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**PERCEPTIONS OF PARENTS, TEACHERS AND STUDENTS TOWARDS SEXUAL
AND REPRODUCTIVE HEALTH EDUCATION IN JUNIOR HIGH SCHOOLS IN
OKAIKOI NORTH SUB-METRO, ACCRA, GHANA**

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DECLARATION

I, Lerina Baaba Coker, hereby declare that this thesis is the result of an original research conducted by me under the supervision of Dr. Alice Boateng and Dr. Cynthia Sottie of the Department of Social Work, University of Ghana, Legon and no part of it has been submitted anywhere for any other degree. All references cited have been duly acknowledged.

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DEDICATION

This thesis is dedicated to Almighty God and all who contributed to its completion.



ABSTRACT

Access to reproductive health information is considered key in forestalling risk associated with adolescent sexual life. To this end, there has been considerable effort by government and civil society organisations to facilitate access to sexual and reproduction health (SRH) information among adolescents in Ghana to make them aware of their sexual and reproductive health issues. Among these efforts is the introduction of SRH education in the curriculum in Junior High Schools (JHS) throughout the country. The study seeks to explore the perception of parents, teachers and students towards SRH education in JHS within the Okaikoi North Sub-metro. Using theoretical triangulation, the study adopts the theory of reasoned action / planned behaviour, cultural conservatism and cultural liberalism as theoretical framework and discusses the concept of perception and adolescent SRH. It adopts a purely qualitative approach to gathering and analysing data. Thus, interviews and participant observation were utilised in collecting primary data, while the thematic framework analysis technique of organising data according to key themes and concepts evident in a dataset was adopted for analyses of data. The study reveals that there is tremendous endorsement of SRH education in Junior High School (JHS) by parents, teachers and students, thus the need to promote it in JHS. In addition, the study shows that, while culture and religion has no effect on the perception of teachers and students towards SRH education in schools, parents were very much affected by culture and religion as far as certain aspects of SRH education is concerned. Finally, it establishes that SRH education in schools is faced with resource, cultural and religious challenges and recommends among other things that school-based SRH education be intensified in order to break the cycle of strong adherence to conservative culture.

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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

Access to information on Adolescent Sexual and Reproductive Health (ASRH) is considered vital in forestalling the spread of Sexually Transmitted Diseases (STDs) and pregnancy among teenagers (United Nations Educational Science and Cultural Organisation [UNESCO] 2009). To this end, as evidenced by the adoption of the Adolescent Reproductive Health Policy drafted by the National Population Council (National Population Council [NPC] 2000), there has been support by government and civil society organisations for adolescent sexual and reproductive health education in schools in Ghana. This interest is expected to make teenagers aware of the details of their reproductive health in order to prevent problems associated with their sexual development. This notwithstanding, the cultural setup of Ghana portrays sex education as an adult matter, which ought to be discussed only by adults and married couples in private (Kumi-Kyereme, Awusabo-Asare & Darteh, 2014). Consequently, it can be inferred that a conflict possibly could arise between the need for Sexual and Reproductive Health (SRH) education in schools on one hand and the cultural setup restrictions of the country on another hand. Thus, there is a need to establish whether the culture-influenced perception towards issues of SRH among the general populace in Ghana has any bearing on SRH education in schools. In view of this, this study explores the perceptions of parents, teachers and students towards sexual reproductive health education in Junior High Schools (JHS) within the Okaikoi North Sub-metro of Accra.

The Ghana Statistical Service [GSS] (2013) estimates that 22.4% of Ghana's population of about 25 million are adolescents aged between 10-19 years. These adolescents face challenges and difficulties in many areas of their lives, particularly, their sexual development. For

example, the onset of menarche in girls at a mean age of 13 years (Aryeetey, Ashinyo & Adjuik, 2011), complemented with other physical and emotional changes such as attraction to members of the opposite sex can be very challenging. This could contribute to early debut of sexual activity¹, sexually transmitted infections, unwanted teen pregnancies and practicing of unsafe abortions because of their inability to correctly assess risks at their stage of cognitive development (Dixon-Mueller, 2011).

Several authors and evidence available show that effective **SRH** education leads to modification of risky behaviours, increase in contraception use, and reductions in unwanted pregnancies and **STDs** including HIV (Collins, Alagiri, & Summers, 2002; Grunseit & Aggleton 1998; Kirby, Laris, & Roller 2005; Meyrick & Swann 1998; Santelli et al., 2006). The provision of SRH education is expected to develop young people's skills to enhance the quality of their relationships (Oakley et al. 1995) and enable them make meaningful contribution to the development of their nation (Cook & Fathalla 1996; Shtarkshall, Santelli & Hirsch, 2007; United Nations, 1994). This goal is in line with the objective of giving children the right to information critical to survival and development, as set in the 1990 Declaration of the Convention on the Rights of the Child. The need for SRH education is also expressed in the 1994 International Conference on Population and Development's (ICPD) Programme of Action, which calls for the sexual and reproductive health needs of adolescents (10-19 years) and young people (10-24 years) to be met.

Consequently, ASRH in Ghana has gained the interest of government and civil society organisations such as the Ministries of Health and Education, Planned Parenthood Association of Ghana and Marie Stopes International Ghana (NPC, 2000). These organisations have implemented and sustained policies and programmes geared towards the promotion of

¹ "Sexually activity" in this study refers to sexual intercourse or penetrative sex.

reproductive health of adolescents in the country. Among these programmes and policies, is the 1994 National Population Policy (NPP) which seeks to educate the youth on population matters directly affecting them (NPC, 1994). Another policy is the 2000 Ghana Adolescent Reproductive Health Policy (GARHP), which seeks to strengthen the teaching and learning of issues on reproductive health in the school curriculum for in-school adolescents and also create avenues to enable out-of-school adolescents to benefit from such SRH programmes (NPC, 2000).

Notwithstanding these efforts to promote SRH education, the mention of sex in Ghana, particularly among adolescents, raises eyebrows because of the country's cultural orientation. Schmidt, Olomob and Corcoran (2012) for instance have noted that sex education in Africa is considered a taboo, irrespective of where the discussions are being held or with whom it is shared. Partington (2013) noted that within the Ghanaian context, children are viewed as naïve and innocent and so it is inappropriate to expose them to information on human sexuality. Therefore, with culture playing an important role in shaping the perception of people with regard to their acceptance or rejection of SRH education, it is critical to explore the perceptions of stakeholders towards SRH education in JHS.

1.2 Problem Statement

Perceptions play a significant role in whether or not policies and programmes would be accepted or not. Negative perceptions towards SRH education, exhibited through silence on the discussion of SRH matters with adolescents, have been noted to contribute to the SRH challenges faced by some adolescents (Oakley et al., 1995). It has been estimated by the Ghana Coalition of NGOs on health that, annually 750,000 adolescents become pregnant (Ghana News Agency [GNA], 2013). Furthermore, the Adolescent Health and Development Programme Report of the Ministry of Health (GNA, 2014) shows an increase in teenage

abortion from 8,717 in 2009 to 16,182 in 2011. These high numbers may have resulted from unprotected sexual practices by the adolescents. In support of this claim is the finding by Mellanby et al. (1993) that, adolescents who are engaged in sex exhibit high level of risk-taking behaviours and are less likely to use contraception.

The SRH of male adolescents and their contribution to teenage pregnancies and unsafe abortions cannot be overlooked. For instance, Afenyadu and Goparaju (2003) have reported that male adolescents and male sexual partners are not in favour of condom use. Girls become pregnant as a result of male adolescents' non-use of contraception and sometimes due to their financial incapability of taking care of a child, they tend to request for abortion which, in some cases, are unsafe. Besides teenage pregnancies and unsafe abortions among adolescents, is the incidence of sexually transmitted diseases. The National HIV Prevalence and AIDS Estimates Report indicated HIV prevalence of 0.36% in 2012 among the 15-24 year group, within the general population (Ghana AIDS Commission [GAC] 2014).

Although the prevalence rate shows a downward trend, from 0.6% in 2011 to 0.36% in 2012, it is still a significant rate as young people contributed 28% of the total rate of 7,991 new infections (GAC, 2014). Unwanted teenage pregnancies, unsafe abortions and the contracting of STIs among adolescents can in the end affect the education of young people and in the long run affect the human resource development of the nation.

In an attempt to curtail the SRH challenges faced by adolescents, steps have been taken to provide adolescents with relevant information on SRH issues. Such education is to empower them to take control over their sexual and reproductive health. In addition to education on SRH, is the availability of health care services for both in-school and out-of-school adolescents in Ghana. However, some barriers such as negative perceptions influenced by cultural values and beliefs are hampering the efforts to provide SRH information and services to adolescents.

Consequently, it has become necessary that a greater understanding is gained with regard to factors affecting SRH education.

Moreover, various studies in Ghana have looked at perceptions on adolescent SRH education in either the Primary School or Senior High School but not many have focused on the Junior High School level of education. For instance, Nyarko, Adentwi, Asumeng and Ahulu (2014), in their study of attitudes of parents to sex education at the lower primary level, found that parents were not in favour of SRH being provided to primary school children as they considered them to be too young. Based on the identified gap, this study sought to explore the perceptions that parents, teachers and students have toward SRH education in JHS.

1.3 Objectives

Generally, the research aimed at exploring the perceptions of parents, teachers and students towards school-based SRH education in the JHS level of education. To this end the following specific objectives were addressed.

- a. To determine parents, teachers and students support of sexual and reproductive health education in school.
- b. To identify socio-cultural factors influencing perceptions towards sexual and reproductive health education.
- c. To identify challenges associated with the impartation and learning of SRH education.
- d. To explore how the challenges can be surmounted to make reproductive health education successful in schools.

1.4 Research Questions

The following questions served as a guide towards the achievement of the objectives of the study.

- a. What are the positions of parents, teachers and students as far as support of sexual and reproductive health education in school is concerned?
- b. What are the socio-cultural factors that influence perceptions towards sexual and reproductive health education?
- c. What challenges are encountered in the impartation and learning of SRH education?
- d. In what ways can the challenges be surmounted to make sexual and reproductive health education successful in schools?

1.5 Significance of the Study

This study provides an insight into the perceptions of Ghanaian parents, teachers as well as adolescent in Junior High school, to the teaching and learning of sexual and reproductive health in schools. Additionally, the findings of this research contribute to knowledge on Adolescent Sexual and Reproductive Health as pertained to the Ghanaian situation.

The findings of this study will be made available in prints and presentations at seminars and colloquiums to the Government of Ghana and policy-makers. This is expected to give government and policy makers an insight into challenges encountered by teachers in imparting reproductive health education at the Junior High School (JHS) level. It is also hoped that this will enable government and policy makers to put measures in place that will enable teachers deliver effective sexual and reproductive health lessons that meet the needs of JHS students and also contribute to the curtailment of adolescent pregnancies and contracting of STIs among in-school teenagers.

Again, it is hoped that the findings of this research will inform social work practice particularly in the field of school social work, so as to promote sexual and reproductive health among adolescents in schools.

1.6 Overview of Thesis

The thesis is organised into five chapters. The first chapter introduces the study, presents the problem from which the objectives of the study were derived and outlines the questions the study sought to provide answers to, as well as the significance of the study.

Chapter 2 comprises of the theoretical framework guiding the topic under study and a review of existing work relevant to SRH education of adolescents, as well as attitudes towards SRH education. Chapter 3 is made up of the research methodology. The chapter contains the description of the study area, research design that was implored and methods of data collection. Chapter 4 presents and discusses the findings. Chapter 5 summarizes the findings and draws conclusions based on the findings. The chapter also suggests recommendations toward addressing challenges regarding school-based SRH education based on the suggestions of participants and conclusions drawn from the findings. In addition, the implications of the findings of this study for Social Work practice are included in this chapter.



CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 Introduction

This chapter is primarily concerned with reviewing literature on school-based Sexual and Reproductive Health (SRH) education. The reason for reviewing such literature is to provide a theoretical background and conceptualisation to the issues addressed in this research and put this study within the context of existing studies. The review thus shows how the topic under study has been shaped by the outcome of previous investigations. The chapter is divided into two main sections. The first section focuses on the theoretical framework of the study while the second section focuses on review of literature on the main themes of the study. The theoretical framework for this study is rooted in cultural conservatism, cultural liberalism and the Theory of Reasoned Action/Theory of Planned Behaviour. Literature review is placed in two main sections. In the first section, literature is reviewed on the concept of perception, adolescence and adolescent sexual and reproductive health as well as the goals, objectives and content of school-based SRH Education. The remaining section of the literature review is grouped into three parts based on the objectives of this study. The first part deals with indicators of approval of SRH Education. Here, the usefulness of school-based SRH education from the perspectives of parents, teachers and students is also discussed. The second part deals with the socio-cultural factors such as culture, religion and adaptation to current global norms, which influence perceptions of SRH education. In order to situate the third research objective within existing studies, literature is reviewed on challenges associated with school-based SRH education.

2.2 Theoretical Framework

The theoretical underpinning of this research is in three theories which reflect how differences in values influence people's approach to phenomena of the world (Xu, Mar & Peterson, 2013). These are Cultural Conservatism, Cultural Liberalism and Theory of Reasoned Action/Planned Behaviour. The use of the three theories constitutes perspective triangulation, which according to Flick (2009) and Stake (2010) is an approach to doing qualitative research in a proper way and increase confidence in the findings from the study. Perspective or theory triangulation is one of four triangulation types (Denzin, 2009), which refers to the use of "different perspectives on an issue under study or – more generally speaking – in answering research questions. These perspectives can be substantiated in using several methods and/or in several theoretical approaches" (Flick, 2009, p. 445). The other three types of triangulation identified by Denzin (2009) are:

- Data triangulation – gathering data from different sources (studying data from various people, different places and time).
- Investigator triangulation – involving different interviewers.
- Methodological triangulation – usage of multiple methods for gathering information

2.2.1 Cultural Conservatism

This theory emphasises the importance placed on the culture and tradition of people and the attempts made to maintain these cultures and traditions (Seaton, 1996). Thus inferring from the cultural conservatism theory, people who are culturally conservative tend to uphold the pre-existing ways of life they have been socialised into and have come to accept as the proper way of life. Major writers of cultural theories such as Schwartz (1999) argue that the culture of a people must be preserved so that it does not collapse. According to Schwartz (2000), in situations where cultural conservatism is supported, people are seen as inherent members of society; hence, they must adhere to the norms of their society. For conservatives, "meaning in

life is expected to come largely through social relationships, through identifying with the group, participating in its shared way of life, and striving toward its shared goals” (Schwartz, 2000, p. 7). Social order, respect for tradition, obedience, and wisdom are among some of the cultural values of conservatives. The unambiguous and implied value emphasis that are characteristic of a culture are transferred to societal members through everyday orientation to customs, laws and norms that are influenced by and portray the existing cultural values (Bourdieu, 1972; Markus & Kitayama, 1991). Grief (1994) also affirmed this when he mentioned that culture becomes identical and commonly known through the socialisation process, where culture is unified, maintained and communicated. In Ghana, some members of the society are socialised through direct teachings or observation of parents and teachers, to desist from discussing matters concerning sex and everything that has to do with it. This is because of the presumption that such topics are meant to be private and children must be kept innocent.

