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**ADOLESCENT REPRODUCTIVE HEALTH EDUCATION AND HEALTH
SEEKING BEHAVIOUR OF IN-SCHOOL FEMALE ADOLESCENTS IN THE
ADANSI SOUTH DISTRICT, ASHANTI REGION**

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DECLARATION

I, Robert Tanti Ali, the author of this dissertation declare that with the exception of references to other research works which have been duly cited, this work is my own work. This had not been submitted in part or whole anywhere for any degree.

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DEDICATION

This work is dedicated to my late father, Mr. Ali Sadungu and my mother Azumah Poponu for their support. This work is also dedicated to my wife, Alice Ababio for her patience and endurance during my many days of absence from home as a result of this work.

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I am ever grateful to God Almighty for his mercy, grace, guidance and protection throughout this course. I am most grateful to my supervisor Dr. Irene Kretchy for her guidance which has made this work a reality.

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I pray that the God Almighty blesses each and every one who contributed towards the success of this research.

ABSTRACT

This research explored the school health education programme and the reproductive [reproductive](#) health seeking behaviours of female adolescents in selected Junior High Schools in the Adansi South District, Ashanti Region. The study [also looked at](#) also looked at the scope of the school health education programme, knowledge level of in-school female adolescents on sexual and reproductive health issues and their health seeking behaviour. The study was a descriptive cross-sectional design which employed quantitative and qualitative data collection methods on the health seeking behaviour of four hundred and ten (410) female basic school adolescents and five (5) Community Health Workers in the Adansi South District in the Ashanti Region of the Republic of Ghana. Semi-structured interview guides and a structured questionnaire were used for the data collection. Thematic analysis of the data from the interviews was done by coding and categorizing the data into themes for easy interpretation while quantitative data obtained from the questionnaire were analyzed using Stata 15.

The study showed; that, the School Health Education Programme offered varied information on health ranging from personal hygiene to sexual and reproductive health. The result showed that; in-school female adolescents were generally knowledgeable on sexual and reproductive health issues such as menstrual hygiene, teenage pregnancy, family planning, unsafe abortion practices and sexually transmitted Diseases (STDs).

The research also identified stigma, misconception and high cost of services as some of the challenges that hindered adolescents from seeking reproductive health services.

The study recommends that the Health Ministry and Ghana Health Service give major attention to the implementation of the Adolescent Friendly Health Services initiative in all facilities at all levels to ensure that adolescents get the privacy that they desired. This will go a long way to encourage them to access Sexual Reproductive Health services.

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LIST OF ABBREVIATIONS

AIDS	:	Acquired Immune Deficiency Syndrome
ASDA	:	Adansi South District Assembly
ASRH	:	Adolescent Sexual and Reproductive Health
BECE	:	Basic Education Certificate Examination
CHOs	:	Community Health Officers
CHPS	:	Certified in Healthcare Privacy and Security
CSOs	:	Civil Society Organizations
GDHS	:	Ghana Demographic and Health Survey
GES	:	Ghana Education Service
GHS	:	Ghana Health Service
GSFP	:	Ghana School Feeding Programme
GSS	:	Ghana Statistical Service
HIV	:	Human Immunodeficiency Virus
HWWS	:	Hand Washing With Soap and water
ICPD	:	International Conference on Population and Development
IUD	:	Intrauterine Contraceptive Device
JHS	:	Junior High School
MMDAs	:	Metropolitan, Municipal and District Assemblies
MOH	:	Ministry of Education
NGOs	:	Non Governmental Organisations
RHE	:	Reproductive Health Education
SCT	:	Social Cognitive Theory
SDGs	:	Sustainable Development Goals
SHEP	:	School Health Education Programme
SRH	:	Sexual and Reproductive Health
STIs	:	Sexually Transmitted Infections
SWA	:	Sanitation and Water for All
UNAIDS	:	United Nations Programme on HIV and AIDS
UNESCO	:	United Nations Educational, Scientific and Cultural Organization

UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations International Children's Emergency Fund
WASH	:	Water, Sanitation And Hygiene
WHO	:	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

It is estimated globally that adolescents constitute an important part of the human population and most of these adolescents live in sub-Saharan Africa (Abajobir & Seme, 2014).

Reproductive health has been widely defined as a state of complete mental, physical and social well-being and not the mere absence of disease or infirmity, in all matters relating to the reproductive system (Lancet, 2006). The World Health Organization (WHO) defines an adolescent as a person aged between 10-19 years. However, the term adolescent connotes different ideas from different societies. According to MacKay and Duran (2007), the term 'adolescent' can vary in scope and age, and ranges from puberty to adulthood, often ages 10 to 21.

Adolescence is the period where an individual makes a gradual transition from being a child to becoming an adult. During these years, following puberty, the individual gradually matures to become an adult, but do not immediately take up roles and responsibilities that are normally associated with adulthood (Rondini & Krugu, 2009). This stage is where young people are normally in a state of confusion and are torn between friends and parents, societal norms and religion, information and knowledge (Rondini & Krugu, 2009). Adolescents' population can be an advantage for positive economic growth in a country. For instance, the Ghana Demographic and Health Survey (2014) report indicates that higher numbers of adolescents can serve as economic potential for countries like Ghana if the right investments are made in them (GDHS, 2014). Adolescents have been identified as one of the most vulnerable groups to sexual exploitation and this exposes them to the risk of negative reproductive health outcomes (GDHS, 2014). Some studies have disclosed that early and

unprotected sexual practices by adolescents is a common trend which exposes them to many reproductive health challenges including unsafe abortion, school drop outs, pregnancies , sexually transmitted Diseases (STDs) and HIV (Tegegn, Yazachew, & Gelaw, 2008). The Ghana Health Service (GHS) and other non-governmental organizations in the Adansi South District are implementing adolescent friendly reproductive interventions such as antenatal and postnatal services, contraceptive services, voluntary counselling and testing for HIV/AIDS, comprehensive abortion services, School Health Education Programme (SHEP), regenerative health and nutrition (ASDHD, 2015). The SHEP intervention has four main themes, namely; Skills-based Health Education, Disease Prevention and Control, Nutrition Control and Education and Safe and Healthy School Environment to primary and Junior High School pupils (GES, 2012). The unanswered question is whether these services are being accessed by all adolescents, especially those in junior high schools, and how is it influencing their sexual behaviours. The Ashanti Region is currently experiencing a downward trend in teenage pregnancy. A total of 18,441 adolescents got pregnant, last year, compared with the year 2015 figure of 19,416 and the 20,395 reported in 2014 (MOH, 2016). However, the Adansi South District has experienced an increase in reported cases of teenage pregnancy within the same period. The District recorded 640 cases in 2016 as compared to 580 in 2015 and as indicated, a girl under eighteen gives birth everyday (Daily Graphic, 2017).

This study therefore sought to find out the School Health and Education Programme (SHEP) services and the health seeking behaviour of female adolescents in Junior High Schools in the Adansi South District of the Ashanti Region.

1.1 Problem Statement

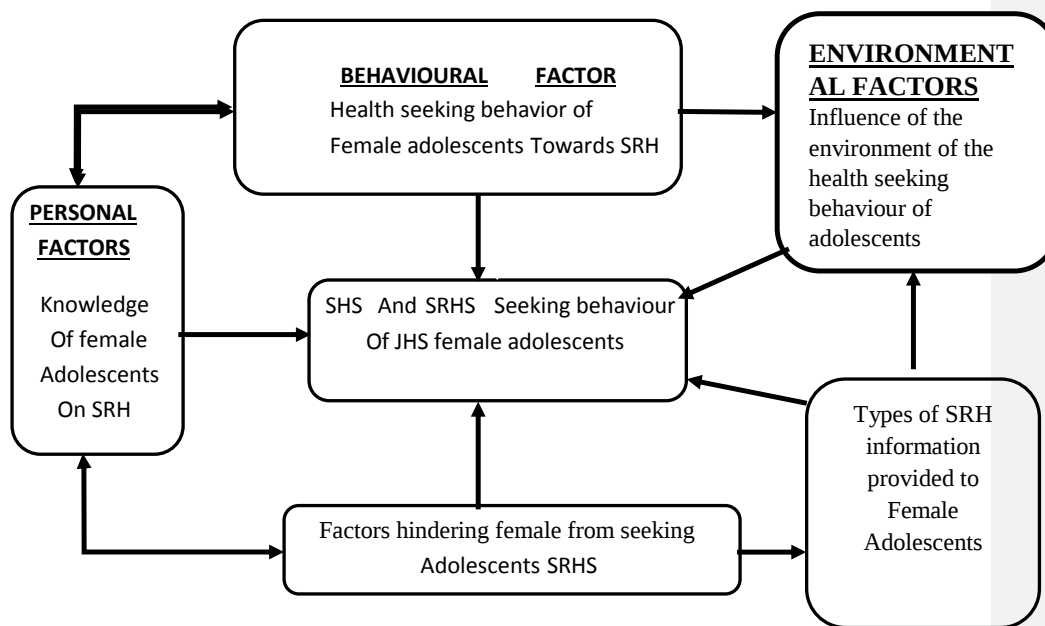
Promoting adolescents sexual and reproductive health services (ASRH) is a major global health challenge. In their work, Aninanya et al., (2015), reiterated that many countries

including Ghana, have pursued various strategies to address these ASRH challenges. According to Mensah & Owusu-Ansah (2014), about 70% of adolescents access SRH information from schools and the media. More so, an evaluation of a SRH intervention revealed that schools and private organizations contribute significantly to adolescents' knowledge on SRH issues, especially HIV and AIDs (Geugten, Meijel, Uyl, & Vries, 2015). The census conducted in Ghana by the Statistical Service of Ghana (GSS) revealed that the population of Ghana has moved from 18,912,079 in the year 2000 to 24,223,431 in the year 2010 which also shows an increase in the population of adolescents (GSS, 2011). A majority of young adolescents in Ghana engage in sex before attaining 18 years (Biney, 2013). According to a research conducted in two of the regions in Ghana, 42% of male students and 15% of female students have had sexual intercourse. A similar research by Awusabo-Asare (2004) found that out of every three adolescent females who have ever had sex before, at least one had gotten pregnant. This has been corroborated by GDHS (2014) that currently, the teenage pregnancy rate in Ghana stands at 14.3 %.

Adolescents' reproductive health was ranked a priority problem of the Adansi South Health Management Team (DHMT), 2015 health sector review report. Teenage pregnancy and early sexual debut were major health concerns in the District. The District has over the years seen interventions aimed at improving the sexual and reproductive health of the adolescent. These interventions included, girls' clubs, training of peer educators, and provision of youth friendly corners by the District Health Directorate. Despite these interventions, adolescent behavior has not achieved the desired results towards making informed choices due to increased reported cases of teenage pregnancies (GES, 2014). The District Directorate of Education has reports of a consistent increase in Basic Education Certificate Examination (BECE) candidates getting pregnant on annual basis prior to taking their examinations.

A total of 140 pregnancies were recorded among final year BECE candidates between 2004 and 2014 in the Adansi South District. Out of this figure, 5 gave birth during the examinations and 66 failed to turn up for the examinations. (GES, 2014).

