic, have led to a proliferation of studies examining the correlates of sexual activity; yet, there is a

relative paucity of studies that assess the characteristics of young people who chose to abstain from sexual intercourse. Thus, they examined differences across never married primary abstainers, secondary, recent and sexually active adolescents aged 15-19 years in four sub-Saharan African countries. Kabiru & Ezeh (2007), in their studies reported that all sexually inexperienced respondents and sexually experienced respondents who did not report sexual activity in the 3 months preceding the survey were asked to state the main reason why they were abstinent. Reasons given for not having intercourse included, among others: the lack of a partner, postponement of sex until marriage, fear of pregnancy, avoiding STIs, and young age. Close to 70% of Malawian and Ugandan males stated that their main reason for not engaging in sexual intercourse was to avoid STIs and HIV and this did not differ much by sexual status. Among Burkinabé and Ghanaian males, this proportion was much lower at 13% and 20% respectively, with secondary abstainers being about twice as likely as primary abstainers to give this reason. Twenty four percent of secondary abstainers from Burkina Faso reported that they were abstaining from sexual intercourse because they lacked a partner. In all countries, except Malawi, female adolescents were about 2 times more likely than males to report a desire to wait until marriage before being sexually active. Burkinabé, Malawian, and Ugandan females were also 4 times more likely than their male counterparts to report fear of pregnancy as a key reason for being abstinent. Across all countries and for both males and females, primary abstainers were more likely to report a desire to wait for marriage than secondary and recent abstainers except in Uganda where similar proportions of abstinent males reported this reason. Nearly a quarter of primary abstinent Burkinabé males reported that they were too young as their main reason for being sexually abstinent.

In a cross-sectional survey of Minnesota adolescents by Loewenson *et al*.(2004), High school students who have never had sex or who decide to abstain after becoming sexually experienced often say their choice is rooted in a fear of negative consequences, such as pregnancy and sexually transmitted diseases (STDs), and personal beliefs about the appropriateness of teenage sex. According to Loewenson *et al*. (2004), males who practiced secondary abstinence were significantly more likely than sexually active males to have caused a pregnancy (21% against 9%), to be raising a child (25% against 11%) or to be raising their own child (10% against 4%). Females practicing secondary abstinence were no more likely than sexually active females to have ever been pregnant (11% against 12%), to be raising a child (20% against 16%) or to be raising their own child (6% against 4%).

Loewenson *et al*.(2004), reported that the most common reasons for abstinence selected by females who had never had sex were a fear of pregnancy (82% of ninth-grade, 77% of 12th-grade students) or of STIs (75% and 61%, respectively). The third most common reason selected by ninth graders was the belief that sex was not right for a person their age (70%), and by 12th graders was a decision to wait until marriage (58%). Among males who had never had sex, only about one in five in each grade cited concern about pregnancy as a reason for their abstinence. Concern about STIs was the most common reason selected by ninth graders (57%) and the second most common reason selected by 12th graders (46%). The most common reason selected by 12th-grade males who had never had sex was a decision to wait until marriage (47%). Half of sexually inexperienced ninth-grade males and one-third of 12th-grade males felt that intercourse was inappropriate for a person their age. Ayalew *et al.* (2014) in a cross-sectional study

in Eastern Ethiopia on parent-adolescent communication found that adolescents who have abstained from sexual intercourse cited the following reasons for not engaging in sex: religious values (30.7%), fear of STIs/HIV (15.9%), waiting until marriage (5.9%) and fear of unwanted pregnancy (4.5%).

### 2.4. Sex Information and Education Sources

Adolescents receive information, values and societal norms about sexual behaviours from variety of sources including individuals, institutions and many other sources. Some of these individuals and institutions include parents, teachers, peers/friends, religious leaders etc. Different sources of sexual information may disseminate different messages about sex and thus the sources adolescents turn to for sexual information may differentially influence their sexual beliefs as well as their sexual behaviour (Bleakley *et al*., 2009). Bleakley *et al.*(2009), in their report of how sources of sexual information related to adolescents' belief about sex indicated that adolescents learn about sex from several sources. The most frequent according to Bleakley *et al.*(2009), were friends (74.9%), teachers (62.2%), mothers (60.9%), the media (57.0%) and doctors (41.5%) and fathers (32.8%), Grandparents (13.5%) and religious leaders (12.0%). Abakah (2015), on her studies on Sex Education And Its Influence On Sexual Behaviour In The West African Senior High School In The Greater Accra Region reported that 91% of the respondents reported of having some information on sex and reproductive health of whom 52% were male. Her findings indicated that the main sources from which respondents obtain sex education were teachers and social media, the distribution were as follows: 58% of respondents obtain SRH information from teachers, 25% from mothers, 12 % from fathers, 11% siblings, 11% boy/girlfriends, 40% television, 27% radio and 24% internet.



Asked to identify the sources they would never go to obtain information on sex and reproductive health, the results indicated 33% would never go to their fathers, mothers (20%), teacher (15%), pastor/ religious leaders (29%), siblings (16%), boy/girlfriend (19%).

In Ghana, Attibu (2015) reported that a large majority of adolescents (98.3%) indicated they have ever had information on sex. When respondents were further probed to state their major source of sex education, the results show that adolescents received information on sex from Teachers (32.6%) and friends (29%) as the two major sources of sex information. They gave the reason for seeking information from the teacher as being knowledgeable in the area of sex and its related issues.

Youth learn about sexual health from formal sex education in schools, parents and other adult role models, health care providers, peers, the internet, and digital and traditional media (Brown, 2008). There is great difference in the content and quality of sexual health information across these sources: even formal sex education curriculum varies by state (State Policies in Brief, 2013). In a 2001 survey of 12-17 year olds, the three most popular sources of information about sexual health were school health class (75%), parents (70%), and healthcare providers (62%) (SexSmarts, 2001). In a 2011 study of youth and young adults ages 13-24, the internet was reported as the top source of sex information among 89% of respondents (Boyar *et al*., 2011). Boyar *et al*. (2011), reported that in contrast, when asked about the most effective way to learn about sexual health, about 20% of youth cited formal education in schools, 18% of women and 11% of men mentioned family as a resource, and approximately 12% cited an internet search. Despite feeling like they know where to get information, youth ages 12-17 report wanting more

information on the following topics (SexSmarts, 2001): How to know if you have an STI (58%); How to protect yourself from getting an STI (57%); STI treatment (54%); What is involved in getting an STI test (51%); Where to go to get tested for STIs (50%); Confidentiality of STI testing (48%); How to talk with a boyfriend or girlfriend about STIs (47%); How to talk with parents about STIs (45%); Cost of an STI test (45%); STI transmission (44%).

Bankole *et al.* (2007), in their study of very young adolescents age 12-14 in four sub-Saharan Africa countries indicated that the sensitive issue of the need for information on HIV and pregnancy prevention among young adolescents in Sub-Saharan Africa has led to policy and political debates about what information to give adolescents and the age at which to start such interventions. Various stakeholders (particularly religions leaders) have argued that teaching adolescents about sex and reproductive health would encourage them to indulge in sexual activities. And yet, despite the sensitivity of the issue, there is increasing consensus and acknowledgement that it is important to institute effective sex education programs to equip young people with information as well as skills to help them make informed and responsible decisions on sexual and reproductive health matters. Bankole *et al.* (2007), examined the range of sources of information on sexual and reproductive health issues that young adolescents report using the extent to which school-based family life or sex education programs are reaching this group in four countries. They indicated that young adolescents get information about HIV, STIs and contraceptives from a wide range of sources and that they often do so from more than one source. Mass media was reported the most commonly used source of information for these three topics combined for young male adolescents in all four countries and for

females as well in Burkina Faso and Ghana. Among Malawian and Ugandan young adolescent females, however, schools and teachers were a slightly more common source of information than mass media. In all four countries, young male adolescents are more likely to report having received information from mass media than young females. While close to 6 in 10 young adolescents accessed information on sexual and reproductive health from schools in Ghana, Malawi, and Uganda, less than 25% did so in Burkina Faso (a result of the low levels of school attendance). Friends are a key source of sexual and reproductive health information for young adolescents, especially in Malawi and Uganda where at least half of both male and female young adolescents mentioned this source. Health facilities and professionals are not a major source of information for young adolescents; with the exception of Malawi where 50% of girls and 36% of boys reported having gotten information from this source. Parents are a significant source of information among young Ugandan girls (51%) as well as boys (27%) and much less so in the other three countries. Other relatives play a bigger role than parents in all three countries (not Ghana) though not near the level of the mass media in all four countries or, in Ghana, Malawi and Uganda, teachers and schools.



According to Bankole *et al*.(2007), adolescents who received sex education in schools were also asked whether they had received information on each of four specific topics (how pregnancy happens; contraception/ how to prevent pregnancy; abstinence/say “no” to sex; and sexually transmitted infections or diseases). These results show that there is a good balance in coverage of issues relating to pregnancy and sexually transmitted infections, and that most adolescents who received sex education did so for all four topics. Although the absolute differences are not large, more boys than girls report having

received sex education on all topics in Malawi and on one topic (sexually transmitted infections or diseases) in Burkina Faso. In contrast, in Ghana and Uganda, more girls than boys reported receiving information on all topics.

Studies suggest that parental attitudes play a large role in adolescent sexual behaviour, and that frequent, open and positive sexuality communication between adolescents, parents, teachers and peers decreases risky sexual behaviour and promotes positive behaviour – including delaying sexual activity and promoting contraceptive use (Bastien *et al*., 2011; Blake *et al.,* 2001). The results from Esantsi *et al.* (2015) indicated that three out of five parents (61%) had ever discussed sexual matters with their adolescents. However, of this figure, 66% of parents indicated that they needed more information on family planning, contraception, STIs and HIV/AIDS to enable them have more meaningful discussions. Adolescents in this study rely heavily on teachers for sexual information.

About 79% of males and 64% of females indicated that they currently receive information on puberty from their school teachers. Seventy four percent (74%) of males and 65% of females receive information on pregnancy and sexual and reproductive from school as well. This indicates that the school system does provide adolescents with significant information on sexual maturation and related issues. This study also revealed that adolescents – primarily girls – also tend to rely more on their mothers than their fathers for sexual information. On the topic of puberty, 35% of girls and 18% of boys would prefer to obtain information from their mothers, and on reproduction, 29% of girls and 14% of males would prefer this.

Esantsi *et al*. (2015) also argued that because the majority of adolescents would prefer to receive information on SRH issues at home yet had never had a discussion on sexuality with either their father (89%) or mother (69%) there is therefore a clear need and opportunity for improving and increasing these discussions. However, because the majority of parents/guardians (61%) did believe that they discussed sexual matters with the adolescents, there is the additional need to improve parental efficacy at these discussions. They also reported that almost half of the adolescents (45% of females and 49% of males) obtained information on relationships principally from their friends, but only 22% of females and 27% of males actually preferred this source; many indicated that they would prefer to obtain information on relationships from their mothers (29% of females and 15% of males).

### 2.5. Parent-Adolescent Communication and Sexual Behaviour

The adolescent is born into a family and to a larger extent, a society which determines socialization and norms. The family as the first unit of contact with the adolescent has a great influence on the attitude, behaviours and perception including those of initiation into sexual activity. Parental condition such as their economic status and social relation with the adolescent such as communication and level of monitoring and supervisions are known to have great influence on the decision adolescents make concerning their sexuality (Adu- Mireku, 2003; Asampong *et al*., 2013; Stephenson *et al*., 2014). The attitudes, societal norms and values of parents towards sex can influence the choices that adolescents make concerning their sexuality (Awusabo-Asare, *et al.*, 2004; Lefkowitz & Stoppa, 2006). These can include family religious beliefs, educational status and norms

about sex. These values are usually imbibed in the child unconsciously during the process of socialization.

Most parents believe that their children are too innocent and as such not matured enough to think about or engage in any form of sexual activity while some other parents perceive their children to be "good" and not possibly sexual (Elliot, 2014). These thinking and assumptions tends to make parents avoid the entire discussion of sex thereby relegating that responsibility to their peers¸ and possibly the school.

Parent-adolescent communication about sexuality is an ongoing process rather than a one-time conversation, and one that focuses on what information are sent, what information are heard, and what messages are understood. These messages or information can be direct or indirect, and the timing, frequency, and ways in which messages are delivered can all affect how adolescents internalize and respond to parental communication about sex (Guilamo-Ramos & Bouris, 2008).

Most parents communicate with their adolescent children in a wide range of topics including, puberty, dating, sexual abstinence values and expectations, marriage, pregnancy, and contraception. Research suggests that, in general, most parents often talk about puberty, the negative effect of sexual behaviour and about sexual morals, attitudes and values (Ancheta *et al.*, 2005; Raffaelli & Ontai, 2001; Guilamo-Ramos *et al.*, 2007). With respect to values and attitudes, parents often emphasize the need to abstain from sex until marriage or until adolescents finish school and establish a meaningful career (Guilamo-Ramos & Bouris, 2008). In addition, parents discuss how having sex would be morally wrong, a message that adolescents appear to internalize. According to Guilamo-Ramos & Bouris (2008), studies show that parental disapproval of sex is related to less

risky sexual behaviour in both adolescence and adulthood. Despite this, a review of literature show that parents have a difficult time talking about the technical aspects of sexuality, including contraceptives and birth control (Guilamo-Ramos & Bouris , 2008). This may be because many parents believe they lack the knowledge to discuss such topics or that talking about contraception may encourage adolescent sexual activity. Most parents tend to talk about sex with their daughters more than with their sons which should never be as adolescents boys equally need to be educated about sex.

Guilamo-Ramos & Bouris (2008) also argued that the way parents deliver sex education messages influences adolescents' receptiveness to the message itself. Thus, the context of communication indicates that greater levels of perceived parental openness, responsiveness, comfort, and confidence in discussions about sexual and reproductive issues are associated with lower levels of adolescent sexual risk behaviour implying that adolescents' perceptions of the quality of communication may influence the effectiveness of parental messages about sex. Guilamo-Ramos & Bouris (2008), suggest that adolescents want their parents to talk to them in an open way; being an expert on sexual issues; being accessible or available to them; parents who trust and love them no matter the issue; listen to them; stay calm while talking to them about sexual issues and giving them full attention.

The timing of parent-adolescent communication about sex is very crucial. Studies suggests that parents should begin talking to their children about sex, love, and relationships before their adolescents start dating or become sexually active (Guzmán *et al.*, 2003; O'Donnell *et al.*, 2006 cited in Guilamo-Ramos & Bouris, 2008). This means

that parents should socialize their children about acceptable sexual behaviour before the find themselves in situations that increases the risk of sexual activity (before dating).

The frequency of communication between parents and children is a direct measure of the sexual socialization that adolescents receive from parents (Sue & Sue, 2003 cited in Guilamo-Ramos & Bouris, 2008). That is, the more that parents talk about sex, the more opportunities adolescents or youth have to be exposed to parental messages and values that reduce the risk of pregnancy and STDs. However, parents and adolescents have always disagreed on the frequency of communication about sex. For instance, a review of literature show that when parents and adolescents report how often they have talked about sex, parents report a greater frequency of conversations than do adolescents (Raffaelli & Green, 2003 cited in Guilamo-Ramos & Bouris, 2008). This disconnect may be due to differences in context as parents may initiate a discussion on sex whereas adolescent do not know that the discussion is about sexual issues. Parent-adolescent communication about sex should therefore be done throughout the period of adolescence. Guilamo-Ramos & Bouris (2008) report that studies with Latino youth shows that the more parents talk about specific sexuality-related topics, the more likely it is that adolescents will share similar views with their parents on that topic. This means that adolescents are indeed listening to parents and that greater frequency of parental communication about sex affects adolescents' sexual decision-making.

Parental initiation of sexual communication and involvement in the sexuality of wards is very crucial as many young people see their parents as the most or main important authority in their life. Nikkens & deGraaf (2013) argued that parents avoid or frown on talking to their children about sex due to factors like embarrassment, poor

communication skills or even ignorance of its importance or purpose in the development of their adolescents. Other studies suggest that parents are so busy at work site that they tend to neglect their responsibilities to the growing adolescent.

Parent-adolescent communication is said to mean the sharing of information between parents and their adolescent children. Frequency of parent-adolescents communication about sex is the most common tool used to measure parental impact on adolescent's sexual behaviour. Parents play an important role in influencing adolescent sexual decision-making and behaviour, including access to information about HIV and sexual health (Whitaker & Miller 2000). Positive communication between parents and youth about sex has been identified as influencing behaviour, including increased contraceptive use and delayed sexual debut, particularly for females (Halpern-Felsher *et al.,* 2004; Markham *et al.,* 2010; Miller *et al.,* 2001), and increased willingness to participate in HIV prevention trials (Otwombe *et al.,* 2009). However, research shows that there are numerous aspects of communication that determine its effectiveness and ability to influence risk behaviour, including qualities of the source (parent) and recipient (adolescent), content of the message, how the message is communicated, and the context (Bastien, & Muhwezi 2011; Jaccard, *et al.,* 2002; Poulsen *et al.,* 2010 cited in Soon *et al*., 2015). Bastien *et al.*, 2011; Wamoyi *et al.,* 2010) reported that while most parents and children desire open, direct and mutually valued discussions about sexuality, studies show that communication tends to be unidirectional, top-down and negative.

