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PROBLEMS OF TEENAGE PREGNANCY IN NKWANTA DISTRICT OF VOLTA REGION

BY: YAW OSEI ASIBEY



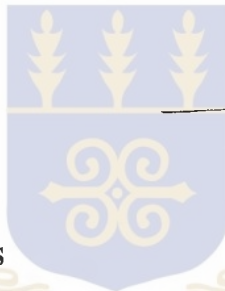
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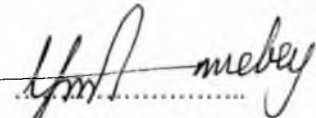
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MASTER OF PUBLIC HEALTH COURSE**DECLARATION**

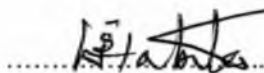
This dissertation is the result of an independent investigation. I have made acknowledgement, where my work is indebted to the work of others.

I declare that, this piece of work has not already been accepted in substance for any other degree, nor, is it concurrently been submitted in candidature for any other degree.

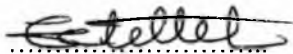



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DEDICATION

This piece of work is dedicated to all people and organisations which have the welfare of teenagers at heart and are concerned about their well - being.



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I thank everybody who in diverse ways have contributed towards my study and work at the school of Public Health, University of Ghana, Legon.

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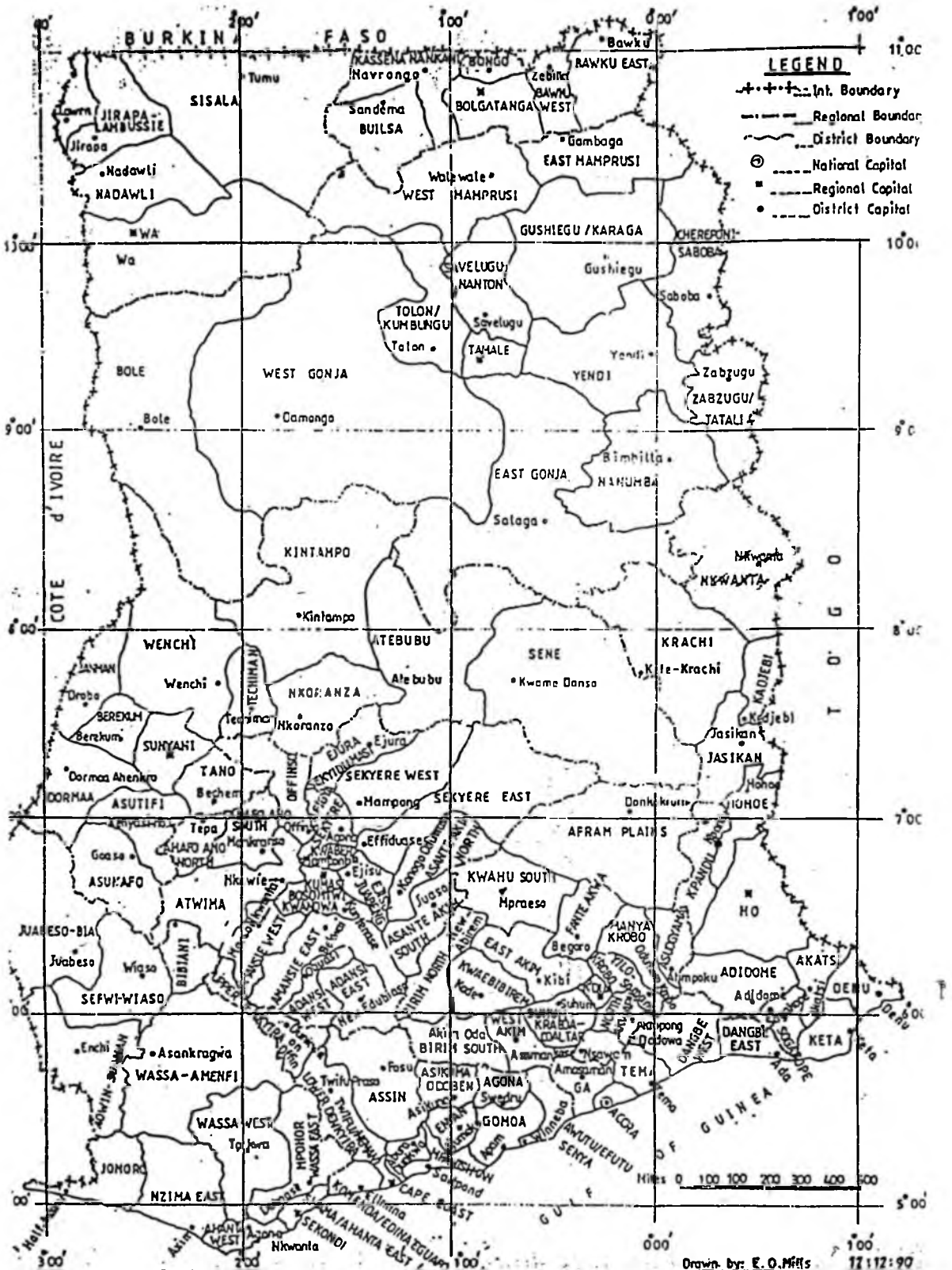
However, I must confess that, I am solely liable for any shortcoming that may arise from this piece of work.

Yaw Osei-Asibey

SPH

Legon

September, 1998



NKWANTA SUB-DISTRICTS OF HEALTH

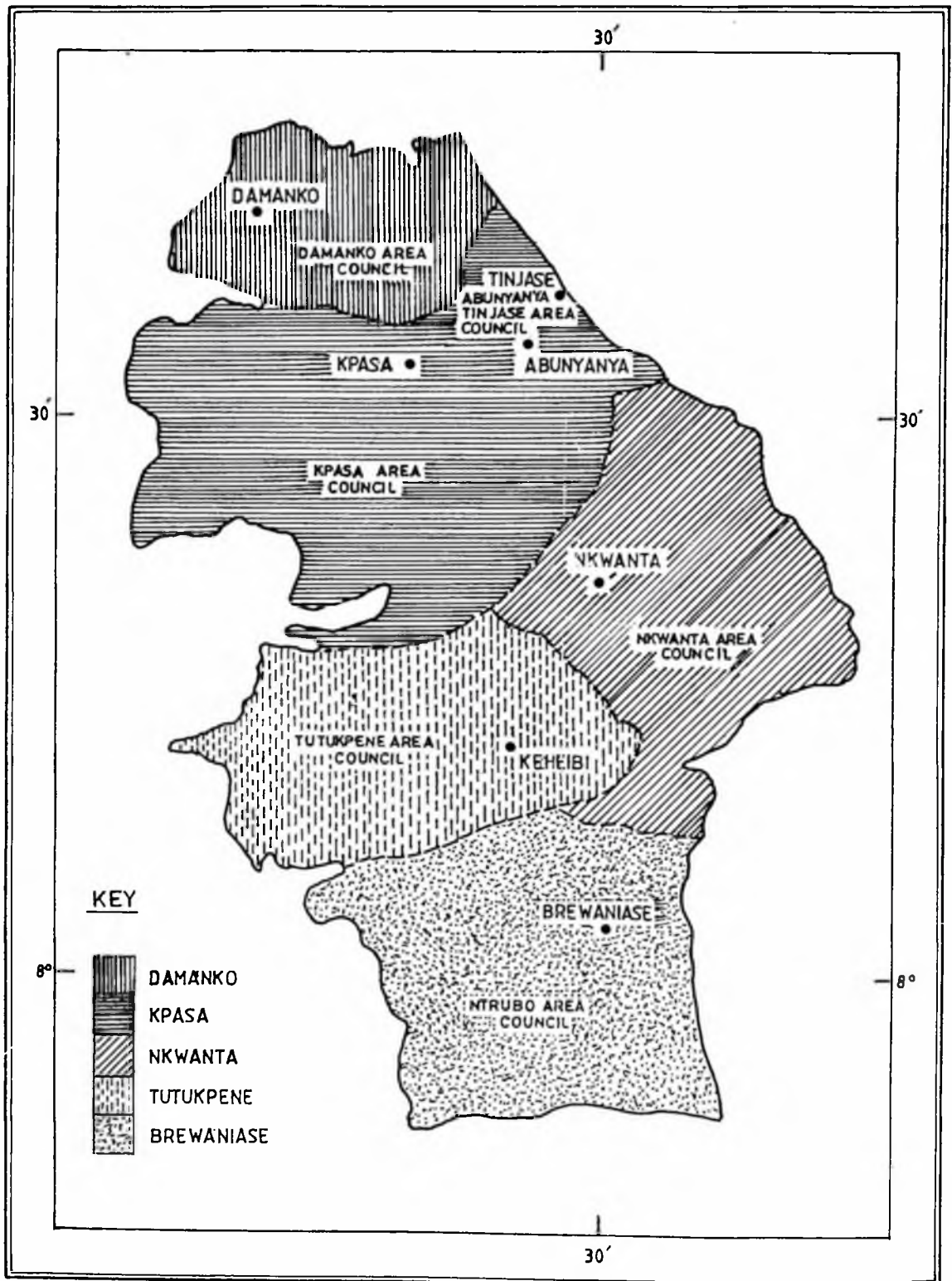


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ABSTRACT

Unwanted pregnancy among teenage girls has been identified as one of the major social problems in the Nkwanta district. The study assessed the factors responsible for, and the consequence as well as recommendations for remedial measures to help address some of the problems associated with teenage pregnancy.

This is a descriptive study using both quantitative and qualitative approaches. Data were collected through the administration of questionnaire and focus group discussion, collation of service statistics and informal discussions with community gatekeepers. One hundred and eighty-four (184) respondents selected from 12 communities in five sub-districts were involved in the study.

Findings show that informal sources of help with sexual and reproductive health matters, particularly from peers are much more important to young people than formal sources such as teachers and parents. Both young people and adults interviewed agreed that the major sources of information and help in sexual matters are peers, some of whom are popular because of their supposed knowledge in sexual issues. Some young people for example are popular because of their supposed knowledge in sexual issues. These were called “experts” in dealing with sexual problems including abortifacets, local herbs for sexually transmitted diseases.

Even though forced abortion is almost always the first string to many young girls outside marriage in the research area, in cases where they are not successful; the pregnancy is carried to term. In this case, the man responsible for the pregnancy cares for the girl. Some may refuse to accept responsibility for the pregnancy and this brings conflict between the two families. However, where the young girl had already

been betrothed to the man who is responsible for the pregnancy, the situation is perceived differently.

Findings further revealed that the chiefs and elders in the various communities are aware of the increasing number of unwanted pregnancies and have tried to put in place some measures to curb the situation. In one community for example, a fine of ₵50,000, a ram and 2 bottles of schnapps has been instituted as punishment to any male who impregnated any adolescent outside marriage. To them, the issue is teenage pregnancy outside marriage and not teenage pregnancy per se.

One major related issue is the comparatively low rate of school attendance by girls. In most cases a girl is disadvantaged and marginalised and may never be sent to school at all or even where she is sent, she may not be given the necessary support to help her complete her education. She may be betrothed at an early age and therefore could become pregnant at anytime. That becomes a disincentive to many young girls since they play the role of married people long before they are matured to do so.

It was suggested that female-teachers should be posted to the rural areas to serve as role models to young girls. Efforts should also be made to bring back to school teenagers who become pregnant. This group could also be trained to offer peer-counselling services in the community.

LIST OF ABBREVIATIONS

1.	AIDS	Acquired Immuned Deficiency Syndrome
2.	ARH	Adolescent Reproductive Health
3.	DA	District Assembly
4.	DCE	District Chief Executive
5.	DHA	District Health Administration
6.	DHMT	District Health Management Team
6.	FGD	Focus Group Discussions
7.	HIV	Human Immuno-Deficiency Virus
8.	ICPD	International Conference on Population and Development
9.	IEC	Information, Education and Communication
10.	JSS	Junior Secondary School
11.	MOH	Ministry of Health
12.	NGO	Non-Governmental Organisation
13.	PPAG	Planned Parenthood Association of Ghana
14.	SPH	School of Public Health
15.	SSS	Senior Secondary School
16.	STDS	Sexually Transmitted Diseases
17.	STC	State Transport Company
18.	TBA	Traditional Birth Attendant
19.	TZ	Tuo Zaafi
20.	UAPS	Union for African Population Studies
21.	UCC	University of Cape Coast
22.	UG	University of Ghana
23.	USA	United States of America
24.	USAID	United states Agency for International Development
25.	WHO	World Health Organisation
26.	WVI	World Vision International
27.	YC	Youth Concerns

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CHAPTER ONE

PROBLEMS OF TEENAGE PREGNANCY

1.1 GENERAL INTRODUCTION

Concern for teenage pregnancy as members of families, social scientists, demographers and planners and medical scientists stems from the fact that, the incidence of teenage pregnancy has obstetric, pediatric, psychological and social implications on the teenage mothers and their children in particular, and the society as a whole.

