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RISKY SEXUAL BEHAVIORS AMONG ADOLESCENTS IN THE LA-DADEKOTOPON MUNICIPALITY OF THE GREATER ACCRA REGION OF GHANA

BY

BENJAMIN ANANG SOWAH

(10012826)

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DECLARATION

I hereby declare that this work is the result of my own research and has not been presented by anyone for any academic award in this or any other university. All references used in the work have been fully acknowledged. Any shortfalls therein are my sole responsibility.

STUDENT: BENJAMIN ANANG SOWAH

SIGNATURE:……

DATE:……

SUPERVISOR: DR. RICHMOND ARYEETEY

SIGNATURE……

DATE:……

DEDICATION

I dedicate this work to my dearest and best, my wife – Irene Ama Frimpomaa Sowah who literally took care of me and supported me as I had to proceed on study leave without pay to be able to do this programme effectively. There was no way I could complete this course if it had not been for your persistent support.

Thank you Ama.

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I also am grateful to Dr. Abu Manu who gave invaluable insights through the entire process. I am so grateful Sir.

LIST OF ABBREVIATIONS

ADHD	Adolescent Health and Development
ASRH	Adolescent Sexual & Reproductive Health
CSE	Comprehensive Sexuality Education
GES	Ghana Education Service
GDHS	Ghana Demographic & Health Survey
GHS	Ghana Health Service
GNADHD	Ghana National Adolescent Health and Development
GSS	Ghana Statistical Services
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSS	HIV Sentinel Survey
PTA	Parent Teacher Association
SHEP	School Health Education Programme
STIs	Sexually Transmitted Infections
SRHR	Sexual Reproductive Health & Rights
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
WHO	World Health Organization

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DEFINITION OF TERMS

1. Adolescent: Young people aged 10-19 years
2. Contraception: The use of various devices, drugs, agents, sexual practices, or surgical procedures to prevent conception or impregnation (pregnancy)
3. Contraceptive: A method, device or drug that prevents pregnancy
4. Sexually active: Having a previous history of peno-vaginal sexual intercourse.
5. Unintended pregnancy: Pregnancy occurring without one's intention to have it.
6. Peer influence: Is influence on a peer group, observers or individual that encourages others to change their attitudes, values, or behaviors to conform to groups.
7. Risky Sexual Behavior: It is any activity that increases risk of contracting STIs or becoming pregnant unintentionally.

ABSTRACT

Risky Sexual Behavior is described as any act that augments the risk of getting Sexually Transmitted Infections (STIs) or getting pregnant unintentionally. It comprises early sexual debut, sex with someone else apart from regular sexual partner, non-use of condoms during sex, non-use of family planning during sex and sex under the control of alcohol. The rest are sex with someone 10 years or older and sex under the influence of other substances. Given the rapid hormonal changes that occur during adolescence, the exposure to sexually suggestive media content, socio-cultural factors among others, taking sexual risks can be very common, with their attendant consequences of Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), unintended pregnancies, dropping out of school, child labour and the ultimate cessation of career development, among others.

This study aimed at determining the prevalence of risky sexual behaviors among adolescents aged 10-19 years in the La-Dadekotopon municipality and the factors associated with such behaviors. It also identified adolescents' sources of information on Sexual Reproductive Health and Rights (SRHR), in order to make appropriate recommendations to help address their challenges.

This study was a cross-sectional survey. It involved adolescents living in three localities: La Central, the Opetentum-Agyemang and La-Koo Areas. From each of these three localities, approximately 150 adolescents were randomly selected. Structured questionnaires were administered to obtain information on risky sexual behaviors and associated factors. Key findings and conclusions of the study included a median age of sexual debut at ten years, low usage of condoms, religiosity and parental level of education as factors associated with risky sexual behaviour of adolescents in the municipality. The major recommendation made was a call for action by government,

traditional and religious authorities, NGOs, families and the youth in addressing adolescent sexual and reproductive health issues.

CHAPTER ONE

INTRODUCTION

1.1 Background

Young people in Ghana are confronted with varied challenges. The 2014 Ghana Demographic and Health Survey indicated that 11% of girls and 9% of boys aged 15, have had sexual intercourse. According to the study, 14% of girls and 7% of boys age 15-19 were sexually active in the four weeks preceding the survey (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2014). In spite of this situation, condom use at First Sexual Intercourse among 15-19year olds is - Female: 25.9% and Male: 31.4% (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2014).

Adolescence is a transitional stage from childhood into adulthood. Adolescents are no longer children and yet they are not adults. It is a stage when their decisions, behavior and relationships decide their health and development. Some of these decisions may bring them into conflict with themselves, family and the society at large (M.O.H, 2009). Early sexual activity is associated with higher STI rates (Kaestle, Halpern, Miller & Ford, 2005. In addition, the not fully formed gynaecological tract of a young adolescent places her at additional biological vulnerability (O'Donohue et al., 2013). In 2013 alone, 120,000 adolescents lost their lives from AIDS-related causes: more than 300 every day (UNAIDS, 2015). AIDS is the second most common cause of death among adolescents globally, and the leading cause of death among adolescents (10-19) in Africa (UNAIDS, 2015).

Risky sexual behaviour is any activity that raises the risk of getting STIs or becoming pregnant unintentionally. This behavior constitute early sexual debut, unprotected sex, inconsistent condom use and sex with high-risk partners (Taylor-Seehafer, 2000). Most of the HIV cases in Sub-Saharan Africa resulted from unprotected heterosexual activity which is usually started during mid-adolescence (Singh, Bankole, & Woog, 2005).

Due to improvements in health, nutrition and childhood hygiene over the last half of the century, age at menarche has fallen. Consequently, children attain puberty earlier, thus making them wait much longer to discharge adult roles at an older age than they did some years back. This has extended the years spent completing school; resulting in late marriage. All these coupled with decreasing influence of culture on behavior provides ample opportunity to explore sexual activities of all kinds (Sawyer et al., 2012).

Given the importance of adolescents to the future of the country and the fact that they are particularly challenged to take risks that could lead to unintended pregnancies, sexually transmitted infections including HIV and AIDS, it is crucial that efforts are expended at looking into their sexual and reproductive health challenges in order to proffer enduring interventions for their wellbeing.

This study will therefore look into the extent of risky sexual behaviors among adolescents aged 10-19 in La Dadekotopon Municipal and the factors that influence them to get into these behaviours.

1.2 Problem Statement

According to the 2014 GDHS, 11% of girls and 9% of boys aged 15, have had sexual intercourse. The study further indicated that 14% of girls and 7% of boys age 15-19

were sexually active in the four weeks preceding the survey (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2014).

These notwithstanding, condom use at First Sexual Intercourse among 15-19year olds is - Female: 25.9% and Male: 31.4% (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2014). This is a clear indication that whilst adolescents are sexually active, they are not taking the necessary precautions to prevent the dangers of risky sexual behaviours.

Pregnancies among adolescents aged 10 – 19 rose from 107,536 in 2004 to 115,232 in 2010 (Ghana National Adolescent Health & Development, 2012). The 2014 GDHS indicated that 14% of adolescent girls age 15-19 had begun childbearing at the time of the survey with 11% having a live birth and 3% pregnant with their first child (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2015). Adolescents are terminating pregnancies and unfortunately most of these abortions are done by quacks and abortionists in unhygienic conditions resulting in complications and needless deaths (Ghana Statistical Service, 2012). Hesse and Samba have stated that 37.8% of abortions were performed at the abortionist's clinic under unacceptable conditions (Hesse, Eaton, Flise & Samba, 2006), 4.5% were performed at home and 26.7% were self-induced (Hagan & Buxton, 2012). Adolescents accounted for 11% of all maternal deaths, most of which resulted from unsafe abortions according to the 2008 GDHS (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro. 2009). The odds of teenage girls dropping out of school due to unintended pregnancy or STI is high and are likely to be confronted with social and economic crisis which aggravates the ability to raise children (Hagan & Buxton, 2012).

Additionally, HIV prevalence among 15-24 year olds for example is 1.2%, compared to a National prevalence of 1.3% (HSS, 2013). This is especially disturbing vis-à-vis the goings on in family planning (FP) clinics who provide more counseling on the use of contraception to married people than provision of services targeted at adolescents (Hesse & Samba, 2006).

This work is therefore aimed at researching into the prevalence of risky sexual behavior among adolescents in the La-Dadekotopon Municipality in order to help develop appropriate interventions. It is hoped that the findings will contribute to adolescent sexual and reproductive health programming to address gaps between knowledge and sexual practices.

