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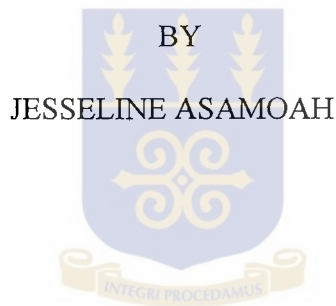
CAUSES OF TEENAGE PREGNANCY IN SENYA BEREKU COMMUNITY OF AWUTU- EFUTU- SENYA DISTRICT

BY

JESSELINE ASAMOAH



THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MA DEVELOPMENT STUDIES DEGREE

JULY 2005

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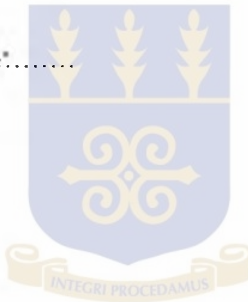
DECLARATION

I, JESSELINE ASAMOAH, do hereby declare that except for the references cited in this work, which have been duly acknowledged, this dissertation is the result of my own work produced from research undertaken under supervision and that it has not been presented for another degree elsewhere.



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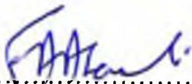

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DR. FELIX ASANTE

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DEDICATION

This work is dedicated to God Almighty in whom I live and have my being and to my love AMA CHIPO KHUMALO. Ama may you grow in the Grace of God always. The work is also dedicated to all the teenage mothers who have beaten the odds to carve out a niche for themselves in the society.

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ACKNOWLEDGMENT

I ascribe thanks to Almighty God for His Grace and continual mercies in my life. I am grateful to my supervisors Prof. C. Ahiadeke and Dr. F. Asante for the help and direction given to carry out this project. I wish to thank all the staff of ISSER for their warmness and friendliness towards me. I am so grateful to Mrs. M. Ackumey and Nash who took time off their busy schedule to help me shape this project. Thanks to all my friends who supported me with prayers. A shout out to all my course mates.

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ABSTRACT

The main objective of the study was to investigate into factors contributing to teenage pregnancy in the Senya- Bereku community of the Awutu-Effutu-Senya District, which has a high drop out rate of girls in the educational facilities make recommendations to the District Health Management Team and District Assembly of Awutu-Effutu-Senya District. The dissertation is based on data collected from the field between June 2004 and June 2005.

Data on 200 adolescents of which 82 was male, 10 teenage mothers, 5 mothers of adolescent mothers and ten opinion leaders. Distribution of respondents was presented in tables, pie charts, bar charts and cross tabulations. The chi-square test was used to establish the association between independent variables stated in the hypothesis and teenage pregnancy.

The finding of the study showed that coercion, career aspirations, parental control, knowledge and usage of contraceptives and involvement in extracurricular activities were significantly related to adolescent sexuality. The median age of sexual debut was 16 years for males and females, and there was poor usage of conventional family planning methods despite education on teenage pregnancy and HIV/AIDS.

Programmes to help reduce the incidence of teenage pregnancy will need the combined efforts of all stakeholders. Health services and counselling centres should be established for the youth with emphasis on reproductive behaviour and sexuality. Early onset of education on teenage pregnancy and contraceptives is recommended

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for the youth in the early teenage years prior to the median age of sexual debut. Channelling of sexual energy into asexual activity such as athletics and clubs will be helpful for the youth. Teenage mothers can be helped and supported by the community to continue their education.

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CHAPTER ONE: INTRODUCTION

1.1 Background

Adolescent and Reproductive health has become an issue of concern to governments, demographers and planners all over the world. It is estimated that 23% of the world's population comprises the youth aged 10-20 years. Worldwide, pregnancy-related conditions are the leading cause of death among women aged 15-19years. There are 2 main risks for the pregnant adolescent: pre-eclamptic toxaemia and cephalopelvic disproportions (Karim 2003). Both can present serious problems.

The International Population Conference of August 1984 in Mexico City addressed the issue of teenage pregnancy and childbearing in four of the 88 recommendations endorsed by delegates of the 147 nations represented at the conference. Governments were advised to encourage delay in the commencement of childbearing and to raise the age of entry into marriage. Infact the year 1985 was designated by the United Nations as International Youth Year and it was an added incentive to increase the focus on dimensions and problems of adolescent fertility.

In September 2000, the General Assembly of the United Nations adopted the United Nations Millennium Declaration. The Declaration, described as a major landmark in the annals of global development partnerships endorsed by 192 countries, was then translated into a roadmap setting out goals to be reached by the year 2015.

The UN recognizes the contribution that developed countries can make through trade, development assistance, debt relief and debt sustainability, access to essential drugs and technology transfer to the global economy and global human capital development. Although Adolescent Reproductive health is not specifically mentioned

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in the MDGs per se, it is linked to four out of the eight goals namely: promote gender equality and women empowerment; reduce child mortality; improve maternal health; combat HIV/AIDS and other diseases. Adolescent health is also to be considered if the goal of universal primary education is to be attained especially in developing countries where the average age of pupil may be as high as 15 years. By 2020 according to the UN medium projections, the world total of adolescents aged 10-19 will be well over 1.3 billion and of these 1.1 billion or 86 percent will be living in the developing countries. Inspite of these figures Adolescent and Reproductive Health has not been accorded as much attention as it deserves.

The society in which adolescents grow up has an important influence on their development, relationships, adjustments and problems. The expectations of the society mold their personalities, influence their roles, and guide their future. The structure and functions of the society help them fulfill their needs or create new problems by stimulating further tension and frustration. Because adolescents are social beings who are part of a larger society, we need to understand this social order and some of the ways it influences them. There are some important influences on today's adolescent among which is computer technology (which some term the computer revolution age), the materialistic revolution, education revolution, the family, the sexual revolution and the violence revolution (Henshaw et al 1986).

The success of any adolescent reproductive health program will need to include efforts at improving the status of women. Sadik (1995) has identified specific development goals involved with improving the status of women as follows:

- Reduction in levels of illiteracy, especially female illiteracy;

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- Expansion of girl's enrolment in schools and their retention in the school system;
- Securing women's legal and social rights to free marriage, land and ownership and paid employment; and
- Increasing income-generating programs for women

In Ghana 51.4 percent of the total population of about 18 million is less than 19 years. The medium term objective of the Government of Ghana is to achieve a middle income status by 2015. The state recognizes the fact that the objective can best be attained and sustained by developing and harnessing the potential of the youth who are "the spirit of today and the hope for the future" (Adolescent Reproductive Health Policy, 2000), through education and skills training. Teenage pregnancy unfortunately has the potential to curtail a teenager's aspirations and promising future as well as increase gender disparity in the formal school enrolment. Once the female teenager is unable to continue with her formal education because of childbearing; she loses the opportunity to hold positions of influence in society.

In Ghana to reduce the disparity between female and male enrolment in the formal education sector, the government set up the Ministry of Girl Child Education. The Ministry initiated the Science Club for girls to get them interested in the science subjects and science careers, an area which hitherto has been predominantly occupied by males. The Ministry of Women and Children's Affairs also a fairly new ministry set up in 2000 are all part of the state efforts to empower women and to attain the gender balance in all spheres of the society in Ghana. Vocational Schools and Institutions have been set up to train many girls in employable skills.

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teenage pregnancy not only burdens individual teenagers and their babies but also its wide effect on the community and the nation as a whole is evidenced by the number of street children, adolescent gangsters who indulge in armed robbery, commercial sex work and many other vices.

A study by Nabila and Fayorsey (1995) showed that by 17 years of age, 60 percent of adolescent females and males interviewed in Kumasi and Accra had either become pregnant or impregnated a female. Most adolescent pregnancies were however outside the context of marriage and this has negative consequences on teenage mothers who are ill equipped to raise children.

The population of Ghana can be described as youthful since the median age is 17.5 years. The proportion of the population aged more than 15years is around 45 percent. Total fertility in Ghana has declined over the decade from 6.4 per female in 1988 to 4.6 children in 1998.

There are however spatial variations in the teenage fertility in the country. Table 1.1 shows the regional differences in teenage fertility.

Central region has the highest rate of teenage fertility at 24.1 percent; the lowest rate of teenage fertility in the nation is found in the Greater Accra region, while the national average is 14.8 percent. At the time of the Ghana Demographic and Health Survey in 2003 the Central region had the highest percentage of teenagers pregnant with their first child i.e. 10.5 percent.

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Table 1.1 Regional Teenage fertility in Ghana

Name of region	% of teen mothers	% teen pregnant with 1st child	% teen who have began childbearing
Central region	13.7	10.5	24.1
Northern region	15.7	7.9	23.6
Volta region	14.3	2.7	17.1
Western region	10.2	4.0	14.2
Brong Ahafo region	10.7	2.9	13.6
Eastern region	9.5	3.7	13.2
Upper East region	9.1	3.5	12.6
Ashanti region	8.1	2.2	10.3
Upper West region	8.5	1.3	9.8
Greater Accra region	8.4	1.1	9.5
Total	10.8	4.0	14.8

Source: GDHS 2003

A linear relationship between age at first marriage and level of education has been observed. Females with no formal education married at 18.5 years of age as compared to those with a secondary or higher education who married at 23 years of age (GDHS 1998). These findings were also reflected in the 2003 GDHS shown in Figure 1.

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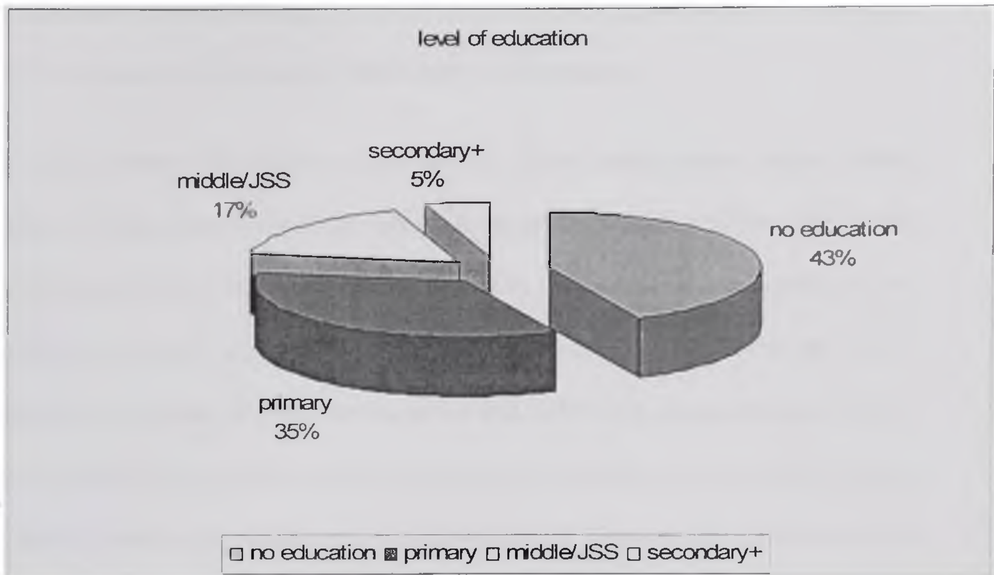
Figure 1 Relationship between Level of Education and Teenage Fertility



Source: GDHS 2003

The highest percentage of teenage mothers were those with no education (43 percent) and the rate decreased to 5 percent as the level of education increased to secondary plus.

Majority of youth (60 percent) by age 17 years will have had unprotected sexual intercourse putting them at risk of unintended pregnancy and sexually transmitted diseases and HIV/AIDS. Mass national campaigns to educate the youth on HIV through the media etc. means most teenagers have heard about the disease yet many believe they are not at risk so there has not been much change in sexual behaviour. The youth in Ghana do not use contraceptives to protect against teenage pregnancy; results from the national survey on teenage fertility show (GDHS 2003). The director of the Ghana AIDS Commission reported this year that there has been a decrease in the use of condoms; the most effective way of reducing pregnancy and HIV/AIDS in sexually active people. Among those who had used a condom the last time they had

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sex, only about half of young women and one-quarter of young men did so to prevent the transmission of HIV/AIDS—indicating that preventing unintended pregnancies may be a greater concern among sexually active adolescents.