This study therefore sought to identify the knowledge level of adolescents on sexual and reproductive health, their source of information on SRH and how these might be contributing to their health seeking behavior.



1.2 Conceptual Framework

Figure 1: Conceptual Framework for School Health Education and the Health Seeking Behaviour of Female Adolescents on reproductive health in Adansi South District.

(Source: Adapted from Bandura, 1998)

This framework is a deduction from the social cognitive theory (SCT) by Albert Bandura. The SCT describes the individual's experience, the reactions of other persons and the impact of the environment on a person's health. The theory provides an avenue for societal

expectations, self-efficacy, and the use of observational learning and reinforcements to achieve a desired behavior change. The model is based on three factors, namely; personal factors, environmental influences, and behavioral factors which continually interact (Bandura, 1998). In this framework, behavior, cognitive, and other personal factors and environmental events operate as interacting determinants that influence each other bidirectionally in addressing issues such as the exposure to the necessary information and services for a healthy sexual life. The goal of the third segment is to improve support among schools and adolescent health services which are friendly. It is also to promote the reproductive health services for adolescents. These friendly health services are condoms accessibility, availability of contraceptives, and test for pregnancy which is not available in the school circles. This aspect also involved feedback from deliberations that included all stakeholders such as parent, health personnel and teachers during program development.

The personal factors such as knowledge on SRHR and access to health facilities will lead to a good health seeking behaviour.

It may be particularly useful in rural communities for examining how individuals interact with their surroundings. The SCT can be used to understand the influence of social determinants of health and a person's past experiences on behavior change.

The framework guided the researcher to discover the human aspects that can influence school health services, and the SRH services seeking behavior of JHS female adolescents. The identification of danger and safe periods, family planning use, prevention of teenage pregnancy and safe abortion will be considered to be segments of the five characteristics;

- (i) Types of SRH information provided to female adolescents
- (ii) Personal factors (Knowledge of female adolescents on SRH, Age, Religion)
- (iii) Behavioral factors (Health seeking behavior of female adolescents towards SRH)
- (iv) Environmental Factors

- (v) Factors hindering female adolescents from seeking adolescents' SRHS.

The relationship is such that the occurrence of any of the factors above is influenced by one or more of the other factors in the framework. Knowledge here can be interpreted as awareness of the SHEP initiative and the need to seek and use these services and how important these services will be to them.

1.3 Justification for the Study

Over 15 million adolescent girls from 15 to 19 years and some 1 million female adolescents under 15 years give birth annually and majority of these girls are from living in low income countries (WHO, 2014). Pregnancy complications and birth related issues are one of the leading causes of death among adolescent girls in the world (WHO, 2014). It is estimated that 3 million girls 15 between and 19 years illegally terminate pregnancies every year. Children born to teen mothers are likely to die than babies born to adults (WHO, 2014). The Ghana Health Service reported that 750,000 teenagers were pregnant in their 2014 annual report (GHS, 2014).

The Ghana Education Service aims at using the school health education programme to equip primary and junior high school pupils with basic knowledge in SRH complement lessons delivered in the classroom on what is already in curriculum (GES, 2012). This is to enable adolescents practice safe sexual and reproductive lifestyles.

Many studies have been done to evaluate the impact of interventions with reference to adolescent's Sexual Reproductive Health, but much has not been done to assess the School Health Education Programme and how it associates with adolescent's sexual and reproductive health-seeking behavior.

Findings from this work will contribute to available research on Sexual Reproductive Health and School Health Education issues in the Adansi South District. Secondly, the Ministry of Health and Ghana Health Service, and other relevant stakeholders that are into adolescent

health issues in the district will find the findings from this study as a useful policy guideline and as an effective reference material.

1.4 Research Questions

- What is the Sexual Reproductive Health services provided to in-school adolescent females by the school health education service programme?
- What is the knowledge level of in-school adolescent females on Sexual Reproductive Health?
- What are the behaviours of in – school female adolescents towards sexual and reproductive health ideals of the District?

1.5 Objectives of the Study

1.5.1 Main Objective

The study assessed school health education services, level of knowledge and the reproductive health-seeking behaviour of female adolescents in selected Junior High Schools in the Adansi South District of the Ashanti region.

1.5.2 Specific Objectives

The study achieved the following specific objectives:

1. To identify the types of Sexual and Reproductive Health services provided to in-school adolescents during school health services.
2. To assess the knowledge level of in-school female adolescents on Sexual and Reproductive Health.
3. To identify the current sexual and reproductive health-seeking behaviours of in-school female adolescents.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The chapter reviews other research works that have been done in relation to adolescent Sexual and Reproductive Health (SRH). It touches on the key elements of the issue under study, and provides an in-depth knowledge of what has been done from the Ghanaian perspective on adolescent's SRH and the gaps yet to be filled.

2.1 Reproductive Health Needs

The Ghana Demographic and Health Survey conducted in 2003 recorded that about half the total population is below 15 years and adolescent reproductive health is receiving maximum attention with the prominent social and health issues being teenage pregnancy (GHS, 2003). What has increased the risk for non-marital pregnancy and exposure to STIs is early initiation and non-use of contraceptives, resulting in high cost on the society (Rondini & Krugu, 2009). The reproductive health crisis faced by adolescent school dropouts are from the early sex bouts which leads to teenage pregnancy, illegal abortions and STIs, including HIV and AIDS. Social consequences attached to accessing reproductive health needs by adolescent school dropouts in relation to their reproductive health activity results in teenage pregnancy, abortions and STIs including HIV/AIDS. These are major health and social problems experienced in many developing countries. Early parenthood is a major impediment to the empowerment of adolescent young women in all parts of the world (UNESCO, 2001). Many adolescents who engage in sexual activities before marriage, often do not use any of the modern contraceptives such as contraceptive pills, condoms, jadelle, injectables, Intrauterine contraceptive device (IUD) thereby exposing them to the risks of sexually transmitted diseases and teenage pregnancy (UNICEF, 1997).

For most people, sexual activity begins in adolescence (Abubeker, 2004). In many developing countries, unmarried adolescents are sexually active before they reach 15 years. A survey conducted by the United Nation Children Fund, United Nation Programme on HIV/AIDS and World Health Organization (2002) using adolescent boys in Brazil, Hungary and Kenya showed that more than a majority of the adolescents reported had sex before attaining age 15. Another research conducted in Bangladesh revealed that 88% of unmarried urban boys and 35% of unmarried urban girls had experienced in sex before attaining age 18 (UNICEF, UNAIDS & WHO, 2002).

2.2 Awareness of Reproductive Health

Improving adolescent sexual and reproductive health service (ASRH) usage is a public health challenge globally. Several countries have adopted strategies to address the specific sexual and reproductive health needs of adolescents after the International Conference on Population and Development (ICPD) in 1994 prioritized ASRH on the international strategy (Mbizvo & Zaidi, 2010). The relatively high proportion of adolescents' population in developing countries continue to experience high rates of HIV/AIDS, early pregnancy, maternal mortality and unsafe abortion among other sex related diseases (Secor-Turner et al., 2010).

Adolescents across the globe encounter several hindrances in their quest to access contraception (WHO, 2018). This includes laws on restrictions and policies on contraceptive use based on one's age, attitude of healthcare workers the readiness to accept the needs of adolescents 'and adolescents' inability to have opportunity to contraceptives because of their inadequate knowledge and financial challenges (WHO, 2018).

The adolescent birth rate at the global level has experienced a decline from about 65 births per 1000 women in 1990 to about 47 births per 1000 women in 2015 (Ganchimeg et al., 2015). In spite of this general success chalked, the population of adolescents in the world

continues to grow. Some researchers have projections which indicate the number of adolescent pregnancies may experience some increase globally by the year 2030, with an expected increases in Africa (UNFPA, 2013).

In a WHO report, *Health for the World's Adolescents* exhibited that investments in maternal and child health interventions risked being lost if there no equal investments in adolescent reproductive health. The current statistics show that over 3,000 adolescent die every day from preventable causes, and in addition many risk factors for adult disease begin in the adolescence stage (WHO, 2017).

A study conducted in the United States found that most of the teens aged between 15 and 19 had received some formal instruction on saying no to sex before the age of 18years (Gebhart & Coy, 2007) However, 69.9% females and 66.2% males who form a smaller majority reported having received instruction on birth control methods. Incidence in sexually transmitted diseases among the age group, however, remains high despite this education. The use of contraceptive methods increases with increasing level of education. For instance, 30% of married women with secondary or higher level of education are using a method of contraception compared to 14% of married women with no education (GSS, 2009).

An estimated 750,000 adolescents get pregnant every year, 2 out of every 3 adolescents with STIs refuse seeking medical care, and about 50% of sexually active adolescent females have ever had unprotected sex (Aninanya et al., 2015; Hessburg et al., 2007). Cultural and religious beliefs, coupled with personal experiences, have made adolescents have negative perceptions about modern contraceptives (Okereke, 2010).

According to Abajobir et al., (2014), about 50.6% of adolescents with reproductive health problems have never thought of seeking formal care, and that 34.4% did not see the need to seek care in the first place. The study also revealed that 24.3% lacked knowledge on formal

care for their SRH problems, while 17.4% considered themselves to be healthy and too young to seek care even if they have a problem. However, it has also been revealed that provision of adolescent friendly services do not necessarily translate to improving health seeking behaviour of adolescents, hence the need for policy makers and programmers to factor in needs assessments before initiating AFHSs in order to know their current interest and preferences (Joshi et al., 2006). Additionally, making available correct and age appropriate comprehensive sexual and SRH information will enable adolescent girls seek care when faced with a problem. Studies have shown that in order for adolescents to effectively utilize SRH services, information must be comprehensive, varied, non-discriminatory, be provided in a confidential environment and at a low cost (Bender & Fulbright, 2013). Professional training of health care providers on adolescent friendly service provision has been shown to improve service uptake by adolescents (Makenzius, Giland Gadin, Tyden, Ulla, & Larssen, 2009).

2.3 The Ghana School Health Education Programme

The School Health Education Programme was established in 1992 following declaration of Education for All (1990) and Ratification of Convention on the Rights for the Child (GES, 2012).

According to the GES (2012), school health education services have been identified as one of the major routes of strengthening health promotion and education activities among adolescents. The SHEP Unit under the Ghana Education Service (GES) is run jointly by the GHS and GES. The Ministry of Education (MOE) plays the lead role while the Ministry of Health (MOH) provides technical support in the implementation process.

Target beneficiaries of the SHEP are pupils/students and teachers in public and private basic schools, including pre-school, primary and junior high schools and special schools; students

and teachers in public and private second cycle institutions; students in teacher training colleges; and school community workers (GES, 2012).

The SHEP interventions consist of four main themes, namely; skills-based health education, disease prevention and control, nutrition control and education, and safe and healthy school environment.

