SOCIAL RESILIENCE OF ADOLESCENT GIRLS TO SEX, TEENAGE PREGNANCY AND MOTHERHOOD IN GHANA

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DECLARATION

I hereby declare that this thesis is the result of my own research work, carried out in the Department of Sociology, University of Ghana under the supervision of Professor Clara Korkor Fayorsey, Dr. Collins Ahorlu and Dr. Dan-Bright S. Dzorgbo. References cited in this work have been duly acknowledged and all errors found in this work are solely mine.

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DEDICATION

I dedicate this work to my parents, Mr. George Adu-Gyamfi and Mrs. Cynthia Hilda Adu-Gyamfi for having faith in me. To my dear husband, thank you for understanding. Nana Gyan, Nana Aduse-Poku and my unborn child, this should inspire you to achieve greater heights beyond this.

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ABSTRACT

This study is about older adolescent girls and how they experience sex, cope with teenage pregnancy and early motherhood in Begoro, the district capital of Fanteakwa in the Eastern region of Ghana. Fanteakwa has one of the high teenage pregnancy rates (16%) in the country. The study investigated the socio-demographic background of adolescent girls in Begoro, the social context that influenced their sexual behaviour and experience, and how non-pregnant and ever-pregnant girls build resilience to sex, teenage pregnancy and motherhood. Guided by a social resilience framework, the study focuses on how older adolescent girls access resources within their social environment and how they utilize these resources to avoid, overcome and or adjust positively to the exigencies of sex, pregnancy and motherhood in Ghana. The study employs the mixed method approach, involving the simultaneous use of the quantitative and qualitative approaches. Starting with the collection of the quantitative data, a survey of five hundred adolescent girls (15-19 years) was conducted. This was followed by the qualitative approach where data were gathered through in-depth interviews with twenty adolescent girls purposively selected from the survey respondents. In-depth interviews were conducted with twelve adults (six males and six females), twenty adolescent girls and six adolescent boys in addition to two focus group discussions with eight boys in each group. The in-depth interviews and focus group discussions were held with adult and adolescent boys in the community to provide the community‟s perspective on adolescent girls‟ sexual experience. The findings indicate that adolescent girls live in a changing social environment, with the emergence of new agents of socialization in sexual and reproductive issues. Adolescent girls now live in a society where they have access to multiple sources of information to guide their sexual behaviour. Although community members do not openly accept it, the findings show that there is a gradual

move from abstinence from sex, which is the expected sexual behaviour of girls in the community to the practice of abstinence to sex or the use of contraceptives in sexual activities. Thus, the social context influenced adolescent girls‟ exposure to risk as well as how they developed resilience in their sexual and reproductive experience. To maintain a good reputation, non-pregnant girls accessed social, economic and cultural capitals that helped them to avoid unprotected sex and teenage pregnancy. For the ever-pregnant girls, they also strived to have a good social reputation by using their access to social, economic and cultural capital to take care of their health and that of their babies, go back to school or learn a vocation. Hence, girls used their access to the other forms of capital to maintain a good reputation, which made them resilient in their sexual and reproductive experience. The study recommends that to help adolescents develop resilience to sex, teenage pregnancy and motherhood, more awareness must be created at the individual, family and community levels to propagate not only abstinence, but also the use of contraceptive pills and condoms by adolescent girls whenever they indulge in premarital sex. In addition, more studies should be focused on how to support adolescent boys to act responsibly when they engage in sexual relations with girls.

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LIST OF ABBREVIATIONS

ABR	Adolescent Birth Rate
AIDS	Acquired Immune Deficiency Syndrome
ARHP	Adolescent Reproductive Health Policy
CHAG	Christian Health Association of Ghana
DOVVSU	Domestic Violence and Victims Support Unit
EP	Ever-Pregnant
EPH	Ever-Pregnant High Resilience
EPL	Ever-Pregnant Low Resilience
FCUBE	Free Compulsory Universal Basic Education
GDHS	Ghana Demographic Health Survey
GES	Ghana Education Service
GI	Guttmacher Institute
GMHS	Ghana Medical Health Survey
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
JHS	Junior High School
NCCR	National Centre of Competence in Research
NP	Non-Pregnant
NPH	Non-Pregnant High Resilience
NPL	Non-Pregnant Low Resilience
NYP	National Youth Policy
PHC	Population and Housing Census
SHS	Senior High School
STI	Sexually Transmitted Infection

TBA	Traditional Birth Attendant
UK	United Kingdom
UNICEF	United Nations Children‟s Fund
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Populations Fund
USA	United States of America
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

This study is about adolescent girls‟ experience of sex, teenage pregnancy and early motherhood in Begoro, the district capital of Fanteakwa in the Eastern region of Ghana. Fanteakwa has one of the highest teenage pregnancy rates (16%) in the country against a national average rate of 13% (GHS, 2007; GDHS, 2008). The study is part of an international research project on Adolescent Sexual and Reproductive Health in Ghana and Tanzania funded by the National Centre of Competence in Research (NCCR) North-South. It focuses on how adolescent girls develop resilience through access to resources within their social environment to avoid, overcome and or adjust positively to the exigencies of sex, teenage pregnancy and early motherhood.

Resilience research has always been used in the domain of child development psychology and ecology. However, in recent times other social scientists have also studied resilience of individuals to social problems (Ungar, 2004; Carey et al., 1998). Social resilience is an individual‟s ability to access resources to adjust or cope well with as well as being able to search for or create options that helps her/him to overcome a threat (Obrist et al., 2010). Research from a resilience perspective focuses on the competencies and positive outcomes rather than on negative ones (Obrist, Pfeiffer and Henley, 2010). As such, resilience of a person is often discussed in terms of risk, protective factors and positive outcomes (Masten, 2011; Obrist et al., 2010; Luthar, 2006; Carey et al., 1998). Risks include the factors that expose an individual to negative outcomes, protective factors are the various resources that support a person to reduce the effects of adversity leading to positive outcomes. These protective factors have been

identified in child development psychology and human development research as the disposition of the individual, relationship with significant others and the social environment (Masten, 2011; Luthar, 2006; Garmezy, 1984). An individual‟s resilience in her sexual experience, teenage pregnancy and early motherhood can be defined in terms of her capacity to positively adapt or reduce the effect of risk in a specific context. This is because resilience develops when risk factors are minimized and protective factors are present (Masten, 2011). Resilience research is therefore significant in the study of adolescent girls‟ sexual and reproductive experience since studies have shown that adolescents are predisposed to sex and teenage pregnancy (Hindin and Fatusi, 2009: Awusabo-Asare et al., 2004; Henry and Fayorsey, 2002).

The population of adolescents is estimated to be more than one billion in the world, with about 70% of these adolescents living in developing countries (UNFPA, 2003 in Hindin and Fatusi, 2009). Adolescents are people between the ages of 10 to 19 years. Young adolescents are those aged between 10 to 14 years and older adolescents are those in the age bracket of 15 to 19 years (Ghana Statistical Service [GSS], 2013; WHO, 2007). In 2009, reports from UNICEF indicate that globally, 16 million girls between the ages of 15-19 years give birth every year. Despite the large number of adolescent girls bearing children, studies have shown that 60% of all pregnancies and births among adolescent girls between ages 10-19 years in developing countries are unintended (Weiss et al., 2010). The United Nations Department of Economic and Social Affairs (UNDESA, 2013) indicates that between 2005 and 2010 the adolescent birth rate (ABR[1]) was 49 per 1000 births at the global level, 53 per 1000 births in developing countries and 104 per 1000 births in Africa. Since most adolescent pregnancies are unintended and out of

[1] The annual number of birth for women 15-19 years of age per 1000 live birth

wedlock, abortion is a frequent response. WHO (2010) reports that 2.5 million adolescents the world over have unsafe abortions every year with 14% of all unsafe abortions occurring among adolescent girls 15-19 years in low and middle income countries. This global picture on adolescent sexual and reproductive health is not different from what pertains in sub-Saharan Africa and Ghana. In sub-Saharan Africa, studies have shown that most adolescents initiate sex and experience sex before marriage (Hindin and Fatusi, 2009) with some adolescents experiencing sex at the age of 16 years (Nabila and Fayorsey, 1996).

Evidence from Ghana also shows that more adolescent girls (29%) compared to adolescent boys (15%) engage in premarital sex (Guttmacher Institute Fact Brief, 2006). The median age at first sex in Ghana is 18.4 years in the urban areas and 17.9 years in the rural areas (GDHS, 2008; GSS, 2013). This notwithstanding, other studies in specific regions in Ghana have found the median age at first sex to be as low as 15 years (Agyei et al., 2000, Nabila and Fayorsey, 1996). The average age of first marriage in rural Ghana is 20.9 years for females and 24.9 years for their male counterparts among people between the ages of 20-24 years (GDHS, 2008). Although the age of first marriage in Ghana is steadily rising the change does not correspond with the age of first sex. The age at which adolescents experience their first sexual intercourse does not tally with the age at first marriage, suggesting that most adolescent girls‟ experience sex out of wedlock. Adolescents seem to be postponing age at marriage because of formal education and the changing values on age for marriage (Awusabo-Asare, 2004; Glover, Bannerman, Pence et al., 2003).

Furthermore, Ghana‟s ABR in 2011 was 60 per 1000 birth (GSS, 2013), which is higher than the total adolescent birth rate globally and in Africa. The GDHS (2008) report indicates that there has not been any substantial change in the overall percentage of teenage girls who have begun childbearing. In 2003, the percentage of teenagers who had begun child bearing was 14% and in 2008 it decreased by 1% to 13% (GDHS, 2008). It means that within five years the issue of teenage pregnancy continues to be pressing. This notwithstanding, the proportion of adolescent girls who are married is 9% (GSS, 2013), which suggests that some adolescent girls become pregnant out of wedlock.

Women with unwanted pregnancy in Ghana may turn to self-induced abortion since abortion in some cases is illegal[2]. In Ghana, 16% of women between ages 12 and 24 years who have ever had sex have been involved in terminating pregnancy (Awusabo-Asare et al., 2004). Most of these abortions are not professionally done, neither are they done in health facilities and this can result in post abortion complications and at times death (GSS, 2013; GDHS, 2008; Awusabo-Asare et al., 2004). The GSS (2013) reports that of all deaths recorded in the past twelve months before the Population and Housing Census 2010, 60% were females aged 15-19 years and 9% of such deaths were because of pregnancy related problems. It was identified that 16% of death among adolescents 15-19 years were also due to violence, homicide, accidents and suicides (GSS, 2013). Ghana Statistical Service, in their report, suggests that the high rates of death

[2] An abortion performed by a qualified medical practitioner is legal:
a. “where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks capacity to make such request”
b. “where the continuance of the pregnancy would involve risk to the life of the pregnant woman injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis” (Criminal Code, 1960, Act 29, Section 58)

among females compared to males may be because of maternal related causes. This rate of adolescent maternal mortality is confirmed by Der and his colleagues‟ study that found that abortion, haemorrhage and infections were among the top causes of death among women aged between 15-49 years in Ghana (Der, Moyer, Gyasi et al., 2013). These maternal related deaths can be avoided if adolescents can be protected from unwanted pregnancies or provided with resources that can help them adapt positively to motherhood. These indicators highlight the extent to which adolescents are at risk concerning their sexual and reproductive experience.

Among the population of adolescents, females tend to face higher risk of sexual and reproductive health problems due to the societal norms and values, social change, socio-cultural factors and gender roles within the society (East, Jackson, O‟Brien et al. 2011; Hindin and Fatusi, 2009; UNFPA, 2008; Awusabo-Asare, Abane, Kumi-Kyereme, 2004; Ahlberg, 1994). Adolescent girls are confronted by traditional, religious, legal and their own „romantic‟ values as they enter into their sexual and reproductive stage of life (Ahlberg, 1994; Weiss, Whelan and Gupta, 2010). The traditional and religious value systems are against sex before marriage, while the legal system defines the appropriate age for marriage. These values tend to be in conflict due to the long wait between puberty and marriage with the changes taking place in society and the fact that adolescents spend more years in school and postpone marriage. As such, these values and the changes predispose girls to sexual and reproductive health risk. In addition, discriminations in the societal expectations of appropriate (chaste) female and male behaviour (Adomako Ampofo, 2001) also predispose girls to unsafe sexual behaviours. Many societal values on sexuality are such that a woman has to choose between societal approval by being passive in sexual matters or risk being labelled as promiscuous by being proactive in sexual matters (Reddy and Dunne,

2007, Adomako Ampofo, 2001). Such sexuality issues predisposes girls to early sexual initiations, unsafe sex, unintended pregnancy and early motherhood (Morhe, Tagbor, Ankobea et al., 2012; East et al., 2011; Karim, Magnani, Morgan and Bond, 2003; Glover et al., 2003). Early sexual initiation with little or no contraceptive use has multiple effects on the adolescent girl, her family, community and the nation at large (Morhe et al., 2012; Awusabo-Asare et al., 2004; Glover et al., 2003).

The large population of adolescent the world over are confronted with issues related to their sexual and reproductive health experiences and as such, a wide range of research has been done to address these problems. Despite these studies and numerous interventions, the problem of adolescent sexual and reproductive experience remain high. Even, World Health Organization (WHO) acknowledges the sexual and reproductive health problems confronting them, thus calling for researches that would lead to a better understanding of what sexuality, gender, family and having children means to adolescents (WHO, 2007). This is to provide insights as well as serve as a guide for young women and men towards responsible adulthood. In view of this, research that identifies the strengths and positive outcome of adolescents who are exposed to sexual and reproductive health problems has become necessary. Research from a resilience perspective has become pertinent since it focuses on the positive outcomes such as how to avoid, overcome and positively adjust when one is exposed to risk rather than on negative outcomes (Obrist et al., 2010).

1.2 Problem Statement

The issue of adolescent sexual and reproductive health is not a new phenomenon. Studies abound on adolescent sexual and reproductive issues in Ghana. These studies on adolescent sexual and reproductive experiences in Ghana have focused extensively on the health-risks, economic strain and social implications of adolescents‟ sexuality, teenage pregnancy and motherhood (Gyesaw and Ankomah, 2013; Awusabo-Asare et al., 2004; Agyei et al, 2000; Nabila and Fayorsey, 1996). Other studies have looked at the determinants of teenage pregnancies, identifying factors such as lack of basic needs (as a result of poverty), sexual violence, exploitation, peer pressure and lack of parental control as the main determining factors of adolescent sexuality and reproduction (Nabila et al., 1996; Population Impact Project, 1995; Adomako Ampofo, 2001). Furthermore, studies have looked at the various intervention methods or approaches that have been developed over the years to address the issue of adolescent sexual and reproductive problems (Bearinger, Sieving, Ferguson and Sharma, 2007). So far, these investigations have focused on what is happening to adolescent girls and those who have actually experienced the challenges associated with premarital sex, teenage pregnancy and early motherhood.

Studies from the United States of America (USA), United Kingdom (UK) and other countries have shown that not all adolescent girls who go through puberty end up experiencing the negative consequences of sex, teenage pregnancy and early motherhood (Hurd and Zimmerman, 2010; Weed et al., 2000; Blinn-Pike, 1999 Carey et al., 1998). Little is known about how some non-pregnant girls go through puberty and abstain from sex or risky sexual behaviours, although they may be exposed to premarital sex or may be involved in sexual activities (Blinn-Pike, 1999; Hurd and Zimmerman, 2010). In addition, only a few studies exist on how some girls have been able to cope successfully with unintended pregnancy and early motherhood (Weed et al., 2000;

Carey et al., 1998). It is often assumed that once a girl becomes pregnant in her teenage years, then her future is destroyed, but some are able to cope well with these challenges and are able to have a good and better life in general during and after pregnancy (Carey et al., 1998).

This study identified such girls whether pregnant or not to find out how they were surviving or "making it" despite being exposed to risk factors in their sexual and reproductive life. For those girls who were not pregnant and have never had a live birth, the study investigated the various resources available to them, how they had access to them and how that played a role in their ability to avoid unintended pregnancy. This study looked at which resources non-pregnant girls relied on to avoid premarital sex and teenage pregnancy. For those who were pregnant or mothers already, the study investigated the resources available to them, how they had access to these and how these enabled them to adjust positively with early motherhood. The issue here is to identify what helps them to avoid, overcome and adjust positively to the problem associated with their sexual and reproductive experience.

1.3 Objectives of Study

Main Objective of Study

The main objective of this study is to find out how adolescent girls develop resilience to teenage pregnancy and early motherhood in Begoro. For the teenage mothers, the study sought to find out how they adapt positively to early motherhood, and for those who are not pregnant and have no live births, the study finds out how they also become resilient to teenage pregnancy.

Specific Objectives

1. To investigate the social context influencing adolescent girls‟ sexual behaviour in Begoro
2. To ascertain how non-pregnant adolescent girls develop resilience against sex and teenage pregnancy in Begoro
3. To investigate how adolescent girls cope with teenage pregnancy and motherhood in Begoro

1.4 Rationale for the Study

Most of the studies on adolescent sexual and reproductive health in Ghana have been on teenage mothers or pregnant teenagers forgetting about those who are not pregnant. Studies that look at abstinent adolescents have been done mainly in developed countries with only a few focusing on developing countries (Abbot and Dallas, 2008; Kabiru and Ezeh, 2007; Blinn-Pike, 1999). There are several lessons to be learnt from adolescents who do not get pregnant in their teenage years, lessons that intervention methods can adapt. These lessons have to do with how some of these adolescent girls are able to overcome, avoid or positively adjust to the risk associated with their sexual and reproductive experience given the available resources within their social environment. Identifying factors within the society from the perspective of the adolescent girls can provide policy makers and other stakeholders‟ with evidence for policy formation to enhance girls‟ ability to avoid sex and teenage.

Adolescent sexual and reproductive experience requires a focus on specific categorization of people on the bases of gender, age or educational characteristics (Glover et al., 2003). The call for studying and understanding adolescent sexual and reproductive behaviour based on specific

categorization has informed this study. Findings show that there is a disparity between sexual and reproductive experiences of adolescent girls and boys, with high proportions of adolescent girls being at risk. Based on these findings there is the need for further studies into the contextual factors associated with sexual behaviours. This therefore calls for specific studies to understand the factors that influence adolescent girls in their sexual and reproductive experiences within their social context. An individual‟s exposure to risk and how she is able to avoid or overcome the risk is greatly influenced by socio-cultural factors stemming from the societal norms and values on gender and sexuality (Varga, 2001).

Addressing challenges to resilience is an important component of ensuring teenage girls and teenage mothers and their children reach their potential. Using the resilience approach identifies aspects of individual adolescent lives that can be improved to make adolescent girls make the most of their reproductive life with little or no negative outcomes or consequences. In addition, the resilience approach identifies the factors that make adolescent girls resilient to teenage pregnancy and early motherhood and can directly inform policy and future research to improve resilience in adolescent girls during their reproductive age.

Furthermore, the study has the potential to inform current policy discussions and support the design and implementation of future adolescent sexual and reproductive health focused interventions because resilience research helps to understand how people adapt positively when risk factors are minimized. Finally, the study contributes importantly to the resilience literature on adolescents and teenage pregnancy in developing and low-income countries by providing a

Ghanaian perspective in a context in which the majority of literature is produced in western contexts.

1.5 Study Area

An Overview of Fanteakwa District (Begoro)

Fanteakwa District is one of the twenty-one (21) districts within the Eastern Region of Ghana with Begoro as its District capital. Begoro is bounded to the North by the Volta Lake, to the North-West by Kwahu-South District, South-West by the East Akim Municipal, Lower Manya Krobo District to the East and to the South East by the Yilo Krobo District. It is located exactly at the middle of the Eastern Region. In terms of ethnicity, the population is varied; there are six ethnic groups with the Akans (61.3%) dominating followed by the Ga-Adangmes. The other ethnic groups include the Ewes, Dagati and Frafra. The district according to 2010 population and housing census has a total population of 108,614 out of which 50.3% are females (GSS, PHC, 2010). The average household size for the district is 5.7 as compared with the national average of 5.24 persons.

Social Structure of Begoro

Begoro has a social structure similar to other Akan communities. The Akan is the largest ethnic group in Ghana. Similar to the Akan political system, Begoro has its own traditional rulers who run the day-to-day affairs of the community concurrently with the government appointees. There is a sub-chief and elders who see to the daily running of the community. In Begoro Township the sub-chief as is the practice in most Akan communities sits over disputes (Nukunya, 1992) and also undertake developmental activities in conjunction with the local government in the district.

The dominant religion of the people is Christianity (86.3%) with Islam (11.2%) and traditionalist constituting 2.5% (GSS, 2013).

The main economic activity of the people is subsistence farming mainly in food crops such as cabbage, plantain, tomatoes and cassava. Since agriculture is the main economic activity in the community it is the highest employer, employing about 62.2% of the population (ghanadistricts.com). Others are employed in the formal sector (16.1%) with 19.3% engaged in trading and 3.4% employed in the industrial sector (ghanadistricts.com). The percentage of unemployed people within the working force is 33.2% (ghanadistricts.com). The high unemployment rate in the district is explained by underemployment due to the seasonality of farming activities and the farmers who constitute the largest working population have little to do during off seasons.

The district has a good educational infrastructure because of government and private partnership. There are 79 pre-schools, 110 primary schools, 54 Junior High Schools (JHS) and 3 Senior High Schools (SHS) with a technical and vocational school (ghanadistricts.com). About 23.8% of the people have never attended school before, 40% have attended school in the past and 30% are presently in school (ghanadistricts.com). .

There are 22 public and private health institutions in Fanteakwa with the district hospital situated in Begoro. These institutions are all government establishments except the Salvation Army clinic, which is part of the Christian Health Association of Ghana (CHAG). The district has Fifty-four outreach points where Reproductive and Child Health Services are rendered.

Moreover, there are thirty-five trained Traditional Birth Attendants (TBAs) augmenting the community health activities.

1.6 Definition of Concepts

Adolescents

The World Health Organization defines adolescents as young people between the ages of 10 and 19 years (WHO, 2007). Adolescents can be classified into two, Young Adolescents and Older Adolescents. The young adolescents are those adolescents who fall with the ages of 10 to 14 whereas the older adolescents are those that fall within the ages of 15 to 19 years. This study focuses on the older adolescents and therefore an adolescent in this study refers to the older adolescent group.

Social Resilience

Social resilience is defined as "the capacity of actors to access capitals in order to – not only cope with and adjust to adverse conditions (that is reactive capacity)- but also search for and create options (that is proactive capacity), and thus develop increased competence (that is positive outcomes) in dealing with a threat (Obrist et al., 2010). In this study, social resilience refers to an individual"s ability to access capitals to adjust or cope with as well as being able to search for or create options that will help them overcome a threat.

Non-Pregnant Girls (NP)

Adolescent girls who are not pregnant or have not had any live birth. It includes girls who abstain from sex or girls who are sexually active but have not had any live birth. The study

classifies such girls as non-pregnant girls (NP). This includes girls who may have had abortions or miscarriages or sometimes shied away from disclosing it because it was a taboo to mention their misdemeanour given their social context.

1.7 Structure of the Thesis

The thesis is organized into nine chapters. This first chapter, the introductory chapter of the study, provides a background to the study; it discusses the issues under investigation, the main and specific objectives guiding the study and the rationale for this study. An overview of the study area is also given to give a background context to where the study was conducted.

The second chapter provides a review of the social context of teenage pregnancy in Ghana to place the study within the Ghanaian context first before narrowing it to the social context of adolescent sexual and reproductive experiences in Begoro. Specifically, it looks at the social change that has taken place concerning adolescent sexual experiences, the trend now, some indicators of adolescent sexual and reproductive health issues in Ghana.

Chapter 3 discusses the conceptual framework guiding the study. It looks at the origins of the concept of resilience, its adaptation in the social sciences, how other researchers have used it in their study on adolescents‟ sexual and reproductive experiences. Then finally, the chapter focuses on how the social resilience framework is used for this study and how the study adapts it.

Chapter 4 discusses the research method used for the study. It looks at why the mixed method approach was used as the research design and how the choice of mixed method approach is

guided by the principles of feminist research methods. The chapter provides a detailed discussion of how the study was conducted, detailing the study population, the sampling method and procedure, the data collection instruments, data collection processes and procedures. Furthermore, this chapter looks at how the collected data is processed and analysed to produce the results discussed in Chapters five, six, seven and eight.

Four chapters, namely, five, six, seven and eight are devoted to the analysis, interpretation and discussion of data collected from the field. These analyses chapters discuss how adolescent girls develop resilience pathways given the resources available within a specific context. In chapter five, the background of the survey respondents are discussed looking at the socio-demographic characteristics of the adolescent girls and their pregnancy status. The sixth chapter discusses the social context influencing adolescent girls‟ sexual and reproductive experience in Begoro. It looks at this from the perspective of the adolescent girls and the community members, taking into consideration the changes that have taken place in adolescent sexual and reproductive experiences. In Chapter 7, the resilience pathways of non-pregnant girls are discussed. This chapter discusses how non-pregnant girls transform resources available to them to develop resilience against sex and teenage pregnancy. Chapter 8 discusses how pregnant and or adolescent mothers are able to overcome and adjust positively to the challenges associated with motherhood.

The last chapter (Chapter Nine) summarises major findings of the study and draws conclusions from the findings. It also outlines recommendations for further research and policy makers on adolescent sexual and reproductive issues.

CHAPTER TWO

BACKGROUND: CONTEXTUALIZING ADOLESCENT SEXUAL BEHAVIOUR, PREGNANCY AND MOTHERHOOD IN GHANA

2.1 Introduction

Adolescents‟ experience of pre-marital sex, becoming pregnant as well as mothers in their teenage years can be attributed to several factors including social change, socio-cultural factors, gendered roles and the socio-demographic background of the individual adolescent girl (Awusabo-Asare, 2004; Adomako Ampofo, 2001; Ahlberg, 1994). This fits the perspective that all human activities occur within socially constructed fields (Bourdieu, 1986). According to Marston and King (2006: 1582), "…worldwide, not only is sexual behaviour strongly shaped by social forces, but those forces are surprisingly similar in different settings, with variations of the extent to which each theme is present rather than of kinds of themes". To this effect, the contextual experiences of adolescent sexual behaviour in Ghana may have relevance to other countries. This chapter provides a broad social context in which adolescents experience their sexual and reproductive life to provide a general background of the situation in Ghana. First a historical overview of the adolescents life in Ghana, including the traditional practices, changing and conflicting values and societal norms that guide adolescent‟s sexual and reproductive behaviours are critically discussed. This is followed by a critical analysis of adolescent sexuality, knowledge and contraceptive use, adolescent childbearing, motherhood and marriage. How formal education plays a role in adolescents‟ sexual and reproductive experience is also discussed. Furthermore, the issue of abortion among adolescents in Ghana, specifically self-induced abortion and its effect are reviewed. Finally, the socio-economic factors that predispose adolescents to premarital sex, pregnancy and motherhood in Ghana are reviewed

2.2 A Historical Overview of Adolescent Sexuality in Ghana

A girl‟s adolescence in Ghana begins with the onset of menarche and is often celebrated among many ethnic groups with initiation rites. In the past, most ethnic groups, as part of their traditional values and norms, perform initiation rites for girls to mark their entry into womanhood an indication that fertility is of great importance (Adomako Ampofo, 2001; Sarpong, 1977). The common initiation rites for girls are „Bragoro[3]‟ among the Akan ethnic groups and „Dipo[4]‟ among the Krobos. During such initiation rites, girls are secluded for days or weeks where they are taught the secrets of womanhood such as how to be good wives, lessons about their sexuality and how to be the caretakers of their future marital home ((Adomako Ampofo, 2001, Sarpong, 1977). The initiation rites are usually climaxed with a durbar where the initiated girls walked through the town in rich cloths and beads to announce that they are ready to get married. This was done because most ethnic groups in the past supported early marriages as such parading girls on the streets after going through the puberty rites helps them to attract potential suitors (Sarpong, 1977). These initiation rites can therefore be said to be ceremonies that prepared girls for marriage. Thus, marriage and childbearing in the past closely followed puberty among most ethnic groups in Ghana.

Traditionally, young girls were expected to be virgins before marriage and therefore girls who became pregnant before marriage were severely punished and this included punishments such as banishment from the community (Bleek, 1981; Sarpong, 1977). Despite the importance attached to a girl‟s initiation into her reproductive life, Adomako Ampofo (2001) observes that, there were no corresponding puberty rites for boys on their sexuality an indication that issues of sex

[3] Bragoro is the puberty rites performed for an adolescent among the Akan ethnic group in Ghana.

[4] Dipo is the puberty rites preformed for an adolescent girl among some Ga-Adangme ethnic groups in Ghana.

and reproduction were regarded as the domain for girls and not boys. Thus, Adomako Ampofo (2001) observed that the socialization of girls and boys based on gendered roles influenced their relationship with each other such that it made boys more dominant in their relationship with girls. Thus, right from childhood, girls are socialized to submit to boys and this kind of gendered socialization of children is carried on into adolescents‟ sexual relations, encouraging girls‟ to submit even in sexual relations with the opposite sex (Adomako Ampofo, 2001). Sexual and reproductive experiences of adolescents are gendered in the traditional value systems and norms. As revealed by Adomako Ampofo (2001), the socialization of adolescent boys and girls about their sexual and reproductive life is tailored in such a way that, from the onset it discriminates against girls in all aspect of their lives. Adomako Ampofo‟s (2001) observed that her respondents both male and female held the view that adolescent girls bear the consequences of premarital sex. Since Adomako Ampofo‟s (2001) respondents (adults, adolescent boys and girls) never identified a boy‟s responsibility to a girl in sexual relations, this creates an unequal opportunity girls where the social norms and values tend to favour adolescent boys compared to adolescent girls in their sexual behaviours. Whereas girls were severely punished for becoming pregnant out of wedlock, Adomako Ampofo (2001) observed that there was no equivalent punishment for boys in most cases. This discrimination in the socialization of boys and girls on their sexual and reproductive life offers an example of Marston and King‟s (2006:1582) assertion that, „women‟s sexual freedom is universally restricted compared with men‟s‟.

The social environment in which adolescents experience sex, pregnancy and motherhood is changing due to increasing rates of migration, rise in Free Compulsory Universal Basic Education (FCUBE) and the dominance of the Muslim and Christian religion (Biddlecom et al

2008; Awusabo-Asare et al., 2004; Glover et al., 2003; Addai, 2000). As a result of the change, Ahlberg (1994) observed that adolescents are confronted by four value systems namely, traditional, religious, legal and romantic with their associated normative behaviour. Firstly, adolescents are confronted with traditional and religious value systems where virginity is cherished and young people are expected to have sex only within marriage (Marston and King, 2006; Addai, 2000; Ahlberg, 1994). Also confronting them now are the legal value system defined by the laws of the country which gives the age for marriage as 18 years as stated in the Children"s Act of 1998. Then finally, a romantic love value system characterized by romantic ideas of friendship and love (Awusabo-Asare et al., 2004; Ahlberg, 1994). The traditional value system in which girls are socialized with values and norms that uphold sexual intercourse and childbearing as acceptable only within marriage now competes with the religious, legal and „romantic" value systems (Ahlberg, 1994). The tension among these values expose girls to the risks of not negotiating for safe sexual and reproductive practices in their attempt to meet the expectations of the society"s appropriate behaviour (chastity before marriage) to avoid being labelled as a „bad girl" (Adomako Ampofo, 2001).

2.3 Adolescent Sexuality

Despite the value systems that uphold chastity before marriage, substantial proportions (37%) of adolescent girls in Ghana engage in pre-marital sex (GDHS, 2008). However, the national statistics show a decline in the proportion of adolescent girls who have ever had sexual intercourse from 59% in 1993 to 37% in 2008 (GDHS, 1993, 2008). The decline in the proportion of adolescents who have ever had sexual intercourse coincides with the rise in the creation of awareness of HIV/AIDS and advertisement in the Ghanaian media by some

stakeholders and international organizations encouraging the use of condoms (Awuasabo-Asare et al., 2004). This is because the GDHS (2008) reported that 78.7% of adolescent girls and 80.5% of adolescent boys accept abstaining from sex as a way of avoiding HIV. Hence, the decline can be attributed to adolescents‟ awareness and knowledge of HIV/AIDS and its influence on their sexual behaviours making them abstain from sex. The national data gives the median age at first sex as 18.4 years with a variation between the rural (17.9 years) and the urban (18.8 years) areas (GDHS, 2008). However, Awusabo-Asare (2004) observed that other surveys conducted in specific regions of Ghana found the median age for sexual initiation to be between 15 and 16 years for adolescents between the ages of 10-19 years. This indicates that adolescents‟ initial sexual intercourse starts in their late teenage years.

2.4 Knowledge and Contraceptive Usage

Globally, studies indicate that adolescents have knowledge on contraceptives and their usage (East et al., 2011; Hindin and Fatusi, 2009). However, their knowledge does not correspond to their effective use of contraceptives in their sexual activities because of misinformation and misuse, superficial knowledge, socio-cultural factors and gender roles (East et al., 2011; Awusabo-Asare et al., 2004; Arai, 2003; Agyei et al. 2000; Okonofua, 1994). Arai (2003) discovered that teenage girls in the United Kingdom (UK) have knowledge about contraceptives and are aware of the consequences of whatever reproductive health decisions they take. In her study, she observed that the girls she researched in the UK used their knowledge about contraception to protect themselves against teenage pregnancy (ibid). Girls in Arai‟s study attributed pregnancy and motherhood to the failure of contraceptives, which could be due to their poor use or misinformation on the use of contraceptives (ibid). Studies in Sub-Saharan Africa

have generated similar findings (Doyle et al., 2012; Hindin, et al., 2009; Awusabo-Asare et al., 2004, Okonofua, 1994). In Sub-Saharan Africa, the use of contraceptives among both married and unmarried adolescent girls is very low, despite knowledge of it (especially the contraceptive pill and condoms) (Hindin and Fatusi, 2009; Awusabo-Asare et al., 2004). Okonofua (1994) observed that the low use was because adolescent girls in rural Nigeria had poor knowledge around contraceptives and their use, which informed their negative attitude towards them.

Studies in Ghana over the years indicate that adolescents are aware of contraceptives and even know where to get them from; however, there is low use of them and knowledge on how to use them appropriately is superficial (GDHS, 2008; Awusabo-Asare et al., 2004; Agyei, Biritwum, Ashitey and Hill 2000; Nabila and Fayorsey, 1996). The national data indicate that 92.5% of adolescent girls have knowledge on the modern methods of contraception (GDHS, 2008) however, this does not correspond to the proportion of adolescent girls who use contraceptive. The GDHS (2008) report shows that only 19.4% of adolescent girls have ever used any method of contraceptive. It was also reported that 14.7% of adolescent boys have ever used any form of contraceptive (GDHS, 2008). The problem of the low or non-usage of contraceptives among adolescents in Ghana has to do with the fear of being negatively labelled by community members as well as the providers of such facilities (Adomako Ampofo, 2001; Nabila and Fayorsey, 1996). Most adolescents in Ghana are reluctant to access clinics for information on sexual and reproductive health issues for fear of being labelled as „bad" girls.

The GDHS (1998) shows that about half of all users of modern contraceptive methods obtained their supplies from the public sector (e.g. government hospitals, government health centres,

family planning clinics, mobile clinics and fieldworkers) and the other half did so from the private sector (e.g., private hospitals, private clinics and drugstores). Although a variety of sources exist, adolescents may not have access due to fear and stigma from society. Furthermore, since sexual intercourse is only accepted in marriage by the value systems, most girls are afraid to visit facilities that provide such services. The fear of being „stigmatised" and labelled for buying contraceptives leads to the low contraceptive use among adolescent girls (Morhe et al, 2012; Glover et al., 2003). The social environment in which adolescent girls find themselves does not make it easy for them to access contraceptives. This means that adolescents may have knowledge about contraceptives but they may not have that flexibility of accessing and using them as and when they want. As such, a more deeply engrained negative attitude to contraception by community members and health service providers needs to be addressed.

Awusabo-Asare et al. (2004) provide another explanation for adolescents" low use of contraceptives. They observed that despite adolescents" knowledge of contraceptives, there are times that their sexual encounters are unplanned, in such cases adolescents tend not to be prepared for sexual intercourse and therefore are not able to protect themselves against teenage pregnancy or STIs (Awusabo-Asare et al., 2004). On their part, Agyei et al., (2000) in their study in Ghana identified three main reasons why adolescents do not use contraceptives. These include the fact that adolescent girls do not think about contraceptives, they were more concerned about the safety of contraceptives and finally partners" objections.

Although there is low usage of contraceptives by adolescents in Ghana, the percentage of adolescents who use contraceptives increased from 4.8% in 1998 to 14.8% in 2008 (GDHS,

1998, 2008). This is attributed to the increase in activities targeted at adolescents to create awareness and knowledge of contraceptives. Awusabo-Asare et al. (2004) observed that the media, both television and radio campaigns developed by some stake holders and international organizations such as the Ghana Social Marketing Foundation (GSMF) and the United State Agency for International Development (USAID) promoted programmes that focused on the promotion of condom use. This shows that the age of sex as mentioned earlier is increasing and on the other hand, adolescents are practicing both abstinence and contraceptive use to protect themselves, an observation that this study explores.

From the various reports, adolescents in Ghana have knowledge of contraceptives, but whether they access and use them is what makes the difference in the impact of contraceptives. Overall, it can be concluded that Ghanaian adolescents‟ knowledge of contraceptives does not inform effective contraceptive usage since data show low usage of contraception among adolescents in Ghana (GDHS, 2008). The low use of contraceptives among adolescent girls has the tendency to increase their risk to unwanted pregnancy, early child bearing and sexually transmitted infections and HIV. Studies suggest that adolescent girls‟ sexual and reproductive experiences are influenced by their socio-cultural and gendered roles (Morhe et al., 2012; Adomako Ampofo, 2001). This suggests that there may be other factors leading to the low usage of contraceptives by adolescent girls. The missing link is how those who use contraceptives to develop resilience pathways given their social context are able to do so.

2.5 Adolescent Child Bearing, Motherhood and Marriage

Globally, approximately 16 million teenage girls become mothers every year, with the highest concentration of this population in sub-Saharan Africa, where it is estimated that 20%–40% of teenagers are mothers or currently pregnant (UNICEF, 2009). The 2010 Population and Housing Census report indicates that 12% of adolescent girls are either pregnant or mothers already with one in every ten births occurring among adolescent mothers (GSS, 2013). According to the GDHS (2008) the proportion of adolescent girls who have begun childbearing increases with age from less than 1% among those who are 15 years, to 29% among adolescents who are 19 years. Thus, the proportion of adolescents who have begun childbearing is positively correlated with age. In addition, the proportion of adolescents who have begun child bearing in urban areas differs from their rural counterparts. Whereas 11% of adolescents in urban areas have begun childbearing, in the rural areas 16% of adolescent girls have begun child bearing (GDHS, 2008). However, the urban-rural gap in teenage childbearing has reduced compared to 7% in urban areas and 22% in rural areas in 2003 (GDHS, 2008, 2003). The recent difference in the proportion of adolescents who have begun child bearing in the rural and urban areas can be attributed to the government‟s policy of making information on sexual and reproductive health available to all with a specific focus on rural areas.

There is a disparity between sexual activity and marriage with the median age at first marriage for women aged 25-49 being 19.8 years while the median age of first sex was 18.4 according to the GDHS (2008) reports. This shows that adolescent sexual experience does not follow the legal age of marriage, the traditional and religious value systems that adolescents are confronted with in Ghana (Awusabo-Asare et al., 2004; Ahlberg, 1994). In her study on adolescents in Ghana Adomako Ampofo (2001) indicated that her respondents associated the accepted age for

adolescent sexual relations with economic independence, having completed school and having a job rather than marital status and age. Adomako Ampofo (2001) observed that the age for sexual relations was not the issue but rather the consequences (premarital pregnancy) of sexual relations. This suggests that the traditional value of the acceptance of childbirth only in marriage is changing.

Despite the legal age for marriage, being 18 years as stated in the constitution, in practice this is not followed. The 2010 National Population and Housing Census data revealed that some adolescents marry at a much younger age than legally permitted. More girls enter into marriage earlier than their male counterparts do with 9% of adolescent girls aged between 15-19 years being married as compared to 5% of adolescent boys the same age (GSS, 2013). The 2010 census data also indicates that out of the 9% married adolescent girls, 3% lived together with their spouses (GSS, 2013). The Ghana Statistical Service has identified that "strangely, although quite negligible, some (1.1%) of the adolescents in these age brackets were reported to be divorced, separated or widowed" (GSS, 2013:55). The GSS (2013) indicates that 6.4% of adolescent girls in urban areas are married as compared to 12.6% of adolescent girls in the rural areas. The difference in marital status by the rural-urban dichotomy is largely influenced by the traditional values that accept childbearing within marriage. A higher proportion of adolescent girls in rural areas are married as compared to those in the urban areas because adherence to traditional values is much stronger in rural communities than in the urban communities. As such, parents of pregnant adolescent girls in order to avoid the "shame" associated with out of wedlock pregnancy encourage and at times force their daughters into marriage. However, Adomako Ampofo (2001) observed that this trend of forcing girls into marriages because of out of wedlock

pregnancy causes some adolescent boys not to accept responsibility for impregnating a girl for fear of being forced into marriage. Thus, whereas parents see marriage as way of preserving their reputation, adolescent boys on their part see marriage as a punishment for getting a girl pregnant. (Adomako Ampofo, 2001).

In view of this, the Adolescent Reproductive Health Policy (ARHP, 2000) has as one of its objectives to reduce the proportion of females who marry before age 18 by 80% by 2020. There are enacted Laws that abolish cultural practices that encouraged early marriages. Various stakeholders have been empowered to ensure the coming into fruition of the policy on adolescent marriage such that no girl is forced into marriage before the legal age of marriage (Children‟s Act 1998; Constitution of Ghana, 1992). In addition, these policies caution against any form of discrimination against adolescents who are married. The Ministry of Gender, Children and Social Protection and the Domestic Violence and Victim Support Unit (DOVVSU) a special unit formed by the police service have been established to address the problems of women and children (Awusabo-Asare, 2004).

However, despite the existence of such measures, adolescent marriages persist in Ghana as reflected in the census data (GSS, 2013). In spite of the policy interventions and the support of stakeholders and international organizations to reduce the rates of adolescent child bearing, the rates have shown little change over recent years, falling from 10.8% in 1993 to 8.2% in 2008 (GDHS, 2008). Ghana‟s adolescent birth rate in 2011 was 60 per 1000 birth (GSS, 2012) showing a decline in the total fertility rate of adolescents in Ghana since 1993.

2.6 Formal Education and Adolescent Girls‟ Sexual and Reproductive Behaviour

Adolescent pregnancy and motherhood is widely recognised to have an influence on the educational attainment of adolescent girls. There is a two-way relationship between education and teenage pregnancy and early motherhood. An adolescent girl‟s access to formal education can help her avoid teenage pregnancy and teenage pregnancy can cause a girl to drop out from school. Forsyth and Palmer (1990) in a study in the United States of America (USA) observed that early childbearing was one of the factors that led to low educational attainment among adolescent girls. Twenty-five years later the identified relationship continues between teenage pregnancy and the educational achievements of girls (Woodward e al., 2001; Arai, 2003). Arai (2003) in a study on teenage pregnancy and fertility in English communities observed that contrary to what policy makers suggest as a cause for high teenage pregnancy rates (sexual attitudes and knowledge about contraception) among girls in deprived communities factors such as dislike for school and poor academic performance explain teenage pregnancy better. Other studies also suggest that low level of education, poor academic performance and dislike for school were factors that increased the vulnerability of adolescents to teenage pregnancy and early motherhood in developed countries (Arai, 2003; Woodward et al., 2003; Forsyth and Palmer, 1990).

In Sub-Saharan Africa, there are studies that corroborate the findings that tend to associate low educational attainment to teenage pregnancy and early motherhood (Gyan, 2013; GDHS, 2008; Okonofua, 1994). A study in sub-Saharan Africa indicates that adolescent girls are more likely to drop out of school once they engage in premarital sex (Biddlecom et al., 2008). In a study in Nigeria, Okonofua (1994) discovered that teenage pregnancy can halt or disrupt a girl‟s formal education. Studies in sub-Saharan Africa and Ghana indicate that the fear of being stigmatized

for conceiving or having a baby can also account for school dropout and low educational attainment (Imoro, 2009; Obeng, 2003).

On the other hand, formal education can delay sexual activities and thus can stop teenage pregnancy. In a study of sexually inexperienced adolescents who abstained from sex in Ghana, Malawi, Burkina Faso and Uganda, it was discovered that 70% were enrolled in school with the exception of Burkina Faso, which had only 25% (Ezeh and Kabiru, 2007). The low school enrolment of adolescent girls in Burkina Faso was due to dominance of Islam, thus most parents were reluctant to educate their girl children. In Ghana, whereas 30.9% of adolescent girls with no education had begun childbearing only 3% of adolescent girls at the Senior High School (SHS) level of education and above in Ghana had begun child bearing (GDHS, 2008). The GDHS (2008) report therefore indicates that the more years adolescent girls spend in school the further they postpone child bearing. The introduction of sexual and reproductive health education in the syllabi at the basic and secondary school levels of education by the Ministry of Education has also contributed to the change process.

The educational policy in Ghana formally supports adolescent girls‟ continuation with their education regardless of their marital or reproductive status (ARHP, 2000; National Youth Policy (NYP), 1999, Constitution of Ghana, 1992). For instance, the ARHP (2000) came out with policies that aimed at increasing the proportion of adolescent girls in secondary and higher education to 80% by 2020. Currently, the basic and secondary school levels of education have included information on sexual and reproductive health in the social science syllabi in Ghana.