The Senya Bereku community of the Awutu Effutu Senya district in the Central Region of Ghana has had over the years increasing dropout of girls from the formal education sector due to teenage pregnancy. This has led to intensification of sex education in schools and communities in the district. Certain NGOs and CBOs operating in the areas of youth development and HIV/AIDS awareness have done a commendable job by setting up Peer Educators and Counselors in the schools within the past 3 years in the community. The formation of Virgins Club whose aim is to promote sexual abstinence among the youth and encourage sexual morality before marriage is part of the programme to reduce teenage pregnancy. The AYA (African Youth Alliance) educates the youth on the usage of contraceptives and has made available through its peer educators free condoms for the youth in the district.

1.2 Problem Statement

Results from the World Fertility Survey published in the Population Bulletin of the United Nations have shown a considerable mortality before age 5 of children born to teenage mothers, especially those under age 18, and most importantly among children born after short birth intervals.

Most adolescents when faced with an unwanted pregnancy resort to unsafe abortion because of restrictions such as parental permission for legal procedures. Those who keep their pregnancies encounter problems associated with early childbearing such as curtailing of education and a reduction in economic opportunities.

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The gap between first intercourse and first marriage leaves a window of time when adolescents are potentially at high risk of HIV/AIDS and other Sexually Transmitted Infections (STI's), as well as unplanned pregnancy. This is partly because this period may involve sexual experimentation, relationship instability and a lack of access to health services. In Ghana, this window of exposure is approximately two years for women and more than five years for men, and is a crucial period for adolescents to protect themselves from the consequences of risky sexual behavior that could shorten or change their lives (Awubaso-Asare, 2004).

Adolescent pregnancy in the Central Region has been listed as a priority for international organizations like the UNFPA as well as the District Assemblies in the region. Many programs that have been introduced in this problematic area seem not to have dealt with the problem using the teenagers themselves. So these programs have not been sustained. There has been therefore the need to go back to the drawing board and seek help from those who are the target group that is the teenagers themselves.

There has been increasing school drop out of female students due to teenage pregnancy in the study area that is Senya Bereku in the Awutu-Effutu-Senya District and this is a matter of concern to all the authorities in the educational institutions and the society at large.

Pregnancy records at the Senya Health Centre, the only health facility in the community were assessed for the first antenatal attendance. The attendees were then grouped into two: namely those aged 19 years and below; and those aged above 19 years. The percentage of teenage pregnancy was determined from the total number of first antenatal attendance as shown in Table 1.2 for the period of six years from the year 1999 to the year 2004.

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Table 1.2 Pregnancy Records at the Senya Health Centre from 1999- 2004

Year	Total No of pregnancies	% teenage pregnancy
1999	878	17.2
2000	883	16.9
2001	678	21.0
2002	878	16.3
2003	923	17.6
2004	878	17.2

Source: Senya Bereku Health Centre

The average percentage of teenage pregnancy for Senya Bereku was 17.7 percent for the past 6 years (taking the sum total of teenage pregnancy for the period and finding the average) and this is greater than the national cumulative fertility average of 8.68 percent for adolescents from ages 15- 19 years (GDHS 2003). The health centre at Senya is ill-equipped both in terms of human resource as well as logistics to deal with delivery of babies of pregnant teenagers so they are referred to the district hospital to forestall any labour complication common to them such as cephalopelvic disproportion, eclampsia etc. The health centre though deals with the prenatal care and counselling of pregnant teenagers. The study seeks to find out the causes of teenage pregnancy in the Senya Bereku community.

1.3 Objectives

General objective:

To analyse the causes of teenage pregnancy in the Senya Bereku community of the Awutu-Effutu-Senya District.

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Specific objectives of the study:

1. To assess sexual experience of teenagers in the community.
2. To determine the knowledge and usage of contraceptives among the adolescents.
3. To understand the community's perception about teenage pregnancy.
4. To recommend strategies to address the problem of teenage pregnancy

The research seeks to address the question: Why are children having children? Do the factors such as need for financial support, peer pressure, poor knowledge and use of contraceptives, low career aspirations, contribute to the incidence of teenage pregnancy in the Senya Bereku community of the Awutu-Effutu-Senya District?

Hypothesis

Null Hypothesis

Ho= Coercion, Peer pressure, Poor knowledge and use of contraceptives, Low career aspirations are not contributory factors to Teenage Pregnancy in Senya- Bereku community.

Alternate Hypothesis

Ha= Coercion, Peer Pressure, Poor knowledge and use of contraceptives, Low career aspirations are contributory factors to Teenage Pregnancy in Senya- Bereku community.

1.4 Significance of Study

Adolescent child bearing has potentially negative demographic and social consequences. Births that occur to teenage mothers have been found to have the

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highest infant and child mortality in Ghana (Ghana Statistical Service, 1994 and 1999). This may be due to the fact that teenage mothers are more likely to suffer from pregnancy and delivery complications than older mothers, resulting in higher morbidity and mortality for both themselves and their children. In addition, early childbearing may foreclose a teenager's ability to pursue educational and job opportunities.

It is estimated that 1 in every 4 teenager is sexually active globally though older teenagers from ages 15 were found to be more sexually active as compared to younger teenagers from ages 12 to 13 from a CDC National Survey of Family Growth undertaken in 1995 in the United States.

Most pregnant teenagers will attempt abortion so as to be able to continue their education. This poses a problem in Ghana where abortion is only legalized on medical grounds and should be performed by a qualified medical practitioner in a health institution. Teenage pregnancy, according to the laws of the land is no justification for a legal abortion except when medically proven that the health of the mother is at risk should the pregnancy be allowed to reach its full term. This has given rise to lots of unqualified doctors who attempt illegal abortions under unhygienic conditions with poorly sterilized instruments with which they tend to infect the girls who end up at the health institutions with complications such as uterine infections, severe anaemia from uterine bleeding, perforated uterus, secondary infertility, as well as loss of life.

The majority of adolescents are sexually experienced by the time they turn 20. In the year 2002, more than 3 percent of 15-24-year-olds were estimated to be HIV positive.

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Women—particularly young women—are at a greater risk of HIV/AIDS and are infected at a younger age than are men. Between 1986 and 2001, women accounted for 61 percent of the cumulative AIDS cases in Ghana –Awubaso-Asare et al (2004). Infant mortality and literacy are indicators of development of any nation incorporated in the Human Development Index. The study is useful to direct future policies that direct at developing interventions that minimize adolescent fertility and reduce the potential threat of HIV/AIDS in Senya Bereku community and the nation.

1.5 Limitations to the study

The results of the study especially on 'ever experienced sex' were solely subjective and the respondents may not give truthful responses due to fear of being branded 'bad' by others. Teenage mothers may also when asked retrospectively give different reasons for being pregnant in the first place and give a different twist to their relationship to the father of their child prior to the pregnancy.

1.6 Outline of dissertation

Chapter one, the introductory chapter outlines the background to the project topic and states the problem statement as well as the justification for the study. The state of teenage fertility in Ghana and in the study area Senya Bereku of the Awutu-Effutu-Senya District in the Central region is emphasized.

Chapter two posits other research and demographic findings on adolescent reproductive health and sexuality through literature review. Chapter three describes the demographic features of the study area, the economic activities of the area, educational and health

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facilities in the district as well as Senya Bereku community. The method of data collection and instruments of data collection are outlined in this chapter as well. The sample size and sampling technique are described in this chapter.

The fourth chapter presents and diffuses the results of the data analysis.

Chapter five, the concluding chapter, outlines the summary, conclusion and recommendations from the survey.

CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0 Introduction

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This chapter provides a theoretical background to the study/ topic. It seeks to explore materials on the factors that influence teenage pregnancy by various authors.

2.1 Adolescent Sexuality

Globally from a survey by the Pregnancy Centre in Virginia (2004), it is estimated that 1 in every 5 adolescents has ever had sexual intercourse before his or her 15th birthday. The centre posits that by age 19years, 80 percent of males and females will have had sexual intercourse. According to the centre the percentage of high school students who have remained virgins has also risen from 45.9 percent in 1991 to 54.5 percent in 2001 in the USA. The reasons teenagers give for engaging in sexual intercourse include peer/ social pressure, pressure from partner, curiosity, rebellion, an expression of love and a response to the need to be loved, lack of understanding about real love, it feels good, 'no longer a virgin' so no big deal to engage in sexual intercourse.

According to Vadies et al (1977), a majority of young males were willing to lie about love in order to have sex and that peer pressure was an important influence in their sexual activity.

Hojcak et al (1988) conclude that non-sexual needs drive sexual behavior among adolescents. They argue that adolescents engage in sexual intercourse to confirm their sexual identity i.e. masculinity/ femininity; gain affection; rebel against authority of parents and social norms; build self-esteem; alleviate anger and boredom; hurt or degrade others and express jealousy. They recommend that parents and therapists can alleviate teenage sexuality by teaching teenagers to use nonsexual techniques to satisfy sexual needs.

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Hanson et al (1981) conclude that females with employed mothers were more likely to have initiated sexual activity at an earlier age, were less knowledgeable about contraception and expressed a willingness to accept a higher risk of pregnancy.

In the United States the average age for initiating sexual activity is 16 years according to Crieghton- Zollar A. (1985), although in certain cities such as New York, the average age of first sexual intercourse is 11.6 years for the African-American youth, and 12.8 years for the Hispanic youth and 14.5years for the white youth

Miller et al (1986) report on a relationship between parental control and adolescent sexual experience. The highest level of sexually permissive attitudes and experience in sexual intercourse among adolescents were associated with a lack of parental rules. Moore et al (1986) analyzed data from a survey that indicates that parental discussion with children is associated with a lower frequency of the initiation of sexual activity only in families that held traditional family values and beliefs. Miller (1998) agrees from a review of research synthesized findings that parental values favouring sexual abstinence as well as parental supervision are related to reduced teen pregnancy risk. Findings though were mixed about parent/child closeness and teenage pregnancy related behaviours. Miller posit that teenagers from disadvantaged neighbourhoods and who had single parents, had older sexually active siblings or were sexually abused were more likely to start having sexual intercourse at an early age.

According to Awusabo-Asare et al (2004), four in 10 Ghanaian women and two in 10 men aged 15-19 have ever had sex; by age 20, 83 percent of women and 56 percent of men have had sex and that the median age at first intercourse is 17.4 for women and nineteen and a half years for men. They hold the view that among those who have had

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sex, four in 10 women and six in 10 men aged 12-24 have had more than one sexual partner. They posit that the proportion of 15-19-year-olds who have had sex declined substantially between 1993 and 1998: from 59 percent to 38 percent among women and from 33 percent to 19 percent among men. Sexual coercion they found out is a common occurrence in Ghana: one in four sexually experienced young women say that they have ever been forced against their will to have sexual intercourse (8 percent of sexually experienced young men report the same). Twelve percent of women and 2 percent of men were forced into their first sexual experience.

2.2 Adolescent Contraceptive Use

Card et al (1988) hold the view that low contraceptive usage among adolescents is due to reasons that the sexual intercourse is not planned and that planning may require admission to the fact that one was becoming sexually active, especially among the young females. Awusabo-Asare et al (2004) suggests that many women do not have an accurate understanding of conception or how to use contraceptives effectively. They posit that many females are not comfortable enough with their sexuality to plan ahead, obtain contraceptives or even talk about method use with their partners. Some adolescents actually hold the erroneous view that they could not get pregnant at the initial sexual act.

