COMMUNITY LEADERS' PERCEPTION OF TEENAGE PREGNANCY IN THE ASSIN DISTRICT OF THE CENTRAL REGION OF GHANA

BY

SETH ABU-BONSRAH

A DISSERTATION SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH,
UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
AWARD OF THE MASTERS DEGREE IN PUBLIC HEALTH (MPH)

AUGUST, 1999

DECLARATION

I hereby declare that, except for references to other people's work which have been duly acknowledged, the views presented in this work are mine and the work has neither in part nor in whole been presented elsewhere for another degree.

Signed:.....
SETH ABU-BONSRAH

Supervisors

1. Dr. A.B.Quainoo.....

2. Dr. Kwadwo A. Koram.....

DEDICATION

This study is dedicated to the Seventh-Day Adventist Church in Ghana and the Adventist Development and Relief Agency (ADRA/Ghana); two sister organizations which have provided the religious and professional environments for my moral and career development this far.

ACKNOWLEDGEMENTS

Once again I have been fortunate to draw on the resources, expertise, experience and skills of others to complete this study. Without them it would have been almost impossible to do the work.

I want to thank the Board of Directors and Management of the Adventist Development and Relief Agency (ADRA/Ghana) for the financial assistance provided for this study and indeed the entire course.

My sincere gratitude also goes to my Academic Supervisors Drs. Kwadwo A. Koram and A. B. Quainoo as well as the Field supervisor Dr. K. Sekyi Appiah for their inputs and guidance in the course of this study. The entire staff of the School of Public Health also deserve my special thanks for the general knowledge that shaped my thoughts as this work progressed.

I have also been fortunate to receive a great deal of support and assistance from the entire staff of the Ministry of Health and allied agencies in the Assin District. Without them the entire field work would have been a nightmare.

My course-mates at the School of Public Health have been a source of inspiration for the period of study especially my room-mate Cletus Opoku-Amankwaah and Yaw Otchere my colleague during the Field Residency at Assin Foso.

Ms. Sarah Antwi of ADRA/Ghana also deserves special thanks for typing this write-up despite her heavy official schedules.

Finally, I wish to acknowledge the support of my parents, wife and children, brothers and sisters during the period of my studies.

May the Almighty God bless all those who have contributed in diverse ways towards the successful completion of this work.

I will however, like to admit that any limitations associated with this work are entirely due to my own short comings.

TABLE OF CONTENTS

LIST OF TABLES

SUMMARY

This study was conducted in the Assin District of the Central Region over a period of 10 days between July 6 and 16, 1999. The aim was to find the knowledge, attitudes and beliefs of the community leaders about teenage pregnancy with reference to the available literature on the subject. It was also meant to determine if educational attainment, gender and type of community leadership have any significant influence on knowledge, attitudes and beliefs. A cross-sectional study was conducted in 30 communities with 146 leaders out of a total of 147 communities with a study population of 735 leaders. A multi-stage sampling methodology was applied using simple random sampling techniques to select the respondents.

Data collection was done using a questionnaire designed by the researcher and pre-tested in six communities not covered in the main study.

The questionnaires were administered to all the identified leaders in the selected communities by six trained assistants.

Information collected included respondents demographic characteristics, their knowledge and experiences on the causes, effects and implications of teenage pregnancy. Ninety-two (63%) of the leaders were aware of the problems of teenage pregnancy in the communities.

One hundred and five (72%) of respondents believe that the ideal age for marriage should be between the ages of 20 to 25 years; whilst 119(82%) indicated the same age as ideal for child birth.

One hundred and thirty-eight (95%) believe pregnant teenagers resort to abortion and that these teen

and mortality rates than children born to adult women.

One hundred and forty-three(97%) of the leaders believe teenage mothers suffer more economic hardships whilst ninety (62%) also believe that teenage mothers drop-out of school permanently.

Most leaders (92.5% or 135) also believed that male teenagers were mostly responsible for the pregnancy of their female counterparts. Respondents were however, divided (51% against 49%) as to whether the male or the females should be blamed for the pregnancies. Over 90 percent of the leaders had experienced teenage pregnancies in their communities whilst 90%(132) had actually discussed the problem with community members.

The major causes of teenage pregnancy were identified as poverty, peer group pressure, lack of parental control, social pressures and lack of sex education.

The community leaders felt that the intensification of sex education in the home, churches and schools; the enhancement of educational opportunities for girls and the application of sanctions can help solve the problems of teenage pregnancy in the communities. Majority of the respondents(76%) were against the supply of contraceptives to the youth as a solution to the problem.

The results of the study indicated that the146 leaders surveyed had a high level of awareness about the socio-economic and health implications of teenage pregnancy.

It was discovered that, most respondents, usually over 80 percent, agreed with the established views in the literature that teenage mothers experience more socio-economic and medical problems during pregnancy, childbirth and in the care of their children than their adult counterparts. Gender and type of leadership had no significant influence on the views of respondents. Education, however , was the most significant influential factor where there were differences in respondents views.

It is recommended that any intervention to address the problem of teenage pregnancy should be a collaborative effort between parents, schools, churches, traditional authorities, health and social workers. Training programmes should be instituted to enhance the abilities of parents and youth groups to conduct educational campaigns for teenagers.

Programmes meant to encourage teenage mothers to continue their education after delivery should be implemented to reduce the high school drop out rates among them.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND INFORMATION

More than one billion of the nearly six billion people in the world today are between the ages of 10 and 19. In response to their needs, national and international agencies are focusing attention on the problems of the youth and on programs to help young people make a smooth transition to responsible adulthood. The major challenges that young people today face include education, employment, marriage, substance abuse and reproductive health[1].

The reproductive health risks that confront the youth include the increasing incidence of sexually transmitted diseases including HIV/AIDS, teenage pregnancies, illegal bortions, higher risks of maternal morbidity and mortality, low birth weights and prematurity among the children of young mothers.

Teenage girls who continue their pregnancy to term face considerable health risks due to their age and socio-economic status. Births to girls under age 18 are considered high risk due to their physiological under-development which increases the likelihood of prolonged and obstructed labour. Lastly, the likelihood of having a caesarean section or an underweight baby is greater for teenage mothers than adult women[2].

The United Nations Children's Fund (UNICEF) also estimates that a quarter of the 500,000 women who die annually from child birth are teenage girls[3].

In Ghanaian traditional society, most girls tend to marry soon after their basic education. Those who do not go to school are even given in marriage earlier. In line with the traditional pronatalist value system teenage childbearing within the context of marriage have never been critically assessed in terms of its health implications. The social system also provided enough support for the teenage mother in the care of her children and any financial assistance needed could be sourced through the extended family system.

With the dawn of modernisation and growing western influence, more girls are going to school whilst others are delaying marriage in order to learn a trade. As the cost of living continue to rise, the extended family system which used to provide socio-economic safety nets is also crumbling. Associated with these developments are changes in some traditional values including the prestige accorded large families.It is therefore likely that changes might have occurred in the peoples' perception of early childbearing.

The question is whether community leaders are aware of the health and socio-economic implications of early childbearing and what other aspects of teenage childbearing constitute a problem for them? Do they believe they have any role to play in the solution of such problems? And what specific recommendations will they make by way of interventions to address such problems.

