

**NAVIGATING AROUND TEENAGE PREGNANCY:
RESILIENCE OF ADOLESCENT GIRLS IN ACCRA**

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DECLARATION

I hereby declare that, except for references to other people's work which have been acknowledged, this thesis is the result of my own research work carried out in the department of sociology under supervision.

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DEDICATION

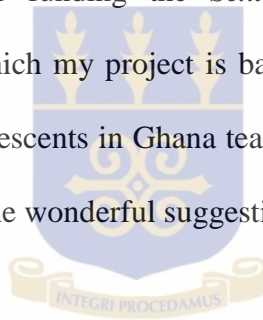
To the author and finisher of my faith



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ABSTRACT

This study examines the resilience strategies of adolescent girls in Nima, a suburb of Accra against teenage pregnancy. Specifically, it sought to find out the resilience pathways of adolescent girls against teenage pregnancy, determine the factors which influenced the resilience decision making process of these adolescent girls, examine the factors which help in building resilience and finally, understand the socio-cultural and economic factors which promote the building of resilience against teenage pregnancy. In the area of resilience studies in Ghana, this work is novel and thus adopted an explorative approach with a total sample of 120 girls. Questionnaires were administered and the data supplemented with five in-depth interviews. Using the EpiInfo software, the questionnaire data was analyzed to generate frequencies and the interviews analyzed based on themes. The results show multiple resilience pathways for adolescent girls in the face of teenage pregnancy but specific preference was placed on abstinence by ‘never been pregnant girls’ whilst for those who have been pregnant before, the preferred pathway was the use of contraceptives. The major factor influencing the resilience decision making of the adolescent girls included education/future aspirations, personal values, family name, poverty and advice/ threats of parents. The study also found the girls to have good knowledge about their reproductive health rights which was explained to be important for dealing with their personal rights including reproductive rights and thereby helps in building their resilience. Although the involvement of parents was found to be very fundamental to the building of resilience, the study found that most of the parents were not communicating with their adolescent girls about issues relating to pregnancy and child birth. While some parents began to do so only with the onset of pregnancy, the help of significant adults not necessarily their biological parents (chemists, teachers, friends and relations) was found to be crucial for the resilience building. With regards to the socio-cultural and economic contexts that flourish resilience,

most of the respondents identified parental/guardian advice as one of the measures to protect themselves from pregnancy. None of the respondents underwent any puberty rites but all they knew in relation to their menarche was thought at home. Based on the findings, two recommendations are being made for adolescent sexual and reproductive health policy making in Ghana, namely the need for a community based approach to educating and assisting adolescents to deal with pregnancy and pregnancy related issues, and further research in the area of adolescent sexual and reproductive health for a more comprehensive approach to be adapted in dealing with matters of adolescent sexuality and the reproductive intricacies that come with it.

TABLE OF CONTENT

Declaration	i
Dedication	ii
Acknowledgement	iii
Abstract	v
Table of Content	vii
List of Tables and Figures	xi

CHAPTER ONE: SETTING THE RESEARCH CONTEXT

1.1 Background to the study	1
1.2 Statement of Research Problem	6
1.3 Aim and Objectives	7
1.4 Relevance of the Study	8
1.5 Definition of Terms	9
1.6 Organization of the thesis	9

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction	11
2.2 Studies in Resilience	11
2.3 Circumstances Surrounding Teenage Pregnancy	15
2.4 Teenage pregnancy - Health and Social Implications	16
2.5 Adolescent period as a Rite of Passage	17
2.6 Sexual and Reproductive Health Experiences/Challenges of the Ghanaian Adolescent	19

<i>2.6.1 Age at First Sex</i>	19
<i>2.6.2 Number of Sexual Partners</i>	21
<i>2.6.3 Sexual Partnerships</i>	22
<i>2.6.4 Sexual Coercion</i>	23
<i>2.6.5 Adolescent Childbearing</i>	24
<i>2.6.6 Abortion</i>	26
<i>2.6.7 Contraceptive Use</i>	27
<i>2.6.8 Knowledge of HIV/AIDS and Experiences with Other STIs</i>	28
2.7 Conceptual Framework of the study	30
<i>2.7.1 Individual Resources</i>	31
<i>2.7.2 Socio-cultural Resources</i>	33
<i>2.7.3 Educational Resources</i>	33
CHAPTER THREE: PROFILE OF NIMA - THE STUDY AREA	
3.1 Introduction	35
3.2 Geographical Location of Nima	35
3.3 History of Nima	36
3.4 Political System	38
3.5 Religious Organisation	39
3.6 Economic System	40
3.7 Infrastructure	42
CHAPTER FOUR: METHODS OF RESEARCH	
4.1 Introduction	44
4.2 The Study Population	44
4.3 The Sample Size and Sampling Procedure	44

4.4 Reconnaissance visit to Nima	46
4.5 Data Sources	46
4.6 Data Collection Methods and Instruments	47
4.7 Data Analysis	49

CHAPTER FIVE: SOCIO-DEMOGRAPHIC CONTEXTS OF ADOLESCENT RESILIENCE AGAINST TEENAGE PREGNANCY IN NIMA

5.1 Introduction	50
5.2 Demographic characteristics of respondents	50
5.2.1 <i>Age Distribution of Respondents</i>	51
5.2.2 <i>Educational profile of respondents</i>	52
5.2.3 <i>Religious profile of respondents</i>	53
5.2.4 <i>Ethnic background</i>	53
5.2.5 <i>Source of livelihood</i>	54
5.2.6 <i>Marital Status of respondents</i>	56
5.2.7 <i>Family background</i>	56
5.2.8 <i>Access to television and radio at home</i>	58
5.3 Socio-cultural and economic contexts for adolescent resilience	59
5.3.1 <i>The economic context</i>	59
5.3.2 <i>Socio-Cultural Resources</i>	61

CHAPTER SIX: RESILIENCE OF FEMALE ADOLESCENTS AGAINST TEENAGE PREGNANCY IN NIMA

6.1 Introduction	63
6.2 Resilience pathways of female adolescents	63
6.2.1 <i>Resilience pathways after a previous pregnancy</i>	64
6.2.2 <i>Knowledge and use of contraception</i>	66

<i>6.2.3 Some other considerations for resilience pathways</i>	70
6.3 Factors influencing resilience decision making of female adolescents	73
6.4 Factors affecting resilience building process of female adolescents	77
6.5 Socio-cultural and economic contexts for adolescents resilience	82
CHAPTER SEVEN: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	
7.1 Introduction	83
7.2 Summary	84
7.3 Conclusion	87
7.4 Recommendation	88
REFERENCES	89
APPENDIX I: QUESTIONNAIRE	96
APPENDIX II: INTERVIEW GUIDE	104

LIST OF TABLES AND FIGURES

Table 3.1: Ethnic Composition of Nima, 2000	38
Table 3.2: Religious Affiliations of Nima Population, 2000	40
Table 5.1: Age distribution of respondents	51
Table 5.2: Educational profile of respondents	52
Table 5.3: Religion of respondents	53
Table: 5.4: Ethnic origins of respondents	54
Table 5.5: Sources of livelihood	55
Table 5.6: Access to TV and radio	58
Table 5.7: Characteristics of in-depth interviewees	59
Table 5.8: Sources of Economic Resources	60
Table 6.1: Outcome of pregnancies	64
Table 6.2: Modes of contraception	66
Table 6.3: Source of Information about Contraceptives	68
Table 6.4: Contraceptives Familiar to Respondents	69
Table 6.5: Source of Advice Relating to Pregnancy Prevention	72
Table 6.6: Factors Influencing Resilience Decision Making Process	74
Figure 1: Conceptual framework for the study	31

CHAPTER ONE

THE RESEARCH CONTEXT

1.1 Background to the study

Globally, individuals, families and communities are more and more being placed at risk including HIV plague food and water shortages, terrorism, and acts of violence (Theron and Theron, 2010). Women and children, especially the youth (adolescents) are susceptible to these risks because of their peculiar circumstances. In the particular case of adolescents, estimated to be 1.2 billion around the globe, the risks include those relating to sex, education, employment, acceptance among one's peers, among others. For this reason, International bodies like the United Nations, World Health Organisation have had to put in place interventions believed to better the lives of people. Some of the interventions include the United Nations Millennium Development Goals (MDGs), the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of all forms of Discrimination against Women (CEDAW).

The conventions on the rights of the child and the one on the elimination of all forms of discrimination were agreed upon by various governments around the world promising to treat all women and children in their countries fairly by ensuring the elimination of both direct and indirect discrimination. Like the CEDAW, some MDGs were put in place specifically to improve upon the lives of adolescents (youth) and these were done in the areas of maternal mortality, education, gender disparity and women empowerment, employment, and infant mortality. The MDGs serve (d) as ideal point of reference towards which countries and heads of state confronted these global challenges. Directly related to adolescents, the MDGs sought to halve the number of underweight children under age five, by the year 2015, and also ensure that boys and girls complete their primary education at least and increase the literacy level of

the youth especially those aged between 15-24 years. Additionally, the MDGs sought to eliminate gender disparity amongst the youth in primary and secondary schools by the year 2005 and at every level of education by 2015. In the area of infant mortality, the proportion of children below age one who have been immunised against measles were to be greater than before. Also there was to be a reduction in the rate of under-five mortality. For a reduction in maternal and infant death, the countries that ratified the MDGs were to increase the proportion of births supervised by qualified health personnel. In the area of combating HIV/AIDS, the prevalence of the disease among pregnant women aged 15-24 and by so doing the spread of the disease from mother to child may be curtailed.

In the area of youth unemployment too, the United Nations have not sat down unconcerned. Recognizing the soaring rates of youth unemployment, the UN in year 2001, launched the Youth Employment Network (YEN) as a collaborative programme with the International Labour Organisation and the World Bank to help governments, especially those in the developing world to provide their youths with productive employment opportunities. One such country which worked closely with the YEN order to present the youth with improved employment opportunities was Uganda. Based on recommendations by the YEN, Uganda's Ministry of Education and Sports and the City Council in Kampala and the German International Technical Agency, the GTZ widened the scope of the educational curriculum to include teaching children about their rights and then giving them skills to enhance their employment opportunities (CSD, ISSER, KIPPRA, New ERA, & Universidad de los Andes, 2012).

In Kenya, the government developed the National Youth Policy in a bid to augment the involvement of the youth in national development. Following the National Youth Policy of Kenya, the Youth Enterprise Development Fund was created in 2006 to give the youth

economic freedom through easy access to capital to fund their businesses. The fund also aided the youth in starting their business ideas, created markets both locally and internationally for their products (YDF, 2009 in CSD, ISSER, KIPPRA, New ERA, & Universidad de los Andes, 2012). For a young entrepreneur to become eligible for a loan, he or she must be able to bring forward 20% of the total cost of the project. This prerequisite may promote in the youth the habit of saving. Other measures put in place to improve the lot of the youth in Kenya include giving an estimated 8000 youth skills in entrepreneurship, some 16000 of them were also trained to take industrial jobs. Also, the Trees for Jobs Programme was developed which employed some 24000 youth.

In the case of Ghana, the National Youth Employment Programme (NYEP) was developed in 2006 where youths who were unemployed were put into groups and trained to teach, while other received training in health assistantship and motor traffic control. The NYEP has now been renamed the Ghana Youth Employment and Entrepreneurship Development Authority (GYEEDA). This authority has now introduced new modules under the youth programme including the road maintenance module, waste and sanitation module, the Alive Health Check module, the ICT module, the Trades and Vocations module and the youth in driving module. A complementary initiative put in place by the ministry of local government and rural development in 2011 is the Local Enterprises and Skills Development Program (LESDEP), which had a vision of training 20,000 youth by 2012. The various fields of the LESDEP programme include, Laptop and mobile phone assembly/repair, catering, fashion, photography, intra-city goods transport services, constructional services, aquaculture, honey production, beads making, goods distribution vans, mobile car washing services among others. In the area of education, the move to the JSS from the middle school system included in the system the vocational and technical courses like sewing, catering, bead-making, and pre-technical skills.

In protecting the rights of children in Ghana, the Domestic Violence and Victim Support Unit (DOVSVU) formerly known as the Women and Juvenile Unit (WAJU) has been set up. Though this unit of the Police Service is doing tremendous work it has no presence in many rural areas thereby making many rural youth unable to access its services.

In spite of all that both the governmental and non-governmental organizations have done for the youth, the fact that the period of adolescence is a turbulent one is never in disrepute (see Kwankye, 2007; Cameron, 2003; Berer, 2001). This view is not only universal but has also been held for a long time. It was for instance one of the reasons for Margaret Mead's seminal work on the Samoa (Mead, 1928).

In Ghana, a number of studies have explored the conditions of adolescents, including the challenges they face. Concentrating on female adolescents, Kwankye (2005) mentioned that rapid urbanisation has resulted in migration of adolescents to towns. This situation breaks down the steady parental and other social controls, which existed prior to migration. He also noted that girls are at times tempted to take on commercial sex work as a means of survival. Meanwhile, other challenges that girls are faced with include early exposure to sexual activities and low or no contraceptive use. In effect, they come face to face with teenage pregnancy. In a similar vein, Henry and Fayorsey (2002) conducted a study in Ga Mashie, Accra in which they found that some of the major obstacles for young girls are financial limitations, teenage pregnancy and illicit abortions.

Teenage/adolescent pregnancy has been identified as one of the challenges many adolescents are confronted with globally (WHO, 2009). Reports indicate that in South Africa 22% of the girls between the ages of 15-19 have ever been pregnant (Manzini, 2001). According to

Manzini (ibid), most of these pregnancies often end up in risky abortions and heightens the negative effects on the adolescent mother and child.

Reports from Cameroon show that for every three women aged 15-19, almost one of them gets pregnant (Cameroon Demographic and Health Survey, 1998 in Elhag, 2003). In a study in Cameroon, Elhag (2003) found that early exposure to sex (that is before age 15), early marital age (before 17) and being a Muslim increases the risk of teenage pregnancy. Here the reasons which make Muslims more susceptible to teenage pregnancy are not mentioned.

In Ghana, this has been identified as a key setback facing young girls (Hutchinson, Magnani, Macintyre, Mehyrar, and Brown(2005). Awusabo-Asare, Kumi-Kyereme, and Biddlecom, (2007) in a study among Ghanaian adolescents in both rural and urban settings, identified the likely costs of teenage pregnancy as problems relating to health, dropping out of school, risky abortions, premature parenthood, withdrawal of social support and the like.

Mortality is twice as high amongst 15 to 19 year olds as amongst 20 to 24 year olds (UNFPA, 2007). Stillbirths and death in the first week of life are 50% higher amongst babies born to mothers younger than 20 years than amongst babies born to mothers 20–29 years old (WHO, 2009). The rates of premature birth and low birth weight are higher amongst children of adolescents swelling the likelihood of fatality and potential health problems for the baby (Nyinaku, 2010).

The teen mothers themselves are at risk of premature labour, high blood pressure and anemia (Graham, 1991). Socio-economic wise, they are more likely to terminate their training, leave home, start marital life, childbearing and adult work (Bledsoe and Cohen, 1993). These situations could pose a threat to their social and economic well being and those of their children.

1.2 Statement of Research Problem

One area of chief concern during the period of adolescence is sexual and reproductive health (WHO, 2006) as adolescents face a lot of problems regarding their sexuality and reproductive lives. These problems include teenage pregnancy, inaccessibility of contraceptives, early initiation in to sexual escapades and also the fact that in the Ghanaian society, adults are not willing to discuss openly issues concerning sexuality and reproductive health with adolescents. Health workers are often unfriendly towards adolescents and express diverse unwilling behaviours when it comes to providing family planning services like pills, intra-uterine device and injectables to unmarried adolescents (GSS, 1994; Henry and Fayorsey, 2002; Awusabo-Asare et al, 2007; Kwankye, 2007).

Most of these researches dwell on the fact that adolescents are a high risk group (Dent and Cameron, 2003; Berer, 2001) and they constantly view them as a horde of risk factors (Kwankye, 2007). For instance, Todis, Bullis, Waintrup, Schultz, and D'Ambrosio, (2001) have listed a whole range of labels used to refer to these adolescents which include “at risk, behaviourally disordered, emotionally handicapped, emotionally and behaviourally disordered, socially maladjusted, emotionally disturbed, out of control, antisocial”, among others.

Despite the risks they face, some adolescents are able to brace themselves and pass through the risks successfully (Werner and Smith, 1977). Those individuals who are able to successfully pass through these are often thought to possess the quality of resilience. The point of departure of this study in relation to other studies of similar orientation is that instead of dwelling on the deficits of adolescents, this study gives prominence to the strengths and positive qualities such as confidence, among others that enable some adolescents to resist,

adapt and bounce back after falling prey to teenage pregnancy. To this end, I posed the following questions:

1. What techniques/strategies do adolescents use to demonstrate their resilience against teenage pregnancy?
2. Which factors (protective) aid them to develop the trait of resilience towards teenage pregnancy
3. Which factors influence adolescents to become resilient; and
4. In which context does resilience flourish?

1.3 Aim and Objectives

The aim of this study is to understand the resilient behaviour of older female adolescents (aged 15-19 years) in Nima, a suburb of Accra. The specific objectives of the study are as follows:

1. To determine the resilience pathways used by older female adolescents in the face of their exposure to teenage pregnancy.
2. To examine the factors affecting the resilience building process among female adolescents.
3. To determine the factors influencing resilience decision-making process.
4. To understand the socio-cultural and economic contexts within which older female adolescents become resilient.