The importance of the well being of teenagers in any society is based on the view that teenagers constitute a major source of potential human resource which, when given the necessary guidance to grow into adulthood, will shape the socio-economic future of a country. Teenage pregnancy in a country could undermine the development of that potential.

Teenagers form an age group of people that are about to enter their reproductive stage and will soon become parents. In most societies, the needs of teenagers are often overlooked, probably because; they are generally perceived as a very healthy group of people.

The basis for action on adolescents as presented in Section 7.42 of the report of the International Conference on Population and Development (ICPD: 1994) held in Cairo in September, 1994, states that:

“Poor educational and economic opportunities and sexual exploitation are important factors in the high levels of adolescent child-bearing. In both developed and developing countries teenagers faced with apparent life choices have little incentive to avoiding pregnancy and child-bearing” (ICPD, 1994: 7.42).

“The responses of societies to the reproductive needs of adolescents should be based on information that will help them to attain a level of maturity, required to make responsible decisions. Countries with the support of the international community should protect and promote the rights of adolescents to reproductive health, education, and information and areas that will greatly reduce teenage pregnancies. Governments are urged in collaboration with NGOs, to establish appropriate mechanisms to respond to the special needs of adolescents. Furthermore, Countries must ensure that programmes and attitudes of health-care providers do not restrict adolescent's access to the services they need. The services must safeguard the rights of teenagers to privacy, confidentiality, respect and informed consent. In this regard, cultural values, religious beliefs, the rights and duties and responsibilities, of parents must be respected.” (ICPD. 1994:)

Indeed one of the major aims of the ICPD was to reduce teenage pregnancies both within and outside marriage. And to come to grips with the underlying factors of teenage pregnancy, there is the need to understand the problems of teenage pregnancy.

According to Ghana Demographic and Health Survey of 1993, though teenage fertility rate has dropped from 33.3% in 1988 (GDHS: 1988) to 22%, in 1993 the

figure is still high. Furthermore, the overall unmarried rates are increasing as males who impregnate these teenagers refuse to marry them. One of the major contributory factors of teenage pregnancy is lack of parental care due to poverty.

Indeed the ICPD of 1994 underscored this concern by emphasizing on teenage reproductive health issues. The study is based on the same concerns as expressed at Cairo as well as that of the DHMT of Nkwanta and other people including Headmasters and District Chief Executive of the Nkwanta District in the Volta Region, Ghana.

1.2 STATEMENT OF PROBLEM

Teenage pregnancy has been recognised by many people including the District Chief Executive, and Headmasters of SSS in the district, the District Assembly and DHMT as one of the major health and social problems in the district. Data from service delivery points in the district attest to a high incidence rate of teenage pregnancy.

The available data showed that in 1995, 21% (1049 out of 4946) reported cases of pregnancy at health facilities in the district were among teenagers. In 1996, about 21.1% (1039 out of 4911) of reported cases were teenagers and in 1997 about 20% (1080 out of 5397) cases were also among teenagers. Compared with the regional teenage pregnancy rate of 11% (GDHS: 1993) this is very high.

If the reported cases of teenage pregnancy rate is about 21% over the three-year period 1995-1997 in Nkwanta district, then the unreported cases may even be higher in this district where the bulk of the population lives in the rural farming communities without accessible roads, particularly during the rainy season.

Besides this, there are several untrained Traditional Birth Attendants (TBAs) whose activities are not documented. In August 1998, the District Health Management Team

(DHMT) brought together 50 untrained TBAs from 12 villages for a workshop at Nkwanta. During the selection of the TBAs, the team was reliably informed by the chiefs and elders of the various communities that each, community/village had not less than about 10 untrained TBAs. If the activities of these TBAs where many of the teenagers delivered were recorded and reported to the MOH, the number of teenage-pregnancies would have been higher than stated.

In all the villages the DHMT visited, the team saw pregnant teenagers / mothers. The team also observed this during market days, when pregnant teenagers / mothers brought wares and farm produce for sale. Only a few of them attended the MCH clinics. The TBAs attested that more teenagers were getting pregnant than in previous years. Many of these pregnancies were and are mistimed and therefore unwanted. Some of those who carry the pregnancy to term often had post partum complications. This increases the maternal morbidity and mortality in the district.

Perhaps the most serious consequences, which bother parents and the community, are unwanted pregnancies, sexually transmitted diseases including HIV/AIDS and the social stigma attached to the family about teenage pregnancies.

If an STD is not treated properly, it can lead to sterility and may have serious health and economic implications. Teenagers may neglect the first signs of STDs due to ignorance, fear, embarrassment and lack of funds to seek the necessary treatment at health delivery points. Fear and embarrassment because at some health facilities, some health workers subject teenagers who are pregnant to harsh and unfriendly treatment which make the facilities unfriendly to them. Added to the above, is the possibility of abortion and the abandoning of children which make headlines in the national dailies from time to time. A probable dimension is death through abortion and infanticide. However, there are no documented records on abortion and infanticide in the district.

This is a concern to families, the communities, district and the nation due to the social, economic, psychological and health implications on the girls and their babies. The situation therefore calls for a community study of the magnitude of the problem, the factors that lead to teenage pregnancy in the district, so that, recommendations could be made for the necessary policies and interventions to address the issue towards the proper development of the district.

1.3 OBJECTIVES

1.3.1 GENERAL OBJECTIVES OF THE STUDY

The general objective of the study is to examine the causes of teenage pregnancy in Nkwanta district with the view to making recommendations for developing interventions to address the issue.

The specific objectives of the study are to :

1. Examine the factors that contribute towards teenage pregnancy in Nkwanta district.
2. Discuss the consequences of teenage pregnancies in the district
3. Indicate some of the measures or interventions to put in place to address the issue.
4. Offer some recommendations to the DHMT and District Assembly for policy formulation and implementation within the above stated objectives.

1.4 JUSTIFICATION OF THE STUDY

The study of teenage pregnancy in Nkwanta District of the Volta Region is important and timely for several reasons.

The problem associated with teenage pregnancy is of national interest. The National Population Policy (1990) has identified teenage pregnancy as one of the major issues it seeks to address.

The study is justified based on the fact that teenage pregnancy is associated with social, economic and health problems. These problems do not only affect the teenagers, but the family and the nation as well. Prominent among such problems is the high drop out rate from schools among females and early marriage.

Table 1: SSS ENROLMENT IN NKWANTA. 1997/98

SCHOOL	BOYS	GIRLS	TOTAL
BREWANIASE	135	31	166
KPASSA	140	35	175
NKWANTA	266	64	330
TOTAL	541	130	671

Source: Headmasters of SSS-Nkwanta.

From the above table, girls form about 19.3% of the student population at the SSS level in the district. However, girls form about 35.2% and 40% of the total school enrolment at the JSS and Primary school levels respectively.

Table 2: SCHOOL ENROLMENT IN NKWANTA DISTRICT 1995-1998

YEAR	1994/95		1995/96		1996/97		1997/98	
SEX	M	F	M	F	M	F	M	F
KINDERGARTEN	590	573	701	649	741	668	883	784
PRIMARY	6347	4523	6181	4395	6223	4440	7035	5020
JSS	2208	1166	2230	1181	2296	1173	2313	1256
SSS	802	196	721	142	687	128	541	130
TOTAL	9947	6458	9833	6367	9947	6409	10772	7190

Source: GES. Regional Office: Ho V/R.

From the table above, one finds out that the number of females in schools start to drop from Junior Secondary School level. By the time they enter the SSS system, the number would have dropped drastically. This may be partially attributed to teenage pregnancy as many of the girls at SSS level enjoy various forms of scholarship and

therefore poverty may not be a major constraint to female education in the district (discussions with headmasters).

At Brewaniase SSS, the table below paints the school programme vis-a-vis the female population. This is not different from the other two SSS.

Table 3 :BREWANIASE SSS PROGRAMME-1997/98

CLASS	PROGRAMMES	BOYS	GIRLS	TOTAL	FORM TOTAL
SSS 1A	AGRICULTURE	35	7	42	64
SSS 1B	VISUAL ART	14	8	22	
SSS 2A	AGRICULTURE	26	3	29	47
SSS 2B	VISUAL ART	14	4	18	
SSS 3A	AGRICULTURE	25	3	28	55
SSS3B	VISUAL ART	21	6	27	
TOTAL		135	31	166	

Source: Headmaster's Office-Brewaniase SSS 1997/98.

The Ministry of Health (MOH) in collaboration with World Vision International (WVI) has introduced the community register system into the Nkwanta District. Through this exercise, the various communities are able to record all vital statistics as well as know the population at any point in time “T”. During a day’s orientation seminar for the volunteers who would register the people and take the vital statistics at Brewaniase on 19th June, 1998, the resident student who was with the team of facilitators wanted to find out why there was no female among the volunteers. One of the participants answered: “hardly does one get a “*local*” or (indigenous) literate in a Female to serve on a committee as a treasurer when any is (to be) formed” The other workshop participants from the zones in the sub-district supported the first speaker and said that females in the district are almost always pregnant. In their contribution towards the discussion, it was added that females in the district are more interested in giving birth rather than attending schools. They are almost pregnant or seen carrying babies. So there was no wonder no female was among the group. It is worthy to note that in many social clubs or associations in Ghana, females are preferred for the position of a treasurer than men. The common belief is that a female will not misappropriate the Society’s funds. Should this ever happen, a male, for that matter the husband or suitor will settle the misappropriated funds. Later on, Major (rtd) Mensah, a social worker of WVI resident in the Brewaniase sub-district confirmed this.

Available data from Health Centers in the district including the District hospital show that, teenagers (10-19 years) who reported at the various facilities with pregnancy were 1049 in 1995, reduced to 1039 in 1996 and increase to 1050 in 1997. The total number of reported pregnancies for females 15-49 at these health centers for the same period (1995-1997) were 4946, 4911 and 5397. This gives an average teenage pregnancy rate of about 20.6 % for reported cases in the district. This data show that there is high incidence of teenage pregnancy in the district as the reported cases could be the tip of the iceberg. Because, there could be many unreported cases. Perhaps this

may be a contributory factor towards low female education and development in particular in the district.

The study will be a preview of the situation in Nkwanta district (VR) who share a common boundary with The Republic of Togo, Nanumba, Jasikan, Kete-Krachi and Kadjebi district in Ghana. Furthermore, it will be a continuation of a recent study in the country by Nabila, Fayorsey and Pappoe (1995), which has thrown more light on teenage pregnancy in Ashanti, Central and Greater Accra regions. The outcome of the study will also be used as a guide to formulate policies on Adolescent Reproductive Health (ARH), which will impact on the education of the girl child and thus improve upon her health. It is anticipated that when the number of females in schools increase it will eventually help to reduce the fertility rate of the district, which is estimated at 5.2%. This will enhance the status of teenagers in the short run and women in the long run.

1.5 LITERATURE REVIEW

According to the state of the world's population (1995). Africa registered 136 birth per 1000 women (136%) aged 15-19 years as compared to 32 per 1000 women in the advanced countries. The same report indicated that Botswana recorded 100 birth per 1000 women within the same age group.

The Seychelles has one of the highest teenage pregnancy rates in the world. In 1979, about 26% of all births in that country (Seychelles) were to teenagers (15-19 years) (Pradenuad: 1981).

In Nigeria, cultural differences between the South and Muslims in the North leads to different patterns. In the Southern part of Nigeria, early childbearing practices among urban girls is similar to Ghana. Often, this tend to be out of wed lock and there is high

rate of induced abortion. But in Northern Nigeria, a larger proportion of birth to teenagers occur within marriage (Nicholas et al 1986).

The situation in Northern Nigeria is aggravated by lack of places in government schools for girls. For instance, in Kano State, 30,000 people who complete primary school each year could not be absorbed into the government school. Only 10% gain admission into secondary schools. Those girls who are unable to continue their studies are usually married within the next year (Baker & Rich: 1990). Though many teenagers in Nkwanta get pregnant, one will want to find out if they are “properly” married and if they resort to abort these pregnancies. In the case of Nkwanta District there are many schools to absorb both girls and boys. Teenage pregnancy cannot be attributed to lack of schools and one will want to find the causes as well as the percentage. In Kenya birth to teenagers represent up to 20% of the country’s total fertility rate of 6.7%. Approximately 142,000 birth occurs to girls between 15-19 years every year.