1.2 STATEMENT OF THE PROBLEM

Many adolescents are sexually active and the incidence of teenage pregnancy is becoming increasingly common worldwide. Estimates show that about 15 million teenage girls give birth each year and these form about 20 per cent of all births[2]. Most of these births occur in Asia - 5.7m, and sub-saharan Africa - 4.5m; with the developed countries, Latin America and North Africa including the Middle East contributing 1.3 million, 1.8 million and 1.0 million respectively[4]

Findings from the 1988 round of the Demographic and Health Survey in 11 countries in Sub-Saharan Africa suggest that the proportion of births to adolescent females aged 15-19 years ranged between 15 and 20 per cent of total births[2]. According to the 1993 Ghana Demographic and Health Survey (GDHS), births to teenagers aged 15 - 19 represent 13 per cent of the total births in the country. Furthermore, 19 per cent of teenagers have at least one child. The (GDHS) revealed that due to low adolescent contraceptive use, 45 percent of adolescents aged 19 years were either mothers or pregnant for the first time. The survey also revealed that most teenagers who had given birth or were pregnant, lived in the rural areas[5].

The Central Region is one of the regions in the country that continues to record high teenage pregnancies. Out of a total of 51,089 ante-natal registrants in 1992, nineteen percent (9,709) were teenagers. In 1996, 10,647(19.4%) of ante-natal attendants were in their teens out of a total of 54,795 registrants whilst in 1997, 16.5 per cent(8978) of the

registrants were teenagers out of a total of 54333 attendants.[6]

The Assin District is the largest in the Central Region in terms of land area and population. In 1992, the District Health Sector Annual Report stated that teenagers constituted 22.3 per cent of ante-natal registrants. Though by 1997, the figure had reduced to 14 per cent(0ut of a totalof 7924 ante-natal registrants), the Maternal and Child Health/Family Planning Unit conceded that the figure could be higher given the fact that some teenage expectant mothers feel shy to attend ante-natal clinics.

The 1997 ante-natal information is also corroborated by data from the Catholic Hospital at Assin Fosu. Out of a total of 1600 pregnancy and delivery related admissions at the maternity ward from August 23, 1998 to May 26, 1999, 223 (13.9%) were women below 20 years.

Most adolescent pregnancies in Ghana previously took place within the context of sanctioned marriages. However, currently the combinations of delayed marriage, early menarche and premarital initiation of sexual activity has resulted in an increase in teenage births. Currently, teenage childbearing is occurring in the absence of the institutional structures of marriage and the traditional village support systems which in the past helped young adolescent mothers[7]. The society's perception of adolescent child bearing might therefore have undergone some changes.

1.3 JUSTIFICATION FOR THE STUDY

When childbearing begins at a young age, the average number of children a woman is likely to have, in an environment of low contraceptive use, tends to be very high, thus fostering a high total fertility rate. In addition to the health implications, teenage pregnancy causes school dropout for such girls, single parenting and child abandonment which tend to be issues inimical to the socio-economic development of a resource poor country such as Ghana.

In their efforts to address these issues, health professionals, demographers and planners admit that the involvement of community leaders are crucial to ensure community participation and the sustainability of any programme of action. However, the involvement of such leaders, will depend on how they perceive the problem - its effect on the people, the severity of the problem and the expected benefits of their actions. This study was meant to help throw some light on these issues and therefore assist the relevant professionals to plan and implement programmes with the community leaders to address the problem of adolescent childbearing in the district in particular and Ghana as a whole.

1.4 OBJECTIVES OF THE STUDY

The general objective of the study was to examine the problem of teenage pregnancy and childbearing from the perspective of community leaders in rural Ghana as against the established views of demographers and public health professionals.

The specific objectives are:

1. To determine community leaders knowledge, attitudes and beliefs about teenage pregnancy.
2. To determine if educational attainment, gender and the type of community leadership have significant influence on leaders perception.
3. To determine what recommendations the respondents may have by way of programmes that seek to address teenage childbearing as a problem in the district.

1.5 RESEARCH HYPOTHESIS

The study was based on the hypothesis that community leaders' in Ghana have always taken teenage pregnancy for granted and have therefore not really assessed its negative health and socio-economic implications.

The study also tested the hypothesis that education, gender and type of leadership had no significant influence on leaders' perception.

1.6 DEFINITION OF TERMS:

TEENAGE: For the pupose of this study, teenage is defined as the period from age 13 to 19 years.

TEENAGE PREGNANCY:- Pregnancies occuring to girls between the ages of 13 to 19 years. For the purpose of this study the terms teenage pregnancy and adolescent pregnancy are used interchangeably.

COMMUNITY:- A group of people living in a well defined settlement who recognise

the authority of one head.

COMMUNITY LEADER:- Any person whose authority or influence is recognised by the whole community, a section or an institution within the community on the basis of tradition, convention, function or by law.

COMMUNITY LEADERSHIP:- The process of directing and influencing the activities and views of a group or community by virtue of an individual's position within the group or community.

CHAPTER TWO

LITERATURE REVIEW

2.1 MAGNITUDE OF TEENAGE PREGNANCY:-

According to the United Nations, recent reviews of adolescent childbearing the world over suggest that high levels of childbearing persist in most countries[8]. It is estimated that world wide, some 15 million babies are born to adolescent mothers[9]. Adolescent fertility rates measured as the number of births per 1,000 women aged 15 - 19 years are generally higher in Africa than in Latin America and the Caribbean.

Most African countries have age specific fertility rates of more than 150 per 1,000 women aged 15 - 19. In Latin America and the Caribbean the rate is between 50 and 100 per 1,000 whilst the majority of Asian countries have rates between 30 and 100 per 1,000 women aged 15 - 19[9]

According to the Population Reference Bureau, the percentage of young women who have a child by age 20 among developing countries is highest in West Africa (56%) and lowest in Asia (8%). In Latin America, one-third of young women become parents during the teenage years with the exception of Guatemala and Nicaragua where approximately half of all teens are mothers by age 20. Among developed countries, the United States has one of the highest rates of teen child-bearing; where 19 per cent of young women give birth by age 20, compared with 7 per cent in France and only 2 per cent in Japan[10]. Worldwide the

teenage population aged 15 - 19 giving birth by age 20 is 30 per cent[11].

Demographic and Health Survey (DHS) findings from 11 countries in Sub-Saharan Africa indicate that births to adolescent females aged 15 - 19 years range between 15% - 20% of Africa's total births, with significant regional and inter-country variations[12]. But comparison of adolescent fertility trends in African countries is difficult, since the availability and quality of data vary considerably between countries.

Examining data from DHS conducted between 1986 and 1989 in Burundi, Ghana, Kenya, Liberia, Mali, Togo and Zimbabwe, Meekers confirmed the increasing trend in adolescent fertility[13]. In Kenya, approximately 142,000 births occur to girls aged 15 19 each year, which account for about 12 per cent of Kenya's total fertility. By age 19, 44 per cent of girls have begun childbearing even though most (over 90%) of pregnancies to adolescent girls are undesired[14]. In Ghana births to adolescents accounted for 11 per cent of the country's births in 1979 - 1980[15]. By 1993, births to teenagers aged 15 - 19 represented 13 per cent of total births in Ghana. When births to young adults aged 20 - 24 are included, they account for approximately one-third (33.3%) of all births. Furthermore, 19 per cent of teenagers have at least one child, while an additional 3 per cent are pregnant with their first child[16]

In recent years, the proportion of teenage births occuring outside marriage has risen to 26% in Botswana, nearly 70% in Kenya, compared to 50% in the U.S.A since 1990. In Ghana, the majority of parenting or pregnant teens either live in consensual unions (35%) are never married (20%) or are divorced (4%). The 1993 GDHS revealed that among teenage mothers

aged 15 -19, more than two-thirds (69%) never wanted their last births or they were mistimed[2].

2.2 DETERMINANTS OF TEENAGE PREGNANCY IN GHANA.

Many studies[17] have identified low levels of education, early age at menarche and marriage, premarital sexual activity, economic incentives, lack of knowledge of reproduction and contraception and low use of modern family planning methods as some of the factors that determine the incidence of teenage pregnancy and births.