2.7 Abortion

The WHO reported that 14% of all unsafe abortions occur among adolescent girls aged 15-19 years in low and middle-income countries (WHO, 2010). Abortion is permitted for adolescents in many developed countries because of the liberalization of abortion laws (Rahman et al., 1998). On the other hand, in most developing countries there are restrictive laws that prevent people from seeking professional assistance for abortion or laws that punish people who abort pregnancy (Morhe et al, 2012). These notwithstanding, a large proportion of adolescent girls who become pregnant in Ghana terminate their pregnancies (Awusabo-Asare et al., 2004; Agyei et al., 2000). According to Agyei et al. (2000), approximately 47% of adolescents who have ever been pregnant have had an abortion. In their report, Awusabo-Asare et al. (2004) noted that 16% of women between ages 12 and 24 years in Ghana who have ever had sex have terminated a pregnancy. Data on abortion rates may not reflect the actual problem because many women do not wish to report having an abortion in Ghana and thus most survey rates of abortion are under reported (Guttmacher Institute, 2010). Nabila et al. (1996) in their study on adolescents in Ghana attributed low rate of abortion (10%) recorded in their study to the reluctance of respondents to disclose their abortion experiences because of the stigma associated with abortion in Ghana. The teenage pregnancy abortion rates in Ghana are nevertheless high although abortion continues to remain a sensitive and socially stigmatized issue for women in Ghana (Morhe et al., 2012; Nabila and Fayorsey, 1996).

There are socio-cultural stigmas attached to aborting a pregnancy at all levels of society (Awusabo-Asare et al., 2004, Nabila and Fayorsey, 1996). Bleek (1981) in his study on the ethical context of abortion in Ghana among the Akans concluded that abortion was an abominable act in the society. Traditionally, abortion is taboo among most ethnic groups and is

not openly discussed (Bleek, 1990). Aside that, the religious influences of Christianity and Islam that are also present in the country similarly teach against premarital sex and may impose sanctions such as suspension of members who are deviant (Addai, 2000). Since the traditional and religious values advocate chastity before marriage, girls who cannot stand the „stigma" that sometimes comes with teenage pregnancy may turn to abortion as a way to avoid this in their community.

Adolescents resort to abortion for several reasons including the desire to continue education, unintended pregnancy, lack of financial means to support a child and in some cases a man"s denial of paternity (Awusabo-Asare et al., 2004, Afenyadu and Goparaju, 2003). In addition, the fear of reactions from parents and the community as well as the shame associated with pre-marital childbearing also put girls at the risk of aborting unwanted pregnancies (Awusabo-Asare et al., 2004). The law in Ghana criminalizes abortion with the exception of pregnancies by rape or incest, or having serious health implications for mother or foetus (Criminal Code, 1960). The Ghanaian social environment is such that an adolescent girl, who is confronted with an unwanted pregnancy may turn to self-induced abortions for fear of being stigmatized, the cost involved and the lack of knowledge that abortion in some cases are legal (Guttmacher Institute, 2010; Awuasabo-Asare, 2004; Nabila and Fayorsey, 2004,). Given these circumstances, many girls who do not want to continue with a pregnancy have no option than to seek self-induced abortion which explains why 30% of women in Ghana who have had abortions carried these out at home (Awusabo-Asare et al., 2004). The legalities and socio-cultural norms surrounding pregnancy and abortion in Ghana leave adolescent girls with little options and therefore girls may use rudimentary methods to terminate their pregnancies on their own or with the help of non-

professionals (Morhee and Morhee, 2006). Teenage girls who seek to abort their pregnancy resort to self-induced abortions or untrained abortionists, which may lead to complications and in extreme cases death (Awusabo-Asare et al., 2004; Afenyadu and Gorapoju, 2003). Most abortion cases are only taken to the hospital when complications set in after self-induced abortion, which at times could be fatal.

Abortion in pregnancy is one of the leading causes of death among adolescent girls in low and middle-income countries contributing to high maternal mortality rate for adolescent girls (WHO, 2006). This is because unwanted pregnancies are associated with increased levels of induced abortion, which when carried out in an unsafe condition carries severe health risks, including death. The GSS (2013) reports that of all deaths recorded 12 months before the 2010 Population and Housing Census (PHC), 60% were made up of females aged 15-19 years and 9% of such deaths were because of pregnancy related problems including self-induced abortions. Many women who go through unsafe abortion suffer complications in future (Guttmacher Institute, 2010).

2.8 Socioeconomic Factors Influencing Sexuality, Pregnancy and Motherhood

> Teenage pregnancy represents a selective process in which girls who are raised in socially disadvantaged and dysfunctional families and who are characterised by antisocial tendencies are more likely to become pregnant (Woodward et al., 2001: 1173)

Singh et al., (2001) in their study in five developed countries (Sweden, Britain, Canada, France and USA) concluded that disadvantaged adolescents are more likely to become pregnant. They defined disadvantaged adolescents as "characterised by such factors as living in poverty, being poor, having poorly educated parents, being raised in a single parent family or an economically

struggling neighbourhood and lacking educational and job opportunities" (Singh et al, 2001; 251). Findings from sub-Saharan Africa also support the effect of being disadvantaged and/or dysfunctional family backgrounds on adolescent early sexual activity, pregnancy and motherhood. The GDHS (2008) report revealed that socioeconomic background determined childbearing among adolescents. According to the report, "by wealth status, adolescent childbearing decreases from 21% in the second wealth quintile to 4% in the highest wealth quintile" (GDHS, 2008: 107).

Poverty is identified as a major cause of adolescent early sexual initiation, pregnancies and consequently motherhood in Ghana (Gyesaw and Ankomah, 2013; Domhnaill, 2011; Henry and Fayorsey, 2002). Girls whose parents are not able to provide for basic needs such as food, clothing and shelter and other essentials tend to seek economic support from male partners (Afenyadu and Goparaju, 2003; Henry and Fayorsey, 2002). Where parents have difficulty in raising money to pay for these demands, some adolescents drop out of school, which exposes them to initiate early sexual activity that can lead to teenage pregnancy (Henry and Fayorsey, 2002). Gyesaw and Ankomah (2013) in their study of adolescents in Ga East municipality found out that the respondents became pregnant because of transactional sex in order to meet their basic needs, which their parents could not provide for them. As such, poverty can predispose girls to seek for financial favours to pay their fees in order to stay in school or drop out of school. This may push girls into early sex that may lead to unintended and unwanted pregnancy.

In studies on adolescent sexual behaviour and pregnancy, the family is seen as both a blessing and a curse in adolescents‟ vulnerability and resilience to teenage pregnancy (Singh et al., 2001;

Woodward et al., 2001; Furtensberg et al., 1987; Kiernan, 1986). Single parenting is identified as one of the determinants of negative behaviour in children by researchers (Gyan, 2013; Harden et al., 2009; Obeng, 2008; Woodward et al., 2001). For instance, in their study of 533 New Zealand women, Woodward et al. (2001) found out that most young women, who had given birth before the age of 20 years were brought up by a single mother who was once a teenage mother who has low level of education and socioeconomic disadvantage. In another study in Ecuador, it was discovered that parental separation or divorce was one of the factors that put girls at risk to teenage pregnancy (Guijaro, et al., 1999). Other studies have linked single parenting to a girl‟s exposure to early sexual activity with its subsequent effect of teenage pregnancy and early motherhood (Woodward et al., 2001; Guijaro et al., 1999; Forsyth and Palmer, 1990; Kiernan, 1986).

Similarly, in Ghana, studies have identified single parenting as one of the major factors that exposes adolescents to early sexual activities and teenage pregnancy (Gyan, 2013; Nabila and Fayorsey, 1996; Population Impact Project, 1995). This is because single parents tend to have poor monitoring on the activities of their children due to the burden of being the breadwinner of the family. Thus, the financial burden of providing for their household keeps them out of the home most often, giving their children freedom to engage in risky behaviours. The financial burden of taking care of their children as a single parent can be challenging leaving the children at a disadvantage (Nabila and Fayorsey, 1996). However, single parenting may not always predispose adolescent girls to sexual activities and its consequence of teenage pregnancy. Morhee and Morhee (2006) observed that this could be due to the extended family support system that existed in the study area (Ejisu Juabeng District). Adolescents who live in a society

where the extended family system is effective tend to receive support from other family members aside from their parents (Morhee and Morhee, 2006). However, due to the changing Ghanaian family system and increasing urbanization of the society, the extended family system seems to be breaking down, leaving the responsibility of child upbringing with parents (Ardayfio-Schandorf, 2007).

Aside parents, peers also tend to play a key role in adolescent sexual and reproductive behaviour. However, there are divergent views on the impact of peers on adolescents‟ sexual and reproductive behaviour. Peers have been associated with having a negative influence on sexual and reproductive behaviours (Seiving, Eisenberg, Pettingell and Skay, 2006). Adolescents are influenced by what their peers approve as the right behaviour and therefore where peers encourage risky sexual behaviours this could be easily adopted and practiced. In addition, some adolescents for fear of being labelled by their peers conform to the normative values of their peers regarding sexual and reproductive activities. Studies have identified negative peer influence as the cause of most adolescent sexual and reproductive health experiences (Karim et al., 2004; Nabila and Fayorsey, 1996; Forsyth and Palmer, 1990). Seiving et al., (2006) found that the timing of adolescents‟ first sexual intercourse is determined in part by the norms for sexual behaviour and the perceived values of their peer group. In Ghana, studies by Nabila et al (1996) affirm peer influence on adolescents‟ sexual behaviours. Adolescents‟ decisions to terminate or keep a pregnancy according to Tabberer et al., (2000) can be influenced by their peers. In situations where adolescents are afraid of being stigmatized by their friends, they may terminate a pregnancy to continue to be part of their peer group.

In her study in UK, Arai (2003) found contrasting views about peer influence on teenage pregnancy and early motherhood. Whereas teenage mothers rejected the idea of being influenced by their peers, the coordinators of the teenage programme felt young women were more vulnerable to external influences than the young mothers saw themselves (Arai, 2003). Thus, adolescent girls find it difficult to accept that their peers influence their sexual and reproductive experiences. However, Keller et al., (1999) in their study in Ghana found that peer pressure did not influence a girl‟s pregnancy status. Arai (2003) further indicates that norms of a community or neighbourhood where friends and neighbours begin child bearing in their teen years create a culture that accepts early fertility. Aside from peer influence, the communal norms can influence and determine adolescents‟ sexual behaviours and attitudes (Little and Rankin, 2001). In some cases, adolescent girls could be influenced by how the community reacts to other adolescents who are pregnant or mothers already and this can influence adolescent girls‟ attitudes to early sexual initiation or teenage pregnancy and early motherhood.

2.9 Conclusion

This chapter has described the cultural, social and economic contexts which influence adolescent girls sexual and reproductive experiences in Ghana. The chapter has provided a historical context of adolescent sexual and reproductive experiences and the changes that are taking place in the Ghanaian society. The changes that are taking place in society are influenced by the two dominant religions in the country, Christianity and Islam as well as laws that govern the appropriate age for marriage. This suggests that adolescents continue to live in a society where they are expected to remain chaste until marriage. However, due to factors such as free compulsory education and the legal age for marriage being 18 years and above, girls spend more

years in school creating a long gap between the onset of menarche and marriage, hence marriage does not follow menarche as it used to be in the past.

Although age at first sex is 18.4 years for adolescents other studies done in specific regions indicates otherwise, highlighting that some adolescents initiate their first sexual experience at age 15 years. This suggests that, adolescents are initiating sex at a lower age as well as before the legally acceptable age of marriage. Knowledge of contraceptives and their usage is common among adolescents; however, their knowledge does not correspond with their usage. This can be attributed to the fear of stigmatization by service providers, which makes adolescent girls continue to engage in risky sexual behaviour with little or no use of contraceptives. This has created tension between the traditional value system and the new value systems thus exposing adolescent girls to risky sexual behaviours.

Additionally, socioeconomic factors influencing adolescent girls‟ early sexual activities, pregnancy and motherhood were also reviewed. These included poverty, broken homes and single/divorced family backgrounds. Adolescents‟ socioeconomic background has the tendency to influence their sexual and reproductive experience, with a high proportion of girls who come from dysfunctional families being more likely to experience negative sexual and reproductive life. With this background information on adolescent sexuality, pregnancy and motherhood experience, it provides a starting point for the research to find out how adolescent girls are able to develop resilience to premarital sex, teenage pregnancy and early motherhood given their social context. The next chapter reviews literature on social resilience and how it is used as a framework for this study.

CHAPTER THREE: LITERATURE REVIEW

SOCIAL RESILIENCE FRAMEWORK FOR ADOLESCENT SEXUAL AND REPRODUCTIVE BEHAVIOUR

3.1 Introduction

Social resilience framework involves identifying what presents a risk to an individual as well as the protective factors that help the at-risk individual to avoid, overcome and or adjust to consequences of a given risk. In this chapter, the social resilience framework is adapted to explore the resilience pathways of adolescent girls to sex, teenage pregnancy and motherhood. In view of this, the chapter reviews literature on the concepts that makes up the social resilience framework, namely risks and protective factors (social, economic, cultural and symbolic capitals). The issue of risk in adolescent girls‟ early sexual activity, teenage pregnancy and motherhood is discussed. It identifies various risk factors and their effect on adolescent girls‟ sexual experiences. Literature is reviewed along the lines of the different levels at which individual adolescent girls interact in society, that is the individual, her family and the society. The chapter also uses Bourdieu‟s work on forms of capital to contextualise issues of social resilience. Bourdieu‟s forms of capital are adapted to represent protective factors available to girls to avoid or successfully cope with sex, pregnancy and motherhood. This is followed by a review of literature aimed at demystifying resilience. Some definitions of resilience are critically discussed. In addition, representations of resilience in research are reviewed. Finally, the multi-layered social resilience framework (Obrist et al., 2010) which is the guiding framework for the study is discussed indicating how it is adapted in this study to explain the resilience pathways of adolescent girls.

3.2 Defining Risk

Risk has been defined in relation to the society and modernization of society (Beck, 1992). Giddens sees risk as society concerns about the future and this he observes generates the notion of risk. Beck (1992:21) also defines it as "a systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself. According to Jenson and Fraser (1994:10), "risk factors are individual, school, peer, family and community influences that increase the likelihood that a child will experience a social or a health problem". This definition suggests that risk factors can stem from the individual, family and the community and has social and health consequences. In another definition, Fraser and Terzian (2005:5) provide a broad definition of „risk factor", they explained "… the term risk factor relates to any event, condition or experience that increases the probability that a problem will be formed, maintained or exacerbated". Similar to Jenson and Fraser (1994), Fraser and Terzian (2005) identified risk factors to have the potential of creating problems for the affected individual. Fraser et al."s (2005) definition further suggests that what constitute risk factors may be in existence, may have occurred already and or has the potential of becoming worse. An adolescent girl"s behaviour, family background and community norms may create the condition or experience that increases a girls" likelihood of engaging in unsafe sex, becoming pregnant and a mother as discussed in chapter two. However, although risk factors may be evident in a social environment, it does not automatically imply that individuals in such environment will definitely have a problem (Jenson and Fraser, 1994). As such, the presence of risk factors indicates that an individual may be exposed to challenges and difficulties that can disrupt the expected outcome of that person"s life (Hawley, 2000, Jenson and Fraser, 1994). This suggests that in the case of adolescent girls who are not pregnant the likelihood of being exposed to problems of sexual experience "may be formed, maintained or exacerbated" by risk factors emanating from the individuals behaviour,

family and community (Jenson and Fraser, 1994; Fraser, et al., 2005). Thus the following sub-sections look at the risk factors present at the three different levels at which adolescent girls interact and take social actions, namely at the individual, the family and community levels (Obrist et al., 2010; Jenson and Fraser, 1994).

Risk Factors at the Individual Level

Risk factors may be present at the individual level in various forms. The individual risk factors identified by Jenson and Fraser (1994:12) include "family history, sensation-seeking orientation, poor impulse [lack of self-control], attention deficits and hyperactivity". In adolescent sexual and reproductive experience, the family history of a girl is identified as one of the risk factors in her sexual experience and consequently pregnancy and motherhood status (Obeng-Denteh and Amedeker, 2011). Adolescent girls with a family history of having a mother who gave birth in their adolescent years are at a higher risk of becoming pregnant and adolescent mothers. This was also observed by Woodward et al. (2001) who found that most young women who had given birth before the age of 20 years were brought up by a single mother who was once a teenage mother. Teenage mothers in most cases are not able to provide sex education for their own children and this could predispose their daughters to early sex and pregnancy (Awusabo-Asare et al., 2004).

Furthermore, individual behaviour and attitudes towards sex, such as educational attainment, financial strength and fear of community members may increase the risk factors for adolescent girls. Morhee and Morhee (2006) found that being in school reduced the likelihood of girls aged 16 years and above to become pregnant. Dropping out of school may create or increase

conditions to early sexual behaviour and consequently pregnancy and motherhood. Henry and Fayorsey (2002) observed that most of their respondents became sexually active after dropping out of school. Girls who envisage financial constraints in taking care of a child may face the risk of aborting a pregnancy, which in most cases are self-induced (Morhe et al., 2012). Adolescent girls may practice unsafe sex in an environment that does not accept girls‟ involvement in premarital sex. Adomako Ampofo explains from her study in the Eastern region that, "while males have always enjoyed some social support for sexual license, females who do the same are perceived as loose women so that these messages may implicitly be saying that if a woman needs to use a condom she must fall into that category" (Adomako Ampofo, 2001; 209). Such socio-cultural norms and values may constitute barriers for girls in proposing the use or using contraceptives effectively in their sexual activities (Morhe et al., 2012; Glover et al., 2012; Adomako Ampofo, 2001).

Risk Factors at the Family Level

The family background can also create, maintain or increase the risk factors of girls‟ sexual and reproductive experience. Adolescent girls who come from socially disadvantaged and dysfunctional families are more likely to be exposed to, and engage in, risky sexual behaviours (Singh et al., 2001; Woodward et al., 2001). In Ghana, girls who come from family backgrounds characterized by poverty, single/divorced parents, are more exposed to problems associated with early sex, pregnancy and motherhood (Gyesaw and Ankomah, 2013; Domhnaill, 2011; Henry and Fayorsey, 2002). This is because their families‟ economic condition may push them to seek for financial favours from men in exchange for sex (Gyesaw and Ankomah, 2013; Afenyadu and Goparaju, 2003). Poor interaction between parent and child is identified in adolescent sexual and

reproductive research as a risk factor, because parents are not able to pass on important knowledge about sex to their children (Hindin and Fatusi, 2009). Hindin and Fatusi (2009:58) observed, "the discomfort many parents feel about talking to their children about sexuality further impedes their ability to provide guidance". Other studies have identified broken homes and low parental control as factors that expose adolescent girls to risky sexual behaviours that could lead to pregnancy and motherhood (Obeng-Denteh and Amedeker, 2011).

Risk Factors at the Community Level

The community in which adolescent girls experience sex, pregnancy and motherhood present several risk factors that may create problems for them. The social environment through its norms, values, legislation as well as its economic conditions can create conditions that may increase the likelihood of exposure to risks associated with sex, pregnancy and motherhood (Glover et al., 2012; Jenson, et al., 2011; Morhee and Morhee, 2006, Adomako Ampofo, 2001). Sociocultural factors in the form of gendered roles through inequality in norms and values guiding sexual and reproductive activities of girls and boys may increase their exposure to early sex, pregnancy and motherhood (Weiss et al., 2010). The norms and values that govern adolescents‟ sexual and reproductive behaviour often favour boys as compared to girls. Whereas boys‟ sexual behaviours are not sanctioned in most communities in Ghana, girls‟ sexual behaviours are sanctioned creating a more risky social environment for girls (Adomako Ampofo, 2001; Awusabo-Asare, 2004). In communities where premarital sex is forbidden and out of wedlock pregnancy may be punished or stigmatized, it increases the risk of adolescent girls who go against such societal norms. Adolescent girls who become mothers may face stigma, girls who cannot bear the shame of pregnancy and or have the desire to further their education may

turn to abortion as a solution to teenage pregnancy exposing themselves to health risks (Morhe et al., 2012; Henry and Fayorsey, 2002; Obeng, 2002). The issue of labelling and stigmatization emerges as a result of the values and norms found within a particular social context.

The laws that govern aspects of sexual and reproductive health may also create conditions that may increase the negative adolescent girls‟ sexual and reproductive behaviour. The lack of clarity in the law of abortion and the attitude of some health professionals may affect girls‟ sexual and reproductive life (Morhee and Morhee, 2006). As such, it may increase the likelihood of girls turning to self-induced abortion whereby they may end up with complications and in some cases death. In addition, girls may feel reluctant to seek healthcare and information from the health institutions such as hospitals and pharmacy shops on sexual and reproductive health matters.

Risk in Sex, Pregnancy and Motherhood among Adolescent Girls

In terms of the risk associated with sex, pregnancy and motherhood, studies have shown that adolescent girls who engage in premarital sex are more likely to be exposed to sexually transmitted infections and HIV/AIDS (Weiss et al., 2010; Gant et al., 2009; Kabiru and Ezeh, 2007). A report from UNICEF (2009) indicates that young people aged 15-24 years account for 40% of all new HIV infection cases. Hindin and Fatusi, (2009) observed that, in most sub-Saharan African countries, AIDS is a generalized epidemic.

The consequence of adolescent pregnancy affects the individual adolescent, the family, and society at large (Morhe et al., 2012; Singh, 1998). Chen et al. (2008) in their study in America

found that teenage pregnancy was associated with increased neonatal mortality and post neo-natal mortality. Most of these health risks in adolescent pregnancy and child birth are due to lack of pre-natal care during pregnancy and post natal care after delivery, which in some cases leads to maternal and neo-natal deaths (Chen et al., 2008; Forsyth and Palmer, 1990). Not seeking pre-natal care may be because adolescents may not be aware of their pregnancy, others just because they lack knowledge on the importance of antenatal care. An adolescent girl‟s individual attitude and behaviour, family background and the societal values and norms may „form, maintain or exacerbate‟ the risk that comes with her sexual behaviour and experience which may result in low educational attainments, STI/AIDS and unwanted pregnancy. These risks could be avoided, overcome or positively adjusted to when girls‟ have access to protective factors, which are discussed in the next section.

3.3 Defining Protective Factors

Protective factors are "influences that modify, ameliorate or alter a person‟s response to some environmental hazard that predisposes them to a maladaptive outcome" (Rutter, 1985; 600). Luthar and Cicchetti (2000) refer to protective factors as those that alter the effects of risk in a positive direction. In their definition, Fergus and Zimmerman (2005) identify protective factors as those elements that help to bring about a positive outcome, or reduce a negative outcome, or avoid it if possible. Looking at the definitions, protective factors are identified as resources that help a person at risk to alter the negative outcome of that risk. In their definition of protective factors, Fraser and Terzian (2005) identified individual and environmental resources as sources of protective factors that help to reduce the effect of risk. They explained that "protective factors [are] resources – individual or environmental that minimizes the impact of risk" (Fraser and

Terzian, 2005:12). They identified resources available to the individual from the social environment as providing protection that reduces the effect of risk. This definition views protective factors as individual characteristics and environmental conditions, which interact with specific risk factors of adolescent girls (Jenson and Fraser, 1994). Thus, in this study protective factors refer to available and accessible resources from the social environment that individuals rely on to protect themselves from the negative effect of risk. These may include advice, emotional support, financial support, societal norms, values, knowledge and information.

Protective factors are contextually defined since there could be differences in socio-cultural and economic values in different societies. The protective factors that help individuals to adapt positively to risks can vary based on the individual‟s ability and family background as well as the social environment (Theron, Theron and Malindi, 2013; Alvord, 2005; Garmezy, 1984). This means that what may be a protective factor for an individual may vary from one social context to another. Protective factors are also relevant to specific events or conditions within a context. For instance, what may be identified as a protective factor at one stage in life may not represent a protective factor at another stage, which suggests they are context specific (Luthar and Cicchetti, 2000). This highlights why adolescent girls who are pregnant and or mothers may require specific resources to minimize the effect of risk on one hand. On the other hand, adolescent girls who may not be pregnant may require specific resource to avoid or overcome risk.

3.4 Protective Factors in Adolescent Girls Experience of Sex, Pregnancy and Motherhood

Individual factors include assets that can be found within the individual such as coping skills, competence and self-efficacy (Fergus and Zimmerman, 2005). According to Alvord and Grados

(2005; 239) one‟s "intelligence, success at making friends and ability to regulate…behaviour" are the individual assets that one possesses from within that can make one resilient in the advent of risk. These „internal‟ capacities are not inherent but are imbibed through the socialization process the individual goes through as a member of a society. Wolin and Wolin (1993) also suggest seven protective characteristics of a child namely „insight, independence, relationships, initiative, humour, creativity and morality‟. Alvord and Grados (2005:239) identify six protective factors including "proactive orientation, self-regulation, proactive parenting, community, connections and attachments and school achievements and involvement" that buffer against risk factors. The protective factors identified by Wolin and Wolin (1993) and Alvord and Grados (2005) can be categorized into three as outlined by Garmezy (1984). Garmezy (1984) categorizes protective factors in children into the individual‟s disposition, strong relationship with significant others and the social environment of the individual. When faced with risk the individual‟s ability to take a positive action such as seeking help from significant others can serve as a buffer against the effect of a risk. Having a strong relationship with people who can help has been identified in almost all resilient research as an important protective factor in children as well as adolescents (Luthar and Cicchetti, 2000; Alvord and Grados, 2005; Wolin and Wolin; 1993; Garmezy, 1984). This means attachment with the right people who can provide support can lead to a positive adaptation (Bourdieu, 1986).

Protective factors can be external to the individual and it includes positive factors in the social environment that help to overcome risk (Alvord and Grados, 2005; Fergus and Zimmerman, 2005). The external influences can be in the form of parental support, friendships, effective schools, adult monitoring or community organizations that promote positive youth development

(Alvord, 2005; Fergus and Zimmerman, 2005). These protective factors help individuals to adapt and successfully cope with risk within their social environment. For instance, Alvord and Grados (2005) identifies „proactive parenting' where parents take initiatives to build strong relationships with their children so that they can overcome adversities. Alvord and Grados (2005) assert that children with a proactive parent or a significant other are more likely to overcome or minimize the effect of risk.

The social environment of the individual is another source of protection against the effect of risk (Alvord and Grados, 2005; Luthar and Cicchetti, 2000; Wolin and Wolin, 1993 Garmezy, 1984). Being a part of society and feeling accepted also serve as a protective factor for at risk individuals. Some common environmental factors that may be a protective factor to at-risk individuals include "opportunity for education, employment, caring relationships with adult or extended family members, social support from non-family members" as mentioned by Jenson and Fraser (1994:14). In the next section, Bourdieu"s forms of capital are discussed with a focus on how they constitute protective factors in the resilience building process of adolescent girls.

3.5 Forms of Capital as a Protective Factor for Adolescent Girls

From Fraser and Terzian"s (2005) perspective, protective factors are resources that help an individual subvert the negative effect of risk to a positive outcome. This study adapts Bourdieu"s (1986) forms of capitals namely social, economic, cultural and symbolic as protective factors in adolescent girls" resilience to sex, teenage pregnancy and motherhood. Anheier, Gerhards and Romo (1995) see capital as "a generalized resource that can assume monetary and non-monetary as well as tangible and in-tangible forms" (Anheier et al., 1995: 862). Although the concept of

capital has been strongly influenced by economic theory, Bourdieu‟s work on capital emphasizes the importance of recognizing the various forms of capital in order to understand social relationships and interactions in society (Bourdieu, 1986). To understand the various interactions, that take place in society among individuals and their society, capitals in all forms and "not only in one form recognized by economic theory" must be accounted for (Bourdieu, 1986:46). This is because relying on only the economic theory of capital means only addressing the exchanges in the world of trade with the aim of making profits. Bourdieu (1986) suggests that depending on the field that the concept is being used, capital can take on three forms namely social, economic and cultural capital. After these, he later introduced the concept of symbolic capital, which determines all the other forms of capitals (Bourdieu, 1986). This study adapts the social, economic, cultural and symbolic capitals to explain how they serve as protective factors for adolescent girls in their sexual and reproductive experiences. The study does this by looking at how each form of capital is accessed and utilized by the individual adolescent girl in overcoming, avoiding and or positively adjusting to their sexual, pregnancy and motherhood experiences.

Social Capital

Social capital, according to Bourdieu (1986), is the sum of the actual and potential resources that a person can mobilize by virtue of being a member of any form of association, social group or organization. "Social capital is defined as relational capital, or in other words, the power and advantages one gains from having a network of „contracts‟ as well as a series of other more personal or intimate relations" (Moi, 1991). It helps the possessor to develop and increase other forms of capital and may greatly enhance his or her chances of achieving legitimacy in a given

field. Social capital involves participation in social relationships that allow one to have access to resources possessed by one‟s associates and as well as the amount and quality of those resources (Portes, 1998). Social capital as an individual protective factor involves an adolescent girl‟s proactive orientation such as success at making friends with significant people and taking initiative to avoid, overcome and successfully coping with issues about sex, pregnancy and motherhood (Alvord and Grados, 2005; Jenson and Fraser, 1994; Wolin and Wolin, 1993). Having a family with a strong interpersonal relationship is a protective factor against risk. Families that are more cohesive, have a sense of obligation to each other reduces the effect of risk (Alvord and Grados, 2005; Jenson and Fraser, 1994). Social capital is therefore seen as how such relationships serve as social control mechanisms, family support and benefits through social network with other community members, groups or organizations (Portes, 2000).

Economic Capital

Economic capital involves access to financial support and command over economic resources, mainly cash and assets (Bourdieu, 1986). Economic capital as a protective factor in adolescent girls premarital sex, pregnancy and motherhood, can take the form of money needed to buy contraceptives, access family planning health care, buy medicine and healthy food during and after delivery. Access to financial resources can be a protective factor in an adolescent girls‟ sexual and reproductive experience where girls have initiative (savings), proactive orientation (purchasing power) and independence (working) (Alvord and Grados, 2005; Wolin and Wolin., 1993). It involves how at the individual level an adolescent girl acquires economic status through her own labour or from her family and in some cases from a partner or father of her baby. The family of an adolescent girl can serve as buffer against her risk to premarital sex, pregnancy and

motherhood in the form of remittances such as school fees, pocket money for school as well as provision of basic needs. Parents‟ provision of financial support can serve as a protective factor when girls‟ financial needs are provided for them.

Cultural and Symbolic Capital

Cultural capital refers to the ideas and knowledge that people draw upon as they participate in social life. This includes resources acquired through the values and norms that exist in a specific social context. The acquired cultural knowledge informs an adolescent girls‟ skills, behaviour and attitudes which can be used to avoid, overcome and or adjust positively to risk factors (Alvord and Grados, 2005; Jenson and Fraser, 1994). It is reflected mainly in a person‟s behaviour because of knowledge or socialization based on traditions, formal education or other sources such as books, the print and electronic media. Bourdieu identifies three types of cultural capital. First he identifies individual dispositions and habits acquired in the socialization process (embodied cultural capital), secondly the accumulation of valued cultural objects (objectified cultural capital) and lastly institutionalized state of cultural capital based on formal educational qualifications and training (Bourdieu, 1986). The study dwells more on the objectified type of cultural capital, which are observed in this study as the other sources of information (books, television, radio etc.) that has protective influence on adolescent girls‟ to avoid, overcome and or adjust positively to the risk of premarital sex, teenage pregnancy or motherhood. Accessing cultural capital in the three types as identified by Bourdieu, means that an adolescent girl must go through a socialization process both through the formal and informal way to learn about the values of the society as well as how to access information from different media sources. This is

because objectified culture can only be useful to a person if they can transform it to their benefit and this can only be achieved through socialization.

Cultural capital includes the sources of information, usually from the media where knowledge on sexual and reproductive health issues are discussed. Cultural capital as used in this study is more inclined towards the objectified form of cultural capital, which deals with sources of information for non-pregnant and ever-pregnant girls on sexual and reproductive health. This is reflected in the embodied form by how they respond to sexual and reproductive issues (Sullivan, 2001). Engaging in cultural activities such as reading, the type of material read the type of programme watched or listened to as well as the type of music listened to all constitute components of cultural capital that can serve as protective factors against risk (De Graaf et al., 2000).

Bourdieu later added symbolic capital (honour, recognition and prestige), which he saw as power-related resource that influences the way in which actors can access the other forms of capital (Bourdieu, 1986). Symbolic capital is the "degree of accumulated prestige, celebrity, consecration or honour" (Bourdieu, 1993:7). It refers to an individual‟s reputation, honour or prestige within a social space (Bourdieu, 1993). Although Bourdieu did not use his symbolic capital to explain the differences in power relations when it comes to gender differences that exist in society, his explanation of symbolic capital is appropriate for analysing this. Symbolic capital requires gendered analysis that has so far been absent. The gender dynamics in how social reputation is maintained in society highlights how individuals are influenced by the norms and values in their society. Symbolic capital like the other forms of capital also plays a role in an individual‟s access to the other forms of capital. In this study, symbolic capital refers to an

adolescent girl‟s reputation in the society, whether they feel accepted within their community or whether the community members accept them for who they are. Symbolic capital is based on the individual‟s social status and how this can influence access to the other capitals (social, economic and cultural) to avoid or overcome the challenges associated with premarital sex, teenage pregnancy or early motherhood.

3.6 Effects of Protective Factors

The various forms of capital work together as a protective factor for adolescent girls‟ to "reduce the impact of risk, interrupt a chain of risk factors and prevent or block the onset of risk factors (Fraser and Terzian, 2005). The different forms of capital do not stand in isolation but are interrelated and interdependent. For instance, economic capital (money) and social capital (strong relationships) can help an adolescent to acquire cultural capital (educational qualification). An individual‟s access to capital in any form can be mobilised and transformed to yield positive outcomes. During or after risk, individuals rely on their capacity to structure and restructure social order with reference to the challenges and risks that they face in their daily lives. How capital is transformed and distributed is shaped by the ability of the individual as well as the social environment. Through social interactions, individuals can access capitals to avert risk. Thus, access to and the use of capital in any form is determined by the individual as well as the society.

3.7 Understanding Resilience

Resilience studies in its early stages in the 1970s focused mainly on young people. Early research on resilience came from child development psychology in search of the causes of

neonatal illness and other health problems in children at risk of psychopathology (Masten, 2011). The study on at-risk children showed differences in how children respond to risk and this set the ground for researchers to look for the protective factors that inform the differences in children (Masten, 2011). The concept of resilience since then has been widely used in several other disciplines in different ways to research at-risk individuals, groups and communities.

Masten, Best, and Garmezy (1990:426) defined resilience "the process of, capacity for or outcome of successful adaptation despite challenging or threatening circumstances". In this definition, resilience is explained in relation to adapting successfully to a risk. According to Rutter (1999) resilience is "a term used to describe relative resistance to psychosocial risk experiences" (Rutter, 1999:119). In Rutter‟s definition, resilience is equated to resistance to risk, thus the ability of a person to overcome the effects of a risky experience. Luthar and Cicchetti (2000) defined resilience as "a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma" (Luthar and Cicchetti, 2000). Luthar and Cicchetti (2000) see resilience as a way of adapting after going through a negative experience where an individual is able to manifest positive adjustment outcomes. Adversity in this sense refers to the risk of, the negative life circumstances that are associated with difficult adjustments. Luthar and Cicchetti (2000) explain that positive adaptation refers to how an individual is able to exhibit expected behaviour in a positive way. Positive adjustment is defined based on "behaviourally manifested social competence or success at meeting stage salient developmental task" (Luthar and Cicchetti, 2000:858). In this case, resilience of an individual is explained based on socially recognized expected behaviour that is normal for a person at that stage in life. It involves leading a „nomal‟ life, the same as one‟s peers who have not had such negative

experience. In their definitions, resilience is associated with individuals experiencing adversity or risk and the process they go through to come out positively. In Masten et al. (1990), Rutter, (1999) and Luthar et al.‟s (2000) they did not account for children who may be exposed to risk but have not yet experienced the risk. Furthermore, they focused on psychosocial issues, as such, this study intends to take it a step further by looking at at-risk adolescent girls both those who have experienced and not experienced the risk associated with pre-marital sex, pregnancy and motherhood. This moves resilience research from a psychosocial analysis to a sociological analysis of how adolescent girls through their interaction with their social environment are able to avoid teenage pregnancy on one hand and on the other hand, how they adapt to teenage pregnancy and motherhood when they experience it.

Later, Alvord and Grados (2005: 238) in more simple terms defined resilience as “those skills, attributes and abilities that enable individuals to adapt to hardships, difficulties and challenge”. Other definitions see resilience as a process of overcoming, coping and avoiding risk (Fergus and Zimmerman, 2005; Masten, 2011). Fergus and Zimmerman refer to resilience as “the process of overcoming the negative effects of risk exposure, coping successfully with traumatic experience and avoiding the negative trajectories associated with risks” (2005: 399). In their quest to develop an African definition of resilience, Theron et al. (2013) conducted a study in a rural South African community and based on the accounts of the adults‟ views of what resilience among the youth was, identified five core concepts of resilience. They observed that the core concepts were not mutually exclusive and they included, “a resilient personality, a future orientation, educational progress, value adherence, and equanimity, and interpersonal strength” (Theron et al., 2013: 75).

Resilience is based on three different outcomes, which are, overcoming the effect of risk, successfully coping after experiencing the risk and avoiding the pathways that expose one to risk (Fergus and Zimmerman, 2005). Masten (2011) later defined resilience by extending it to include how the individual adapts during or after experiencing the risk. He defines resilience as "the study of the processes of capacity for, or pathways and patterns of positive adaptation during or following significant threats or disturbances" (Masten, 2011: 494). This definition points to a feature of resilience, that is the fact that resilience is not an act that is static but an on-going process where individuals experience a risk, overcome the risk, adapt positively after experiencing the risk and avoiding pathways that could lead to experiencing the risk. This re-emphasizes Luthar et al."s (2000b) definition of positive adaptation, which calls for identifying adaption in terms of the expected behaviour that falls in line with the developmental stage of a person. Resilience research therefore focuses on three central objectives; the risk factors, the protective factors and the positive outcomes as a process in an at-risk individual, group or society (Luthar and Cicchetti, 2000).

According to Obrist et al. (2010), the concepts "risk, vulnerability and resilience are analytical constructs and at the same time, normative concepts which represent values of those who define them". Therefore, Obrist and her colleagues suggest that what is described as risk and resilience must be contextually defined. This assertion supports the call for resilience to be contextually and culturally defined to get a clear understanding of the processes involved in how an individual builds resilience to adversity in a particular social construct (Theron et al., 2013; Obrist et al., 2010). The definitions of resilience tend to describe resilience with reference to an individual"s experience of a challenge that should have negative effects on her/him but she/he is able to

decrease the negative effects by positively adapting to or overcoming the problem (Alvord, 2005; Fergus and Zimmerman, 2005; Luthar and Cicchetti, 2000; Rutter, 1999; Masten et al., 1990). Definitions of resilience abound in literature making it difficult to generate a universally accepted meaning (Masten, 2011; Alvord and Grados, 2005; Luthar and Cicchetti, 2000; Rutter, 1999). Nevertheless, what is common in all the above definitions is that they seem to express some underlying factors that tend to focus on the strengths and positive outcomes for the individuals exposed to risk. The definitions reviewed above demonstrates that there are three components that describe resilience; the existence of a risk to a person, the process that leads to the successful outcome and the outcome exhibited by the person at risk in terms of positive adaptations. Thus, resilience is an on-going process, which involves the various actions and steps that the at-risk individual takes to avoid, overcome or positively adapt to risk. Beyond the existence of risk and the individual‟s ability to overcome it, Fergus and Zimmerman (2005) also suggest that resilience includes avoiding the negative pathways associated with risks. Thus, resilience can be seen as processes that an individual goes through to successfully cope with or avoid challenges that could have negative effects on them. It implies the individual having the ability to take actions that can change misfortunes to fortunes (Luthar and Cicchetti, 2000; Rutter, 1999; Masten et al., 1990).

Although from the discussions above resilience has been defined as the pathways of individuals to adapt positively to risk, there is a missing link. There are no indications that resilience of an individual has to do with how the individual in the face of risk structures his or her resilience pathways through interactions with the social environment and how the social environment on the other hand structures the resilience pathways of the individual (Obrist et al., 2010).

According to Giddens (1984), both institutions and individuals influence social actions. This means that the institutions are structured by society and this in turn influences the social interaction and social action of members of the society. Thus, resilience can be inferred by observing an individual‟s exposure to risk, the protective factors and the positive outcomes (Obrist et al., 2010).

Representations of Resilience in Research

"Resilience research involves progression from an empirical identification of vulnerability or protective factors to an exploration of processes underlying their effects" (Luthar and Cicchetti, 2000: 859). In behavioural and ecology resilience research the focus has mainly been on positive outcomes relating to health, and including good mental health, functional capacity, resistance and social competence (Fergus and Zimmerman, 2005; Luthar and Cicchetti, 2000; Rutter, 1999). For Fergus and Zimmerman (2005) resilience has to do with healthy development of the adolescent despite facing risk. To Olsson et al. (2003) resilience is a dynamic process where an individual in the face of risk is able to act to change what would have been a negative effect of the risk to a better outcome.

According to Luthar and Cicchetti, (2000: 853) "high social competence is not, however, the only or even necessarily the preferred index used to define successful adaptation in resilience research; sometimes the mere absence of emotional or behavioural maladjustment is appropriate". This indicates that an individual in the face of risk might not have to be competent to overcome or successfully cope but needs to adjust positively to the situation. Luthar and Cicchetti (2000: 858) further assert, "The optimal outcome indicators are those that are

conceptually most relevant to the risk encountered". Thus, researchers have the task of defining the risk as identified by the individuals they study as well as defining the specific expected outcome that they are interested.

Resilience, in as much as it is defined in terms of positively adapting to risk factors is not the same as positive adjustments, coping or competence (Fergus and Zimmerman, 2005). Fergus and Zimmerman, (2005) notes that positive adjustment refers to an outcome of resilience; it comes about when a person after being exposed to risk is able to overcome that risk. Hence, positive adjustment is an outcome of an individual‟s pathways of adaptation during or after experiencing risk and the process of overcoming the risk is resilience (Masten 2011; Fergus and Zimmerman, 2005; Luthar and Cicchetti, 2000).

According to Obrist et al. (2010:290), "resilience is more than coping in the sense of minimising the consequences of an adversity and managing vulnerability to ensure short-term survival. In fact, people may cope but erode their own resilience by consuming less…, or spending less … or harming the resilience of others". Coping suggests a positive or negative way of minimising the effect of risk by an individual. Resilience is again different from competence; competence is seen as an asset of an individual that helps the individual to reduce the negative effects of exposure to risk. Thus, competence helps in the outcome of the resilience process (Obrist et al., 2010; Fergus and Zimmerman, 2005). Fergus and Zimmerman (2005) see resilience as an individual‟s ability to demonstrate and maintain competence despite being at risk.

Resilience research is not based on the static aspect of an individual‟s behaviour or attitude since it involves "change and search for new options" (Obrist et al., 2010:291). Fergus and Zimmerman, (2005) and Luthar and Cicchetti (2000) emphasize that resilience in individuals should not be discussed as traits that are inherent of the individual, since resilience is a dynamic process and not static. Furthermore, discussing resilience as a personal trait does not recognize the influence of the social environment that shapes the resilience pathways of individual, since resilience is contextually defined (Theron et al., 2013; Alvord and Grados, 2005; Luthar and Cicchetti, 2000; Garmezy, 1984). Rather, resilience of individuals should be seen as an attribute that is attained through interaction with the social environment or as "attributes that are shaped by the life circumstances" (Luthar and Cicchetti, 2000:858). Where resilience is misinterpreted as a personal attribute of an individual, it has the tendency to blame other individuals who are not able to overcome risk (Fergus and Zimmerman, 2005; Luthar and Cicchetti, 2000). It implied that if others can avoid, overcome or adjust positively to risk then all other individuals who also experience risk must be able to emerge successful when exposed to or after experiencing risk. What this study discusses is the fact that resilience is not a personal trait or static.

Resilience Research on Adolescent Sexuality, Pregnancy and Motherhood

Studies on adolescent resilience abound in the developed countries but limited in the developing countries (Theron et al., 2013; Hurd and Zimmerman, 2010; Blinn-Pike, 1999; Carey et al., 1998). These studies investigate why and how adolescent abstain from sexual intercourse (sexual resilience), how teenage mothers deal with stress that comes with parenting as well as the protective factors that help girls during pregnancy (Easterbrooks et al., 2011; Hurd and

Zimmerman, 2010; Blinn-Pike, 1999). Most of these studies are psychological in nature focusing on psychological wellbeing as the positive outcome of resilience pathways of adolescents.

Blinn-Pike (1999) investigated why some adolescents abstain from sex in Missouri in the United States of America (USA). The sample for the study consisted of 647 students from 20 schools in Missouri who indicated in a survey of sexual attitudes and behaviours that they had not had sex (Blinn-Pike, 1999). In his study, Blinn-Pike concluded that abstinent adolescents could be labelled as „sexually resilient" because they face the same opportunities and pressures to have sex as their sexually active peers. This assumption of Blinn-Pike over simplifies the resilience concept since it does not conform with the core factors of resilience research which requires that there must be an identified risk or threat which the individual at risk must acknowledge and be aware of in order that it can be tackled (Obrist et al., 2010; Luthar and Cicchetti, 2000). It also falls short of the conceptualization of risk in resilience research that notes that what may present as risk factors for individuals vary from one person to the other. Even within the group of sexually active adolescent girls, the risk factors cannot be generalized for all due to the differences in their socioeconomic characteristics. In the same way, abstinent adolescents cannot be assumed to have faced the same risks that their sexually active counterparts face.

