CENTRAL UNIVERSITY

FACTORS CONTRIBUTING TO HIGH PREVALENCE OF TEENAGE PREGNANCY: A CASE STUDY OF THE GA MANTSE COMMUNITY, ACCRA.

BY

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A PROJECT SUBMITTED TO THE FAMILY COUNSELLING UNIT, THE DEPARTMENT OF THEOLOGY & EDUCATION, CENTRAL UNIVERSITY, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF ARTS (FAMILY COUNSELLING)

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APPROVAL PAGE

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DECLARATION

Candidate's Declaration

I hereby declare that this dissertation is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's Signature…….Date……

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Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with guidelines on supervision of project work at the Central University.

Supervisor's Signature …… Date…….

Name: Mrs. Aku Hayfron

DEDICATION

This work is first dedicated to the Almighty God who has seen me through the thin and tough times during my academic pursuit, my ever ready and supportive wife, Mrs Emmanuela Ofosu-Okyere, for her prayers and immense contribution, my dear mother, Late Rachel Victoria Naa Selly Crabbe and my younger brother, Mr. Kabba Roberts, for their encouragement and financial support.

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ABSTRACT

The study examined the factors associated with adolescent pregnancy in the Ga Mantse community, Accra, with a sample size of 50 teenagers aged between 15 years to 19 years, using purposive and convenience sampling techniques. The study used quantitative approaches and a questionnaire was designed. The finding of the study revealed that factors contributing to high prevalence of teenage pregnancy in the Ga Mantse community, Accra, include lack of parental care and peer pressure, cultural beliefs on Sexual and Reproductive Health Issues, non-use of contraceptives, desire for a child, forced marriage, low educational level, lack of communication and supervision on Reproductive Health Services among teenagers, socio-economic status of the family income inequality and sexual behaviour and religious commitment.

The study also revealed that teenagers encounter multiple barriers in accessing sexual and reproductive health information. Some information obtained from the media do not equip them with adequate knowledge on sexual and reproductive health. These are not enough, clear and understandable to most teenagers; rather, they create misconceptions.

The factors driving teenage pregnancy are complex and varied and therefore require multifaceted interventions. There should be an improvement related to education, family planning, school-based health centers, youth-friendly clinics and youth development programs.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

According to the United Nations Children Fund (UNICEF), teenage pregnancy is defined as pregnancy in girls within the ages of 13–19. It is a global problem and creates issues for all those concerned about young women and their children's health and well-being. (Whitehead, 2007). Annually, about 21 million girls aged from 15 to 19 years in developing regions become pregnant (WHO, 2019) Around half of these pregnancies were unintended, and more than half ended in abortion, often in unsafe conditions. Teenage pregnancy is one of the main issues in every healthcare system since early pregnancy can have harmful long-lasting implications on girls' physical, psychological, economic and social status. (Mersal, Esmat & Khalil, 2013). One of the targets of sustainable development goals (SDGs 3.1) is ending preventable maternal deaths which aims for less than 70 maternal deaths per 100,000 live births globally by the year 2030. (UN, 2017). Preventing teenage pregnancy can help this goal since it is associated with poor maternal and child health outcomes and increased risks of dying during pregnancy. (Kalipeni, Iwelunmor and Grigsby-Toussaint, 2015)

Adolescent pregnancies are linked to disadvantaged social and economic situations (Sedgh, Finer, Bankole, Eilers & Singh, 2015). This phenomenon is regarded as a serious public health issue worldwide (World Health Organization, 2018). In low and middle income countries, about 21 million adolescent girls aged 15–19 years are estimated to get pregnant and about 16 million give birth annually (Darroch, Woog, Bankole, & Ashford, 2016; United

Nations Population Fund, 2015). Globally, adolescent pregnancy is expected to increase by 2030, with high concentrations in sub-Saharan Africa (United Nations Population Fund, 2013). Already, the highest teenage pregnancy rates are recorded in Africa (Worldatlas, 2017). Records show high pre-valence across the sub-Saharan Africa regions: 16.3% in Eastern, 27.9%in Western, and 28.9% in Southern Africa (Odimegwu & Mkwananzi, 2016).

Ghana, from the western side, reports that about 14% of adolescent girls aged between 15 and 19 years have started child-bearing with about 11% live birth rate (Ghana Statistical Service, 2014). Adolescent pregnancy is associated with a higher risk of maternal and neonatal complications (Abbas, Ali, Ali, Fouly, & Altraigey, 2017). Adolescent mothers are at risk of complications including hypertensive pregnancy disorders, unsafe abortion, urinary tract infections, and premature rupture of the fetal membranes (Azevedo, Diniz, Fonseca,Azevedo, & Evangelista, 2015). Others include high risk of poor nutrition, anemia, sexually transmitted diseases and a high rate of instrument delivery and Caesarean section (Najati & Gojazadeh, 2010). Complications arising from pregnancy and childbirth are indicated to be the number one cause of death among adolescent girls (15–19 years) worldwide (World Health Organization, 2016).

Societal and traditional norms such as early marriage (Rutaremwa, 2013), childbearing as a measure of maturity and a means to elicit societal respect (Gyesaw & Ankomah, 2013), sexual abuse and living in violent communities (Brahmbhatt et al.,2014), lower level of education (Faisal-Cury et al., 2017; Raj, Bhattarai,Poobalan, Van Teijlingen & Chapman, 2010), and influence or

pressure from peers (Mushwansa, Monareng, Richter & Muller, 2015) are the major factors associated with adolescent pregnancies in Ghana.

Adolescent sexual behaviours such as unprotected sex and/or lack of use of contraceptives (Hindin & Fatusi, 2009), early sexual debut, frequent sexual intercourse and alcohol consumption (Panova, Kulikov, Berchtold & Suris, 2016), family related factors such as divorce or non-intact family structure (Panovaet al., 2016), history of maternal and sibling adolescent pregnancy (Akella & Jordan, 2015; East, Reyes, & Horn, 2007) and poor family economic status (Akella & Jordan, 2015; Nyovani, Zulu, & Ciera, 2007) and the influence of the media (Chandra et al., 2008) could also contributing factors for adolescent pregnancy.

1.2 Problem Statement

About 11% of all births worldwide are from mothers aged 15 to 19 years with about 95% occurring in low and middle-income countries (World Health Organization, 2014). Complications during pregnancy and childbirth are the second cause of death for girls aged 15 to 19 years. Globally, 3 million girls aged 15 –19 years undergo unsafe abortion every year, which remains a major contributor to maternal mortality. About 65% of women who develop obstetric fistula developed it during adolescence (WHO, 2013). About 36.4 million girls become mothers before age 18 (Loaiza and Liang, 2013, WHO, 2014). According to WHO, about 50% of still birth risk is associated with babies born to mothers who are under the age of 20 years compared to mothers above 20 years. (WHO, 2014).

Although adolescent pregnancy is also a problem in Ghana, use of contraceptives among adolescents in Ghana is low. Only 30% of sexually active adolescents are currently using contraceptives with an even lower proportion (2%) in Northern Ghana (GDHS, 2014; Awusabo-Asare et al., 2017). The 2015 annual report of GHS, Family Health Division indicates that unsafe abortion contributes to 7% of all maternal deaths in Ghana. About 12.1% of girls between 10 to 19 years got pregnant in 2015, 12.1% in 2014, and 12.3% in 2013 which was higher than the national target of 10% (FHDR, 2015). Abortion among the same group was 17.3% in 2015 of all pregnant adolescents (FHDR, 2015). There may be some unreported pregnancies and abortions which are not captured in the institutional report. Therefore, this study aimed to examine the factors associated with adolescent pregnancy in the GA MANTSE community, Accra.