Traditionally, young people have been overlooked by society and they receive little or no reproductive health care and services. Yet young people represent the largest generation in human history. Their decisions and choices, will, to a large extent determine whether world population will stabilize at 10 billion or 15 billion. “we cannot any longer afford to treat young people needs as peripheral or too delicate” Clare: (1998). Teenagers or adolescents who experience pregnancies are likely to suffer from childbirth related morbidity and mortality. Thus pregnancy occurring to teenagers could have serious health risks, psychological, socio-cultural as well as economic implications on them, their off-springs, the family and the community at large” (Clare: 1998)

Though both adults and teenagers see teenage pregnancy as a problem, yet some teenagers do not see it as such. In a study done in Gana-Botswana (1986) 32% of teenage respondents indicated some advantages in teenage child bearing.

The advantages they saw were:

- might not have a child when old
- able to look after the child while young
- the child will look after you when they grow (social security)
- When one has children while young, she does not grow old.

In Ghana the 1993 Demographic and Health Survey indicated that female adolescents aged 15-24 years form 38% of the women in reproductive age (15-49). About 22% of teenage girls 15-19 years have started child bearing. Five percent of 19 year-olds have already given birth to two or more children. The percentage of teenagers who have already had their first child is higher in rural centres (26%) than urban centres (16%). Those without formal education are even higher and are likely to be about five times as likely to have started child bearing (33%) than those with secondary or higher education (GDHS: 1993).

According to the state of world population report of 1995, for some African countries, 38 to 60% of women hospitalised with abortion complications were aged 19 years and below.

A study on Determinants of maternal mortality in Botswana indicated that the maternal deaths occurring amongst the 15-19 year group was from septic incomplete abortions which accounted for 33% of deaths. In Ghana, the incidence of pre-eclampsia and maternal infant mortality are known to be higher among teenage mothers. According to a research by Ampofo in 1986, “the most common cause of maternal mortality among teenagers that accounts for 42% of such deaths is septic abortion (Ampofo; 1986)

In Botswana, a teenage pregnancy study conducted in 1986 showed that 8% of the pregnant girls (15-19) years considered something else such as adoption, marriage or suicide, which may well, include infanticide than keeping the child.

In 1990, University of Ghana Medical School (UGMMS) students conducted a survey on teenage pregnancy at Ablekuma, a suburb of Accra. Among the teenage girls interviewed (at Ablekuma) who were pregnant at the time of the research, twenty percent (i.e. 24 out of 120) of the pregnant teenagers had actually visited a health facility / institution to terminate their pregnancies prior to the survey (UGMS.1990)

A study by Boulton et al (1991) points to the association between teenage pregnancies, with disorganised family structure, disregard for cultural norms, low education and lack of knowledge of and the use of contraception.

1.5.1 Factors that lead to teenage pregnancy

Factors that lead to teenage pregnancy are many and varied. Some of them are discotheque attendance by teenagers, alcoholism, and early maturation, lack of parental control, broken homes and early marriages. Many communities frown upon teenage pregnancy. Yet their daughters are married at early ages. Even some parents betroth their daughters to men before they are born. Thus, before the baby is born into this world, her fate had already been decided by either the father or its family.

Lack of guidance about sex and sexuality by parents is a factor. Some parents are shy to talk to their children about sex and sexuality. Others are ignorant and therefore unable to discuss sexuality issues with their children because they do not know what to impact to the teenagers. This results in lack of family life education in most homes.

Currently, with the breakdown of traditional ways of socialisation and educating the child in the home, the teenager is often left to himself or herself. Though the school is supposed to fill the gap by teaching family life education, this is not taught properly. For one thing, many teachers lack the skills to teach the subject. For another, students consider the subject too less important since it is one of the non-examinable subjects. Therefore it is not given the attention it deserves.

Urbanisation and economic factors play major roles in teenage pregnancy. Ghana has witnessed massive migration of teenagers into the urban centres in search of jobs which are non-existent. Many of these teenagers, particularly girls are drawn into sexual relationship for survival and in the extreme cases many end up in prostitution (Nabila and Fayorsey: 1996). As a result of economic hardships teenagers are left to fend for themselves by some parents.

As many parents can not support their children financially, the teenager does all sorts of things including early street trading and soliciting for help from men and prostitution. In certain cases some families even depend upon the money their teenage daughters bring home to support family income. Following this, some of them directly or indirectly encourage their children onto the street with the view to working for money. In their attempt to work they end up being impregnated.

A societal value of admiring people with many children in the villages and looking down on childless people is yet another factor. Childless couples or women are ridiculed and such practices could influence teenagers to become pregnant early.

A lot of money is needed for secondary school education in Ghana. This compels many parents who cannot afford to help in their children's or wards' education push them into marriage. There is the issue of the period during which school re-opens for new admissions. The academic year starts during the lean season, when many parents may have barely little to live on. Parents therefore tend to be selective and often send

male children to school when there is a choice to be made. The fear being that the girl may get pregnant and investment made in her will be wasted.

Another side of this issue is the notion that the female teenager will be married out of the family, while the male boy-child will marry into the family and will have to be prepared to cater for his future family.

Many adages in the country among traditionalists contribute overtly towards teenage pregnancy. For example, the Akans say that *“the female’s place is in the kitchen ” and “a female sells garden eggs but not gun-powder“*. This points to the issue of gender roles. It is believed that, such sayings have psychological effects on the female child and puts her at a disadvantage.

Another factor that leads to teenage pregnancy is “Sugar daddies and Sugar mummies” Teenagers strike up sexual acquaintances with older-rich people popularly termed as sugar daddies and sugar mummies. These people exchange gifts and money for sexual relationships, while others use their positions to influence teenagers. This issue is confirmed by a study at Ramotswa in the Botswana (1995). In the United States studies have found out that male adults were responsible for 65% of births to school –age mothers. The average difference between girls younger than 16 years of age and their partners was 6.7 years. The same figure for girls 16-18 years of age was 4.2 years. A study in South Africa observed the same age difference found in the US, and identified the relative absence of socio-economic support by the father, which caused the teenage-mother to rely on her parents for support (Dhlamini et al : 1997).

Another factor that leads to teenage pregnancy is peer influence. For example a study of adolescents in Ramotswa, a village near Gabrone in Botswana, by a group of I.E.C personnel from 12 Anglophone countries in Africa, also enumerated peer influence as one of the common causes of teenage pregnancy in the country. This was confirmed in both interview and focus group discussions organised among teenagers.(UNFPA:1995)

A study in Ghana on Adolescent Reproductive Health on the Akwapem Ridge by PPAG has shown that peer influence on the youth often leads them to indulge in unprotected sex which leads to teenage pregnancy. (PPAG:1996)

SUMMARY

Available literature shows that teenage pregnancy is a world wide phenomenon. While people frown upon it some teenagers see advantages in teenage child bearing as expressed by teenagers in Ghana in Botswana. Among prominent factors that lead to teenage pregnancy are lack of parental control, poverty and peer influence. It is established that a sizeable number of pregnant teenagers resort to abortion. This is indicative that such pregnancies are unwanted and therefore mistimed.

CHAPTER TWO

2.0 THE STUDY AREA

The study area is Nkwanta District, which derives its name from the district capital Nkwanta. The town was sometime ago known as Krachi-Nkwanta.

2.1 GEOGRAPHY OF THE DISTRICT

Nkwanta District occupies the north-eastern part of Volta Region of Ghana. It covers an approximate area of 4530sq km; and accounts for 21.4% of the total surface area of the Volta Region. This makes it the largest of the 12 districts in the region (Nkwanta District Profile: 1997).

The district boundaries are Kadjebi district to the south, Kete-Krachi to the south-west, Nanumba to the north and by the Republic of Togo to the east where a chain of mountain ranges form a divide.

The north eastern ranges are the extension of the Akwapim-Togo ranges. This section is marked by Mt. Djebobo (884 metres) near Chilinga and Kelembo mountains (738 metres) south of Brewaniase. The Togo-Atakora ranges are to the south of these ranges. The second relief zone is a vast undulating Savannah grassland, which stretches out from the forest zone in the south to the north-western parts of the district. The altitude ranges between 100 and 200 metres.

Several rivers run from the Buem-Togo Ranges along the eastern border of the district, fall sharply and flow in the south-western direction into River Oti, a tributary of the Volta Lake. Some of the main rivers are: Kpasa, Bonakye, Chai, Ma, Sabu, Nano and Asukawkaw. The Shaire waterfalls is found in this area. There are several tributaries to these major rivers. These provide domestic water to majority of the population. Most of these rivers and streams dry up during the dry season.

Occasionally, the Oti River overflows its banks. However, the natural drainage system does not pose any serious threat to human occupancy.

The climate of Nkwanta is characterised by a rainy season with warm south-westerly winds, from May to September, and a dry season from November to February/ March. The latter period is characterised by hazy conditions as a result of dust from the Sahara Desert. The average temperature varies from 28°C in March/April to 24°C in July with a daily variation of 10°C. The annual rainfall varies from 1500mm - 1750 in the south to 1250 - 1500mm in the north. The rainfall regime is characterised by a double maximum (April/May-July and September-October). The average number of rain days is 86 days. (16 years record from Nkwanta Meteo Station). Thus, rainfall is very critical to the predominantly agricultural economy of the district.

The vegetation of the district comprises moist semi-deciduous rain forest found on the mountain slopes of the eastern border of the Buem-Togo ranges. Some forest is also found along river courses. These gradually change into guinea savannah woodland that extends from the north-eastern part of the district southwards. The third zone is made up of savanna grassland, which extends for about 20kms. eastwards from River Oti.

As a result of bush fires and shifting cultivation most of the primary forest has changed into secondary forest. In spite of this, the forest provides economic species of timbers that are exploited by chain-saw operators who work under permit. Two forest reserves have been established in the district. They are Asukawkaw and Chai Rivers Reserves, with a total area of 276.60sq km. (103.32sq mls). A National Game Park, the Kabobo Range Game Reserve, has been established in the district. It has an area of about 440sq.km. and situated on the north-eastern international border with Togo and adjoining the FAZAO National Park of Togo. The rich fauna of the area

include monkeys and baboons, ant bears, lions, leopards, elephants, porcupine, antelopes, bush pig; African and royal python, guinea fowls and stone partridges.

The soils of the Savannah areas consist of groundwater laterite and laterite ochrosal integrades. Only a small area consists of savannah ochrosil. The mountain tops near to the Togo border are covered with forest lithosols. The other ranges are covered with forest ochrosols and oxysols.

The savanna areas are favourable for the cultivation of crops such as: yams, cassava, groundnuts, maize cowpea and sorghum. Tree crops such as cocoa, citrus, oil palm, avocado pear and cola are grown in the forest zones. Other crops are plantain, banana, cocoyam and pineapple.

2.2 ECONOMIC ACTIVITY

The district grows mainly yams cassava, guinea corn, maize, groundnuts, plantain, banana and vegetables. These constitute the staples of the people. The cultivation of legumes and other vegetables depend upon the season. Yam cultivation is the main occupation of the people, and yams are sent to other parts of the country. Fish and meat are found in the markets but they are very expensive, and at times in short supply.

Other crops grown are cashew and cocoa. The processing of cassava into gari is done mainly by women as an economic activity. Trading is done in products such as foodstuff and hardware.

2.3 POPULATION

In 1995, the total population of the district was estimated as 130,246, based on projection from the 1984 population census (with an annual growth rate of 1.8% for

the Volta Region). The district had 300 settlements in 1984. Currently the projected population is 139,880, with the number of settlements increasing from 300 to 337.

Table 4: Nkwanta – Number of Villages and their Population

Village Population	No. of Villages	Population	% of Total Popu.
100<	163	8253	5.9
100 – 500	125	31193	22.26
500 – 2500	41	59169	42.34
< 2500	8	41265	29.50
Total	337	139,880	100

The annual growth rate of the district is 5.2%. This is higher than both the regional and national rates of 1.8% and 3.0% (Development Plan. Nkwanta District Assembly 1995-2000).

2.4 SUB-DISTRICTS POPULATION

Nkwanta-District is divided into five (5) sub-districts. They are: Nkwanta, Tutukpene, Brewaniase, Kpassa and Damanko.

Table 5: Sub-Districts population, and Health delivery points

District	Population	Health Delivery Points
Nkwanta	32,521	3
Tutukpene	14,036	1
Brewaniase	21,725	3
Kpassa	49,935	2
Damanko	27,663	2
Total	139,880	11

2.5 ETHNIC GROUP

There are no reliable data on the various ethnic groups of the district. However, it is found that the Konkombas and Kabres are predominant in the north of the district. The languages spoken by these ethnic groups are comparable with only some slight differences. The central and southern parts are occupied by: the Atwodes, Adeles, Challas and Ntrubos. Each of these ethnic groups occupies a traditional area. Ewes, Akans and Kotokoli speaking people are found throughout the district, but they are not in large members. A peculiarity of the district is that Akan is spoken throughout the entire district.