Cohen and Rose (1984) argue that males contraceptive behaviour is primarily self-oriented and that adolescent men were more inclined to use contraceptives in casual encounters than with steady girlfriends; the men also tended to view birth control as female decisions. Finkel and Finkel (1975) conclude from a research of 421 male high

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school students that low birth control methods usage among them was due to the sporadic nature of sexual activity and lateness of sexual education.

Hogan et al (1985) explore the correlation between social factors and use of contraceptives at first sexual intercourse. They conclude that teenagers who were higher in socioeconomic status, live in higher status neighbourhoods and had parents with intact marriages were more likely than others to use contraceptives at the first sexual debut.

Awusabo- Asare et al confirm that among 15-19-year-olds in Ghana, 76 percent of women and 88 percent of men are aware of at least one modern family planning method. The condom is the most frequently cited method. They suggest that although about two-thirds of 15-19 year olds (female and male) approve of family planning, most sexually active teenagers do not use contraceptives. Among sexually active adolescents in this age-group, 80 percent of females and 63 percent of males currently do not use any modern method.

They confirm that only 10-12 percent of 15-19 year olds who are not currently using contraceptives intend to use a method in the next 12 months. They posit that young people in Ghana do not feel confident insisting on condom use and that 27 percent of men and 30 percent of women say that they could not insist on using a condom if their partner did not want to use one.

2.3 Adolescent Marriage and Culture

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There are cultural beliefs in every society concerning teenage marriage. Asian and Middle- East cultures accept teenage marriage. In many cultural strict societies the one responsible for impregnating the teenager will be coerced to marry her. This used to be the practice in Ghana but it is gradually dying. Westney et al (1986) contend that most adolescent fathers ignore responsibility for the child and tend to be high school dropouts with no meaningful education aspirations. The longer the relationship before the pregnancy, the more supportive the young man was of the young mother and child and the more the likelihood that the couple will marry according to Westney et al (1986). They conclude that there is no difference in marriage opportunities between an unwed teenage mother and never been pregnant teenage mother.

There is a window between time of sexual debut and marriage. This increases the risk of the adolescent to STIs. The average time between first sexual activity and marriage is about two years for young women and more than five years for young men in Ghana according to Awusabo-Asare et al (2004).

They conclude that half of women aged 20-24 in 1998 had married by age 19.3 but in the year 1988, half had married by 18.7years. Men marry later than women in Ghana, in 1998, half of men had married by age 24.8.

2.4 Teenage Childbearing

Bearing a child tend to have negative effects on both the teenage mother and teenage father, though the negative consequences are far more outreaching for the young

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mothers Card et al (1978). Teenage childbearing has negative consequences for educational attainment, occupational achievement, marital stability and the ability to control subsequent fertility; children of adolescent mothers had lower academic achievement, were more likely to live in single or stepparent families and wee a little more likely to duplicate the early fertility, early marriage pattern of their parents. Illegitimate births are the outcomes of first pregnancies in two thirds of teenagers, according to Zelnick et al (1974). Awusabo-Asare et al (2004) conclude from their study that twelve percent of women and one percent of men aged 15-19 have ever had a child and that one in 10 births in Ghana occur among teenage mothers. Adolescent women in rural areas are more than twice as likely as those in urban areas to have a child. The Pregnant Centre in Virginia (2005) confirms that although some teens marry, the vast majority of boy friends leave when the girlfriends have a baby, sixty seven percent of births occurred to unmarried teenage mothers in 1989 and in the year 1994, 75 percent of teenagers aged 15- 19 are unmarried by the time the pregnancy ends.

Cohen et al (2004) agree that one fifth of all teenage girls who drop out of school do so because they got pregnant and that less than 50 percent of teenage mothers are able to graduate from high school.

2.5 Adolescent and Abortion

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Abortion is a common occurrence among adolescents. Twenty percent of abortions in the U.S. are obtained by teenagers in a survey by CDC (1993). Forty five percent of teenagers who become pregnant unintentionally have abortions posits Henshaw et al (1998). They found out in a study of 439 females that 49 percent did not inform their parents before having an abortion. Whites who do not marry terminate their pregnancies through abortions seven times more frequently than blacks according to Zelnick et al (1974). Sixteen percent of women and eleven percent of men aged 12-24 who ever had sex reported being involved in terminating a pregnancy in Ghana according to Awusabo-Asare et al (2004) and not all abortions take place in a clinical setting: thirty percent of women and thirty nine percent of men aged 12-24 say that the last abortion they were involved in took place at home. They posit that young women most often cite a desire to continue their education, the lack of financial means to support a child or their male partner's denial of paternity as the main reason for having an abortion.

2.6 Sexually Transmitted Infections

From the GDHS (2003) about one in four adolescents (27 percent of males and twenty two percent of females) say that they know one or more people who have ever had an STI. Among adolescents who have ever had an STI, three-quarters of young men and more than half of young women sought treatment, most often from a drug store, hospital or clinic. After HIV/AIDS, adolescents are most likely to have heard of gonorrhea, followed by syphilis.

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2.7 Focus on HIV/AIDS

General awareness of the disease is nearly universal among 15-19-year-olds, with ninety seven percent of both males and females reporting that they had heard of HIV/AIDS. However, about one in five young men and women still cannot name any specific way by which HIV is transmitted, and only about one in four believe themselves to be at risk of infection. In response to the outbreak of the HIV/AIDS epidemic in 1986, the Ghanaian government embarked on a set of educational programs designed to increase awareness. The mass media and the workplace are the main sources of HIV/AIDS information for adolescents. Among those aged 15-19 who have heard of HIV/AIDS, the reported sources of information for females and males, respectively, are radio (66 percent and 68 percent); workplace (52 percent and fifty percent); television (49 percent and 46 percent); print (13 percent and 18 percent); friends and relatives (7 percent and 5 percent); and health workers (2 percent and 3 percent) (GDHS).

Six in 10 teenagers say that knowledge of HIV/AIDS has influenced their behavior, according to one study of 10-19 years-olds in three areas of Ghana.

National studies have also shown, however, that fewer than half of adolescents who have heard of HIV/AIDS have actually changed their behavior by abstaining from sex, limiting their number of partners or using condoms as a result of HIV/AIDS knowledge.

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2.8 Conceptual framework

The term teenager is of fairly recent origin. It first appeared in the Readers' Guide to Periodical Literature in the 1943-1945 issue but since has become a popular term to denote people aged between 13-19 years. These subjects are the focus of this study. Adolescent refer to the period of transition in human development from childhood to adulthood. It is characterized by rapid emotional and physical changes, and an increasing awareness of ones sexuality and awareness of the sexuality of others- same and opposite sex. There are variations in definitions on the exact period of time of the adolescent period but most define it as a period between ages 10-19 years. In Ghana, the booklet on Adolescent Reproductive Health Policy, 2000 defines adolescence as the period between 10 to 19 years and defines youth as ages 10 to 19 years.

Many factors have been thought to influence teenage pregnancy and adolescent sexuality. Some of the factors include peer pressure exhibited by a need to belong to a group, curiosity, the need to love and be loved in return, and lack of parental control among others. Socio-cultural acceptance of early marriages in certain countries also is a major factor causing teenage pregnancy. Lack of career aspirations and future goals will influence a teenager's waywardness and indulgence in sexual activity. Negative media influences especially in this era of globalization, poor knowledge of contraceptives as well as the reproductive organs and cycle and irregular usage of contraceptives all act as determinates of teenage pregnancy.

Factors that will be explored in the study include peer pressure, need for financial support and age at menarche. Socio-cultural factors will indirectly be assessed using religion and religious practice, festival celebration and participation in the

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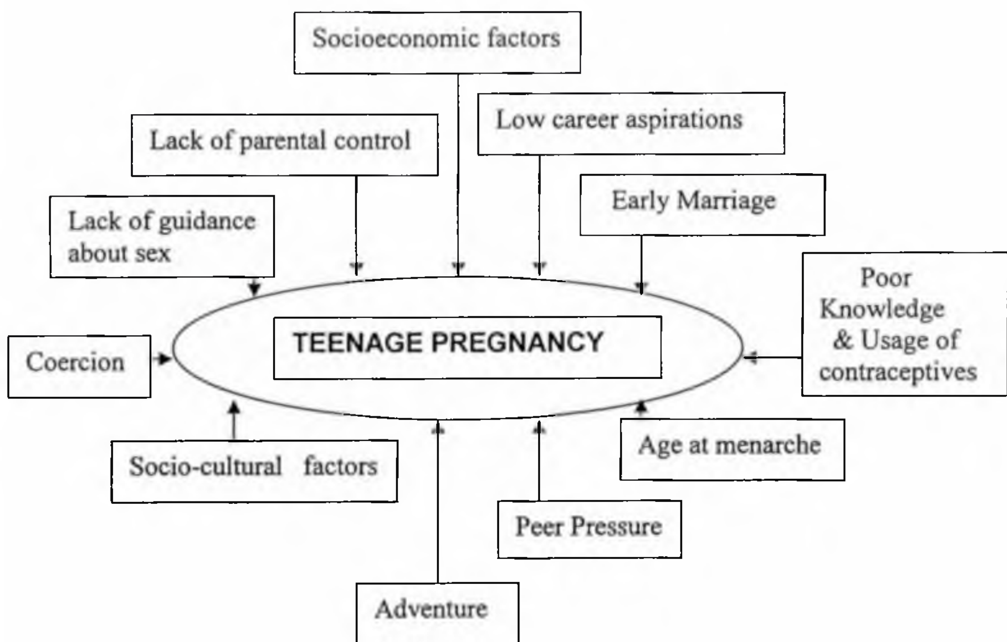
community, early marriage. Socioeconomic factors will be investigated indirectly through the variables: occupation of the parents, living arrangements, bathing facilities, who pays the school fees. Contraceptive knowledge and usage by sexually active youth, knowledge of HIV/AIDS and education on teenage pregnancy will help to identify reproductive knowledge of the respondents.

Figure 2. Diagrammatic Presentation of Factors that Cause Teenage Pregnancy



The factors such as age at menarche, poor knowledge and usage of contraceptives, lack of guidance about sex, low career aspirations, socioeconomic factors, socio-cultural factors, coercion, adventure, peer pressure and lack of parental control in the community will be explored in the study.

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CHAPTER THREE: STUDY AREA AND METHODOLOGY

3.1 STUDY AREA

3.1.1 Location and Size

Awutu Effutu Senya District is in the Central Region. It was carved out of the former Gomoa-Awutu-Effutu District in 1988 to facilitate government's decentralization and local government reform policy. It is situated between latitude 5 20' north and longitudes 5 42' and longitudes 0 25' and 0 37' west on the eastern part of the Central Region of Ghana. It is bordered by the Greater Accra and three districts, namely Ga District Agona Gomoa. It is bordered to the north by Agona District, to the north – east by the West Akim District, to the south by the Gulf of Guinea, to east by Gomoa District and Ga District and on the Gomoa District. The district covers an area of approximately 417.3 sq/ km.

3.1.2 Socio-Demographic Features

According to the 2000 population and housing census, the population of the district was approximately 169,972. This represents ten percent of the population of the central region. The district has approximately168 settlements with Winneba as the district capital. The table 3.1 shows population characteristics of the district.

The major settlements in the district are Winneba, Senya, Kasoa, Awutu Bereku, Bontrase, Bawjiase. These settlements have 60 percent of the district population. The main ethnic group in the district are the Guans.