Ambition to attain higher education is strongly associated with a girl's postponement of marriage and childbearing until after her adolescent years. Based on DHS data from 33 developing countries, Bongaarts (1994) found that the median ages at marriage and first birth for girls without education was 17.6yrs and 19.3yrs respectively. For those with primary education the figures were 19.1yrs and 20.2yrs whilst those with secondary education had median ages of 21.7yrs and 22.8yrs for marriage and first birth respectively[18].

The median age at marriage in Ghana is currently 19 years, although regional variations exist, with the lowest median age in Upper East region (17.7), Central Region (19.3) and the highest median age in the Eastern region (19.8)[2]. A youthful age at first marriage usually portends a long reproductive period and a higher total fertility rate in the absence of contraception.

It is also generally believed that Ghanaian girls may be entering menarche at younger ages than in the past due to improvements in health care and the nutritional status of young girls.

The impact of this development is that girls are capable of conceiving at younger ages than in the past[2].

The Population Impact Project also contends that although women in Ghana are delaying marriage until they reach nearly 19 years of age, survey evidence indicates that adolescents are becoming sexually active prior to marriage. Among youths aged 15 - 19 years, 59 per cent are sexually active. Among 19 year olds, the proportion not yet sexually active decreases to just 15 per cent. Correspondingly the number of adolescents that give birth increases steadily with age[2].

It is also widely believed in Ghana that many female adolescents in the large urban centres are entering into sexual relationships, particularly with older men for the material comfort they hope to enjoy. In a study by Nabila and Fayorsey (1995)[19] of adolescents in Accra and Kumasi, economic gain was cited in focus group discussions as the most common cause of adolescent promiscuity and subsequent pregnancy in the two cities.

Lack of knowledge of reproduction and contraception is a substantial barrier to avoiding unintended pregnancies. In Ghana, just 16 per cent of teenage girls can correctly identify when, during a woman's ovulatory cycle, she is most fertile and likely to become pregnant. Among sexually active teenagers, the percentange recognising the fertile period is only slightly higher (22 per cent).Knowledge of the fertile period is a pre-requisite for successfully preventing pregnancy through periodic abstenance and monitoring reproductive health[2].

Knowledge of modern methods of contraception is relatively low among the youth aged 15-19 years as compared to any group within the reproductive ages 15 - 49 years. Adolescent females aged 15 - 19, thus have the lowest rate of current use of family planning (11 per cent) compared with any age group of women in the reproductive period in Ghana. Among sexually active adolescents aged 15 - 19 who reported having had intercourse during the month preceding the 1993 GDHS, 73 per cent reported not using any family planning method. Many of the sexually active adolescents are, as a result, not protected from unintented pregnancies[2].

2.3 EFFECTS OF TEENAGE PREGNANCY AND CHILD BEARING

The consequences of adolescent pregnancy and child bearing are dramatic. They relate to a wide range of health, psychological, social, economic and demographic outcomes. The effects go beyond the young mother or father to affect other members of the adolescent's family, her offspring and society itself[20].

Research findings in both the developed and developing countries have shown that early child bearing among other things is strongly associated with increased pregnancy complications, higher maternal and infant mortality. According to Bledsoe and Cohen (1993)[21], most reproductive health problems experienced by adolescents are also experienced by older women. However, they are exacerbated among the young, due to physical immaturity, primiparity or social condemnation. Problems arise mainly from the mother's physiological immaturity, they may not even be mature enough to carry a foetus to term or

bear a baby; their babies suffer from low birth weights and birth trauma. Adolescent mothers in the developing world also suffer the most pregnancy related complications such as eclampsia, sepsis, obstructed labour, haemorrhage, fistulas and unsafe abortions, basically because of their physical immaturity and their tendency, to avoid or delay treatment, because their pregnancies are not socially approved.

Research findings suggests that premature deliveries are more prevalent among adolescent or teenage mothers. Septic or incomplete abortions often result in infertility and sometimes death. Hospital data from 1983 - 85 substantiate the association between unsafe abortion and adolescent maternal mortality. Maternal deaths at Korle-bu Teaching Hospital, Accra due to infection arising from septic abortion were 25 per cent higher among adolescents than among adults[2].

In addition to the health risks, the very young mother is by definition a girl-woman whose educational chances were eclipsed by pregnancy either within or outside marriage. She is also therefore a mother whose children experience severe disadvantages at the onset of life, due to the mother's age and ignorance(9).

Also well documented are the socio-economic consequences of early child bearing for mothers and children. In many societies, the young mother, particularly if she is single, faces psychological and emotional problems in adjusting to parenthood. Some children born to adolescent mothers also suffer reduced mental capacity and psychological consequences[22].

Studies done in some countries have revealed that they tend to have slightly lower intelligent quotent (I.Q) compared to children born to older mothers. Also their social and emotional development is affected. According to studies done in Britain such children also suffer increased risk of abuse and health hazards[22]. In a society where out- of- wedlock parenthood is frowned upon, the young mother may be forced into an inappropriate marriage to the person responsible for the pregnancy. Such a marriage more often than not, ends in a divorce or separation(2).

Children born out of wedlock face social discriminations, leading to greater chances of neglect and even abandonment. Empirical findings have shown that many of these children end up being street children. In the event that such a child is a girl, she is likely to become pregnant herself in her adolescence[23]. These children end up as social deviants and constitute a big social problem for the nation, which has to bear the brunt of these children's emotional and psychological make up.

Prominent among the problems associated with teenage pregnancy is cost in terms of lost investments in education resulting in lost job opportunities. This is due to the curtailment of education, due to school drop-out rates related to pregnancy and early child birth or marriage. In the United States, only 50 per cent of teenage women who gave birth before age 18 ever completed high school, compared to 96 per cent who did not have children until after age 20. Teenage fathers are also affected; only 70 per cent complete school compared to 95 per cent of non-parenting adolescent boys[22].

The literature from diverse developed and developing countries reports lowered occupational status and reduced income as a result of curtailed education. Again in the United States, teenage mothers who dropped out of school earn 50 per cent of the incomes of mothers who had their first birth after they completed high school in their twenties. Additionally, society is faced with the added costs of providing support to single mothers and their children. The United States, which has one of the highest rates of teen pregnancy in the developed world, reportedly spent 16.65 billion dollars on families begun when the mother was a teen, in 1985. Virtually all these costs were associated with public assistance including Aid to Families With Dependent Children, Medicals and food stamps[24].

The negative health and social outcomes of unintended, premarital, adolescent pregnancy and subsequent child bearing present to the medical and public health communities a challenge of the greatest magnitude. Experience has shown that teen pregnancy is first a social problem. As such, unilateral attempts to resolve the problem by health professionals alone or schools alone will have modest impact at best[24].

Most of the studies cited above have focused mainly on the health and socio-economic effects, the magnitude, determinants and the strategies to address the problem of teenage pregnancy. There is little or no information as to how the phenomenon is perceived by community leaders within the context of current debates about its negative effects on society. It is this gap of information that this study seeks to address in order to help fashion out broader community-based strategies to control it amidst disparate views.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 STUDY AREA

The study was conducted in the Assin District of the Central Region.The district is the largest among the 12 districts in the region with a land area of 2,375 sq. Km and an estimated population of 184,838 people. Assin Foso serves as the capital of the district(Appendix 1). About 85 per cent of the population live in rural settlements with farming as the main economic activity. The major agricultural produce include cocoa, palm fruits, cassava, plantain, cocoyam and citrus fruits.

Educational institutions in the district include 64 Kindergartens, 157 primary schools, 76 Junior Secondary Schools, 6 Senior Secondary Schools, 1 Teacher Training College and 2 Vocational Training institutions. The people rely mainly on harvested rain water, hand-dug wells, boreholes, rivers, and streams for their sources of water.