2.3.1 Skills-Based Health Education

This intervention delivers health education to the doorsteps of school children in order to equip them with basic life skills for healthy living. Interventions focus on behavioral change approaches and how to sustain the changes (MOE, 2010). These include both curricular and co-curricular activities and formation of relevant school health committees and clubs such as health and hygiene education through regular school lessons. Others are co-curricular activities such as quizzes, competitions, peer education, health talks, drama, role plays and mass media campaigns, formation and training of School Health Committees, Clubs and Peer Educators (MOE, 2010). These activities and lessons are delivered by teachers, community health nurses from GHS and sometimes project staff of NGOs.

Aninanya et al., (2015), emphasized that the skills-based health education as an intervention area of SHEP entails the collaboration between GHS and GES to improve knowledge and skill practice of in-school adolescents. The programme encompasses training of teachers on standard SRH curriculum and promotion of co-curricular and extracurricular activities. These trained staff employ in-class participatory teaching, and co-curricular SRH activities such as inter-school competitions and debates, video performances, dramas, and role plays, sports) in their delivery of adolescents SRH lessons (Aninanya, Debpuur, Awine, & Williams, 2015). It is also done through SRH teaching and learning in schools. The key objective of this theme is to provide appropriate reproductive health information in school, life-skills building and influencing sexual attitudes and behavior (MOE, 2010).

A study conducted in the Republic of Tanzania (Mainland) by the Global School Health Survey revealed that attitudes towards reproductive health contribute to the Infection of HIV/AIDS and unplanned Pregnancies. In all, 20% of the adolescents had sexual intercourse in their life, among which 76.5% started before the age of 14 and 5% had sex with more partners in their life experience. In addition, adolescents who had ever had sexual intercourse, only 36.5% used condom and 33.1% used other birth control methods during their last sexual intercourse (Nyandindi. 2017).

Another research in Tanzania showed that parental influence and peer pressure are key factors of early sexual initiation among teenagers (Mmbaga et al., 2012). A similar study from a school oriented strategy hinted that discussions with teachers about STIs and sex in Dar es Salaam were associated with delayed reported sexual initiation among adolescents after considering the confounding factors (Kawai et.al, 2008).

2.3.2 Disease Prevention and Control Aspects of SHEP

This component of SHEP is carried out by trained staff of the GHS and sometimes staff of NGOs running intervention programmes in schools. It ensures early detection of diseases, defects and disability in school children for prompt referral and management. It promotes, prevents, cures, rehabilitates and regenerates children health in schools. This is done through regular school assessments and collaborative outreach programmes by screening of pupils and students and other educational workers (GES, 2012).

These screening activities include general physical examination, vision testing, hearing, speech and language assessment, oral health and growth monitoring and promotion. It also ensures referral services, First Aid facilities and treatment of minor ailments like headache, fever and diarrhea within the school premises. Other services rendered include de-worming, immunization against diseases, sensitization programmes on communicable diseases in children, including HIV and AIDS, STI, Tuberculosis, Cholera and other locally endemic

diseases, prevention and control of non-communicable diseases, including violence, injury, mental health, substance (alcohol, tobacco, etc.) use and obesity. The effort of this theme is to ensure that preventive mechanisms are put in place to avoid as much as possible such preventable diseases from spreading.

There is an estimated 68% of all HIV positive patients, Africa remains the region of the world which is severely hit by the pandemic (UNESCO, 2011). The 5 million young people who lived with AIDS worldwide in 2008, 80% are in sub-Saharan Africa (UNAIDS, 2010). Therefore Programmes on prevention must target adults as well as adolescents. Preventive strategies aiming at adolescents have been shown to be very effective if it includes several stakeholders such as teachers, health personnel and parents (De Vries, Dijk et al., 2006). Studies have shown that HIV prevention interventions targeting adolescents are more effective especially if they include inexperienced youth (Maticka-Tyndale, Wildish et al, 2007).

2.3.3 Food Safety and Nutrition Education

This component of SHEP intervention focuses on food safety and quality, nutrition education and regular assessment of children's nutritional status. It is also meant to promote healthy eating habits among school children and their teachers by identifying, training and monitoring of school food vendors to ensure food hygiene and nutrition. This component also ensures monitoring of the Ghana School Feeding Programme (GSFP). The key objective of this theme is to minimize the spread of diseases that arise through unhealthy food.

2.3.4 Safe and Healthy School Health Environment

This encompasses all the physical and social structures that promote effective teaching and learning, as well as the health and safety of members of the school community. It is aimed at creating an environment which encourages children to attend and stay in school. It includes

the physical structures such as safe water for drinking and hand washing and provision of school latrines. This component of physical structures also makes room for disability friendly and gender sensitive environment. Basically, this theme tries to look at the safe physical environment, safe water and sanitation and healthy psychosocial environment. Only 1 in 7 (14 per cent) of all households have access to a decent, household sanitation facility and 1 in 6 households are involved in open defecation (UNICEF, 2017).

Every year more than 3,600 children die in Ghana alone from diarrhea. However households with decent sanitation have child diarrhea rates lower than households practicing open defecation and about half that of those who share facilities. Even though there exist some inequities in terms of access rates between urban and rural people and between the poor and the rich households, the overall access rates are still low. This calls for increase access to sanitation at the national level, with a major focus on the northern region, where open defecation rate is relatively high (UNICEF, 2017). About 44% who represent two of five children in Ghana do not have toilets in their schools. Three out of every five Children in Ghana representing 62 per cent attend schools which do not have source of water (UNICEF, 2017). There exist significant inequities at the regional level with children in the Western Region about half as likely to have access to school toilets as those in Upper East and West about 50 percent less likely to have access to water than those in Central Region. Even though there is no data on school facilities for hand washing and menstrual hygiene management, the poor access rates for water and toilets is an indicator that there are also likely to be low rates for both (UNICEF, 2017). The most effective and cost-effective way to minimize child diarrhea and pneumonia mortality is through hand washing with soap and water or ash (HWWS), but Ghana has less than 21% of people who have household hand washing facilities. This rate has doubled in three years so it is likely that most Ghanaians do not practice hand washing regularly. Rates of HWWS vary from region to region and urban

rates are double of those in the rural areas. Rates are so low nationally that HWWS remains an important national issue. In spite of the private sector interest in hand washing, engagement of the sector in increasing household demand has been limited (UNICEF, 2017).

2.3.5 Implementation Constraints

The policy document however revealed that, as a result of resource constraints and local conditions, some schools are unable to deliver all the above outlined services even though they are covered by SHEP and the schools' syllabuses. Service delivery therefore varies from district to district and school to school and this is usually determined by the District SHEP Committee. According to UNICEF (2017) some level of progress has been achieved in improving sectorial capacity, however the non-commitment exhibited in implementing the water for all policy including state financial support, have been a hindrance.

2.3.6 Mode of Delivery

Most sexual and reproductive health topics in schools are delivered in the form of lessons by teachers, project staff of implementation organizations and health staff from the GHS (Geugten et al., 2015). There are lessons with questions and clarification as well as demonstration sessions. These lessons last for about 45-60 minutes once a week and they are meant to be offered to a class of about 25-50. Support in the form of education and training will focus on building the capacity of personnel at the country and local levels for emergency reaction, including behaviour change strategies into the training of nurses and teachers (UNICEF, 2017).

2.3.7 Scope of School-Based Sexual and Reproductive Health Intervention in Ghana

School health education has been found to delay early sex, and increase condom use among adolescents (Bilal et al., 2015). The 2014 Ghana Demographic and Health Survey report indicates that, nationally, 14% of adolescents between the ages of 15-19 years begun

childbearing or have had a child by age 15 years, with the Upper East region recording 9.7% (GDHS, 2014). The report also revealed that, heightened sexual activity of adolescents facilitates the acquisition of sexually transmitted infections such as HIV, as they are less knowledgeable when it comes to HIV prevention methods. The report further indicated knowledge on HIV prevention increases with increase in age, educational level and income status (GDHS, 2014).

School-based reproductive health interventions provide varied SRH information to in-school adolescents in the form of lectures, slide presentations, classroom delivery by teachers, leaflets, and posters (Mason-Jones et al., 2012). These health interventions have been found to be one of the major routes of addressing adolescent SRH challenges, and have contributed significantly to improving knowledge on adolescent reproductive health issues (Capuanoa, Simeone, Serena Giuseppina Scaravillia, & Balbia, 2009). Literature available indicates that school-based comprehensive sex education has proven to delay early sexual intercourse and increase utilization of other reproductive services by adolescents (Awotidebe, Phillips, & Lens, 2014), in addition to impacting positively on the behaviour of adolescents with reference to safe sexual practices and decreased infections of STIs (Aransiola et al., 2013).

According to Aninanya et al., (2015), adolescents who are exposed to SRH information double their chances of accessing treatment for STIs and other reproductive ailments such as menstrual disorders. This goes a long way to increasing contraceptive use among adolescents, reduced teenage pregnancy and its complications such as unsafe abortion, maternal and infant mortality. Access to comprehensive sexual and reproductive health information by adolescents in the early stages of their life, builds their self-efficacy in attaining safer sexuality. Adolescents' SRH education needs to be factored in basic school's curriculum. This will not only correct the myths and misconceptions surrounding SRH

services for adolescents, while improving their health-seeking behaviour (Kotwal, Khan, & Kaul, 2014).

2.4 Sources of Adolescent Sexual and Reproductive Health Information

Adolescents have varied sources of accessing SRH information. Biddlecom et al. (2006), report that, 6 in every 10 adolescents get their SRH information from the school (Biddlecom, Guiella, & et.al, 2007). Reports by the World Health Organization (WHO) also indicate that, most adolescents get their SRH information from peers, teachers, school counsellors, and health care providers, whereas others also access their information from the internet (WHO, 2007). However, Hessburg, et al. (2007), revealed that adolescents aged 12-14 years prefer to receive SRH information from professionals such as health care providers, teachers, mass media, rather than their parents. The most common source of SRH information for adolescents is however the radio and television (Hessburg et al., 2007). Krugu et al., (2016), confirm that school-based sex education has proven to contribute positively to positive sexual behaviour of adolescent girls such as condom use and pregnancy prevention. They add that parents-adolescent communication also serves as a positive influencing factor (Krug, Mevissen, Prinsen, & Ruiter, 2016). A study in Ethiopia by Bogale and Seme (2014), reported that early initiation of sexual activity by adolescents was a pre-requisite for unsafe sex. It added that quite a significant number of in-school adolescents are involved in early premarital sexual activities and this was being facilitated by their exposure to pornographic videos and other social media platforms. This early exposure according to the paper increases their risky sexual behaviour such as having multiple sexual relationships, sex under the influence of drugs and practicing of unprotected sex. The paper suggested that health care providers should pay significant attention to school-based SRH services in order to equip in school adolescents to practice safer sex (Bogale & Seme, 2014).