Studies by the National Coalition for Sexual Health (2013) on the Sexual Health of Youth in the United States, indicated that for most adolescents, sexual health and sexual decision making is influenced by their parents. A large majority of adolescents believe

that increased parental communication would help them make healthy choices (SexSmarts, 2000; Albert, 2012). Studies underscore the need for open, honest, and individualized parent–youth communication about sexual health. Studies show that parent-adolescent sexual health communication is associated with delayed sexual initiation, increased contraceptive use, and fewer sex partners among sexually experienced youth (Martinez *et al.*, 2010; Khurana & Cooksey, 2012; Deptula *et al.*, 2010). However, about half of 15-17 year olds report that they have never talked with their parents about sexual decision making and one in three 12-17 year olds report that they want more information about sexual health from their parents (SexSmarts, 2001, 2002). Parents are likely to take an abstinence-based approach to sex discussion and may also be comfortable to talk about marriage. However, other relevant and necessary topics such as family planning and STIs/HIV preventions are often left out in such discussions. According to NCSH (2013), studies in U.S. indicated that 70% of male youth and 79% of female youth report having conversations with a parent about at least one of the following six sex education topics: How to say no to sex (42% of men and 63% of women); STIs (50% of men and 55% of women); Methods of birth control (31% of men and 51% of women); How to prevent HIV infection (39% of men and 41% of women); How to use a condom (38% of men and 29% of women); and Where to obtain birth control (20% of men and 38% of women).

Esantsi *et al*.(2015), in a study in Ghana among slum dwellers reported that parents who talked with their adolescents about sex felt that the following issues are important to discuss: Teenage pregnancy (31%); Sex education(abortion, contraception, abstinence until marriage) (28%); STI/HIV AIDS (14%); Boy/girl relationships (4%);

Alcoholism/smoking (3%); Personal hygiene (11%). According to Esantsi *et al.* (2015), about three out of five parents (61%) indicated they had ever discussed sexuality issues with their adolescents. A majority (87%) of those who had had these discussions indicated they were comfortable and not shy in discussing this subject. Conversely, when adolescents were asked whether they had discussed sexuality issues with their parents, their responses differed greatly from their parents'. A majority (89%) of adolescents indicated that they had never discussed sex related issues with their fathers, 2% said they often had those discussions and 8% said they occasionally did. Roughly 69% of adolescents also indicated they had never had such discussions with their mothers, 9% often had such discussions, and 22% occasionally discussed this with their mothers. There is therefore a mismatch between the proportion of parents who feel that they discussed sexuality with their adolescents and the number of adolescents who agree that these discussions took place. The implications of this study is that it is possible that what parents consider as communicating on sexuality does not meet the needs of the adolescents, or that parents are ineffectively opening these discussions and the adolescents are unaware of their efforts. Parents and guardians expressed that they themselves require more information in order to have meaningful discussions on sexuality. Close to 66% needed more information on family planning, contraceptive use, and STIs and HIV/AIDS; 5% needed information on abortion; 8% needed information on puberty, rape and peer pressure; and 9% needed information on marriage.

Abakah (2015), in her study reported that more than half of the respondents reported to being close to their parents (65%), while 6% reported not being close to their parents. Most of the respondents (69.5%) also indicated that they have had no parental discussion

on issues related to relationship and dating while 30.5% had such discussion. Out of those who never had discussion with their parents, 91% of male respondents had never had any discussion on sex with parents while 86% of female respondents did not have discussion on sex. Of those who had discussion with parents 66% had had such a discussion only once whilst 33% had it every time they had an issue relating to relationship and dating. When asked on discussions on sexual intercourse, 89% of respondents had not had any discussions with parent concerning sexual intercourse and 11% of respondents had had communication with parents. Of those who had such conversation, only 9% of the males whilst 14% of the females had. For parental discussions on sexually transmitted infections 51% of the total respondents had had such discussions whilst 49% had not, of this number 56% of males and 46% of females responded to not having such discussions whilst 44% of males and 54% of females had ever had a discussion with parents on sexually transmitted infections.

Concerning the reasons adolescents are not able to discuss sexual issues with parents, Abakah (2015), indicated that more than half of the respondents (72%) reported not being comfortable discussing issues related to sexual and reproductive health with their parents with 27% being comfortable to discuss such topics with their parents and guardians. Most males were not comfortable discussing sexual and reproductive matters with their parents (53%) as compared to 47% of females who were uncomfortable. When asked of the reasons for not being comfortable communicating with parents on sexual and reproductive health, 43% of respondents indicated they were too shy, 10% said parents were too strict, 20% said they were afraid, 18% said their parents would think they are bad and 9% said their parents would not understand them. More males than females

reported to being shy and being uncomfortable, however more females reported to parents being strict and not understanding them.

Muthengia & Feredeb (n. d.) in their studies in Tanzania reported that girls who had discussion with their parents about sexual relation, family planning or HIV/AIDs were more likely to have had initiated sex than girls who did not discussed any issue with their parents. Muthengia & Feredeb (n.d.) further reported in the same study that girls who discussed HIV with parents were significantly more likely to delay the initiation of sex and to have used family planning method or modern contraceptive. Adolescent girls who said they discussed sexual relations with a parent were significantly more likely to delay their sexual debut, and to have tested for HIV.

According to Muthengia & Feredeb (n.d.), the fact that the majority of parents are not discussing sexual and reproductive health messages with their daughters suggests that these discussion are not considered normal in rural Tabora. Some of the barriers to parent-adolescents communication about sexuality from other studies in Africa include: insufficient knowledge about sexual and reproductive health issues, parents feeling uncomfortable about discussing sexual issues with daughters, assumptions that children would learn this information from elsewhere, and concerns that discussing sexuality with children will lead to early sexual experimentation (Kish, 1994 cited in Muthengia & Feredeb, n.d.).

In a qualitative study by Aperkor (2016) in Accra, it was discovered that parents inability to consistently interact with their adolescents were due to time constraints, work-related issues, apathy and parents‘ beliefs of not being responsible for such communication. Conversely, in the same study, the adolescents’ participants alluded that interactions with

their parents were infrequent with respect to communication. Adolescents blamed lack of knowledge and apathy on the part of their parents as the reasons for the poor frequency in communication. Parent's priority was placed on ways of making money (busy work schedule) rather than communication with their children.

Aperkor (2016) further revealed that parental communication about Sexual and Reproductive Health issues lacked salient details. Adolescents who reported that their parents have ever talked to them about SRH issues stated that their parents used folklores and proverbs in communicating with them. These usually lacked clearly defined details. Parents on the contrary felt that giving too much information to the adolescents would spoil them hence were cautious in discussing such matters. In the same study, APerkor (2016) reported that majority of the adolescents mentioned that it was difficult discussing sexual issues with their parents because their parents may perceive them as spoilt children hence their resort to their peers who they felt comfortable and safe to discuss such issues with.



In a study in Kenya by Gathii (2015) on the Influence of Parent -Adolescent Communication on Sexual and Reproductive Behaviour of Adolescents, it was reported that majority (50.7%) of the adolescents agreed that discussion between them and their parents influence their sexual behaviour. Additionally, most parents (32.3%) agreed that communication between them and adolescents influence their adolescent's sexual behaviour. From the same studies, most of the adolescents feel that the communication between adolescents and parents on sexual matters were helpful (80%), others felt that the conversations between adolescents and parents on sexual matters were very beneficial (75%). Gathii (2015) further discovered that higher effect of parent-adolescent

communication on sexual behaviours was on; delayed sexual initiation (92%); reduced sexual activity (90%); improved use of condoms and/or other contraceptives and sex with an unknown partner (89.5% each), increased communication between adolescents and their sex partners (89%), a lower risk of pregnancy (88%), increased self-efficacy to negotiate safer sex (87%) as well as communicating with sexual partners about sexual risk and condom use (84%). He therefore concluded that parent-adolescent communication positively affects sexual behaviour amongst adolescents especially by delayed sexual initiation, reduced sexual activity, improved use of condoms and/or other contraceptives and sex with an unknown partner.

In a qualitative study which identifies the facilitators and barriers of parent-adolescent sexual communication, Turnbull (2012) identified various facilitators of communication which help to build a positive relationship. These facilitators include love, trust, respect, commitment, support and stability. Parents show these qualities from early in their child's life, allowing for expansion and forming good relationships between family members. Turnbull (2012) argued that this was evident in families who discussed sexual matters openly. It was found that trust was paramount. Numerous statements from children revealed that if they trusted their parents, then they were more likely to talk to them about sexual matters and their personal experiences. It was also found that children who regarded their parents as role models were likely to mimic their parents' behaviour by reciprocating the openness of discussing sexual matters within families. In addition, parents' knowledge also facilitated communications concerning sexual matters. It was revealed that if children perceived their parents to have the knowledge to teach them, communications regarding sexual topics were enhanced.

In another study by Seldin (2009) in analysis of barriers to parent-adolescent sexual communication, he reported that the most common parental barriers are embarrassment and lack of knowledge on the part of parents. Ayalew *et al.* (2014), reported in their studies of parent-adolescent sexual communication in Ethiopia that cultural taboos, fear of parents, being ashamed or embarrass, parents failure to give time to listen, lack of interest by parents and lack of communication skill of adolescent makes them not to discuss openly with their parent about sexual and reproductive health issue. They also reported that adolescents prefer to discuss sexuality issues with same sex parents.

This chapter reviewed the existing literature and a more focused discussion of the sexual health issues affecting young people generally and with specific research works on Ghana. In sum, the literature reviewed shows, among other things that, even though a lot of scholarly work has been done on the issue of adolescent sexual health, no systematic empirical work has been carried out to date among this segment of the population in the East Mamprusi District in relation to issues including: Activities adolescents consider as sex; sexual practices among adolescents; What adolescents see as the strengths, weaknesses, opportunities and threats (SWOT) related to early sexual debut; And how parent-child communication affect sexual behavior of adolescents in target communities. The purpose of this research therefore is to fill in this niche and to bring recommendations for policy making.



# CHAPTER THREE

# METHODOLOGY

## 3.0. Introduction

This chapter describes the study design, the study population, the source of data, and the sampling technique including the sample size. Also discussed in this chapter are the research instrument, the method of data collection, data processing and analysis, ethical issues involved and how they were addressed and the problems encountered during the study.

## 3.1. The study Area

The study was conducted in the East Mamprusi District. East Mamprusi District is located in the North-Eastern part of the Northern Region. The district capital is Gambaga. The district shares common borders with the following: Binduri and Bawku West to the North, Bunkpurugu-Yunyoo to the East, Karaga to the South, and West Mamprusi to the West.

The district covers a land mass of 1,660sqkm, representing about 2.2% of the total land mass of the region. The district has a total population of 121,009 representing 4.9 percent of the region's total population (GSS, 2014). The population of the district is youthful (0-14 years) constituting 47.6 percent and depicting a broad base population pyramid which tapers off with a small number of old people representing 6.3 percent (GSS, 2014). The district has a total fertility rate of 3.6 which is little higher than the regional average of 3.5 and a crude birth rate of 23.0 per 1000 population (GSS, 2014). According to GSS (2014), about 57.4 percent of the population of the district aged 12 years and older is



married, while 36.6 percent has never married. Majority (70%) of the people are Moslems. The rest are made of Christian and Traditional Faith Practitioners

Health Services in the District Assembly are a mix of both government and health facilities of Christian Missions. In all, the district has thirteen health facilities: four (4) health centers, seven (7) CHPS facilities, one hospital and one district health administration. These facilities provide preventive health services and curative health services including family planning services. The district had a family planning acceptance rate of 42.6 percent in 2014 (East Mamprusi District Assembly, 2014).

The District Education Directorate had 100 Pre-Schools including 29 Private, 101 Primary Schools including 30 in the Private Sector, 37 JHS with 18 being Private, and 2 Senior High Schools (SHS). In addition, the district has the Gambaga College of Education, the College of Nursing and Midwifery in Nalerigu and the Youth Leadership Training Institute.

The major towns of the district are Nalerigu, Gambaga, Langbesi, Nagbo and Gbintiri. The main occupation of the indigenes is farming including the rearing of livestock on commercial scale in pockets of the district. Some few residents also engage in petty trading.

The schools of interest in this study are Nalerigu Senior High School and Gambaga Girls Senior High School located in the Nalerigu Township and Gambaga Township respectively.

The major ethnic group in the District is the Mamprusi who speak Mampruli. Other ethnic groups found in the eastern part of the District are the Konkombas and the

Bimobas; these are the dominant ethnic groups. Minority groups found in the area include the Mossi, Talensi, Hausa, Fulani, Frafra and Chokosi.

The land is rocky with highlands and Sahel savannah vegetation. Shea trees are wildly grown and other trees such as dawada. Cashew also thrives well. The district has long dry months with severe heat around February to April resulting in high cases of cerebro-spinal meningitis. Outbreaks are usually experienced during these periods.

The district also has a lot of hard-to-reach communities due to the rocky nature, rivers and streams. The district has a fairly good drainage system. There are five urban settlements with population of 5,000 and above. These settlements include: Gambaga, Nalerigu, Sakogu, Langbinsi, and Gbintiri. The people in these urban settlements constitute about 30% of the total population of the District. Seventy percent of the people are thus rural dwellers.

Since all the major social and economic infrastructure and services are located in the urban areas, majority of the people are either deprived totally of utilizing these facilities or have limited access to them. Throughout the district, settlement patterns are largely dispersed. A number of compounds made up of usually round huts roofed with thatch and owned by a number of households are scattered over large farmlands. This pattern in the rural areas sometimes poses a problem of distinguishing one community from another in some cases.

Most of the people especially in the rural areas live in circular structures roofed with thatch. These are usually built in circular groups to form a compound. Compound houses in most rural communities found in the western part of the District are mostly nucleated;

scattered compounds are mostly associated with the Konkombas and other communities in the eastern part of the District. The scattered nature of the settlements in the eastern part of the District makes accessibility to communities quite difficult. Most of the roads linking such places are only footpaths or roads in very bad conditions.

The major road across the District from the East to the West is however motorable throughout the year. The scattered nature of the settlements especially in the eastern part of the District implies that there should be greater investments in the provision of socioeconomic infrastructure like roads and boreholes. Another implication of the scattered nature of settlements on the provision of water facilities for instance is that boreholes with pump for separate settlements are more feasible and cost effective than mechanized boreholes usually sited in small towns.

The people are mostly subsistent farmers who cultivate food and some cash crops such as groundnuts, maize, millet, vegetables and animal rearing. The district is one of the poorest districts in the region. Many youth, especially young girls migrate to Kumasi and Accra to work as head porters (Kayaye). This practice has serious implications for HIV/AIDS, STI, and teenage pregnancy among others.



### 3.2. Study Design

Descriptive research design was employed for the study. Cross-sectional descriptive design describes phenomena at one point in time. Descriptive research design is a scientific method or type of study which involves observing, describing, collecting and recording of the behavior of respondents without influencing them in any way (Creswell, 2005). This method was used to obtain a general overview of the subjects or participants.

A cross sectional study is usually conducted to estimate the prevalence of the outcome of interest for a given population, commonly for the purposes of public health planning. Data can also be collected on individual characteristics, including exposure to risk factors, alongside information about the outcome. In this way cross-sectional studies provide a 'snapshot' of the outcome and the characteristics associated with it, at a specific point in time (Creswell, 2005). In this study, the researcher solicited information from each respondent once, within a specified period of time for the research and analysis was made after the data collection.

The study was both quantitative and qualitative (integrated method) in nature. The validating quantitative data model of mixed method was employed in this study. The researcher used this method to validate and expand on the quantitative findings from the survey by including a few open-ended qualitative questions in the survey questionnaire (Creswell *et al.,* 2003). In this model of mixed method, the researcher collected both types of data within one survey instrument (the questionnaire). The qualitative data provide the researcher with quotes that are used to validate and embellish the quantitative survey findings. Thus, the qualitative data was used as supportive or complementary to the quantitative.



### 3.3. Study Population

The population for the study was students in Senior High Schools. The researcher chose Senior High students because looking at the Ghanaian educational system most adolescents are found in the Senior High schools. For the purpose of this study,

adolescent referred to people aged 10 to 24 years. Thus, the focus was on both adolescent girls and boys who are between the ages of 10 and 24 and are attending Senior High School in the East Mamprusi District, Northern Region, Ghana (Gambaga Girls SHS and Nalerigu SHS).

### 3.4. Sample Size

The targeted population included all students in the two senior high schools in the district. This target population comprised all students between the ages of 10-24 years in both schools. In estimating the sample size, the Cochran's sample size formula was used:

$$ss = \frac{z^2 p(1-p)}{E^2}$$

Where SS= sample size; z= the value from standard normal distribution (95% confidence level which is 1.96); p= is the estimated proportion of in-school adolescents in the study area that are involved in sexual activity (since P is not known for the study population, its value is assumed to be 50% as it ensures maximum sample size); and E= margin of error (is the desired level of precision which is assume as 5% expressed as 0.05).

The resulting sample size is demonstrated in Equation 2 below

$ss = \frac{1.96^2(0.5)(0.5)}{(0.05)^2}$ = 385 in-school adolescents.

In order to cater for non-responses, the researcher added 5 % to the sample size of 385 which led to the final sample size of 405 adolescents.

### 3.5. Sampling Procedures

A multi-stage sampling procedure was employed in the study. This method involved the drawing of a sequence of samples from already selected samples, so that only the last sample of subjects is studied. Indeed, East Mampurusi District was purposively chosen because such in- depth studies about in-school adolescents have not been carried out in the area. In the first stage, stratified sampling technique was used where the two Senior High Schools in the District each served as a stratum. In the second stage, a quota was assigned to each stratum based on the proportion of each school population. In the third stage, a stratified sampling technique was used where each level (form 1, 2 and 3) served as a stratum with a sample assigned to each level (stratum). In the final stage, systematic sampling technique was used in selecting the respondents from each stratum. The systematic sampling technique was employed here to ensure that every potential participant had an equal chance of being selected into the sample. This was done to ensure that the finding of the study would be representative of the population and as such could be used for generalization.



### 3.6. Sources of Data

Both primary data and secondary information were used for this study. The primary data was generated from the responses of the respondents. The secondary information used in this study included information from the DHMT, district assembly, GHS, GSS, published journal articles, magazines, books, published theses and the internet sources that were relevant to the study.

### 3.7. Study Variables

The dependent variable in this study was "ever had sexual intercourse?" The concept of sexual intercourse used in this study was limited to sex in heterosexual relationship (penetrative vaginal sex).