1.4 Relevance of the Study

A number of studies have dealt with the process of resilience in relation to children and adolescents in the developed world. Luther et al. (2000) studied how some children appear to have successful outcomes in spite of accidents, changes in the structure of the family and

other experiences which pose challenge to their lives including experiences with depression, behavioural problems and adjustment problems. Jackson and Martin (1998) also studied the extent to which individual and environmental factors in the lives of individuals tend to balance the risk factors which come up when children are faced with very risky situations. Other studies by researchers like Smith and Carlson (1997), Minnard (2001), and Blum et al (2002) have tried to understand what makes it possible for certain children, who despite exposure to adversity, are able to 'bounce back'. One observation about these studies is that most of them were based on western societies. Besides, majority of these studies dealt with illnesses and school situations other than teenage pregnancy.

The important novelty of this research is in its contribution towards the understanding and identification of strategies that contribute to the resilience building of adolescents towards teenage pregnancy. Additionally, the study contributes to the growing body of literature on resilience of adolescents towards teenage pregnancy and provides a non western perspective on the resilience debate with a focus on adolescent girls in the face of teenage pregnancy. On the part of parents, guardians, government and policy makers, the context in which resilience flourishes are explained including factors which aid adolescent girls to develop the trait of resilience towards teenage pregnancy.

1.5 Definition of Terms

Adolescents: The term adolescent is derived from a Latin word 'adolescere', meaning to mature (Geysler, 1997 cited in Steyn, 2006). There are a lot of differences in the way researchers perceive the sequential ages for adolescents (Beeka, 2008). As indicated by Sadock and Sadock (2003), this phase of life spans from age 13 to 21 years. For Nicholson and Ayers (2004), adolescence starts in the region of 10 to 13 years and ends between the ages of 18 and 22. Some writers like Shaffer (1993 cited in Beeka 2008), Craig (1996) and

Salkind (1981) estimate that adolescence begins from 12 to 20 years old. When a review of the age sets within which an adolescent falls is undertaken, it would be noticed that, the earliest age for the commencement of adolescence is eight years old and the closing age for adolescence is 25 years old (Manaster, 1989; Meyer, Moore & Viljoen, 1997; Sadock & Sadock, 2003). This study defines adolescents as individuals aged from 10-19 and it is consistent with that provided by the World Health Organisation.

Resilience: For the purpose of this study, the definition of resilience is adopted from Alvord and Grados (2005) as those skills, attributes, and abilities that enable individuals to adapt to hardships, difficulties, and challenges.

1.6 Organization of the thesis

This work is organised into seven chapters along the following lines: the introductory chapter is followed immediately by the second chapter, which consists of the literature review and the conceptual and theoretical framework. The third chapter presents information about the study area beginning with the geographical area, the social structure of the area, the historical background of the place and the infrastructural development. The fourth chapter deals with the research methodology used in this study whereas the fifth chapter has to do with the socio-demographic contexts of adolescent resilience against teenage pregnancy in Nima. The sixth chapter of this study discusses the resilience pathways of female adolescents, factors influencing resilience decision making process, factors affecting the resilience building process of female adolescents and finally, the socio-cultural and economic contexts that make for the flourishing of resilience. The seventh chapter expounds on the summary of the findings, conclusions of the study and offers some recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews existing literature on resilience behavior of different categories of people. In addition the chapter throws light on the circumstances that surround teenage pregnancy and its causes, the health and social implications of teenage/ adolescent pregnancy. Of great importance is the discussion done on the rites of passage and the sexual and reproductive experiences of Ghanaian adolescent girls. Thus, the chapter provides an interface line for understanding the resilience behaviour of adolescent girls in Ghana in the face of teenage pregnancy.

2.2 Studies in Resilience

In the area of resilience, one of the often cited work is a study often referred to as the Kauai study. This study was a longitudinal one conducted in the Hawaiian Island of Kauai. It spanned from 1954 through to 1986. Werner and her co-investigators kept track of a cohort of 698 children from their birth through to adulthood for approximately around age forty. This study is notable for the multiple data sources and its various stages of data collection and high retention rates of the respondents. It explored the influence of a collection of biological and psychosocial risk factors, stressful life events and protective factors of the subjects (Werner, 2005). It also examined different records of the study population among which were demographic, prenatal, and perinatal data sets. Werner and her colleagues made follow up visits to gain new information about these individuals in the study at the ages 2, 10,18,31,32 and finally 40. They conducted interviews with the subjects, their parents, teachers and other important people in the lives of the subjects. Other methods were employed to gather

information from the observations of public health nurses, court records and mental health system records (ibid).

Thirty percent of all the survivors in the study population lived in poverty-stricken homes have gone through either pre- or perinatal complications, lived in troubled families grappling with persistent disputes, divorce or parental psychopathology. Of these thirty percent, two-thirds of them who had experienced four or more risk factors by the time they were two years old had either developed learning or behavioural problems by age ten. Others also had records of delinquent acts or mental problems by the time they were eighteen or both. The findings of the study further revealed that some of the children who were labeled to be at-risk grew to be capable, caring and confident adults who performed well at school, managed home and their social life quite well. They could set realistic educational and vocational goals for themselves. Later studies on resilience discovered that it was not only the inner qualities of the children that did the trick but also aspects of their families and characteristics of the wider environment also count (Luther et al, 2000; Smokowski et al., 1999; Masten and Coatsworth, 1998; Werner and Smith, 1982).

Studies on resilience have not only centred on individuals but also on different categories of people, communities and businesses. Some studies have dealt with children and adolescents living in poverty (Luthar, 1991), parental substance abuse (Werner, 1993), HIV/AIDS (Beeker, 2008; Kruger, 2006) and violence (Kennedy, 2005). Other studies have considered resilience in people with addictive behaviours (Veselka et al, 2009), resilience in refugee children (McEwen, 2007) and the predictors of resilience after traumatic experiences (Bonanno and Galea, 2007).

Of all the different studies aforementioned, the closest in orientation to this study is the study done by Pike (1999). In this work, the author explored why some adolescents abstained from sexual activities using quantitative techniques. Out of the larger sample of 1112 adolescents, 697 of them were chosen based on the fact that they were abstaining from sex. When asked the reason for abstinence, some of the responses indicated were the fact that they were afraid of contracting the dreaded HIV/AIDS; that they did not want to become pregnant or impregnate someone and also that they feared STIs. Other respondents said that they believed it was wrong to have sex before marriage, wanted to wait until they were married whereas a few of them also indicated that they were embarrassed to use birth control/contraceptives and also that they did not know how to get access to birth control.

Pike (1999) conceptualised the idea of resilience in terms of abstaining one's self from sex. This, in the opinion of this study, was a limitation. A critical look at the resilience literature shows that for someone to be labelled as having the quality of resilience, they should have good outcomes despite high-risk status; continuous proficiency under threat; and recovered from trauma (see Boyden and Cooper, 2009 in Addison, Hulme and Kanbur). The concept of resilience discerned from the work of Pike (1999) encompasses only the first two indicators leaving out those who have actually been traumatised and are recovering.

In a similar vein, McGaha-Garnett (undated) examined how South African adolescent mothers built resilience and student successes in high schools. According to this study, adolescents who decided to go to school struggled to juggle the parenting role with academic work. Adolescent mothers who did not have social support were less likely to triumph over their challenges. The two main social avenues through which the adolescents got help were through parent-adolescent relationships and peer involvement. Those adolescents who did not

get maternal/ parental and peer support usually felt isolated and were bereft of higher educational aspirations.

Contrary to what most studies say, McGaha-Garnett (undated) opined that adolescent mothers were often encouraged to improve their standards of life in terms of school attendance, improved academic records, and improved relationships. The study further suggested that adolescents disconnected either mentally or physically people who they considered repulsive and uncooperative to their newly adjusted routine. For McGaha-Garnett, should counselling interventions be made available to adolescent mothers, its focal point should be the development of a sense of self-worth.

Another point made by McGaha-Garnett was that, young mothers with personal characteristics that are positive are more likely to have higher aspirations in education. He goes on to state that adolescent mothers who had a positive self view are less likely to feel marginalized and alienated from school, peers, family, and within their community.

The school environment, according to McGaha-Garnett, is an additional factor, which is associated with young mothers who are either able or unable to pursue their education. Significant student perceptions of the school atmosphere towards success include teaching quality, school involvement, and school size. Dropout rates are higher in schools reported to have poorer teaching quality, reduced school participation, and increased school size. Student mobility was also associated with dropout. Many individuals who became pregnant were more inclined to attend an alternative school due to pregnancy-related illnesses, desired self-pace in learning, and increased feelings of safety. Despite the reasons associated with mobility, the more schools a student attended the more unlikely of finishing high school (McGaha-Garnett, undated).

Community involvement was another important factor identified to be related to high school dropout. It has been found that, community involvement and after-school activities are essential in promoting academic success (Bickel et al., 1997). Students who are engaged in community involvement and after-school activities are more likely to finish high school and less likely to become pregnant.

Intervention programmes are particularly needed for adolescent mothers, given the fact that pregnancy, a risk factor, has already occurred. Intervention programmes that collaborate with agencies within the community can be a healthy source of support to enhance family unity and social connections, and increased educational aspirations.

2.3 Circumstances Surrounding Teenage Pregnancy

Teenage pregnancy is one challenge that is global in the sense that it occurs everywhere whether in developed or developing countries. The differences are in the rate at which they occur in these countries (WHO, 2009). Pregnancies that happen to unmarried adolescents are very likely to be unplanned and perhaps even lead to induced abortion. In very many countries, girls marry quite early; at times even before they begin menstruating. Child marriage is an uncommon traditional practice in many Ghanaian communities though it is prevalent in a few areas. In places where such a practice is encouraged, adolescent pregnancy becomes the order of the day, giving the impression that, adolescent pregnancy is an acceptable norm. Amongst the various ethnic groups in Ghana, 'adolescence' is the pre-pubertal stage after childhood within which the individual attains physical, sexual and social maturity (Awusabo-Asare et al., 2007). This period is often associated with sexual socialisation and experimentation, and through these, pregnancy may occur. According to UNICEF (2008), the causes of teenage/adolescent pregnancy consists of poverty, sexual

abuse like rape, incorrect/non use of contraception, low self esteem, low educational goals, lack of knowledge about sexual and reproductive health, risky adolescent sexual behaviour, as well as customs and traditions that lead to early marriage of adolescents.

2.4 Teenage pregnancy - Health and Social Implications

Teenagers between the ages of 15-19 are about 15 million globally and they are responsible for more than ten percent of the babies born every year (WHO, 2006). UNICEF (2008) estimates the number of children born to both married and unmarried adolescent girls between the ages 15 to 19 to about 14 million. Though pregnancy and child birth is supposed to be a happy occasion, for most adolescents, due to unplanned pregnancy and lack of support, this whole experience becomes a nightmare. Also adolescent girls are confronted with lots of health threats during pregnancy and childbirth and such girls account for 15% of the Global Burden of Disease for maternal conditions and 13% of all maternal mortality. Adolescents are more likely to die in childbirth than adult mothers (US Census Bureau, 1996; WHO, 2000). What accounts, according to a review by the WHO, for the deaths could not be solely the age of the girls. Other factors responsible for the deaths include the level of education, social status and use of medical facilities (WHO, 2006).

For every young woman who dies in childbirth, 30-50 others are left with an injury, infection or disease. Young mothers are more likely to have less than average weight babies, at risk of malnourishment, poor development or death. Infant and child mortality is highest amongst children of adolescent mothers. Girls who give birth miss schooling and opportunities for employment. There is a risk of the cycle repeating itself (GDHS, 2008; WHO, 2006; HDA, 2003).

Teenage mothers also stand the risk of having negative short, medium and long term mental health outcomes (HDA, 2003). Other health complications that confront these young mothers

include hypertension, anemia, obstructed labour and vesico-vaginal fistulae (VVF). Most of them have housing problems and move houses several times during pregnancy. Teenage girls who are pregnant are less likely to receive antenatal care. In terms of the family structure of such teenage mothers, it has been reported that teenage mothers are more likely to be lone parents, and more likely to find themselves in the middle of family conflict (HDA, 2003).

2.5 Adolescent period as a Rite of Passage

Traditionally, adolescent phase began for females with menarche and ended with marriage or childbearing. For males, the period was marked by initiation or marriage. For example, among the *Krobo* of the *Ga-Adangbe* and the *Akan*, puberty rites were performed for girls with the onset of menarche to signify their maturity. Known as *Dipo* among the *Krobo*, *Otofo* among the *Ga/Adangme* and *Bragro* among the *Akan*, the initiation ceremony was a community affair and was held under the auspices of the queen mother. An adolescent girl who became pregnant before initiation rites committed an offence and was ostracised from the community (Sarpong, 1976). At this stage, young people were responsible for cleaning public places, such as paths to water bodies and farms, and for the security of the community.

In the past, but also much a part of contemporary norms, the process of socialization and preparation for adult life included informal training and apprenticeship. While girls were taught personal hygiene, domestic activities, child care, vocational skills and the art of trading, boys were taught to be farmers, hunters, fishermen and craftsmen. It was quite common for boys to take after the professions of their fathers. These illustrate the different gender roles society tailored for males and females.

Within the traditional system, it was the responsibility of parents and other community members to bring up children. In certain ethnic groups, there was a general belief that a

child's biological parents were not necessarily the best people to bring them up. Children were thus raised by other adults other than their own parents. According to Sarpong (1976), among the Dagombas of northern Ghana, it was usual for a child to be handed over to a foster parent, usually from the paternal side of the family, to be trained.

There were other arrangements such as adoption, which involved the transfer of children to an adopted parent. In most Akan communities, maternal relatives raise the child until marriage or later in life. There were also distinct male and female roles and responsibilities, especially with respect to labour. Females were responsible for household chores while males were responsible for public activities, and some evidence suggests that adolescents today still hold to these traditional gender norms quite strongly (Ampofo, 2001).

In other areas, this differentiation in gender roles extended into living arrangements. For example, amongst the *Ga* and the *Akan*, marriage did not necessarily lead to cohabitation. A married couple may possibly live in separate houses or detached parts of the same compound, and this includes young males and females (Awusabo-Asare, 1990). In the patrilineal *Mole-Dagbani* culture, couples lived together in compounds but with separate areas for males and females. In such settings, young males and females were socialized separately. This continues to exist in some areas and is partly responsible for some of the observed strong male and female differences in ways of life. Within the traditional structure as noted by Jones (1995), there was no distinct transition in residence such as moving away from the childhood home to live on one's own, as observed in other countries. In urbanized areas most adolescents are living on their own away from their traditional homes making them more independent of their parents (Jones, 1995).

Despite cultural norms which disapprove of sexual intercourse before marriage (Gage & Meekers, 1993) there are conflicting observations made by writers like Grindal (1982) who noted that premarital sexual activity apparently was approved of. According to Smock's (1977) analysis of pre-colonial Ghana, the ethnic groups in the North of the country, the *Akan* and the *Ewe*, in the South, did not believe female chastity to be of particular importance. Most crucial was that a girl did not become sexually active and pregnant before the commemoration of puberty rites, which were usually held soon after menarche so as to reduce the possibility of an unsanctioned birth.

2.6 Sexual and Reproductive Health Experiences/Challenges of the Ghanaian Adolescent

Adolescent Sexual and Reproductive Health (ASRH) refers to the physical and emotional well-being of adolescents (defined as people between the ages of 10-19). This includes their ability to be healthy and remain free from early or unwanted pregnancy, unsafe abortion, sexually transmitted diseases including HIV/AIDS and sexual violence or coercion (UNFPA Facts sheet, 2002.)

2.6.1 Age at First Sex

Various studies have revealed that Ghanaian adolescents are highly sexually active and begin sexual activity at an early age. According to the 1998 GDHS, 17% of adolescents between 15 and 19 had their first sexual intercourse at age 15. This figure reduced greatly in the following Demographic and Health Survey. As indicated by Ghana Demographic and Health Survey, (GDHS, 2003), 9.0% of women and 4.0% of men reported having sexual intercourse by age 15. However, by age eighteen, 48.0% of women and 25.0% of men have had sexual intercourse. These figures imply that some proportion of first sexual experience occurs in premarital relationships. The GDH Survey, 2003, again indicated that at national level, some 14.0% of 15-19 years old adolescents are pregnant or are already mothers. This figure

decreased as the GDH Survey, 2008 reported that 9.9% of 15-19 years old adolescents had at least one child. A staggering 69.0% of all births to 15-19 year olds were either unwanted or mistimed.

Moreover, subnational studies have shown different median ages of sexual initiation. For example, a study conducted by Sallar (2001) among 1,415 males and females aged 10–19 showed a median age of 16. Earlier Nabila and Fayorsey (1996) found that among adolescents aged 12–20 studied in Kumasi and Accra, the median age at first sexual experience was 16 for both boys and girls. In a study of 1,782 unmarried young people aged 15–19 in the Greater Accra and Eastern Regions, Agyei, Biritwum, Ashitey, and Hill, (2000) found that 67% of males and 78% of females had ever had sex, and the mean age at sexual debut among those who had ever had sexual intercourse was 15.5 for males and 16.2 for females. Similar studies carried out in 2000 in Accra, Kumasi and Agomanya by family Health International (2000) have reported median ages of 18, 17 and 16 among single female youth and 17 among males in Accra and Kumasi. In a survey of 1,038 students (471 females and 567 males) aged 13–18 in nine senior secondary schools, 50% of the adolescents considered chastity as an ideal to attain and thought that it was realistically attainable (Adomako 1991). Yet 42% of the male students and 15% of the female students surveyed had had sexual intercourse. The average age at first sexual experience was 15 (the youngest was 8, a case of defilement; the oldest was 23). Half of the sexually experienced students had their first sexual experience between ages 14 and 17, and 25% had their first sexual experience at age 13 or younger.