1.3 Research Questions

The study will seek to find answers to the following questions:

a. What is the median age of sexual debut among adolescents in La-Dadekotopon Municipality

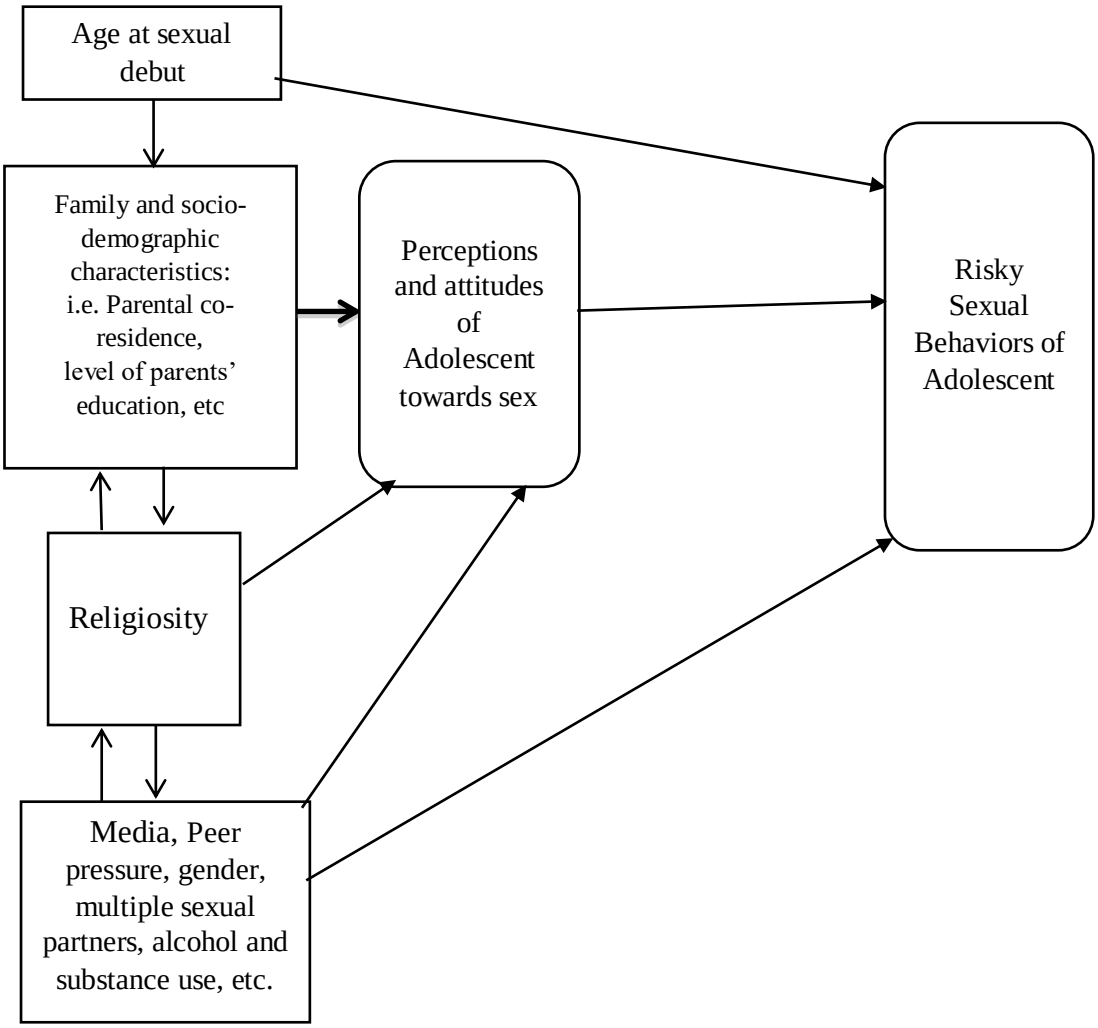
b. What are the risky sexual behaviors among adolescents in La-Dadekotopon Municipality

c. What are the factors associated with risky sexual behaviors among adolescents in La-Dadekotopon Municipality.

d. What are the sources of information on sexual and reproductive health and rights for adolescents in the La-Dadekotopon Municipality

1.4 Conceptual Framework

Figure 1: Conceptual Framework Showing Linkages between the Identified Variables



1.4.1 Conceptual Framework Narrative

For a thorough understanding of factors associated with risky sexual behavior there is interplay of factors that shape the perceptions and attitudes of the adolescent towards sex (Kirby, 2007). These include the adolescent's age, family and socio-economic and cultural backgrounds, the influence of religiosity and exposure to the media. The impact of these will influence the adolescent's perceptions towards sex and ultimately the taking on of risky sexual behaviors.

1.5 Justification

The findings of this study would generate the required awareness among parents/guardians on the influence of what they do on the sexual behavior of their adolescent children. It will provide insights into the relevance of parents' monitoring/supervision to the present and future well-being of adolescents. It will also inform adolescents of the key dangers involved in risky sexual behavior and therefore enable them manage their teenage age with more caution.

The findings of this study would benefit governmental ministries and agencies including the Ministries of Health and Education; Non-Governmental Agencies and other stake-holders in fashioning out effectual and result-oriented interventions for adolescents.

Lastly, it will add to the growth of knowledge regarding adolescent sexual behavior and also serve as an essential reference material for upcoming research in the field.

1.6 Objectives

1.6.1 General Objectives

The overarching objective of this research will be to study the occurrence of risky sexual behaviors among adolescents in La-Dadekotopon Municipality and determine the factors associated with risky sexual behaviors.

Specifically this research intends to:

1. Estimate median age of sexual debut among adolescents in La-Dadekotopon Municipality
2. Describe risky sexual behaviors among adolescents in La-Dadekotopon Municipality

3. Identify factors associated with risky sexual behaviors among adolescents in La-Dadekotopon Municipality
4. Identify the sources of information on SRHR for adolescents in the La-Dadekotopon Municipality

CHAPTER TWO

LITERATURE REVIEW

2.0 Brief Description and Background of Adolescents

The United Nations defines adolescents to include persons aged 10-19 years and youth as those between 15-24 years. Together, adolescents and youth are referred to as young people, encompassing the ages of 10-24 years (UNFPA, 1995).

Adolescents are a distinct population in a transitional period from childhood into adulthood. They are no longer children yet not adults. The major physical, psychological and sociological changes which occur during this period shape their entire lives. It is a period when their decisions, behavior and relationships determine their health and development. Some of these decisions may bring them into conflict with themselves and family and the society at large (MOH, 2009)

The period poses challenges such as relative vulnerability and pressure from society including peer pressure to adopt risky sexual behaviors. Their desire to develop an individual identity and dealing with one's sexuality have been identified to be challenging also. The combination of children commencing puberty earlier and taking on characteristically adult roles at an older age than they did historically has extended and altered the shape of adolescence, leading to late age at completion of education and marriage. All these coupled with decreasing influence of culture and parental influence on behavior among them provide an ample opportunity to explore sexual activities of all kinds (Sawyer et al., 2012b).

Today, the world is home to 1.8 billion young people between the ages of 10 and 24 (UNFPA, 2014). Young people aged 10-24 constitute 25% of the population in

developing countries (Sawyer et al, 2012). There are 5.5 million adolescents (10-19) in Ghana constituting 22% of the total population (GSS, 2014.

Adolescents are the future workforce of any country. They hold the fortunes for sustained development and progress of nations. Investing in them and ensuring their wellbeing is therefore crucial for securing the future (UNFPA, 2014).

2.1 Adolescent Sexuality

This refers to feelings for sex, development and behavior in an adolescent. It is a human sexuality stage. Sexuality is frequently an essential aspect of the lives of teenagers. Adolescents' sexual behavior is more often than not influenced by their culture's norms and values, their sexual orientation, and socialization, the issues of social control such as age of consent laws (Sawyer et al., 2012a).

Sexuality is defined as "A central aspect of being human throughout life encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships" (WHO, 2002). While sexuality can include all of these aspects, not all of them are always experienced or expressed. Sexuality is influenced by a blend of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (WHO, 2002).

Sexuality, sexual relationships and sexual behavior are important and a necessary part of human development (WHO, 2002). Responsible sexual behavior (e.g. choosing caring and respectful partners, delaying initiation of sexual intercourse, increasing the use of

condoms, and using effective contraception) is an important public health concern. Since adolescents are at an age of experimentation, this becomes an issue as they encounter several pressures from society, peer and the media especially in this age where the world has become a global village.

2.1.1 Services for Adolescents

The World Health Organization (WHO) and other interested agencies in health have also identified adolescent –friendly health services as a worldwide priority (Koh, 2010), given that 70% or more than 1 billion youth (10 to 19 years) are living in developing countries. It has been identified that educating the adolescent on matters relating to sex can be used as a strategy to delay sexual initiation (Advocates for Youth, 2014). This is used to equip them to make informed choices.

2.1.2 Age at Sexual Debut/Early Sexual Debut

Globally, the age at which young people commence sexual initiation is said to be decreasing (Rose et al., 2005). This age varies widely in countries and depends on the acceptable cultural practices which may have negative influences on their sexual behavior. In Ghana, the median age for women and men between the ages of 20 and 24 years is 18.4 years and 20 years respectively. However, some initiate sex as young as 10 years in some societies although earlier ages of onset have been reported (Boislard P. & Poulin, 2011; Lawoyin & Kanthula, 2010).

The age at which adolescents begin sexual activity is of significant public health importance, as it has been found to expose them to potential sexual risky outcomes both in the short and long terms (Sandfort, Orr, Hirsch, & Santelli, 2008). Participation in

multiple sex partners is significantly more probable among men and women who live in societies in which early sexual debut or "polygyny" is most widespread. Early sexual activity results in a long period of premarital sexual activity during which changing partners is relatively common, thus leading to the development of higher risk sexual orientations (Bongaarts & Watkins, 1996). This indicates that early sexual debut is likely to increase repeated sexual activity and to virtually preclude a man's and/or woman's capability to abstain from sex.