1.3 Objective of the Study

The main purpose of the study is to access the factors associated with adolescent pregnancy in the GA MANTSE community, Accra. However, the following specific objectives will be achieved;

1. Examine the contributing factors of adolescent pregnancy in the GA MANTSE community, Accra.
2. Identify the consequence or the challenges of adolescent pregnancy in the GA MANTSE community, Accra.
3. The effect of adolescent pregnancy in the GA MANTSE community, Accra.

1.4 Research Questions

In order to achieve the objectives of the study the following questions will be answered;

1. What are the contributing factors of adolescent pregnancy in the GA MANTSE community, Accra?
2. What is the consequence or the challenges of adolescent pregnancy in the GA MANTSE community, Accra?
3. What is the effect of adolescent pregnancy in the GA MANTSE community, Accra?

1.5 Significance of the Study

The outcome of the study will be useful to policy makers in developing policies and strategies that will address factors identified to be influencing teenage pregnancy at a local level. The findings from this study in the Ga Mantse Community, Accra would provide the contextual evidence as expected in a case study to draw the attention of authorities and all stakeholders towards solution development. The study will help authorities in the planning and carrying out interventions to address the issue of adolescent pregnancy. The study also adds to the nascent and fledging works on adolescent pregnancy and its influence on the teenage mother and the society.

1.6 Scope and Limitation of the Study

This study was limited to adolescent girls who are either pregnant or not in the Ga Mantse Community, Accra. The study is restricted to the factors associated to the rise of teenage pregnancy among young girls in Ghana such as level of education of both the adolescent and the guardian/parent, marital status of the

adolescent girl, economic class, access and use of contraceptives, parent-adolescent communication, parental attitude towards boy-girl relationships, alcohol/substance abuse, coerced sex and peer influence. Geographically, this study will be limited to Ga Mantse Community, in greater Accra region. The study does not consider other variables and as such is limited to only those areas specified above due to financial constraints and time availability for the study.

1.7 Definition of Terms / Operational Definitions

For the purpose of this study the following definitions apply:

Adolescence is a period where a child transits to adulthood and is associated with the age limits 10 to 19 years (WHO, 2012).

Adolescent refers to anyone who falls within the period of transition to adulthood, usually from age 10 to 19 years (WHO, 2008).

Adolescent-pregnancy is pregnancy occurring in a girl aged 10 to 19 years.

Peer refers to one that is of equal standing with another: equal; especially: one belonging to the same societal group especially based on age, grade, or status (Merriam-Webster Online Dictionary, retrieved 13th December, 2015).

Peer influence for the purposes of this study refers to the impact an adolescent girl is able to exert on other girls of her age category such that she is able to encourage them to change their attitude, values or perception towards adolescent pregnancy.

1.8 Organization of the Study

This study was organized into five chapters. Chapter one is on the Introduction and it covers the background information on adolescent pregnancy, the problem

statement, objectives of the study, research questions, and the scope of the study.

Chapter two reviews related literature based on the objective and study variables for that matter. Chapter three describes the methodological approach to the study including the study type, study area, variables to be measured, instruments used, sampling technique and size, pre-testing, analysis and ethical issues. Chapter four presents results and discussion of the study. Chapter five presents conclusions and specific recommendations based on the major findings made in the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter explores information from different researchers, books, news article and reports on what other authors have done concerning the related topic. It looks at previous literature on factors that influence teenage pregnancy. It also discusses the theoretical framework and the conceptual framework of the study.

2.2 Theoretical Framework

The study adopted Bronfenbrenners ecological theory of human development (Brofenbrenner, 1986) and Banduras (1977) Social Learning Theory to explain the factors that influence teenage pregnancy in the Ga Mantse Community, Accra;

2.2.1 Ecological theory of human development (Brofenbrenner, 1986)

This theory adapted ecological systems theory from the physical sciences to human behavior. It discussed the different system levels as: Macro system Level. At this level, the social economic status (SES) has been found to be a significant factor to teenage pregnancy and child bearing (Abrahamse, et al., 1988; Barnett, et al, 1991; Hason, et al., 1987; Mayfield-Brown, 1989). In the Ga Mantse Community, Accra, girls from economically challenged families are prone to early sexual activity which results to teenage pregnancy and sexually transmitted infections.

At the Mesosystem level, different aspects of peer influence that have been examined in literature include Peer educational goals (Hanson et al., 1987), Peer

involvement (Yamaguchi & Kandel, 1987), Pressure from sexual partners and liberal sexual attitudes of peers (Shah & Zelnik 1981). Evans Found liberal sexual attitudes among friends to be associated with pregnancy and parenting, whereas they discovered that females with views on sexuality closer to those of their friends rather than those of their parents were more likely to experience premature pregnancy. In addition, teenagers experiencing family problems might be more at risk for influence by a negative peer group (Yamaguchi&Kandel1987). At this level, the other influential factor to teenage pregnancy is Education; with grade level being the most important aspect to be discussed (Ralph, et al., 1984). Other aspects under study are; Conduct problems (Abrahamse et al., 1998) and attitudes towards school (Landry, Bertrand, Cherry & Rice, 1986). Studies also indicate that poor academic performance and the relationship with the school setting, the greater the risk for premature pregnancy (Abrahamse et al., 1998; Hanson et al., 1987; Ralph et al., 1984). Applied to the family structure, the theory refers to the manner in which contexts beyond the family may help shapen adolescent functioning through their influence on the family (Bronfenbrenner, 1986). Parents serve as the principal link between environmental settings and adolescent functioning and the other contextual factors which influence adolescent functioning.

2.2.2 Social Learning theory (Banduras, 1977)

This theory identifies three main processes involved in learning: Direct experience, indirect or vicarious experience from observing others (modeling),

and the storing and processing of complex information through cognitive operations. This theory suggests that behaviors are learned and that they are influenced by social context; the media and more so, television is seen as an increasingly influential agent of socialization that produces its effects through teenagers' propensity to learn by imitation. In applying Social Learning Theory to Adolescent Pregnancy, a major component would be modeling. Adolescents imitate behavior from others in their environment through observational learning. It is often the job of health educators and counselors to help adolescents recognize that difference, sometimes conflicting, social norms may well exist in their community or environment. The messages they receive about sexual behavior from the media, from their peers, or from family members, religious leaders, and others, will almost inevitably be different to some extent. By providing adolescents with an increased awareness of the influence of other significant individuals in their lives, as well as knowledge and negotiation skills about abstinence and contraceptives, the chances of an unplanned pregnancy can be lessened.

2.3 Family Planning Policy and Guidelines

Every human has the legal right to access quality and affordable sexual and reproductive health services. No one is allowed to obstruct individuals to make a right choice of these services in any way. For that case, every country or community should make sure that no one lacks quality service of reproductive and sexual health as it is the right that all individuals should access regardless of his or her age or gender. This right is recognized in the International Conference on Population and Development in Cairo in 1994. According to Adolescent Reproductive Health Policy National Population Council (2000), all

men and women including young people (10–24 years of age), irrespective of their parity and marital status, are eligible to access accurate and complete family planning information, education and services. Although our policy allows teenagers to access reproductive and health services, yet the policy has not been effectively implemented in most areas, as teenagers still face difficulties, when they are in need of the services.

2.4 Cultural beliefs on Sexual and Reproductive Health Issues

In most of our societies, sexual and reproductive health issues are considered as secret and undisclosed matters that are not allowed to be discussed in public and even at home with parents or close relatives. When the need to transmit such information to the adolescents arises, parents are supposed to find someone, who is a relative or selected member of the community, to instruct the young ones on all matters concerning sexual and reproductive health. Such norms has caused teenagers to sometimes get inadequate and wrong information. Most of them get information from unreliable sources i.e. Peer groups, Friends at School, Magazine and Radio. Study by Ruto (1999) in Kenya evidenced that parents and adults do not give teenagers information on sex and contraception, because it is not considered culturally appropriate, hence they turn to their peers who give them inappropriate and/or inaccurate advice.