The independent variables that the researcher was interested at are indicated below;

- Sex of respondent
- Age of respondent
- Type of school (mixed or single sex school)
- Current level in school
- Educational level of respondent's parents
- Employment status of respondent's parents
- Sources of sex education.
- Parent-child communication about sexual issues
- Knowledge on sexual and reproductive health issues



### 3.8. Instruments for Data Collection

The data collection instrument was a self-administered questionnaire which is a modified version of "Asking young people about sexual and reproductive behaviours: Illustrative Core Instruments" by Cleland, Ingham & Stone (2001). A questionnaire is a self-report instrument used for gathering information about variables of interest.The questionnaire for the study contained both open and close ended questions reflecting the themes from the specific objectives of this study.The questionnaire was divided into six sections. The first section (A) contained the socio-demographic data of the study participants and their families. The second section (B) explored the meaning of sex and sexuality according to

the adolescent perspective. The section three (C) contained questions on the sexual practices of adolescents. The next section (D) contained questions on the sources of sex information and education for the adolescent. The fifth section (E) investigated parent-child communication patterns and how it affected adolescents. The last section (F) contained questions for the sexually inexperience adolescents.



### 3.9. Data Collection Procedure

The questionnaire was administered by the researcher and two trained data collectors to the students and with the help of the teachers in the two Senior High Schools. A written permission was sought from the school authorities (the Headmaster and the Headmistress) before the field work. On the day of the data collection, the study participants were informed of the nature and purpose of the study. This was done in compliance with the ethics and ethical principle of research. The participants were informed that participation in the survey is voluntary and they were also assured of anonymity and confidentiality of all information given. The actual data collection started on the 1st of May and ended on 11th May, 2016. Two trained data collectors and one teacher each from each school were recruited.

### 3.10. Data Analysis and Presentation of Results

The completed questionnaires were sorted out, collated and cleaned by the researcher. This was followed by coding and the development of a frame for the final analysis to be carried out. The data collected from the field were screened for content validity and

consistencies in the questions and the responses provided. The templates for the questionnaires were developed after the data were collected from the field and analysis was done using the Statistical Product for Service Solutions (SPSS version 22.0) and Microsoft excel 2013. The data was presented using tables, charts, graphs and crosstabs. The qualitative data was extracted from the open-ended questions of the questionnaires. The qualitative study findings from the open-ended questions were triangulated with the quantitative results and presented.

### 3.11. Training and Pre-Testing

After designing the research instruments (questionnaire), a pretest was carried out in Nalerigu Senior High School. Ten questionnaires were administered to ten adolescents in Nalerigu Senior High School by accidental sampling technique. The pretest was done to test the reliability and validity of the research instrument. The necessary ambiguities and clarifications which were detected were corrected. The final questionnaire was then printed for administration. The two research assistants and two teachers from each school were trained for one day on the objectives of the study, sampling procedure, structure of the questionnaire, checking the completeness of questionnaire.



### 3.12. Quality Control

The questionnaire was subjected to content validity by the researcher's Supervisor after which it was piloted to delete or reconstruct questions found to be of no relevance. In addition, the researcher employed the services of research assistants who were trained on questionnaire administration and particularly in relation to the current study.

In addition to the research assistants, the researcher was present on the field in person to give clear explanation of the purpose and procedure for the study and clarified issues of concerns regarding the filling of the questionnaire. During the data collection period, filled questionnaires were cross-checked after administering to ensure that all questions applicable to the respondents were answered correctly and appropriately recorded or ticked. After the exercise from the field, the questionnaires were put in secured places for entry into a computer software package for analysis.



### 3.13. Limitations of the Study

In the first place, the findings of this study may be limited by respondent's recall bias. Adolescents may not be able to recall clearly on issues relating to their early adolescent stages. Also, in relation to the above is the issue of privacy. The topic under investigation was based on the individual adolescent privacy and as such it is a sensitive issue for some of them. Thirdly, the focus of the study is mainly on adolescents attending Senior High School in the East Mamprusi District including in-school adolescents in Nalerigu Senior High School and Gambaga Girls Senior High School. The study did not cover all adolescents (out-of- school adolescents) in the district which may have similar sexual and reproductive health challenges or issues. Hence, generalization of the research findings to out-of-school adolescents may not be appropriate. Finally, limited time and resource constraints created some difficulties in some cases in the field. Nonetheless, these limitations did not influence the quality of data gathered and its analysis.

### 3.14. Dissemination of Findings

Once the research work is completed, the researcher seek to share the findings with public health professionals, school authorities and policy makers in adolescent sexual and reproductive health care through stakeholders' meetings, professional conferences, media programs and publications in health related journals for public access.



### 3.15. Ethical issues Involved and how these were Addressed.

Conducting a study with adolescents is fraught with practical and ethical challenges. Sex and Sexuality is such a sensitive issue in many cultures including that of Ghana. It is therefore imperative for any researcher in the field of adolescent's sexuality and reproductive health to be careful more especially with regards to how individual's privacy and integrity are protected and respected. To deal with these challenges, ethical clearance was taken from the University for Development Studies Graduate School Ethics Control Board; informed permission was also sought from the District Education Directorate, the District Directorate of Health Services and a copy of the questionnaire was also given to school authorities prior to the day of the data collection to ensure that they were comfortable with the questions. Participants were also assured of confidentiality, privacy and anonymity of information provided and that all information provided was to be used purely for academic purposes. Consent form was printed on the front page of the questionnaire for participants to consent to before participation. Confidentiality was also maintained by reminding study participants not to write their names and to put the questionnaires on a table after they have completed. All these were

done because the topic under investigation boarded on their privacy and as such, it was done in compliance with the ethics and ethical practices governing scientific research.



# CHAPTER FOUR

# RESULTS

## 4.1. Introduction

This chapter presents the results of the study. Four hundred and five questionnaires were administered to the two Senior High Schools in the East Mamprusi District which are made up of one mixed-sex and one single-sex Senior High School. All the questionnaires were retrieved but due to incompleteness and omissions committed by the respondents on some of the questionnaires the researcher could only use, a total of 392 which were well filled for the analysis and presentation of the results.

The results of the study are presented using tables, charts and chi-square tables with major headings under the various specific objectives.

## 4.2. Background Characteristics of Respondents

The socio-demographic characteristics of the respondents in this study are presented in table 4.1 below.

**Table 4.1: Demographic Data on adolescents and their family (N = 392).**

| VARIABLE | FREQUENCY | PERCENTAGE |
|---|---|---|
| **SEX** | | |
| Male | 152 | 38.8 |
| Female | 240 | 61.2 |
| **AGE OF RESPONDENT** | | |
| 10-14 years | 16 | 4.1 |
| 15-19 years | 334 | 85.2 |
| 20-24 years | 42 | 10.7 |
| **RELIGION** | | |
| Christian (protestants) | 188 | 48.0 |
| Catholic | 17 | 4.3 |
| Muslim | 176 | 44.9 |
| Traditional African religion | 11 | 2.8 |
| **TYPE OF SCHOOL** | | |
| Single-sex school | 97 | 24.7 |
| Mixed-sex school | 295 | 75.3 |
| **CURRENT YEAR IN SCHOOL** | | |
| Form one | 126 | 32.1 |
| Form two | 180 | 45.9 |
| Form three | 86 | 21.9 |
| **EDUCATIONAL BACKGROUND OF MOTHER** | | |
| None | 254 | 64.8 |
| Primary | 45 | 11.5 |
| JHS | 35 | 8.9 |
| SHS | 44 | 11.2 |
| Tertiary | 14 | 3.6 |
| **EDUCATIONAL BACKGROUND OF FATHER** | | |
| None | 234 | 59.7 |

| | | |
|---|---|---|
| Primary | 24 | 6.1 |
| JHS | 46 | 11.7 |
| SHS | 31 | 7.9 |
| Tertiary | 57 | 14.5 |
| **OCCUPATIONAL STATUS OF FATHER** | | |
| Public/civic servant | 69 | 17.6 |
| Businessman | 26 | 6.6 |
| Farmer | 297 | 75.8 |
| **OCCUPATIONAL STATUS OF MOTHER** | | |
| Public/civic servant | 21 | 5.4 |
| Businesswoman | 115 | 29.3 |
| Farmer | 256 | 65.3 |

Source: Field survey, 2017.

Table 4.1 shows that out of the total sample size of 392 respondents, 38.8% were males while 61.2% were females. The age distribution shows that the modal age group for the study was 15-19 years constituting 85.2% of all the respondents while the least age group was 10 -14 years forming 4.1% of respondents. Slightly more than half of respondents (52.3%) were of the Christian faith with the second majority group (44.9%) being Muslim and least in terms of religion is the Traditional African Religion (2.8%). With type of school, majority of the respondents (75.3%) were in the mixed sex school while the rest of the respondents (24.7%) were from a single sex school. The year groups were graded into Form 1-3 with the highest proportion of respondents (45.9%) being in year two while the least year group in this study was form three (21.9%). From table 4.1, majority of respondents' mothers (64.8%) never had any formal education while 59.7% of respondents' fathers never had any form of formal education. On employment status of respondents' parents, majority of parents (fathers' 75.8% and 65.3% mothers) were farmers.

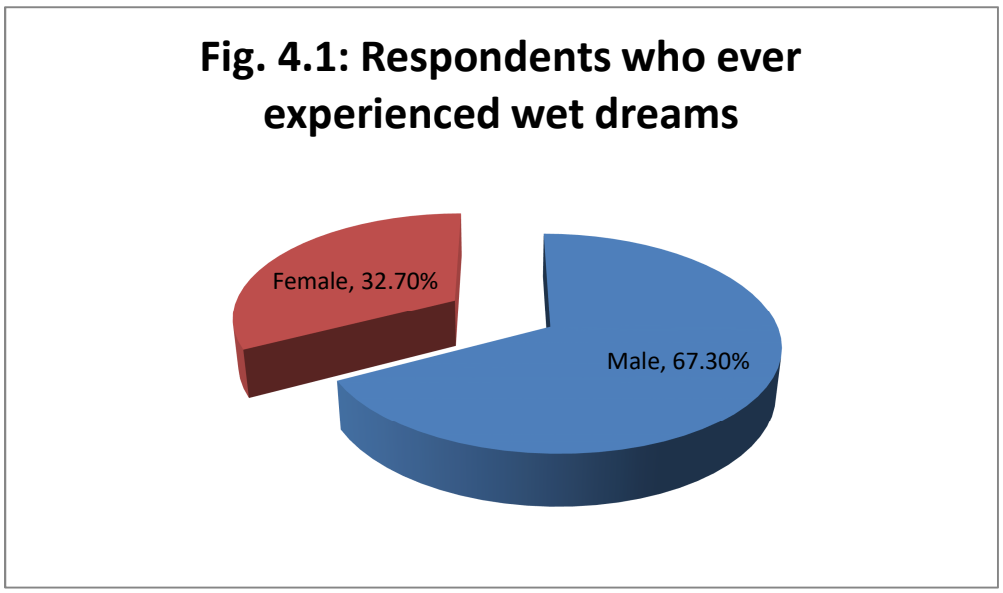
### 4.3 Practices Adolescents consider as Sex and Sexuality

Sexuality is a complex human behaviour which is influenced by many factors including physical appearance, emotions, social factors, cultural norms and previous experiences. Adolescent sexuality encompasses both penetrative penile-vaginal and non- penetrative vaginal sexual activities. The studies of adolescent sexuality is very important as it enables public health professionals to know and trace the potential routes of transmission of sexually transmitted infections or diseases and other related health problems.

As part of the study to explore adolescent sexuality and sexual status, a number of questions sought to explore the activities adolescents consider as sex and sexuality among the target group. In the first instance, respondents were asked to indicate whether they are aware of the phenomenon of 'wet dreams' and whether they have ever experienced 'wet dreams'. Indeed this is considered important against the background that during adolescence "wet dreams" or nocturnal emission do occur (Barbara, 2017). A nocturnal emission is an involuntary ejaculation of semen that occurs during sleep.

There is a difference between nocturnal orgasms and nocturnal emissions, because males can have a nocturnal orgasm (a sexual climax) without ejaculating (an emission of seminal fluids). Females can also experience a nocturnal orgasm, although there won't be an emission. Wet dreams is one of the markers of puberty (Barbara, 2017). During the process of sexual maturation, males start to produce sperms and gain the ability to ejaculate. Thus, wet dreams are just a sign of puberty. According to Barbara (2017), Females experience less frequent nocturnal orgasms than males, and rarely do they experience emission.

Figure 4.1 below shows that, even though all respondents were aware of the phenomenon called wet dreams, only 38.3% of the respondents said they ever experienced wet dreams. Majority of the respondents (67.3%) who have ever experienced wet dreams were males and about 33% were females. The findings were not completely surprising given the socio-cultural notions attached to this natural phenomenon in most societies in Ghana. The finding that more boys than girls are prone to wet dreams is also to be expected as literature show that more males experience nocturnal emission than females (Barbara, 2017). The finding that only slightly more than a third of respondents reported that they ever experienced wet dreams may be seen against customary meanings attached to the phenomenon which may prompt a level of denial. Indeed the phenomenon of wet dreams has always been given various meanings across various cultures and societies. This may account for underreporting of the prevalence of the phenomenon among respondents.




Source: Field survey, 2017

**Figure 4.1 Respondents who ever experienced the phenomenon 'wet dreams'.**

In order to ascertain meanings attached to the phenomenon, respondents were asked to explain the issue of wet dreams and their perceptions. The views expressed by respondents are varied reflecting the various dimensions ranging from lack of understanding to spiritual connotations. Some of these opinions show that respondents are aware of the phenomenon as a natural one:

> *I know that wet dreams are caused by sexual maturity of the adolescent boy and therefore it is a normal thing for boys to experience it* (Female; Christian; 18 years; form three; mixed sex school)

Another noted that:

> *I think wet dreams happen to males as they grow up but I don't think females have the same thing happening to them* (Female; Muslim; 17 years; form two; single sex school)

But other opinions related wet dreams to emotional promptings enforced through the modern day dressing style of some women that expose some body parts and therefore evoke such strong sexual and emotional feelings that translate into dreams:

> *I think that men have wet dreams as a result of strong emotions caused by the way girls are dressing these days. If you reach puberty and you see a girl dressing to 'kill' and to tease; exposing parts of the body like the breast and her buttocks, a man naturally*

*would dream such dreams* (Male; Christian; 17 years; form two; mixed school)

The idea that wet dreams are caused by demonic forces that attack young people have been a very common opinion among respondents. One female respondent explains it as follows:

*Wet dreams are caused by demons. When you are going to sleep and you do not pray, some evil spirits could come and have sex with you. It can also happen in the form of a spiritual marriage with a spirit being* (Female Christian; 17 years; form one; mixed school)

The findings as expressed above suggest that adolescents have varied interpretation they ascribe to wet dreams or nocturnal emission. A wide segment of respondents correctly identifies wet dreams as marking the onset of adolescence. Thus, the experience of wet dreams by an adolescent is an indication that the individual have reached sexual maturity and that wet dreams are normal part of physical development. From the opinions, it can be deduced that wet dreams are mostly associated with males generally. Even where the female acknowledges the phenomenon, it is expressed as one imposed by the devil. As evidenced by one of the informants, females experience dreams that engender nocturnal orgasm. However the phenomenon is hardly discussed because it is culturally seen to be a demonic invasion. The most common notion is the association of wet dreams and nocturnal orgasm with spiritual causes. This implies that even though respondents are generally aware of nocturnal emissions some of them lack adequate knowledge to inform their attitude towards the situation.

The findings also show that respondents have different ways of dealing with nocturnal emission. Some of these opinions are illustrated below:

> *For adolescents to avoid wet dreams, they should avoid watching sexy phenomenon and they should avoid thinking deep about girls* (Male; Muslim; 17 years; form three; mixed sex school)

Another informant is of the opinion that:

> *For me, adolescent boys should avoid thinking of girls all the time as that is the only way to avoid getting wet dreams* (Female; Muslim; 16 years; form two; mixed sex school)

Informants who associate wet dreams with the dressing styles of females that expose sensitive areas of the body are quick to say that females should dress 'decently', and discreetly so as to ensure safety. Those who see nocturnal emission as a function of spiritual challenges claim prayer could do much.

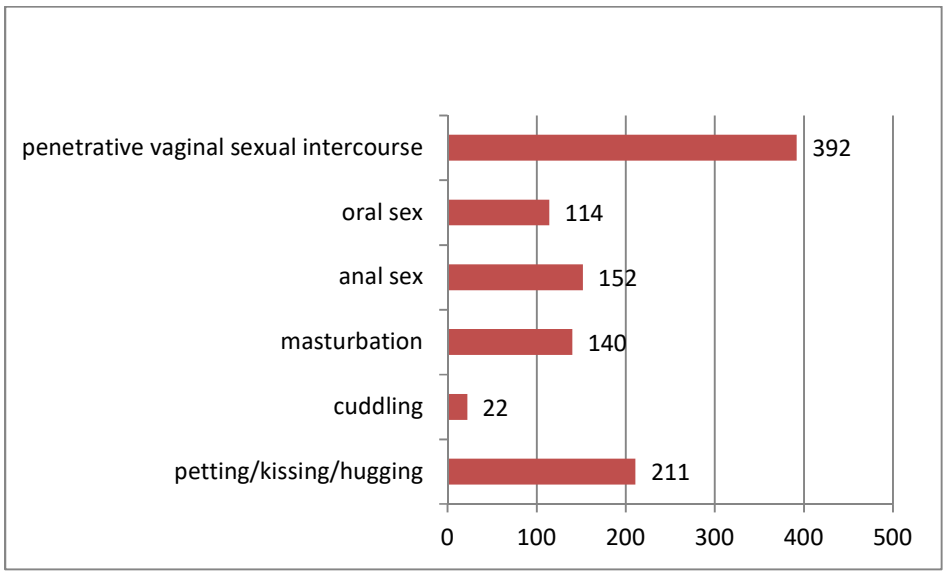
> *For me, I pray for God to deliver me from doing such thinking and take away those demons* (Female; Christian; 18 years; form two; single sex school)

The findings as expressed by adolescents above show that adolescents have different meanings for wet dreams hence varied ways of dealing with it. For those who see wet dreams as part of the developmental stages of the individual, there is no solution to wet

dreams as it is part of the experiences an adolescent is likely to experience. For those who think that wet dreams have spiritual connotations, they proffer spiritual solutions.

