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RESEARCH ARTICLE

Attitudes and Barriers towards Adolescent Sexuality and Abortion Care in the Northern Part of Ghana

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Abstract

The adolescence period is generally perceived as being healthy, however, most adolescents in the Tamale Metropolisgo through this period with health challenges such as sexual and reproductive problems and unsafe abortion. This study aimed to determine the attitude and barriers toward Adolescent Sexuality and abortion in the Tamale Metropolis.

A descriptive cross-sectional design with a sample size of 246 adolescents from a Senior High School within the Tamale metropolis. A structured questionnaire wasused for the data collection and data was analyzed using Excel and SPSS version 21. Frequencies and percentages were used in the presentation of the results.

More than half of the adolescents were females (58.1%) and between the ages of 16-19 (77.2%). Most were single (81.3%) while 18.7% were in a relationship. About 43.1% of adolescents have had sex before. Most adolescents agreed that their culture does not support abortion. The majority of the adolescents showed a positive attitude towards adolescent sexuality. The barriers encountered by the adolescents in seeking abortion services were the dangers involved in abortion, culture, lack of confidentiality and lack of support person. This study emphasized the need to strongly enforce community-wide promotional activities, particularly those involving adolescents in other to educate them on ways of overcoming the barriers of Adolescent Sexuality and abortion care.

Keywords

Adolescent, Sexuality, Abortion, Care, Ghana

Introduction

According to UNICEF, 2016, there are about 1.2 billion adolescents which make up 16.0% of the world's population. Though adolescence is generally perceived as being healthy, most adolescents transition into adulthood with health problems such as sexual and reproductive problems and unsafe abortion [1,2]. Even though adolescent sexuality and abortion care have been prioritized, they remain highly charged moral problems around the world, with midwives serving as the primary health care providers for these services. While the importance of adolescent sexual and reproductive health has been recognized around the world, many of these needs remain unmet [3]. Unprotected intercourse, which can lead to unplanned pregnancy, unsafe abortion, and sexually transmitted infections (STIs), including HIV, are serious public health issues among adolescents and young people in many areas of the world [4]. The sexual conduct of young people reflects a changing culture, but healthcare providers have been hesitant to offer practical and appropriate services to

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them [5]. At the International Conference on Population and Development in 1994, teenage reproductive health and rights were for the first time placed on the international agenda. Despite international accords, reproductive health services are woefully inadequate, and teenage sexual and reproductive health remains a neglected concern in many countries [6]. However, specific issues with contraceptive and abortion services for adolescents have been noted, as well as the need for high-quality provider-client interaction in gaining their trust and assisting them in protecting their sexual and reproductive health. Gueteng is a province in South Africa (2015). Family planning (FP) counseling and services; prenatal and postnatal care and delivery; termination of pregnancy (TOP); post-abortion care (PAC); treatment and prevention of sexually transmitted infections (STIs), including HIV; and information and counseling services regarding human sexuality are among the sexual and reproductive healthcare services available to adolescents [7]. Because adolescents are prone to risky behaviors, such as dangerous sexual encounters, the availability and usage of these services is critical for improving sexual reproductive healthcare outcomes [3]. Midwives are a key group of specialists that provide reproductive health services to adolescents with special needs. The importance of involving midwives and other mid-level providers has been acknowledged on a global scale in order to improve access to and the quality of abortion services [8].

Adolescents, particularly in Sub-Saharan Africa, underutilize sexual reproductive healthcare services [9]. According to [10], factors such as service cost and distance, lack of understanding about where to acquire contraceptives, stigma, poor provider attitude, and lack of confidentiality contribute to underutilization of these services.