People who begin to have intercourse at younger ages are more likely to engage in sexual intercourse with casual partners and to have multiple and concurrent partnerships (Uchudi, Magadi, & Mostazir, 2010a). Other outcomes noticed among adolescents who engage in early sexual debut are involvement in several types of social vices such as stealing, fighting, use of controlled substances, school absenteeism and increased number of friends (Sawyer et al., 2012).

Most early sexual debut has also been found to have been nonconsensual because of the lack of negotiation skills for protective coitus and lack of assertive ability by the adolescent (Harrison, Cleland, Gouws, & Frohlich, 2005). The age at sexual debut is increasing in the younger females, 27% by the age of between 15 – 19 years have initiated sexual coitus. Males however are showing a decreasing age at sexual debut (GSS et al., 2009, Fatusi & Blum, 2008). The increasing age in females is not unrelated to female education, late marriage and programmes at increasing female education on reproductive health issues.

2.1.3 Peer Pressure

Adolescents are at a stage of experimentation and exploration, with lots of energy to use there is a desire to discover themselves and the society. This has become an issue as they encounter several pressures from society including their peers. The heightened sensitivity to peer pressure at this stage affects their experimentation with health-related behaviors such as substance use and sexual risky behavior. Both peer and parental influences have been associated with delayed coitus (Nonnemaker et al. 2003).

In a review by Sawyer et.al, they suggest that adolescents can make surprising decisions despite knowledge of risks. Adolescents seem to be more affected by exciting or stressful situations when making decisions about the so-called "hot cognitions" especially in the presence of peers. This is consistent with the notion of sensation seeking, the willingness to take risks to attain new, varied and stimulating experiences – an important mediator for risky behavior which increases between age 10 – 15, suggesting this behavior is affected by puberty (Sawyer et. al, 2013).

At this stage they begin to interact more with their peers. They also shift their reliance on their parents to their peers due to increased socialization. Values begin to change and in order to be accepted by peers they engage in activities that would make them conform to the group to avoid rejection. One of such activities is engagement in substance abuse which has a positive correlate with engaging in increased sexual risky behaviors which was noted to occur concurrently (Cooper & Guthrie, 2007).

Ali and Dwyer (2011) found out that peer pressure increases the chances of an adolescent engaging in sexual debut. They also found out that for every 10% increase in

the proportion of close friends who initiate sex, it increases the probability that an individual chooses to initiate sex by 5% (Ali & Dwyer, 2011).

In Ghana it was found that boys who perceived that their friends engaged in sexual risk behavior were more than 2 times likely to engage in such themselves. There was even greater influence of peers in female adolescents to engage in sexual intercourse (Karim, Magnani, Morgan & Bond, 2003, Magnani et. al, 2002). It is also important to note however that other studies have shown that peers can have positive protective influences on young people.

2.1.4 Parental Co-residence

Studies have shown a negative relationship between parental co-residence and adolescents' sexual activities. There is a lower possibility of being sexually active when adolescents live with their parents (Ngom P. et al, 2003)

Connectedness gives insights into how relationships give an individual a sense of protection, support and direction. It presents an atmosphere for healthy growth where one is able to receive support and encouragement. Consequently, it would be expected that as adolescents remain connected to grown ups, friends and major communal institutions like religious bodies and other social entities, the lower the probability of getting involved in risky sexual behaviors.

2.1.5 Parental Monitoring of Adolescents

Studies have also revealed that parents' ability to know well the peers and whereabouts of their adolescents precludes negative sexual behaviour among them. This is true for both females and males.

Parents' interest in wanting to know who their ward or child is friends with sends a clear message to the adolescent that his/her welfare is paramount, thus offering emotional support for the adolescent.

2.1.6 Religiosity

Billy and associates (1994) define religiosity, as a composite indicator of religious practice, including measures of frequency of praying, church attendance, and personal importance of religion.

Gallup International Millennium Worldwide Survey (2012) found Ghanaians the most religious country in the world: 96% indicate God is very important in their lives.

Religion is an essential communal institution for adolescents. More than 9 in 10 have a religious affiliation (Awusabo-Asare et al, 2004). Religiosity is associated with delayed sexual debut (Rostosky et al. 2003), fewer sexual partners (Murray-Swank et al. 2005), and negative attitudes about premarital sex (Koenig 2001).

In general, greater adolescent religiosity (defined by frequency of engaging in religious/ spiritual activities; McCree et al. 2003) is associated with later age of first coitus and fewer sexual behaviors such as intercourse without a condom and sexual intercourse with an unknown partner (Langer et al. 2001; Steinman and Zimmerman 2004).

However, the association of religiosity with sexual outcomes is complex. For instance, religiosity has been associated with contraception non-use, although not consistently (McCree et al. 2003; Nonnemaker et al. 2003), and more recent research has found religiosity to be negatively related to sexual activity within imagined relationships but unrelated to the actual sexual and contraceptive behavior of adolescents (Leonard and Scott-Jones 2010). Manlove, et al. (2006) showed that having religious parents might delay the age at which a teen first has sex. They also demonstrated, however, that parent's religiosity is negatively correlated with whether their teen uses contraception at first intercourse (Manlove, et al., 2006).

Although no religion promotes premarital sex in its central tenets, the theology and praxis of religious groups differ in their commitment and condemnation of premarital sexual relations (Cochran & Beeghley, 1991; Cochran et al., 2004). Per this assertion by Cochran et. al, adolescents sexual behavior may be informed by the commitment or condemnation of premarital relations by the religious group they belong to.

2.1.7 Gender

Gender has been shown to have a definite influence on sexual risk behavior of young people. Early onset of puberty is known to expose especially females to interest by those of the opposite sex which may end up in early onset of intercourse which is usually non-consensual, unplanned and unprotected (Eichorn, 1975) and this exposes them to injuries, risk of STIs, Human Papiloma Virus (HPV) infection, possible long term risk of cervical cancer later in life among so many others (Norman & Uche, 2002, Robert & Kristin, 2005, Kritz & Gurak, 1989).

2.1.8 Parental Level of Education & Sexual Behaviour of Adolescents

A study by Abu and Akerele (2006), found that the level of education of parents is a determinant of sexual behaviour of adolescents. They said that it is expected that parents with sound education through formal and informal education exposure will direct their children toward positive sexual behaviour.

Furthermore, according to Ezewu (1990), children from highly educated homes and conducive environment are likely to be prone to good behaviour and acceptable norms and values of the society than children from illiterate, poor and poverty ridden homes. In the same vein Sarumi (1998) argued that children from poor and illiterate homes are mostly street children, hawkers and bad eggs in the society and their antisocial behaviour are more pronounced in the society than that of the children from rich homes and well educated parents.

2.1.9 Alcohol & Substance Abuse & Sexual Behaviour of Adolescents

As stated earlier, unintended pregnancy, STIs including HIV among others are a few of the risky outcomes adolescents experience when they become sexually active. However, sexual activity under the influence of drugs, including alcohol, can raise the risks even higher.

Teens often drink or use other drugs when they engage in sexual activity. So perhaps it's not surprising that many young people lose their virginity while drunk. Unfortunately, many teens who get drunk and have sex also become pregnant because they aren't thinking about or able to use protection at the time (National Campaign to Prevent Teen Pregnancy's "Fact Sheet, 2000).

Thirteen percent of teens say they have done something sexual while using alcohol and other drugs that they might not have done if they had been sober (Kaiser Family Foundation and *YM Magazine*, 1998).

According to Whitbeck, et al. (1993), adolescents who drink and smoke are more likely to hang out with other adolescents they perceive to be sexually "advanced" — which usually results in a higher level of sexual activity among those teens themselves.

According to Harvey and Spigner (1995), sexual activity is associated with relatively high rates of alcohol consumption and, among boys, with a tendency to engage in physical fights.

2.2 Cross-Generational Sex

Cross-generational sex generally refers to relationships between older men and younger women, although some cross-generation relationships include older women and younger men. In the first type of relationship, young women are usually below age 20 and their male partners at least 10 years older. Gregson et al. (2002) argued that the risk of infection with HIV increases with the age of partner. Hawkins et al. (2005) observed that gender, age and economic disparities increase risky sexual behavior and reduce a young woman's ability to negotiate safer sexual behaviors. According to Luke & Kurz, (2002), it is not surprising that girls who become pregnant or present with induced abortions have much older partners on average. The aforegoing appreciably underscore the risks involved for adolescents in sexual relationships with partners 10 years or older than themselves.