2.6 RELIGION

Many people in the district practice traditional religion. In spite of this, Christianity is rapidly establishing itself. The Catholics were the first to start missionary activities in the district. They operate both in towns and rural communities and have several outstations in the smaller communities.

The activities of the Presbyterian Church are confined to the big towns. Multiplicity of Pentecostals and other spiritual churches are springing up in the district especially in the central and southern parts of the district.

The Hausas and Kotokolis who are mainly involved in trading activities in the urban centres practise Islam.

2.7 TRANSPORT AND COMMUNICATION

The district is served with three (3)-untarred trunk roads. The first runs from the south through Abrubruwa, Nkwanta (district capital) to Damanko in the north. It forms part of Hohoe Bimbila road and connects the food producing areas of the district with urban centres in the south of the country. Another one stretches from Hohoe through Worawora, Tutukpene to Nkwanta. While the third one connects Nkwanta to Dambai and other market centres. This road provides an alternative route whenever the other two north-south routes become unmotorable especially during the

rainy season.

Feeder roads connect the bigger villages with the main routes. All roads in the district vary with the seasons.

Most of the vehicles in the district are privately owned, and poorly maintained. Notably among such vehicles are; small buses, pick-ups cargo and mummy trucks.

Due to the deplorable nature of the roads, the State Transport Company has withdrawn its services in the district.

2.8 EDUCATION

The district has 156 educational institutions including three Senior Secondary Schools (SSS). These are situated at Brewaniase, Nkwanta and Kpassa, on the main Bimbila-Nkwanta-Hohoe trunk road. The table below shows the number of schools, teachers and pupils.

SCHOOL ENROLLMENT IN NKWANTA DISTRICT

Table 6: Nkwanta District schools, teachers and pupils enrolment (1997/1998)

Type of School	Number	Teachers	Pupils
Kindergarten	25	45	1667
Primary	85	322	12055
Junior Sec. Sch.	43	178	3569
Senior Sec. Sch.	3	47	671
Total	156	592	17,962

Source: District education office Nkwanta

The district is divided into eight (8) educational circuits, manned by Circuit Officers.

The statistics from the District Education Office indicate that, in the Primary and Junior Secondary schools level the population of girls is almost at par with that of the boys. But at the Senior Secondary School level, the female population decreases considerably. One of the major causes of this may be due to teenage pregnancies.

Although the adult literacy rate of Volta region is close to the national figure of 49% (Ghana Statistical Service, 1995 pp 16), yet that of Nkwanta District is 10% with females being the underdogs.

About 20% of the student population of these SSS are females. The table below (Table 4) show the school enrolment in Nkwanta from 1994/95 to 1997/98 academic years.

Table 7 : School enrolment in Nkwanta district 1995-1998

YEAR	1994/95		1995/96		1996/97		1997/98	
SEX	M	F	M	F	M	F	M	F
KINDERGARTEN	590	573	701	649	741	668	883	784
PRIMARY	6347	4523	6181	4395	6223	4440	7035	5020
JSS	2208	1166	2230	1181	2296	1173	2313	1256
SSS	802	196	721	142	687	128	541*	130*
TOTAL	9947	6458	9833	6367	9947	6409	10772	7190

*Source: GES, Regional Office: Ho V/R. * From HeadMasters – Nkwanta SSS (Figures NA at GES Office – Ho)*

The number of females in school starts to drop from Junior Secondary school level. By the time they enter the SSS level, the number reduces drastically.

2.9 HEALTH FACILITIES

There are 6 government and 5 private health facilities in the district. Each of the 5 sub-districts has at least one health facility. Nkwanta, the district capital has one government hospital and a clinic owned by the Roman Catholic Church. The government hospital is manned by a Medical Officer. The District Medical Officer works at the government hospital at Nkwanta. Since he is the only Medical Officer around, some patients have to be discharged when circumstances such as workshops take the Medical Officer out of the district for more than a week.

There are traditional birth attendants at the community level to take care of deliveries. Out-reach programmes are carried out by both Nkwanta government hospital and St. Joseph's Clinic. The doctor-patient ratio: 1: 139880

Twenty-drug houses are spread throughout the district. Some of these chemical shops provide all kinds of treatment and make poor and inadequate prescriptions.

Drug peddlers abound in the district. They sell all sorts of drugs, and give injections especially in the remote parts of the district. Their activities are hard to control. There are also traditional healers and soothsayers in the district.

2.9.1 HEALTH PROBLEMS

The major health problems in the district include, malaria, diarrhoea diseases, guinea worm, schistosomiasis, malnutrition, and teenage pregnancy, sexually transmitted diseases (STDs) and low family planning acceptor rate.

SUMMARY

Nkwanta district is the largest in the Volta Region. It has an estimated population of 139,880 people based on the 1984 population census. The district has one hospital and ten other health facilities in five sub districts. The doctor-patient ratio is 1:139,880. Among the major health problems in the district are malaria, guinea-worm, teenage pregnancy, STDs low family planning rate and malnutrition among children (0-5) years.

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY TYPE

The study was descriptive. A sample of pregnant teenage girls and those who have given birth within a year prior to the study and between (10-19 years) were selected for the interview. Additionally, 12 randomly selected Traditional Birth Attendants (TBAs) and 33 Parents / Guardians were interviewed to solicit their views on the issues at stake. This was done purposely to cross-check with the information given by the teenage girls (15-19 years) who were interviewed.

A second mode of data collection was through Focus Group Discussions (FGDs) of married and unmarried teenage girls (10-19 years) who were pregnant or had given birth within a year prior to the interview. The (FGDs) also covered the chief and elders of one of the communities (Nyangbom) involved in the study. Each of the groups for the FGD comprised eight people except that organized among the chiefs and his elders that was made up of ten people. (Nine males and one queen mother).

The field data collection began on 17th August, 1998 and ended on 22nd August 1998. (See appendix 1,II, and III for structured questionnaires for teenagers (10-19years), parents and an FGD guide.

3.2 STUDY POPULATION

The primary study population was defined as teenage girls (10-19 years) who were either pregnant or have given birth within a year prior to the study period and lived within the study communities. Parents or Guardians who constituted the secondary target group were people (males and females) who were above 20 years of age,

resided in the study communities and were living with and caring for or providing the needs of a child or teenager as described above.

3.3 LOCATION OF RESPONDENTS

The respondents were located at Damanko, Kpassa, Bonakye Nyambong, Aberewankor, Nkwanta, (District Capital) Tutukpene, Kecheibi, Brewaniase, Bontibor and Obanda in all the sub-districts. Owing to ethnic conflicts that had erupted during the period (August, 1998), the team could not visit Kabonwule. Also, due to heavy rains, which rendered the roads impassable, the team could not go to Tinjase, Kwei, Shiare, Alopatsa and Kotokoro-Baako-Dondo-Mmienno.

Apart from the sub-district capitals- (Brewaniase, Nkwanta, Tutukpene, Kpassa and Damako) all the above mentioned villages and clusters were chosen through the lotto method.

3.4 SAMPLE PROCEDURE AND SIZE

The Selection of areas for questionnaire administration was done by considering the resources available at the time, the number of towns in the district, the health facilities in the sub-district and the population of the sub-districts. The population was based on estimates from the 1984 population census.

The study chose all five sub-district capitals as urban centers because each of them had a population of over 5000 people, and had more than one primary school. Three of these sub district capitals (Nkwanta, Kpassa and Brewaniase) have Senior Secondary Schools each. Any cluster or village that is outside of ten miles radius of the sub-district was considered rural. The ten miles radius was chosen because it was the distance beyond which the indigenous people are unwilling to walk for health services.

3.5 SAMPLE SIZE

The selection was purposive One hundred and five (105) interviewees who were teenage girls (10-19 years) and who were either pregnant during the time of the study or, had given birth within a year prior to the study period were selected. Seventy three (73) of them were pregnant while 32 had given birth. Of the 32, five had lost their babies prior to the study period. (However the study did not find out the causes of death of these babies.)

The selection of the primary target group (i.e. pregnant teenagers / mothers (10-19 years) was purposive and based on quota system as follows:

Total estimated population of district:	139,880
20% youth (10-24) years:	27,976
15% teenagers (10-19) years:	4196.(4)
50% teenage-females (10-19) years:	2098.
20% teenage pregnancies	420.
25% sampled for study	105.

Each of the eleven health delivery points in the sub districts was awarded a point and used for the quota distribution. The assumption being that a health facility would determine the health status (including safe-mother-hood issues) of the communities.

Table 8 :SUB-DISTRICT HEALTH FACILITY AND QUOTA SYSTEM.

SUB-DISTRICT	HEALTH FACILITY	QUOTA
NKWANTA	3	29
TUTUKPENE	1	11
BREWANIASE	3	29
KPASSA	2	18
DAMANKO	2	18
TOTAL	11	105

With the secondary target group (parents / guardians) there were 45 respondents.

These were classified into workers from Ministry of Education (MOE) 13 health providers (MOH) 12, Traditional Birth Attendants (TBAs) (12) and Judicial services (8). These respondents were randomly chosen from their places of work.

The selection of the respondents from Ministry of Education, (MOE), and the Judicial Services were purposive. This was based on the assumption that their occupation is sensitive to the plight of pregnant teenagers and they may have much information about the topic. For instance where as MOE circuit officers in the district may know about pregnant teenagers through school-drop outs, the MOH staff may know through attendance at the health facilities and pre and post-natal and post- abortion care services. On the other hand, issues involving abortion and litigation on who is responsible for a pregnancy may end in the courts through the police. Hence the involvement of the judiciary service personnel.

The samples for the four (4) FGDs conducted were selected from urban (2) – Nkwanta and Kpassa and Rural (2) – Abrewankor and Nyangbom.

The selection was done through the lottery method. The names of the towns and villages were written on pieces of paper and four people were chosen to pick a piece of paper from the lot. A selection guide was used to select the 34 people who were involved in the focus group discussions.

3.6 DATA COLLECTION TECHNIQUE

Thirteen research assistants were recruited and given a one-day orientation for the exercise. They were all members of the District Health Management Team's (DHMT) research unit.

3.6.1 Pretesting

The questionnaires were pre-tested at Ofosukrom and Odumase in Dambai District of Kete-Krachi. These villages are situated on the border between Kete-Krachi and Nkwanta District and the people have similarities as those of Nkwanta. Sometimes the

area is not covered during immunization exercises. For one time this parcel of land is claimed to be part of Kete-Krachi District, for another it is claimed to be part of Nkwanta District.

3.6.2 Interviews in the Communities

The research assistants conducted interviews every day during the time scheduled for the exercise; 17th – 22nd August 1998.

3.6.3 Focus group discussions (FGD)

Four FGDs involving 24 teenage girls who were either pregnant or have given birth within a year prior to the interview and 10 adults (chief and elders and one queen mother) were conducted by a facilitator and notes taker (scribe) or recorder. A tape recorder was used to record the proceedings during the FGDs except the one conducted at Kpassa. There was a technical fault with one of the tape recorders. FGDs participants consent was sought before the tape recorders were used. The FGDs were conducted in two days and simultaneously as the questionnaires were being administered. The principal investigator and a recorder conducted 3 FGDs. One at Abrewankor, involving pregnant teenage girls (only), a mixed group of pregnant teenagers and those who have given birth (4 each) at Nkwanta and the chief and elders at Nyangbom. The health superintendent and a recorder conducted the fourth FGD at Damanko. The FGDs were transcribed by the principal investigator.

3.6.4 Data Processing

All questionnaires were coded by PPAG research assistants and summarized in a data sheet to facilitate analysis. After data entry clerks have undertaken data entry and office editing, they also flagged out questions that were inconsistent before coding. Frequency tables were drawn from the data sheet for all variables. Responses to open ended questions were categorized and entered into the master sheet. A Statistical Package for Social Sciences (SPSS version 7.0) software program was used to analyze the data from the structured questionnaire.

3.7 LIMITATIONS OF THE STUDY

The study was faced with some problems and limitations which should be kept in mind in interpreting the findings. These may be classified as socio-cultural and technical problems.

3.7.1 Time constraint

The greatest limitation to the study of problems of teenage pregnancy in Nkwanta district was time factor. The time for the study in the field was just too short in view of the vastness of the area, sensitivity of the topic vis-à-vis the recent ethnic conflicts that stretched into the district from the Northern region of Ghana. This even compelled the team not to go into the area around Kabonwule which had been selected during the initial stages of the sampling. The reason was that the Northern conflict which stretched into the northern part of the Volta Region had re-erupted (August 1998)

The political misunderstanding after the presidential elections in Togo also compelled the team not to collect data from Tinjase, a border town-where there had been an influx of Togolese. All the above factors affected sample selection. However the team managed to collect data from all the five sub-districts to make the study representative enough of respondents' views.