One of the main objectives of this current study is to explore the meaning of sex and sexuality among adolescents. The concept of sex has many meanings including biological, psychosexual, social and cultural dimensions. This makes the study of sexuality exceptionally challenging. Sexual practices are either vaginal intercourse or non-vaginal sexual practices. Any of these may expose adolescents to negative health outcomes. Much as the concept of 'sexuality' is tooted, the question as to what 'sexuality' really means to individuals is quite evasive. With the current emphasis on abstinence, efforts were made in this study to explore the meaning of 'sexuality' to respondents. Respondents were asked first to indicate their understanding of 'sex'. The results are represented in figure 4.2 below. Fig 4.2 below shows that all the respondents asserted that penile penetration of vagina is considered absolutely as sex. Apart from that, 39% of respondents mentioned penile-anal penetration as sex; 36% consider masturbation as sex; 54% consider petting/kissing/hugging as sex; 29% consider oral sex and only 6% consider cuddling also as sex.

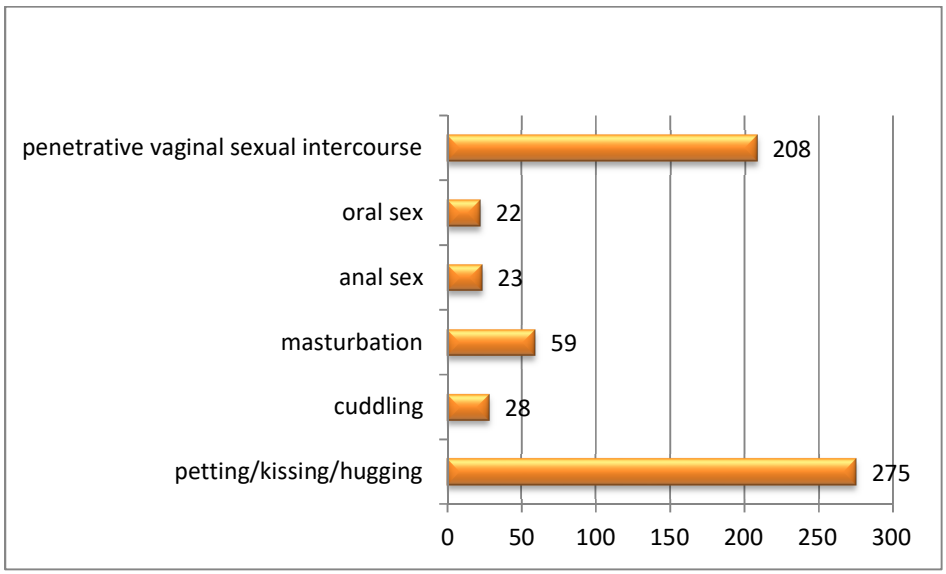





*Source: field survey, 2017: Multiple responses possible*

**Figure 4.2: What adolescents consider as sex**

A follow up question sought to explore sexual practices of respondents by asking them to indicate sexual activities they ever engaged in. Figure 4.3 below gives a summary of the findings. Figure 4.3 shows that about two- thirds (70.15%) of respondents have ever engaged in petting/kissing/hugging; 28 (7.1%) of respondents engaged in cuddling; 59 (15.05%) of the respondents have engaged in masturbation; 23 (5.8%) of respondents engaged in anal sex; 22 (5.8%) of respondents engaged in oral sex and 208 (53.1%) of respondents reported ever having had penetrative vaginal sexual intercourse. The least sexual activity engaged in by adolescents is oral sex 22 (5.6%).




*Source: field survey, 2017: Multiple responses possible*

**Figure 4.3: Sensual activities adolescents ever engaged in**

The views and beliefs held by an individual on a particular issue may influence the practice of that person. In this study, efforts were made to gauge the views of respondents in relation to certain sexual practices. Issues related to attitude towards homosexuality, dating, kissing/hugging and opinion about forced sex were discussed (Table 4.3). From table 4.3, about 14.5% of respondents asserted that they have ever been attracted sexually to people of the same sex. Respondents were asked if it is all right for unmarried boys and girls to have dates (boyfriend/girlfriend or lovers?). The results revealed that 43.1% of respondents were of the opinion that it is all right for unmarried boys and girls to have dates while 18.1% of respondents said, they do not know/not sure. The study participants were also asked whether it is all right for boys and girls to kiss; hug and touch each other sexually. With this, half of all respondents (50.8%) disagree.

Another topic of importance in adolescent sexual studies is the issue of sexual coercion and violence in sexual relationships. The question on coercive sex is posed as: if a girl says 'No' to sex should the boyfriend force to have sex with her? The results show that majority of the respondents (68.1%) disagreed with this assertion while 20.9% of the respondents agreed that such girls should be forced to have sex. Another dimension to the issue of sexual violence and coercion is the perception among members of the society that women do not really mean what they say when they say 'No' to sex. With this, the further question sought to find out the opinions of respondents in this regard. The results show that more than half of the respondents (60.5%) said girls do not really mean 'No' when they say no to sex. The impression is that girls who say "No" to sexual advances of a boyfriend may after all be seeking attention and pampering from the suitor. A girl saying No to the advances of the boyfriend is thus interpreted as part of the 'game' in courtship. It is regarded as gender normative for the girl to be passive and to play along. A girl who accepts sexual advances from the boyfriend without showing a level of 'pretentious' avoidance is seen as a weakling or promiscuous. Respondents were also asked if they believe that girls/boys should remain virgin until marriage. The results shows that more than three-quarters of the respondents (77.2%) agree to this assertion while 17.4% disagreed that unmarried adolescent should remain virgin until marriage.

**Table 4.2: Adolescents views on sexuality (N=392)**

| VARIABLE | FREQUENCY | PERCENTAGE |
|---|---|---|
| **Ever been attracted sexually to a person of the same sex as you?** | | |
| Yes | 57 | 14.5 |
| No | 335 | 85.5 |
| **Unmarried adolescents should be allowed to have dates** | | |
| Agree | 169 | 43.1 |
| Don't know/not sure | 71 | 18.1 |
| Disagree | 152 | 38.8 |
| **It's all right for adolescents to sexually kiss, hug and touch each other** | | |
| Agree | 146 | 37.2 |
| Don't know/not sure | 47 | 12.0 |
| Disagree | 199 | 50.8 |
| **If a girl says 'No' to sex, she really means 'No' always** | | |
| Yes | 155 | 39.5 |
| No | 237 | 60.5 |
| **Should girls be forced to have sex** | | |
| Agree | 82 | 20.9 |
| Don't know/not sure | 43 | 11.0 |
| Disagree | 267 | 68.1 |
| **Boy/girls should remain virgins until marriage** | | |
| Agree | 302 | 77.2 |
| Don't know/not sure | 21 | 5.4 |
| Disagree | 68 | 17.4 |

*Source: Field survey, 2017*



### 4.4.1. Sexual Practices of Adolescents

The sexual practices of adolescents are issues of public health concern as they have implication for the sexual and reproductive health of the individual adolescent and the entire society. Initiation of sexual activities whether penetrative vaginal sexual intercourse or non-vaginal sexual activity, are sometimes the defining events in the lives of adolescents because of its implications now or in the future. The initiation of sex, the type of sexual relationship adolescents engage in, the age of entry into sexual activities,

and the number of sexual partners all have impact on the sexual health of the individual adolescent and that of the society they live. One important concern of this study was to identify the type of sexual practices that respondents get involved in and its implications for the general wellbeing of the adolescent. Respondents were asked series of questions related to sexual relationships and practices. The results of the sexual practices of adolescents in the study area are presented in Table 4.3 below.

From table 4.3 below adolescents were asked as to whether they have ever been in a sexual relationship with the opposite sex or same sex? The result shows that more than half (52.0%) of the respondents have ever been in a sexual relationship. Concerning the type of sexual relation, about eight in ten (84.4%) of those who have ever been in sexual relations said, they have been in a penetrative penile-vaginal sexual intercourse relationship.

Specifically, findings show that slightly more than half of the respondents (53.1%) have ever had penetrative sex. Out of this number, majority were females (62.1%) as compared to males (38.8%). On the age of sexual debut, majority of the respondents (62.1%) have had their first sex between ages 14 to 17 years. Also, 33.9% of those who had experienced their first sexual intercourse have sexual partners currently.

Indicators for risk of pregnancy and STIs including HIV include an individual's number of sexual partners. To measure this, respondents were asked to indicate the number of sexual partner they have had. Out of those who have had sex, 21.9% reported that they have had one sexual partner within the last three months. Concerning live time sexual partners, majority of respondents (52.9%) indicated that they have had one sexual partner

while (47.1%) reported two or more sexual partners. Respondents who had had sex were asked to describe their first sexual experience. The results show that it was a mutual agreement between partners (46.2%) while 21.2% were deceived/coaxed and 32.7% were forced into sex.



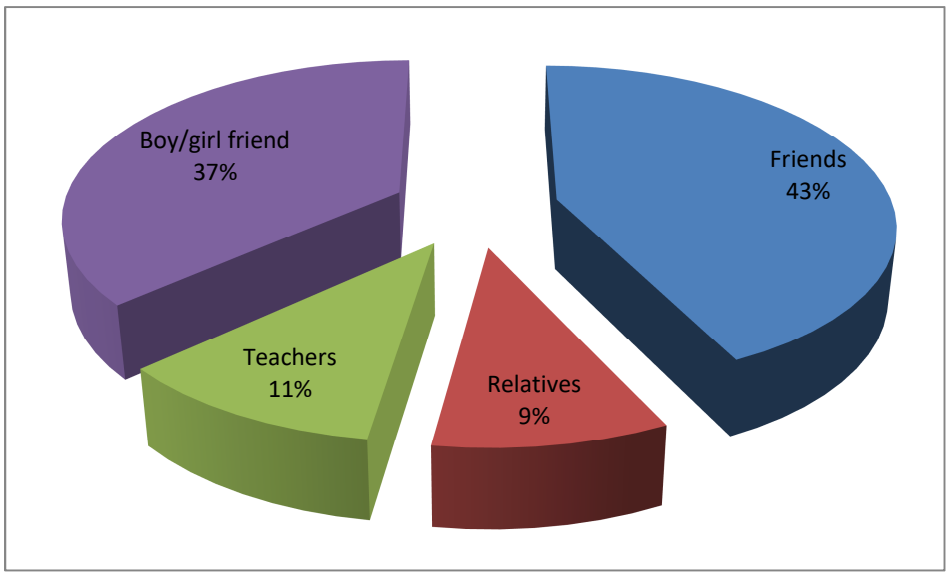
**Table 4.3: Sexual practices of respondents**

| VARIABLE | Frequency | Percentage |
|---|---|---|
| **Ever been in sexual relationship** | | |
| Yes | 204 | 52.0 |
| No | 188 | 48.0 |
| **Type of sexual relation** | | |
| Petting/kissing/hugging | 23 | 11.2 |
| Masturbation | 1 | 0.5 |
| Anal sex | 3 | 1.5 |
| Oral sex | 5 | 2.4 |
| Penetrative vaginal sexual intercourse | 173 | 84.4 |
| **Ever had sex** | | |
| Yes | 208 | 53.1 |
| No | 184 | 46.9 |
| **Ever had sex (208)** | | |
| Male | 59 | 38.8 |
| Female | 149 | 62.1 |
| **Age at first sex** | | |
| 10-13 years | 9 | 4.4 |
| 14-17 years | 128 | 62.1 |
| 18-20 years | 68 | 33.0 |
| 21-24 years | 1 | 0.5 |
| **Currently have a sexual partner** | | |
| Yes | 133 | 33.9 |
| No | 259 | 66.1 |
| **Sexual partners within last 3 months** | | |
| One partner | 86 | 21.9 |
| Two partners | 34 | 8.7 |
| Three partners | 10 | 2.6 |
| Four and above partners | 3 | 0.8 |
| **Description of first sex experience** | | |
| Own will | 96 | 46.2 |
| Coaxed/deceived | 44 | 21.2 |
| Forced | 68 | 32.7 |
| **Whole life sexual partners** | | |
| One partner | 110 | 52.9 |
| Two partners | 31 | 14.9 |
| Three partners | 41 | 19.7 |
| Four partners and above | 26 | 12.5 |

*Source: Field survey, 2017*

Furthermore, respondents were asked whether they felt pressured from others to have sexual intercourse. The results are presented in table figure 4.3. Analysis of the results

shows that 62.5% of the respondents reported that they were pressured to have sexual intercourse (not shown on the figure). Friends and peers serve as the major group that exerts pressure on adolescents to have sexual intercourse (42.9%) while the least in this category are relatives (9.4%).




*Source: Field survey, 2017*

**Figure 4.4: Groups from which pressure is felt to have sexual intercourse**

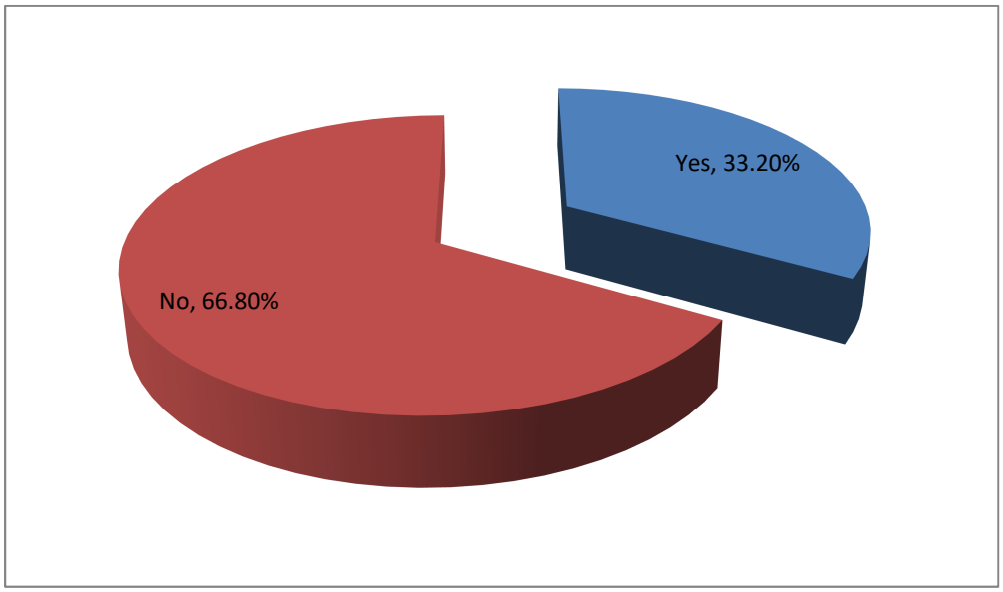


### 4.4.2 Transactional Sex

The issue of transactional sexual relationships where the exchange of money or gifts is the motivation for the initiation and continuation of sexual relations was also investigated in this study. The results are presents in table 4.4 below.

The result from fig 4.4 indicates that one in three adolescents (33.2%) who have ever had sex said they ever engaged in sex for which they had some physical benefits including money, gifts and favours. Anecdotal evidence points to the fact that the practice of

gaining physical benefits for sexual favours has generally become a common phenomenon among young people. Young people especially females seeking support for school fees, new phones, phone cards, laptop computers and modern style of life are said to be prone towards sexual favours for material gains.

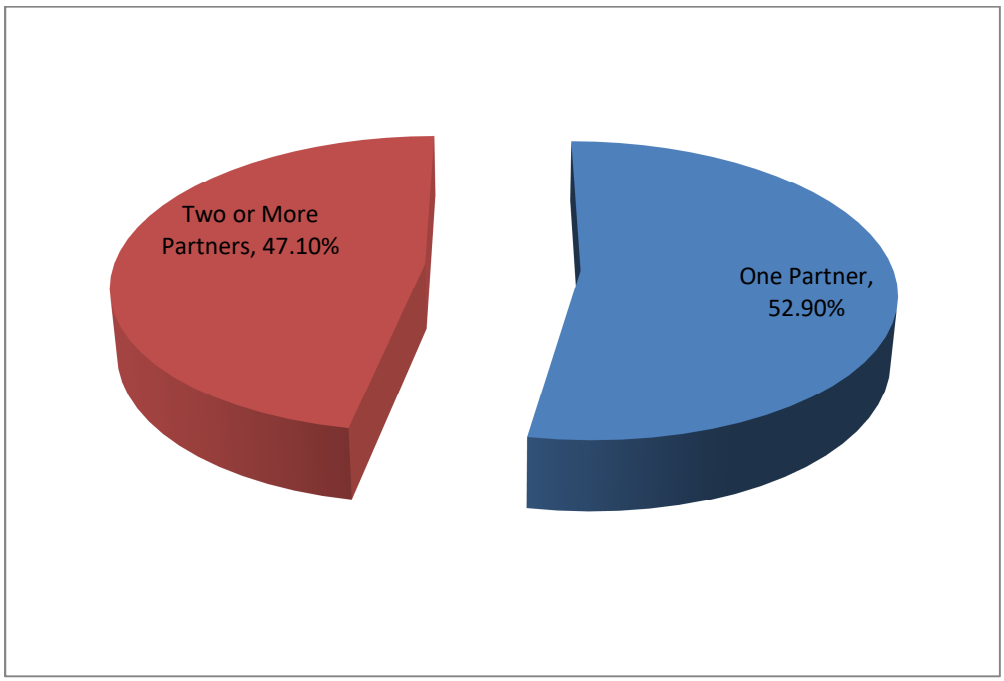



*Source: Field survey, 2017*

**Fig. 4.5: Respondents who have ever engaged in transactional sex**

The follow-up question therefore sought to explore number of sexual partners respondents had engaged in transactional sex with (Figure 4.5)

The findings as presented in fig 4.5 below show that 52.9% of the respondents who have had transactional sex have had one partner while about 47.1% have had transactional sex with two or more partners. This is an indication that the issue of sexual networking is prevalent among sexually active respondents.