2.5 Knowledge Level of Female Adolescents on Sexual and Reproductive Health

Some studies show that, adolescents have limited knowledge on SRH issues (Abajobir & Seme, 2014; Adinew, Worku, & Mengesha, 2013; Aktar, Sarker, & Jenkins, 2014). However, other studies report that there is increase awareness of adolescent females on ‘danger periods’ during menstruation and contraceptive use. Providing adolescents with knowledge and information on their physical and physiological changes that occur in their bodies help them make informed choices on SRH services (Rao, Lena, Nair, Kamath, & Kamath, 2008). Educated females are believed to delay marriage and childbearing. This eventually leads to improved health outcomes and socio-economic growth of both mother and child if the educated woman finally gives birth, thereby reducing the high incidence of maternal and infant mortality.

Adolescents have unique health needs, expectations and behaviour which are not being met by many health care services. Knowledge on available youth friendly services are poor and hence most adolescent girls’ resort to friends for help with their problems. Studies have also identified inadequate access to reproductive health knowledge as pre-requisite for poor self-confidence among adolescents (Lindberg et al., 2006).

Adolescent girls are gradually taking control of their lives through career goals and aspirations, and hence are very proactive and assertive when it comes to issues about their sexual and reproductive activities. Krugu et al., (2016), points to the fact that if adolescent girls are well informed of other hormonal contraceptives, in addition to the abstinence and condom use as the ways of preventing pregnancy, it will enable them to make healthier sexual choices. According to a study by Mawunyo-Akakpo (2008), about a quarter of adolescents aged 10-14 years have ever heard of STIs and 47% of adolescents knew STIs can be transmitted by having multiple sexual partners. The report further indicates that, about 76% of adolescents have heard of HIV/AIDS.

2.6 Sexual and Reproductive Health-Seeking Behaviour of Female Adolescents

According to Yari et al., (2015), adolescents have challenges with different SRH problems which include unwanted pregnancy, unsafe abortion and STIs/STDs. Most of these problems are as a result of poor health seeking behaviour of adolescents which increases their vulnerability to teenage pregnancy and unsafe abortion practices and STIs and HIV (Brown & Guthrie, 2010).

The SHEP initiative is in support of incorporating reproductive health into school curriculum but does not completely support the promotion of contraceptives in schools. More so, providing adolescent SRH services with the outmost privacy has been seen to encourage adolescents to utilize SRH services (Adogu, Udigwe, Udigwe, Nwabueze, & Onwasigwe, 2014)

2.7 Attitude of Adolescent towards Sexual and Reproductive Health Ideals

In the transition period to adulthood, adolescents assume adult behaviours by practicing sexual activities (UNFPA, 2010). The majority of these adolescents who practice sexual activities do not however protect themselves like condom use which can prevent pregnancy and infection of Sex related Diseases (WHO, 2008). Although the adolescents may have the intention to prevent pregnancies and infections, they do not use reproductive health services consistently (Fitzpatrick & Walton, 2011). In a study in India (Borkar , Patil & Meshram, 2015) it was found that student's had healthy & positive attitude towards reproductive health issues like ideal family size, premarital sex and family planning. Majority of students recommended Reproductive Health Education in school curriculum and lecture by experts was mentioned as desired method for imparting RHE by about half of the students. Most of the students preferred to communicate with Doctor / Health Worker followed by friends regarding Reproductive Health Issues. There is need of providing correct scientific information regarding reproductive health to adolescents by incorporating reproductive

health education in school curriculum and avoid peer pressure, need to understand more about their responsibilities in marriage and as parents, preparation for childbirth, etc. and lead a more productive & healthy life (Borkar, Patil & Meshram, 2015).

Many researchers have examined the interplay between risk and protective factors in the quest to explain the potential for adolescents to engage in behavior that can place them in a state of personal harm (Loeber, 2002). This behavior may be interpreted as problem behaviour and can take place within the personal, biological, psychological, social and environmental context of the adolescent's life experience. In Ghana, Afenyadu and Goparaju (2003), in a survey in Dodowa, found pre-marital sex among adolescents to be a fairly common phenomenon. About 88% representing 9 in 10 of all sexually active adolescents were never married. About 54% of the males and 32% of the females had experienced sex. About 58% of the men and about 83% of the women revealed that their first sexual companion was not their spouse. Several reasons were given for the practice of early sex among adolescents in Dodowa and these included money, sexual pleasure and peer pressure. Fatusi and Blum, (2008) in a study in Nigeria found that 8% males; 22% females were sexually experienced, representing a fifth of adolescent respondents. In Southern Nigeria, 24.3% men and 28.7% women had initiated sex compared to 12.1% of males and 13.1% females in the Northern Nigeria.

CHAPTER THREE

METHODS

3.0 The Design of the Study

The study adopted a cross-sectional study design using both qualitative and the quantitative research approaches. Cross-sectional studies are used to assess the burden of disease or health needs of a population and are particularly useful in informing the planning and allocation of health resources (Hennekens CH, Buring JE, 1987).

3.1 Study Area

The study was conducted in the Adansi South District Assembly (ASDA) in the Ashanti Region. The District was created in 2004 by a Legislative Instrument (LI 1752) through an Act of parliament (Act 462, 1993). The District forms part of the thirty (30) administrative Metropolitan, Municipal and District Assemblies (MMDAs) in the Ashanti Region of Ghana. The District capital, New Edubiase is about 92km from Kumasi, the regional capital, along the Cape Coast - Kumasi trunk road. The District according to 2010 Census has a population of 115,378. This is made up of 58,039 males and 57,339 females (Ghana Statistical Service, 2010).

A total fertility rate in the District was recorded as 4.4 whilst the general fertility rate of 130.4 was recorded in the district (GSS, 2010). A Crude birth rate of 29.7 per thousand populations was also recorded. During the 12 months preceding the 2010 Population and Housing Census, 778 persons (0.7%) died. The recorded Crude death rate is 6.7 per thousand deaths. Also, the district recorded a more under five mortalities for males (11.4%) than females (9.0%).

Agriculture employs over 73 percent of the total work force in the area and greater number of the farmers engages in oil palm, cassava and plantain cultivation (GSS, 2010).

3.2 Study Sites

The researcher selected twenty Schools from five Circuits in the Adansi South District.

The twenty Schools are listed below.

New Edubiase Circuit

- Amudurase Junior High School
- Methodist Basic School
- Experimental School
- Catholic Basic School
- New Edubiase D/A Basic School
- Atobiase Junior High School

Ataase Nkwanta Circuit

- Prekese Ase Basic
- Kojo Makron Junior High School
- Ataase Basic School
- Atobiase Roman Catholic Junior High School
- Apgya Roman Catholic Basic

Praso Circuit

- Adansi Praso Basic School
- Atwereboana Junior High School
- Edwinase Junior High School
- Kotwea Basic School
- Wureyie Junior High School

Akutreso Circuit

- Subiriso Junior High School
- Akutreso Basic
- Tonkoase NO 2 Basic School
- Kojo Yentumi Junior High School

In addition, five health facilities were visited by the researcher to conduct in-depth interviews with health service providers. The facilities visited were the New Edubiase Government Hospital, Ataase Health Center, Akotereso Health Center, Atwereboana CHPS Compound and Akrofuom Health Center. Two Health Service providers were interviewed in each of the above facilities.

3.3.4 Variables

The variables that were assessed included:

- Types of SRH information provided to female adolescents during SHEP.
- Knowledge level of female adolescents on SRH
- Sexual and reproductive health-seeking behavior of female adolescents.
- Attitudes towards reproductive health

3.4 Sampling

3.4.1 Study Population

Population is defined as a group of persons with similar feature (Polit & Beck, 2010). For the purpose of this study population refers to female students in their 1st, 2nd, and 3rd years in the public Junior High Schools aged 12-18 years. The study population also included community health officers (CHOs) who offered school health services to the selected Junior High Schools. Only female pupils who qualified the selection criteria set participated in the study.

Five facilities which served the selected schools were also included. One Community Health Officer was selected from each facility and engaged in in-depth interviews.

3.4.2 Inclusion Criteria

Participants were female pupils of a public Junior High School, and enrolled in the selected school for at least an academic term between the ages of 12 and 18 years. Community Health Officers who voluntarily showed interest in participating in the study, and consented to be recorded were recruited by the researcher.

3.4.3 Exclusion Criteria

Female adolescents whose legal guardians did not consent were excluded even if they were willing to be part of the study.

3.4.4 Sampling Technique

The study adopted three sampling techniques namely purposive, convenient and criterion. The Purposive sampling was used in selecting the Community Health Officers. The criterion sampling was employed in selecting the female adolescents in Junior High School because it allows for selection of respondents from the target population who satisfied the inclusion criteria for the study (Polit & Beck, 2010). The Simple Random sampling method was then employed in recruiting the female pupils in each class. 415 people responded to the study and this comprises 410 junior high school females and 5 CHOs. One CHO was selected from each of the five facilities. Each of the CHOs participated in face-to-face in-depth interviews.

3.4.5 Sample Size Computation

A sample size of 410 was used for collecting quantitative data. The sample size was calculated based on the formula below:

$$\text{Sample size} = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1 + \left(\frac{z^2 \times p(1-p)}{e^2 \cdot N}\right)}$$

Where N = the size of the population,

e = margin of error (represented as percentage in decimal form)

z = z-score

p = population proportion

From the statistics churned out of the 2010 population census, the total number of females between ages 10 and 19 was 12, 639 (Ghana Statistical Service, 2014). With the rise in Ghana's population since the 2010 Population and Housing Census, and taking into account the rise in the population over the past 7 years, the population of females between the ages of 10 and 19 was estimated as 18, 849. Using a 5% margin of error, a 95% confidence interval which translates into a z-score of 1.96, and a 50% population proportion, the sample size was computed as follows:

$$\text{Sample size} = \frac{\frac{1.96^2 \times 0.5(1-0.5)}{0.05^2}}{1 + \left(\frac{1.96^2 \times 0.5(1-0.5)}{0.05^2 \times 18849}\right)}$$

This yields a sample size of 376.5 which approximately is 377.

A non-response rate of 10% was added to result in a final sample size of 410.

3.5 Data Collection Tools and Techniques

A semi-structured in-depth interview guide and a questionnaire were used to collect the data in English. A detailed description of both instruments was provided. The questionnaire contained twenty eight closed ended questions and each participant spent an average of

twenty minutes in answering the questions. In some instances the researcher and research assistants read the questions to the respondents. The semi-structured interview guide contained open-ended questions and discussion points which allowed respondents to speak freely to questions that cropped up during the face-to-face interactions. The semi-structured in-depth interview guide was used to conduct face-to-face interview with Community Health Officers on a one-on-one, face-to-face basis, while the questionnaire was used during discussions with female pupils.

3.6 Data Processing and Analysis

Data from the questionnaire was cleaned, entered and analyzed with Stata version 15.0. Statistical tools such as frequency distribution tables, charts and cross tabulations were used to analyze data from the questionnaire. The frequency tables and cross tabulation provided the summary of data for easy understanding while the charts showed diagrammatic representation of responses. Analysis looking at the associations between certain demographic attributes of the adolescents and reproductive health needs was tested using the Chi Square test. Statistical significance was set at p value of less than 0.05.