Ghana is a West African country with a population of 30.10 million people, according to the Ghana Statistical Service (2019). Ghana's average per capita income is at $1,810, making it a middle-income country. Ghana's health pattern is similar to that of other nations in the region, with a sustained burden of infectious disease among the poor and rural populations, as well as an increase in noncommunicable disease among the urban middle class [11]. Although both male and female adolescents have many sexual and reproductive health challenges, the females have extra burdens that are gender specifics [12]. Female adolescents are at high risk of unwanted pregnancies that are associated with poor outcomes like unsafe abortions, stillbirths and other complications that can result in maternal mortality [13]. According to Cudjoe, et al. [14], the WHO 2014 [15] factsheets on adolescent pregnancy revealed that every year, around 16 million people between the ages of fifteen and nineteen, as well as some children under the age of fifteen, give birth in poor and middle-income countries. According to Yussif, et al. [16] adolescents were responsible for 30% of all births reported in the country in 2014. In Ghana, there are regional variations in the rates of adolescent pregnancies with the Central and Northern regions having the highest rates [17]. According to Birny and Dodoo, et al. [18] adolescents pregnancy in Ghana slightly increased from 13.3 in 2008 to 14.2 in 2014. Adolescent unintended pregnancy creates anxiety, and desperation Gomnah, et al. [17]. Due to these challenges, most adolescents try to resolve their unintended pregnancies with unsafe abortion Birny and Dodoo, [18]. Abortion is defined by the National Center for Health Statistics, the Center for Disease Control, and the World Health Organization as the termination of a pregnancy before the 20th week of pregnancy or the birth of a live baby weighing less than 500 grams [19]. In Sub-Saharan Africa, unsafe abortion is the main cause of death among adolescents [20].

Abortion-related problems account for a significant portion of gynecological ward admissions in Ghanaian hospitals. Safe abortion care has been related to improved mother and child health outcomes, and it has been recognised as critical to furthering women's economic and social equality [21]. According to the Ghana Medical Association, unsafe abortion is the second leading cause of maternal death in the country, with 540 fatalities per 100,000 live births [11]. Abortion is the second-leading cause of maternal mortality in Ghana, despite the fact that it is typically legal [22]. Rehnstrom Loi, et al. [23] included that Ghana's abortion law has been fairly liberal since 1985. Adjei, et al. [24] further explained that there are three exceptions to this law. These exceptions are when a pregnancy is a result of rape, defilement and incest when a pregnancy will pose a risk to the mother or injury to her physical and mental health and then when there are gross fetal malformations and abnormality. According to Fullerton, et al. [25] the ICM statements on midwives' provision of abortion-related services state that "a woman who seeks or requires abortion-related services is entitled to be provided with such services by midwives." However, adolescents who are poor and or living in rural areas often lack information about the legality of abortion and don't also know where to seek quality abortion care. They also added that, even if they knew, they lack the decision-making power in seeking this service or they might be discouraged by the negative attitudes of midwives [26]. Literature has been written on adolescent reproductive health, barriers to adolescent abortion care and the use of contraceptives among adolescents yet, little is known about sexuality and abortion care for adolescents. Given this, this study seeks to elaborate more on adolescent sexuality and abortion care by exploring the adolescents'attitudes and barriers towards sexuality in the Tamale Metropolis.

Materials and Methods

This study used cross-sectional design since it is going to deal with the way adolescents think and act

in certain ways. We also employed the quantitative method approach to guide us in getting information on adolescent sexuality and the barriers to adolescent sexuality and abortion care.Our study population for this research was 246 adolescents at the Ghana Senior High School.

The sampling technique used in this study was the systematic sampling technique and simple random sampling technique. Adolescent boys and girls were systematically selected. The adolescents were systematically selected using the class register where every second pupil was selected for the research. The school was selected using the simple random sampling technique.Information was gathered from adolescents who fall within the inclusion criteria after taking verbal and written consent. To prevent several questioning of respondents, data was collected in various classrooms at different times. Also, respondents were asked if they have filled out the questionnaires or not. Data collection was done using structured questionnaires. The questionnaire contained Likert scale type of questions. The questionnaires were structured per the objectives of the study. After data collection, the raw data collected was organized to facilitate analysis. Completed questionnaires were cross-examined for completeness and consistency which were coded and entered into computer software programmed for data analysis. The Statistical Package for Social Sciences (SPSS software version 21) and Excel were used for data analysis. Simple frequencies and percentages were used in the presentation of the results. Results were presented using tables.