2.2.1 Media

Information Technology has revolutionized the variety of platforms for information sharing – radio, television, mobile phones, the internet, social media, among others are now easily accessible. Today mass media has become critical to adolescents' sexual socialization as they are the earliest adopters of information and communication technology. Several theories have been used to corroborate this assertion. Social learning theory and its close relation, social cognitive theory, argue that screen-media exposure leads to the cognitive acquisition of behaviors along with their expected social, emotional, and cognitive consequences (Bandura, 2002). Exposure to portrayals suggesting that a behavior (sex) will lead to social disapproval or other negative outcomes (e.g., pregnancy, STIs) is likely to foster negative attitudes toward the depicted behavior, not promote its enactment. Thus, the content portrayed (sexual or not) and the specific nature of the content (consequences of sex) are critical to measure if one wishes to accurately predict subsequent beliefs and behavior.

The Integrative Model of Behavior Change (Fishbein, 2002), builds on social cognitive theory and integrates it with other theories, such as the Theory of Reasoned Action (Azjen & Fishbein, 1980) to predict that media exposure will influence behavior through shifts in behavioral intentions, which are themselves a function of attitudes, norms, and perceptions of self-efficacy acquired through media and other sources. Thus, media users learn not only what is likely to be the outcome of sexual activity, but also whether others engage in it or approve of it, and come to see themselves as more or less able to engage in similar activities themselves.

Closely related to social cognitive theory are script theories of media use (Huesmann, 2007). These theories argue that individuals acquire a diverse and ordered set of beliefs as a result of exposure to media portrayals. Individuals not only learn whether a behavior is common and whether it will result in positive outcomes, but they are also presented with a series of ordered events describing how and when it is appropriate to enact the behavior (i.e., procedural knowledge). These scripts are not always used, but when events or circumstances in the environment trigger them (for example, a first date or an unexpected kiss), they may be acted out (Udry, 1987).

It is evident from the theories that adolescents' access to sexually suggestive media can predispose them to risky sexual behaviors because they are likely to act out what they see or hear through those media.

2.2.2 Adolescent Policy

Ghana has an Adolescent Reproductive Health Policy. This was first published in 2000 with a broad objective of promoting a healthy policy framework with which young people can obtain information and services on reproductive health and exercise their reproductive rights. The policy purports to delay age at sexual debut, increase female enrolment in school, thereby decreasing early entrance into marriage and the occurrence of sexually transmitted infections among adolescents.

In 1996, the MOH and MOE developed a comprehensive sex education programme which has been integrated into the school curriculum from primary up to senior high school for adolescents between the ages of 15 to 24 years called ADHD programme and focuses on 'promoting the health of young people, preventing and responding to health

problems from early, unprotected, unwanted sex, use and misuse of drugs including cigarettes and alcohol, poor nutrition, endemic diseases, violence and injuries (GHS Annual Report, 2010).

Additionally, there is the Ghana Strategic Plan for the Health and Development of Adolescents and Young People 2009-2015. This policy which has a holistic outlook to supporting the adolescent's health also has a multi-sectoral approach to meeting the needs of the adolescent. It has the School Health Education Programme (SHEP) being implemented in basic schools to promote HIV/AIDS education in schools to reduce HIV incidence.

Whilst these are laudable ideas, there is a key dissonance in the implementation of the policies. Whilst the adolescent's right to information and services is clearly stated and provided for in the National Adolescent Reproductive Health Policy, the Ghana Education Service does not allow condom demonstrations and the provision of contraceptive services in the schools. This effectively waters down the comprehensiveness of sexuality education in the schools. This undermines the good policies outlined for adolescents given that majority of them go through the basic school system and are losing out on Comprehensive Sexuality Education (CSE).

CHAPTER THREE

METHODS

3.1 Study Design

A cross-sectional study design was used to generate the factors associated with risky sexual behaviors among adolescents in the La Dade-Kotopon Municipality in the Greater Accra Region.

3.2 Study Area

This study was conducted in the La Dade-Kotopon Municipality of the Greater Accra Region. The Municipality was weaned off the Accra Metropolitan Assembly in 2012. The Municipality covers an area of 360 square kilometres.

3.2.1 Location of the Municipality

La Dade-Kotopon Municipality is located between longitude 05degrees 35'N and on Latitude 00 degrees 06'W. It is about 4.83km east of the centre of Accra. The Municipality is bounded both in the North and West by Accra Metropolitan Assembly, on the East by Ledzokuku Krowor Municipal Assembly and on the South by the Gulf of Guinea. It includes areas like La, Labone, La-Abese, La Abafum-Kowe, Airport Residential, Cantonments, East Dadekotopon (behind the Trade Fair Site) and Nyaniba Estates.

3.2.2 Population Structure

According to the 2010 Population and Housing Census of Ghana, the population of the municipality was 306,424 with total number of houses being 10,372 and 30,925 households. Given an annual growth rate of 2.6% per annum, it is currently estimated at

465,620. The population of the municipality is youthful with 56% under the age of 24. The population structure is 51% females and 49% males. The sex ratio of female to male is 1.04 to 1.00. The dependency ratio is approximately 60%. La Dade-Kotopon is made up different ethnic groups. It is however predominantly Ga (95%), the remaining 5% is Akan, Ewe, and other ethnic groups and foreign nationals. The municipality is home to a lot of diplomatic missions and corporate organizations whose employees live and work in the neighbourhood. Religions of the people in the area are Christianity, Islam and the traditional religion indigenous to the area. It has key health facilities like the La General Hospital and the Police Hospital. There are a good number of private hospitals and numerous primary health care units and CHPS (Community-Based Health Planning and Services) Compounds.

The occupation of the people in the area include both the formal and informal sectors of the economy: civil servants, fishermen, business/women, traders, artisans, manufacturers, banking etc. The area is home to the only International Airport in the country; with several military installations such as the Ministry of Defence (MOD) and Burma Camp. Social/Sports facilities include the El-wak Stadium and the Aviation Social Centre. There are several Government and private basic and senior high schools in the area.

3.3 Variables

3.3.1 Dependent Variable

- Risky Sexual Behaviors

This was measured as:

1. Early sexual debut (sex before age 16)

2. Sex with someone else apart from regular sexual partner
3. Non condom use during sex encounter(s)
4. Non family planning usage during sex encounter(s)
5. Sex under the influence of alcohol
6. Sex under the influence of other substances
7. Sex with someone 10 years or older

In this study, early sexual debut was defined as sex before age 16. This is so because Ghana's age for consensual sex is 16 years (Ghana Statutory Rape Law). Adolescents who get sexually involved before this age may not be mature enough to make informed decisions about their actions. Besides, they may be less likely to use any form of contraception either to prevent STIs or unintended pregnancy.

3.3.2 Independent Variables:

1. Peer pressure
2. Gender
3. Parental co-residence
4. Access to Media (social media, internet, etc.) and its influence
5. Religiosity
6. Socio-demographic characteristics (age, sex, place of residence and family structure including parents' level of education)

These were directly measured through a questionnaire.

3.4 Study Population

The study was targeted 10-19 year olds in La-Dadekotopon. The population of the Municipality is 306,424 (Ghana Statistical Services, 2014). Young people age 24 and below make up 56% of the population i.e. 171,597.

3.5 Sampling

3.5.1 Sample Size Calculation

The sample size was calculated using the Cochrane formula for sample size calculation:

$$\frac{Z^2 p(1-p)}{d^2}$$

It was based on assumptions that:

- proportion of adolescents who are engaged in risky sexual behaviours (P=50%) taken to get the maximum sample size,
- Z=1.96 at 95% confidence interval,
- d= the level of precision (0.05), and
- non-response rate = 10%;

Total sample size therefore came to 423 (≈ 430).

A maximum of 450 adolescents were however selected to cater for eventualities.

3.5.2 Sampling Procedure/Method

The Municipality was split into three clusters: La Central, Opetentum-Agyeman and La-Koo Areas. Based on the maximum sample size of 450 and the 3 clusters, a hundred and fifty (150) adolescents were selected from each cluster by using simple random sampling. Household numbers were obtained from the planning department of the La-

Dadekotopon Municipality and fed into a Microsoft Excel sheet. The numbers were liberally selected from each locality and used for the study. Where there were no eligible adolescents in a selected household, the closest household with an eligible respondent was selected for the study.

3.6 Data Collection Techniques/Methods and Tools

Structured questionnaires were administered to elicit information on risky sexual behaviors. These behaviors include multiple sexual partners, use and non-use of condoms and/or family planning during sexual episodes and any sexual practice that could result in pregnancy and STIs. Questionnaires further gathered information that could be associated with risky sexual behavior like adolescents' socio-demographic backgrounds, exposure to sexually arousing images via various forms of media, religiosity, level of parents' education, among others. The bio demographic information of each participant including age, sex, and level of education, etc, were also asked.

3.7 Quality Control

3.7.1 Training of Research Assistants

To ensure good quality response to the questionnaires, research assistants were given a one-day training. This afforded the entire team to clarify issues in the questionnaire and helped fine-tune some of the areas before questionnaires were finally administered.

3.7.2 Inclusion and Exclusion Criteria

Target population for this survey was adolescents age 10 – 19 residing in the La Dadekotopon Municipality. Those excluded were all young people outside this age group.