Data from the interviews were transcribed verbatim from the tape recordings in Microsoft Office Word document template. The transcribed data were then analyzed using thematic analysis as proposed by Braun and Clarke (2006). The thematic analysis was suitable for the study because it provided an easy to understand guidelines pertaining to the analysis of qualitative data. It helped the researcher describe data, formulated and found close relationships between the data generated (Mathews & Ross, 2010). The five-steps of thematic analysis are described below:

Familiarization with data: The researcher read through respondents' transcribed data over and over again along his field observations to be able to relate the transcribed data to the objectives of the study.

Initial codes Generation: The researcher used phrases and keywords to identify some characteristics of the data that were in relation with the research questions and objectives of the study.

Defining and naming themes: In defining and naming the themes, the researcher determined the nature of each theme and what it was about, which data in the transcripts best explained the generated themes and reviewed them as such.

Themes searching: The researcher then grouped similar codes into themes.

Reviewing themes: The researcher reviewed the themes to ensure that they do not fall under other themes.

3.7 Data Quality Management

A two-and-a-half hour training was organized by the researcher for four research assistants recruited to assist with the data collection. The training provided detailed instructions and opportunity for practice sessions using the data collections tools. Interviews from the Community Health Officers were tape-recorded after the consent of each respondent was sought. Detailed field notes were also taken to help in the triangulation of data gathered from questionnaires and interviews. There was daily checking and monitoring of questionnaire and interviews administered by the research volunteers to ensure consistency.

3.8 Ethical Considerations

The researcher obtained clearance for this study from the Ghana Health Service Ethics Review Committee through the School of Public Health. The researcher sought permission

from the Ghana Education Service, Adansi South Directorate to have access to the Schools. Permission was also sought from the Adansi South District Health Directorate for access to the Health Facilities and Personnel. Adolescents who were above 18 years were given consent forms to sign after information on the study had been provided. Parents and Guardians of adolescents aged 12 to 17 years were given consent forms to sign willingly to allow their children to be involved in the research. After the parental consent, assent forms were given to the adolescents (12 to 17 years) themselves to sign willingly they to participate or not in the research.

Community Health Nurses who provided school health services also participated in the study with informed consent.

3.8.1 Confidentiality

The researcher ensured that confidentiality was kept. The data record form used to transcribe information from the respondents of the interviews had codes instead of names of the respondents. Respondents of the questionnaire were also given a special identity number instead of their names. All data were stored in a locker, which was locked and accessible only to the researcher.

3.9 Pretesting

The researcher conducted a pre-test of the data collection tools at the Assin North District which shares boundary with the study area. The pre-test of the questionnaire was conducted with thirty (30) pupils of the Assin Praso Junior High School using respondents who met the inclusion criteria and are outside the study area. The pre-testing of the interview guide was done at the Assin Praso Presbyterian Clinic with two community Health Officers who qualified under the inclusion criteria. The pre- test enabled the researcher identify challenges with data collection tools and processes, and the necessary changes were effected before the

real study. The options for question 11 on the questionnaire were increased from 3 to 8 after respondents in the pre-test mentioned other means of safe sex. The researcher and research assistants assisted respondents who had difficulty in reading to understand each item on the questionnaire by providing some explanation to the respondents.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the results of the analyses conducted on the data sourced from in-school female adolescents from the Adansi South District of the Ashanti Region. The first section presents the socio-demographic characteristics of the surveyed in-school female adolescents. The second section focused on sexual and reproductive health services provided by the School Health Education Program (SHEP). The results obtained from the assessment of the level of knowledge of in-school female adolescents on their reproductive health issues are presented in the third section of this chapter. The last two sections represent the last two study objectives focused respectively on determining the reproductive health seeking behaviours of the surveyed female adolescents and examining the attitudes of in-school female adolescents towards the SRH ideals the district.

4.1 Demography of Respondents

The demographic features of the respondents are presented in Table 4.1. It was observed from the table that out of the 410 surveyed in-school female adolescents in the Adansi South District, with mean age of 13.8 years, 72.2% are aged 9-14 years, with 27.8 aged 15-18 years. Most of the adolescents are Christians (94.57%), with a considerable population as Pentecostal/Charismatic, and a predominant percentage (97.07%) of their families deem it very important that the adolescents should further their education beyond the basic level. It was also observed that majority (79.76%) of the surveyed adolescents were in Junior High School and most (72.2%) of the parents of the adolescents were self-employed.

Table 4.1: Sociodemographic Characteristics of Respondents (N=410)

Variable	Frequency	Percentage (%)
Age		
9-14	296	72.2
15-18	114	27.8
Average (year)	13.8	
Education level		
Primary	83	20.24
Junior High	327	79.76
Religion		
Catholic	34	8.29
Protestant	40	9.76
Pentecostal/ Charismatic	314	76.59
Muslim	12	2.93
Traditional Religion	9	2.2
No Religion	1	0.24
Importance of post-basic education to respondent's family		
Not important	12	2.93
Very important	398	97.07
Occupation of parent/guardian		
Self employed	296	72.2
Government employee	86	20.98
Non-governmental	5	1.22
Other	11	2.68
Don't know	12	2.93

Source: field survey, Adansi South District, 2018

4.2 Sexual and Reproductive Health Services Provided by SHEP

The results deduced from the analysis of themes of the interview data reflected the research questions of the study. The Interviewees mentioned some types of SRH services provided during school health services. This was also further categorized by the researcher as types of SRH information, scope of SHEP services and sources of information on adolescents SRH.

4.2.1 Types of Sexual Reproductive Health information

The findings showed that the School health programme as an intervention provides variety of Sexual Reproductive Health education to basic school pupils in the Adansi South District. The programme also provides aspects of personal hygiene. The respondents mentioned family planning, teenage pregnancy, menstrual hygiene and abortion as some of the SRH information provided during school health sessions.

” We basically inform them on vital health issues which is followed with screening and if we identify any challenge, we refer to the health center and the District Hospital for early treatment” (Female CHO).

“We teach them how to control themselves from sex, avoid sex if possible or use contraceptives” (Female CHO).

“We provide health education; educate them on how to take care of themselves especially during menstruation. We also provide education on how to take care of themselves so that they don't become pregnant” (Female CHO).

4.2.2 Scope of the School Health Services

The topic for discussions during a visit is deduced from monthly data on adolescent health services rendered for the month. Sometimes the topic is based on a request of the teachers of a school when they are confronted with a pertinent issue bothering the pupils or based on their observations.

“Sometimes we initiate the discussion by informing the headmaster and staff of an emerging health issue that we will want to alert the students on” (Female CHO).” We provide health education, we educate them on important health topics and after that we do screening.” (Female CHO)

“We rely on the complaint and what the adolescent tells you when she visits the health facility to determine what will be discussed during school health session” (Female CHO).

“We give them education on their health and how to take care of themselves during menstruation. We also teach them how to take care of themselves not to become pregnant... we also provide education on STI especially HIV/AIDS” (Female CHO)

According to the findings notice is normally served to teachers to pre-inform the school before the health Officers visit a school. The health programmes are done in the form of talks and lecturers and are normally ended with questions and responses. It was observed that a session normally last for a minimum of 30 minutes and a maximum of one hour. Respondents stated that subsequent visit dates are announced to the school before a session ends. However pupils with special needs are normally requested to come to the facility for individual attention and counseling.

4.2.3 Source of information on adolescents SRH

CHOs mentioned that they get information on adolescent SRH from reading books, news from the media, trainings and conferences and news.

I read a lot of books on reproductive health and then when we go for workshops or training” (Female CHO).

“Despite the fact that I was trained in school on those issues, I equally use the internet a lot..., I have my books with me, I read through, and sometimes too we have the support of the Health Directorate for more expert explanations to the issues” (Female CHO).

4.3 Level of Knowledge of In-school Female Adolescents on SRH

A major objective of this study was to assess the level of knowledge of in-school female adolescents on sexual and reproductive health issues.

4.3.1 Participation in Sex Education and Personal Development Programs

Table 4.2 presents the summary of responses on the participation in talk shows, classes, and other events toward the end of educating adolescents on sex education and personal development. A majority of the respondents (80.49%) asserted that they have ever attended a class or talk event on sexual reproductive health education, while 69 respondents (16.83%) have never attended any such organized events. With respect to attending classes or talk events on personal development, almost 90% of the surveyed in-school female adolescents have ever attended such organized educative events. Few (8.78%) of the respondents have never attended such events and seven (7) (1.71%) could not recall ever attending such programs. Additionally, it was observed that almost half (45.37%) of the surveyed in-school female adolescents who have ever attended classes and/or talks on sex education and personal development are aged 9-14 years.

Table 4.2 Participation of Surveyed Respondents in Talks and Classes on SRH

Question/ Response	Frequency	Percentage (%)
Ever attended classes or talks on sex education?		
Yes	330	80.49
No	69	16.83
Don't know	11	2.68
Ever attended classes or talks on personal development?		
Yes	367	89.51
No	36	8.78
Don't know	7	1.71
Age when respondent first attended these classes or talks?		
9-14	186	45.37
15-19	9	2.2
Don't know	215	52.44

Source: field survey, Adansi South District, 2018

4.3.2 Level of Knowledge of In-school Female Adolescents on Safe Sex and Pregnancy

From Table 4.3, only a few (16.7%) of the students demonstrated an understanding of the concept of safe sex. More than half (57.07%) of the female adolescents asserted that safe sex means abstaining from sex, while 19 respondents (4.63%) indicated that avoiding multiple sex partners is a way of practicing safe sex. Others (18.54%) expressed that they lack knowledge on the issue of safe sex and 7 (1.76%), one (0.24%), and 6 (1.46%) other respondents respectively responded that avoiding sex with prostitutes; avoiding anal sex; and sex without the knowledge of parents are ways of practicing safe sex.

To this end, the surveyed respondents were questioned on their menstrual cycles to determine if they were self-aware of the period within which they were most likely to get pregnant, should they indulge in an unsafe sex.

Moreover, the views of the respondents were sought on whether a girl can get pregnant at first sex. To this, 178 (43.41%) of the surveyed respondents responded in agreement, while 16.83% of the surveyed in-school female adolescents disagreed. Some 393 (39.76%) of the respondents however could not tell whether a girl can get pregnant at first sex.

Table 4.3 Knowledge of Respondents on Safe Sex and Pregnancy

Question/ Response	Frequency	Percent	Mean
What is safe sex			
Abstaining from sex	234	57.07	2.69
Using condom	67	16.34	
Avoiding multiple sex partners	19	4.63	
Avoiding sex with prostitutes	7	1.71	

Avoiding anal sex	1	0.24	
Sex without your parent's knowledge	6	1.46	
Don't know	76	18.54	
During which time of the menstrual cycle does a woman have the greatest chance of becoming pregnant?			
Just before her period begins	87	21.22	
During her period	62	15.12	
Right after her period begins	92	22.44	3.19
In the middle of her cycle	24	5.85	
Don't know	145	35.37	
Can a girl get pregnant at first sex?			
Yes	178	43.41	
No	69	16.83	1.96
Don't know	163	39.76	

Source: field survey, Adansi South District (2018)

Additionally, the issue of how old a boy can be to make a girl pregnant and the age at which a girl can get pregnant was presented before the surveyed respondents. The responses gathered for these questions are presented in Figures 3 and 4. Inferring from these figures, the greatest frequencies of responses on both questions represented a lack of knowledge of the respondents on these issues. As many as 201 out 410 respondents do not know at what age a boy can make a girl pregnant. Similarly, 155 responded had no idea about the age at which a girl can become pregnant in the case where she indulges in an unprotected sexual intercourse.