As noted by Smith (2014), the primary conservative function of education is the cultural reproduction in society, through preservation and reproduction of dominant traditional models of expertise, knowledge and values through mainstream schooling. Conservatives such as Wynne (1985/1986) also hold the view that the main mission of schools is to inculcate moral values to young ones. Hence, anyone who is conservative or holds on to tradition is most likely not to be in support of the teaching of a subject or topics such as SRH, except where abstinence-only is being taught. This is because of the fear that a subject like this could equip young ones with knowledge about sexual matters (from abstinence to methods of family planning) which they are not supposed to know about.

2.2.2 Cultural Liberalism

As the name suggests, Cultural Liberalism stresses on the liberty and autonomy of the individual from the standard way of life (culture). Scholars have identified the following major

common facets of liberal thought: belief in equality, individual autonomy, and individual rights (Young, 2002; Schwartz, 2000). Therefore, where people support cultural liberalism or autonomy, they “cultivate and express their own preferences, feelings, ideas, and abilities, and find meaning in their own uniqueness”, (Schwartz, 2000, p. 7) separate from cultural norms. This is affirmed by Jost, Nosek and Gosling (2008) who argue that, liberalism or autonomy encourages persons to go after their own ideas, to be broadminded, curious, and creative. This means that where stakeholders involved in SRH education are more inclined towards cultural liberalism, it is expected that the widespread culture-influenced ill-perceived notion on issues of SRH in Ghana will be minimal or absent. Thus, liberal stakeholders are more likely to accept the impartation of SRH education among JHS students with the hope that it will create a positive effect in the SRH of adolescents.

2.2.3 Theory of Reasoned Action (TRA) / Planned Behaviour (TPB)

The TRA as formulated by Ajzen and Fishbein (Ajzen, 1991) asserts that the commission of any behaviour is first and foremost influenced by an intention to pursue that behaviour. This intention, according to proponents of the theory is also influenced by attitude towards the behaviour in question and subjective norms. The theory was later modified to TPB after a third influence on intention, behavioural control, was added. A common rule associated with the theory is that, the more favourable an attitude and subjective norm, and a larger perceived behavioural control, the stronger an individual’s intention will be to perform a specific behaviour. That is, if stakeholders assess a behaviour (SRH education) as positive (attitude), and if they think people they look up to in society want them to perform this behaviour (subjective norm), this will lead to a higher intention, which results in performance of the behaviour (acceptance of SRH education in JHS).

According to Ajzen (1991), intention is a cognitive depiction of an individual's preparedness to perform a given behaviour. This means, the extent to which SRH education among the youth will be accepted in a society where culture frowns on sex topics among the youth, is depended on the readiness of major stakeholder to accept SRH in schools. As mentioned earlier, this intention, thus readiness to accept SRH education in schools, is influenced by three factors. The first, attitude, influenced by behavioural beliefs, is an individual's estimation as to whether behaviour is positive or negative. Reasoning from the attitude/behavioural beliefs factor supposes that, the extent to which stakeholders (parents, teachers and students) consider SRH education as positive or otherwise will play a major role in determining if they would accept school-based SRH education. Their attitude would also determine if the objectives of teaching SRH topics in school will be met.

The second factor, subjective norms which is also influenced by normative beliefs, is the communal pressure an individual feels to perform or not perform a particular behaviour (Ajzen, 1991). These subjective norms/normative beliefs are mainly beliefs about how people they care about will view the behaviour in question. That is, knowing the beliefs of students on what society, especially parents and teachers they look up to, think of them studying or even discussing SRH topics, is key in determining their acceptance of SRH education. In addition, establishing the normative beliefs of the people (parents and teachers) the students look up to on appropriateness of students receiving SRH education is equally important.

Perceived behavioural control, which is the last influential factor on intention, is determined by control beliefs. Thus, it is the perceptions of a person's ability to perform a given behaviour (Ajzen, 1991).

This means that, if students perceive they have the ability to learn SRH topics, it can be predicted that they would accept SRH education, albeit, in the midst of positive attitude and favourable subjective norms.

2.2.4 Concept of Perception

The perception that people hold helps them to gain information about the elements of their environment which in turn helps them to create their experience of the world. In line with this, Wagner (2008) defines perception as the sensory experience of people of the world around them and that, it is made up of both the recognition of environmental stimuli and actions in response to these stimuli.

The perception of stakeholders is inevitable for the successful implementation of any policy. This is because they occupy the centre stage to initiate changes (Pelgrum, 2001). The works of Collingwood (1979) and Fullan and Pomfret (1977) suggest that the perception of a phenomenon held by potential stakeholders of the phenomenon is a very significant factor that can influence the success of the implementation of the phenomenon in question. Similarly, Hall, Wallace and Dossett (1973) claim that the concerns of people about a change are a very important dimension of the change process itself.

To further buttress this point, Hughes and Keith (1980), report that research findings have established a relationship between stakeholder perception of phenomenon and the degree of implementation of the phenomenon. They further assert that in the process of implementing educational policies, it is the policy as perceived by stakeholders, which matter most as the critical variable but not the policy “in some objective sense or as perceived by experts” (p. 44).

Furthermore, Rogers and Shoemaker (1971) also observed that educational reforms often have five eminent attributes that have strong relationship with stakeholder perception of a

reform and the degree of implementation. These attributes are relative advantage of the reform, compatibility of the reform, complexity of the reform, “trialability” of the reform and “observability” of the reform. Of relevance to this study is “compatibility of the reform” attribute. Compatibility as an attribute of perception refers to the perception of the degree to which a phenomenon can easily be integrated into old practices without the potential stakeholder requiring a revision of values, goals, beliefs, or capabilities (Hughes & Keith 1980). A reform with higher compatibility means it requires little changes to old practices and therefore easier for the potential stakeholder to adopt. Therefore, educational policy makers need to be aware of the less compatible attribute of policies so as to make provision for its implementation. In line with these suggestions, it is imperative to explore the perception of stakeholders towards the incorporation of SRH lessons in the curriculum at the JHS level.

2.2.5 Connection between the theories and Perceptions towards SRH Education in JHS

The decision of government to introduce sexual and reproductive health education into the education curriculum is a step that would bring about positive change in the lives of Ghanaian adolescents, thereby contributing to human resource development. However, some studies have found that some parents had negative perception towards SRH education in school (Kumi-Kyereme et al. (2014); Nyarko et al., 2014). Deducing from Rogers and Shoemaker’s (1971), “compatibility of the reform” attribute, it is possible some values of the Ghanaian culture could have contributed to the negative perceptions in these studies.

Also, according to Parwej, Kumar, Walia, and Aggarwal (2005), the increasing importation and distribution of international mass media is changing the social values and shifting the standard of societal behaviour from conservatism to liberal interactions between males and females. Furthermore, in a study in Windhoek, Namibia, Nambambi and Mufune (2011) found

that due to HIV/AIDs, modernisation, the influence of western culture and the media, times have changed from when parents traditionally did not talk about SRH issues with children because the children are exposed to SRH information in any case. However, they also found that information given is restricted to menstruation, pregnancy and HIV/AIDs. Thus, the more sensitive aspects such as sexual intercourse and relationships were not discussed. Adolescents are often caught in the dilemma of prying into sex related issues, influenced by western culture on one hand, and a shunning away from sex issues influenced by conservatism at home, on the other. This dichotomy further aggravates the period of stress and storm (Coleman, 1992) of the adolescent period or stage. From the perspectives of the participants in the studies mentioned above, the transformations in social values from conservative to liberal values may have two sides in terms of benefits and disadvantages. For example, on one hand, it may lead to increased premarital sexual activity and pregnancy among adolescents, apart from the incidence of abortion and STDs. On the other hand, it may also promote education on SRH matters in order to reduce ignorance among adolescents with regards to their sexual and reproductive health.

Hence, the theories of cultural conservatism and liberalism are important in this exploratory research because considering that there are people who are conservatives or liberals, these theories will help to identify participants who may support or oppose SRH education in schools in this study. Also considering the fact that, behavioural beliefs/attitudes, normative beliefs/subjective norms and control beliefs/perceived behavioural control influence intention to perform behaviour as suggested by TRA/TPB this will enable the researcher explain why the study participants accept or do not SRH education.

2.3 Concept of Adolescence and Adolescent Sexual and Reproductive Health (ASRH)

Individuals all over the world have different paces at which they develop physically and psychologically. This therefore has had an influence on how adolescence as a concept is defined in terms of age. For instance, the World Health Organisation [WHO] (2014) and GSS (2013) identify adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. For Master, Johnson and Kolodny (1995) adolescence starts from the age 12 -19, whereas Coleman (1992) suggests that it falls within the teenage years 13-19. Although there are different age specifications for adolescence, it generally covers the period when an individual is expected to have attained pubescence. The various classifications of Adolescence in this section all agree on the termination point of the adolescence period. The difference in definition is just the start point, hence the definition with least start point in all three definitions (WHO, 2014), will be adopted in this study. This is to ensure every qualified adolescent is not left out in the data collection phase, because of individual variances in maturity and growth. Based on the chosen period of adolescence for this study, “adolescent²” in this study will refer to all individuals aged between 10 and 19 years.

In paragraph 7.2 of the ICPD Programme of Action, reproductive health was defined as “the state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.” (United Nations, 2014, para. 7.2). Inferring from the two definitions therefore, adolescent sexual and reproductive health implies the complete physical mental and social well-being in all matters relating to the sexual health and reproductive system of persons between the ages of 10 and 19.

² Adolescent, teenagers, youth and young people are used interchangeably in this work

The period of adolescence is characterised by some changes that occur in individuals. These changes are physical, psychological, cognitive and sexual maturation, owing to hormonal changes (Master, Johnson & Kolodny, 1995; Coleman, 1992). Due to the changes that take place during adolescence, some young people experience confusion and stress with dealing with the changes as well as finding and adjusting to their personality. Hence, adolescence has also been described as the period of ‘storm and stress’ (Coleman, 1992, p. 14).

2.4 Goals and Objectives of School-Based SRH Education

It has become necessary to provide teenagers with knowledge about their reproductive health with venereal diseases and especially HIV/AIDs and teenage pregnancies being recorded among younger people (Kirby et al., 1994; Esantsi, Onyango, Asare, Kuffuor, Tapsoba, Birungi, & Askew, 2015). Hence, all over the world, programmes have been implemented for both in-school and out-of-school adolescents to provide them one form of Adolescent Sexual and Reproductive Health education or the other, with the goal to provide adolescents with information about their SRH. Thus, the goal of SRH education is to ensure the sexual health of young people through the provision of information concerning relationships, sex, sexual rights, reproduction, reproductive right and health among others. In the Canadian Guidelines for Sexual Health Education (Public Health Agency of Canada, 2003), the goals are:

- a. To help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding human relationships, informed reproductive choices); and
- b. To avoid negative outcomes (e.g., STI/HIV, sexual coercion, unintended pregnancy).

In Ghana, the goal of ASRH education taught in subjects such as social studies and Integrated Science is not any different from that stated in the Canadian Guidelines for Sexual Health Education.

This can be inferred from the general objectives of SRH education in these subjects. In Integrated Science, the objectives among others are to enable students to be aware of the physiological processes in reproduction and be aware of the dangers of indiscriminate sex (MoE, 2007a). In the Social Studies subject, the general objective of the adolescent reproductive health topic taught in JHS 1 is to enable students recognize the importance of reproductive health and chastity (MoE, 2007b). It is important to note that in Ghana (as evident in the Integrated Science and Social Studies syllabi) just like in Uganda (Iyer & Aggleton, 2013) the subject seems to stress on abstinence-only as a method of prevention of teenage pregnancy and STI's including HIV/AIDs.

2.5 SRH Education in Ghana

In some parts of the world such as Malawi, SRH is taught as a standalone subject to secondary school students, while in other parts, like Mexico and Tanzania, it is merged with other subjects (UNESCO, 2009). In Ghana, a perusal of the Ministry of Education's (MoE) subject curriculum reveals that the education curriculum does not have sexual and reproductive health education as a subject on its own. However, topics on adolescent SRH and rights are taught under the umbrella of the School Health Education Programme (SHEP) in subjects such as Integrated Science and Social Studies at the Junior High School level (MoE, 2007a; MoE, 2007b). Educating adolescents about their sexual and reproductive health is done in an attempt to meet the needs of adolescents for information regarding their sexuality. SRH education takes two forms; abstinence-only and abstinence plus. Abstinence-only purports that the only way to avoid teenage pregnancy and the contraction of STIs is by abstaining from sex, while the abstinence-plus approach provides information on abstinence as well as safe sex practices (Daschel, 2012).

2.6 Content of School-Based SRH Education

In a study such as the present research, which focuses on perceptions towards school based SRH education, it is important to provide information on the content of SRH education in schools. Since cultural values vary from one community to another and also from one country to another, it is expected that what goes into school-based SRH education would also vary in countries. The goal of a school-based SRH education also influences the content of the SRH syllabus.

An International Technical Guidance on Sexuality Education provided by the United Nations Educational, Science and Cultural Organisation (UNESCO), has the aim to provide schools, teachers and SRH educators with an evidence-informed approach to the imparting of SRH knowledge. Contained in the Guidelines are four components of the learning process. These are;

- i. Information: sexuality education provides accurate information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual diversity; sexual abuse; gender-based violence; and harmful practices.
- ii. Values, attitudes and social norms: sexuality education offers students opportunities to explore values, attitudes and norms (personal, family, peer and community) in relation to sexual behaviour, health, risk-taking and decision-making and in consideration of the principles of tolerance, respect, gender equality, human rights, and equality.
- iii. Interpersonal and relationship skills: sexuality education promotes the acquisition of skills in relation to: decision-making; assertiveness; communication; negotiation; and

refusal. Such skills can contribute to better and more productive relationships with family members, peers, friends and romantic or sexual partners.

- iv. Responsibility: sexuality education encourages students to assume responsibility for their own behaviour as well as their behaviour towards other people through respect; acceptance; tolerance and empathy for all people regardless of their health status or sexual orientation. Sexuality education also insists on gender equality; resisting early, unwanted or coerced sex and rejecting violence in relationships; and the practice of safer sex, including the correct and consistent use of condoms and contraceptives (UNESCO, 2009, Vol.1, p. 5).

These four major components of the learning process are further divided into six key concepts for the SRH education of children and adolescents from the ages of 5 to 18 years. These are: relationships, values, attitudes and skills, culture, society and human rights, human development, sexual behaviour and sexual and reproductive health (UNESCO, 2009). The SRH concept as explained by the international technical guidance, states that abstinence is the most effective form of contraception. It is intended to teach adolescents how peer norms can influence the decision of both men and women to use contraception and condoms. It is also intended to teach adolescents how unplanned pregnancy at an early age can bring about negative health and social consequences. Furthermore, the SRH concept is intended to inform adolescents about the effective methods of preventing unplanned pregnancy and their related efficacy. In addition, it is designed to describe to adolescents personal benefits as well as likely risks concerning methods of contraception. Last but not the least of the provisions of the SRH concept, is the provision to explain how STIs, including HIV are transmitted, treated and prevented.

In India, a reproductive health education program designed in consultation with parents and teachers to suit the sensitiveness of their culture consisted of the anatomy and physiology of male and female reproductive system, physical and sexual changes during adolescence, menstrual cycle, conception and contraception, nutritional requirements, immunizations, provisions of Child Marriage Restraint Act and Medical Termination of Pregnancy Act, reproductive tract infections and sexually transmitted diseases including HIV/AIDS (Parwej et al., 2005).