Health care services are provided in the district at the Catholic Hospital at Assin Foso and seven other Health Centres spread throughout the district(Appendix 1).There are 40 community clinics but only 25 are functioning effectively. There are two private Maternity Homes and two Homeopathic Practitioners operating in the district. Sixty-six chemical sellers also operate in the district with approximately 400 traditional medical practitioners. About 300 Traditional Birth Attendants also operate in the district. For the purpose of medical service administration, the district is divided into eight sub-districts.

Maternal and Child Health (MCH/FP) Services are provided at the Catholic Hospital at Foso

and all the Health Centres with a number of outreach centres to serve the smaller rural communities.

The major transportation network is the Cape Coast-Bekwai-Kumasi asphalt road which passes through the capital, but most parts of the district are served by feeder roads. The Accra-Takoradi Raiway Line also passes through Foso, the district capital and some other smaller settlements in the district. Telecommunication facilities are provided by Ghana Telecom and one private communication centre at Foso. A number of decentralised government departments are also linked to the outside world by radio.

3.2 PERIOD OF STUDY

The study was conducted as part of the activities for a field practice in the Assin District from May 19 to July 31, 1999.

The actual collection of data for this study was done from July 6 to 16, 1999.

3.3 UNITS OF STUDY

The study focused on the following categories of community leaders:

1. Assembly Members
2. Chiefs
3. Queen Mothers
4. Church Leaders
5. Headteachers/Headmasters

These community leaders were chosen in order to give representation to elected political

leaders, traditional rulers, religious leaders and heads of educational institutions. Also as parents and community leaders they have a role to play in any programme that seeks to address the problem of teen pregnancies and childbearing. These leaders also affect community opinion in their specific duties.

As members of the highest political authority in the district, Assembly Members are responsible for policy formulation and implementation in the district. They also serve as intermediaries between the district assembly, its decentralised departments and the general public. It is through them that the political and administrative units get to know the concerns of the people.

Since Chiefs are seen as custodians of the traditional value systems and cultural practices, innovations and new technologies may have a greater chance of being accepted by the people when passed through the chiefs and their elders. Consequently, development workers and other agents of change who work at the district and community levels work with the chiefs and their elders. When a chief or queen mother is supportive of an issue, the probability of any programme associated with that issue receiving the necessary patronage from their subjects is greater.

Most religions also have strict policies on issues related to adolescent reproductive health. For example most religions in Ghana oppose the provision of contraceptives to adolescents. They rather advocate Religious or Moral education in churches and schools.Since most of the strategies to address adolescent fertility issues revolve around contraception and family

life education it is better to know the perceptions of these leaders in order to plan programmes that will be acceptable to them to ensure their participation and that of their members.

Teachers, by virtue of their position have a great deal of influence on school children in terms of their knowledge and attitudes about many issues including reproductive health. By knowing their perceptions, it will be easier to determine the content of educational messages that they can deliver to school children.

At the grassroots level most of these leaders are strong opinion leaders who can either oppose or support interventions that address adolescent reproductive health matters like teenage pregnancy, depending on their knowledge, attitudes and beliefs.

At the national level also religious and traditional leaders have various opportunities, (such as serving on statutory bodies) to influence policies on the health and welfare of adolescents as well as the implementation of such policies. As advocates and role models, these leaders need to be equipped with the correct information. The right information can only be provided when their baseline knowledge, beliefs and attitudes are already known to those involved in the design and delivery of the information.

3.4 STUDY DESIGN

A cross section of 30 communities were randomly chosen from the 147 communities listed

as operational areas by the eight subdistricts of the District Health Administration.This was based on a sample size of 20 percent initially determined for the study. Once a community fell within the study sample, all the units of study previously identified were interviewed as sources of information to address the study objectives.

3.5 SAMPLING TECHNIQUES

A multi-stage sampling technique was applied using simple random sampling to select the communities covered by the study. Initially, four out of the eight subdistricts were randomly selected. The four selected were Foso, Bereku, Manso and Nyankomasi. Fifteen communities were randomly chosen from the Foso subdistrict whilst five communities were picked from each of the remaining three subdistricts, making a total of 30 communities. The proportion of communities selected from the Foso subdistrict was due to its larger number of villages compared to the others.

3.6 DATA COLLECTION, TECHNIQUES AND TOOLS

A structured questionnaire designed by the researcher was used to collect information on respondents bacground characteristics and their knowledge about the causes , implications and effects of teenage pregnancy(appendix 3).

The questionnaires were administered through interviews to the leaders in the 30 villages by six trained assistants over a period of 10 days between July 6 and 16, 1999.

The questionnaire was pre-tested in five communities outside the study sample by the

researcher to assess its reliability, clarity and applicability to the study population. Supervisory visits to 10 selected communities by the researcher were also conducted during the actual field interviews. These visits were meant to check on the proper conduct of interviews by the field assistants, ensure the appropriate completion of questionnaires and also ensure that the selected communities and their leaders were covered by the assistants.

3.7 METHODS OF DATA ANALYSIS

Descriptive statistics were mostly used to analyse the information collected from the field since most of the information were quantitative. Chi-Square Tests were also used to analyse the influence of education, gender and type of leadership on respondents views as to who should be blamed (males or females) when teenage pregnancies occur.

3.8 LIMITATIONS OF THE STUDY

The use of simple random sampling procedures to select communities from the chosen subdistricts led to the selection of some communities without queen mothers whilst some of them also had no resident assemblymembers. This led to the under representation of some categories of community leadership in the final sample. Therefore the sample size was 146 instead of 150 The results of the structured interviews with the community leaders could have been enriched with further details from focus group discussions but this could not be done.

3.9 ETHICAL ISSUES

In all the study communities formal permission was sought from the community leaders and their consent provided before interviews were conducted.

The purpose of the study was fully explained to the respondents who were also assured of the confidentiality of any information they provide during the interviews.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 DEMOGRAPHIC INFORMATION

A total of 30 communities from the four selected subdistricts were actually covered for the research.There were 146 respondents.

(a) Sub-Districts Distribution of Respondents

Sixty-seven (45.9%) of respondents were from the Foso sub-district whilst 29(19.9%) came from the Nyankomasi sub district. The other two sub-districts, Bereku and Manso recorded 25 respondents each (Refer to table 1 below)

Table 1: Distribution of Respondents According to Sub-Districts

SUB-DISTRICT	NUMBER OF RESPONDENTS	PERCENTAGE
FOSO	67	45.9%
NYANKOMASI	29	19.9%
BEREKU	25	17.1%
MANSO	25	17.1%
TOTAL	**146**	**100**

The Foso sub-district recorded a lower level of respondents as against the expected figure of 75. The Nyankomasi sub-district, however recorded a higher number of respondents as compared to the expected figure of 25.

(b) Types of leadership interviewed.

The community leaders interviewed for the study were made up of 39 Headteachers or Headmasters, 37 Religious Leaders, 30 Chiefs, 21 Assembly Members and 19 Queenmothers **(Refer to table 2)**

Table 2: Type of Leaders Interviewed during the Study

Type of Leadership	# of Respondents	Percentage
Chief	30	21%
Headteacher/Headmaster	39	27%
Religious Leader	37	25%
Assembly Member	21	14%
Queenmother	19	13%
Total	**146**	**100**

Though the study was initially meant to cover almost equal numbers of the categories of leaders selected, these variations in numbers occured for a number of reasons.

Most of the communities covered in the study were settler communities without the traditionally recognised queen mothers though there were village heads who were recognised as chiefs. Some of the communities also had more than one school which meant that additional school heads were interviewed in such communities.