3.7.2 Different Study Population

Two data collection methods were used for the study. These were structured questionnaire and Focus Group Discussions (FGD). Each of the methods also targeted two different set of people. These were the main target group (teenage-girls 10-19 years) and guardians or adults within the communities The principal investigator's main focus was on pregnant teenagers and those who have given birth a

year prior to the study. This was based on the assumption that: *"she who wears the shoes knows where it pinches the most"*.

The structured questionnaires were used to collect data among respondents from both urban and rural areas and covered both pregnant and non- pregnant teenagers but who have delivered and were between 10-19 years.

The FGD also covered participants from both rural and urban communities. FGDs among guardians or parents were limited only to one rural community NYANGBOM. The other 3 FGDs involving teenagers were biased against the rural community. Two were conducted in urban areas Nkwanta and Kpassa and the third one was at Abrewankor.(rural)

The questionnaires were administered at Bonakye, Obanda, Bontibor, Kecheibi, Abrewankor and Nyangbom, (rural) while in Brewaniase, Nkwanta Tutukpene, Kpassa and Damanko and Nyangbom both structured questionnaire and the FGD were used to bring about a balance. There was not much difference in the responses from the use of both methods (questionnaire and FGD).

3.7.3 Fear And Suspicion By Respondents

There was fear and suspicion about the study (in-spite of the fact that the objectives of the study was clearly explained) as some of the respondents felt they were going to be registered to pay taxes. Again some respondents did not feel at ease due to the sensitivity of the questions asked whilst others fears were due to the tape recorders used during the FDGs.

3.7.4 Length of Questionnaire

It was realised later that the structured questionnaire was long. It took between 30 and 45 minutes to administer one copy. This sometimes affected the level of co-operation among respondents.

3.7.5 Interviewer Bias

If any difference would have occurred, it might have arisen from an interviewer bias, which might have arisen from language barriers in certain cases via (may be) an interpreter. Admittedly there was the need for an interpreter under some circumstances.

Generally, the study had interesting findings on the causes and consequences of problems of teenage pregnancy as well as some suggested measures to address the issues from the target groups - (the teenagers) point of view. Therefore the study has some recommendations to make.

SUMMARY

The study is descriptive. The primary target were teenage girls (10-19 years) who were either pregnant or have delivered within a year prior to the study. Information was gathered through interviews and FGDs among teenage girls (primary target) and guardians. Data from the guardians were collected to cross-check with that from the teenage girls.

Research assistants coded all questionnaires and summarised these into data sheets. SPSS (version 7.0) software programme was used to analyse the structural questionnaire while the investigator transcribed all the FGDs.

Among the limitations of the study were time constraints, different study population and fear or suspicion of respondents.

CHAPTER FOUR

BACKGROUND OF RESPONDENTS

4.0 Introduction

A total of 105 teenagers who were either pregnant or have delivered within a year prior to the data collection were interviewed. A total of 45 adults were also interviewed to double check with the information given by the teenagers. Thirty-four people were involved in the focus group discussion (FGDs). Twenty-four of these were teenagers selected from Nkwanta (8) and Brewaniase (8) urban and Abrewankor (8) and Nyangbom (10) rural and made up of chief and elders including a queen mother and an Assemblyman.

4.1 Age, Education and Religion of Respondents

Table 9A: Age of respondents - Teenagers

Measures of central tendency	Age
Mean Age	17.8
Range	12-19
Median	15..5
Standard deviation	1.59

Table 9B: Age of respondents – Parents / Guardians

Measures of central tendency	Age
Mean Age	41..5
Range	23-65
Median	38
Standard deviation	10.13

The mean age for the target group was 17.86 years, the range was 12-19 years. The age group 12-15 was grossly misrepresented. It formed 4.9% while 16-19 years formed 93.2%. However, the median age was 16.5 where as the mean age of parents was 41.15 years, the median age was 38 and the range was between 31 and 50 years.

Table 10A: Educational status of respondents - teenagers

	Frequency	Percentage
None	20	19
Primary	26	24.8
JSS/Middle	55	52.4
SSS	2	1.9
Others (Poly, College, University)	2	1.9

Where as nineteen percent (19%) of the teenage girls interviewed had had no formal education, 24.8% had had up to primary education and 52.4% had had education up to the Junior Secondary School (JSS) or Middle School Level. All the teenage girls who had had no formal education and education up to primary level had given birth or were pregnant during the interview (43.8%).

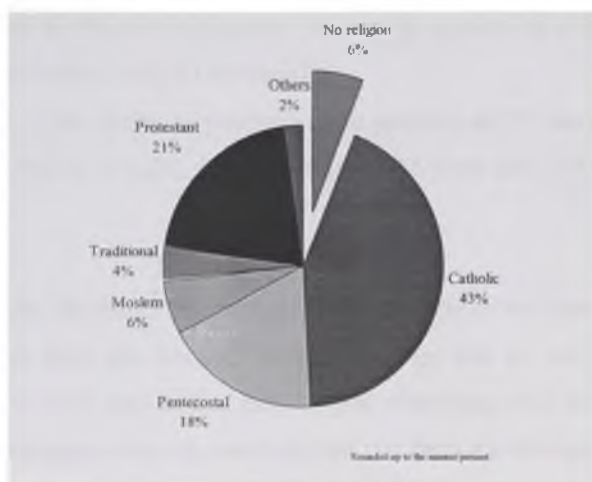
This proves the fact that educational attainment has influence on the fertility levels especially in the rural areas. It further buttresses the view in Nkwanta district that teenage girls start dropping out of the school system from the JSS level. Correspondingly about 24% of parents interviewed have had no formal education. About 18% of them have had Middle / JSS education. Another 18% have had Secondary / SSS education and yet another 18% Tertiary education. Thirteen percent (13%) have had college education (Teacher / Nursing Training). This is illustrated in the table 10B below.

Table 10 B: Educational level attained by respondents – Parents /Guardians

	Frequency	Percentage
None	11	24.4
Primary	1	2.2
JSS / Middle	8	17.8
SSS	8	17.8
College	6	13.3
Tertiary	8	17.8
Others	3	6.7

Table 11A: Religious background of teenage respondents

Religion	Frequency	Percentage	Cumulative
Catholic	46	43.8	43.8
Protestant	22	21.0	64.8
Pentecostal	19	18.1	82.9
Moslem	6	5.7	88.6
No religion	6	5.7	94.3
Traditional	4	3.8	98.1
Others	2	1.9	100

Fig 1: Religious background of teenage respondents

From the above Table (11A) and graph (fig 1), approximately forty four percent (43.3%) of respondents were Catholics, 21% were Protestants (Presbyterians, Methodist, Anglicans etc) while 18.1% were Pentecostals. Muslims and people who had no religion constituted 5.7% each, while Traditional Religion was 3.7%.

Table 11B: Attendance to religious services by teenage respondents

Times	Frequency	Percentage	Cumulative
Very often	49	47.6	47.6
Often	41	39.8	87.4
Occasionally	8	7.8	95.1
Never	5	4.9	100.0

About 48% of respondents said that they very often attended religious services, 39% often while 7.8% said they occasionally attended religious services. About 4.9% said they never attended any religious service. This proved that many of the teenagers went to church as directed by their parents.

4.2 Marital status of teenagers

On the whole 43.8% of the teenagers claimed to be married while 56.2% were not as illustrated in Table 12 (Pg 31 overleaf).

Out of this 3.1% of the respondents were married at 15 years of age. Thirty-eight percent (37.5%) at 16 years, 34% at the age of 18 years and 15.6% at the age of 19.

Unfortunately, 30.4% of the teenagers who claimed to be married could not tell the age at which they got married. Perhaps the age was so low that they felt shy to mention it. It could also be that they are just cohabiting with their partners. The issue was that customary rites on marriage had not been performed on some of the girls who claimed to have been married. Besides some of the males who impregnated those girls had gone to live in the urban areas and were not caring for these girls and their babies. This cropped up during all the FGDs held in both the rural and urban areas.

This confirms the study by Boulton et al (1994) that the mates who impregnate teenagers are often unable to care for them and their babies. As a result the responsibility of caring for the teenage mother and child become the burden of the girls parents

Table 12: Marital status of teenagers

	Frequency	Percentage	Cumulative
Married	46	43.8	43.8
Not married	59	56.2	100

About 63.8% of the teenage-girls have children while 36.2% had no children. Eighty percent (80%) of those who have children have had a child each, 17.8% had two children and 1.3% had three children.

Six percent of them had children when they were 15 years old, 6.2% at 16 years, 28.1% at 17 years, 26.5 % at 18 years and 17.6 % at 19 years.

4.2.1 Marital status of respondents (Parents / Guardians)

Thirty and a half percent (30.5%) of teenage respondents said that their parents were divorced and 22% claimed that their parents were separated while 47% said their parents were still married. Ten of the respondents did not answer the question.

At the FGD at Nyangbom and Kpassa, it was alluded to by the discussants that marriages were not stable as compared to the past (about twenty years ago.) and many of the males have not performed the customary marriage rites.

4.3 First Menstruation

Table 13: Age at first Menstruation

Age (years)	Frequency	Percentage	Cumulative
10-12	18	18.4	18.4
13-15	54	55.1	73.5
16-19	20	20.4	93.9
Others	6	6.1	100

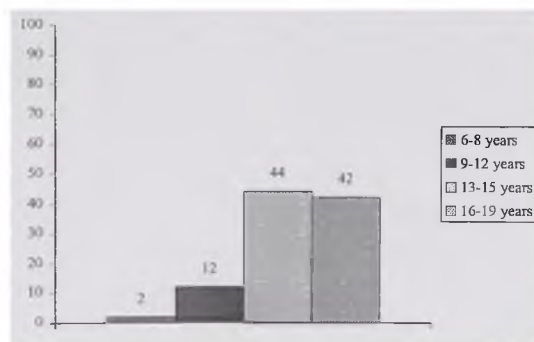
On the issue of first menstruation, 18.4% menstruated between 10-12 years, 55.1 % between 13-15 years and 20.6% between 16-19 years. The others (6.1%) could not tell when they had their first menstruation. This proves that girls are menstruating earlier than their parents used to. Unfortunately these young adults (girls) do not know about the anatomy and physiology of the human body as such, they do not protect themselves against STDs and pregnancies during sexual intercourse, as their knowledge base on contraception is scanty.

4.4 First Sexual Intercourse

Table 14: Age at first Sexual intercourse

Age (years)	Frequency	Percentage	Cumulative
6-8	2	2.0	2.0
9-12	12	12.0	14.0
13-15	44	44.0	58.0
16-19	42	42.0	100

Fig 2: Age at first sexual intercourse



On the issue of when the teenage girl respondents had first sexual intercourse (Table 14 and Figure 2), two percent of respondents had sexual intercourse between 6-8 years, 12% between 9-12 years 44% between 13-15 years and 42% between 16-19 years. This confirms Stanley Diamenu's Study (1994) that sexual intercourse starts at a very tender age of 8 years in the Volta Region. This may have health, financial and psychological implications among others on the minor. The question is were such minors raped or voluntarily went in for the sexual experience?

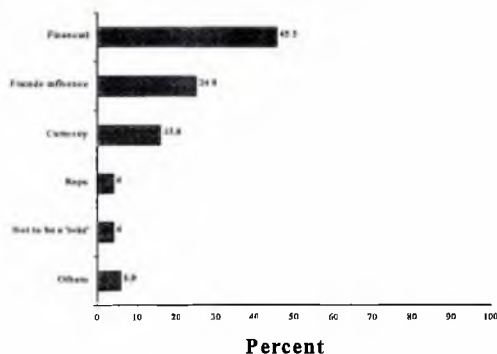
4.5 Factors leading to sexual experience

Table 15: Factors which led to sexual experience

Reasons	Frequency	Percentage	Cumulative
Financial	46	45.5	45.5
Friends Influence	25	24.8	70.3
Curiosity	16	15.8	86.1
Rape	4	4.0	90.1
Not to be a 'toke'	4	4.0	94.1
Others – lust etc.	6	5.9	100

It must be noted that five respondents did not answer the question.

Fig 3: Factors leading to sexual experience



From responses received from the field (Table 15 and figure 3 above), the following factors led the respondents to sexual experiences. Curiosity 15.8%, not to become stupid or a toke 4%. That is to say they were being teased by their friends that they would be stupid if they did not have sexual intercourse at their age. For financial reasons, respondents were 45.5% while 24.8% were influenced by their friends to have sexual intercourse to which they obliged.