Ethical consideration

Administrative approvals were sought for the conduct of the study. Equally, the study protocol went through vigorous scrutiny at the School of Nursing and Midwifery, University for Development Studies. Permission was obtained from the research unit of the Ghana Education Service, Tamale, Ghana. Informed consent was sought from the students and those that were below 18 years of age, consent was sought before the study from the school authorities. We also adhered to Helsinki's Declaration on ethical principles for human research.

Results

Socio-demographic characteristics of the adolescents

Most of the adolescents were between the ages of 16 and 19 (77.2%), females 58.1%, Muslims (65%), and 18.7% of them were in a sexual relationship although not married (Table 1).

Table 1: Socio-demographic characteristics of the adolescents.

Variables	Frequency	Percent (%)
Age (years)		
13-15	56	22.8
16-19	190	77.2
Sex		
Male	103	41.9
Female	143	58.1
Religion		
Islam	160	65.0
Christianity	86	35.0
Relationship type		
Single	200	81.3
Boy-Girl relationship	46	18.7
Course Offering		
General Arts	145	58.9
General Science	40	16.3
Home Economics	50	20.3
Agricultural Science	11	4.5
Residence		
Boarding House	200	81.7
Day	46	18.7

Source: Field survey, 2021.

Attitude of adolescents towards adolescent sexuality

Out of 246 adolescents, 40.2% and 17.1% agreed and strongly agreed respectfully and indicated that sex is normal in adolescent development. The adolescents were asked whether they are able to control their sexual desires most of the time; 16.3% and 9.3% disagreed and strongly disagree respectively. A percentage of 38.2 agreed that they should be given access to sexual and reproductive health information. Out of the 246 adolescents, 23.6% agreed, 19.1% strongly agreed and 30.1% disagreed with the statement, adolescents who have sex are not bad boys and girls.

Out of the 246 adolescents, 22.0% agreed, 21.1% strongly agreed and 19.5.5% and 34.1 disagreed and strongly disagreed respectfully that they have had sex before, fifty-six adolescents (22.8%) agreed it is good for boys to have sex rather than girls.

Fifty-eight adolescents (23.6%) agreed they should not be punished for having sex. A percentage of 14.6 agreed that masturbation is good for them, 15.9% strongly agreed, 20.7% disagreed and 40.7% strongly disagreed, however, 8.1% were uncertain. A percentage of 14.6 agreed that sex makes them healthy and strong, 11% strongly agreed, 21.5% disagreed and 44.3% strongly disagreed. However, 8.5% were uncertain.

On the issue of access to sexual and reproductive services, 33.3% agreed, 17.5% strongly agree, 22.8% disagreed, 15.0% strongly disagree and 11.4% were uncertain (Table 2).

Table 2: Attitude of adolescents towards adolescent sexuality.

Variable	Strongly Agree N (%)	Agree N (%)	Disagree N (%)	Strongly Disagree N (%)	Uncertain N (%)	Total N
1. Sex is normal in adolescent development	42 (17.1)	99 (40.2)	57 (23.2)	42 (17.1)	6 (2.4)	246
2. I'm able to control my sexual desires most of the time	82 (33.3)	95 (38.6)	40 (16.3)	23 (9.3)	6 (2.4)	246
3. I should be given access to sexual and reproductive health information	116 (47.2)	94 (38.2)	12 (4.9)	16 (6.5)	8 (3.3)	246
4. Adolescent who have sex are not bad boys and girls	47 (19.1)	58 (23.6)	55 (22.4)	74 (30.1)	12 (4.9)	246
5. I have had sex before	52 (21.1)	54 (22.0)	48 (19.5)	84 (34.1)	8 (3.3)	246
6. It's good for boys to have sex rather than girls	35 (14.2)	56 (22.8)	55 (22.4)	79 (32.1)	21 (8.5)	246
7. I should be punished for having sex	47 (19.1)	58 (23.6)	55 (22.4)	74 (30.1)	12 (4.9)	246
8. Masturbation is good for adolescent	39 (15.9)	36 (14.6)	51 (20.7)	100 (40.7)	20 (8.1)	246
9. Sex makes me healthy and strong	27 (11.0)	36 (14.6)	53 (21.5)	109 (44.3)	21 (8.5)	246
10. I have a hard time accessing sexual and reproductive health needs	43 (17.5)	82 (33.3)	56 (22.8)	37 (15.0)	28 (11.4)	246

Source: Field data, 2021.