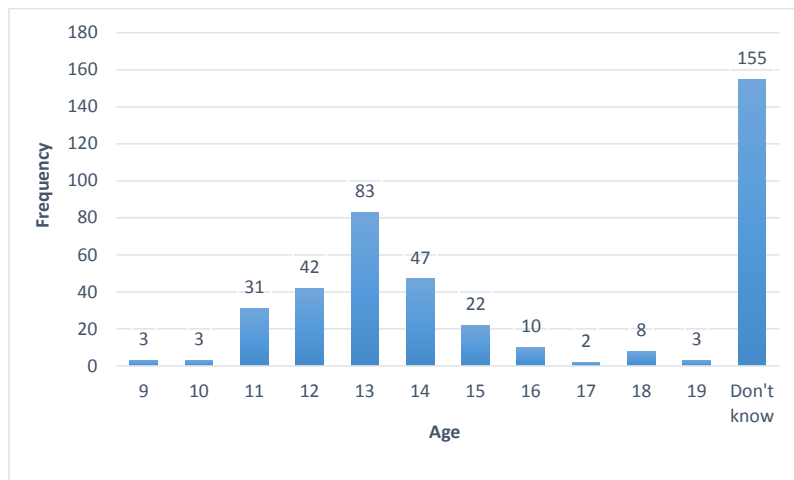


Figure 2: Age at which a girl can become pregnant.

With regards to the age at which a boy can make a girl pregnant, 83 (20.24 %) respondents indicated that at age 13, a boy can make a girl pregnant, while 51 (12.43) of the surveyed in-school female adolescents believed that until age 18, a boy would not be able to impregnate a girl. The responses on the age at which a girl can become pregnant had an almost normal distribution, except for those who responded “Don’t know.” Of all the respondents, 83 (20.24 %) in-school females specified that at age 13, a girl can become pregnant if she engages in an unprotected sex, while 42 (10.24%) and 47 (11.46%) respondents respectively stated that a girl can become pregnant at ages 12 and 14.

4.3.3 Level of Knowledge of In-school Female Adolescents on STIs

Table 4.4 Responses on STIs

Question/ Response	Frequency	Percent	Mean
Have you ever heard of Sexually Transmitted Infections?			
Yes	307	74.88	1.25
No	103	25.12	
What are Sexually Transmitted Infections?			
Diseases acquired from sexual intercourse	227	55.37	2
Diseases from toilet infection	50	12.2	
Diseases gotten through blood transfusion	36	8.78	
Don't know	97	23.66	

Source: field survey, Adansi South District (2018)

It was observed from Table 4.4 that majority (74.88%) of the in-school female adolescents had ever heard of Sexually Transmitted Infections (STIs) whereas 103 respondents (25.12%) had never heard of STIs. Concerning the meaning of STIs, more than half (55.37%) of the surveyed adolescents specified that STIs are diseases acquired from sexual intercourse. Others 50 respondents (12.2%) understood STIs to be diseases obtained from sexual infection, while thirty-six (36) respondents (8.78%) understood STIs as diseases contracted through blood transfusion. This notwithstanding, it was observed that 23.66% (97) of all the respondents do not know what STIs are.

4.4 Reproductive Health Seeking Behaviour of Female Adolescents in School

The results revealed that, there are some factors that hinder adolescents from seeking formal health care on reproductive health. The problems can be broadly categorized into three major

headings namely high cost of SRH services, misconception about family planning. The researcher categorized this as barriers to adolescent SRH services.

4.4.1 Health seeking behaviour of female adolescents

Findings showed that female adolescents discuss their health issues such as menstrual pain or pregnancy with their parents, friends, elder sisters, and school health teachers if she is a female. However most adolescents who became pregnant resort to an unsafe abortion.

“We screen the pupils and listen to their complaints and test if we identify any challenge, we advise the person or refer the person to the hospital for further investigation.” (A female CHO)

Findings revealed that adolescents in the District resort to various crude means of getting rid of unwanted pregnancies through drinking of some herbal medicines, consumption of alcoholic beverages mixed with sugar and over the counter drugs. It was realized that although respondents knew the adverse effects of unsafe abortion practices such as death and infertility, they were quick to justify their actions with aspirations and educational and career goals, and dropping out of school being reasons why they would resort to abortions.

“We provide health education for the adolescents to know more about pregnancies and the consequences that come with it.” (A female CHO).

4.4.2 Barriers to adolescent’s health seeking behaviour on SRH

Interview respondents revealed that most adolescents prefer other alternative way of seeking health care because they see that as comparatively cheaper. According to respondents there is a general perception that it was expensive to do abortion at the hospital and cheaper to get abortion drugs in the drug stores and pharmacies or concoctions used to carry out unsafe abortion at homes.

“The girls who commit abortions at home always complain that they do not have the means to go to the health facilities and it is not covered by insurance. However they are always rushed to the hospital when there are complications after unsafe abortion.” (A female CHO).

“Some of the girls I personally engage on regular basis tell me they do not have money to access health services in the District. We also observed that most of these girls do not have an up to date health insurance card” (A female CHO).

There is a general fear of being tagged by adults and even some health personnel as a bad girl when they discover that an adolescent is accessing or using family planning services. Respondents also added that, their own utterances sometimes also push the girls away from seeking formal healthcare.

“When grown-ups discover that adolescents are accessing family planning or even see them buy condom, they will tag them as bad girls who are just sleeping around “(A female CHO).

“When adults in the community get to know that you an adolescent has caused abortion even if it is safe, they will be talking about that person everywhere, so most of them will hide to do it” (A female CHO).

CHAPTER FIVE

DISCUSSIONS

5.0 Introduction

The discussions chapter expounds on the findings of the research by explaining what the major findings mean and how the findings relate to research works done by other researchers on topics similar to that of this study.

5.1 Sexual and Reproductive Health Services Provided by SHEP

Findings from the study showed that the school health education programme provided adolescents with information on their sexual reproductive health with particular attention on menstrual hygiene practices, family planning, family planning methods available, teenage pregnancy prevention, counseling and education. The findings are in sync with a study by Mason-Jones et al., (2012), which reported that school-based interventions have been found to provide variety of SRH information to adolescents.

The issues for discussion during school health sessions were either influenced by emerging health trends, a specific request made by teachers or an observation made by health staff during their monthly data analysis. Some other factors were commonly identified conditions reported by adolescents to health facilities. This result is similar to the research conducted by Joshi (2006), which called on policy makers and programmers to factor in needs assessments before initiating adolescent-friendly services.

CHOs who deliver the school health education services indicated that, they got their information on adolescent SRH from reading of literature, trainings from workshops and news from the media as well as emerging issues from the internet.

5.2 Level of Knowledge of In-school Female Adolescents on SRH

The research findings showed that most respondents generally have some knowledge on SRH. Respondents described SRH as having to do with pregnancy and STIs/STDs prevention, while others added that it also included issues about abortion, menstruation and personal hygiene. The findings clearly show an indication that respondents knew about SRH. This supports the study of Hessburg, et al., (2007), which revealed that there was an increase in awareness of adolescent females on their menstrual period and the use of contraceptives. The majority of the respondents were aware that they could get pregnant just before the start of their menses. However a few of the respondents did not know that one can get pregnant during ovulation. Rao et al., (2008) in their research admonished stakeholders to provide adolescents with knowledge and information on their physical and physiological changes. On the issue of how old a boy can be to make a girl pregnant, respondents showed a lack of knowledge on the subject matter. The majority of the respondents had no idea about the age at which a girl can become pregnant in the case where she indulges in an unprotected sexual intercourse. This result supports and amplifies the scholarly finding by Abajobir and Seme (2014), who found out that adolescents have limited knowledge on SRH issues.

The majority of them stated that safe sex means abstaining from sex and further indicated that avoiding multiple sex partners was a way of practicing safe sex.

On STIs/STDs prevention, respondents advocated for abstinence, condom use and avoidance of multiple sexual partners. This finding supports the findings from a study by Akakpo (2008) where about a quarter of adolescents aged 10-14 years had heard of STIs.

5.3 Health Seeking Behaviour of Female Adolescents on Reproductive Health

The poor health seeking behaviour of female adolescents does not only make them susceptible to teenage pregnancy and unsafe abortion practices but also increase their risk of getting STDs (Brown & Guthrie, 2010). Findings from the research showed that, female adolescents knew the measures to take to prevent them from encountering some of the SRH challenges that they face. For example, respondents know that, having unprotected sex increases one's risk of teenage pregnancy, having multiple sexual partners also increases one's risk of being infected with STIs. It was also indicated in the findings, that adolescents did not see the need to take up steps in protecting themselves from SRH challenges. This result is in agreement with a study by Abajobir, et al., (2014) which stated that 34.4% of adolescents do not see the need to seek care with their problems. The study by Kennedy, et al., (2013) also revealed that about 12.6% of adolescent girls do not seek formal healthcare due to fear and shame. Respondents admitted that some adolescents visit the health facilities to seek solutions for their health problems such as abortion services. However most of them resort to various crude means of getting rid of unwanted pregnancies. Some of which were mentioned as drinking of grounded broken bottles, herbs, consumption of alcoholic beverages mixed with sugar and buying of drugs from pharmacy. These findings are similar to what Adogu et al., (2014), revealed in his study that adolescents' resort to taking concoctions to prevent unwanted pregnancies. From the results, it was also realized that even though female adolescents knew the adverse effects of unsafe abortion practices they were always quick to justify their actions with aspirations and educational goals.

5.3.1 Barriers to adolescent's health seeking behaviour on SRH

The results showed that female adolescents knew where to seek help when they have problems with SRH. However, they are deterred by the high cost of some of the services,

myths and misconceptions about family planning and the stigma society especially adults attached to adolescents who seek for SRH services such as family planning and abortion.

Misconception on the side effects of contraceptives especially future infertility came out as a major barrier to female adolescent's taking up family planning methods. The respondents said these were the concerns shared by the adolescents when they visit the health facilities. The result agrees with the study by Okereke (2010) which showed that cultural and religious beliefs, coupled with personal experiences, have made adolescents to have negative perceptions about modern contraceptives. Chauhan et al., (2015), also revealed similar results which showed that the use of contraceptives leads to womb destruction. Other studies also revealed that most adolescents associated contraceptives to excessive weight gain and weight loss, heavy menstrual flow and future bareness (Adogu et al., 2014). The above findings call for an improvement in providing comprehensive reproductive health services especially to in-school female adolescents on contraceptive use. Respondents revealed that female adolescents mentioned cost of family planning products and abortion services as a barrier that prevent them from seeking formal healthcare. This supports the findings by Biddlecom *et al.* (2006), and Gebremichael & Chaka (2015), which mentioned factors contributing to adolescent reproductive health and behaviour to peer pressure, early age at menarche, and lack of parental guidance.