2.5 Lack of Knowledge on Reproductive Health

Knowledge about reproductive health among teenagers has effect on the welfare of both teenagers and the community as a whole. Lack or inadequate knowledge about reproductive health has a serious problem to the welfare of a teenager. Most of the teenagers have been exposed to various risks such as unprotected sexual activities and early pregnancy. Teenage pregnancy has prolonged effect

on teenagers. Most of them do not continue with school programs even after delivery; they spend their time taking care of their new-born babies. A study conducted in Philippines by WHO(2003) conceded that there is a clear relationship between knowledge and pregnancy. The findings showed that two out of every ten young women gave birth before age 20. Among the less-educated women, the number increased to four out of 10. Less educated women were more likely to become pregnant during their teen years than their better-educated counterparts. Out-of-school youth estimated to be 5.5 million and mostly concentrated in urban areas, faced a higher risk of teenage pregnancy.

A study in Latin America has also shown that there is a relation of high proportion of teenage pregnancy due to poor exposure to sexual and reproductive health education and to family planning services among teenagers. In Africa, studies have demonstrated that a large proportion of teenagers in Uganda and Nigeria are exposed to the risk of conception as the result of receiving poor sexual and reproductive health education as well as contraceptive education (Mfono, 1998). Survey in Swaziland has also shown that knowledge on use of condoms is high among teenagers, about 97 percent but only 20 percent of young women aged 15-19 and 30percent of young men aged 15-19 have never used a condom during sex (Biaye, 2004).

Sex education stands effective, if the knowledge of birth control pills and their usage are made clear to teenagers. This is evident from the Youth Risk Behaviour Survey carried out by Centre for Disease Control(CDC) in USA which found that 80 percent of lowered teen pregnancies have been reported to be caused by more effective practice of contraception techniques among them

(Dasgupta, 2011). In a study conducted by Mushwana et al., (2015) on Factors influencing the adolescent pregnancy rate in the Greater Giyani Municipality, Limpopo Province–South found that inadequate sexual knowledge (61%), changing attitudes towards sex (58.9%) and peer pressure (56.3%) contribute to high pregnancy rate among teenagers.

2.6 Lack of Information about Reproductive Health Services among Teenagers

The attitude that adults hold about providing information to young people on reproductive health is crucial in shaping the content of messages provided to the youth. In a study conducted in Bangladesh by (Bhuiya et al., 2004) to assess reproductive health services for adolescents found that adolescents had limited access to Reproductive health services and the available services are not friendly especially those who were married who could not access family planning methods. Giving information about reproductive health to teenage has positive impact rather than restricting them. Parents are advised to discuss matters concerning reproductive health rather than limiting on cultural issues. Boys and girls learn about traditions through peer effects, the social process at home and in the community during the initiation rites. Still they need comprehensive sexual and reproductive health education so that they can prepare themselves for healthy adult relationships, increase adolescents' knowledge and help them to explore attitudes, feelings and values about human development, relationships, dating, gender roles, sexual orientation, sexual behavior and informed healthy sexual decision-making.

2.7 Socio-economic Status of the Family Income Inequality

Economic status of the family has an impact on the teenager. At this age, a teenager faced with different demand to support day-to-day life thus needs financial assistance to basic needs such as clothes, body makeup, entertainment, etc, hence the need to be supported by parents, guardians or close relatives. The absences of support from parents compel the teenagers to find support outside their parents and consequently, they engage in sexual activities in return for gifts or assistance received. One of the responses that came instantly on the question as to why girls get pregnant was poverty. In many cases, it was noted that inability of parents to provide their girls' basic needs exposes them to risks of pregnancy (Ahikire and Madada, 2011). Among teens aged 15–17, income inequality and per capita income were independently associated with birth rate; the mean birth rate was 54 per 1,000 in countries with low income and high-income inequality, and 19 per 1,000 in countries with high income and low inequality. Among older teens (aged 18–19), only per capita income was significantly associated with birth rate. Although teen childbearing is the result of individual behaviours, community-level factors such as income and income inequality may contribute significantly to differences in teen birth rates. In a study conducted on factors that contribute to adolescent pregnancy among secondary students in Kinondoni by Peter (2009), it was observed that low socio-economic status is one of the causes for adolescent pregnancies. Other factors responsible were luxury and deprivation of education to girls (43.5% and 16.5% respectively).

Acharya et al., (2010) stated that socio-economic status, educational attainment, cultural factor and family structure were all identified as risk factors for teenage

pregnancies in South Asia. Teenage pregnancies are significantly higher in the lower social classes (52%) than in the higher social classes (26%). Teenage pregnancy is associated with the most deprived and socially excluded of young people. Difficulties in young people's lives such as poor family, relationships, low self-esteem and unhappiness at school also put them at greater risk. These are among the reasons that contribute to school dropout. Once a girl has become pregnant, they are not allowed to continue classes and are discriminated by the family as well as the community. The event has great consequences to the overall wellbeing of a teenager, family and the whole community; destroy her future career and threatening their future economic prospects.

2.8 Environmental Factors and External Forces from the Community

Teenagers have been engaging in early sexual activities as a result of external forces from the community they live. Many of the teenagers today live in stressful environments, where there is violence, poor housing conditions and many of them experience discrimination on a daily basis. All these determinants have impact on how the teenagers perceive their future; this also has an impact on their sexual decision-making. In some African cultures, once a girl or a boy is matured, they are supposed to show that he or she is capable of undertaking sexual activities. In a Study of sexual behavior among young people conducted in Kenya found that 21% of females and 11% of males had experienced sex under coercive conditions. Most of the perpetrators were intimate partners including boyfriends and girlfriends (Erulkar, 2004). A study conducted in Lindi by Tumbo (1994) said that instructions given to boys and girls during the Initiation can contribute to the increase of rate of teenage pregnancy, as these boys and girls are trained on how to satisfy their partner during sexual

intercourse. Girls are trained on how to move their waist rhythmically during intercourse, this coaching needs more practice before they get masterly. To master, they continue practicing and as a result, most of them have ended up in pregnancy. Violence may be related to teenage pregnancy indirectly or directly. Women who have suffered childhood abuse may tend to engage in bad behaviors, for example, sex, risk taking, drug and alcohol abuse that prevent consistent or correct contraceptive use. They may also not use contraceptives due to fear and culture (Bruyn, 2002). The problem of teenage pregnancy is cyclical in nature, because, children born to teen mothers are 66% more likely to become teen mothers themselves (Basch, 2011).

2.9 Sexual Behaviour and Religious Commitment

Religious teachings have an important role in shaping the behavior of an individual; in the formation of an individual's attitude, values for them to make proper decisions toward sexual practice. A study conducted in Nigeria on relationship between faith and sexual behavior found that there is a correlation between teenager's sexual behaviour and religious commitment. Religious values are the source of moral prescriptions for many individuals, and the teachings of the churches are likely to play a role in the formation of individual attitudes, values and decisions. The extent to which religion influences individual attitudes and behaviour, however, depends on the specific doctrines and policies of the churches and on the degree of integration and commitment of individuals to their particular religious institutions (Odimegwu, 2005).

2.10 Parenting Nurture Style

The environment that surrounds the teenagers have strongly correlated to increased rates of teenage pregnancy. For example, there is a strong correlation between teenage pregnancy and the neighbourhoods in which the teenagers live. Teenagers who live in neighbourhoods with high levels of poverty, low levels of education and high residential turnover are at higher risk for teenage pregnancy. Teenagers whose mother or sister gave birth at teen age are also more likely to become pregnant during their teenage years. Females who grow up without fathers in the home usually end up having pre-marital sex (Hinckely, 1998). They subconsciously want to make up for the affection that they did not receive from their fathers. They become too dependent on men because they want someone who can replace their fathers. These women usually do not know how to relate to other males and they have the wrong idea about what a relationship should be like. With respect to factors that lead to teenage pregnancy, it was evident that poor parenting, poverty and peer influence are the major causes of teenage pregnancy.