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Table 3.1 Population Characteristics of Awutu-Effutu-Senya District and Senya Bereku Community

Name of locality	Total population	sex	
		male	female
Awutu-Effutu-Senya District	169,972	80,535	89,437
Senya Bereku Community	15,908	7,100	8,808

Source: Ghana Statistical Service 2002

3.1.3 Major Economic Activities

Agriculture, commerce, service, and manufacturing and processing are the main economic activities. Agriculture constitutes the main economic activity of the district economy. It employs about 58 percent of the district population. The farming population is 99,116, including fishermen who total 16,519. Agricultural production in the district is on two levels: subsistence level constitutes 70 percent of the farming population while commercial farming constitutes 30 percent. Senya is basically a fishing community and this is the main economic activity in the district. Because it is along the coast however it has a potential to grow in the tourist sector especially with the construction of hotels along the beach.

3.1.4 Income per household

The average annual income per household from a survey in October 2002 (GLSS 4) was 6,944,091cedis as against the expenditure of 12,460,618cedis. Education represented 7.1 percent of the household expenditure.

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3.1.5 Educational facilities

The percentage of girls' enrolment in the educational facilities decreases as the level of education increases from an average of 53.2 percent to 46.5 percent, then increases at the Senior Secondary School (SSS) level. The increase at the SSS level may be due to the fact that some of the girls are from outside the district since the schools have boarding facilities for students who live outside the district. According to the District Director of Education, the drop-out of girls from the schools is due primarily to pregnancy.

Drop-out of girls is greatest at the level of Junior Secondary School (JSS).

Table 3.2 Distribution of educational facilities in AESD

Type of School	Number	Enrolment	% of Girls	Drop-out rate of girls %
Nursery/ Kindergarten	101	7,220	53.2	
Primary	121	25,642	47.8	5.3
JSS	60	9,804	46.5	10.1
SSS	4	3,518	48.8	0.83
Total	286	46,184		

Source: District Education Office (2002)

The percentage enrolment for girls at the JSS level is lower for Senya Bereku (43.8 percent) as compared to the percentage enrolment for the district at (46.5 percent). This is due to the reason that teenage pregnancy in the community of Senya Bereku according to the District Director of education is higher than in any part of the district.

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is celebrated in the month of August which coincides with the season of fish bumper catch.

3.2 METHOD OF DATA COLLECTION

3.2.1 Sources of data and Sampling Frame

The data were collected from primary and secondary sources. The secondary data includes literature from the internet, journals, statistical service reports, quarterly reports from the health centre and the district education service office as well as the district assembly. Primary sources are observations from field, in-depth interviews with opinion leaders and key informants and focus group discussions.

Since the entire student population of about 1500 in the community could not be included in the study, a representative sample of 200 respondents was used for answering the questionnaires. These 200 teenagers 'never been pregnant' were selected this way: 120 students from five Junior Secondary Schools and 80 students from the only Senior Secondary School in the district.

Ten teenage mothers were picked for in-depth interviews

Twenty teenagers participated in 2 focus group discussions: 10 males and 10 females in each respectively

Fifteen key informant interviews with the following persons were held:

- The youth leader of the Muslim community
- The peer educator for AYA in the community
- Three teachers
- The Medical Assistant
- One midwife

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- A public Health nurse
- Five mothers of teenage mothers for their opinions
- The District Assembly Officer
- The District Director of Education

3.2.2 Sampling Technique

The students from all the JSS schools in the community were used in the research. This was done to ensure equal representation of the sampling population and to avoid any bias. The Senya Senior Secondary School being the only SSS in the community was picked by the purposive sampling method.

Two hundred teenagers 'never been pregnant' were selected from the five Junior Secondary Schools in the community by the simple random technique. The students were made to pick ballot papers that had 'Yes' or 'No' written on them. The papers were equal in size, texture and colour and were identical. The papers were shuffled prior to being picked by respondents. The 200 who picked 'Yes' ballot papers were included in the research: 120 students from JSS and 80 students from the SSS. Ten teenage mothers were also picked using the snowball approach with the help of 5 key informants.

Twenty teenagers participated in 2 focus group discussions: 10 males and 10 females in each group. The focus group discussions were done with the help of a moderator and recorded on audio tape. The recorded information was then transcribed. A research assistant was enlisted to help in the collection of data from the students in the field.

Key informants interviews were held with teachers, the youth leader of the Muslim community, the peer educator for AYA in the community and the Medical Assistant,

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midwife, public health nurse at the Senya Bereku Health Centre, mothers of five teenage mothers, the District Assembly Officer and the District Education Officer as opinion leaders.

3.2.3 Instruments of data collection and analysis

The instruments used in collecting data from the field included questionnaire which was in the form of open ended, closed-ended and semi-closed questions. All the questionnaires were self-administered. In-depth focus group discussion and in-depth interviews with opinion leaders and key informants helped to solicit views, which would otherwise not have been captured in the questionnaires. Data collected was transferred to the Statistical Programmes for Social Sciences (SPSS) after all the data cleaning had been completed. Descriptive statistical tools were used to summary statistics in forms of frequencies and relative percentages. Bivariate analysis, T and Chi-square and Correlations were run to study relationships between variables. The results have been presented in the forms of tables, graphs, charts and bars.

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Ethnicity of respondents

The ethnic distribution of the respondents reflects the socio-demographic features of the community as the main ethnic group (77 percent) of respondents are Akans/ Guans.

The other ethnic groups refers to migrants from neighbouring countries in West Africa – most of them Liberians which is understandable considering the proximity of the refugee camp at Bunduburam to the community.

Pattern of ethnic background is presented in Table 4.1.

Table 4.1 Ethnicity of respondents

Distribution of respondents by ethnicity	**Ethnic group**					
	Akan/Guan	Ga/Adangme	Ewe	Gur	Hausa	Other ethnic groups
	77%	6%	3%	5%	5%	4%

Source: Field survey

Characteristic by the parent being alive, whom they stay with

Data was collected about their parents being alive or not, whom they stay with to assess if students were from broken homes and to assess the head of household.

Parents alive or not

All the respondents' mother was alive and 14 percent of the respondents' father was deceased.

Parent respondent stays with

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CHAPTER FOUR: RESULTS AND DISCUSSION

4.0 Introduction

Information collected from the field survey is discussed in this chapter. The study variables included gender, age, age at first intercourse, age at menarche, occupation of father and mother, religion and religious practice, family composition, current living situation, condom knowledge and usage, 'ever had sex', HIV/AIDS knowledge, education on teenage pregnancy, communication with parents, guardians or other people when respondents have problems.

4.1 Socio -Demographic Characteristics of Respondents

Sex and age of respondents

The number of male students who answered the questionnaire totaled 58 and the total number of females 'never been pregnant' totaled 142. The median age of males is 16.6 years and that of females is 16.09 years in the survey.

The median age for teenage mothers in the survey was 18 years.

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Majority of the 'never pregnant' respondents lived with their mother only (46 percent), as against 37 percent who lived with both parents; 7 percent who lived with their father only and ten percent who lived with other relatives. From the survey it was found out that majority of the 'never pregnant' respondents were from homes where their parents were either divorced or separated or had polygamous marriages. One hundred percent of the teenage mothers were from female headed households and out of this 20 percent stayed with a female relative other than their mother. All the teenage mothers were from homes which lacked a fatherly figure. Fifty percent of the teenage mothers were from homes where their parents were divorced or separated. Ten percent said their fathers had traveled outside the county for some years and had not been in touch. Thirty percent were from polygamous homes and father was deceased in ten percent of cases.

Table 4.2 Parent respondent stays with

Description	'Never pregnant' teenager	Teenage mothers
Both parents	37%	
Mother only	46%	80%
Father only	7%	
Relatives	10%	20%
Total	100%	100%

Family instability, need to love and express love, lack of a proper male role model contributed to the incidence of adolescent pregnancy in their situation.

Family size

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Family size was assessed using information gathered by the number of siblings each respondent had. Number of siblings in the family of respondents ranges from 1 to 9. Majority of respondents (27 percent) had 5 siblings. Mean number of siblings of respondents is 4.7 per family. Since family size is a reflection on the financial constraints on the household head, especially female headed households (GDHS 2003), it is reasonable to assume most of the respondents came from large families with low income levels.

4.2 Socio-Economic Characteristics of respondents

The parent's occupation

The main occupation of father (29 percent) was found out to be civil servant from the field survey. The next main occupation of the father was fisherman. Not specific (6 percent) was of students whose fathers were deceased even though some of the students stated the occupation of their father though he was deceased.

Figure 3. Occupation of Father of Respondents

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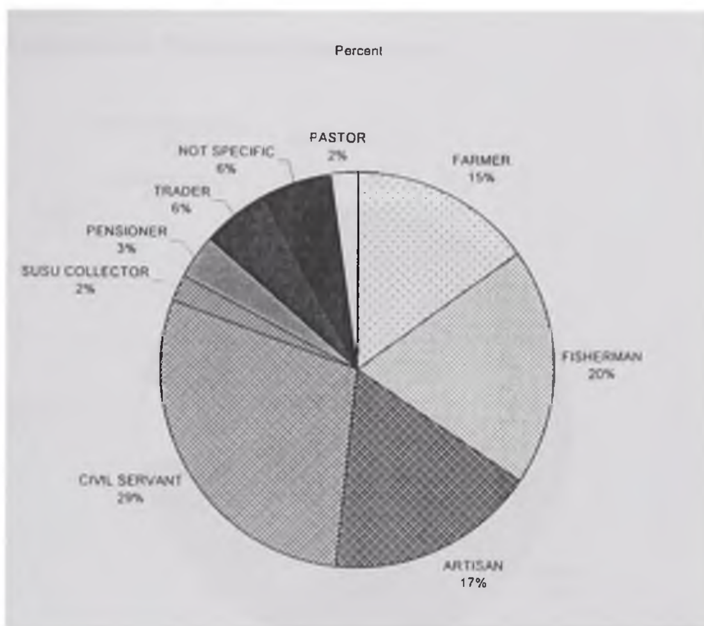

Source: Field Survey

Most mothers of respondents were found to be traders (72 percent) from the field survey. Fishmongers occupied only seven percent of occupation of mothers. The distribution is illustrated in Figure 4. The three percent stated as non specific is of those respondents who did not make available the occupation of their mothers. All the mothers of the teenage mothers were petty traders which imply an irregular source of income as compared to that of civil servants.

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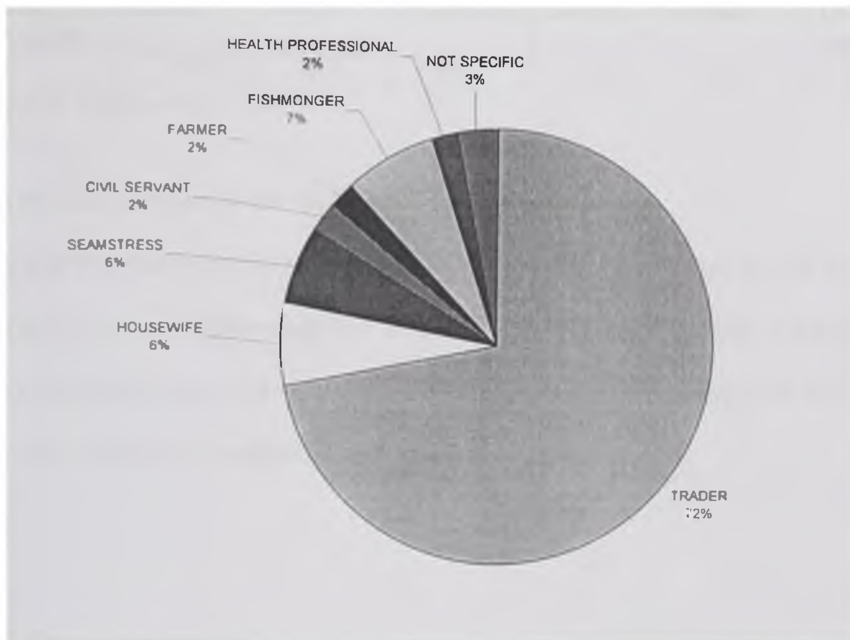
Figure 4. Occupation of Mother of Respondents



Source: Field survey

Payment of school fees

Forty- eight percent of the students had their fees paid by their fathers; this is less than fifty percent of the respondents. Of concern are the students who paid their fees themselves. These were female students who also worked and received money from their sexual partners in order to pay their fees. Detailed information is outlined in Table 4.3. These female students are at risk of getting pregnant because of the financial support they need to continue their education.