Other studies that looked at why adolescents do not engage in sexual intercourse can be classified as resilience research despite not explicitly mentioning risk, protective factors and the positive outcomes in an individual"s experience. For instance there have been further studies aimed at explaining why some adolescents do not engage in early sexual intercourse (Abbot and Dallas, 2008; Kabiru and Ezeh, 2007). These studies identified personal, familial and

environmental factors as contributing to adolescents‟ early involvement in sexual activities (Abott and Dalla, 2008; Kabiru and Ezeh, 2007). For instance, in Abott and Dalla‟s (2008) study they observed that youths‟ sexual decision-making is influenced by personal values and beliefs as well as the larger social contexts they find themselves in. Abott and Dalla (2008) again observed that on the issue of sexual intercourse, sexually abstinent adolescents held the belief that it was a personal decision whereas their values about abstinence were highly influenced by parental beliefs. Kabiru and Ezeh (2007) also discovered that the fear of contracting STIs/HIV made adolescents who lived in countries with a high rate of HIV/AIDS infection abstain from sexual intercourse. In as much as these studies have identified positive outcomes in adolescents‟ response to sexual intercourse, the positive outcome alone is not sufficient to infer resilience. Fergus and Zimmerman (2005) suggest that resilience requires the presence of a risk factor since positive outcomes alone are not sufficient for inferring resilience in individuals. Although these studies have observed why and how individuals abstain from sexual intercourse, resilience research is different from such researches because it focuses on positive outcomes and not just the negative ones (Obrist et al, 2010; Luthar and Cicchetti, 2000).

In another resilience focused study in the USA, Weed, Keogh and Borkowski (2000) sought to identify the protective factors at the time of the initial pregnancy that made adolescent mothers resilient. Their focus was on early child bearers who were resilient and who were able to adapt and had achieved some success and stability despite the additional challenges and responsibilities of a child (Weed et al., 2000). They observed from their study that adolescent girls who exhibited resilient features had completed more schooling at the time of the pregnancy, were relatively younger and had more support from friends, siblings and more empathic parenting

attitudes (Weed et al., 2000). Relatively younger girls tend to receive support from their family and parents were more involved. These findings support the findings of other research on at-risk individuals that identify strong relationships (support from friends, siblings, parents) as a protective factor that reduces the effect of risk factors. In addition, the individual‟s disposition (educational level) also played a role in their success of dealing with early motherhood (Weed et al., 2000).

In a study of African-American adolescent mothers in the USA, Hurd and Zimmerman (2010) identified informal relationships with significant others as playing a role in how adolescent mothers developed resilience. According to Hurd and Zimmerman (2010: 791), "natural mentors are non-parental supportive adults who are a part of adolescents‟ social networks (e.g., extended family members, neighbours, family members‟ friends)". Their findings suggest that relationships with a natural mentor may promote resilience since having natural mentors reduced the relationships between stress and depressive symptoms as well as relationships between stress and anxiety symptoms among African-American adolescent mothers (Hurd and Zimmerman, 2010). Their study also confirms other studies of resilience in at-risk individuals where strong supportive relationships, in this case natural mentors, can be classified as one of the protective factors that help individuals decrease or avoid the negative effect of risk factors (Masten, 2011; Luthar and Cicchetti, 2000). This study had a psychological focus (looking at stress and anxiety related to parenting) with a psychological outcome (being able to overcome stress and anxiety in parenting). Resilience in this study was based on adolescent girls‟ success in dealing with stress and anxiety. Stress and anxiety represents just an aspect of the total wellbeing of an adolescent mother. What are the resources available to teen mothers in their social environment, how do

they access such resources to adapt to their new status as young mothers? Answers to these questions demand research into how society structures adolescent motherhood and how adolescent mothers structure being mothers through interaction with society to create resilience pathways. It also requires using a research approach that allows resilience to be measured and at the same time hear the voice of how girls develop resilience pathways as mothers.

Carey, Ratliff and Lyle (1998) carried out another study that focused on the resilience of adolescent mothers who were enrolled in a Texas school district‟s parenting programme. Carey et al.‟s (1998) study used a study population with similar characteristics as Hurd and Zimmerman (2010) in that both studies conducted research on adolescent girls who were enrolled on a programme designed to help adolescent mothers cope and adapt with the challenges of early motherhood. In their study, Carey et al. (1998) described the strength and successes of resilient mothers through a qualitative research study using Wolin and Wolin‟s Resiliency model (measures resilience based on one‟s insight, initiative, independence, relationships, creativity, humour and morality) to determine successful adolescent mothers‟ perceptions of their strengths (Wolin and Wolin, 1993; Carey et al., 1998). Findings from their study suggests that the respondents were resilient mainly because of their insights, initiatives, healthy relationships and their act of rebellion to prove a point to others (Carey et al., 1998). As such, Carey et al. (1998) found an additional resilient characteristic of at-risk individuals, which is the need to prove to others one‟s ability to overcome a challenge. This study provides insight into which capacities of adolescent mothers helped them to develop resilience pathways, however the current study intends to take it a step further by studying adolescent girls in a social context where such programmes are not available.

Most resilience studies on adolescent sexuality, pregnancy and early motherhood focused on adolescents who are in a programme purposely designed to help adolescent mothers cope with their situation (Hurd and Zimmerman, 2010; Carey et al., 1998). They looked at how formal institutions influence the resilience pathways of individuals. For instance, both Hurd and Zimmerman (2010) and Carey et al. (1998) focused on adolescent girls who were enrolled on a programme designed to help adolescent mothers. Focusing on just how agents (individuals) develop resilience profiles through a one-way approach, without taking into consideration how both the agents and the structures influence each other to yield positive outcomes does not provide a complete understanding into resilience pathways of individuals. Since individuals are active members of their society, who act and react based on the circumstances in which they find themselves, there is the need for studies to look at how individual adolescent girls through their own initiatives are able to develop resilience to teenage pregnancy and early motherhood in their daily activities. Studies that focus on adolescent girls who are beneficiaries of a programme designed to help address the challenges associated with adolescent reproductive health experiences must look at other factors outside the programmes and how they influence resilience of a person.

3.8 A Social Resilience Framework for Adolescents‟ Resilience to Sex, Pregnancy and Motherhood

Obrist et al. (2010) have explored social resilience from a structuration perspective. Social structuration is defined as “the structuring of social relations across time and space in virtue of the duality of the structure” (Giddens, 1984: 376). Giddens (1984) identifies that human agency and social structure are not two separate concepts or constructs but are two ways of considering social action. Structuration means studying the ways in which social systems are produced and

reproduced in social interaction. Structuration theory looks at how the individual rationalises and makes use of the opportunities or resources available to „her" in the society to address or meet „her" needs. Although the individual finds herself in a society where there are existing institutional norms and values, in the face of a challenge the individual carves her way around the institutions to solve or address the challenge.

The structuration theory as postulated by Giddens is therefore adapted to study the resilience of adolescent girls in their sexual and reproductive experience by looking at how the society structures the resilience pathways of an individual and how the individual through interactions in the society shape and develop her resilience pathways. The insight that the structuration theory brings to bear on this framework is that it recognises that actors operate within the context of rules produced by social structures and only by acting in a compliant manner are these structures reinforced. Thus on one side, actors undertake social actions in their day to day interactions in the society and on the other side there are the various institutions that are produced and reproduced in social interactions. This perspective of the structuration theory is reflected in Obrist et al."s definition of social resilience. Obrist et al. defines social resilience as, "the capacity of actors to access different forms of capital in order to – not only cope with and adjust to adverse conditions (reactive capacity) – but to also search for and create options (proactive capacity), and thus develop increased competence (positive outcomes) in dealing with a threat" (Obrist et al., 2010: 289). Social resilience is the capacity of individuals to access capitals in order to deal with a risk. Through the exercise of reflexivity (cause and effect), agents (individuals) modify social structures by acting outside the constraints the structure places on them (Giddens, 1984). Instead of describing the capacity of human action as being constrained

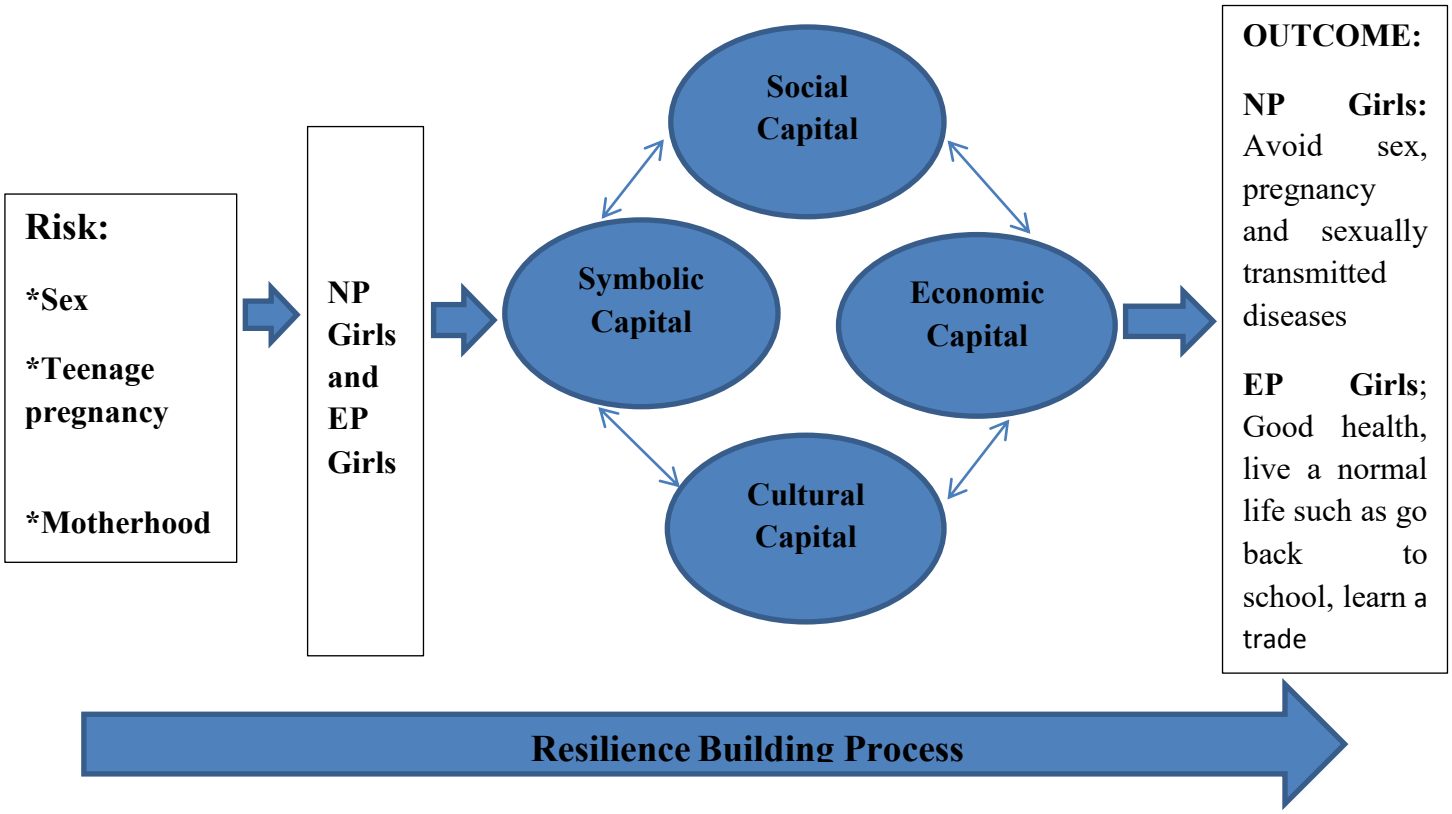
by powerful stable societal structures (such as educational, religious or political institutions) or as a function of the individual expression of will (that is agency), structuration theory acknowledges the interaction of meanings, standards, values and power and suggests a dynamic relationship between these different facets of society (Giddens, 1984).

The social resilience framework focuses on the interactions between the individual and her social environment in responding to risk. In Figure 1, a social resilience framework adapted from Obrist et al. (2010) is used to show the resilience building process for adolescent girls against the risk of sex, teenage pregnancy and motherhood. According to Obrist et al. (2010), resilience must be examined with reference to a risk. The risk in this study is sex, teenage pregnancy and motherhood often resulting from early sexual activity (Figure 1). This has social, economic and health consequences for the adolescent girl. To minimize the effect of this risk on adolescent girls, they require access to protective factors from their social environment in the form of capitals (power) to positively adjust, avoid or overcome risk (Figure 1). These capitals are not mutually exclusive but interdependent and interrelated, as such working together to reinforce each other.

In terms of social capital, the study looks at an adolescent girl‟s sources of advice, social support and social control around sexual and reproductive health matters. Concerning the economic capital, the study looks at adolescent girls‟ sources of financial support in dealing with the risk of teenage pregnancy. In the study, cultural capital looks at the other sources of information from where adolescent girls acquire knowledge on adolescent sexual and reproductive behaviour. The symbolic capital in this study is measured in terms of the reputation of the adolescent girl. A

girl‟s reputation in the community depends on her relationship with significant others at various levels of the society such as family, peers, school and the community as a whole. Reputation of a girl as a symbolic capital in this study is measured by the individuals‟ own explanation of whether she feels accepted by the people in the different social fields and if she is concerned about how people see and relate to her and what she does to maintain her social reputation. According to Bourdieu (1986), symbolic capital bears influence on how actors can access capital. As such, how an adolescent girl is recognized and accepted by her family, peers, school and community may determine her access to the other forms of capital and even the quality and quantity of such capitals. Once individuals have access to these forms of capital, which are determined by their social environment, it increases their competence to deal with the risk of early sexual experience and may lead to positive outcomes (Figure 1).

Figure 1: Social Resilience Framework for Adolescent Sexual and Reproductive Experience



Source: Author‟s Own, Adapted from Obrist et al., 2010

This study looks at the two categories of at-risk adolescents, those who have never been pregnant and those who are pregnant or mothers. For those who have never been pregnant they are at risk of engaging in unprotected sex and all the consequences that this comes with. To be resilient the positive outcome expected is abstinence from early sexual intercourse or use of contraceptives to prevent unwanted pregnancy and contracting STIs including HIV/AIDS. For the adolescent girls who are already pregnant or mothers, the risk has to do with pre-natal and post-natal health problems, lack of financial and social support as well as being accepted in the community despite bearing a child out of wedlock in most cases. The positive outcomes for the pregnant and adolescent mothers include being healthy, socially accepted and able to continue with the expectations of age relevant developmental stages and having healthy children.

3.9 Conclusion

This chapter has presented a review of selected issues in the existing literature on resilience in order to provide the framework that would guide the analysis of the research findings. This chapter concludes that resilience is a process where individuals in the face of risk are able to avoid, overcome and or positively adjust. It identifies three major features of the social resilience framework as the presence of risk, the protective factors and the positive outcome. Risk factors are the factors that increase the likelihood that a child will experience a social or a health problem. An individual‟s exposure to risk can stem from the individual‟s attitude or behaviour, family background or the community. Protective factors on the other hand tend to alter the effects of risk in a positive way. They could be from resources available to the individual, his/her family and or the community that helps him/her adapt positively to risks. This chapter concludes that the resilience of a person has to do with the process of overcoming risk that result in a

positive outcome. In the subsequent chapters, the social resilience framework is used to analyse how adolescent girls develop resilience pathways because of the availability and access to protective factors despite the presence of risk factors.

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

This chapter discusses the research design adopted for the study, the mixed method that combines quantitative and qualitative approaches. The perspective of the mixed method approach is that reality can be explained by employing both the quantitative and qualitative approaches. Thus, to explore how adolescent girls develop resilience to sex, teenage pregnancy and motherhood, both quantitative and qualitative approaches were used in a sequential manner to collect data to address the research question. The quantitative approach section describes the study population, sample size, sampling method used, the type of data collection instrument and how the data was analysed. This is followed by a section on qualitative approach, which also discusses the data collection instruments, the process of data collection and data analysis. The last section of this chapter explains the ethical issues involved in the study and how these issues were addressed.

4.2 Research Design: The Mixed Method Approach

A mixed method approach was selected and used for this study. It involved the use of both quantitative and qualitative methods to collect, analyse and interpret data. Specifically, a mixed method sequential explanatory design was adapted for the collection and analysis of the data for this study. The sequential data collection in mixed method involves the collection of data in stages (Birenbaum-Carmeli et al., 2008; Creswell and Plano, 2007; Johnson and Turner, 2003). This approach was used because the respondents from the survey were needed for the qualitative data and had to be purposively selected based on their resilience score, which was captured in the

survey instrument. Thus, the data collection was done in two distinct phases: the quantitative data were collected and analysed first. This then informed the selection of respondents (adolescent girls) for the qualitative data collection. This was done because both the qualitative and quantitative findings were related in that one set of the qualitative data depended on the outcome of the scores in the quantitative data. It involved the collection and analysis of data, from which the results are then used to select participants for collection and analyses of data. The rationale for using the mixed method research was because the quantitative data and their subsequent analysis provided a general understanding of the research problem as well as the participants required for the follow up qualitative study. Collection and analysis of the qualitative data helped to explain and elaborate on the quantitative results obtained in the first phase of the data collection. Through the collection of data by in-depth interviews and the analysis of the qualitative data, more depth and explanation was provided to the quantitative findings. By mixing methods, the strengths of one offset the weakness of the other (Beckman, 2014; Birenbaum-Carmeli et al., 2008; Shapiro, 2003; Oakley, 1998). In this study, the qualitative data addressed and enriched the quantitative. Thus, the qualitative approach provided a means to collect data to complement and expand the weakness that quantitative approach brings into the study.

The quantitative data approach involved the use of a questionnaire with close-ended questions to collect data after which the data were statistically analysed to answer the objectives of the study. The qualitative research approach, allowed the respondents to provide detailed information by describing their perceptions, attitudes, beliefs, views and feelings as well as the meanings and interpretations of events (Hakim, 2000). Respondents had the opportunity to provide their

responses in their own words and the researcher had the opportunity to probe for further insights into responses (Finch, 1984; Oakley, 1981). The qualitative tools used to collect data in this study were semi structured interview guides and focus group discussion guides. The semi structured in-depth interview as a technique was used, in that although an interview guide was used to direct the focus of the discussion on the topic of interest, it provided enough freedom for the respondents to express their views. This type of in-depth interview was used to collect data from the adolescent girls who constituted the main target for the study. Furthermore, to situate the experiences of the adolescent girls within a specific social context, the semi structured interview guide was used to collect data on the views of the community members on adolescent girls‟ sexual and reproductive health experiences in the community.

The second qualitative method used for data gathering was the focus group discussion, a group discussion between four to twelve people who discuss the topic of concern with the guidance of a moderator (Barbour and Kitzinger, 1999). This qualitative method was used to examine adolescent boys‟ perceptions of the social context of adolescent girls‟ sexual and reproductive behaviour in Begoro in a natural environment. Combining focus group (and in-depth interviews) with quantitative methods complements data collected from other methods as well as challenged how data are interpreted (Barbour and Kitzinger, 1999). Thus, focus group discussions were included in the design to complement data collected from the six adolescent boys through the in-depth interviews.

4.4 Quantitative Approach

The quantitative approach discusses the study population, sample size, the sampling method and procedure. In addition, the data collection instrument used to collect the data, how the data were collected, processed and analysed are also discussed in the following sections.

4.4.1 Study Population

The study population was older adolescent girls who were between the ages of 15-19 years living in the Begoro community. These cohorts of girls were selected because they contribute to the national fertility rate (GDHS, 2008). According to Babbie (2007:198) the study population is "that aggregation of elements from which the sample is actually selected". As such, older adolescent girls who reside in Begoro constituted the study population from which the study sample was selected. This included all girls 15-19 years who were reached in their homes and their parents or guardians gave their consents for such girls under the age of 18 years.

4.4.2 Sample Size

Resilience research is context specific as such the findings may be peculiar to the study area although the approach could be replicated in other social context, based on this a sample size that allowed for a meaningful analysis was selected. The sample size used in the survey was 500 adolescent girls, living in the Begoro community. A sample size of 500 older adolescent was selected to represent 10% of the study population. Creswell et al. (2007) suggest that the sample size needed in a mixed method approach for quantitative data must be specified for statistical procedures to be used. This, according to Creswell et al. (2007), will make it possible for inferences to be drawn with some confidence that the sample reflects the characteristics of the entire population. May (2011) argues that there is no straight forward answer to what a sample

size should be and that the guiding principle is to collect enough data to undertake a meaningful analysis.

4.4.3 Sampling Method and Procedure

Multi-stage cluster sampling was selected for this study because of the scattered nature of the study population, which made it impossible to compile a list of all the older adolescent girls in the study area. The multi-stage cluster sampling required that the population was first organized into geographical clusters and then individuals were randomly sampled from within the clusters selected (Buckingham and Saunders, 2004). The sampling method in any quantitative research is critical to how the outcomes of the study can be generalized (Cargan, 2007). Frankfort-Nachmais and Nachmais (2004) reported that sampling units should be subjectively selected in order to obtain a sample that appears to be representative of the population. Fisher-Giorlando (1992) suggests using clusters in selecting a sample randomly when doing surveys in areas where a sampling frame is not available.

An enumeration area list was obtained from the Ghana Health Service in the District to identify the different clusters in the Begoro community. In the first stage the enumeration area list from the GHS in Fanteakwa District listing all the outreach sites in Begoro was used, thus the various outreach sites in the communities constituted the clusters for the first stage of sampling. In all, the GHS in the district provided a list of 58 enumeration areas in Begoro out of which four (Belco, Odumase, Akwansrem and Obuasi) were purposively selected for the study. In the second stage of the sampling, the four selected communities were used as the cluster for the selection of the final sample of respondents out of which the study sample was obtained. In these

four communities and using the saturation technique, every home in the cluster was visited to select respondents. Bowen (2008:140) describes, "data saturation entails bringing new participants continually into the study until the data set is complete". The concept of saturation is usually used in qualitative research (Bowen, 2008). However, in this study the concept of saturation was applied in the sample selection so that every home in the selected cluster is visited. When saturation was attained 500 respondents were interviewed.

4.4.4 Data Collection Instruments for Quantitative Data

A questionnaire was used to collect data from the survey respondents. The questionnaire was made up of mainly close-ended questions with some questions allowing multiple responses. Multiple-choice answer questions were included so that respondents would provide a uniform answer for easy coding and analyses because respondents could have used different terms to describe their answers. The questionnaire focused on collecting data on socio demographic characteristics, pregnancy status, social environments, personal knowledge and skills as well as personal experiences of the adolescents. In addition, the questionnaire had a set of questions that was used to measure the resilience of each respondent. The questionnaire was used to ensure that interviews conducted for all the 500 girls were uniform and the questions followed a particular order for easy analysis (May, 2011).

4.4.5 The Process of Collecting the Data

The data collection process started with the careful selection of five field assistants for training. The selection was based on gender, educational background, age and proficiency in the local language of the study area. The gender factor was considered because the study was a sensitive

one that demanded trust from the interviewers. Sharing information with one‟s peers who identify with the topic is more likely to yield more honest responses from the respondents than talking with the opposite sex or adults where they may feel reluctant to divulge personal information about themselves (Oakley, 1981). More so, the educational background of the field assistants played an important role in their selection because of the data collection instrument used. It demanded that the interviewers should be able to translate the questions from English to the local language for respondents who could not grasp the meaning of a question in English. Furthermore, because of the differences in the level of education of respondents, translating the questions into their mother tongue enhanced their understanding and the credibility of their responses.

In all, five field assistants were selected for the fieldwork with the researcher working as a supervisor and an interviewer at the same time. Data collection was done in ten days. The five field assistants were all women and between the ages of 20 to 25 years. They were preferred over older women because younger women have views that are more progressive and as such would be less intimidating to the girls being researched. In addition, the choice of younger women reflected the gender and age of the interviewees. They were selected because interviewing adolescent girls on sexual and reproductive issues was a sensitive topic that required winning the confidence and trust of the respondents. As such, the interviewers were trained on how to conduct a good interview and how to win the trust of the interviewees in order to collect valid response. Every field assistant was also encouraged to work independently with their respondents after seeking informed consent from parents or guardians to assure the respondents of confidentiality and privacy.

In the field, interviewers had to visit households and inquire about teenagers within the ages of 15 and 19 years living in the selected clusters. Where such girls were identified, informed consent was sought from parents before the adolescent was asked to give her assent to be interviewed. Parents were briefed on the purpose of the study and were given the freedom to opt out. Furthermore, parents were required to sign or thumbprint a consent form. After going through this procedure with the parent and the respondent, the interviewer and the interviewee found a private space to carry out the interview. This was done to encourage the interviewees to express themselves without any external intimidation. The field assistants read and translated the questions to the respondents and recorded their responses on their questionnaire to afford all the respondents to understand the questions appropriately. This face-to-face interview type of survey was preferred over self-administered questionnaire because respondents in the survey were from varied educational backgrounds (Neuman, 2011). The face-to-face interview also has the advantages of getting the cooperation of respondents, motivate and guide them through the questionnaire.

4.4.6 Quantitative Data Processing

The survey data collected from the 500 respondents were processed in three ways namely coding, data entry and data cleaning. Since most of the questions in the questionnaire were pre-coded, only the open-ended questions were coded after the collection of data. After the coding, the data were entered into the computer using the Epi Info software. Data cleaning was done to identify and correct errors and inconsistencies in coding. A few questionnaires, which were not coded properly, were identified and rectified by going back to the exact questionnaires to enter the correct codes.

Data analyses were done using by Epi Info software version 3.5.1, a statistical tool for analysing and storing data. Epi Info is widely used in research in public health and other medical fields. It was a preferred choice because it performed the same functions as the widely used Statistical Package for Social Science (SPSS). With the help of the Epi Info analytical software, the data was interpreted into frequencies, cross tabulations and chi-square analyses. The software was also used to generate the resilience scores for respondents in the survey.

To categorize adolescent girls into high or low resilience, a set of questions were included in the survey questionnaire for both non-pregnant and ever-pregnant girls respectively. These questions examined the source of social, economic and cultural capitals of girls and their success at accessing these capitals. As such, the non-pregnant girls had eight sets of questions whereas the ever-pregnant girls had ten sets of questions. A high resilience girl is one who was successful at accessing two or more resources from a significant source. As such for the non-pregnant girls, those who had the average mark and above were classified as high resilience and the rest as low resilience girls. In the same way the ever-pregnant girls who had the average mark and above were classified as high resilience whereas the rest were classified as low resilience girls. Epi Info was used to analyse the quantitative data because it easily identifies wrong data entry for immediate corrections or editing. In addition, it stored data just as it is entered as such ensuring consistency.

4.4.7 Quantitative Data Analysis

A univariate analysis of the socio demographic characteristics of the respondents was carried out. Univariate analysis describes the units of analysis of a study and allows us to make descriptive

inferences about the larger population (Neuman, 2011; Babbie, 2007). This was done since it makes the data clearer by identifying the patterns arising from the data. In the study, knowing the proportions and percentages of the survey respondents makes it possible to compare different frequency distributions of the characteristics of respondents and their knowledge and use of resources in their society.

A bivariate analysis of the sources of capitals for the survey respondents was carried out. As a first step in examining the relationships between two variables, a bivariate Table was constructed. This was used to explore the relationship between pregnancy status and socio-demographic background of adolescent girls. In addition, bivariate analysis was done to determine the relationship between the sources of capital and the resilience level of adolescent girls. The relevance of doing bivariate analysis is because it helps with the exploration of the concept of relationships between two variables (Neuman, 2011; Frankfort-Nachmais et al., 2004).

4.5 Qualitative Approach

The qualitative approach discusses the data collection instruments namely in-depth interviews and focus group discussions which were used to collect the data are discussed. Furthermore, the data collection processes, data processing and analyses procedures are also discussed in the following sections.

4.5.1 Data Collection Instruments for Qualitative Data

The interview guide was used to collect data from the respondents and a discussion guide for the focus group. The interview guide allowed the researcher to be personal with the respondents as well as creating a rapport with them in order to probe into responses given to obtain complete information, and at the same time stay focused. It also complemented the purposive sampling method chosen in that it allowed the researcher to probe further, building on prior knowledge obtained from respondents from the survey. Three distinct interview guides were designed and used to collect the qualitative data for the study (Appendix 2, 3& 4). One of the interview guides was designed to solicit the perceptions of the adult community members about the changes in adolescent sexual and reproductive experience of girls. It was also designed to gather their views on the contextual situation of adolescent sexual and reproductive behaviour in the community. The questions included what a good social reputation is for an adolescent girl, what resources are available to adolescent girls and how the availability or non-availability of these resources influenced the sexual and reproductive behaviour and outcome of girls.

The interview guide for adolescent girls probed further into the previous results gathered from the survey. It afforded girls voices to be heard about how they developed resilience pathways to premarital sex, teenage pregnancy and early motherhood. Girls were asked about their sources of capitals, the type of support they received from their sources, how they transformed the capitals available to them to avoid, overcome and or adjust to the risk associated with premarital sex, teenage pregnancy and motherhood.

For the adolescent boys, their interview guide included questions about adolescent girls‟ sexual behaviour, reproductive experiences, and their perceptions‟ about the resources available within the community and how these help adolescent girls to develop resilience pathways. The focus group discussion guide enabled the discussion of themes identified in the interview guide for the adolescent boys.

4.5.2 The Process of Collecting Data

The researcher personally did in-depth interviews because this type of data collection required skills in order to gather the right data for analysis (Finch, 1984). More so, it provided an opportunity to observe the respondents and their environment to ascertain if some aspects of their responses actually tallied with observations made during the interview and to ensure consistency. Although the process of collecting qualitative data through in-depth interviews and focus group discussions are grouped under the forms of unstructured data collection, it still required a high degree of planning (Legard, Keegan and Ward, 2003). In discussing sexual and reproductive issues, being a woman made it easier to win the confidence and trust of the female respondents who constituted the bulk of the respondents. Through the interactions with the female respondents, it was observed that most of them especially the adolescent girls felt at home with the interviewer because they could identify with her and she could identify with them. The experience on the field as a woman researcher interviewing women makes me agree with Finch (1984:76) “there is still necessarily an additional dimension when the interviewer is also a woman, because both parties share a subordinate structural position by virtue of their gender. A particular kind of identification will develop”. These private one-on-one in-depth interviews with the adolescent girls made it possible for them to say things they might not say in an open and

public discussion (Legard et al., 2003). This notwithstanding, the sensitivity of the study was addressed by reassuring the adolescent girls about confidentiality at the onset of the interview as such putting them at ease about disclosing potentially sensitive issues.

The interview guides were semi-structured to allow respondents the freedom to pursue those topics they considered relevant, while ensuring that the focus of the study was not neglected. Since the researcher was the moderator in the data collection, data was collected in phases, starting with the adolescent girls, followed by the adult community members and finally the adolescent boys. Furthermore, being the moderator also made it possible to keep the focus of the study throughout the data collection processes. All the in-depth interviews and the focus group discussion were audio recorded with the permission of the respondents and the discussants.

The first phase of the data collection covered in-depth interviews with twenty adolescent girls in Begoro to learn about their resilience pathways. The adolescent girls were interviewed in their homes, where permission of the parents was sought again. Interviewing the adolescent girls in their homes reduced anxiety and facilitated free discussions. The adolescent girls were asked for their assent to participate in the study. This phase of data collection was readily welcomed because both the parents and the adolescent girls had knowledge about the on-going research and were therefore willing to participate. After going through pleasantries with the parents and receiving girls assent to go through with the one-on-one in-depth interview, a private space was selected for the interview. This fits with Spratling et al."s (2010) experience that, "rich data were obtained from children when parents were willing to allow the child to be interviewed alone".

This was a way of reassuring girls of privacy, which was crucial because it allowed girls to open up about their private lives and openly discuss sensitive issues, which enriched data collected.

Interviews were always started with an icebreaker. This is because as Legard et al. (2003:145) suggests, "the researcher needs to play the role of the guest while at the same time being quietly confident and relaxed, making conversation but avoiding the research topic until the interview begins". The researcher always shared her status as a nursing mother with the adolescent girls who were mothers, telling them she also had a baby boy whom she had left in Accra to travel to Begoro in order to conduct the research. For the adolescent girls who were not pregnant and did not have a baby, the researcher always started by introducing herself as a student researcher and enquiring about their aspirations before going on with the interview. These icebreakers helped to take away the hierarchical relationship as well as the anxiety between the adolescent girls and the researcher. This reinforces the feminist perspective on approaching interviews that, "the goal of finding out about people through interviewing is best achieved when relationship of the interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (Oakley, 1981:41). The interviews were started whenever the interviewees were comfortable and felt relaxed. The interviewees were introduced to the research topic and with their permission, the interviews were audio recorded. The respondents were interviewed on various aspects of their sexual and reproductive experiences with a focus on the resources available within their social context and how they accessed and transform them to develop resilience. This process was carried out until twenty girls; ten high resilient girls (five non-pregnant and five ever pregnant) and ten low resilient girls (five non-pregnant and five ever pregnant) had been interviewed. However, due to some

difficulties in locating the selected girls, only girls who were found at the time of the follow up and who formed part of the study sample for the qualitative research were interviewed.

In the second phase of data collection process, twelve adult community members and six adolescent boys were taken through in-depth interviews to gather detailed knowledge on their perspectives on adolescent girls‟ sexual and reproductive experiences in the community as well as seeking their insights into resources within the community that were available for adolescent girls to develop resilience pathways. Adult community members who were farmers were contacted in their homes whereas the traders were contacted in their shops. Most of the traders could only be reached at their workplace because they spent virtually the entire day in their shops. For the adolescent boys, they were contacted mainly in their homes.

The third phase of data collection was focus group discussions with adolescent boys. The focus group discussion held with adolescent boys was to have a more „natural‟ environment where adolescent boys “ask questions of each other, seek clarification, comment on what they have heard and prompt others to reveal more” (Finch and Lewis, 2003). The adolescent boys for the two focus group discussions were selected from Odumase and Belco in Begoro. In both focus group discussions, eight boys each participated. In each of the discussions, a moderator directed the issues discussed to prevent discussants from deviating from the subject under discussion. In the first focus group, permission was sought from the internet café owner, who gave us some chairs to sit on to carry out the discussion in an empty space in the café. As Finch and Lewis (2003) suggests we sat in a circular form so that all the discussants could see each other and the moderator. The moderator introduced herself to the participants and explained the purpose and

process of the focus group discussion as well as assuring the discussants of confidentiality of information provided. After going through the procedures for discussion, the tape recorder was turned on and each discussant was asked to introduce himself, mentioning his first name, age and educational level (Finch and Lewis, 2003). Then the discussion was started with a question from the discussion guide, which addressed the research questions.

When the discussions were over, the audio-recorded discussion was played for those who wanted to listen to the discussion. Audio recording the interviews and discussions allowed the researcher to devote full attention to listening to the responses. It also has the advantage of providing an accurate verbatim record of the interview, capturing the language used by the participants and a more neutral and intrusive way of recording interviews (Legard et al., 2003).

4.5.3 Data Collection

As in the case of qualitative research, the researcher purposefully selected individuals and sites that could provide the necessary information to achieve the objectives of the study. The target population for the qualitative data comprised three categories of people, namely, adolescent girls, adults and adolescent boys. The total sample size for the qualitative data collection was fifty-four.

In-Depth Interviews with Adolescent Girls

In all twenty adolescent girls were selected for the in-depth interview, comprising of 10 non-pregnant and 10 ever-pregnant girls. The adolescent girls selected for the in-depth interview were part of the 500 survey respondents. These girls were purposively selected based on their

pregnancy status and resilience scores from the survey. This group of girls were selected to give detailed insight and explanation of how they developed resilience pathways to sex, teenage pregnancy and motherhood. Purposive sampling method was preferred because it allowed the researcher to select relevant interviewees to provide the needed data that answers the research questions. As Frankfort-Nachmias et al. (2004) suggested, purposive sampling helps a researcher to select participants who have experience with the central phenomenon or the key concept being explored.

In-Depth Interviews with Adult Community Members

In-depth interviews were conducted with twelve adult community members (six males and six females). It included adults who had lived in the Begoro community for more than thirty years. This population of adults in the community was targeted in order to have a background into the past and present sexual and reproductive health practices of adolescents in the community. The participants for the in-depth interviews were selected using the purposive sampling technique. The purposive sampling method was used in this study since it ensures that respondents who met specific criteria intended for the study are selected. Furthermore, the gender consideration was addressed by purposively selecting equal proportions of male and female adult community members who had lived in the community for more than thirty years.

In-Depth Interviews and Focus Group Discussions with Adolescent Boys

Twenty-two adolescent boys (six for in-depth interviews and eight each for the two focus group discussions) living in the community were also interviewed as well as put in groups for discussions. Targeting of older adolescent boys was to provide the study with the views of the

opposite sex on adolescent girls‟ sexual and reproductive experiences. The participants for the in-depth interviews were selected using the purposive sampling method.

Initial attempts to use the accidental sampling technique to select older adolescent boys for the focus group discussion proved challenging, since the boys could not agree on a time and venue for the focus group discussion. This was because the boys were initially contacted on the street, which made it difficult to settle on a suitable time and venue. The drawback called for a quick change to the sampling method for the focus group discussions. In place of the accidental sampling method, snowballing was adapted to select the focus group discussants in one group. The snowballing sampling technique, "involves asking people to identify other people they know who fit the selection criteria" (Ritchie, Lewis and Elam, 2003a: 94). An adolescent boy was purposively selected and asked to organize seven of his peers in the age brackets of 15 to 19 years. Since the discussants in the group had a pre-existing relationship it allowed the discussant to open up easily as well as served as a check on them in their responses. Thus, focus groups that are made up of peers or people who had a relationship pre-existing the research setting had the advantage of providing data that are useful (Green and Hart in Barbour and Kitzinger, 1999).

For the second focus group, the accidental sampling method was used to gather the discussants who were chanced upon by the researcher. A group of boys in an internet café numbering about eleven were asked to take part in a focus group discussion on adolescent girls‟ sexual and reproductive experiences in their community. At the end of the negotiations, eight adolescent boys aged between 15 and 18 years accepted and took part in the discussion.

4.5.4 Qualitative Data Processing

For the qualitative data, since both in-depth interviews and focus group discussions were conducted in Twi[5], the audio-recorded responses from the in-depth interviews and focus group discussions were transcribed. The transcripts were important because they provided a permanent source of data collected on paper , which was later translated into English and typed in Microsoft word for analysis. The whole process of transcribing, translating and typing into Microsoft word was a daunting task (Ritchie, Spencer and O'Cornnor, 2003b). This task was made easier because the researcher was present and could translate what the respondents said and what or how they used specific expressions in their responses. The difficulty of translating the local language to English was minimal, although there were situations where one could not find the English equivalent of some expressions or words in Twi and vice versa. For instance, words such as contraceptives, emergency contraceptive pills were some of the few words that did not have its equivalent word in Twi. This notwithstanding, attempts were made to provide the exact meaning that respondents expressed in their responses. In addition, the face-to-face interaction with respondents offered an opportunity to ask for clarity when they used words that seemed difficult to understand. The translated transcriptions were grouped under common themes and coded accordingly.

4.5.5 Qualitative Data Analysis

Preparing data for analysis is a process of transformation. Although a daunting task, all the qualitative data were analysed manually. Morse and Richards (2002) suggest that analysing transcribed data should start with the identification of themes under which the data would be

[5] Twi is the dominant local language used to communicate in the study area.

labelled because it helps to manage data. With this suggestion, one has to diligently read the transcriptions, reflecting on the information and identifying topical issues from them. Topic codes were developed to reflect all the different ways in which various respondents discussed their views, experiences and knowledge on adolescent sexual and reproductive behaviour and resilience (Kowal et al., 2005). According to Morse and Richards (2002), topic coding involves bringing of passages together by identifying a portion of the transcribed data as part of a topic. After identifying the themes emerging from the transcribed data, the emerging themes were identified as topics and coded. The topic codes became a guide for selecting texts for the analysis. "Coding means relating particular passages in the text of an interview to one category, in the version that best fits theses textual passages" (Kowal et al., 2005: 255). With these topic codes, the texts were copied and pasted under the appropriate topic codes. Going by this analysis helped to identify patterns in the responses gathered from the field as well as the experiences of respondents.

4.6 Ethical Considerations

> The voluntary consent of the human subject is absolutely essential. This means that the person concerned should have legal capacity to give consent, should be so situated as to exercise free power of choice, without the intervention of any elements of force, fraud, deceit, duress, overarching or any other ulterior form of constraint or conversion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlighten decision (Homan, 1991:69)

This study involved the private lives of adolescents therefore some ethical concerns were taken into consideration. This is particularly important where "minors" are concerned. Parental consent was sought for all respondents below 18 years. Since the age eighteen years is the legal age for marriage as well as voting in an election, the age 18 signified independence for a person in

Ghana. This is also in accordance with the laws that state that a person below age 18 is a minor and therefore every decision must be taken with recourse to an adult responsible for that person. Furthermore, because seeking consent from the legal guardians of minors was not enough to involve them in the study, the researcher went further to also seek the minors assent to participate. Thus, the adolescent girls who provided data and their parents or guardians both gave their consents before the interview was carried out. According to Cunningham, Weathington and Pittenger (2013) were of the view that minors cannot give informed consent and therefore consent must be obtained from their legal guardians.

In cases where the participants were not comfortable in taking part in the research they were not forced to take part. The respondents were assured of anonymity and therefore no names were used in order not to disclose their identity. In addition, very sensitive and private issues were conscientiously handled with the reassurance of confidentiality. The underlining import of ethical considerations in the study was to respect the privacy of adolescents due to the high sensitivity of the issues discussed, thus the focus on not harming the participants and respondents of the study.

Permission was sought for this study in the community. As a researcher and an outsider to the study site, there was the need to seek permission from the gatekeepers of the study area before data collection. It is important to gain access to the site by seeking the approval of gatekeepers, individuals at the site who provide access to the site to allow or permit the research to be done (Creswell et al., 2007). Permission was sought from the District Chief Executive (DCE) of Fanteakwa because he is in charge of the district politically and his consent was required before

the Ghana Health Service (GHS) in the District could assist in any way. Thus with the permission from the DCE next gatekeeper contacted was the GHS director in the district who also gave his consent and support for the study. Aside the government officials the „Odikro" (traditional leader) for the town was also informed about the study through a discussion that was held with him at his palace. The „Odikro" readily gave his consent and agreed to be one of the respondents in the interview for community members.

4.7 Conclusion

This chapter has discussed the research methodology used to collect and analyse the data for the study. The chapter started by describing the research design used for the study, which is the mixed method approach. A mixed method approach, which involves the simultaneous use of both the quantitative and qualitative approach in doing research, was adapted. Hence, the data were collected sequentially, starting with the collection of quantitative data after which the qualitative data was collected. A questionnaire was used to collect data from the survey respondents after which the data were processed and analysed with the Epi Info software. In-depth interviews were conducted afterwards with twenty of the survey respondents who were purposively selected based on their pregnancy status and resilience level. In addition, twelve adult community members and six adolescent boys were also interviewed. Two focus group discussions were held with two groups of older adolescent boys to complement the six in-depth interviews held with the boys. Since all the interviews were conducted in Twi, the audio-recorded interviews were transcribed and translated into English. To satisfy all ethical considerations, permission was sought at the community level, from the adolescents and their parents/guardians. The qualitative data were analysed based on themes, which were coded

accordingly based on the topics. In the next four chapters, the results from the study are described, explained and interpreted to answer the research objectives.

CHAPTER FIVE

BACKGROUND OF SURVEY RESPONDENTS

5.1 Introduction

Literature on adolescent sexual and reproductive health shows that their socio-demographic backgrounds have an influence on their sexual and reproductive experiences (GSS, 2013; Imoro, 2009; GDHS, 2008; Arai, 2003; Obeng, 2003). This chapter analyses the socio-demographic background of survey respondents and their pregnancy status. The data in this chapter are based on the analysis of quantitative data collected from five hundred adolescent girls‟ in Begoro. The first section focuses on the socio-demographic background of respondents by describing their age, educational level and relationship status. In addition, their religious, family and ethnic backgrounds are also discussed. In the next section, the pregnancy status of the individual adolescent girl is described. This takes into consideration the relationship between their socio-demographic backgrounds and their pregnancy status. The socio-demographic characteristic highlights the differences and similarities among the adolescent girls, thus providing a background into why and how adolescents may be at risk due to premarital sex, teenage pregnancy and early motherhood.

5.2 Socio-Demographic Background of Survey Respondents

The socio demographic background of respondents that was focused on were age, level of education, family background, relationship status, religious affiliation and ethnic background. In Table 5.1, descriptions of the 500 adolescent girls involved in the survey are provided.

Table 5.1 Socio Demographic Characteristics of Adolescents Girls

Variables	Frequency n=500 (%)
Age	
15	145 (29.0)
16	102 (20.4)
17	77 (15.4)
18	94 (18.8)
19	82 (16.4)
Level of Education	
Primary Education	74 (15.2)
JHS Education	270 (54.0)
SHS Education	118 (23.6)
Vocational Training	10 (2.0)
No Formal Education	26 (5.2)
Ethnicity	
Akan	306 (61.2)
Ga/Dangme	131 (26.2)
Others	63 (12.6)
Religion	
Muslim	36 (7.2)
Christian	458 (91.6)
Traditional	4 (0.8)
Others	2 (0.4)
Relationship Status	
Single	237 (49.2)
Relationship not married	171 (34.2)
Married/Cohabiting	42 (8.4)
Divorced/Separated	39 (7.8)
Remarried	1 (0.2)
Widowed	10 (2.2)

Source: Author"s Fieldwork, 2012

5.2.1 Age of Respondents

From the survey, the average age of the respondents was 17 years with a modal age of 15 years. The adolescents who fall within the legal age for marriage (between ages 18 and 19 years) were 35.2% (Table 5.1). While the Constitution of Ghana and the Child Act outlines the designated age for marriage in Ghana to be at age 18 years, the traditional and religious value systems do not lay emphasis on age for marriage, they discourage pre-marital sex and out of wedlock childbearing. Knowing the age of respondents was necessary since studies indicate that there is an inverse relationship between age and pregnancy status (GDHS, 2008; Awusabo-Asare et al., 2004).

