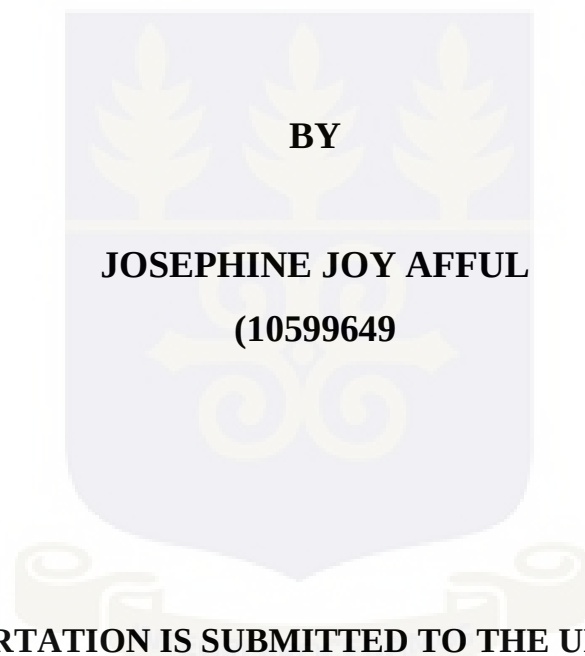


**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**

**EDUCATION-ENTERTAINMENT AS AN ADOLESCENT SEXUAL
REPRODUCTIVE HEALTH COMMUNICATION STRATEGY: THE CASE
OF THE YOLO TV SERIES IN GHANA**



**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF
GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE AWARD OF MASTER OF PUBLIC HEALTH DEGREE**

JULY, 2017

DECLARATION

I hereby declare that except for references of other people's work which have been duly acknowledged, this dissertation is the result of my own research and that this thesis, either in whole or part, has not been presented elsewhere for another degree.

.....	
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(STUDENT)	
	
.....	
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(SUPERVISOR)	

DEDICATION

This thesis is dedicated to my dear mother, Ms. Joy Ofori, for her unfailing support, for rallying me on when the going got tough and her fervent prayers. I love you.



ACKNOWLEDGEMENT

All thanks to the Almighty God for His divine favour and strength throughout my study. I also would like to express my profound gratitude to Dr. Collins Arholu, my supervisor for his patience, guidance and understanding throughout this study. Also, Mr. Nana Yaw Abankwah, Mr. Christian Atum and Mr. Kenneth Mawuta Hayibor for their constant support. Many thanks goes to the all staff and students of the West Africa Senior High School. Finally, my deepest gratitude goes to my father Prof. J.B. A Afful and my sisters Priscilla Afful and Marilyn S. Afful you gave me the strength, faith and courage I needed to see this work through. Am forever grateful, God bless you all.



ABSTRACT

Adolescent Sexual and Reproductive Health (ASRH) contributes largely to the burden of sexual ill health in Ghana. It is, therefore, important to apply a continuum of strategies to curtail these outcomes (postpartum hemorrhage, puerperal endometritis, operative vaginal delivery, episiotomy, pre- term delivery, maternal disability and death). The Ghana Demographic and Health Survey (GSS, 2014) recorded low (25.1%) Sexual Reproductive Health (SRH) knowledge among Ghanaian adolescents. To reduce sexual ill health among adolescents, it is important that a continuum of interventions be put in place to address the knowledge gap. The YOLO TV series is one of such interventions. A cross-sectional study was conducted to assess exposure to the YOLO TV series and its influence on Adolescent Sexual Reproductive Health Knowledge among older adolescents in the West Africa Senior High School (WASS) in the Greater Accra Region. It was also to investigate adolescents' perceptions on the ASRH issues/topics discussed on the YOLO TV show. A total of 303 adolescents between the ages of 15-19 were selected for the study. Self-administered questionnaires were used to collect quantitative data on the study objectives. The data was processed and analysed using Microsoft Excel 2016 and Statistical Package for Social Sciences (SPSS) Version 16. The study established that three-in-five adolescents in the West Africa Senior High School access the YOLO TV series either through television or social media. The findings also revealed that although majority of respondents held positive perceptions towards contraceptives and teenage pregnancy, the majority had negative perceptions on STI's. Using the chi-square statistic, it was established that the YOLO TV series has no influence on the ASRH knowledge of older adolescents in WASS. Statistical significance was set at p-value of 0.05. The findings suggest that chit-chat sessions should be organized by the school to ensure that lessons from each episode is thoroughly discussed to increase awareness of ASRH issues addressed on the YOLO TV show.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual Reproductive Health
CSE	Comprehensive Sexuality Education
EE	Education Entertainment
GDHS	Ghana Demographics and Health Survey
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
MICS	Multiple Indicators Cluster Survey
PHC	Population and Housing Census
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TV	Television
Ukaid	Aid from the People of The United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/ Acquired Immune Deficiency Syndrome
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

DEFINITION OF KEY TERMS

Adolescent

In line with World Health Organization (WHO), the Ministry of Health (MOH)/Ghana Health Service (GHS) define adolescents as people between the ages of 10 to 19 years.

Adolescence

Adolescence refers to the period of transition from childhood to adulthood. It is a time of rapid changes in the body, emotions, attitudes and values, intellect, relationships with parents and peers, and responsibility.

Adolescent Sexual and Reproductive Health

This refers to the physical and emotional well-being of adolescents including their ability to remain free from unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs) including HIV/AIDS, and from all forms of sexual violence and coercion.

Communication Strategy

This is a plan for communicating information related to specific issues, events, situations or audiences. It serves as a blueprint for communicating with public stakeholders.

Education- Entertainment

The process of purposely designing and implementing a media message both to entertain and educate, to increase the audience's knowledge about an educational issue, create favourable attitudes, and change overt behaviour.

Knowledge: Knowledge means having awareness and understanding of a particular issue.

CHAPTER ONE

INTRODUCTION

1.1 Background

Adolescent Sexual and Reproductive Health (ASRH) contributes substantially to the global sexual health burden (Morris & Rushwan, 2015). Every day, twenty thousand girls younger than the age of 18 years give birth every day. Yearly, 2.5 million adolescents are estimated to have unsafe abortions (UNFPA, 2016) and 70,000 adolescents die from pregnancy-related complications (UNFPA, 2016). Adolescents die more from AIDS- related illnesses annually than from any other cause, except road accidents. (UNICEF & UNAIDS, 2015).

The devastating effects of ASRH cannot be ignored. Even though both adolescent boys and girls suffer harm, adolescent girls are disproportionately affected and have increased risk for maternal and neonatal adverse health outcomes including: postpartum hemorrhage, puerperal endometritis, operative vaginal delivery (vacuum extraction and forceps delivery), episiotomy, low birth weight, pre- term delivery, maternal disability and death (Conde-Agudelo, Beliz, 2005; Whitworth, Cockerill, 2010). ASRH impacts a person's physical and mental health hugely, it also has emotional, psychological, social, and economic consequences for their families and their communities (Hindin & Fatusi, 2009).

These consequences have led to the implementation of several programmes, which attempt to address the sexual and reproductive health needs of adolescents. The programmes are based on the premise that young people need accurate information about their sexuality and sexual and reproductive health services to enable them to make informed choices. These programmes, which aim at ensuring that young people grow into responsible adults, vary widely in communication strategies. Advances in the field include participatory teaching and learning methodologies, interactive media, the use of pharmacies as the first point of

contact for health service delivery, assimilating ASRH interventions into livelihoods programmes and media advocacy and activism and education-entertainment (WHO, 2004).

However, ASRHR challenges have remained high in several countries. This, if not checked, could threaten the realisation of the Sustainable Development Goal 3.7 which states that “By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes” (UN, 2015)

The picture being painted is that messages are not getting through, target audience listen and take no action. This leaves room for several questions: Do communicators study and research on the target audience and the type of communication strategy to employ? Do communicators take into account culture in the design of communication strategies? Indubitably, it is important to rethink communication initiatives being used to address this problem.

In as much as there are still challenges, major successes have been chalked with respect to communication strategies employed by some organisations to contain the challenges. Such strategies hold valuable lessons for current and future responses. One of such strategies is the use of education-entertainment to disseminate ASRH information.

This study sought to investigate the potential of education-entertainment as an ASRH communication strategy. The study focused on the YOLO TV series, which airs on TV channels in Ghana. National Population Council supported by Palladium and the UKAid introduced the YOLO TV series in 2015. The YOLO TV series is a TV series that addresses ASRH issues in a plot that centres on the day-to-day challenges faced by today’s adolescents. For universal access, the TV series is aired on three different TV channels, GTV, TV3 and Viasat1 TV networks. The project operates with the objective of increasing

ASRH knowledge, attitude and practices among Ghanaian adolescents. The YOLO TV series is currently airing its fourth season.

1.2 Problem Statement

The world's population is made up of over one billion 10–19-year-olds, 70% of whom live in developing nations (UNFPA, 2014). The environment in which these young people are making sexual and reproductive health decisions is also rapidly changing. Sexual debut rates during young adulthood are rising or remaining unchanged in many developing countries (UNFPA, 2008). Childbearing and marriage are increasingly unlinked, and in many countries, high HIV prevalence increases the risks associated with early sexual activity (UNFPA, 2008)

The same trend is being observed in Ghana with total adolescent population (10-19 years) of about 5.5million, according to the 2010 Population and Housing Census. Of this, 49% is female, and 51% is male (GSS, 2010). This large proportion of young people is of considerable demographic importance since it accounts for the future momentum of population growth.

The Ghanaian youth is plagued with many health and social challenges, with sexual reproductive health issues taking a front seat. These sexual health issues range from STI and HIV infections, teenage pregnancy, unsafe abortions to gender-based violence. According to the Ghana Demographic and Health Survey report (GDHS, 2014), a total of 750,000 cases of teenage pregnancies were recorded, with the highest occurring among 18 to 19 years' age group. A good number of these pregnancies are aborted through unsafe means. Young people also contributed 0.3% to the country's HIV prevalence of 2.2%. The cause of these alarming statistics is attributed to unsafe sex practices which are as a result of young people being uninformed or misinformed about their sexual and reproductive health (Guttmacher,

2004). Also, older adolescents (15-19 years) presented the lowest knowledge on sexual and reproductive health, with males scoring 25.1% and females scoring 21.8%, and all these challenges cannot be ignored.

Studies (WHO, 2014; UNESCO, 2012; & UNFPA, 2014) have revealed the importance of comprehensive sexuality education in resolving these ASRH challenges. Over the years a multi-sectoral approach has been employed to complement efforts at different levels to address the sexual health needs of the Ghanaian youth. ASRH communication strategies have ranged from school-based sexuality education, peer education to Interactive Theatre and more recently education-entertainment, all aimed at getting young people informed to make the right choices concerning their sexuality. Even though there has been considerable improvement regarding ASRH in Ghana, there is the need to employ innovative ways of addressing the sexual health concerns of the Ghanaian youth.

This study, therefore, sought to assess the place of Education-Entertainment, via TV drama, as an authentic outlet for spreading comprehensive sexuality information among Senior High School Students in the Greater Accra Region. The results of the study would also contribute to the national body of lessons learnt and best practices that can strengthen sexual and reproductive health programs in Ghana.

1.3 Research Questions

The study answered the following research questions to achieve the stated objectives:

- Do adolescents in Senior High Schools in the Greater Accra Region access the YOLO TV series?
- What are the perceptions of adolescents on the Sexual and Reproductive Health issues/topics covered in the YOLO series?

- What is the influence of the YOLO TV series on adolescents' ASRH knowledge in Senior High Schools in the Greater Accra Region?

1.4 Study Objectives

1.4.1 General Objective

The purpose of this study was to analyse the potential of Education-Entertainment as an Adolescent Sexual Reproductive Health communication strategy among older adolescents (15-19) in Ghana.

1.4.2 Specific Objectives

- To determine Senior High School adolescents' access to YOLO TV series in the Greater Accra Region.
- To examine perceptions on Adolescent Sexual and Reproductive Health issues/topics covered in the YOLO TV series.
- To investigate the influence of the YOLO TV series on Senior High School Adolescents' Sexual and Reproductive Health knowledge in the Greater Accra Region.

1.5 Justification

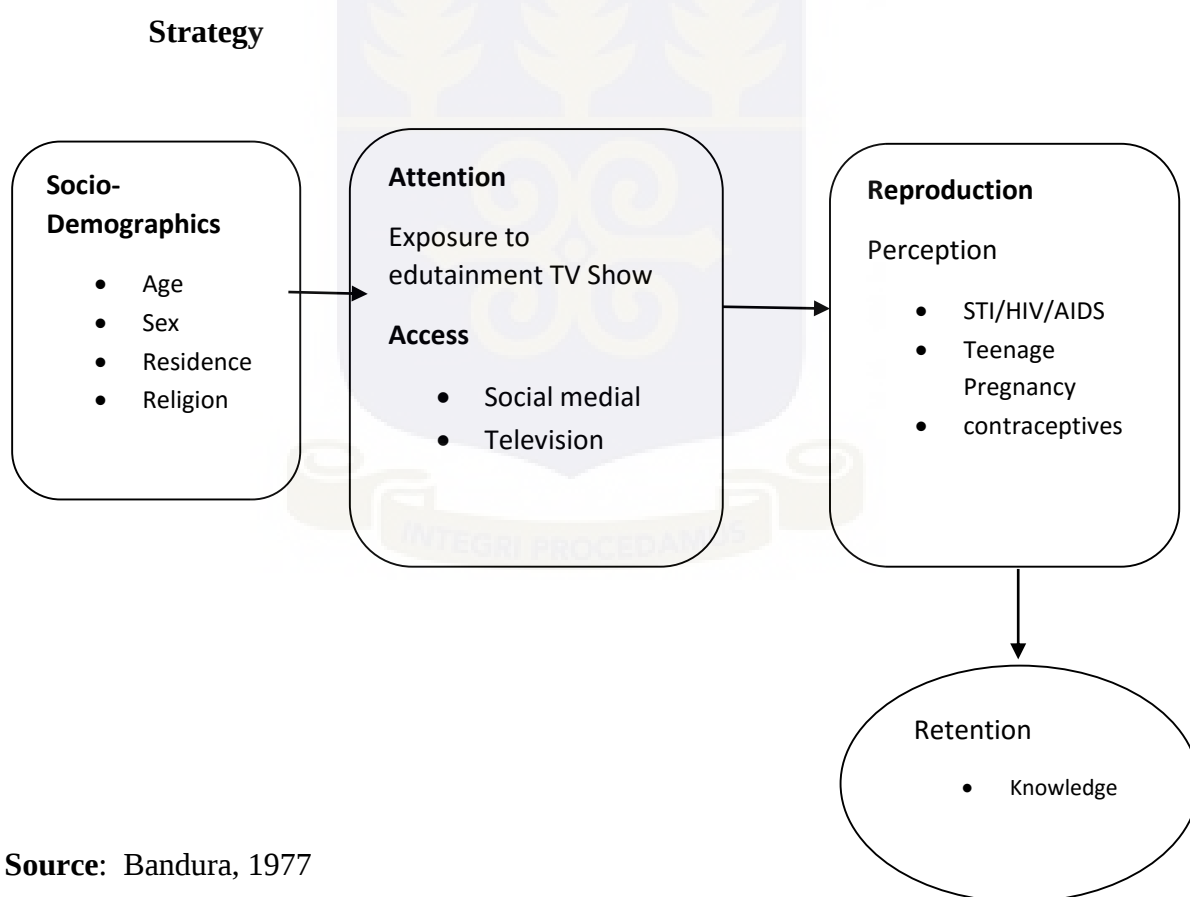
ASRH programmes are designed to help young people to reduce their sexual and reproductive risks. To build comprehensive ASRH programmes which meet intended outcomes, it is important to have information on what works and what does not. Evidence-based information is needed to inform programme implementers of the success or otherwise of the programme. It is important at this stage of implementation of the programme to determine if the project is on course regarding achieving its set objectives.

The final results of the study will:

Contribute to the national understanding of education-entertainment in ASRH programming. The study will also inform the design of communication strategies for public health interventions and contribute to lessons learnt and inform communication strategies for other development challenges (poor illiteracy and water sanitation and hygiene, etc.). The study will additionally provide the opportunity to inform stakeholders to ensure social, financial and political support for education-entertainment interventions.

1.6 Conceptual Framework

Figure 1: Conceptual Framework for Education-Entertainment as a Communication



Source: Bandura, 1977

1.6.1 Description of Conceptual framework

The relationship to be explored will show how mediational processes will influence knowledge among viewers of the education entertainment TV series. The model recognises

the complex interplay between the attention, retention, reproduction, and motivation. It allows us to address factors that will contribute to adolescents acquiring knowledge on ASRH issues: These are explained below.

- **Socio-demographics:** Even though not a part of the model, socio-demographics in this context will explain the inter-relationships. The socio-demographic construct identifies factors such as age, sex, residence, and religion.
- **Attention:** The degree to which a person is exposed to behaviour. For a behaviour to be imitated, it has to grab attention. Attention is, therefore critical in deciding whether a person imitates an observed behaviour. Attention construct of the model examined access to the education entertainment TV series.
- **Retention:** This explains how well a behaviour is recalled. A behaviour may be observed, but not always remembered which prevents imitation. It is important that a memory of the behaviour is formed to be performed later by the observer. How well the behaviour being observed is remembered. The behaviour may be noticed, but not always remembered which prevents imitation. ASRH knowledge was examined under this component.
- **Reproduction:** This involves converting symbolic representations into appropriate actions by organising one's responses spatially and temporarily in accordance with the modelled pattern. Perceptions on STI's, teenage pregnancy and contraceptives were measured under this construct.
- **Motivation:** The will to perform the behaviour. To perform a behaviour, rewards and punishments that precede a behaviour will be considered by the observer. If the rewards outweigh the cost, then the behaviour will more likely be imitated by the observer.

- For the purpose of this study, the fourth construct discussed above does not apply. To fit the context, an additional variable, socio-demographics was introduced.
- In essence, the interaction of these factors will influence the level of knowledge of ASRH issues among adolescents.

1.7 Organization of the Study

The study is structured in six parts. The first Chapter is composed of the introduction/background, objectives, research questions and justification of the study.

Chapter Two of the study discusses reviewed literature from the empirical and theoretical perspective.

Chapter three gives an in-depth explanation of the methodology used to conduct the study. It discusses the study area, research design, study approach, sampling techniques and size, sources of data as well as methods of data analysis.

Chapter four looks at the data analysis. A presentation and discussion of the findings are captured in chapter five. The results are discussed in relation to relevant concepts presented in Chapter two.

Chapter six provides the conclusion and recommendations of this study

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature reviewed on education-entertainment as an ASRH communication strategy. It starts with the definition of key ASRH concepts, provides an overview of Ghana's ASRH situation, discusses access to reproductive health Information, the YOLO TV series, perceptions on ASRH and knowledge on ASRH issues, definitional issues and reviews the mediational process theory which is considered relevant to the study.

2.2 World Adolescent Population

In line with World Health Organization (WHO), the Ministry of Health (MOH)/Ghana Health Service (GHS) define adolescents as people between the ages of 10 to 19 years. Further categorised into: younger adolescents 10 - 14 years and older adolescents 15 - 19 years.

According to UNICEF (2012), 1.2 billion adolescents constitute 18 percent of the world's population, nearly one-fifth of the world's population. More than half of these adolescents live in Asia. India is home to more adolescents, around 243 million, than any other country, followed by China, with around 200 million adolescents (UNICEF, 2012). Africa is the region where adolescents make up the greatest proportion of the population, with 23 percent of the region's population aged 10-19 (UNICEF, 2016).

2.3 Ghana's Adolescent Population

The Population and Housing Census (2010) reports that a little less than a quarter (5.5 million) of all persons in Ghana are adolescents aged 10-19 years, 12% being 10-14-year-olds and 11% being 15-19-year-olds. The rural-urban variation shows that in the rural areas,

males 10-19 years made up 24.4% of the population compared to 21.4% of the females. This information compares with almost 22% of the urban population being classified as adolescents, either among the males or females.

2.4 ASRH: The Ghanaian Situation

Teenage pregnancy and motherhood is a central social and health issue in Ghana (GSS, 2014). The Ghana Demographic and Health Survey (2014) reports that 14% of women aged 15-19 have begun childbearing either they have had a live birth (11%) or are pregnant with their first child (3%). Rural areas report higher teenage pregnancies (17%) than in urban areas (12%) (GSS, 2014). There were regional variations with regards to teenage pregnancy, the Volta region reported the highest prevalence (22%), with the Greater Accra region reporting the lowest (8%) (GSS, 2014). The Guttmacher Institute (2004) reported that 16 percent of women and 11 percent of men 12-24 years in Ghana had been involved in terminating a pregnancy. Also, a considerable proportion of abortion among this group occurs outside modern health facilities that lack professionally trained health officers, often resulting in post-abortion complications such as haemorrhage, infection, and injury to the genital tract and internal organs, including death in extreme cases. As high as 30% of women and 39% of men 12-24 years in Ghana reported that the last abortion they committed took place at home (Guttmacher Institute, 2004). Furthermore, the Ghana Demographic and Health Survey (2014), reported contraceptive use to be lowest among women aged 15-19 (19 percent).

Ghana is reported to have one of the highest child marriage prevalence rates in the world - on average, one out of 4 girls will be married before their 18th birthday (UNFPA, 2010). Also, according to the 2011 Multiple Indicators Cluster Survey, about 28% of women are either married or in unions before the age of 18 and about 6% before age 15.

The Ghana Demographics and Health Survey (2014) reports HIV/AIDS prevalence among young people at 0.3%. The survey (GSS, 2014) also reports that never-married women and men are more likely to report an STI or symptoms of an STI than other women and men, with the difference being more pronounced among women (35 percent of never-married women compared with 21 percent of married women). Women in urban areas and men in the countryside are more likely than their counterparts to report having had an STI or symptoms of an STI.

Most people become sexually active in adolescence. According to the GDHS (2014), women aged 25-49, 11% had their first sexual intercourse by age 15, 44 % by age 18, and 68 % by age 20. The median age at first intercourse among women age 25-49 is 18.4 years. Five percent of men aged 25-49 had their first sexual intercourse by age 15, 27 percent by age 18, and 52 percent by age 20. Men between age 25-49 years' median age at first sexual intercourse was reported to be 19.8 years, higher than among women in the same age group (18.4 years). The need to acknowledge that young people are having sex but lack the proper knowledge to protect themselves is important in the fight against ASRH-related outcomes (WHO/UNICEF/UNAIDS, 2002).

2.5 Access to ASRH Information

Adolescents have a pressing need for correct and reliable information about their sexuality; these include information on the physical changes they are undergoing and the changes that take place in human relationships at this stage (Abakah, 2015). Adults silence towards sexual discussion does not prevent adolescents from becoming sexually active nor does it reverse the negative consequences of teenage sexual activity that is facing the world as a whole (Osaikhuwuomwan & Osemwenkha, 2013). In traditional Ghanaian homes and schools, it is believed that children should be brought up with strict discipline and fear and

punished for asking questions that are considered to be inappropriate for children to ask (Nyarko, Adentwi, Asumeng, & Ahulu, 2014). Adolescents, therefore, resort to other alternatives for information on sex rather than their parents, teachers and health workers who are better equipped to give more accurate information. The comparatively weak dependence on interpersonal communication with parents or family members for sexual and reproductive health information is highlighted in other studies. A survey carried out by Tengia-Kessy & Kamugisha (2006) similarly found that in Tanzania, young people received much of their information on STIs from the mass media, with television providing 75% of the information. In another study, adolescent boys cited classmates, friends (26%) and teachers, school counselors and other health-care providers (25%) as the principal sources of information on puberty and sex. However, according to a study conducted by Alister (2004) in Malawi, three primary sources of sexual and reproductive health information for young people were youth clubs (38%), the radio (29%) and government health facilities (23%). Other sources mentioned by the adolescents were the print media (11%), community-based distribution agents (5%), non-governmental organizations (4%), parents (5%), friends (6%) and District Youth Offices (1%). Abakah's (2015) study conducted in Ghana had similar findings: the primary sources from which respondents obtained sex education were teachers and social media. Respondents also identified 33% their fathers, mothers (20%), teacher (15%), pastor/ religious leaders (29%), siblings (16%), boy/girlfriend (19%), as sources they would never go to obtain information on sex and reproductive health.

In Africa, including Ghana, the majority of adolescents still do not have access to information and education on sexuality, reproduction and sexual and reproductive health. This lack of information is believed to have dire consequences not only on adolescents but the nation as a whole (Fortenberry, 2013). Providing adolescents with access to information,

education and services is thus the main challenge for future programmes (Gupta & Gupta 2008).

2.6 Health Communication Defined

According to Schiavo (2007, p.7), “Health communication is a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt, or sustain a behavior, practice, or policy that will ultimately improve health outcomes” Health Communication recognises the complexity of attaining behavioural and social change and uses a multifaceted approach that is founded on the application of several theoretical frameworks and disciplines, including health education, social marketing, and behavioural and social change theories (Schiavo, 2007). Health communication takes place at different levels; the individual, the social network, the organisation, the community and the society, the more levels a communication program can impact, the better the likelihood of creating and sustaining the desired change (Healthy People, 2010). It depends on various communication activities or action areas, including interpersonal communications, public relations, public advocacy, community mobilisation, and professional communications (World Health Organization, 2003; Bernhardt, 2004). Well-designed health communication activities can help individuals better understand their own and their communities’ needs so that they can take appropriate actions to maximise health (Healthy People, 2010).

It is important to note, however, that health communication alone cannot change systemic challenges linked to health, such as lack of access to health care, poverty, environmental degradation, nevertheless, comprehensive health communication programs should include a systematic assessment of all the factors that contribute to health and the strategies that

could be used to influence these factors (Healthy People, 2010) . Health communication cannot work in a vacuum and is usually a critical component of larger public health interventions or corporate efforts.

Fuglesang (2005, p.385), however, argues, “changing social and behavioural patterns is very difficult. Engaging people and communities in adopting and adapting new ideas about social relations to help them internalise these ideas and then express them in new practices/changed behaviours is a huge challenge.”

Hence, it is necessary to understand the role and the potential impact of health communication on different aspects of public health and health care in general. To take full advantage of the contribution of this emerging field to health outcomes as well as to set realistic expectations on what can be accomplished between the main stakeholders, intended audiences, team members and program partners.

2.6.1 Education-Entertainment in Health Communication

Health communication involves several strategies through which the message is sent from the source to the receiver--one such strategy is Entertainment-Education. Entertainment-education has extended history. For hundreds of years, entertaining stories have passed on wisdom and values from generation to generation (de Fossard & Lande 2008). The entertainment-education strategy has been implemented worldwide in radio and television soap operas, popular music, comic books, and other entertainment genres by engaging audiences emotions to change behaviours, attitude and social norms to promote a broad range of developmental issues, in the developing countries of Asia, Africa, and Latin America (de Fossard & Lande 2008; Khalid & Ahmed, 2014). Several hundred major projects have used the EE strategy globally to improve health. Several studies conducted internationally have yielded broadly similar findings.

An independent evaluation (Population Media Centre, 2004), of the *YekenKignit* “Looking Over One’s Daily Life”, radio program in Ethiopia in December 2002, just two and a half years of nationwide broadcasting reported that among married women in the Amhara and Addis Ababa regions who were listeners, there was a 55.1 percent increase in those who had ever used family planning methods, as compared to non-listeners, family planning use grew by 23.5 percent. The study also reported a 50% increase in communication between mothers and their children about sexuality issues. A survey conducted by Usdin, Singhal, Shongie, Goldstein & Shabala (2004) reported similar findings; one of the most successful and long-running Entertainment-Education campaigns produced in South Africa (Soul City), contributed to changing beliefs about sexual practices and sexual behaviour. Another research by Buening & Brown (2013), to evaluate the Yellow card, an EE intervention in Nigeria found that most participants reported that they would likely change their sexual behaviour after seeing Yellow Card. Respondents mentioned reasons like increased knowledge on reproductive health matters, like understanding that girls can get pregnant from having sex only once, or that AIDS cannot be transmitted by hugging. Others said they would likely be more careful to avoid the potential negative consequences of premarital sex, such as sexually transmitted diseases, HIV/AIDS, or an unplanned pregnancy.

The survey also revealed that personalising the costs of indiscriminate sex, through the eyes of and consequences realised by the characters, provided motivation for many of the participants to be more careful about their sexual encounters (Buening & Brown, 2013).

Contrary to these findings Durden and Nduhura’s (2005) study suggests that the use of EE strategies for health communication in Africa and other developing countries has not always been effective because they have been centred on Western theories and models of behaviour change. Likewise, Dutta (2006) submits that many EE programs still follow a very top-down approach where E-E interventions are developed for local communities where the site of

agency lies predominantly with the funders/donors, who impose their Western values and philosophies and derail from providing a conversational space for local voices. Dutta (2006) contends that even in cases of participatory communication in E-E campaigns, the challenges of subaltern participants are still defined by Western interventionists.

It is therefore important to set education-entertainment campaigns in the right cultural context to ensure that its target audiences identify with the message of the campaigns. Also, the need to promote community voices through a process of dialogue is crucial for setting E-E agenda.

2.7 The YOLO TV Series

YOLO is an ASRH Education-Entertainment TV series, which airs on TV channels in Ghana. National Population Council supported by Palladium and the UKaid introduced the YOLO TV series in 2015. The TV show addresses ASRH issues in a plot that centres on the day-to-day challenges faced by today's adolescents. ASRH issues discussed in the series are teenage pregnancy, contraceptives, HIV/AIDS/STIs, peer pressure, abstinence, relationships, etc. For universal accessibility, the TV series is aired on three different TV channels, GTV, TV3 and Viasat1. The project operates with the objective of increasing SRH knowledge, attitude and practices among Ghanaian adolescents. The YOLO TV series is currently airing its fourth season; each season airs 13 episodes. The TV series has a massive social media following. As at June 2017, YOLO had 34,567 likes on facebook, 15,400 followers on Twitter and 35,017 subscribers on YouTube with viewership at an average of 100,000 per episode.

2.7.1 Perceptions on Teenage Pregnancy

Findings of a survey conducted by Osaikhuwuomwan & Osemwenkha (2013) to identify adolescents' perceptions on teenage pregnancy in Nigeria reported that pressure from

friends to have sex (71.8%%) had the highest rating on participant's perceptions about the causes of adolescent pregnancy. Other factors perceived to be the causes of teenage pregnancy were ignorance of basics of sexuality and pregnancy, having sex without contraception as well as want of financial support from men and girls wanting to prove or test their fertility.

On the other hand, a study by Ngidi (2007) revealed that 25% of respondents believed that alcohol, drugs and alcohol contribute to the high rate of teenage pregnancy. These findings were similar to a study carried out among Swedish high school students; where respondents reported liberal attitudes towards casual sex, alcohol consumption, fear of hormonal contraceptives, financial difficulties and poor school-based sexual education as being associated with teenage pregnancy (Ekstrand, Larsson, Von Essen, & Tyden, 2005).

Another study which sought to unearth perceptions parents held towards teenage pregnancy, found that 93% of parents held the opinion that a teenager getting pregnant outside wedlock is a social deviant, with 85.8% agreeing that teenage pregnancy is a sign of parental failure (Mgbokwere, Ekpoanwan, Esienumoh, & Uyanah, 2015). However, a study carried out by Ekstrand, Larsson, Von Essen, and Tydén, (2005), yielded different results where the majority (53.4%) of respondents believed that their parents perceived teenage pregnancy as God's blessing. In the same study, school teachers (36.5%) saw teenage pregnancy as a sign of poverty.

Respondents viewed adolescent pregnancy as disruptive and burdened with medical, socio-economic and educational problems; this is consistent with other studies that have reported teenage pregnancy as being associated with medical and social consequences including disruption of educational pursuits.

2.7.2 Perceptions on Contraceptives

Contraceptive uptake remains low in Ghana and several third world countries. In Ghana contraceptive use is lowest (19%) among the 15-19 age bracket (GSS, 2014). Knowledge of contraceptives is sometimes negated by perceptions of links between modern family planning methods and infertility, stillbirths and congenital deformities. Among young women, the fear of side effects and personal opposition to family planning are the most common factors discouraging uptake (Eliason, Awoonor-Williams, Novignon, & Aikins, 2014).

A study in Nigeria conducted by Ojikutu and Adeleke (2009) reported that among older adolescents (15-19 years old), 80% of the females and 63% of the males did not use any modern contraceptive. The majority (68.7%) felt embarrassed or ashamed to use or purchase condoms/contraceptives, 9.8 percent of respondents also feared the side effects of contraceptives. There was also the belief that occasional sex could not lead to pregnancy. These findings corresponded with another study conducted in South Africa as high as 80% of adolescents who were engaged in a focused group discussion using adolescents within the Buffalo City Municipality of Eastern Cape, viewed contraceptives as being harmful to their health and fertility as well as it not being an acceptable practice (Mnyanda, 2013). Similarly, a study conducted by Hagan & Buxton (2012) found adolescents having negative perceptions towards contraceptives. Majority of the study participants were of the view that they are insusceptible from the dangers resulting from not using contraceptives, which includes getting pregnant. They also perceived that contraceptive use will lead to them gaining weight, so avoid using it.

In a qualitative study conducted by Appiah-Agyekum & Kayi (2013) to understand students' perceptions of contraceptives, it was revealed that contraceptive users were not stigmatised

but were perceived as bad people, as stated by some of the participants. While this was the case for some of the participants, other participants viewed contraceptive users as enlightened individuals and well-informed of risky health behaviours.

Results from a survey carried out among students in Malaysia reported that a significant number of respondents (89.1%) were of the view that that only women are responsible for using contraceptive methods. Similarly, only 48.1% agreed or strongly agreed that contraception/contraceptives could protect the health of family and society. Likewise, another research conducted in Sweden to understand teenagers' perceptions towards contraceptives and contraception reported, girls were perceived as more obliged than boys for being in charge of contraceptive compliance and avoidance of pregnancy (Elkalmi, Khan, Ahmad, Srikanth, Abdurhaman, Jamshed, BintiAb Hadi, 2015).

In Bangi's (2011) survey conducted among adolescents aged 15 – 18 in Lagos, Nigeria; 4 out of the 35 respondents, responded positively to having used contraceptives in their sexual encounters, while the rest of the 31 admitted to never resorting to any form of contraceptive use. This they claimed was because they had the perception that contraceptives were only meant for married people and not teenagers. Again, family planning and contraceptive use is viewed as a tool for promoting promiscuity among the female population (Nettey, et al., 2015).

This is thought to be so because there is a shared perception that, once the adolescent is given education on sexual and reproductive health issues, the education might, in turn, lead to the adolescent becoming more sexually aware of themselves (Awusabo –Asare, et al., 2008).

Another found that roughly one-quarter (23-26%) did not correctly identify the pill's inability to protect against HIV and other STDs (Kihara, Kramer, Bain, Kiharo, Mandel, 2001). These perceptions have contributed to the uptake of contraceptives.

2.7.3 Perceptions of STIs/HIV/AIDS

According to Ndeti (2013), understanding the way perception of HIV risk is shaped and fashioned is crucial in understanding why it has been so difficult to mitigate the spread of HIV and AIDS. In Ndeti's study (2013), high school students reacted to HIV risk by simply denying its existence and considering themselves as not at risk, a syndrome he refers to as 'it-cannot-happen-to-me syndrome'. In his study, he also found out that most of the youth had a shared thinking about HIV and AIDS as a normal disease like malaria. About 75.7% of respondents knew that HIV/AIDS could not be cured (Nwabueze, S.A., et al. (2014).

Conversely, a study conducted among undergraduate students in the North-West University in South Africa revealed that about half (49%) of the respondents agreed with the statement that more than 90% of all adult HIV infections occur in developing countries and two-thirds occur in Sub-Saharan Africa. The majority of the interviewees (79%) agreed with the statement that HIV/AIDS contributes to a rise in poverty and that poverty reduces the ability of poor people living with HIV/AIDS to cope with the disease (Wyk, 2015).

Findings from a study conducted among men in India revealed that sex within marriage is considered to be safe and free of risk, but sex with 'bad' women (sex workers or promiscuous women) as risks that makes one vulnerable to STIs (Joshi , Ragini Kulkarni, Nandan, Zodpey, Raut, Khaparde, Ahmed, Chitra, & Manjrekar, 2009). Nevertheless, some churches responded to HIV with the message that it was a punishment from God for what they understood to be immoral behaviour (Clifford, 2004). The findings were similar to a

study carried out in Abia state, where Nigeria 75% of respondents had poor knowledge of sexually transmitted infections including HIV/AIDS. HIV and other STIs were seen as a punishment from God for committing adultery and fornication. A total of 70% respondents were of the opinion that People Living with HIV/AIDS (PLWHA) committed ominous sin and should be isolated. Most participants (52%) said if infected, they would not disclose their HIV. Although a good number of respondents (22%) believed that prayer could cure HIV, as high as 102 (19%) of respondents were of the view that HIV has no cure and that youth should avoid being infected (Ezinne & Ahuizi, 2013)

2.8. Knowledge on ASRH Issues

The knowledge of contraceptives may have a bearing on usage by the adolescents. According to (WHO, 2004), except male and female sterilisation, all methods that are suitable for healthy adults are also potentially suitable for healthy, post-pubertal adolescents. After puberty, methods that are physiologically harmless for adults are also physiologically safe for adolescents. The WHO lists the following as the available contraceptive methods for adolescents; dual protection and dual method use, barrier methods, emergency contraception, low-dose combined oral contraceptives (COCs), combined injectable contraceptives (CICs), new hormonal delivery systems, Progestin-only pills (POPs), progestin-only injectable, progestin-only implants, intrauterine devices (IUDs), natural family planning/fertility awareness-based methods, lactation amenorrhea method (LAM), withdrawal and male and female sterilization (although adolescents are medically eligible for this, these methods should only be rarely recommended).

A review of 15 studies to determine awareness and knowledge of STIs among adolescents revealed that those aged 13 to 19 years showed awareness and knowledge that varied among the subjects, depending on gender (Sankange-Zeeb, Mikolajczyk & Zeeb, 2011). In general,

the studies reported low levels of awareness and knowledge of STIs, except HIV/AIDS and recommended that attention be paid to infections such as Chlamydia, gonorrhoea, and syphilis.

A study conducted in rural North Vietnam also reported that the majority of females examined were found lacking knowledge of STI's. In this study, about three-quarters of respondents did not know any symptom of STIs, one-half could not identify any cause of STIs, and another one-half did not know that STIs can be prevented. Only one-third said that condom could be used to protect against STIs (Lan, Lundborg, Mogren, Phuc, & Chuc, 2009). The researchers concluded that low levels of knowledge of STIs were found among women of reproductive age in a rural district of Vietnam. However, a cross-sectional descriptive study carried out among SS2 and SS3 students in Nnewi North Local Government Area of Anambra state, Nigeria reported different findings; almost all the participants (98%) had heard about HIV/AIDS, 23% about syphilis, 17% about gonorrhoea, and 2% about chancroids. However, only 27% of all participants had any knowledge about syphilis, gonorrhoea, and chancroids. The majority of respondents knew that HIV/AIDS (89.8%), syphilis (58.1%) and Gonorrhoea (56.9%) were STIs (Nwabueze, S.A., et al. (2014).

In another study conducted by a Mou, Bhuiya & Islam (2015), a vast majority of the participants (79%) were familiar with the term "STDs" or had heard of it, 19% did not know about STDs, and 2% provided no response. Of all the participants, 72% mentioned that STDs were infectious, 24% indicated that STDs were not infectious, and 4% were confused as to whether STDs were infectious. In another survey carried out to ascertain adolescents knowledge on the transmission of STD's, 26% mentioned sexual intercourse, 4% indicated virus, 3% mentioned bacteria, and 73% had no knowledge (Nwabueze et al. (2014). Peter's

(2013) study, which investigated the level of knowledge on transmission of STD's, was measured based on four questions: unprotected sex with an infected person, infected mother to child, infected blood transfusion and sharing of sharp instruments. The majority of them, 92% knew unprotected sex with an infected person, followed by 89% who knew sharing of sharp instruments and more than half of them 56% knew infected blood transfusion and only 25% knew infected mother to child. Overall, 68% of students were found to have good knowledge on how HIV/AIDS is transmitted.

Studies were also reviewed to ascertain adolescents' knowledge level on contraceptives. A survey conducted by Appiah-Agyekum & Kayi (2013), reported ample knowledge and awareness about contraceptives. The main contraceptive types reported were male and female condoms. Only 11.1% participants stated emergency contraceptive Pills, Intra-uterine device (IUD), withdrawal and spermicidal creams as other forms of contraceptives. This proposes that participants were not adequately informed about several modern methods of contraception. Similarly, Hessburg, Awusabu-Asare et al's., (2007) study in Ghana found that 90% of adolescent respondents had heard of, at least, one modern contraceptive method. The male condom was familiar to (88% of females and 91% of males), the female condom (70% of females and 73% of males), the injectable (57% of females and 56% of males) and the pill (53% of both females and males). One in five of the adolescent respondents were aware of emergency contraception. However, adolescents' knowledge on contraceptives did not align with knowledge on how pregnancy occurs. Twenty-eight percent of females and 21% of male adolescents aged 15–19, had detailed knowledge about pregnancy prevention. Among 12–14 year-olds, 12% of females and 6% of males had this level of knowledge.

Fewer than 10% of respondents could identify the point during the menstrual cycle when a girl is most likely to get pregnant, and only about one-third knew that pregnancy is possible

at first sexual intercourse. Adolescents seemed most knowledgeable when it came to condom use (Guttmacher, 2006). Furthermore, a survey by Peter (2013) reported that more than three-quarter of the participants had poor knowledge on pregnancy regarding fertility period. The same study also found that majority of respondents 50.9% stated that girls could not get pregnant the first time they had sex, the remaining 49.1% indicated that girls could not get pregnant the first time they had sex.

2.9 Summary

Evidence of the global trend revealed that, even though there are several studies on education-entertainment as a health communication strategy, there is limited literature on E-E via TV drama as an ASRH communication strategy in the Ghanaian context. The literature also revealed that adolescents main source of information on ASRH issues is from mass media and friends. Nevertheless, they would have preferred receiving information from parents, school and health staff than from the media. They generally possessed low knowledge on ASRH issues relating to reproduction, STI's/HIV/AIDS and contraceptives. Studies reported that adolescents held varied perceptions on teenage pregnancy, STI's/HIV/AIDS and contraceptives.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the research assumptions and strategy. It discusses the data collection and methods of analysis used for the study. The first section presents the study area and the philosophical paradigm of the research while the second section looks at the methods employed.

3.2 Study Area

The West African Senior High School is a government-assisted, co-educational, day Senior High School located in the La Nkwantanan Madina Municipality. It is the most populous non-denominational institution that provides a three-year senior high school education in the La-Nkwantanan Madina Municipality.

The school started in Tudu as the West Africa College of Commerce in 1946. In 1954, the school was absorbed into the public system. The school moved from Tudu to Accra New Town before finally moving to its present location in Adenta on October 5, 1988. The school is located on the Dodowa-Madina highway close to the Adenta barrier.

The school offers courses in General Arts, General Science, Business, Visual Art, Agricultural Science and Home Economics. These classes are spread out across 29 classrooms. The school has a total population of 1800. The school is run by a headmaster and two assistant head teachers with staff strength of about 20 teaching and non-teaching staff.

3.3 Study Design

According to (Creswell, 2009), research design comprises all the plans and the procedures for doing research. These plans and procedures extend across the decisions from broad assumptions to detailed methods of data collection and analysis. The design for this study was cross-sectional which has been one of the most common and well-known study designs. In this type of research, a subset of the population was selected, and from these individuals, data was collected to help answer research questions of interest (Olsen & Marie, 2004). Cross sectional designs are usually conducted to estimate the prevalence of the outcome of interest for a given population.

3.4 Study Variables

Dependent Variable:

Adolescent Sexual and Reproductive Health Knowledge

Independent variables:

- Socio-demographic characteristics: Age, Sex, Location, Religion
- Access to the YOLO TV series: Television, social media
- Perceptions on ASRH topics discussed on the TV series: contraceptives/contraception, STIs/, HIV/AIDS, Teenage Pregnancy

3.5 Study Population

The study population were adolescents who were enrolled as students at the West African Senior High School. Even though the age definition for adolescents lies between 10-19 years, the study used older adolescents who fall within 15-19 years.

3.6 Sample Size

A sample size of 303 students was used for the study. This sample was drawn from the adolescent students' population in the West African Senior High.

3.6.1 Sample Size Calculation

The sample size for this study was determined taking the following factors into consideration.

- Estimated level of knowledge on SRH among male adolescents was 25.1% (GSS,2014).
- Desired level of confidence in this study was 95% (a standard value of 1.96)
- Acceptable margin of error 5% with a standard value of 0.05

$$N = \frac{Z^2 \times P(1-P)}{d^2}$$

Where N=minimum required sample size

D= margin of error at 5%

Z= confidence level at 95%

P= estimated level of knowledge on SRH among male adolescents was 25.1% (GSS,2014).

$$N = \frac{(1.96)^2 \times 0.25 \times 1 - 0.25}{(0.05)^2}$$

$$N = 288.1$$

The calculation above was based on a proportionate sampling method. The sample size was adjusted upward by 10% to make up for non-response

$$\text{Thus, the sample size } 10 \div 100 \times 288 = 28.8$$

$$288 + 28.8 = 317$$

3.7 Sampling Method

The West African Senior High School was chosen for this study because it is the largest co-educational day senior high school in the La Nkwantanang Madina Municipality. Based on the size of the school, allocation of the number of respondents who were enrolled into the study for each level and class was determined proportionately. Calculation of the number of respondents in each class was based on the proportion of the class population in relation to the determined sample size for each level. That is, the number per class was divided by the total number in the school and multiplied by the sample size. Then, using the sample size determined for each class subject, the number of respondent per classroom was computed. The total number of sample per class ranged from ten to twenty respondents per class, depending on the class size. This was then computed to achieve the total sample size of 317. Finally, the students' class register for each classroom was used to randomly select the required number of respondents using random number assignment generated with Microsoft Excel. This process was repeated to obtain the number of respondents per individual class in the school. Where a selected student was absent or unwilling to participate in the study, the next student of the same sex on the register agreed to be part of the study was chosen to replace that student.

3.8 Inclusion Criteria

Students present on the day of data collection in the West African Senior High school between the ages of 15-19 years were used for the study. Respondents who agreed to be part of the study consented by signing the assent form.

3.9 Exclusion Criteria

Students on exchange programme to the West African Senior High school and students below and above the ages 15-19 years respectively were excluded from the study. Students who refused to be part of the study were also exempted from the study.

3.10 Data Collection Instrument

A self-administered questionnaire was used to obtain quantitative information from respondents. Both closed and open-ended questions were used to collect specific and general responses to answer the research objectives. The questions asked sought answers to socio-demographics, Perceptions on ASRH topics discussed on the TV series, access to the education-entertainment TV series, and ASRH knowledge.

3.11 Data Processing and Analysis

To ensure that data entry into the computer was accurate, the Research Assistants and the Principal Investigator independently cross-checked each entry. Data were coded, entered and cleaned, using Microsoft Excel 2016 and imported into SPSS for analysis.

Descriptive statistics were used to describe the frequencies and percentages of sex, age, residence, religion and TV and social media exposure to the YOLO TV series.

In comparing the various proportions, a chi-square test of association was used to find significant differences among the different variables. Firstly, between knowledge and exposure to the YOLO TV series and secondly exposure to the YOLO TV series and perceptions of ASRH issues (teenage pregnancy, STI/HIV/AIDS, contraceptives) A p-value of 0.05 was considered as statistically significant.

3.12 Quality Control

The following measures were put in place to ensure data quality: A two-day training was organised for two Research Assistants on the content of the questionnaire, its administration and issues related to confidentiality of the responses and the rights of the respondents. Data collection was thoroughly coordinated by the Principal Investigator. The Principal Investigator supervised and also took part in the data collection.

The data collected were critically examined at the end of each day. The Principal Investigator cross-checked data collected by Research Assistants for consistency and completeness. Research Assistants also double-checked data gathered by the Principal Investigator with the aim to achieve accuracy.

3.13 Ethical Consideration

Approval was sought from the Ghana Health Service Ethical Review Board. Letters from the School of Public Health introducing the Principal Investigator and the purpose of the study was sent to the West African Senior High School to seek permission to use the school as the study population. Consent was also sought from parents of the students through the Parent Teacher Association.

The objectives and details of the study were explained to participants as well as the benefits of the study. Participants who agreed to be part of the study signed the assent form. Participants were informed of their right to withdraw from the study without any coercion and punishments. Students' identity remained anonymous to ensure confidentiality. Respondent's confidentiality was assured during the interview. Subject codes were used to hide respondents' identity. Questionnaires were filled individually by students without interference from colleagues and teachers. Data collected were password protected, stored

on the computer and backed on an online storage facility (drop box). Hard copies were locked up in cabinets with limited access to only the Principal Investigator.



CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the analysis of the data and interpretations. The study looked at exposure to the YOLO TV series and its influence on Adolescent Sexual Reproductive Health knowledge among Senior High School students of the West Africa Senior High School. Out of the 288 sample size calculated, 303 participants were sampled for the study. The survey data were subjected to statistical analysis using the Statistical Package for Social Sciences (SPSS). Results from the analysis were presented in frequency distribution tables and chi-square test of association.

4.2 Demographic information of Respondents

Respondents were made up of 55.45% males and 44.55% females. The age range of the respondents was 15 to 19 years with a majority of them between the ages 15-17 (77.2 %). The analysis revealed that most (57.1%) of the respondents lived in peri-urban areas. Majority (85.15%) of the respondents were Christian (Table 4.1.1).

Table 4.1.1: Demographic information of Respondents

Options	Frequency (N=303)	Percentage
Sex		
Male	168	55.4
Female	135	44.6
Age		
15 - 17	234	77.2
18 - 19	69	22.8
Residence		
Urban	102	33.7
Peri-urban	173	57.1
Rural	28	9.2
Religion		
Christian	258	85.15
Islam	42	13.86
Traditional	1	0.66
Judaism	2	0.33

4.3 Access to the YOLO TV series

Findings indicate that majority (70%) of the respondents watch the YOLO TV show via television. TV3 recorded the highest viewership (56.4%) while Viasat1 reported the lowest viewership (10.2%). Not interested in the YOLO TV series was the most (61.4%) cited reason for not viewing the show. It was interesting to note that some respondents were banned from watching the YOLO TV series and this was reported by 11.4% (Table 4.2.1).

The analysis revealed that, majority (57.3%) of the study participants watched season 1 of the YOLO TV show, while season 4 was the least watched season, representing 9.3% (Table 4.2.1).

The findings depict that majority of respondents (59.1%) reported not following the YOLO TV show on social media. The results further revealed that most of the respondents (56.4%) follow YOLO on facebook, with the minority 6.0% following on Twitter.

Table 4.2.1: Access to the YOLO TV series

Option	Frequency N=(303)	Percentage %
TV access		
Yes	212	70
No	91	30
TV stations accessed		
Watch YOLO on GTV	31	10.2
Watch YOLO on TV3	171	56.4
Watch YOLO on Viasat1	70	23.1
Reasons for Not watching		
Not interested	54	61.4
No Television	15	17
Unaware	9	10.2
Banned from watching	10	11.4
Seasons watched		
Season 1	130	57.3
Season 2	38	16.7
Season 3	38	16.7
Season 4	21	9.3
Social media access		
Yes	124	40.9
No	179	59.1
Social media platform		
Facebook	84	56.4
Twitter	9	6
YouTube	56	37.6

4.4 Perceptions on Adolescent Sexual Reproductive Health issues

A third of the respondents (36.9%) agreed with the statement that “discussing contraceptives with adolescents promotes promiscuity”, but interestingly, a similar proportion of the participants (36%) disagreed with the statement. Respondents predominantly (64%) disagreed with the view that there is no need for condoms in serious relationships.

Majority of study participants (83.4%) disagreed that teenage pregnancy brings shame to the family. More than half of the respondents (54.1%) disagreed that teen mothers are less likely to marry, while minority (22.8%) agreed with the statement. Poor sex education was

seen as contributing to teenage pregnancy by majority (75.9%) of respondents. Poverty was regarded as a cause of teenage pregnancy by more than half of the respondents (69.9%).

Findings indicated that 80% of respondents disagreed that HIV/AIDS is a spiritual disease, 9.2% however, agreed that HIV/AIDS is a spiritual disease. A significant proportion of participants (37.6%) agreed that HIV is a punishment for sexual promiscuity. The findings revealed that 72.3% disagreed that prayers can cure STI's (Table 4.3.1).

Table: 4.3.1: Perceptions on Contraceptives, teenage pregnancy and STI's

Option			Disagree Freq (%)	Neutral Freq (%)	Agree Freq (%)
Perceptions on contraceptives					
Discussing	contraceptives	promotes	110 (36.0)	81 (26.7)	112 (36.9)
promiscuity					
Contraceptives are for adult married people			167 (55.1)	40 (13.2)	96 (31.6)
No need for condoms in serious relationships			194 (64.0)	37 (12.2)	72 (23.7)
Adolescents who use contraceptives are bad			158(52.1)	62(20.5)	83(27.4)
Contraceptives use leads to infertility			127(41.9)	80(26.4)	96(31.6)
Perceptions on teenage pregnancy					
Teen mothers less likely to marry			164(54.1)	70(23.1)	69(22.8)
Absence of sex education causes teenage pregnancy			55(22.8)	18(5.9)	230(75.9)
Peer pressure causes teenage pregnancy			32(10.6)	15(5)	256(84.5)
Poverty causes teenage pregnancy			212(69.9)	45(14.9)	46(15.2)
Perceptions on STI's					
HIV is a spiritual disease			244(80.5)	31(10.2)	28(9.2)
HIV is a punishment for sexual promiscuity			119(39.3)	70(23.1)	114(37.6)
Sexual immoral people get STI's			118(38.9)	59(19.5)	126(41.6)
Contraceptive pills protect against STI's			122(40.3)	64(21.1)	117(38.6)
Prayers cure STI's			219(72.3)	40(13.2)	44(14.6)

4.4.1 Access to the YOLO TV series and Perceptions

Majority of respondents (56.7%) held positive perceptions on contraceptives. More than half of the exposed group (66.9%) had positive perceptions on contraceptives, 54.2% of the unexposed group also held positive views on contraceptives. The study found that there was no significant difference ($P = 0.176 > 0.05$) between respondents' exposed to the YOLO series and those not exposed to the YOLO TV series in terms of perceptions on contraceptives.

A greater proportion (93.7%) of study participants held positive views on teenage pregnancy. Majority of the respondents (95.2%) exposed to the YOLO TV series held slightly higher positive views on teenage pregnancy than the unexposed (90.1%). The study revealed that there was no statistical difference ($P = 0.089 > 0.05$) between those exposed to the YOLO TV series and those not exposed to the YOLO TV series with regards to perceptions on teenage pregnancy.

The analysis showed that 76.2% of study participants held negative perceptions on STI's. Most of the respondents (77.4%) in the exposed group and 73.6% in the unexposed group held negative perceptions on STI's, indicating that there was no statistical difference between the group exposed to the YOLO TV series and the unexposed group.

Table 4.3.2: Access to the YOLO TV Series and Perception

Options	Exposure to the YOLO TV series		Total	P-Value
	Yes	No		
Contraceptives				
Negative Perception	97(45.7%)	34(37.3)	131(43.2)	0.176
Positive Perception	115(54.2%)	57(62.6%)	172(56.7%)	
Teenage Pregnancy				
Negative Perception	10(4.7%)	9(9.8%)	19(6.3%)	.089
Positive Perception	202(95.2%)	82(90.1%)	284(93.7%)	
STI's				
Negative Perception	164(77.4.0%)	67(73.64%)	231(76.2%)	.484
Positive Perception	48(22.6%)	24(26.4%)	72(23.8%)	

4.5 Reproductive Health Knowledge

Table 4.4.1 presents results of respondents' knowledge on reproduction, contraceptives, and STIs/STDs. A greater proportion of respondents (64.6%) who were exposed to the YOLO TV series stated that, "a girl could get pregnant the first time of sex". Similarly, among the unexposed group, 67% indicated that a girl could get pregnant the first time of sex. Majority of respondents (86.8%) exposed to the YOLO TV series reported that a girl could get pregnant if she engaged in unprotected sex occasionally, likewise, 91.2% of the unexposed group.

It was rather unexpected to find that more respondents in the unexposed group (81.3%) compared to 68.6% of those exposed to YOLO said they knew at least one contraceptive method. Condoms were the most known (58%) contraceptive method mentioned by respondents who watch the YOLO TV series, while spermicide was the least mentioned (0.9%) method. Similarly, the most mentioned contraceptive method for respondents unexposed to the YOLO TV series was condoms (49.5%).

Majority of the unexposed group (94.5%) reported knowing at least one STD, however, a marginally lower proportion of the exposed group (84.4%) reported knowing at least one STD. HIV/AIDS was the most mentioned STD by both the unexposed group (79.1%) and the exposed group (76.4%). More than half the respondents (54.4%) exposed to the YOLO TV series mentioned that a person can contract HIV at first sex, interestingly, a slightly higher proportion (61.5%) of the unexposed group reported that HIV can be contracted at first time of sex. Thirty percent of the exposed respondents stated that HIV is not curable, however, a significant proportion (29.7%) of the unexposed respondents stated that HIV is curable. (Table 4.4.1)

Table:4.4.1: Knowledge on ASRH issues

Option	Exposure to the YOLO TV series		
	Yes	N=(303)	No
stage a boy can impregnate a girl			
before puberty	64(30.2%)		36(39.6%)
after puberty	119(56.1%)		38(41.7%)
don't know	29(13.6%)		17(8.0%)
Knowledge of contraceptive methods			
Condom	123(58%)		45(49.5)
Contraceptive Pill	66(31.1%)		17(18.7%)
Emergency Contraceptive Pill	8(3.8%)		4(4.4%)
Withdrawal Method	7(3.3%)		0(0.0%)
Spermicide	2(0.9%)		2(2.2%)
less effective contraceptive method			
Withdrawal	6(1.9%)		4(4.3%)
Condom	98(46.2%)		38(41.8)
Pills	43(20.2%)		27(29.7%)
No Idea	65(30.7%)		22(24.2%)
Knowledge of STI			
Yes	179(84.4)		86(94.5)
No	33(15.6)		5(5.5)
Infections through sex			
HIV/AIDS	162(76.4)		72(79.1)
Syphilis	91(42.9)		50(54.9)
Gonorrhea	83(39.2)		40(44)
Herpes	1(0.4)		0
Genital warts	0		3(3.3)
Chlamydia	1(0.4)		0

4.5.1 Access to the YOLO TV series and ASRH Knowledge

A Pearson's chi-square was fitted to establish a causal relationship between access to the YOLO TV series and reproductive health knowledge. Findings depict that 68.1% of the unexposed and 64.2% of the group exposed to the YOLO TV series were knowledgeable on reproduction. Comparing knowledge on reproduction between the exposed to the YOLO TV series and the unexposed group showed that there was no statistical difference ($P=0.504 > 0.05$) between the exposed and unexposed groups. Respondents exposed to the YOLO TV series and those not exposed to the YOLO TV series were knowledgeable on contraceptives. The study found that there is no causal relationship between the group exposed to the YOLO TV series and the group unexposed to the YOLO TV series with regards to knowledge on contraceptives. The findings of the study indicated that a greater proportion of participants not exposed to the YOLO TV series (68.1%) and 58.5% of those exposed to the YOLO TV series were knowledgeable on STD's. The study revealed that there is no causal relationship ($P=0.114 > 0.05$) between those exposed to the YOLO TV series and those not exposed to the YOLO TV series knowledge on STD's. (Table 4.4.2)

Table 4.4.2: Access to the YOLO TV series and ASRH Knowledge

ASRH knowledge	Access to the YOLO TV series (N=303)		Total	chi-square	P-value		
	Yes	No					
Knowledge on Getting Pregnant							
Knowledgeable	136(64.2%)	62(68.1%)	198(65.3%)	.446 ^a	0.504		
Not Knowledgeable	76(35.8%)	29(31.9%)	105(34.7%)				
Knowledge on Contraceptives							
Knowledgeable	212(100.0%)	91(100.0)	303(100.0%)	2.497 ^a	0.114		
Knowledge on STD's							
Knowledgeable	124(58.5%)	62(68.1%)	186(61.4%)				
Not Knowledgeable	88(41.5%)	29(31.9%)	117(38.6%)				

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter provides interpretation of the findings and explains their significance. The findings of this study are discussed under three themes; access to ASRH information, perceptions on contraceptives, teenage pregnancy and STI's and knowledge on reproduction, contraceptives and STI's.

5.2 Access to the YOLO TV Series

From the analysis, it was found that more than half of the study participants access the YOLO TV series. This is consistent with reports from an evaluation of Shuga, a SRH TV series aired in Kenya which found that 60% of Kenyan young people had been reached by the Shuga TV series (Guardian, 2015). In determining access to the YOLO TV series two measures were considered; access through television and access through social media. The findings that more adolescents accessed the TV series through television than through social media could be attributed to easier access to Television sets as compared to smart phone devices with internet connectivity as well as computer with internet connectivity. Among the three TV stations that aired the TV series, TV3 has the highest viewer rating for the YOLO TV series this could be attributed to convenience in time of airing for the young people. TV3 airs the programme at 6:30pm on Sundays. In Ghana facebook is the most commonly used social media platform partly due to the friendly user interface and the application's low consumption of internet bundle/data as such the study found that majority of respondents follow the YOLO TV series on facebook.

The results also showed that viewership of the TV series declined as the seasons of the TV series progressed. This finding is similar to an evaluation of edutainment component of the

“I Choose Life” campaign, a SRH intervention that was implemented in the University of Nairobi. The report revealed that one-third of the female and one-half of the male first-year students attended at least one event. However, exposure to the intervention decreased over time for both males and females (FHI, 2007). At the introduction of the YOLO TV series on the Ghanaian TV scene, it was aired on three TV stations (GTV, TV3 and Viasat1) with different airing days. In the subsequent seasons, airing was reduced to one TV station. This might have contributed to the decline in viewership. The multiple airing provided adolescents the opportunity to catch up with missed episodes and increased exposure to SRH messages broadcast on the TV series. The massive advertisement that preceded the airing of new seasons also ceased after the first season and this may have also contributing to the decline in viewership.

The influx of equally entertaining TV series on the airwaves and apathy towards locally produced TV series might also account for the disinterest in the YOLO TV series. Strikingly, it was found that some parents and guardians banned their wards from watching the YOLO TV series. Parents and guardians who are oblivious to the importance of educating adolescents on their sexual and reproductive health restrict their wards from watching the TV series due to the perception that when the adolescents have become sexually informed through education on sexual and reproductive health issues, they might become more sexually aware of themselves and therefore begin to practice sex (Awusabo –Asare, et al., 2008).

5.3. Perceptions on Contraceptives

The study examined adolescents’ perceptions on contraceptives and found no difference between the group exposed to the YOLO TV series and the unexposed group. Even though, the study revealed that respondents had knowledge on contraceptives, they had mixed views

on the discussion of contraceptives with some saying that it may lead to promiscuity. This proves the need for continued education to dispel misconceptions surrounding contraceptives. Trust is a foundation on which relationships are built and this forms that basis of the belief that using condoms in committed relationships is a sign of distrust, thus no need for condoms in serious relationships. A similar finding was reported by John-Briggs, Lieu, Carter- Pokras & Barnet (2008), they reported that consistent condom users were of the view that it was more important to use condoms with a new boyfriend than with their baby's father regardless whether their main partner was the father of their baby or a new boyfriend.

The study found that there was no significant difference between respondents who were exposed to the YOLO series and those not exposed to the YOLO TV series in terms of perceptions on contraceptives. Both groups generally had positive perceptions towards contraceptives. This could be attributed to the high level of knowledge on contraceptives as studies have shown the link between knowledge on a subject matter and the corresponding positive perceptions (Omo-Aghoja, Omo-Aghoja, Aghoja, Okonofua, Aghedo, Umueri, Otayohwo , Feyi-Waboso , Onowhakpor & K. A. Inikori , 2009; Aryeetey, Kotoh & Hindin, 2010). Despite the high level of knowledge on contraceptives, a significant proportion nonetheless held negative perceptions. A study conducted by Kanku (2010), similarly found that majority of study participants had negative perceptions on contraceptives. To correct these negative views towards contraceptives, strategies must be developed by the school to educate adolescents on reproductive health issues with age appropriate messages that can influence adolescents' positive perception on contraceptives and its use. Accurate information on sexuality would enhance positive perceptions and informed decision making on contraception by adolescents.

5.3.1 Perceptions of STIs/HIV/AIDS

Perceptions held towards the cause of HIV has the potency to aggravate or mitigate the spread of HIV. We found that a high proportion of study participants did not hold the perception that HIV/AIDS is a spiritual disease; a minority however, was of the belief that HIV is a spiritual disease. This was in support of a study conducted by Ike & Aniebue (2007) which reported that a greater proportion of study participants believed viruses cause HIV/AIDS but had a significant proportion having the perception that it was caused by God's anger or witches. Respondents' positive perception on the cause of HIV/AIDS therefore suggests that interventions geared towards educating young people on the cause of HIV are making the desired impact.

Religious beliefs play a large role in shaping people's perspectives about HIV, a significant proportion of respondents held the belief that HIV/AIDS is a punishment resulting from sexual promiscuity. The findings are consistent with what Hess & McKinney (2007) reported, that majority of their study participants believed that HIV/AIDS is a punishment from God. This belief about HIV can contribute to fatalistic attitudes and passive resignation, which hinders participation in treatment. This calls for continued HIV education to improve the HIV care continuum. Even though, all study participants belonged to a religious sect, with majority being Christians, only a small proportion of respondents had the perception that prayers can cure STIs. The belief that prayers can cure STIs may also challenge adherence to treatment programs. A study on ARV adherence in Uganda found that patients discontinued their treatment because they believed that their pastors' prayers had cured them of HIV (Zou, Watt, Ostermann & Thielmann, 2009).

Our finding that STIs was as a result of sexual promiscuity confirmed a study that was conducted among men in India, which concluded that sex within marriage is considered to be safe and free of risk, but sex with 'bad' women (sex workers or promiscuous women) as

risks that makes one vulnerable to STIs (Joshi, Ragini, Kulkarni, Nandan, Zodpey, Raut, Khaparde, Ahmed, Chitra, & Manjrekar, 2009). This view may affect adolescents' access to health care from the formal sector for the treatment of STI's due to the fear of being seen as promiscuous (Okereke, 2010). All these point to the need to give STI's more attention when teaching students on reproductive health issues.

5.3.2 Perceptions on Teenage Pregnancy

By tradition it was not acceptable to get pregnant before marriage, but cultural norms have shifted and teenage pregnancy is no longer seen as so immoral. This is reflected in the findings where many of the respondents disagreed with the shame associated with teenage pregnancy. A young girl who could be previously ostracised for getting pregnant in her teen may today be proud of being a mother and receive social support and acceptance from the family (Osaikhuwuomwan & Osemwenkha, 2013). A study of parents' perception on teenage pregnancy, found that majority of parents held the opinion that a teenager getting pregnant outside wedlock is a social deviant (Mgbokwere, Ekpoanwan, Esienumoh, & Uyanah, 2015). In our study, this deviant behaviour may not lead to social exclusion.

Poverty was regarded as a cause of teenage pregnancy by more than half of the respondents and this confirmed what was reported by Ekstrand, Larsson, Von Essen, and Tydén, (2005), where they found that participants rated poverty as a leading cause of teenage pregnancy. This suggests the need for composite programmes that address the SRH needs of adolescents as well as their financial needs.

Poor sex education was seen as contributing to teenage pregnancy by 75.9% of respondents and this supports finding reported by Osaikhuwuomwan & Osemwenkha (2013), that ignorance of basics of sexuality, pregnancy and having sex without contraception was found high among the study participants. To improve adolescents' knowledge on sexual and

reproductive health will require the incorporation of comprehensive sexuality education (CSE) into the school curriculum. Also, extracurricular activities such as the formation of ASRH clubs should be formed to compliment what is thought in the classroom. This will equip young people with information to make informed choices about their sexuality.

5.3.3 Knowledge on ASRH issues

Our findings indicate that, adolescents were generally aware of contraceptives. The study also found that there is no relationship between contraceptive knowledge and exposure to the YOLO TV series. We found that both the exposed and the unexposed to the YOLO TV series have a similar level of contraceptives related knowledge. Respondents demonstrated knowledge on modern methods of contraceptives than the traditional methods. The unexposed group reported higher knowledge on contraceptive methods and this could be as a result of other sexual reproductive health information sources they might have been exposed to. The male condom is the most recognized and considered as the most easily accessible and simplest form of contraceptives to use among adolescents. As much as condoms are easily available, the prime of place that it occupied among our respondents could be due to the lack of knowledge on the other contraceptive methods as was reported by Buxton & Hagan (2012), where respondents were more acquainted with condoms and oral pills. Evidence has proved that once the adolescent knows how to correctly use contraceptives, it increases the chances as well as confidence of it being used (Kinaro, et al., 2015).

The majority of our respondents, both the exposed and unexposed to the YOLO TV series were knowledgeable on STDs and this confirmed what was reported by Mou, Bhuiya & Islam (2015), that the majority of their study participants were familiar with the term "STDs" or had heard of it. The STDs most commonly mentioned by respondents were HIV/AIDS, gonorrhea and syphilis. Similar finding was reported by Nwabueze, et al's, (2014), where

majority of study participants knew that HIV/AIDS, syphilis and Gonorrhoea were STIs. This suggests that respondents were not adequately informed on the other forms of STIs and this may require a continued sexuality education to expose young people to the various forms of STIs.

Furthermore, a survey by Peter (2013) reported that more than three-quarter of the participants had poor knowledge on pregnancy regarding fertility period. The same study also found that majority of respondents stated that girls could not get pregnant the first time they have sex. Contrary to their findings, more than half of our respondents mentioned that a girl could get pregnant at her first sex. Majority of respondents knew that a girl could get pregnant when she engaged in occasional unprotected sex. This conflicted with what was reported by Neema (2006), where fewer than 10% of respondents could identify the period during the menstrual cycle when a girl is most likely to get pregnant, and only about one-third knew that pregnancy is possible at first sexual intercourse.

5.4 Application of the Mediational Process Theory to Education-Entertainment as an Adolescent Sexual Reproductive Health Communication Strategy

The Mediational Process Theory since its inception in 1977 by Bandura has not been used much, but is currently experiencing some interest as health practitioners and researchers are applying the concept to understanding cognitive processes that inform health behaviour.

This model was used to examine moderation and mediation of sexual risk reduction interventions for South African adolescents (Jemmot, O'Leary, Ngwane, Icard & Bellamy, 2010), and HIV intervention studies (Hardnett, Pals, Borkowf, Parsons, Gomez & O'Leary, 2009). Although the originator of the model identified four factors or constructs; Attention, Retention, Reproduction and Motivation, in the context of this study, the fourth construct

(Motivation) was not applied. To fit the context, an additional variable, socio-demographics was introduced.

Socio-demographics

This study revealed that socio-demographic factors such as age, sex, residence, and religion influence older adolescents access to the YOLO TV series. Majority of the respondents were found to access the YOLO TV series through social media or television. The majority of respondents were residents of urban centres where televisions sets, computers and smart phones are easily accessible making it easier to access the YOLO TV series. A study conducted by Bastien (2008), found that place of residence significantly influenced older adolescents knowledge on Adolescent Sexual Reproductive Health (ASRH) issues.

Attention

Attention has been shown to have an impact on a person's knowledge and behavior. Access to the YOLO TV series was considered under the attention construct of the framework. Findings of this study reported that majority of the study participants accessed the YOLO TV series through television. Accessing the YOLO TV series exposed study participants to ASRH issues discussed on the TV show. A report on the evaluation of Shuga; a SRH TV series aired in Kenya which found that majority of Kenyan young people had been reached with ASRH information through the Shuga TV series (Guardian, 2015).

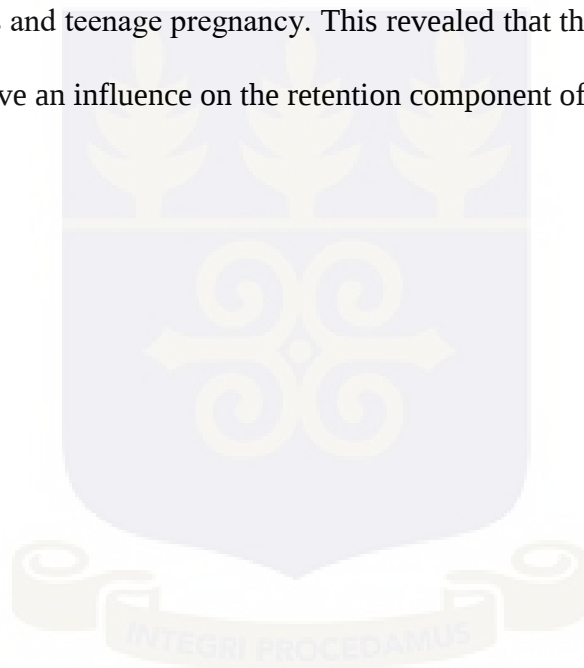
Reproduction

Under this factor perceptions on contraceptives, teenage pregnancy and Sexually Transmitted Infections (STI's) were examined. From this study it was revealed that while both respondents exposed to the YOLO TV series and those unexposed held positive perceptions on contraceptives and teenage pregnancy, both groups had negative views on STI's. In the case of this study it seemed the reproduction component of the framework was

not largely influenced by the attention construct of the framework. Contrary to this finding, a survey carried out by Tengia-Kessy & Kamugisha (2006) in Tanzania reported that study participants who were exposed to ASRH information through the mass media held positive views on the use of contraceptives.

Retention

This component of the mediational process framework examined older adolescent's knowledge of ASRH issues. It was found that both the group exposed to the YOLO TV series and the unexposed group were knowledgeable on ASRH issues pertaining to contraceptives, STI's and teenage pregnancy. This revealed that the reproductive construct seemingly did not have an influence on the retention component of the framework.



CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The study examined the influence of the YOLO TV series on knowledge of adolescent sexual reproductive health issues. Three objectives informed the investigation.

The first objective was to determine Senior High School adolescents' access to YOLO TV series in the Greater Accra Region. The study established that three-in-five adolescents in the West Africa Senior High School have access to the YOLO TV series either through television or social media with majority accessing it through television. Disinterest in the YOLO TV was identified as the predominant reason for not accessing the series.

The second objective sought to examine perceptions on Adolescent Sexual and Reproductive Health issues/topics covered in the YOLO TV series. The key findings revealed that although, majority of respondents held positive perceptions towards contraceptives and teenage pregnancy, a significant proportion had negative perceptions on STIs. The study further revealed that access to the YOLO TV series did not influence respondents' perceptions on contraceptives, teenage pregnancy and STDs.

The third objective set out to investigate the influence of the YOLO TV series on Senior High School adolescents' sexual and reproductive health knowledge in the Greater Accra Region. Using the chi-square test, it was established that the YOLO TV series has no influence on the ASRH knowledge of older adolescents in the West Africa Senior High School.