Table 4.3 Distribution by Who pays School fees for Respondents

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% of students	Payment of school fees					
	Father	Mother	Guardian	Siblings	Myself	Both parents
	48%	40%	7%	1%	2%	1%

Source: Field survey

Economic activities of the students

Twenty five percent of the respondents said they worked for income as well as attend school. The most common job they were involved in was petty trading of ice-water and other items that is (94.4 percent). The rest of the working respondents that is 4.6 percent sold cooked foodstuffs.

4.3 Career aspirations

Majority of the 'never pregnant' respondents had career aspirations; only 24.7 percent did not know what to do in the future. The professions chosen were civil servant (45 percent), seamstress/ tailor (14.4 percent), health professional (7.2 percent), broadcaster (4.1 percent), caterer (2.1percent), and air hostess (1percent).

4.4 Socio-Cultural Characteristics of respondents

4.4.1 Religion and religious practice

Majority of respondents were Christians i.e. 90 percent and forty percent of them practiced their religion daily. Only 10 percent of the respondents were Moslems. Crosstabulation of religion and religious practice was run to assess the differences if any between the two main religion and religious practice. Findings are in Table 4.2. Other as stated in Table 4.4 i.e. 2 percent of respondents, for religious practice, were

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students who practiced their religion irregularly and sporadically. Some 4 percent reported truthfully that they did not practice their religion at all.

Table 4.4 Characteristics of respondents by religion and religious practice

Religion	Religious practice					
	Daily	Twice weekly	Weekly	Fortnightly	Not at all	Other
Christian	40%	22%	19%	5%	4%	
Moslem	5%		2%	1%		2%
Total	45%	22%	21%	6%	4%	2%

Source: Field survey

4.4.2 Living arrangements

Place of abode

Sixty- eight percent of 'never pregnant' respondents said they lived in a compound house as against thirty two percent who do not live in a compound house. Ninety percent of the teenage mothers lived in a compound house and the rest 10 percent lived in a single house unit.

Sleeping arrangements

The sleeping arrangement reflects the income of the family of the respondents. Majority of students shared rooms with either their parents (34percent) or their siblings (47 percent). Only 14 percent of the students had a room to themselves and a few even slept on the corridor of their homes. Prior to being pregnant, the seventy percent of the teenage mothers shared a room with the household head or their siblings, thirty percent had a room to themselves. It is was suggested by some opinion leaders that, that might be a contributory factor to teenage pregnancy in the case of

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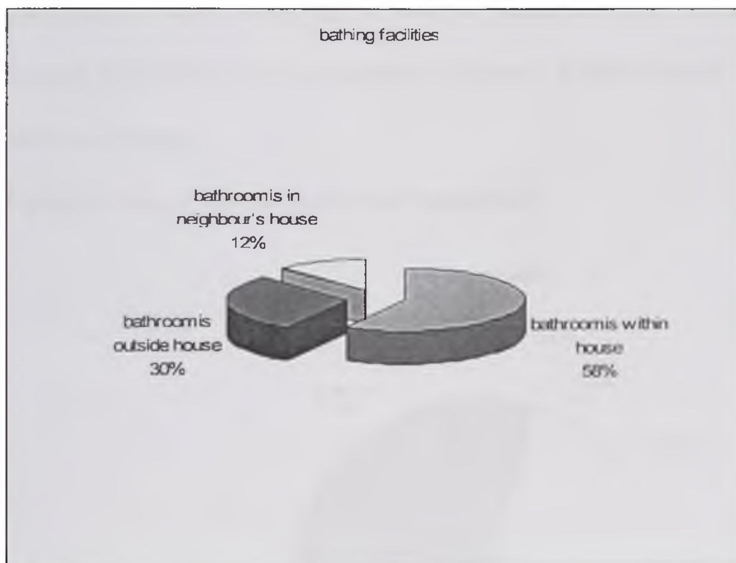
those who share rooms with their parents but this was not reflected in the survey results of the teenage mothers since they lived in female headed housholds.

Bathing facilities

Since most of the respondents live in a compound house their bathing facilities were included in the survey. Fifty- eight percent of the students had bathing facilities within the house though some had their bath outside their house or in a neighbour's house. Having a bath outside the house may increase the risk of coercion to participate in a sexual act. Data has been represented in Figure 5.

Figure 5. Percentage distribution of bathing facilities of respondents



Source: Field survey

4.4.3 Festivals

The months for the festivals were stated as August (94.7 percent), followed by May (4.2 percent) then February and September (1percent) each. The discrepancies may be due to the fact that not all the students are from the community so they will have

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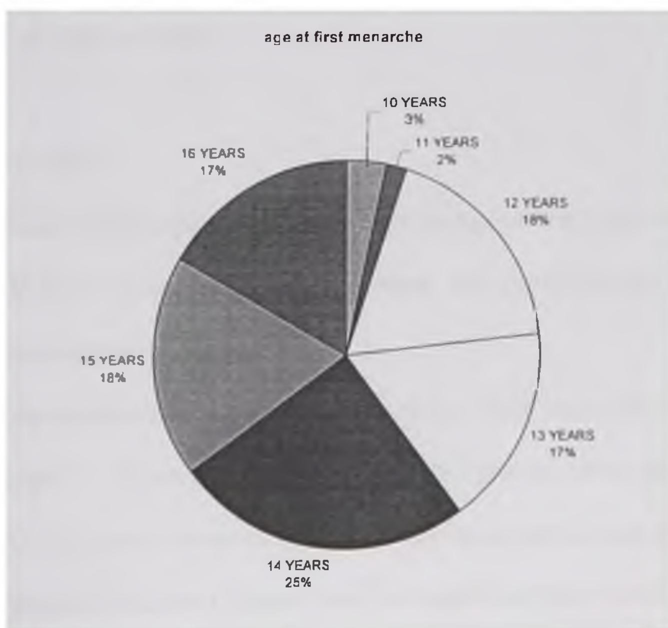
different festivals in their hometown, since the question read as 'Do you have any festival in your community?' Fifteen percent of respondents said they stay out late during the festival seasons and seventy one percent said they make new friends during that time. Festivals are social gatherings and in this time many parents are lax on strict rules for their children.

4.5 Menarche and Sex Experience

Menarche

Most common age at first menarche is 14 years (25 percent), followed by 15 years and 12years at 18 percent respectively. The least age is 11 years. Median age for menarche is 14.06 years. Age at onset of menarche from the field survey has not reduced as expected in the community compared to global trends. Figure 6 shows the community trend.

Figure 6. Age at first menarche of respondents



Source: Field survey

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'Ever Had Sex' Experience

Respondents were asked if they had ever engaged in sexual intercourse and 56 percent of the respondents answered in the affirmative. To determine the gender differences for those who have ever had sexual intercourse a crosstabulation with a Chi-square test was performed. The results show that majority i.e. 82.8 percent of the male respondents had eve had sexual intercourse whilst 45.1 percent of the females had ever had any sexual intercourse. These results show that male students are approximately 12 times more likely to have ever had sex as compared to the female students.

Table 4.5 Percentage distribution of respondents by sex and sexual experience

sex	no	yes	N
Male	**17.2%**	**82.8%**	**58**
Female	**54.9%**	**45.1%**	**112**

[X^2 (1, 200) =11.869, p=0.001]

Age at sexual debut

Eighteen percent of the respondents did not state the age of first intercourse though most stated if they had ever had sexual intercourse. The eighty two who stated their age of first intercourse are illustrated in Fig.8.

Majority of the students had sexual intercourse at age 15-16 years (50 percent) followed by age 17- 18 years at 38.9 percent, with 5.6 percent having had sexual intercourse at less than ten years of age. These were male respondents that had sexual intercourse at ages 4 years and 5 years. Many teenagers had their sexual debut in later teen years that is from 15 years onward.

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Figure 7. Age at sexual debut

Source: Field survey

How the sexual debut took place

Majority 58 percent of the never pregnant teenagers stated that they were coerced in their first sexual debut. The next largest group, 26 percent said they were tricked into having sexual intercourse.

Sexual debut pattern was significantly different for the males and the females as shown in Fig. 9. Many female respondents stated that they were forced or tricked. Significantly some of the male respondents 11percent stated that the sexual act was planned. Gender and violence plays a significant role in sexual debut. This pattern reflects in the findings from the teenage mothers, 60 percent of who stated that they were coerced, 20 percent- they were tricked and 20 percent said it just happened. With a Chi-square of ([X^2 (3,84)=9.064, p=0.028]) the alternate hypothesis that coercion

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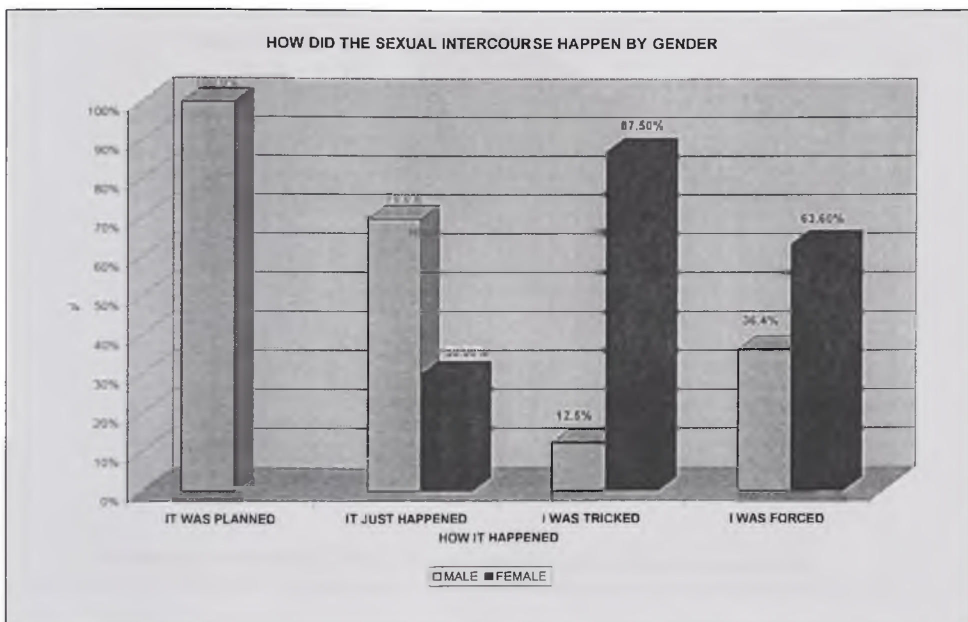
plays an important role in the cause of teenage pregnancy is accepted . Percentage distribution for gender is represented in Figure 8.

Figure 8. Situation in which the sexual debut took place



Source: Field survey

Present Sexual activity

Only 18 percent of the students who had ever had sexual intercourse answered questions on their present sexual activity. Of these sexual activity is as follows: daily (5.6 percent); once a week (33.3 percent); once monthly (44.4 percent); twice monthly (11.1 percent); sex just once (5.6 percent). Frequency of sexual activity was not dependent on the gender of the respondents.