Barriers to adolescent sexuality and abortion care (adolescents)

Up to 103 (41.9%) agree and 82 (33.3%) strongly agreed that their culture is a barrier seeking adolescent and abortion services. Religion was another barrier to adolescent sexuality and abortion care, 33.3% and 36.2% agreed and strongly agreed to that statement. Some mentioned that money was a barrier and 30.9 and 23.6% agreed and strongly agreed to that. However, 30.1% agree to stigmatization from mates and society. Also, 43.9% strongly agree that there are lots of risks/ dangers involved and 31.3% agree that there is no privacy in providing the service.

Most 32.5% of the adolescents strongly agree that there is lack of confidentiality while 30.9% strongly agree that they would not be respected and 30.9% agree that they had a bad previous experience. Also, 30.9% strongly agree to lack of a support person. However, 22.0% and 24.4% agreed and strongly agreed respectively to the fact that availability of concoction as a barrier (Table 3).

Discussions

Most of the adolescents (57.3%) approved that sex is normal in adolescent development and are able to control their sexual desire most of the time. However, about half of the respondents have had sex before. The majority of the adolescent had the urge to have sex but were able to control their desire though some of them had not had sex before. This accords with Legibo, et al. [27] who identified that interest in sexuality intensifies during the onset of puberty, and sexuality is often a vital aspect of adolescents' lives.

This finding from a related qualitative study conducted in the Northern region of Ghana opined that having lots of sexual partners was regarded as a matter of pride by both male and female participants. Some teen expectations include marriage. Some people expect to have a good time and feel good about themselves as a girl or boy. Others expect a boyfriend or girlfriend to give them money, gifts, clothes and other items. Some people expect complete trust from their girlfriends, so much so that girls shouldn't be friends with any other boys [28]. It should however be noted that sexual activity carries risks of pregnancy and other STDs, but that doesn't stop most teens from fulfilling their sexual identity. Another study from India however shows that participants' average sexual attitude score was 37.99 (± 6.11), indicating a liberal attitude toward sexuality. A little above average 61% agreed that extramarital sex is always bad; 75% agreed that abortion should always be done with permission; 55% agreed that chastity should be incentivized in our societal structure, and 52% disagreed that abortion is not a crime [29]. The findings show that adolescents' attitudes toward sexuality and sexual health could be either positive or negative. This knowledge should be used to provide insight and educate adolescents in the Tamale metropolis on

Table 3: Barriers to adolescent sexuality and abortion care.

Variable	Agree N (%)	Strongly Agree N (%)	Uncertain N (%)	Disagree N (%)	Strongly Disagree N (%)	Total N
1. My culture is against abortion	103 (41.9)	82 (33.3)	11 (4.5)	33 (13.4)	17 (6.9)	246
2. My religion prohibits abortion	82 (33.3)	89 (36.8)	9 (3.7)	42 (17.1)	23 (9.4)	246
3. Lack of comfort	76 (30.9)	49 (19.9)	18 (7.3)	66 (26.8)	37 (15.0)	246
4. Midwives have bad attitude	28 (11.4)	42 (17.1)	34 (13.8)	86 (35.0)	56 (22.8)	246
5. Tagging/ labeling from mates	61 (24.8)	39 (15.9)	45 (18.3)	70 (28.5)	31 (12.6)	246
6. Monetary reasons	76 (30.9)	58 (23.6)	43 (17.5)	38 (15.4)	31 (12.6)	246
7. Stigmatization from mates and society	74 (30.1)	70 (28.5)	28 (11.4)	58 (23.6)	16 (6.5)	246
8. There are lots of risks and dangers in abortion	81 (32.9)	108 (43.9)	4 (1.6)	24 (9.8)	29 (11.8)	246
9. There is no privacy	77 (31.3)	71 (28.9)	21 (8.5)	43 (17.5)	34 (13.8)	246
10. Lack of confidentiality	80 (32.5)	81 (32.9)	16 (6.5)	47 (19.1)	22 (8.9)	246
11. There would be no respect for me	76 (30.9)	86 (35.0)	14 (5.7)	36 (14.6)	34 (13.8)	246
12. I had a previous bad experience	76 (30.9)	50 (20.3)	21 (8.5)	60 (24.4)	39 (15.9)	246
13. Lack of support person	76 (30.9)	76 (30.9)	27 (11.0)	40 (16.3)	27 (11.0)	246
14. Availability of concoction	54 (22.0)	60 (24.4)	46 (18.7)	46 (18.7)	40 (16.3)	246

Source: Field data, 2021.

issues relating to their sexual health in order to instill in them sexual health behavior change strategies in the metropolis.