There were also communities without resident assembly members. Such communities were being covered by assembly members from nearby villages. The multiplicity of churches in villages also accounted for the number of religious leaders interviewed. Generally,

however, the actual number of respondents fell short of the expected sample size of 150 because of the low numbers of Queen Mothers and Assembly Members.

(c) Age and Sex Distribution of Respondents

The total of 146 respondents were made up of 122 males (84%) and 24 females (16%). Most of these respondents(85%) were between 30 and 70 years of age, 12% were above 70 years with the remaining 3% below 30 years of age.(Refer to Table 3)

Table 3: Age and Sex Distribution of Respondents.

Age	Male	Female	Total	Percentage
Below 30	4	0	4	2.7
30-49	51	10	61	41.8
50-69	57	6	63	43.2
70 and Above	10	8	18	12.3
Total	122(84%)	24(16%)	146	100

In addition to the 19 Queenmothers who were exclusively females, only 5 of the other categories of leaders were females. The dominance of males in leadership positions at the community level was clearly demonstrated by this study.

The age distribution of the respondents indicate that most leaders were matured and experienced enough to discuss the issue of teenage pregnancy in their communities. About 55 per cent of them were 50 years or above whilst almost 42 per cent were between 30 and 49 years. Only 2.7 per cent were below 30 years.

(d) Marital Status of Respondents

One hundred and thirty-three (91.1%) of the leaders interviewed were married, seven were single, four widowed whilst the remaining two were divorced.

(e)Religious Affiliation of Respondents.

In terms of their religion, eighty-eight per cent (128) indicated that they were Christians, 12 of them (8%) were muslims and the last 6 (4%) were followers of the various forms of traditional religion.

(f)Educational Background of Respondents

The educational background of the community leaders varied from those with no formal education through basic and second-cycle education to tertiary forms of education. Twenty-two (15%) of the leaders had no formal education, whilst 48(33%) had had basic education. Second cycle and tertiary education were each reported by 38 (26%) of the respondents (Refer to Table 4).

Table 4: Educational Background of Respondents

Type of Education	# of Respondents	Percentage
No Formal Education	22	15%
Basic Education	48	33%
Second Cycle Education	38	26%
Tertiary Education	38	26%
Total	146	100

The data in the table above show that most of the respondents have had some formal

education. A majority of them (52%) had even gone beyond basic education up to the secondary and tertiary levels of education. It can therefore be said that the respondents had appreciable levels of knowledge to discuss the phenomenon under study.

(g)Occupation of Respondents

The information provided on respondents occupation showed that 62 (43%) were farmers, 54 (37%) were teachers whilst 12 (8%) were pastors. Five other respondents (3%) were traders.The remaining 13 (9%) were self employed in activities like carpentry, painting, chemical selling, tailoring.

4.2 MAGNITUDE OF TEENAGE CHILDBIRTHS

The personal experiences of respondents with regard to adolescent or teenage childbearing within their own households was explored during the study. A total of 80 respondents (55%) confirmed that they had experienced the phenomenon in their households within the last five years. At the community level, 134 of the leaders (92%) interviewed confirmed that teenage pregnancy and childbearing was a problem in their communities. Ninety percent (131) of respondents had discussed the issue with some community members, but only 96(66%) had gone further to discuss it with a social or health worker. This however, provides some indication that these leaders recognise the issue as a health and social problem, and that health and social workers could play a role in its solution.

Further evidence of leaders' perception of teenage child bearing as a problem can be indirectly inferred from the fact that most respondents, 131 (90%) said the best age for childbirth is from 20 years. Even in terms of marriage only 25 percent (37) of leaders interviewed said it was good to marry before age 20 years. Indeed only one community leader categorically stated that teenage pregnancy was not a problem in his community.

4.3 HEALTH IMPLICATIONS OF TEENAGE PREGNANCY.

The possibility of having more children in a life time is generally seen to be higher for women who start child bearing in their teens than those who start births later in life. Community leaders interviewed also believe that this assertion could be true. Out of the number of respondents, only 14%(20) disagreed with this belief whilst 5%(7) said they did not have enough information to agree or disagree with the statement.

Pregnant teenagers were seen to resort to abortion more than adult women who get pregnant. One hundred and thirty-eight (95%) of respondents really believe that teenage girls resort to abortion when pregnant. This confirms the fact that most teen pregnancies are unwanted or unplanned. In Sub-Saharan Africa between 10 and 58 per cent of teen births are reported to be unplanned. Over half of all teen births are said to be unplanned in countries such as Namibia, Ghana, Kenya and Botswana where desired family sizes are falling(25).

Pregnant teenagers were also seen to have more medical problems by 93.6% (137)of respondents whilst a similar percentage 95.2%(139) agreed that teenage mothers suffer more complications during child birth than adult women. The children born to teenage mothers

were also seen to experience high morbidity and mortality rates by 133 respondents (91.1%) due to lack of proper care. Teenage mothers were believed to face difficulties in the care of their children due to problems of finance and inexperience by 97%(143) of the community leaders.

One Hundred and forty- three (97%) of respondents felt that at the time of such pregnancies, most of the girls have no independent sources of income and therefore have to depend on family income which are generally inadequate.The teenagers are also by nature children themselves who are suddenly burdened with adult responsibilities for which they are not prepared.

4.4 SOCIO-ECONOMIC IMPLICATIONS OF TEENAGE PREGNANCY:

Traditionally, many Ghanaian societies have had a way of announcing the maturity of girls into womanhood and consequently their freedom to marry and start child bearing. Such customary practices took the form of "Bragro" in Akan societies whilst the Krobos also performed the "Dipo" Rites. Though the current level of socio-economic development with its attendant urbanisation has led to the collapse of these practices, the society mostly believe in girls entering into formal marriage before beginning childbirths.

Teenage pregnancy, which 135 respondents (92.5%) said frequently occur outside marriage is mostly seen as a disgrace to the girl's family. For these reasons, 92 percent (134) of the leaders also confirmed that the phenomenon is frowned upon in the communities. The girls

themselves feel ashamed about their situation according to 95 per cent (139) of leaders. About 90 per cent (131) of the respondents felt such girls are likely to be forced into marriage with the males responsible for their pregnancy in order to formalise their relationship before delivery. Such males are mostly also teenagers, according to 92.5 per cent (135) of respondents, who are financially handicapped. Economic hardships become the lot of such couples and most of such marriages end in divorce or separation later in life. Ninety-seven per cent(142) of the leaders interviewed confirmed that this scenario exists in their communities.

The biggest challenge for any possible intervention programme, however, is the apparent acceptance of teenage pregnancy once it occurs within a formal marriage. This might account for why marriages are hurriedly arranged between the girls and the males responsible for the pregnancies once they are detected. In most cases, however, such marriages, according to respondents also fail because both parties were not prepared for it.

The care of children born to teenagers mostly become the burden of their parents and this belief is also confirmed by 98.6% of respondents. In the United States where data is available, almost 8 of every 10 teen pregnancies occur outside marriage.(25) National support to such teen families was reported around 16.65 billion dollars in 1985.(24) In a developing country such as Ghana where national support for such families are non-existent, already deprived families bear the cost of their upkeep making such teen mothers worse off than their counterparts elsewhere.

The school drop out rate for most teenage mothers was also believed to be high by 98%(143)

of the respondents. This also permanently affects their chances of getting jobs in the future, unlike their male partners who may continue their education.In most cases the girls feel ashamed to go back to school after delivery. Those who may even wish to do so face the problem of caring for their babies or lack of financial support because the society now consider them as adults who should fend for themselves. Interestingly, the society rarely extend this same attitude to their male counterparts who may eventually escape this trap and at least finish their basic education. Most respondents (98%) therefore felt that girls suffered more than their male partners in the event of teen childbirths

Respondents, however, differ on whether the male partners should be blamed for teenage pregnancies in the communities. Unlike the other aspects of the issue on which respondents were almost unanimous in their views, respondents were divided on who to blame. Whilst 51 per cent (74) agreed that the male partners should be blamed, 49 per cent (72) felt both parties should be made equally responsible. Those who wanted to put the blame more on the males said, it was the males who lured the girls with money and other gifts into the sexual acts that resulted in the pregnancies. The others also felt that the girls could have refused such gifts in which case the boys could not have forced them.