2.11 Consequences or Challenges of Adolescent Pregnancy

A lot of health risks and socioeconomic effects have been associated with early or adolescent pregnancy. These effects are not only concentrated on the adolescent mother, but also the infant and the society as a whole. A study in the United States of America indicated that about a million adolescents get pregnant each year which brings great cost to the adolescent mother, the baby and the society (Odu & Ayodele, 2007). Early child bearing has been found to be associated with many health glitches including Anemia, mental illness (puerperal psychosis), Malaria, unsafe abortion, and obstetric fistulae (WHO,

2008). Most girls after realizing they are pregnant resort to any means possible to terminate the pregnancy. Some go to the extent of undergoing unsafe abortion which even if they survive leaves permanent mark or adverse effect on their reproductive life. This usually occurs in developing countries where abortion is not legalized. About 2-4 million adolescents practice unsafe abortion every year in developing countries (WHO, 2011). Adolescent pregnancy contributes immensely to maternal mortality, perinatal mortality and infant mortality. In 2008, WHO stated that adolescent pregnancy contributed to 13% of all deaths and 23% of all disability adjusted life years (WHO, 2008). Adolescent pregnancy was also found to contribute to rancorous cycle of ill-health and poverty (WHO, 2008 & WHO, 2011).

Pregnancy related deaths are found to be the leading cause of mortality among adolescent girls who are between the ages of 15 and 19 years worldwide (Isa et al., 2012). However, recent studies have shown a decline in the rate of deaths in all regions globally especially in South-East Asia where mortality rates have reduced from 21 to 9 deaths per 100,000 girls since the year 2000 (WHO Fact Sheet, 2014). It is in view of this that the UN Secretary General launched The Global Strategy for Women's and Children's Health in September 2010 to address the issues concerning the health and welfare of adolescent girls. This was also to achieve the Millennium Development Goal -5 which is related to reduction of maternal mortality (WHO, 2011). The WHO also reported that perinatal deaths among infants born to mothers who are below the age of 20 are 50% higher compared to infants born to mothers who are above 20 years (WHO, 2011). Babies who are born to adolescent mothers also have the likelihood of

developing childhood health problems than babies born to older mothers (Odu & Ayodele, 2007).

The adverse effect of poor new born health resulting from adolescent pregnancy can have inter-generational effect and also long term effects which may result in adulthood diseases (Foetal Origins of Adulthood Diseases) (WHO, 2008). In Ghana, it has been revealed that birth to adolescent mothers between the ages of 15 and 19 years have the highest rate of infant and child mortality (GSS, 2010). There have been various studies that spell out the nexus between adolescent pregnancy and undesirable socioeconomic consequences on the mother and her baby. Recent studies however have shown that there is no clear evidence as to whether adolescent pregnancy results in adverse socioeconomic factors or socioeconomic factors lead to adolescent pregnancy (WHO, 2008). Blanch et al. (2011), indicated that low socioeconomic effects do not only affect the adolescent mother just after birth of the child but also it affects future care of the mother and the child, especially, if the adolescent mother does not have any support system available to her. Gyan (2013) revealed that about 86% of respondents of the study were out of school due to adolescent pregnancy. As many as 82.8% of respondents indicated that the pregnancy had affected their academic performance whilst 94% of the respondents had no intentions of going back to school after delivery.

Although there is the existence of literature on the factors influencing adolescent pregnancy, most of these studies were carried out in the United States and other parts of Africa. Much has not been done in Ghana. Also, most of the studies do not bring out the reasons why some adolescents get pregnant, whilst others do

not give that they are all exposed to same or similar conditions. The study therefore seeks to research into the reasons for this phenomenon and also contribute to existing literature to facilitate future studies.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the research design and research setting. It also describes the study population, sampling, data collection, data analysis and ethical consideration for the study. Finally, the chapter addresses issues of rigor in this study.

3.2 Research Design

A research design is defined as "a blue print for conducting a study with maximum control over factors that may interfere with the validity of the findings" (Burns and Groves, 2003). Also, Parahoo (1997) describes research design as "a plan that describes how, when and where data are to be collected and analyzed". A quantitative method was adopted by the study. According to Aliaga and Gunderson (2000), quantitative approach is the process of giving explanation to phenomena by gathering arithmetical statistics which are examined, scrutinized and analyzed utilizing methods and approaches that are scientifically based. Furthermore, Creswell (1994) gave an extremely succinct meaning of quantitative research as a kind of study or research that explains parameters or phenomena by collating or gathering arithmetical or numerical data and statistics that are examined based on mathematical methods in particular statistics. This study is focused on investigating 'factors contributing to high prevalence of teenage pregnancy in the Ga Mantse community, Accra'. To conduct this study, the positivist philosophy was adopted. The research design followed an inductive approach that sought to answer the research questions formulated in the first chapter. The population of the study covers all

girls between the ages of 10 to 19 years, living in the Ga Mantse community. The study sample was drawn using the purposive and convenience sampling technique and both primary and secondary data were collected to complete the study. A descriptive survey approach using questionnaires as the research instrument was employed. Creswell (2003) defines descriptive survey as a method of collecting data for the purpose of answering research questions concerning the current status of the subject under study.

3.3 Source of Data

Data for the study was collected from both primary and secondary sources. The administration of questionnaires forms the basis for primary data. Data collected from this source was centered on the background characteristics of respondents and factors contributing to high prevalence of teenage pregnancy. In the case of secondary sources, information from published and unpublished sources including journals, textbooks, periodicals, government publications, the internet as well as reports and official documents from AMA were used to support the primary data.

3.4 Target population

Target population is the particular populace about which data is coveted. As per Kombo and Tromp (2006), a population is a set of people, organizations, segments, events, social occasion of things or families that are being inspected. This definition expected that the populace is not homogeneous. The population of this study comprised of all girls between the ages of 10 to 19 years, living in Ga Mantse community.

3.4 Sample size and techniques

The study employed purposive and convenience sampling techniques to select 50 citizens who are within the ages of 10 years to 19 years old. Convenience sampling techniques was used to select the respondents from the targeted population due to the size of the population of the study, availability of time. Convenience sampling is a type of nonprobability sampling in which people are sampled simply because they are "convenient" sources of data for researchers. In probability sampling, each element in the population has a known non-zero chance of being selected through the use of a random selection procedure. Non-probability sampling on the other hand, does not involve no non-zero probabilities of selection. Rather, subjective methods are used to decide which elements should be included in the sample.

3.5 Research Instrument

The research instrument employed to elicit data from the field survey was questionnaires. The questionnaires were well-structured using both open-ended questions and close-ended questions in two sections. Questionnaires were self-administered over a period of three (3) weeks. Considering the characteristics of the study population, questionnaire was the ideal instrument due to the simplicity of its administration and low cost involved.

3.6 Data Collection Procedure

A pre-test was conducted using five teenagers in the Ga Mantse community in a day to enable the researcher to test the adequacy and completeness of the responses and how respondents understood the questions. This helped the researcher to effect the necessary corrections to avoid ambiguity or

misunderstanding of the questions. To gather the required primary data that will be relevant to achieving objectives of the study, the sample was carefully recruited. To ensure right to informed consent, the potential research participants were given sufficient information to make knowledgeable decision as to participate or withdraw from participation at any stage of the data collection process. Anonymity and confidentiality were ensured since the questionnaire did not require respondents to write their names and addresses. The respondents were allowed to withhold any information they felt uncomfortable in order to ensure their right to privacy. The field survey was carried out over a period of four (4) weeks. One major challenge faced was that some of the target audience did not return the questionnaires. The researcher distributed more questionnaires to achieve the appropriate sample size.