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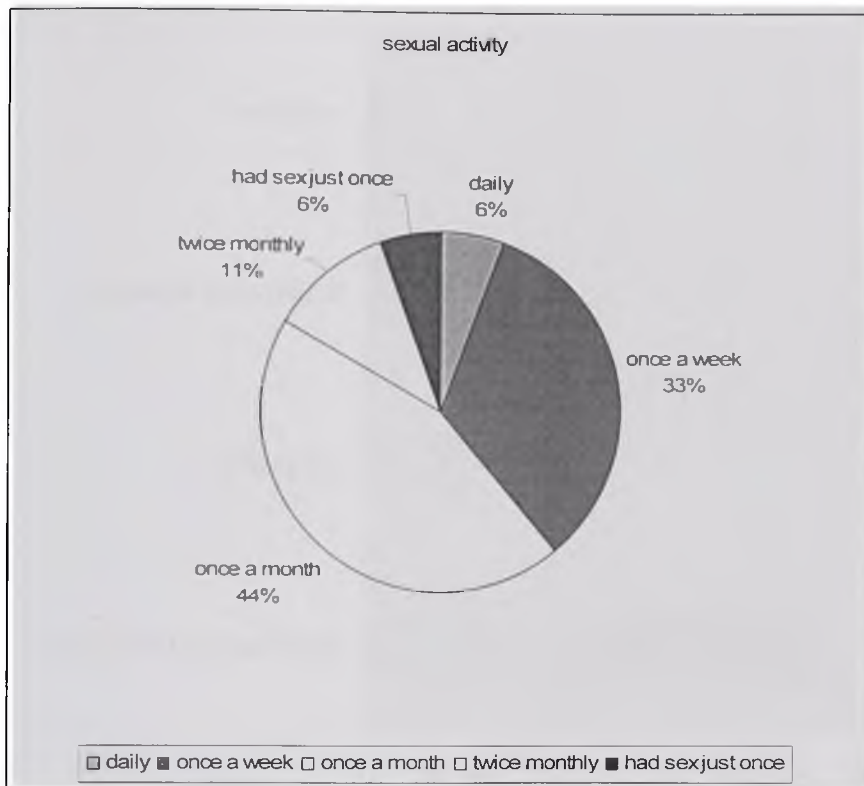
Figure 9. Sexual Activity of students



Source: Field Survey

Relationship to the person you last had sexual intercourse with

Thirty one percent of the respondents responded to the question of relationship to the person they last had sexual intercourse with. There was no statistical difference for gender in the relationship to the person they last had sexual intercourse with (p=0.445). Most respondents are in consensual relationships.

Figure 10 shows the diagrammatic presentation of the gender and the various categories of boyfriend/ girlfriend, stranger, casual acquaintance, and relative.

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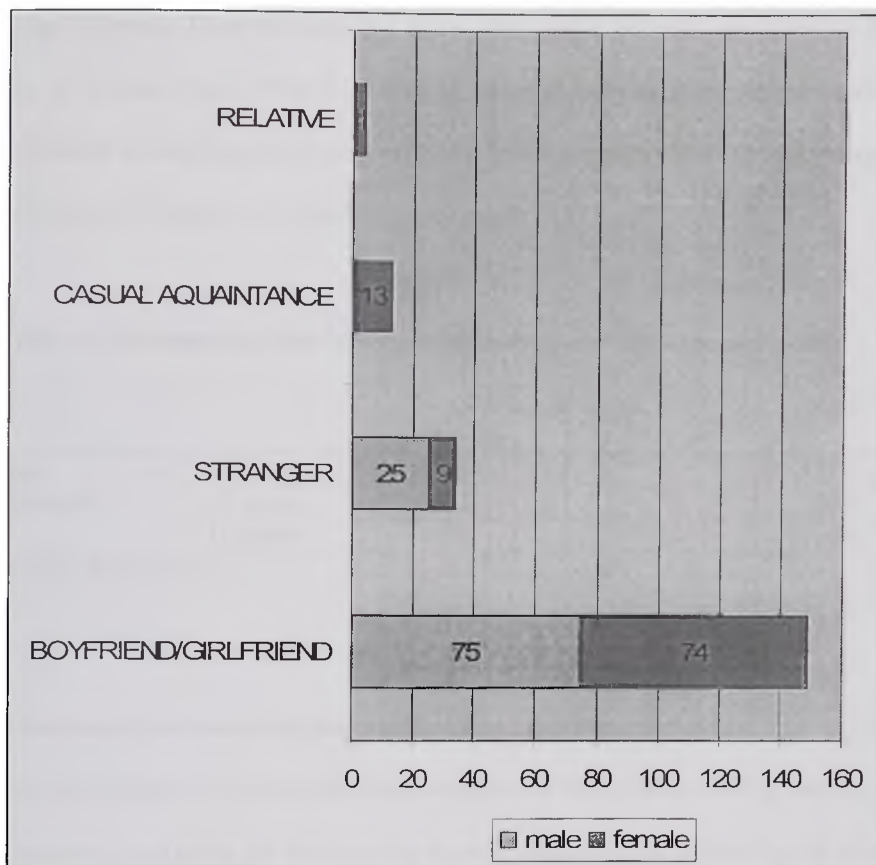
Figure 10. Relationship to the person you last had sexual intercourse with



Source: Field survey

Relationship between age at menarche and sexual debut

Early age at sexual debut influences the probability that a teenager will either get pregnant or contract sexually transmitted diseases. Most young adolescents receive education on sexual education much later than their age of sexual debut. All the respondents who had menarche at age 12 years had sexual intercourse at ages 15-16 years and they are 50 percent of the female respondents who affirmed their age of first sexual intercourse. None of the respondents with earlier menarche ages made their

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sexual debut after the age of 17 years, but much earlier than those who had menarche at age 16 years. There is a strong positive relationship between age at menarche and age of sexual debut (r=0.651, p=0.042), proving that early age at menarche may contribute to early sex debut and puts these females at high risk of getting pregnant in adolescence if protective measures are not taken.

Table 4.6 Relationship between age at menarche and age at sexual debut

		Age at sexual debut		Total
		15-16 years	17-18 years	
Age at menarche	12 years	50%		50%
	14 years	10%	10%	20%
	16 years	10%	20%	30%

Source: Field survey

Relationship between religious practice and age of sexual debut

Religious practice was assessed using categories of daily, twice weekly, weekly, fortnightly, and not at all. Relationship between religious practice and age at sexual debut was investigated by using a cross tabulation.

Table 4.7 Relationship between religious practice and age at sexual debut

		Age at first sexual intercourse				Total
		Less than 10yrs	13-14yrs	15-16yrs	17-18yrs	
Religious practice	Daily			16.7%	22.3%	38.7%
	Twice Weekly			16.7%	5.6%	22.3%
	Weekly		5.6%	16.7%		22.3%
	Fortnightly	5.6%				5.6%
	Not at all				11%	11%
Total		5.6%	5.6%	50.1%	38.9%	

Source: Field survey

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There is a highly significant relationship between religious practice and age at sexual debut [X^2 (12, 36)=27.735, p=0.006]. Those who practiced their religion daily made their sexual debut at a later stage in their teenage life than those who practiced their religion weekly and fortnightly for. All the teenage mothers said prior to being pregnant they had practiced their religion fortnightly.

Career aspirations and 'ever had sex' experience

There was a relationship found between specific career aspirations and sexual activity [X^2(6, 194)=14.165, p=0.028]. All the respondents who aspired to be health professionals in future had never had any sexual intercourse whereas for all the other students irrespective of their choice of career, majority of them, over 50 percent had ever indulged in sexual intercourse. Aspiring health professionals may be more focused and interested more in their health and the consequences of getting pregnant.

Financial exchange in relationships

Many respondents said they neither receive money nor give money to their sexual partners but those who do receive money, spend the money on food (36.4 percent), clothes (36.4 percent) and school fees (22.7 percent), and other things (4.5 percent). All respondents who need financial assistance from sexual partners in order to pay or subsidize their school fees are more at risk from sexually transmitted infections and teenage pregnancy.

4.7 Contraceptive knowledge and use

Contraceptive use

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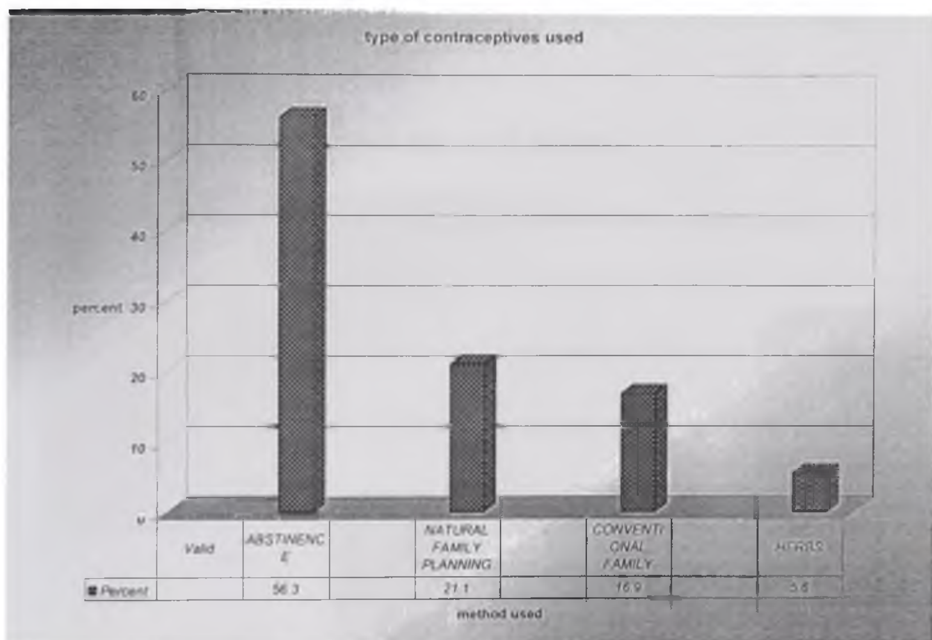
Seventy one percent of respondents said they were doing something to prevent pregnancy. The methods used are as follows: abstinence (56.3 percent); natural family planning (21.1 percent); conventional family planning method (16.9 percent); herbs (5.6 percent). Figure 11 shows a graphic presentation on the methods used to prevent pregnancy.

Figure 11. Contraceptive usage



Source: Field survey

This means that the teenagers from the survey are not using conventional family planning methods but are relying on natural family planning methods and herbs; placing themselves and their partners at risk from Sexually Transmitted Infections, HIV/AIDSs as well as unplanned pregnancies. Despite education some are using herbs (5 percent) to prevent unwanted pregnancy. The efficacy of this method cannot be vouched for. The majority of the students though are abstaining from sexual activity.

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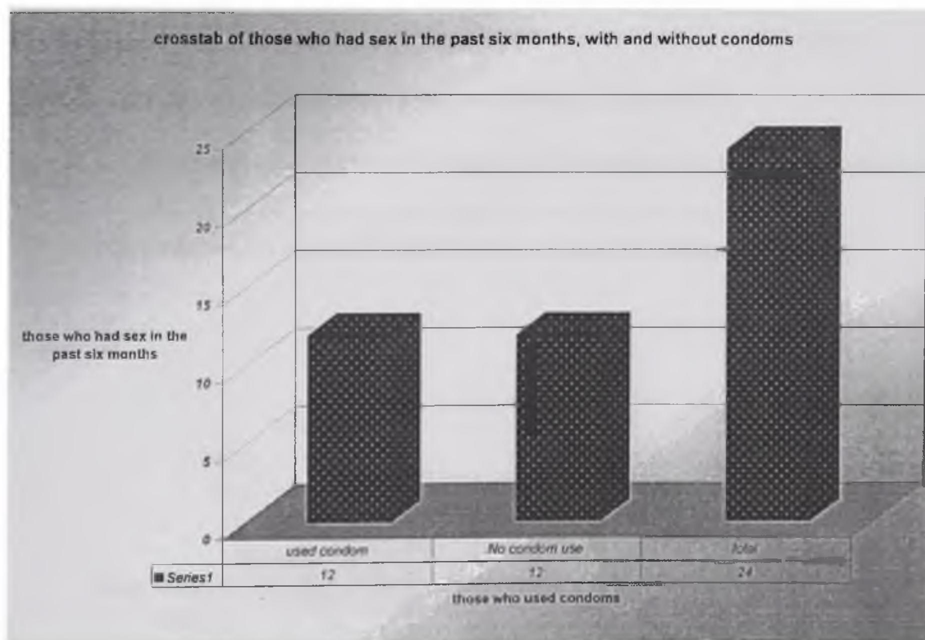
Focus on Condom usage

Twenty four percent of students said they had had sexual intercourse in the past six months, out of which only 50 percent of them used a condom. Despite education on teenage pregnancy and HIV/AIDS, 50 percent of the students who had sexual intercourse in the past 6 months did not use condoms for the sexual activity.