This current study observed that lots of risks/dangers involved in abortion, culture and religious beliefs, support person, lack of privacy and comfort, stigmatization from mates and society and loss of respect were the most common barriers to adolescent sexuality and abortion care. This finding is in support with Cudjoe [14], who mentioned that fear of being stigmatized, lack of privacy and confidentiality, religious and cultural beliefs were some of the barriers. This was also in accordance with [30], who stated cost and availability of services as barriers since there was a general agreement in a study they conducted. In addition, these findings also accord to Bankole and Malacher [31] who indicated that, adolescents seeking to obtain services are subjected to discriminatory behaviors by healthcare providers as compared to elderly people. The adolescent who accepted that, midwives have bad attitude were 28.5%, 57.8% did not agree to it. This contradicts Cudjoe [14], who mention attitude of health workers as a barrier. The most significant barriers to young people's access to sexual and reproductive health services are cognitive and psychosocial barriers. Lack of sexual knowledge and service awareness are two cognitive accessibility barriers. Shyness and shame caused by negative cultural attitudes toward premarital sex, as well as parental fear of discovering access to public sexual and reproductive health services due to a lack of confidentiality between services and health providers, are barriers to psychosocial accessibility. Other barriers include geographic accessibility, primarily the lack of youth-friendly health clinics [32]. Personal factors, such as lack of knowledge about and negative attitudes towards reproductive health services (RHS); social factors, such as parental influence, community and religious norms, financial constraints and stigma; health system factors such as poor service provider attitudes and inconvenient health facility opening hours All hinder the use of RHS by young people. Social factors have the strongest impact on adolescents, so much so that they feel compelled to use RHS freely because of their commitment to religious values [33].

Adolescents in the tamale metropolis face several obstacles that restrict their access to sexual health information and abortion care. Policymakers could use these findings to improve access to Reproductive and sexual health services.

Conclusion

Most of the adolescents were of the Islamic faith, females and their ethnicity were Mole Dagbani. The majority of the adolescents were between the ages of 16-

19 years of age, single, offering General Arts, staying at the boarding house, staying with both parents at home, and their fathers have one wife. The study revealed that adolescent respondents have a positive attitude towards adolescent sexuality. The challenges encountered by the adolescents in order of significanceare as follows; there are lots of risks/dangers involved in abortion, culture, religion, no respect for them, lack of confidentiality, lack of support person, no privacy, stigmatization from mates and society, monetary reasons, previous bad experience, lack of comfort, availability of concoction. Tagging/labeling from mates and midwives' bad attitude were not considered significant barriers. Adopting interventions that address these Barriers can help to improve adolescent sexual health services significantly. Future research is needed for programs that provide community-based reproductive health education and culturally sensitive services to adolescents in the Tamale metropolis. Community awareness campaigns and youth health education programs should be among the interventions. The capacity of primary health care centers to provide comprehensive adolescent-friendly reproductive health services must be increased. Health care providers should have up-to-date knowledge and skills to provide youth-friendly health care. The government should allocate sufficient resources, such as manpower, medicines and contraceptives, as well as educational materials.

Data Availability

The data set used in the analysis of the study are available from the corresponding author upon request.

Conflict of Interest

There was no conflict of interest in the study.

Funding Statement

There were no external sources of funding received for this study.

Contributions

AB and MN designed the study and developed the study tools and recruitment strategy. JOM, YNA and RNN coordinated data collection and analyzed the datacontributed to the interpretation of the findings. AB and RNN wrote the first manuscript and all authors reviewed and approved the final manuscript for publication.

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