3.8 Data Processing and Analysis

3.8.1 Statistical Analysis

Upon completion of administering the questionnaires, they were checked for completeness, internal consistency and cleaned. Data were first entered into Microsoft Excel. The data entry sheet was designed with appropriate definitions. Completed questionnaires were doubly entered to help identify inconsistencies. This was further cross-checked and the necessary corrections made for accuracy of the final entered data. The final data from the field entered into Microsoft Excel were then exported into STATA version 13.1 for analysis. The level of significance (alpha) was set at 0.05. The results were presented in Tables. A univariate analysis was used to determine the median age at sexual debut (objective one). Frequencies and percentages were used as descriptive analysis for all risky sexual behaviours (objective 2) identified and the sources of SRHR information for adolescents (objective 4). Bivariate (Pearson's chi-square) and multivariate (logistic regression) analyses were used to determine the association between each of the risky sexual behaviours and the independent variables (objective 3).

3.9 Ethical Consideration/Issues

The School of Public Health's (SPH) permission to conduct this research was duly obtained. Ethical approval was obtained from the Ghana Health Service Ethical Review Committee. In view of the sensitive nature of the study, permission was also sought from the respondents and informed written consent obtained from each respondent.

The objective and rationale of the study were discussed with each respondent before proceedings commenced. Entry and/or withdrawal from the study was entirely voluntary and duly consented by respondents. Client privacy and confidentiality were assured –

their identity and/or personal information was disclosed except as authorized by themselves or as required by law. They were however informed that the results of the research may be presented at scientific or medical meetings or published in scientific journals.

Participants were informed that though there were no risks attached to the study, questions will border on personal life and experiences especially with sex and romantic relationships; which may generate some discomfort and inconveniences. They were also informed that the research does not guarantee or promise receipt of any benefits (monetary or otherwise) except that the results could be used to advice on policies regarding improved adolescents sexual and reproductive health which will benefit several other communities across the country and beyond.

They were further informed that data collected would be coded, entered and saved using a password known only to the principal investigator and that to facilitate publication of the research, data would be stored for 3-4 years, after which data would be destroyed. They were duly informed that apart from its academic and public health importance, there were no other conflicting or personal interests in the study.

CHAPTER FOUR

RESULTS

This chapter presents the results of the study. Although the survey intended to cover 150 adolescents from each cluster - La Central, Opetentum-Agyeman and La-Koo, this was not feasible on account of prevailing circumstances regarding adolescents who qualify for the study. Furthermore, the 450 students originally intended to participate came to 425 as some answered questionnaires had to be discarded because they did not meet the required standards and quality.

4.1 Distribution of Study Respondents

There were 425 respondents participating in the survey. Of this, 54.69% (232) were males and 45.41% (193) were females. Fourteen year olds formed majority (28.71%) followed by 13 year olds (19.06%). The lowest was 10 and 19 year olds who had 0.24% each. Religious backgrounds of respondents were three fold- Christianity, Islam and Traditional Religion with Christians forming almost 95% of respondents followed by Muslims who were 4.47%.

As regards whom adolescents have been living with over the past 12months, 79.06% live with either one or both parents while 20.93% live with guardians, grandparents, siblings among others. Furthermore over 70% said they were very close to their parents with 12% saying they are not close to their parents.

Completed levels of education of mothers and fathers showed some key differences. A greater proportion of mothers (32.94%) as compared to fathers (20.71%) had basic education. When it came to tertiary education however, fathers were over twice as much

(26.71%) compared to mothers (12.24%). Further socio-demographic characteristics are shown in Table 1.

Table 1: Socio-Demographic Characteristics of Adolescents

Variable	Frequency	Percentage (%)
Sex		
Male	232	54.59
Female	193	45.41
Age Groups *(in years)*		
10-14	263	61.88%
15-19	162	38.11%
Religion		
Christian	402	94.59
Muslim	19	4.47
Traditionalist	4	0.94
Mother's level of Education		
Basic	140	32.94
Secondary	130	30.59
Tertiary	52	12.24
None	43	10.12
Other (Don't know)	60	14.12
Father's level of Education		
Basic	88	20.71
Secondary	124	29.18
Tertiary	114	26.82
None	19	4.47
Other (Don't know)	79	18.59
Ethnic Group		
Ga/Adangme	250	58.82
Akan	91	21.41
Ewe	50	11.76
Other	34	8.00
Place of Residence		
La Central	147	34.59
Opetentum/Agyeman	203	47.76
La-Koo	75	17.65
Family Structure		
Both Parents	167	39.29
Mother	134	31.53
Father	35	8.24
Grandparents	31	7.29
Sibling	11	2.59
Step Parents	12	2.82
Other Family Member	12	2.82
Guardian (non family member)	16	3.76
Other	7	1.65
Closeness to Parents		
Not close	51	12.00
Somewhat close	71	16.71
Very close	303	71.29

4.2 Types of Risky Sexual Behaviour

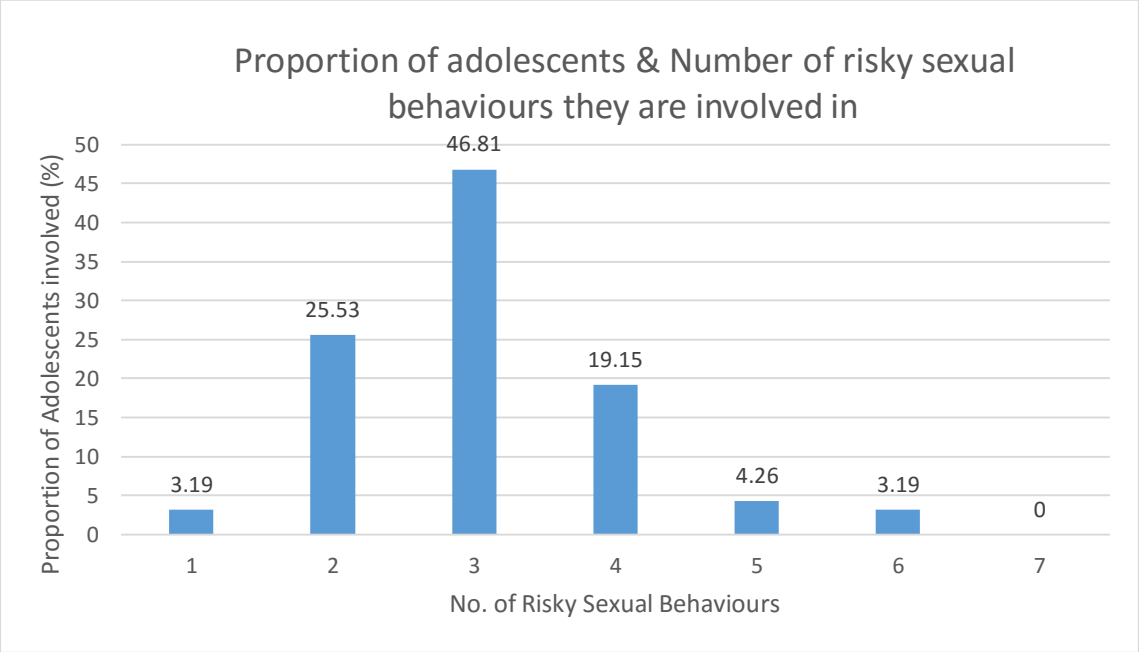
Risky sexual behaviour was based on the seven-fold sexual risk behaviours earlier outlined - early sexual debut, sex with someone else apart from regular sexual partner, non-condom use during sex encounters, non-family planning usage during sex encounters, sex under the influence of alcohol, sex under the influence of other substances and having sex with someone 10 years older or more. The frequency distributions for the various risky sex behaviours are shown in Table 2.

Table 2: Risky Sexual Behaviours among Adolescents

Variable	**Frequency**	Percentage (%)
Early sexual debut		
Above 16years	10	10.64
Below 16 years	84	89.36
Pattern of adolescents' condoms usage		
Always	3	3.19
Never	91	96.81
Sex with someone else apart from regular sexual partner		
Yes	25	26.60
No	69	73.40
Adolescents who always use Family Planning during sex		
Yes	3	3.19
No	91	96.81
Sex with someone 10years or older		
Yes	19	20.21
No	55	58.51
Don't Know	19	20.21
Sex under influence of Alcohol		
Yes	7	7.45
No	87	92.55
Sex under influence of other Substance		
Yes	5	5.32
No	89	94.68

The sexually active among respondents was 22.10%. Of the sexually active 67.02% were males and 32.98% were females.

Figure 2: Proportion of Adolescents & Number of Risky Sexual Behaviours they are Involved in



The graph shows that 46.81% of adolescents were involved in three (3) of the risky sexual behaviours identified, whilst 3.19% were involved in one (1) risky sexual behaviour. No adolescent was found to be involved in all the seven risky sexual behaviours identified.

4.3 Median Age of Sexual Debut

The median age of sexual debut for both sexes was 10years. Further analysis however showed that median age for sexual debut was 9 years for females and 10 years for males.

4.4 Factors Associated With Risky Sexual Behaviours

The factors identified to determine whether they have an association with any of the risky sexual behaviours were peer pressure, parental co-residence, level of education of father and mother, access to sexually suggestive media, religiosity (in terms of how

often one prays on their own, participates in religious youth activities and attends religious services. A bivariate analysis of the above is shown in Table 3.