Figure 12. Contraceptive use in the past 6 months



Source: Field survey

In the focus group discussion the general consensus was that they did not patronise condoms because as one respondent put it "we do not like condoms".

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Most of the students (90 percent) did know where to get condoms; with the chemist shop being the common option, though some students had knowledge about assessing condoms from peer educators in the community.

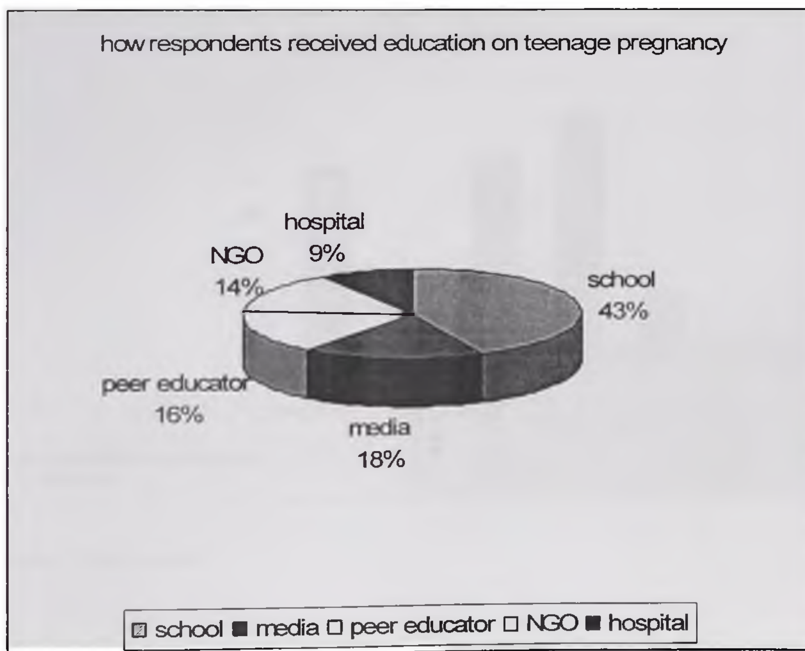
Only 25 percent of the teenage mothers interviewed used injectable contraceptive to prevent pregnancy but this failed over a period of time because all contraceptives have failure rates.

4.8 Education and knowledge of teenage pregnancy

Education on teenage pregnancy

All the respondents had received education on teenage pregnancy. Method of education was by the means of school, media, peer education, NGO, and hospital. Education was given within the past 2 years on teenage pregnancy.

Figure 13. Percentage distribution of methods of education on teenage pregnancy



Source: Field survey

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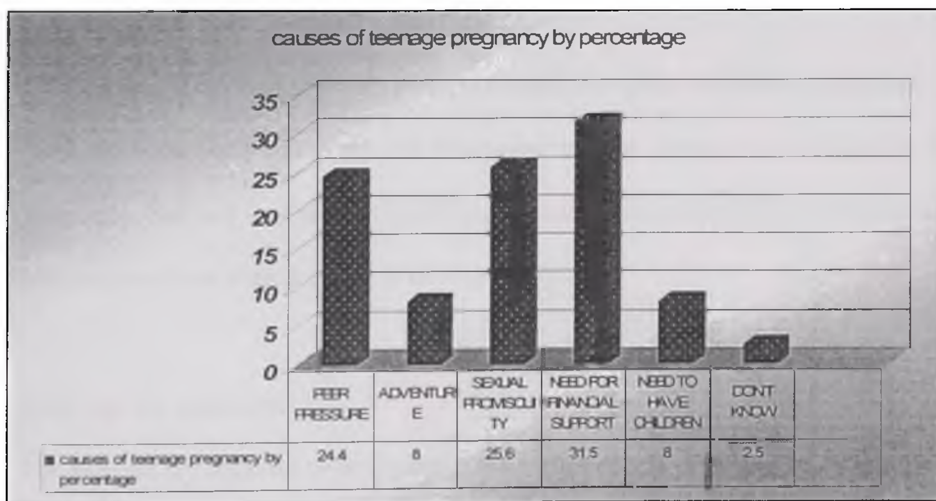
Reasons for increase in teenage pregnancy

This was a multiple response question and respondents could give as many reasons as they wanted for the cause of teenage pregnancy. The answers included need for financial support (31.5 percent), sexual promiscuity (25.6 percent), peer pressure (24.4 percent), adventure (8 percent), need to have children by certain age (8 percent), don't know (2.5 percent).

None stated coercion as the reason for teenage pregnancy, though as much as 58 percent of respondents stated that they were coerced at the first sexual act: bringing to the fore the misconception among most teenagers that one cannot get pregnant in the first sexual act. Figure 14 is a graphic presentation of the causes of teenage pregnancy according to the students themselves.

Figure 14 Causes of teenage pregnancy in Senya according to students in community



Source: Field survey

All respondents at the focus group discussions felt sex was an integral part of 'boyfriend-girlfriend relationship' and that if someone was in a relationship with the

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opposite sex then the person could not refuse to have sex with the partner. Seventy-five percent of the teenage mothers interviewed entered into their sexual relationships willingly with their partners but 25 percent of the teenage mothers did say they were coerced and got pregnant at the initial sexual act.

Knowledge about teenage mother

Eighty five percent of the students knew of a girl who had gotten pregnant in the past four years and had to drop out of school. Eighty seven percent of the respondents knew the situation of the teenage mothers as at now.

The following reasons were given as their assessment of the teenage mother's present situation: nothing idling at home -32.2 percent; petty trading -27.6 percent; formal schooling -13.8 percent; apprenticeship- 12.6 percent; cohabiting with the one who impregnated her -9.2 percent; married to the one who impregnated her -3.4 percent; cohabiting with someone else -1.1 percent.

All the teenage mothers interviewed were not married to the one who impregnated them. With the exception of one, the fathers had actually denied responsibility for the pregnancy. Seventy five percent of the teenage were continuing their formal education with support from their families in rearing the child.

Ideal age for marriage

The age that the majority of students felt was ideal for girls to get married is between the 25-30 years range. Despite the education on teenage pregnancy 2.1 percent felt the ideal age for marriage was from 15-19 years.

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Table 4.8 Students Opinion for the Ideal age for Marriage of Women

% of students	Ideal age for marriage in a range			
	15-19yrs	20-24yrs	25-30yrs	>30yrs
	2.1%	18.6%	76.3%	3.1%

Source: Field survey

4.8 Communication

Interpersonal relationships is very important in development during the teenage years for it helps shape their lives emotionally and psychologically so having someone to talk to when teenagers have problems is very important. The majority of students said they talked to their mothers when they have problems. The results were mother only (39 percent), parents and friends (5.2 percent), both parents (13.1 percent), friends (1.1 percent), no one (9.1 percent), relatives (5.1 percent), pastor/church elder (3 percent), teacher (2 percent).The 'relatives' in the survey referred to siblings and grand parents. Of concern is the 9.1 percent who do not communicate with anyone when they have problems. They will need counseling.

4.9 The Community Perceptions about Teenage Pregnancy

Results from in depth interviews held with opinion leaders, key informant persons were used to assess the perception about teenage pregnancy in the community. According to some opinion leaders, early marriage was a culturally acceptable norm in the community. In fact parents and relatives got worried if by 17 years of age, daughters had no suitor in sight and persisted in continuing their education; 'a woman's place in society is to have a family of her own and care for them as a housewife whilst the man must be the breadwinner' –is their belief. Poverty and lack of parental control were stated as contributory factors to teenage pregnancy in the

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community. Fifty percent of the mothers of teenage mothers bemoaned their lack of parental control that they believe contributed to the pregnancy. The other 50 percent thought it was in place for the child to be married by age 17 years though regretting that no traditional marriage had taken place prior to the pregnancy. Mothers of the teenage mothers bemoaned the irresponsibility of the men responsible for the pregnancy.

The District Assembly instituted a curfew on the youth in the community as a measure to curb teenage pregnancies where no youth is to be seen in dark shadowy places after 8pm or the guardian/ parent will pay a fine after two admonitions.

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CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary and Conclusions

The study researched the causes of teenage pregnancy in the Senya Bereku community of the Awutu Effutu Senya District. Teenage pregnancies accounted for 17.2 percent of the total pregnancies in the Senya Bereku community of the Awutu Effutu Senya District in the Central Region in the year 2004 from a total of 878 antenatal visits to the health centre. Central Region has the highest teenage fertility rate in the nation from the GDHS (2003) at a rate of 24.1 percent. Drop out rate of girls from the educational institutions is higher in Senya Bereku than the other communities in the district and this is primarily due to teenage pregnancy.

Fifty six percent of the students in the survey had ever had sex before, the median age at sexual debut being about 16 years. The median age of the respondents was also 16 years. Male students were more likely to have engaged in sexual intercourse than female respondents. Coercion was an important feature in sexual debut for the female respondents though it also featured for some men. There exists a relationship between age at menarche and age at sexual debut where girls who had menarche before age 12 years also had an earlier sexual debut. The study found a strong relationship between extracurricular activities such as religious activities and sexual debut, where those who were active in extracurricular activities delayed their sexual debut to later teen year. No relationship was found between sexual debut and sleeping arrangements; sexual debut and bathing arrangements. There was a relationship between sexual activity and the various career aspirations with all the health professional aspirants abstaining from sexual activity.

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All respondents had knowledge about condoms but only 50 percent of sexually active students used this method to prevent pregnancy in the past 6 months and not to prevent HIV/AIDS. Twenty one percent of respondents are using natural family planning methods to prevent pregnancy and only ten percent are using conventional family planning methods. As much as 5 percent of the respondents are using traditional methods of herbs to prevent pregnancy. Getting students to use condoms is fraught with many challenges because despite education, some still resorted to herbs and natural family planning methods to prevent pregnancy despite numerous educations on teenage pregnancy and HIV/AIDS. The attitude to condom usage is an indirect reflection of how relaxed the students view the threat of the HIV/AIDS epidemic.

The most common reasons for teenage pregnancy given by the students themselves were need for financial support, followed by sexual promiscuity, then peer pressure. Lack of parental control may play a significant role since many respondents and all teenage mothers were from female headed households. Opinion leaders confirmed that poverty and lack of parental control played a key role in teenage fertility in the community. Teenage pregnancy is not perceived to be a problem in the community because early marriage is acceptable and having a child in adolescence is perceived to be the optimum period to start raising a family.

Majority of students knew of a girl who had had to drop out of school because of pregnancy but only 13.8 percent of respondents knew of teenage mothers who were formally schooling, the rest were either idling at home or in petty trading. None of the teenage mothers were married to the one who impregnated her. Ninety percent of the

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fathers had denied responsibility for the pregnancy and caused further burdens on the young mothers and their families.

5.2 Recommendations

More education on teenage pregnancy and HIV/AIDS should be given as often as possible at least on a yearly basis with emphasis on contraceptive usage by all stakeholders in the schools and in the society. Cultural beliefs on early marriages can be addressed at festivals by all concerned to reach a larger target group of all levels of society in Senya Bereku. Teenage mothers should be used in the peer education programmes. Talking about practical experiences will help discourage their peers from indulging in sexual intercourse or at least promote the usage of contraceptives. Peer educators and counselors should be more youth friendly, offer adolescent health services not just information and encourage a feedback from the youth. Improved communication between students and teachers will help the students who have problems especially financial and psychological ones.