It could be inferred from these responses that interventions meant to address the issue should include deterrent measures for males whilst girls are equipped with the knowledge, attitudes and skills to resist the advances from potential male partners.

The almost equal division of respondents in terms of responses to which partner should be

blamed in the event of a teen pregnancy necessitated some further analysis. In terms of gender, out of the 122 male respondents, 61(50%) agreed that the male partners are more to be blamed whilst the other half maintained that both partners should be equally blamed. The same picture came up among the 24 female respondents.Gender influence was therefore insignificant in responses(Chi-square- 0.00, df- 1, P-1.000)

The influence of leadership type was also not significant at the 95% Confidence Level.

Chi-square calculated - 8.498 Degree of Freedom - 4, P Value- 0.0707

Table Value - 9.488

Education, however, had a significant influence when responses were analysed for leaders with no formal education, basic education, secondary and tertiary education.

Chi-square calculated 14.31 Degree of Freedom - 3, P Value - 0.0025

Table Value 7. 81

Another social aspect of teen childbearing explored in the study was the community leaders view as to whether the society expects girls to have given birth by age 20 years. Only 19%(28) of respondents agreed that a girl could be considered barren in her community if she had not delivered by age 20 years. Even for this minority that held this view, their reason was that by that age most of the girl's peers would have given birth such that her case will be seen as contrary to the norm.

Interestingly the 81% (118) who disagreed with that view felt that such a girl is seen either, to have listened to her parents advice (65), wanted to continue her education (33) or learn a trade (20) before childbearing. This seems to confirm the view that though teenage child bearing is rampant in the community, it is not seen as the best thing to happen to the girls involved.

However, majority (71%) of the leaders interviewed felt that there was no problem with teenage child bearing once it occurred within marriage. Out of the 146 respondents, only 29%(42) disagreed with the view that it was not necessary to delay childbearing until age 20 years once the teenage girl is married. It could therefore be said that these community leaders are ready to disregard all other effects of teenage child births once the girl was married. One respondent actually recommended early marriage as a solution to teenage pregnancy. For most respondents (110) the most acceptable sequence of events is that of marriage followed by pregnancy and childbirths and not vice versa.

4.5 CAUSES OF TEENAGE PREGNANCY

When questioned about the possible causes of teenage pregnancy in their communities, the respondents views were as presented in the table below:

Table 5: Causes of Teenage Pregnancy as enumerated by respondents.

Cause	Frequency	% of Resp.
Poverty	132	90
Lack of Parental Control	127	87
Peer Group Influence	127	87
Social Pressure	100	68.5
Lack of sex education	86	58.9
Early Marriage	39	26.7
Lack of knowledge about contraception	35	24
Exposure to Pornographic Films	9	6
Others	6	4

Poverty was the main cause of teenage pregnancy and this was given by 90% (132) of respondents. This was followed by lack of parental control and peer group pressure with 87%(127) each. One hundred respondents (68.5%) mentioned social pressure whilst 86 (58.9%) talked about lack of sex education. Only 6%(9) of respondents gave exposure to pornographic films as a cause of teenage pregnancy.

The listing of poverty as a major cause of teenage pregnancy by the majority of respondents is corroborated by the findings of a research carried out on adolescent pregnancy in Accra and Kumasi by Nabila and Fayorsey in 1995 and cited elsewhere in this study, where economic gain was mentioned in focus group discussions as the major reason for adolescent promiscuity and subsequent pregnancy in the cities.

Ninety percent (132) of the respondents felt that the inability of parents to provide the needs

of their teenage girls due to poverty makes them lose control over such girls who tend to fend for themselves early in life. These girls become victims of the influences of their male and female peers as they employ all sorts of means to satisfy their needs. This situation was said to be more rampant in large families and broken homes.

4.6 SOLUTIONS

One Hundred and thirty-one (89.7%) respondents interviewed endorsed the intensification of family life or sex education in schools and homes to expose teenagers to the consequences of premarital sex. Only 10 per cent (15)of the community leaders would not support the idea of sex education for the youth. One Hundred and sixteen (79%) of the leaders also felt that the responsibility should first rest with parents and guardians, the churches and individual leaders in collaboration with health and social workers.

According to 65 respondents (45%) the education of girls should also be further enhanced, whilst parents should also strive to meet the needs of their female children.

Forty-three per cent (63) of respondents also believe that some laws can be passed that allows sanctions to be applied to the males responsible for the teenage pregnancies when they occur. Such laws should also be used to restrict the exposure of teenagers to pornographic films in the communities.

Out of the 146 respondents, only 35(24%) endorced the supply of contraceptives to teenagers as a solution to the problem of teenage pregnancy. Most of them (76%) felt that such actions will only encourage premarital sex in the communities. The best solution as indicated by

127 (87%) is to encourage the youth to abstain from sex through education and proper parental control.

This view is further enforced by the fact that only 35 respondents listed lack of knowledge about contraception as one of the causes of teenage pregnancy.

A few other respondents(6) also mentioned that parents should be educated to plan their families so that they can adequately train their children and take care of their needs.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

This study was meant to determine community leaders perception of teenage pregnancy in Ghana with a focus on the Assin district in the Central Region. The objectives were to assess leaders' knowledge, attitudes and beliefs about teenage pregnancy and also to determine if gender, education and type of leadership had any influence on leaders perception.

The main hypothesis tested was that community leaders have always taken teenage pregnancy and child bearing for granted and thus not really assessed its negative health and socio-economic effects. The hypothesis that gender, education and type of leadership had no influence on perception was also tested in one instance where respondents were sharply divided in their views.

The results from this study indicate that the respondents have a high level of awareness about the effects of teenage pregnancy in terms of the health of the mother and child and also the socio-economic effects as well as the causes.

Most of the respondents, usually over 80 per cent, agreed with the established views in the literature that teenagers experience more medical problems during pregnancy and child birth than their adult counterparts, manly due to their physical immaturity.

Community members also generally frown on teenage childbearing which makes pregnant

teenagers feel ashamed. Most of them therefore resort to abortions which in turn expose them to serious medical complications.

Most of the time the care of the mothers and children become the burden of parents of the girls because of their inexperience and low economic status. Such pregnancies also mean permanent drop out from school for the girls which further limits employment opportunities for the girls in their adult life.

Another aspect of the issue is the fact that the pregnancies mostly occur outside marriage and sometimes there is controversy over who is responsible for the pregnancy.This is the main reason why those involved suffer the economic hardships which was mentioned as one of the consequences of teenage childbearing.

Community leaders also see the problem as mainly due to poverty, peer group pressure, lack of parental control, the influence of foreign culture and the consequent breakdown of the traditions which served as checks on premarital sex.

The most important solution as advocated by the respondents is the teaching of sex education in the home, churches and schools by parents, pastors and teachers. Parents need to control the movement of their children and also ensure that the needs of female children are well catered for. The education of the girls should also be facilitated to ensure that they stay in school to acquire the necessary skills for a better life in the future.

The provision of contraceptives to the youth was not seen as a good solution to the problem. Efforts are rather to be focussed on interventions that promote abstainance from premarital sex.