2.6.2 Number of Sexual Partners

According to 2008 GDHS data, 19.4% of sexually experienced 15–19-year-old adolescents had had two or more partners in the 12 months prior to the survey. Also the 1998 GDHS data, 17% of sexually experienced 15–19-year-old males had had two or more partners in the 12

months prior to the survey. In another 1998 national study, Tweedie and Witte (2000) reported that 79% of females and 68% of males aged 12–24 in the 1998 Ghana Youth Reproductive Health Survey (GYRHS) had one current sexual partner while 3% of females and 10% of males reported having had two or more sexual partners within the three months prior to the survey. Among those who had ever experienced sex, 60% of females and 39% of males reported one lifetime sexual partner, 38% of females and 53% of males had two to three lifetime partners, and 1% of females and 5% of males reported four or more lifetime sexual partners (Tweedie and Witte, 2000).

Earlier studies had reported a high number of partners among adolescents. In a 1999 study by Sallar (2001) of three local areas in Ghana, revealed that among adolescents aged 10–19 with previous sexual experience, 77% reported one sexual partner, and 15% reported 2–4 partners and the rest had five or more partners within the 12 months preceding the survey. Although the time periods and samples for the two studies are different, the results point to a fairly high level of multiple partnerships among young men in Ghana.

2.6.3 Sexual Partnerships

The 1998 Ghana Youth Reproductive Health Study (GYRHS) showed that some young people engaged in same-sex as well as heterosexual sexual relationships: About 1% of males and females aged 12–24 report that they had ever had sex with a same sex partner (Tweedie and Witte, 2000). From the same data, the average age of the respondents' first sexual partner was 16.5 for adolescent males and 20.7 for adolescent females. Sallar (2001) also observed that among those who ever had sex, 67% of males and 55% of females aged 14–19 had their first sexual experience with someone their own age. In the 1998 GYRHS, most first sex partners were boyfriends or girlfriends of the young people. About four out of every five adolescents who had ever had sex reported that they had first sexual intercourse with a

boyfriend or girlfriend. Less than 1% said that their first sex partner was a “sugar mommy” or “sugar daddy” (i.e., an older adult who gives the young person gifts, money or other items in exchange for sex); however, 12% of young females and 5% of young males said they had ever been paid for sex (Tweedie and Witte, 2000). Based on 29 case studies in Accra of 13– 19-year-old females who had experienced at least one unintended pregnancy, Henry and Fayorsey (2002) found that obtaining financial support and affection were the main reasons for starting a relationship. Awusabo-Asare, Abane, Kumi-Kyereme, (2004) also noted that the financial support from boyfriends was an integral part of a relationship and was used for daily needs, including food, medical expenses, school fees and clothing.

Adolescents’ reasons for having sexual intercourse range from pleasure through peer pressure to financial reasons. In a study of three districts in Ghana, Sallar (2001) reported that 38% of adolescents had sex for the first time for pleasure while 23% of males and 24% of females had sex because of peer pressure. In the 1998 GYRHS, 62% of males and 38% of females reported that they had sex because they wanted to do so; the first sexual experience “just happened” for another 34% of males and 47% of females (Tweedie and Witte, 2000). This is an indication that some of the first sexual experiences occurred under circumstances that adolescents, especially females, had not prepared for; therefore, they may not have been able to protect themselves against infection or pregnancy.

2.6.4 Sexual Coercion

According to the 1998 GYRHS, 2% of males and 12% of females were forced into their first sexual experience, with 0.5% of males and 0.6% of females reporting that their first sexual intercourse was with a family member (Tweedie and Witte, 2000). An earlier study by Nabila, Fayorsey and Pappoe (1997) among adolescent traders in Accra revealed that 2% of males and 12% of females reported that the first time they had sex they were forced;

moreover, 8% of males and 25% of females who had ever had sex reported having been coerced to have sex at some point in time. Awusabo-Asare, Abane, Delali and Anarfi (1999) in a study among young people aged 12–24 in junior secondary, senior secondary and university in the Central Region, observed that among 415 adolescents who had had sex with their boyfriend or girlfriend, 19% reported that they were forced; of the 211 who had had sex with schoolmates, 13% reported being forced; of the 234 who had had sex with neighbours, 13% said they were forced; and of the 101 who had had sex with teachers, 6% reported that they were forced. A qualitative study in urban Accra based on 29 case studies of girls aged 13–19 found that about one-third of the girls described their first sexual experiences as involving force, deception or rape (Henry and Fayorsey 2002). They further observed that many of the girls who were forced at their first sexual intercourse were “still with the same boys and even had children with them.

Another dimension of sexual coercion is the perception among males, and even many females, that women do not mean what they say when they say “no” to sex. Approximately two-thirds of both males and females aged 12–24 in the 1998 GYRHS who had ever had sex stated that most girls did not really mean “no” when they said “no” to sex. Such attitudes can translate into an acceptance of sexual violence, because a substantial proportion of adolescent males do not appear to believe that girls really mean what they say and therefore with a little “pressure” a girl could be made to change her mind (Awusabo-Asare, Abane, Kumi-Kyereme, 2004). Tweedie and Witte (2000) reported that 13% of males and 14% of females who had ever had sex indicated that it is acceptable for a boyfriend to beat his girlfriend when she does not provide sex.

2.6.5 Adolescent Childbearing

According to Ghana Statistical Service, (1999) the age-specific fertility rate among 15–19-year-olds has declined from 124 births per 1,000 women in 1988 to 90 births per 1,000 women in 1998. This decline was part of a general fertility decline in Ghana, and teenage fertility still accounted for about 10% of total fertility in 1998, as was the case in 1988. The 1998 GDHS shows that 14% of 15–19-year old females were pregnant or ever had a child. According to Tweedie and Witte (2000) results from the 1998 GYRHS show that 22% of females aged 12–24 who had ever had sex had experienced at least one pregnancy, and 40% of males who ever had sex said they had made someone pregnant. According to Nabila and Fayorsey (1996) study of 1,571 young people aged 12–20 in Accra and Kumasi, by age 17, 60% of those who had ever had sex had become pregnant or made someone pregnant.

In one study, teenage pregnancy was observed to be high among adolescents in the Eastern and Greater Accra Regions (Agyei et al., 2000). They found in a sample of 829 unmarried females in these two regions that more than one out of every three adolescents who had ever had sex had become pregnant at least once, and the incidence of pregnancy was higher in urban than in rural areas.

A survey by the University of Ghana Medical School (1990) in the Ablekuma sub-district of Accra of 1,307 adolescent females and males aged 13–19 showed that 120 of the women were pregnant at the time of the survey. The study further observed that among the pregnant teenagers, 27% had complications such as general weakness, bleeding and anemia. In a quasi-experimental study of problems associated with adolescent pregnancy in Ghana, Adjei and Ampofo (1996) studied 198 cases of females who were pregnant before age 20 and the same number of respondents who became pregnant after age 20 as a control group. Both groups were pregnant women seeking antenatal care at Korle-Bu Teaching Hospital. They observed

that among the main study group, 60% did not want their pregnancy, compared to 38% of those in the control group. Half of the partners of those in the main study group but only 31% of the partners of those in the control group did not want the pregnancy. However, 41% of those who were pregnant before age 20 had ever had an abortion, compared to 57% of those in the control group.

In general, childbearing varies by demographic characteristics such as age, residence and education. In the 1998 GDHS, 15% of females aged 15–19 in rural areas had ever given birth compared to only 7% of females the same age in urban areas. Higher education is also associated with delayed childbearing. In 1998, 16% of 15–19-year-old females who had less than seven years of education had ever given birth compared to 9% of those with seven or more years of education (Awusabo-Asare, Abane, Kumi-Kyereme, 2004).

2.6.6 Abortion

Data from a national survey (GYRHS, 1998) show that 11% of males and 16% of females aged 12–24 who ever had sex reported ever being involved in terminating a pregnancy (Tweedie and Witte, 2000). Of those who had been involved in terminating a pregnancy, 77% of females and 72% of males aborted just one pregnancy, and the majority of these respondents were not married (67% and 86%, respectively). There was a general perception that the level of abortion was high: 58% of females who had had sex considered abortion to be common among teenage girls who get pregnant and 31% knew of at least one unmarried teenage female friend who had had an abortion (Tweedie and Witte, 2000).

A large-scale 1997–1998 study of women in southern Ghana who experienced a recent pregnancy showed an abortion ratio of 19 abortions per 100 pregnancies for all women; 60% of women who had had an abortion were younger than 30 (Ahiadeke, 2001). A study in one section of Accra found that 20% of the 120 respondents who were pregnant at the time of the

survey had visited a health institution to terminate their pregnancy (University of Ghana medical School, 1990) Agyei et al. (2000) observed that 47% of young unmarried women in the Greater Accra and Eastern Regions of Ghana who had ever been pregnant had terminated a pregnancy.

According to Tweedie and Witte, (2000) data from the 1998 GYRHS show that more than half of adolescents who reported ever being involved in an abortion said that the last abortion was at a hospital or clinic (64% of females and 58% of males) and about one-third said that the last abortion was at home (30% of females and 39% of males). In addition, the study raised the question as to when in the abortion process youth go to a hospital or clinic, because the relatively high percentage of respondents who reported going to a hospital or clinic for the last abortion may have included those who were seeking treatment for complications of abortions performed in other contexts. In the 1997–1998 study in southern Ghana, 38% had relied on help from a pharmacist and 11% had self-medicated, while only 12% had obtained an abortion from a physician (Ahiadeke, 2001). Afenyadu and Goparaju (2003) have also reported that young females use harmful but inexpensive methods to terminate pregnancies.

In contrast, a recent qualitative study by (Henry and Fayorsey, 2002) of 13–19-yearold females in Ga Mashi District, Accra, who had experienced at least one unintended pregnancy found that most girls used clinics and hospitals for their abortions (23 of the terminated pregnancies were clinic abortions and five were herbal). In the same study, all the respondents said that their first pregnancy and most of the subsequent ones were not planned; 23 out of 49 pregnancies reported by respondents were aborted in order to delay childbearing and to space children; and the main reasons given for opting for abortion were to improve sources of financial support and the respondent's employment. Reasons for obtaining an abortion given by young women included the wish to continue education, lack of financial means to support a child and a man's denial of paternity. Some studies have also observed the fear of

community sanctions and the shame associated with pre-marital childbearing (Adomako, 1991; Bleek, 1976; and Nabila, Fayorsey and Pappoe, 1997).

2.6.7 Contraceptive Use

Various studies conducted in Ghana show that the awareness of young people about contraceptives and where to obtain them is high. Results from the 1998 GYRHS indicate that 76% of females aged 15–19 and 88% of males that age were aware of at least one modern family planning method (Tweedie and Witte, 2000). Among 12–14- year-olds, 33% of females and 6% of males knew of at least one modern family planning method. The condom was the most reported method known (77% of males and 66% of females knew the method). In the 2008 GDHS, the proportion of both males and females aged 15–19 who knew at least one modern method was over 80%. However, adolescents' knowledge of some specific methods is superficial. For example, data from the 1998 GYRHS show that while 49% of females aged 12–24 and 25% of males that age know of the pill, 21% of females and 46% of males who know the method do not know that it has to be taken daily for it to be effective (Tweedie and Witte, 2000).

In spite of the general recognition of the importance of meeting the reproductive health needs of young people and the high level of awareness among adolescents of modern methods of contraception, contraceptive use among them is generally low. Thirteen percent of all 15–19-year-old females and 35% of married females had ever used a modern family planning method in 1998 (Ghana Statistical Service, 1999) Effective contraceptive use even among those at risk of pregnancy is relatively low. In 1998, only 20% and 37%, sexually active females and males were using some form of modern contraceptives respectively. Tweedie and Witte (2000) observed in the 1998 GYRHS that 77% of female and 85% of male sexually experienced adolescents had ever used any contraceptive method, and 64% of the females and

74% of the males had ever used a modern contraceptive method. The male condom was the most popular contraceptive ever used (58% of female and 71% of male respondents) while the least ever used contraceptive methods were the IUD and diaphragm among females (about 1% for each method). In another study by Agyei et al., (2000), 96% of unmarried females and 98% of unmarried males aged 15–19 were aware of at least one contraceptive method.

2.6.8 Knowledge of HIV/AIDS and Experiences with Other STIs

According to the 2008 GDHS 97.6% of adolescents aged between 15 and 19 years have knowledge of HIV/AIDS. Also the 2004 national survey, 95% of adolescents heard about HIV/AIDS, however one in five reported misconceptions on HIV/AIDS transmission. Results from the 2002 report on STI attendees at clinics estimated the prevalence of syphilis to be 0.6% among 15–24-year-olds (Ghana Health Service, 2003) The problems in obtaining accurate information about STIs are numerous. People are afraid to report STI symptoms for fear of being labeled promiscuous (Anarfi and Antwi, 1995; Nabila, Fayorsey and Pappoe, 1997). STIs are also likely to be underreported because such infections are not considered to be major problems. Misconceptions about STIs also exist: For example, 51% of males and 37% of females interviewed on the streets of Accra stated that one could get an STI through witchcraft (Anarfi and Antwi, 1995) through juju (voodoo) as punishment for adultery, or, for females, as a result of “eating lots of sweets (Sallar, 2001). As an indirect way to determine the prevalence rate of STIs among young people, one study asked adolescent respondents to mention the number of people they knew who currently or previously had an STI: Twenty-seven percent of males and 22% of females reported that they knew one or more people who ever had an STI (Tweedie and Witte, 2000).

After HIV/AIDS, the most commonly known STI among adolescents is gonorrhoea, of which 41% of 15–19-year-old females and 46% of males are aware, followed by syphilis, of which

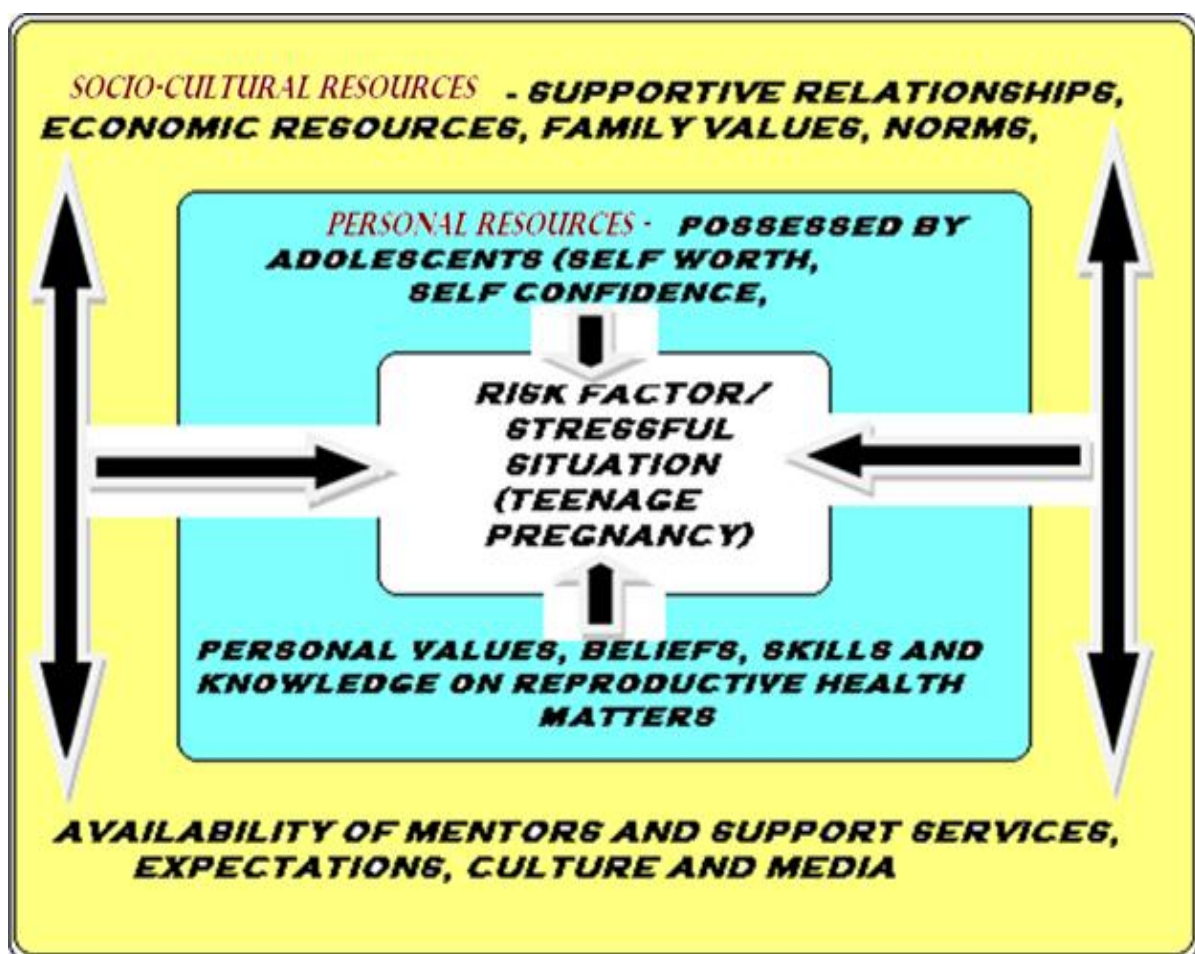
about one in 10 adolescents are aware of it (GSS, 1999). Sallar (2001) has also reported that 74% of adolescents had heard of gonorrhoea and 51% had heard of syphilis. A similar study by Awusabo-Asare and Anarfi (1995) also reported that in 1993 97% of males and 94% of females aged 15–24 had heard of an STI. Of that number, 29% of the males and 5% of the females reported ever contracting STI. In another study among street youth aged 8–19, 59% Anarfi (1997) reported that they could not mention any other STI besides AIDS. Results from another study of street youth showed that 98% had heard of a least one STI (Anarfi and Antwi, 1995).