In Ghana, the specific contents of the Adolescent Sexual and Reproductive Health topic taught under the School Health Education Programme (SHEP) curriculum are parts of the reproductive system and their functions, and stages of reproduction. Also included in the curriculum is, the dangers of indiscriminate sex such as unwanted teenage pregnancies on the part of girls, abortion, dropout of school, early fatherhood for boys, possibility of contracting sexually transmitted diseases, including HIV/AIDS (Adu-Mireku, 2003). The students are also taught the various types of STIs, including their causative organisms as well as the various types of contraception. Again, Adu-Mireku (2003) has argued that the coverage of these health topics by some schools was less than required by the national policy guidelines. Reasons for this shortfall included inadequate materials, especially instructional materials, and the variations in the knowledge and competence of health promoters at local schools due to training. The Ghanaian culture, not being open to issues of sex and reproduction with children and adolescents could also be a reason.

Inferring from the contents of school-based SRH education, across the globe, the syllabus for SRH education in schools is similar. They all seem to touch on the anatomy of the reproductive system and the changes that occur as an individual matures, the stages of pregnancy, teenage pregnancy, including its consequences and prevention, the causes, effects treatment and

prevention of STIs including HIV/AIDs. In as much as the contents are similar, in some places educators tend to stress more on abstinence from sex rather than abstinence-plus, and this can be said to be as a result of the predominant culture of those settings or the personal values of the educators (Iyer & Aggleton, 2013; Kibombo, Neema, Moore & Ahmed, 2008).

2.7 Usefulness and Appropriateness of School-Based SRH Education

Schools, according to Goldman (2006) are the places for imparting timely, independent, higher-order, sequential and replicable learning. According to UNESCO (2009), in many countries, children between the ages of 5 and 13 spend a considerable amount of time in school. SRH education is defined as “an age-appropriate, culturally relevant approach to teaching about sex and relationships, by providing scientifically accurate, realistic, non-judgmental information” (Vol.1, p. 2). School based SRH education basically refers to information about SRH formally taught in schools. It has been noted that schools are the ideal place for the impartation of evidential and age-specific sexual and reproductive health knowledge to adolescents (Lloyd, 2010). In the words of Goldman and Collier-Harris (2012),

In order to be effective, sexual and reproductive health education has to be scientifically and evidentially based, be tailored by professional educators to the specific needs within each educational authority, and content has to be delivered sequentially and consistently in every grade level. The young adolescents who are most at risk of uninformed and/or too early sexual activity, that is, those who have reached reproductive fertility at puberty, should be the first group to have their human rights to such information and understanding fulfilled by education systems (p. 458).

Effective sexual and reproductive health education has been shown to “reduce misinformation; increase correct knowledge; clarify and strengthen positive values and attitudes; increase skills

to make informed decisions and act upon them; improve perceptions about peer groups and social norms; and increase communication with parents or other trusted adults” (UNESCO, 2009, Vol. 1, pp. 2-3). Hence, sexual and reproductive health education is useful in curbing the sexual activities of adolescents rather than influencing them to initiate sex or engage in casual sex. Some studies have found that sexual and reproductive health education has helped to promote abstinence until marriage and in other instances where adolescents do engage in sex, they are able to practice safe sex with the use of condoms and other barrier methods to prevent teenage pregnancies and the contraction of STIs. For instance, in a study conducted by Saaka (2005), it was found that in comparison to adolescents in schools, adolescents out of school were more likely to be engaged in sexual intercourse. The results indicate that in-school respondents (100%) had a high knowledge of HIV/AIDS than did their out-of-school counterparts (97%). Almost half (46%) of out-of-school adolescents were sexually active as compared with participants in school (22%). Majority of the respondents in both groups also wanted to be screened and tested for HIV/STIs [in-school (97%), out-of-school (57%)]. In-school adolescents had better knowledge of the causes of STIs than those out of school. According to the study, adolescents who are not in school often practiced risky sexual behaviours that could lead to acquisition of HIV/STIs than in-school adolescents. More students (77%) were willing to undergo Voluntary Counselling and Testing (VCT), compared with their out-of-school counterparts (57%).

Another study by Menezes, Ribeiro and Cabral-Gouveia (2013) has also shown the usefulness of SRH education. In the study, school-based exhibition of prevention materials designed by adolescents was found to help improve students’, particularly, females’ knowledge on AIDS-related issues. Aside the improved knowledge, the findings of the study contributed to the development of AIDS education initiatives in participating schools.

Hence, school-based AIDs prevention projects do not just benefit students only in terms of informed decision making, but also help in policy formulation. On the other hand, some studies such as one by Kumi-Kyereme et al. (2014) observed that parents perceived providing adolescents and young people with SRH information encourages them to engage in early sex activity, as a result of putting into practice what they have been taught. Whiles some researchers have shown the benefits of SRH education in the sexual and reproductive wellbeing of adolescents, others have reported that it adds nothing to reduce the risk-taking behaviours of learners or to reduce the incidence of teen pregnancies and STIs among them. Thus, school-based SRH education has received its share of criticisms, regarding its importance based on the findings of some researches. However, it must be noted that reports on the positive influence or impact of SRH education in the sexual behaviour of adolescents and young people outweighs the negative ones.

2.7.1 Perspectives on SRH Education

In a study such as this which involves different groups of participants, it is important to understand some of the perspectives held by these different groups on SRH education. Thus, literature is reviewed on the perspectives of parents, teachers and students regarding the usefulness of SRH education.

a. Parents Perspective

Research proves that across the globe, stakeholders of adolescent reproductive health have varying opinions concerning the imparting of SRH to young people. For example, in an Australian study carried out by Dyson and Smith (2012) most parents reported that they want sexual and reproductive health education in schools. However, they showed concern about who teaches their children and the content and approach that is used at their children's different ages and stages, and wanted to retain a sense of engagement with the context being covered by the

school. Similar to the aforementioned research is another research conducted in Vietnam by Ha and Fisher (2011), which looked at parents' expectations of SRH education for their wards. The parents endorsed the relevance of SRH education for their children and were in approval of their wards being informed about contraception, HIV/AIDS/STD prevention and intimate relationships, in details when they turned 15 years. The study also reported parents desire to access information on adolescent SRH to enable them better appreciate adolescents' SRH experiences. The parents interviewed also acknowledged some difficulties in educating their wards on SRH and expected schools and youth groups to take up the primary role in the impartation of knowledge on SRH. As can be inferred from this research, parents in this study also were in support of some kind of SRH education or the other, but wanted to be involved in what information their children were provided with in school.

Also, in an exploratory study by Schmidt et al. (2012) in the UK, it was found that many participants disapproved of their children being taught about sex and sexual health in school, except on the condition that those lessons would focus on abstinence from sex until marriage. Yadeta, Bedane and Tura (2014) also sought to find out the attitude of parents towards discussion on RH issues. They found that, majority of the parents (94.14%) agreed on the need to discuss RH matters. 88.75% of the respondents indicated that parents should encourage their adolescents to ask questions related to their RH needs. However, around 21.84% of parents had the view that discussion with adolescents will make them promiscuous, in that, it will make them engage in premarital sex. In general, the results showed that most of the respondents (parents) had positive attitude towards reproductive health and its discussion (Yadeta et al., 2014).

b. Teachers Perspective

Teachers are very important agents of socialisation within the school setting and they impart knowledge to pupils and students so as to help develop their human resource. Therefore, their perspective on school-based SRH education is needed in the development of this study. A study was carried out by Iyer and Aggleton (2013), which focused on the perception of teachers concerning SRH education. The purpose of this research was to understand whether teachers' perceptions about parents and students' approval of SRH education have some influence on how they taught the topic to students. The results showed that the perceptions that teachers hold about parents and students tend to influence their delivery of reproductive health education. In other studies, teachers showed support for SRH education even though they had some factors restraining them.

In a research conducted by Mlyakado (2013) in Tanzania, the attitudes and views of secondary school teachers and heads of schools towards students' sexual relationships in some secondary schools were assessed. Findings showed that many teachers favoured the provision of sex education; yet, most of them were either not conversant with sex education or did not want to educate or assist students in sexual related matters. Similarly, Aransiola et al. (2013) in their study on the perspective of teachers on sexual and reproductive health interventions for adolescent students found that teachers thought SRH in school to be good in improving the knowledge of students concerning SRH issues. But it must be noted here that, they had some reservations on teaching some sensitive topics, such as family planning and contraceptive use.

c. Students Perspective

Generally, students who receive SRH education tend to be in support of the provision of the topic, because they find it interesting and informative. A study by Mkumbo (2013) with the

objective of assessing students' attitudes towards school-based sex and relationships education (SRE) in Tanzania found that the majority (more than 80%) of students supported the provision of SRE in schools. In another study conducted in Nigeria (Eko, Abeshi, Osonwa, Uwanede & Offiong, 2013), students had the view that SRH education was important when most of them, that is about 324 representing 86.9% showed that they were in favour of sex education. In addition the students tended to disagree with the assertion that SRH will corrupt and encourage them to engage in sex. It can be asserted that when students are in favour of SRH they are more likely to take it serious and apply lessons learnt to their lives. Other studies have found different views.

In Korea it was found in an evaluation that only 20% of adolescents were in support of SRH education, while about 80% of the students had the opinion that they learnt nothing new in SRH education and thought that the lessons were boring (WHO, 2007). Similarly, another study by Hashimoto et al. (2012) to investigate the perceptions of students regarding sexuality education in Japan, found that the students, particularly, the males reported that there was nothing in particular that they wanted to know about sexuality education and this portrays their negative view of SRH education. Indication from the reviewed literature is that, whereas some students have the opinion that SRH education is good for them, others have negative perception about SRH education. The negative opinion about SRH education suggests that the students may not take the lessons seriously, thereby increasing their chances of falling into dangers associated with their sexual and reproductive development.

2.8 Socio-cultural Factors Influencing Perceptions of SRH Education

Socio-cultural factors are simply the combination of social and cultural factors or characteristics that influence values and beliefs. Among these socio-cultural factors perceived to probably influence perceptions of SRH education include culture, religion and adaptation.

2.8.1 Culture and SRH Education

Schwartz (2000) defines culture as the rich complex of meanings, beliefs, practices, symbols, norms, and values prevalent among people in a society. Because culture is defined by the prevalence of one or more of the aforementioned variables, to a large extent it can influence people's approach to the world; for example it can determine what is said, how it should be said and with whom certain information can be shared. Concerning information sharing, traditionally, it was the role of the extended family members such as grandparents, uncles and aunts to provide some form of SRH education to its young members. SRH education which mostly took place when an individual reached puberty took the form of knowledge on the changes (physical, emotional and reproductive maturity) that occurred in the body, the abstinence of sex until marriage and also training on the roles expected to be played by women and men (Schmidt et al., 2012). Currently, with the breakdown of the family system due to increase in modernization and urbanization, it has become the role of parents, teachers and health care professionals to provide SRH education to young people (Njue, Voeten, & Ahlberg, 2011). However, cultural values and norms still play a vital role in whether SRH education would be accepted or not.

Schmidt et al. (2012) and Dyson and Smith, (2012) have reported that although participants received some form of SRH education, their cultural background was a barrier to what information they got and how much of it they received and this cultural barrier went further to affect whether or not they imparted their young members with SRH education).

This shows that socialisation is very important as it tends to influence newer or younger generations. A study conducted by Nundwe, (2012) to explore the barriers to communication between parents and adolescents concerning sexual and reproductive health issues found traditional norms of the participants to be a barrier. Most of the parents in the study reported

that their culture did not allow them to discuss issues of sexuality or even puberty with their children. Thus, it was shameful or simply inappropriate for them to communicate with the children on matters of SRH with their children. It was also found that they preferred other people such as guardians, grand-parents or teachers to provide children with information on SRH. Mbonile and Kayombo (2008) conducted a study to find out how parents were in support of SRH in school. The results showed that most of the parents thought they should provide their children with SRH information, but could not do it because they saw their cultural background as a hindrance. In a another study by Ahmed, Flisher, Mathews, Mukoma and Jansen (2009) in South Africa, to understand the teachers' beliefs and attitudes towards providing sexual and reproductive health education in school, the findings showed that the teachers had conflicting views about their beliefs and teaching the topic to students. These conflicting views could be as result of the African culture, which is very important with regard to how Africans approach issues.

Also, years of experience in teaching SRH and the age of educators tend to have some influence on the delivery of SRH information to students. For instance, a study by Helleve et al. (2009) found that teachers with more experience in teaching SRH subjects, and those who had received formal training tend to show more confidence in the ability to teach SRH issues to students.

2.8.2 Religion and SRH education

Geertz (1973, p. 90) defines religion as a “system of symbols, which acts to establish powerful, pervasive, and long lasting moods and motivations in men, by formulating conceptions with such an aura of factuality that moods and motivations seem uniquely realistic.” The United Nations Educational, Science and Cultural Organisation (UNESCO, 1999) alludes that the culture of any given society has the capacity to influence attitudes because it plays a pivotal role in shaping how its members see the world. Embedded in culture are a set of beliefs that go

beyond both self and the natural world. These sets of beliefs are often expressed in religion. Thus, it is clear that culture to a large extent shapes the religious values of any society and vice versa (UNESCO, 2010).

Odimegwu (2005) has opined that there is a strong relationship between religion and the sexual behaviours of adolescents. Hence, understanding the role of religion in SRH education is vital for this study. The most dominant religion in Ghana, Christianity, considers sex as sacred; hence, one should only engage in it when married. Thus, the focus of SRH education should be one based on total abstinence until one is legally married. The rationale according to Dolan (1984) is that fornication and adultery are serious sins based on the Bible. Dolan (1984) buttresses this with the analogy that when students learn mathematics, it is expected that they can put that into practice by going to the store and bringing back the right change. Similarly, it can be inferred from this analogy that, when students are provided with other aspects of SRH education other than abstinence, they are regarded as ready to make use of the information. A study was conducted by Mbonile and Kayombo (2008) to assess acceptability of parents or guardians of adolescents towards the introduction of sex and reproductive health education in the community and schools. They found that about 64% of the participants were in support of SRH in schools, but they opposed the use of condoms to their adolescent children.

Indication from the preceding paragraph shows that while there is support from the Christian religious group on the need for SRH education, the focus of the education should be one of abstinence. Thus, given the fact that religion shapes culture, which also shapes attitudes towards SRH education by parents, teachers and students who are members of various religious groups, they are likely to be affected by the idea of abstinence only. The findings from a study by Nundwe (2012) showed that the religious beliefs of parents served as a barrier to SRH education on STIs, including HIV, prevention of teen pregnancy and condom use. In that study it was reported that parents used statements that are provided in holy books, such as the Bible

and Quran to guide their children to avoid sexual risk behaviours like multiple partners. Parent participants also used religious teaching rather than direct communication about condom use. In the study, they refused to talk with their children about condom use.

A study conducted in Uganda showed that teachers used the opportunity to impart SRH information to transmit their own religious values about sexuality, in that; they tend to stress abstinence (Iyer & Aggleton, 2013). This, is feared, might increase the students' vulnerability to SRH issues, since they are not being taught all they need to know to keep them safe.