3.7 Data Analysis Technique

Collected data were analysed using quantitative and descriptive research approach to reach valid conclusions on the study objectives as well as answer the research questions. To adequately draw logical and consistent conclusions, data gathered from the field survey was processed, removing all incompletely filled questionnaires. The responses to the questions were coded and entered into the SPSS (Statistical Package for Social Sciences, SPSS, 20.0) computer software for analysis and interpretation. Statistical tables were used to present the analysed data collected, descriptive statistical tools such as percentages were used.

3.8 Ethical Consideration

The researcher sought authorization from the management of the University and AMA and engaged the Assembly man in the area before the study was conducted and also from respondents who were willing to partake in the study. Due to the age of the respondents, they were made to sign a consent form before participating in the study. Respondents were assured of the confidentiality of all information they gave in the research and made known that all information obtained was solely for academic purpose.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents analyses and discusses empirical findings on the factors contributing to high prevalence of teenage pregnancy in the Ga Mantse community, Accra. Data were collected by the researcher using structured questionnaires from 50 teenagers between the ages of 10 years to 19 years. This section describes how the data was meticulously analyzed and discussion of data.

4.2 Rate of Responses

Fifty questionnaires were administered and all questionnaires were retrieved and analysis representing 100% response rate. The greater the responses rate, the more reliable the results of the sample will be and thus, the research findings can be said to be reliable.

4.3 Sex of the respondents

Majority (68%) of the respondents were females, while the rest (32%) of the respondents were males.

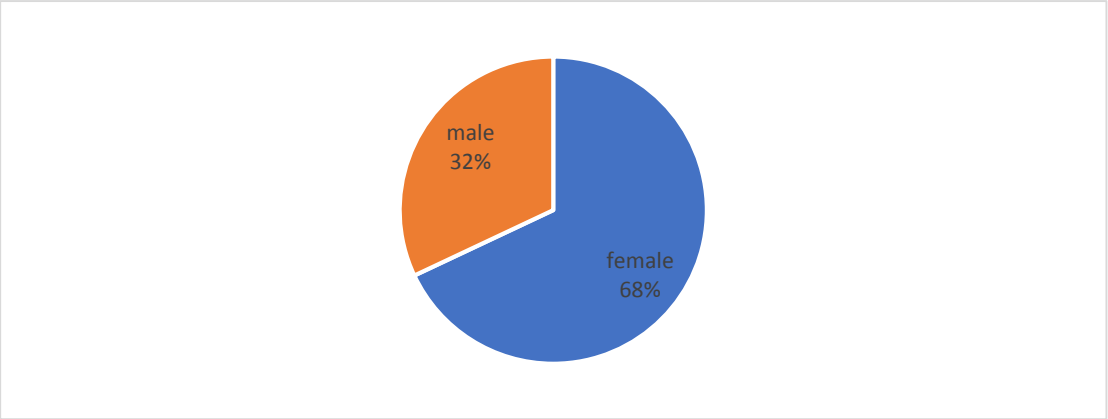

Figure.4. 1: Sex of the Respondents

Source: field work 2021

4.4 Distribution of respondents by Age

Table 1 shows that the highest number of the respondents 12 (24%) were 18 years of age, while the lowest number of the respondents were at the age of 11 years.

Table 1: Distribution of respondents by Age

Age (in years)	Frequency	Percentage
11	1	2
12	3	6
13	3	6
14	2	4
15	4	8
16	8	16
17	11	22
18	12	24
19	6	12

Total	50	100

Source: field work 2021

4.5 Highest Educational background of the respondents

Majority (50%) of the respondents were in Senior High School, 24% of the respondents were in Junior High and 14% of the respondents were in Primary School. However, 12% of the respondents had no formal Education.

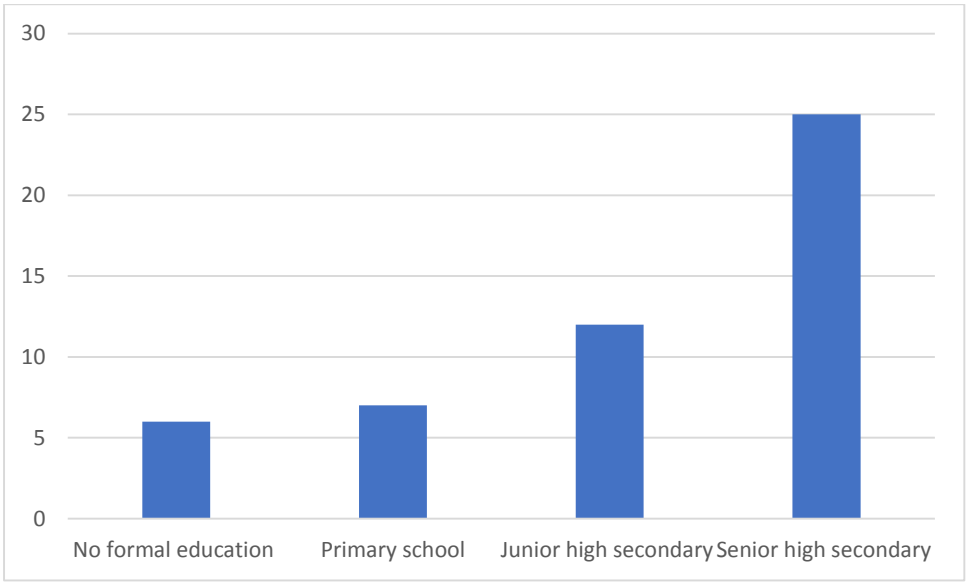

Figure 2: Highest Educational background of the respondents

Source: field work 2021

4.6 Awareness on Teenage pregnancy

Table 2 indicates that majority (94%) of the respondents were aware of teenage pregnancy compared to 6% who were not aware.

Table.4. 2: Respondent's awareness of Teenage Pregnancy

Responses	Frequency	Pregnancy
Aware	47	94
Not aware	3	6
Total	**50**	**100**

Source: field work 2021

4.7 Source of information on Teenage Pregnancy

Table 3 shows that majority (54%) of their respondents got the information and education about teenage pregnancy from the various media, 28% of the respondents got the information and education about teenage pregnancy from family members, 12% of the respondents got the information and education about teenage pregnancy from their teachers while the rest (6%) of the respondents got the information and education about teenage pregnancy from medical personnel.

Table.4. 3: distribution of respondents by source of information about teenage pregnancy

Responses	Frequency	Percentage
Media	27	54
Family members	14	28
Medical personnel	3	6
Teachers	6	12
Total	**50**	**100**

Source: field work 2021

4.8 Factors contributing to high prevalence of teenage pregnancy

On the factors contributing to high prevalence of teenage pregnancy, it was observed that majority of the participants mentioned different reasons that they think can be the cause of teenage pregnancy, all the respondents said that Non-use of contraceptives, desire for a child, forced marriage, low educational level and need for dowries were some of the factors contributing to high prevalence of teenage pregnancy in the Ga Mantse Community, Accra. 94% of the respondents said that lack of communication and supervision on reproductive health services among teenagers was a contributing factor to high prevalence of teenage pregnancy, 90% of the respondents said that cultural beliefs on sexual and reproductive health issues was a key factor contributing to high prevalence of teenage pregnancy, 86% of the respondents said that lack of parental care and peer pressure was one of the contributing factors to high prevalence of teenage pregnancy, 74% of the respondents said that socio-economic status of the family and income inequality was one of the contributing factors to high prevalence of teenage pregnancy, 100% of the respondents said that non-use of contraceptives, desire for a child, forced marriage, low educational level and need for dowries was one of the contributing factors for high prevalence of teenage pregnancy, while 50% of the respondents said that sexual behaviour and religious commitment was one of the contributing factors to high prevalence of teenage pregnancy.