Other available data suggest that although young people are aware of formal medical services for STI diagnosis and treatment, when they are confronted with an STI, the vast majority do not actually utilize formal medical services. In the 1998 GYRHS, Tweedie and Witte, (2000) observed that 94% of both males and females reported a hospital or clinic as the place one can go for STI treatment, followed by drugstore (27% of males and 19% of females). In the same study, Tweedie and Witte, (2000) observed that of those who ever had sex and ever had an STI, 75% of males and 57% of females sought treatment; the most common sources for treatment were drugstores (41% of males and 16% of females), hospitals/clinics/health posts (39% of males and 49% of females) and pharmacies (19% of males and 21% of females). The authors found that the major reasons for not seeking professional medical treatment for an STI were that the infection was not serious and that the infection “just went”. Anarfi’s (1997) study of 1,147 street youth in Accra showed that, of those who ever contracted an STI (58 males and 27 females), 43% of the males and 15% of the females self-medicated, 35% of the males and 22% of the females sought treatment from a druggist and only 18% went to a hospital or health centre. A young person reporting infection is likely to face hostility at government hospitals. He further observed that some of them do not seem to appreciate the gravity of STIs and therefore treat the infection with any antibiotic and in some cases use

alcohol (palm wine and locally manufactured rum/akpeteshie) as a medium for the drug. The knowledge-practice gap on STI treatment is similar to that observed with family planning in Ghana: Awareness of effective sources of care does not necessarily translate into actual use.

2.7 Conceptual Framework of the study

In this study, teenage pregnancy is conceptualized as a risk or stressful situation for adolescents. When it occurs, or for it not to occur, adolescents need both **individual** or **personal** and **socio-cultural** resources in order to adapt successfully, overcome its damaging effects and also lead healthy, successful lives. These individual and socio-cultural resources are explained below (see also, Box 1)



SOURCE: PERSONAL CONSTRUCT

2.7.1 Individual Resources

These are the factors which are personal to an individual that can reduce the effect of a perceived risk. These factors includes a person's confidence, self-worth, values, knowledge on reproductive health issues such as having knowledge on contraceptives and their usage, knowledge on reproductive health rights could prove to be helpful to adolescent girls. To this end the girls should know a number of contraceptives and also how they are used. They were asked to identify some contraceptives during the study and respondents were also tested on issues relating to their reproductive health rights. Opportunely, mass media, especially radio contributed immensely to spreading facts on reproductive health especially on contraceptives to the adolescents.

Different studies conducted in Ghana confirm the awareness of young people about contraceptives. Results from the 1998 GYRHS indicate that 76% of females aged 15–19 and 88% of males the same age were aware of at least one contraception type. The Alan Guttmacher Institute in a study also found that among 12–14- year-olds, 33% of females and 6% of males knew of at least one modern family planning method. Studies on sources of information on sexual and reproductive health for young people show that many sources are utilized, with one form or the other dominating, depending upon location. According to results from the 1998 GDHS, 26% of 15–19-year-olds had heard of family planning from both radio and television, 16% from radio only and another 5% from television only. The need for adolescent-friendly health services (AFHS) is needed as a result of increased understanding and better definition of the life stages of adolescents. To that end efforts to meet their age-specific needs have emerged, including meeting their sexual and reproductive health needs.

Such services were meant for older married women, but currently demand has shifted to young people needing reproductive health care more than ever with emphasis on preventive

methods. Studies have also indicated that adolescents are more concerned about provider characteristics than specific site or service characteristics for “friendly” services. The provider characteristics mentioned include respect for adolescents, experience and confidentiality (WHO, 1998, Mirembe 1999). Based on this, during the study respondents were asked if they had ever made use of the health posts.

The desire to achieve educational and vocational aspirations can go a long way in helping a girl to postpone pregnancy. Omrod (2006) and McGaha-Garnett (undated) opines that students with higher esteem have a greater likelihood of identifying and fulfilling academic completion. Additionally, an adolescent’s capacity to approach and communicate to significant others particularly a knowledgeable adult who is not necessarily their biological parents on matters that relate to pregnancy prevention is a stepping stone to becoming resilient. In the light of these, the study is interested in knowing if adolescents are able to communicate on personal matters in relation to reproductive health with their teachers, peers, family, health workers and religious leaders.

2.7.2 Socio-cultural Resources

Socio-cultural resources are those like the economic resources, supportive relationships from within and out of the family, availability of mentors, among other things which together constitute the stock of capital/resources with which adolescents deal with teenage pregnancy or the threat of it.

Families have substantial impact on sexual pathways of adolescents. This relates to how families socialize their younger ones. Research has revealed that parenting techniques that exercises firm, non forceful authority builds social competence for adolescents (Buehler and Gerard, 2002). This, Longmore et al.(2001) reasons, has indications on adolescents’ sexual debut and emphasizes emotional support. When parents are strict but do not impose things on

their adolescent children, the children tend to build social confidence (Buehler and Gerard, 2002). This way, the adolescents would receive constant emotional support from their parents. Effective parenting and using the appropriate techniques had the potential of affecting the sexual behaviors of adolescents (Dittus and Jaccard, 2000). A mother, who had felt the effects of adolescent motherhood, would be a good source of protection for her adolescent child. Living with both biological parents may help adolescents not to be interested in romantic relationships as they looked up to their parents who were in a harmonious monogamous relationship (Paikoff et al., 1997). All things being equal, resilience will occur with the presence of personal and socio-cultural resources than when they are absent.

2.7.3 Educational Resource

One way of reducing the negative effects of pregnancy is allowing the pregnant adolescents to pursue education according to Howard (1999). Schools could help reduce stigmatization by providing education for them. This way, they contribute to helping the disoriented adolescents meet their aspirations and help avoid repeat pregnancies. When teachers are caring, they provide a source of protection for the teenagers (Resnick et al., 1997). Dubois et al. (1994) also believed that such support from the school would particularly help young people in serious problems and those with low self-esteem. Zama (1999) also found out that educated parents gave their wards the second opportunity to pursue education after child birth. On the other hand, parents with less education would insist that children remain at home or resort to petty trading after child birth. Dallirnore (2002) discovered that adolescents with no educational goals are more susceptible to sex at an early age. Hanson, Myers and Ginsburg (1987) found that female adolescents, who had high educational expectations and parents with high educational expectations for their daughters, were less likely to experience adolescent childbirth. Higher educational expectations delay the likelihood of premarital pregnancy (Plotnick, 1992). Closely related to educational expectations are the future opportunities

education affords. Perceived life options may also play a role in sexual decision making. Living in an urban area and having a higher level of education is therefore expected to be associated with low prevalence of adolescent pregnancy. This is because there is an increased need to educate girls to attain at least secondary education to improve their employment opportunities (Singh, 1998).

With an increase in education, the traditional authority structures governing marriage and sexual behaviour have been broken down. The family and community support networks that eased young people's transition to adulthood have been erased (Barker and Rich 1992). Women's age at marriage is on the rise in much of the region, a development attributed generally to the years girls spent schooling (Gage and Bledsoe 1994; Bledsoe and Pison 1994).

CHAPTER THREE

PROFILE OF NIMA - THE STUDY AREA

3.1 Introduction

To understand a people, one must take a look at the world view of the people in terms of their life as well as the constitution of the social structure that shape the way they think and do things. Some of these include the religious system, their political life, their infrastructure, and their economic system, among others. This part of the study therefore focuses on the social structure of the study area. It gives details on the geographical location, history of its development, religious background, economic and political systems of the Nima community. In this profile of Nima, the study area, we resort to the 2000 census and housing statistics because, even though the 2010 population and housing census results are out, place specific details such as those pertaining to Nima are yet to be made available.

3.2 Geographical Location of Nima

Nima, described as ‘a postwar slum community’ (Brand, 1972:3-4) lies in the north of central Accra, approximately five miles from the Accra city centre. It is bordered by the Kanda Estates in the east, Accra New Town in the west, Maamobi in the north and the Kokomlele/Ring Road in the south. Nima as a word has an Arabic origin which means the resting place for “strangers”. It was first applied to the area when migrants led by Alhaji Amadu Futa from northern Ghana settled there. Thus, in a study in 2009, Sowah (2009) observed that, Nima was one of the oldest migrant communities in the city of Accra and Ghana for that matter. The appearance of the area is very likely to surprise any first time visitor to Accra. The area is congested and given the way the iron roofing sheets are rusted gives the place instantaneous label of “a distressed community trying to survive” (Owusu et al., 2008).

3.3 History of Nima

According to Awumbila and Agyei-Mensah(2009), the Nima community was started in 1931 as home for Fulani nomads. Owusu, Agyei-Mensah, and Lund, (2008) have also observed that, the Futa family of the Fulani tribe made Nima the pasturing and resting grounds for their cattle before they started making sales in the Accra market.

According to historical records reviewed by Freduah (undated), the site of Nima was a cattle grazing grounds for Alhaji Futa. Earlier, he built few mud huts for his Hausa/Fulani cattle herd and formally obtained permission from the traditional Ga family, the Odukpong family at Osu and Gbese people at Accra (the customary owners of the land) for settlement and for cattle grazing. Thus, the community of Nima grew out of Alhaji Futa's compound (ibid).

As a prominent cattle dealer and Muslim teacher, Alhaji Futa made his house a resting place for strangers. This gave him a lot of respect within the predominantly Muslim community. As observed by Freduah, Muslim norms of hospitality required that, people of social significance received strangers and give them the necessary assistance in overcoming their immediate problems. As Accra expanded in the course of the 1940s, the Fulanis had to give away part of their land to other migrants who were not necessarily of Futa or Muslim origin for residence. What led to the growth in the influx of other groups of people to the area was the setting up of the United States Military Base during the Second World War. The people who flocked to the military base which was in the north-eastern part of Nima went there in search of job offers in the base as cooks, labourers and stewards. The influx of people reached its peak with the return of service men from Asia.

On their return, majority of them settled in Nima because rent was low and there was land available for building (Yankson, 2000; Essuman and Tonah, 2004). Nima as a community is dominated by people from the three northern regions along with other migrants from the West

African sub-region especially the Wangaras, Fulanis, Zambrama, Hausas among other migrants (Awumbila and Agyei-Mensah, 2009).

Citing a series of Gold Coast Survey maps of Accra, Harvey and Brand (1974) observe that, Nima was depicted as only a name on a virtually uninhabited sub-urban area in 1949. Eight years later in 1957, the area was packed with an unordered mass of irregularly shaped buildings with no access roads or signs of urban infrastructure. In 1958, Nima was officially designated as a slum in urgent need of remedial treatment (see also MHTCPD, 1958).

By the middle of the 1960s, Nima had become a popular destination for all manner of people from the northern part of Ghana and indeed other West African migrants resident in Ghana (Yankson, 2000). Thus, in-migration of people from the north of Ghana and other countries of West Africa has turned out to be a permanent feature of the Nima community. To add to this, recently there has been a further influx of other ethnic groups in Ghana other than those of the three northern regions. This situation has given Nima a mix of ethnic profile. In the 2000 Population and Housing Census of Ghana for example, Nima recorded more than eight ethnicities, with majority of them being northern in origin. Akan was the largest ethnic group followed by Ewe and the indigenous Ga (Table 1).

Table 1: Ethnic Composition of Nima, 2000

Ethnicity	Nima (in %)
Akan	24.6
Ewe	16.3
Mole-Dagbani	16.1
Ga Dangbe	11.8
Guan	6.9
Gurma	6.8
Grusi	5.6
Mande	4.5
All other Tribes	7.5
Total	100.0

Source: 2000 Ghana Population and Housing Census: Ghana Statistical Service

By year 2000, the population of Nima was close to 70,000 with density of 437 people per a hectare of landmass. Compared to the 1960 population of 29,797 and density of 188.59 (Owusu, Agyei-Mensah, and Lund, 2008), one can argue that, Nima has come a long way.

On the other hand, within the enclave of Nima one key language for conversation is Hausa. However, the findings of the GSS on the ethnic composition of Nima provide no idea of people with Hausa ethnic group origin.

3.4 Political System

Nima forms part of Ayawaso East sub metropolitan area of the Accra region and it is segmented into two administrative zones: East and West. Nima, according to Sowah (2009), has a two pronged political system; the local traditional authority which is based on ethnic lines and the local government authority based on hierarchy. Traditionally, there are chiefs for most of the ethnic groups present in the community. There are chiefs for the Ga, Ewe, Fulani, Mossi, Chamba and many other ethnic groups who are usually seen representing their people at durbar grounds in full regalia during festive periods. In spite of this they cohabit peacefully.

At the local government level, the Ayawaso sub-metro sees to all developmental and governmental issues in the area. The assembly members are next in line with the unit committee members closely in row. It is the assembly members who administer the electoral areas - Nima East and Nima West. Other duties of the local government leaders include planning developmental projects for the community and revenue collection.

There is a proliferation of political parties and clubs in Nima which indicates their belief in participatory democracy. Examples of these clubs include Mothers Club. These political associations have offices which are painted with their party colours and symbol and individuals here are staunch supporters. Nima also boasts of a police station/post for the maintenance of law and order in the community.

3.5 Religious Organisation

Religion, in the perspective of Nukunya 1992 is a set of beliefs and practice associated with the supernatural. In terms of religion, Nima can be described as a breeding ground for all the three major religions in Ghana. Historically, Nima has been known to be a place with a lot of people of Islamic persuasion when issues of religion come up. Since its establishment, Nima has been dominated by people of the Islamic faith. This is understandable given the history that, the place was established by Alhaji Futih, a Muslim. It is no wonder that on a typical Friday in Nima lots of people are seen overflowing from the numerous mosques unto the streets. According to the 2000 Population and Housing Census of Ghana, people of the Islamic faith constituted 54.3 percent and were followed by Christians with 42.7 percent. The Christian population was dominated by Pentecostals/Charismatics, Protestants and Catholics (Table 2).

Table 2: Religious Affiliations of Nima Population, 2000

Religious Affiliation	Percentage (%)
Islam	54.3
Pentecostal/Charismatic	16.7
Protestant	11.3
Catholic	10.5
Other Christians	4.2
Traditional	0.5
Other Religions	0.4
No Religion	1.9

Source: 2000 Ghana Population and Housing Census: Ghana Statistical Service

In 2009, Sowah (2009) cited the Community Business Development Plan for the Ayawaso Sub-Metro of the Accra Metropolitan Assembly and observed that, the number of Christians in Nima has ascended to 69.15%. The breakdown of the statistics indicates that the Pentecostal and Charismatic churches outnumbered the Catholics and Protestants. In spite of the fact that Christianity is on the ascendancy, Islamic religion still has an overwhelming number of men to women. In most cases the Akans, Ewes, and Gas form the greater part of

the Christian population (Freduah, undated). The current situation could be similar given the dominance of people of other ethnic groups other than those from northern Ghana infiltrating Nima. Another explanation for the ascendancy of Christianity in Nima could be explicated by the new evangelical waves which have hit the place and the rest of Accra and Ghana. A lot of new churches are springing up at a very fast pace; most of them being Apostolic, Pentecostal and Charismatic.

3.6 Economic System

Most of the people resident in Nima work in the private or informal sector Sowah (2009). Trading is a popular economic activity in the community for both men and women. However, women dominate in the trading sector. This trading activity involves food stuff, household items and provisions. Some of the traders ply their trade only within the Nima community while others transcend to adjoining communities such as Mamobi and Accra New town. Besides the main Nima market, there are several small scale shops dotted in front of residential houses. There are other traders who only display their wares on tables in front of their houses. In Nima market, Wednesday is considered the main market day. On this day, many traders from different places in Accra and elsewhere in other parts of the country enter Nima to trade and also do other business activities. On a typical market day in Nima, the market comes alive and one can find people selling all kinds of fish from 'koobi' to 'Amani', the famous 'Akrantie' and various vegetables for all kinds of local Ghanaian soups and stews.

There are butchers in one corner selling their meat with flies gallivanting all over the exposed meat. As one walks through the market one sound that cannot escape the ears is the bleating and mooing of goats, cattle and all manner of livestock all over the places mixed with the voices of traders calling the attention of passersby to patronise their ways. One interesting incident I observed was a man selling shoes at the market and while he tries effortlessly to get

people to buy his wares, one look at his feet would send one wondering. This is because the man himself was wearing a worn out ‘Charlie wote’. How ironic that he was selling all manner of footwear. At another section of this market, a very voluminous woman can be seen standing beside a large heap of hibiscus and calling out to prospective customers to patronise. Also, a prominent part of the economic discourse in the market is the sale of Islamic religious items ranging from clothing, caps, prayer beads and others.

While majority of adult men work as, “watchmen” (security men) and labourers, younger men make their living by carrying loads for both sellers and buyers in the Nima market, what is often referred to as *kayaye*. The transport sector has been improved due to the large number of people who constantly move in and out of the area every other day. As such some of the residents in the community are provided with employment in the transport sector. Income levels in Nima are generally low as majority of the residents have low formal educational backgrounds (Fredua, undated).

Almost 54% of the people in Nima are employed in the private sector compared with less than 30% of them in public sector work. There are still others who do their own business and have employed other people. There are some residents who are apprentices and domestic helps but lumped together could be less than 15% of the population.

3.7 Infrastructure

The slum situation in Nima has been documented by scholars who take the Nima community as their study area. Though the community is often described as poor, there are several houses with conditioners fixed. There is high level of irregularity in the infrastructure system of the community. For instance, most of the roads are tarred but gutters left uncovered, just like

many gutters in Accra and Ghana as whole. These gutters are often choked and filled with filth and a common sight in the gutters is the presence of livestock playing all over.