Table 3: Bivariate Analyses of Factors Associated with Early Sexual Debut

Variable	Early Sexual Debutants/Sex below 16years	P-value	Chi Square value
Peer pressure to have sex		**0.791**	**0.070**
Yes	36		
No	43		
Parental Co-Residence		**0.544**	**6.932**
Adolescents living with both parents	23		
Adolescents living with Mother	29		
Adolescents living with Father	13		
Adolescents not living with either parent but with guardians	19		
Level of Education of Father		**0.005**	**14.789**
Basic	19		
Secondary	24		
Tertiary	20		
None	2		
Other (most specified they don't know)	15		
Level of Education of Mother		**0.019**	**11.764**
Basic	28		
Secondary	24		
Tertiary	10		
None	7		
Other (most specified they don't know)	13		
Access to sexually suggestive Media		**0.500**	**5.349**
Once a week	21		
Twice a week	4		
Thrice a week	3		
Four or more times a week	36		
Occasionally/Less than once a week	7		
Don't know	9		

Variable	Early Sexual Debutants/Sex below 16years	P-value	Chi Square value
Religiosity *(how often one participates in religious youth group meetings)*		**0.677**	**1.523**
Once a year or less	21		
At least once every six months	9		
At least once a month	12		
At least once a week	40		
Religiosity (*How many times do you participate in religious services in a week)*		**0.229**	**6.887**
Once a week	28		
Twice a week	21		
Thrice a week	8		
Four or more times a week	15		
Don't Know	11		
Religiosity (*How often do you pray on your own)*		**0.045**	**8.041**
Never	3		
Once a while	33		
At least once a week (often)	12		
At least once a day (very often)	36		

The above indicates that the level of education of mother **(p=0.019)** and father **(p=0.005)** had an association with early sexual debut. Of all the aspects of religiosity that were tested, only frequency of prayers showed an association with early sexual debut (p=**0.045).**

Having identified factors that had association, a multivariate logistic regression was run to confirm the significance of the association.

Table 4: Logistic Regression Analyses of Factors Associated with Early Sexual Debut

Explanatory Factors	No. (%) who are early sex debutants	Total No.	Odds Ratio	95% Confidence Intervals
Level of Education of Father				
None	2 (40.0)	5	Ref.	
Basic	22 (95.65)	23	7.54	0.140, 405.032
Secondary	24 (96.00)	25	13.67	0.364, 513.171
Tertiary	20 (90.91)	22	7.22	0.272, 191.308
Level of Education of Mother				
None	7 (63.64)	11	Ref.	
Basic	31 (96.88)	32	9.47	0.324, 276.602
Secondary	23 (92.00)	25	4.49	0.363, 55.651
Tertiary	10 (100.00)	10	-	-
Religiosity (number of times one prays on their own)				
Never	3 (60.00)	5	Ref.	
Once a while	33 (84.62)	39	1.02	0.042, 25.234
Once a week	12 (100.00)	12	-	-
Daily	36 (94.74)	38	2.78	0.077, 100.291

The multivariate analysis showed no significant association.

4.5 Sources of Information on Sexual & Reproductive Health & Rights

Respondents selected in multiples the various sources they get sexual and reproductive health and rights (SRHR) information. The results are captured in Table 4.

Table 5: Adolescents' Sources of Information on SRHR

Variable	**Frequency**	Percentage (%)
School	345	81.18
TV	244	57.55
Church	176	41.41
Radio	125	29.41
Friends	106	24.94
Hospital	97	22.82
Internet	77	18.12
Youth Friendly Centres	70	16.47
Mosque	13	3.06
Other (sources indicated were parents, siblings, books)	13	3.06

As many as 81.18% get their SRH information from school, followed by TV, which presents a sharp drop (57.55%) as compared to school. This is followed by Church, which registered 41.41%.

It is clear from the results that youth friendly centres are about the least (16.47%) sources for SRHR information among the adolescents.

CHAPTER FIVE

DISCUSSION

The study findings showed that the median age for sex initiation for both sexes is 10years. However, the median age for sex initiation for females was 9 whilst that of males was 10. This finding is in consonance with other studies in Ghana and elsewhere which have concluded that females initiate sex earlier than males (Eichorn, 1975, Uthman, 2008, Mc-Question, Ahiadeke, Posner &William 2012; GSS & Macro, 2009). It is therefore crucial that adolescent SRHR programmers prioritize and design appropriate programmes to support female adolescents to help them delay sexual debut especially in the light of the fact that they encounter pubertal changes earlier than boys.

Whilst the above is consistent with previous findings, it is inconsistent with other previously conducted national studies on adolescents which put median age of sex initiation at 18.4 for females and 19.8 years for males; an indication that the age of sexual debut was on the rise (Zaba, Pisani, Slaymaker & Boerma, 2004; Awusabo-Asare & Anarfi, 1999; GSS & Macro, 2014). The declining age of puberty, compounded by the weakening influence of culture and parenting on adolescents among other reasons present opportunities to explore sexual activities of all kinds (Sawyer et al., 2012). This finding may also be showing this difference due to the fact that the sample size was way smaller compared to nationally representative studies.

The study showed that among the sexually active, 67.02% were males and 32.98% were females. This indicates that more males were engaged in risky sexual behaviours than females, which is inconsistent with a study that said early onset of puberty exposes females especially to interest by the opposite sex which may end up in early onset of

intercourse (Eichorn, 1975). It could be that the males are behaving this way because there are a lot of adverts in recent times on the media saying that manhood is proven by one's virility. This calls for urgent programmes that target male adolescents on how to contain the testosterone storm.

Religiosity, in terms of frequency of prayers did show an association with early sexual debut, albeit not significant. Those who reported praying daily had 2.78 odds of early sexual debut as compared to those who never pray. This is inconsistent with earlier studies which have postulated that religiosity is associated with later age of first coitus and fewer sexual behaviors such as intercourse without a condom and sexual intercourse with an unknown partner (Langer et al. 2001; Steinman and Zimmerman 2004). Their involvement in early sexual debut in spite of their religiosity might be due to the fact that religiosity may just be fashionable among them; congruent to the Gallup International Millennium Worldwide Survey (2012) which found Ghanaians the most religious country in the world.

One of the key associations expected in this study was an association between parental co-residence and risky sexual behaviours. There was however no association with any of the risky sexual behaviours; inconsistent with an earlier study which showed that co-residence was associated with a lesser probability of being sexually active (Ngom et al, 2003). It could be that the sample size of this study could not corroborate this previous finding. With more numbers in the sub groups of the sample size, this relationship might have clearly been established.

Again, there was an association between parent's level of education and early sexual debut. Those whose fathers have secondary education for example had 13.67 odds of involvement in early sexual debut. In other words, adolescents whose parents had secondary education were more likely to be involved in early sexual debut. This is inconsistent with the findings of Abu and Akerele (2006), who found that the level of education of parents is a determinant of sexual behaviour of their adolescent children. It could well mean that this outcome may just have been by chance given that the study sample size is small.

Sources of SRHR information were identified among adolescents in the municipality. The study showed that 81.18% get their SRH information from school. This is consistent with the 2005 Global Digest's position which said that schools are the primary institutions able to reach a majority of adolescents.

TV follows school as source of SRHR information with 57.55% and Churches come after with 41.41%. The result further showed that youth friendly centres are about the least (16.47%) sources for SRHR information among the adolescents. It was clear that such centres are not available at all in the municipality thus denying majority of adolescents what could be a comprehensive source of SRHR information to them. There is an urgent need for such an intervention.

The study was limited however as regards the significance of the relationship between parental level of education and adolescents' risky sexual behaviour. The study did not question adolescents how their parents' educational levels speak to their sexual choices and behaviours. The study did not also target parents to look into how educated parents may be influencing their adolescents into early sexual debut.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

The study findings establish that the median age of sexual debut among adolescents age 10-19 in La Dadekotopon Municipality is 10years.

Over 80% of sexually active adolescents never used a condom in all their sexual encounters and just under 4% reported using family planning always during sex.

Findings of this study further conclude that the level of education of parents of adolescents has an association with early sexual debut among adolescents in the municipality. Those whose parents have basic and secondary education are more likely to be involved in early sex.

The school system is the primary source of SRHR information for adolescents. The other leading sources are TV and Churches. Adolescent friendly centres are not a popular source of SRHR information for adolescents in the municipality.

6.1 Recommendations

Issues in adolescent sexual and reproductive health have always been multifaceted and therefore require a multi-sectoral approach in addressing them. The following recommendations are proffered for the consideration of relevant stakeholders.

6.1.1 Improved Policy Environment for Adolescents Government

The large numbers of adolescents getting information on sexual and reproductive health from their schools underscores the importance of the School Health Education

Programme (SHEP) which is under the Ghana Education Service.and the ADHD programme moderated by the Ghana Health Service. Government must ensure that these programmes are sustained and continued for more adolescents to benefit.

There is a need for an integration of adolescent sexual and reproductive health education into mainstream TV programming given that TV is a second source of information to them. The wide access adolescents have to both accurate and inaccurate SRHR information via TV channels, the internet, social media among others, call for a credible alternative programme that is youth friendly and gives accurate SRHR information to adolescents.