The results of the study also showed that the respondents were almost unanimous in their views about the problems of teenage pregnancy. Gender and type of leadership had no significant influence on the views of respondents. Education, however, was the most significant influencial factor where there were differences in perception.

5.2 RECOMMENDATIONS

1. Any intervention that seeks to address the problem of teenage pregnancy should be a collaborative effort between parents, schools, churches, traditional authorities, health and social workers.

   The district assembly should intitute a technical committee that will involve the stakeholders

   mentioned above to plan educational programs to expose the youth to the dangers of premarital sex.

2. The DHMT should work with other stakeholders to train parents and some teenagers as counsellors to help educate the youth on the subject. Educational messages should

also be developed to facilitate sex education in the home, churches and schools

3. Educational campaigns should also be organised periodically in the communities to help create the necessary awareness about the problem. Such campaigns should initially focus on the socio-economic effects which are mostly apparent to the people and their leaders.

4. Traditional leaders can institute scholarship schemes for girls in their local schools in order to encourage them to go to school. Such tradditional leaders can also institute customary laws that will sanction males who take advantage of the plight of poor girls to engage them in sex.

5. Programmes meant to encourage pregnant teenagers to continue their education after delivery should also be instituted to reduce the high school drop out rates among them.

5.3 AREAS FOR FURTHER STUDY

1. The apparent approval of teenage childbearing within marriage should be further explored to find out how marriage helps to mitigate the health and socio-economic impacts of teenage pregnancy.

2. The role of parents in the conduct of sex education in the home should also be studied in order to develop strategies to enhance such activities.

Community leaders views on contraceptive supply to teenagers should also be examined in more detail.

REFERENCES

1. Population Reports(1985), Youth in the 1980s: Social and Health Concerns, Pop. Rep. Series M, No. 9, Nov-Dec. 1985.
2. Population Impact Project(1995), Adolescent Fertility and Reproductive Health in Ghana, PIP, Department of Geography and Resource Development, University of Ghana, Legon.
3. UNICEF(1993), Girls and Women: A UNICEF Development Priority.
4. The Alan Guttmacher Institute(AGI), Into A New World, Young Women's sexual and Reproductive Lives, AGI, 1998.
5. Ghana Statistical Service(GSS), Ghana Demographic and Health Survey(DHS)1993, Preliminary Report, GSS, April 1994.
6. Ministry of Health,Ghana(MCH/FP), Annual Reports, 1995-1997.
7. Nabila J. S, Fayorsey C and Pappoe M.(1997), Youth And Reproductive Health in Africa: Assessment of Adolescent Reproductive Health Needs in Ghana.
8. Population Studies(PS), Adolescent Reproductive Behaviour, Evidence from Developing Countries, PS, Vol. 11, No. 109, UN, New York, 1989.
9. The Alan Guttmacher Institute(AGI), Risks and Realities of Early Childbearing Worldwide, AGI, New York and Washington, 1996.
10. Population Reference Bureau, World Population Data Sheet, USAID, 1996.
11. Noble J, Cover J and Yanagishua M, The World's Youth, World Population Data Sheet, Population Reference Bureau, ed 1996.
12. Baker E, (1992), Adolescent Fertility in Sub-Saharan Africa: Strategies for a New Generation, CPO, Washington D.C

13. Meekers (1993), Sexual Initiation and Premarital Childbearing in Sub-Sahara Africa, DHS Working Paper No. 5, Macro International Inc. Columbia, Maryland, USA.

14. Njogu W. and Radeny S. (1995), Adolescence in Kenya, The Faces; The Centre for the Study of Adolescence, Nairobi.

15. Gyepi-Garbrah B(1987), Some Implications of Early Childbearing in Ghana, PIP, Department of Geography and Resource Development, University of Ghana, Legon.

16. Ghana Statistical Service(GSS), Ghana Demographic and Health Survey, 1988, GSS and Macro International Inc. 1989, Columbia, Maryland.

17. Felicia Dagadu(1997), The Magnitude and Determinants of Teenage Pregnancy in the Cape Coast Municipality, MPH Dissertation, School of Public Health, University of Ghana, Legon.

18. Bongaarts J. (1994), Population Policy Options in the Developing World, Science, 263 (5148).

19. Nabila J.S. and Fayorsey C.(1995), Adolescent Fertility and Reproductive Behaviour in Ghana: A Case Study of Accra and Kumasi.

20. Pobee-Hayford, F.(1998), An Analysis of Adolescent Fertility and Reproductive Health in Ghana, MA Dissertation, RIPS, University of Ghana, Legon.

21. Bledsoe, C.H. and Cohen B. eds(1993), Social Dynamics of Adolescent Fertility in Sub-Saharan Africa, Population Dynamics of Sub-Saharan Africa Series, National Research Council, Academy Press, Washington D.C.

22. Senderowitz, J. and Paxman, J.M. (1985), Adolescent Fertility: Worldwide Concerns, Population Bulletin, Vol. 40, No. 2, April 1985.

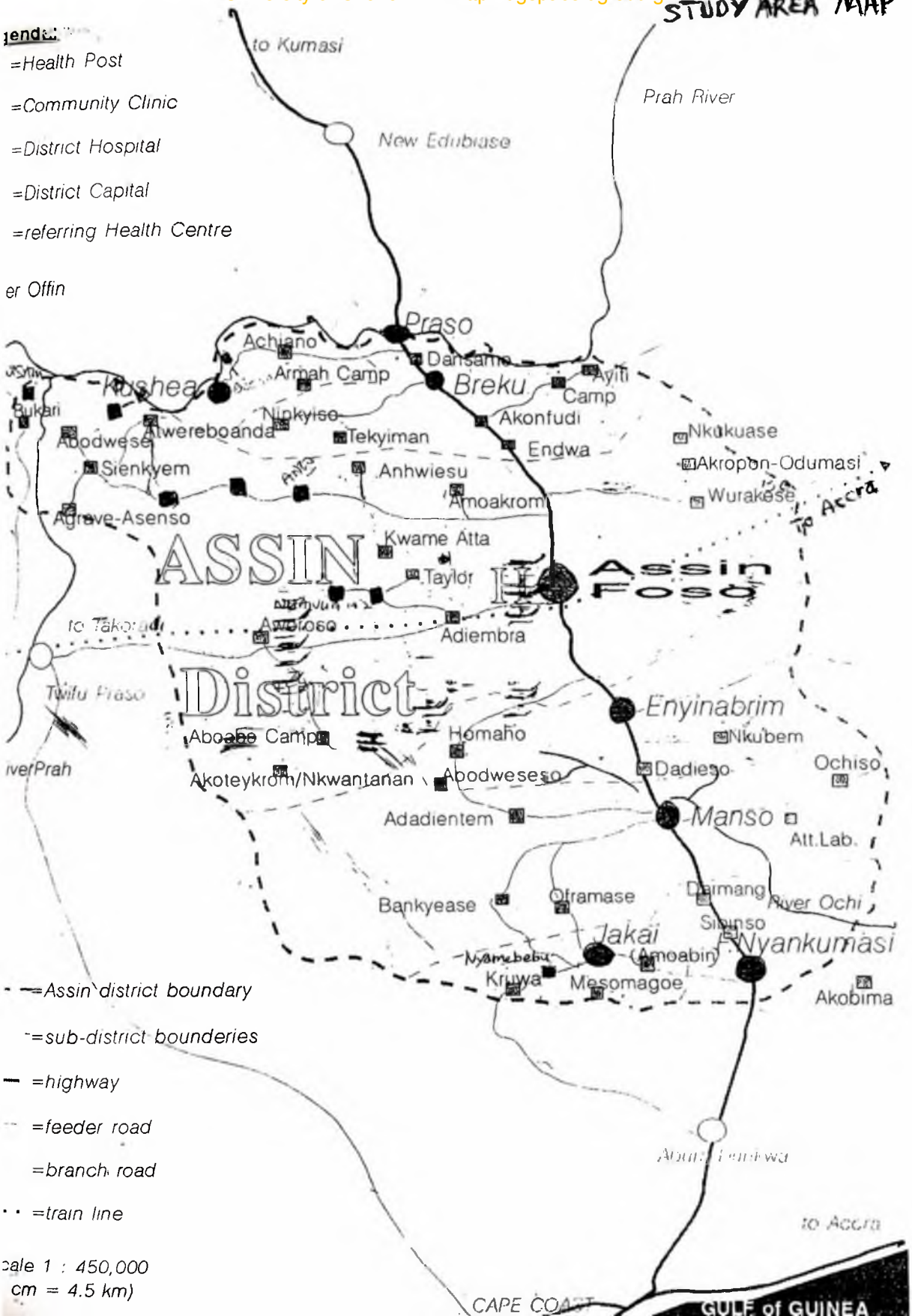
23. Buvimic et al (1992), The Fortunes of Adolescent Mothers and Their Children: The Transmission of Poverty in Santiago, Chile, Population and Development Review 18, No. 2, June 1992.