5.2.2 Educational Background of Respondents

In all, 94.4% of the respondents indicated that they had some level of formal education (Table 5.1). More than half of the respondents (54%) had Junior High School (JHS) level of education, while 23.6% and 14.8% had Senior High School (SHS) and primary levels of education respectively. With the exception of the girls who had no formal education (5.2%), this suggested that the other respondents had some basic knowledge on sexual and reproductive health information from school. This is because the Ghana Education Service (GES) had included sexual and reproductive health education in its school curriculum as part of government policy of making such information available to adolescents. Thus, the assumption is that adolescent girls involved in the study had some level of formal education as well as knowledge about their sexual and reproductive life.

The educational background of respondents highlights the possible risk adolescent girls encounter as well as how they developed resilience pathways since education provided a girl with the knowledge and skills (cultural capital, social capital) needed to overcome the risk associated with engaging in early sexual activities, pregnancy and early motherhood. Educational progress and school achievement and involvement are identified in resilience research as a protective factor for at risk adolescents in relation to pregnancy (Theron et al., 2013; Alvord and Grados, 2005). The desire for educational achievement can motivate adolescent girls to avoid premarital sex and teenage pregnancy or return to school after bearing children. On the other hand, it can also put a girl‟s life at risk where they abort a pregnancy in order not to disrupt their education, avoid the shame that comes with being pregnant or a mother in school (Obeng, 2003). Imoro (2009) found that teenage pregnancy was one of the leading causes of school dropout in his study of Asutifi District. His study also found that peers and teachers sometimes stigmatized girls who tried to go back to school after pregnancy. Therefore, adolescent girls‟ sexual and reproductive experience sometimes influenced their educational attainment and progress.

5.2.3 Religious Background

A large number, 458 out of the 500 adolescent girls in the study were affiliates of various churches in their community including orthodox, pentecostal and charismatic. In all, 91.6% of the respondents identified themselves as Christians, while 7.2% indicated that they were Muslims (Table 5.1). This was not surprising since the 2010 Population and Housing census showed that 71.2% of Ghanaians are Christians and 17.6% are Moslems. The rest of the respondents indicated that they were African Traditional believers or not affiliated to any religion. Associating oneself with any of these religious group presupposes that majority of the

adolescent girls in the study were mainly guided by Christian or Muslim values. Christianity and Islam are often against pre-marital sex and out of wedlock pregnancy. The adherence to these religious rules can be a protective factor for adolescent girls. However, the same religious values and norms can predispose girls to risk in their sexual and reproductive life. Religious values of girls may push them not to buy contraceptives to prevent pregnancy for fear of being discovered as engaging in pre-marital sex (Addai, 2000).

From the perspective of the structuration theory, religion plays an important role in the society, by outlining the moral values for members of the society as well as influencing social action of the individual. Religion is also one of the four value systems (traditional, religious, legal and romantic) that exist side by side to influence the sexual and reproductive behaviour of adolescent girls (Ahlberg, 1994; Awusabo-Asare et al., 2004). Since resilience is the process of overcoming risk, religion serves as an important source of capital that can help girls in their sexual and reproductive experience in Begoro. The religious values of the adolescent girls can determine their attitudes towards pre-marital sex and pregnancy. Hence, the religious backgrounds of respondents provides an insight into how the religious value systems may contribute to how adolescent girls are able to avoid, overcome and adjust positively to the risk of sex, teenage pregnancy and early motherhood.

5.2.4 Family Background

The family backgrounds of adolescent girls considered in the study included marital status of their parents and the family‟s source of income. This is an important variable since it can determine exposure to risk as well as resilience of adolescents to sexual and reproductive health

experiences. The survey revealed that 53.1% of the respondents had both parents living together with 21% living with a parent who was either divorced and/or had another spouse. The remaining adolescents (25.9%) lived with a single parent (Table 5.1). On their family‟s financial backgrounds, it was revealed that the main sources of income were trading/business (50.2%) and farming (42.4%). Others explained that their family‟s sources of income were from official employment (11.6%) and working as casual labour (10.2%) (Table 5.2).

Table 5.2 Family‟s Source of Income

Source of Income	Frequency(N=500*)	Percentage
Trade/Business	251	50.2
Farming	212	42.4
Official Employee	58	11.6
Casual Labour	51	10.2
Other	24	4.8

Source: Author‟s Fieldwork, 2011/12
*multiple choices allowed

Parents‟ marital status and financial wellbeing can determine or influence the exposure of a girl to early sexual activities that may lead to early sexual activities, teenage pregnancy and early motherhood. Since Begoro is a farming community, the main source of income for most families was farming and trading/business. Most farmers in Ghana are into subsistence farming which gives them enough income to „acquire manufactured goods and pay for services‟ (Asamoa, 2011:122). Farming in Ghana is seasonal and most farmers depend on the weather for their farming activities. Farming by individuals in most rural communities in Ghana is usually not done on a large scale. Those who also had their family source of income from casual labour also means that such incomes were not regular and stable again indicating that this source of income

presents a challenge for the economic wellbeing of the family. This provides a picture of the economic background of respondents. The economic background of parents, thus, can predispose girls to sex, teenage pregnancy and early motherhood since girls may be pushed into sexual relationships with men in order to get economic gains from men in exchange for sex (Gyesaw and Ankomah, 2013; GDHS, 2008; Henry and Fayorsey, 2002).

Poor economic background may also influence educational attainment, girls may drop out of school as a result of lack of financial support and this can also result in risky sexual behaviours (Afenyadu and Goparaju, 2003; Henry and Fayorsey, 2002). Functional families can serve as a protective factor for adolescent girls by reducing the factors that expose adolescents‟ to risky sexual and reproductive behaviour. Adolescents from dysfunctional family backgrounds such as a broken home due to divorce, poor monitoring or single parenting have been identified to be more susceptible to engage in early sexual activities, which is highly correlated with pregnancy and early motherhood (Obeng-Denteh and Amedeker, 2011; Woodward et al., 2001). Thus, the family background of an adolescent girl can expose her to risk on one hand and on the other hand help her avoid, overcome and adjust positively to the risk in pre-marital sex, pregnancy and motherhood.

5.2.5 Relationship Status

The survey revealed that 49.2% of the respondents were single at the time of the study with 34.2% being in a relationship with the opposite sex (Table 5.1). The proportion of respondents who were married/cohabiting was 8.4%. A high percentage of adolescents where not married an indication that they are predisposed to premarital sex and teenage pregnancy thus, the need to

avoid early sex and pregnancy. Since the dorminant value systems (tradition and religion) in the community approved of sex only within marriage, the tendency to hide sexual activity tend to highten the risks of adolescent girls sexual experience.

There were adolescent girls who indicated that they were divorced, widowed or remarried (Table 5.1). These unusual cases were also found in the population and housing census in 2010, where some divorced adolescents were captured in the census data (GSS, 2013). Some of the girls tend to set up cohabitation and remain with the men or get pregnant and then classify such unions as marriage. However, most of these unions do not last long and when they break down the women see themselves as divorced. In general about 53% of the respondents were either in a relationship, married, separated or divorced or widowed.

Adolescents‟ relationship with the opposite sex predisposes them to teenage pregnancy in most societies and since more than half of the respondents were in some kinds of relationship or have been in some kinds of relationships with the opposite sex, it may have exposed them to a high risk of getting pregnant and becoming mothers at an early age. Having a relationship with the opposite sex can be a determining factor of an adolescent‟s sexual behaviour and attitude (Henry and Fayorsey, 2002). Adolescents who are in a relationship with the opposite sex have a higher risk of engaging in pre-marital sex as compared with their counterparts who are not (Kabiru and Ezeh, 2007). Since adolescence is a transitional stage from childhood to adulthood where girls and boys are attracted to each other, knowing the relationship status of the respondents can help understand the risks that they face.

5.2.6 Ethnic Background

In the study, the Akans who are the largest ethnic group in Ghana constituted more than 50% of the respondents whereas the Ga-Adangmes constituted 26% (Table 5.1). There were other ethnic groups apart from the Akans and the Ga-Adangmes, who represented approximately 13% of the respondents. This shows that the study area is a multi-ethnic society constituting mainly the Akans, the Ga-Adangmes and other ethnic groups. Traditionally the Akans" have the Bragoro and the Ga-Adangmes have the Dipo rites of passages that ushered girls into puberty. The cultural values of the Akans and the Ga-Adangmes influence adolescent sexual and reproductive behaviours.

5.3 Pregnancy Status of Respondents

The data revealed that out of the 500 respondents, 81 (16%) were pregnant or already mothers. Part of the process of identifying participants for this research was to first identify adolescent girls who were between the ages of 15 and 19 years old. Those who were not pregnant and had no children were presented as the „non-pregnant" (NP) and those who were pregnant (or) and have had a live birth at the time of the study as the „ever-pregnant" (EP) (Table 5.3). The proportion of girls who were pregnant or mothers increased as age increased, approximately 10% were 15 years old and 38% were 19 years old (Table 5.3). On the other hand, the proportion of non-pregnant girls decreased as age increased, thus approximately 33% of NP girls were 15 years old and 12% were 19 years old.

Table 5.3 Age Distribution by Pregnancy Status

Age	Non-P regnant n=419 (%)	Ever Pregnant n=81 (%)
15	137 (32.7)	8 (9.9)
16	94 (22.4)	8 (9.9)
17	64 (15.3)	13 (16.0)
18	73 (17.4)	21 (25.9)
19	51 (12.2)	31 (38.3)

Source: Author‟s Fieldwork, 2012

The proportion of pregnant adolescents and teenage mothers reflects the national data, which also reported that 16% of adolescent girls in rural Ghana have started childbearing (GDHS, 2008). As the data indicate, girls aged 19 years were more likely to be pregnant or mothers than girls aged 15 years. As the age of girls increased, they get closer to the age for marriage and therefore this explains why the proportion of girls who are pregnant or mothers increases with age. According to the GDHS 2008, while only 1% of women aged 15 years in Ghana have started childbearing, 29% of women were either mothers or pregnant with their first child by age 19 years. Therefore it can be concluded that there is an inverse relationship between age and pregnancy status among adolescent girls in Ghana.

5.4 Comparing Non-Pregnant and Ever-Pregnant Girls‟ Socio-Demographic Background

The socio-demographic backgrounds of adolescent girls have been reported to have an influence on the pregnancy status of a girl (Gyan, 2013; GDHS, 2008; Woodward et al., 2001; Singh, 1998; Okonofua, 1994). In this section, some socio-demographic backgrounds of girls such as,

education, family and religious affiliations are examined to see the relationship between pregnancy status and socio-demographic backgrounds.

5.4.1 The Educational Level of Non-Pregnant and Ever-Pregnant Girls

The study shows that for the non-pregnant girls, 52.7% had junior high school levels of education (Table 5.4). The data further revealed that 15.3% of the non-pregnant girls had upper primary level of education with 3.8% having no formal education (Table 5.4). For the ever-pregnant girls, 56.8% had JHS level of education, 14.8% had upper primary education whereas 13.6% had no formal education. This indicates that majority of the respondents both non-pregnant and ever-pregnant had JHS level of education. At the upper primary level, there was a low a proportion of non-pregnant girls as compared to the proportion of girls at the SHS level. However, there were more ever-pregnant girls with upper primary level of education as compared to those with SHS level of education. This could be attributed to the fact that most girls tend to drop out of school when they become pregnant or mothers, hence accounting for the low proportion of ever-pregnant girls at the SHS level.

Table 5.4 Level of Educational Attainment by Pregnancy Status

Level of Education	Non-Pregnant (N=419) %	Ever Pregnant (N=81) %
Upper Primary	64 (15.3)	12 (14.8)
JHS	221(52.7)	46 (56.8)
SHS	109 (26.0)	11 (13.6)
Vocational	9 (2.2)	1(1.2)
No Formal Education	16 (3.8)	11(13.6)

Source: Author"s Fieldwork, 2012

Both non-pregnant and ever-pregnant adolescent girls‟ level of education indicated that the majority of them had Junior High School level of education. However, as girls attained higher educational levels, the proportion of ever-pregnant girls decreased as that of non-pregnant girls increased (Table 5.4). A high proportion of non-pregnant girls had Senior High School level of education, compared to that of the ever-pregnant girls. This supports studies that suggest that adolescents tend to delay the age of child bearing when they spend more years in school (Awusabo-Asare et al., 2004). Overall, the study revealed that 96.2% of the non-pregnant respondents had some level of formal education.

The finding indicates that as the level of education rises the percentage of girls who were pregnant also declined. The GDHS (2008) reported that age for childbearing increases substantially as educational level increases. The data on the educational level and the pregnancy status of the respondents shows that attaining high educational level reduced exposure to risk factors that predisposes a girl to early sexual activities, pregnancy and motherhood. On the other hand, low or lack of formal education also increases the tendency of girls to engage in behaviours that could lead to unwanted pregnancy and early motherhood during their adolescent stage. These findings corroborate the GDHS (2008) reports which indicate that, 31% of adolescents with no education have begun childbearing, compared with just 1% of teenagers with secondary or higher education. This is because early childbearing can disrupt a girl‟s education on the one hand and on the other hand, childbearing can be an outcome of low level or no education. Studies show that girls who spend more years in school are less likely to engage in sexual activities that could lead to teenage pregnancy (Gyan, 2013; GDHS, 2008; Singh, 1998; Okonofua, 1994). Thus, education had an influence on the pregnancy status of girls.

5.4.2 Family Backgrounds and Adolescent Girls Pregnancy Status

With farming and trading/business being the main source of family income for the survey respondents, the research sought to find out if the source of income of an adolescent girl‟s family influenced her pregnancy status. Findings showed that all the family of adolescent girls in the study had a source of income. Most of the ever-pregnant (51.2%) and non-pregnant (46.7%) girls family source of income was trading/business. The second most identified source of income for ever-pregnant (34.1%) and non-pregnant girls (47.9%) was farming. The differences in proportion between pregnancy status and family source of income are shown in Table 5.5 below.

5.5 Family Source of Income by Pregnancy Status

Family Source of Income	Non-Pregnant 419(%)*	Ever Pregnant 81(%)*
Trade/Business	46.7	51.2
Farming	47.9	34.1
Official Employee	12.8	4.9
Casual Labour	10.1	12.2
Other	4.7	4.9

Source: Authors Field Data, 2012
*Multiple choice allowed

In the study area, more ever-pregnant girls had parents who were involved in trading and business. Moreover, the data revealed that the proportion of adolescent girls whose families‟ source of income was from doing casual labour work was high for ever-pregnant girls as compared to non-pregnant girls. This indicates that the economic background of respondents was not a determining factor in their pregnancy status. This differs from studies that assert that girls who come from economically disadvantaged backgrounds turn to men for financial support, which predisposes them to pre-marital sex and pregnancy. Despite the observations of previous studies which have shown that poverty is an important factor to consider in understanding

adolescent childbearing in Ghana(Gyesaw and Ankomah, 2013; Henry and Fayorsey, 2002; Domhnaill, 2011), this study show that there are other factors such as living or residential arrangements other than just poverty as shown in Table 5.6. Among the non-pregnant girls, 55.6% lived with both parents as compared to 38.3% ever-pregnant girls (Table 5.6). The rest lived with a single parent who had either remarried or not.

Table 5.6: Residential Arrangements by Pregnancy Status

Residential Arrangements	Non-Pregnant Girls n = 419 (%)	Ever-Pregnant Girls N =81 (%)
Both Parents Living together	233 (55.6)	31 (38.3)
Live with a single parent only	92 (21.9)	30 (37.0)
Live with partner/cohabiting	6 (0.5)	4 (4.9)
Father has another wife	88 (21.0)	16 (19.8)

Source: Author"s Fieldwork, 2012

This indicated that more girls that are non-pregnant were living together with both parents than ever-pregnant girls were. This presupposes that living with both parents influenced a girl"s pregnancy status in that living with a parent creates difficulties in taking care of children both socially and economically. Additionally, where adolescent girls had parents who lived apart, monitoring of behaviour has been identified to be problematic. An adult respondent stated:

> *Teenage pregnancy is on the rise in this town…, it is due to lack of parental care and poverty. When there is a divorce, the children are confused as to which parent to trust or rely on for financial and social support. Some girls use the excuse of going to visit the other parent to stay away from home and engage in sexual relationships with men* (Man 2, In-depth interview, Begoro)

Girls from broken homes tend to lack parental monitoring and this sometimes exposes them to engage in sexual behaviours that could result in unwanted pregnancy and early motherhood. This

corroborates studies carried out in Ghana (Gyan, 2013; Afenyadu and Goparaju, 2003; Singh, 2001; Nabila and Fayorsey, 1996) which suggest that girls whose fathers were absent during their formative years, have a high risk of engaging in early sexual activity and experiencing adolescent pregnancy because they lacked parental monitoring.

5.4.3 The Religious Background of Non-Pregnant and Ever-Pregnant Girls

The result revealed that 6.9% of the non-pregnant girls were Muslims whereas 91.9% were Christians. Among the ever-pregnant girls, 8.6% were Muslims and 90.1% where Christians (Table 5.7). The other distributions are displayed in Table 5.7.

Table 5.7 Religious Affiliation by Pregnancy Status

Religion	Non-Pregnant n=419 (%)	Ever Pregnant n=81 (%)
Muslim	29 (6.9)	7 (8.6)
Christian	385 (91.9)	73 (90.1)
Traditional	3 (0.7)	1 (1.2)
No Religion	2 (0.5)	0 (0.0)

Source: Author‟s Fieldwork, 2012

According to Addai (2000), religion influences people‟s attitudes and experiences regarding sexual behaviour. Religious background can influence the sexual and reproductive behaviour of people because of the moral values associated with most religions (Addai, 2000; Heaton and Darkwah, 2011; Ahlberg, 1994). Most religious groups preach abstinence from pre-marital sex and this value is thought to influence the sexual behaviours of members of such religious groups. However, the study findings show that religious affiliation does not influence a girl‟s pregnancy status. This was also reported by Addai (2000) that the number of women who are sexually experienced did not vary much across religious groups.

5.4.4 Sexual Experience of Non-Pregnant Adolescent Girls in Begoro

To find out about the sexual experience of the non-pregnant girls the first question was to find out if they have ever had sexual intercourse before. The response indicated that 176 (42%) of the non-pregnant girls had experienced sexual intercourse. More so, 17% of the non-pregnant girls who were 15 years had experienced sexual intercourse (Table 5.8). The overall mean age of non-pregnant girls who have ever had sexual intercourse was 17 years (Table 5.8). This suggests that although the non-pregnant girls were not pregnant or did not have any live births 42% were sexually experienced an indication that they were predispose to teenage pregnancy and sexually transmitted infections.

Table 5.7 Age of Non-Pregnant Girls who have Experienced Sexual Intercourse

AGE	Frequency n=176 (%)
15	29 (16.5)
16	32 (18.2)
17	28 (15.9)
18	47 (26.7)
19	40 (22.7)

Source: Author"s Fieldwork, 2012

These findings suggest that almost half (42%) of non-pregnant girls had sexual experience and have had sexual intercourse. It also shows that having sexual intercourse is not dependent on the age of the individual, all girls aged 15-19 years had relatively equal proportions of those having had sex with ages 18 and 19 years having slightly higher proportions. This trend of girls having sexual experience is not different from what pertains around the world and within the Ghanaian community (GDHS, 2008; Agyei et al., 2000; UNICEF, 2012). It confirms reports that girls are

initiating sex as early as age 15 years. The results shows that adolescents‟ sexual experience does not follow the legal age of marriage (18 years), the traditional value system and the religious value system that propose chastity before marriage (Ahlberg, 1994; Awusabo-Asare et al., 2004). Therefore, an adolescent‟s sexual experience has an influence on her pregnancy status or her exposure to becoming pregnant. Knowing the sexual experience of adolescent girls in this study highlights two important facts about adolescent sexual and reproductive health. First, it helped to identify girls who are predispose to premarital sex and teenage pregnancy and second it showed how girls avoid or overcome the risk associated with their sexual experience.

5.5 Conclusion

The socio-demographic characteristics of the adolescent girls show that girls came from varied backgrounds. The girls involved in the study were all between ages 15 and 19 years, indicating that the survey respondents had a fair representation of all older adolescents. In addition, the study revealed that there were some differences in the socio-demographic characteristics of non-pregnant and ever-pregnant girls. There is an inverse relationship between education and adolescent girls‟ pregnancy status. For instance, the study showed that more girls who are non-pregnant had more education as compared to the ever-pregnant girls. The more years girls spent in school, the less likely they are to get pregnant. Therefore, adolescent girls‟ sexual and reproductive experience can have an influence on their educational attainment and progress.

Despite studies that conclude that religious values of girls puts them at risk as well as influence their resilience (Addai, 2000), this study found that there was no relationship between girls pregnancy status and religion. The study further showed that more girls who came from

dysfunctional homes were either pregnant or mothers. As such, the socio-demographic characteristic of a girl influenced her pregnancy status and at the same time her resilience to sex, teenage pregnancy and motherhood.

CHAPTER SIX

SOCIAL CONTEXT OF ADOLESCENT GIRLS‟ SEXUAL BEHAVIOUR

6.1 Introduction

This chapter addresses one of the study objectives by exploring the social context of Begoro in which adolescent girls experience sex, pregnancy and motherhood in order to understand how it determines their resilience to risk. In resilience research, the social context of an individual presents both risk and protective factors that influence resilience pathways (Obrist et al., 2010; Theron et al., 2013). Thus, to understand adolescent resilience in this research the factors that put them at risk and those that help them avoid, overcome and adjust positively to risk must be studied simultaneously. The chapter analysed data from a survey of 500 adolescent girls, in-depth interviews with both male and female adult community members, adolescent boys and focus group discussions with boys to gain insight into the social attitudes towards girls‟ sexual behaviour and childbearing in Begoro. To achieve this, the study focuses on the perceptions of community members on the changing trends in adolescent sexual and reproductive behaviour. It looks at the traditional context, the changes that have taken place and how they have affected adolescent girls‟ sexual behaviour and childbearing. The social attitudes towards girls‟ sexual behaviour and childbearing are also discussed.

Knowing the social context of adolescent sexual and reproductive behaviours provides an understanding into why and how adolescents in the study area face the risk of premarital sex, teenage pregnancy and early motherhood and how some girls are able to avoid, overcome and adjust positively to the challenges associated with it.

6.2 The Traditional Context of Adolescent Girls‟ Sexual Behaviour and Childbearing

From the perspective of community members, traditionally adolescent girls‟ sexual behaviour was shaped by the norms and values of the community, which expected girls to go through puberty rites when they experienced menarche after which they are permitted to marry and have children. The people of Begoro, as other Akan ethnic groups, had puberty rites for adolescent girls to usher them into womanhood after the onset of menarche. One respondent who is a sub-chief of the community sheds light on the traditional process for ushering girls into womanhood:

> *The tradition is that when you have your first menstruation, the old women will teach you (adolescent girl) certain things about womanhood and take you to the river with your friends, some rituals are performed for you, and then you are advised to be careful with men…* (Man 3, In-depth interview, Begoro)

Similarly, another community member stressed the role of parents in adolescent girls‟ sexual behaviour after the onset of menarche, by noting that:

> *In the past their (adolescent girls) parents would prepare ripe plantain with eggs for them and keep them indoors for a week to teach them all there is to know about womanhood and if a man is interested in you (adolescent girl), he comes to perform the necessary rites afterwards* (Woman 6, In-depth interview, Begoro)

The tradition in the community was that adolescent girls on the onset of menarche go through puberty rites during which they were taught about their sexuality and prepared for marriage. These views suggest that great importance was attached to adolescent girls‟ fertility in the traditional system and as such, when girls experienced menarche they were taken through initiation rites to usher them into womanhood and their fertility was celebrated (Adomako Ampofo, 2001; Sarpong, 1977). This was evident in the narrations of all the adult community members, a man summarises this by his observations:

> *Traditionally we have the puberty rite, which was performed by the old women for the teenagers. If you are a girl and you become pregnant before you went through the rites, you were severely punished, they were banished from the town* (Man 1, In-depth interview, Begoro)

Girls who became pregnant before going through the puberty rites were banished from the community, which indicates that the norms and values guiding adolescent girls‟ sexual behaviour advocates chastity before puberty rite, which was usually followed by marriage. As such, traditionally sexual activities for adolescent girls and childbearing were only sanctioned in marriage and those who deviated from such norms risked being expelled from the community (Bleek, 1981; Sarpong, 1977). Punishing only adolescent girls for becoming pregnant before going through puberty rites reinforces the gender inequality that exist between boys and girls, with the norms favouring boys relative to girls in their sexual behaviours. This means that adolescent girls were held responsible in matters of sexual and reproductive behaviour and not their male counterparts (Marston and King, 2006; Adomako Ampofo, 2001). This can be interpreted as gender discrimination in sexual norms and values. It is men/boys who get girls pregnant, but they get away with sexual activities easily compared to girls who are expected to remain chaste until marriage and therefore punished when they do not conform to such norms (Anarfi and Owusu, 2011; Awusabo-Asare et al., 2004).

From the views of the respondents, old women of the community and mothers socialized adolescent girls on norms and values concerning sexual behaviour after menarche. The quote from a seventy-three year old female respondent who had lived in the community all her life summarizes the views on the role of agents of socialization for adolescent girls‟ sexual behaviour:

> *Traditionally the old women of this town were in charge of providing sexual and reproductive health education for the teenage girls in this community…in the olden days they (adolescent girls) would tell their mothers and all the rites of puberty will be done for them. If you are an Akan, you will go through Bragoro and if you are a Krobo, Dipo is performed for you* (Woman 5, In-depth interview, Begoro)

Another woman opined:

> *The tradition is that when you turn eighteen years, they would prepare ripe plantain and egg for you, and they give the leftover to children so that you can be blessed with many children and then they wish you good luck. If you were a traditional worshiper, they would take you to the riverside and bath and sing for you, if you are a Christian then you go to church and they pray for you (Woman 4, In-depth interview, Begoro)*

Upon the onset of menarche, adolescent girls were expected to inform their mothers who then with the help of the old women in the community took them through the puberty rites to initiate them into womanhood. Women and preferably older women were the main actors in the socialization of adolescent girls‟ about sex, marriage and motherhood. This was because, it was believed that older women had experience and therefore had knowledge to teach the girls all they needed to know about their sexuality and womanhood. Mothers were identified as a source of social support in adolescent girls‟ sexual and reproductive life. The discussions of the community members highlight the role of mothers as important actors in adolescent girls‟ sexual and reproductive health education. This notwithstanding, in as much as parents had a responsibility to their daughters about their sexual behaviour, the study found that girls also had a role to play. Adolescent girls were expected to inform their parents upon the onset of menarche in order for their parents to provide them with the necessary support. After which parents with the help of the older women in the community would take them through puberty rites where they are taught and advised about their sexuality and issues pertaining to womanhood. The old women took girls through initiation rites, „Dipo‟ for the Ga-Adangme adolescent girls and „Bragoro‟ for the adolescent girls with Akan ethnic backgrounds in the community. This highlights that traditionally when a girl reached puberty; it was the responsibility of the old women and parents to teach them about sexuality and reproductive life in the community (Adomako Ampofo, 2001).

A sub-chief of the community explains the importance of taking girls through the puberty rites:

> *They (parents and old women) did all these because they did not want any unwanted pregnancy and they will advise you to come and introduce your boyfriend to them if you had one, so that they can investigate the person for you to get married. The puberty rite helps you (adolescent girl) to know that you have to be careful so that you do not become pregnant* (Man 3. In-depth interview, Begoro)

The tradition of taking girls through puberty rites and teaching them about sexuality after they had experienced menarche was to prevent girls from unwanted pregnancy and inappropriate sexual behaviours. It was also a way to prepare girls for, and get them into marriage. Parents and older women took the opportunity during the puberty rites to teach girls about their sexual and reproductive health as well as prepare them to take up marital roles in future (Adomako Ampofo, 2001; Sarpong, 1977). This suggests that for many girls, puberty is followed by marriage, which minimized the risk of girls engaging in risky sexual behaviour after the onset of menarche. Marrying early was a form of social control for girls‟ sexual behaviour and that could explain why in the traditional system, teenage pregnancy was not as a problem as having a child out of wedlock. Thus, the concept is different from now.

6.3 Issues of Change in Adolescent Girls‟ Sexual Behaviour and Childbearing

All traditional communities in Ghana have experienced and are still experiencing social change and this has affected the social structure including puberty rites and adolescent sexual behaviour. Social change in Begoro has affected the agents of adolescent sexual socialization in many ways. Almost all the respondents accepted that there has been change in the socialization of adolescent girls to womanhood. There are new agents (teachers, social media etc.) in the socialization of adolescents about their sexuality, more and more adolescents are spending more years in school and the diminishing traditional practice of puberty rites to usher girls into womanhood. This

changing trend has affected the traditional practice of taking girls through puberty rites by older women. They observed that there are changes in adolescent sexual and reproductive behaviour in recent times and shared their sentiments:

> *Parents do not get the opportunity to teach their children how to prevent teenage pregnancy and some (adolescent girls) do not inform their parents about menarche, by the time they inform their parents they would have already gone out to sleep (have sex) with someone* (Woman 5, In-depth interview, Begoro)

> *... When they have their first menstruation, they just go and buy pads (sanitary pads) but at first, they would report to their parents who would then use the opportunity to teach them about the change in their reproductive life after having their "period"* (Man 4, In-depth interview, Begoro)

> **...** *They are their own masters, as I said; when I experienced my first menstruation, my mother noticed it and performed all the necessary rites for me but now they do* not *even tell their parents when they menstruate* (Woman 3, In-depth interview, Begoro)

These perceptions of the adult respondents show that girls no longer feel obliged to inform their mothers about the onset of menarche because they had knowledge on what to do when they menstruate. They attributed the changes to the lack of communication between adolescent girls and their mothers about the onset of menarche. As such, girls were perceived to be their „own masters" buying sanitary pads and not informing their parents. This notwithstanding, an adult respondent observed that the traditional way of socializing adolescent girls on the norms and values regarding sexual behaviours has not changed, but rather the attitudes of girls towards the norms and values has changed. He explained:

> *... This practice (puberty rites) has not changed in recent times, rather it is the youth that do not listen to the advice they (old women and parents) give them* (Woman 1, In-depth interview, Begoro)

Thus, the change in the traditional practice where old women and parents had the responsibility of educating adolescent girls on sexual and reproductive issues has largely been affected by the attitudes of girls towards their parents. In cases where adolescent girls did not inform their parents about the onset of menarche, as Henry and Fayorsey (2002) observed it was because they

were too shy to discuss such issues with their parents or relatives. The changes in the traditional practice had to do more with lack of communication between girls and their mothers. Since girls‟ do not inform their mothers about their menarche, parents do not know when they have their first menstruation to advise them on their sexual and reproductive behaviour or even take them through the initiation rites.

From the perspective of adult respondents, although the emergence of new actors in adolescents‟ socialization on sexual and reproductive matters had some advantages, it also had some negative impact on the sexual behaviour of adolescents in the community. The emergence of new social actors such as teachers, radio and television in the socialization of adolescent was identified by respondents as one of the sources of change in adolescent sexual behaviour. They observed that the traditional role of parents and other older women has been largely taken over by these new social actors such as the formal educational system. A man recounts:

> *Things have changed … because of the girl child education. In the olden days, teenagers did not know how to avoid pregnancy, but now with the introduction of family planning methods they can protect themselves* (Man 3, In-depth interview Begoro)

Formal education is perceived to influence adolescents‟ sexual behaviour in that they tend to be more inclined to what they are taught in school than what they are taught at home. The perception is that the educational system offers opportunity for adolescent girls to learn about their sexuality and manage their sexual experiences. With the incorporation of sexual and reproductive health education in the school syllabi, adolescents are probably receiving sexual and reproductive health information from school than from their parents, as was the case previously (Biddlecom et al., 2008; Awusabo-Asare et al., 2004; Henry and Fayorsey, 2002).

Henry and Fayorsey (2002) observed that adolescents who stayed in school long enough were taught about sex and other related topics.

Other sources identified as providing adolescent girls with sexual and reproductive health education include the radio and hospitals. A woman observed:

> *They (radio programmes) teach them (adolescents) how to protect themselves from teenage pregnancy when they have sex on the radio and at the hospital but the stubborn ones do not listen, so it is never going to stop. Some do (listen) others do not even care all they do is to enjoy having sex… They (adolescent girls) get the knowledge from the clinic where they are advised to use family planning methods….* " (Woman 6, In-depth interview, Begoro)

Community members identified the hospitals and the electronic media (radio) as additional sources of information for adolescent girls. They explained that in recent times, these other actors have come in to help with teaching and advising adolescents about their sexual and reproductive health. However, they were of the view that because of the negative attitudes of girls towards advice these other sources of information would not have any impact on their sexual behaviour. Those who listened to information provided by these other sources may either adhere to them or reject them. Furthermore, the adult respondents were of the view that because girls knew how to access family planning methods to prevent pregnancy they engaged in sexual activities believing that modern contraceptives would help them avoid unwanted pregnancy. Despite identifying the health facility as one of the sources that adolescents got support from on sexual and reproductive health matters, respondents observed that most adolescent girls do not access it. They explained:

> *… Some do not even go for the family planning; they feel shy to go to the hospital* (Woman 6, In-depth interview Begoro)

This suggests that although change is taking place, the traditional value of abstinence from sex until marriage persist and therefore girls tend to shy away from openly accessing family planning services.

Relationships with peers were also observed to be influencing adolescents‟ sexual and reproductive behaviour in the community. One man asserted:

> *The peer group is a group that shares ideas to help each other, but if the peer group is not good, you will get into trouble* (Man 2, In-depth interview, Begoro)

Another person observed:

> S*ome of them (adolescent girls) pay more attention to what their friends tell them than what you (adult) tell them* (Man 4, In-depth interview, Begoro)

A man sums the influence of peers on adolescent girls‟ sexual and reproductive experience with a local proverb

> *The reason why the crab does not have a head is because of bad company*, he explains, *they (adolescent girls) do not make good friends so they don"t listen to their parents* (Man 3, In-depth interview, Begoro)

Peers are perceived to have both positive and negative influence on adolescent girls‟ sexual behaviour (Karim et al., 2004; Arai, 2003; Nabila and Fayorsey, 1996; Forsyth and Palmer, 1990). Although studies on adolescent sexual and reproductive health tend to be divided on the influence of peers on sexual behaviour, adult respondents‟ views seem to align with the perspective that adolescent sexual behaviours are influenced by the values of their peers. They perceived adolescents sexual behaviour to be influenced by the values of their peers compared to that of their parents. Peers sometimes tend to provide information similar to what parents may provide on sexual behaviour and thus in some cases may be a positive influence (Henry and Fayorsey, 2002:7).

Some respondents opined that the changing trend in adolescent sexual and reproductive experience in Begoro was because of the changed in the age at which girls experienced menarche. A female respondent discussed:

> *Now people give birth before the age of sixteen, but at first, you even reach puberty around age sixteen*" (Woman 4, In-depth interview, Begoro)

The fact that most adolescent girls experienced menarche at a latter age in the past, but in recent times experienced menarche early was supported by the adult respondents. Early onset of menarche increased the likelihood of adolescent girls becoming pregnant when they engage in early sexual activities. This assertion by community members corroborates earlier findings, which suggested that early sexual and reproductive maturity is associated with risky sexual behaviours among adolescent girls (Dunbar et al., 2008). Gollenberg et al., (2010) attributed the change in the timing of onset of menarche to nutrition and other chemical intake.

The involvement of new agents of socialization, the inclusion of sexual and reproductive health education in the school syllabi, proliferation of radio and television programmes, influence of peers and the early onset of menarche among adolescent girls has led to changes in their sexual and reproductive experiences. This means that adolescent girls now lived in an environment where they had diverse sources from where they access resources to develop resilience to sex, teenage pregnancy and early motherhood. This ranges from their families, schools, community members and the health centres within their community. Bankole et al. (2007) observed that adolescents have access to diverse sources of information on sexual and reproductive health such as schools, peers, mass media, parents, other relatives and the health facilities. Although, adolescent girls had diverse sources of information, there was a perception that not all of them were able to utilise these resources in their sexual and reproductive life. It was perceived that

girls attitude to advice and information such as not respecting, underrating adults views on sexual matters and not seeking information contributed to their underutilization of the new agents of socialization. Additionally, the diversity also exposes girls to risky sexual behaviours in that the diversity exposes them to early sexual activities, teenage pregnancy and early motherhood. Girls are confronted with societies‟ familial values of chastity and at the same time, their own romantic values and the emerging national value such as the legally accepted age for marriage being age 18 years and the use of contraceptives (East et al., 2011; Ahlberg, 1994).

6.4 The Effect of Change on Adolescent Sexual Behaviour

The traditional value of adolescent girls‟ abstinence from sex and the acceptance of childbearing in marriage are undergoing changes in the community. One woman, explained:

> *At first, you have to be married before giving birth but now it is not like that anymore* (Woman 4, In-depth interview, Begoro)

Thus, the traditional value system on adolescent sexuality and reproductive behaviour in Begoro taught abstinence until marriage, and childbearing was preferred in marriage. With the increasing rate of teenage pregnancy, the trend now is to teach and advise adolescents on how to either abstain or use contraceptive and family planning methods to avoid pregnancy. From the perspective of adult respondents, family planning is an alternative if adolescent girls cannot stay away from sexual activities. A woman opined:

> *If they are around seventeen years, you can advise them (adolescent girls) to stay away from men or they should buy drugs to protect themselves, but some of the women complain that they do not like the family planning drugs* (Woman 5, In-depth interviews, Begoro)

Citing the age seventeen years shows how sexual behaviours are preferred at an older age as such in this woman‟s opinion 17 years seemed a likely age to advice adolescent girls to stay away

from men or use contraceptives. However, delaying sex education until age 17 years would be too late, since adolescents are initiating sex as early as age 15 years (Agyei et al., 2000; Nabila and Fayorsey, 1996). This notwithstanding, there were views that parents for fear of their daughters becoming pregnant now take the initiative to introduce and enrol their daughters into family planning programmes. An adolescent boy shared his sentiments on how parents have included family planning measures as part of providing support for their daughters:

> *I know of one or two families who encouraged their daughters to go for family planning and some have even enrolled their daughters on family planning programmes at the district hospital* (Boy 2, In-depth interview, Begoro)

Similarly, a man recounts his experience:

> *I know some parents whose daughters are on the family planning programme. The parents know their children; they cannot stop their children from going out. They have something they put on their hand and that is what I know. ... one of the women whose daughter was enrolled on a family planning programme asked me to check if the date for renewal was due since it had a three months interval* (Man 1, In-depth interview, Begoro)

The traditional value of abstinence from sex until marriage is largely giving way to the advice „if you cannot abstain from sex, then use contraceptives or access family planning". This has brought tension in adolescent sexual behaviour as a result of the duality of value, abstinence or protection (condom/family planning). The value of protection against teenage pregnancy now comes from some parents and the new actors such as the media and the schools who are involved in adolescent sexual and reproductive education. This reiterates the observations made by Ahlberg (1994) that adolescents encounter traditional, religious, legal and romantic value systems that are not mutually exclusive but exist side by side depending on their social context. Findings presented in this section shows that adolescents are being influenced more by different values that are making demands on their sexual and reproductive life and thus find themselves in a dilemma.

6.5 Community‟s Perceptions on Adolescent Girls‟ Sexual Behaviour and Childbearing

Several factors such as the individual behaviours of adolescent girls and socio-economic factors where perceived by the community members as the causes of girls‟ engagement in sex and teenage pregnancy. The community‟s perceptions on adolescent girls‟ sexual behaviour and childbearing are discussed along the lines of girls‟ attitudes, parenting, effects of financial support, the role of the electronic media, acceptable age for marriage and adolescent childbearing.

6.5.1 Attitudes of Girls

One common view that kept coming up consistently throughout the in-depth interviews was adolescent girls‟ lack of respect for parents and the elderly in the community. The phrase that began most of the responses of the community members‟ explanations for the change in adolescent girls‟ sexual behaviour and the causes of teenage pregnancy in the community was "*Most of them (adolescent girls) don't respect …*". According to some respondents,

> *Teenagers do not respect, they do not listen to the advice of their parents. What happens is that, they do not listen to advice and then they get pregnant and because you cannot disown them, they deliver* (Woman 3, In-depth interview, Begoro)

> *Teenagers do not respect their parents, so they (teenagers) do not say anything before you realize they (teenagers) are pregnant* (Woman 6, In-depth interview, Begoro)

> *… now the teenagers do not respect and because you are not the one taking care of them you cannot really say anything or else they (teenagers) will insult you* (Man 1, In-depth interview, Begoro)

These views of the respondents on adolescent girls attitude towards advice about their sexuality indicates that there is a perception that girls do not listen to advice. Due to this, they end up engaging in risky sexual behaviours that usually leads to teenage pregnancy and early motherhood. In view of this it was concluded by the respondents that adolescent girls are

disrespectful and do not listen to advice from parents and the elderly. All the respondents (men, women, adolescent boys) in the in-depth interviews identified "disrespect" as the underlying cause of girls engaging in pre-marital sex. These assertions suggest that the main cause of adolescent pregnancy in Begoro from community member"s point of view has to do with attitudes of adolescents towards their parents and the elderly in the community. The contrast between the girls" attitudes and those of their elders represented the clash of value systems unearthed by the research.

In addition, respondents asserted that most adolescent girls in the community stayed out late and this exposed them to engaging in risky sexual behaviours. A man explained:

> *... Because of the nightclubs and movies, the teenagers do not sleep early* (Man 1, In-depth interview, Begoro)

A woman corroborates this by explaining:

> *Teenage pregnancy is very high because the teenagers stay out almost all night* (Woman 5, In-depth interview, Begoro)

It was emphasised that adolescents" behaviours such as staying out late at night was one of the reasons why adolescent girls end up pregnant or become mothers. Adolescents tend to stay out late because of the existence of cinema centres, which hold late night programmes. This was seen as encouraging girls to go out and stay out late at night, where they learn and practice all kinds of behaviours including sexual activities.

6.5.2 Poor Parenting

A factor that came up as exposing adolescent girls to the risk of early sexual activities, pregnancy and motherhood was poor parenting. Respondents perceived poor parenting as

instability in the marital status of parents, and the inability of parents to teach and advice their adolescent daughters. A man shared his views:

> *When there is a divorce, the children are confused as to which parent to trust and then they become wayward* (Man 2, In-depth interview, Begoro)

Another man observed:

> *Some of the parents feel shy telling their children about sex and its consequences, so the children also might engage in it without telling anybody and this leads to these unwanted pregnancies* (Man 1, In-depth interview, Begoro)

Others also attributed the cause of teenage pregnancy in the community to the cycle of adolescent girls having mothers who gave birth in their adolescent years. As such, a woman shared her sentiments:

> *… It is the fault of the parents, because some of the parents gave birth when they were teenagers, so they see nothing wrong with that* (Woman 2, In-depth interview, Begoro)

From the focus discussions, an adolescent boy who shared a similar view reiterated:

> *… Most of the parents themselves experienced teenage pregnancies when they were teenagers so I think a girl"sfamily background can influence her sexual behaviour; their mothers are not able to control them because they also acted like them when they were teenagers* (FGD 2, Boy 1)

These indicate that there was a perception among community members that an adolescent girl‟s family background had an effect on her sexual and reproductive behaviour. In families where parents are divorced, it could have an effect on parental monitoring and this predisposed to adolescents to risky sexual behaviours. This supports studies that identified broken homes and low parental control as factors that exposed adolescent girls to risky sexual behaviours (Obeng-Denteh and Amerdeker, 2011). Furthermore, the tendency of girls‟ whose mothers gave birth during their adolescent years to repeat that cycle were also perceived by community members as a determinant of adolescents sexual behaviour. They attributed this to the fact that such parents lacked the ability to advise their daughters against risky sexual behaviours. This creates a cycle

where teenage mothers have daughters who are more likely to give birth during their teenage years. This was also observed by Woodward et al. (2001) who found out that most young women who had given birth before the age of 20 years were brought up by a single mother who was once a teenage mother.

Aside from poor parenting, socio-economic background also came up as a contributing factor to adolescents being involved in early sexual activities. A man suggested:

> *Teenage pregnancy is on the rise in this town due to lack of parental care and poverty. If you (adolescent girls) do not have money to buy food, you have to use your body …* (Man 2, In-depth interview, Begoro)

Another adult respondent observed:

> *… Some parents are not able to take good care of their children, most of these children do not work so when they need something and their parents are not able to provide it for them they turn to men… Their (adolescent girls) parents do not provide them with food and clothes and therefore they (adolescent girls) have sexual relationships with men for financial favours* (Woman 2, In-depth interview, Begoro)

Similarly, the adolescent boys also attributed adolescent girls‟ pregnancy to economic disadvantage by observing:

> *… Some of the parents too do not have money to take care of their children so they (adolescent girls) rely on their boyfriends.* (Boy 3, In-depth interview, Begoro)

Similarly, some adults explained:

> *… Most of them (adolescent girls) are not working and because of their taste for good things in life, the men deceive them with money* (Woman 6, In-depth interview, Begoro)

> *Poverty also contributes because when a girl does not have money to buy food or go to school, men can deceive her; they say an idle mind is the workshop of the devil* (Man 6, In-depth interview, Begoro)

The highlights of these views is that adolescent girls who come from a background where there are financial problems and therefore do not get financial assistance to meet their basic needs may

turn to men for financial favours by having sexual relationships that can lead to unwanted pregnancy and consequently early motherhood. Due to poverty, some girls do not go to school and that increased their vulnerability to engaging in premarital sex. This suggests that when adolescent girls have financial support from their parents towards their needs it could prevent them from turning to men for such support and therefore will reduce the risk of them engaging in sexual activities that leads to teenage pregnancy and early motherhood.

6.5.3 Controversy on the Effect of Financial Support

The study sought the views of the community members to find out their perceptions on how financial support influenced adolescent girls‟ sexual experiences. From the in-depth interviews, two opposing views emerged. One group suggested that girls engaged in sexual relationships with the opposite sex for financial favours because they lacked financial support from their parents. An adolescent boy shared this view:

> *If you are a parent who advises your children not to go out with boys, you must ensure that you feed them well and provide them with all their needs, so that they will not go and follow men to make them pregnant* (Boy 3, In-depth interview, Begoro)

Similarly, a female adult also shared her sentiments:

> *Some of the parents do not have the money and some even end up pushing their daughters to go out with men. Financial support can help the adolescent girls to avoid teenage pregnancy, because most of these misfortunes are caused by the lack of money, so most of the parents are to be blamed, they are not able to provide their children with all their needs* (Female adult 4, In-depth interview, Begoro)

Another respondent expressed this view:

> *If they (adolescent girls) get financial support, they will not go and ask the men ... If there are jobs in town and they earn something every month, they will stay away from men* (Female adult 3, In-depth interview, Begoro)

These findings indicate that community members had the perception that adolescents‟ engagement in premarital sex was because of lack of financial support from their parents. It suggests that parents are to blame for adolescents‟ risky sexual behaviour because it is their responsibility to provide their children with their basic needs since most of the adolescent girls are still in school. The perception of attributing adolescent teenage pregnancy to parents‟ poor economic background has been confirmed in a number of studies in Ghana (Obeng-Denteh and Amerdeker, 2011; Afenyadu and Goparaju, 2003; Nabila and Fayorsey, 1996).

On the other hand, respondents who said that teenage pregnancy was not as a result of lack of financial support from parents explained this in two ways. In the first explanation they observed that an adolescent‟s access to financial support alone could not help her avoid teenage pregnancy. A respondent argued:

> *For now, you cannot really say that if someone gets pregnant then it is because of lack of money because most of the parents supply them with whatever they need, because I have a niece who is pregnant and is now at home, I cannot say that it was because of financial difficulties. However, some of them genuinely do not really have money to buy food and clothes, because some of the parents would rather use the money to buy clothes for themselves* (Male adult 1, In-depth interview, Begoro)

Similarly, an adolescent boy expressed:

> *... Some girls have rich parents but they still live promiscuous lifestyles, so the best thing is to advise them to go for family planning. What I can say is that a girl"sfamily wealth cannot really help her avoid teenage pregnancy, so I think the best thing is to go for family planning. All parents who know that their daughters have boyfriends should take them for family planning* (Boy 2, In-depth interview, Begoro)

Another adult respondent said:

> *Financial support cannot help teenage girls avoid pregnancy. The money you will give them(adolescent girls) will never be enough because you (parent) might have it (money) today but tomorrow you might not be in a position to help them (adolescent girls)* (Female adult 2, In-depth interview, Begoro)

The other explanation why some of the respondents did not perceive lack of financial support as the cause of adolescent girls engagement in risky sexual behaviours was because financial support was seen as an incentive for the non-pregnant girls to engage in premarital sex. An adolescent boy shared his sentiments:

> *Money cannot advise them, the money will rather encourage them to engage in such immoral act, so what you have to do is to talk to them, and even with that, some will listen to your advice others will not. With money they can go and buy condom themselves, but you cannot give them money to go and buy it (condom) … it means you are encouraging them to have premarital sex* (Boy 1, In-depth interview, Begoro)

Another adult community member who also expressed similar sentiments from a different angle observed that, supporting adolescent girls financially helped them to look good to attract the opposite sex. He explained:

> *It (financial support) can help in a way, but sometimes when you give the money to some of them (non-pregnant adolescent girls) they will use it to buy clothes and makeup to look good for their boyfriends, and rely on their boyfriends to give them money for their upkeep* (Male adult 4, In-depth interview, Begoro)

These sentiments expressed in the quotes were also shared by other community members. This indicates that they believe advice and money could help adolescent girls to avoid unwanted pregnancy, at the same time they were skeptical because of moral issues. There was this perception that it was morally wrong to specifically give adolescent girls money to have access to modern contraceptives.

These views highlights the need for other protective factors such as family support to be available in addition to economic support in order for girls to avoid or overcome the risk of sex and teenage pregnancy. Some of these protective factors include access to advice and information about their sexual and reproductive life and how to avoid pregnancy and sexually transmitted disease (social, cultural and symbolic capitals). This is because as would be

discussed in chapter seven, some girls based on their knowledge about contraceptives use part of the money they have to buy contraceptives (pills and condoms) for protection. They did this regardless of where they got the money from.

Two schools of thought emerged from the study on the influence of financial support for adolescent girls. Whereas some community members held the view financial support helped adolescent girls avoid teenage pregnancy, the other school of thought believed financial support did not help girls to avoid pregnancy. These assertions indicated that when adolescent girls have access to money it could help them meet their basic needs and they would stay away from engaging in sexual relationships with the opposite sex. However, what these arguments about the influence of financial support on determinants of adolescents‟ resilience to teenage pregnancy suggest is that, financial support alone cannot help a girl avoid risk to sex and teenage pregnancy. Rather, financial support in addition to other resources such as social support, and the right information can help adolescent girls to develop resilience against teenage pregnancy and sex.

6.5.4 Influence of the Electronic Media

The electronic media specifically, television came out strongly as a determinant of adolescent sexual experience in Begoro. In spite of TV being among the major sources of adolescents‟ information on sexual and reproductive life, there were some concerns about TV programmes having negative influence on adolescent sexual and reproductive behaviour. According to the adult respondents, most television programmes had sexual scenes, which were not good for the viewing of adolescent girls. These were discussed in the following representative quotes:

> *… The television is not good for them (adolescents), but there are very educative programmes on the radio* (Male Adult 5, In-depth interview, Begoro)

> *The television does not teach the youth any good thing… some of the movies are not good and I will not buy such movies for my daughter, there are nude pictures, which are not good for the children, examples are the Nigerian films* (Female adult 1, In-depth interview, Begoro)

> *The television programmes are not good. It teaches them (adolescent girls) negative lifestyles. It is better for them to acquire knowledge from their books. Some get their information from books and some get it from the radio. The radio stations have very educative programmes* (Female adult 2, In-depth interview, Begoro)

Others also held the view that the TV was not a good source for the acquisition of knowledge and information about sexual and reproductive health behaviour for adolescent girls. Some respondents shared their sentiments on TV programmes:

> *It (TV) is not good because it has many sexual scenes, which is not good for the children, my grandson was very good at school but now because of the television his grades have fallen* (Female adult 3, In-depth interview, Begoro)

> *… The radio and television can also help although some of the television programmes have sex scenes, which are not good for the children* (Female adult 5, In-depth interview, Begoro)

They based their arguments on the contents of the TV programmes. The adult community members and some of the adolescents expressed concerns about the sex scenes as well as the nude pictures that were shown on the television programmes. Nonetheless, some adolescent boys held the view that despite complains about TV programmes having bad influence on adolescent girls, its effect varied and was not the same for all. A boy shared his views about TV programmes:

> *Some complain that TV is a bad influence on us (adolescents). However, it does not apply to everyone, some parents send their children away when they are showing adult programmes* (Boy 4, In-depth interview, Begoro)

Some adolescent boys observed that radio and TV programmes were good sources of acquiring knowledge that influenced the sexual and reproductive health experiences of girls. According to a boy:

> *From the television programmes, for example, someone may have a programme that they watch at specific times that educate them on such things, some also listen to the radio and some also go to the hospital, it depends on the individual. ... If a person watches a programme on television, which teaches on how to avoid pregnancy it can help* (Boy 2, In-depth interview, Begoro)

However, it was observed that some girls did not have time to listen or watch such programmes. According to a boy:

> *They (adolescent girls) do not really have time to watch TV or listen to the radio, all they like to hear is that there is a program in town and they wear their miniskirts and go there to party and come back home. The radio and TV can help but the girls in this town do not have time for these programmes* (Boy 3, In-depth interview, Begoro)

An adult community member corroborated:

> *They (adolescent girls) do not have time for the television, they come back home very late. ...* (Male adult 2, In-depth interview, Begoro)

The lack of time to watch or listen to educative programmes on TV and radio was attributed to adolescent girls‟ habit of staying out late. An NP girl in the quote below confirmed the assertions:

> *I listen to the radio occasionally. I seldom watch television we use to have one, but it is not working now aside that I do not have time to watch television and listen to the radio* (Mansa, NPL, In-depth interview, Begoro)

The general concerns raised on adolescent girls other sources of information such as radio and television programmes indicated that the electronic media could influence adolescent girls‟ sexual behaviour positively if parents controlled or regulated the types of programmes their children watched on TV. Thus, TV could be a good source of information, but the information may benefit those who take the initiative to watch programmes such as „things we do for love‟

that provide education on sexual and reproductive health. Therefore, television programmes as a source of information and knowledge about adolescent sexuality and pregnancy contribute positively to adolescent sexual and reproductive behaviour.

Despite the assertion that television programmes were rather influencing adolescents to engage in risky sexual behaviours because of what they watched on the television, some thought otherwise. Some community members hold the view that some television and radio programmes had positive influence on adolescents because they taught and advised adolescents on healthy sexual behaviours. They rather put the blame on adolescents asserting that adolescents do not make time to watch and listen to such programmes. A community member expressed:

> *They (adolescent girls) do not have time for the television, they come back home very late, the person has to be from a very good family to take advantage of such programs on television, but it is not the same in poor homes* (Man 2, In-depth interview, Begoro)

The community members saw the electronic media as influencing adolescents to engage in risky sexual behaviours on one hand and on the other hand, held the view it educates and advice adolescents on healthy sexual and reproductive behaviours. Despite these concerns, the electronic media remained a major source of information for adolescent girls about their sexual and reproductive health life (Awusabo-Asare et al., 2004; Bankole et al., 2007). Therefore, from the views of the community members the electronic medium was seen as a bane and blessing to adolescent sexual and reproductive behaviour.

6.5.5 Views on Acceptable Age for Childbearing

Although community members shared similar views on the acceptable age for a girl to start childbearing in Begoro, and mentioned between 20 and 25 years as the right ages, they observed

that there was no culturally defined age for childbearing in the community. According to one adult respondent:

> *... the right age for a girl to give birth is twenty years because at that age she will be matured enough to take care of a child, at eighteen or fifteen years a person cannot do that, that"s why we advise that twenty is the best age to give birth* (Woman 4, In-depth interview, Begoro)

One woman noted:

> *... about twenty years, because by the age of fifteen they would have menstruated so if they wait for five more years that will be okay at that age they will be matured and they will be working so they can take care of their babies, they can buy their clothes and other things they need* (Woman 3, In-depth interview, Begoro)

Another woman said:

> *The appropriate age that girls can give birth is around twenty years, by that age they would have finished with their secondary school education* (Woman 6, In-depth interview, Begoro)

Another woman in support of this view explained further:

> *I think the age of eighteen or twenty years is appropriate for a lady to give birth since at that age she would have matured and also at that age you can"t do much to stop them from doing what they want* (Woman 2, In-depth interview, Begoro)

The in-depth interviews with the adult respondents indicated that there was a consensus on the preferred age at which girls should have children. Their reasons for accepting ages eighteen years and above had nothing to do with their marital status. The reasons they gave had to do with the maturity of a girl, her financial standing, completion of higher education (at least senior high). In addition to these, the study also found that, at age eighteen years and above, parents did not have much control over the activities of their children for that matter their sexual and reproductive activities. Responses from the respondents on the appropriate age for a girl to start child bearing was in line with the constitutional age (18 years) for marriage as stated in the 1992 Constitution of Ghana. The responses support Adomako Amopofo"s (2001) findings that

childbearing is associated with maturity, completion of some level of education and good socioeconomic wellbeing. Hence, childbirth was viewed as an additional responsibility where a person should be working in order to take care and meet the financial demand that comes with having a child.

6.5.6 Attitudes towards Girls‟ Childbearing

When a girl becomes pregnant or has a child out of wedlock, the parents of the pregnant girl had the responsibility of taking care of her. A woman explains:

> *When a teenage girl gets pregnant out of wedlock, during and after her pregnancy it is the responsibility of her parents to take care of all her needs* (Woman 4, In-depth interview, Begoro)

However, other respondents also believe that supporting adolescent mothers during and after pregnancy can have both positive and negative consequences for the girls. The positive consequences was summarised by a man when he said:

> *Experience is the best teacher so once they have been through something like that they will change their lifestyle* (Man 2, In-depth interview, Begoro)

The negative consequences of supporting adolescents through and after pregnancy was explained by yet another man as,

> *When the girls get pregnant, if you do not handle them (girls) with care they (girls) might go and abort the baby* (Man 4, In-depth interview, Begoro)

Findings suggest that when the community condemns a pregnant girl, the tendency for her to terminate the pregnancy is high (Obeng, 2003). This tendency to abort a pregnancy has to do with the reaction of the girls‟ family, peers and the community as a whole. This supports Obeng‟s (2003) assertion that adolescent girls turn to abortion in order to avoid the shame that out of wedlock pregnancy can bring to them and thus presenting a risk to the health of a girl. As

such, it is important to help pregnant girls go through the challenges of teenage pregnancy by relating well with them. In addition, most parents provide social support for their teenage pregnant daughters in order for them to continue to maintain a good reputation in the community. A man explains:

> *We relate well with teenagers who give birth out of wedlock, because most of them after making such mistakes, humble themselves and most of the parents are ready to help because they do not want to earn a bad reputation* (Man 4, In-depth interview, Begoro)

> *Parents support, they (parents) adopt the babies for their daughters in order for them (daughters) to continue with their education or they let them learn a trade so that the girl will also make some money to take care of the child* (Boy 3, In-depth interview, Begoro)

Religious bodies also provided social support for adolescent mothers by training them in vocational skills to make them independent. A man illustrates this in the quote,

> *The Salvation Army helps teenage mothers by giving them training on some vocational skills* (Man 3, In-depth interviews, Begoro)

Some religious groups also provided social support for adolescents in the community through organizing programmes that aimed at educating and advising adolescents on their sexual and reproductive behaviour.

Parents sometimes provided financial support to their pregnant teenage daughters. Getting financial support from one‟s parents depends on the socio-economic background of one‟s family. A woman explains:

> *Some parents take care of their children, some also will pay for your bills after delivery and you will have to take care of your baby by yourself. In other cases some of the parents do not even have food to eat (they are not able to make ends meet) so they disown you so that next time you will not repeat it* (Woman 4, In-depth interviews)

> *My sister is an example; she is very intelligent so when her baby turned one, my mother used all her money to sponsor her to go back to school, because she believes that she will be a prominent person in future, so she takes care of the baby whiles she is in school* (Boy 3, In-depth interviews)

According to a woman:

> *When a child gets pregnant out of wedlock their parents, must help them, the men who impregnate them at times deny the babies so if you don"t want to prolong matters you take care of your child and the baby* (Woman 6, In-depth interviews)

In situations where a girl has no one to support her financially, she takes care of herself. According to a man,

> *If a teenager gets pregnant out of wedlock, she takes care of herself. I can help you identify some of the teenagers who are selling things just to take care of their children; they take care of their own babies* (Man 2, In-depth interview, Begoro)

Where the man accepts the responsibility of a pregnancy, he supports the adolescent girl financially. Where the man denies responsibility of a pregnancy, the parents of the girl are the ones who take care of their daughter. Although there are laws that required that parents have the responsibility to support their children, these laws are not always enforced, in reality, they are not practiced.

6.5.7 Expected Sexual Behaviour of Adolescent

A good social reputation for adolescent girls in Begoro has to do with their attitudes towards their parents and adult community members as well as their pregnancy status. A girl with a good reputation is a girl who is respectful and has not gotten pregnant yet. Some women expressed these views:

> *To have a good reputation in this town they (adolescent girls) should be obedient to their parents and lead good lives. Some try their best but others also do not really care* (Woman 5, In-depth interviews, Begoro)

> *A good reputation in this town for adolescent girls is their ability to avoid pregnancy. Some are good but some of them also take undue advantage of the family planning drugs and just keep sleeping with men and destroy their lives but some also stay away from those things* (Woman 6, In-depth interviews, Begoro)

A woman observed that, maintaining a good reputation among non-pregnant girls influences their behaviour. She expressed:

> *Having respect from people encourages some of them (non-pregnant girls) to even go for family planning, so even though they are having sex they won"tget pregnant and people keep praising them without knowing what they do in secret* (Woman 6, In-depth interviews, Begoro)

Thus, having and maintaining a good reputation among non-pregnant adolescent girls helps them to avoid teenage pregnancy by staying away from sex. This suggests that having a good social reputation in the community depended mainly on two things, respect for parents and the elderly in the society and not becoming pregnant out of wedlock. They explained that some girls in their effort to maintain a good reputation in the community turn to family planning to avoid pregnancy although they believe this makes them abuse it. Whereas, some girls genuinely stayed away from pre-marital sex, others accessed family planning to avoid pregnancy in order to maintain a good reputation in the community. This highlights the notion of respectable femininity, where women try to conform to the norms of their social environment in order to be accepted (Skeggs, 2005).

6.6 Conclusion

In conclusion, findings indicate that the Begoro community presents a social context for adolescent"s sexual and reproductive experiences. The social context suggests that adolescents are at risk in terms of premarital sex, pregnancy and early motherhood. Adolescent girls live in society, which is undergoing change. The traditional practice where puberty rites were performed for girls when they experienced menarche is changing. Whereas, some parents do not allow the puberty rites to be performed for their daughters because of religious reasons, girls on the other hand do not also inform their parents when they experience menarche. Aside the emergence of new agents of socialization in adolescent girls sexual behaviour has eroded girls absolute

reliance on the older women for information on their sexual and reproductive behaviour. As such, while it was perceived that some of the new agents of socialization such as teachers and religious leaders helped girls to avoid sex and teenage pregnancy, the media especially television was seen as predisposing girls to sex and teenage pregnancy.

The social context also presented adolescent girls with resources that helped them to develop resilience despite the risk they face. For instance, although pre-marital sex is not acceptable in the community the responses from the adult respondents indicate that community members do not abandoned girls who become pregnant out of wedlock. Rather two categories of relationship with pregnant or teenage mothers emerged. There are girls who may face rejection because of the values of their family (traditional values) on premarital sex and those whose families or the man responsible for the pregnancy/child accept and support them. This insight into the social context in which adolescent girls‟ experience their sexual and reproductive life leads us to the next chapter that looks at how non-pregnant girls use the resources available to them in their community to avoid and overcome the risk associated with their sexual experience.

CHAPTER SEVEN

DEVELOPING RESILIENCE AGAINST SEX AND TEENAGE PREGNANCY

7.1 Introduction

This chapter answers the second objective of the study by analysing how non-pregnant adolescent girls utilize the resources within their social environment to avoid and overcome the risk of premarital sex and teenage pregnancy. In this chapter, the focus is on adolescent girls who are not pregnant or have not had any live birth at the time of interview. The study classifies such girls as non-pregnant girls (NP). For analytical purposes, they are girls who may have had abortions or miscarriages or sometimes shied away from disclosing it because it was a taboo to mention their misdemeanour given their social context. A resilience scale with eight sets of questions based on the personal experiences of the girls related to the risk of premarital sex and pregnancy was used to find out how they responded to these risks. Based on their response and for analytical purposes those who had the average score and above were classified as high resilience girls and those who scored below average were classified as low resilience (see Appendix 6 for resilience scores).

To assess how NP adolescent girls avoid and overcome the risk of sex and teenage pregnancy, the chapter discusses the protective factors derived from social, economic, cultural and symbolic capitals. These capitals are viewed as resources that adolescent girls access and transform to overcome or avoid the risk they may face in their sexual behaviour and experiences. Obrist et al. (2010) suggest that when social actors have access to different forms of capitals, it could help them adapt by either searching for or creating options to deal with risk. In line with this, four

forms of capitals (social, economic, cultural and symbolic) as identified by Bourdieu (1986) are adapted to determine how non-pregnant adolescent girls develop resilience to the risk associated with premarital sex.

The findings in this chapter are based on both the quantitative and qualitative data gathered from the study with a focus on non-pregnant adolescent girls. The non-pregnant girls were interviewed with a set of close ended structured interview guide to collect information about their various sources of capital. This information was further explored and explained by conducting in-depth interviews with selected non-pregnant girls. Community members‟ views were also collected and analysed to provide the community‟s perspective on the resilience of adolescent girls within the community. The chapter is organised into four sections with each section focusing on one of the capitals. In each section, the results of how non-pregnant girls got access to capital and how it helped them to avoid and overcome the risk of sex and pregnancy are descibed, analysed and discussed.

7.2 Social Capital as a Protective Factor against Sex and Teenage Pregnancy

Social capital as reiterated from chapter three refers to how relationships served as social control mechanisms, family support and benefits through social network with other community members, groups or organizations (Portes, 2000). In this section social capital, is adapted to describe the benefits that non-pregnant adolescent girls get from their relationship with their family members and the community in the form of advice and social control. The survey data revealed that 85% of the NP girls believed they had the ability to establish and maintain relationships with people to whom they could ask for advice related to sexuality and teenage

pregnancy (Table 7.4, Appendix 7). Girls received these support from relevant sources such as parents, teachers or religious leaders to avoid or overcome the risk of sex and teenage pregnancy. The discussion in this section looks at the sources and the type of advice and social control as well as how it helped girls build resilience to sex and teenage pregnancy.

7.2.1 Source of Social Capital among Non-Pregnant Girls

Girls access social capital from various sources. The frequency distributions of the sources of social capital for non-pregnant adolescent girls identified in the study are listed in Table 7.1. From Table 7.1, parents (56.6%) stood out as the main source of social capital for non-pregnant girls, with other relatives (24.1%) being the second highest. The least identified source of social capital for adolescent girls were nurses/doctors (2%). The small proportion of adolescent girls who identified nurses/doctors as a source of social capital was expected because this group of respondents were not pregnant and therefore had little or no interaction with nurses and doctors.

Table 7.1: Source of Social Capital for Non-Pregnant Adolescent Girls

Source of Social Capital	Frequency n=419*(%)	High Resilience Frequency n=209* (%)	Low Resilience Frequency n=210* (%)	χ2 (P value)
Parents	237(56.6)	156 (74.6)	81 (38.6)	39.02 (<0.001)**
Other Relatives	101(24.1)	60 (28.7)	41 (19.5)	3.05 (<0.080)
Teachers	72 (17.2)	45 (21.5)	27 (12.9)	3.13 (0.076)
Peers	63 (15.0)	24 (11.5)	39 (18.6)	1.17 (0.278)
Religious Leader	48 (11.5)	37 (17.7)	11 (5.2)	11.87 (<0.001)**
Boyfriends/Partner	41 (9.8)	21 (10.0)	20 (9.5)	0.21 (0.648)
Nurses/Doctors	11 (2.0)	9 (4.2)	2 (1.0)	1.98 (0.158)

Source: Author"s Fieldwork, 2012
*multiple choices allowed
**P<0.05
χ2 = Chi Square: df = 1

The result shows that 74.6% of the high resilience non-pregnant (NPH) girls and 38.6% of the low resilience non-pregnant (NPL) girls identified their parents as their source of social capital (Table 7.1). Parents provided advice, social control mechanism and served as people girls could trust and rely on for social support. The following narratives confirm this:

> *All my siblings are girls so my mother occasionally sits us down and advise us to abstain from sex and be careful with boys or else we will end up with teenage pregnancy* (Yaayaa, NPH, In-depth interview, Begoro)

> *My parents advise me to concentrate on my studies and they provide me with whatever I need. My father has threatened to disown me if I become pregnant because I am not matured enough to have a baby* (Frema, NPH, In-depth interview, Begoro)

Comparatively only 38.6% of non-pregnant girls with low resilience identified their parents as a source of advice on sexual and reproductive health issues. The NPL girls also shared:

> *My mother provides me with whatever I need when I help her in whatever she does, so I help her on the farm and she in turn provides me whatever I need* (Naana, Non-Pregnant Low Resilience [NPL] , In-depth interview, Begoro)

> *If you have someone like your parents to advice you on teenage pregnancy, it can help you to stay away from men* (Kuukua, NPL, In-depth interview, Begoro)

The findings suggest that more NPH girls had high resilience scores because they received advice and social support on sexual and reproductive health from their parents as compared to the NPL girls. High resilience non-pregnant girls had parents who supported them through advice as well as monitoring their activities that prevented them from engaging in sex. From the representative narratives presented above, parents often taught about abstinence from sex and being careful around boys. Studies show that such one sided and shallow sex education could leave girls with superficial knowledge about their sexuality and may leave girls partially informed about how to avoid risky sexual behaviours (Hindin and Fatusi, 2009). Advising adolescents on only abstinence leaves them with little options in their sexual experience, which increases their risk to premarital sex. However, this study found that girls still had high resilience

scores despite receiving advice from their parents because parents went further to monitor behaviour and provide girls with their basic needs.

From the narratives, it was observed that almost all the non-pregnant girls who had received advice from their parents identified their mothers as advice givers, which confirms studies that observed that adolescents preferred to talk about sex issues with parents of the same sex (Awusabo-Asare, 2004; Adomako Ampofo, 2001). Society expects parents to perform their roles as primary agents of socialization by inculcating in their children the norms and values of the society. As such, parents by performing their „expected" duties provided their children access to social capital, which is depended on the relationship between adolescent girls and their parents.

Statistically, there is a significant relationship ($p=<0.001$) between parents as a source of advice and adolescent girls" resilience against sex and teenage pregnancy (Table 7.1). This suggests that girls who receive advice on sex from their parents are more likely to avoid sex and teenage pregnancy. Therefore, this calls for the empowerment of parents on how to educate their children since they play an important role in the sexual behaviour of their children.

The non-pregnant girls identified other relatives such as older siblings as source of social capital. The survey data revealed that 28.7% of the non-pregnant girls" had high resilience scores compared to 19.5% low resilience girls who had their other relatives as their source of social capital (Table 7.1). The study found that older siblings sometimes gave their younger sisters

advice on sexual behaviour and teenage pregnancy. Adwoa, a high resilient girl identified her elder sister as one of the sources from where she received advice. Adwoa explained:

> *I have an older sister who is a hairdresser, she always advises me to stay away from men when I visit her or when she comes to visit us. I ask her questions related to teenage pregnancy and she answers them* (Adwoa, *Non-Pregnant High Resilience [NPH]*, In-depth interview, Begoro)

Kuukua, a low resilient girl also expressed:

> *Anytime my sisters see me talking to the opposite sex, they call and advise me to be careful with them (boys) or else I will end up pregnant in my teenage years. As for one of my sisters, she keeps advising me that if I have sex with a man, I will contract HIV/AIDS…* (Kuukua, NPH, In-depth interview, Begoro)

Other relatives, specifically older siblings supported younger ones through advice to help them avoid sex and teenage pregnancy. In addition, from the representative narratives, most of the girls who identified their sisters as a source of advice indicated that they sometimes took the initiative to ask questions. This confirms Tweedie and Witte's (2000) report that indeed girls are more comfortable talking to people other than their parents about sex since the findings indicate that girls sometimes took the initiative to ask their older siblings questions about sex and teenage pregnancy.

Statistically, there is no significant relationship ($p = <0.080$) between other relatives as a source of social capital and the resilience of a girl against sex and teenage pregnancy (Table 7.1). Thus, though girls received advice and had access to social support from other relatives, it did not play a significant role in how they avoid sex and teenage pregnancy.

Sexual and reproductive health education is part of the school syllabi and therefore it was expected that, because a large number of the respondents were in school, they would identify

their teachers as a source of social capital on sexual and reproductive health issues. This was not the case from the study. Findings from this study indicate that only 17.2% of the non-pregnant girls mentioned their teachers as providing them with social support through advice and encouragement on sexual and reproductive health matters (Table 7.1). The teachers provided advice on how girls should relate with the opposite sex both in and out of school to avoid pregnancy. Teachers in addition, also advised adolescent girls on how to avoid pregnancy and sexually transmitted infections. Thus, 21.5% of the non-pregnant girls who identified their teachers as a source of social capital had high resilience scores, whereas 12.9% had low resilience scores. Adwoa and Yaa who had high resilience scores illustrated how their teachers supported them in the following narratives:

> *They (teachers) teach us those things (sexual and reproductive health) at school. The teachers teach us how to use condoms to protect ourselves and how to access family planning. They also teach us that we can buy medicine at the pharmacy shop to prevent pregnancy* (Adwoa, NPH, In-depth interview, Begoro)

> *They (teachers) teach us that if we have sex we can get pregnant or a sexually transmitted infection. They also make time to teach us how to avoid teenage pregnancy and they advise us to concentrate on our studies* (Yaayaa, NPH, In-depth interview, Begoro)

The low resilience girls who also narrated corroborated this:

> *I am in JHS 1. Sexual and reproductive health is part of our science syllabus… We were taught in our science class that if you want to avoid teenage pregnancy you could use a condom or take a pill* (Mansa, NPL, In-depth interview, Begoro)

Although in their study in Africa, Bankole et al. (2007) identified teachers as standing out as a major source of information for adolescents on sexual and reproductive health issues this was not the case in this study. Henry and Fayorsey's (2002) observation that girls did not recall learning about sex and related topics from their school (teachers) might explain the small proportion of adolescent girls. Alternatively, it could be attributed to the quality of instruction as observed by

Agyei et al. (2000), where teachers made such lessons abstract resulting in girls not being able to reconcile it with real life experiences.

This notwithstanding, teachers still contributed to non-pregnant girls‟ resilience level, since 21.5% had high resilience scores compared to 12.9% who had low resilience scores. Statistically, teachers‟ as a source of social capital was not significantly (p= 0.076) related to adolescent girls resilience against sex and teenage pregnancy (Table 7.1). This suggests that despite the inclusion of sexual and reproductive health matters in the school syllabi, it still did not play a significant role in adolescent girls‟ resilience against sex and teenage pregnancy. Hence, should be trained to handle such topics well in order to influence adolescents‟ sexual behaviour.

The study showed that 11.5% of the non-pregnant girls identified their religious groups as a source of social capital (Table 7.1). The adolescent girls who had access to social capital from their religious groups revealed that they were taught about how to live a life of chaste, which helped them to avoid engaging in premarital sex. The study found that out of the 11.5% of the non-pregnant girls, 17.7% had high resilience scores and 5.2% had low resilience scores (Table 7.1). This shows that religious groups through the leaders‟ advised and taught on chastity before marriage to non-pregnant girls, which helped them to avoid and overcome the risk of sex and teenage pregnancy. Yaayaa who is a member of the Ladies‟ Wing of her church sheds light on how the teachings and advice from her religious group helps her to avoid pre-marital sex and for that matter teenage pregnancy. She explained:

> *We have ladies" youth wing headed by the pastor"s wife and she teaches us on these things (premarital sex and teenage pregnancy)… I am a member of the Ladies" wing of*

> *my church and our leader admonishes us against premarital sex, because of this, I always strive to maintain a good reputation ... and we have specific days that we meet for these teachings* (Yaayaa, NPH, In-depth interview, Begoro)

Akosua, a low resilience girl on the contrary observed that although she was a member of the youth wing of her church, she does not receive advice or teachings on sex and teenage pregnancy from the leaders of her church. She expressed:

> *I am in Junior Youth at my church but they do not teach us these things. Our leaders are silent on issues about sex and pregnancy* (Akosua, NPL, In-depth interview, Begoro)

However, Frema sums up the views of the other girls on why only 11.5% identified religious leaders as a source of advice in this narrative:

> *The leaders sometimes try to advise us at the mosques, but they do not do it frequently otherwise, the pregnant teenagers will complain that the elders just want to condemn them* (Frema, NPH, In-depth interview, Begoro)

Although girls may be affiliated to a religious group, it is not all religious leaders who give advice on sex and teenage pregnancy. The explanation from the adolescent girls explains why despite 72.0% of the non-pregnant girls asserting that religious beliefs helped them to avoid pregnancy only, 11.5% identified their religious group as a source of social capital (Appendix 7; Table 7.1). This notwithstanding, religious groups teachings and advice on abstinence to sex before marriage to the non-pregnant girls helped them to avoid sex and teenage pregnancy as stated by Yaayaa who had high resilience scores.

Religious leaders‟ advice statistically, is significantly ($p = <0.001$) related to non-pregnant girls‟ resilience against sex and teenage pregnancy (Table 7.1). This suggests that girls who receive support in the form of teachings and advice on sex from their religious groups are more likely to avoid and overcome the risk of sex and teenage pregnancy.

Furthermore, 15% of the non-pregnant girls identified their peers as their source of social capital (Table 7.1). However, peers did not influence the resilience scores of the non-pregnant girls. The study found that 11.5% of the high resilience girls identified their peers as a source of advice, whereas 18.6% who had low resilience scores identified their peers as their source of advice. This showed that more girls who received advice from their peers turned out to have low resilience to sex and teenage pregnancy. The high resilience non-pregnant girls who identified their peers as a source of social capital observed that their peers advised them on how and where to get information that could help them to learn more about how to avoid teenage pregnancy. The impact of peers on the resilience score of girls had to do with the quality of information or support that peers made available to their colleagues. Obaa Yaa explained:

> *A friend of mine advised me to go and buy „Life Guide" … It is a book that teaches on how to avoid teenage pregnancy. She (friend) also advised me to go and get a Tablet (emergency pill) and it really helped me to protect myself from pregnancy* (Obaa Yaa, NPH, In-depth interview, Begoro)

In addition, peers who were already pregnant or mothers also provided support in the form of advice to their non-pregnant friends. Asor who benefitted from advice from her peers who were mothers observed:

> *… Some of my friends who have babies sometimes shared their experiences with me and advise me to be weary of men. My parents and sisters used to advise me to avoid entering into sexual relationship with the opposite sex. It has been a while now, but I usually ask my friends … we discuss it when we meet* (Asor, NPH, In-depth interview, Begoro)

Majority of the non-pregnant girls shared their sentiments on why they rarely discussed issues of sex with their peers. Mansa stated:

> *I have many friends both at school and at home. Well we never talk about sex; I think we do not have to discuss such things when we meet… As for me though I have knowledge on sex and pregnancy I keep it to myself or else my friends will think I am having sex with boy* (Mansa, NPL, In-depth interview, Begoro)

This confirms Glover et al. (2003) observation that the youth do not share ideas on sexual and reproductive experience. More so, other studies indicate that peers who were already pregnant or mothers might influence adolescent girls negatively (Domhnaill et al., 2011; Arai, 2005). Despite this, the findings revealed that non-pregnant girls sometimes received advice from teenage mothers on how to avoid pregnancy and as such wield a positive influence on their sexual life. Nonetheless, there was no significant relationship (p= 0.278) between peers as a source of social capital and resilience of non-pregnant (Table 7.1). This indicated that peers were not a major source of support in the development of adolescent resilience against sex and teenage pregnancy. However, when peers are equipped with the right information they would have a positive impact on sexual behaviour of their colleagues.

The study further revealed that 9.8% of the non-pregnant girls identified their boyfriend/partner as a source of their social capital (Table 7.1). Statistically, there is no significant relationship between boyfriend/partner as a source of social capital and resilience level (Table 7.1). However, those who identified boyfriend/partner as a source stated that they sometimes supported them by using condoms when they had sex. According to Asor a high resilience girl, her boyfriend provided her with social support in that he encourages her to buy condoms and even gives her money to buy them. Asor explained:

> *He (boyfriend) has no problem with us using condoms during sex; sometimes he even gives me money to buy them (condom)* (Asor, NPH, In-depth interview, Begoro)

Asor in this case relies on advice and information she received from sources, especially those who have experienced childbirth and uses condoms to prevent pregnancy. With Asor‟s case, her boyfriend accepted the use of condoms, which made things easier for her to be able to protect

herself from teenage pregnancy with a latent function of also protecting herself from sexually transmitted infections.

As part of the sources of social capital, 5% of the non-pregnant girls identified other sources, which were temporal such as the elderly and community members (Table 7.1). According to these non-pregnant girls, they sometimes got advice from the elderly women who cautioned them about their risky sexual behaviours. Kuukua explained:

> *Those that we live with advise us to use a condom and if not then the boy must be ready to take care of a baby* (Kuukua, NPL, In-depth interview, Begoro)

This was corroborated in a community member"s view, where she recounts how she provided support to adolescent girls in her community. She expressed:

> *... I also advice some of them that if they want to have sex they should go for family planning* (Female Adult 6, In-depth interview, Begoro)

Although health professionals had information and should have been the major source of social capital for non-pregnant girls, they appeared to be the least source from where girls received support on their sexual and reproductive life. In all, only 2% of the non-pregnant girls identified nurses/doctors as a source of support (Table 7.1). According to Yaayaa, she relied on her friendship with some nurses to seek information on how to protect herself from becoming pregnant. She explained:

> *I ask my parents and some of the nurses who are my friends about some of the medications that can help me avoid pregnancy and they teach me the side effects of such medications* (Yaayaa, NPH, In-depth interview, Begoro)

Thus, those who got support from health professionals were those who had a relationship with them through either family ties or friendship. This suggests that non-pregnant girls only sought the services of health professionals at the health centres when they have health needs. This also

stems from the social norms that do not expect children to ask questions about sex let alone procure sex related materials like condoms (Adomako Ampofo, 2001).

7.2.2 Role of Social Capital in NP Girls‟ Resilience against Sex and Teenage Pregnancy

The high resilient adolescent girls relied on their access to social capital in the form of advice, encouragement and social control from their relationship with parents, older siblings, teachers and religious groups to avoid and overcome the risk associated with premarital sex in two ways, by abstinence or with the use of contraceptive pills or condoms. Those who abstained from sex in order to avoid risk were able to do this because of the advice and teachings they had from their parents, teachers and their religious leaders (Table 7.1). Parents, older siblings, teachers and religious leaders advised and encouraged girls to abstain from sex, concentrate on their education and stay away from boys.

Whereas parents and religious leaders only advised on abstinence, teachers and older siblings on the other hand did not limit their advice on sexual behaviour to abstinence only, they also went further to advice and encourage adolescent girls to use protection when they have sex to avoid sexually transmitted infections and pregnancy. Parents tend to advise their daughters to stay away from sexual relations to avoid pregnancy, which does not usually include advice on the use of contraceptives to protect themselves in case they engage in sexual activities. This was because parents tend to shy away from discussing in detail issues about sex with their children and the fact that teaching adolescents how to use condoms may suggest encouraging them to engage in sexual relationship, which is against the values and norms of the society (Morhe et al, 2012; Glover et al., 2003). Parents are not able to communicate sexual information to their

daughters properly (Hindin and Fatusi, 2009), as such whereas parents mainly continue to teach abstinence, this finding suggest that parents must be empowered and their perceptions transformed to advice their daughters on how to protect themselves or practice safe sex.

High resilient girls benefitted from having access to advice on both abstinence and the use of protection in order to avoid sex and teenage pregnancy. Most high resilient non-pregnant girls‟ recounted their experiences and shared similar views reflected in Asor‟s narrative:

> *They (teachers) make time to teach you how to avoid teenage pregnancy… they (teachers) teach me how to protect myself when I have sex. I know that you can use pills to protect yourself, condoms and even go for injections. It is really helping me, because without that I would have had a baby. I got this knowledge from some of my friends who have babies as well as some of my teachers* (Asor, NPH, In-depth interview, Begoro)

The sexually active adolescent girls were able to avoid and overcome the risk associated with premarital sex from the advice and teachings they received mainly from their teachers and older siblings. Since teachers did not only focus on abstinence, girls were able to use the advice they received from their teachers to protect themselves when they had sex. Asor‟s narrative shows that non-pregnant girls did not rely on only one source for social capital. They accessed social capital from different sources, which helped them to develop resilience against sex and pregnancy. For instance, in the case of Obaa Yaa, her friends and teachers provided her with the necessary information and as such based on these information and advice, she used the emergency contraceptive pills to avoid pregnancy after having sex.

> *I was taught in school and I heard some from my friends… A friend of mine advised me to go and get a Tablet (emergency contraceptive pill) and it really helped me… it has helped me avoid teenage pregnancy* (Obaa Yaa, NPH, In-depth interview, Begoro)

Influence from friends as identified by Obaa Yaa helped girls to protect themselves from sexually transmitted diseases as well as teenage pregnancy. Friends do help adolescent girls to

avoid risky sexual behaviour when they have the right information. Thus, peers with a positive attitude towards sex could have a positive influence on the sexual behaviour of each other and vice versa. This suggests that while peer pressure from other non-pregnant girls potentially influences girls to avoid risky sexual behaviour, it also leads some to engage in risky sexual behaviours.

This suggests that for adolescent girls to be able to minimize the effect of sexual behaviours parents should be encouraged to teach their daughters about abstinence and protection or the other actors involved in adolescent sexual and reproductive education should increase their education on protective sex. This would require proactive parents to initiate such discussions with their daughter‟s about their sexuality. It also suggests that since teachers, nurses/doctors, siblings and peers are the ones who taught both abstinence and protection, they should be more empowered to disseminate such knowledge in ways that would benefit the adolescent girls for them to make their decision on which way to go in their sexual experience. Having multiple sources from which to draw social capital was useful to building high resilience among girls because just teaching abstinence is not enough to help girls avoid premarital sex and teenage pregnancy.

7.3 Economic Capital as a Protective Factor against Sex and Teenage Pregnancy

As mentioned in Chapter 3, economic capital encompasses access to financial support and command over economic resources, mainly cash and assets (Bourdieu, 1986). Economic capital as a protective factor involves how adolescent girls avoid and overcome the risk of sex and pregnancy through access to financial support such as the provision of basic needs, access to

money needed to buy contraceptives and access family planning health care. In this section economic capital, refers to the financial support non-pregnant girls receive from relevant sources such as parents, other relatives and boyfriend/partner to avoid or overcome the risk of sex and teenage pregnancy. The discussion in this section looks at the sources and the types of financial support as well as how it helped girls build resilience against sex and teenage pregnancy.

7.3.1 Source of Economic Capital among Non-Pregnant Girls

The sources of economic capital identified by non-pregnant girls are listed in Table 7.2. From the Table majority (59.9%) of the respondents identified parents as their source of economic capital with less than 18.1% identifying other relatives. This suggests that parents were the major source of financial support for non-pregnant adolescent girls (Table 7.2).

Table 7.2: Source of Economic Capital for Non-Pregnant Adolescent Girls

Source of Economic Capital	Frequency n=419* (%)	High Resilience Frequency n=209* (%)	Low Resilience Frequency n=210* (%)	χ2 (P value)
Parents	251(59.9)	169 (80.9)	82 (39.0)	58.77 (0.001)**
Other Relatives	76 (18.1)	40 (19.1)	36 (17.1)	0.09 (0.975)
Boyfriends/Partner	54 (12.9)	17 (8.1)	37 (17.6)	4.88 (0.027)**
Peers	40 (9.5)	20 (9.6)	20 (9.5)	0.11 (0.741)
Religious Group	20 (4.8)	14 (6.7)	6 (2.9)	0.69 (0.405)
Teachers	18 (4.3)	10 (4.8)	8 (3.8)	0.05 (0.820)

Source: Author"s Fieldwork, 2012
*multiple choices allowed
**P<0.05
χ2 = Chi Square: df =1

From the survey data, 59.9% of the respondents identified their parents as their source of economic capital (Table 7.2). Parents provided adolescent girls with their material needs in the

form of food, clothing and shelter as well as monetary needs such as school-fees[6] and pocket money.The findings show that 80.9% of the non-pregnant girls who received financial support from their parents had high resilience scores, whereas 39% had low resilience scores. This shows that access to financial support from parents was important in adolescents" resilience against sex and pregnancy. Obaa Yaa sheds light on how her mother supported her financially:

> *Some of the girls engage in such acts because of financial difficulties but I am lucky that my mother is around and she gives me all that I need. She pays my school fees, gives me money for school and buys me clothes. She tries her best to make sure that I do not lack anything* (Obaa Yaa, NPH, In-depth interview, Begoro)

Although the data show that 39.0% low resilience girls had access to financial support from parents, the rest who did not receive financial support from their parents shared these sentiments:

> *It (financial support) somehow helps but I do not have anyone to take care of me so I end up going back to the men for money* (Kuukua, NPL, In-depth interview, Begoro)

> *If you see a friend in a nice dress and you do not have the money for it, you might be tempted to get the money from somewhere to buy it but if I get the money from my parents, I will not do that* (Naana, NPL, In-depth interview, Begoro)

Some parents supported their daughters financially by giving them money for their upkeep and paying for their school fees and other school-supplies[7]. Hence, non-pregnant girls like Yaayaa believed that having this support from her parents prevented her from going to men/boys to seek for financial support. The narratives suggest that some girls entered into relationships with men/boys because of financial difficulties. Thus, with majority of adolescent girls identifying their parents as a source of economic capital, where parents are not able to provide such financial support girls were sometimes compelled to look else where and this predisposed them to sexual

[6] School fees here applies to those who are at the Senior High School level because public schools are supposed to be tuition free at the basic level

[7] School supplies include stationary, school uniforms, school shoes

activities in exchange for financial assistance. Girls whose parents are not able to provide their needs are more exposed to the risk of seeking economic support from men confirming findings from other studies (Afenyadu and Goparaju, 2003; Henry and Fayorsey, 2002).

Statistically, there is a significant relationship (p= <0.001) between parents as a source of economic capital and girls‟ resilience against sex and teenage pregnancy (Table 7.2). This is because more girls who had access to financial support from their parents had high resilience scores (Table 7.2).

The survey data revealed that 12.9% of the non-pregnant girls identified their boyfriend/partner as a source of financial support (Table 7.2). More girls (17.6%) who had access to financial support from their boyfriends/partner had low resilience (Table 7.2). Boyfriends as a source of financial support provided girls with money for their personal and general use. Naana, a low resilience girl relied on her boyfriend for financial support because she had no other source of financial support, thus the monetary support from her boyfriend helped her to meet her basic needs. She expressed this view, which is shared by other non-pregnant girls who received financial support from a boyfriend/partner:

> *It (financial support) really helps me because I use some of the money he (boyfriend) gives me to buy food* (Naana, NPL, In-depth interview, Begoro)

On her part, Obaa Yaa‟s boyfriend frequently gave her money and out of that, she saved some to protect herself from pregnancy. Obaa Yaa stated:

> *My boyfriend gives me money and I save some of the money to buy contraceptives to protect myself* (Obaa Yaa, NPH, In-depth interview, Begoro)

The financial support received from boyfriend/partner did not appear as a major source for non-pregnant girls especially high resilient girls. This was because high resilient girls (80.9%) identified their parents as their source and therefore rarely relied on boyfriends (Table 7.2). Nonetheless, 17.6% of the low resilient girls received financial support from boyfriends because most girls who do not have access to financial support turn to men (boyfriends) and this exposes them to early sexual initiating and teenage pregnancy.

Statistically, there is a significant relationship (p= 0.027) between boyfriend/partner as a source of financial support and resilience against sex (Table 7.2). However, the relationship was such that more low resilience girls had access to money from their boyfriends/partner. This suggests that boyfriends as a source of girls financial support results in more girls with low resilience score since relying on the opposite sex for financial support may predispose girls to sex.

Additionally, the survey data revealed that other relatives (older siblings, aunties and grandparents), peers and religious leaders were not a major source of financial support for non-pregnant girls. For instance, 10% of the respondents identified their peers as a source of financial support (Table 7.2). According to Akosua a low resilient adolescent girl, she received financial assistance from her peers and some community members who were her friends. Friends and other sources such as neighbours tend to support girls financially in order to buy food. Akosua stated:

> *There are times that I do not have money to buy food. On such occasions, my friends and sometimes the elderly in my community give me money to buy food* (Akosua NPL, In-depth interview, Begoro)

Although, survey respondents identified religious groups and other sources for their financial support, during the in-depth interviews, none of the girls mentioned the religious groups as a source of financial support.

These findings suggest that the major source of financial support available to the non-pregnant girls was their parents. The economic support they received was either goods or money. Financial support adolescent girls received were not directly provided to support them to buy contraceptives and access family planning in order to avoid pregnancy. Rather in most cases adolescent girls were provided with their basic needs by parents as part of their parental duties, this obligation had a latent function of preventing girls from relying on men/boys for financial support that could increase their risk of engaging in risky sexual behaviours. Thus, girls were provided either with or given money for their general upkeep such as food, clothes and pocket money by their parents. In the changing Ghanaian family system as suggested by Ardayfio-Schandorf (2007), the burden of childcare is increasingly becoming the responsibility of parents than that of the extended family. This suggests that when adolescent girls‟ basic needs are provided by their parents, it reduces their exposure to factors that lead to risky sexual behaviours. Once their financial needs are provided they tend not to go out to look for such financial support from outside (men/boys), which exposes them to risky sexual behaviours in exchange. Aside that it prevented some girls from turning to men for financial support, some girls also through their own initiative saved some of the money they received from their parents and used it to buy condoms and contraceptive pills to prevent them from becoming pregnant when they had sex.

In other instances, the non-pregnant adolescent girls had access to economic capital through their own labour, where they worked to make money. Kuukua, a low resilience girl stated:

> *I make money by doing labour work. I work for people and use the money to support myself* (Kuukua, NPL, In-depth interview, Begoro)

The fact that some adolescent girls had to work in order to have access to money shows how some girls are likely to be predisposed to sex in exchange for financial support. Thus, girls who come from socioeconomic background characterized by financial difficulties may be more exposed to engage in sexual behaviours that could lead to teenage pregnancy (Obeng-Denteh and Amerdeker, 2011, Woodward et al, 2001).

Girls had access to economic capital through their own savings. According to Adwoa a high resilience girl, she saved money from what she was given by her parents as pocket money for school to help her avoid pregnancy. Adwoa explained:

> *I save some of the money they give me for school to do that, I use some to buy condoms and some for family planning…* (Adwoa, NPH, In-depth interview, Begoro)

The non-pregnant girls further indicated that they saved some of their money to fall back on when their parents are not able to meet their needs on certain occasions. Yaayaa and Obaa Yaa explained:

> *Sometimes my mother does not have money so I use the money I have saved to buy what I need* (Yaayaa, NPH, In-depth interview, Begoro)

> *I save some of the money my parents give me, because my parents will not always have money for me. I also save some of the money that my boyfriend gives me* (Obaa Yaa, NPH, In-depth interview, Begoro)

Others also saved money from what they received from their boyfriends in order to have access to money when they needed it to protect themselves from pregnancy. Adolescent girls saved some of the money they received from their affiliates and their own labour to which they relied

on to avoid sex and teenage pregnancy. This suggests that girls sometimes took the initiative to use their access to financial resources to avoid the risk associated with premarital sex. The act of saving money from different sources, provided protection against risk, which is a feature of the individual‟s disposition as identified by Gamerzy (1984). The adolescent girls by accessing financial resources to seek for protection against sex and teenage pregnancy also indicate that girls take initiatives in their own lives to avoid or overcome risk (Alvord and Grados, 2005; Wolin et al, 1993; Garmezy, 1984).

It is important to mention here that the non-pregnant adolescent girls did not directly receive financial support for sexual and reproductive health issues in most cases. However, girls used the financial support they received from their parents and other sources to protect themselves against sex and teenage pregnancy. Similarly, other girls also saved money from what they received from their parents, boyfriend/partner and their own labour in order to have money for protection against pregnancy and sometimes sexually transmitted infections.

Most studies that identified poverty as a determinant of teenage pregnancy explained that adolescents‟ lack of financial support is what leads them to have sex with men in exchange for financial support (Gyesaw and Ankomah, 2013; Afenyadu and Goparaju, 2003). This study also identified lack of financial support as a possible determinant of adolescent girls‟ engagement in risky sexual behaviours. Nevertheless, this study found that, non-pregnant girls who had high resilience turned around to avoid pregnancy by using some of the money they received from their boyfriends to buy condoms and access family planning programmes. Therefore, although the lack of financial support from a significant source tend to push some adolescent girls to go

out with men, they used some of the resources they received from the men to protect themselves from teenage pregnancy. This highlights that financial support alone is not enough to help girls avoid sex and teenage pregnancy, but financial support and having knowledge on how to avoid teenage pregnancy goes hand in hand in helping girls to avoid risky sexual behaviours that could lead to teenage pregnancy.

7.3.2 Role of Economic Capital in NP Girls‟ Resilience against Teenage Pregnancy

Adolescent girls‟ utilized their access to financial support from significant sources to avoid and overcome the risk of sex and pregnancy. Access to economic capital was used in two ways, namely the use of financial support to meet basic needs and access to financial support as a means of seeking protection to avoid sex and teenage pregnancy.

Meeting the Basic Needs of Non-Pregnant Girls

The non-pregnant girls expressed the view that having financial support prevented them from depending on the opposite sex. Asor observed:

> *I think financial support helps me to avoid pregnancy, because some of the girls engage in these things because of financial difficulties* (Asor, NPH, In-depth interview, Begoro)

This means that when parents provide the material needs of their non-pregnant adolescent girls it served as a deterrent for girls not to rely on the opposite sex for such financial benefits, which can predispose them to engage in risky sexual behaviours that may have dire consequences. This suggests that girls whose financial needs are not met tend to seek such economic support from the opposite sex, which exposed them to the risk of engaging in premarital sex (Domhnaill, 2011; Afenyadu and Goparaju, 2003; Nabila and Fayorsey, 1996). Such findings suggest that non-pregnant adolescent girls sometimes engaged in risky sexual activities due to financial

difficulties, which this study does not dispute. However, what this study has shown beyond such findings is that non-pregnant girls are not always passive actors in their sexual and reproductive behaviour. The study found out that the high resilience adolescent girls tend to be proactive, self-independent and took initiative (Alvord and Grados, 2005; Fergus and Zimmerman, 2005). As such, they were able to avoid or overcome premarital sex and teenage pregnancy by adjusting to their social condition as shown in the next discussion (Obrist et al. 2010).

Financial Access to Family Planning and Contraceptives

The sexually active non-pregnant girls were able to purchase contraceptives as well as access family planning to prevent them from becoming pregnant when they had sexual intercourse. The following narratives demonstrates how some high resilience non-pregnant girls through their access to economic capital from a significant other were able to avoid teenage pregnancy:

> *Having money helps me to avoid teenage pregnancy. I have money to buy contraceptives to protect myself. My boyfriend gives me money and I save some of my pocket money. ... I usually buy the emergency pill after sex* (Obaa Yaa, NPH, In-depth interview, Begoro)

> *I save some of the money they (parents) give me for school to do that (prevent teenage pregnancy). I use some to buy condoms ... I have not really done the family planning yet although I have been there to make enquiries* (Adwoa, NPH, In-depth interview, Begoro)

From these statements, having money according to the non-pregnant girls helped them to have the purchasing power to buy contraceptives (pills and condoms) or access family planning healthcare. This purchasing power helped the non-pregnant girls who were sexually active to avoid pregnancy. Whereas adolescent girls received financial support for manifest functions such as buying food and clothes, the resilient non-pregnant adolescent girls transformed them into resources such as condoms and contraceptive pills that helped them avoid pregnancy. Studies in Ghana have indicated that adolescents had knowledge about contraceptives and that there is low

use of contraceptives among adolescents in Ghana (GDHS, 2008; Awusabo-Asare et al., 2004; Agyei et al., 2000). Despite the findings from these other studies, this study‟s findings indicates that resilient non-pregnant girls had knowledge about contraceptives which they applied in their sexual relationships by using their access to economic capital to make use of the information they had on how to avoid pregnancy and as such buying and using contraceptives. In addition, the high resilience girls sometimes received this support from their boyfriends to buy and use condoms during sexual intercourse. This means that when the sexual partners of adolescent girls accept the use of condoms and encourage its usage, it helped adolescent girls avoid the risk associated with having premarital sex. Thus, as revealed from the study, all the high resilience girls who were sexually active revealed that although they engaged in sexual activities they practiced safe sex by using contraceptives to help them avoid pregnancy.

In conclusion, access to financial support played an important role in adolescent girls‟ avoidance of premarital sex and pregnancy in two ways. On one hand, access to financial support served as a deterrent for girls from seeking for support from men/boys. This implied that because the basic needs of adolescent girls were obtained from the financial support they received, it reduced the tendency of girls to rely on men/boys for such support. It indicates that lack of financial support could push girls to enter into sexual relationships with men/boys who may sometimes seek sexual favours in return for money. Then on the other hand, non-pregnant girls used some of the financial support they received from their sources to protect themselves from pregnancy by buying contraceptives and accessing family planning healthcare. That is, the financial support that non-pregnant adolescent girls received from their sources provided them with the purchasing power to access the various ways of preventing teenage pregnancy although they had sex with

men/boys. Thus, girls depended on the financial support they had to buy condoms, contraceptive pills and access other family planning healthcare.

7.4 Cultural Capital as a Protective Factor against Sex and Teenage Pregnancy

Cultural capital as mentioned earlier in Chapter three is observed in this study as the other sources of information (books, television, radio etc.) that has protective influence on adolescent girls‟ to avoid and overcome the risk of sex and teenage pregnancy. In this section cultural capital, refers to the other sources of information such as the media, books and billboards that provide girls with knowledge on how to avoid sex and teenage pregnancy. According to the survey data, 74% of the NP girls believed they know how to protect themselves against pregnancy (Table 7.4, Appendix 7). The discussion in this section looks at the sources and the type of information that helped girls to build resilience against sex and teenage pregnancy.

7.4.1 Source of Cultural Capital

Adolescent girls acquired knowledge from other sources such as the print and electronic media that enabled them to avoid sex and teenage pregnancy. The frequency distributions indicate that the electronic media (radio and television) was identified by more than 65% of the adolescent girls as their source of information (Table 7.3). With the print media, 48% of the non-pregnant girls identified books, whereas only 7% identified magazines (Table 7.3).

Table 7.3: Source of Cultural Capital for Non-Pregnant Adolescent Girls

Source of Cultural Capital	Frequency n=419* (%)	High Resilience Frequency n=209* (%)	Low Resilience Frequency n=210* (%)	χ2 (P value)
Radio	291(69.5)	168 (80.4)	123 (58.6)	12.12 (0.001)**
Television	280 (66.8)	148(70.8)	132 (62.9)	1.24 (0.264)
Books	200 (47.7)	118(56.5)	82 (39.0)	13.32 (0.001)**
Cell Phones	101(24.1)	77 (36.8)	24 (11.4)	35.63 (0.001)**
Music	64 (15.3)	51 (24.4)	13(6.2)	14.71 (0.001)**
Bill Boards/Posters	47 (11.2)	31 (14.8)	16 (7.6)	1.11 (0.290)

Source: Author"s Fieldwork, 2012
*multiple choices allowed
**P<0.05
χ2 = Chi Square: df= 1

The study identified that 69.5% and 66.8% of adolescent girls turned to radio and TV respectively as their other sources of acquiring information on sexual and reproductive health issues in order to avoid teenage pregnancy. Although, both the high and low resilience girls had access to radio, 80.4% had high resilience compared to 58.5%. On the other hand, 70.8% who had access to information from television had high resilience scores whereas 62.9% had low resilience scores (Table 7.3). The adolescent girls who accessed information from these media explained that they watched and listened to programmes that talked about the effects and consequences of sex and teenage pregnancy. They also identified some advertisements on the radio and TV as providing them with information on how to avoid sex and teenage pregnancy. The radio and TV ran advertisements on the importance of family planning especially creating awareness of the use of contraceptives. The high resilience non-pregnant girls narrated:

> *Apart from my mother, my friends and my teachers I also get information from other sources such as the television and radio. They have programmes that teach us how to protect ourselves from pregnancy and AIDS* (Asor, NPH, In-depth interview, Begoro)

> *... The television, radio and books, they really help me, especially the television advertisements. They (advertisements) tell us what we can do to avoid pregnancy ... the ones on family planning* (Obaa Yaa, NPH, In-depth interview, Begoro)

Since 58.6% and 62.9% of the low resilient girls also identified the radio and television respectively as a source of information, they also confirmed the assertions of the high resilience girls. They also shared similar sentiments:

> *I watch television or listen to the radio, and they teach on these things (sex and teenage pregnancy). ... However, the radio is the one that really helps me. They (radio) have programmes that talk about these things, for example, someone may be pregnant, the man does not want to accept it, and they discuss it* (Akosua, NPL, In-depth interview, Begoro)

> *We do not have a television at home, so when I visit someone and there is an educative programme, I make sure I watch to receive that knowledge* (Kuukua, NPL In-depth interview, Begoro)

These narratives suggest that the non-pregnant adolescent girls did not access information from one source only, but explored multiple sources for knowledge on how to avoid teenage pregnancy and sexually transmitted infections. Although some non-pregnant girls did not have access to television at home, they sometimes had access to watch programmes from neighbours or friends who had one. This was because from the responses of the non-pregnant girls it became known that most families did not own a television set and therefore girls had access to watching television from other people‟s homes. Nonetheless, the electronic media was still an important source of disseminating information as well as educating the adolescent girls on sex and teenage pregnancy. This finding therefore supports other studies that identified the radio and television as a major source of information for adolescent girls on sexual and reproductive health issues (Awusabo-Asare et al., 2004).

Statistically, there is a significant relationship (p= <0.001) between radio as a source of information in non-pregnant girls resilience against sex and teenage pregnancy. However, there is no significant relationship between television and non-pregnant girls‟ resilience against sex and teenage pregnancy (Table 7.3). This means that access to radio helped girls to avoid and overcome the risk of sex and teenage pregnancy.

In addition, 47.7% of the adolescent girls identified books/magazines as their other source of information (Table 7.3). More (56.5%) non-pregnant girls who had access to books as a source of information on sex and pregnancy had high resilience scores compared to 39.0% who had low resilience scores (Table 7.3). They explained that they learned about their sexuality and the prevention of diseases from books/magazines. The high resilient adolescent girls observed:

> *I get knowledge from my friends and from books. They (books) talk about the fact that you have to abstain from sex, use a condom or go for family planning, for me this is what I learn from this information to avoid teenage pregnancy* (Frema, NPH, In-depth interview, Begoro)

> *I read the Daily Graphic anytime I come across one … the more you read it the more you get information on such things (sex and teenage pregnancy). Sometimes the newspapers talk about how girls who become pregnant while in school suffer and drop out of school. I also read a column in the newspaper that advice adolescent boys and girls to abstain from sex and concentrate on our education* (Adwoa, NPH, In-depth interview, Begoro)

The low resilience girls also shared similar sentiments about books as a source of a source of cultural capital:

> *I read the "Life Cycle Book" where it teaches you how to prevent diseases and how to avoid pregnancy* (Korkor, NPL, In-depth interview, Begoro)

The books identified by the non-pregnant girls were the "*Life Cycle*" textbook from school and "*Life Guide*" another book on adolescent sexual and reproductive health issues. The study findings show that non-pregnant girls in terms of reading were more inclined to reading from

books as compared to other reading materials. This could be because more than 90% of the respondents were in school and therefore had access to sexual and reproductive health books since it forms part of the school‟s syllabus in Ghana. This initiative by the Ministry of Education in Ghana has made books on sexual and reproductive health readily available to non-pregnant girls who are in school. Reading from books provided adolescents with knowledge about their sexual and reproductive life including how to prevent diseases such as sexually transmitted infections and HIV/AIDS. Interestingly, the non-pregnant girls sought for knowledge about their sexual and reproductive health from multiple sources, which confirms that adolescents tend to have diverse sources from where they acquired information about their sexuality (Awusabo-Asare et al., 2004).

Statistically, there is a significant relationship (p=0.001) between books/magazine as a source of information and girls‟ resilience against sex and teenage pregnancy (Table 7.3). This means that more (56.6%) girls who had access to books/magazine had information that helped them to avoid sex and teenage pregnancy.

The GSS (2013) observed that use and ownership of cell phones is high among older adolescents compared to younger adolescents as such, cell phone ownership increases as age increases, which explain why 24.1% of the respondents of this study identified the cell phone as their source of information. The survey data revealed that 36.8% had high resilience scores whereas 11.4% had low resilience scores. Cell phones provided girls with messages and tit bits on how to avoid risk of sex and teenage pregnancy. In addition, some girls also used their cell phones to

browse the internet for information about sexual and reproductive health issues. Yaayaa sheds light on how she accessed information from her cell phone on how to avoid teenage pregnancy:

> *You can use the internet on your cell phone to find information on how to avoid pregnancy. When you have access it helps you draw your own conclusion, you will know the things you have to do to avoid pregnancy* (Yaayaa, NPH, In-depth interview, Begoro)

The non-pregnant girls who had cell phones explained that it gave them access to the internet where they searched for and read to acquire knowledge on how to avoid teenage pregnancy. They did not only read from the internet, they also asserted that they received and read text messages on sexual and reproductive issues from their mobile networks.

Statistically, there is a significant relationship (p= <0.001) between cell phones and resilience against sex and teenage pregnancy (Table 7.3). This means that more girls who had access to cell phones had information that helped them to avoid sex and teenage pregnancy, thus making them high resilient.

Furthermore, only 15.3% and 11.2% of the non-pregnant girls identified music and billboards/posters respectively as a source of information. More girls (24.4%) who mentioned music as a source had high resilience scores compared to 6.2% who had low resilience scores. The lyrics in some of the music played on the radio and television taught about how to protect one"s self from sex and teenage pregnancy. Yaayaa shared:

> *There is an advertisement about the use of contraceptives and they play a particular song anytime they show that advert, which says –„it is your life it is your choice, obraa eni wara bo, eni wara bo…"*(Yaayaa, NPH, In-depth interview, Begoro)

Such songs teach girls about life and the choices they make concerning their sexual behaviour. It is not surprising that more of the high resilience girls listened to music, because they had access to radio and television.

Statistically, there is a significant relationship (p= <0.001) between music and resilience of non-pregnant girls against teenage pregnancy (Table 7.3). This means that music with lyrics that educate girls on their sexual behaviour played a significant role in girls‟ resilience against sex because more girls who had access to music had high resilience scores.

7.4.2 Role of Cultural Capital in NP Girls‟ Resilience against Sex and Teenage Pregnancy

Having access to other sources of information was important in adolescent girls‟ resilience to teenage pregnancy. From the in-depth interviews, majority of the non-pregnant adolescent girls had knowledge about how to avoid pregnancy and sexually transmitted infections by either abstaining from sexual intercourse or using modern contraceptives. Frema sheds light on the knowledge she had:

> *I know you have to abstain, use a condom or go for family planning… I got this information from friends and from books* (Frema, NPH, In-depth interview, Begoro)

Based on the information the non-pregnant girls had, some abstained from premarital sex to avoid teenage pregnancy and contracting sexually transmitted infections. Thus, because of adolescent girls‟ knowledge on sexual and reproductive health risk, they abstained from sex. In addition, those who were sexually active took protective measures based on the knowledge they had to avoid unwanted pregnancy.

When the non-pregnant girls were probed further to find out the knowledge they had to protect themselves against teenage pregnancy, it was observed that the non-pregnant girls had knowledge on modern contraceptives. They demonstrated their knowledge of modern contraceptives in the following quotes:

> *I know that you have to use a condom to protect yourself when having sex* (Korkor, NPL, In-depth interview, Begoro)

> *I know about contraceptives… like how to use a condom and about family planning and abstinence* (Yaayaa, NPH, In-depth interview, Begoro)

Although, non-pregnant girls had access to information from radio and television, they sometimes misinterpreted the information. This is evident from Akosua‟s submission:

> *I learn (from the TV and radio programmes) that if you sleep with a man you will get pregnant … you have to stick to only one boyfriend… You can go for an injection that can help you avoid teenage pregnancy, and you can even go for drugs to commit abortion, or go to the pharmacy shop* (Akosua, NPL, In-depth interview, Begoro)

For instance, Akosua knows that having sex with a man can lead to pregnancy. However, sticking to one man does not mean she cannot get pregnant. The narratives showed that some non-pregnant girls‟ knowledge about modern contraceptives and how to it could be used to avoid pregnancy was superficial. This tends to defeat the purpose of disseminating knowledge on how to avoid or prevent pregnancy and not aborting pregnancy.

On the other hand based on the knowledge they had about sexual and reproductive health the non-pregnant girls who were sexually active explained that they relied on the information they had to protect themselves from becoming pregnant. The non-pregnant girls who were able to avoid pregnancy by applying their knowledge illustrated:

> *I know that you can use pills and condoms to protect yourself, some people go for injections … it is really helping me, without that I would have had a baby by now* (Asor, NPH, In-depth interview, Begoro)

Obaa Yaa on the other hand explained that she bought emergency contraceptive pills because most of her sexual encounters with her boyfriend were unplanned and since she did not want to become pregnant, she used the contraceptive pill to avoid pregnancy. This suggests that girls who had knowledge about the different types of modern contraceptives used it to prevent pregnancy as such using the knowledge they acquired from their other sources. According to Yaayaa a high resilience girl,

> *When you acquire knowledge on the different family planning methods such as how to use the pill, it helps you draw your own conclusions; you will know the things you have to do to avoid pregnancy* (Yaayaa, NPH, In-depth interview, Begoro)

However, it is worth mentioning that having knowledge alone without any other support cannot help a girl to avoid risky sexual behaviours. Kuukua demonstrated this:

> *It (TV programmes) somehow helps but I do not have anyone to take care of me (financial support) so I end up going back to engage in risky sexual behaviours* (Kuukua, NPL, In-depth interview, Begoro)

Non-pregnant high resilient adolescent girls had knowledge on how to avoid teenage pregnancies, by either abstinence or using contraceptives. Those who abstained from sex did that mainly because they wanted to avoid pregnancy. On the other hand, the study found out that the high resilience girls who were sexually active used the knowledge they received from other sources to protect themselves against teenage pregnancy and sexually transmitted infections. Although the sexually active girls used condoms, the study found out that the non-pregnant girls were more concerned about avoiding pregnancy and not necessarily sexually transmitted infections. However, having knowledge alone cannot help adolescent girls to develop resilience to teenage pregnancy. It required other forms of support including social capital, economic capital and symbolic capital. Girls who had knowledge (cultural capital) about contraceptives were able to buy them because of their purchasing power (economic capital). In addition, girls

would be willing to buy contraceptives if the community‟s attitude (social context) towards them is acceptable and not labelling them as bad girls for buying modern contraceptives. These suggestions reiterate the interdependence and interrelatedness of the various forms capital and how they all work together to make adolescents avoid or overcome the challenges associated with their sexual and reproductive life.

7.5 Symbolic Capital as a Protective Factor against Sex and Teenage Pregnancy

Symbolic capital refers to an individual‟s reputation, honour or prestige within a social space (Bourdieu, 1993). Symbolic capital denotes girls‟ reputation in society; whether they feel accepted within the community or whether the community members accept them for who they are. It is based on the individual‟s social status and how she maintains it using her access to the other capitals (social, economic and cultural) to avoid and overcome the risk of sex and teenage pregnancy. The discussion in this section focuses on the views of some community members and the adolescent girls on what a good social reputation is and how girls build resilience against sex and pregnancy.

7.5.1 Perceptions of a “Good” Social Reputation for Non-Pregnant Girls‟

The community members‟ perception of the meaning of a good social reputation for a non-pregnant girl was not different from the views of the girls. One of the defining factors of a good social reputation for a non-pregnant adolescent girl was based on how she dressed:

> *Some (girls) don"t really dress well, it"s too bad, you can come around at night and witness it for yourself and judge whether what am saying is true or not, because as soon as they start developing breasts they start putting on miniskirts* (Male adult 6, In-depth interview, Begoro)

Others also based their perceptions of what a good social reputation constitutes for a non-pregnant girl on her character:

> *The first thing is that, they have to be God fearing, they should always consult their mothers, listen to advice and not go out at night* (Female adult 2, In-depth interview, Begoro)

In addition, the pregnancy status of an adolescent girl influenced her social reputation within her community as expressed below:

> *If you are a very good girl you will not get pregnant, if you stay away from men, people will respect you* (Male adult 1, In-depth interview, Begoro)

This suggests that the community members held the view that a "good" girl does not get pregnant out of wedlock. A perception that was shared by both adult community members and the adolescent boys involved in the study was about the fact that girls had a responsibility to stay away from boys/men. Several community members expressed sentiments along the same lines:

> *They (adolescent girls) should stop the „boyfriend-girlfriend thing" and that will make them earn the praises of people* (Male adult 2, In-depth interview, Begoro)

This shows attribution of responsibility and negative judgement to girls, for the relations that they and boys have together. Again this confirmed what Adomako Ampofo (2001) found about the differences in how adolescent boys and girls sexual relations are judged. The attribution of responsibility to girls for being in a relationship with boys indicates that whereas girls are held responsible for the consequences of being in a sexual relationship with the opposite sex, boys‟ responsibilities to girls are not mentioned at all. This study has shown that the perceptions of the community members on girls‟ responsibility in sexual and reproductive issues is one sided, making the girls the bad ones and their partners left untouched.

7.5.2 Girls Perception of "Good" Social Reputation

The non-pregnant girls identified several factors that community members associated with a good reputation. Asor a high resilience girl discusses why she thinks she has a good reputation in her community:

> *They (community members) praise me because I do not usually go out at night, I respect my elders, and I go on errands for them* (Asor, NPH, In-depth interview, Begoro)

Similarly, Korkor also sheds light on how she maintains a good reputation in her community:

> *To maintain a good reputation, I go on errands for them (community members) and I keep my relationship secret* (Korkor, NPL, In-depth interview, Begoro)

From the in-depth interviews with non-pregnant girls, it came up that almost all the girls who were in a relationship with the opposite sex kept it a secret with the exception of Frema who observed that her relationship was a secret between she and her mother. Frema highlighted:

> M*y mother is the only one who knows I have a boyfriend and it is a secret between us* (Frema, NPL, In-depth interview, Begoro)

These assertions from the non-pregnant girls is an indication that to have a good reputation in the community a girl must not go out at night, must not have a boyfriend, must not engage in premarital sex or become pregnant out of wedlock and must show respect for her elders. These factors hightlights the norms and values of the community which non-pregnant girls are expected to exhibit in their interactions with members of their community. Going contrary to the expectations of the community one does not have a good social reputation. Akosua demonstrated this in her discussions on why she thought she did not have a good social reputation:

> *I like going out at night, and thus they (community members) brand me as a bad girl. I am making efforts to change their perception about me, I will stop going out and stop wearing short skirts* (Akosua, NPL, In-depth interview, Begoro)

This suggests that not having a good reputation in the community was based on doing the opposite of what merits a good reputation and that could explain why adolescent girls kept their relationships with the opposite sex a secret.

7.5.3 Role of Good Reputation in NP Girls‟ Resilience against Sex and Teenage Pregnancy

Maintaining a good reputation helped adolescent girls to avoid teenage pregnancy in the first instance by making them abstain from sex or practice safe sex to avoid pregnancy. It was observed that some non-pregnant girls abstained from sex in order to maintain a good social reputation within their communities. Second, they refrained from having relationships with the opposite sex in order to maintain a good reputation. Yaayaa‟s view in the narrative below is shared by most of the girls:

> *Many men propose love to me, but I turn them down …when people see that you have a boyfriend, they conclude that you are having sex and they label you as a bad girl, because of that, I reject proposals from boys so that people would say I am a good girl* (Yaayaa, NPH, In-depth interview, Begoro)

Finally, to maintain a good reputation, adolescent girls used contraceptives when they had sex in order not to get pregnant. Thus in their bid to conceal from the community that they were involved in sexual activities, they used contraceptives to avoid the consequences of having sex. Obaa Yaa stated:

> *People do not really know me well so when you even say something bad about me people will not believe it….I usually buy the pills from Obuasi [Obaa Yaa as noted in the earlier sections uses the emergency pill after having sex]* (Obaa Yaa, NPH, In-depth interview, Begoro)

Based on how the community members defined a girl‟s reputation, the non-pregnant girls explained that they kept their relationships secret and did things in secret to maintain a good

social reputation. Others also kept their relationship with the opposite sex a secret to maintain a good social reputation within the community.

This notwithstanding, concerns were raised about how adolescents tried to maintain a good reputation in terms of sexual behaviour. Some community members felt adolescent girls in their bid to maintain a good reputation in their community abused the use of contraceptives to avoid unwanted pregnancy. An adult community member illustrated:

> *It encourages them to avoid pregnancy … some of them even go for family planning programmes, so even though they are having sex they will not get pregnant and people keep praising them without knowing what they do in secret. Some (NP girls) are good but some of them also take undue advantage of the family planning drugs and just keep sleeping with men and destroy their lives* (Woman 6, In-depth interview, Begoro)

From the evidence so far, maintaining a good social reputation served two major functions in adolescent girls‟ resilience to premarital sex and teenage pregnancy. The first function was the manifest function where girls in their bid to be accepted by their community members and social networks try to either avoid pregnancy by abstinence from sex or stay away from any relationship with the opposite sex. In this way, the manifest function here is that it helped girls to avoid pregnancy. The latent function underlining all the effort of maintaining a good reputation is that it encouraged girls to find ways and means to avoid pregnancy. As such, in their bid to conceal that they were having sexual intercourse, they took measures to avoid becoming pregnant by using contraceptives. This notwithstanding, the desire to maintain a good reputation pushed girls who were sexually active to be secretive in their sexual relations which could have dire consequences in certain situations. It meant that girls did not have regular access to contraceptives when they needed it for fear of being classified as bad girls. Adomako Ampofo (2001) also drew this conclusion.

This could explain why although adolescent girls have knowledge about the use of contraceptives, the use of it is still low. However, this study found that despite the fear of being labelled for buying contraceptives, adolescent girls averted this by buying from places that they were unknown to maintain their anonymity. This was demonstrated in Obaa Yaa‟s quote above, where she explained that she bought her pills from a neighbouring town to ensure her anonymity. This notwithstanding, a girl‟s inability to access modern contraceptives for fear of being labelled defeats the importance of using contraceptives. This is because girls may end up not having regular access to modern contraceptives when they needed it. Judging from these findings, it calls for a lot of awareness creation in the community for members to be educated about the need for adolescents to be encouraged to use protection when they have sex and not just encouraging non-pregnant girls to abstain from sex.

7.6 Conclusion

This chapter has examined the relationship between various forms of capital including social, economic, cultural and symbolic capital. The discussions so far have shown how non-pregnant girls had access to the social, economic and cultural capital that helped them to maintain a good social reputation and by so doing developing resilience against sex and teenage pregnancy. Sources of social capital that were significant to girls‟ resilience building process were mainly from parents and religious leaders. The type of benefit girls derived from these sources included advice, encouragement, social control and information on how to avoid and overcome the risk of sex and teenage pregnancy. However, whereas parents and religious leaders limited their advice to only abstinence to sex, older siblings and teachers advised girls to either abstain from sex or use contraceptives to avoid pregnancy and sexually transmitted infections. Parents and

boyfriend/partner were other significant sources of economic capital in adolescent girls‟ development of resilience against sex and teenage pregnancy. For the high resilience non-pregnant girls, parents provided them with financial support such as providing their basic needs, school fees and pocket money. These helped them not to enter into sexual relationships with the opposite sex in exchange for financial favours. However, although the low resilience girls identified boyfriend/partner as their source of financial support, turning to men can predispose them to sex and teenage pregnancy. Thus, access to economic capital from parents helped girls to develop resilience against sex and teenage pregnancy than from boyfriends. It also appeared that non-pregnant girls had access to multiple sources of cultural capital, which helped them to avoid and overcome teenage pregnancy. The radio, cell phones, books and music were also significant sources of information that helped girls to develop resilience against sex and teenage pregnancy. This indicates that adolescents are more inclined to sources of information that are more mobile as reflected in the data as compared to sitting to watch an educative programme on the television. Thus, media sources of information that can be consumed „on the go‟ are more likely to be statistically preferred. These other sources of information helped girls to acquire knowledge on their sexuality, which they applied to avoid unprotected sex and pregnancy. In conclusion, girls‟ access to multiple sources of capital played a role in resilience building. In addition, girls did not rely on only one source of capital, but accessed as many capitals as they can. Evidence of non-pregnant girls‟ resilience against sex and teenage pregnancy can be seen in the number of capitals they had access to and how successful they accessed these capitals. Thus, resilience level of adolescent girls against sex and teenage pregnancy is dependent on the number of resources (capital) available to the individual adolescent girl and their success at accessing these resources to abstain or protect them when they have sex.

CHAPTER EIGHT

COPING WITH TEENAGE PREGNANCY AND MOTHERHOOD

8.1 Introduction

This chapter addresses one of the objectives of the study by investigating how adolescent girls coped with teenage pregnancy and motherhood. In resilience research, an individuals‟ disposition, relationship with family as well as the social environment determines the way he/she adapt to risks (Theron et al., 2013; Alvord and Grados, 2005; Garmezy, 1984). Thus, data were collected and analysed to show how ever-pregnant girls adjust positively to teenage pregnancy and early motherhood. The analyses focused on how girls who are pregnant or have had a live birth (ever-pregnant girls) utilize their access to social, economic, cultural and symbolic capitals available to them in coping with the risk. A resilience scale with a set of ten questions based on the personal experiences of the EP girls related to the risk of teenage pregnancy and motherhood was used to find out how they responded to these risks. Based on their responses and for analytical purposes those who had the average score and above were classified as high resilience ever-pregnant girls (EPH) and those who scored below average were classified as low resilience ever-pregnant girl (EPL) (see Appendix 6 for resilience scores). Findings in this chapter are based on analysis from both the quantitative and qualitative data gathered from the field. The survey data provided a description of the various sources of capitals for the eighty-one (81) ever-pregnant girls while the in-depth interviews and focus group discussions provided detailed explanations to the descriptions from the survey data. The chapter is organised into five sections with each section focusing on one of the four forms of capital (social, economic cultural and symbolic). In the first three sections, the results of how ever-pregnant girls got access to social, economic and cultural capital and how it helped them to adjust positively to the risk of teenage

pregnancy and motherhood are descibed, analysed and discussed. This is followed by a section that analyses how symbolic capital contributes to the development of resilience among ever-pregnant girls. The section looks at what it means to have a good reputation in the community during pregnancy and after having a baby and how it affects coping with teenage pregnancy and early motherhood.

8.2 Access to Social Capital in Coping with Teenage Pregnancy and Motherhood

Social capital as discussed in Chapter 3 refers to how relationships served as social control mechanisms, family support and benefits through social network with other community members, groups or organizations (Portes, 2000). In this section social capital for ever-pregnant girls, is adapted to mean practical social support such as help from parents, and others in taking care of one‟s self as well as the baby. Thus, it includes the benefits that one receives from relevant sources such as parents and other relatives to adjust positively to teenage pregnancy and motherhood. The section discusses the various sources of capital available to ever-pregnant girls, indicating how it helped them adjust positively to the risk of teenage pregnancy and motherhood.

8.2.1 Source of Social Capital for Ever-Pregnant Girls

The adolescent girls who were either pregnant or mothers (ever-pregnant girls) were provided with a list of possible sources of social capital they accessed during and after pregnancy. Parents (48%) and other relatives (25%) stood out as the main sources of social capital for the ever-pregnant girls (Table 8.1). Boyfriends/partners on the other hand did not turn out as a major source of social capital for the ever-pregnant girls (Table 8.1). This suggests that ever-pregnant

girls tend to receive practical and emotional support from their family members as compared to the fathers of their babies.

Table 8.1: Source of Social Capital for Ever-Pregnant Adolescent Girls

Source of Social Capital	Frequency n=81* (%)	High Resilience Frequency n=40* (%)	Low Resilience Frequency n=41* (%)	χ2 (P value)
Parents	39 (48.1)	26 (65.0)	13 (31.7)	7.70 (0.005)**
Other Relatives	20 (24.7)	14 (35.0)	6 (14.6)	3.48 (0.061)
Boyfriend/Partner	11(13.6)	9 (22.5)	2 (4.9)	3.96 (0.046)**
Peers	8 (9.9)	6 (15.0)	2 (4.9)	1.33 (0.248)
Religious Groups	7(8.6)	6 (15.0)	1 (2.4)	2.61 (0.106)
Nurses/Doctors	6 (7.4)	3 (7.5)	3 (7.3)	0.15 (0.651)

Source: Author"s Fieldwork, 2012
*multiple choices allowed
**P<0.05
χ2 = Chi Square: df = 1

Significantly more (p=0.005) of the high resilience girls (65.0%) compared to low resilience girls (31.7%) mentioned their parents (Table 8.1). Parents supported their daughters with advice, encouragement as well as parental and childcare for both the adolescent mother and her child. Parents advised girls on how to take care of themselves during and after pregnancy as well as how to prevent subsequent pregnancy. Parents of the ever-pregnant girls also provided social support by encouraging and advising them to go back to school or learn a trade after having their babies. In addition, parents provided practical support by helping girls to take care of their babies such as bathing and feeding of babies. Some high resilient ever-pregnant girls narrated:

> *My mother has advised me on how to protect myself from teenage pregnancy so that I do not repeat the mistake again. It has helped me avoid certain things, and now I know how to protect myself from certain things. She (mother) has showed me how to protect myself*

> *if I want to have sex to prevent pregnancy, she has taught me to go for family planning if I want to avoid another pregnancy, and that I should avoid sexual intercourse for now until I am married* (Boatemaa, EPH, In-depth interview, Begoro)

> *My mother and my grandmother are both helping me to take care of my baby. They sometimes help me to feed and bath my baby and I try my best to please them by helping to fetch water for them and go on errands for them, which they appreciate. ... My mother told me that when you go for weighing (post-natal care at the health centre), they would immunize your child for you so I followed her advice and make sure that I honour my weighing appointments* (Maku, EPH, In-depth interview, Begoro)

> *My parents supported me and it has really helped us (mother and child). They have helped me to go back to school and my child is in school as well. They provide me with all my school supplies, and they also provide all the things I need* (Sheila, EPH, In-depth interview, Begoro)

The low resilient ever-pregnant girls who received social support from their parents also confirmed this by stating:

> *I am still staying with my parents and my mother is always around to offer a helping hand. She cooks for me and my child because, I still show her respect and do the house chores as expected of me. She (mother) takes care of my baby when I am busy and when I am going out I leave the baby in her care* (Owusua, EPH, In-depth interview, Begoro)

> *She (mother) advices me not to associate with „bad friends" ... that is I should not be friends with people who have boyfriends and like going out at night. She (mother) takes care of the child and always calls whenever she is away to find out how the baby is doing* (Drowa, EPH, In-depth interview, Begoro)

An adolescent boy who confirmed the role of parents expressed his view on how parents took the responsibility of assisting their daughters who became pregnant or mothers out of wedlock:

> *They (parents) adopt the babies for their children to continue with their education or they let them learn a trade so that the girl will also make some money to take care of the child* (Boy 3, In-depth interview, Begoro)

These narratives indicate that parents, especially, mothers supported their daughters from pregnancy through to delivery and even after delivery. Thus, the support from parents resulted in more girls being able to adjust positively to teenage pregnancy and motherhood. From the representative narratives above, parents advised and encouraged their daughters and even helped

them with childcare and babysitting by practically taking care of their babies. Parents did this by advising their daughters on how to avoid another unintended pregnancy, encouraging and supporting them to go back to school or learn a vocational skill.

The result shows that in as much as adolescent girls had access to social support from parents, it was sometimes based on reciprocal terms. To have access to social capital from parents, the ever-pregnant girls continued to live with their family and played their roles as daughters which is similar to the experience of non-pregnant girls as identified in chapter seven. For instance, girls had to show respect, continue to live with parents and help with the house chores in order to receive support from them. Submitting to parents‟ authority brings out the reciprocity in accessing social capital from one‟s social networks (Portes, 2000). To have access to social capital as Portes (2000) suggested, a person must be related to others who are the actual source of her advantage. Although parents tend not to be happy when their daughters become pregnant out of wedlock, they still provided them with the support that they need to go through pregnancy and motherhood (Gyesaw and Ankomah, 2013; Keller et al., 1999).

Findings showed that significantly more (p=0.046) high resilience girls (22.5%) identified their boyfriend/partner as a source of social capital compared to low resilience girls (4.9%). Ever-pregnant girls had access to social support from boyfriends/partners only when they (partners) accepted responsibility for the pregnancy and in some cases were cohabiting. Thus, when girls moved in with the fathers of their babies the men supported them by helping to take care of them and their babies. Gloria who is currently cohabiting with her boyfriend moved in when she became pregnant observed:

> *Anytime he (partner) is around, he holds the baby for me to wash, cook or take my bath. He also goes on errands for the baby, like going to buy medicine or "pampers" for our baby* (Gloria, EPL, In-depth interview, Begoro)

Some of the ever-pregnant girls asserted that their parents refused any form of support from the fathers of their babies and their family members because they were not happy with the terms of settlement. For instance in the case of Grace she received social support from her mother because her mother refused any help from the father of her baby. Grace recounts:

> *When I became pregnant, he (father of her baby) went for money from his father but my mother did not take it because she said it was not enough to take care of me throughout my pregnancy, so she threatened to take the matter to court* (Grace, EPL, In-depth interview, Begoro)

Whereas in some cases the fathers of the babies refused to accept responsibility, in other cases parents of the girls also rejected the boys/men"s acceptance of their daughter"s pregnancy. Where the latter is the case, adolescent girls tend to receive support from their parents not because their boyfriends/partners did not accept responsibility, but because of antagonism between the two families. Additionally, some pregnant adolescent girls refused to disclose the identity of the father of their baby and therefore tended not to get any support from such men. This explains why in most cases parents became the only source from which ever-pregnant girls were able to access social support.

From Table 8.1, the second major source of social capital for ever-pregnant adolescent girls was from other relatives (24.7%) such as grandparents and aunties. Other relatives such as grandmothers and aunties provided social support to ever-pregnant girls by advising them against becoming pregnant again as well as supporting them with taking care of their children. There was no relationship between other relatives as a source of social capital and resilience level, though nominally, more high resilience girls (35.0%) reported it than low resilience girls

(14.6%). The ever-pregnant girls received two types of support from their other relatives; usually grandparents provided advice and practical support. Several high resilient ever-pregnant girls shared sentiments along these lines:

> *My grandmother lives in the house with us. She (grandmother) is the one who just offers her help, when she realizes that things are not really going well, she steps in to help…she and my mother always make sure I am okay and that I have food to eat and they make sure that all my needs are provided. They (grandmother and mother) make sure I have food, clothing and everything I need. When I am very busy, she (grandmother) takes care of the child. She also helps when my child is sick, she teaches me the medicine to use and she shows me what to do* (Dede, EPH, In-depth interview, Begoro)

> *My grandmother really made time for me … she always made sure my baby and I were okay before she would go out. My grandmother always makes sure I am okay and she gives me food to eat and ensures that all my needs are provided* (Serwaa, EPH, In-depth interview, Begoro)

> *My mother"s senior sister (maternal aunt), who is a nurse at Salvation (Clinic) advices me on how to avoid becoming pregnant again* (Boatemaa, EPH, In-depth interview, Begoro)

On the other hand, the low resilient girls who identified their other relatives as a source of social support also stated:

> *When my baby was sick three months after her birth, she (grandmother) was the one who took her to the hospital for blood transfusion* (Adiza EPL, In-depth interview, Begoro)

From in-depth interviews, it came out that the ever-pregnant girls who received social support from other relatives often mentioned their grandmothers as their source of social support. Other relatives were an important source of social support for ever-pregnant girls. Although studies suggest that the Ghanaian family system is undergoing changes such as the nucleation of the family, in this study traces of the extended family system can be observed, with grandparents being a part of the family. The existence of the extended family system therefore afforded some adolescent girls the chance to benefit from the support of their grandparents. As such, for the ever-pregnant girls who had their grandparents living with them or who lived with their

grandparents, they were provided with practical childcare support such as bathing, feeding and babysitting that helped teenage mothers to go through motherhood successfully. Thus, the ever-pregnant girls who were living together with their grandparents had access to social support in the form of advice on how to care for their babies" as well as practical childcare support by helping them to take care of the babies. Hurd and Zimmerman (2010) in their studies identified support from natural mentors (non-parental supportive adults) as helping adolescent mothers to overcome stress and anxiety and thus making them resilience in their situation, this study has shown that such actors provided more than psychological needs in the form of practical support.

Only 8.6% of the ever-pregnant girls identified their religious groups as providing them with social support. Although religious values are against premarital sex and childbearing out of wedlock, religious leaders sometimes provided advice and social support for some ever-pregnant girls. For instance, the church supported the adolescent girls by helping with organizing and holding naming ceremonies for their babies in the church. The church also provided social support in the form of prayers for the ever-pregnant girls during pregnancy and after pregnancy for their safe delivery. In addition, they showed concern and encouraged girls through visits to enquire of their wellbeing, which provided emotional support for the teenage mothers. Dede demonstrated how the church provided her with social support in the following narrative,

> *They (the church leaders) help you organize the naming ceremony … they also pray for you during your pregnancy. … When they do not see us in church, they come to visit us* (Dede, EPH, In-depth interview, Begoro)

The thought of other people showing concern about their well-being helped to ease the „shame" that sometimes comes with getting pregnant out of wedlock among adolescent girls.

Furthermore, the study revealed that 7.4% of the ever-pregnant girls gained access to information from the doctors/nurses. Sheila noted,

> *They (nurses) teach you how to plan your family, and the medication you have to take* (Sheila, EPH, In-depth interview, Begoro)

Despite the support that nurses/doctors provide to ever-pregnant girls, the proportion of girls who identified them as a source of social capital was less than expected. This was because ever-pregnant girls only sought for medical attention when they were pregnant. However, the low proportion of ever-pregnant girls who received support from the nurses/doctors indicate that most girls do not attend prenatal sections neither do they take their children to the post-natal clinic nor participate in the postnatal classes that are organized at the health centres due to the social stigma attached to adolescent motherhood. Additionally, most parents tend to take the responsibility of taking the babies to the health centres or when they go with their daughters, the parents tend to deal with the nurses on behalf of their daughters and this explains why most adolescent mothers did not identify the nurses/doctors as a source of social capital.

The respondents explained that they received social support from other sources such as their neighbours and some community members through their own initiatives, their parents‟ initiatives or the community members own initiative. Boatemaa observed:

> *… I did not want to continue school after having my baby but people (the elders in the community) advised me that because I was intelligent I could become a prominent person in future, because of such advice I have gone back to school. I shared my problems with people and they helped me out. I told them (some adults) what my mother wanted me to do (go back to school). They supported the idea and encouraged me to continue with my school because it will be of benefit to me in the future* (Boatemaa, EPH, In-depth interview, Begoro)

An adult respondent who shared his experience confirmed this:

> *A friend of mine, has a daughter who had a baby, he invited us to his house so that we would advise his daughter to go back to school and she is now back in school* (Male Adult 5, In-depth interview, Begoro)

Adult community members provide advice freely to pregnant girls and adolescent mothers. Some EPH shed light on how community members provided them with social support:

> *... Some of the community members check up on us (she and her baby) to see if we are doing well, when they see you carrying your baby in the wrong way, they approach you and teach you how to do it right* (EPH, Drowa, In-depth interview, Begoro)

> *When I was pregnant, they (the elders in the town) told me not to carry water or buy food outside because it might affect the baby* (Maku, EPH, In-depth interview, Begoro)

These findings indicate that although teenage pregnancy and having children out of wedlock was not acceptable and in some cases condemned by both parents and community members, when such things happened, community members despite their condemnation of adolescent pregnancy tend to support girls with advice and showing concern about their wellbeing.

Statistically, there are no significant relationship between other relatives, peers, religious leaders and nurses and girls‟ resilience against sex and teenage pregnancy (Table 8.1). This suggests that parents and boyfriend/partner were the only significant sources of social capital for ever-pregnant girls in Begoro.

From the results, two main forms of social support emerged. On one hand, adolescent girls received advice and on the other hand, they received practical support in different forms ranging from assistance with feeding, bathing and babysitting among other forms of supports. The advice was mainly from their parents, relatives and other adult community members. The girls were advised to get back to school or learn a vocation, avoid becoming pregnant again when they are not ready and what to do to secure their health and that of their babies. Where girls received

support from significant others, they were supported in taking care of themselves and their babies and this enabled some of them to go back to school, learn a trade or get a job to improve their socioeconomic status

8.2.2 Role of Social Capital on EP Girls‟ Resilience to Teenage Pregnancy and Motherhood

Through the advice and encouragement that adolescent girls received, some went back to their normal life, by going back to school. This was usually because of the advice and the practical support they received from significant others such as parents. Sheila stated:

> *They (parents) have helped me go back to school, my child is in school… because of the advice I am now in school, and my boyfriend is in school* (Sheila, EPH, In-depth interview, Begoro)

Some parents also helped to take care of the babies of their daughters in order for them to work to raise money to support themselves. An adult community member suggested:

> *It (social support) is mostly from their parents, some also do not have anyone to help them. The young girl who sells here has a baby. In her case after giving birth she went back to school and later stopped because she realised she was too matured for the class, so she started this business and is doing very well and the parents are also helping her by taking care of her child* (Male Adult 4, In-depth interview, Begoro)

An adolescent boy illustrated how social support helped an ever-pregnant girl to go back to school:

> *…When the girl got pregnant the boy refused to accept responsibility, but the boy"s mother took care of the girl until she matured, but the boy did not marry her, so she has gone back to her mother to continue her education* (Boy 4, In-depth interview, Begoro)

Adiza sums up the role of social support in the resilience of ever-pregnant girls by explaining how her colleagues in a similar situation to her were not able to cope well with teenage pregnancy and motherhood due to lack of social support from a significant source. Adiza lamented:

> *If they (significant others) do not really help, things will become very difficult, some of the teenagers do not have their peace of mind, and some of them move out and find it even difficult to feed themselves and their babies* (Adiza, EPL, In-depth interview, Begoro)

Practical social support and advice had the ability to help ever-pregnant girls cope well with teenage pregnancy and motherhood. Although becoming pregnant and having a baby could expose girls to the risk of dropping out of school, economic hardship and stigma. This study has shown that adolescent girls who had support from their family (Gyesaw et al, 2013; Henry and Fayorsey, 2002) benefited more in terms of overcoming the challenges associated with teenage pregnancy and motherhood, a common feature identified in resilience studies on adolescent sexual experience (Hurd and Zimmerman, 2010; Weed et al., 2000). When people who matter in the life of girls support them through advice, directing them as to what to do after getting pregnant and having a baby, it goes a long way to help them adjust to their situation. Studies have indicated that at-risk individuals who received social support from significant others are able to adjust to their situation as well as even come up with alternative ways to deal with the situation (Hurd and Zimmerman, 2010; Weed et al, 2000).

Overall, the ever-pregnant girls were able to cope well with teenage pregnancy and early motherhood better when social support came from their parents and other relatives because they helped to care for their babies. Although Hurd and Zimmerman (2010), identified that among African-American girls, informal relationships with family members, friends and neighbours provided support for resilient girls, this study found that ever-pregnant girls who received social support from family members particularly parents and grandparents tend to be more resilient because of the diversity in the support they provided. They helped to babysit for teenage mothers to enable them to go ahead and pursue their dreams or continue to live a normal life, such as

going back to school, learning a trade or vocation or working. Hence, when girls continue to receive support from their parents it reduces their risk level of engaging in premarital sex that might lead to another teenage pregnancy or having a sexually transmitted infection.

8.3 Access to Economic Capital in Coping with Teenage Pregnancy and Motherhood

Economic capital as mentioned earlier in Chapter 3 involves access to financial support and command over economic resources, mainly cash and assets (Bourdieu, 1986). In this section economic capital, refers to the financial support EP girls received from relevant sources such as parents and boyfriend/partner to adjust positively to teenage pregnancy and motherhood. Economic capital for ever-pregnant girls includes provision of basic needs, access to money for school fees and healthcare. The discussion in this section looks at the sources and the types of financial support as well as how it helped girls to build resilience to teenage pregnancy and motherhood.

8.3.1 Source of Economic Capital for Ever-Pregnant Girls

The ever-pregnant girls had access to economic capital from various sources. The most common sources of financial support to ever-pregnant girls came from their parents, relatives and boyfriend/partner. The frequency distribution of the source of economic capital for ever-pregnant girls indicates that they had fewer sources compared to social capital (Table 8.2). Out of the five sources of economic capital, parents (53.4%) and other relatives (46.9%) were the major ones reported by the ever-pregnant girls (Table 8.2). Similar to access to social capital, parents stood out as the major source of economic capital for girls in coping with teenage pregnancy and motherhood.

Table 8.2: Source of Economic Capital for Ever-Pregnant Adolescent Girls

Source of Social Capital	Frequency n=81* (%)	High Resilience Frequency n=40* (%)	Low Resilience Frequency n=41* (%)	χ2(P value)
Parents	44 (54.3)	31(77.5)	13 (31.7)	15.31(<0.001)**
Other Relatives	38 (46.9)	18 (45.0)	20 (48.8)	0.01(0.905)
Boyfriend/Partner	17 (20.9)	12 (30.0)	5 (12.2)	2.87(0.090)
Peers	7 (8.6)	3 (7.5)	4 (9.8)	0.51(0.972)

Source: Author"s Fieldwork, 2012
*multiple choices allowed
**P<0.05
χ2 = Chi Square: df = 1

Results indicated that significantly (p<0.001) more ever-pregnant girls with high resilience scores (77.5%) identified their parents as a source of financial support compared to ever-pregnant girls with low resilience scores (31.7%). Parents provided economic support in the form of paying for hospital bills, school fees, and provision of food, clothing and shelter for both daughter and grandchild. Parents also registered their daughters on the National Health Insurance Scheme (NHIS) as a way of supporting them financially to cater for their hospital bills during pregnancy and after childbirth. The high resilient ever-pregnant girls narrated how they accessed financial support from parents:

> *She (mother) sends us money, she is a nurse so we do not really pay anything when we visit the hospital and she takes care of all the bills* (Drowa, EPH, In-depth interview, Begoro)

> *... Currently I am unemployed but she (mother) is paying for my education. I am in school now and I am in Senior High School form 1*(Boatemaa, EPH, In-depth interview, Begoro)

Similarly, the low resilient girls also recounted:

> *I am living with my parents, so they continue to provide my basic needs such as food, clothing and shelter* (Abiba, EPL, In-depth interview, Begoro)

> *She (mother) gives us food, clothes and pays for our hospital bills whenever we go to the hospital* (Grace, EPL, In-depth interviews, Begoro)

Where parents provided financial support in the form of school fees, it allowed the ever-pregnant girls to go back to school to continue with their education, which reduces the negative effect of dropping out of school. According to Agyei et al. (2000), lack of education or a break in education due to motherhood could be a barrier to a girl‟s economic independence. Sometimes the girls who dropped out of school because of teenage pregnancy, had a dislike for school or did not perform well in school and as such end up working with their parents either selling or farming or start their own business. Others also go on to learn a vocation to improve their economic status to prepare them to take care of themselves and their babies. Parents provided financial support because sometimes there were challenges that came with out of wedlock pregnancy and childbirth such as litigation or denial of responsibility by the men and that left pregnant girls with no support from the fathers of their babies. As such, parents had to provide the financial needs of both their daughters and their grandchildren. This shows the importance of having financial support from parents during and after pregnancy, which is crucial for girls to secure their health and that of their baby as well as cope well with motherhood.

It is important to mention here that although women are entitled to free healthcare for pregnancy and childbirth under the National Health Insurance Scheme (NHIS), the scheme does not cover all healthcare expenses. Pregnant women including teenagers have to pay for some healthcare services that are not covered under the health insurance scheme such as blood transfusion and scanning. Having someone to provide one‟s basic needs thus reduces adolescent maternal morbidity and related mortality and therefore most parents had to take full responsibility of their daughters‟ financial needs. This may explain why in one of the focus group discussion with

adolescent boys, a discussant shared a view, which was shared by almost all the community members in the study:

> *When they (adolescent girls) become pregnant, the entire burden tends to be on their parents* (Focus group discussion 1, Boy 3)

From the study, it was identified that 46.9% of the respondents identified other relatives such as grandparents as a source of economic capital (Table 8.2). Those who did specifically mentioned their grandmothers as supporting them financially to take care of their babies. The high resilient girls narrated:

> *I dropped out of school when I became pregnant. I am unemployed as such it is my grandmother and boyfriend who support me and my baby financially* (Dede, EPH, In-depth interview, Begoro)

> *I help them (mother and grandmother) in their business, so they also give me some of the money. That is how I get money to take care of my child and myself* (Maku, EPH, In-depth interview, Begoro)

The low resilient girls also confirmed how their grandmothers supported them:

> *My grandmother supported me financially throughout my pregnancy and after having the baby. When my baby fell sick three months after her birth, she was the one who took her to the hospital for blood transfusion and she paid for the bills* (Adiza, EPL, In-depth interview, Begoro)

> *… I sell oranges for my grandmother by the roadside. She remits me GH¢ 10 a month, so I use it to buy the clothes I need* (Gloria, EPL, In-depth interview, Begoro)

Furthermore, the study revealed that 20.9% of the respondents received economic support from their boyfriends/partners during and after pregnancy (Table 8.2). Some ever-pregnant girls stated how their boyfriends/partner supported them financially:

> *My boyfriend supports us (mother and child) financially; the money he gives me is for the two of us"* (Maku, EPH, In-depth interview, Begoro)

> *I am not working. The father of the baby gives me the money for my hospital bills. When I run out of money, I ask him (partner) and sometimes he just gives it to me for my upkeep, now we have a baby so he has to take responsibility and make sure that I always have money to take care of the baby* (Dede, EPH, In-depth interview, Begoro)

Boyfriends/partners who accepted responsibility for a pregnancy tend to help in paying for the hospital bills and provide money to support both mother and child in terms of food, clothing and in some cases shelter during pregnancy and after delivery. The study revealed that boyfriends/partners are more likely to provide economic support to the ever-pregnant girls and their babies rather than practical or emotional support. This was because most adolescent girls gave birth out of wedlock and do not live together with the fathers of their babies. In other cases although the fathers of the babies do not marry the girls, they feel obliged to provide the financial needs of their babies. In effect, partners/boyfriends and parents tend to provide financial support to ever-pregnant girls (Gyesaw and Ankomah, 2013). However, whereas there is a significant relationship ($p = <0.001$) between parents as a source of economic capital and resilience level, there is no significant relationship ($p = 0.090$) between boyfriend/partner and resilience level (Table 8.2).

Although peers did not appear as a common source of financial support for ever-pregnant girls, 8.6% identified their peers as a source of their economic capital (Table 8.3). Adiza discussed how her peers supported her when she had her baby:

… *They brought me gifts when I gave birth* (Adiza, EPL, In-depth interview, Begoro)

Peers usually supported their colleagues financially during the naming ceremony by donating money and gifts to help mother and child take care of their needs.

In addition, 7.4% identified other sources such as religious groups and their own savings (Table 8.2). The religious group which one was associated with sometimes contributed financially by

taking an offering for people who had given birth during the naming ceremony. These are described in the following narratives:

> *With some (churches) when you go for the naming ceremony or thanksgiving, they contribute money for you and your baby* (Sheila, EPH, In-depth interview, Begoro)

> *They (the church) help you organize the naming ceremony, they also support you financially and they pray for you during pregnancy* (Dede, EPH, In-depth interview, Begoro)

This suggests that one‟s affiliation to a religious group sometimes gave her access to financial support. This is usually through the naming ceremony, whereby some churches take an offering from their members as a gift for the mother and her baby. When adolescent girls deliver and hold their naming ceremonies, the churches donated money to them and this helps them to meet their financial needs. Hence, the ever-pregnant girls through this onetime financial support had money at the initial stages of their motherhood from their religious group.

Furthermore, some girls had access to economic capital from their own labour and savings. They shared:

> *When I became pregnant, my mother gave me money to start a mobile transfer business where I made some profit which I used to buy the things I wanted, I also saved some for my future use* (Boatemaa, EPH, In-depth interview, Begoro)

> *My mother and my partner give me money out of which I save some of the money they gave me for future use* (Owusua, EPH, In-depth interview, Begoro)

An adult community member corroborated this by observing:

> *They (adolescent mothers) have to try to sell things such as oranges and eggs in order to make some money and take care of their children* (Male adult 2, In-depth interview, Begoro)

This shows that ever-pregnant girls who had access to financial support sometimes saved money. This provides a means for them to have access to financial support and command over economic

resources, mainly money (Bourdieu, 1986). Thus, savings provided the ever-pregnant girls with financial security when the need arose.

Findings indicate that some ever-pregnant girls had access to money for their hospital bills, school fees, food and medicine that helped them to cope well with teenage pregnancy and motherhood. They had access in the first place because they had parents who accepted the responsibility to support them financially. Proactive parents provided support for adolescent mothers to overcome risk they encounter as such ever-pregnant girls who had proactive parents had access to financial support. Furthermore taking initiatives is a protective factor in resilient adolescent mothers (Carey, 1998). For adolescents to succeed when they take initiative to raise money, they needed the support of significant others such as receiving capital to start a business or have access to financial support through being involved in the family business activities. So that while they received this financial support, they could raise their own money either through savings from what they received or through working to earn money to have access to financial resources or to have command over economic resources. Therefore, taking initiative or having initiative on the part of both girls and parents is part of the resilience building process.

Statistically, there are no significant relationship between other relatives, boyfriend/partner, peers and other sources of economic capital and ever-pregnant girls‟ resilience level (Table 8.2). This means that apart from parents no sources of economic capital played any significant role in how girls adjust positively to teenage pregnancy and motherhood.

8.3.2 Role of Economic Capital in EP Girls" Resilience to Pregnancy and Motherhood

Support for ever-pregnant girls through the provision of material needs such as food, clothing and shelter helped the girls and their babies to maintain good health. Maku and Boatemaa both high resilience girls explained:

> *They (parents) always make sure I am okay and that I have food to eat and they make sure that all my needs are supplied* (Maku, EPH, In-depth interviews, Begoro)

> *She (mother) gives my child good food that will help him to grow stronger and she gives me food that will help me stay healthy* (Boatemaa, EPH, In-depth interviews, Begoro)

The ever-pregnant girls who had access to financial support observed that it helped them to secure their health and that of their babies. Adiza acknowledged how through her grandmother"s financial support her baby was able to survive after birth. She demonstrated:

> *Without her (grandmother) help my baby would not have survived, because when we went to the hospital, they told us to buy GH¢ 35 pound worth of blood and we paid around GH¢ 250 for our bills so without her we wouldn"thave made it* (Adiza, EPL, In-depth interview, Begoro)

Similarly, Drowa also explained:

> *Without her (mother) financial support, things would have been very difficult for us, for example without her support we would have paid for all our hospital bills* (Drowa, EPH, In-depth interview, Begoro)

The adult respondents, who shared similar sentiments, corroborated this:

> *It (financial support) can help because they (ever-pregnant girls) need money to take care of their babies so the parents are to support them financially* (Female adult 4, In-depth interview, Begoro)

The financial support helped the ever-pregnant girls to have access to their basic needs during and after pregnancy. This is because girls needed money to have access to good food for both mother and child during and after pregnancy. It is essential that a girl eat well to have a safe pre-natal and post-natal life.

Aside from the basic needs of girls being met through financial support, financial support made ever-pregnant girls have some sort of financial independence through being given capital to start up their own business or in some cases working for the family to earn some wages. According to Boatemaa a high resilient ever-pregnant girl, she was in business during her pregnancy in order to meet her financial needs but is back in school and supported financially by her mother through school. She noted:

> *I stopped going to school when I became pregnant. She (mother) gave me money to start the transfer business so that if I need something I will get the money to buy it* (Boatemaa, EPH, In-depth interview, Begoro)

In other cases, access to financial support provided the ever-pregnant girls with capital to start a business for them, which make them independent as well as self-sufficient financially. An adult community member shared this view:

> *Having money can help a teenage mother to access family planning and use some to start a business. There was one lady who went to join the national youth employment but she couldn"tfinish because her mother didn"tt register her due to lack of money, so she is unemployed* (Female adult 6, In-depth interview, Begoro)

Thus, it gives them the purchasing power to access family planning services including the use of contraceptives to protect them from another unwanted pregnancy and sexually transmitted infections. In addition, it helped them to meet or afford to buy their basic needs when the need arose.

The financial support for the ever-pregnant girls helped them to continue their education. Boatemaa who used to do mobile transfer as a business when she became pregnant shed light on how she stopped that business and her mother was supporting her financially through school:

> *She (mother) is paying for my education. She (mother) sells „kenkey",and then saves part of the profit for my schooling and part to keep her business running* (Boatemaa, EPH, In-depth interview, Begoro)

Additionally, having money helps to secure a girl‟s future in many ways. Girls whose parents supported them with money were able to return to school and in some cases send their children to school. Lack of access to financial support from a significant source such as parents exposed the young-mother and her child to economic hardship. This was because most adolescent girls who became pregnant dropped out of school and remained unemployed and as such rely on their relationships with a significant others such as parents and boyfriend/partner for financial support.

Financial support in the form of monetary assistance helped girls to secure the health of their babies. As demonstrated in some of the narratives from the ever-pregnant girls, they were able to secure the health of their babies because they had access to financial support. Aside from having money to secure the health needs of their babies, eating good food during and after pregnancy was also important to secure the health of both mother and child.

Coping well with teenage pregnancy and early motherhood therefore extended beyond being advised on what to do to carry on with life, it demands practical actions such as using money to put into practice all the „good advice‟, such as attending antenatal or post natal clinics and going back to school. Since most adolescent girls were dependent on their parents before they became pregnant they did not have any source of income neither were they employed during pregnancy and as such, continued to be unemployed after having children, hence needed financial support to be able to survive or adjust to teenage pregnancy and early motherhood. Most girls who came to this realization try to find work to do in order to have a source of income or relate well with their parents in return for support. Financial supports from a significant other, mainly parents helped

the ever-pregnant girls to overcome risks associated with teenage pregnancy and early motherhood (Fergus and Zimmerman, 2005; Alvord, 2005).

8.4 Access to Cultural Capital in Coping with Teenage Pregnancy and Motherhood

Cultural capital is observed in this study as the other sources of information (books, television, radio etc.) that has protective influence on adolescent girls‟ to adjust positively teenage pregnancy and motherhood. In this section cultural capital, refers to the other sources of information such as the media, books and billboards that provide girls with knowledge on teenage pregnancy and motherhood. The discussion in this section looks at the sources and the type of information that helped girls to build resilience to motherhood.

8.4.1 Source of Cultural Capital for Ever-Pregnant Girls

This section focuses on how ever-pregnant girls acquired knowledge about their reproductive life and their role as mothers in their society. Ever-pregnant girls gained access to knowledge and information on how to cope successfully with teenage pregnancy and early motherhood through other sources by which information is shared such as radio, television, books, cell phones and billboards. From Table 8.3, the main sources of information identified by the ever-pregnant girls were radio programmes (65%) and television programmes (54%). The sources of information identified by the ever-pregnant girls that helped them to adjust to teenage pregnancy and early motherhood are displayed in Table 8.3.

Table 8.3: Source of Cultural Capital for Ever-Pregnant Adolescent Girls

Source of Cultural Capital	Frequency n=81* (%)	High Resilience Frequency n=40* (%)	Low Resilience Frequency n=41* (%)	χ2 (P value)
Radio	53 (65.4)	33 (82.5)	20 (48.8)	8.74 (0.003)**
Television	44 (54.3)	27 (67.5)	17 (41.5)	4.53 (0.033)**
Cell Phones	20 (24.7)	17 (42.5)	3 (7.3)	11.65 (0.001)**
Books	19 (23.5)	16 (40.0)	3 (7.3)	10.29 (<0.001)**
Bill Boards/Posters	7 (8.6)	6 (15.0)	1 (7.6)	2.61 (0.106)
Music	6 (7.0)	5 (12.5)	1(2.4)	1.70 (0.191)

Source: Author"s Fieldwork, 2012
*multiple choices allowed
**P<0.05
χ2 = Chi Square: df = 1

The study revealed a significant relationship between radio and resilience level, thus girls who had access to radio were more resilient than those who did not. Significantly more high resilient ever pregnant girls (82.5%) mentioned radio (p=0.003) compared to the low resilient girls (48.8%), as a source of information on sexual and reproductive health in general but teenage pregnancy in particular. The radio programmes informed girls about their sexual and reproductive life as well as how to care for their children. Some high resilience girls narrated how they had access to information from radio:

> *I started listening in to a radio programme about two months ago and they actually confirmed the advice my mother has been giving me. There is a programme on Adom FM (local radio station) that I listen to and it helps me…* (Boatemaa, EPH, In-depth interview, Begoro)

> *I listen to a programme on one of the radio stations (Adom FM) that educated the youth on how to secure our health. They have nice programmes that can help you to secure your health and that of your baby… it has really helped me* (Maku, EPH, In-depth interview, Begoro)

Similarly, some low resilience girls who had information and knowledge about teenage pregnancy and motherhood from radio stated:

> *Sometimes when they are giving the news on the radio, they talk about the types of immunization that our babies need. They also educate us on what to do to keep them healthy. … They (radio stations) invite doctors and some of them even advice that we should give our children fruits before meals* (Adiza, EPL, In-depth interview, Begoro)

This confirms that ever-pregnant girls had access to information and knowledge from the radio on sexual and reproductive health. Access to knowledge from the radio was from either programmes or advertisements that focused on sexual and reproductive health issues and general programmes such as the news that occasionally contained such information. Although some girls mentioned listening to the news as a way of having access to information on teenage pregnancy and motherhood, it suggests that they only had access to relevant information when the news focused on relevant topics related to sexual and reproductive health. Listening to radio to acquire knowledge thus, required consistency as well as the relevance of the information that is being accessed. Therefore, listening in to specific programmes that focuses on sexual and reproductive health issues is more likely to benefit girls.

Aside from listening to the radio to have access to information on sexual and reproductive health issues, watching of relevant television programme also provides knowledge about sexual and reproductive health as well as motherhood to the ever-pregnant girls. Significantly more ($p=0.033$) girls with high resilience scores (67.5%) reported television as a source of information and knowledge compared to those with low resilience scores (41.5%). Access to knowledge from television programmes was from talk shows, drama series and advertisement on family planning and contraceptives. Owusua, a high resilient girl sheds light on how she accessed knowledge from television programmes:

> *I love watching television programmes and so sometimes when they have programmes like „Mmaa Nkomo[8]" I learn about issues in life as well as how to be a good mother to my child. I get knowledge on how to secure my health and that of my baby from the television through advertisements too… The advertisement about family planning tells us how we can avoid pregnancy until we are ready to have another baby* (Owusua, EPH, In-depth interview, Begoro)

To have access to relevant information on sexual and reproductive health demanded that adolescent girls identified relevant programmes. The ever-pregnant girls from the narratives had access to information by watching relevant programmes and advertisements that focused on reproductive health on the television. This notwithstanding, the girls indicated that some of the programmes and advertisements were not directly designed for them, but because they find themselves as „mothers", they took the opportunity to learn about motherhood from such sources. What this study has found is that although adolescent mothers have access to information about pregnancy and motherhood, they were general information meant for adults and not necessarily for adolescent mothers and therefore did not address adolescents" specific needs

Although some of the ever-pregnant girls identified the TV as a good source of information, they explained that they often turned to the radio programmes more because they did not have access to televisions in their homes. Some girls shared sentiments about their access to television:

> *We do not have a television set at home, due to that I do not have any interest in watching TV* (Drowa, EPH, In-depth interview, Begoro)

> *The television programmes are also very good, but most of us here do not have television sets so most of us listen to the radio* (Dede, EPH, In-depth interview, Begoro)

Since some ever-pregnant girls did not have access to television sets, it influenced their source of information making them incline more to radio programmes as compared to TV programmes for

[8] „MmaaNkomo" literally means conversations about women, a local programme on television that discusses issues about women in general.

knowledge. The study also revealed that, sometimes the ever-pregnant girls did not get the essence of the information passed through the electronic media. The response from Grace a low resilience ever-pregnant girl who was cohabiting with her partner expressed this during an in-depth interview as shown below:

S: What do you learn from the television programmes you watch?
R: There are some men who are married but they have girlfriends
S: So how does that help you?
R: I learn that I do not have to allow my "husband" to cheat on me

Grace‟s response in the interview demonstrated how some girls misinterpreted programmes intended to educate them about not going after married men, because all they might want from a girl is sex. As such, radio and television programmes that aimed at educating adolescents about their sexuality and teenage pregnancy should make the message clearer for easy understanding by the targeted audience.

Finding that radio and television are the two most important sources of information for ever-pregnant girls is consistent with national survey data on adolescent sources of information on sexual and reproductive health in Ghana (GDHS, 2003). The radio and television programmes that the girls discussed showed that they focused more on how to avoid subsequent pregnancies and how to stay healthy. However, what this study has found is the lack of specific programmes that focused on adolescent mothers and their needs. Thus, there was no mention of a programme that target adolescent mothers‟ educational and economic life. Since radio and television programmes have been identified as having impact on adolescent girls sexual and reproductive life (Awusabo-Asare et al., 2004), other programmes that would serve as a motivation for girls not to drop out of school because of pregnancy and childbirth should be introduced to meet the specific needs of adolescent mothers. This would then encourage and inform girls about the

possibility of going back to school or learning a trade to prepare them for the future in order to secure their economic life.

Additionally, 24.7% of the ever-pregnant girls identified cell phones as the other sources of information that helped them to cope with teenage pregnancy and early motherhood (Table 8.3). The data revealed that significantly more (p=0.001) girls with high resilience scores (42.5%) had access to information from the use of cell phones compared to girls with low resilience scores (7.3%) , establishing a relationship between having access to cell phone and building resilience among ever pregnant girls. The ever-pregnant girls who identified their cell phones as a source explained that they sometimes received text messages that gave them information about the different types of family planning methods available.

The study also showed that some ever-pregnant girls had access to cultural capital through reading relevant materials. Those who read had to read relevant information from relevant sources to cope with teenage pregnancy and motherhood. It was found that 23.5% of the ever-pregnant girls had access to information from books that helped them to cope well with teenage pregnancy and motherhood (Table 8.3). There was a relationship between having access to books and developing resilience among ever pregnant girls as significantly more (p=<0.001) of the girls with high resilience scores (40.0%) reportedly have access to books compared to those with low resilience scores (7.3%). Both a high and a low resilience girl stated this about access to books:

> *When we go for weighing, they have some posters on the walls that have pictures and literature showing how to breast feed, there are pictures that encourage us to make sure we immunize our babies so that they will not fall sick* (Sheila, EPH, In-depth interview, Begoro)

> *I get information from books and graphic (daily newspaper) … this information has helped me to take good care of myself and my child, I know how to feed, clothe and access family planning* (Gloria, EPL, In-depth interview, Begoro)

The low proportion of adolescent girls who turned to reading of books for information had to do with several factors including making of time to read and reading from a relevant source. For instance, Boatemaa who after having a baby has gone back to school explained that she preferred listening to the radio rather than reading books to acquire knowledge and information about teenage pregnancy and childcare. She observed:

> *… I only read for my academics but not the one on how to avoid teenage pregnancy* (Boatemaa, EPH, In-depth interview, Begoro)

Reading was not so popular among the ever-pregnant girls who attributed it to lack of adequate time for reading, since reading could not be done simultaneously with other activities such as childcare, cooking and doing schoolwork. This explains why Boatemaa made a categorical statement that she read for her academics and not about sexual and reproductive health issues because she got such information from the radio. This explains why most ever-pregnant girls were more unlikely to turn to books for information.

On the other hand, 8.6% and 7% accessed information from billboards/posters and lyrics from music respectively (Table 8.3). The few who reported access to posters/billboards link them to the hospital. Posters made information readily available for girls to read and acquire knowledge about their reproductive life where they are available but in the study, it appeared access to billboards/posters were limited. A high resilient girl identified posters at the hospital as her source of information. She observed that whenever she went to the hospital she read the posters that talked about motherhood such as breastfeeding and immunization.

> *When we go for weighing, they have some posters on the walls that have pictures and literature showing how to breast feed, there are pictures that encourage us to make sure we immunize our babies so that they will not fall sick* (Sheila, EPH, In-depth interview, Begoro)

Dede, another high resilient ever-pregnant girl on the other hand identified music as her source of information on sexual and reproductive health issues when she noted:

> Some *of the songs are very educative; they help you avoid many misfortunes. For instance this popular advertisement song: „I"syour life it"syour choice"…* (Dede, EPH, In-depth interview, Begoro, In-depth interview, Begoro)

This suggest that at a confidence level of p=0.05, there was no significant relationship between billboards/posters (p= 0.106) and music (p=0.191) as a source of cultural capital and resilience level. Billboards/posters and music did not play a significant role in how EP girls adjusted to teenage pregnancy and motherhood.

Researchers have always identified the electronic media as a powerful source of information for adolescents and for that matter ever-pregnant girl on how to adjust to the responsibilities of pregnancy and motherhood (Awusabo-Asare, 2004; GDHS, 2003). Although both radio and TV were highly identified as a source of information, the radio stood out compared to the TV. The latest addition on the block was the use of cell phones as a source of information. The cell phone served as a source of information because some ever-pregnant girls explained that they received text messages. These text messages were usually sent to them alerting them on dates for immunization as well as motivational messages. Most ever-pregnant girls from the results did not have time to read books for information and asserted that printed materials on adolescent motherhood were not common. Therefore, with the exception of billboards /posters and music, all the other sources of information played a significant role in EP girls‟ resilience to teenage pregnancy and motherhood.

8.4.2 Role of Cultural Capital in EP Girls" Resilience to Pregnancy and Motherhood

The ever-pregnant girls shed light on how the knowledge they had helped them to avoid subsequent unwanted pregnancy. Boatemaa a high resilience ever-pregnant girl shared this view held by the other ever-pregnant girls:

> *I have knowledge about other things. You can have sex with a man but there are ways you can protect yourself. Like using a condom, using pills and other things* (Boatemaa, EPH, In-depth interview, Begoro)

An adolescent boy who believed that adolescent girls who had ever been pregnant before still needed education on how to avoid subsequent unwanted pregnancy shared this view:

> *An adolescent girl may have a baby but still wants to continue sleeping with her boyfriend in such a situation the best thing is to teach her how to protect herself. This can help her take care of the baby* (Boy 2, In-depth interview, Begoro)

In addition, having information about family planning and the use of contraceptives after becoming pregnant or having a baby helped the ever-pregnant girls to make decisions about subsequent childbirth. Gloria an ever-pregnant girl with low resilience shared how the information she had on sexual and reproductive health had influenced her decisions on when next she intends to get pregnant:

> *I know that I have to wait for about five years before giving birth. To achieve this, I will go for an injection (family planning)* (Gloria, EPL, In-depth interview, Begoro)

These assertions by the ever-pregnant girls demonstrated that they acquired knowledge from other sources of information on how to avoid subsequent unwanted pregnancy, which in effect helped them to secure their wellbeing as well as their babies. This is well explained by Dede when she said:

> *They (radio and TV) teach us how to secure our health and that of our babies, if you act on what they teach you, it will help you and your baby* (Dede, EPH, In-depth interview, Begoro)

Similarly, Adiza a low resilience girl and Drowa a high resilience girl both shed light on how accessing information from other sources had helped them to live a healthy life:

> *To ensure that my baby is healthy, I give her good food, we sleep in treated mosquito nets, and then whenever she falls sick I take her to the hospital. Previously I did not know about this… but thanks to the information from the radio…* (Adiza, EPL, In-depth interview, Begoro)

> *I know that you have to take good care of your child so that she grows well. They (radio) educate us on how to give our babies the care and affection they need. It has thought me how to secure my health and that of my baby, so that the baby can grow well* (Drowa, EPH, In-depth interview, Begoro)

These sources provided adolescent girls with information on how to secure their health and that of their babies through healthy sexual practices as well as feeding and health related issues. For instance, information about sleeping under mosquito nets when pregnant or after delivery, helped girls avoid malaria during and after delivery was received from these sources (radio and television) and helped to prevent or reduce childhood malaria among the babies, considering the fact that malaria is a deadly infant disease.

Having access to information helped ever-pregnant girls to cope well with pregnancy and motherhood and this prevented them from resorting to self-induced abortion when they were pregnant. An adolescent boy perceived:

> *Maybe at first they were ignorant but when they get the knowledge, it can help them, because if they have this knowledge it can help them avoid things like abortion* (Male adult 2, In-depth interview, Begoro)

Although ever-pregnant girls did not talk about having ever had self-induced abortions, comments from community members suggested that most adolescent girls in the community did not often resort to self-induced abortion due to the support they received from their parents and other members of the community:

> *When girls become pregnant and you do not handle them with care they might go and abort the pregnancy, they (parents) encourage them to have the baby and promise to help them continue with their education* (Male adult 4, In-depth interview, Begoro)

The view expressed by community members explains why none of the ever-pregnant girls involved in the study identified abortion as an option. This notwithstanding, since abortion is stigmatized, it could also account for why the ever-pregnant girls did not disclose whether they have had a self-induced abortion before.

8.5 Symbolic Capital as a Protective Factor against Sex and Teenage Pregnancy

Symbolic capital denotes girls‟ reputation in society; whether they feel accepted within the community or whether the community members accept them for who they are. Symbolic capital refers to an individual‟s reputation, honour or prestige within a social space (Bourdieu, 1993). It is based on the individual‟s social status and how access to the other capitals (social, economic and cultural) helps one to adjust positively to the challenges associated with teenage pregnancy and early motherhood.

8.5.1 Perceptions of a “Good” Social Reputation for Ever-Pregnant Girls‟

A good reputation for an ever-pregnant girl is associated with being respectful to parents and adult community members. The ever-pregnant girls explained that being respectful to adults in the community could make one earn a good reputation. Adiza an ever-pregnant girl explained why she had a good reputation in the community although she has a baby:

> *I respect the elders, I help them carry their foodstuff from the farm, I go on errands for some and also fetch water for some of them* (Adiza, EPL, In-depth interview, Begoro)

Grace also corroborated this:

> *I help with the house chores and on market days, I help them (parents) to sell their foodstuffs* (Grace, EPL, In-depth interview, Begoro)

Community members saw these acts as signs of humility because of the adolescent girls‟ experience with teenage pregnancy. The experience of teenage pregnancy and motherhood tend to have a humbling effect on adolescent girls‟ as such it makes some of them turn on a „new leaf‟.

The adolescent mothers further explained that they earned good reputations from people because they were able to take good care of their babies as well as themselves after becoming pregnant. Dede a high resilience ever-pregnant girl explained:

> *People will really praise you that you have been able to take good care of yourself and your baby…. I really take good care of my daughter and everyone showers me with praises anytime they see the baby* (Dede, EPH, In-depth interview, Begoro)

A few of the adolescent mothers had the perception that having a husband on becoming pregnant was a way of earning a good reputation in the society. As such, some associated their good reputation to the fact that the fathers of their babies have accepted to marry them. In such cases, girls who went on to marry the fathers of their babies after becoming pregnant enjoyed some level of respect in the community. Tina expressed:

> *They praise me because I have a husband (partner); it is not all the teenage mothers who have a husband (partner)* (Tina, EPL, In-depth interview, Begoro)

Tina‟s explanation indicates that some adolescent girls after becoming pregnant ended up marrying or cohabiting with their boyfriends/partners which most of them interpret as marriage. Early marriage although is regarded as illegal by the constitution of Ghana for under 18 year olds, some parents and adolescent girls see it as a security to protect girls (Bruce, 2002). However, marrying girls off early because of pregnancy has the tendency to disrupt their

education, which reduces their employability value and such girls are more likely to experience domestic violence (Jensen and Thornton, 2003).

These findings indicate that having a good reputation has to do with being respectful to adult community members, being able to take good care of one‟s self and one‟s baby. It also included being able to go on with one‟s normal life such as going back to school, learning a vocation or being employed that is doing something that allows one to have a source of income. On few occasions, a pregnant teenage girl earned good reputations when the boy/man responsible for the pregnancy accepts and marries them.

8.5.2 Role of Maintaining a Good Social Reputation in Adolescent Mothers Resilience

Maintaining a good social reputation played a role in the way ever-pregnant girls coped with teenage pregnancy and early motherhood. Firstly, ever-pregnant girls in their bid to maintain and earn good reputations in their community despite having a baby strived to go back to continue with their education. Boatemaa observed:

> *By God's grace after having my baby, I am back in school and next year my baby will start schooling so people praise me because most teenage mothers do not continue with schooling after giving birth* (Boatemaa, EPH, In-depth interview, Begoro)

Some ever-pregnant girls strived to concentrate on their academic work to earn the commendation and approval of community members. Sheila observed:

> *I make sure I take my academic work seriously to secure my future because if I drop out of school people will say that after I had the baby I was not able to continue with my schooling. People use me as an example to advice their children, they tell them of how I have been able to continue with my school after giving birth* (Sheila, EPH, In-depth interview, Begoro)

According to the ever-pregnant girls, being able to continue with one‟s education after having a baby earned them praises from community members, to the extent that some of them became role models for other girls who became pregnant. As role models, they were used as examples to encourage other teenage mothers to go back to school after having a baby. In addition, those who had more education such as JHS and SHS students, tend to strive to go back to school after having a baby. For instance, Boatemaa, who had a baby after her Basic Education Certificate Examinations (BECE), went back to school and has since moved on to Senior High School (SHS). This finding indicates that although there is an inverse relationship between pregnancy status and educational background, when girls receive social, economic and cultural capital from significant sources it helps them to return to the classroom after having their babies. Thus, in this case to maintain a good reputation despite one‟s pregnancy status, it rather encouraged them to return to the classroom to further their education regardless of getting and being mothers.

Secondly, some ever-pregnant girls who dropped out of school as a result of pregnancy and childbirth went on to trade or learn a vocation in order to earn money to take care of their financial needs. In her view, Gloria noted:

> *You have to make the effort yourself to sell something to take care of your child* (Gloria, EPL, In-depth interview, Begoro)

Furthermore, because ever-pregnant girls do not want people to have negative impressions about them, such as being unable to take care of themselves and their babies as a result of being "teenage mothers", it pushed them to strive hard to take good care of themselves and their baby. Owusua demonstrated this in her narrative:

> *If you don"t take good care of your child and leave him to be moving from house to house in search of food, people will say you are irresponsible but if you are able to take good care of your child they praise you* (Owusua, EPH, In-depth interview, Begoro)

For the ever-pregnant girls, the desire to feel accepted in the eyes of community members pushed them to do things that would earn them praises despite being pregnant or teenage mothers. Carey et al. (1998) described girls who wanted to prove a point to society that they could make it in life despite experiencing teenage pregnancy as being "rebellious". This study has shown that ever-pregnant girls in their bid to prove a point to their community members put up good behaviour including working hard and returning to school just to earn good reputations. The attempt to earn and maintain good social reputations helped the ever-pregnant girls to build resilience to cope well with teenage pregnancy and motherhood. They do this not necessarily to "rebel" but to be accepted by society. This is why they took good care of their babies, went back to school and took their academic work seriously or even find work to do to make money. The findings also revealed that, adolescent girls who had high resilience had completed more schooling at the time of pregnancy and had more support from their parents, other relatives and other community members (Weed et al., 2000). Those who engaged in trading or did some work, did so in order to earn money so they could afford to provide for their babies' need as well as their own needs.

8.6 Conclusion

This chapter has discussed how ever-pregnant girls had access to social, economic, and cultural capital that helped them to maintain a good social reputation (symbolic capital), which helped them to overcome the risk of teenage pregnancy and early motherhood. Source of social capital that was significant to adolescent mothers' resilience building was mainly from parents and other relatives such as grandparents. The type of social capital received was advice and practical support with childcare. Thus, non-pregnant girls had access to social capital from more sources compared to the ever-pregnant girls. Furthermore, while non-pregnant girls had access to social

capital in the form of advice, encouragements and social control from their sources, ever-pregnant girls received advice and practical social support such as bathing, feeding and babysitting. Parents and boyfriend/partner was another significant source of economic capital in adolescent girls‟ development of resilience to teenage pregnancy and motherhood. However, having access to social support was not in itself enough because to cope well with pregnancy and motherhood also required having financial support in order to have access to basic needs such as food, clothing and shelter. Financial support helped the ever-pregnant girls to maintain good health and have a normal life like their non-pregnant colleagues. Findings so far indicate that ever-pregnant girls had access to information on how to respond to the challenges of teenage pregnancy and early motherhood by listening, watching and reading from sources that provided such information. Bourdieu (1986) identified three ways in which cultural capital could be identified and this study found that the ever-pregnant girls had access to the objectified cultural capital more in coping successfully with being an adolescent mother. This objectified form of cultural capital according to Sullivan (2001) could be measured by looking at the type of materials girls read, what they listened to (music and radio) and the programmes they watched.

From the findings, ever-pregnant girls developed resilience based on the number of capitals they had access to as well as how successful they accessed these capitals. Thus, resilience level of adolescent mothers is therefore dependent on the number of resources (capital) available to the individual adolescent girl and her success at accessing these resources during and after pregnancy. It is however important to note that these actions that individual adolescent girls take are not carried out independently or in isolation but are done in addition to applying various resources they are able to access from their community.

CHAPTER NINE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

The key considerations in this study has been to examine how adolescent girls are able to avoid, overcome and adjust to the risk associated with their sexual and reproductive life experiences in their social context. The main objective of the study was to investigate how adolescent girls who were not pregnant (non-pregnant girls) and adolescent girls who were pregnant or have had a live birth (ever-pregnant) used the various social, economic, cultural and symbolic capitals available to them within their given social context to avoid, overcome and adjust positively to sex, pregnancy and motherhood. This study was guided by the social resilience framework, which identifies three components namely risk, protective factors (capitals) and the positive outcome as the resilience building process. The social resilience framework was used as a guide in order to establish the relationship between the various forms of capital and how they relate to adolescent girls‟ ability to avoid, overcome and adjust to teenage pregnancy and early motherhood.

This concluding chapter is presented in three parts. The first part presents a summary of the main findings of the study. The second section discusses the conclusions made based on findings from the study. The third section focuses on recommendations based on the conclusions from the study.

9.2 Summary of Findings

The main objective of this study was to find out how adolescent girls developed resilience to sex, teenage pregnancy and early motherhood. For the adolescent mothers the study found out how

they adapted positively to early motherhood and for those who were not pregnant and have no children, the study found out how they avoided sex and teenage pregnancy.

Background of Survey Respondents

All the age sets-(15-19 years) that constituted older adolescents were fairly represented in the study. Almost all the respondents had some level of education with the exception of 5.2% who had no formal education. However, the majority had at least junior high school level of education that is both for non-pregnant (52.7%) and ever-pregnant girls (56.8%). The main ethnic groups involved in the study were Akans and the Ga-Adagmes with only 12.6% representing other ethnic groups such as the Ewes. Christians constituted the dominant religious group in the study. Most of the respondents were either single (49.2%) or in a relationship (34.2%). The proportion of pregnant girls (16%) identified in the study supports the GDHS (2008) report on the proportion of adolescent girls who were pregnant and teenage mothers (16%) in the rural areas.

The data revealed that pregnancy status of the respondents increased with age. The likelihood of adolescent girls to have children increased as their age increased. There was an inverse relationship between pregnancy status and educational level. The adolescent girls with higher education were less likely to be pregnant. The family source of income did not determine a girl‟s pregnancy status with the exception of farming. Parent‟s marital relationship status had an influence on pregnancy status in that more girls that were non-pregnant lived with both parents as compared to ever-pregnant girls.

Social Context of Adolescent Girls Sexual Behaviour in Begoro

Community members perceived that adolescent girls‟ behaviours and attitudes to sexual and reproductive health issues had undergone contemporary changes. These changes were perceived to have influenced the attitudes of adolescent girls to socio-cultural norms and values concerning sexual activities. It was reported that the traditional way of ushering girls into womanhood has undergone some changes because of formal education and the emergence of other sources of information such as radio, television and cell phones, which influenced adolescent girls‟ sexual behaviour. The traditional institutions, which once governed norms and values, rites of passage and marriage, have been largely replaced or exist side by side with the religious, health and educational institutions (Ahlberg, 1994; National Population Council, Ghana, 1994). Thus, there was a perception among adult community members that the decline in the traditional way of ushering adolescent girls into womanhood through the performance of puberty rites is the cause of the increasing out of wedlock pregnancy

Traditionally, the social actors in adolescent girls‟ sexual and reproductive life were parents and other old women. However, due to the changing attitudes and behaviour of adolescent girls, such as not informing parents when they experienced menarche, parents were not able to advise and take them through the puberty rites. Parents traditionally, were advisors as well as a source of knowledge on sexual and reproductive health issues. Elderly women usually took girls through puberty rites during which they taught them about their sexuality and reproductive life. Thus, there were perceptions that with the erosion of the roles of the elderly women and the decreasing role of parents in adolescent girls‟ sexual and reproductive life, girls were predispose to premarital sex and teenage pregnancy. This notwithstanding, parents were still part of the nexus

of social actors although the role of the old women (performing the puberty rites) has diminished because of the emergence of new social actors as well as the attitudes of the girls. With this change, adolescents receive additional social support in the form of knowledge and advice on their sexuality from school, social media and the community members. This has reduced and replaced their total reliance on their parents as a major source of social support. However, parents continue to have an influence in their daughters‟ sexual and reproductive behaviour despite the persisting change, by developing a strong relationship with them so that through their support they will be able to avoid or overcome such challenges (Alvord and Grados, 2005).

The study also found that although parents still played important roles in adolescents‟ sexual and reproductive lives, the appearance of other actors now means adolescent girls have a vast array of resources such as teachers, books and radio they turn to for information on their sexuality and reproductive life. While having a wide range of sources of information on sexual and reproductive issues, it also has a potential of increasing risk depending on the quality of information coming from these sources.

Furthermore, the traditional value of abstinence to sex until marriage is giving way to the duality of abstinence from sex or the use of contraceptives. Childbearing and marriage are also becoming “increasingly unlinked” as suggested by Hindin and Fatusi (2009:58), in that childbearing is becoming more acceptable out of marriage, which previously was the case where childbearing was accepted mainly within marriage. Adult community members did not openly acknowledge the promotion of the use of contraceptives, although contraceptive use by adolescent girls emerged strongly as an option for girls to avoid pregnancy. The influence of

change has led to some community members‟ advising girls to either abstain totally from premarital sex or use protection by accessing family planning or using condoms when they engage in premarital sexual activities.

The study found that change in age of adolescent sexual debut and childbirth was attributed to the age at which girls experienced menarche. As such, early menarche in girls was perceived by the adult respondents to predispose girls to early motherhood when they engage in sex. Early sexual and reproductive maturity among adolescent girls emerged as a determinant in the exposure of adolescent girls to teenage pregnancy and early motherhood, which was also reported by Dunbar et al., (2008).

Furthermore, the study found that the perceptions on the appropriate age for childbearing among adolescent girls were not only based on age but also on other factors such as completion of school (at least senior high school), financial competence and maturity, this finding was in line with what was reported by Adomako Ampofo (2001). Respondents‟ views showed that the preferred age for adolescent girls to have children was eighteen years and above which is the same age for marriage, as stated in the 1992 Constitution of Ghana. The justification for this is that at that age an adolescent girl would have completed some level of education, be financially independent as well as be matured, a requirement for having a child. These views indicate a change from the traditional values where childbearing was accepted and associated with marriage with little regard for age. This suggests that community members now consider it more acceptable than in the past for adolescent girls to have babies out of wedlock as long as they are „matured‟ enough for motherhood.

Resilience Pathways against Sex and Teenage Pregnancy

Non-pregnant adolescent girls were able to avoid sex and teenage pregnancy by accessing social, economic and cultural capitals through their own initiative, family and community in their effort to maintain a good reputation (symbolic capital) in the society. The study found that, although the social context presented girls with risk and protective factors in the form of social, economic, cultural and symbolic capitals some non-pregnant girls took advantage of the protective factors to avoid sex and teenage pregnancy.

Parents and religious leaders were the main sources of social capital that had a significant relationship with non-pregnant girls‟ resilience level. Parents supported their non-pregnant daughters through advice on abstinence. Although adolescent girls tend to shy away from asking parents questions relating to sex, some parents who took the initiative and helped their daughters to have knowledge about their sexuality and reproductive issues. On the part of familial source of social capital older siblings were contacted for advice and answers related to sexual and reproductive health issues. Additionally the study found that, although sexual and reproductive health issues have been included in the school curricula in Ghana, only a few of the adolescent girls identified their teachers as a source of social capital. The study further revealed that religious leaders‟ advice on adolescent sexual behaviour had a significant relationship with their resilience level. Girls who received advice on abstinence from sex and living a life of chaste from religious leaders were able to avoid sex and teenage pregnancy.

Furthermore, the advice resilient girls received from the four major sources (parents, other relatives, teachers and peers) were in two forms, abstinence and protection. Whereas, parents and

religious leaders only advised on abstinence from sex, teachers and other relatives advised on abstinence and the use of contraceptives.

Economic support accessed by non-pregnant girls was money for school fees, pocket money and the provision of their basic needs such as food, clothing and shelter. The source of economic support for the non-pregnant girls was mainly parents, other relatives and boyfriends. There was a significant relationship between parents and boyfriends as a source of economic support for non-pregnant girls. Parents provided basic needs, school fees and pocket money, which helped the non-pregnant girls to avoid the risk of sex and pregnancy. Although boyfriends supported girls financially, these were usually not directly for sexual and reproductive health issues. As such, girls who were resilient diverted and saved such money for protection when they had sexual intercourse by buying condoms and contraceptive pills. Some of the girls also had access to economic capital through their own initiative by saving money meant for other purposes such as pocket money to secure their sexual and reproductive health needs. Savings was usually from money received from parents or boyfriends, which served as a reserve to rely on when necessary.

With the advice they received and their knowledge on the risks associated with sex, sexually active resilient girls relied on their access to financial assistance to protect themselves when they had sex. The impact of economic capital in the non-pregnant girls‟ resilience against sex and teenage pregnancy is linked to the other three forms of capital. That is, once they have advice and information about their sexual and reproductive life, it had an influence on them by encouraging them to abstain or use their financial resources to buy contraceptives to avoid the risk associated with engaging in premarital sexual activities. Hence, those who had knowledge

and advice and wanted to maintain a good reputation, used part of the money they had to buy contraceptives, books and access family planning services to avoid pregnancy.

The non-pregnant girls had access to cultural capital through reading, listening and watching relevant materials that provided knowledge about sexual and reproductive health issues. With the exception of television, all the other sources of cultural capital had a significant relationship with level of resilience. The high resilience girls applied the information they acquired in decision making regarding their sexual behaviour. This helped them to either abstain from sexual intercourse or use contraceptives to avoid the risk associated with premarital sex.

Since society judged adolescent girls‟ reputation based on their pregnancy status, high resilience girls, in order to maintain a good reputation, abstained from sex or use contraceptives to avoid pregnancy. By so doing, they maintain good social reputations within their community and avoid negative labelling. These were done manifestly to avoid pregnancy in order to maintain a good social reputation in the community. However, the latent function of this was that it made adolescent girls prevent pregnancy and or the risk of sex.

Resilience Pathways to Teenage Pregnancy and Motherhood

Parents and other relatives, usually mothers and grandmothers advised and helped girls with their new status as mothers. These kinds of support were accessible to ever-pregnant girls when they had proactive familial relations. Hence, high resilient ever-pregnant girls had access to advice and practical support mainly from their parents and grandparents. They received diverse forms of social support from their parents including advice, information and practical support in the form

of assistance in taking care of their babies. However, whereas the non-pregnant girls had their older siblings as those who supported them, the ever-pregnant girls had support from their grandparents. Grandparents, usually grandmothers provided support in the form of practical childcare (bathing and feeding of baby) and assistance to the adolescent mother and her child. The study found that most adolescent mothers did not receive social capital from the fathers of their babies because sometimes the fathers refused to accept the pregnancy or there may be antagonism between the two families involved. In cases where fathers were peers, they were not regarded as matured enough to provide such support. In addition, most girls continued to stay with their parents when they become pregnant or have their babies. Parents did not only support through advice, but went on to provide practical support to girls and their babies. Where ever-pregnant girls had a reliable source of social support, it helped them to overcome the challenges associated with motherhood.

For the ever-pregnant girls their sources of financial support were mainly from parents and boyfriends/partners. Parents supported girls financially to go back to school by paying their school fees where applicable and provided them with pocket money. Boyfriends/partners saw financial support as an obligation towards their child and the mother of their child. They provided money for the up-keep of both mother and child. Therefore, girls who were resilient very often had their parents and boyfriends/partner to support them financially. Access to financial support helped girls to have access to basic needs, secure their health and that of their babies and have their life back by going back to school, learning a vocation or finding employment. It also helped girls to be independent because ever-pregnant girls, like the non-pregnant girls, saved some money for their future use from what they received from their

sources. Although the ever-pregnant girls identified religious groups as source of financial support, this was usually a one-off activity through offertory and gifts presented to an adolescent mother in church during the naming ceremony of her child.

The ever-pregnant girls also identified the radio and television as a source of information. However, the types of programmes differed in that the non-pregnant girls focused on programmes that discussed issues about adolescent sexual and reproductive health. The majority usually listened more to the radio, with only a hand full combining it with television programmes. Reading was not part of the source of information for the majority of the ever-pregnant girls. For the ever-pregnant girls the cell phone served as a reminder as well as a source of information on immunisation programmes taking place in the community. Others also used their cell phones to browse the internet for information.

The study found that the ever-pregnant girls strived to maintain their reputation (symbolic capital) after pregnancy by accessing other forms of capital (social, economic and cultural). Access to the various forms of capital influenced how ever-pregnant girls overcame and adjusted positively to teenage pregnancy and motherhood. Girls with their access to capitals were able to take care of themselves and their baby as well as live a normal life such as going to school, learning a vocation or finding work to do. Thus, although the social context of the ever-pregnant girls predisposed them to teenage pregnancy and early motherhood, at the same time it provided them with resources that served as protective factors (Alvord and Grados, 2005; Luthar et al., 2000; Garmezy, 1984). The ever-pregnant girls, although according to the values and norms of their social environment had marred their reputation by becoming pregnant and having babies,

most of them had strived to maintain good social reputations as adolescent mothers. They try to avoid negative labels by striving to take good care of themselves and their babies to meet society‟s expectations.

9.3 Conclusions

The findings on the influence of the social context suggest that there was tension between the changing value systems and adolescent girls‟ sexual and reproductive behaviour. The social context adolescent girls lived is changing and therefore presented them with both risk and protective factors in terms of their sexual and reproductive experiences. This is indicative of changes in the society as the literature by Hindin and Fatusi (2009:58) suggests, "the environment in which young people are making decisions related to sexual and reproductive health is rapidly evolving". Therefore, adolescent sexual and reproductive health programmes if they are to be truly successful must carefully consider a holistic approach that target both the individual, the family and the community at the same time. Social change over the years from the introduction of formal education, Christianity and Islam has had an influence on the sexual and reproductive behaviour of adolescent girls. Now adolescents are confronted with varied value systems in the society leaving them in a dilemma. The value systems adolescents are confronted with uphold the values of chastity before marriage. Aside from the diverse value systems, with the introduction of free compulsory basic education (FCUBE) now girls are seeking education, which makes them stay longer in school and as such postpone marriage (Glover et al., 2003). This notwithstanding, within this periods, girls often have sexual relationships, which can lead to out of wedlock pregnancy. With girls having to wait longer years after the „early‟ onset of menarche because of education and the constitution, they have to

postpone sexual activity if they are to uphold the traditional and religious value of chastity before marriage. These tensions between the value systems (traditional, religious and the legal) and the „adolescent romantic" values affect adolescents" sexual and reproductive behaviour and activity (Ahlberg, 1994). Now girls know that the traditional and religious values in their community advocates for no sex until marriage, but they are also confronted with their own romantic values where some may be drawn to have premarital sex. Consequently, over time, a normalisation of sex before marriage among adolescents has taken place (Henry and Fayorsey, 2002) but it is still not openly accepted among community members. This restricts girls" access to modern contraceptives and as such reducing the frequency at which girls use them in their sexual activities (Adomako Ampofo, 2001). As revealed by the study, based on the knowledge and advice they receive from their parents and significant others, adolescent girls know how to avoid pregnancy when they engage in sexual activity. However, there are barriers created by the societal norms and value systems, which makes them to hide their sexual relations or activities and therefore do not have the luxury of patronising such things frequently (Glover et al., 2003). Therefore, the tension between the traditional, religious, legal and „romantic" value systems identified by Ahlberg (1994) which girls are confronted with in their social environment exposed girls to engaging in risky sexual behaviours with little or no use of modern contraceptives.

Torn between the various value systems and the tensions between them in their social environment, adolescent girls try to maintain good social reputations within their community. So for the non-pregnant girls who abstain from sex, they rely on the social capital (advice) and economic capital (provision of basic needs) and cultural capital (the knowledge about risk associated with pre-marital sex). For the non-pregnant girls who are sexually active, in their

effort to maintain a good social reputation tried to avoid teenage pregnancy by using the advice and the knowledge they had to access protection using their economic capital to acquire and use contraceptives. As such, the various forms of capital played significant roles depending on the context of the individual adolescent girl. On the part of the ever-pregnant girls, they also strived to maintain a good social reputation in their status as adolescent mothers (Carey et al., 1998). They did this by taking good care of themselves and their baby as well as in some cases going back to school, learning a trade or finding a job and in doing so avoid being labelled as failures.

Looking at how the various forms of capital influenced how individual adolescent girls developed resilience against sex, teenage pregnancy and early motherhood, suggest that there is a mutual relationship among them. For the resilient non-pregnant adolescent girls, they were influenced by the social values and norms of their society, where chastity before marriage was the acceptable norm. According to Abott and Dalla (2008), youth"s sexual values are influenced by their personal values and the values of the wider social context. Hence, as a sign of their „chastity", girls tried to avoid or prevent pregnancy by either abstaining from sex or by accessing and using contraceptives to prevent pregnancy. Therefore, although Agyei et al. (2000) in their study in Ghana observed that adolescents did not use contraceptives because they did not think about contraceptives and had fears concerning their safety, this study found that resilient girls used contraceptives to avoid pregnancy. Since resilient non-pregnant sexually active girls use contraceptives to maintain a good reputation in their community, barriers that make access to contraceptives irregular should be broken for effective use of contraceptives among sexually active adolescent girls. Since the barriers stems up from the values of the family and community

members, there should be awareness creation about the importance of contraceptive usage among unmarried adolescent girls in the community to make them acceptable.

For the ever-pregnant girls they maintained their reputation by taking good care of themselves and their babies, going back to school or learning a vocation or working. They achieved this through relying on the other forms of capitals namely social, economic and cultural. This indicates that the various forms of capital were not mutually exclusive in the resilience pathways of the adolescent girls, but interdependent on each other. Thus having access to social, economic and cultural capital helped girls to maintain a good social reputation (symbolic capital) concerning their sexual and reproductive life.

However, having financial support was fundamental because it influenced and determined the resilience building process of both the non-pregnant and ever-pregnant girls. Girls who had financial support were able to transform their social capital and have access to cultural capital by using the knowledge and advice that they had to take actions that helped them to avoid the risk associated with risky sexual behaviours. On the other hand, financial support helped the ever-pregnant girls to cope well with pregnancy and motherhood because such supports helped them to meet their basic needs and that of their babies. Furthermore, parents supported their daughters to go back to school by either taking care of the babies and or providing them with their basic needs. As such, economic support was important in adolescent resilience to teenage pregnancy and motherhood.

The non-pregnant girls had access to more sources of cultural capital as compared to the ever-pregnant girls. Social capital was more useful to the ever-pregnant girls who did not only require economic capital but also practical social support such as having someone to help them take care of their baby so that they could have a „nomal" life such as going back to school or work. Since having a baby was their first experience, they required the support from adults to be able to take good care of themselves and their babies.

Although the non-pregnant and ever-pregnant girls had access to capital from similar sources, especially parents, the support they needed varied. The non-pregnant girls required advice and social support to avoid sex and teenage pregnancy, while the ever-pregnant girls required advice and social support to overcome and adjust to motherhood and childcare. In terms of the information available to both groups, whereas the non-pregnant girls required knowledge on how to have a healthy sexual and reproductive life, especially to avoid pregnancy, the ever-pregnant girls required knowledge not only for healthy sexual life but also childcare and how to overcome the risk of early motherhood.

Both the ever-pregnant and non-pregnant girls had their parents as their main source of social capital. They received diverse forms of support from their parents including advice, information and social support in the form of assistance in taking care of their babies. However, whereas the non-pregnant girls had their older siblings as the other family members who supported them, the ever-pregnant girls had support from their grandparents. Grandparents provided support in the form of practical childcare and assistance to mother and child.

9.4 Contribution to Knowledge

The main contribution of this thesis is that, it brings to light the sexual and reproductive experiences of adolescent girls (both non-pregnant and ever-pregnant). Findings demonstrate how resilience levels of adolescent girls influence their sexual and reproductive health and experiences. The thesis sheds light on how girls in their own ways given the resources available to them are able to overcome, avoid or adjust to sexual and reproductive health challenges they encounter in their social environment, such as how to avoid pregnancy or cope with pregnancy and childbirth.

Theoretically, this thesis contributes to literature on social resilience and for that matter, how it applies to adolescent sexual and reproductive health in Begoro if not Ghana. It contributes to sustainable development research discourse, which looks more at building resilience to overcome adversity than just managing risk.

9.5 Recommendations

The source of tension among the various value systems concerning adolescent sexual and reproductive behaviour should be addressed. I recommend that this should be done in two ways. First, the state through the media should create of awareness at the individual, family and communal level to propagate not only abstinence, but also the use of contraceptive pills and condoms by adolescent girls whenever they indulge in premarital sex. With the changing trend in adolescent sexual and reproductive behaviour, community leaders, teachers and other stakeholders should create the awareness among parents and community members to have an open mind about educating their children on the use and importance of contraceptives. It calls for

community awareness creation of the need for adolescents to be educated on both abstinence and contraception usage to avoid pregnancy and sexually transmitted infections.

In addition, adolescents‟ access to contraceptives should be made more favourable. Preferably, the idea of walk in clinics where adolescent girls could easily walk in to access sexual and reproductive health facilities should be provided in all communities. Since adolescent girls are shy of going to the normal health centres to seek for information and services, government should put measures in place to allow community health workers to take their services to the doorsteps of adolescents within the community to provide support and advice. Such actions should involve both parents and the adolescents to encourage both to seek support. Also, adolescent should be educated about preventing sexually transmitted infections and HIV/AIDS since the findings revealed that adolescents were more concern about preventing pregnancy.

This study has shown that ever-pregnant girls who received social support from the fathers of their babies had high resilience scores. However, the non-pregnant girls did not receive any social support from their boyfriends. This suggests that boys/men could be supported to be responsible in their relationship with girls especially in safe sex practices. This calls for more education of young men and their attitude to sex and young women. More studies should be focused on how to support adolescent boys to act responsibly when they engage in sexual relations with girls. Varga (2001: 176) observes that focusing on men‟s sexual and reproductive education is important because, “they (men) are more likely than women to behave in ways that place both themselves and their partners at risk of sexual and reproductive health complications”.

Parents need to be empowered both socially and economically to be more proactive in supporting their daughters during their transition from childhood to adulthood. This is because the study findings indicate that resilient girls had proactive parents who provided advice and social support to their daughters.

The study identified that, resilient ever-pregnant and non-pregnant girls, despite having access to similar sources of social support to develop resilience had different needs. There is a need for specially targeted television and radio programmes addressing how adolescent girls should live their lives to avoid the risk and challenges associated with unsafe premarital sex. However, for the ever-pregnant girls, there is also a need for more education geared towards how they negotiate their lives as mothers and at the same time as adolescents in order to attain best positive future outcomes. This is because as the ever-pregnant girls revealed in the study, their source of cultural capital was from radio and television programmes intended for the adult populace and this may sometimes have negative influence on them instead of benefiting them.

Finally, the ever-pregnant girls should not be treated as „adults" but rather should be related to as adolescent mothers who need supports from everybody, especially their parents, family members, community members and organizations such as schools and religious bodies to build resilience to forge ahead with their developmental trajectories.

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APPENDIX 1

Questionnaire

Sub-Metro Name: ----------
Enumeration Area: ----------
House Number/Description : ----------

Date Of Interview:

				2	0	1	

🗣 **INTERVIEWER:**

We are interviewing adolescents to get a better understanding about what teenage pregnancy and having children means for you.

Your participation in the study is voluntary. We would also like to assure you that all information collected in the course of the study would remain confidential.

→ *Ask for oral consent.*

Thanks a lot for your participation. In case you have any questions, please let us know.

Please also ask when you have a problem understanding a question.

DEMOGRAPHICS

No.	Question	Response	Code
1	Age	15 □	1
		16 □	2
		17 □	3
		18 □	4
		19 □	5
		Don't know_____	96
2	Education	Primary 4 □	1
		Primary 5 □	2
		Primary 6 □	3

		JHS 1 □	4
		JHS 2 □	5
		JHS 3 □	6
		SHS 1 □	7
		SHS 2 □	8
		SHS 3 □	9
		Tertiary □	10
		Vocational training (1st year) □	11
		Vocational training (2nd year) □	12
		Vocational training (3rd year) □	13
		No formal training/schooling □	14
		Other, specify_____	96
3	Religion	Muslim □	1
		Catholic □	2
		Lutheran □	3
		Anglican □	4
		Protestant □	5
		Pentecostal □	6
		Charismatic □	7
		Seven Days Adventists (SDA) □	8
		Jehovah Witness □	9
		Traditional □	10
		No religion □	11
		Other, specify_____	96
4	Ethnic background	Akan	1
		Ga/Dangme	2
		Ewe	3

		Guan	4
		Gruma	5
		Mole Dagbani	6
		Grusi	7
		Mande	8
		Mamprusi	9
		Kussasi	10
		Other, specify_____	96
5	Family‟s source of income and livelihood?	Trade/Business □	1
		Farming □	2
		Fishing □	3
		Farming + Fishing □	4
		Official employee □	5
		Casual labour □	6
		Other, specify_____	96
6	Relationship status	Single □	1
		In a relationship but not married □	2
		Married □	3
		Divorced/separated □	4
		Remarried □	5
		Widowed □	6
7	Is your father living together with your mother?	Yes □	1
		No □	2
		Other, specify_____	96
8	Besides your mother, is your father having another wife or other wives?	Yes □	1
		No □	2
		Other, specify_____	96

GENERAL QUESTIONS

I. Pregnancy status

1. Have you ever been pregnant or are you now pregnant?

Tick the appropriate answer

1. Yes	2. No

If „No" to question 1, continue at the next page but if „Yes" go to page

Questionnaire for girls that are not/have not been pregnant

II. Social environment

2.1 Do you have someone you can turn to in case you have questions/need support related to how to protect yourself against teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

2.2 If yes, among all of these listed to whom would you turn to (mention as many as you wish)? If no, please proceed to Q. 3.1

Tick the appropriate answers

1. Peers	2. Husband/Partner	3. Parents	4. Other relatives	5. Peer educators
6. Religious leaders	7. Teachers	8. Initiators	9. Nurses/ doctors	10. Other, specify .....

3.1 Do you have someone you can turn to in case you need money for sexuality related costs such as for contraceptives, health services etc.?

Tick the appropriate answer

1. Yes	2. No

3.2 If yes, among all of these listed to whom would you turn to (mention as many as you wish)? If no, please proceed to Q. 4.1

Tick the appropriate answers

1. Peers	2. Husband/Partner	3. Parents	4. Other relatives	5. Peer educators
6. Religious leaders	7. Teachers	8. Initiators	9. Nurses/doctors	10. Other, specify

4.1 Do you have access to other sources of information such as magazines, TV, radio, etc. in order to learn about how to protect yourself against teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

4.2 If yes, among all of these listed, which ones do you use (mention as many as you wish)? If no, please proceed to Q. 5.1

Tick the appropriate answers

1. Radio	2.Music songs	3. Magazines (P&P, Agoo, Awo etc)	4. TV	5. Cell phones
6. Books	7.Information brochures	8. Billboards/posters	9. Other, specify	

5.1 Do you feel accepted within your social environment?

Tick the appropriate answer

1. Yes	2. No

5.2 Do you actively strive for a good reputation in terms of sexual behaviour?

Tick the appropriate answer

1. Yes	2. No

III. Personal knowledge, skills and attitude

6. Do you know how to protect yourself from pregnancy?

Tick the appropriate answer

1. Yes	2. No

7. Do spiritual & religious beliefs help you to protect yourself against teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

8. Do you have the ability to establish and maintain relationships with people who you can ask for advice related to sexuality and teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

9. Do you have the ability to organise support related to questions around protecting yourself against teenage pregnancy in case you need it?

Tick the appropriate answer

1. Yes	2. No

10. Do you believe that you can successfully manage to protect yourself against teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

11. Do you have sexual and reproductive rights?

Tick the appropriate answer

1. Yes	2. No

12. Do you dare to speak out when someone approaches you in a sexual way and you do not want it?

Tick the appropriate answer

1. Yes	2. No

13. Do you decide freely if, when and with whom you want to have sex?

Tick the appropriate answer

1. Yes	2. No

IV. Personal experiences related to risk of pregnancy

14. Have you ever had sex?

Tick the appropriate answer

1. Yes	2. No

15. Did you at any time deliberately decide to abstain from sex because you wanted to protect yourself against teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

16. Would you/do you protect yourself from pregnancy by using contraceptives such as condoms, pills etc.?

Tick the appropriate answer

1. Yes	2. No

17. Have you mobilised any social support (family members, peers, nurses etc.) in order to actively protect yourself from teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

18. If yes, did you manage to mobilise these resources successfully? If no, proceed to Q. 19

Tick the appropriate answer

1. Yes	2. No

19. Have you mobilised any economic resources (cash, loans, savings etc.) in order to actively protect yourself from teenage pregnancy?

Tick the appropriate answer

1. Yes	2. No

20. If yes, did you manage to mobilise them successfully? If no, please proceed to Q.21

Tick the appropriate answer

1. Yes	2. No

21. Have you actively looked for other sources of information on teenage pregnancy, contraceptives etc. in order to protect yourself from pregnancy?

Tick the appropriate answer

1. Yes	2. No

22. If yes, did you manage to mobilise them successfully?

Tick the appropriate answer

1. Yes	2. No

🗣 **INTERVIEWER:** *Thank you very much for the information and your time!*

Questionnaire for girls that are pregnant or have a baby

II. Social environment

2.1 Do you have someone you can turn to in case you have questions/need support related to pregnancy, delivery and neonatal care?

Tick the appropriate answer

1. Yes	2. No

2.2 If yes, among all of these listed to whom would you turn to (mention as many as you wish)? If no, please proceed to Q. 3.1

Tick the appropriate answers

1. Peers	2. Husband/Partner	3. Parents	4. Other relatives	5. Peer educators
6. Religious leaders	7. Teachers	8. Initiators	9. Nurses/doctors	10. Other, specify

3.1 Do you have someone you can turn to in case you need money for pregnancy or neonatal care related costs such as for medication, food or clothes?

Tick the appropriate answer

1. Yes	2. No

3.2 If yes, among all of these listed to whom would you turn to (mention as many as you wish)? If no, please proceed to Q. 4.1

Tick the appropriate answers

1. Peers	2. Husband/Partner	3. Parents	4. Other relatives	5. Peer educators
6. Religious leaders	7. Teachers	8. Initiators	9. Nurses/doctors	10. Other, specify ……

4.1 Do you have access to other sources of information such as magazines, TV, radio, etc. in order to learn about pregnancy, delivery and neonatal care?

Tick the appropriate answer

1. Yes	2. No

4.2 If yes, among all of these listed, which ones do you use (mention as many as you wish)? If no, please proceed to Q. 5.1

Tick the appropriate answers

1. Radio	2. Music songs	3. Magazines (P&P, Graphic)	4. TV	5. Cell phones
6. Books	7. Information brochures	8.Billboards/posters	9. Other, specify ……..	

5.1 Do you feel accepted within your social environment?

Tick the appropriate answer

1. Yes	2. No

5.2 Do you actively strive for a good reputation in terms of sexual behaviour?

Tick the appropriate answer

1. Yes	2. No

III. Personal knowledge, skills and attitude (Capacity)

6. Do you know how to protect yourself from pregnancy?

Tick the appropriate answer

1. Yes	2. No

7. Do spiritual & religious beliefs help you to cope with health risks during and after pregnancy?

Tick the appropriate answer

1. Yes	2. No

8. Do you have the ability to establish and maintain relationships with people who you can ask for advice related to pregnancy and having a baby?

Tick the appropriate answer

1. Yes	2. No

9. Do you have the ability to organise support related to questions around pregnancy and having a baby in case you need it?

Tick the appropriate answer

1. Yes	2. No

10. Do you believe that you can successfully manage to avoid health risks for you and your baby?

Tick the appropriate answer

1. Yes	2. No

11. Do you have sexual and reproductive rights?

Tick the appropriate answer

1. Yes	2. No

12. Do you dare to speak out when someone approaches you in a sexual way and you do not want it?

Tick the appropriate answer

1. Yes	2. No

13. Do you decide freely if, when and with whom you want to have sex?

Tick the appropriate answer

1. Yes	2. No

IV. Personal experiences related to coping with pregnancy and neonatal care

14. Did you try to continue your schooling or start/continue any other training after pregnancy?

Tick the appropriate answer

1. Yes	2. No

15. Did you make regular use of health services in order to check your health and the health of your baby?

Tick the appropriate answer

1. Yes	2. No

16. Have you mobilized any social support (family members, peers, nurses etc.) in order to guarantee your health?

Tick the appropriate answer

1. Yes	2. No

17. Have you mobilized any social support (family members, peers, nurses etc.) in order to guarantee the health of your baby?

Tick the appropriate answer

1. Yes	2. No

18. If yes, did you manage to mobilise social support successfully?

Tick the appropriate answer

1. Yes	2. No

19. Have you mobilized any economic support (cash, loans, savings etc.) in order to guarantee your health?

Tick the appropriate answer

1. Yes	2. No

20. Have you mobilized any economic support (cash, loans, savings etc.) in order to guarantee the health of your baby?

Tick the appropriate answer

1. Yes	2. No

21. Did you manage to mobilise economic support successfully?

Tick the appropriate answer

1. Yes	2. No

22. Have you actively looked for other sources of information on teenage pregnancy, delivery and neonatal care?

Tick the appropriate answer

1. Yes	2. No

23. Did you manage to get the information you were looking for?

Tick the appropriate answer

1. Yes	2. No

🗣 **INTERVIEWER:** *Thank you very much for the information and your time!*

APPENDIX 2

Interview Guide for Selected Non-Pregnant and Ever-Pregnant Girls

Social Capital

Do you think social support helps you to:

NP: avoid teenage pregnancy

EP: secure your health and the health of your baby? If yes explain **WHY** and **HOW;** if no explain **WHY**?

What type of social support (close relationship with whom?) Can you give examples indicating **where, when and how** you mobilized these social supports in order to?

NP: avoid teenage pregnancy

EP: secure your health and the health of your baby?

Did the mobilization of social support improve your live situation? If yes explain **WHY** and **HOW;** if no explain **WHY** not? (Please give examples)

Economic Capital

Do you think economic support helps you to:
NP: avoid teenage pregnancy

EP: secure your health and the health of your baby?

If yes explain **WHY** and **HOW;** if no explain **WHY** not?

What type of economic support?

Can you give examples where, when and how you mobilized economic support in order to?
NP: avoid teenage pregnancy

EP: securing your health and the health of your baby?

Did the mobilization of economic support improve your situation? If yes explain **WHY** and **HOW;** if no explain **WHY** not? (Please give examples)

Cultural Capital

Do you think that your knowledge about how to:

NP: avoid teenage pregnancy, helps you in anyway?

EP: secure your health and the health of your baby help you in anyway.

If yes explain **WHY** and **HOW;** if no explain **WHY** not?

What type of knowledge? Can you give examples when and how you tried to gain more knowledge in order to:

NP: avoid teenage pregnancy

EP: secure your health and the health of your baby?

If yes explain **WHY** and **HOW;** if no explain **WHY** not?

Please be as precise as possible. What kinds of information sources did you use (Probe for Radio, TV, Music songs, Magazines, Books, Cell phones, Information brochure, Billboards, Posters and any other)

Did these sources of information improve your situation? If yes explain **WHY** and **HOW;** if no explain **WHY** not? (Please give examples)

Symbolic Capital

Do you think a good social reputation helps you to:

NP: avoid teenage pregnancy

EP: secure your health and the health of your baby?

If yes explain **WHY** and **HOW;** if no explain **WHY** not?

Please be as precise as possible and provide examples? How should a girl behave in order to have a good reputation (good name) in her neighbourhood?

Do you try to build and maintain a good reputation? Can you give examples of when and how you tried to do so in order to avoid teenage pregnancy/secure your health and the health of your baby?

Please be as precise as possible. Did your reputation improve your life situation? If yes explain **WHY** and **HOW;** if no explain **WHY** not?

What other things in terms of people or behaviour or organisation/institutions that supports you to: **NP**: avoid pregnancy. **EP**: cope with your health and that of your child?

What organisations/institutions are in this community to support teenagers to avoid pregnancy or cope well with pregnancy and childbirth? Probe: Faith-based organizations like churches. Local and international NGOs, public and private institutions like schools and clinics as well as social clubs, sporting clubs etc.

APPENDIX 3

Interview Guide for Adolescent Boys

Social Capital

1. Do you think social support help teenage girls to: **NP**: avoid teenage pregnancy? **EP:** To secure their health and the health of their babies? If yes, how and why; If no, why (give examples to explain your answer)
2. What types of support are available for the teenage girls (relationship, financial social etc) to help: **NP**: Avoid teenage pregnancy. **EP:** To secure their health and the health of their babies; If there is, please give examples and how such a support operates. If none, why not?

Economic capital

3. Do you think economic support helps teenage girls? NP: to avoid pregnancy? **E**P: to secure their health and the health of their babies. If yes, explain how. If no, why?
4. What types of economic/financial support are available to teenage girls to: NP: Avoid teenage pregnancy. **E**P: secure their health and the health of their babies? If there is, kindly explain how it is mobilized to support or improve their health situation

Cultural capital

5. Do you think their (teenage girls) knowledge on how to: **NP**: avoid teenage pregnancy help them in anyway? **EP**: secure your health and the health of their babies help them in anyway? If yes, explain why and how. If no, why not
6. What type of knowledge? Can you give example when and how they (teenage girls) tried to gain more knowledge in order to: Avoid teenage pregnancy? Secure their health and the health of their babies? If any, explain why and how. If none, explain why?
7. What kinds of information source do they (teenage girls) use (probe for Radio, TV, Music/songs, Magazines, books, cell phones, information brochure, Billboards, poster and any other). Did this source of information improve their situation? If yes, explain why and how. If no explain why not?

Symbolic capital

8. Do you think a good social reputation helps teenage girls to: **NP**: avoid teenage pregnancy **EP**: secure their health and the health of their babies. If yes explained why and how. If no, explain why?
9. How should a girl behave in order to have a good reputation (good name) in her neighbourhood?
   Please be precise as possible and provide examples?
10. Do teenage girls try to build and maintain a good reputation? Can you give examples of when and how they tried to do so in order to….. **NP**: Avoid teenage pregnancy. **EP**: Secure their health and the health of their babies. Please be as precise as possible.
11. Did their reputation improve their life situation? If yes, explain why and how. If no, explain why not?

12. What other things in terms of people or behaviour or organization/institutions that supports you to: **NP**: avoid pregnancy. **EP**: cope with your health and that of your child?
13. What organizations/institutions are in this community to support teenagers to avoid pregnancy or cope well with pregnancy and childbirth? Probe: Faith-based organizations like churches. Local and international NGOs, public and private institutions like schools and clinics as well as social clubs, sporting clubs etc.

APPENDIX 4

Interview Guide for Adult Community Members

Background
How long have you be living in this community?
What do you do for a living?

Community perception on adolescent sexual and reproductive health

1. Traditionally/culturally, who is in charge of providing sexual and reproductive health education to teenage girls in this community? Probe whether the role has changed in recent times due to modernization/urbanization?

2. Are parents, especially mothers able to provide sex education to their teenage girls well? Probe how they do it and if no why not?

3. At what age are girls considered mature enough to get pregnant in this area? What informed the choice of this age?

4. How a teenage mother/mother-to-be is treated in this community? Probe: they are loved, cared for, scorned/shine stigmatized, not respected, considered as bad girls among others

5. When a teenage girl gets pregnant out of wedlock, who take care of her during pregnancy, childbirth and postnatal care? Probe for parents, other family members/guardians, the one who made her pregnant/the family of the one who made her pregnant, neighbours, benevolent and charitable individuals and institutions etc.?

6. What do you think are the causes of the rising teenage pregnancy among teenagers? (probe for as many factors as possible and ask why for each to be identified)

7. Those adolescents, who are single parents, are they welcomed/accepted in the community. Probe: structure/framework available to catering for single adolescent mothers

Social Capital

8. Do you think social support help teenage girls to: **NP:** avoid teenage pregnancy? **EP:** To secure their health and the health of their babies? If yes, how and why; If no, why (give examples to explain your answer)
9. What types of supports (relationships-family members, friends, peers, nurses etc) are available for the teenage girls to seek advice or help from to: **NP**: avoid teenage pregnancy? **EP:** secure their health and the health of their babies?
   If there is, please give examples and how such a support operates; if none, why not?

Economic Capital

10. Do you think economic support helps teenage girls to? **NP**: avoid pregnancy? **EP:** secure their health and the health of their babies. If yes, explain how. If no, explain why?

11. What sources (relationships-family members, friends, peers, nurses etc) and types of economic/financial support are available to teenage girls in this community to: **NP:** avoid teenage pregnancy. **EP:** secure their health and the health of their babies? Probe how it is mobilized to support the above activities, in what situations are they mobilized (provide examples)? Probe for contraceptives, antenatal and postnatal care

Cultural capital

12. Do you think that teenage girls‟ knowledge on how to: **NP**: avoid teenage pregnancy help them in any way to avoid getting pregnant? **EP**: secure their health and the health of their babies help them in any way to cope well with pregnancy and having babies? If yes, explain why and how. If no, explain why?
13. What types of knowledge do you think that they need to be able to: **NP**: avoid teenage pregnancy. **EP**: secure their health and the health of their babies? If any, explain why and how. If none, explain why?
14. Can you give example when and how teenage girls tried to gain/acquire more knowledge in order to: **NP**: avoid teenage pregnancy. **EP**: secure their health and the health of their babies?
15. What kinds of information sources do teenage girls use to gain information on how to: **NP**: prevent/avoid pregnancy. **EP**: secure their health and the health of their babies? (probe for Radio, TV, Music/songs, Magazines, books, cell phones, information brochure, Billboards, poster and any other) Do you think that information from these sources improve their situation? **NP**: to avoid getting pregnant. **EP**: to secure their health and the health of their babies? If yes, explain why and how. If no explain why not ?

Symbolic capital

16. Do you think that good social reputations help Teenage girls to: **NP**: avoid teenage pregnancy **EP**: secure their health and the health of their babies. If yes, explained why and how. If no, explain why?
17. How should a girl behave in order to have a good reputation (good name) in this neighbourhood?
18. Do teenage girls try to build and maintain a good reputation in this community?
19. What is regarded as a good reputation for teenage girls in this community? Can you give examples of when and how a teenage girl tried to build a good reputation in order to: **NP:** avoid teenage pregnancy. **EP: s**ecure their health and the health of their babies. Please be as precise as possible.
20. Do you think that those who have good reputations have their life situations improve in terms of: **NP**: avoiding teenage pregnancy. **EP**: secure their health and the health of their babies? If yes, explain why and how. If no, explain why?
21. What other things in terms of people or behaviour do you think support the teenage girls to: **NP:** avoid pregnancy. **EP:** cope well with pregnancy and having baby? And cope with your health and that of your child?
22. What organisations/institutions are in this community to support teenagers to avoid pregnancy or cope well with pregnancy and childbirth? Probe: Faith-based organizations like churches. Local and international NGOs, public and private institutions like schools and clinics as well as social clubs, sporting clubs etc.

APPENDIX 5

Informed Consent Form

"I have been informed about the essence of the study and my rights have been made known to me in a language that I understand. I have had the opportunity to ask questions about it and any questions I have asked have been duly answered to my satisfaction. I consent voluntarily to allow my ward to participate or as a participant in this study and understand that I have the right to withdraw from the study at any time without it in any way affecting my position (rights and privileges) in the community."

---------- ----------

Guardian/Participant"s name Signature/Thumb print

---------- ----------

Moderator"s Name Signature

---------- ----------

Witness (Name) Signature/thumb print

Date:---------- Place:----------

Appendix 6

Resilience Scores for Non-Pregnant Girls

Resilience Score for Non-Pregnant Girls	Frequency	%	Cum. %
0	4	1.00%	1.00%
1	30	7.20%	8.10%
2	45	10.70%	18.90%
3	49	11.70%	30.50%
4	81	19.30%	49.90%
5	48	11.50%	61.30%
6	120	28.60%	90.00%
7	23	5.50%	95.50%
8	19	4.50%	100.00%
Total	**419**	**100.00%**	**100.00%**

Source: Author"s Fieldwork, 2012

Resilience Scores for Ever-Pregnant Girls

Resilience Score for Ever-Pregnant Girls	Frequency	%	Cum. %
0	2	2.50%	2.50%
1	6	7.40%	9.90%
2	4	4.90%	14.80%
3	7	8.60%	23.50%
4	12	14.80%	38.30%
5	10	12.30%	50.60%
6	11	13.60%	64.20%
7	13	16.00%	80.20%
8	7	8.60%	88.90%
9	4	4.90%	93.80%
10	5	6.20%	100.00%
Total	**81**	**100.00%**	**100.00%**

Source: Author"s Fieldwork, 2014

Appendix 7

Table 7.4 Some Selected Capacities of NP Girls

CAPACITY	FREQUENCY (N=419)*
Have the ability to establish and maintain relationships with people whom they can ask for advice related to sexuality and teenage pregnancy	85%
Have the ability to organise support related to questions around protecting themselves against teenage pregnancy in case they needed it	75%
Believe that they have sexual and reproductive rights	92%
Know how to protect themselves against pregnancy	74%
Believe that they can successfully manage to avoid pregnancy	96%
Decide freely with whom they want to have sex	91%
Believe that spiritual & religious beliefs helps them to protect themselves against teenage pregnancy	72%
Dared to speak out when someone approaches them in a sexual way they did not like	89%

Source: Author"s Fieldwork, 2011/12
**multiple choices allowed*

Table 8.4: Some Selected Capacities of both EP Girls

Capacities of Ever-Pregnant Girls	Frequency N=81*
Have the ability to establish and maintain relationships with people whom they can ask for advice related to pregnancy and having a baby	85%
Have the ability to organise support related to questions around pregnancy and having a baby in case they needed it	75%
Believe that they have sexual and reproductive rights	95%
Know how to protect themselves against pregnancy	64%
Believe that they can successfully manage to avoid health risks for themselves and their baby	93%
Decide freely with whom they want to have sex	94%
Dared to speak out when someone approaches them in a sexual way and they do not want it	91%
Believe that spiritual & religious beliefs help them to cope with health risks during and after pregnancy	65%

Source: Author"s Fieldwork, 2012

**multiple choices allowed*