2.9 Challenges Associated with School-Based SRH Education

Sexual and reproductive health education has proven to be beneficial to the health of adolescents, hence its promotion in schools. However, certain factors and situations have been identified as hindrances to the effectiveness of SRH education in schools. Some of these hindrances are the absence of confidence in teaching the topic, shyness, and also the absence of teaching and learning materials (TLMs). These factors or hindrances are further expounded in the subsequent sub headings.

2.9.1 Lack of Confidence in Teaching SRH

How comfortable or confident teachers are in imparting knowledge on SRH to adolescents is key to the amount of information adolescents receive to enable them to be empowered to make informed decisions about their SRH. Many studies have been conducted to investigate how true this assertion is. For instance, Kibombo et al. (2008) in their research to investigate adult-adolescent communication on issues related to sexual and reproductive health from adults' perspectives found, among other things, that teachers were not comfortable or confident in teaching students SRH. This was because it conflicted with their tradition, which was not in support of public discussions of sex. This is not surprising, as this revelation was made in a rural community where it is believed, inhabitants find discussion on sexual issues to be

unacceptable. In urban settings, people are likely to be found to be more open to new approaches to dealing with issues. However, the above mentioned research is not proof that all teachers are uncomfortable or not confident in teaching SRH topics to adolescents.

Helleve et al. (2009) in their study aimed to investigate how confident and comfortable teachers in Tanzanian and South African urban and rural schools were in teaching HIV/AIDS and sexuality. It also aimed at identifying factors associated with teacher confidence, such as gender, age, years of teaching and religion. The study also investigated how the confidence reported by teachers influenced the implementation of HIV/AIDS and sexuality educational programmes. The outcome of this study was that teachers were fairly confident in teaching HIV/AIDS and sexuality. The finding of the study was more general, as it was not clear if the teachers' confidence was specific to their provision of HIV/AIDS education or other subjects in general. Another study supporting the findings of Helleve et al. (2009) is the research conducted by Ahmed et al. (2006) to describe the knowledge, skills and confidence of teachers after undergoing an HIV education programme. It was revealed that teachers reported being confident to impart SRH knowledge to their students.

Again, the teachers' reported confidence in the study by Ahmed et al. (2006) could have been as a result of the training the teachers received. Thus, the self-reported confidence of teachers who had not undergone the training was not included.

2.9.2 Shyness of Students as an Influence on Teachers' Lack of Confidence

Shyness on the part of students can sometimes disrupt the teaching of SRH. For some teachers, when the students seem to be shy in the reproductive health class, they tend to be uncomfortable teaching them and this may lead to skipping or abandoning some important topics which may be very sensitive but beneficial to the students. For instance, Kibombo et al. (2008) found among other things that when teachers are imparting lessons on SRH, some of the students tend

to be shy or become shocked that their teacher who they hold in such high esteem could be talking with them matters of SRH.

Similarly, Herman, Ovuga , Mshilla, Ojara, Kimbugwe, Adrawa and Mahuro (2013) found that in Gulu District, Northern Uganda, a major barrier to SRH education was students feeling shy to learn about SRH from their teachers. A possible implication of the students being shy in an SRH class is that they would not be able to ask questions when they need to get their thoughts clarified, thereby contributing to the ineffectiveness of the SRH education.

2.9.3 Inadequate Teaching and Learning Materials (TLMs)

In the process of education, certain facilities are necessary to ensure effective teaching and learning. Among these are adequate facilities such as shelter, furniture, and materials such as books and other learning aids. Bilinga and Mabula (2014) in their study on the challenges and implications of teaching sexuality education in primary schools in Tanzania found that unavailability of learning facilities hindered effective teaching of SRH to students. Other studies conducted in the field of SRH education have also shown similar results.

In Kibombo et al. (2008) and Hashimoto et al. (2012) teachers reported that among the challenges they faced with SRH education was lack of relevant supplies such as condoms and dummy penises, insufficient materials and information needed for effective impartation of knowledge. TLMs help to demonstrate to students how these items look like and also how they are used. There is no doubt that appropriate teaching and learning materials when available will facilitate the effective delivery of the SRH education to students; hence, they must be supplied to schools.

2.9.4 Time Constraints

In Ghana, the SRH topic is taught under the umbrella of Integrated Science subject and also in the Social Studies subject. It lasts approximately for five weeks in the school term. Considering

the benefits of the SRH education to the health and wellbeing of adolescents, this time may be regarded as inadequate to enable teachers effectively impart knowledge on SRH matters to the students. Hashimoto et al. (2012) found that in Japan, the time allocated for SRH education in school was minimal, that is about three hours for the whole school year, compared to other countries such as Finland, which allocates about 17 hours. Thus, in some studies, participants asked for the duration for the SRH topic to be extended. For instance, in a study by Smith et al. (2011), it was recommended that SRH education should be taught earlier than it is normally done, so that teachers and students will be able to spend more time imparting and receiving SRH information respectively. Time constraints are an important factor that affects the content and depth of SRH education. Thus, adequate time needs to be allocated for SRH education, in order for all the contents to be covered.

In another research, due to time limitations, the content of stand-alone SRH programmes or those that were built into broader programmes or subjects, as in the case of Ghana, had to be reduced to ensure that such courses were treated during the allocated time (Ott, Rouse, Resseguie, Smith & Woodcox, 2011). Beginning SRH education before students reach pubescence or initiate sexual activity will be more useful in helping to reduce the incidence of teenage pregnancies and the possible contracting of STIs and it will also enable teachers to adequately treat each aspect of the SRH topic without having to rush through the topic.

From the literature reviewed in this section, there is indication that some contributions have been made to SRH knowledge. Thus, various authors have provided knowledge on the benefits of SRH education to adolescents, as well as some socio-cultural factors that affect SRH education.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter looks at the methodology used in the study. It begins with an overview of the study area and presents and justifies the research design adopted for the study. The chapter also details how participants were selected for the study and the methods used in the collection, management and analysis of data. The chapter concludes with a discussion of issues considered in the conduct of the research.

3.2 Study Area

The study area was the Okaikoi North Sub-Metro of the Accra Metropolitan Assembly. The Sub-metro was chosen because it has a number of Junior High Schools (JHS) and a health facility with a centre devoted to addressing the needs of adolescents. Additionally, it is diversified in ethnicity and religious background, which is expected to have some influence on parental perceptions about sexual and reproductive health education in school. This Sub-metro was also chosen because of the researcher's familiarity with the area.

The Okaikoi North Sub-metro is one of 11 Sub-metros of the Accra Metropolitan Assembly (AMA) in the Greater Accra Region, created under the Legislative Instrument (L.I.) 1722 in 2003. Per the 2010 population and housing census, the number of people in the Okaikoi North Sub-metro stood at a total of 228,271 of which males constituted 110,681 and females 117,590 (GSS, 2012). Though the Okaikoi North Sub-metro is originally a Ga community, it has become a migrant community with people from ethnic groups all over the country. Key among these migrants or ethnic groups are the Akans, Ewes and Dagombas.

Notwithstanding the presence of many ethnic groups in the Sub-metro, Ga and Twi languages are predominantly spoken in the community. The majority of the community members appear to be Christians with few being Muslims, judging by the presence of many churches, both orthodox and charismatic as opposed to few mosques located in the Sub-metro.

Generally, the pattern of settlement is nucleated with buildings grouped or arranged close together without any clear pattern. The types of dwelling comprise of compound houses, improvised homes (kiosk and containers) and separate houses (bungalows/self-contained houses). Some of the people occupy rooms in compound houses, and are thus exposed to the different cultures of their co-tenants.

There are both public and private basic and second cycle schools located within the Sub-metro. There is also one tertiary institution, the Ghana Technology University College, situated within the Okaikoi North Sub-metro. The Sub-metro boasts of healthcare centres, such as the Iran clinic, Lapaz Community Hospital and the Achimota Hospital, which has an adolescent centre to address the health needs of adolescents. There is also a Community Health and Planning Services (CHPS) compound located at Apenkwa, a suburb of the Sub-metro. There are also traditional healing facilities, where some people with dislocated joints or broken bones seek help. These traditional healing facilities play an important role in healthcare delivery by augmenting services of the clinic and hospitals in the Sub-metro.

3.3 Research Design

This study is a qualitative exploratory research. The aim of qualitative research is to discover meanings and involves both interpretation and a critical approach to the social world (Ahiadeke, 2008). According to Davies (2006), an exploratory research is a methodological approach that is primarily concerned with discovery. In qualitative research method, the depth of understanding and the deeper meaning of human experiences are emphasised, with the aim

to generate theoretically richer observations (Rubin & Babbie, 2008). Qualitative methodology was implored, because of the focus of the study, which requires deep understanding of the views and opinions of participants on the teaching and learning of adolescent Sexual and Reproductive Health (SRH) in Junior High Schools (JHS). Suggesting answers to them by way of closed ended questions, as in the case of quantitative methodology, may not be exhaustive enough to bring out their true perceptions towards the issue under study.

3.4 Population and Sample Size

The population for this study consisted of all parents, teachers and school going adolescents in the Okaikoi North Sub-metro. The sample, however, was drawn from JHS teachers who impart SRH education, parents with children in JHS, and adolescents in JHS. These groups were chosen because they had the qualities and knowledge that could help to answer the research questions.

A purposive sample size of 31 participants was used in the study. The choice of the sample size was made with consideration of the diverse nature of the population under study and the resource capacity of the researcher. Baker and Edwards (2012) assert that in qualitative research, the number of interviews to be conducted should be dependent on the availability of resources, participants, heterogeneity of the population and how it will influence the responses, and time constraints. Also Strauss and Corbin (1998) have stated that saturation of information in a qualitative research is an important issue to be considered just as decision on sample size is important. Saturation is a term used to describe the point when a researcher has heard the range of ideas and is not getting new information. Thus, in the midst of time constraints, as well as the exhaustion of new information, a sample size of 31 for this study was considered adequate in enabling the researcher explore the various perceptions held by parents, teachers

and students within the Okaikoi North Sub-metro towards reproductive health education in schools.

Out of the 31 participants interviewed, 20 were JHS Year 2 (Grade 8) students, while the remaining 11 were made up of 6 teachers and 5 parents. The choice of Year 2 students was because of time variations in the completion of syllabi among schools. Thus, targeting this category of students ensured that at least, participants, irrespective of the school, would have been introduced to SRH lessons. Cognisance of a possible variation in the teaching of SRH in private and public schools, the choice of schools for the study included participants from both private and public school, with 10 of the 20 students coming from a private school, and the rest from a public school. Similarly, three of the teachers interviewed were from a public school, with three from a private school. Regarding the parents, only mothers were interviewed as all fathers the researcher approached requested that the mothers should be interviewed, because they were the most appropriate persons to talk to because the mothers spent more time with the students.

The relationship between the researcher and the study participants was ethical. Thus, prior to data collection, the researcher visited the schools of teachers and student participants to establish rapport with them as means of gaining their friendship and trust. There was also mutual respect between the researcher and study participants, whereby, participants respected the researcher's role as interviewer and facilitator while views of participants were also respected by the researcher.

3.5 Sampling Techniques

Two (Purposive and convenience sampling) non-probability sampling techniques were employed in the selection of participants in this study. Non-probability sampling is a sampling technique where members of a population do not have equal chance of being selected in the

determination of samples (Rubin & Babbie, 2008). Thus, representativeness of the sample is limited with non-probability sampling. Therefore, caution must be taken in generalising to a wider population.

Purposive sampling is a sampling technique where the researcher selects a participant in a study based on his/her knowledge and the purpose of the research (Oliver, 2006). The purposive sampling method allows for the selection of interviewees whose qualities as well as experiences permit an understanding of the phenomena in question, and are therefore valuable. Thus, the choice of this sampling technique was because it allowed for the selection of participants who suited the purpose of the study, in terms of knowledge and experiences they already have on SRH education.

The role of the convenience sampling techniques was to select participants who were readily available and willing to provide information to enable the researcher to answer the research questions. Convenience sampling is also another form of non-probability sampling where participants in a study are chosen based on their easy accessibility or availability (Rubin & Babbie, 2008). In other words, the researcher selects his study participants based on some characteristics they have, which fit in the purpose of the study and also their availability.

Selection of student participants was voluntary in all schools. Students were given an overview of the study and afterwards asked if they would want to be interviewed. Volunteers in all schools exceeded the required number of participants needed, therefore, a simple initial questioning to establish the background of the student was asked. The initial questioning was on the age of the students and whether they lived with their parents or guardians. Based on this, ten students were selected from each of the two schools depending on uniquely identified characteristics.

The questioning sought to ascertain their parents' education level and career, as well as residence and sex of student. This approach ensured that views of participants from diverse backgrounds were collated.

Selection of teachers was based mainly on their teaching areas. Thus, six teachers who handled SRH related courses such as Integrated Science were interviewed.

Parents were mainly conveniently identified and interviewed for the study. However, a screening questioning was undertaken to verify if the participant had a child in JHS Year 2 or JHS Year 3. Where the parent had no ward in any of these classes, they were not interviewed.

3.6 Methods of Data Collection

Primary sources of data were used to gather information in this study. Primary data were obtained through participant observation, interviews with parents and teachers and focus group discussions (FGD) with students. Data collection was undertaken between April and May, 2015.

3.6.1 Interview

Interviews were employed to obtain data from the study participants. An interview is an interaction between an interviewer and a participant, where the interviewer has a general plan of inquiry but not a specific set of questions that must be asked in particular words and in a particular order. The role of the interviewer is to establish a general guideline for the interaction and allow the participant to do most of the talking about the topic under study. According to Freebody (2003), interviews enable participants to report on themselves, their views, their beliefs and also create the opportunity for the interviewees to ask for clarification when they do not understand a question. Furthermore, it enables the interviewer to also ask for elaborations on answers given by interviewees.

In this study, individual in-depth interviews were conducted with parents and teachers using an interview guide developed by the researcher. This enabled the researcher to capture their views independent of those of the other parents and teachers. Interview sessions for parents were held in their respective homes on weekends, when it was expected that they would be off work. However, where this arrangement was not convenient for a participant, another day and place which the participant considered favourable was scheduled. Considering the fact that Twi and Ga languages are predominantly spoken by the people in the study area, the interviews were conducted in Twi, Ga and English languages, depending on the preference of the participant. The average time for each interview was approximately 50 minutes. Questions sought to find out, among other things, the thoughts of parents on SRH education in school. The interview guide for both teachers and parents are attached as Appendix A and B respectively.

3.6.2 Focus Group Discussion

Unlike parents and teachers, students who took part in this study were not interviewed individually. They were engaged in four (two all-male and two all-female) focus groups comprising of five-members each due to the intended benefits of Focus Group Discussions (FGD). A FGD discussion enables research participants to deal with problematic issues together, raising opposing viewpoints and also resolving conflicting perceptions (Adler & Adler, 1987). Kitzinger (1994; 1995), argues that interaction is the crucial feature of focus groups, because the interaction between participants highlights their view of the world, and their values and beliefs about a situation. Interaction also enables participants to ask questions of each other, as well as to re-evaluate and reconsider their own understandings of their specific experiences. Krueger and Casey (2000) have recommended that a researcher should plan three or four FGD sessions, after which he can identify and decide whether he has reached the point

of saturation. In this study, saturation was reached at the end of the four focus group discussions.