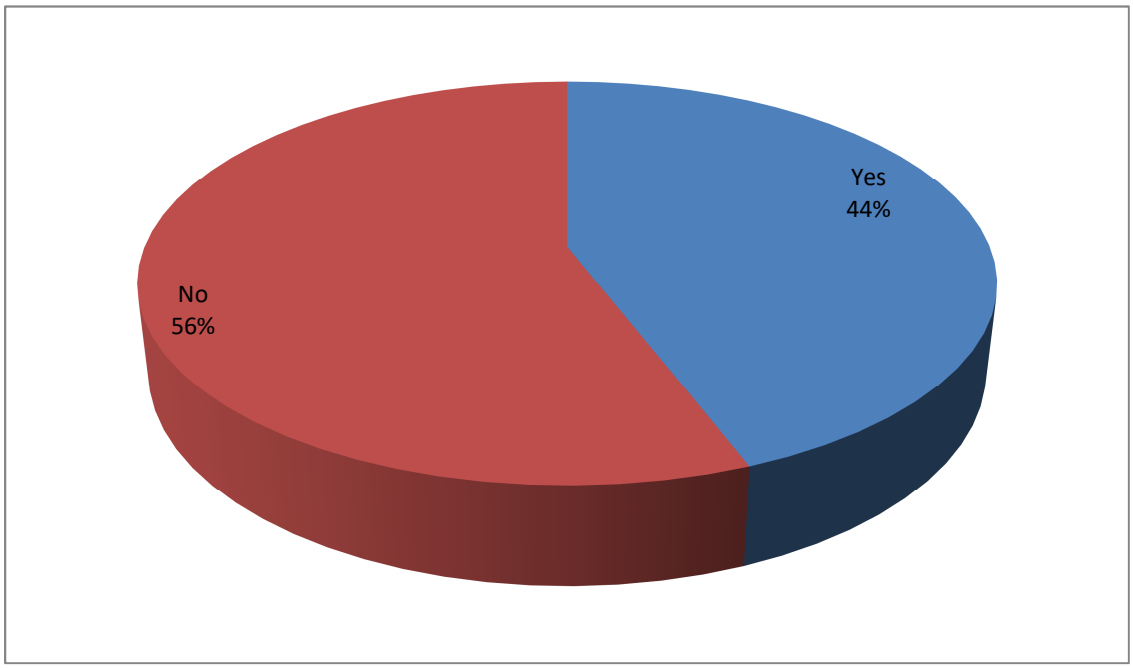



*Source: Field survey, 2017*

**Fig. 4.5: Number of partners one ever engaged in transactional sex with before**

### 4.4.3 Contraceptives Usage and Consequence of Premarital Sex among Adolescents

To prevent unwanted pregnancies and STI's including HIV, it is important that sexually active people, especially adolescents use contraceptives especially the condom which serves dual purposes of preventing pregnancy and STIs/HIV. Table 4.6 below shows the distribution of contraceptive use among adolescents in Senior High School in the East Mamprusi District. First, sexually active respondents were asked whether they used condoms during their first sexual encounter (Figure 4.6). It was found that 44.2% of those who had had sex did use condoms whereas slightly more than half (55.8%) of the sexually active adolescents indicated that they did not use condom




*Source: Field survey, 2017*

**Fig.4.6: Condom use at first sex**

The researcher probed further to know why adolescents did not use condom at their first sexual debut. Varied reasons were given for the situation:

> *I did not use condom because at that time I was staying in my village and I did not know condom. It was later that I heard about condom* (Male; Muslim; 18 years; form three; mixed sex school)

Poor knowledge about modern contraceptives among young people especially in rural areas is here given as the main challenge for the non-use of contraceptives during first sexual intercourse.

However another respondent also noted that non-use of condoms for first sex is related to the belief that contraceptives should be avoided for the first sexual intercourse.

*For me, we did not use condom because at that time I was a v*irgin. I*n our community, they say that it is a taboo to use a condom if you are a virgin* (Female; African Traditional Religion; 18 years; form two; single sex school).

Non use of condoms for first sex is also related to the feeling that sexual sensitivity could be reduced if the condom is used:

*We did not use condom because I was told by my friend that if you use condom, you will not get the feeling like when you do it raw* (Female; Christian; 19 years; form one; mixed sex school)

In another sense, condom use may not be feasible especially where sex is unplanned. For a number of informants, sex is sporadic and in many instances, spontaneous. Informants explain that in much of these first encounters, the anxiety caused by the pull-push romantic versus moral underpinnings creates the notion of vagueness prompted by strong emotional anticipation and desire that engenders defiance and therefore deviance.

*I did not use condom because it was not my intension to have sex at the time. It just happened … we found ourselves alone and one thing led to the other and without thinking about what next, we were already lost to reason and naturally drifted; the feeling was good … a good surprise that made all other fears zero … it is like being caught in a strong storm, you just have to let go…* (Male; Christian; 20 years; form one; mixed sex school)

*For me, I did not use condom because sex is an unplanned activity. I did not plan for it but the opportunity came along and I found*

*myself already locked in…* (Male; Muslim; 20 years; form three; mixed sex school)

For many informants like these ones, the sense of anomie associated with being engulfed by the strong pull of emotional gratification that quivers through the whole body shuddering all the social forces of order and values underscore the awkwardness associated with the situation and may make it difficult for young people caught in this nexus to acquire a condom for the purpose. For others, the non-use of the condom may also be purposive. It follows as a reaction to information given by others in which avoiding the use of condoms is seen as measure towards maximizing the sensitivity of sex.

*We did not use condom because that was my first time and so I wanted to get the actual experience as my friends have described it before* (Female; Christian; 19 years; form two; single sex school)

In the same vein another respondents noted:

*I did not use condom because I was told by my friends that condom has no feelings. How can you take tofie without peeling it?* (Female; Muslim; 18 years; form two; single sex school)

In some cases however, condoms were not used especially in forced sex or rape.

*I did not use condom because mine was a rape. The boy raped me* (Female; Christian; 16 years; form one; mixed sex school)

The stories cited reveal that there are so many reasons for the non-use of condom among adolescents. Some of these reasons are borne out of erroneous views held by adolescent peers who do not have adequate knowledge about the contraceptive (condom) while others are influenced by social forces and lived experiences that seem to blur the essence of using condoms. Generally however, the findings suggest the need for more education on sexuality. It also suggests that even though respondents are generally aware of condoms, the poor knowledge about sexuality and peer pressure seem to hold sway.

Also, the findings also reveal that though there is high awareness about contraceptive use in Ghana, young people in the rural areas especially have poor knowledge about contraceptives.

Another reason worth discussing is the issue of sexual coercion or rape among adolescents and their partners as expressed. Among other issues, power imbalance favouring males against females have been noted as a major concern. Factors such as older males and especially significant others in society pressurizing adolescent females especially for sex has variously been noted by informants as a major concern. In such imbalance of power, the adolescent female is the underdog, the vulnerable. Examples are cited especially of teacher-student sexual relationships.

At another level, efforts were made in this study to find out a number of other issues related to pregnancy (Table 4.5). From table 4.5 below, respondents were also asked whether they have ever used any contraceptive method to avoid getting pregnant. It was found that slightly more than half (53.1%) of all respondents that have ever had sex indicated they had ever used a contraceptive method.

The health implications of adolescent unwanted pregnancy cannot be over emphasized. Adolescent pregnancy and its outcomes are matters of public health concern. Respondents were asked whether they have ever been pregnant or made someone pregnant before. The results from table 4.5 show that two in ten adolescents (22.11%) have ever been pregnant or made someone pregnant of which 39.1% have had two or more pregnancies. The results also show that majority of respondents (71.1%) became pregnant/or ever made a female pregnant when they were between the ages of 14 and 17 years. Respondents were asked to indicate the outcome of their first pregnancy. It was found that majority (73.9%) of all who have ever been pregnant/made someone pregnant ended the pregnancy with induced abortion while (2.2%) claimed miscarriage.

Another outcome of adolescent sexual activity is the issue of STIs including HIV. Respondents were asked whether they know how STIs and HIV is acquired. The data show that nearly all adolescents (93.1%) who took part in the survey indicated that STIs and HIV are acquired by having sexual intercourse without the use of condom while (6.9%) did not know how STIs/HIV is acquired.



**Table 4.4: Contraceptive use among adolescents**

| VARIABLES | FREQUENCY | PERCENTAGE |
|---|---|---|
| **Ever used contraceptive methods to delay or avoid getting pregnant (N=208)** | | |
| Yes | 90 | 43.3 |
| No | 118 | 56.7 |
| **Ever been pregnant or made someone pregnant (N=208)** | | |
| Yes | 46 | 22.11 |
| No | 162 | 77.88 |
| **Number of pregnancies (N=46)** | | |
| One time | 28 | 60.9 |
| Two times | 10 | 21.7 |
| Three times | 6 | 13.1 |
| Four and above times | 2 | 4.3 |
| **Age during first pregnancy (N=46)** | | |
| 10-13 years | 1 | 2.2 |
| 14-17 years | 33 | 71.1 |
| 18-20 years | 12 | 26.1 |
| 21-20 years | | |
| **Outcome of first pregnancy (N=46)** | | |
| Live birth | 11 | 23.9 |
| Miscarriage | 1 | 2.2 |
| An abortion | 34 | 73.9 |
| **How STIs/AIDS is acquired (N=392)** | | |
| Yes | 365 | 93.1 |
| No | 27 | 6.9 |

Source: Field survey, 2017.



### 4.4.4 Risks Associated with Early Sexual Intercourse

Early sexual debut among adolescents marks the onset of the risk for unwanted pregnancy, STIs/HIV, and many other implications. Respondents were asked to indicate what they consider as the risks associated with early sexual intercourse.

Table 4.6 below presents results of reasons given by respondents about risks associated with early sexual intercourse. A scale of 1-6 was given to respondents to rank six risks

associated with early pregnancy. 1 represented the most serious risk and 6 represents the least serious risk for early sexual debut. From the rankings; averages were calculated in line with the scale to determine the most serious risk associated with early sexual intercourse. Analysis of the results as shown in table 4.6 revealed that the most serious risk associated with early sexual debut among adolescents is unwanted pregnancy with a mean rank of 1.93. The second most serious risk associated with early sexual debut according to the respondents was STIs/HIV. School drop outs was ranked as the third most serious risk associated with early sexual intercourse with the mean rank of 2.81. Respondents ranked loss of virginity as the fourth most serious risk associated with early sexual intercourse among adolescents. Respondents' ranked infertility arising from forced abortion and stigmatization respectively as the fifth and sixth risk associated with early sexual intercourse with mean ranks of 4.76 and 5.85.

**Table 4.5: risk associated with early sexual intercourse (N=392)**

| VARIABLE | MEAN RANK |
|---|---|
| Unwanted pregnancy | 1.93 |
| STIs/HIV | 2.02 |
| School drop out | 2.81 |
| Loss of virginity | 3.59 |
| Infertility arising from abortion | 4.76 |
| Stigmatization | 5.85 |

*Source: Field survey, 2017*

### 4.4.5 Determinants of Sexual Abstinence

Adolescents abstain from early sexual debut for a number of reasons including moral, fear of contracting STIs/HIV, becoming pregnant, fear of being reprimanded by parents and many other negative outcomes. This study also sought to find out why those who are

not sexually active abstain from sexual intercourse. The result is presented in table 4.7 below.

For respondents who had no sexual experience, this study sought to find out the reasons for their abstinence. Six possible reasons were given by respondents. Respondents were asked to rank in order of importance the factors. In this, 1 represents most important reason and 6 is used as the least important factor for abstinence. Averages were calculated in line with the scale to determine the factors that led to abstinence in order of importance. The results show that respondents felt that sex before marriage is wrong ranked the most important factor with a mean of 1.89. Being afraid of getting HIV/AIDS was the second most important factor with a mean of 2.75. The third most important factor according to the rankings was that they were afraid of their parents with a mean of 2.98. The fourth factor was respondents have been afraid of getting pregnant with a mean of 3.30. Respondents not having had the opportunity and respondents not feeling ready to have sex were ranked 5th and 6th respectively with means of 4.91 and 5.08



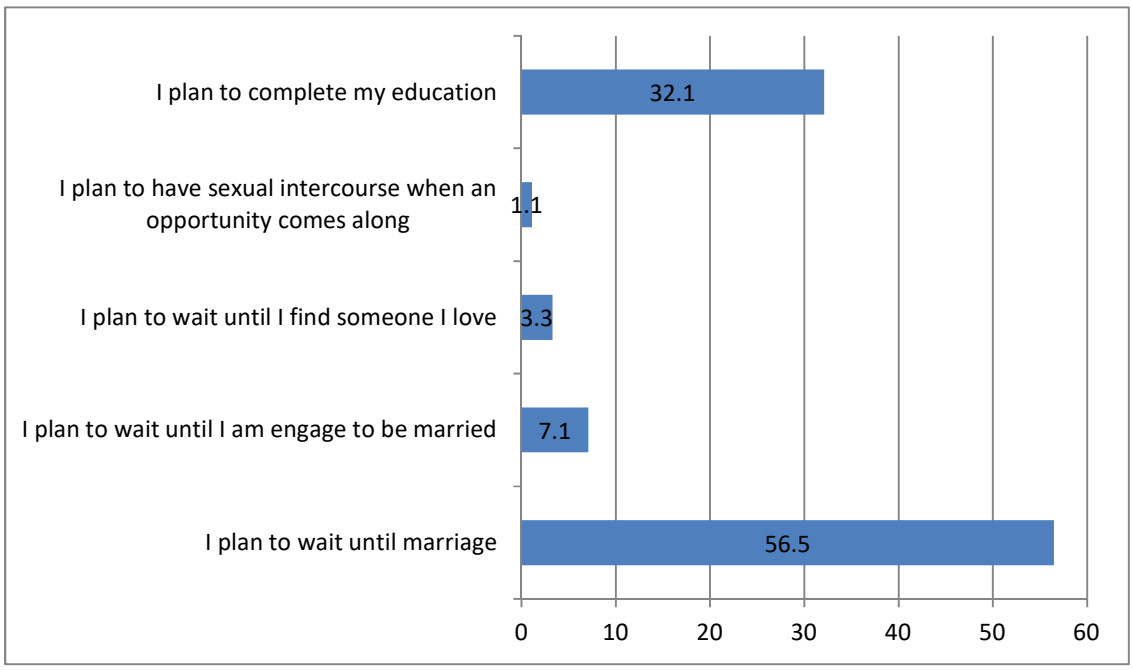
**Table 4:6: Reasons for sexual abstinence in adolescents who have not had their first sexual intercourse (N=184)**

| VARIABLE | MEAN RANK |
|---|---|
| I think that sex before marriage is wrong | 1.89 |
| I am afraid of getting HIV/AIDS | 2.75 |
| I am afraid of my parents | 2.98 |
| I am afraid of getting pregnant | 3.30 |
| I have not had the opportunity | 4.91 |
| I don't feel ready to have sex | 5.08 |

*Source: Field survey, 2017*

Respondents who have never experienced sexual intercourse were further asked to indicate their future plans regarding sexual intercourse (Fig. 4.6). The results from figure 4.6 show that more than half of the respondents (56.5%) plan to wait until they married.

The second major plan by adolescents who are not sexually active is to wait until they complete school (32.1%) while 1.1% said they plan to have sexual intercourse when an opportunity comes along.




*Source: Field survey, 2017*

**Figure 4.7: Respondents' future plans regarding sexual intercourse**



### 4.4.6 Secondary Virginity

For sexually active adolescents, there are time that adolescents after their first sexual experience, may feel that if given the opportunity they would not have engaged in sexual intercourse. Views of sexually active adolescents as to why they would want to abstain from sexual intercourse after initial sexual experience are presented on table 4.9 below.

The analysis of the results show that 76% of sexually active adolescents would want to abstain (not showed in the table) from sex until they reach adulthood. For this category of respondents, six possible reasons were outlined for respondents to rank in order of importance the reasons they would want to abstain from sex. Table 4.9 presents results analyzed in respect of this. A scale of 1-6 was given to respondents to rank them in order of importance where 1 represented the most important reason and 6 been the least important reason for wanting to abstain from sex. From the rankings; averages were calculated in line with the scale to determine the most important reason why they would want to abstain from sex after initial sexual experience from the list outlined for them. The analysis of table 4.9, show that the most important reason why sexually active adolescents would want to abstain until adulthood is because of religious affiliation with a mean rank of 1.56. The second most important reasons they would want to abstain is to prevent STIs/HIV with a mean rank of 2.77. The third most important reason adolescent would want to abstain is to prevent unwanted pregnancy with a mean rank of 3.10. To wait until marriage was ranked the fourth most important reason respondents would want to abstain. The fear of dropping out of school and in order not to be stigmatized were ranked fifth and sixth respectively with mean rank of 4.77 and 5.28.

**Table 4.7: why adolescents would want to abstain after initial sexual experience (N=208)**

| VARIABLE | MEAN RANK |
|---|---|
| Because of religious affiliation | 1.56 |
| To prevent STI/HIV | 2.77 |
| Unwanted pregnancy | 3.10 |
| To wait until marriage | 3.47 |

| | |
|---|---|
| Fear of dropping out of school | 4.77 |
| In order not to be stigmatized | 5.28 |

*Source: Field survey, 2017*

**4.5 Sources of Sex Information**

Adolescents receive information, values and societal norms about sexual behaviours from variety of sources including institutions, parents, teachers, peers/friends, social media and religious leaders. The current study intended to find out the sources of sexual information to respondents and to verify reasons why these are the popular sources for sex information. The results are presented in table 4.10 below.