Homes/houses in Nima are generally made of mud and sometimes concretes. These houses are very congested (Yankson, 2000) and often without in-house toilet facilities. For instance, Agyei-Mensah and Owusu (2010) have observed that, almost 90% of residents of Nima access toilet from public places of convenience or to a limited extent using toilet facilities in houses close by. For recreation, the Nima community makes use of a fenced football field at the Kaokudi junction in the area. There are four basic schools in the Nima community and a number of private/preparatory schools owned by either individuals or religious bodies. The community also owns a library - the Gale library, which it shares with Maamobi. The community has one government hospital, the Nima Government Hospital and a private one, the Iran Clinic which serves all the people of Nima. Sowah (2009) explains that due to this, some of the residents of Nima rather patronise the Mamobi poly clinic to seek medical care. In Nima, like many unplanned residential areas in Ghana particularly peri-urban and sub-urban areas, one finds high television aerials, illegal power and water connections, open drains, among others.

What informed the choice of Nima as the study area is that though a migrant community, it is mixed bag of all the other ethnic groups. Besides, the area is seen as a hub for all the negatives vices one can think of. So the researcher reasoned that moving from the usual negative limelight in which adolescents are usually cast, these resilient adolescents might as well be coming from a slum.

CHAPTER FOUR

METHODS OF RESEARCH

4.1 Introduction

This section of the study deals with matters relating to the methods of research employed in the study. It describes issues pertaining to the study area, the target population sampling procedure, data collection methods and the instrument for data collection, research ethic adhered to in this study as well as data analyses techniques.

4.2 The Study Population

The study population for the study consists of female adolescents in the study area who are at risk of being pregnant. The exact population of these adolescents cannot be estimated. However, the community has seen an increase in its population since the 1960s. It grew in population from 29,797 in 1960 to 52,270 in 1970 and reached 69000 in year 2000. In 2008, the population of Nima was estimated to be 82,329 people (CIHSD, 2008; cf. Rachmadyanto, 2010). With a new population and housing census in Ghana in 2010, the population of Nima is expected to rise as is the norm with several other sub-urban areas in Ghana.

4.3 The Sample Size and Sampling Procedure

In the opinion of Alreck and Settle (1985), 10% of the study population is representative enough, but Fraenkel and Wallen (2000) object to it, arguing that, there is no clear-cut answer to the question on sample size selection. They rather suggest that, the answer to the question on sample size selection lies in a sample, as large as the researcher can depend on to obtain the needed data with affordable time and energy. Accordingly, they further suggest that the sample size should not be too small or too large; researchers ought to obtain as large a sample as they reasonably can have. In the midst of answering the question on sample size selection, Lincoln and Guba (1985) have come up with the idea of sampling until saturation is reached.

They argue that, researchers must continue data collection until a time when additional interviews provide no new information regarding the research questions.

In the light of the large array of sample size selection prescriptions, a number of issues seem to serve the interest of this study, that is, the fact that there is no clear-cut answer to the question on sample size selection, that the answer to the question on sample size selection lies in a sample as large as the researcher can depend on to obtain the needed data with affordable time and energy, and the fact that, the sample size should not be too small or too large. Guided by these principles, a total of 120 respondents were selected for this study. Apart from the above mentioned theoretical conditions, this number of respondents is just the right number for the researcher in view of the constraint of time.

In selecting respondents for this study, contacts were first made with a few adolescents I interacted with during the reconnaissance/pilot study. These individuals served as main contacts in the initial stage of the sampling process. They further helped in identifying other respondents with similar characteristic in the community and willing to participate in the study. Thus, the sampling procedure employed in this study can be described as purposive and snowballing. According to Silverman (2005:129), these approaches allow a researcher to choose a case because it offers an explanation to a feature or a process that she or he is interested in.

4.4 Reconnaissance visit to Nima

Earlier in the study, several visits were made to the study area for preliminary understanding of the study area. One of the places I visited was the Mamobi Poly Clinic, one of the nearest government health facility to Nima. I went to the Family Planning unit to learn more about contraceptives, their uses, how they looked like and their advantages and disadvantages. On

my first visit to Nima, I passed the Nima overhead area and walked through the market to the Nima Gutter area. There I met a couple of girls sitting in front of a house chatting as one of them sold provisions. I approached them to buy sachet water from them. I actually sat by them for a while since I was tired. I established rapport with them and told them that I was student researcher. I tried to explain to them in simple terms what the research was about and told them to be honest with me as much as possible because I was not there to judge them.

The first person who answered the draft questionnaire was a seventeen years old adolescent mother of one. Her child was still a baby, about one year old. At the time she was answering the questionnaire, her baby was with her mother and she really was open about what happened for her to get pregnant and what she sees as the way forward. In the course of the data collection, I had to play the role of youth counsellor and nurse. One young woman actually decided she would not speak to me because I was a total stranger. Similar episodes of this nature characterised my interactions subsequently with other adolescents I met at Nima for my reconnaissance/pilot study. Some of the interactions helped me to re-think some of my questions and also re-structures a few of the questions in the questionnaire.

4.5 Data Sources

Both secondary and primary data were used in this study. Secondary Data for the study was derived from journal articles, books and reports on adolescents in Ghana, particularly in the Greater Accra region. Additionally, sub-metro reports were accessed for the purposes of understanding the area. Resilience information was also accessed from the website¹ to complement those I obtained from books, and journal articles. Primary data for the study

¹ See for example www.projectresilience.com and <http://resilnet.uiuc.edu>

consisted of data collected directly by the researcher from respondents in the study, using structured questionnaire and in-depth interview guide.

4.6 Data Collection Methods and Instruments

According to Barbour (2008:151), mixed methods permit the researcher to compensate for the apparent limitations of each individual method. Triangulation is the application and combination of more than one research perspective in the study of the same phenomenon. The study made use of the quantitative method with a trace of qualitative method. A questionnaire was designed with the help of the literature, which helped to expand the range of options. With the help of existing literature, the quantitative questions were followed with answer options. There were also qualitative questions in which respondents were made to speak their minds on the issues of sexual and reproductive resilience in adolescent girls. The questionnaires were administered in a face-to-face manner due to the fact that some of the respondents were illiterates. In all, the questions helped to explore the issues relating to respondents' understanding of sexual and reproductive resilience among female adolescents within the study area. The questionnaire was structured to cover, the following areas:

- The demographic characteristics of respondents,
- The kinds of resilience pathways used by female adolescents.
- The factors affecting resilience building process among female adolescents.
- The factors influencing resilience decision-making process
- The socio-cultural and economic contexts within which older female adolescents become resilient.

In-depth interviews were also conducted to generate detailed personal narratives from selected individuals. Five in-depth interviews of interesting cases were undertaken to generate ‘meaty’ episodes for the study. In-depth interview is used to paint a clear picture of the information on the topic under investigation from the point of view of the respondent. This technique is motivated by the desire to learn everything the respondents would be willing to share with utmost neutrality. This kind of interview is usually done in a face-to-face manner. Here, the respondent is considered the expert (FHI, undated). An in-depth interview allows a researcher to gain access to individual viewpoints. In addition, it is an effective qualitative method for getting people to come out with their feelings, opinions and experiences.

According to McCracken (1990) in Antwi Bosiakoh (2009), in-depth interviews present us with the chance to enter the thoughts of the respondents and experience the world just like they do. It is appropriate for addressing sensitive issues which respondents might be averse to discussing in a group setting. Also the interviewer can observe the physical environs and also use non-verbal cues (Nueman, 1997).

The demerits of this technique include interviewer bias. For instance, the tone of voice or wording of questions can affect the respondent (ibid). In-depth interviews are appropriate for this study because after dealing with views of adolescents as a group, the study finds it proper to isolate various cases which tell the stories of resilient adolescents from the perspective of individual adolescents. The use of this technique will ensure that the views of those respondents are highlighted and that access is gained to certain sensitive but important information which respondents will otherwise not share.

4.7 Data Analysis

Data for this study were handled and analyzed in two ways. The quantitative part of the data was handled and analyzed with the help of Epiinfo. Here, the purpose was to quantify and tabulate the parts of the data which required quantification and tabulation. Frequency tables, cross tabulations, and bar graphs were generated to help organize the data for presentation. Before the analysis was done the data was coded.

The analysis of the qualitative data (in-depth interviews) on the other hand took the form of retelling the story of the respondents with specific emphasis on significant statements that have a bearing on the focus of the study and its objectives. First they were transcribed and organised into themes. Thematic statements were then extracted and treated within the context of the study objectives. They were then used to provide details to data captured quantitatively, or to deal with issues which were not explored quantitatively.

CHAPTER FIVE

SOCIO-DEMOGRAPHIC CONTEXTS OF ADOLESCENT RESILIENCE AGAINST TEENAGE PREGNANCY IN NIMA

5.1 Introduction

In this chapter, the primary data from the field of study is presented and the findings discussed with reference to the relevant literature. Data was collected from a total of 125 respondents from Nima. For 120 of the respondents, the data collection was done using a questionnaire and for the five remaining respondents the data was elicited through the use of an interview guide. The chapter has main as well as subsections in accordance with the research objectives and findings. It is instructive to mention here that the question of whether or not respondents had ever been pregnant divided them into two categories. The sample captured 10 persons who at the time the survey was being conducted were pregnant or indicated that they had been pregnant before. The remaining 110 were those who were not pregnant and said they had never been pregnant before. On the pregnancy status of the five interviewees, it came to light that three had been pregnant before whereas the remaining two had never been pregnant. This chapter highlights the following topics: the socio-demographic profile of the respondents and the socio-cultural and economic contexts that make resilience flourish in Nima.

5.2 Demographic characteristics of respondents

Some key information on the background of respondents is presented in this section. Significant comparative analyses of those who had ever been pregnant and those who had never been pregnant are also presented here. Although adolescents are defined as people between the ages of 10 and 19 years, the target population for the study was adolescent females aged from 15 to 19 years since they are the ones who according to the WHO, (2006) are responsible for more than 10% of babies born each year. According to the report of the

GDHS (1998) about 17% of Ghanaians aged 15 had had their first sexual intercourse and this corresponds with the assertion of the WHO.

5.2.1 Age Distribution of Respondents

Table 3 below shows the age distribution of respondents. It is observed from the table below that 93.5% of the respondents, who were or reported to have ever been pregnant, were mostly 19 years of age. On the other hand for those who had not been pregnant before, the age which recorded the highest frequency was 15 years representing 37.6% of the total population.

Table 3: Age distribution of respondents

Age	Ever been pregnant		Never been pregnant	
	Frequency	Percent	Frequency	Percent
15	1	44.5	31	37.6
16	0	0	19	25.7
17	1	44.5	12	18.3
18	1	44.5	22	28.7
19	7	93.5	26	32.7
Total	10	100	110	100

Source: Fieldwork, 2012

Here, one is tempted to conclude that the younger a person is, the less likely she is to get pregnant as depicted in the table above. It is however obvious from the table that respondents who had not been pregnant before were mostly 15 years (37%), as many as 26 (32.7%) of them were also 19 years. This suggests that, so far as the age of first sex is established the possibility of pregnancy also follows almost automatically.

5.2.2 Educational profile of respondents

The level of educational attainment of respondents was also examined. Data on this variable is presented in table 4 below. For respondents who had ever been pregnant, the highest level of educational attainment recorded was first year in a vocational institute.

Table 4: Educational profile of respondents

Educational level	Ever been pregnant		Never been pregnant	
	Frequency	Percent	Frequency	Percent
Primary 4	-	0	1	0.9
Primary 5	-	0	1	0.9
Primary 6	1	10	7	6.4
JHS 1	2	20	10	9.1
JHS 2	1	10	21	19.1
JHS 3	2	20	23	20.9
SHS 1	-	0	6	5.5
SHS 2	1	10	11	10
SHS 3	2	20	16	14.5
Tertiary	-	0	3	2.7
Vocational (1 st year)	1	10	3	2.7
Vocational (2 nd year)	-	0	1	0.9
Vocational (3 rd year)	-	0	2	1.8
No formal training	-	0	4	3.6
Others	-	0	1	0.9
Total	10	100	110	100

Source: Fieldwork, 2012

Those who had never been pregnant had 2.7% of them getting to the tertiary level which is the highest level of education an individual could get to. It is clear that a general overview of the educational attainment of respondents shows that those who have never been pregnant have attained higher levels of education than those who have been pregnant before. It is common knowledge that one of the implications of teenage pregnancy, at least in the Ghanaian context, is that the affected girl often has her education truncated. The disparity in the levels of education of these two categories of respondents may be reflective of this factor.

5.2.3 Religious profile of respondents

Religion in the Ghanaian society is one of the factors which play a significant role in controlling people's attitudes towards issues concerning sexual relations. In other words religious values amongst other factors are important in determining the level of sexual

permissiveness or otherwise of an individual. Against this background, respondents were asked to indicate their religious background. Amongst the options provided for them were traditional religion and no religion at all.

Table 5: Religion of respondents

Religion	Frequency	Percent
Christianity	51	42.5
Islam	69	57.5
Total	120	100

Source: Fieldwork, 2012

It is however observed from table 5 above that all 120 respondents had a religious inclination. They were either Christians or Muslims with the Muslims being more than the Christians. According to Nukunya, (2003) the Nima community has the largest concentration of Muslims in Accra. This assertion thus offers a possible explanation as to why Muslims outnumbered the Christians in this sample.

5.2.4 Ethnic background

According to the report of the Ghana Population and Housing Census, (2002), there are eight major indigenous ethnic groups in Ghana. There are however migrants from other parts of the world residing in Ghana and Nima has migrants from the sub-region of West Africa notably the Wangaras, Zambramas who are mostly traders, Hausas and Fulanis who are also mostly butchers and herdsmen (Awumbila and Agyei-Mensah, 2009). The sample for this study therefore did not constitute only Ghanaians but also other people from different parts of Africa. Table 6 below shows the details of the ethnic composition of respondents.

Table 6: Ethnic origin of respondents

Ethnic Group	Frequency	Percent
Ewe	20	16.6
Akan	17	14.1
Mande-Busanga	17	14.1
Mole-Dagbani	12	10.0
Ga-Adangme	11	9.16
Gurma	5	4.16
Grusi	4	3.33
Fulani	4	3.33
Hausa	3	2.5
Wangara	2	1.66
Loso	2	1.66
Guan	1	0.83
Kotokoli	1	0.83
Total	119	100.00

Source: Fieldwork, 2012

As can be seen from the table, all eight ethnic groups in Ghana were represented in the sample the highest number being the Ewes and the lowest being the Guans. There were also a total of 12 of the respondents who indicated that their ethnic groups were not any of the native Ghanaian ethnic groups. These were the Fulani, Hausa, Wangara, Kotokoli and Loso. Although these respondents were not Ghanaians, most of them had been born and brought up in Ghana. They had integrated in to the Ghanaian community and some of them even saw themselves as Ghanaians. One respondent however failed to specify the ethnic group she belongs to.

5.2.5 Source of livelihood

One other variable which was looked at was how respondents made a living for this reason respondents were requested to mention their sources of livelihood. It would be expected that when one is a teenager, he/she would most probably be in school, with the parents or guardians being the source of livelihood. This however is not the case with several teenagers especially in urban centers like Nima. As pointed out by Jones, (1995), there are many

adolescents in urban centers who live on their own and as such are not dependent on their parents.

The source of livelihood which also provides some level of insight into the financial standing of respondents was therefore examined. Data on this is shown in table 7 below.

Table 7: Sources of livelihood

Source of Livelihood	Ever been pregnant		Never been pregnant	
	Frequency	Percent	Frequency	Percent
Guardian's care	6	60	54	65.9
Trade/Business	3	30	20	24.4
Boyfriend's care	1	10	6	7.3
Farming	-	0	1	1.2
Fishing	-	0	1	1.2
Total	10	100	82	100.0

Source: Fieldwork, 2012

Most of the respondents (60%) who had ever been pregnant and 65.9% of those who have never been pregnant were being taken care of by their guardians as is expected of teenagers. An interesting observation here however is that in percentage terms there were more of those who had ever been pregnant (30%) in employment avenues than those respondents who had never been pregnant (26.8%) proposing that the former category are more independent than the later. Being independent may also mean reduced parental control a situation which in the long run could increase the chances of teenage pregnancy. Apart from the employment avenues and guardians as sources of livelihood, another source which was indicated was respondents' boyfriends.

Whilst 10% of those who had ever been pregnant were being taken care of by their boyfriends, it was 7.3% for those who had never been pregnant. One would expect that for those who had been pregnant before, they are less likely to be financially dependent on people like their boyfriends. Being in the care of one's boyfriend may also contribute to the incidence

of pregnancy as more often than not the economic dependence on the part of the girl could also mean less control of their own sexuality. What these two categories of respondents have in common however is that though they are teenagers, it is not always the case that they are taken care of by guardians.

5.2.6 Marital Status of respondents

In a society like Ghana where child marriage is not common, teenagers are not expected to be married even though the constitution defines 18 and 19 year olds as adults. All 120 respondents for this study reported that they had never been married including the 10 who at the time of the study were pregnant or had been pregnant before. This evidently supports the argument that, though sex outside marriage and especially amongst teenagers, may be frowned upon by society, the practice still goes on and one of the results is the occurrence of teenage pregnancies.

5.2.7 Family background

Often in the Ghanaian society when girls are sexually permissive and especially when teenage pregnancy occurs, the family background of the individual in question is seen as a contributing factor. Indeed some see teenage pregnancy as being an incident mostly associated with those from broken or unstable homes. HAD, (2003) observes that teenage mothers are more likely to be in the middle of some family crises. It is often thought that when couples live together and jointly bring up their children, the possibility of sexual experimentation and teenage pregnancies reduces. Respondents in light of this were to state whether or not their parents lived together and also to answer to the question of whether their fathers had wives besides their mother.