With the permission of the study participants, information shared during the interviews and FGDs were recorded to ensure that information was captured precisely. Participants of the FGDs were given unique identification numbers which they mentioned prior to responding to topics under discussion. This was done in order to avoid mismatching of participants and their responses and make the enormous volume of data manageable during analysis. Also, notes of salient points, facial expressions and gestures made by the participants were recorded in a field diary. It was important to record the facial expressions and gestures, as they helped to capture the non-verbal responses which the audio recorder was limited in doing, thereby giving additional meaning to what the participants said. The notes served as a complement to the voices captured on the tape recorder. The FGD guide was developed by the researcher and the discussions were conducted in English and Twi based on the preference of the participant. The average time for each FGD was approximately 70 minutes. The guide for the FGD is attached as Appendix C.

3.6.3 Participant Observation

Sometimes, what people say in an interview may be different from what they do (Marshall & Rossman, 1995). Therefore, given this human inconsistency, observation can be a great check against what people report about themselves in interviews. Observation has its roots in anthropological studies, where researchers would travel to faraway places to study the traditions and practices of less known societies (DeWalt & DeWalt, 2002). It involves looking at the situation, while, at the same time, recording what is being observed instead of just listening to people. In view of this, participant observation was employed by the researcher to gain insight into perceptions of stakeholders towards SRH education. Approaches used

included, the researcher sitting through a couple of SRH lessons in both schools and also observing behaviours of participants during interview and FGD sessions.

3.7 Data Handling and Analysis

The recordings of all interviews and FGDs conducted in English language were transcribed verbatim and password protected on a personal computer to ensure confidentiality. Since the researcher has proficiency in the two local languages (Twi and Ga) used in the interviews and FGDs, there was no need to outsource translation service. Translation was done simultaneously with the transcription of the field recordings. In the process of verbatim translation, English language equivalent to some words in the local dialects, that is, Twi and Ga were not found and thus, the researcher had to manage with English words closest in meaning. For example, “w’asei” was substituted with ‘spoilt’ in the text.

A relational-thematic framework analysis was conducted using both inductive and deductive approaches. The deductive approach was mainly to verify the theoretical underpinning of the study, while the inductive was used to fish out new dimension or concepts of the various research questions that might not have been covered by existing studies.

Thematic framework analysis (TFA) is a content analysis variance of making meaning out of qualitative dataset by organising data according to key themes and concepts that are evident in a dataset (Braun & Clarke, 2006). Braun and Clarke (2006) have outlined 6 phases for carrying out qualitative analysis which the researcher utilised in analysing data from the one-on-one interviews and FGDs. First, there was familiarisation with the contents of the data by reading and re-reading of transcriptions. Second, initial codes were generated from the transcripts by giving numbers to salient responses based on their similarity and difference. Themes were then identified in the generated codes in the third phase. The fourth phase consisted of reviewing the themes by going over the identified themes to determine which ones could be merged into

broader themes or separated into sub-themes. In the fifth phase, the identified themes were defined and named. In other words, from the responses of the participants, the researcher decided on what each theme meant and then gave appropriate names that would best describe the themes. The sixth phase consisted of the production of the final report of the findings, which was done by writing the findings in the form of a narrative. Similar to TFA, relational analysis also involves examination of qualitative data to identify themes vis-à-vis the research questions, but in addition, it explores the relationship between identified themes. After following the basic steps for the TFA, the researcher went further to do a relational analysis for the FGDs. This was done by finding the relationship between the themes identified from the students' responses to decipher their points of agreement or diversion. The combination of the two data analysis methods greatly enhanced the analysis of data to address the research objectives.

3.8 Ethical Considerations

In any research it is important that appropriate research ethics are adhered to in ensuring the wellbeing of the participants, as well as, achieving the purpose of the research. In view of this, in recruiting participants for this research, informed consent was sought from all participants. Informed consent was gained by letting participants know the purpose of the research, what is expected of them as research participants, including the amount of time likely to be required for participation and expected benefits of the research to literature and policy making. In the case of students, since they were all less than 18 years, consent forms were given to their parents for the approval of their parents or guardians before the students were included in the FGD. They were also assured of the fact that their participation was voluntary and that they could withdraw at any time with no repercussions. Thus, participants were not coerced to take part in the study. The content of the consent form is attached as Appendix D.

Due to the sensitive nature of this research, the participants in this study were assured of the confidentiality of their responses and made aware pseudonyms would be used to protect their identity in the final write-up of the thesis. Questionnaires collecting demographic details of participants were handed out to them to fill privately before the beginning of the discussions and were collected at the end of the FGD.

Also, data falsification and data fabrication were avoided in order to ensure the trustworthiness of this study. Through member checking, clarity and confirmation of responses were sought from study participants during and after the data collection to contribute to the trustworthiness of the findings. All references used were duly acknowledged to avoid plagiarism.



CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the research and discuss them to address the research questions guiding the study. Data from individual in-depth interviews with parents and teachers and four FGDs with Junior High School (JHS) students were analysed. The first and second FGDs (FGD 1 and FGD 2) comprised of males and females respectively, from one school. The third and fourth FGD (FGD 3 and FGD 4) also comprised of males and females respectively, from another school. Findings are presented in the first part of the chapter while discussions of the findings are presented in the second part. The findings are presented under three major themes, these are stakeholder perspective on Sexual and Reproductive Health (SRH) education, socio-cultural factors influencing SRH education and challenges associated with the impartation and learning of SRH education in schools.

4.2 Demographic Characteristics of Participants

Information regarding the demographic characteristics of participants in this study is important in providing assurance that the participants possessed the qualities needed for the study, thereby giving validity to their responses. Background characteristics of participants of this study comprised of sex, age, religion and marital status. All of the five parents interviewed were mothers, out of which three were married. The study participants were Christians with the exception of one, who was a Muslim. The ages of the student participants ranged from 13 to 17 years. Table 1 summarises the background characteristics of the participants.

Table 1: Background of Participants

Variables Participants	Sex		Age	Religious Affiliation		Marital Status*		
	Females	Males		Christian	Moslem	M	S	N/M
Parents	5	-	31-48	5	-	3	2	-
Teachers	3	3	27-52	6	-	4		2
Students	10	10	13-17	19	1	-	-	20
Total**	18	13		30	1	7	2	22

*M = Married, S = Single, N/M = Never Married
 **Total number of respondents = 31



4.3 Stakeholder Support of Sexual and Reproductive Health Education in School

The success of SRH education in JHS, to a large extent, will be dependent on key stakeholders' (parents, teacher and students) approval or otherwise. The deductive approach was used to analyse responses based on themes identified in Section 2.7 of the literature review, that is, the usefulness of SRH education from the perspectives of parents, teachers and students. The identified themes were categorised into two main themes, with sub-themes for each main theme. The main themes centred around perception of stakeholders on relevance of SRH education to adolescents and appropriateness of the school in providing SRH education. With respect to relevance of SRH education as a main theme, the sub-themes captured comprised, increased confidence of students, better understanding, cleared misconception, additional/complementary source of SRH education and improved healthy relationship with the opposite sex. Under the second main theme, appropriateness of the school in providing SRH education, the sub-themes identified included, endorsement or otherwise of the content of SRH education and best person to handle SRH education. On the best person to handle SRH education, responses centred on, healthcare professionals and both parents and teachers.

4.3.1 Relevance of SRH Education to Adolescents

This theme highlights the various ways in which study participants perceive SRH education as important. These include: increased confidence of students, better understanding of SRH, cleared misconception, improved healthy relationship with the opposite sex and additional /complementary source of SRH knowledge.

a. Increased Confidence of Students

SRH education carried out in a professional atmosphere in the school, promote a relationship of trust between students and their teachers, which in the long run, help the students to be confident and even confide in their teachers. For instance one teacher interviewed indicated:

...It has really helped them. Any problem they have in the house they are able to express themselves. With their parents, they are not able to but since I started teaching them they are able to express themselves and tell me whatever problem they have. [Flora, Teacher]

The comment made by the teacher summarises how the teachers perceived the importance of SRH education to adolescents. The openness with which teachers imparted SRH knowledge enabled the students to also open up and discuss with their teachers issues bothering them about their SRH, which they may not be able to talk about with their parents or guardians.

b. Better Understanding of SRH

From the perspective of the participants, SRH education provided to in-school adolescents helped them to have a better understanding of the sexual and reproductive system, as well as, protect themselves from dangers of indiscriminate sexual activities. These are highlighted in their comments below:

Most of the time if there is something the child doesn't know and the parent does not also teach the child or the child doesn't learn from the school, the child will go and explore with such things and in the end it will bring problems to the home. But if the child learns from the school and the parents also add to it (the knowledge of SRH), then the child will know how to behave. [Esther, Parent]

It will reduce teenage pregnancy and then school dropout. It will also help them to prevent themselves from STIs, because the moment you involve yourself with this boyfriend affairs by all means, you won't know the person is having the STI and those kinds of things. So if you know the effect, the problem or challenges that will affect you when you involve yourself in this kind of activities it will help you to prevent yourself from those kinds of things. [Auntie B, Parent]

Erm, I think it is very useful for them because it helps the children to be aware of the dangers of their reproductive health. There is this aspect, that is, teenage pregnancy also part of the course or the topic and it helps the children, especially the females so that they will be aware of the dangers or the problems involved in teenage pregnancy that is, when they get pregnant at an early age. [Emmanuel, Teacher]

From the parents and teachers' perspective, the provision of SRH education to adolescents in JHS is very necessary to safeguard their reproductive health. In addition, some of the parents and teachers indicated that SRH education was useful in preventing teenage pregnancy, which sometimes endangered the health of girls. The emphasis was placed on girls because, effects of teenage pregnancy such as interruption in schooling, was often greater on girls. The parents and teachers also stated that SRH education enabled adolescents to protect themselves from other dangers of early sexual exploration, such as the contraction of STIs, including HIV/AIDs. This will help the students complete their education so that in the future they can have an increased possibility of being engaged in professions and careers.

The male students in the focus groups were unanimous in establishing that the SRH topics helped them to know that wet dreams are normal features of growing up. It also helped them to know how to control sexual feelings, bearing in mind the consequences of early sex and unprotected sex.

Some of the students reported that in the initial stages when the topic was introduced, they were confused as to its purpose but later they came to understand its usefulness. Thus, they came to understand that they were not being taught to practice sexual activities; instead, the lessons were to help them abstain from sex or in extreme cases practice safe sex. Female students reported that the SRH education they received helped them to understand how the reproductive system works in their bodies. Below are some of their comments:

It has helped me a lot. At first, I used to worry about wet dreams; I didn't even know it was called wet dreams but, I think since Year 2 second term when we were taught, I don't worry anymore when I have it. [Emmanuel, FGD 3]

It helps us to know when one can become pregnant; the time and also the period. You can't normally discuss this with your parents [Gifty, FGD 2]

When Sir was teaching I decided that, if I know what I will do and the woman will not get pregnant, why not practice it? But when he went further and I listened to him, now I know it is not good. So now when I have that experience (sexual arousal), I just go out to play football and by the time I come back, everything is ok. [Prosper, FGD 1].

c. Cleared Misconceptions

This theme was peculiar only to the students. When asked if students had prior knowledge on some of the topics discussed in the SRH class, some student participants reported that they knew about some of the dangers of indiscriminate sex and the use of condom to prevent STIs and pregnancies. This notwithstanding, some of the students reported that some of the prior knowledge they had tended to be wrong. Thus, the SRH education helped to debrief and then brief them on the right information about their sexual development.

Their views are captured in the comments below.

The subject has helped us prevent ourselves from having sex because we are afraid of the consequences. Sometimes we hear people say if you have a female friend and you don't have sex with her she will not respect you. But now I know it's not true [Shadrack, FGD 1].

I was told by one of my friends that if I have sex, then I won't feel menstrual pains again, but when I asked Madam during the class she said that it is not true and that I should rather do exercise and eat well or take menstrual pain killers. I couldn't have asked my parent this. [Helena, FGD 2]

Findings from the preceding comments by the students confirm that school-based SRH education indeed provides accurate information to students, in that, the knowledge provided are based on facts and evidence as it has been approved by the Ministry of Education (MoE) and the Ghana Education Service (GES).

d. Additional/Complementary Source of SRH Knowledge

Female students, in particular, reported that SRH education helped them gain new knowledge in addition to other previous knowledge which they had received from their parents.

I knew about menstruation and personal hygiene and all those things but I did not know about ovulation, the stages of pregnancy and health risks associated with each stage. [Gladys, FGD 2]

My mother told me about menstruation and she also said I shouldn't play with boys. But during the reproductive health topic, I also learnt that it is not every time that you have sex that you will get pregnant. [Lydia, FGD 4]

The responses of the students showed that some of the students had received some form of SRH education from their parents prior to what they were taught in school.

For instance, the female students knew only about menstruation and some level of personal hygiene during menstrual period. Hence, the SRH education they received enabled them know about other useful information such as ovulation, the stages of pregnancy and health risks associated with each stage. Thus, the SRH education they received in school gave them new knowledge.

e. Improved Healthy Relationship with the Opposite Sex

Some of the teachers and parents reported that SRH education was useful in enabling the students relate in a positive manner with their colleagues of the opposite sex. One of the female teachers said:

...It has really helped them. A lot of them have changed in areas of how they relate with the opposite sex, [Flora, Teacher]

Both male and female students unanimously confirmed what some of the teachers had said when they mentioned that the SRH education received in school has helped them to develop a healthy relationship or friendship with the opposite gender. Below are samples of their comments:

First, I didn't want to play with the girls in my class because when you play with them they will say you like (love) them. But now I know it's normal, it's part of our development [Divine, FGD 1].

The boys like touching us when we are playing and then during the reproductive health class, Madam told us that for girls our feelings is in touching, so we shouldn't let the boys touch us anyhow they like. Even though we still play with them we don't let them touch us anyhow because it can lead to other things. [Ama, FGD 2]

Responses of the teachers and students showed that, if SRH education had not been imparted to adolescents, they would not have the information they needed to tread cautiously with regard to their SRH. SRH education enables adolescents to know that there are different kinds of friendships, that is, the unhealthy and healthy kind. It also helps them to know that they can have healthy relationships or friendships with the opposite sex while taking precautions to avoid situations that will make them engage in sexual activities.

4.3.2 Appropriateness of the School in Providing SRH Education

Another indicator of approval of school-based SRH education is reflected in how participants perceive the appropriateness of SRH education in school, as well as their endorsement or otherwise of the contents of SRH syllabus. To this end, the views of teachers, parents and students were sought on what topics are appropriate to be covered under SRH education, and who should be responsible for the provision of SRH education for adolescents. Some of the participants had the perception that SRH education should be provided by both parents and teachers, whereas some students had the opinion that healthcare professionals should provide SRH education. Whether teachers or healthcare professionals, the rationale for the choice of provider was because the students believed they have been trained to do so.

a. Endorsement or Otherwise of the Contents of SRH Education

Some of the parents and teachers interviewed had some reservations about the content of the school-based SRH education. One of the parents said:

They (the teachers) shouldn't teach them about sex. When the children are ready to marry the parents can teach them. [Rose, Parent]

Two of the teachers interviewed unanimously mentioned that some topics were too sensitive for teachers to handle. Hence, such topics should be the reserve of parents.