From table 4.10, nearly all the respondents (99.2%) indicated that they ever received information on sex. Majority of respondents (56.6%) suggested teachers as their main source of sex education and information. Teachers were cited as very knowledgeable (58.9%) and are regarded as authority on the subject.

The issue of communication on sexual issues was also investigated. Quite a significant proportion of respondents (45.8%) indicated that they receive sexual information very often while 12.6% said they rarely receive sexual information. Respondents were also asked whether they were satisfied with the sexual information they received. The results show that more than half of the respondents (55.5%) were not satisfied with the information they received. The findings also show that respondents would want more information on contraceptives generally (53.1%).

**Table 4.8: Sources of sex information (N=392)**

| VARIABLE | FREQUENCY | PERCENTAGE |
|---|---|---|
| **Ever receive information on sex** | | |
| Yes | 389 | 99.2 |
| No | 3 | 0.8 |
| **Source of sex information** | | |
| Family (parents) | 95 | 24.4 |
| Teachers | 220 | 56.6 |
| Friends/peers | 55 | 14.1 |
| Social/mass media | 19 | 4.9 |
| **Why that choice as source information on sex** | | |
| Feel comfortable with | 107 | 27.5 |
| Knowledgeable | 229 | 58.9 |
| Readily available | 53 | 13.6 |
| **How often sex information is received from this source** | | |
| Very often | 178 | 45.8 |
| Occasionally | 162 | 41.6 |
| Rarely | 49 | 12.6 |
| **Satisfaction with sex information received** | | |
| Yes | 173 | 44.5 |
| No | 216 | 55.5 |
| **Other information on sex?** | | |
| Yes | 363 | 93.3 |
| No | 26 | 6.7 |
| **Aspect of sex information lacked** | | |
| Sexual issues | 34 | 9.1 |
| STIs/HIV | 64 | 17.0 |
| Family planning | 199 | 53.1 |
| Marriage | 78 | 20.8 |

*Source: Field, 2017.*



### 4.6.1 Parent–Adolescent Communication about Sex

Parent-child communication can be said to mean the sharing of information between parents and their adolescent children. Frequency of parent-child communication about sex is the most common tool used to measure parental impact on adolescent's sexual behaviour. One of the objectives of this study was to assess the effect of parent-adolescent communication on the sexual behaviour of adolescents. The results of parent-adolescent communication are presented in Table 4.11.

Findings from Table 4.11 below revealed that 74.0% of the respondents live with their biological parents of which 82.4% of them reported that their parents talk to them about sex. The findings suggest that slightly above half of the parents (56.0%) who discussed sex issues with their adolescent children were mothers and the content of sex education often discussed with parents was on marriage (41.8%).

The frequency of parent-child communication about sex is an important variable in determining the initiation and continuation of sex. Thus, respondents were asked how often their parents talk to them about sex. The results from table 4.11, show that majority of the respondents parents (56.3%) occasionally (at least once in a month) discuss something related to sexual issues while 13.9% rarely (about once in a two or in more months) discuss with their children something related to sex and sexuality

**Table 4.9: Parent –child Communication about sex**

| VARIABLE | FREQUENCY | PERCENTAGE |
|---|---|---|
| **Who do you live with (N=392)** | | |
| Both biological parents | 290 | 74.0 |
| Biological mother only | 57 | 14.5 |
| Biological father only | 7 | 1.8 |
| Guardian | 38 | 9.7 |
| **Parents talk to you about sex (N=392)** | | |
| Yes | 323 | 82.4 |
| No | 69 | 17.6 |
| **Who among parents talk to adolescent about sex (N=323)** | | |
| Both parents | 102 | 31.6 |
| Mother only | 181 | 56.0 |
| Father only | 17 | 5.3 |
| Guardian | 23 | 7.1 |
| **Content of sex education received (N=323)** | | |
| Sexual issues | 95 | 29.4 |
| STIs/HIV | 77 | 23.8 |
| Family planning | 16 | 5.0 |
| Marriage | 135 | 41.8 |
| **How often parents educate adolescents on sex (N=323)** | | |
| Very often | 96 | 29.7 |
| Occasionally | 182 | 56.3 |
| Rarely | 45 | 13.9 |

*Source: Field survey, 2017*

Another question sought to find out why some parents do not engage adolescent children on sexual communication despite the importance of parent-child communication on the sexual behaviour of their wards. A number of reasons were adduced by adolescents as to

why their parents do not educate them on sexual issues. Some of the reasons reported by respondents include the following:

> *I think my parents do not educate me because they are always busy in their work site that they do not have enough time for me. They also come home very late from work* (Male; Christian; 18 years; form two; mixed sex school)

The occupation of parents is here cited as a possible reason why discussions about sex and sexuality are difficult between parents and their wards.

> *For me, I don't know the reason but I feel that they are so religious that they do not want to talk about sex to me* (Female; Christian; 19 years; form three; single sex school)

There is also the feeling that some parents would rather pray about God directing their wards than they themselves as parents communicating on the issue of sex and sexuality with their wards.

A number of respondents also assume that their parents being illiterates may account for their inability to communicate on the subject of sex and sexuality at home. A related issue often cited is that cultural avoidance by parents of the subject has been a common phenomenon in many ethnic groups. In many places, relatives like aunts and uncles take up that responsibility rather than parents per se.

> *My parents do not educate me because they are illiterates so I think they do not have the knowledge about sexual issues* (Female; Muslim; 19 years; form two; single sex school)

The fear that such discussions would have latent functions like making the young person more curious about sexual issues is a common explanation for lack of openness at home about discussions on the subject.

> *My parents think that they will spoil me if they talk to me about sex and so they don't even want to hear about it* (Female; African Traditional Religion; 19 years; form two; mixed sex school)

> *For my parents, they think talking to me about sex will expose me more to sexual information that I will do or test it* (Female; Christian; 17 years; form three; single sex school)

Some parents are seen as not just able to handle the topic at home. They feel embarrassed about such discussions.

> *For me, my parents feel shy or embarrassed to talk about sexual issues with us as their children. My parents don't even want to mention any thing relating to sex matters* (Male; Christian; 20 years; form three; mixed sex school)

> *On my part, I don't know but I think my parents think that I am too small and therefore there is no need to be talking about issues of*

*sexuality to me* (Male; Christian; 16 years; form one; in a mixed sex school)

From the findings above, it is noted that there are so many factors that are hindering parent-adolescent sexual communication. One of such challenges to parent-adolescent sexual communication is the issue of embarrassment. Thus, some adolescents feel that their parents feel embarrassed or shy to discuss sexual issues with them. The second other reason respondents ascribed to their parents inability to talk to them about sexual issues is the issue of fear that exposing adolescents to such issues could lead them to become promiscuous. Another reason cited by respondents for poor communication of sexual issues at home is because of ignorance or inadequate knowledge of sexual issues by parents themselves. Some respondents also think the low educational status of their parents may account for their lack of knowledge on sexual and reproductive health issues and their poor performance in providing the necessary education at home on the subject. The third most important reason advanced by adolescents as to why parents do not educate their adolescent wards on sexuality is the issue of religious extremism. Some parents erroneously avoid the topic of sexuality at home with the excuse that it is not religious to talk about sex with children. Such parents tend to associate any such discussions with immorality thus they shy away from their children any time an issue is mentioned. The second but last reason as reported in the above finding is that of lack of time or time constraints as a result of occupational demands. Some parents have neglected their responsibility to their children because of the demands of work. Parents are so occupied at work site that they do not have time for the family particularly on issues related to sexuality. Timing of such discussions was also noted as important. Some

parents are not certain of the appropriate time to initiate sexual communication with their adolescents. Some parents feel their children are too young to be engaged in sexual activities hence there is no need to start sexual communication. This however, may lead to adolescents seeking and receiving wrong information from their peers with its sometimes attendant negative consequences.

As part of the study, respondents were also asked whether they are able to approach their parents to discuss personal issues about sex. The results show that majority of the adolescents (55.6%) said they could not approach their parents on personal issues regarding sex while 44.4% indicated that they could approach their parents. A further probe by the researcher to ascertain why some adolescents could approach their parents reveals the following reasons.

> *For me, my mother is the open type of person. She talks to us all the time so we do not always fear to talk to her over sexual matters* (Female; Christian; 16 years; form one; mixed single school)

> *For me, our family is the open type where we are free to question anything. There is always easy flow of information about everything including sexual related topics* (Male; Christian; 18 years; form three; mixed sex school)

> *In our family, my parents consider us as their friends and therefore we feel comfortable to ask them about anything we want* (Female; Muslim; 16 years; form two; single sex school)



> *My mother is a midwife, she always talk to us about contraceptive use and how to prevent pregnancy. So because she has being talking to me about it, I feel comfortable to ask hear about anything in relation to sex* (Female; Christian; 18 years; form three; single sex school)



Findings suggest that positive parent-adolescent sex communication is associated with several factors. Some of these include the willingness of parents to be open to their children. It means that adolescents who think their parents are open minded on the issue are more able to approach them on any issue including those of sexuality. One other factor that stands clear from the above finding is the issue of perceived friendliness of parents to their wards. Parents who see their children as friends are a motivation for such children to be able to approach them to discuss with them on matters of sexuality. The last issue worth highlighting is the perceptions adolescents hold about their parents in terms of their knowledge in the area of sexuality. Thus, if adolescents perceive that their parents have adequate knowledge about sexual and reproductive health, such adolescents will be willing to approach them.

As stated above, the researcher probed further to ascertain why some adolescents are not able to approach their parents with issues regarding sexuality. Adolescents in this study reported several reasons why they could not approach their parents as presented below.

> *Some parents are so hard. And that is the type of parents I have. They always rebuke me whenever you talk and mention anything*

*relating to sex to them* (Male; Christian- the Church of Pentecost; 19 years; form one; mixed sex school)

*For my parents, they are not friendly at all. They are always fond of shouting at me at the least thing you do or say. So because of that, I fear them so much I do not even want to talk to them on this thing* (Female; Christian; 18 years; form two; single sex School)

A female respondent, Muslim, 18 years of age, second year student of a single sex school was of the opinion that:

*As for issues related to sex and sexuality, it is not easy; my parents have developed eagle eyes that suspect any movement at all. Because of their attitude, I am very careful not to make them think I am into sexual relationship. So I don't even talk about anything like that with them. The way my parents are, if you ask questions about this thing (sexual issue), they will start having ideas and monitoring you seriously.*



Two other respondents noted that:

*For this topic, it is difficult. How can you feel confident to talk to them about sex? I feel very shy or shame to talk about sex to them* (Male; African Traditional Religion; 17 years; form one; mixed sex school)

> *I cannot talk to her about this issue. The reason is that she is a female and I am a male. So for that matter, how can I tell her all my problems* (Male; Christian- Deeper Life; 15 years; for one; mixed sex school)

The findings as illustrated above reveal a lot of dynamics about parent-adolescent sexual communication. In the first instance, the place of sex in our society is called into question. Sex is viewed as a secret affair or "no go area for children" such that they are not to be heard talking about it. The child and for that matter adolescents are not regarded as sexually mature people at this stage and it is assumed that they should remain innocent, hence things relating to sexuality should not be discussed.

The issue of trust between parents and their adolescents as reported by the respondent is an important one. Respondents believe that their parents suspect them of engaging in bad practices. Thus seeking explanations about sex could be seen as an indication that the adolescent is engaging in such sexual practices.

Another challenge of parent-adolescent sexual communication as reported above is the fear of being branded a spoilt child or bad child. Some adolescents do not seek sexual information from their parents so as to avoid being tagged. Related to the above is the issue of assertiveness. Some adolescents are not brought up to be assertive in their dealing with their parents as well as any other person. They lack the confidence to approach their parents with issues relating to sex. Parents have not inculcated in adolescents how to be assertive in their communication including those on sexual issues. One other issue that serves as a hindrance to parent-adolescent sexual communication is

the issue of parental hostility. Adolescents who feel parents are hostile to them tend to avoid discussing their personal issues with such parents including sexual issues. This is noted in attitudes such as beatings and shouting at adolescents. These are said to deter them away from parents. However, respondents said if parents are warm and receptive, they would be willing to confer with their parents on everything including those of sexual issues. The last issue as noted above is that of gender differences in parent-adolescent sexual communication. As reported above, gender difference between an adolescent and his or her parent could serve as a barrier to effective parent-adolescent sexual communication. Thus, adolescent boys tend to feel comfortable talking to their father on issues of sexual and reproductive health whereas adolescent girls prefer to discuss issues of sexual and reproductive health with their mother.



### 4.6.2 The Associations between Parent-Child Communication and Sexual Behaviour pattern of Adolescents.

The survey also sought to find out the effects of parent-child communication and their implications on the sexual behaviour patterns of adolescents.

A bivariate analysis of the association between the living condition of the adolescent and sexual initiation as presented in table 4.12 below shows that 44.8% of the respondents who live with both parents reported ever initiating sexual intercourse while 55.2% of those who live with both parents indicated they have not initiated sexual intercourse. Again, analysis from the table reveals that 52.6% of adolescents who live with their mothers only reported ever initiating sexual intercourse while 47.4% of those who live with their mothers only have not initiated sexual intercourse yet. For respondents who

live with their fathers only, 28.6% reported that they have initiated sexual intercourse while 71.4% reported that they have not initiated sexual intercourse.

Source of sex information to an adolescent is very important as it determine whether or not he/she would engage in early sexual debut. For this measurement, four indicators namely family (parents), teachers, friends/peers, and social/mass media were outlined for respondents to indicate which amongst them is their main source of sex information. This was to establish the relationship between source of sex information and the sexual status of the adolescent. From the result, 47.4% of respondents who received sex information from parents reported ever having sexual intercourse while 52.6% who received sex information from their parents have not initiated sexual intercourse. Similarly, for respondents who reported teachers as their main source of sex education, 53.2% reported ever having had sexual intercourse while 46.8% indicated that they abstain from sexual intercourse. For respondents who reported friends/peers as their main source of sex information, 58.2% indicated they ever had sexual intercourse while 41.8% abstain from sexual intercourse. For adolescents who received sex information from social/mass media, 68.4% reported having had sexual intercourse while 31.6% abstain from sexual intercourse.



One significant objective for this current study was to establish the relationship between parent-adolescent communication and its impact on the sexual behaviour pattern of adolescents. A chi-square analysis of this relationship as presented in Table 4.12 reveals that for respondents who said both parents talk to them about sex, 42.3% reported ever had sexual intercourse while 57.8% reported that they abstain from sexual intercourse. From the table, adolescents who indicated that it was their mothers who talk to them

about sex, 45.3% indicated that they have had sex while 54.7% abstained. For respondents who reported that it was their fathers who talk to them about sex, 35.3% reported having initiated sexual intercourse while 64.7% abstain from sex.

The study further probed into whether sex information provided by parents could make adolescents abstain from sex; it is seen from Table 4.13, that 52.1 % of respondents reported being talked to by parents could make them abstain while 47.9% stated that sex education from parents could not make them abstain from sexual intercourse. Thus, there is a statistically significant relationship between sex education provided by parents and the sexual debut of their adolescents as seen in Table 4.13 with a p-value of (0.00). That is, adolescents who received sex education from their parents are less likely to initiate sexual intercourse than those who do not receive sex education from their parents. Hence, there is an inverse relationship between sex education provided by parents and the sexual debut of their adolescent wards.



**Table 4.10: Bivariate analysis of parent-adolescent sexual communication and patterns of sexual behaviour of adolescents**

| Variable | | Ever had sexual intercourse | | | | |
|---|---|---|---|---|---|---|
| | | Yes | | No | | |
| | | Freq. | % | Freq | % | (p-value) |
| Living condition of adolescents | Both parents | 130 | 44.8 | 160 | 55.2 | (0.05) |
| | Mother only | 30 | 52.6 | 27 | 47.4 | |
| | Father only | 2 | 26.6 | 5 | 71.4 | |
| | Guardian | 19 | 50.0 | 19 | 50.0 | |
| Main source of sex education | Family (parents) | 45 | 47.4 | 50 | 52.6 | (0.30) |
| | Teachers | 117 | 53.2 | 103 | 46.8 | |
| | Friends/peers | 32 | 58.2 | 23 | 41.8 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Social/mass media | 13 | 68.4 | 6 | 31.6 | |
| Parents who talk to adolescents about sex | Both parents | 43 | 42.2 | 59 | 57.8 | (0.01) |
| | Mother only | 82 | 45.3 | 99 | 54.7 | |
| | Father only | 8 | 47.1 | 9 | 52.9 | |
| | Guardian | 12 | 52.2 | 11 | 47.8 | |
| Abstinence from sex because of sex education | Yes | 130 | 49.1 | 141 | 52.1 | (0.00) |
| | No | 43 | 82.7 | 9 | 17.3 | |

*Source: Field survey, 2017*

From the above analysis, it can be concluded that adolescents with both parents talking to them about sex are more likely (57.8%) to abstain from sexual intercourse as compared to when it is done by the mother only (54.7%) or father only (53.9%).



# CHAPTER FIVE

# DISCUSSION

## 5.1. Introduction

This study aimed at exploring the sexual behaviour of adolescents in Senior High Schools in the East Mamprusi District. Specifically, the study examined the sexual status of adolescents and the activities they consider as sex and sexuality. It was also to explore the sexual practices adolescents in the Senior High Schools in the District engage in and the sources from which adolescents receive sex information and education. This study was also to investigate parent-child communication patterns and how they affect adolescent sexual behaviour

The motivation for this current study is that though there have been some studies on adolescent sexual and reproductive health, there have not been systematic empirical investigation into activities adolescents consider as sex and more specifically among that segment of the population (10-24 years) in – school adolescents in the district. This chapter discusses the research findings in line with the above stated objectives.