Respondents expressed the fear of being mocked by friends or been seen as school dropouts, hence their involvement in unsafe abortions. This also support the findings by Chauhan *et al.* (2015), that 12.6% of adolescent girls do not seek formal treatment for reproductive health problems as a result of fear and shame. It is therefore important that healthcare providers intensify community sensitization on SRH to raise awareness in communities on the benefits of adolescents seeking SRH services. Community-based health facilities should also make their facilities more adolescent friendly.

5.4 Enabling Factors that improves female adolescents' health seeking behaviour on SRH

Respondents mentioned factors that influence the health-seeking behaviour of female adolescents as trust in the professional competence of health personnel and also their ability to keep what they share with them confidential. Partners of female adolescents also serve as facilitators when it comes to seeking reproductive health services. According to respondents adolescents confide in some particular people when faced with SRH problems because those people are knowledgeable and also because they trust them. Respondents were unanimous that teachers and healthcare professionals should lead the process in improving adolescents' access to SRH services. A few however added that parents should be more responsible by providing the needs of their adolescent females in order to prevent them from getting into trouble.

5.4 Limitations of the Study

The study experienced a number of limitations, one of which involved financial cost. Hence the study could not cover many of the schools in other circuits in the District to present a more holistic view of the research.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Conclusion

Based on the results of this study, it was established that some of the services provided by the School Health Education Program in the Adansi South District were related to but not limited to personal hygiene, teenage pregnancy, abortion, menstrual hygiene, and family planning.

The findings showed that the School Health Education Programme did not create the avenue for individual counseling since most service sessions were short.

It was observed that 80% and 90% of the adolescents respectively have ever attended classes or talks on adolescent sexual and reproductive health and personal development. Almost half (45%) of those who had exposure to adolescent sexual and reproductive health issues through classes or talks were aged 9-14years. Despite this early exposure, they lacked understanding of some sexual and reproductive health issues such as STIs.

The study also revealed that although most the of the adolescents open up to their parents, elder sisters, friends, and female teachers, certain factors hinder them from seeking for health care from appropriate health care centers. Some of these hindrances include financial constraints; stigma associated with accessing some health care services like family planning; as well as some utterances by the elderly in the society against adolescents who seek for some kinds of healthcare services like safe abortions.

The findings also indicated that most female adolescents are aware of some of the risky behaviours they are involved in but are uncertain of confidentiality and future implications when it comes to family planning usage. Respondents called for more professional training on confidentiality and also massive public education on the reproductive health issues. It is also important that separate facilities are created for adolescent services to ensure the privacy.

In conclusion, the views expressed in this study were by just a limited number of respondents and the results reflect their opinions and experiences with regards to adolescent SRH. It is therefore recommended future research should be carried out with broader adolescent group in the same District or a different setting to assess their knowledge on SRH issues and how the knowledge influence their health seeking-behaviour.

6. 1 Recommendations

Based on the findings of the research and the conclusions, the following recommendations are made;

6.1.1 Recommendations for policy implementers

- The Health Ministry and the Ghana Health Service should give major attention to the implementation of the Adolescent Friendly Health Services initiative in all facilities by providing a decent space at all levels to ensure that adolescents get the privacy that they desired. This will go a long way to encourage them to access SRH services.
- The Ghana Education Service should establish functional Guidance and Counseling offices in basic schools to cater for the needs of pupils in all areas of life, especially on sexual engagement.
- Regular training for school health teachers so that they can be informed with emerging issues on adolescent health is recommended.

6.1.2 Recommendation for Adolescents

- Regular attendance during the School Health Education Sessions in School
- Seek information on their sexual reproductive health by visiting the adolescent friendly centers in the various districts.

6.1.3 Recommendation for future studies

- Reproductive health-seeking behaviour of out of school female adolescents in the Adansi South District.
- Reproductive health-seeking behaviour of in school male adolescents

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APPENDIX

Appendix 1: Participants' information sheet for Community Health Officials

Research topic: “Adolescent Reproductive Health Education and the Health Seeking Behaviour of in-school Female Adolescent in the Adansi South District, Ashanti Region”

I am Robert Tanti Ali, a student pursuing a Master of Public Health Degree at the University of Ghana, Legon. This document aims to provide you with information about a research I intend to carry out. Your decision to participate will be voluntary. If your questions have been answered to your satisfaction, and you decide to participate in this research, you will be asked to sign a consent form. If you consent, you will be interviewed about your school health services and reproductive health services available to you.

Purpose of the study

The study will explore school health education services and the reproductive health-seeking behaviour of female adolescents in selected Junior High Schools in the Adansi South District of the Ashanti region.

The objectives of the research are:

1. To find out the types of Sexual Reproductive Health services provided to in-school adolescents during school health services
2. To assess the knowledge level of female adolescents on Sexual Reproductive Health
3. To identify the current sexual and reproductive health-seeking behaviour of female adolescents
4. To explore the attitude of in – school adolescent towards sexual and reproductive health ideals of the community.

The findings of the research will be of great value in exploring school health services and female adolescent health seeking behaviour among Junior High School pupils in the Adansi South District, Ashanti Region. The results will further contribute to the completion of my Master's Degree in Public Health.

Research Procedures

The study will involve Junior High School girls who are willing to participate with informed consent. A tape recorder will be available during the interview session, but will only be used if the participants agree.

Time required

The participants will be requested to spare thirty minutes with the researcher.

Risks and discomfort

The study will involve minimal risks to the participants. Interviews and all information will be kept confidential.

Benefits

There will be no direct benefits to individuals who will participate in the study.

However, there will be an overall benefit of the research because the findings will give us more information on how school health services and adolescent reproductive health seeking behaviour could be enhanced.

Confidentiality

The researcher will ensure that confidentiality is kept. The data record form used to transcribe information from the respondents will have codes instead of names of the respondents. All

data will be stored in a locker, and will be locked and it will be accessible only to the researcher and the supervisor.

Participation and withdrawal

Your participation is entirely voluntary. Your refusal to participate will not affect you or your school. Even if you consent to be part of the study, you have the right to withdraw at any time up to the analysis of the data. You could therefore withdraw up to two weeks after your participation.

Questions about the study

If you have questions or concerns even after completion of the study, please contact:

Researcher: Robert Tanti Ali (rtali@st.ug.edu.gh)

Supervisor: Supervisor: Dr Irene Kretchy (iakretchy@yahoo.com)

Hannah Frimpong: Administrative Secretary, Ghana Health Service Ethics Review Committee

(ghserc@gmail.com)

Appendix 2 Informed consent forms for Questionnaires (Female JHS Participants)

Research topic: “Adolescent Reproductive Health Education and the Health Seeking Behaviour of in-school Female Adolescent in the Adansi South District, Ashanti Region”

[Instruction: Please tick (☐) if eligible and consenting]

☐ I have read the participant information sheet and this consent form, and I understand what is being requested of me.

☐ I understand that I may withdraw from this study without giving a reason, and I can request my data not to be included if I wish, up until the date given for analysis of the data.

☐ My questions concerning this study have been answered to my satisfaction.

I freely consent and accept that the researcher can access my information. I have been provided a copy of this form. My parents have assented to my participation in this

☐ study

☐ I give consent to be part of the research.

I accept to take part in answering the questionnaire.

Name and signature of participant

Date

Name and signature of researcher

Date

If you have questions or concerns even after completion of the study, please contact:

Researcher: Robert Tanti Ali (rtali@st.ug.edu.gh)

Supervisor: Supervisor: Dr Irene Kretchy (iakretchy@yahoo.com)

Hannah Frimpong: Administrative Secretary, Ghana Health Service Ethics Review Committee
(ghserc@gmail.com)

Appendix 3 Assent form for parents/guardians of adolescents less than 18years

Research topic: “Adolescent Reproductive Health Education and the Health Seeking Behaviour of in-school Female Adolescent in the Adansi South District, Ashanti Region”

[Instruction: Please tick (☐) if eligible and assenting]

☐ I have read the participant information sheet and this assent form, and I understand what is being requested of me.

☐ I understand that I can withdraw my ward from this study without giving a reason, and I can request my ward's data not to be included if I wish, up until the date given for ☐ analysis of the data.

My questions concerning this study have been answered to my satisfaction.

☐ I freely assent and accept that the researcher can access my wards' information. I have been provided a copy of this form.

☐ I give my assent for my ward to be part of the research.

☐ I accept that my ward takes part in answering the Questionnaires.

Name and signature of parent

Date

Name and signature of researcher

Date

If you have questions or concerns even after completion of the study, please contact:

Researcher: Robert Tanti Ali (rtali@st.ug.edu.gh)

Supervisor: Supervisor: Dr Irene Kretchy (iakretchy@yahoo.com)

Hannah Frimpong: Administrative Secretary, Ghana Health Service Ethics Review Committee
(ghserc@gmail.com)

Appendix 4: In-depth interview guide for community health officers

Research Topic: “Adolescent Reproductive Health Education and the Health Seeking Behaviour of in-school Female Adolescent in the Adansi South District, Ashanti Region”

Notes:

- Ensure that participant is comfortable
- Introduce myself and the study
- Check that participant has read and understood the Participant Information Sheet, signed the consent forms (and also consented to being audio-recorded)
- Ask for participant’s permission to start interview, and then switch on audio recording device to start interview

Lead question

- How is work going on here at this facility?
- Tell me about the work you do in delivering adolescent health services?

Section A: Knowledge of female adolescents on sexual and reproductive health

Can you tell me what you know about sexual and reproductive health?

Probe:

Sexual health- Menstruation, ovulation, STDs

Reproductive health-Family planning, Teenage pregnancy, abortion

What sexually transmitted infections/diseases can affect in-school adolescent females in your catchment area?

Probe:

Do you have any more to add?

Can you tell me some of the signs/symptoms of these sexually transmitted infections/diseases? *[Interviewer to take note and discuss in detail each health problem/infection mentioned]*

Can you tell me about how each of these sexually transmitted

Infections/diseases can be prevented? *[Interviewer to take note and discuss in detail each health problem/infection mentioned]*

Can you tell me about what can be done when an in-school adolescent female contracts these sexually transmitted infections/diseases?

What sexual and reproductive health problems can affect in-school adolescent females in your school or community?

Probe:

Do you have any more to add?

Can you tell me some of the signs/symptoms of these sexual and reproductive health problems? *[Interviewer to take note and discuss in detail each health problem/infection mentioned]*

Can you tell me about how each of these sexual and reproductive health problems could be prevented? *[Interviewer to take note and discuss in detail each health problem/infection mentioned]*

Can you tell me about what can be done when an in-school adolescent has reproductive health problems?

Where do you normally get information on sexual and reproductive health from?

Probe:

Which other sources do you get sexual and reproductive health information from

Section B: Types of reproductive health information provided to in-school adolescence during School Health Services

Can you tell me what services you render when you go for school health services? Probe:

Concerning adolescent sexual and reproductive health services, what do you do, when you go for school health services?