Below are some of their comments:

I think we can educate the student on SRH but it is not everything we can teach. You just imagine a teacher having to teach a young girl how to fix sanitary pad in her panties. That will be too much for us, we will need support of the parents. [John, Teacher]

Me for one I can't stand in front of the class and teach the children how to wear a condom. I don't know for other teachers, but I can't do this one. This is where the parents come in. This one is extra sensitive so the parents should handle it at home. [Grace, Teacher]

Two out of the five teachers indicated that parents have an important role to play with regards to their children's wellbeing. Although the teachers have been trained to teach the SRH topic, they still considered some aspects as appropriate for parents to handle at home. Some of the parent participants also requested that sensitive topics such as on contraception should be left for them to teach their children.

b. Best Person to Handle SRH Education

Some of the parents indicated that teachers should be mainly responsible for SRH education while they provide supportive role on sensitive issues. These comments are captured below.

The teachers can teach them the book aspect of menstruation, pregnancy and the diseases. Then in the house, the parents can teach the girls how the pad should be worn.

I don't think they can teach all that in the school, so the parents can do that. [Rose, Parent]

Sometimes our children are shy of us (the parents). But it is right that teachers should be the main people to teach the children, because they spend a lot of time in the school than we even spend with them in the house. [Esther, Parent]

As evinced from the responses of the parents, they acknowledged that they have a supportive role to play in SRH education of their wards. They are of the view that, while teachers ought to take a lead role in SRH education of wards, they (parents) are responsible to provide a supportive role by handling sensitive topics. This is an indication of their support or approval of school-based SRH education being imparted to adolescents.

All the students, but for two in FGD 2, were unanimous on the opinion that SRH education should be the duty of both teachers and parents. This shows their understanding that multiple stakeholders have a role to play in SRH education. Below are sample of their responses:

I believe that it is the work of both parents and guardians and the teachers as well. All the same the standard at which the teachers teach us...is quite different from what we also get to know at home. So yes, we must be taught about these things at home, but the teachers must also teach us so that we get some more clarifications. [Favour, FGD 3]

It should be the role of parents and teachers. Parents must teach us in the house before we come out. When we get to adolescence stage, our parents have to teach us how to keep ourselves, how to protect ourselves from bad friends. They have to teach us before the teachers can also teach us. [Promise, FGD 4]

For some students, as indicated in the first quote, parents and teachers will complement each other where the other falls short of accurate knowledge in SRH education. As indicated in the second quote, other students are of the view that, although SRH education should be the role of both parents and teachers, it is best if parents start. Probably, they hold this view because parents are the primary agents of socialisation or the first point of contact with the students, and so while the students wait until second year in Junior High School (JHS) to be taught this very important topic, parents can initiate it.

There was however a deviation by two students who were of the view that health professionals such as doctors and nurses should impart SRH knowledge. Their reason was that, health professionals are more knowledgeable in the field of adolescent reproductive health, thus making information coming from them more authentic. In their own words:

... the doctors, they have been taught about everything so maybe when they come to teach us they will go into details. They will teach us everything. But sometimes the teachers, it's not all of them that can teach us. But the doctors, they have been to the [medical] school and know everything about female and male reproductive system.

[Helena, FGD 2]

I think that doctors and nurses should teach this topic because they have been trained.

[Ama, FGD 2]

4.4 Socio-Cultural Influence on Perceptions to SRH Education

Participants in this study gave various reasons for their perceptions towards school-based SRH education. The inductive approach was used to thematise participants' responses under two main themes – cultural and religious perceptions and adaptation to current global norms.

4.4.1 Cultural and Religious Perceptions towards SRH Education

Responses from all parents, irrespective of their age, showed some impediment to the provision of SRH education, resulting from preservation of, or identification with their respective cultures and religious principles. While they wanted their children to be exposed to SRH education and also had no challenges discussing basic topics such as personal hygiene and abstinence with their wards, it was difficult discussing sensitive topics on use of condoms and other contraceptives. The parents indicated their culture frowned on such discussions and they wanted to maintain the status quo. Also due to the fact that the Catholic Church disapproves the use of contraceptives, some parent participants who were Catholics, expressed disapproval

of SRH education which teaches contraception as means of preventing pregnancies. Thus, two salient points that emerged from their comments were, emphasis on abstinence and virtual silence on condom use:

Me, when I was growing up I didn't have any sex education. In our culture it is not allowed. The only thing we were taught was about our menses and personal hygiene and abstinence. Besides, I was also staying with somebody, I did not get the chance to ask her further questions and she also did not teach me. So if I have become a parent now I should teach my children same. Abstinence! no need for condoms and those pills. God will not even be happy with me. [Comfort, Parent].

I tell my children to shave and not keep their pubic hairs bushy and my girls too I taught them how to use pads. But I don't tell them how to use condoms, because I'm a Christian and even our culture unlike those abroad does not support that. [Rose, Parent]

...Ah! I won't agree to that. We are Catholics and we are against condoms or pills (contraceptives). [Auntie B, Parent]

Unlike the parents, responses from teachers indicate that culture and religious affiliation or principles did not affect their role in the teaching or learning of SRH. Teachers in this study had undergone training at teacher training colleges hence, their ability to comfortably teach SRH to adolescents. Even those who are yet to have children of their own, said they will commence SRH education before their children reached adolescence. Below are some of their responses:

I have no problem at all teaching SRH topics. I am a trained teacher so I have no issues with that. [Flora, Teacher]

There is no problem with me discussing SRH topics with teenagers. In fact if I have children, I will seriously teach my children. If I have a female child, what I will teach her is the menstrual cycle, because I know about it. I wouldn't mind teaching my male child how to use condoms because there are certain things that you have to learn it, yes. Definitely, he will grow; he will marry so he has to know all these things.

[Emmanuel, Teacher]

Similar to the perspectives of the teachers, responses of student participants suggested that culture and religious affiliation did not affect their discussion of SRH issues outside the home. The students were of the view that Christian teachings helped them not to engage in premarital sex but it had no effect on the discussion of the matter in the classroom or with friends. Their comments are captured below:

I always remember what the Bible even said about that so I can't involve myself in that (sex). [Prosper, FGD 1]

I know the Bible says we shouldn't fornicate but that does not mean we shouldn't be taught about our sexual and reproductive health. So when we are talking about it in class I see nothing wrong. [Divine, FGD 1]

The only Muslim student, just like the Christians, also mentioned that Islamic teachings discourage them from fornication. He added:

...They tell us to stay away from sex completely until we are married. If you do that (premarital sex) under sharia law, you will be killed. [Awal, FGD 3]

Although, the student mentioned that Sharia law is not in favour of fornication and may punish such an act with death, it must be noted that Sharia law is not applicable in Ghana.

The comment he made only adds to what his colleague participants said regarding religion; and just like his other colleagues, religion did not dissuade him from discussing SRH issues at school and with his peers.

Comments from student participants in the FGDs show some cultural influence on the discussion of SRH topics with their parents or guardians, due to shyness and fear of being labelled a bad boy or girl. The students however, considered this cultural deterrence on sexual matters funny. Perhaps, this is an indication of their disapproval of the status quo where certain aspects of SRH education is frowned on.

I didn't talk to my parents about it because I feel shy to approach them and talk to them about sex...I don't know why I feel shy but I think it is the way our society is. But I have been talking to my elder brother. With him I feel freer than with my parents. [Awal, FGD 3]

I didn't ask them anything because I think that if I do they may insult me that I'm a bad boy because I'm talking about grown up things. So that's why I don't ask them. [Cliff, FGD 3]

After the teacher had taught us the SRH topic, when I went home to learn about it, I was outside and some man came and said that "ah you girl! What are you learning?" [All group members laugh]. So I told him that I'm learning about the reproductive system and he said that "this thing, they teach you in school?" I said yes, and he said that it's not good they should not allow us to know these things at this age. [Augustina, FDG 4]

Other students mentioned the Ghanaian culture of silence on SRH issues as the reasons why they are shy or afraid to open or engage in SRH discussions with their parents or guardians.

Some of their comments presented below are indicative of this view.

... You know the African tradition they don't want us to hear about sex. Even when you are with adults and they start talking about it and you are sitting there then they start saying you are a bad child. [Isaac, FGD 4]

Our culture makes it look like it is only adults who can talk about sex. So when you are talking about sex and you are young they will say that you are spoilt or you are not a good girl. [Ama, FGD 4]

4.4.2 Adaptation to Current Global Norms

From the comments of the participants, the idea of global village is playing an influential role on SRH education in the midst of opposing cultural inclinations. The following sub themes were identified from the comments of the participants: globalisation or modernity; need to change the status quo; and involvement of older generation in SRH education.

a. Globalisation and modernity

It has become necessary to teach SRH to adolescents because trade and dissemination of knowledge resulting from globalisation, have exposed adolescents to enormous amount of both appropriate and inappropriate information about SRH. This form of modernity has also had an influence on teachers' decision to accept SRH education being imparted to adolescents so that they will be empowered through the reception of the right information to take charge of their reproductive health. Sample responses from participants include:

These days everything is on TV. The children watch TV so even if you don't tell them they will see it on the TV. That is why we also have to talk to them so that they will know that it is not everything that they see on the TV that is good for them to learn from. [Helen, Parent]

Now we live in a global village, and since those European cultures don't hide sex issues, young people in Ghana will learn them as they interact within a globalised village even though our culture doesn't support that. So it's important we let them know about it before they find out from movies or the internet through pornography which may not paint the real picture. [Mark, Teacher]

b. Need to Change the Status Quo/Ghanaian Culture Obsolete

This sub-theme captures the comments of some of the participants on the need to make some changes to traditional ways of living. Responses from parents interviewed show that although, the cultural setup they grew up in did not allow them to receive SRH as adolescents, they have found it needful to allow their children to acquire such knowledge, because of current global norms. One of the parents said:

These days everybody is going to university. If they are taught this topic in the school and the teachers also advise them to abstain, it will help them to not make the mistake I made and they can complete school in peace. I didn't have that (SRH education) and so I had to learn by experimenting which I paid dearly for. So I don't want my daughter to go through that so I draw her attention to some of these things. [Helen, Parent]

Also, noted from the students' responses was that, the Ghanaian culture of shrouding SRH education in secrecy was obsolete and needs to be abolished because, currently, the world is such that issues on sex cannot be hidden. This offers further explanation on why they considered cultural deterrence on aspects of SRH education funny and laughed over it.

Below are some of their responses:

Now we see all the things about sex they don't want us to talk about on TV. But still they don't want us to talk about sex because we are young. I think this part of our culture is archaic and must be changed. [Augustina, FGD 4]

...It's time we leave these kinds of old traditions of the elderly screaming at you when you talk about sex to their hearing... [Isaac, FGD 4]

c. Older Generation's Involvement in SRH Education

Some participants had the opinion that due to globalisation and modernity, although teachers belonging to an older generation may not have received SRH education when they were adolescents, they have been trained to meet the current needs of students by providing SRH education. They believe such teachers have to their advantage both experience and training in teaching the topic than the younger teachers. Also, the students will be obedient to take the advice and information provided by the teacher more seriously. Few of the students, however, mentioned that both young and older teachers can impart SRH knowledge to them because they have all been trained to teach. Some of their responses are provided below:

The older ones have more experience than the young ones. These days the young ones don't really teach. When it gets to this topic then they will be covering up some of the aspects. But the older ones, those who are matured can teach because this topic is about human. [Helen, Parent]

A female teacher also commented:

I wasn't taught this topic, my mother only told me about menstruation and abstinence. Now I am 52 years, I'm married with children. I taught my children when they reached adolescence because I went to training college. I even wrote my thesis on personal hygiene among adolescents. I will say that I am able to teach the topic because of training and my age. You know, age comes with experience. [Cecelia, Teacher]

A young male teacher added to this by saying:

As a young teacher with little personal experience, I believe I don't know much by way of real examples to give to the children. But an older teacher, who has more life experience, can teach the children more things so that it can help them. [Emmanuel, Teacher]

Many of the students showed preference for older teachers (above 40 years) for SRH lessons.

Some of their responses were:

I think the old men can teach us better than the young ones. Because the old men might have experienced having sex with somebody so they will talk with experience but if the young one doesn't have any girlfriend or wife that he or she has not had sex with they can't teach with experience. So I think the old men are better than the young ones. [Lydia, FGD 4]

...She is a mother. She has been trained and she talks to us like we are her children. Even when you have a problem and you go to her she can advise you. [Sandra, FGD 2]

4.5 Challenges Encountered with the Impartation and Learning of SRH

The inductive approach was utilised for analysing data to address this research question. From the responses of the parents, it was discovered that the main challenges they faced with regards to SRH education fell under the theme Cultural and Religious Challenges. Regarding teachers and students, although all those interviewed made it explicitly clear they had no socio-cultural factors that affected their teaching and learning of SRH topics in the classroom, they however reported facing some resource challenges. These challenges were thematised under Absence of Teaching and Learning Materials (TLMs) and Time Constraint.

4.5.1 Culture and Religious Challenge

The major challenges parents faced in discussing SRH topics with wards were ones of culture and religion. For instance, the parents interviewed stated that, due to the nature of the Ghanaian culture and beliefs, they found it quite difficult discussing some aspects of the SRH topic such as wet dreams, ejaculation and use of condoms. These challenges identified in the comments below, were basically centred on the parent's faith or religious identification. Here, faith refers to both the religious beliefs and affiliations of parent participants.

I am a Christian and my mother even is a prophetess so I can't involve myself in that. So when I tell my children that the Bible say we should not fornicate and I am teaching them about condom what will that mean to them? So you see... [Rose, Parent]

I'm a Catholic and we don't believe in use of contraceptives, so I don't teach my children those aspects of SRH, aside that, it is not done in our society. [Auntie B, Parent]

Parents face the challenge of being unable to give any SRH advice to their children besides abstinence due to their religious beliefs, which prohibit fornication. One of the parents had a challenge because of her religious affiliation with the Catholic Church which does not approve of contraceptive use, hence, inability to talk to her children about contraceptives as an alternative to abstinence. An indication from their comments is that, parents in this study are unable to play a supportive role to SRH education as the teachers will want them to. Hence, adolescents may not receive the benefit of SRH education, which can endanger their sexual and reproductive wellbeing.

4.5.2 Absence of TLMs

Teaching and learning materials (TLMs) are very essential for the impartation of SRH knowledge to adolescents. However, in the case of the teachers and students interviewed, they

reported that they did not have the relevant teaching and learning materials (TLMs) such as diagrams, SRH educative videos, condoms and toy penises, which they required to carry out effective SRH education. Below are some of the responses indicating teachers and students concern regarding the unavailability of TLMs.

We don't have much TLMs. In fact we don't even have at all. So when I'm teaching I just have to say it verbally or at times I have to draw it on the board. And I can't draw everything. But there are pictures that show everything. We don't have such things here.
[Emmanuel, Teacher]

We don't have videos to show them. Sometimes when we teach them they don't know what we are talking about. For example, they don't know how the sperm looks like or how it moves to go and fertilise the egg. [Cecilia, Teacher].