Communication between teachers and students should be encouraged. Most students could not talk to their teacher about their problems. Social problems in teenagers' lives can reflect on their performance in school. Counseling for students with visiting professionals will help those who have no one to talk to if they have problems

In- school and out of school activities will help channel sexual energy of the youth into asexual means. Peer pressure, sexual promiscuity and adventure can be channeled into other non sexual activities like book clubs, quiz and athletic activities.

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Mentoring programmes with successful people from the community, especially male role models will help the youth stay focused. Prizes for brilliant students and well behaved students should be given to boost the morale of students.

National programmes like the implementation of the Ghana Poverty Reduction Programme will reduce the need for financial support by some students and scholarships can be given to needy teenagers to help them continue their education.

Vocational training for teenage mothers will increase their employable skills and reduce any conjugal dependence for financial support. Skills training should be an integral part of the formal education to help needy students support themselves.

Cultural activities for the adult in the community during festivals can incorporate education on teenage pregnancy and early marriage so that the community's acceptance of teenage pregnancy can be changed.

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APPENDIX 1

RESEARCH TOPIC

CAUSES OF TEENAGE PREGNANCY IN SENYA BEREKU COMMUNITY OF THE AWUTU-EFFUTU SENYA DISTRICT

QUESTIONNAIRE FOR TEENAGERS IN SCHOOL

INFORMED CONSENT

My name is Jesseline Asamoah, a student at ISSER- Legon. I would like to ask you some questions about teenage pregnancy in this district. This information will help in my research studies.

Participation in this survey is voluntary.

All the information collected will be treated with confidentiality and in aggregation form.

Name of sampled schools:...

Section A DEMOGRAPHIC

1. Age................................

2. Sex

1. Male [ ]

2. Female [ ]

3. Is your biological mother alive?

1. Yes [ ]

2. No [ ]

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4. Is your biological father alive

   1. Yes [ ]

   2. No [ ]

5. Who do you stay with?

   1. Father only [ ]

   2. Mother only [ ]

   3. Both parents [ ]

   4. Relatives [ ]

   5. Other, specify.......................................

6. What is your level of education?

   1. Primary [ ]

   2. JSS incomplete [ ]

   3. SSS incomplete [ ]

   4. JSS complete [ ]

   5. SSS complete [ ]

7. What is your religion?

   1. Muslim [ ]

   2. Christian [ ]

   3. Traditional [ ]

   4. Other, specify..........................

8. How often do you practice your religion?

   1. daily [ ]

   2. twice a week [ ]

   3. weekly [ ]

   4. fortnightly [ ]

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5. not at all [ ]

6. other, specify................................

9. Which ethnic group do you belong to?

1. Akan [ ]

2. Ga/ Dangme [ ]

3. Ewe [ ]

4. Talesme [ ]

5. Hausa [ ]

6. Other, specify................................

10. How many siblings do you have? ....

Section B SOCIO-ECONOMIC STATUS

11. What work does your father do?

1. farmer[ ]

2. fisherman [ ]

3. artisan [ ]

4. civil servant [ ]

5. other, specify......... ....

12. What work does your mother do?

1. trader [ ]

2. housewife [ ]

3. seamstress[ ]

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4. civil servant [ ]

5. other...

13. Do you live in a compound house?

1. Yes [ ]

2. No [ ]

14. Where do you sleep?

1. In the same room as parents [ ]

2. Share the room with siblings [ ]

3. Sleep alone in one room [ ]

4. Sleep outside on corridor [ ]

15. Where do you take your bath?

1. Open space outside the house [ ]

2. Bathroom is within the house [ ]

3. Neighbour's house [ ]

16. Who pays your school fees?

1. mother [ ]

2. father [ ]

3. myself [ ]

4. other , specify........................

17. Do you work as well as go to school?

1. Yes [ ]

2. No [ ]

18. If yes what work do you do? ....

19. What do you aspire to be in the future?

1. don't know [ ]

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2. civil servant [ ]

3. seamstress/tailor [ ]

4. fisherman [ ]

5. other, specify...

Section C CULTURAL PRACTICES

20. Do you have any festivals in your community?

1. Yes [ ]

2. [ ]

21. What months do you celebrate the festival? ....

22. Do you stay out late during the festival season?

1. Yes [ ]

2. No [ ]

23. Do you make new friends during the festival season?

1. Yes [ ]

2. No [ ]

Section D EDUCATION AND KNOWLEDGE

24. Have you had any education on teenage pregnancy?

1. Yes [ ]

2. No [ ]

25. When did you have the education on teenage pregnancy?

1. This year [ ]

2. Last year [ ]

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3. Two years ago [ ]

4. Three years ago [ ]

5. Other, specify...

26. How did you get the education on teenage pregnancy?

1. School [ ]

2. Media [ ]

3. Peer education [ ]

4. NGO [ ]

5. Hospital [ ]

6. Other, specify..............................

27. Do you think that teenage pregnancy is on the increase?

1. Yes [ ]

2. No [ ]

28. If yes, what do you think may be the cause for the increase in teenage pregnancy?

1. Teenagers are pressurized by friends [ ]

2. Adventure [ ]

3. Sexual promiscuity [ ]

4. Lack of financial support [ ]

5. Then need to have children by a certain age [ ]

6. Coercion [ ]

7. Need to love and feel loved [ ]

8. Lack of parental control [ ]

9. Don't know [ ]

29. Do you know someone who got pregnant and had to drop out of school in the past four years?

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1. Yes [ ]

2. No [ ]

30. If yes to question 29, what is the girl doing now?

1. Nothing, idling at home [ ]

2. Petty trading [ ]

3. Schooling [ ]

4. Apprenticeship [ ]

5. Married to the one who impregnated her [ ]

6. Married to someone else [ ]

7. Cohabiting with the one who impregnated her [ ]

8. Cohabiting with someone else [ ]

31. What age do you think is ideal for a girl to get married?

....

32. Have you heard of HIV/AIDS?

1. Yes [ ]

2. No [ ]

33. How did you hear of it?

1. TV [ ]

2. Radio [ ]

3. Print media [ ]

4. Friends [ ]

5. School/ Teacher [ ]

6. Relatives [ ]

7. Church/ Mosque [ ]

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8. Other, specify............................

36. What conventional family planning method do you know?

....

Section E INVOLVEMENT

37. At what age did you have your first menstruation?......................................

38. Have you had sex before?

1. Yes [ ]

2. No [ ]

39. Are you currently doing something or using any method to delay or avoid getting pregnant or impregnating someone?

1. Yes [ ]

2. No [ ]

40. If yes to 39, what method did you use?

1. Abstinence [ ]

2. Natural family planning [ ]

3. Conventional family planning [ ]

4. Herbs [ ]

41. How old were you when you first had sexual intercourse?

....

42. How did the first sexual intercourse happen?

1. It was planned [ ]

2. It just happened [ ]

3. I was tricked [ ]

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4. I was forced [ ]

43. How often do you have sexual intercourse?

1. Everyday [ ]

2. Once a week [ ]

3. Twice weekly [ ]

4. Thrice weekly [ ]

5. Once a month [ ]

6. Twice a month [ ]

44. Have you had sexual intercourse in the past 6 months?

1. Yes [ ]

2. No [ ]

45. Did you use a condom?

1. Yes [ ]

2. No [ ]

46. What is your relationship to the person you last had sex witih?

1. Boyfriend/ Girlfriend [ ]

2. Spouse [ ]

3. Stranger [ ]

4. Casual acquaintance [ ]

5. Relative [ ]

47. Is the person older, younger or about the same age as you?

1. Younger [ ]

2. Older [ ]

3. Same age [ ]

4. No idea [ ]

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48. Does your sexual partner give you money?

1. Yes [ ]

2. No [ ]

49. Do you give your sexual partner money?

1. Yes [ ]

2. No [ ]

50. If your partner gives you money, what do you use it for?

1. Food [ ]

2. School fees [ ]

3. Clothes [ ]

4. Other, specify.................................

50. Do you know of a place where a person can get condoms, if yes specify.

1. Health facility [ ]

2. Shop [ ]

3. Chemist

4. Peer educator [ ]

5. All the above [ ]

51. If you have problems who do you talk to?

1. Friend [ ]

2. Father [ ]

3. Mother [ ]

4. Church elder/pastor [ ]

5. No one [ ]

6. Other, specify..

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APPENDIX 2

RESEARCH TOPIC: CAUSES OF TEENAGE PREGNANCY IN THE SENYA BEREKU COMMUNITY OF THE AWUTU-EFFUTU- SENYA DISTRICT

GUIDELINES FOR IN-DEPTH INTERVIEW WITH OPINION LEADERS IN COMMUNITY

1. Introduction
2. What is your profession? ……………………………………………..
3. How long have you lived in this community?...
4. Do you believe teenage pregnancy is on the increase?...................................
5. What in your opinion may be the reason for teenage pregnancy in the community?

………………………………………………………………………………………

...

6. What is the perception about teenage pregnancy in the community?

………………………………………………………………………………………

7. How can teenage pregnancy be curbed or decreased in the community in your opinion?

………………………………………………………………………………………..

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APPENDIX 3

RESEARCH TOPIC: CAUSES OF TEENAGE PREGNANCY IN SENYA BEREKU COMMUNITY OF THE AWUTU-EFFUTU- SENYA DISTRICT

GUIDELINES FOR FOCUS GROUP DISCUSSIONS WITH NEVER PREGNANT TEENAGERS

1. Introduction
2. Do you socialize after classes?

   ....

3. What extracurricular activities do you participate in after classes?

   ....

4. Have you heard about HIV/AIDS?

   ....

5. How did you hear about it?

   ....

6. Do you think you are at risk of getting HIV/AIDS?

   ....

7. How can one protect oneself from the disease?

   ....

8. Is it fashionable in the community to have a boyfriend/ girlfriend?

   ....

9. Do you have a boyfriend/ girlfriend?

   ....

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10. When and how do you fellowship with your partner?

    ....

11. Have you had any education on teenage pregnancy?

    ....

12. Are you doing something to prevent getting pregnant or impregnating someone?

....

.....

13. What do you think is the reason for teenage pregnancy in the community?

....

.....

14. Do you know someone who got pregnant and had to drop out of school?

....

15. What is the person doing now?

    ....

16. How is she coping with rearing a child?

17. Is the father helping in the upbringing of the child or did he deny responsibility for the pregnancy?

18. How does the community view teenage pregnancy?

    ....

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APPENDIX 4

RESEARCH TOPIC: CAUSES OF TEENAGE PREGNANCY IN SENYA BEREKU COMMUNITY OF THE AWUTU-EFFUTU- SENYA DISTRICT

GUIDELINES FOR IN-DEPTH INTERVIEWS WITH TEENAGE MOTHERS

1. Introduction
2. How old are you? ....
3. How old is your child?

   ....

4. At what age did you get pregnant? ....
5. What class were you in when you got pregnant?

   ....

6. Did you use any method to prevent pregnancy prior to your getting pregnant?

   ....

7. What circumstance led to your getting pregnant, where you coerced or you had a mutual agreement?

   ....

8. What is your relationship to the father of your child, before the pregnancy and after the pregnancy?

   ....

9. Is the father of the child sharing in the responsibility of caring for the child?

....

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10. Are your relatives helping you care for the child?

....

11. Are the relatives of the child's father helping you care for the child?

....

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12. Do you plan to further your education?

....

13. Are you working to earn some income to help you care for your child?

....

..

14. How do you see your prospects in the future for marriage, education, etc.?

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