In the focus group discussions, one of the participants said *“my boy friend sent me here to learn a trade (seamstress.) Neither he nor my parents send me money. How do feed my self ?. I have to resort to give sex for money to subsist”*. This underscores the role of poverty in teenage pregnancy in Nkwanta District.

The above also shows that financial considerations and peer pressure are the major factors which lead teenagers in Nkwanta to have sex.

Four percent of respondents claimed that the males raped them. It was claimed during the FGDs held at Abrewankor, Nkwanta and Kpassa that elderly men who sent the teenagers to buy items such as cigarettes, bread and matches raped some of the teenagers, leading to teenage pregnancies as has been reported in the daily papers in the country.

4.6 Discussing sexuality issues with teenagers

On the issue of parents discussing sexuality issues with teenagers, 31.4% claimed that their parents did while 68.6% said that they did not do it. However, 66.7% of parents and guidance claimed that they did, while 33.3% did not. The reasons assigned by the teenagers were that their parents / guardians themselves have low knowledge base about the topic (29.2%). Still others claimed their parents were too busy with their economic activities such as farming, gari processing and trading to have time to educate them on sexuality issues. Some parents claimed they did not know they should (26%) while others maintained they knew the teenagers were not matured enough to be taught about sexuality (22%).

Those who claimed that their parents / guardians talked to them about sexuality issues said that “the talking to” was always in the form of reprimanding (36.4%).

Twenty four percent said they were only talked to when they went wayward or there was a rumor of abortion in the neighborhood.

An interesting revelation by the target group during the study was that:

“Since many parents felt uncomfortable to talk about sexuality issues to teenagers, they encouraged them to go to church”. The percentage that claimed this was 30.3%. This was also confirmed in the 4 FGDs conducted. During a FGD at Nyangbom, (among the chiefs and elders), the members agreed that since parents could not talk about sex and sexuality issues in the homes, they “drove” their children to church to be talked to by the priest or church elders. However, *a lot more teenagers were getting pregnant. what then is the cause?* – “The queen mother of Nyangbom asked during the FGD”

CHAPTER FIVE

RESULTS / FINDINGS

5.1 Introduction

Teenagers (10-19 years) in Nkwanta district as elsewhere, are sexually active. Indulgence in sexual activities starts usually early between 8-12 years in the district. This is often promoted by lack of parental care, economic needs especially material gains by teenage girls and peer influence. Since many of the girls indulge in unprotected sex due to low knowledge and practice of contraception, often this results in STDs and unintended pregnancies outside customary sanctioned marriages and abortions. This chapter will review the issues as they obtain in the district.

In fact, the above confirm studies by Diamenu (1994), Ampofo (1986) and Nabila et al (1997) that in the country many teenagers are sexually active, they indulge in early sex and do not practice contraception. Such acts often result in STDs and unwanted pregnancies which compel most of them to resort to abortion.

5.2 Teenage pregnancy

A sizeable proportion of Ghanaian women give birth during their teenage years especially in the rural areas. This is partly due to some cultural practices such as bethrotal which makes the girls marry earlier in the rural areas than the urban centres. Thus while 26% of rural young adults have begun child bearing, only 16% of their urban counterparts have done so (GDHS 1993). The median age at first birth among rural women is 19.8 while it is 21.3 among urban women. Further more, about 22.% of Ghanaian women become mothers before they are 20 years old. (GDHS 1993).

During the study, about 86.7% of the teenager girls interviewed (105) said that they have heard about teenage pregnancy while 13.3% claimed they have not. All the guardians responded that they have heard and knew about it. About 91.2% of the teenage respondents claimed they knew of a girl(s) of their age group (10-19 years) who had been or was pregnant and that this was a problem in their communities. This showed inconsistency in the answers given by the teenage girls. The snag here was that 4.5% of the teenagers who said that they had not heard about teenage pregnancy in the previous question subsequently answered that, they new of a girl (s) about their age who was pregnant or had been pregnant. They even did not consider themselves to be teenagers, though. In spite of this the responses proved that teenage pregnancy is common in Nkwanta district and also constituted a problem. It also confirms the fears expressed by the District Chief Executive, DHMT, and other opinion leaders in the district (pg.3)

5.3 Abortion

Table 16: What teenagers did when pregnant

	Frequency	Percentage	Cumulative
Removed it / Abort	62	60.8	60.8
Had the baby	39	38.2	90.0
Miscarriage	1	1.0	100.0

In Nkwanta district most of the births among teenagers are unplanned or unwanted as they do not practice safer sex or family planning. When the targeted teenagers were asked the question "What teenagers did when pregnant?" Thirty – eighth percent (38%) of the respondents said that; the girls who got pregnant delivered the babies while 61% said that the teenagers aborted the pregnancies.

During the focus group discussions, all the four groups confessed that many of the teenagers in Nkwanta District resort to abortion when pregnant.

On probing as to where they went for abortions, some of the teenagers claimed that they went to the hospital for abortion, but others disagreed with them. *A member from the FGD held at Nkwanta (district capital) said: "It is not true. Our boyfriends cannot afford to give us money, how come they are saying that they give us money for abortion. As for me, I use local herbs such as "pawpaw leaves" for enema to abort. I know some girls who use herbs to abort, even within this group."*

Another person in the group said that teenagers used "Black Power" to abort. A quiet girl (14 years) smiled and said "Guinness mixed with paracetamol" does it with ease and with less pains.

At Abrewankor, (rural), three teenagers said after one another that they have been inserting herbs into their private parts (vagina) to dilate the cervix to get rid of unwanted pregnancies.

During informal discussion with some of the nurses at Nkwanta Government Hospital, it came to light that they (nurses) have developed a term "STICK" to describe teenagers who on admission have inserted objects into their vagina to induce abortion of a pregnancy.

At Nkwanta, the teenagers claimed they used Guinness and Nescafe, paracetamol and Akpeteshie, (locally brewed gin) as well as salt and Beer. These mixtures are drunk to abort. Others used a popular herb called "Acheampong (named after the late Mr. Kutu Acheampong – former head of State of Ghana) to abort.

This shows that some of the girls visited the hospital after attempting to tamper with a pregnancy.

The above also confirms the fact that teenagers resort to abortion when there is unwanted pregnancy as happens in other parts of Ghana. It further confirms the study of Ampofo (1986) and UGMS (1990) that many teenagers resort to abortion when they are pregnant.

These abortions have serious adverse health, economic and social implications for the teenagers and society at large. The methods used are crude and unhealthy.

There are lots and lots of these methods these teenagers use to abort. The use of “local” herbs for abortion will be an interesting topic to further research into in the District.

5.4 How unwanted Pregnancy can be prevented

Table17: How can an unwanted pregnancy be prevented?

	Frequency	Percentage	Cumulative
Use of family planning method	78	74.2	74.2
Abstinence	13	12.4	86.7
Other methods: education etc	5	4.8	91.5
No response	9	8.6	100.0

Participants views on how can an unwanted pregnancy be prevented and below are their views.

On this issue, 74.2% said that family planning must be used while 12.4% talked about abstinence. About 8.6% of the 105 respondents did not give any response and 4.8% preferred other methods apart from family planning and abstinence. Unfortunately they did not mention the preferred methods.

In the FGD, participants said education and self-discipline were the best ways to prevent an unwanted pregnancy. Two out of eight participants (25%) at Abrewankor said that:

“We will use our experience to talk to our young ones who are coming (i.e. growing up). If they like they must take the advice. IF they don't like, they can leave it to regret later in future”

And one of them continued;

“I have regretted for giving myself to the boy who made me pregnant. He does not talk to me nor feed me and my child. You see, Hmm! I do prepare gari for sale for a living. So if people do not buy gari from me, it becomes a problem.”

Another teenager said:

“I find it very difficult to get money to send my child to hospital when she is ill.” Showing the child with blisters like boils on the body (Penfigus – a disease the local people describe as TOMATOES) There is no money to send the child to hospital for treatment. It is a problem. The men who made us pregnant have no interest in us again. They make us suffer” This also confirms the study that the males who impregnate these teenagers often abandon them for the teenage-girls’ parents to care for them. This also worsens the economic plight of such parents. (pp. 10)

One after another, the participants also complained about a disease called ‘Kokobo’ (Prolapse of the rectum) that was prevalent in the community. In unison the others agreed with them. The group asked that a clinic be built in the area to offer health service to them. One person in the group disagreed and said “though it is a laudable idea to have a clinic, this cannot be done immediately. The MOH staff must rather run an outreach programme in the village in the interim.” {The idea has since been carried to the DDHS and District Public Health Nurse to institute an action on the issue}

Some of the teenagers appealed to the Government for loans while others said that the Government should buy their farm produce and the gari they produce to enable them have money to buy their needs. The community needs markets for their farm produce. The ministry of Food and Agriculture must take up the challenge.

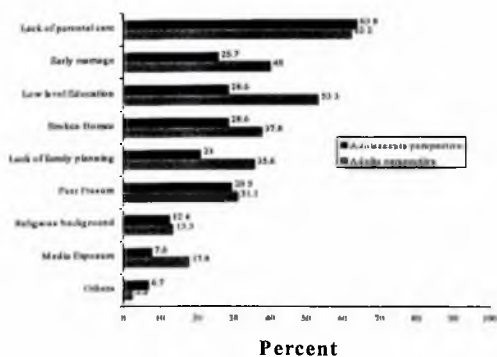
5.5 Causes of teenage pregnancy

Table 18: Causes of teenage pregnancy

Cause	Teenagers Perspective		Parents / guardians / Adults perspective	
	Frequency	Percentage	Frequency	Percentage
Lack of parental care	67	63.8	28	62.2
Early marriage	27	25.7	18	40.0
Low level Education	30	28.6	24	53.3
Broken Homes	30	28.6	17	37.8
Lack of family planning	22	21.0	16	35.6
Peer Pressure	31	29.5	14	31.1
Religious background	13	12.4	6	13.3
Media exposure	8	7.6	8	17.8
Others	7	6.7	1	2.2

The total number of respondents were teenagers = 105, Guardians / Adults = 45

Fig 4: Causes of teenage pregnancy



The above table and graph (Table 18 and figure 4) indicate that lack of parental care was the major cause of teenage pregnancy in Nkwanta district (62.2%). This results from poverty and traditional practices, which often compelled parents to betroth their baby girls to males when they are even not born to people. The practice is common among some ethnic groups such as the Kokombas in the district. These people pay money, tubers of yams and work on the farms of their in-laws to be in order to marry the girls. So as stated in the literature review, poverty, lack of parental care and some traditional practices such as early betrothal and lack of others such as puberty celebrations are some of the factors, which lead to teenage pregnancies in the district.

Other reasons, some of the respondents alluded to are; that most of the girls do not know anything about their menstrual cycle. Some of them are disrespectful and not heed to their parents' advice. About 20% of the teenagers interviewed said that.

"Sometimes when parents even talk to their children, they don't listen to them. This is a sign of disrespect so parents keep quiet even when we are wayward." This issue also confirms lack of parental control as one of the factors leading to teenage pregnancy.

A sixteen - year old pregnant teenager complained about the treatment metted out to her by her step-mother which compelled her to befriend a boy that resulted in the pregnancy. *"My stepmother wields a lot of influence over my father"* She said with tears in the eyes. This is an issue of broken marriages / homes and the role of stepmothers / parents towards teenage pregnancy as in the literature review.(pg.7)

During the focus group discussions, this issue of early marriage was discussed. Invariably all the 4 groups condemned its practice in the district. According to the discussants, females are withdrawn from schools to marry. This has affected female education and development in the district. This is illustrated below in Table 11 by both category of respondents (Teenagers and guardians). Where-as 71% guardians

claimed girls are allowed to marry before age 20, 63% of teenage girls (respondents) said the contrary. However, the 37% teenage girls who affirmed the statement is on the high side. Therefore the issue needs to be addressed.

Table 19: Girls are allowed to marry before age 20

	Teenagers Perspective		Parents / guardians / Adults perspective	
	Frequency	Percentage	Frequency	Percentage
Yes	38	37.3	32	71.1%
No	64	62.7	13	28.9%

Another finding of the study was that men do take care of girls from childhood and marry them. The percentage of respondents who said yes among guardians was 55.6% while it was 45% among the teenage group. This is a prove that the traditional custom of betrothal is still practised in the district. Invariably, this may be a factor towards teenage pregnancy in the district since females are allowed to marry before the age of 20. Eighteen percent of teenagers and 34.3% of guardians claimed that there is some rites of passage practices in the district. Unfortunately this is dying off and needs to be revived or replaced, because it served as a check on teenage pregnancy. They called such a rite BRAGRO (PUBERTY RITES) by the Akans.