Table.4. 4: Factors contributing to high prevalence of teenage pregnancy

Responses	Frequency	Percentage
lack of parental care and peer pressure	43	86
Cultural beliefs on Sexual and Reproductive Health Issues	45	90
Non-use of contraceptives, desire for a child, forced marriage, low educational level and need for dowries**.**	50	100
Lack of communication and supervision on Reproductive Health Services among Teenagers	47	94
Socio-economic Status of the Family and Income Inequality	37	74
Sexual Behaviour and Religious Commitment	25	50

Source: field work 2021

Majority (58%) of the respondents had poor knowledge of teenage sexual and reproductive health, while 22% of the respondents had good knowledge of teenage sexual and reproductive health and 20% of the respondents had moderate knowledge of teenage sexual and reproductive health.

Table 4. 5: Respondents Level of awareness on Sexual and Reproductive Health among Teenage

Responses	Frequency	Percentage
Good knowledge	11	22
Moderate knowledge	10	20
Poor knowledge	29	58
Total	**50**	**100**

Source: field work 2021

4.9 Responses on whether girls can get pregnant on first sexual intercourse.

Majority (54%) of the respondents said that they cannot get pregnant on first sexual intercourse while the rest (46%) of the respondents said that they can get pregnant on first sexual intercourse.

Table.4. 6: Responses on whether Girls can get pregnant on first sexual intercourse.

Responses	Frequency	Percentage
Yes	23	46
No	27	54
Total	**50**	**100**

Source: field work 2021

4.10 Consequences of Early Pregnancy

A greater number (40%) of the respondents had a good knowledge of the consequences of early pregnancy among teenagers, 36% of the respondents had moderate knowledge of the consequences of early pregnancy among teenagers,

while the rest (24%) of the respondents had poor knowledge of the consequences of early pregnancy among teenagers.

Table.4. 7: Level of knowledge on the Consequences of Early Pregnancy among Teenage

Responses	Frequency	Percentage
Good knowledge	20	40
Moderate knowledge	18	36
Poor knowledge	12	24
Total	**50**	**100**

Source: field work 2021

4.11 Knowledge on Contraceptive Methods

Majority (52%) of the respondents had poor knowledge of the contraceptive methods available**,** 28% of the respondents had moderate knowledge of the contraceptive methods available, while the rest (20%) of the respondents had good knowledge of the contraceptive methods available.

Table 4. 8: Respondents Knowledge on Contraceptive Methods

Responses	Frequency	Percentage
Good knowledge	10	20
Moderate knowledge	14	28
Poor knowledge	26	52
Total	**50**	**100**

Source: field work 2021

4.12 Knowledge on how to avoid pregnancy

With regards to the knowledge on how teenagers can avoid getting pregnant, the responses are as shown in Table 7. Majority (30%) of the respondents said that they could use Condom to prevent getting the girl pregnant, 18% of the respondents said that they could make sure that the girl takes pills to prevent pregnancy, 14% of the respondents said that they could abstain to prevent pregnancy, 6% the respondents said that they could withdraw their penis before ejaculation to prevent pregnancy, while the rest (4%) the respondents said that they could respect the girl's unsafe days for having sex to prevent pregnancy. However, 28% of the respondents were uncertain.

Table.4. 9: Respondents' Knowledge on how to avoid pregnancy

Responses	Frequency	Percentage
Use a Condom	15	30
Withdraw the penis before ejaculation	3	6
Make sure that the girl takes pills	9	18
Respect the girl's unsafe days for having sex	2	4
Do not know	14	28
Abstain	7	14
Total	50	100

Source: field work 2021

4.13 The relationship between methods of contraceptives and awareness on teenage pregnancy

It was necessary to test if there is any relationship between knowledge on methods of contraceptives and awareness on teenage pregnancy. It was realized from the study that majority (53%) of the respondents had poor knowledge on the method of contraceptives and were aware of teenage pregnancy, 26% of the respondents had moderate knowledge on the method of contraceptives and were aware of teenage pregnancy while the rest (21%) of the respondents had good knowledge on the method of contraceptives and are aware of teenage pregnancy.

On the other hand, 67% of the respondents had poor knowledge on the method of contraceptives but were not aware of teenage pregnancy while the rest (33%) of the respondents had good knowledge on the method of contraceptives but were not aware of teenage pregnancy.

Table.4.10: The relationship between methods of contraceptives and awareness on teenage pregnancy

		Awareness on teenage pregnancy					
		Aware		Not Aware		Total	
		No.	%	No	%	No	%
Knowledge on methods of contraceptives	Poor Knowledge	25	53	2	0.67	27	54
	Moderate knowledge	12	26	0	-	12	24

	Good knowledge	**10**	**21**	**1**	**0.33**	**11**	**22**
	Total	**47**		**3**		**50**	**100**

Source: field work 2021

4.14 Accessibility to reproductive health services among teenage

To assess accessibility of reproductive health services among teenagers, questions were asked to assess whether teenagers have access to reproductive health services or not. Majority (68%) of the respondents said they could not access reproductive health services, due to the culture and the beliefs in the community, comparing to 32% of the respondents who could access reproductive health services.

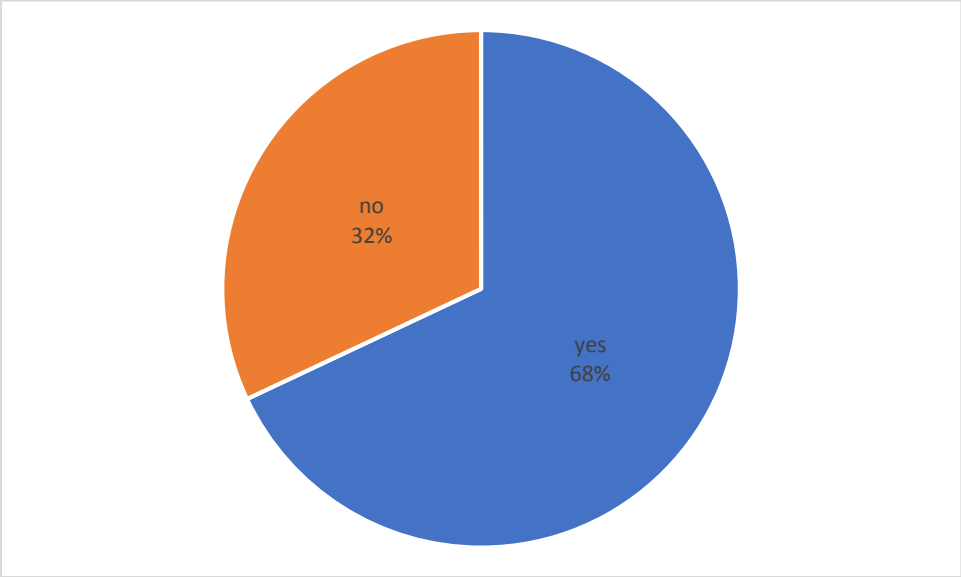

Figure.4. 3: Accessibility to reproductive health services among teenagers

Source: field work 2021

4.15 Source of information about contraceptives and reproductive health services

Concerning where the respondents received their knowledge about contraceptives and reproductive health services, majority (38%) of the respondents said they had their education from their friends, 32% of the respondents said they had their education from health workers, 26% of the respondents said they had their education from the Media, while the rest (4%) of the respondents said they had their education from their family.

Table.4. 11: Source of information about contraceptives and reproductive health services

Responses	Frequency	Percentage
Friends	19	38
Health workers	26	32
Media	13	26
Family	2	4
Total	**50**	**100**

Source: field work 2021

4.16 Teenagers' preference for advice on sexual and reproductive health services

Majority (50%) of the respondents preferred to receive their education on sexual and reproductive health services from health workers, 30% of the respondents preferred to receive their education on sexual and reproductive health services from their teachers, 24% of the respondents preferred to receive their education on sexual and reproductive health services from their friends, while the rest

(16%) of the respondents preferred to receive their education on sexual and reproductive health services from their family.

Table.4. 12: Teenager preference for advice on sexual and reproductive health services

Responses	Frequency	Percentage
Friends	12	24
Health workers	25	50
Teachers	15	30
Family	8	16
Total	**50**	**100**

Source: field work 2021

4.17 Reasons hindering teenagers' accessibility to reproductive health services

Teenagers were asked to mention the reasons that hinder them from getting the advice or help that they needed concerning sexual and reproductive health services. Respondents had the opportunity to mention more than one option provided. From their responses; all (100%) the respondents did not know where to go for health and reproductive education; 98% of the respondents feel ashamed to go for health and reproductive education; 70% of the respondents felt they would be embarrassed by service provider; 56% of the respondents were afraid of their parents, while 42% of the respondents would not access the health and reproductive service, due to fear of their religious leaders.

Table.4. 13: Reasons hindering teenager accessibility to the reproduction health services

Reasons	Frequency	Percentage
Embarrassment from service providers	35	70
Feel ashamed	49	98
Don't know where to go	50	100
Fear of parents/ guardians	28	56
Fear of religious leaders	21	42

Source: field work 2021

4.18 Suggestion to Ways to Reduce Teenage Pregnancy

Majority (84%) of the respondents suggested that sexual and reproductive health should be intensively integrated into school curriculum and adult education programmes. 80% of the respondents suggested that there should be a specific day for conducting sexual and reproductive health education in the community, 78% of the respondents suggested that parents should support and give advice to their children about sexual and reproductive health education. 68% of the respondents suggested that contraceptive services should be provided in confidential way, while 66% of the respondents suggested the preparation and supply informative and Communication materials i.e. Posters, leaflets etc.

Table.4. 14: Suggestion to ways to reduce teenage pregnancy

Suggestions	Frequency	Percentage
There should be a specific day for conducting sexual and reproductive health education in the community.	**40**	**80**
Sexual and reproductive health should be intensively integrated into school curriculum and adult education programmes.	**42**	**84**
Prepare and supply Informative and Communication materials i.e. Posters, leaflets etc.	**33**	**66**
Contraceptive services should be provided in confidential way.	**34**	**68**
Parents should support and give advice to their children about sexual and reproductive health education.	**39**	**78**

Source: field work 2021

4.19 Any obstacles, which hinder teenagers to utilize sexual and reproductive health services

On exploring whether there were any obstacles which hinder teenagers to utilize sexual and reproductive health services, majority of participants commented that the system of providing sexual and reproductive health services make the teenagers to hesitate to use the services. There is no confidentiality as there is no separation of the teenagers and the adults. However, some of the service providers do not like to provide the services to the teenagers and do not use

polite language. One of the participants said that clinics that provide reproductive and health services are opened and closed at the time they were at school. It is also very difficult to access the service even if you go early during office hours as you meet with other customers of different age groups among of them are relatives i.e., mothers and sisters who restrict them to access the service. It becomes very difficult to join queues and wait for the services. The researcher continued to explore if there are other reasons that hinder teenagers to utilize the available services. Among the reasons mentioned were using contraceptives such as pills or injectables might cause sterility thus once one uses contraceptives, she will never conceive the time she would wish to conceive in future. Parents and the community have negative perceptions towards the use of contraceptives especially to the teenagers. They think that those who use contraceptives are prostitutes.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This section provides the summary to the findings of the study, conclusions drawn from findings and recommendations based on the findings against the backdrop of the key study variables. Also, features the conclusions drawn from the study, as well as recommendations, both for policy formulation and suggestions for further research.

5.2 Summary

The study examines the factors contributing to high prevalence of teenage pregnancy in the Ga Mantse community Accra. However, the following specific objectives were achieved;

1. Identified the cause and consequences of teenage pregnancy in the Ga Mantse community, Accra.
2. Ascertained the level of awareness of reproductive health among teenagers in the Ga Mantse community, Accra.
3. Examined the relationship between methods of contraceptives and awareness on teenage pregnancy.
4. Suggested Strategies to reduce teenage pregnancy in the Ga Mantse community, Accra.

To facilitate the research and investigate the problems identified in the study, four research questions were used to gather, discuss and analyze data; the literature reviewed relevant to the study provided guidelines and laid the

background to the study. Descriptive survey design method and quantitative approach were used to collect data. To achieve this purpose, structured questionnaires were used to collect data from respondents. In the study, 50 copies of questionnaires were administered to the respondents, all were retrieved which were duly completed giving rise to a response rate of 100%. Descriptive and inferential statistics were used to analyze the data and then presented as mean, frequencies and percentages. The data was analyzed with the aid of an Excel sheet.

5.3 Major findings

It was realized from the study that inadequate knowledge on sexual and reproductive health leads to the possibility of teenagers to become pregnant if not provided with comprehensive sexual and reproductive health information at earlier ages. This can help the teenagers so that by the time they are initiating sexual activities, they are in a position to make informed decisions. Information can equip them with skills so as to be able to differentiate between accurate and inaccurate information. It can help them to handle situations of unwanted sexual advances and useful relationship skills such as communication, negotiation, listening and decision-making. They can discuss a range of moral and social issues and perspectives on sex and contraception.

Again it was realized that peer pressure and economic challenges were some of the factors contributing to high rate of teenage pregnancy at Ga Mantse communities in Greater region; this is explained by the Social Learning theory (Banduras, 1977), it suggests that behaviors are learned and that they are influenced by social context; the media and more so, television is seen as an increasingly influential agent of socialization that produces its effects through

teenagers' propensity to learn by imitation. Further it was realized that the respondents were faced with different demand to support day-to-day life thus needs financial assistance to basic needs such as clothes, body makeup, entertainment, etc, hence the need to be supported by parents, guardians or close relatives. The absences of support from parents compel them to find support outside their parents and consequently, they engage in sexual activities in return for gifts or assistance received. According to Acharya et al., (2010) stated that socio-economic status, educational attainment, cultural factor and family structure were all identified as risk factors for teenage pregnancies.

The study also revealed that teenagers encounter multiple barriers to access sexual and reproductive health information. Some information obtained from media does not equip them with adequate knowledge on sexual and reproductive health. These are not enough, clear and understandable to most of teenagers, rather they create misconceptions. . These results confirm a study conducted by Ruto (1999) in Kenya, which was evidenced that parents and adults do not give teenagers information on sex and contraception, because it is not considered culturally appropriate, hence they turn to their peers who give them inappropriate and/or inaccurate advice

It was realized that the increasing problem of teenage pregnancy in the Ga Mantse community, Accra, could have been attributed to lack of proper information among teenagers. Regardless of the initiatives done by the authority (Municipality) in cooperation with different NGOs to distribute reproductive health materials which provide information to teenagers about sexual and reproductive health services still the problem exists.

It was realized that despite inadequate information on sexual and reproductive health services among the teenagers, those who need the services are not still able to access them. Majority do not know where to go for the services, pressure from the community, family, friends, unwillingness of some service providers to provide service to the teenagers, lack of motivation and beliefs.

The findings show that majority of the teenagers interviewed do not know where to go for sexual and reproductive health services, embarrassment from service providers, fear of being noticed by their parents/guardians, fear of being told off and fear of religious leaders.

5.4 Conclusions

Generally, the findings from the study revealed that sexual and reproductive health services for teenagers are surrounded by stigma especially among parents, community leaders and religious leaders as well as the service providers. Such environment has been contributing to lack of knowledge and skills about reproductive health hence they engage in sexual activity without making informed decision. There is no doubt that if this situation continues the problem of teenage pregnancy might persist. For that reason, there is a need to conduct sensitization to the parents, members of the family, influential leaders and the community at large on the impact of teenage pregnancy. Knowledge on contraceptive methods is still low. It shows some factors contribute to high prevalence of teenage pregnancy which have been identified were negative beliefs about the uses of family planning and reproductive services, inadequate information on sexuality, unavailability of teenagers' friendly services, culture that hinder parents to talk with the teenagers about sexual matters.