When there are teaching aids such as condoms and toy penises available we can just show them instead of just mentioning some of the words. [John, Teacher]

We don't have diagrams that teachers can use to show us what they are saying. So sometimes we find it difficult to understand. For example I have not held a condom before so you can imagine how difficult it will be for me to understand how to wear condom with just explanation from the teacher. [James, FGD 4]

4.5.3 Time Constraint

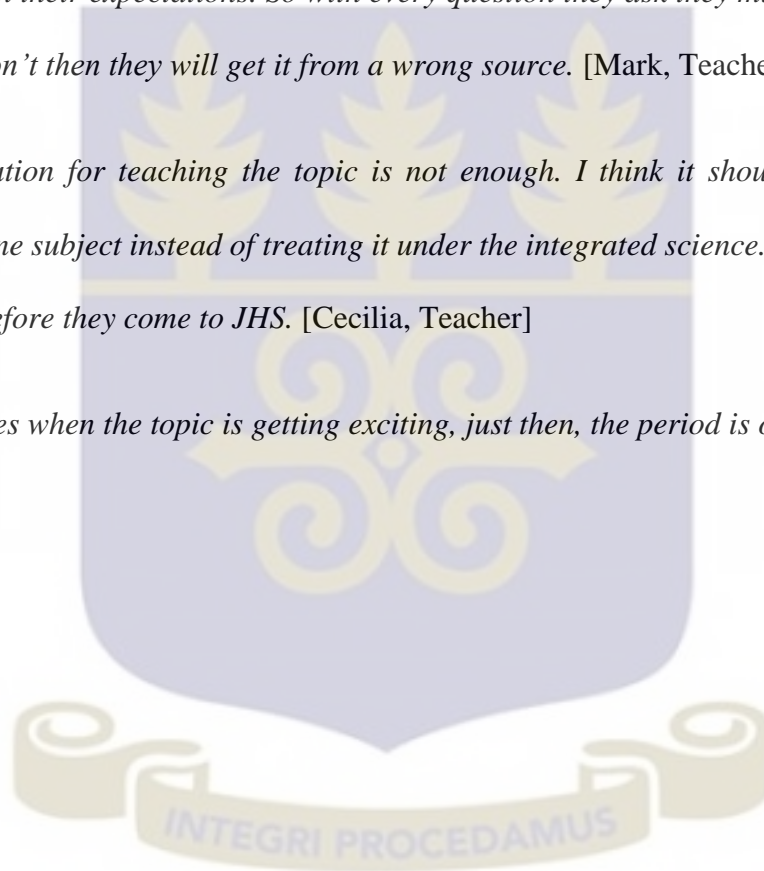
Time is a valuable resource needed to impart SRH education for the benefit of adolescents. As illustrated in the quotes below, teachers did not have enough time to teach the topic to the satisfaction of the students. The quotes revealed that students tend to have lots of questions regarding SRH when the topic is being taught and this sometimes extends lesson periods

beyond the specified duration. Teachers find it needful to address the questions the students raise, despite the limited time, so that they would not seek answers from the wrong source.

The topic normally takes longer than it is supposed to. I get a lot of questions coming from the students and if I want to deal with all of them then I will have to extend the time. That is the challenge I have because they want to know and some of the questions they ask are not within the scope of the lesson, but if I refuse to answer then that also cuts down their expectations. So with every question they ask they must get directions, if they don't then they will get it from a wrong source. [Mark, Teacher]

The duration for teaching the topic is not enough. I think it should be made as a standalone subject instead of treating it under the integrated science. It should even be taught before they come to JHS. [Cecilia, Teacher]

Sometimes when the topic is getting exciting, just then, the period is over. [Awal, FGD 3]



4.6 Discussion of Findings

This section briefly highlights the implication of the demographic characteristics on the results of the study. It also discusses the findings based on the objectives of the study.

4.6.1 Implications of Demographic Characteristics of the Study Participants

The age range of 13-17 years identified for student participants conforms to the WHO (2014) reference of adolescence as the period of human development from age 10 to 19 years. This

suggests that the views collated were those of the required target group the study sought to reach and therefore were appropriate for addressing the objective of the study.

Also, the wide variation (27 to 52 years) in the ages of parents and teachers offered the assessment of perceptions from different cultural generations which enriched the result of the study.

Religion has been found to be key in shaping the perception of people especially those on SRH (Odimegwu, 2005), hence the absence of an atheist participant ensured only participants with characteristics essential for the study were interviewed. In addition, the presence of married, unmarried, divorced, parents and non-parent's strata in the participants, allowed for data that is reflective of the various strata in the population. However, the absence of a traditionalist limits the study considerably because traditionalism is often associated with strong adherence to culture.

4.6.2 Stakeholder Support of Sexual and Reproductive Health Education in School

Based on the findings of this study, parents, teachers and students generally agreed that SRH education should be provided to adolescents in JHS because of its known benefits in reducing teenage pregnancies, school dropout and misinformation among others.

This finding supports the behavioural beliefs and attitudes aspects of the TPB/TRA which supposes that people would or would not accept behaviour based on their belief that that behaviour is positive or negative.

From the findings, though there was one divergent theme (healthcare professionals) to the provision of SRH education in JHS, this theme does not necessarily indicate opposition to the provision of SRH lessons to adolescents in JHS. Indeed this is a laudable opinion which also indicates the participants' endorsement of the provision of SRH lessons in JHS because a healthcare professional could be invited to the schools to educate students on SRH. The

possible underlying assumption for this opinion is that, all the participants in this study prefer SRH education to be provided by people purposefully trained to do so, hence, approval of school-based SRH education. It is therefore not surprising that the result in this study concurs with several others including Yadeta et al. (2014), Mlyakado (2013) and Dyson and Smith (2012).

Again, the endorsement of the relevance of SRH education to students by the teachers is an indication of a likelihood of achievement of the goals and objectives of SRH education in Ghana, as outlined in the Canadian Guidelines for Sexual Health Education (Public Health Agency of Canada, 2003), the teaching syllabi of Integrated Science and Social Studies (MoE, 2007) and the International Technical Guidance on Sexuality Education (UNESCO, 2009). Teachers constitute the main source of knowledge of SRH education in school. Thus, their realisation of the importance of such lessons as a means of safeguarding the lives and future of their students is likely to encourage them to provide accurate information about human sexuality, including: growth and development; sexual anatomy and physiology as outlined in International Technical Guidance on Sexuality Education (UNESCO, 2009).

Furthermore, the reasons given by both male and female students as to why SRH education in JHS is important suggest a closer attention ought to be paid to delivery of SRH lessons to female students in particular. Many female students reported that SRH taught in school is key in addressing misconception about the subject, because they found it uncomfortable talking to their parents about SRH and often received wrong information from friends. Hence, with SRH lessons in school as the most preferred means of learning about SRH issues by female students in JHS, there is a need to pay particular attention to them in order to address their issue as not all issues could be addressed within lesson periods. This finding supports UNESCO (2009,

Vol.1, p. 2) consideration of SRH education as “... *relevant approach to teaching about sex ... by providing scientifically accurate ... information*” as well as, findings of UNESCO (2009) which show that effective sexual and reproductive health education reduces misinformation and increase correct knowledge.

The finding that most of the parents interviewed preferred teachers to handle SRH education of their wards while they provide supportive role, also tends to support the finding of Ha and Fisher (2011) that parents considered themselves unable to educate their children about SRH issues and expected the schools to be primary educators. This provides possible explanation as to why many female students indicated SRH education in school as additional or complementary and more comfortable means of SRH education. Hence, with SRH education in schools only a recent phenomenon, many parents whose children are now in JHS may not have received SRH lessons while in school. Thus, teaching their children something they did not receive may be quite challenging. This explanation is in sync with finding by Helleve et al. (2009) that those who have received formal training in SRH education tend to show more confidence in the ability to teach SRH issues to students.

4.6.3 Socio-Cultural Factors Influencing Perceptions about Reproductive Health Education

Findings from the study indicate that the desire to preserve or identify with one's culture and religion had a considerable influence on parents' perception about SRH education in schools. The normative beliefs/subjective norms aspect of TRA/TPB is supported by this finding because the cultural principles which the parents looked up to disapproved of the discussion of some aspects of SRH issues with adolescents. Mbonile and Kayombo (2008) found that, parents endorsed SRH education, but their cultural background made them oppose condom use among adolescents. Similarly, parents interviewed in this study showed willingness to allow

their wards to learn about SRH, but they wanted it to be limited to only abstinence in accordance to their culture and religious principles. This is indicative of parents leaning partially towards cultural liberalism by embracing SRH education partially, with the acceptance to discuss some topics while rejecting others. The position of the parents on the topics they did not approve appears to be an entrenched one showing a strong sense of cultural conservatism. This is of great concern considering Rogers and Shoemaker's (1971) view on "compatibility of the reform" attribute of perception. This is not peculiar to Ghana alone as other researchers have identified similar patterns in their studies. For instance Schmidt et al. (2012) found that some parents had reservation about their children being taught SRH, except teachers would teach about only abstinence. Dyson and Smith (2012) also observed that parents were concerned about the content and approach used in imparting SRH knowledge to their children. In addition, the current study found that although the parents wanted to play supportive role in SRH education, particularly the sensitive topics, they were unable to discuss sensitive topics with their children. A possible outcome is that, in the situation where teachers do not teach the sensitive topics, adolescent students would not have all the information they need regarding their SRH.

Unlike parents, responses from teachers show a complete sway towards cultural liberalism, which is as a result of the training they received as teachers. Similar to findings by Helleve et al. (2009), teachers in the study reported no socio-cultural barriers in their teaching of SRH topics. This suggests students would be given the required lessons needed without any restrictions that could have resulted from social or cultural influence. This is particularly important when students in this study showed preference for school-based SRH education, because it is more conducive and relaxing for them. In addition, findings in the study also suggest that the introduction of SRH education in school is likely to shift the conservatism culture of parents towards SRH to a liberal one in the next three decades when current students

become parents. This projection concurs with the constructs of the theory of cultural liberalism, that is, broadmindedness, creativity and autonomy (Jost et al., 2008).

Findings from students interviewed shows that the perceptions of their parents about SRH education had an effect on them as well. This was expected because the first point of socialization of an individual is the family. Therefore, if parents had conservative perception towards complete exposure to SRH education, their children were likely to have same. But with the school as an additional or complementary source of SRH education, students may also be socialised into cultural liberalism. This goes to reinforce the point that in the next three decades parental perceptions towards SRH education will be swayed towards cultural liberalism. Again, indication by students of the obsolescence of the Ghanaian culture towards SRH education, confirms the likely change from conservatism to liberalism as far as parents' perceptions about SRH education in JHS is concerned. According to Nambambi and Mufune, (2011) and Parwej et al. (2005), this could be possibly due to modernisation and exposure to mass media, which are changing social values.

The view of the students that Christian and Islamic principles helped them not to engage in fornication is also an indication that normative beliefs/subjective norms influence intention to perform behaviour. The students' indication that due to the influence of culture at home, they were unable to discuss SRH matters with their parents or guardians supports the normative beliefs/subjective norms aspect of TRA/TPB. This is because the referent individuals, that is, parents, who they look up to at home, tend to label them as bad boys and girls when issues of SRH are raised.

Furthermore, findings from the study endorse the assertion of UNESCO (2010) of a strong linkage between culture and religion. However, unlike culture, religion did not have any effect on student perceptions about SRH education. This shows that, though students may maintain

their religious beliefs when they become parents, it may not affect their shift towards liberal approach to SRH education. This is particularly true in the midst of modernity and globalisation on one hand and a desire of parents to safeguard the sexual and reproductive wellbeing of their children on the other hand.

4.6.4 Challenges Faced in Imparting Sexual and Reproductive Health Knowledge to Students

Responses from parents in the study shows they were not likely to provide comprehensive SRH education to their wards, because they faced cultural and religious challenges. This means that the relevance of SRH education in JHS cannot be overemphasised, because it provides additional or complementary means of comprehensive SRH education to adolescents.

Whereas parents were faced with cultural and religious challenges, the teachers were faced with resource challenges. Similar to findings by Helleve et al. (2009), teachers in this study, just like those in Tanzania and South Africa, were fairly comfortable in teaching HIV/AIDS and sexuality to adolescents. However, they faced resource challenges. Time allotted to SRH lesson was inadequate. This means students may not have all lingering questions answered or lessons may not be detailed or completed as was observed by Ott et al. (2011). This could have serious repercussions on the future of adolescents, because they rely on SRH lesson to address the challenges they face in their sexual development. Furthermore, teachers interviewed also reported absence of teaching aids for SRH lessons. Descriptive lessons of some SRH topics such as proper wearing of condoms may be difficult to comprehend without diagrams or model. Therefore, students may not be able to get a clear picture of what they are being taught and apply them when they are faced with reality. This concurs with participant observations made by the researcher during a sit-in of two SRH lessons. Among the observations made was when, in the absence of a diagram of the female reproductive system, a non-artistic teacher faced a

herculean task drawing a sub-standard representation of the female reproductive system. Thus, the absence of the TLMs may create the possibility of the students not understanding what is being said by the teacher, thereby making SRH education ineffective. This is in agreement with the findings by Bilinga and Mabula (2014) that unavailability of learning facilities hindered effective teaching and learning of SRH to students in Tanzania. It also syncs with that of Kibombo et al. (2008) who found that lack of relevant supplies such as condoms, toy penises and sanitary towels to demonstrate to students how these items look like and how they are used, hindered their ability to deliver effective SRH education to students.

The study also found that students were shy and feared being victimised when discussing SRH topics with parents. These challenges were a result of the cultural orientation of the society they lived. Therefore since students faced no challenges as far as discussions of SRH topics in school was concerned, they were more likely to resolve their sexual development challenges at school than at home.

4.7 Limitations of the Study

The use of convenience sampling limits the study, in that; the number of participants is not a true representation of the study population. Thus, the findings from the sample cannot be generalised to the population under study. In order to reduce the effect of this limitation, the researcher ensured that saturation of data was reached so that references can be made to the entire population under study.

Also, conducting some of the interviews in Twi and Ga had some implication on the data and analysis since the exact meaning of some words could not be found in the English language. However, in the process of translation, the researcher selected appropriate words nearest in meaning to some of the words spoken by the respondents. For some of the words, the researcher verified with the participants if they captured the participants views.



CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter is divided into four sections. The first section deals with the summary of the findings. The second section provides the conclusions drawn from the study. The third section suggests the way forward in addressing the challenges associated with school-based Sexual and Reproductive Health (SRH) education. In the fourth section, the implications of the findings for social work practice are discussed.

5.2 Summary of the Findings

This study sought to explore the cultural influence on SRH education in junior high schools in the Okaikoi North Sub-metro. There are myriad works on SRH in Ghana but none has concentrated on culture. It is therefore important this thesis was written to better the understanding of the intricacies of culture and SRH in the study area in order to aid policy adoption and implementation in Ghana. The following was thus found from the study based on the outlined objectives.

The findings showed the support of all three participant groups (parents, teachers and students) for SRH education in JHS. However, parents' support of SRH was partial as they were not in support of some SRH topics such as condom use among adolescents. Their support for SRH education was based on its perceived usefulness to students by way of providing better understanding of sexual development experiences, discouraging premarital and indiscriminate sex, preventing STIs, teenage pregnancies and abortions.