5.6 How teenage pregnancy can be prevented

Table 20: Teenage pregnancy prevention

	Teenagers Perspective		Parents / guardians / Adults perspective	
	Frequency	Percentage	Frequency	Percentage
Education	27	27.6	21	50.0
Family Planning	63	64.1	20	47.6
Go to Hospital	2	2	1	2.4
Policies	3	3.1		

The study found out that teenagers are impregnated by both men and teenage boys. During an FGD at Nyangbom, the chief and elders said that the government or district assembly must draw special policies to curb teenage pregnancy in the district and the country. According to the chief and elders, Nyangbom community has laws to the effect that “any person who impregnates a girl will have to pay a fine of 50,000 Cedis,

a ram and 2 bottles of schnapps to the chief and elders. In addition, the would-be husband (boy or man) is made to perform the marriage rites after the girl has delivered.

According to the elders (which included the assemblyman), the measures have curbed the rate of teenage pregnancy. However some of the young boys in the community are able to pay the fine on their own. Because they get lots of money from the sale of the yams they grow. Some of them are able to pay the fine about four times in a year and this makes the laws ineffective to such people. At the same forum, one of the sub chiefs said that the parents must be held responsible for their children’s behaviour because some parents give lots of money to their sons when they go to school to the extent that some of the boys have lots of money to run after girls instead of studying.

During FGDs at Kpassa and Abrewankor, the discussants agreed that the district assembly or government must build a vocational school for the Community to enable

the teenage girls learn some kind of trade to earn a living to stop them from running after men for money. At Nyangbom one of the participants in an FGD suggested that the ministry of education should post female teachers to teach in the rural areas to (enable them) serve as role models, to inspire the teenage girls to study. The others supported her by clapping their hands.

5.7 Ideal age for marriage

The findings on this issue were that girls are to marry between 20 and 25 years by which time they would have been more matured. Males should marry between 25 and 30 years so that they will be matured and responsible enough to look after their families. The percentages were 77.3% and 93.0% respectively for the teenage girls and guardians interviewed.

5.8 Knowledge on reproductive health and contraception

That teenagers in Nkwanta district are sexually active cannot be disputed. This is shown in the Table below: For while those who disagreed with the suggestion that sex before marriage is good is 43.2% those in favour were 49.6%.

Table 21: Sex before marriage is good

	Frequency	Percentage
Strongly agree	24	23.3
Agree	27	26.3
Don't know	8	7.8
Strongly disagree	15	14.6
Disagree	29	28.6

Respondents claimed that teenage pregnancy is a problem in the district. This

assertion was made by 73% teenagers and 97.8% guardians who responded to the questions

Furthermore, they also claimed that teenagers could afford to use contraceptives (76.5%), yet their (teenager's) knowledge level was very scanty about reproductive health issues. For example 35.9% of them said that contraceptives do not prevent unwanted pregnancies, and 70% alleged that the use of contraceptives methods makes teenagers want to have sex. This will make them promiscuous. Furthermore, 42.2% said that girls couldn't get pregnant the first time they have sexual intercourse without any preventive measure.

The study also found that 30.6% of teenagers were using contraceptives while in future about 80.0% will want to be on contraception. There is a need to address this issue and the other findings during the study. The above paragraphs support the studies by Nabila et al (1996) and Boulton et al (1991) that low education and lack of knowledge and use of contraception are some of the factors that lead to teenage pregnancy.

5.9 Consequences of teenage pregnancy.

Some of the consequences of teenage pregnancy as seen by respondents are that it has social, economic and health implications on the community. On probing, the following explanations were given. Teenage girls are unable to complete school. They increase the number of the people in the district. This is a problem because parents cannot feed them properly.

In the FGDs, the discussants agreed that sometimes the boys refuse responsibility and the young mothers become psychologically affected. Often they don't even have any cloth for themselves and the children. *"The teenage father is tempted to steal farm produce and goats since he has no money to look after the child and mother when he accepts responsibility"*, said a participant.

In these FGDs participants conceded that the teenage - mothers are also not matured to take care of themselves and the babies. The babies are often left in the care of their grandmothers. *“Some of these grandmothers are happy to keep the children but many of them complain”* said a participant during a FGD at Nyangbom. Some of the teenagers are sent to Nkwanta hospital to deliver which make the family incur debts. This makes parents scold and quarrel with the teenagers. Some teenagers are disowned when they impregnate girls or are impregnated. This often results in conflicts among family members.

Some of the respondents complained about STD's and the possibility of AIDS. However, they have not seen an AIDS patient before. The government is to show the community films on HIV/AIDS patients to educate them.

They also talked about abortion, some of the problems associated with abortion such as bleeding and death. Some of the teenagers complained that the children disturbed their sleep in the night. *“Their freedom has been restricted by these children. I cannot move freely about, nor have enough sleep in the night,”* a participant said. During a FGD at Abrewankor, participants complained about problems associated with teenage pregnancy. For example one of them said *“when I was pregnant my feet were swollen, I couldn't eat and there were sore in my mouth”* Other people in the group agreed with her and complained about other illnesses such as fever and malaria during pregnancy. About 86% of respondents said that the earning capability of teenage girls become limited. On probing further respondent said *“because the pregnant teenager has not finished school, she can't work for the government, to earn any money. She can't also work on the farm because she has not been trained for that. So she will either sell bread, groundnuts, banana or fry yams, as happens along the street in Nkwanta”*

This idea was supported in the 4 FGDs organised in the communities. They also believed that some of the teenagers who claimed to be doing other jobs for a living may be involved in commercial sex activities as it is expressed by the table below because they wear nice clothes, but do not work.

Table 22: What work do you do?

	Frequency	Percentage	Cumulative Frequency
Sells oranges / Banana	27	26.2	26.2
Seamstress (Apprentice)	21	20.4	46.6
Hair dressing	10	9.7	56.3
Petty trading	9	8.7	5.0
Other	36	35.0	100

The above responses were received on the question of: "*How do you finance yourself*" from 81 respondents. Thirty five percent (35%) of the respondents said that they did other forms of work apart from what is shown in the table above, while 26.2% sold oranges and banana. 20.4% were seamstresses apprentices while 10 percent were learning hairdressing.

The above supports the claim that teenagers do all sorts of things to fend for themselves as many parents cannot support them financially.

SUMMARY :

Teenage pregnancy is common and constitutes a problem in Nkwanta District. Most births among young-adult girls are unplanned and also unwanted. Their knowledge on SRH issues and contraception is low. Many pregnant teenage girls use crude methods to abort. Most of the males who impregnate the girls refuse responsibility for the pregnancy. Those who accept responsibility are unable to cater for the needs of the young mother and child. This often worsens the plight of the girl's family and leads to conflicts in the community.

In fact, the above have confirmed studies by Diamenu (1994), Ampofo (1986) and Nabila et al (1997) that many teenagers are sexually active in the country. They indulge in early sex and do not practice contraception. Such acts most often result in STDs and unwanted pregnancies which compel most of them to resort to abortion. The teenage girls interviewed knew of the causes and the consequences of their pregnancies. As a result they have made possible suggestions towards reducing teenage pregnancy in the district. These form the basis of the recommendations in the next chapter.

CHAPTER SIX

RECOMMENDATIONS

6.1 Introduction

The problems of teenage pregnancy have been identified in terms of the causes, effects or consequences and remedial measures as suggested by respondents. What must be done is to develop practical and comprehensive policies and interventions or programmes to implement with the view to addressing the issues involved. Below are suggestions from people interviewed which form the bases for the recommendations.

6.2. Nkwanta District Assembly

- Nkwanta district assembly must evolve policies that will protect teenagers from forced marriages and betrothals. Such policies must protect the teenage girls against rape and sexual harassment within the context of marital laws and policies. Chiefs, elders and opinion leaders including teenagers must be involved in developing such policies. The measures such as has been instituted in Nyangbom by the Chief and His elders to protect teenager girls must be given legal backing by the Assembly and vigorously enforced.
- Traditional practices such as puberty rites (Bragro) must be revised, and implemented. However those that are inimical to the development of the district and the nation such as female genital mutilation (FGM) and child marriage as is practised among some ethnic groups in the district must be abolished. The initiative must start from the District Assembly.
- The District Assembly must encourage the formation of co-operative societies in the farming and rural areas to enable them sell their farm produce and have access to bank loans. The District Assembly will have to loan part of its common fund to

these helpless girls to enable them not to fall easy a prey to unscrupulous men who entice them with small amounts of money.

- The District Assembly must sponsor some of the few females who have managed to pass through the SSS system into Teacher and Nursing Training Colleges. These are to be bonded to serve in the rural areas for three-years after completion of the courses to serve as role models for the rural communities.
- The District Assembly in collaboration with Ghana National Commission on Children (GNCC) must start developing recreational facilities in the district. Recreational facilities are just non existent. No wonder some of the discussants in an FGD said “Our only source of entertainment is to sing and play in the night with the names of our friends”.

6.3 District Education Office

- There are no public libraries in the district it would be appreciated if some library of a sort may be established in the sub-district capitals and some rural areas such as Bontibor, Bonakye, Kacheibi and Gyekrong to cater for the needs of teenagers. The district Education office must take the initiative and collaborate with the District Assembly and Ghana Book Trust to establish libraries in one of the communities.

6.3.1 Family Life Education

Family Life Education must be given the attention it deserves in the school curriculum of the district. The programme must provide teenagers with education on sexuality including the anatomy and physiology of human reproductive system; contraceptive education and information to enable the teenagers make informed decisions. There must also be links with health facilities for referrals to enable sexually active teenagers to be served. Such facilities must be youth friendly. However teenagers

must be counselled to delay or postpone sex. It has been proved that sexuality education can delay sexual intercourse while contraceptive information, when provided prior to the onset of sexual activity may have greater influence on the decision to contracept. (Howard et al: 1990; Kurby et al: 1991)

The teaching of FLE in the district must involve resource persons such as Doctors, Nurses and Social Workers from the community. The GES must post some female teachers into the rural areas to serve as role models.

6.3.2 Establishment of youth centres

There is the need to establish counselling centres in the schools and communities to provide services and answer pertinent questions and issues bothering the minds of teenagers. This will help provide them with appropriate guidance into the future. To this end NGOs such as Planned Parenthood Association of Ghana (PPAG) World Vision International (WVI) and Youth Concern (YC) can team up or collaborate to develop and implement programmes for the teenagers in the district. Already WVI is providing assistance in the area of School Health projects

6.4 Role of the Church

- Christianity is gaining grounds in the district. It would be appropriate if churches will develop counselling units to do marriage counselling in the communities to reduce the incidence of divorces. These have influence on teenagers as it was found out in the study.
- Majority of the youth in the district belongs to one religion or the other. Beside this, it was also found out that parents “drive” their children to the churches for moral education and issues relating to sexuality. It is recommended that, the churches form a coalition to evolve programmes to assist the district towards the development of the young population for the future.

6.5 MCH / Family Planning

The teenager's knowledge level about reproductive health and contraception is very low (39%) the MCH/FP unit and community nurses must step-up their education campaigns in this regard. NGOs such as the WVI and Rural Concern must assist with the educational campaigns by providing assistance and mobilising the young people.

6.6 Parents and Guardians

One of the findings was that lack of parental care was the major cause of teenage pregnancy in the district. Parents are therefore to be alive to their duties and responsibilities. It was emphatically said by 92% of respondents that parents must discuss sexual issues with their children. Therefore guardians must learn to be knowledgeable about sexuality issues in order to educate their teenagers. They should not shy away from these issues. Parents who encourage or drive their children into the streets must desist from such behaviours. Step-mothers must not pester their step-children to force them into the streets.

The youth must always ask for guidance, since “ ASKING SAVES A LOT OF GUESS WORK.

6.7 Establishment of a Vocational School

Finally, it is recommended that a vocational school be set up in one of the communities by government to cater for the interest of teenage-girls who have dropped out of school due to pregnancy. This will help them to develop their potentials to contribute meaningfully towards the development of the Nkwanta district and Ghana in general.

CONCLUSION

Births to teenagers contribute towards the overall births in Ghana. This level of child-bearing has economic, social, health and educational implications for the general development of the teenage mothers as well as their children and the entire country. One of the out comes is that teenagers are unable to complete their formal education in Nkwanta district in particular and the country as a whole. In order to avoid this and other bitter consequences, society has to accept that teenage sexuality issues and challenges are real and therefore there is the need to evolve programmes to address these needs as suggested in the study of Problems of teenage pregnancy in Nkwanta District of Volta Region.