## 5.2. Socio-Demographic Characteristics

The result of the study shows that out of the total sample size of 392 respondents, 38.8% were males while 61.2% were females. This skewed proportion of sex toward female could be attributed to the presence of a female single sex school and a mixed school with almost equal numbers of both sexes. The age distribution shows that majority of the respondents (eighty –five percent), who took part in the survey, were between the age group of 15 – 19 years which is in line with the educational system of Ghana where the entry age at Senior High School is fifteen years (form one).

### 5.3. What Adolescents consider as Sex and Sexuality

Adolescent sexuality encompasses both vaginal (coital) and non-vaginal (non-coital) sexual activities. The result shows that all the respondents asserted that penetrative vaginal sex is considered as sex; 152 respondents representing thirty-nine percent consider anal sex as sex; 140 respondents representing 36% consider masturbation as sex; 211 respondents (54%) consider petting/kissing/hugging as sex; 114 respondents (29%) consider oral sex as sex and 22 respondents (6%) consider cuddling as sex. These findings corroborate studies by Lindberg *et al.* (2012) that non-coital behaviours are common expressions of human sexuality these days. These non-coital sexual activities, which include mutual masturbation, oral sex, and anal sex are considered by adolescents as sex and are commonly practiced by opposite sex and same-sex couples as well as adolescents. The implication of these findings is that any discussion about adolescent sexuality must recognize that adolescents these days engage in a wide range of sexual behaviours other than penetrative vaginal intercourse.

This current study also investigated the issue of wet dream or nocturnal emission among adolescents. The experience of wet dreams by adolescents which also serves as a marker of sexual maturity forms part of adolescent sexuality. The result of the study shows that nearly four out of ten adolescents (38.3%) have experience wet dreams in their life time with the majority of whom are males (67.3%) respondents compared to female (32.7%).

The results of this current study also show that about two- third 275(70.15%) have ever engaged in petting/kissing/hugging; 28 (7.1%) of respondents engaged in cuddling; 59 (15.05%) of the respondents have engaged in masturbation; 23 (5.8%) of respondents engaged in anal sex; 22 (5.6%) of respondents engaged in oral sex and 208 (53.0%) of

respondents reported ever having had penetrative vaginal sexual intercourse. The least sexual activity engaged in by adolescents is oral sex (22). These findings contradict with earlier studies which reported low levels of penetrative vaginal sex (coital) but a slightly high prevalence of non coital sex activities among senior high school students in the Greater Accra Region of Ghana and among 15–24 years old adolescents attending a large state university in Manila, Philippines respectively (Odonkor *et al*., 2012; De Jose, 2013).

Another issue of importance for this study was the opinion of adolescents regarding certain aspects of sexuality. These opinions serve as determinants of what adolescents' belief and practice. Thus, Respondents were also asked if they believe that girls/boys should remain virgins until marriage. The results show that more than three-quarters of the respondents (77.2%) agree to this assertion that adolescents should remain virgin till marriage. The finding of this study confirms studies by Awusabo-Asare *et al*. (2006) that more of all adolescents (females and males, older and younger) agreed that young women and young men should remain virgins until they marry. The implication of this finding is that virginity among adolescents is still a cherished virtue in the Ghanaian society.



### 5.4. Sexual Practices among Adolescents

The sexual practices of adolescents are issues of public health concern as they have implication for the sexual and reproductive health of the individual adolescent and the entire society. Initiation of sexual activities whether penetrative vaginal sexual intercourse or non-vaginal sexual activity, are sometime the defining events in the lives of adolescents because of its implications now or in the future. The initiation of sex, the type of sexual relationship adolescents engage in, the age of entry into sexual activities,

and the number of sexual partners all have impact on the sexual health of the individual adolescent and that of the society.

Being in a sexual relationship is a prelude to being sexually active. The result of the study shows that more than half (52.0%) of the respondents have ever been in a sexual relationship before. This finding is in line with the findings by Attibu (2015) that majority of adolescents are in a sexual relationship. Concerning the type of sexual relation, more than eight in ten adolescents (84.4%) of those who have ever being in sexual relations said, they have being in a penetrative vaginal sexual intercourse relationship. Attibu (2015) also found that more than half of the adolescents who are in sexual relationship are into penetrative vaginal sexual intercourse relationship.

A key determinant of exposure to the risk of pregnancy and STIs is the issue of initiation of sexual intercourse. The age at first sexual intercourse is an important indicator of the onset of exposure to risk of both pregnancies and STIs including HIV (Awusabo-Asare *et al*., 2006). The findings from this study show that slightly above half of the respondents (53.1%) have ever had sex in their live time. Out of this number, majority were females (62.1%) as compared to males (38.8%). On the age of sexual debut, majority of the respondents' age 14 to 17 years (62.1%) have had their first sex. Also, nearly one in three (33.9%) of those who had experienced their first sexual intercourse currently have sexual partners. These findings agree with several studies that more than half of adolescents age 10-24 are sexually active (Glover *et al.,* 2003; GSS, GHS & ICF, 2015; Attibu, 2015).

Indicators for risk of pregnancy and STIs include the number of sexual partners of the individual. Statistics on the current and lifetime sexual partners are indicators of the level of exposure to pregnancy and STIs. In this study, the results concerning live time sexual

partners, show that majority of respondents (52.9%) have had one sexual partner while (47.1%) reported two or more sexual partners. This finding on sexual partnership is similar to finding by Attibu (2015) where she reported that nearly half of adolescents in her survey reported having two or more sexual partners. The implication of this sexual networking is that adolescents do not stay in long time sexual relationship but may go into new relationship because of some unfulfilled expectation such as financial gains or rewards which is a recipe for the transmission of sexually transmitted infections including HIV/AIDS.

Another sexual practice in which adolescents get involved is the issue of sexual exploitation and coercion. Over the years, there have been reported cases of rape, defilement and sexual abuse in the mass media. Evidence from Ghana and elsewhere shows that the issue of sexual coercion is a major public health concern for adolescents as well as adults. For young people in particular, sexual coercion has long lasting and profound negative sexual and reproductive health consequences (Moore *et al.*, 2007; Tweedie & Witte, 2000 cited in Awusabo-Asare *et al.*, 2006). In this current study, respondents who have had sex were asked to describe their first sexual experience. The results show that nearly half (46.2%) willingly offered themselves on their first sexual intercourse while 21.2% and 32.7% were deceived/coaxed and forced respectively. This finding is in agreement with several other studies in Ghana and elsewhere that two in ten adolescents first sexual experience were as a result of coercion/force (Awusabo-Asare *et al.*, 2006; Glover *et al*., 2003; Ochieng, 2013; Chukwunonye *et al.*, 2015).

Related to the issue of sexual coercion is the problem of pressure to go into sexual intercourse. Adolescents' decision to engage in sexual intercourse is also influenced by

the pressure which they fell from friends, family members, their boyfriend/girlfriends, teachers and other adults. Analysis of the results in this study shows that 62.5% of the respondents reported that they were pressured to have sexual intercourse of which the main group from which pressure is felt is friends (42.9%). This finding is consistent with studies by Abakah (2015) that more than half of adolescents felt pressure from friends and classmates to have sexual intercourse.

One other sexual practice which poses a great challenge to adolescents is the issue of transactional sex where money or gift is the reason for the initiation and continuation of sexual relation. Transactional sex increases the risks and prevalence of HIV infection through various ways such as multiple sexual partnerships, sex with older men who are more likely to be HIV infected, and engagement in sexual activity under the influence of drugs and alcohol (Cote *et al*., 2004; Dunkle *et al*., 2004; Luke N, 2003 cited in Okigbo *et al.*, 2014). The results from the study indicate that one in three adolescents (33.2%) who have ever had sex did engaged in transactional sex of which 52.9% have had transactional sex with one partner while about 47.1% have had transactional sex with two or more partners. This finding is in contrast with the findings of Okigbo *et al.* (2014) where nearly three-quarters of adolescents in Liberia have engaged in transactional sex in their lifetime.

To prevent unwanted pregnancies and STI's including HIV, it is important that sexually active people, especially adolescents, use the various contraceptives especially the condom which serve dual purposes of preventing pregnancy and STIs/HIV. In contrast with previous studies this study found that less than half of the respondents (forty-four percent) who are sexually active admitted of not using condom at first sexual encounter

(Ochieng, 2013; Jorgensen, 2014; GSS, GHS, & ICF, 2015). Adolescents in this study enumerated several reasons for the non-use of condom in their sexual episode. Some of these reasons are born out of erroneous views held by adolescent's peers who do not have adequate knowledge about contraceptive (condom) while others are influence by the geographical location of the individual adolescent. It means that adolescents lack the adequate knowledge about condom and are therefore easily influenced by the opinions of their friends which might not be correct. Also, the findings also revealed that though there is high awareness of contraceptive use in Ghana; there are still people in the rural areas who do not know about contraceptives. This calls for a concerted effort by stakeholders to continue to educate the general public about contraceptives.

Another finding relates to sexual coercion or rape among adolescents and their partners. This may be as a result of power imbalance between the partners. The findings suggest that this is a problem especially where one sexual partner is older than the adolescent or if it involves a person who is at a higher authority of which the adolescent is afraid to resist or report, for example, in a teacher-student sexual relationship.

The issue of culture and taboos for the use of modern contraceptives like condoms by young people is another challenge in health education and service provision for young people. The situation may explain the reason behind the yawning gap between awareness about contraceptive methods among the youth and the poor use of these modern contraceptives among unmarried youth in Ghana (GSS, GHS, & ICF, 2015).

The findings from this study show that one in ten adolescents (eleven percent) have ever been pregnant or made someone pregnant of which thirty-nine percent have had two or more pregnancies. This finding is in contrast with previous studies elsewhere in Vietnam

where the prevalence of teenage pregnancy was reported to be less (four percent) by Nguyen *et al.,* 2016 and similar finding by Ochieng (2013) in Kenya where it was also reported less prevalence of adolescent pregnancies (about five percent). The results also show that majority of respondents (seventy-one percent) became pregnant between the ages of 14 to 17 years. It was also found that 74% of those who have ever been pregnant indicated that their pregnancies resulted in an abortion which is similar to finding by Glover *et al*., 2003 that nearly three-quarters (seventy-two percent) of all pregnancies in their study resulted in abortion. The implication of this finding is that it is likely that all pregnancies to in-school adolescents are unwanted hence the high tendency to resort to abortion to get rid of it in order to continue their education.

The issue of sexual abstinence seems to be the most popular topic for most parents and all stakeholders in adolescent sexual health programmes. Review of the literature revealed that many reasons have been given by adolescents as responsible for sexual abstinence. Some of these reasons include religious injunction against premarital sex, fear of unwanted pregnancy and its associated negative outcome such as abortion, shame and infertility, parental disapproval and many other negative outcome of sexual intercourse. This current study outlined six reasons for adolescents who are not sexually active to rank in order of importance why they abstain from sex. The results show that the most important reasons why adolescents in this survey abstain from sexual intercourse was that sex before marriage is wrong (religious reason). The second important factor was fear of STIs/HIV followed by fear of parents being the third most important reason. Adolescents further stated fear of pregnancy as the fourth reasons for abstaining. The next most important reason why adolescents abstain is because they do not have the opportunity.

This finding is in line with studies by Loewenson *et al.* (2004) that the most common reason selected by 12th-grade males who had never had sex was a decision to wait until marriage and the second reason being that sexual intercourse was not appropriate for their age and also by Ayalew *et al*. (2014) in a cross-sectional study in Eastern Ethiopia that adolescents who have abstain from sexual intercourse cited: religious values (about thirty-one percent), fear of STIs/HIV ( about sixteen percent), waiting until marriage (about six percent) and fear of unwanted pregnancy (about five percent).



### 5.5. Sex Information and Education Sources

Various studies have attempted to investigate sources where adolescents search for information on issues of sexual and reproductive health. Many of these studies have reported that adolescents seek and receive sex information and education from various sources include friends, teachers, mothers, the media, doctors, fathers, grandparents and religious leaders (Bleakley *et al*., 2009; Abakah, 2015; Attibu, 2015; Bankole *et al*., 2007). The findings from this current study show that majority of respondents (about 57%) received sex information from teachers. This finding is in contrast with that reported by Bleakley *et al.* (2009) where about three-quarters of adolescents received sex information from friends. Adolescents in this study also cited teachers as knowledgeable as the main reason why they sought sex information from them.

The implication of this finding is that adolescents may be using teachers and by extension the school as a source of sex information because they do not believe their parents are knowledgeable enough to educate them on the range of topics related to sex and sexuality. This perception of parents themselves being ill prepared to educate their children about sex is collaborated by the findings from Esantsi *et al*.(2015) where it is

reported that about seven in ten parents indicated that they needed more information on contraception, STIs and HIV/AIDs to enable them to have meaningful discussion with their adolescents wards.

Despite adolescents receiving sex information from various sources in this study, about fifty-six percent of the adolescents in this survey reported that they lacked adequate information in certain aspect of sex education with the majority citing family planning (fifty-three percent). This result is in line with reports in the U.S. by SexSmarts, 2001 cited in NCSH, 2013 that adolescents needed information on many aspects of sex education including contraception. The implication of this finding is that family planning (contraceptive use) lessons or discussion may not be adequately covered in the school curriculum as the school is the major source of sex education for adolescents.



### 5.6. Parent-Adolescent Communication and Sexual Behaviour

The adolescent is born into a family and to a larger extent, a society which determines socialization and norms. The family as the first unit of contact with the adolescent has a great influence on the attitude, behaviours and perception including those of initiation into sexual activity. Parental condition such as their economic status, knowledge and social relation with the adolescent such as communication and level of monitoring and supervisions are known to have great influence on the decision adolescents make concerning their sexuality. The attitudes, societal norms and values of parents towards sex can influence the choices that adolescents make concerning their sexuality (Awusab-Asare *et al.*, 2004; Abakah, 2015; Soon *et al.*, 2013; NCSH, 2013). These can include family religious beliefs, educational status and norms about sex. These values are usually imbibed in the child unconsciously during the process of socialization.

The results in this survey reveal that majority (eighty-two percent) of adolescents' parents talk to them about sex of which mothers (fifty-six percent) were the main group that discussed sexual issues with their adolescent wards. This study is in contrast with that of the study reported by Muthengia & Feredeb (n.d.) elsewhere in rural Tanzania where parent-adolescent communication among unmarried girls was generally low (twenty-one percent).

The findings show that slightly above half of the parents (56.0%) who discussed sex issues with their adolescent children were mothers and the content of sex education often discussed with parents was on marriage (about forty-two percent). This finding is consistent with other findings as observed by Guilamo-Ramos & Bouris (2008) that most parents have a difficult time discussing about the technical aspects of sexuality, including contraceptives/birth control and STIs including HIV/AIDS. With the issue of frequency of communication with parents on sexual issues, the study discovered that majority of the respondents' parents (fifty-six percent) occasionally (at least once in a month) educated them on sexual issues.

A further probe to find out why despite the importance of parent-adolescent sexual communication, parents failed to discuss sexuality issues with their adolescents reveal a lot of reasons as reported by adolescents in their own statements. The analysis of these reasons show that there are so many factors that hindered parent-adolescent sexual communication. One of such challenges to parent-adolescent sexual communication is the issue of embarrassment. Thus, some adolescents think that their parents feel shame or shy to discuss sexual issues with them. The second other reason adolescents ascribed to their parents inability to talk to them about sexual issues is the issue of fear that exposing

adolescents to such issues could lead them to become promiscuous. According to adolescents, their parents think that when they discuss sexual issues with them, they (parents) are directing them (adolescents) to engage in such sexual practices hence they are avoiding it. Another reason worth discussion is the issues of ignorance or inadequate knowledge of sexual issues by parents' themselves. The third most important reason advanced by adolescents in this current study as to why parents do not educate their adolescent wards on sexuality is the issue of religious fanatics or extremism. As reported by the respondent "Female; Christian; 19 years; form three; single sex school" , some parents erroneously avoid the topic of sexuality at home with the excuse that it is not religious to talk about sex with children. Such parents turn to associate any sexuality discussion with immorality thus they shy away from their children any time an issue of it is mention. The second but last reason as reported in the above finding is that of lack of time or time constraint as a result of occupational demands. Parents are so occupied at work site that they do not have time to talk to their children including those of sexuality. The last reason as reported in the analysis of the finding is the issue of the appropriate time parent-adolescent sexual communication should begin. As reported by respondent "Male; Christian; 16 years; form one; in a mixed sex school" above, parents are not certain the appropriate time to initiate sexual communication to their adolescents. Some parents feel their children are too young to be engaged in sexual activities hence there is no need to start sexual communication. This however, may lead to adolescents seeking and receiving wrong information from their peers with its attendant consequences. These findings as identified by adolescents in this study are similar to those reported by Ayalew *et al.*(2014) in Ethiopia and Seldin (2009) that cultural taboos, fear of parents, being

ashamed or embarrass, parents failure to give time to listen, lack of interest by parents and lack of communication skill of adolescent makes them not to discuss openly with their adolescents about sexual and reproductive health issue.

The implication of this survey finding is that, the East Mamprusi District being one of the rural districts in Ghana where cultural taboos frown on open discussion about sex is still upheld, parents within the locality still expect their adolescents' wards to be innocent about sexual issues.

The study also found that majority of the adolescents (about fifty-six percent) could not approach their parents on personal issues regarding sex with the reason being that they were afraid of their parents (over sixty-two percent) while thirty-eight percent could not approach their parents on issues of sexuality. A further probe by the researcher to ascertain why some adolescents could approach their parents reveals the following reasons. One reason is the willingness of parents to be open with their wards. When adolescents find themselves in an environment where the parents are open, it serves as a motivation for such adolescents to be able to approach their parents on any issue including those of sexuality. Again, one other factor that stands clear from the finding is the issue of friendliness. Parents whose treats their children as friends motivate them to be able to approach them to discuss with them on matters of sexuality. The last issue worth highlighting is the perceptions adolescents hold about their parents in term of their knowledge in the area of sexuality. Thus, if adolescents perceive that their parents have adequate knowledge about sexual and reproductive health, such adolescents will be willing to approach them. These findings are similar to those observed by Turnbull (2012) where he reported that parent-adolescent sexual communication thrives in families

where there is trust, love, commitment, support and where children perceive their parents to be having adequate knowledge on sexuality.