The students also showed their support for school-based SRH education through their affirmation of its benefit in clearing misconceptions students may have about SRH issues. The

students' support for SRH education was also identified through their declaration of the importance of SRH education in improving healthy relations among students, irrespective of their sex. Additionally, the comments of students on the importance of SRH education in providing additional or complementary means of sex education showed their support for school-based SRH education. The study participants' endorsement of teachers as primary providers of SRH education was also indicative of their approval of SRH education in school.

Drawing from the study, social and cultural factors were found to have an influence on parents' acceptance on school-based SRH in totality and this had an influence on the students' ability to discuss SRH matters with their parents. However, socio-cultural factors had no influence on teachers and students' discussion of the topic in school. Socio-cultural factors were identified as: preservation of or identification with culture which influence parents' emphasis on abstinence from sex and silence on condom use; students being shy or afraid to talk with parents about SRH issues; students fear of being tagged as bad boy or bad girl due to culture; influence of religion on parents' perception about SRH education; adaptation to current global norms as a result of globalisation or modernity; and the obsolescence of Ghanaian culture due to adaptation to global norms.

With regard to the challenges encountered in the impartation and learning of SRH in school, the responses of the study participants showed that they faced some challenges (religious, resource and cultural). Parents in this study experienced some cultural and religious challenges with regard to their acceptance of the entire content of SRH education being given to their wards. Thus, they considered some topics such as sex and condom use and wet dreams too sensitive to be talked about with children, be it in school or at home.

The absence of Teaching and Learning Materials (TLMs) was one of the resource challenges faced by teachers. Time constraints or inadequate time for the impartation of SRH education in school was also another resource challenge teachers faced. Student participants also reported being shy and afraid to discuss SRH issues with parents, because of fear of being labelled as bad boy or bad girl. Thus, for most of the students, comprehensive SRH education ends in the school.

5.3 Conclusion

Sexual and reproductive health education has been noted to be useful in mitigating the challenges adolescents face vis-à-vis their sexual development. This notwithstanding, certain factors have been noted to act as barriers to the acceptance and effective teaching of SRH to in-school adolescents. The following conclusions were drawn from the findings.

Based on the findings of the study, there is tremendous endorsement of SRH education in Junior High School (JHS). This is because all the three groups of participants have a positive outlook of SRH education being provided to adolescents in school. Therefore, the inclusion of SRH education in the JHS syllabus is important for the sexual and reproductive development of adolescents. SRH education can help to empower adolescents to make informed decisions about their reproductive health, thereby reducing cases of teenage pregnancies, abortions and sexually transmitted diseases.

An indication of the findings is that within the study area, cultural conservatism is gradually giving way to cultural liberalism. Culture and religion does not influence parents, teachers and students perception about SRH education being provided to Junior High School students. This is because of their knowledge of the usefulness of SRH education to adolescents and also because of training that teachers have received. This also supports the tenet of the TRA/TPB that people would accept behaviour based on their belief that the behaviour is positive.

However, culture and religion does have an influence on parents' perceptions about the content of SRH education. The reason is that parents tend to perceive that topics such as condom use and methods of contraception in general are too much information for adolescents and as such should not be included in the lessons. This perception affects the ability of parents to play a supportive role in SRH education. Another indication of the findings is that teachers and students tend to be more culturally liberal whereas parents are partly culturally conservative and partly culturally liberal. Furthermore, adaptation to current global norms as a result of globalisation and modernity, acceptance of the need to change status quo and involvement of older generation in SRH education, positively influence participants' perceptions towards SRH education in school.

Based on the findings there are some challenges encountered in impartation and learning of SRH in school. The challenges encountered with the impartation of SRH knowledge in school are identified as cultural and religious challenges as well as resource challenges. The resource challenges which are peculiar to the responses of teachers are time constraints and absence of teaching and learning materials (TLMs). The resource challenges affect the ability of teachers to deliver effective SRH education. Parents tend to have some reservations with regard to the content of SRH education due to their cultural and religious background. Thus, they are handicapped in playing their supportive role in SRH education at home, where they are to touch on sensitive aspects of SRH education as the teachers expected them to. In the case of students, their cultural and religious backgrounds makes them afraid or shy of being labelled as bad boys or girls and affect their ability to discuss with their parents or guardians, SRH matters that they have been taught in school.

5.4 Recommendations

Teachers are doing their best to impart SRH knowledge to in-school adolescents. However, considering the challenges they face in teaching SRH topics, such as absence of teaching and learning materials and inadequate time devoted to the topic, they are unable to fully impart SRH knowledge for the full benefit of the students. Also, the influence of culture and religion on the perceptions that parents have towards some aspects of SRH education has implications for them not being able to play their supportive role to SRH education. Some recommendations are hereby made which will aid in addressing the challenges.

With regard to the absence of teaching and learning materials, it is suggested that government, non-governmental organisations, and individuals supply schools with teaching and learning aids in the form of books, diagrams, educative videos on SRH, toy penises, condoms and sanitary pads which will be used for practical teaching. The availability of these TLMs for illustrations will also enable students get a clear and vivid picture of what they are being taught in school. Also, when pictures and images are formed in their memories, they are more likely to live a healthy sexual and reproductive life, which they can in turn teach to their children.

Concerning inadequate time for SRH education in school, it is recommended that a standalone subject on adolescent SRH education be created to enable teachers have more time to impart SRH knowledge to students. The creation of a standalone SRH subject can be done successfully by policy makers, in collaboration with the Ministry of Education (MOE), the Ghana Education Service (GES), teachers and students.

The inclusion of students will ensure that the development of a new curricular for the standalone SRH education will have contents that address the lingering questions which adolescent students may have with regard to their SRH.

This new standalone adolescent SRH subject may be made examinable but the most important thing is that adolescent students will receive the SRH education they need.

Alternatively, it is recommended that adolescent sexual and reproductive health clubs should be formed in all JHS to promote the health of students. If ASRH clubs are in existence in schools, students can receive extra knowledge. Also, adolescent friendly centres should extend their services to JHS to provide expert knowledge and services to JHS students, so that where they cannot go to health centres for information, it will be brought to their doorsteps. As suggested by some of the students, health professionals, such as doctors and nurses are the appropriate sources of SRH information.

On the issue of culture and religion, an indication from the findings is that because parents did not receive SRH education while growing up, they have some reservations on some aspects of the SRH education, such as condom use for adolescents who cannot abstain, so as to prevent the dangers of teen pregnancies and STIs. Also, findings from the responses of parents in this study indicate strong influence of conservative culture on their perception towards SRH, which they learnt from their parents. This could be different for students in the present generation because they have parents who endorse SRH education and well-trained teachers to deliver SRH to the best of their ability. This can only mean that when they become parents, they will ensure that their children receive comprehensive SRH education both from the home and the school. Based on this projection, it is recommended that, SRH education in schools be intensified so as to completely break the cycle of strong adherence to conservative culture. This intensification of SRH education in schools can be achieved by teachers providing evidence-based SRH education, and devoting time to address the questions that students may need answers to in order to meet their right to information about their SRH.

The role of parents in imparting reproductive health knowledge cannot be emphasised enough, because they are the first agents of socialisation the child encounters. The United Nations (2014), among other organisations and individuals have reiterated this. Parents should therefore make time to talk to their children about SRH matters, especially on sensitive issues. Also, awareness among parents on the relevance of including the sensitive aspects of SRH education in the school curriculum must be intensified so as to help them embrace SRH education in totality. This can be achieved through comprehensive education and sensitisation of parents on SRH education.

5.4 Implications of the Findings for Social Work Practice

The conclusions drawn from the study necessitates some recommendations as far as social work practice is concerned. These recommendations are important in the school, public education and advocacy aspects of the social work practice.

Social workers may be employed in schools to assist teachers with the impartation of SRH knowledge. School social workers may organise workshops to teach SRH to adolescents. Here they can take a topic under SRH and enlighten students on that particular topic. School social workers can invite resource persons such as, doctors and nurses to talk on selected topics. Social workers may also volunteer to impart SRH knowledge to students and also provide professional counselling to ensure that students have a healthy relationship with parents that will enable free discussion of SRH matters with parents. This will enable social workers adhere to the ethical principles of service and importance of human relationships.

Social workers as educators can embark on public education to educate members of the community on the benefit of SRH being imparted to adolescents and also the need to sway from conservative culture that does not embrace SRH education in totality.

They can do this by organising reproductive health programs which target improving awareness of parents and addressing socio-cultural factors surrounding reproductive health issues.

Social workers can also advocate for the supply of relevant teaching and learning materials to schools to facilitate SRH education. This can be done by petitioning appropriate government organisations such as the Ministry of Education and the Ghana Education Service to provide schools with teaching and learning aids that will enable teachers carry out their duties and also enable students to gain adequate knowledge in SRH matters.



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APPENDIX A: INTERVIEW GUIDE FOR TEACHERS

Interview with Junior High School Teachers

1. Date of Interview

2. Time

I am an Mphil student of the Department of Social Work, University of Ghana.

I appreciate that you have taken the time to participate in this research process which I know will greatly help me to understand the perceptions of Ghanaian parents, teachers and students towards school-based sexual and reproductive health education. Whatever we will discuss here will be treated confidential and used for academic purposes. At any time during the interview, if you feel you cannot continue with the exercise feel free to inform me.

Background Information:

i. Sex

ii. Religion

iii. Occupation

iv. Marital status

OBJECTIVE 1: To find out whether parents, teachers and students support sexual and reproductive health education in school.

- a) In what ways do you find SRH education useful in protecting the health of adolescents?
- b) In your opinion whose role should it be to provide SRH information?

Probe for whether it is the role of the school or home to impart sexual and reproductive health education?

OBJECTIVE 2: To identify the socio-cultural bases for attitudes to reproductive health education.

a) Growing up, did you receive some form of SRH education?

Probe on whom or where they received such education from.

b) Would you teach your children about SRH issues? If you won't, why not?

Probe on their views on what ways cultural and personal beliefs influence SRH education?

OBJECTIVE 3: To identify challenges faced by teachers in imparting sexual and reproductive health knowledge in students.

a) How comfortable are you when you have to impart SRH knowledge?

b) What are some of the challenges you encounter as a teacher imparting SRH information to JHS students?

OBJECTIVE 4: To explore how the challenges can be surmounted to make sexual and reproductive health education successful in schools.

a) What ways do you suggest these challenges can be dealt with?



APPENDIX B: INTERVIEW GUIDE FOR PARENTS

Interview with Parents

1. Date of Interview

2. Time

I am an Mphil student of the Department of Social Work, University of Ghana.

I appreciate that you have taken the time to participate in this research process which I know will greatly help me to understand the perceptions of Ghanaian parents, teachers and students towards school-based sexual and reproductive health education. Whatever we will discuss here will be treated confidential and used for academic purposes. At any time during the interview, if you feel you cannot continue with the exercise feel free to inform me.

Background Information:

i. Sex

iii. Religion

iv. Occupation

v. Marital status

OBJECTIVE 1: To find out whether parents, teachers and students support sexual and reproductive health education in school.

- a) Are you aware your child is taught SRH education in school?
- b) If you are, can you please tell me whether you approve of this education
- c) If you do not approve of the SRH education, can you please tell me why?
- d) In what ways do you find SRH education useful in protecting the health of adolescents?
- e) Whose role should it be to provide SRH information to adolescents?

Probe for perceptions about providing sexual health information

If you have a chance, will you tell/teach/give any information about sexual health to adolescents (your children, your students)?

What would you want to tell them?

How do you feel if you have to talk about sex and sexual health topic?

- f) What do you think about sexual and reproductive health education in school?

Probe for attitude towards sexual and reproductive health education in school

OBJECTIVE 2: To identify the socio-cultural bases for attitudes to reproductive health education.

- a) Growing up, did you receive some form of SRH education?

Probe on whom or where they received such education from.

At what age did you receive this information?

If they received it at a later age, what do they think accounted for this?

- b) What is your opinion about SRH education being taught to JHS students?

Probe on whether they approve of the school imparting SRH information to their children?

Whether culture or religion played a role in their attitude.

What is their reason for this position?

OBJECTIVE 3: To identify challenges faced by teachers in imparting sexual and reproductive health knowledge in students.

- a) What can you suggest are some of the challenges teachers will face or are facing in

- b) Teaching a sensitive topic such as SRH?

OBJECTIVE 4: To explore how the challenges can be surmounted to make sexual and reproductive health education successful in schools.

- a) What do you suggest can be done to overcome the challenges to SRH education?

APPENDIX C: FGD GUIDE FOR STUDENTS

Students' Focus Group Discussion Guide

1. Date of Interview

2. Time

I am an Mphil student of the Department of Social Work, University of Ghana.

I appreciate that you have taken the time to participate in this research process which I know will greatly help me to understand the perceptions of Ghanaian parents, teachers and students towards school-based sexual and reproductive health education. Whatever we will discuss here will be treated confidential and used for academic purposes. At any time during the interview, if you feel you cannot continue with the exercise feel free to inform me.

Background Information (To be filled privately by each participant):

i. Sex

ii. Religion

iii. Occupation

iv. Marital status

OBJECTIVE 1: To find out whether parents, teachers and students support sexual and reproductive health education in school.

a) In your opinion whose role should it be to provide SRH information?

Probe for whether it is the role of the school or home to impart sexual and reproductive health education?

b) Have the lessons influenced you to want to engage in any sexual activity?

c) How useful do you find the sexual and reproductive health lessons?

Probe on their knowledge on any SRH topic (condom use, teenage pregnancy, abortion, STI) prior to receiving the lessons.

Lessons learnt (condom use, teenage pregnancy, STI).

How they intend to use the knowledge gained.

OBJECTIVE 2: To identify the socio-cultural bases for attitudes to reproductive health education.

- a) Do you tell your parents about the SRH lessons you receive in school? If not, why? If you do, what are their responses?
- b) How can generational gap affect SRH education?

Probe on whether an older or younger teacher can influence how well or otherwise they receive the SRH lessons

OBJECTIVE 3: To identify challenges faced by teachers in imparting sexual and reproductive health knowledge in students.

- a) What are the approaches (choice of words and content) your teacher(s) use in imparting SRH knowledge in your school?

Probe on whether teachers mention parts of the body or terms relevant to the SRH lessons as they should. If they appear uncomfortable, what do you think is the reason?

Probe on the approaches used by their teachers in imparting SRH education?

Whether they think they are being taught all they need to know considering the challenges/obstacle

- b) Are you able to understand the SRH lesson you receive? If not, why not?

OBJECTIVE 4: To explore how the challenges can be surmounted to make sexual and reproductive health education successful in schools.

- a) What do you suggest you can do or what can be done to help your teacher impart the kind of SRH information you need?

APPENDIX D: CONSENT FORM

I am an Mphil student of the Department of Social Work, University of Ghana.

I am conducting a research as part of my Mphil programme on the topic, **Perceptions of Parents, Teachers and Students towards Sexual and Reproductive Health Education in Junior High Schools in the Okaikoi North Sub-metro, Accra, Ghana**

This research will greatly help in the understanding of the attitudes of Ghanaian parents, teachers and students towards school-based sexual and reproductive health education.

Your ward has been selected at random to participate in this research. His/her participation or otherwise will not affect his/her academic records. Whatever will be discussed with your ward will be treated confidential and used for academic purposes.

If you agree that your ward should take part in this study, please write your name and append your signature or thumb print below.

Thank you.

Name:

Signature/ Thumbprint:

