

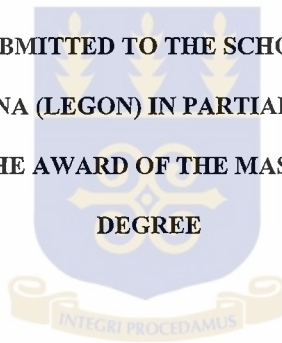


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**THE MAGNITUDE AND DETERMINANTS OF TEENAGE  
PREGNANCY IN THE CAPE COAST MUNICIPALITY**

**A PROJECT REPORT SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH,  
UNIVERSITY OF GHANA (LEGON) IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE AWARD OF THE MASTER OF PUBLIC HEALTH  
DEGREE**



**BY**

**FELICIA DAGADU (MRS)**

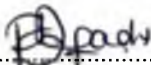
**JUNE 1997**

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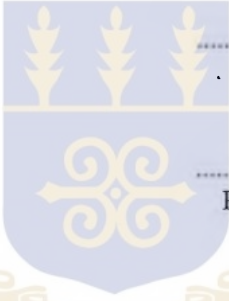

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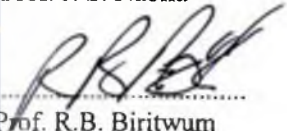
**DECLARATION**


I, Felicia Dagadu, do hereby declare that except for the duly acknowledged citations and ideas, this work contains a true account of a study personally conducted under supervision in the Cape Coast municipality of the Central Region. I do also declare that this work has not been published in any form else where.

Student:  .....  
Mrs. Felicia Dagadu

Academic Supervisors

  .....  
Prof. J. S. Nabila

 .....  
Prof. R.B. Biritwum

 INTEGRI PROCEDAMUS

**DEDICATION**

To my beloved husband, Nii Amatei, whose sacrifices have seen me to this level.

## **ACKNOWLEDGEMENT**

This work could not have been carried out and completed without the help, assistance, support and encouragement which I received from my supervisors, community members, my family and friends.

I must acknowledge my profound gratitude to God for bringing me this far. I sincerely thank Professor J. Nabila, Prof. R. Biritwum and Dr. Constance Marfo, my supervisors for the guidance offered, the useful suggestions, constructive advice, the patience, their cool and calm but inspiring attitude portrayed as I worked on this study.

My thanks also go to the District Health Management Team of the Cape Coast municipality who sponsored the project and especially to Mrs. Patricia Banson (District Public Health Nurse) and her subdistrict heads who assisted me with the data collection. To the women in the fertile age group, especially the teenagers used as respondents for the study, I owe you a lot of gratitude for your interest and cooperation.

Finally I wish to acknowledge my deep appreciation to my son Nii Armah for his immense contribution in the data entry and Naa Sakle and Nii Kwei for demonstrating great tolerance and forbearance for my reduced attention to many of their needs during the time of this study.

This work could not have been produced on time to meet the deadline but for the dedicated and expert work of Miss Rita Nikoi, who typed the final script. I am deeply grateful to her.

**LIST OF ABBREVIATIONS**

AAK	Abura-Asebu Kwamnakese district
DHMT	District Health Management Team
ERP	Economic Recovery Programme
FADEP	Family and Development Programme
GDHS	Ghana Demographic and Health Survey
GLSS	Ghana Living Standard Survey
ICPD	International Conference on Population and Development
K E E A	Komenda-Edina-Equafo Abrem district
KDHS	Kenya Demographic and Health Survey
MCH	Maternal and Child Health
PAMSCAD	Programme of Action to Mitigate the Social Cost of Adjustment.
RA	Research Assistant
SAP	Structural Adjustment Programme
UCC	University of Cape Coast

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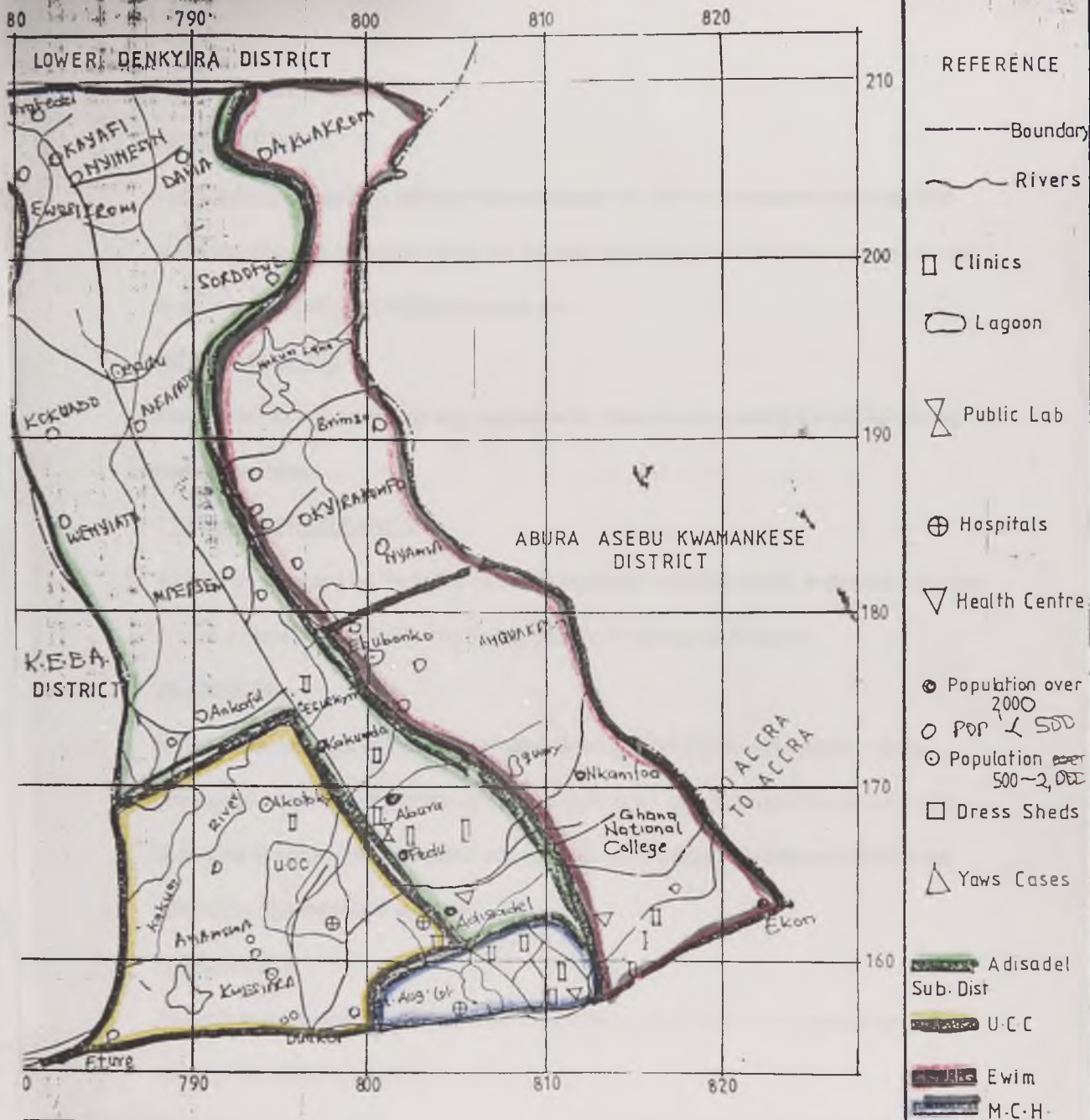
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# DISTRICT MAP OF GHANA





DISTRICT MAP SHOWING HEALTH FACILITIES & SUB DISTRICT DEMARCATATIONS

Scale = 1:100,000

## **DEFINITION OF TERMS**

### **MAGNITUDE**

For this study, magnitude refers to the percentage of obviously pregnant teenagers and teenagers who had delivered within the last year per other obviously pregnant women and those who had delivered within the same year.

### **DETERMINANTS**

These relate to factors that strongly influence or determine pregnancies occurring among teenage mothers.

### **TEENAGE PREGNANCY**

Women in the ages 13-19 whether married or not and have had a child within the last year or such a teenager who is obviously pregnant (i.e. 5 months and above)

### **TEENAGER**

In this study, teenager refers to those between the ages of 13-19, although the Ghana Demographic and Health Survey (GDHS) defined it as those between the ages of 15-19. Data from the district health institutions revealed a percentage of teenagers between the ages of 13-15, hence their inclusion.

### **PREGNANCY**

This refers to the absence of menstruation, the person claiming she has missed her period and showing obvious signs of pregnancy.

## **ABSTRACT**

The purpose of this study was to determine the magnitude of teenage pregnancy and identify the factors that contribute to teenage pregnancy in the Cape Coast municipality.

Women in the fertile age group (WIFA) who were obviously pregnant and those who had delivered within the last year (April 1996-April 1997) were enumerated through a household survey. Three hundred and two households were surveyed in 21 randomly selected communities based on the population size of the four sub districts in the municipality. Two hundred and twenty nine pregnant and twenty non pregnant teenagers were interviewed by means of a structured questionnaire.

The results of the study indicated that the prevalence of teenage pregnancy was 47.3%. The mean age of the teenagers was 18.2 years with a standard deviation of  $\pm 1.8$ .

The basic determinants of teenage pregnancy were school dropouts, unemployment especially among a high number of JSS graduates, single parenthood and poverty. Others included search for financial gain by striking up sexual relationship with boyfriends who were between the ages of 20 to 23. Peer pressure was found to be a major contributing factor to teenage pregnancy. However, contact with tourists did not appear to play any role. Although the hypothesis revealed that there was no difference between

education, socio economic background and knowledge in reproductive health, there was a significant difference in the number of pregnant friends among respondents. (P=0.01)

Based on the findings it is recommended that teens clinic should be established as a priority to cater for the counseling needs of teenagers. Youth placement centres should be established with the collaborative efforts of the Cape Coast Municipal Assembly, Ministry of Youth and Sports, Ministry of Employment and Social Welfare and the Business Advisory Centre (BAC). Parents should also be advised to improve upon their income with the needed assistance from BAC, and together with religious leaders, take it upon themselves to instil good moral training and discipline in their wards.

Lastly, the Municipal Assembly should adopt a policy on measures to deal with men who impregnate teenagers. With these strategies, it is hoped that teenage pregnancy will be reduced.

## CHAPTER ONE

### 1 0 INTRODUCTION

Adolescent reproductive health has become an issue of concern to governments, demographers and planners all over the world. Estimates show that almost half of the world's population comprises young people aged 10-24.<sup>1</sup> This group of young people are sexually active and many of them are non-users of contraceptives, thereby predisposing themselves to unwanted pregnancies and its related hazards. Some resort to illegal unsafe abortions which often end in death, thus increasing the maternal morbidity and mortality rates.<sup>2</sup> The incidence of teenage pregnancies is currently high worldwide. This has taken on a new dimension and is growing in alarming proportions. In line with this, the United Nations International Conference on Population and Development (ICPD), held in Cairo in 1994, supported the reproductive health needs of youth and therefore made this declaration.

“The response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions. Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care, and greatly reduce the number of adolescent pregnancies”.<sup>3</sup>

According to the Population Reference Bureau, in 1994, one fifth of all births worldwide were to adolescents between the ages of 10 and 19 who make up one fifth of the world's population including sub-Saharan Africa.<sup>4</sup>

The Ghana Demographic and Health Survey (1988)<sup>5</sup> estimated a total of 1.6 million teenage and young adult women in the country, who constitute 40% of women of reproductive age. Teenage pregnancy has become a very serious issue in the country. Although reliable survey data are unavailable, anecdotal evidence seems to support the view that a significant number of young girls are becoming mothers. Childbearing, in this regard, is considered undesirable, as it is often associated with social and economic problems for both the young mother and child. A major area of concern is the large number of unwanted pregnancies and related recourse to induced abortions. In a recent publication,<sup>6</sup> two concerned youth expressed their views about teenage pregnancies which is an indication of the extent of the problem countrywide.