6.2 Recommendations

After a careful analysis of the literature and the results of the study, the researcher proposed two sets of recommendations as follows:

6.2.1 Implications for Practice

It is recommended that the following issues should be considered by the West Africa Senior High School:

1. To improve adolescents' knowledge on their sexual reproductive health, the comprehensive sexuality education (CSE) must be incorporated into the West Africa Senior High School curriculum.
2. Also, for extracurricular activities, ASRH clubs should be formed by the school to compliment what is shown on the YOLO TV series. This will equip students with information to make informed choices about their sexuality.
3. Chit-chat session should be organized by the school authorities to ensure that lessons from each episode is thoroughly discussed to increase awareness on ASRH issues.

6.2.2. Directions for Future Research

Some recommendations are provided with regard to the direction of future research:

1. Future research should be geared towards investigating factors that influence the success of education-entertainment TV dramas.
2. Future research should also be geared towards assessing the impact of disseminating reproductive health information through social media on the reproductive health knowledge of adolescents in Ghana.

6.3 Limitations of the Study

Adolescents in the West Africa Senior High School are exposed to other ASRH interventions as such knowledge on ASRH issues cannot be solely attributed to the YOLO TV series.

Another challenge was that, final year students were not available because they had completed their final exams and had left the schools for home, so the study was limited to only first and second year students.



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APPENDICES

Appendix A: Questionnaire for Senior High School Students

School of Public Health

University of Ghana

Dear respondent,

I am currently carrying out a study for the purpose of writing a thesis as a requirement for the award of Master of Public Health at University of Ghana. The topic for the study is *Education-Entertainment as Adolescent Sexual and Reproductive Health Communication: The Case of The YOLO TV series in Ghana*. You have been selected to participate in this study due to the importance of the information you will provide. The information you supply will remain strictly confidential. Please feel free and answer all the questions truthfully, bearing in mind that there is no wrong or correct answer to any question. Thank you very much.

Part 1: SOCIO-DEMOGRAPHICS			
No	Question	Responses	Code
1	Gender	Male	1
		Female	2
2	Age	15 years old	1
		17 years old	2
		18 years old	3
		19 years old	4
3	Please indicate your area of residence		
4	Please indicate your religion		

Part 2: EXPOSURE TO THE YOLO TV SERIES			
5a	Do you watch the <i>YOLO</i> Television Series?	Yes	1
		No	2
5b	If YES, on which TV station(s) List them (multiple choices are allowed)	GTV	1
		TV3	2
		Viasat1	3
5c	If NO, why don't you watch it?		
6	How many episodes have you watched?	1-10	1
		11- 20	2
		21-30	3
		31-39	4
7a	Do you follow the YOLO TV series on social media?	YES	1
		NO	2
7b	If Yes on which social media platform(s)? (Multiple choices are allowed)	Facebook	1
		Twitter	2
		YouTube	3

Part 3:REPRODUCTIVE HEALTH KNOWLEDGE Please circle appropriate answer(s) and fill in where necessary			
8	Can a girl get pregnant the first time she has sex?	Yes	1
		No	2
		Don't know	3
9	Can a girl get pregnant if she has unprotected sex occasionally?	Yes	1
		No	2
		Don't know	3
10	How old does a boy need to be to be able to physically make a girl pregnant?	Age_____	1
		After puberty	2
		Don't know	3
11	Do you know any ways to avoid getting pregnant?	Yes	1
		No	2
12	What are the ways to avoid getting pregnant?	Please list here 	
13	Which contraceptive method(s) is the least effective	Please list here 	
14	What does 'safe sex' mean to you?	Abstaining from sex	1

	(Multiple choices allowed)	Using condom	2
		Avoiding multiple partners	3
		Avoiding sex with prostitutes	4
		Avoiding anal sex	5
15	Do you know of any infections a person can get through sexual intercourse?	Yes	1
		No	2
16	Which infections do you know about?	Please list here ----- ----- -----	
17	A person can get HIV/AIDS the first time he/she has sex	Yes	1
		No	2
		Don't know	3
19	AIDS is curable in some cases	Yes	1
		No	2
		Don't know	3

Part 4: PERCEPTIONS ON ASRH ISSUES

Please tick the appropriate response in the table below where:

1 stands for strongly disagree, 2 stands for disagree, 3 stands for neutral, 4 stands for agree and 5 stands for strongly agree

20	Do you think that discussing contraceptives with adolescents promotes promiscuity?	1	2	3	4	5
21	Contraceptives are for only adult married persons.	1	2	3	4	5
22	When a relationship moves from casual to serious, it is no longer necessary to use a condom	1	2	3	4	5
23	Adolescents who use contraceptives are bad	1	2	3	4	5
24	Contraceptive use leads to infertility	1	2	3	4	5
25	Teenage pregnancy brings shame to the adolescent's family	1	2	3	4	5
26	Teenage mothers are less likely to get married	1	2	3	4	5
27	Absence of sex education in schools contributes to teenage pregnancy.	1	2	3	4	5
28	.Peer pressure is one of the major causes of teenage pregnancy.	1	2	3	4	5
29	Many teenagers fall pregnant due to poverty.	1	2	3	4	5
30	HIV/AIDS is a spiritual disease	1	2	3	4	5
31	HIV/AIDS is a punishment for sexual promiscuity	1	2	3	4	5
32	Only sexual immoral people get STI's	1	2	3	4	5
33	The contraceptive pill can protect girls against STI's	1	2	3	4	5
34	Prayers cure STI's	1	2	3	4	5

Appendix B: Consent Form

Parental Consent Form

Study Title: Education-Entertainment As an Adolescent Sexual Reproductive Health Communication Strategy: The Case of the YOLO TV Series in Ghana

Principal Investigator: Josephine Joy Afful

PI Version Date: .../April, 2017

What you should know about this study

- Your child is being asked to join a research study.
- This consent form explains the research study and your child's part in the study.
- Please read it carefully and take as much time as you need.
- Your child will be a volunteer. He/She can choose not to take part and if he/she joins, he/she you may quit at any time. There will be no penalty if he/she decides to quit the study.

Purpose of research project

This research is being done to better understand education-entertainment as a communication strategy for Adolescent Sexual Reproductive Health programmes. It is a requirement for the researcher, who is a student at the University of Ghana, School of Public Health to be able to obtain a Master of Public Health Degree.

Why you are being asked to participate

This research is being conducted in a Senior High School in the La Nkwantanang Madina Municipal Assembly in the Greater Accra Region. Your child is being asked to participate in this study because he/ she is an adolescent who might have accessed the YOLO TV series.

Procedures

Your child will be asked questions on his/her exposure to the YOLO TV series, perceptions on ASRH issues discussed on the YOLO TV series and knowledge on ASRH issues discussed on the T series. Your child will complete a self-administered questionnaire.

Risks/discomforts

The study does not involve any risks. However, he/she may feel uneasy with some of the questions we will be asking him/her. His/Her responses will be very helpful to the study. There are no physical risks to participating in this research. He /She may experience a time burden and inconvenience associated with answering the questionnaire.

Benefits

Your child will have no direct benefit; however, findings of the study will add to existing knowledge on young peoples' health and help to improve adolescent friendly programmes

Payment

There is no payment for participation.

Protecting data confidentiality

Your child's name will not be connected to any information or responses you provide. I will use a study identification number to link responses from the questionnaire.

Who do I call if I have questions or problems?

If you have questions or complaints, please call the Principal Investigator, Josephine Joy Afful at 0540982101 or email me at joseafful@yahoo.com. If you have questions about your child's rights as a study participant, if you feel he/she has not been treated fairly, or if you have other concerns, you may also contact the ethics committees that approved this research about any problems or concerns, Ghana Health Services Ethical Review Committee:

Address:	Research and Development Division	Name:	Hannah Frimpong
	Ghana Health Service	Email:	hannah.frimpong@hru.ghs.org
	P. O. Box MB 190, Accra	Mobile:	024 323 5225
Telephone:	030 268 1109		050 704 1223

What does your signature on this consent form mean?

Your signature on this form means:

- You have been informed about this study's purpose, procedures, possible benefits and risks.
- You have been given the chance to ask questions before you sign. You have voluntarily agreed that your child be part of this study.

_____ Name of participant	_____ Signature of participant	_____ Date
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_____ Name of person obtaining consent	_____ Signature of person obtaining consent	_____ Date
---	--	---------------

Sign TWO copies – one for the participant and one for study records.

INFORMED ASSENT FORM

Study Title: Education-Entertainment As an Adolescent Sexual and Reproductive Health Communication Strategy: The Case of The YOLO TV Series

Principal Investigator: Josephine Joy Afful

PI Version Date: v1 November, 15 2016

What you should know about this study

- You are being asked to join a research study.
- This consent form explains the research study and your part in the study.
- Please read it carefully and take as much time as you need.
- You are a volunteer. You can choose not to take part even if your parents sign the informed consent form and if you join, you may quit at any time. There will be no penalty if you decide to quit the study.

Purpose of research project

This research is being done to better understand communication strategies for Adolescent Sexual Reproductive Health programmes. It is a requirement for the researcher, who is a student at the University of Ghana, School of Public Health to be able to obtain a Master of Public Health Degree.

Why you are being asked to participate

This research is being conducted in a Senior High School in the Greater Accra Region and you are being asked to participate in this research because you are an adolescent who might have watched the YOLO TV series.

Procedures

You will be asked questions on your exposure to the YOLO TV series, perceptions on ASRH issues discussed on the YOLO TV series and knowledge on ASRH issues discussed on the TV series. You will complete a self-administered questionnaire.

Risks/discomforts

The study does not involve any risks. However, you may feel uneasy with some of the questions we will be asking you. Your responses will be very helpful to the study. There are no physical risks to participating in this research. I will take several measures to keep all data private and confidential. First, your name will not be written down anywhere. I will not share your responses with your teachers, colleagues, parents or anyone outside of the study.

Benefits

You will receive no direct benefit from participating in this research; however, findings of the study will add to existing knowledge on young peoples' health and help to improve adolescent friendly programmes

Payment

There is no payment for participation.

Protecting data confidentiality

Your name will not be connected to any information or responses you provide. I will use a study identification number to link your responses from the questionnaire.

Who do I call if I have questions or problems?

If you have questions or complaints, please call the Principal Investigator, Josephine Joy Afful at 0540982101 or email me at joyafful@gmail.com. If you have questions about your rights as a study participant, if you feel you have not been treated fairly, or if you have other concerns, you may also contact the ethics committees that approved this research about any problems or concerns, Ghana Health Services Ethical Review Committee:

Address: Research and Development
Division

Name: Hannah Frimpong

Ghana Health Service

Email: hannah.frimpong@hru.ghs.org

P. O. Box MB 190, Accra

Mobile: 024 323 5225

Telephone: 030 268 1109

050 704 1223

What does your signature on this assent form mean?

Your signature on this form means:

- You have been informed about this study's purpose, procedures, possible benefits and risks.
- You have been given the chance to ask questions before you sign.
- You have voluntarily agreed to be in this study.

Name of participant

Age

Signature of participant

Date

Name of person obtaining consent
Date

Signature of person obtaining consent

Name of Witness

Signature of Witness

Date

Appendix C: Ethical Clearance