It is crucial, given the findings that, government puts in place or enforce the Laws on Censorship of films playing on TV especially to curb the showing of sexually suggestive films. It is also crucial for government to censor internet content to protect adolescents.

Furthermore, government must collaborate with religious institutions through the Adolescent Health & Development Programme (ADHD [under the Ghana Health Service]) and SHEP, given the crucial role they (religious institutions) are playing in delivering information on sexual and reproductive health to adolescents. Through this collaboration, youth leaders in churches can be trained in SRHR to strengthen their delivery.

The establishment of youth friendly centres in the municipality is also crucial to help deal with risky sexual behaviours among adolescents. These centres will provide various

games, edutainment programmes and provide the needed confidentiality and privacy needed for adolescents to get counseling and quality SRHR services.

6.1.2 The Role Families Can Play

Families are the first and most significant influences as regards adolescent sexual growth and sexual socialization (Perrino, Gonzalez-Soldevilla, Pantin, & Szapocnik, 2000) and play an important role in sexual risk-taking among teens in psychiatric care (Donenberg, Wilson, Emerson, & Bryant, 2002). Families must therefore support adolescents by initiating and giving age appropriate information on SRHR. Parents must discuss basics like changes as you grow, early sex and its consequences, HIV and other STIs and how to prevent them, among other basics. On account of the effect of parents' education on adolescents risky sexual behaviour, educated parents must be encouraged to be circumspect on what they might be exposing their adolescents to that may be leading them on into early sex. Maybe, because of their level of education they are able to afford and give their adolescents access to TV, internet, mobile phones, etc. and this might be leading them into risky sexual behaviours including early sexual debut.

Parental control and monitoring of adolescents is also an area parents must look at. Adolescents need guidance to enable them make the right choices regarding their sexuality.

It is crucial to keep discussing cultural values as regards sexual health to encourage adolescents to keep sexually healthy. Getting them to engage in healthy activities like sports, to open up and ask questions about their sexuality and other issues is so

important. Maintaining connectedness and building trust with adolescents is a vital role families must play.

6.1.3 Role of Schools

It is recommended that Schools engage with Parent-Teacher Associations to specifically educate them on SRHR issues. This can be done with support from the SHEP and ADHD Programmes. For cost effectiveness, the schools can take advantage of PTA meetings to do these trainings. Such fora will be appropriate for clarification of core issues in adolescent sexual and reproductive health.

Schools must also train peer educators who will positively engage their colleague students about issues in sexual health. New peer educators must be recruited and trained to replace those who graduate and exit on completion of school.

6.1.4 Role of Community Leaders

Traditional, Religious and opinion leaders must take responsibility to advocate and campaign for adolescent SRHR issues including, teen pregnancy, unsafe abortions, unprotected sex among other issues. Various advocacy networks (Traditional, Religious, Parents Advocacy Networks) can be formed by leaders to create the needed awareness on adolescent issues in the community. In this way, the entire membership of the community gets the opportunity to contribute their quota.

6.1.5 Youth Involvement

It is recommended that adolescents themselves come together to deal with their own issues as they understand their issues better and can educate their peers. Youth

pressurize one another in various ways – this can be channeled into positive peer pressure. They can form peer counseling groups to positively engage their peers and also get themselves involved in community service, competitions and other positive engagements and not in risky sexual behaviours.

6.1.6 Role of NGOs in Sexual & Reproductive Health

SRHR related Non-Governmental Organizations (NGOs) have a big role to play in this matter. Institutions like the Planned Parenthood Association of Ghana (PPAG), Ghana Social Marketing Foundation, Hope for Future Generation (HFFG) among others must come to the aid of adolescents in the municipality. In collaboration with the La Dadekotopon Municipal Assembly (LaDMa) they can implement projects in HIV, SRHR, livelihood empowerment skills trainings, etc. This will go a long way to empower adolescents to desist from risky sexual behaviours.

6.2 Future Research

It is recommended that future research look into how parental level of education heightens higher risk sexual behaviours, particularly early sexual debut among adolescents. This will go a long way to inform parents and potential parents about how to properly guide adolescents. Further research should also be done on how the internet is influencing risky sexual behaviours especially in the light of the growing access to the internet by adolescents and the internet's tendency to give both accurate and inaccurate information on sexuality. Research will establish the real effects of the internet on adolescents' sexual behaviour and proffer recommendations to address the issues arising.

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APPENDICES

Appendix I: Consent Information

DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH

SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF GHANA, LEGON

Risky Sexual Behavior among Adolescents

CONSENT INFORMATION

PURPOSE OF RESEARCH

You are invited to participate in a research study of the extent of risky sexual behaviors among adolescents and the factors that influence them to get into these behaviors. This study is to help inform us on appropriate interventions to put in place to support adolescents and thereby improve their sexual health. You were selected as a possible participant in this study because you meet our selection criteria and you were retained in our random sampling. This research study is looking for a minimum of 430 adolescents between the ages of 10-19 years living within the La-Dadekotopon Municipality.

VOLUNTARY PARTICIPATION

Your participation in this study is entirely voluntary. Your decision not to participate will not have any negative effect on you. You can decide to participate now, but withdraw your consent later and stop being in the study without any loss of benefits or medical care to which you are entitled.

DURATION OF STUDY INVOLVEMENT

This research study is expected to take approximately 2 months to interact with selected participants and to gather necessary information. Responses will be put together and analyzed for results in the next month. Final report should be complete by the end of July, 2015.

DESCRIPTION OF CONSENTING PROCESS

If you choose to participate, the research officer will describe all the procedures to be followed in a language you understand. You will be given the opportunity to ask all questions you may have and further explanations given.

Signing or Thumb printing of Questionnaire

If you agree to participate, you will be requested to sign a consent form or thumb print if you wish to indicate that you fully agree to be part.

Administration of Questionnaire

A set of questions will be asked by the research officer for which you will be requested to provide genuine answers as much as possible. You can however decide not to answer questions you feel uncomfortable with. Each questionnaire will take a maximum of 25 minutes to complete.

Risks

There are no risks attached to responding to the questionnaires. Your name will not be taken in this study, however for purposes of data analysis each form will be given a peculiar identification number.

PARTICIPANT RESPONSIBILITIES

As a participant, your responsibilities include:

- Follow the instructions of the research officer
- Complete your questionnaires as instructed
- Ask questions as you think of them
- Tell the research officer if you change your mind about staying in the study

VOLUNTARY WITHDRAWAL FROM STUDY

If you first agree to participate and then you change your mind, you are free to withdraw your consent and discontinue your participation at any time. Your decision will not affect your ability to receive medical care and you will not lose any benefits to which you would otherwise be entitled.

POTENTIAL RISKS, DISCOMFORTS, AND INCONVENIENCES

Even though there are no risks attached to participating in this study, we will be asking questions bordering on your personal life and experiences especially with sex and romantic relationships. These may generate some discomfort and inconveniences. These

deserve careful thought. You should talk with the research officer if you have any such discomforts and ask questions whenever you want for clarification.

POTENTIAL BENEFITS

We cannot and do not guarantee or promise that you will receive any benefits from this study. We hope however that results outcome could be used to advice on policies that border on adolescents sexual and reproductive health especially that which protect them against risky sexual behavior. This is to benefit the entire community as a whole.

PARTICIPANT'S RIGHTS

You should not feel obligated to agree to participate. Your questions should be answered clearly and to your satisfaction. If you decide not to participate, tell the research officer.

COMPENSATION

There will be no monetary payments to you for participation in this research project.

PRIVACY & CONFIDENTIALITY

The results of this research study may be presented at scientific or medical meetings or published in scientific journals. However, your identity and/or your personal information will not be disclosed except as authorized by you or as required by law. No

response given will be disclosed to any unauthorized persons. Neither your name nor your any identity traceable to you will be indicated on the survey forms.

DATA STORAGE & USAGE

Data collected would be coded, entered and saved using a password known only to the principal investigator. The soft copy of data would be put on a CD-ROM and an external hard drive. Data collected would be kept by the principal investigator for 3-4 years to facilitate publication of the research, after which data would be destroyed.

DECLARATION OF CONFLICT OF INTEREST

Apart from its academic and public health importance, there are no other personal interests in the study.

CONTACT INFORMATION

Questions, Concerns, or Complaints: If you have any questions, concerns or complaints about this research study, its procedures, risks and benefits, or alternative courses of treatment, you should ask the research officer.

Independent Contact: If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact:

Dr. Richmond Aryeetey

School of Public Health

University of Ghana, Legon

Tel: 0244129669

Email: rnokai@gmail.com

Or

Benjamin Anang Sowah

School of Public Health

University of Ghana, Legon

Tel: 0244028327

Email: sowee2001@gmail.com

Or

Hannah Frimpong

Administrator

Ethical Review Committee

Ghana Health Service

Tel: 0507041223

APPENDIX II: Statement of Consent

I have read this consent form or it has been read and explained to me. I have had the opportunity to discuss this research study with …….. and or his/her study staff. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statement or implied statements. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in this research study.