The proportion of adolescents who have started child-bearing varies by region. According to the Ghana Demographic and Health Survey (1993) adolescent child bearing is more pronounced in the Central Region (33.3%) than in any other region.<sup>7</sup> The question to ask then is, what brought about these regional variations? Could it be due to the increase in the proportion of adolescents or the factors which enhance their sexual activities? Although studies have been done in Accra and Kumasi to support the latter, it is also a concern for Cape Coast. This study therefore set out to find out what the levels and determinants of adolescent fertility were in the Cape Coast municipality.

## 1.1 **BACKGROUND INFORMATION ON THE STUDY AREA**

### 1.1.1 **Boundary and Area**

Cape Coast district is one of the 12 districts of the Central Region of Ghana. It is bounded on the South by the Gulf of Guinea. In the East by Abra-Asebu-Kwamankese district, in the west by Komenda- Edina- Equafo- Abrem district and in the North, it shares a border with the lower Denkyira district ( p. ix). It occupies a surface area of 1,007 square kilometers.

The current projected population is 113,394 (from the 1984 census) with a population density of 100 km sq.

### 1.1.2 **Subdistricts**

The municipality comprises four subdistricts namely Maternal and Child Health (M.C.H.)/main, Ewim, Adisadel and University of Cape Coast (U.C.C.) with a population of 45,131; 29,596; 21,204 and 17,463 respectively.

### 1.1.3 **Geographical Features**

The topography is that of coastal lowland and scattered hills occupying an extensive area. The vegetation is coastal Savannah which merges with the tropical rain forest inland. There are two rainy seasons, the major one occurs in May/June whilst the minor occurs in October/November.

#### 1.1.4 **Socio-cultural characteristics**

The Municipality is a mix of urban and rural with about 40% of rural population and 60% urban. Cape Coast, the capital of the region is located in the Cape Coast Municipality. It has many historic sites and rich cultural festivals which attract a large number of tourists each year. The major festival is the Fetu Afahye held annually in September.

#### 1.1.5 **Occupation and Ethnicity**

The inhabitants in the hinterland are mainly farmers and along the coast there are fishermen, civil servants and other secondary and tertiary workers. The indigenous people are Fantis but there are other ethnic groups who are migrant workers from all over the country.

#### 1.1.6 **Road Network**

Road networks in the municipality are relatively better than elsewhere in the region. These interconnect the roads to the towns and villages which virtually become unmotorable in the rainy season.

#### 1.1.7 **Health Facilities**

Health Facilities in the municipality include both governmental and private health institutions. The Central Hospital is located in the municipality. It serves the region and it is recognised as a District Hospital as well. It is supported by a quasi-governmental hospital (i.e. the University of Cape Coast hospital). The subdistricts are served by two health centres and one Maternal and Child Health ( M.C.H.) centre. At the community level, there are a total of 39

traditional birth attendants trained to take care of deliveries in and around the municipality. There are 12 private clinics, 8 maternity homes, 31 chemical sellers, 48 registered herbalists and 7 pharmacists.

The major health problems confronting the municipality are diarrhoeal diseases including cholera, typhoid fever and malaria, as a result of poor environmental sanitation. Others are high teenage pregnancy, with the current rate of 18/1000, high maternal deaths with a rate of 13.9/1000, low immunization coverage and low family planning acceptor rate.<sup>8</sup>

## 1.2 STATEMENT OF THE PROBLEM

High incidence of teenage pregnancies has been recognised as a major problem in the Cape Coast municipality. Data collected from service delivery points in the district confirm the assertion that teenage pregnancy is on the ascendancy. Many of these unwanted pregnancies end up as unsafe abortions, others carry the pregnancy to term only to have a fatal outcome of labour or post partum complications, thus increasing the maternal morbidity and mortality rates. Cape Coast municipality for the past 3 years has recorded a high maternal mortality as follows: 10/1000 live births in 1993, 17.8/1000 live births in 1994 and 13.9/1000 live births in 1995, with a significant proportion being teenagers.<sup>8</sup>

According to available statistics on teenage pregnancy, out of the total number of pregnant women who reported at the antenatal clinic in 1993, 13% were teenagers between the ages of 15 and 19, compared to 18% in 1995. These figures are fast catching up with the national average of 20% and if not effectively checked, will take on alarming proportions.

The problem is of great concern to families, the district and the nation as a whole due to the medical, social and economic implications associated with it. This situation therefore calls for a community-based study to find the magnitude of the problem and the factors that lead to teenage pregnancies in order to be able to recommend the necessary intervention to address them.

### 1.3 **JUSTIFICATION FOR THE STUDY**

The following constitute the basis for the study:

1.3.1. The District Health Management Team (DHMT) has listed teenage pregnancy as one of their priority health problems. The study findings will help the District Assembly and the DHMT to provide intervention based on the scientific information available.

1.3.2. According to the Ghana Demographic and Health Survey (1993), teenage pregnancy has been estimated to be high (33.3%) in the Central Region compared to other regions of the country. Recent studies in Accra and Kumasi have thrown more light on teenage pregnancy.<sup>9</sup> This study will be an addition to what has been done and will therefore give a view of the situation in the Cape Coast municipality.

1.3.3. The information/outcome of the study will be a guide for the formulation of district policies on adolescent reproductive health.

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### 2.1 MAGNITUDE

Demographic and Health survey (DHS) findings from 11 countries in sub Saharan Africa indicate that births to adolescent females aged 15-19 range between 15%-20% of Africa's total births, with significant regional and inter-country variations.<sup>10</sup>

Earlier on in 1985, the fast growth in population in Africa was attributed in part to a high incidence of teenage pregnancy.<sup>11</sup> By 1993, births to teenagers aged 15-19 represented 13% 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% of teenagers have at least one child, while an additional 3% are pregnant with their first child.<sup>5</sup>

In Kenya, approximately 142,000 births occur to girls aged 15-19 each year, which account for about 12% of Kenya's total fertility . By age 19, 44% of girls have begun childbearing even though most (over 90%) of pregnancies to adolescent girls were undesired.<sup>12</sup>

Worldwide percentage of the teenage population aged 15-19 giving birth by age 20 is 30%.<sup>13</sup> In another development, the percentage of women giving birth by age 20 by level of education is indicated as:

“With less than seven years of education, Niger 77%, Zambia 74%, Kenya 70% and Namibia 54%. With more than seven years of education, Niger 27%, Zambia 53%, Kenya 45% and Namibia 30%”.<sup>14</sup>

In recent years, the proportion of teenage births occurring outside marriage has risen to 26% in Botswana, nearly 70% in Kenya, compared to 50% in the U.S, since 1990.<sup>13</sup>

Many youth are postponing marriage to stay in school or for other socio-economic reasons. As a consequence, more first pregnancies and first births are taking place outside marriage.<sup>13</sup>

The proportion of teenagers bearing a child by age 20 is about 50% in West Africa and South Central Asia, and 33% in Latin America. Yet, the rates of adolescent child-bearing have fallen along with those of older women in most regions. Because child-bearing among older women has declined more rapidly than among teens, a larger proportion of all births now occur among adolescents.<sup>13</sup>

According to the Population Reference Bureau,<sup>4</sup> the per cent 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. 19% of young women give birth by age 20, compared with 7% in France and only 2% in Japan.<sup>4</sup>

It is believed that early pregnancy and child-bearing are typically associated with less education and lower future outcome for young mothers. For unmarried teens, motherhood often results in social ostracism. In other settings, teenagers may choose to become pregnant or gain status with peers or because they have few other life opportunities outside of motherhood.<sup>13</sup>

Young women who become pregnant experience greater likelihood of childbirth - related morbidity and mortality, with some countries experiencing mortality rates among women aged 15-19 that are twice that of women in their 20's or 30's. For girls aged 10-14, maternal mortality rates may be five (5) times higher than for women in their early twenties.<sup>13</sup>

In a study of longitudinal data from the Sahelian cities of Bamako and Bobo-Dioulasso in Mali, researchers found that teenage school girls were significantly less likely to seek prenatal care, than the non-school girls.<sup>15</sup> This finding confirms other studies that suggest that adverse social and economic consequences of school girl pregnancies may cause women to diet to avoid appearing pregnant, defer prenatal care and occasionally seek illegal abortion.<sup>15</sup>

## 2.2 DETERMINANTS OF TEENAGE PREGNANCY

Early marriage tends to occur while girls are still quite young prior to attaining full biological maturity. Small-scale surveys and reports<sup>5,16,17</sup> exposed the low age at first marriage and decreasing age at marriage among adolescents even though the latter was largely due to improvements in nutrition and health care.

Amadu (1987)<sup>18</sup> found the lack of guidance about sexuality, the need for financial support and peer influence as the major causes of teenage pregnancy in the Tishigu Locality of Tamale in the Northern region. The influence of bad friends was cited in a recent publication<sup>6</sup>, and any girl from a good home who falls into a bad company is at increased risk of becoming pregnant. Nanor<sup>6</sup> also noted further that if girls are maltreated, they may stay away from home and may accept love proposals from men. In addition, large families without adequate rooms may force girls to sleep out with their friends, who may influence them to go after men.

Amofo (1987)<sup>19</sup> observed in Accra that the case of teenage pregnancy was due to lack of proper sex education, unavailability or poor usage of contraceptives, illiteracy or semi-illiteracy, low socio-economic status of parents, death of one parent and declining age at menarche. Bocoorch (1985)<sup>20</sup> also found from a survey that the problem of unemployment prepares the ground for sexual delinquency, since it enforces idleness on a large number of teenage boys and girls.

A study in Breman-Asikuma in the Central region cited the lack of formal education, urbanization, migration, coupled with high cost of living, and pressure from mothers as contributory factors. Social vices such as jeering at women believed to be barren, and the exhortation of grandmothers and mothers who get grandchildren and children, respectively were also identified as potential contributory factors.<sup>21</sup>

Earlier studies on teenage pregnancy in Cape Coast revealed that girls become pregnant as a result of inadequate care and lack of guidance on the part of the parents. Some parents also ignore their daughters' promiscuity because they contribute to the financial upkeep of the home. Again, it also revealed that the teenagers were ignorant about matters relating to sex and some, in an attempt to be independent from their parents intentionally get pregnant.<sup>22</sup>

Girls with poor school performance have a higher incidence of pregnancy.<sup>11</sup> Considerable financial commitment is required for secondary school including school materials, uniforms and examination fees. Because families may place a lower priority on educating their daughters than their sons, girls may need to contribute their own resources to finance their education. In some African countries, school girls resort to establishing sexual relationship with older and more financially-secure men, ("sugar daddies") who exchange money and gifts for sexual relationships. Most researchers agree that poverty and not pleasure is the driving force behind these relationships. In a recent study 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.<sup>9</sup> Dwamena (1996)<sup>6</sup> in a recent

publication outlined the causes of teenage pregnancy as being social, cultural, economic and religion, and advocated for severe punishment of men who impregnate girls, and a requirement for parents to give guidance to their teenage girls on reproductive health.

In sub-Saharan Africa, the social support for teenage child-bearing has been documented in many studies (1991).<sup>23,24</sup> The Western model of adolescent fertility (which treats teenage mothers as a social selected deviant group) is less useful in sub-Saharan Africa because in the latter, early marriage patterns of reproduction<sup>25</sup> and the lineage support for parenthood are still relatively strong.<sup>26</sup>

Unlike the Western World, early parenthood is highly desirable in traditional African societies for social reasons that confer value on women through child bearing.<sup>24</sup>

## 2.3 **OBJECTIVES**

### 2.3.1 **General objective:**

The main objective of this study was to determine the magnitude and identify the factors contributing to teenage pregnancies in the Cape Coast municipality, and to make recommendations to appropriate authorities on ways of dealing with the issue.

### 2.3.2 **Specific objectives**

In pursuance of this objective, the following specifics were examined.

1. To determine the percentage of pregnant teenagers to all pregnancies among women in the fertile age-group (WIFA).

2. To determine the socio-economic background of teenagers (both pregnant and non-pregnant).
3. To identify the cultural factors contributing to teenage pregnancy e.g. religion, early marriage.
4. To determine the role of tourism in teenage pregnancy (by the percentage of pregnancies caused by tourists).
5. To make recommendations on the findings to the appropriate authorities.

### 2.3.3 **Hypothesis**

Lack of education, poor knowledge in reproductive health, cultural, poor socio economic background and contact with tourists do not affect a percentage of teenagers becoming pregnant.

## CHAPTER THREE

### 3.0 STUDY METHODS

#### 3.1 STUDY TYPE AND RESEARCH VARIABLES

##### 3.1.1 The study types

The study was in 2 parts:

The first part was a cross-sectional descriptive study in which a cross-section of the women in the fertile age group (WIFA; 13-44 yrs) were identified through a household survey. Furthermore, those who had delivered within the last year and those pregnant were identified. This was followed by estimation of the prevalence of teenage pregnancies among all pregnancies in the WIFA. In addition, the teenagers (13-19 years) who had delivered within the last year, those obviously pregnant and non-pregnant teenagers were interviewed to elicit information on the following variables:

The dependent variable was teenage pregnancy while the independent variables were broadly categorised into socio-economic factors, cultural factors, tourism and health service factors. The socio-economic factors included age, ethnicity, occupation/employment, monthly income, parental care and support, peer pressure, education (including literacy and level of education), cultural(religion, cultural norms and beliefs), tourism(contact with tourists) and health service factors(contraceptive knowledge and use).

The second part was an analytical study, where a sub-sample of 20 pregnant teenagers (cases) and a comparable control group of 20 non-pregnant teenagers, were selected randomly from the same environment. They were interviewed for further analysis of socio-economic background, educational factors, knowledge in reproductive health, and their contact with tourists.

### 3.2 DATA COLLECTION TOOL

The main data collection tool used in this study was a questionnaire with sections (appendix 1)

The first part (A) was used for household survey, to collect information on all females in a household. It was meant to identify those in the fertile age (13-44 yrs) who had delivered within the last year, those obviously pregnant, and other non-pregnant teenagers among them for interview.

The second part (B) included both closed and open-ended questions on the variables under study. These were administered to obviously pregnant teenagers, those who had delivered within a year and a sub-sample of non-pregnant teenagers.

### 3.3 SAMPLING

#### 3.3.1 Study Population

The study focused on all teenagers, and those who had delivered within the last year in all houses within the communities in the subdistricts. However, it specifically concentrated on the pregnant teenagers and a sub-sample of non-pregnant teenagers.

### 3.3.2 Sample-size determination.

The projected total population of Cape Coast for 1997 (based on 1984 census) is 113,394. The women in the fertile age group is 22,678 (20% of total population). Out of this, the expected pregnancy of 4% is 4,536. The proportion of pregnant teenagers (according to data from health institution) over the past 3 years is approximately 13%. Based on this, the estimated population of pregnant teenagers is 590. Due to logistic constraints, it was not possible to study the entire population of pregnant teenagers, therefore a sample of 174 was used based on,  $n = Z^2 \frac{p(1-p)}{d^2}$  at 95% confidence interval with a margin of error of

$$d^2$$

5%

### 3.3.3 Households for the required respondents

The expectation was that, an obviously pregnant woman or one who had delivered within the last year would be obtained from every household or other. It was therefore necessary to survey a sample of 250 to 300 households in order to interview 174 respondents.

The number of households was divided among the four subdistricts based on the population size.

### 3.3.4 Sampling procedure

#### 3.3.4.1 Selection of Subdistricts

All the four subdistricts in the Cape Coast municipality namely, U.C.C., Adisadel, Ewim

and MCH/main were selected. This was because they are few and there was the need to be sure that the sample obtained was representative of subdistricts in the area.

In addition to the above subdistricts, the Komenda-Edina-Equafo-Abrem district (K.E.E.A.), was also selected purposefully for pretesting the questionnaire. This was because it is adjacent to the Cape Coast municipality and shares similar geographic, ethnic, religious and occupational characteristics.

#### 3.3.4.2 **Selection of communities, households and respondents**

The multi-stage (three stages) sampling was used.

**First Stage:** Selection of communities.

The communities were selected by simple random sampling. All the communities in each subdistrict were numbered between 1 - 20 depending on the number in each subdistrict and placed in a bowl. For each subdistrict, one of the research assistants was asked to pick one at a time until the required numbers for that subdistrict were obtained. Twenty one communities were therefore selected. (Appendix 2)

**Second Stage:** Selection of houses

Sampling of houses in the 21 selected communities was again done by the random sampling technique. Every house was selected into the sample after determining the centre of the

community. The starting house was selected at random by spinning a pen. The interviewer moved in the direction of the pen from the selected house covering every house until they came to a 'dead end' where they then turned backwards towards the direction they came from to cover the other houses that followed.

**Third stage:** Selection of respondents

In every house, the household head was requested to give information on all females in the WIFA, to enumerate them. In the absence of a household head, any resident adult female willing to give the information was used. This was followed by interview of the teenagers among them.

To ensure confidentiality and off set any possible bias, the teenagers were assured of confidentiality and interviewed either outside the confines of their homes, or the parents/adults were asked to excuse them. The interview was purposefully done by female interviewers to avoid any embarrassment because some of the questions were very sensitive.

### 3.4 DATA COLLECTION TECHNIQUE

There were four main steps in the plan for data collection.

#### 3.4.1 **Training of research assistants.**

Four research assistants (RA's), comprising one Public Health Nurse and three senior community health nurse midwives were trained in one day by the researcher and field supervisor (ie principal and co-investigators ) The basis for their selection was that they had been engaged in previous surveys and besides they had undergone training in midwifery and therefore possessed skills in midwifery.

During the training, they were introduced to the rationale of the research, survey techniques, establishing rapport with their respondents to get good response, translation of the questionnaires into the local language (Fanti) and re- translation into English, to get the contents clear. There were practical demonstrations in the office on possible problems they might face when they go out into the field. All questions which were not clear were explained to them, until they were satisfied. The second day was set for pretesting of the questionnaire.

#### 3.4.2 **Pretesting and review of questionnaire**

Pretesting of the questionnaire was done at Elmina in the K.E.E.A district. This was to determine clarity of the questions, and to reveal problems that might be encountered in the main study.

After pretesting, few modifications were made on the questionnaire which included the addition of an identification number and the re-arrangement of some questions for pregnant teenagers only. These were explained to the RA's before the actual data collection began.

#### **3.4.3 Seeking permission from relevant authorities, individuals and the communities Procedure**

Permission for the data collection was sought with letters from regional and community authorities, namely chiefs, Assembly men, town and village committee chairpersons and member of parliament (M.P.) for Cape Coast municipality explaining the purpose of the study and to assure them of confidentiality. This was easily obtained when the authorities were contacted, probably because of their interest in the problem of teenage pregnancy.

#### **3.5. DATA COLLECTION AND PROCESSING**

The study population was given prior information about the study through the community leaders. The period for the study was explained to them in order to gain their maximum co-operation. Since they were informed earlier on before the interviews, they appeared relaxed and interested. The research assistants moved in a systematic direction from one household to the other and returned towards the direction they came from, to cover the other houses until the required number of houses had been interviewed. Thirty to forty five minutes at least was used in each household depending on the number of respondents. and ten to fifteen (10-15 ) minutes was used for each respondent and they were allowed to carry

out any household chore found pressing at the time of the interview. The interview was conducted in all the 21 communities in the four sub-districts and a total of 13 days used for collecting the data.

### 3.5.1 **Data processing**

To ensure quality control checks, all questionnaires filled by the research assistants were checked during supervision in the field by the researcher. Errors and omissions detected were discussed with the respective RA's, who were asked to go back and correct these.

After each day's work, the data were checked for consistency and completeness.

Furthermore, clearly labeled envelopes were provided for the four subdistricts and their communities. After the survey and interview, the completed questionnaires were packed into the respective labeled envelopes to avoid them becoming mixed up. These were later sorted out and the responses to each question were coded for computer processing. Each question, whether closed or open open-ended was re-coded. Answers which were not on the questionnaires were put into a category called "Other" and this was explained in the findings. The computer programmed was used to compile and analyse the data. First a file was created and the questions were entered into the computer. This was followed by the data entry according to the subdistrict.

### 3.6 **DATA ANALYSIS**

The data analysis was done by computer using EPI INFO (version 6.0) software. Frequency distributions were obtained for each of the variables. Furthermore the chi square was used in assessing the relationship between education, knowledge on reproductive health, socio-economic background, contact with tourists and pregnancy among the teenagers.

### 3.7 **LIMITATIONS OF THE STUDY**

Some women may have been pregnant and this may not have been known to them. This may under estimate the magnitude of pregnancies but the sample size had been adjusted to take care of this. The topic is sensitive and may not be liked by respondents, they may therefore not give any response but this had also been controlled for by an addition to the sample size in order not to affect the validity of the results.

During the survey not all the teenagers sampled in the houses were interviewed. Their identities were given in absentia. Some had gone out to sell, others were not available in the homes for the interview. But this was controlled for as stated above in order not to affect the generalizability of the findings.

The researcher would have liked to interview opinion leaders and household heads since they could also contribute to the study by giving their general impression about the factors leading to teenage pregnancy. Unfortunately, they were not included in the sample because it would

have led to an extensive study which is beyond the capability of the researcher, due to financial, logistic and time constraints. This could be taken up later in another attempt. The researcher again had wanted to do focus group discussion to get a direct information from respondents to make up for issues which the nature of the questionnaire could not probe but then for the same constraints stated above it was not possible.

## 4.0 RESULTS

### 4.1 MAGNITUDE OF TEENAGE PREGNANCY

In all, 302 households in 21 communities in the four subdistricts were surveyed. These were made up of peri-urban and rural urban communities. A total of one thousand six hundred and seventy three (1,673) women in the fertile age (WIFA) were obtained from 292 houses. Out of the 1,673, 484 representing 28.9%, were either pregnant or had delivered within the last year. Out of the 484, two hundred and twenty nine (47.3%) were teenagers between the ages of 13-19 years. The UCC subdistrict showed a remarkably high percentage of teenage pregnancy of 76.3%. Out of the 229, only 189 were interviewed. Out of this, 109 (57.7%) had delivered within the last year and 83 (43.9%) were pregnant. But then, 3 (2.7%) of those who had delivered during the last year were pregnant again. (Table 4.1)

**Table 4.1: Distribution of teenage pregnancy to all pregnancies in the sub-districts.**

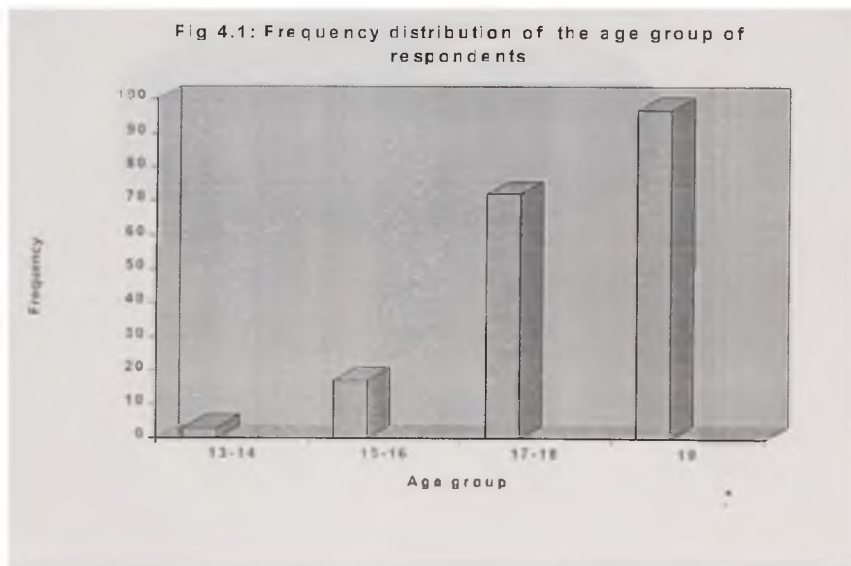
Sub-districts	Total number of households surveyed	No. of women in the fertile age (WIFA)	Total No. of pregnant women	No. of teenage pregnancies	% of teenage pregnancies to all pregnancies
U.C.C	44	297	38	29	76.3
Adisadel	69	321	90	44	48.9
Awim	87	492	179	68	38.0
MCH/ main	102	563	177	88	49.7
District total	302	1,673	484	229	
District mean					47.3

**4.2 CHARACTERISTICS (DEMOGRAPHIC DATA)**

Out of the 229 teenage mothers interviewed during the survey, only 189 (82.5%) were available and willingly agreed to be interviewed. Thirty three (33), representing 14.4%, had gone out to sell and 7 (3.1%) refused to be interviewed.

#### 4.2.1 Age

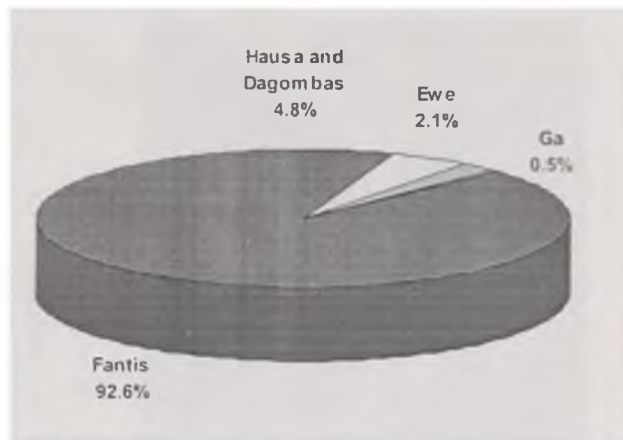
Although the study specifically defined the ages of respondents as between 13-19, the following distributions were obtained. It was found that, out of the 189 respondents those between the ages of 13-14 were 3 (1.6%), ages 15-16 were 17 (9.0%), ages 17-18 were 72 (38.1%) and age 19, 97 (51.3%) ( Fig 4.1)



#### 4.2.2 Ethnicity

Majority of the respondents were Fantis, 175 (92.6%). Ewes represented 4 (2.1%) of the total number of 189, while 1 (0.5%) was a Ga and 9 (4.8%) were Hausas and Dagombas. (Fig 4.2)

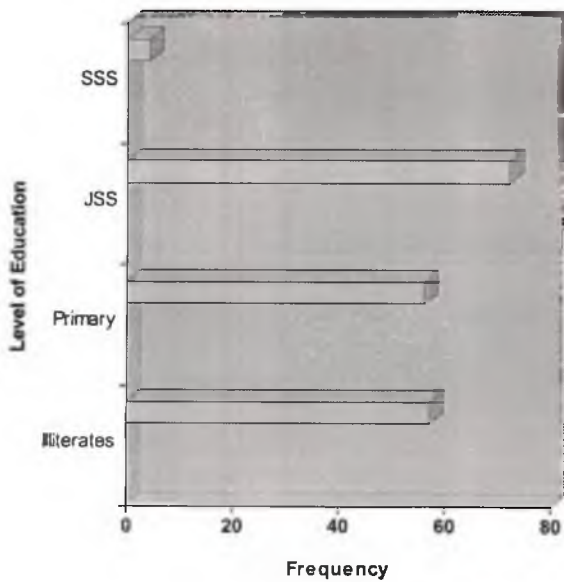
**Fig 4.2 : Frequency distribution of the ethnicity of respondents**



### 4.2.3 Education

Out of the 189 respondents, 57 (30.2%) were illiterates, 56 (29.6%) had primary school education, 72 (38.1%) were J.S.S. graduates, while 4 (2.1%) had senior secondary school education. (Fig 4.3)

Fig. 4.3: Frequency distribution of educational level of respondents



#### 4.2.4 Occupation

With regard to occupation of respondents, 59 (31.2%) gave no response, 84 (44.4%) claimed to be petty traders and mostly working for their parents, 11 (5.8%) were apprentice seamstress, 3 (1.6%) were apprentice hair dressers while 9 (4.8%) sold ice water, pineapple and other fruits in season, 23 (12.2%) however were either unemployed, assisted their parents in farming or fish selling or stone cracking.

### 4.3 SOCIO-ECONOMIC FACTORS

#### 4.3.1 Income per month

It was found that out the 189 respondents 68 (36.0%) did not respond, 86 (45.5%) earned between ₵10,000 - ₵50,000 per month, 8 (4.2%) earned between ₵50,000 - ₵100,000 1 (0.5%) earned between ₵100,000 - ₵150,000, while 26 (13.8%) earned less than ₵10,000 per month. (Table 4.2)

**TABLE 4.2: Frequency distribution of Monthly income of respondents**

Income per month in cedis (¢)	Frequency	Per cent
No response	68	36.0%
Less than 10,000	26	13.8%
10,000-50,000	86	45.5%
50,000-100,000	8	4.2%
100,000-150,000	1	0.5%
Total	189	100.0%

**4.3.2 Parental care and support****4.3.2.1 Parents living/dead**

In an attempt to find out whether the parents of the respondents were alive, it was revealed that 144 (76.2%) were alive, 1 (0.5%) had no living parents, mothers of 13 (6.9%) were dead and 31 (16.4%) had lost their fathers.

**4.3.2.2 Living with parents**

Out of the 189 respondents, 26 (13.8%) lived with both parents, 12 (6.3%) lived with their fathers, 69 (36.5%) lived with their mothers, 12 (6.3%) lived with relatives including aunts and uncles, 21 (11.1%) lived with their guardians, with none of the respondents living with a friend. Fourteen (7.4%) were living with their spouses/partners, 3 (1.6%) were

living with their mothers-in-law. Two 2 (1.1%) were on their own and 30(15.9%) were living with their grandmothers and grandfathers.

#### 4.3.2.3 **Occupation of parents**

Forty- Six (24.3%) of fathers of teenagers were fishermen, 21 (11.1%) were farmers, 58 (30.7%) were civil servants, 9 (4.8%) were unemployed and 38 (20.1%) were either cooks, tailors, drivers, traders, building contractors, pastors, masons or occupation not known, Seventeen (9.0%) however, did not respond. On occupation of mothers, 53 (28.0%) were fish mongers 19 (10.1%) were farmers. 1 (0.5%) was a seamstress, 1 (0.5%) was a hairdresser, 86 (45.5%) were traders and 22 (11.6%) were doing other jobs like keeping chop bars, cooked food vendors, teaching, selling ice water and fruits. Six (3.2%) respondents did not give any response.

#### 4.3.2.4 **Marital status of parents and whether living together**

Again, it was necessary to find out whether the parents were married and living together. Out of the 189 respondents 88 (46.6%) of their parents were married and 74 (39.2%) of the married parents were living together 90 (47.6%) were divorced , 8 (4.2%) had separated and 2 (1.1%) did not respond.

#### 4.3.2.5 Moral/spiritual support/guidance from parents

One hundred and eighty three (96.8%) claimed they did get moral and spiritual support/guidance from their parents, 5 (2.7%) replied negatively, while 1 (0.5%) did not respond. (Table 4.3A) Out of the 183, 158 (83.6%) said parents corrected them when things went wrong, 16 (8.5%) said parents encouraged them to attend church while 8 (4.2%) received constant reprimanding. 7 (3.7%) including the 2.7% who said they did not respond (Table 4.3B). One (0.5%) said parents were too busy, while 1 (0.5%) said the parent did not know they should give this kind of support. (Table 4.3C)

**Table 4.3A Distribution of responses on moral/spiritual support/guidance from parents**

Responses	Frequency	Percent
No Response	1	0.5%
Yes	183	96.8%
No	5	2.7%
Total	189	100.0%

**Table 4.3B Distribution of responses to ways support were given**

Responses	Frequency	Percent
No response	7	3.7%
Constant reprimanding	8	4.2%
Encouragement to attend church	16	8.5%
Corrected when things went wrong	158	83.6%
Total	189	100.0%

**Table 4.3C** Distribution of responses to why no moral/ spiritual support/guidance was given

Responses	Frequency	Percent
No response	184	97.1%
Not ready to do it	2	1.1%
Have no knowledge about it	1	0.6%
Did not know they should do it	1	0.6%
Other (nobody to do it)	1	0.6%
Total	189	100.0%

**4.3.2.6** Financial care

It was found that 81 (42.9%) were financed by their parents or guardians 29 (16.3%) were financed by their spouses or partners, 46 (24.3%) were financed by their boyfriends, while 16 (8.5%) were financed by their mothers-in-law, sisters or grandmothers. Two (1.1%) claimed they financed themselves by doing any menial job they laid their hands on while 15 (7.9%) did not respond. ( Table 4.4)

**TABLE 4.4** Frequency distribution of financial care provision

Responses	Frequency	Percent
No response	15	7.9%
Parents/guardian	81	42.9%
Spouse/Partner	29	15.3%
Boyfriend	46	24.3%
Self	2	1.1%
Others (mother-in-law, sister, grandmother)	16	8.5%
Total	189	100.0%

### 4.3.3 Peer pressure

With regard to peer pressure, the following variables were examined:

#### 4.3.3.1 Number of Friends

In relation to the number of friends respondents had, 25 (13.8%) had no friends, 66 (34.9%) had one or two friends, 46 (24.3%) had 3 or 4 friends, 46 (24.3%) had 5 or 6 friends while 1(0.5%) respondent had more than 6 friends. Three (1.6%), however, did not respond.

#### 4.3.3.2 Pregnancy among friends

Eighty (24.3%) of the respondents said either one or two of their friends were pregnant, 20 (10.5%) said between 3 and 4 friends were pregnant and another 20 (20.5%) stated that more than 4 of their friends were pregnant. Twenty-one (11.1%) did not respond and 45 (23.7%), including those who had no friends, said none of the friends was pregnant.

#### 4.3.3.3 Leisure hours

It was found that respondents spent their leisure hours in various ways. Twenty (10.6%) respondents went to films, 6 (3.2%) went to pubs, 3 (1.6%) went to tourist spots in town and 158 (83.6%) spent their time at home mostly sleeping, watching T.V., because of the pregnancy, otherwise they would go out visiting friends.