For the respondents who at the time of the study were or had been pregnant, they were equally divided between their parents living together or not living together. In other words, 50% of them had parents living together whilst for the remaining 5 (50%) their parents lived separately. For those who were not and had never been pregnant, the parents of 32% were not living together with 67.9% stating that they had their parents living together. Comparatively there were more of persons who were or had ever been pregnant having parents living separately than those respondents who were not or had never been pregnant before. If one goes by the assumption that by saying that their parents were not living together, it also meant that they were perhaps divorced, and then credence is given to the argument that an unstable home may be a predisposing factor of teenage pregnancy or weak resilience on the part of adolescent females. It is however to be noted also that as explained by Awusabo-Asare, (1990), the post marital residence patterns of groups like the Gas and Akans permit the married couples to live separately.

On the question of whether the fathers of respondents had wives apart from respondents mothers, the responses given are explained in the subsequent paragraphs. A total of 63 respondents indicated that their mothers were the only wives their fathers had, implying that all other things being equal they were born into monogamous marriages. On the other hand, for 49 of respondents, their fathers had a wife or other wives apart from their mothers. For 7 respondents however, they claimed not to be in the know as to whether or not their mothers were not the only wives their fathers had. One person did not respond to this question at all.

5.2.8 Access to television and radio at home

Electronic media like the television and radio are sources of all forms of information. Undoubtedly, there are programmes on these two forms of media which educate people on family planning. Consequently these programmes could also be ways of providing people

with adequate information on some strategies to navigate around teenage pregnancy. Respondents were therefore required to indicate whether in their homes they had access to television or radio or both. Table 8 below shows the details of the responses.

Table 8: Access to TV and radio

Electronic media	Ever been pregnant		Never been pregnant		Total
	Frequency	Percent	Frequency	Percent	
Television	10	100	96	80	116
Radio	8	80	90	75	98

Source, Fieldwork, 2012

Data as shown in the table above reveals that persons who have ever been pregnant have more access to the television and radio at home than the others who have never been pregnant. This deduction is being made because whereas a 100% and 80% of respondents with an experience of pregnancy had TV sets and radio respectively, access to these two electronic media was 80% and 75% respectively for those who had never been pregnant. In general however, access to TV sets and radios in the respondents' homes is high. This is based on the fact that when one has access to these electronic media they are exposed to several programmes that deal with sexual education as well as sexual scenes from movies that can affect how they form their opinions on issues that are sexually related.

To make up for the possible lapses in the quantitative aspect of the work due to the sensitive nature of some of the questions, in-depth interviews were conducted with five girls. Like the quantitative part, some of the girls had been pregnant before and others had never had any children. All the girls were nineteen years of age with the exception of one of them who was sixteen. Here, three of the girls had been pregnant before with two of them having a four year old child and a three year old respectively. The last ever pregnant girl had a miscarriage. The two remaining girls had never been pregnant before (Table 9).

The educational background of the respondents is diverse even though none of them was at the tertiary level yet at the time of the study. Of the five girls, one of them had attained just primary education. One of them had completed junior high school and was an apprentice seamstress. One other girl who had also completed junior high school was in her second year of vocational training. Two of them were in the senior high school at the time of the study; one of them in form two and the other girl in form four respectively.

Table 9: Characteristics of in-depth interviewees

Name	Age	Marital status	Educational Background	Pregnancy Status	Resilience Pathway
Rebecca	16	Single	Senior High	Never Pregnant	Abstinence
Atwei	19	Single	School dropout	Ever Pregnant	Artificial Contraceptive
Rabiatu	19	Single	Senior High	Never Pregnant	Natural Method of Contraceptive
Enyornam	19	Single	Junior High	Ever Pregnant	Artificial Contraceptive
Ewura	19	Single	Junior High	Ever Pregnant	Abstinence

Source, Fieldwork, 2012

5.3 Socio-cultural and economic contexts for adolescent resilience

5.3.1 *The economic context*

The prevention of pregnancy is not only affected by social and cultural factors. As adolescent females attempt to be resilient and thus prevent pregnancy, it also requires economic resources especially when it comes to the procurement of contraceptives and other materials needed to aid the prevention of pregnancy. These resources may not necessarily come from the adolescents themselves but also from other stakeholders.

When respondents were asked if any economic resources are made available to them to help them in issues relating to pregnancy prevention, 22 of them representing 18.3% said they had

access to such economic resources. The remaining 81.7% pointed out that they do not get these resources. These figures show that, just a small portion of adolescent females are assisted economically to prevent pregnancy. Considering the fact that most of these teenagers were not economically independent, they were more likely to be handicapped when it comes to economic resources especially when the resources were not coming from other stakeholders.

Where respondents indicated access to economic resources for the prevention of pregnancy, they were also required to mention where the resources were coming from. Possible options were given to respondents and Table 10 shows their responses.

Table 10: Sources of Economic Resources

Source	Frequency	Percent
Religious leaders/Teachers	2	1.7
Parents	1	0.8
Myself	1	0.8
Other relatives	2	1.7
Total	6	5

Source: Fieldwork, 2012

The first observation from this table is that though 22 of the respondents had earlier on said they got economic resources to help them in pregnancy prevention, only 6 of them could tell where they were getting those resources from. This raises questions as to whether all 22 respondents had given the right information on the previous question. This fact notwithstanding, it is still important to note that, the percentage of adolescent females who have access to economic resources is small.

Table 10 shows that other relatives of respondents, their religious leaders and teachers were the ones who are economically investing in these adolescent females. As was recorded in

table 5.8 above, the main source of information on pregnancy prevention for respondents was through sex education at school. What is being revealed here that their teachers are also often their source of economic resources goes to suggest that the teachers play quite a significant role in adolescent resilience. It would be observed that parents who are considered as being important in the upbringing of their children did not seem to be economically investing in their children when it comes to issues relating to pregnancy prevention. Rather, other relatives of the adolescent females are seen more to be a source of economic resource.

5.3.2 Socio-Cultural Resources

A key socio-cultural resource is the rites of passage for adolescents, that is, the puberty rites. Puberty rites are those rites performed for children to show that they have reached adulthood. In the case of the girls, the puberty rites performed among the Krobo is called the ‘Dipo.’ Among the Ga, it is known as the ‘Otofo’ and in the case of the Akan its name is the ‘Bragoro.’

For all girls who answered the questionnaire, none of the girls has gone through the puberty rites. Whatever the respondents had learnt about how to take care of themselves when they had their first menarche, was done by their mothers at home. Some did mention that they were warned that they should not have anything to do with men so as not to get pregnant.

CHAPTER SIX

RESILIENCE OF FEMALE ADOLESCENTS AGAINST TEENAGE PREGNANCY IN NIMA

6.1 Introduction

This chapter of the study focuses on matters that border on the resilience pathways of adolescents in Nima, the factors that influence and also affect the whole resilience building process. The discussions are done in ways to bring out key themes that are in line with the objectives of the study.

6.2 Resilience pathways of female adolescents

One of the key aims of this research was to ascertain ways in which female adolescents are able to build up resilience in an attempt to get around the issue of teenage pregnancy. This section focuses attention on the respondents who were pregnant as at the time of the interview or who pointed out that they had been pregnant before as well as the others who had not experienced any pregnancy. Questions directed towards respondents who have ever been pregnant were therefore asked in an attempt to find out the circumstances of their pregnancy and how after their experience, the resilience factor plays out in their lives. This category of respondents is necessary for the analyses of resilience pathways in the sense that as had been explained in previous parts of this work, resilience does not only pertain to those who have not been pregnant as teenagers but also those who have ever been pregnant. This is because, even after a pregnancy, there is the possibility of a bounce back through the prevention of other pregnancies, which requires ways of resilience.

Focus is also placed on respondents who had never been pregnant to find out the ways in which they have been able to avoid getting pregnant at least as at the time of conducting this

research. Some comparative analyses are also done between these two categories of adolescent females.

6.2.1 Resilience pathways after a previous pregnancy

Getting pregnant as a teenager in the Ghanaian society brings with it so many implications especially where the teenager is unmarried which is often the case. These implications range from public scorn to being ostracized (Sarpong, 1976) in places where there are strict social norms which forbid the occurrence. The consequences of teenage pregnancy in turn have effects on the pregnant teenager and this is what may even bring about abortions or abandonment of the baby after its birth. Respondents who had ever been pregnant were thus asked about the outcome of their pregnancies. The varying responses given to this question are represented in table 11 below.

Table 11: Outcome of pregnancies

Outcome of Pregnancy	Frequency
Miscarriage	5
Carried to term	2
Currently Pregnant	2
Abortion	1
Total	10

Source: Fieldwork, 2012

Out of the 10 adolescent females who stated that they had ever been pregnant, only 2 of them had actually gone through the period of pregnancy and given birth. Five of them experienced miscarriages and one admitted to terminating the pregnancy. Probing further to get to know why the majority of them had miscarriages, it was revealed that two of the girls had the miscarriages due to alcohol consumption at parties not knowing of their pregnancy status. This was pointed out by one respondent in an interview as follows: *'I was not aware of the pregnancy so when I attended a friend's party I drank some alcohol'*. Of the two, one of them

has since been protecting herself against any more of such unwanted pregnancies. She has the support of her mother both socially and economically. She receives money from her mother to procure contraceptives.

However, though it was just one respondent who revealed she had committed an abortion, she gives some credence to the argument that teenage pregnancies are often unwanted or unintended (National Population Council, 2000). She further disclosed that she committed the abortion because the man who impregnated her was not in a position to take care of her and her brother was the one taking care of her since their parents died. Two people who were part of this category of respondents were yet to deliver.

Given the fact that teenage pregnancies are often unintended and also that society often disapproves of it, adolescent females who go through it, to a very large extent, may not want to have the experience repeated in their lives. It is in light of this reasoning that modes of protecting themselves from pregnancy may be resorted to. Thus, attempt was made to find out whether after initial pregnancy, the girls had learnt how to prevent other pregnancies and how they ensured that.

In response to the question of whether adolescent females who had ever been pregnant knew how to protect themselves from pregnancy, 7 of them said they did, while 3 admitted they still did not know how to prevent pregnancies. The case of the 30% shows that there is the possibility of the recurrence of a pregnancy if adolescent female were not abstaining altogether. Perhaps it could also be that depending on the outcome of one's pregnancy, one may or may not be concerned about preventing another one. Comparing this to those adolescent females who had not been pregnant before there seemed to be some differences. For those who had never been pregnant, 78% of them stated that they knew how to prevent

pregnancies and 22% said they did not know. It is observed from these statistics that most of the respondents who had never been pregnant were in the capacity to prevent the pregnancies from occurring in the first place. In the same way fewer of them, that is 22% as against 30% of those who had ever been pregnant, reported being ignorant of the ways of preventing pregnancies. The deduction here could be that the knowledge and therefore use of ways of preventing pregnancy influence the possibility of pregnancies.

The first step to navigating around teenage pregnancy undoubtedly is having the knowledge to do so. Having given a general overview of whether or not the respondents knew how to protect themselves from pregnancy, the next section further explores the specifics of the resilience pathways.

6.2.2 Knowledge and use of contraception

The word contraception literally means any means of avoiding conception or pregnancy. There are both natural and devised ways of contraception. Respondents were asked to mention the specific method they resort to in protecting themselves from pregnancy. Table 12 illustrates the results.

Table 12: Modes of contraception

Contraception method	Ever been pregnant		Never been pregnant	
	Frequency	Percent	Frequency	Percent
Contraceptive usage	4	66.7	13	13.8
Abstinence	1	16.7	67	71.3
Safe period	1	16.7	13	13.8
Withdrawal	0	0	1	1.1
Total	6	100	94	100

Source: Fieldwork, 2012

Figures from the table show that for those who had ever been pregnant, the use of contraceptives was the most common way of contraception. None of them, that is, the 6 out of

the 10 who provided an answer to the question, indicated the practice of withdrawal as a contraception method. The withdrawal method also appeared to be unpopular with those who had never been pregnant, recording the lowest percentage of 1.1. Reference to the immediate preceding section of data presented on the knowledge of ways of preventing pregnancy, it was seen that the knowledge level was higher among respondents who had never been pregnant. In this section too it is observed that whilst 6 of those who had ever been pregnant, representing 60% of them, could tell the specific way of preventing pregnancy, 94 (85.6%) of respondents who had never been pregnant could state how they ensured that. For both categories of respondents, some did not respond to this question and it became evident that for those who evaded the question they were having sex alright but without any precaution whether naturally, artificially or abstinence.

The striking difference in the two categories of respondents was with abstinence. Whereas for those who had not been pregnant before abstinence (71.3%) was the key method of contraception, it was just 16.7% of respondents who had ever been pregnant who were abstaining to avoid getting pregnant. There is no doubt that where abstinence is being practised the possibility of pregnancy almost does not exist. In general terms however, one can conclude that **abstinence** is a major resilience pathway of female adolescents especially for those who have not been pregnant before. Where people are not abstaining, it follows almost invariably that the use of contraceptives will be the other way to navigate around pregnancy. This can be deduced from table 9 above where it is observed that the natural ways of contraception apart from abstinence – safe period and withdrawal – were not much used by the female adolescents. Indeed, in the Ghanaian society it seems to be the case that contraceptive use more than abstinence is promoted when it comes to educating people on how to prevent unwanted pregnancies. The point is thus established that second to abstinence as a major way of protecting oneself from pregnancy is the use of **contraceptives**. It should

however be reiterated here that the use of contraceptives is more common among those who have ever been pregnant than those who have not. The bottom line nonetheless is that both categories of respondents know about this and thus use contraceptives though the degrees of usage differ.

How respondents got informed about the types of contraceptives was also of interest to the researcher especially considering the fact that the area of study, Nima, is a slum area. Respondents mentioned the medium through which they had learnt of contraceptives. Data to this effect is shown in table 13 below.

Table 13: Source of Information about Contraceptives

Source of information	Frequency
Television	64
Sex education at school	40
Friends	28
Radio	15
Books	9
Parents	6
NGOs	1

Source: Fieldwork, 2012

The role of the mass media in the dissemination of information about contraceptives cannot be overestimated. The findings in this study confirms that of Awusabo-Asare et.al (2006) in which he found the mass media, that is the electronic media, as a key source of information to the female adolescents aged 15-19. For more than a half of the number of respondents, that is 64, they had learnt about contraceptives on television. This could have been through advertisements or actual programmes on contraceptive use. As recorded earlier on, as many as 116 out of the 120 respondents had indicated that they had access to television set s at home. This finding reveals how influential the electronic media can be in terms of dissemination of

information. In establishing resilience pathways therefore, the role of the media is quite significant.

After television, sex education at school (40) which could be described as quite encouraging was the next in line. Only 1 of the respondents had learnt about contraceptives from a Non Governmental Agency (NGO). This suggests the likelihood that the activities of NGOs who are into family planning are not very pronounce in the Nima community. It is quite interesting that parents of respondents did not appear to be a source of information for their children when it came to education on contraceptives. Though the first point of socialization is thought to be the family, it is also the case that most parents are unable to openly discuss issues concerning sex and for that matter contraception with their children.

To ascertain the knowledge of respondents on contraceptives, they were asked to identify those contraceptives that they are familiar with and table 14 shows the results.

Table 14: Contraceptives Familiar to Respondents

Contraceptive	Frequency
Condoms	114
Injectables	50
Oral pills	35
IUCD	20
Emergency pills	15
Foaming pills	12
Norplant	4

Source: Fieldwork, 2012

It is clear from the table that the type of contraceptive which is most familiar to respondents was condoms as 114 of respondents mentioned they knew about it. Condoms indeed are the cheapest contraceptives on the market and that obviously could have an effect on its popularity. This finding buttresses and confirms the finding by Awusabo-Asare et. al (2004) The Norplant, on the other hand, recorded a frequency of 4, implying that the respondents

were not so familiar with it. It is however worth noting here that there was at least some level of knowledge of the main types of contraceptives available to people. The knowledge about contraception in fact is reflective of the fact that contraceptive use has come out as one of the main ways adopted by female adolescents in protecting themselves from pregnancy.

Having described their level of knowledge about contraceptives, the researcher attempted to find out how confident they were about their own knowledge levels. To do this, respondents were asked whether they thought they had the capacity to help another girl prevent pregnancy. In response to this 75 of respondents comprising of 7 of those who had ever been pregnant and 68 of those who have never been pregnant, said they believed they were in the capacity to do that. These female adolescents can be said to be quite conversant with contraceptive usage. The researcher went further to ask them how they were going to help that colleague prevent pregnancy. Those who had not been pregnant before, it came out were more likely to mention that they would advise their friend to abstain whereas those had ever been pregnant were likely to recommend the use of contraceptives.

6.2.3 Some other considerations for resilience pathways

Aside the specific strategies that these female adolescents identified as constituting their pathways to resilience, there are also other issues which motivate resilience. In instances where teenagers see pregnancy as a possible obstruction to a successful future they are more likely to be more resilient. When respondents were asked if they thought after getting pregnant they could make it in life, 7 of those who had ever been pregnant and 83 of them that had never been pregnant said they believed that getting pregnant does not end one's chances of making it in life. It is in line with this that those respondents who reported having gotten pregnant before were asked if after getting pregnant they had made any attempt to go back to school or learn a trade. In response to this question, 7 of them responded in the affirmative

proving the point that they had some kind of determination to make a future for themselves. Concentrating on one's future could therefore be a reason why an adolescent female may want to be resilient when it comes to pregnancy. The researcher actually visited three out of the seven at their learning centers.

Most respondents pointed out that they had role models they were looking up to. Some of the respondents mentioned people like Jackie Appiah, and their very own mothers. They therefore went ahead and indicated their aspirations for the future. Respondents, irrespective of whether they had been pregnant before or not mentioned that they were aspiring to become doctors, teachers, lawyers, soldiers and actresses amongst many other noble professions. A few of the ever pregnant girls wanted to be caterers and seamstresses.