What determines(s) what you discuss during each visit?

How long (on the average) do you stay in the schools you visit?

How do the students know you would be coming for school health services?

How often do you render these services?

What do you tell the students when you are leaving the school you visit for school health services?

Can you tell me more about adolescent sexual and reproductive health services you render in your facility?

Probe:

What kind of sexual and reproductive health information do in-school adolescents have?

What determines(s) what you discuss?

Where do you provide these services for adolescents in this facility?

Section C: Sexual and reproductive health-seeking behavior of female adolescents

Where do in-school female adolescent females seek support when they have any sexual and reproductive health problems in your catchment area?

Probe:

Are there any other places they go to seek support?

Why do you think they seek support from these places?

What sexual and reproductive health services are available to in-school adolescent females in your facility?

Probe:

Which of these sexual and reproductive health services do in-school adolescents seek mostly in your facility?

Which other services concerning sexual and reproductive can you tell me of that are not available in your facility?

Section D: Factors that hinder adolescents from seeking sexual and reproductive health services

As a health worker, can you tell me why most adolescents do not seek adolescent health services available to them?

Probe:

Why do you think in-school adolescent females do not access sexual and reproductive health services available to them in your facility?

What are some of the things that make it easier for in-school adolescent females to access sexual and reproductive health services they need in your facility?

What are some of the things that may stop an adolescent who is already seeking sexual and reproductive health services to stop?

How do you think adolescent sexual and reproductive health problems must be addressed?

What can be done to improve adolescent sexual and reproductive health services?

Probe:

What could be done to improve adolescent sexual and reproductive health services during school health sessions/visits?

What could be done to improve adolescent sexual and reproductive health services in your health facility?

Who should lead in these improvements in the schools?

Who should lead in these improvements in your health facilities?

Concluding questions and statements

Is there anything else you would like to add or share about this topic that you feel is important for me to know beside what we have talked about?

Thank you for your time and participation in this study!

Appendix 5: Participants' information sheet for female Junior High School Adolescents

Research topic: “Adolescent Reproductive Health Education and the Health Seeking Behaviour of in-school Female Adolescent in the Adansi South District, Ashanti Region”

I am Robert Tanti Ali, a student pursuing a Master of Public Health Degree at the University of Ghana, Legon. This document aims to provide you with information about a research I intend to carry out. Your decision to participate will be voluntary. If your questions have been answered to your satisfaction, and you decide to participate in this research, you will be asked to sign a consent form. If you consent, you will be interviewed about your school health services and reproductive health services available to you.

Purpose of the study

The study will explore school health education services and the reproductive health-seeking behaviour of female adolescents in selected Junior High Schools in the Adansi South District of the Ashanti region.

The objectives of the research are:

1. To find out the types of Sexual Reproductive Health services provided to in-school adolescents during school health services
2. To assess the knowledge level of female adolescents on Sexual Reproductive Health
3. To identify the current sexual and reproductive health-seeking behaviour of female adolescents
4. To explore the attitude of in – school adolescent towards sexual and reproductive health ideals of the community.

The findings of the research will be of great value in exploring school health services and female adolescent health seeking behaviour among Junior High School pupils in the Adansi South District, Ashanti Region. The results will further contribute to the completion of my Master's Degree in Public Health.

Research Procedures

The study will involve Junior High School girls who are willing to participate with informed consent. A tape recorder will be available during the interview session, but will only be used if the participants agree.

Time required

The participants will be requested to spare thirty minutes with the researcher.

Risks and discomfort

The study will involve minimal risks to the participants. Interviews and all information will be kept confidential.

Benefits

There will be no direct benefits to individuals who will participate in the study.

However, there will be an overall benefit of the research because the findings will give us more information on how school health services and adolescent reproductive health seeking behaviour could be enhanced.

Confidentiality

The researcher will ensure that confidentiality is kept. The data record form used to transcribe information from the respondents will have codes instead of names of the respondents. All

data will be stored in a locker, and will be locked and it will be accessible only to the researcher and the supervisor.

Participation and withdrawal

Your participation is entirely voluntary. Your refusal to participate will not affect you or your school. Even if you consent to be part of the study, you have the right to withdraw at any time up to the analysis of the data. You could therefore withdraw up to two weeks after your participation.

Questions about the study

If you have questions or concerns even after completion of the study, please contact:

Researcher: Robert Tanti Ali (rtali@st.ug.edu.gh)

Supervisor: Supervisor: Dr Irene Kretchy (iakretchy@yahoo.com).

Administrative Secretary, Ghana Health Service Ethics Review Committee: Hannah Frimpong (ghserc@gmail.com)

Appendix 6: Questionnaire**SAMPLE STUDY QUESTIONNAIRE**

ADOLESCENT REPRODUCTIVE HEALTH EDUCATION AND THE HEALTH
SEEKING BEHAVIOUR OF IN-SCHOOL FEMALE ADOLESCENTS IN THE ADANSI
SOUTH DISTRICT, ASHANTI REGION

Place..... ID No of Respondent:
.....

Name of Interviewer..... Date of
interview.....

SECTION A - BACKGROUND INFORMATION

NO	QUESTIONS	CODE
1	Age	Q1 AGE
2	Sex: Male1 Female.....2	Q2 SEX
3	Adolescents Educational Level (CIRCLE ONE) 1. No education 2. Less than Primary 3. Primary 4. Junior High Secondary 5. Secondary High/vocational/technical college	Q3 EDU
4	Religion (CIRCLE ONE) 1. Catholic 2. Protestant 3. Pentecostal/ Charismatic 4. Muslim 5. Traditional Religion 6. No Religion 88. Others (Specify).....	Q4RE
5	How important is it to your family that you continue your education after basic school? (CIRCLE ONE) 1. Not important 2. Very important	Q5FA
6	With whom do you live with most of the time? (CIRCLE ONE) 1. Both parents	Q6T

	2. Mother only 3. Father only 4. Brother/Sister 5. Guardian/Non-relative 6. Uncle 7. Aunt 8. Grandmother 9. Grandfather 88. Other Specify other.....	
7	Occupation of Parents/Guardian <i>(CIRCLE ONE)</i> 1. Self Employed 2. Government Employee 3. Non-Governmental 88. Others(Specify)..... 89. Don't know	Q7P

SECTION B - REPRODUCTIVE HEALTH KNOWLEDGE

NO	QUESTIONS	CODE
8	Have you ever attended any classes or talks on any of the following on Sex Education? 1. Yes 2. No 89. Don't Know	Q8C
9	Have you ever attended any classes or talks on any of the following on your personal development? 1. Yes 2. No 89. Don't Know	Q9P
10	How old were you when you first attended these classes or talks? <i>(CIRCLE ONE)</i> 1. Age..... 89. Don't know	Q10TK
11	Do you remember discussing any of these in your classes or talks? <i>(CIRCLE ONE)</i> 1. How pregnancy happens 2. Contraception/ how to prevent pregnancy 3. Abstinence/ say no to sex 4. Sexually transmitted infections or diseases	Q11CK

	88. Others(Specify)..... 89. Don't know	
12	What is Safe Sex? (CIRCLE ONE) 1. Abstaining from sex 2. Using condom 3. Avoiding multiple sex partners 4. Avoiding sex with prostitutes 5. Avoiding anal sex 6. Having sex without your parent's knowledge 88. Other (specify):..... 89. Don't know	Q12SS
13	During which time of the menstrual cycle does a woman have the greatest chance of becoming pregnant? (CIRCLE ONE) 1. Just before her period begins 2. During her period 3. Right after her period has ended 4. In the middle of her cycle 88. Other (specify):..... 89. Don't know/don't remember	Q13ME
14	Can a girl get pregnant the first time she has sex? (CIRCLE ONE) 1. Yes 2. No 89. Don't know/don't remember	Q14PE
15	In your view, how old can a boy be, to make a girl pregnant? (CIRCLE ONE) 1. Age..... 89. Don't know/don't remember	Q15PG
16	At what age can a girl get pregnant if she had sex? (CIRCLE ONE) 1. Age..... 89. Don't know/don't remember	Q16HS

17	Have you ever heard of Sexually Transmitted Infections? (CIRCLE ONE) 1. Yes 2. No	Q17ST
18	What are they? (CIRCLE ONE) 1. Diseases acquired from sexual intercourse 2. Diseases from toilet infection 3. Diseases gotten through blood transfusion 88. Others(specify) 89. Don't know	Q18SI
19	Which of the following ways can you use to prevent pregnancy? (CIRCLE ALL APPLICABLE) 1. Using condom 2. Using contraceptive (unspecified) 3. Having non-penetrative sex 4. Herbs 5. Safe days/abstinence 6. Emergency contraception 7. Withdrawal before ejaculation 8. Douching 88. Other (<i>specify</i>): 89. Don't know/don't remember	Q19CU

SECTION C - ADOLESCENTS LEVEL OF KNOWLEGDE ON RISKY BEHAVIOUR

20	Have you heard of any of Risky Sexual Behaviour before in School? (CIRCLE ONE) 1. Yes 2. No	Q20RB
21	Have you heard of any of Risky Behaviour before in School? (CIRCLE ONE) 1. Yes 2. No	Q21 BR
22	Why do you think your friend will like to engage in risky behaviour? (CIRCLE ONE) 1. For the fun of it	Q22FE

	2. To satisfy peers 3. For monetary gains 88. Others (Specify)..... 89. Don't know	
23	What in your opinion, should be done to prevent young people from engaging in risky sexual behaviour? (CIRCLE ONE) 7. Abstaining from sex 8. Using condom 9. Avoiding multiple sex partners 10. Avoiding sex with prostitutes 11. Avoiding anal sex 12. Having sex without your parent's knowledge 90. Other (specify):..... 91. Don't know	Q23OP
24	What in your opinion should be done to prevent young people from engaging in risky behaviour? (CIRCLE ONE)	Q24PI

SECTION D - SOURCES OF INFORMATION ON REPRODUCTIVE HEALTH

25	Where do you normally get information on health education? (CIRCLE ALL APPLICABLE) 1. Parents 2. Siblings 3. Friends/Peers 4. TV 5. Radio 6. Newspaper/Magazines 7. School 88. Others(Specify).....	Q25TF
26	From which of the following will you prefer to get information on health education? (CIRCLE ONE) 1. Parents 2. Siblings	Q26SB

	3. Friends/Peers 4. TV 5. Radio 6. Newspaper/Magazines 7. School 88. Others(Specify).....		
27	Which of the following topics did they discuss with you? (CIRCLE ONE) 1. The female menstrual cycle 2. How pregnancy occurs 3. Sexually transmitted infections 4. How to say no to sex 5. Contraceptives 6. How to prevent AIDS 88. Others (Specify).....	Q27FM	
28	Which of the following topics can you discuss with your peers? (CIRCLE ONE) 1. The female menstrual cycle 2. How pregnancy occurs 3. Sexually transmitted infections 4. How to say no to sex 5. Contraceptives 6. How to prevent AIDS 89. Others (Specify).....	Q28PA	

Appendix 7: Ethical Approval