Similar to findings by Ayalew *et al.*(2014) in Ethiopia, Aperkor (2016) and Abakah (2015) of Ghana, this study discovered several reasons why adolescents could not approach their parents on issues of sexuality. The first instance is the place of sex in our society. Sex is viewed as a secret affair or "no go area for children" such that they are not to be heard talking about sex. Children and for that matter adolescents are not regarded as sexual being at this stage and are assumed to be innocent, hence things related to sexuality should not be discussed with them. Another reason adolescents could not approach their parents is the issue of trust between parents and their wards.



**5.7. The Associations between Parent-Child Communication and Sexual Behaviour pattern of Adolescents.**

One significant objective for this current study was to establish the relationship between parent-adolescent communication and its impact on the sexual behaviour pattern of adolescents. A bivariate analysis of this relationship reveals that for respondents who reported having discussion with both parents (father and mother) about sex, majority (over fifty-eight percent) of respondents reported that they abstained from sexual intercourse. This finding is similar to the one observed by Gathii (2015) in a study in Kenya where it was reported that majority (about fifty-one percent) of the adolescents asserted that discussion between them and their parents influence their sexual behaviour. Thus, the implication of this finding is that parent- child communication on sexually is more effective if it is done by both parents as compared to it being done by individual parents that is adolescents with both parents talking to them about sex are more likely

(about fifty-eight percent) to abstain from sexual intercourse as compared to when it is done by the mother only (fifty-five percent) or father only (fifty-four percent).

The result of a further probed into whether sex education provided by parents could make adolescents abstain from sex revealed that more than half (over fifty-two percent) of the respondents agreed to this assertion. Consequently, there is a statistically significant relationship between parent-adolescent communication about sex and the sexual debut of adolescents as seen in the table 4.13 with a p-value of (0.00). Again, this finding is consistent with Gathii (2015) that parent-adolescent communication positively affects the sexual behaviour of adolescents in the areas of delayed sexual debut, reduced sexual activity, and consistent use of condom and/or other contraceptive.



CHAPTER SIX

# SUMMARY, CONCLUSION AND RECOMMENDATION

## 6.0. Introduction

This current study sought to assess the sexual behaviour of adolescents in senior high school in the East Mamprusi District. The issues under focus in this research are sexual practices or behaviours adolescents consider as sex, the sexual practices adolescents in Senior High School engage in, the sources of sex information and education to adolescents and the effects of parent-adolescent communication about sex and its influence on the sexual status of the adolescent.

## 6.1. Summary of the Research Findings

Analysis of the socio-demographic characteristics of the respondents shows that out of the sample size of 392 respondents, 38.8% were males whilst 61.2% were females. The age distribution shows that majority of the respondents (85.2%) who took part in the study were between the ages group of 15 – 19 years. Forty-eight percent of the respondents were Christians (Protestants) with the second majority group (44.9%) being Muslim and least in terms of religion is the Traditional African Religion (2.8%). With type of school, majority of the respondents (75.3%) were in the mixed sex school while the rest (24.7%) were from a single sex school. The highest proportion of respondents (45.9%) was in year two. The majority of respondents' mothers and fathers (64.8% and 59.7%) respectively never had any form of formal education. On employment status of respondents' parents, majority of respondents fathers (75.8%) and mothers (65.3%) were also farmers.

The study revealed that adolescents have varied understanding of the concept of sex and sexuality. These include coital and non-coital sexual practices. The findings show that all the 392 respondents representing hundred percent asserted that penetrative vaginal sex is considered as sex; 152 respondents representing thirty-nine percent consider anal sex as sex; 211 respondents (54%) consider petting/kissing/hugging as sex; 140 respondents representing 36% consider masturbation as sex; 114 respondents (29%) consider oral sex as sex and 22 respondents (6%) consider cuddling as sex.

The study further revealed that two- thirds of the respondents have ever engaged in petting/kissing/hugging; fifty-three percent have experienced sexual intercourse while the least type of sex adolescents have engaged in is oral sex.

The findings show that 53% of respondents have ever had sex. On the age of sexual debut, majority of respondents who ever had sex had first sex between ages 14 and 17 years while about four in ten adolescents who have experience their first sexual intercourse currently have sexual partners. The results also show that almost half of the sexually experienced respondents have had two or more sexual partners.

The study shows that nearly half of the adolescents willingly offered themselves on their first sexual intercourse while about one in three adolescents were forced. The results also revealed that one-third of the adolescents have a history of transactional sex while nearly half of the respondents have had two or more partners.

The study also found that less than half of the respondents (forty-four percent) who are sexually active admitted of not using condom at first sexual encounter. The reasons adolescents assigned for non-use of condom include lack of adequate knowledge about

condom, the issue of sexual coercion or rape among adolescents and their partners, condom do not have sensational feeling and the issue of culture where it is alleged that it is a taboo for a virgin to use condom.

Another aspect of this study was to establish the reasons non-sexually active adolescents assigned for not engaging in sexual intercourse. The results show that the most important reasons why adolescents in this survey abstain from sexual intercourse was that sex before marriage is wrong (religious reason) followed by fear of STIs/HIV and fear of parents being the third most important reason.

One other important objective of this study was to determine the sources of sex information and education for adolescents. The study revealed that majority of adolescents (about fifty-seven percent) received sex information and education from teachers of which they cited as knowledgeable as the main reason why they sought sex information and education from them.

The last specific objective for this current study was to establish the relationship between parent-adolescent communication and its impact on the sexual behaviour pattern of adolescents. A bivariate analysis of this relationship reveals that for adolescents who have sexual communication with their parents, majority of them reported abstaining from sexual intercourse. Consequently, the study found that there is a statistically significant relationship between parent-adolescent communication about sex and the sexual debut of adolescents. Thus, increase parent-adolescent sexual communication is associated with the late onset of sexual activities.

## 6.2. Conclusion

Adolescents consider various practices as sex including both coital and non-coital sexual practices. These practices found in this study are penetrative vaginal intercourse, masturbation, petting/kissing/hugging, oral sex, and cuddling. All these practices are considered as an expression of human sexuality with the main practices being penetrative vaginal intercourse and petting/kissing/hugging.

Early sexual debut or activities among senior high school adolescents continue to be on the rise despite efforts by various stakeholders to minimize it.

Respondents in this study see teachers generally as the most reliable source of information on sexuality issues. This study also found a significant relationship between parent-adolescent sexual communication and sexual initiation of the adolescent.

## 6.3. Recommendations

On the basis of the evidence gathered from the study and conclusions drawn, the following recommendations were made:

1. Any programme intervention targeted at adolescents should not just focus on penetrative vaginal sex but should include a comprehensive sexual health education on safer sex and adolescents should be equipped with assertive skills to negotiate in sexual relationship

2. Parents should be encouraged to build good rapport with their children and to initiate sex communication in the early stages of adolescence in order to bond well with their adolescents.

### 6.4. Directions for Future Research

The duration of the research and financial constraint did not allow the researcher to conduct a detailed study in some relevant areas of adolescent sexual and reproductive health. Therefore, the researcher recommends further study in the following areas:

- That a qualitative study should be carried out into the prevalence of non-coital sexual practices among adolescents in the study areas.
- A further qualitative study should be done to get an in-depth understanding of the attitude and perception of parents toward parent-adolescent sexual communication.



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# APPENDICES

## Appendix A: Questionnaire for High School Students (10-24 Years)

**UNIVERSITY FOR DEVELOPMENT STUDIES**
**SCHOOL OF ALLIED HEALTH SCIENCES**
**DEPARTMENT OF COMMUNITY HEALTH**
**QUESTIONNAIRE FOR HIGH SCHOOL STUDENTS (10-24 YEARS)**



**CONSENT FORM FOR RESPONDENTS**

You are being invited to participate in a research study titled: "Adolescents sexual behaviour among Senior High School Students in East Mamprusi District".

I am conducting this study to learn more about the issues concerning adolescents' sexual and reproductive health behaviour and to come up with findings which will enable policy makers develop appropriate interventions to meet your sexual and reproductive health needs as adolescents. The study is solely for academic purposes. You are assured of confidentiality and anonymity with regards to any information you provide. Please you are required to sign/thumb print below if you agree to be a respondent.

Sign ……  Date…….

**UNIVERSITY FOR DEVELOPMENT STUDIES**
**SCHOOL OF ALLIED HEALTH SCIENCES**
**DEPARTMENT OF COMMUNITY HEALTH AND DEVELOPMENT**

Respondent ID:

(Please for each of the question/statement tick **[√]** or circle the option that matches your view or where appropriate write the answer)

**SECTION A: DEMOGRAPHIC DATA ON ADOLESCENTS AND THEIR FAMILY**

1. Sex of respondent? 1. Male [ ] 2. Female [ ]
2. How old are you? .....
3. Religion of respondent?
   1. Christian (Specify your denomination …….)
   2. Muslim
   3. African traditional religion
   4. Other Specify ……)
4. Type of school respondent is attending
   1. Single sex school private
   2. Single sex school public
   3. Mixed sex school private
   4. Mixed sex school public
5. Current year in school
   1. Year one( form one)
   2. Year two (form two)
   3. Year three (form three)
6. Educational Background of mother
   1. None
   2. Primary
   3. JHS
   4. SHS
   5. Tertiary
7. Educational Background of father
   1. None
   2. primary

3. JHS
4. SHS
5. Tertiary

8. Occupation of Father
   1. Government worker
   2. Businessman
   3. farming
   4. other specify……
9. Occupation of mother
   1. Government worker
   2. businesswoman
   3. farming
   4. other specify ……..

**SECTION B: ADOLESCENT SEXUALITY AND SEXUAL STATUS.**

10. Have you ever had a dream in which you were involved in sex with someone?
    1. Yes [ ] 2. No [ ]

11. What do you think is the cause of wet dreams?
    .....
    ……

12. What have you done to avoid wet dreams?
    …….
    ……

13. Which of the following activities do you consider as sex? (*You can choose more than one option)*
    1. Petting/kissing/hugging
    2. Cuddling
    3. Masturbation
    4. Anal sex
    5. Oral sex
    6. Penetrative Vaginal sexual intercourse
14. Have you ever been in a sexual relationship with the opposite sex or same sex?
    1. Yes (Go to Q16)
    2. No (Go to Q 18)
15. What type of relationship is/was it?
    1. Petting/kissing/hugging only
    2. Cuddling only

3. Masturbation
4. Anal sex
5. Oral sex
6. Penetrative Vaginal sexual intercourse

16. Are you still in the relationship?
    1. Yes
    2. No (Explain why……...)
17. Have you ever had any of these sensual activities (*Mark as many that applies to you*)
    1. None
    2. Petting/kissing/hugging
    3. Cuddling
    4. Masturbation
    5. Anal sex
    6. Oral sex
    7. Penetrative vaginal sexual intercourse
18. Some young people are sexually attracted to people of the same sex. Have you ever been sexually attracted to a person of the same sex?
    1 Yes
    2 No

***Young people have various views about relationships.***

19. Do you believe that it's all right for unmarried boys and girls to have dates (boyfriend /girlfriend or lovers)?
    1. Agree
    2. Don't know/not sure
    3. Disagree
20. Do you believe that it's all right for boys and girls to kiss, hug and touch each other?
    1. Agree
    2. Don't know/not sure
    3. Disagree
21. Do you believe that there is nothing wrong with unmarried boys and girls having penetrative vaginal sexual intercourse if they love each other?
    1. Agree
    2. Don't know/not sure
    3. Disagree
22. Do you think if a girl says 'No' to sex as the boyfriend she needs to be forced to have sex if he loves her?
    1. Agree
    2. Don't know/not sure

3. Disagree

23. Do you think if a girl says No to sex she really means 'No' always?
    1. Yes
    2. No
24. Do you believe that girls/boys should remain virgins until they marry?
    1. Agree
    2. Don't know/not sure
    3. Disagree

**SECTION C: SEXUAL PRACTICES AMONG ADOLESCENTS**



25. Have you ever had penetrative vaginal sexual intercourse in your whole life?
    1. Yes (Go to Q27)
    3. No (Go to Q 34)
26. If yes to (26) above, what was your age when you first had sexual intercourse? Please indicate the exact age:
    .....
27. Do you currently have a sexual partner (boyfriend/girlfriend)?
    1. Yes
    2. No
28. Within the last 3 months, how many sexual partners (boyfriend/girlfriend) have you had?
    .....
29. In your whole life, how many people have you had sexual intercourse with?
    .....
30. Some young people pay/receive money or gifts in exchange for sexual intercourse. Has this ever happened to you?
    1. Yes
    2. No
31. How many women/men have you had sex with for money or gifts?
    .....
32. How will you describe your first sexual intercourse
    1. Own will
    2. Coaxed/deceived
    3. Forced
33. Do you feel any pressure from others to have sexual intercourse?
    1. Yes

2. No (Go to Q 45)

34. If yes to (34) above, mention the main group of person from whom you were pressured
    1. Friends
    2. Relatives
    3. Teachers
    4. Boy/girls friends
    5. Other specify .....
35. The first time you had sexual intercourse, did you use a condom? 1. Yes 2. No
36. If NO to (36) above, what made it impossible or difficulty to use condoms at the time? please specify
    .....
37. Are you currently doing something or using any method to delay or avoid getting pregnant?
    1. Yes
    2. No
38. Have you ever been pregnant/ made someone pregnant? 1. Yes 2. No (Go to 42)
39. If yes to (39) above, how many times?
    .....
40. How old were you when you first became pregnant or made someone pregnant? (Age in completed years) .....
41. What happened to the first pregnancy? Resulted in
    1. a live birth
    2. a miscarriage
    3. an abortion
42. Would you want to abstain from sexual intercourse if you had already had your first sexual intercourse until you reach adulthood?
    1. Yes
    2. No
43. If yes to (43) above, why would you want to abstain? Please rank them in ascending order
    1. Unwanted pregnancy
    2. To prevent STIs/HIV
    3. Fear of dropping out of School
    4. In order not to be stigmatized
    5. To wait until marriage
    6. Because of religious affiliation

7. Other specify
   .....

44. What are the risks associated with early sexual intercourse in adolescents? Please rank them from 1-6 in the order of the most importance

    1. Unwanted pregnancy
    2. Loss of virginity
    3. STIs and HIV
    4. School drop outs
    5. Infertility arising from abortion
    6. Stigmatization

45. How is STIs and HIV acquired?
    1. Having sexual intercourse without condom 1
    2. Do not know

**SECTION D: SEX INFORMATION AND EDUCATION SOURCES**

46. Have you ever received information on sex? 1. Yes [ ] 2. No [ ]
47. If yes to (47) above, who was the main source of sex education?
    1. Family(Parents)
    2. Teachers
    3. Friends/Peers
    4. Social/mass media
    5. Other specify.....
48. Why do you source information on sex from the above mentioned?
    1. Feel comfortable with
    2. Knowledgeable
    3. Readily available
    4. Other specify.....
49. How often do you get some education on sexual issues
    1. Very often= twice or more in a month
    2. Occasionally= once in a month
    3. Rarely=once in a two or in more months)
50. Are you satisfied with the information received? Yes [ ] No [ ]
51. Do you have any other information you want it discussed but do not get educated on?
    1. Yes
    2. No
52. Which aspect of sex education do you lack and will need help?
    1. Sexual issues
    2. STIs/ HIV

3. Family planning
4. Marriage
5. Other specify.....

**SECTION E: PARENT-CHILD COMMUNICATION AND SEXUAL BEHAVIOUR**

53. Who do you live with?
    1. Both Biological Parents
    2. Biological mother only
    3. Biological Father only
    4. Guardian
54. Do your parents talk to you about sexual issues? 1.Yes [ ] 2. No [ ]
55. If yes to (55) above, who among your parents talk to you about sexual issues?
    1. Both parents
    2. Mother only
    3. Father only
    4. Guardian
    5. Other specify.....
56. If yes to (55) above, what is the content of the sex education received?
    1. Sexual issues
    2. STIs/ HIV
    3. Family Planning
    4. Marriage
57. How often do your parents educate you on sexual issues?
    1. Very often= twice or more in a month
    2. Occasionally= once in a month
    3. Rarely=once in a two or in more months
58. Do you think you are able to abstain from sex as a result of the sex education received from your parents? 1. Yes [ ] 2. No [ ]
59. If Never received sexual information from parents, please give reasons why your parents do not educate you on sexual issues
    1. .....
    2. .....
60. Are you able to approach your parents with personal issues regarding sex? 1. Yes [ ] 2. No [ ]
61. If yes to (61) above, why are you able to approach your parents with issues about sex? Give reasons
    1. .....

2. .....

62. If No to (61) above, why are you not able to approach your parents with issues regarding sex? Give reasons
    1. .....
    2. .....

**SECTION F:ONLY FOR THOSE WHO HAVE NEVER EXPERIENCED SEXUAL INTERCOURSE**



**63.** People may have mixed reasons for not having sexual intercourse. Please tell me from the following reasons why you abstain from sex? Please rank them from 1-6 in the order of the most important reason why you abstain from sex
    a. I don't feel ready to have sex
    b. I have not had the opportunity
    c. I think that sex before marriage is wrong
    d. I am afraid of getting pregnant
    e. I am afraid of getting HIV/AIDS
    f. I am afraid of my parents

64. And now I have questions about your future plans with regards to sexual intercourse. Which of these statements best describes your plans?
    a. I plan to wait until marriage
    b. I plan to wait until I am engaged to be married
    c. I plan to wait until I find someone I love
    d. I plan to have sexual intercourse when an opportunity comes along
    e. I plan to complete my education

Any general comments? .....

**Thank you very much for your time and participation.**