#### 4.3.3.4 Groups/Associations

Out of the 189 respondents, 46 (24.3%) said they belonged to a group/association. One hundred and thirty-four (70.9%) did not belong to any; 7 (3.7%) however, did not respond. Of those who belonged to a group, 21 (45.7%) belonged to women fellowship or a women's movement; 5 (10.9%) represented the Methodist youth group 11 (23.9%) belonged to the Christian youth association (C.Y.O). Ten (21.7%) were choristers and 1 (2.2%) belonged to the Girls Brigade.

On how often the groups met, again 14 (30.4%) said once a week, 19 (41.3%) met twice a week and 15 (32.6%) met more than twice a week.

#### 4.4 CULTURAL FACTORS

##### 4.4.1 Religion

With regard to religion, Christians represented 89.4% (169) of the total number of respondents, Muslims formed 5.3% (11), 3 (1.6%) belonged to traditional religion, while 6 (3.2%) belonged to none of the sects.

##### 4.4.2 Marital status of respondents

As to whether the respondents were married, 39 (20.6%) claimed they were married, while 149 (78.8%) were not married; 1 (0.5%) did not respond.

#### 4.4.3 Early marriage of girls

Sixty-six (34.9%) respondents said girls are allowed to marry early in their ethnic group.

Ninety-two (48.7%) said girls are not allowed to marry early, 22 (21.6%) said they did not know, while 9 (4.8%) did not respond.

#### 4.4.4 Age of marriage

Seven (3.7%) respondents said girls marry between the ages of 10-12. Twenty-one

(11.1%) gave between 13-15 yrs, 48 (25.4%) gave 16-18 yrs, while

60 (31.8%) got married between 19-21 yrs . 53 (28.0%) however said girls marry after

21 years. (Table 4.5)

**Table 4.5 Distribution of age at marriage**

Age-group	Frequency	Percent
10-12 years	7	3.7%
13-15 years	21	11.1%
16-18 years	48	25.4%
19-21 years	60	31.8%
others (after 21years)	53	28.0%
Total	189	100.0%

#### 4.4.5 Men looking after girls from childhood and marrying them later

Sixty-six (34.9%) of respondents said men are allowed to look after girls from childhood and marry them later, 80 (42.3%) responded negatively, and 24 (22.2%) did not know.

One (0.5%) did not answer the question.

#### 4.4.6 Age at first menstruation.(menarche)

Out of the 189 respondents, 2 (1.1%) had their menarche between the ages of 7 and 9, 13 (6.9%) had theirs between 10-12 years, 124 (65.6%) had theirs between 13 and 15yrs, 34 (18.0%) menstruated between 19-21 yrs. Seven (3.7%) however had theirs after 21yrs. Five (2.6%) did not respond.

#### 4.4.7 Age At first sexual intercourse

One respondent (0.5%) had sex between the ages 9 and 11, 24 (12.7%) at 12-14yrs, 132 (69.8%) first had sexual intercourse between the ages of 15 and 18 yrs, 11 (5.3%) had sex at 19yrs, while 7 (3.7%) could not remember the age. Fourteen (7.5%) did not answer. (Table 4.6).

**Table 4.6** Distribution of age at first sexual intercourse of respondents

Age-group	Frequency	Percentage
No Response	14	7.4%
9-11	1	0.5%
12-14	24	12.8%
15-18	132	69.8%
19	11	5.8%
Could not remember age	7	3.7%
<b>Total</b>	<b>189</b>	<b>100</b>

#### 4.4.8. Reasons for indulging in sex

Out of the 189 respondents, 77 (40.7%) said they had sex because of curiosity, 9 (4.8%) said they did not want to become a “toke” (ie fool), 10 (5.3%) however said they were raped, 78 (41.3%) had sex because they wanted money, 9 (4.8%) had sex because they were married, while 6 (3.2%) did not respond. (Table 4.7)

**TABLE 4.7** Distribution of reasons for indulging in sex

Response	Frequency	%
No response	6	3.2%
Curiosity	77	40.7%
Not to become a “toke”(ie fool)	9	4.8%
Raped	10	5.3%
For financial gain	78	41.3%
Other married	9	4.8%
Total	189	100.0%

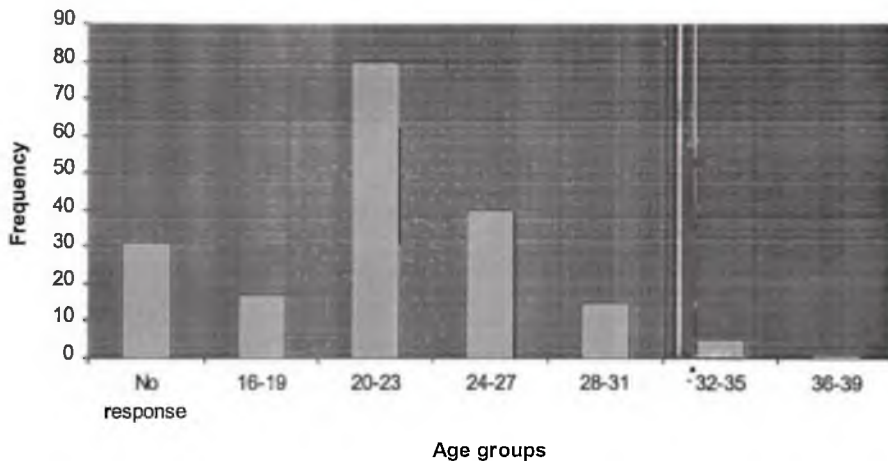
#### 4.4.9 Person responsible for pregnancy

Out of the 189 respondents, 30 (15.9%) said their spouses/partners were responsible for their pregnancies, 150 (79.4%) claimed the responsibility of their boyfriends, 2 (1.1%) attributed it to tourists, while another 2 (1.1%) said it was neither boyfriends nor a spouse/partner. Five (2.6%) did not answer.

#### 4.4.10 Ages of boyfriends and spouses/partners

The ages of the spouses/partners were as follows: 17 (9%) gave the ages as between 16 - 19 yrs. 80 (42.3%) between 20-23 yrs, 40 (21.4%) were between 24 - 27 yrs and 15 (7.9%) were between 28 - 31 yrs. Those who said their boyfriends were between 32-35 yrs represented 2.6% (5), 1 (0.5) said 36-39 yrs and 31 (16.4%) did not respond. (Figure 4.4)

**Fig 4.4 : Frequency distribution of the age groups of boyfriends and spouses/partners**



#### 4.4.11 Reactions of respondents, realising they were pregnant

It appeared that out of the 189 respondents, 39 (20.6%) were happy when they realised they were pregnant. 123 (65.1%) were angry and depressed, while the majority of the 123 respondents desired to have abortion. But out of the total of 189, 20 (10.6%) from the onset wanted abortion, 1 (0.5%) felt nothing about the pregnancy, while 6 (3.2%) did not respond. (Table 4.8)

**Table 4.8: Distribution of the reaction of respondents to pregnancy**

Reactions	Frequency	Percent
No response	6	3.2%
Happy	39	20.6%
Angry and depressed	123	65.1%
Wanted abortion	20	10.6%
Other (felt nothing)	1	0.5%
<b>Total</b>	<b>189</b>	<b>100.0%</b>

## 4.5 HEALTH SERVICE FACTORS

### 4.5.1 Antenatal clinic attendance

On whether respondents ever went to the antenatal clinic or have been going, 167 (88.4%) claimed to have been attending while 17 (9.0%) responded negatively and 5 (2.6%) did not respond.

### 4.5.2 Knowledge about sex, pregnancy and use of contraceptives

On knowledge about sex, pregnancy and use of contraceptives, 163 (86.2%) respondents said they had been talked to about these, 25 (13.2%) replied negatively, while 1 (0.5%) did not respond.

#### 4.5.3 Topic of health education talk

Out of the total respondents, 142 (75.1%) said the topic on health education was on family planning, 20 (10.6%) indicated teenage pregnancy, 2 (1.1%) gave the topic as sexually transmitted diseases, while 25 (13.2%) did not answer.

#### 4.5.4 Source of Information on reproductive health

As to who taught the respondents about reproductive health, it was revealed that 7 (3.7%) were taught by a teacher, 3 (1.6%) by a sibling, 107 (56.6%) by a nurse, 24 (12.7%) by friends, 4 (2.1%) by parents while 21 (11.1%) heard it on radio FM, Television and from their grandmothers. Twenty-three (12.2%) did not respond. (Table 4.9)

**TABLE 4.9 Source of Information on sex. pregnancy and contraceptives**

Sources of information	Frequency	Percent
No response	23	12.2%
Teacher	7	3.7%
Siblings	3	1.6%
Nurse	107	56.6%
Friends	24	12.7%
Parents	4	2.1%
Other (radio FM, T.V. grandmother)	21	11.1%
Total	189	100.0%

#### 4.5.5 Use of contraceptives

Out of the total respondents, only 21 (11.1%) had used contraceptives while 166 (87.8%) had not, and 2 (1.1%) did not respond .

#### 4.5.6 **Desire to use contraceptives**

Out of total, 123 (65.1%) expressed the desire to use contraceptives, 52 (27.5%) would not want to use any now, while 14 (7.4%) did not respond.

#### 4.6.7 **Reason to use contraceptives**

Again, 130 (69.5%) said they would use contraceptives to prevent another pregnancy, 3 (1.6%) said they would use it to prevent AIDS, while 54 (28.9%) did not give any answer.

### 4.6 **RESULTS : HYPOTHESIS ON RELATIONSHIP BETWEEN THE VARIABLES AND PREGNANCY**

#### 4.6.1 **Education**

Out of the 40 respondents (20 pregnant and 20 non-pregnant compared), there was no difference between educational status (Table 4.10). Out of the 20 nonpregnant respondents those with no education were 3 (15.0%) while those pregnant with respect to education were 5 (25,0%). On primary education, non-pregnant teenagers were 4 (20.0%) while the pregnant were 3 (15.0%). With J.S.S. education, both non-pregnant and pregnant respondents were 12 (60.0%) each. One (5.0%) among the non-pregnant respondents, had been to S.S.S. (Table 4.10).

**TABLE 4.10** **FREQUENCY DISTRIBUTION OF EDUCATIONAL STATUS OF PREGNANT AND NON PREGNANT RESPONDENTS**

LEVEL OF EDUCATION	Non- pregnant (Frequency)	Non- pregnant (percentage)	Pregnant (Frequency)	Pregnant (Percentage)
1. No education	3	15.0%	5	25.5%
2. Primary	4	20%	3	15.5%
3. J. S. S.	12	60.0%	12	60.0%
4. S. S. S.	1	5.0%	0	0.0%
<b>TOTAL</b>	<b>20</b>	<b>100%</b>	<b>20</b>	<b>100%</b>

**TABLE 4.11** **RELATIONSHIP BETWEEN EDUCATIONAL STATUS AND PREGNANCY**

	PREGNANT	NON PREGNANT	TOTAL
HAD EDUCATION	15	17	32
NO EDUCATION	5	3	8
<b>TOTAL</b>	<b>20</b>	<b>20</b>	<b>40</b>

Chi square = 0.16

Fisher Exact: 1 - tailed test

P value = 0.3473823

Result is not significant at the 5% level (P=0.347)

#### 4.6.2 Knowledge on reproductive health

Out of the total of 40 respondents, 16 (80.0%) non-pregnant respondents had a talk on sex, pregnancy and use of contraceptives, while 4(20) did not respond. But with respect to who taught them, 5 (25.0) were taught by a teacher, 7 (35.0%) by nurses at the Youth Centre and school, 1 (5.0%) by a parent, while 5 (25.0%) heard it on radio F.M. and

T.V. Two (10.0%) did not respond to the question. Out of the 20 pregnant respondents, 17 (85.0%) had knowledge on reproductive health, 1 (5.0%) said she was taught by a teacher, 10 (50.0%) were taught by nurses, 3 (15.0) by friends, while another 3 (15.0%) heard it on radio F.M. and T.V., and 3 (15.0%) did not respond.