In order to remain committed to resilience pathways for navigating around teenage pregnancy, teenagers may sometimes require the assistance of other people. In other words, apart from those sources of information on contraceptives which have already been looked at, willingness as well as the ability to contact personnel who could offer expert advice on issues surrounding pregnancy is deemed crucial in establishing resilience pathways. To examine this factor, two questions were asked respondents in that direction. The first was to find out if they could go to health personnel for advice on how to prevent pregnancy. Secondly on whether they felt they had the capacity to begin and sustain a relationship with someone who could give them advice related to pregnancy, delivery and neonatal care.

Table 15: Source of Advice Relating to Pregnancy Prevention

Source of advice	Yes		No	
	Frequency	Percentage	Frequency	Percentage
Health personnel	38	31.7	82	68.3
Any other person	83	69.2	27	22.5

Source: Fieldwork, 2012

Data presented in table 15 above brings to bare some striking disparities as to who adolescent females would be more comfortable going to when it comes to getting advice on issues surrounding pregnancy and childcare. It is obvious from the figures provided that where respondents were to get advice from health personnel, 31.7% of them were in favor of it while 68.3% indicated that they could not go to health personnel for advice on the prevention of pregnancy.

Most of the respondents reported that they would prefer to sustain a relationship with any other person for the purpose of obtaining advice and information on pregnant related issuers. This is seen in the 69.2% who answered ‘Yes’ to that question. Some of the people identified here are the local pharmacists, teachers and relations who were in the medical profession. Such people were able to discuss issues relating to pregnancy prevention. This section has basically focused on the resilience pathways of female adolescents in their bid to navigate around teenage pregnancy. It has come out strongly that abstinence is one of the main ways used by adolescents to prevent pregnancy. The use of contraceptives has also been identified as another pathway. However, contraceptive use is more prevalent among girls who have ever been pregnant than among those who have not. Having role models and aspirations for the future motivate the adolescents to keep their pathways for resilience. When it comes to other people helping adolescents to be resilient they seem to be more comfortable with persons other than health personnel. Based on this, during the study respondents were asked if they had ever made use of the health posts to check their health and that of their children if any.

The possible explanations for their refusal to consult the services of the health personnel could be because the adolescents want more friendly services from health personnel and that the service providers do not have respect for adolescents and confidentiality (WHO, 1998; Miremba, 1999). Some of the people the girls mentioned upon further probing that they were comfortable with are the local chemists/ pharmacists in their community, some relations like grandmothers and aunties. Other people outside the family that some the girls were comfortable with were their teachers and friends.

6.3 Factors influencing resilience decision making of female adolescents

Building resilience is more of a process than an event. This means that a decision first has to be made and then the appropriate measures and strategies must also be followed in order to carry through the agenda of being resilient. This process undoubtedly is affected by a number of factors. To assess the factors which influence their resilience building process, respondents were first asked why they had made the decision to protect themselves against pregnancy. This question applied to both those who had ever been pregnant and those who had not. For respondents who had ever been or were still pregnant the question was asked to understand why after a first experience of teenage pregnancy they want to avoid the occurrence. For those who had never been pregnant, it was to appreciate why they wanted to protect themselves from pregnancy in the first place. The responses to this question are presented in Table 16 below.

Table 16: Factors Influencing Resilience Decision Making Process

Factor	Ever been pregnant		Never been pregnant	
	Frequency	Percent	Frequency	Percent
Education/future aspirations	5	50	76	63.3
Personal values	1	10	16	13.3
Religious values	0	0	12	10
Family name	0	0	7	5.8
Poverty	3	30	6	5
Gossip	0	0	6	5
Mother's advice	0	0	3	2.5

Source: Fieldwork, 2012

Seven factors were found to be influential in the resilience decision-making process of adolescent females and they are listed in table 6.6 above. The factor which came out as the most influential was that of education and other future aspirations. Respondents who made this point were basically of the view that becoming pregnant at their age would interrupt their pursuit of education and other plans they might have for the future as was pointed out by one respondent as follows: *'My dream of becoming a banker would be cut short if I get pregnant'* Rabiatu (Never Pregnant, 19). According to Rebecca (Never Pregnant)

My mother has been going through a lot just to look after my sister and me. I do not want to end up like my mother. She met my father while still in school and she started spending her school fees on him until eventually she became pregnant with my sister. They lived together for a short time until she had me and my father left when I was a few weeks old. So I do not know my father.

However, unlike Rebecca, whose mother's bitter experiences are behind her decision to prevent pregnancy, Awura's growing experiences shape her way of life now because she does not want history to repeat itself.

But for my parents' support, I don't know what would have happened to me. The boy who impregnated me denied responsibility. I would have dropped out of school if they had not helped me take care of the child. I do not want to go through the same situation over again. I would wait till I make something of myself and find a responsible man'. (Awura, EverPregnant, 19).

For Atwei, what keeps her going when it comes to pregnancy prevention is a combination of experiences she does not want to repeat and her trade training aspirations. The fact that she does not want to get pregnant for another man outside the institution of marriage explains part of what keeps her going.

After having the child my boyfriend wanted to marry me but his family insisted that I was not one to be married. I do not want a similar experience to repeat itself.' Additionally, Atwei aspires to get some trade training knowledge 'Besides I want to start learning a trade.'

In the preceding discussions, it came out that most of the respondents had role models and they were looking up to and also had some professions they were hoping to get into in future. For both categories of respondents at least 50% of them indicated that it is because of their education and/or future aspirations that they had decided to protect themselves from getting pregnant. The point comes out here quite strongly that whether or not an adolescent female has been pregnant before, most of the time they do not abandon their plans for life and this factor plays an important role in their resilience decision-making process. Indeed, when respondents were earlier on asked if they thought one could still make it in life after getting pregnant, the majority of them had answered in the affirmative. This supports the claims being made here that education and future aspirations are about the most important factors in the resilience decision-making process of adolescent females. According to Rebecca *'I want to be a doctor so I don't want to destroy this opportunity I have.'* Rebecca (Never Pregnant, 16)

Although all 120 respondents had indicated that they were either Christians or Muslims, it was just 10% of them who said they were protecting themselves from pregnancy because of their religious values. As to why this is the case, an immediate reason cannot be given. However in comparison with some other factors one would not be wrong to say that religious values are not the most influential in resilience decision making.

Advice/threats of mothers was seen to be the least influential factor, though one would have assumed that the family being the first point of socialization, daughters especially would learn such family values from home. This however did not turn out to be the case. The decision to protect oneself from pregnancy seems to be influenced more by factors which were more personal. This argument is being made because both ‘education/future aspirations’ and ‘personal values’ can be said to have the personal element common to them.

There were other girls who talked about fear of their mothers, making comments like “*my mother would sack me from the house*” and others also said “*eii, my mother would kill me*”. Such adolescents were afraid due to the warnings of their parent(s). This goes to contradict the finding by Buehler and Gerard (2002) that when parents do not impose things on their children they develop better social confidence. The explanation for their decision to be resilient against may be the wish/ threats of their parents and not their personal decision.

For respondents who were or had ever been pregnant, poverty was another factor 30% of them indicated. Several studies conducted in Ghana and abroad reiterate the fact that teenage pregnancy, is one of the main challenges troubling adolescents (WHO, 2009; Awusabo-Asare et al.,2007; Hutchinson et al.,2005; Henry and Fayorsey, 2002). For Henry and Fayorsey (2002) another setback may be as poverty/ financial difficulty. In the end however, this negative factor becomes responsible for the decision to protect oneself from pregnancy. The obvious reason is that if the teenager who out of the poverty situation is enticed into having sex in exchange for financial assistance, it only gets her situation worsened with the arrival of another mouth to feed. Those girls who cited poverty as what makes them make the resilience decision certainly are of the view that their situation is already bad and they do not want to worsen it.

6.4 Factors affecting resilience building process of female adolescents

Having examined the factors that go into the decision to protect oneself from pregnancy, this section focuses attention on the dynamics of some other issues which affect the whole process of building resilience. These issues border around the family, the society and also the individual.

The family has been known to be the primary agent of socialization where individuals gain some values and principles in life. Few though they may be, there were some respondents who mentioned their family name and their mothers' advice as reasons why they had decided to protect themselves from pregnancy. For respondents who had been pregnant before, they were asked if their immediate families saw anything wrong with them getting pregnant at their age. Eight of them constituting 80% agreed that that was the case. Interestingly, for 20% of them, the occurrence of their pregnancy was not seen as anything untoward. As to why this was the case, they did not tell. However, it follows that when one's immediate family does not find teenage pregnancy problematic; the possibility of its occurrence also increases.

For the 80% whose families were not happy about their pregnancy, they revealed that their families thought teenage pregnancy was wrong because they had their expectations when it came to getting pregnant and having children just like it was for those who had never been pregnant. The expectations of their families concerning getting pregnant were basically about the fact that these adolescent females were expected to grow up and get married before getting pregnant and having children. Though respondents were aware of these expectations, they still got pregnant for varying reasons just like those who had said their families saw nothing wrong with their getting pregnant as teenagers.

In spite of the fact that respondents who had ever been pregnant appeared to have disappointed their families, they said that they got some kind of help from their family when they got pregnant. The help took the form of financial help and social support.

In the words of Enyornam,

“Now my mother talks to me about the need to prevent pregnancy and gives me money to get the contraceptives every month but at first she never said anything about sex and pregnancy. She wants me to finish my apprenticeship.” (Ever Pregnant, 19)

On the part of Atwei the help took the form of the timely intervention of her aunt who is a nursing officer to advice about her dealings with men and also took her to the hospital for the Norplant to be fixed on her arm. Some of those who had children were helped to take care of them. Atwei did not have a parent communicating with her about pregnancy and its exigencies.

Just having the expectation that your female adolescent child protect herself from pregnancy may not be enough to ensure that pregnancy does not occur. For 75.8% of all respondents, their parents or guardians had faith in them that they would take the right decisions when it comes to preventing pregnancy. Deductively as many as 24.2% of them did not have their parents or guardians being confident that they were capable of making the right decisions relating to pregnancy prevention. The right decision here means the decision to avoid getting pregnant. Grotberg(1995) argues that the right kind of relationship and communication could also influence the resilience building process of adolescent females.

When asked if respondents were able to communicate with parents and guardians about issues concerning pregnancy and neo-natal care, 40.8% of them answered in the negative that discussions on sex education, pregnancy and other related issues do not take place between

their guardians and them. This finding is very significant as it tells that other sources of information and advice are more influential in the building of resilience than the immediate family of adolescent females. On the other hand however, 76.7% of respondents pointed out that apart from their parents or guardians, they have been able to establish and maintain a relationship with someone else who could advise them on pregnancy prevention.

Previous discussions have shown that majority of respondents had said that they could build and sustain a relationship with someone for the purposes of getting advice on pregnancy prevention rather than go to health personnel. It comes out clearly here that female adolescents often do not engage in talks about pregnancy and neo-natal care with their parents and guardians just like it is with health personnel.

Aside the role of parents and guardians in resilience building process of female adolescents, the personal efforts of the later also come to play. The question was thus posed to respondents to find out if they themselves tried as much as possible to have a good reputation when it comes to sexual behavior. Most of them, that is, 78.3% claimed they personally made sure they did so. This implies that there are some female adolescents and in this case 21.7% who do not make any conscious efforts to build resilience when it comes to pregnancy prevention. Consequently, they stand a higher chance of getting pregnant as teenagers. Though further probing was not done to ascertain why an adolescent teenager may not want to earn a good reputation in terms of their sexual behavior, it is still an interesting discovery to know that that is the case with teenagers. This means that aside the other factors external to the individual an adolescent female's personal decisions in life play an important role in the resilience building process. It is however also true that most of the factors which affect the resilience building process of the adolescent females are external to them. More of such factors are explored in this section.

Respondents were to indicate whether they had knowledge of their reproductive rights. This question was deemed relevant because sometimes even where society puts in place measures to help adolescents, their knowledge about the measures in question is critical. In the case where people are unaware of their rights, the possibility of those rights being violated and abused is high and vice versa. A total of 97 (80.8%) of all 120 respondents said they knew and have sexual and reproductive rights. This percentage is very encouraging but also tells that there are still others who do not have any idea of what sexual and reproductive rights are, a situation which could make them fall prey to sexual abuse and indeed unwanted teenage pregnancy.

To further explore the issue of sexual and reproductive rights of adolescent females, two questions were asked in that direction. They were first asked if they dared speak out when someone approached them in a sexual way and they did not want it. In response to this 93.3% of them pointed out that they definitely spoke out about such issues. Deductively, most of the adolescent females have the right to talk about their sexuality and it could be an important determining factor in the resilience building process. However, the fact that one speaks about unwanted sexual advances towards them does not entirely mean that they would be abstaining or protecting themselves from pregnancy. Responses to the second question asked about sexual and reproductive rights of respondents opens up the discussion on this issue. Respondents were asked if they freely decided with whom and at what time they wanted to have sex. All 10 respondents who were or had ever been pregnant indicated they freely decided on the person and at what time they wanted to have sex. On the other, 80% of those who had never been pregnant gave the same answer, implying that though they had never been pregnant, some of them may not always be abstaining.

One of the important facilities in helping adolescents with issues about their sexual and reproductive health is the services provided by health institutions. When those respondents who had ever been pregnant some of whom had their children living were asked if they made regular use of health services in order to check their and that of their babies, it was 60% of them who claimed they did that. The rest of them for whatever reasons did not pay that much attention to their sexual and reproductive health and the health of their babies if they had any. The percentage for those who had never been pregnant was also not so encouraging, that is, 24.5% of them. The fact that some others make use of these services means that the services are available just that not all adolescent females use the services.

Coming to the issue of adolescent resource facilities, all the respondents indicated the non-existence of such a facility where adolescents could go and discuss things relating to every sphere of their lives.

6.5 Socio-cultural and economic contexts for adolescent resilience

Most of the girls were advised by relations and friends that they should protect themselves from pregnancy. Those who had children were helped to take care of them by parents and other relations. None of the girls went through any puberty rites to educate them on how to take care of themselves after their first menarche, care for themselves during pregnancy and also how to care for their children. The girls indicated that at menarche it was in their homes that they got the knowledge on how to take care of themselves during menstruation.

Though four of the interviewees had economic support from their parents one of them did get support only from her boyfriend. For those who were using the artificial contraceptives, one of them got support from her mother and the other from her aunt. On Rabiātu's part it is very

commendable that though her parents do not give her money to buy contraceptives, she applied her knowledge about the calendar methods so that she does not get pregnant.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This chapter of the thesis provides a summary of the major findings, conclusion made and the recommendations of the study. There have been quite a number of studies on issues bothering on adolescents and the period of adolescence in different parts of the world. This thesis has focused on the topic “Navigating around Teenage Pregnancy: Resilience of Adolescent Girls in Accra”. To understand the resilience behaviour of older female adolescents in Nima was the general aim of conducting the study. The relevance of the study basically therefore is to provide more insight and contribute to the growing literature on adolescents especially in the area of teenage pregnancy.

The target population for the study was therefore all female adolescents in the Nima community aged from 15 years to 19 years of which there is no official figure. That notwithstanding, a sample size of 120 respondents was chosen for the study based on scholarly principles of research methods. Purposive and snowballing sampling techniques were employed in selecting these respondents. For proper analyses to be made secondary data was relied upon. However, primary data was the major form of information used. This was collected using both quantitative and qualitative methods though principally quantitative. The questionnaire was chiefly the instrument for collecting the primary data. Occasionally, however, respondents were allowed to provide answers outside of those provided by the questionnaire. Having gathered the primary data from the field of study, the Epiinfo was used for the processing of the raw data for further analyses.

In this chapter, a summary of the major findings of the study is provided. A general conclusion of the study is also made, and in addition, some recommendations are offered. Some findings differed between respondents who indicated that they had never been pregnant and those who at the time of the study were or had been ever pregnant. The summary of findings is thus presented with this differentiation where necessary.

7.2 Summary

In terms of age distribution, respondents on the average were 17 years old. However, 93.5% of those who had ever been pregnant were 19 years, whilst for the others most were 15 years representing 37.6%. Although for 4 of the respondents, they did not have any form of formal education, 3 of them had gone up to the tertiary level. Mostly however, respondents had junior high school education.

The ethnic background of respondents cut across all the major ethnic groups in Ghana. Ten of them however were of other ethnic origins like Fulani, Loso and Kotokoli. All 120 respondents reported that they had never been married, including those who were at the time of the study were or had ever been pregnant. Again, they were mostly dependent on their guardians and parents for their source of livelihood.

In relation to the family background of respondents, the 10 of them who had ever been pregnant were equally divided on the issue of whether or not their parents were still married. On the other hand, for respondents who had never been pregnant, 32% of them reported that their parents were no longer together, whilst 67.9% said their parents were still married.

On the resilience pathways of the respondents, contraception was found out to be the main way out. Whilst for most of those who had ever been pregnant (40%) they resorted to the use of contraceptives, respondents who had never been pregnant often chose to abstain from sex

altogether. A percentage of 60.9 of the latter gave that response. Respondents from both categories however indicated that their main source of information on contraception was the television. This was found to be basically because most of the respondents had access to television.

The most familiar type of contraceptive amongst some others to the respondents was condoms which as many as 114 of them knew about. The Norplant on the other hand was known to only 4 of them. These knowledge levels gave them the confidence that there were in the position to advise other girls on contraception.

One very important factor that influenced respondents' resilience decision making process was their wish to pursue higher levels of education and also some aspirations they had for their future. Most of them mentioned that they had role models whom they were striving to be like and thought that pregnancy at their age would interfere with such plans. Some of the respondents took the decision to protect themselves against teenage pregnancy due to the fear of what their parents might do to them. Although all of them were either Christians or Muslims with religious values, none mentioned their religious values as a factor influencing their resilience decision making.

Poverty, especially for respondents who had ever been pregnant also played a role in their resilience decision making. The explanation given here was that, they did not want to make worse their already bad economic circumstances by bringing in more mouths to feed.