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APPENDIX I

QUESTIONNAIRE ON PROBLEMS OF TEENAGE PREGNANCY IN NKWANTA DISTRICT OF VOLTA REGION 1998.

INTRODUCTION

My name is.....and I am a member of a health research team collecting information on selected teenagers aged between (12-19years) for the purpose of understanding the problems of Teenage Pregnancy in order to suggest measures to help solve it.

SECTION A

I would like to ask you a few questions about yourself.

(1) How old were you at your last birthday?

(2) What is the highest level of schooling that you have completed?

- a) None
- b) Primary
- c) Junior Sec. School
- d) Senior Sec. School
- e) College (Trg. Nurses Tr.)
- f) Tertiary institution.....(Poly., University)
- g) Others (specify).....

(3) Are you currently in school? (a) Yes (b) No

(4) What work do you do (if in any) employment (including self employed)

- (a) Sells oranges/banana/bread/groundnuts
- (b) Seamstress
- (c) Petty trading
- (d) Hair dressing/plaiting hair
- (e) Others (specify).....

(5) Who cares for you financially if not employed?

- (a) Boy friend/girl friend
- (b) Parents/guardian
- (c) Spouse or partner
- (d) Self
- (e) Others (specify).....

(6) How do you finance yourself, (if by self)

- (a) Does anything for living
- (b) Carries load at lorry park/kayayoo
- (c) Gifts from friends
- (d) Others (specify).....

(7) With whom do you live in town/village?

Name.....

- (a) One parent
- (b) Friends
- (c) Both Parents
- (d) Spouse
- (e) Others specify.....

(8) What is your parent's/guardian's occupation?

- (a) Farming
- (b) Trading
- (c) Clerical work
- (d) Tradesman
- (e) Others (specify).....

(9) Are your parents/guardians currently:

- (a) divorced
- (b) married
- (c) separated
- (d) co-habitation
- (e) Others (specify).....

(10) How many friends do you have?

- (a) (1-3) (b) (4-6) (c) (7+)

(11) Do your friends make you do things you would not have done yourself?

- (a) Yes (b) No

(12) (a) Are you married? (a) Yes (b) No

- (b) If yes, at what age did you marry?.....

(13) Do you have children of your own?

- (a) Yes (b) No

(15) If yes, at what age did you have your first baby?.....years.

(14) How many children do you have.....?

(16) At what age did you have your first menstruation/wet dream?

- (a) (7-9 years)

- (b) (10-12 years)
- (c) (13-15 years)
- (d) (16-19 years)
- (e) Others (specify).....

(17) At what age did you have first sexual intercourse?

- (a) (6-8 years)
- (b) (9-12 years)
- (c) (12-15 years)
- (d) (16-19 years)

(18) Kindly tell me the factors that led you to this sexual experience?

- (a) Curiosity
- (b) Not to become a "toke"
- (c) Rape
- (d) For financial reasons
- (e) Influence by friends
- (f) Others (specify).....

(19) Do your parents/guardians discuss sexuality issues with you?

- (a) Yes (b) No

(20) If no, why?

- (a) Not ready to do it
- (b) Too busy.....
- (c) Have no knowledge about that
- (d) Do not know they should do it
- (e) Others (specify).....

(21) If yes, in what way(s)

- (a) Constant reprimanding/abusing
- (b) Encourage child(ren) to go to church
- (c) Corrects, when seen going wayward
- (d) Others (specify).....

(22) What is your religion?

- a) Catholic
- b) Muslim
- c) No religion
- d) Protestant (Presby, Methodist, Anglican)
- e) Pentecostals
- f) Traditional religion
- g) Others (specify).....

(23) How often do you attend Religious Services? Would you say that it is:

- Very often
- Often
- Occasionally
- Seldom
- Never

SECTION B

(24) What do you consider to be the major health problems affecting people of your age group (12-19 years) in Nkwanta District?

(25) Have you heard about teenage pregnancy?

- (a) Yes (b) No

(26) Do you know any girl of your age (12-19 years) who got or is pregnant?

- (a) Yes (b) No

(27) What do people of your age group (12-19 years) do when they get pregnant or impregnate a girl before they are married?

They.....

- a) Have the baby.
- b) Remove it/abort
- c) Miscarriage
- d) What else.....

(28) What do you think is the ideal age for marriage for

- a) Boys.....years
- b) Girls.....years
- c) What else

(29) How can an unwanted pregnancy be prevented?

- a) Use of family planning
- b) Not having sexual intercourse or abstinence
- c) No response
- d) Others (specify).....

(30) Which of the following do you think are the causes of teenage pregnancy? (multiple causes accepted)

- | | | |
|------------------------------|--------------------|--------|
| a) Lack of parental guidance | (g) Early marriage | |
| b) Low level of education | (h) Broken homes | |
| c) Lack of contraceptive | (i) | Others |
| (specify)..... | | |

- d) Religious background
 - e) Peer pressure
 - f) Media exposure
- (31) Have you heard about contraceptive (family planning).....?(a) Yes
(b) No
- (32) Mention two of the methods?
- (a) Condom (b) Pill (c) Diaphragm (d) Injectable (e) IUD
(f) Foaming tablets (g) Natural method (h) Others (specify).....
- (33) Are you currently on contraception.....? (a) Yes (b) No
- (34) Would you like to use family planning method or contraception?
(a) Yes (b) No (c) Do not know
- (35) Have you ever used a family planning method.....? (a) Yes (b) No
- (36) In your opinion is teenage pregnancy a problem?
(a) Yes, (b) No, (c) Do not know.
- b) What do you think should be done to prevent teenage pregnancy?.....

CULTURAL BACKGROUND

- (37) Do you belong to any group or association? (a) Yes, (b) No.
- (38) How do you spend your leisure hours?
(a) Sleeping (b) Attending concerts/cinema
(c) Attending functions (d) Going to church/mosque
(e) Others (specify).....
- (39) Do you do this as a group or alone? (a) Yes (b) No .
What is the name of the group?.....
- (40) (a) Are girls allowed to marry early among your ethnic group?
(i) Yes (ii) No
- (b) At what age can a girl marry in your community?
(a) (8-12 years) (b) (13-15 years) (c) (16-19 years) (d) Others (specify).....
- (41) (a) Do girls marry early among your ethnic group?
(i) Yes (ii) No
(b) At what age do they marry (8-12, 13-15, 16-19 years)?

- (42) Are men allowed to look after girls from childhood and marry them later?
(a) Yes (b) No
If yes specify how they look after the girls?.....
- (43) Is it done with permission from?.....(a) parents (b) teenager (c) others.....
- (44) Does your community have any rites of passage or initiations to adulthood?
(a) Yes (b) No (c) Don't know
- (45) Have you ever been talked to about sex and pregnancy
(a) Yes (b) No
- (46) Who talked/educated you on the issue?
(a) Friends (b) Nurses (c) Parents (d) Radio (e) Others (specify).....

SECTION C

I am going to read some statements to you, would you please tell me whether you agree or disagree or do not with each of the statements or do not know

Questions	Strongly Agree	Agree	Don't Know	Strongly Disagree	Disagree
(47) Teenage pregnancy is common among young girls (12-19 years) in Nkwanta District.					
(48) Girls cannot get pregnant the first time they have sex.					
(49) Some teenagers (12-19 years) abort when they get pregnant.					
(50) Parents should discuss sexual issues with their children.					
(51) Some girls (12-19 years) are made pregnant by older men.					
(52) Girls (12-19 years) get pregnant because they do not know how to use contraceptives.					
(53) Girls (12-19 years) get pregnant because they are not given contraceptives by people who go to bed with them.					
(54) Contraceptives do not prevent unwanted pregnancies.					
(55) The use of contraceptive methods by teenagers makes them want to have sex.					
(56) Sex before marriage is good.					
(57) Most teenagers can afford to buy contraceptives.					
(58) Some young boys aged (12-19 years) years make girls pregnant.					
(59) Teenage pregnancies can be prevented if boys between (12-19 years) years use condoms.					
(60) Availability of contraceptive methods to teenagers (12-19 years) makes them want to have sex.					

THANK YOU VERY MUCH FOR YOUR COOPERATION

APPENDIX II

FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

1. What are the major problems facing the youth of Nkwanta District?

HEALTH

2. What are the major health problems of the youth in Nkwanta district?

PROBE FOR: STDs including HIV/AIDS
 Types of STDs
 Where they go for treatment.

TEENAGE PREGNANCY

Let us now discuss the issue of young people getting pregnant and what they do.

3. How do you feel about girls between the ages of (12 –19 years) getting pregnant?

4. How do you feel about the people who make the girls pregnant?

PROBE FOR PEOPLE (AGE) RESPONSIBLE

5. What are some of the reasons why these girls become pregnant?

6. What do young girls do when they get pregnant and do not want the child?

PROBE FOR: Methods used to abort

UNDERSTANDING OF HEALTH PROBLEMS ASSOCIATED WITH ABORTION

7. What do you people do to avoid pregnant?

PROBE FOR: Traditional methods
 Myths related to the practice of modern methods
 Source of methods and ease of access
 Affordability of methods

8. How do young people say about people of their age who have not started having sex?

PROBE FOR: Attitude towards them
 Action towards them
 How they feel when they are treated like that

9. How do young people in this community get information on health matters such as HIV/AIDS, Family Planning etc.

PROBE FOR: Access of mass media (radio, TV)
 Traditional media
 Interpersonal channels
 Preferred sources of information

10. How do young people in NKWANTA District spend their free time?

11. When young people are together, what are some of the things they discuss?

12. We have discussed the health problems of the young in this community. How do you think this problem can be solved?

PROBE FOR: Who should be responsible
 What can the young people do to help solve these problems.

APPENDIX III**QUESTIONNAIRE ON PROBLEMS OF TEENAGE PREGNANCY IN
NKWANTA DISTRICT OF VOLTA REGION-1998. (FOR PARENTS AND
OTHER ELDERLY PEOPLE)**

My name is.....and I am a member of a health research team collecting information on teenagers aged between (12-19years) for the purpose of understanding the problems of Teenage Pregnancy.

(1) How old are you, please?.....

(2) What is the highest level of education you have completed?

(a) None

(b) Primary

(c) Middle school/JSS

(d) SSS/Secondary school

(e) College (Tr. Trg, Nursing school)

(f) Tertiary (Poly, University)

(g) Others (specify).....

(3) What is your occupation?.....

(4) Kindly name the religion you belong to?

(a) Catholic

(b) Muslim

(c) No religion

(d) Pentecostals

(e) Protestant (Presby, Methodist, Anglican)

(5) How many children do you have?.....

(6) Are you currently?.....

(a) married

(b) divorced

(c) separated

(d) co-habitation

(e) Others (specify).....

(7) At what age did you marry?.....

(8) At what age did you have your first child?.....

(9) Do teenagers (12-19 years) get pregnant in Nkwanta district? (a) Yes (b) No

(10) Does teenage pregnancy constitute a problem in the district? (a) Yes (b) No

(11) What are the causes of teenage pregnancy in Nkwanta district?

(a) Lack of parental care

(f) Lack of family planning

(b) Early marriage

(g) Peer pressure

- (c) Low level of education
- (d) Broken-homes
- (e) Media exposure
- (h) Religion background
- (i) Others (specify).....

(12) Why does it constitute a problem? Because.....

- (a)
- (b)
- (c)

(13) Who make these teenagers pregnant?

- (a) Boys alone
- (b) Boys and other men (sugar daddies)
- (c) Older men only
- (d) Others (specify).....

(14) Are there any effects of teenage pregnancy?

- (a) Yes (b) No

(15) Name/List some of the effects you know?

- (a)
- (b)
- (c)
- (d)
- (e)

(16) What do teenagers in Nkwanta district do when they are pregnant and they are not married? They

- (a) Have the baby
- (b) Remove it/abort
- (c) Miscarriage
- (d) Others (specify).....

(17) How can an unwanted pregnancy be prevented?

- (a) Use of family planning
- (b) Abstinence/Not having sex
- (c) No response
- (d) Others (specify).....

(18) Are girls allowed to marry before age 20 years in this community?

- (a) Yes (b) No

(19) What is the ideal age for marriage for (a) girls..... (b) boys.....

(20) Do you talk to your children about sex and sexuality? (a) Yes (b) No

- (21) How can teenage pregnancy be prevented in Nkwanta district?.....
- (22) Men look after girls and marry them later in Nkwanta district? (a) Yes
(b) No
- (23) Does your community have any rites of initiation to adulthood? (a) Yes
(b) No
- (24) Kindly name any of such initiation rites?
- (24) What can teenagers do to solve the problem?

THANK YOU VERY MUCH