24. James S. M. et al (1987), Youth Pregnancy: A Community Solution, Journal of American Medical Association, Vol. 257, No. 24, June 26, 1987.

25. UNFPA Population, The New Generations. The State of World Population, 1998.

APPENDIX I

STUDY AREA MAP



APPENDIX 2

COMMUNITIES COVERED DURING THE FIELD WORK.

A. FOSU SUB-DISTRICT:

1. Gyangan
2. Basofi Ningo
3. Antoabasa
4. Anhwiasu
5. Bungalow
6. Dompim
7. Adiembra
8. Dominase
9. Nyamebekyere-Asuoyaa
10. Ongwa
11. Brofoyedru
12. Akropong
13. Akropong Odumase
14. Nkukuasa
15. Assin Nyankomasi

B.	**BEREKU SUBDISTRICT:**	16. Brasiako
		17. Nuaso
		18. Akonfudi
		19. Bereku
		20. Gold Coast Camp.
C.	**MANSO SUBDISTRICT:**	21. Adadientem
		22. Homaho
		23. Abodweseso
		24. Andoe
		25. Nsuta
D.	**NYANKOMASI SUBDISTRICT:**	
		26. Nyankomasi
		27. Bosomadwe
		28. Subinso
		29. Nkran
		30. Darmang

APPENDIX 3

COMMUNITY LEADERS' PERCEPTION OF TEENAGE PREGNANCY IN GHANA: A STUDY OF THE ASSIN DISTRICT IN THE CENTRAL REGION

QUESTIONNAIRE

A. BACKGROUND INFORMATION

1. Subdistrict._____

2. Community._____

3. Name of Respondent._____

4. Type of Community Leader.

   (a) Chief
   (a) Queen Mother
   (c) Assembly Member
   (d) Religious Leader
   (e) Headteacher

B. DEMOGRAPHIC CHARACTERISTICS

5. Age of respondent at last birthday

   (a) 18 - 29
   (b) 30 - 49
   (c) 50 - 69
   (d) 70 and above

6. Sex of respondent

   a) Male b) Female

7. Marital Status

   a) Married b) Single c) Divorced
   d) Widowed e) Separated

8. Religion

   a) Christian b) Muslim c) Traditional

9. Occupation .....

10. Educational Attainment

a) Primary School
b) Middle School/JSS
c) Secondary Education
d) Tertiary Education

C. HEALTH IMPLICATIONS OF TEENAGE PREGNANCY

11. At what age is it good for a girl to marry?_____

12. At what age is it safe for a woman to start childbearing?_____

13. Teenagers who get pregnant are more likely to seek abortion than their adult counterparts.

a) Yes b) No c) Don't Know

14. A girl who starts childbearing in her teens is likely to have more children than her counterpart who starts after age 20 years.

a) Yes b) No c) Don't Know

15. Teenagers are more likely to have medical problems during pregnancy than adult women.

a) Agree b) Disagree c) Don't Know

16. Teenagers are more likely to suffer complications during child-birth than adult women.

a) Yes b) No c) Don't Know

17. The children born to teenage girls are more likely to get sick or die early in life than

the children of adult women.

a) Yes b) No

Give the reasons for your answer_____

_____

_____

_____

_____

_____

_____

18. Teenagers are more unlikely to seek medical care during pregnancy and after child birth than their adult counterparts.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

Give the reasons for your answer _____

_____

_____

_____

_____

_____

_____

_____

D. SOCIO - ECONOMIC IMPLICATIONS OF TEENAGE PREGNANCY.

19. Teenagers who get pregnant drop out of school more permanently than their counterparts who avoid pregnancy in their teens.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

20. Girls who start child bearing during their teens are more likely to sufer economic hardships than their counterparts who delay births until after age 20 years.

a) Yes
b) No

Give the reasons for your answer _____

21. Teenage mothers are more likely to face difficulties in caring for their children than adult women.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

22. Teenagers usually feel ashamed when they become pregnant.

a) Yes
b) No
Give the reasons for your answer _____

23. Community members usually frown on teenage pregnancies.

a) Yes
b) No
Give the reason for your answer _____

24. Teenage girls are usually impregnated by their male peers more than adult men.

a) Yes b)No c) Don't Know

25. The male partners of pregnant teenagers are more to be blamed than the girls themselves.

a) Yes
b) No
Give the reasons for your answer _____

_____
_____
_____

26. Teenage pregnancies mostly occur outside marriage.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

27. Teenagers who get pregnant before marriage are more likely to be forced into marriage before they are ready for it.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

28. Teenage mothers are more likely to be separated or divorced from their partners later in life than women who begin childbearing later in life.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

29. Once a teenage girl is married, it is not necessary to delay childbearing until after age 20 years.

a) Agree
b) Strongly Agree
c) Disagree
d) Strongly Disagree

30. When a girl has no child by age 20 then she is likely to be considered barren in her local community.

a) Yes
b) No

Give reasons for your answer _____

_____
_____
_____
_____

31. When a teenager gives birth, the care of the child is more likely to become the burden of her parents.

a) Yes.
b) No.

Give the reasons for your answer _____

E. PRIORITIZATION OF TEENAGE PREGNANCY AS A PROBLEM

32. Have you ever experienced a teenage pregnancy in your household over the last five years?

a) Yes b) No

33. Is teenage pregnancy one of the problems in your community?

a) Yes
b) No

34. Have you ever discussed the issue of teenage pregnancy with any of your community members?

a) Yes
b) No

35. Have you ever discussed the issue of teenage pregnancy with any health or social worker?

a) Yes
b) No

F CAUSES AND SOLUTIONS

36. What in your view, are the major causes of teenage pregnancy in your area? Please indicate all the relevant factors.

a) Early marriage
b) Poverty
c) Social Pressures
d) Lack of Sex Education
e) Peer Group Influences
f) Lack of Parental Control
g) Lack of knowledge about contraception
h) Others (Specify)_____
_____

37. What role can you play in solving the problem of teenage pregnancies?

_____
_____
_____

38. What role can your community play in the solution of the problem of teenage pregnancies?

_____
_____
_____
_____
_____

39. Would you recommend the supply of contraceptives to teenagers as a possible solution to the problem of teenage pregnancy?

a) Yes
b) No
Give your reasons _____
_____
_____
_____

40. Would you recommend Family Life or Sex Education in schools as a possible solution to the problem of teenage pregnancy?

a) Yes.
b) No.
Give your reasons _____

41. What other recommendations would you make for the solution of the problem of teenage pregnancy?

THANK YOU !!