In the process of building resilience, the family and especially advice from mothers was a major factor which affected the process. Respondents who had ever been pregnant pointed out that their pregnancy came as a disappointment to their families. It was however these same

families that had supported them financially and socially and that had influenced their decision on resilience.

The study also revealed that the parents or guardians most of the female adolescents do not discuss issues on reproductive health with them. The option of getting information from a health facility was also not preferred by them. They mentioned that they would rather get information and advice on how to prevent pregnancy from a different person altogether. Some of these people are friends, teachers etc

As high as 80.8% of the respondents said they were aware of their reproductive rights. This translated into the 93.3% of them who also said that they were able to speak up when there were sexual advances towards them that they did not desire.

Not all adolescent females however made any personal conscious effort to be resilience to teenage pregnancy. Whilst 78.3% of them consciously built resilience, for 21.7% of them, an effort on their part to prevent teenage pregnancy was not really something they considered.

Although there is evidence of the availability of a health facility where information on reproductive health could be sought, not many of the adolescent females especially those who have never been pregnant patronize the facility. For those who had ever been pregnant, 60% indicated their patronage of the facility whilst 24.5% of those who have never been pregnant have ever visited the health facility.

None of the 120 respondents had gone through any traditional puberty rights where adolescent girls are given some education on reproductive health and also the care of children. That notwithstanding, those who had children had their parents and other relations assisting them with child care.

The importance of having an adult close to the adolescent and not necessarily their biological parent cannot be overestimated. Adolescents did not have any facilities for them in their communities but rather relied on teachers for those who were in school and then local pharmacists and friends were preferred to the largely formal setting of the hospital. For those who had been pregnant before it took that adult figure to give them the final push to change their circumstances. Many of the respondents felt quite comfortable with me and thinking that I was a nurse because I taught them the contraceptives they did not know about, some of them were actually asked to go to the hospital.

7.3 Conclusion

The discussions in this study indicate self consciousness and agency on the part of some of the respondents. This is reflected in their conscious effort to be resilient against teenage pregnancy. The female adolescent should not be looked on as helpless being who just allows herself to get pregnant. Even with those who had been pregnant before if they get the right incentives financially and socially, they could resume their schooling and those who are not in school start learning a vocation. Parents get more involved if the challenge of teenage pregnancy is to be reduced. Parents must endeavour to actually become friends with their adolescent girls so they could communicate with them. This could have positive implications for sexually active children who think they cannot abstain from sexual activities as the parents could educate them about the consequences of teenage pregnancy and encourage them to use contraceptives to protect themselves.

7.4 Recommendation

Based on the findings of this study, two recommendations are being made for adolescent sexual and reproductive health policy makers in Ghana. The first recommendation is a community based approach to educating and assisting adolescents to deal with pregnancy and

pregnancy related issues. This approach is more likely to be patronized by the adolescents as the study revealed that patronage of health facilities for various reasons was not very high.

It is also being recommended that further research be conducted in the area of adolescent sexual and reproductive health for a more comprehensive approach to be adapted in dealing with matters of adolescent sexuality and the reproductive intricacies that come with it. It is recommended that for comprehensive and conclusive research in resilience against teenage pregnancy the respondents should be put into the following sub sample groups:

- a. Those who had/ have never experienced pregnancy.
- b. Those who had/have experienced pregnancy once.
- c. Those who had/have experienced pregnancy more than once.

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APPENDIX I: QUESTIONNAIRE**DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF GHANA, LEGON****NAVIGATING AROUND TEENAGE PREGNANCY: RESILIENCE OF OLDER
ADOLESCENT GIRLS IN ACCRA**

My name is Phyllis Antwi Bosiakoh. This research is being carried out for academic purposes as part of requirements for the award of Master of Philosophy (Mphil.) Degree at the University of Ghana, Legon. The purpose of the research is to understand the resilience of older adolescent girls in Accra towards teenage pregnancy. Participation in this study is absolutely voluntary. Please feel free to express yourself as accurately as possible to the questions. We are interested in your personal viewpoints. Responses will be confidential and will not be disseminated to outside parties.

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SECTION A: Background Information

NO.	Question	Response	Code
1	Age	15 16 17 18 19 Don't know	1 2 3 4 5 99
2	Education	Primary 4 Primary 5 Primary 6 JHS 1 JHS 2 JHS 3 SHS 1 SHS 2 SHS 3 Tertiary Vocational training (1 st year) Vocational training (2 nd year) Vocational training (3 rd year) No formal training/schooling Other, specify__	1 2 3 4 5 6 7 8 9 10 11 12 13 14 99
3	Religion	Muslim Christian Traditional No religion Other, specify	1 2 3 4 99

4	Ethnic Background	Akan Ga/Adangme Ewe Guan Gruma Mole Dagbani Grusi Mande Mamprusi. Kussasi Other, specify.....	1 2 3 4 5 6 7 8 9 10 99
5	Source of livelihood	Trade/Business Farming Fishing Farming + Fishing Official employee Casual labour Other, specify_____	1 2 3 4 5 6
6	Marital Status	Never married Consensual union Married Separated Divorced Widowed	1 2 3 4 5 6
7	Are your parents living together?	Yes No Other, specify	1 0 99
8	Does your father have other wife/wives besides your mother?	Yes No Other, specify	1 0 99
9.1	Do you have a TV at home?	Yes No Other specify.....	1 0 99
9.2	Radio set	Yes No Other specify.....	10 99
10	Have you ever been pregnant?	Yes No	1 0

Questions for respondents who are/have been pregnant.

SECTION B: Resilience pathways of female adolescents

11.	What was the outcome of the pregnancy?	Miscarriage Carried the pregnancy to term Abortion Child died Other specify.....	1 2 3 4 99
12	Do you know how to protect yourself from pregnancy? If No to Q.11 move to Q.13	Yes No	1 0

13	How do you protect yourself from teenage pregnancy?	Contraceptive usage Abstinence Withdrawal methods Safe period method Other specify.....	1 2 3 4 99
14	Have you ever heard of contraceptives before?	Yes No	1 0
15	How did you hear about them?	From friends Sex Education at school Parents Radio Television Books NGOs Other specify.....	1 2 3 4 5 6 7 99
16	Identify which of the following are contraceptives? (Tick as many as apply)	IUD Condoms Injectables Norplant Emergency pills Foaming Tablets Other specify.....	1 2 3 4 5 6 99
17	Have you at any point in time used any contraceptive before?	Yes No	1 2
18	What are your aspirations for the future?	Nurse Doctor Entrepreneur Teacher Banker Other specify.....	1 2 3 4 5 99
19	After getting pregnant, have you made an attempt to go back to school/learn a vocation/trade?	Yes No	1 0
20	Do you have a role model?	Yes No	1 0
21	Could you go to health personnel for advice on how to prevent pregnancy?	Yes No	1 0
22	Have at any point in time abstained from sex in the bid to prevent pregnancy?	Yes No	1 0
23	Do you have the capacity to help another girl prevent pregnancy?	Yes No	1 0
24	Do you have the capacity to begin and sustain a relationship with someone who could give you advice on related to pregnancy, delivery and neonatal care?	Yes No	1 0
25	Do think you have the capacity to successfully prevent pregnancy?	Yes No	1 0
26	Do you think that after getting pregnant you could still make it in life?	Yes No Other specify.....	1 0 99
SECTION C: Factors affecting resilience building process of female adolescents			
27	Does your parent/guardian have faith in you that you would take the right decisions when it comes to preventing pregnancy?	Yes No	1 0

28	Are you able to communicate to your parents/ guardian about issues relating to pregnancy and neonatal care?	Yes No	1 0
29	Apart from your parents, have you been able to establish and maintain with someone who could advise you on pregnancy and neonatal care?	Yes No	1 0
30	Does your family (immediate) found something wrong with getting pregnant at your age?	Yes No	1 0
31	Did you get any kind of help from your family during and after the pregnancy?	Yes No Other specify.....	1 0 99
32	What kind of help did you get?	Financial Social	1 0
33	Do you try as much as possible to have a good reputation when it comes to sexual behaviour?	Yes No	1 0
34	What does your family expect from you when it comes to pregnancy and having children?		
35	Do you have sexual and reproductive health rights?	Yes No	1 0
36	Do you dare to speak out when someone approaches you in a sexual way and you do not want it?	Yes No	1 0
37	Do you freely decide with whom, and at what time you want to have sex?	Yes No	1 0
38	Did you make regular use of health services in order to check your health and the health of your baby?	Yes No	1 0

Section D: Factors influencing resilience decision-making process

39	Why did you decide to protect yourself against teenage pregnancy? Choose as many as apply.	Personal Values Religious values Family name Education/Future Aspirations Peer influence Other specify.....	1 2 3 4
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Section E: Socio-cultural and economic contexts for adolescent resilience

40	Are you considered to be an adult who can fend for herself in your community?	Yes No	1 0
41	Is teenage pregnancy considered a normal occurrence in your community?	Yes No	1 0
42	Are you the first female child of your parents?	Yes No	1 0

43	If no what is her level of education?	Primary 4 Primary 5 Primary 6 JHS 1 JHS 2 JHS 3 SHS 1 SHS 2 SHS 3 Tertiary Vocational training (1 st year) Vocational training (2 nd year) Vocational training (3 rd year) No formal training/schooling	1 2 3 4 5 6 7 8 9 10 11 12 13 14
44	Do you have initiation rites in your community?	Yes No	1 0
45	Have you undergone these rites?	Yes No	1 0
46	Are you considered an adult once you undergo this rite?	Yes No	1 0
47	Are you taught how to prevent pregnancy?	Yes No	1 0
48	Are you taught how to care for yourself during pregnancy?	Yes No	1 0
49	Are you taught what it means to be a parent?	Yes No	1 0
50	Are you taught how to take care of your child?	Yes No	1 2
51	Is there an Adolescent Resource facility in your community?	Yes No	1 0
52	Do you get economic resources to help you in issues relating to pregnancy and child care?	Yes No	1 0
53	Where do you get these resources?	Peers Husband Parents Other relations Peer Educators Religious Leaders Teachers Initiators Nurse/doctors Other specify	1 2 3 4 5 6 7 8 9 99

Questions for respondents who are/have not been pregnant.

SECTION B: Resilience pathways of female adolescents			
No.	Question	Response	Code
12	Do you know how to protect yourself from pregnancy?	Yes No	1 0
13	How do you protect yourself from teenage pregnancy?	Contraceptive usage Abstinence Withdrawal methods Safe period method Other specify.....	1 2 3 4 99
14	Have you ever heard of contraceptives before?	Yes No	1 0
15	How did you hear about them?	From friends Sex Education at school Parents Radio Television Books NGOs Other specify.....	1 2 3 4 5 6 7 99
16	Identify which of the following are contraceptives? (Tick as many as apply)	IUD Condoms Injectables Norplant Emergency pills Foaming Tablets Other specify.....	1 2 3 4 5 6 99
17	Have you at any point in time used any contraceptive before?	Yes No	1 0
18	What are your aspirations for the future?	Nurse Doctor Entrepreneur Teacher Banker Other specify.....	1 2 3 4 5 99
20	Do you have a role model?	Yes No	1 0
21	Could you go to health personnel for advice on how to prevent pregnancy?	Yes No	1 0
22	Have at any point in time abstained from sex in the bid to prevent pregnancy?	Yes No	1 0
23	Do you have the capacity to help another girl prevent pregnancy?	Yes No	1 0

24	Do you have the capacity to begin and sustain a relationship with someone who could give you advice on related to pregnancy, delivery and neonatal care?	Yes No	1 0
25	Do think you have the capacity to successfully prevent pregnancy?	Yes No	1 0
26	Do you think that after getting pregnant you could still make it in life?	Yes No Other specify.....	1 0 99

SECTION C: Factors affecting resilience building process of female adolescents

27	Does your parent/guardian have faith in you that you would take the right decisions when it comes to preventing pregnancy?	Yes No	1 0
28	Are you able to communicate to your parents/ guardian about issues relating to pregnancy and neonatal care?	Yes No	1 0
29	Apart from your parents, have you been able to establish and maintain with someone who could advise you on pregnancy prevention?	Yes No	1 0
30	Does your family (immediate) found something wrong with getting pregnant at your age?	Yes No	1 0
32	What kind of help have you been getting to aid you in preventing pregnancy?	Financial Social Other specify.....	1 2 99
33	Do you try as much as possible to have a good reputation when it comes to sexual behaviour?	Yes No	1 0
34	What does your family expect from you when it comes to pregnancy and having children?		
35	Do you have sexual and reproductive health rights?	Yes No	1 0
36	Do you dare to speak out when someone approaches you in a sexual way and you do not want it?	Yes No	1 0
37	Do you freely decide with whom, and at what time you want to have sex?	Yes No	1 0
38	Did you make regular use of health services in order to check your reproductive health issues?	Yes No	1 0

Section D: Factors influencing resilience decision-making process

39	Why did you decide to protect yourself against teenage pregnancy? Choose as many as apply.	Personal Values Religious values Family name Education/Future Aspirations Peer influence Other specify.....	1 2 3 4
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Section E: Socio-cultural and economic contexts for adolescent resilience

40	Are you considered to be an adult who can fend for herself in your community?	Yes No	1 0
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41	Is teenage pregnancy considered a normal occurrence in your community?	Yes No	1 0
42	Are you the first female child of your parents?	Yes No	1 0
43	If no what is her level of education?	Primary 4 Primary 5 Primary 6 JHS 1 JHS 2 JHS 3 SHS 1 SHS 2 SHS 3 Tertiary Vocational training (1 st year) Vocational training (2 nd year) Vocational training (3 rd year) No formal training/schooling	1 2 3 4 5 6 7 8 9 10 11 12 13 14
44	Do you have initiation rites in your community?	Yes No	1 0
45	Have you undergone these rites?	Yes No	1 0
46	Are you considered an adult once you undergo this rite?	Yes No	1 0
47	Are you taught how to prevent pregnancy?	Yes No	1 0
48	Are you taught how to care for yourself during pregnancy?	Yes No	10
49	Are you taught what it means to be a parent?	Yes No	1 0
50	Are you taught how to take care of a child?	Yes No	1 0
51	Is there an Adolescent Resource facility in your community?	Yes No	1 0
52	Do you get economic resources to help you in issues relating to pregnancy and child care?	Yes No	1 0
53	Where do you get these resources?	Peers Husband Parents Other relations Peer Educators Religious Leaders Teachers Initiators Nurse/doctors Other specify	1 2 3 4 5 6 7 8 9 99

APPENDIX II: INTERVIEW GUIDE

SOCIOLOGY DEPARTMENT UNIVERSITY OF GHANA, LEGON

Interview Guide

NAVIGATING AROUND TEENAGE PREGNANCY: RESILIENCE OF OLDER ADOLESCENT GIRLS IN ACCRA

1. Tell me something about yourself? (ask about family background, education and the like)
2. What are some of the things that have happened to you as an adolescent?
3. Do you have the ability to solve problems that come your way? (Probe about the challenges, how are they solved)
4. How do you handle bad things that happen to you?
5. What are contraceptives? (Probe for as many as possible, probe further about how to use them, source of information, how are they acquired)
6. Have you ever been pregnant? Probe for the outcome if yes

a. For respondents who are /have ever been pregnant

7. How was life after you got pregnant?
8. Did you try to continue school/ learn a trade? (Probe to find out if the try was successful)
9. How do you cope with school/trade and pregnancy /taking care of the child (probe who/what kept respondent going, what were the challenges and was the respondent able to overcome them and how if she did)?
10. Did you receive any financial to help you prevent pregnancy and take of your child (who gave this help)?
11. What of social help; did you get any?
12. Who do you talk to when you need advice on issues relating to preventing pregnancy?
13. Is there an institution/group in your community which gives you information on how to prevent pregnancy and child care (probe about details of the information)?
14. Are the members of staff of this institution friendly?

15. What are some of the practical things you do to prevent pregnancy?
16. What is the basic reason for protecting yourself against teenage pregnancy?
17. Do you have a boyfriend/Partner?
18. How do you negotiate sex with your partner (Probe if the respondent has a say in if and when she has sex)?
19. What do you aspire to become?
20. Does religion impact your sexual lifestyle (probe to know how it does if yes and why not if no)?
21. Does your religious organization teach you about sex?
22. What are the views of your religious group on contraceptive use?
23. What are the views of your religious group on pregnancy?
24. How easily could you approach someone to communicate about reproductive health issues with them?
25. Do you have a role model and what are the qualities you admire in that person?
26. How would you describe someone who grew up in the midst of challenges but was successful?
27. Does your community perform puberty/initiation rites for adolescent girls (Probe further about what is taught relating to pregnancy, its prevention and child care)?

b. Questions for respondents who are/have never been pregnant

7. Did you receive any financial to help you prevent pregnancy (who gave this help)?
8. What of social help; did you get any?
9. Who do you talk to when you need advice on issues relating to preventing pregnancy?
10. Is there an institution/group in your community which gives you information on how to prevent pregnancy (probe about details of the information)?
11. Are the members of staff of this institution friendly?
12. What are some of the practical things you do to prevent pregnancy?
13. What is the basic reason for protecting yourself against teenage pregnancy?
14. Do you have a boyfriend/Partner?
15. How do you negotiate sex with your partner (Probe if the respondent has a say in if and when she has sex)?
16. What do you aspire to become?
17. Does religion impact your sexual lifestyle (probe to know how it does if yes and why not if no)?

18. Does your religious organization teach you about sex?
19. What are the views of your religious group on contraceptive use?
20. What are the views of your religious group on pregnancy?
21. How easily could you approach someone to communicate about reproductive health issues with them?
22. Do you have a role model and what are the qualities you admire in that person?
23. How would you describe someone who grew up in the midst of challenges but was successful?
24. Does your community perform puberty/initiation rites for adolescent girls (Probe further about what is taught relating to pregnancy, its prevention?)