**TABLE 4.12 RELATIONSHIP BETWEEN KNOWLEDGE ON REPRODUCTIVE HEALTH AND PREGNANCY**

	PREGNANT	NON PREGNANT	TOTAL
HAD KNOWLEDGE	17	16	33
NO KNOWLEDGE	3	4	7
<b>TOTAL</b>	<b>20</b>	<b>20</b>	<b>40</b>

Chi square = 0.00

Fisher exact: 1 - tailed test

P value = 0.5000

Result is not significant at the 5% level (p=0.500)

#### 4.6.3 Socio-economic background

##### 4.6.2.1 Moral and spiritual support/guidance from parents

As to whether both pregnant and non-pregnant respondents received moral, spiritual, supports/guidance from parents, it was revealed that all 40 (100.0%) had this support from their parents. Therefore there is no significant difference between them. (P=0.500)

#### 4.6.2.2 Occupation of parents

Among the non-pregnant respondents 4 (20.0%) fathers were fisherman, another 4 (20.0%) were farmers, 7 (35.5%) were civil servants, while 4 (20.0%) were either a trader, teacher or mason. One (5.0%) did not respond.

Among the pregnant, fathers of 2 (10.0%) respondents were fishermen, another 2 (10.0%) were farmers, 10 (50.0%) were civil servants 2(10.0%) were unemployed while another 2(10.0%) were traders 2(10.0%) did no respond (Table 4.13).

**TABLE 4.13      FREQUENCY DISTRIBUTION OF THE OCCUPATION OF FATHERS**

OCCUPATION	Non-pregnant		Pregnant	
	Frequency	Percentage	Frequency	Percentage
1. No response	1	5.0%	2	10.0%
2. Fisherman	4	20.0%	2	10.0%
3. Farmer	4	20.0%	2	10.0%
4. Civil Servant	7	35.0%	10	50.0%
5. Unemployed	0	0.0%	2	10.0%
6. Other (Trader) (Teacher) (Mason)	4	20.0%	2	10.0%
TOTAL	20	100.0%	20	100.0%

**TABLE 4.14** **RELATIONSHIP BETWEEN FATHERS OCCUPATION AND PREGNANCY**

OCCUPATION	PREGNANT	NON-PREGNANT	TOTAL
NO RESPONSE	2	1	3
FISHERMEN	2	4	6
FARMER	2	4	6
CIVIL SERVANT	10	7	17
UNEMPLOYED	2	0	2
OTHER Trader, Teacher, Mason	2	4	6
<b>TOTAL</b>	<b>20</b>	<b>20</b>	<b>40</b>

Chi square = 4.86

P-value = 0.216430

Result is not significant at the 5% level (P=0.216)

#### 4.6.2.3 Occupation of mothers

Among the mothers of non-pregnant respondents, 3 (15.0%) said their mothers were fishmongers, another 3 (15.0%) were farmers, 1 (5.0%) was a seamstress, 1 (0.5%) was a hairdresser, while 11 (55.0%) were traders and, 1(5.0%) did not respond. The pregnant respondents who said their mothers were fishmongers were 6 (30.0%), 10 (50%) were traders, while 3 (15.0%) were unemployed. One (0.5%) did not respond (Table 4.15 & 4.16).

**TABLE 4.15** **FREQUENCY DISTRIBUTION OF OCCUPATION OF MOTHERS**

	Non pregnant	Non-pregnant	Pregnant	Pregnant
1. No. Response	1	5.0%	1	5.0%
2. Fishmonger	3	15.0%	6	30.0%
3. Farmer	3	15.0%	0	0.0%
4. Seamstress	1	5.0%	0	0.0%
5. Hairdresser	1	5.0%	0	0.0%
6. Trader	11	55.0%	10	50.0%
7. Other (unemployed)	0	0.0%	3	15.0%
<b>TOTAL</b>	<b>20</b>	<b>100.0%</b>	<b>20</b>	<b>100.0%</b>

**TABLE 4.16** **RELATIONSHIP BETWEEN OCCUPATION OF MOTHERS AND PREGNANCY**

	Pregnant	Non pregnant	TOTAL
OCCUPATION	19	16	35
NO OCCUPATION	1	4	5
<b>TOTAL</b>	<b>20</b>	<b>20</b>	<b>40</b>

Chi square = 0.91

Fisher exact 1 tailed test

P value = 0.1708247

Result is not significant at 5% level (P=0.171)

#### 4.6.2.4 Occupation of respondents

Out of the total non-pregnant respondents, 9(45.0%) were in school, 8 (40.0%) were working , 1 (5.0%) was neither in school nor working 1 (5.0%) was also unemployed.

One (5.0%) did not respond. Out of these, 7 (35.5%) were assisting their parents in

fish-selling and petty trading, 1 (5.0%) was an apprentice seamstress, 1 (5.0%) assisted at a chop bar and 11 (55.0%) did not respond. Among the pregnant respondents, 13 (65.0%) claimed to be working, 3 (15.0%) were neither working nor in school and 4 (20.0%) did not respond.

As to what work they do, 10 (50.0%) were petty traders, 3 (15.0%) were apprentice seamstresses, 2 (10.0%) sold ice-water and pineapple, 1 (5.0%) could not tell what she did and 4 (20.0%) however did not respond (Table 4.17).

**TABLE 4.17** FREQUENCY DISTRIBUTION OF OCCUPATION OF RESPONDENTS

OCCUPATION	Non-pregnant		Pregnant	
	Frequency	Percentage	Frequency	Percentage
1. No Response	11	55.0%	4	20.0%
2. Petty trader	7	35.0%	10	50.0%
3. Seamstress	1	5.0%	3	15.0%
4. Hairdresser	0	0.0%	0	0.0%
5. Sells ice-water/Pineapples	1	5.0%	2	10.0%
6. Other(chop bar assistant)	0	0.0%	1	5.0%
7. TOTAL	20	100.0%	20	100.0%

**TABLE 4.18 RELATIONSHIP BETWEEN OCCUPATION OF RESPONDENTS AND PREGNANCY**

	PREGNANT	NON-PREGNANT	TOTAL
HAD OCCUPATION	16	9	25
NO OCCUPATION	4	11	15
TOTAL	20	20	40

Chi square = 3.84

Fisher exact 1 tailed test = 0.02500217

P value = 0.0250017

Results is significant at 5% level (P=0.025)

#### 4.6.2.5 Income per month and financial care

It was realised among the non-pregnant respondents that 7 (35.0%) received between ₵10,000 - ₵50,000 from assisting their parents in trading, 1 (5.0%) received less than ₵10,000, while 12 (60.0%) did not respond. On the other hand, 15 (75.0%) non-pregnant respondents were being cared for by their parents, 1 (5.0%) by a boyfriend and 3 (15.0%) by their relatives. Among the pregnant respondents, out of the total, 11 (55.0%) claimed to earn between ₵10,000 - ₵50,000 per month, 2 (10.0%) earned between ₵50,000 - ₵100,000 per month while 3 (15.0%) earned less than ₵10,000. Among these individuals, 9 (45.0%) were cared for financially by their parents, 2 (10.0%) by their spouses/partners, 5 (25.0%) by their boyfriends, 3 (15.0%) by their grandmothers and mothers -in- law, while 1 ( 5.0%) did not respond (Table 4.19).

**TABLE 4.19 FREQUENCY DISTRIBUTION OF FINANCIAL CARE PROVISION OF RESPONDENTS**

PERSON RESPONSIBLE	Frequency	Percentage	Frequency	Percentage
	Non -pregnant	Non-pregnant	Pregnant	Pregnant
1. No response	1	5.0%	1	5.0%
2. Parents/Guardian	15	75.0%	9	45.0%
3. Spouse/Partner	0	0.0%	2	10.0%
4. Boyfriend	1	5.0%	5	25.0%
5. Self	0	0.0%	0	0.0%
6. Other(Relative) (Grandmother) (Mother-in-law)	3	15.0%	3	15.0%
<b>TOTAL</b>	<b>20</b>	<b>100.0%</b>	<b>20</b>	<b>100.0%</b>

**4.6.2.6 Indulgence in sex**

Among the pregnant respondents , 8 (40.0%) said they indulged in sex because of curiosity, 1 (5.0%) said she did it in order not to become a “toke”, another 1 (5.0%) said she was raped, while 8 (40.0%) said for financial gain. 1 (5.0%) said she did it for no reason 1 (5.0%) however did not answer. Among the non pregnant respondents, one (5.0%) said it was due to curiosity, another 1 (5.0%) said she did that in order not to become a “toke” while 3 (15.0%) said it was for financial gain. Fifteen (75.0%) did not respond (Table 4.20 below)

**TABLE 4.20 FREQUENCY DISTRIBUTION OF THE REASON FOR INDULGENCE IN SEX**

REASONS	Non-Pregnant		Pregnant	
	Frequency	Percentage	Frequency	Percentage
1. No Response	15	75.0%	1	5.0%
2. Curiosity	1	5.0%	8	40.0%
3. Not to become a toke	1	5.0%	1	5.0%
4. For financial gain	3	15.0%	8	40.0%
5. Raped	0	5.0%	1	5.0%
6. Other (no reason)	0	0.0%	1	5.0%
<b>TOTAL</b>	<b>20</b>	<b>100%</b>	<b>20</b>	<b>100.0%</b>

**4.6.2.7 Number of friends and number pregnant**

Out of the total of 40 non-pregnant respondents, 2 (10.0%) had 1-2\* friends, 8 (40.0%) had 3-4 friends, 1(5.0%) had between 5-6 friends, another 1 (5.0%) had more than 6 friends, whereas 2 (10.0%) had no friends had no friends. Out of these 13(65%) said non of the friends were pregnant or had had a baby, 4 (20.0%) said either 1 or 2 friends were pregnant, 1 (5.0%) said 3-4 friends were pregnant while another 1 (5.0%) said more than 4 friends were pregnant. Among the pregnant respondents, 1 (5.0%) had no friends , 6 (30.0%) had between 1 and 2 friends, 6 (30.0%) also had between 3 to 4 friends while another 6 (30.0%) also had between 5 to 6 friends. One (5.0%) had between 5 to 6 friends. Five (25.0%) respondents said none of the friends was pregnant, 10 (50.0%) said 1 or 2 friends were pregnant, 4 (20.0%) said between 3-4 friends were pregnant, while 1(5.0%) respondent had more than 4 friends pregnant (Table 4.21)

**TABLE 4.21 FREQUENCY DISTRIBUTION OF THE NUMBER OF FRIENDS OF RESPONDENTS AND NUMBER PREGNANT**

NUMBER OF FRIENDS	Non-pregnant		Non-pregnant		Pregnant		Pregnant	
	frequency	percentage	frequency	percentage	frequency	percentage	frequency	percentage
	Friends	Friends	Pregnant	Pregnant	Friends	Friends	Pregnant	Pregnant
1. No response	0	0.0	1	5.0	0	0.0	0	0.0
2. None	2	10.0	13	65.0	1	5.0	5	25.0
3. 1 - 2 friends	8	40.0	4	20.0	6	30.0	10	50.0
4. 3 - 4 **	8	40.0	1	5.0	6	30.0	4	20.0
5. 5 - 6 **	1	5.0	1	5.0	6	30.0	1	5.0
More than 4 friends	1	5.0	0	0.0	1	5.0	0	0
<b>TOTAL</b>	<b>20</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>

**TABLE 4.22 RELATIONSHIP BETWEEN NUMBER OF FRIENDS OF RESPONDENTS AND PREGNANCY**

	PREGNANT	NON PREGNANT	TOTAL
FRIENDS	19	18	37
NO. FRIENDS	1	2	3
<b>TOTAL</b>	<b>20</b>	<b>20</b>	<b>40</b>

Chi square = 0.00

Fisher exact 1 tailed test

P. Value = 0.500214

Result is not significant at 5% level (P=0.500)

**TABLE 4.23 RELATIONSHIP BETWEEN NUMBER OF FRIENDS OF RESPONDENTS PREGNANT AND PREGNANCY**

	PREGNANT	NON PREGNANT	TOTAL
Friends pregnant	15	7	22
Friends not pregnant	5	13	18
Total	20	20	40

Chi square = 6.46.

Fisher exact 1 tailed test

P value = 0.0110042

Result is significant at 5% level (P=0.011 )

#### 4.6.2.7 Contact with tourists

It was realised that none 0 (100.0%) of the non-pregnant respondents had had any contact with tourist. Among the pregnant respondents, 1 (5.0) spouse/partner was responsible for the pregnancy, 16 (80.0%) were impregnated by their boyfriends, while 3 (15.0%) did not respond to the question. Again, none of the pregnant teenagers 0 (0.0%) had had any contact with a tourist (Table 4.24).

**TABLE 4.24 FREQUENCY DISTRIBUTION OF RESPONDENTS CONTACT WITH TOURISTS AND OTHERS**

CONTACTS	Frequency	Percentage	Frequency	Percentage
	Non Pregnant	Non Pregnant	Pregnant	Pregnant
Contact with tourist	0	0.0%	0	0.0%
Spouses/Partners	0	0.0%	1	5.0%
Boyfriends	0	0.00%	16	80.0%
No response	20	100.0%	3	15.0%
TOTAL	20	100.0%	20	100.0%

## CHAPTER FIVE

### 5.0 DISCUSSION, CONCLUSION AND RECOMMENDATION

#### 5.1 MAGNITUDE OF TEENAGE PREGNANCY

The estimated prevalence of teenage pregnancy within the last year (April 1996 -April 1997) was 47.3% with a the highest prevalence of 76.3% in the UCC subdistrict.

This is quite an alarming figure compared to a rate of 18% from health institutional data for 1995. It clearly shows that what is normally seen is just the tip of the iceberg. This community-based study has revealed another dimension of the teenage pregnancy situation in the Cape Coast Municipality. The high rate of teenage pregnancy obtained, exceeds the Central Regional average of 33.3% and compares closely with the GDHS 1993 findings, where among 19 year olds, 45% were parents or experiencing their first pregnancy, but falls below the 50 - 56% by age 20 for West Africa.

However, the prevalence from this study is about three times that found in the Demographic and Health Survey in sub- Saharan Africa which indicated that births to adolescent females aged 15 - 19 ranged between 15% -20% of Africa's total births, with significant regional and inter-country variations.

## 5.2 **CHARACTERISTICS OF RESPONDENTS**

### 5.2.1 **Age**

The mean age was estimated as 18.2 years with a standard deviation of  $\pm 1.8$ .

It compares closely with the findings from GDHS (1993) and KDHS (1993) that by age 19, 44-45% of 19 year-olds are parents or experiencing their first pregnancy. But then, if the mean age is 18.2 years as the findings indicated, then the issue of high teenage pregnancy should be looked at more critically. At age 19 without a dependable source of income is serious issue which requires collective efforts of parents, extended family, district assembly etc in its intervention.

### 5.2.2 **Education**

Although the number of years of schooling tended to have an influence on teenage pregnancy in this study, JSS graduates and drop-outs with more education contributed quite a significant percentage.

With regard to women giving birth by age 19 in comparison with level of education, the study shows that births among those with less than seven years of education were 59.6%, whilst those with more than seven years of education was (40.3%), which supports the findings of the Alan Guttmacher Institute (1995).

### 5.3 **SOCIO-ECONOMIC FACTORS**

#### 5.3.1 **Income per month**

Those employed were those who were actively working for themselves and earning substantial income to meet their daily needs.

In Ghana, the situation is quite a different, and it is evident from the findings of surveys that

“The high rates of unemployment and under employment have been characteristic features of the Ghanaian population especially since the introduction of the Structural Adjustment Programme (SAP) under the Economic Recovery Programme (ERP) and its associated Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD). The level of unemployment in Ghana is relatively high especially among the youth. An average of 20 per cent of Ghana’s active labour force was unemployed in 1993.

Currently, it is estimated that for every adult, there are four (4) unemployed youth. (GLSS 3 1991/ 92). The evidence of this is on our streets today, where young economically active youth are under employed in non-viable economic ventures such as street hawking and petty trading. Note that their activities do not add to real productivity of the nation’s gross capital” .<sup>27</sup>

In this study, although 44.4% claimed to be doing petty trading for their parents with its consequences explained earlier on, the majority (53.4%) were unemployed and depended on their parents for financial support.

It also became clear that monies obtained from petty trading were woefully inadequate, between ₵10,000-₵50,000 a month (45.5%) but this is not sufficient to take care of a single person in a month. Therefore unemployment and low income were found to be problems with teenagers. This means that they have to look elsewhere for money. Therefore they are forced into sexual relations with men in the hope that their needs would be catered for and gain financially as reiterated by 41.3% as their reason for indulging in sex. As reiterated by Bocoorh (1995) and Nabila and Fayorsey (1995) in their studies.

### 5.3.2 Parental care and support

#### 5.3.2.1 Living with parents

This study revealed that the majority of the parents (76.2%) were alive with 23.1% dead, 13.8% lived with both parents, while 42.8% lived with single parents and others were living with relatives etc. Only 1.1% were on their own. This therefore contradicts the findings of Amofo (1987) the death of one parent being a contributory factor to teenage pregnancy.

#### 5.3.2.2 Occupation of Parents

A question to ask then is, how much do parents earn from these occupations to cater for the needs of the children in this state of absolute poverty (a low level of income where one cannot survive physically). It can therefore be concluded that the type of occupation and income of parents greatly affected the teenagers since as the study revealed 42.9% were financed by their parents, which supports the findings of Amofo (1987) on low socio-economic status of parents as a cause of teenage promiscuity.

### **5.3.2.3 Marital status of parents and whether living together**

It also became clearly evident that although 46.6% of the parents were married, only 39.2% were living together, 51.8% had divorced and separated. What example can the latter offer to the teenage children? In a FADEP (1994) study, over 30% of married women were not currently residing with their husbands. This dual locality is most evident among the Ga and the Fantis.<sup>28</sup> Findings indicated that 92.6% of respondents were Fantis, thus supporting the above assertion. The disruption in marital unions, the dual locality of spouses and the added responsibilities of rearing children usually falls on women and account to a large extent for the increase in children's waywardness. Thus, separation, divorce and single parenthood were found to be contributory factors to teenage pregnancy.

### **5.3.2.4 Moral/spiritual support/guidance from parents**

Lack of moral, spiritual support/guidance increases the tendency of teenagers to become wayward. Findings from this study revealed that 96.8% claimed they got this support from their parents which contradicts findings from Nabila and Fayorsey (1995) in which parental advice was lacking. But in another development, it came up clearly from concerned parents that although these were given, the teenagers did not heed to advice and digressed. One parent frankly said. "In fact they cannot be controlled, when they ask permission and leave the house, they go anywhere and end up with boyfriends in secret places".

### 5.3.3 **Peer Pressure**

Teenagers' attitudes and behaviours are largely shaped by peers. Peers are known to have great influence on their fellow peers, besides parents, teachers, and guardians. They could therefore drive their fellows into sexual relations which may result in unwanted pregnancy.

It became evident that 83.6% had one or more friends and furthermore, friends of 54.8% respondents were pregnant. The likelihood that these pregnant friends imitate one another is so apparent, as the old adage goes "Show me your friend and I will show you your character". And as Fayorsey rightly put it "Commoditization of the life cycle". "There are girls who have not got to the stage of child bearing but after going to certain social gatherings such as out-dooring ceremonies (which are organized in a flamboyant manner) they develop interest in having babies so that they can also organize out-doorings where all sorts of gifts will be showered on them. As such, she easily gives in whenever a boy calls around."<sup>27</sup>

Some respondents confirmed that they share ideas together such that whatever their boyfriends give them they tell the other friends. By so doing other friends also get involved in doing the same thing, thus supporting the earlier findings of Nabila and Fayorsey (1995), Amadu (1987) and Nanor (1996). Therefore peer pressure appears to be a problem contributing to teenage pregnancy.

It was also revealed that quite a number of adolescents spent their time at home, mostly sleeping. Otherwise, they would go out visiting friends where they group themselves together at a common place to share the gossip of the day.

Of those who belonged to various movements namely the women's fellowship, Christian youth association and the choristers, they met twice or more in a week. The question to ask then is, whether they always go for meetings when they leave home? One would also ask what sort of moral guidance is instilled in them for them to emulate? Possibly, the next attempt to study teenagers would look at these issues

#### 5.4 **CULTURAL FACTORS**

Many cultural factors are attributed to teenage pregnancy. The findings revealed that religion had no bearing on it, where 89.4% of respondents claimed they were christians.

It also became evident that 78.8% of the teenagers were not married either and neither living in consensual union with men.

##### 5.4.1 **Early age at marriage and age of marriage**

Although 48.7% commented that girls are not allowed to marry early, quite a significant proportion of them (34.9%) supported the argument that girls marry early. But this is again refuted by the responses on age at marriage that the majority of the girls (59.8%) marry between age 19-21 and after. The study therefore revealed that although girls gave birth early, they did not actually marry early, which shows premarital child-bearing which

contradicts earlier findings by Gyepi - Garbrah (1988), Meekers and Grape - Bandon (1993), on early marriage of girls.

#### 5.4.2 **Age at first sexual intercourse**

It was revealed that majority of the girls (65.6%) had their menarche between 13 and 15 years, which contradicts other findings of Amofo (1987) on declining age at menarche; 69.8% had their first sexual intercourse between the ages of 15 and 18 years with a median age of 16.5 which compares closely with GDHS (1988, 1993). The finding was that, the median age at first sexual activity was 17 years which has neither improved nor changed over time. It further explained that whereas previously adolescent pregnancies took place within the context of sanctioned marriages, early menarche and premarital sexual activity have resulted in an increase in premarital births.

#### 5.4.3 **Reasons for indulging in sex**

The main reasons for indulging in sex revealed by the study were curiosity (40.7%) and for financial gain (41.3%). The latter reason has been the major cause of teenage pregnancy and as the Population Reference Bureau put it, considerable financial commitment is required for school materials etc. because families place a lower priority on educating their daughters than their sons, girls need to contribute their resources to finance their education.<sup>4</sup> Again, according to other researchers, Nabila and Fayorsey (1995) poverty as opposed to pleasure, is the driving force behind these relationships.

#### 5.4.4 Person responsible for pregnancy

The study revealed that 79.4% of the pregnancies were caused by boyfriends, with 1.1% attributed to tourists. It also revealed that of the boyfriends and spouses /partners, 42.3% were between 20-23 years. This refutes the findings of the Population Reference Bureau that some girls resort to striking up sexual relationship with older and more financially secure men, described as “sugar daddies” who exchange money and gifts for sexual relationships. The findings indicate that the girls went in for rather young boys. But then it could also mean that they did not give out the correct ages of their boyfriends.

#### 5.4.5 Reaction of respondents to pregnancy

Again it came up that 65.1% were angry and depressed and majority of them 65.5% desired to have abortion. 20.6% were rather happy because of the social support for teenage pregnancy. The grandmothers and mothers were delighted they would be becoming grandmothers as observed by Eghan-Ekuban (1978) and Lesthaeghe (1989).