Participant signature/Thumb print_____

Date _____

(Day / month / year)

Participant's name: _____

Appendix III: Questionnaire

SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF GHANA

CODE:…….

Risky Sexual Behavior among Adolescents

Date…….. Sex: M / F Age:……

The next several questions deal with boyfriends/girlfriends and sexual behaviors. For some people, these topics are private matters and may be embarrassing to discuss. I appreciate any information you may be willing to share with me on these topics. I also want to remind you that you are free to skip any question that you do not want to answer. In fact, for our research, we would rather have you skip a question than give inaccurate information. So please, if you do not want to answer a question or feel that you cannot answer it honestly, please just ask me to skip ahead to the next question and I will be happy to do so. You may also decide to stop participating at any time. Let's begin.				
I would like to ask you some basic questions about yourself and background				
1.	Which of these will you identify as your religious affiliation	*Christian*……	*1*	*Traditionalist*……..*3*
		Muslim……..	*2*	*Other(specify)*……*4*
2.	What is your completed level of education	*Basic*….. ……	*1*	*None*……*4*
		Secondary……	*2*	*Other(specify)*……..*5*
		Tertiary……..	*3*	
3.	What is the highest level of education of your Mother?	*Basic*….. ……	*1*	*None*……*4*
		Secondary……	*2*	*Other(specify)*……..*5*
		Tertiary……..	*3*	
4.	What is the highest level of education of your Father?	*Basic*….. ……	*1*	*None*……*4*
		Secondary……	*2*	*Other(specify)*……..*5*
		Tertiary……..	*3*	
5.	Are you married?	*Unmarried*….. ……	*1*	*Divorced*……..*3*
		Married……	*2*	*Widowed*……..*4*
6.	Which ethnic group do you belong to	*Ga/Dangme*…..	*1*	*Ewe*……
		Akan……	*2*	*Other (specify)*……
7.	Where is your usual residence	*La Central*……	*1*	*La-Koo*……*3*

	(name of your community) for the last 6 months?	*Opetentum-Agyeman* 2	
8.	What is your main occupation?	*Trader*….. …….. 1 *Apprentice*…… 2 *Student*…… 3	*Unemployed*……4 *Other(specify)*……5
9.	Whom have you been living with over the last 12 months	*Both parents* 1 *Mother* 2 *Father* 3 *Grandparents* 4 *Sibling* 5 *Step Parents* 6 *Other family member* 7 *Guardian (non family)* 8 *Other* 9 *(specify_____)* 10	
Okay, I'd like to learn some of the details of your FIRST partner. If you have had only one romantic or sexual relationship, please think about that person. If you have had more than one romantic or sexual relationship, please think about the first relationship you ever had.			
10.	Have you ever had a BOYFRIEND/GIRLFRIEND? (boyfriend/girlfriend=someone you are in a romantic relationship with)	*Yes*…… 1 *No*…… 2	
11.	How old were you when your relationship with your first boyfriend/girlfriend began? [PROBE: When did you start spending time together as more than friends?	*Age*……	
12.	How old is/was your partner	*Age* ……	
13.	IF ENDED: During your relationship with partner, did any adults in your family know about this relationship? IF ONGIONG: Do any adults in	*Yes*…… 1 *No*…… 2	

	your family know about this relationship?	
14.	IF ENDED: Were adults in your family generally supportive of the relationship, against it, or neutral about it? IF ONGOING: Are adults in your family supportive of the relationship, against it, or neutral about it?	*Supportive*…… *1* *Were Neutral*…… *2* *Against it*…… *3* *Don't know*…… *4*
15.	IF ENDED: Did any of your friends know about this relationship? IF ONGOING: Do any of your friends know about this relationship?	*Yes*…… *1* *No*…… *2*
16.	Did you ever have sexual intercourse with your partner? (By sexual intercourse, I mean a man inserting his penis into a woman's vagina.)	*Yes*…… *1* *No*…… *2*
17.	How old were you when you first had sex with your first partner?	*Age*……
18.	The first time you had sex, was a condom used?	*Yes*…… *1* *No*…… *2*
19.	How would you describe your relationship to that person at the time you first had sex? Would you say that he/she was:	*Your boy/girlfriend*…… *1* *An ordinary friend*…… *2* *A casual acquaintance*..... *3* *A stranger*…… *4* *A teacher*…… *5* *An employer*…… *6* *A relative*…… *7* *Someone else*…… *8* *Don't remember*..... *9*
20.	The first time you had sex with your partner, was any other form of family planning used?	*Yes*…… *1* *No*…… *2*
21.	The first time you had sex with your first partner, would you	*Wanted to have sex*…… *1* *It just happened*…… *2*

	say that you wanted to have sex, it just happened, or you were pressured into doing it, or you were forced to do it?	*Pressured into doing it*..... 3 *Forced to do it*…… 4
22.	Did you have sex with someone else before your first partner?	*Yes*…… 1 *No*…… 2
23.	How old were you the very first time you had sex?	Age:
24.	Have you had sex within the last 3 months?	*Yes*…… 1 *No*…… 2
25.	If yes, was a condom used?	*Yes*…… 1 *No*…… 2
26.	Was any other form of family planning used on that occasion?	*Yes*…… 1 *No*…… 2
27.	Have you had sex within the last 12 months?	*Yes*…… 1 *No*…… 2
28.	If yes, was a condom used?	*Yes*…… 1 *No*…… 2
29.	Was any other form of family planning used on that occasion?	*Yes*…… 1 *No*…… 2
30.	Before your last sex experience, was a condom used?	*Yes*…… 1 *No*…… 2
31.	Before your last sex experience, was a form of family planning used on that occasion?	*Yes*…… 1 *No*…… 2
32.	Are you having sex with someone else apart from your regular partner?	*Yes*…… *No*……
33.	How many sex partners have you had in total in your whole life?	*Two*…… *Three*…… *Four*…… *Five or more*……
34.	Has anyone ever pressured you into having sex with them?	*Yes*…… 1 *No*…… 2 .....
35.	Has anyone ever offered you money or other gifts in an	*Yes*…… 1 *No*…… 2

	attempt to get you to have sex with them or to be in a sexual relationship with them?	
36.	Have you ever had sex with someone 10 or more years older than you?	*Don't know* 2 *Yes* 1 *No* 0
37.	Have you ever had sex when you were drunk?	*Yes*…… 1 *No*…… 2
38.	Have you ever had sex that you were influenced by other substance?	*Yes*…… 1 *No*…… 2
	I want to ask questions about how your parents/guardians relate to you	
39.	How connected /close are you to your parents?	*Not close* 1 *Somewhat close* 2 *Very close* 3
40.	Do your parent(s) guardians enforce restrictions on your movements?	*Yes* 1 *No* 2
41.	How would you rate the level of restriction?	*Low* 1 *Moderate* 2 *High* 3
42.	How often do your parent(s)/guardian(s) know your where about?	*Never* 1 *Occasionally* 2 *Sometimes* 3 *Most of the time* 4 *Always* 5
43.	Do your parents/guardians allow you to go to any place you please without asking?	*Yes* 1 *No* 2
44.	Are your parents/guardians less strict than most parents in allowing you to go out to have	*Yes* 1 *No* 2

	fun with your friends?	
45.	How will you rate your mother's attitude towards premarital sex?	*Strongly disapprove* 1 *Disapprove* 2 *Don't Know/Not sure* 3 *Approve* 4 *Strongly approve* 5
46.	How will you rate your father's attitude towards premarital sex?	*Strongly disapprove* 1 *Disapprove* 2 *Don't Know/Not sure* 3 *Approve* 4 *Strongly approve* 5
Okay, I would like to ask you some questions about your religious background and experience.		
47.	How many times do you participate in religious services in a week?	*Once*..... ..... 1 *Twice*..... 2 *Thrice* ..... 3 *Four or more times*..... 4 *Don't know*..... 9
48.	How often do you pray on your own?	*Never* 1 *Once a while* 2 *At least once a week (often)* 3 *At least once a day(very often)* 4
49.	Religion is important in your life.	*Not at all important* 1 *Somehow important* 2 *Important* 3 *Very important* 4
50.	How often do you participate in religious youth group activities (meetings; work etc.)?	*Once a year or less* 1 *At least once every six months* 2 *At least once a month* 3 *At least once a week* 4
51.	Would you say you abstain from sex because of your religious activities	*Yes*..... ..... 1 *No*..... 2

		Somehow…… 3 *Don't know*…… 4
I would also like to ask you a few questions about your access to sexually suggestive media forms and your sources of information on sexual and reproductive health.		
52.	How many times a week do you see/hear sexually suggestive images/sound bytes on any form of media (TV,DVD, Radio, Phone, social media, etc.)?	*Once*….. …… 1 *Twice*…… 2 *Three times*…… 3 *Four or more times*…… 4 *Occasionally/Less than once a week* 5 *Don't know*…… 9
53.	From where do you get information on sexual and reproductive health	*School*…… 1 *Hospital/Clinic*…… 2 *Youth friendly centres*…… 3 *Friends*…… 4 *Internet*…… 5 *TV*…… 6 *Radio*…… 7 *Church*…… 8 *Mosque*…… 9 *Other (specify)*…… 10