#### 5.5 HEALTH SERVICE FACTORS

Findings indicate that 88.4% attended antenatal clinic and 86.2% had knowledge on reproductive health including family planning, teenage pregnancy and sexually transmitted diseases. The majority (56.6%) were taught by nurses and therefore the teenagers had sufficient knowledge on reproductive health, which contradicts Amadu’s findings.<sup>18</sup>

On the use of contraceptives, 87.8% had not used any before and whether they would like to use any, 65.1% expressed the desire and 27.5% postponed its use. However 69.5% said they would use it to prevent another pregnancy.

The study revealed that although the majority (87.8%) of teenagers had not used contraceptives before, the majority (69.5%) wanted to use it to prevent another pregnancy. This is a clear indication of unmet need for family planning. Therefore these contraceptives should be made available to them.

#### **5.6 THE ASSOCIATION BETWEEN EDUCATION, KNOWLEDGE IN REPRODUCTIVE HEALTH, SOCIO-ECONOMIC BACKGROUND AND CONTACT WITH TOURISTS AMONG PREGNANT AND NON-PREGNANT TEENAGERS.**

Findings indicated that there was an insignificant association in education, and knowledge on reproductive health ( $P=0.347$ )

The same insignificance applies to socio-economic background when the occupation of parents and respondents and their income as well as their indulgence in sex and the number of friends were compared ( $P=0.216$ ).

However, there was significant association between having friends who were pregnant and the pregnant teenagers ( $P=0.011$ ). It could be deduced from this that the pregnant friends influenced each other to become pregnant, which shows the influence of peer pressure.

Also it was revealed that those pregnant had some form of occupation to occupy themselves this was therefore found to be significant ( $P=0.025$ ).

With respect to tourism, findings revealed that there was no contact with a tourist, thus the association was insignificant ( $P=0.347$ ).

## 5.7 CONCLUSION

The magnitude of teenage pregnancy estimated was 47.3%, which is quite high and therefore measures need to be taken to address it.

The mean age was 18.2 years with a standard deviation of  $\pm 1.8$ .

With this, it is evident that high teenage pregnancy is a problem in the Cape Coast municipality Findings indicated that girls marry from 19 years onwards, although those studied were not married, they were quite close to 19 years. But then at 19 years of age without a dependable source of income is a serious issue.

It was obvious that although illiterates formed the majority of the teenagers, the JSS graduates and drop-outs contributed significantly to teenage pregnancy.

As earlier said, it was evident that the majority of the teenagers (78.7%) were not married. They were neither in any employment but rather assisting their parents in their various vocations without any substantive income. They therefore rely on parents and boyfriends for financial support. The latter was cited as a major reason for indulgence in sex. The occupation of parents do not generate enough income for the upkeep of the children, therefore an element of poverty was observed.

Peer pressure was found to be a major factor based on the number of friends the teenagers had (85.1%) compared to the number of them pregnant (63.3%).

Boyfriends were recognized to be responsible for the pregnancy. Their ages ranged between 20-23 years and not older financially secured men “sugar daddies”, as envisaged.

It also became evident that contact with tourists was very low (1.1%), and therefore tourism did not appear to play any major role in teenage pregnancy. Although there was good evidence of high knowledge in reproductive health and contraceptives among the teenagers, both past and current users (contraceptive prevalent rate) were rather low.

Finally, among the obviously pregnant and non-pregnant teenagers, there was no difference between them in relation to education, socio-economic background, knowledge in reproductive health and contact with tourists. There was rather a difference in the number of pregnant friends among them which is an indication of the influence of peer pressure.

## 5.8 **RECOMMENDATIONS**

In view of the findings, it is recommended that:

- Teens clinic or counseling centres should be established in the Cape Coast municipality. This should be given top priority, and should aim at providing information, education and communication (I, E&C) on reproductive health and family planning services to the youth
- Youth placement centres should be established to train the youth in various skills and provide avenues for employment. The Municipal Assembly, the Ministry of Youth and Sports, Ministry of Employment and Social Welfare and the Business Advisory Centre (B. A. C) should collaborate and work on this.
- From the findings, since the JSS graduates and drop-outs form the majority of those pregnant, they should be involved in the designing and implementation of programmes to improve their welfare. They should be encouraged to stay in school, complete have a profession so that they will be better placed to be financially secure, and thus less likely to have to look up to men for money and encourage them to stay in school, complete, have a profession so that they would be better placed.
- Adequate parental responsibility is a necessary precondition to regulate the waywardness of teenagers that often lead to unwanted pregnancies. Therefore, the B. A. C should open its doors to parents to help improve their income to enable them carry out their responsibilities towards their children.

- Religious leaders and parents should take it up as a matter of urgency to instil good moral and spiritual training into the teenagers, since the results indicated that majority of them were Christians.
- Lastly, the District Assembly should adopt a policy on measures to deal with men who impregnate teenagers.

It is hoped that if these strategies are put in place, the teenage pregnancy problem will be reduced.

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**ANNEXES**

**Appendix 1: TITLE OF STUDY: THE MAGNITUDE AND DETERMINANTS OF TEENAGE PREGNANCY IN THE CAPE COAST MUNICIPALITY.**

Subdistrict..... Name of Community.....

Serial Number  
of Household..... Cluster Number.....

Interviewer..... Date.....

**PART A: FOR HOUSEHOLD**

**Section I: Background Information**

1. How many women (females 13 years and above) live in this house? (Enter particulars of females in each household below with codes below)

Names (initials)	Age	Educational status	Ethnicity	Religion	Occupation	Have you had a baby within the last year		Pregnancy status	
						Yes	No	Yes	No

code:

**Educational Status**

1. None
2. Primary
3. J.S.S
4. S.S.S.
5. Post Sec.
6. Other

**Ethnicity**

1. Fanti
2. Ewe
3. Ga
4. Nzema
5. Other

**Religion**

1. Christian
2. Moslem
3. Traditional
4. Other
5. Other

**Occupation**

1. Petty trader
2. Seamstress
3. Hair dresser
4. Sells ice water/pineapple etc
5. Other

Serial Number of Household:.....

ID Number: .....

**PART B: For teenagers who have had babies within the last year, obviously pregnant and non-pregnant teenagers**

**Section II: Socio economic factors**

1. Are your parents alive?

1. Yes
2. No
3. Mother dead
4. Father dead
5. Other

2. Whom do you live with?

- |                 |                       |
|-----------------|-----------------------|
| 1. Both parents | 6. Friends            |
| 2. Father       | 7. Spouse/partner     |
| 3. Mother       | 8. Spouse and parents |
| 4. Relatives    | 9. By myself          |
| 5. Guardian     | 10 Other              |

3. What is the occupation of your parents/guardian?

- |        |                  |        |                |
|--------|------------------|--------|----------------|
| Father | 1. Fisherman     | Mother | 1. Fishmonger  |
|        | 2. Farmer        |        | 2. Farmer      |
|        | 3. Civil servant |        | 3. Seamstress  |
|        | 4. Unemployed    |        | 4. Hairdresser |
|        | 5. Other         |        | 5. Trader      |
|        |                  |        | 6. Other       |

4. Marital status of parents

1. Married
2. Divorce
3. Separated
4. Other

5. If married, are they living together?

1. Yes
2. No

6. Do you get moral and spiritual support/guidance from your parents? (e.g. reprimanded for doing wrong etc)

1. Yes
2. No

7. If no why?

1. Not ready to do it
2. Too busy
3. Have no knowledge about that
4. Do not know they should do it
5. Other

8. If yes, in what way?

1. Constant reprimanding
2. Encourages child to attend church
3. Corrects, when things go wrong
4. Other

9. What do you currently do?

1. In school
2. Working
3. Neither in school or working
4. Other

10. What work do you do, if in employment?

1. Petty trader
2. Seamstress
3. Hair dresser
4. Sells ice water/pineapple
5. Other

11. How much do you earn? (in thousands)

1. ₵10-₵50
2. ₵50-₵100
3. ₵100-₵150
4. ₵150-₵200
5. Other

12. Who cares for you financially, if not in employment?
1. Parents/guardian
  2. Spouse/partner
  3. Boyfriend
  4. Self
  5. Other
13. How do you finance yourself, if by self?
1. Does anything
  2. Token from friends
  3. Other
14. How many, friends do you have?
1. None (Skip to question 20)
  2. 1-2
  3. 3-4
  4. 5-6
15. How many of them are pregnant?
1. None
  2. 1-2
  3. 3-4
  4. More than 4
16. How do you spend your leisure hours?
1. Going to films
  2. Going to pub
  3. Going to tourist spots
  4. Other
17. Do you belong to any group or association?
1. Yes
  2. No
18. If yes, what is the name of the group/association
- Name:
- 1.
  - 2.
  - 3.
  - 4.

19. How often do you meet?
1. Once a week
  2. Twice a week
  3. More than twice a week

**Section III:** Cultural factors

20. Are you married?

1. Yes
2. No

21. Are girls allowed to marry early in your ethnic group?

- Yes  
No

22. At what age can a girl marry?

1. 10-12 yrs
2. 13-15 yrs
3. 16-18 yrs
4. 19-21 yrs
5. Other

23. Are men allowed to look after girls from childhood and marry them later?

1. Yes
  2. No
- Don' t know

24. At what age did you first menstruate?

1. 7-9 yrs
2. 10-12 yrs
3. 13-15 yrs
4. 16-18 yrs
5. 19-21 yrs
6. Other

25. At what age did you first have sexual intercourse?

1. 6-8 yrs
2. 9-11 yrs
3. 12-14 yrs
4. 15-17 yrs
5. 19 yrs

26. Why did you get indulged in sex?
1. Curiosity
  2. Not to become a "toke"
  3. Raped
  4. For financial gain
  5. Other

**Question 27-29 (for pregnant teenagers only)**

27. Who is responsible for the pregnancy
1. Spouse/partner
  2. Boyfriend
  3. Tourist
  4. Other
28. What was your reaction when you realised your were pregnant?
1. Happy
  2. Angry and depressed
  3. Wanted abortion
  4. Other

**Section IV: Health Service factors**

29. Did/have you been going to the antenatal clinic?
1. Yes
  2. No
30. Have you ever been talked to about sex, pregnancy and use of contraceptives at the clinic or anywhere?
1. Yes
  2. No
31. If yes, what was the topic?
- 1.
  - 2.
  - 3.
  - 4.
32. Who taught you?
- |            |                                    |
|------------|------------------------------------|
| 1. Teacher | 2. Siblings (brothers and sisters) |
| 3. Nurse   | 4. Friends                         |
| 5. Parents | 6. Other                           |

33. Have you used any contraceptives?
1. Yes
  2. No
34. If no, would you like to use any?
1. Yes
  2. No
35. If yes, why would you like to use contraceptives?
1. To prevent another pregnancy
  2. To protect against AIDS
  3. To find out if it is reliable
  4. Other

Thank you very much for your cooperation

**Appendix 2: COMMUNITIES WITHIN THE SUBDISTRICTS**

<b><u>Subdistrict</u></b>	<b><u>Communities</u></b>
1. U.C.C.	Apewosika Amamoma
2. Awim	Ekon Nkanfoa Brofoyedur Amanful
3. Adisadel	Brabedze Pedu Abura
4. MCH/Main	Bakano Ntsin (Back of commercial bank street) Gegyemno Idan Old Elmina Road Ntoto (Royal Lane) Beulan Lane (the point ) Beulan Lane (Anakyin) Brickfield Troum Pobee Street Kwamanopado Aboom Road