5.5 Recommendations

From the research findings and the conclusion above, the following recommendations are crucial.

Government and the local authority should advocate for youth friendly health services and support the introduction of life-skills education for girls and boys both in and out of school.

The local authority should ensure girls have the opportunity and are actively encouraged to continue with their education if they become pregnant while still at school.

The assembly should introduce youth-friendly health services throughout the district and should ensure that all health facilities provide supportive and quality reproductive health services to teenagers so that they feel comfortable and confident about expressing their concerns in relation to reproductive health.

The Non-governmental and Civil Society Organizations should support community-based programmes that empower teenage girls to protect themselves and enable them to continue their education if they become pregnant while still at school.

The Ministry of Health and Social Welfare and Ministry of Education should establish an approach which is more holistic to equipping the teenagers with appropriate knowledge on sexuality, access to sexual and reproductive health services rather than traditional coaching approaches that focus upon improving sexual ability, attitudes and norms.

Ministry of Health in collaboration with Ministry of Education should strengthen reproductive health education programs in school and out of the schools that promote communication skills among teenagers.

The Media Should produce features and editorials on the importance of ensuring all young Ghanaians to have access to advice on reproductive health and the means to prevent unwanted pregnancy through life skills education and youth friendly health services.

5.6 Further Research

More studies should be conducted on the contribution of social media on the high prevalence of teenage pregnancy. Further study with similar nature should be conducted on how the foundation of faith and ethics can contribute to the reduction of teenage pregnancy

APPENDICES

QUESTIONNAIRE

FACTORS CONTRIBUTING TO HIGH PREVALENCE OF TEENAGE PREGNANCY: A CASE STUDY OF THE GA MANTSE COMMUNITY, ACCRA.

Introduction

I am ……., a final student at Central University, Accra. I will be conducting several meetings with people like you in Ga Mantse community, Accra, to find out your views and ideas about adolescent pregnancy. Whatever you say will be treated as confidential, so feel at ease to express your candid opinion. Be assured that your responses will not in any way be linked to your identity. Please, be assured that this study is for academic purposes and your confidentiality is guaranteed. Thank you for your understanding.

SECTION A: DEMOGRAPHICS

1. Age ……in completed years

2. Level of highest formal education

1) No education ( ) 2) Primary ( ) 3) Junior High School ( ) Senior High School ( ) 5) Tertiary ( )

3. Which religion do you belong to?

1) Islam ( ) 2) Christianity ( ) 3) Traditional ( ) 4) Others (specify) …… 4. What is your occupation?

1) Fish monger ( ) 2)Unemployed ( ) 3)Self-employed ( ) 4) Apprentice ( )

5) Schooling ( ) 6) Others (specify) ……

5. What is your marital status?

1) Single ( ) 2) Married ( ) 3) Divorced ( ) 4) Cohabiting ( )

5) Separated ( )

5i. If married, at what age …….

SECTION B: ADOLESCENT-PARENT RELATIONSHIP

6. Who were you staying with?

1) Father ( ) 2) Mother ( ) 3) Both Parents ( ) 4) others (specify)

…… 6i. If not staying with parents, why?

……

7. What is your father's / male guardian's level of education?

1) No education ( ) 2) Primary ( ) 3) Junior High School ( )

4) Senior High School ( ) 5) Tertiary ( )

8. What is your father's /male guardian's occupation?

1) Farmer ( ) 2) civil/public servant ( ) 3) Trader ( ) 4) Unemployed ( )

5) Others (specify) ……

9. What is your mother's / female guardian's level of education?

1) No education ( ) 2) Primary ( ) 3) Junior High School ( )

4) Senior High School ( ) 5) Tertiary ( )

10. What is your mothers' /female guardian's occupation?

1) Farmer ( ) 2) civil/public servant ( ) 3) Trader ( ) 4) Unemployed ( )

5) Others (specify) ……

11. Has any of your parents/guardians discussed issues about sex and or pregnancy with you before

1) Yes ( ) 2) No ( )

11i. If yes, how often …….

12. Has any of your parents/guardians discussed issues about contraceptives with you before?

1) Yes ( ) 2) No ( )

13. Do any of your guardians use alcohol/Cigarette/Indian Hemp?

1) Yes ( ) 2) No ( )

14) Is it a concern to your guardians when you are not at home late into the night?

1) Yes ( ) 2) No ( )

15. What is the view of your guardians towards boy-girl relationship?

1) Considerate ( ) 2) Indifferent ( ) 3) Violent ( ) 4) Any Others (specify) ……

16. Has any of your parents/guardians made a material request (money, clothing, food, etc) from you before?

1) Yes ( ) 2) No ( )

17. Has any of your guardian(s) directed you to go for your needs from a man or stranger to the family before?

1) Yes ( ) 2) No ( )

SECTION C: KNOWLEDGE AND USE OF CONTRACEPTIVES

17. Have you heard about preventing, limiting or spacing of pregnancy before?

1) Yes ( ) 2) No ( )

18. Did you know of any way of preventing, limiting, or spacing of pregnancy?

1) Yes ( ) 2) No ( )

19. Can you name any of the ways/methods in number 12 you know of?

1) Condoms ( ) 2) Injectable ( ) 3) Pills ( ) 4) Intra Uterine Device ( ) 5) Withdrawal ( ) Any other, please specify ……

(Tick as many as applicable)

20. Did you know of how to use any of the contraceptive method you know of (If applicable)?

1) Yes ( ) 2) No ( )

20i) Have you ever used any contraceptive method? 1) Yes ( ) 2) No ( )

If yes, which type ……..

If No and sexually active please state reason(s)? ……

SECTION D: SEXUAL AND REPRODUCTIVE HISTORY

21. Are you sexually active? 1) Yes ( ) 2) No ( )

21i) At which age did you experience your first sexual encounter (If applicable)?

ii) Was it consensual or forced? …….

iii) Who was involved? a) Teacher ( ) b) Close Relative ( ) c) Stranger ( )

d) Any other specify ……

iv) Were you married? 1) Yes ( ) 2) No ( )

v) Was any contraceptive method used during that first sexual experience? 1) Yes ( ) 2) No ( )

22. Have you ever been pregnant? 1) Yes ( ) 2) No ( )

If Yes to Q22, how old were you by then? …….

If Yes to Q22, what was the outcome of the pregnancy?

1) A live birth ( ) 2) A stillbirth ( ) 3) An abortion ( ) 4) Any other specify …….

23) Were you under the influence of alcohol/drug during any of your sexual encounter?

1) Yes ( ) 2) No ( )

24) Have you ever had an alcoholic drink? 1) Yes ( ) 2) No ( )

SECTION E: PEER RELATIONSHIP

25) How many friends/peers do you have?

1) One ( ) 2) Between 1 and 10 ( ) 3) More than 10 ( )

26. How many of your peers are/Have been pregnant before?

1) None ( ) 2) One ( ) 3)Two ( ) 4) Three ( ) 5) More than three ( )

27. What would be the reaction of your best friend if you told her, you were pregnant?

1) Happy ( ) 2) Sad ( ) 3) Disappointed ( ) 4) Any other specify ……..

28. What would be the first advice your friend would give if you were pregnant?

1) Encourage me to deliver ( ) 2) Encourage me to abort ( ) 3) Any other specify …….

29. How does your friend's opinion influence your sexual life style, for example relationship?

1) Strongly ( ) 2) Moderately ( ) 3) Weakly ( ) 4) Not at all ( )

30. Has any of your friends advised you on contraceptive before? 1) Yes ( ) 2) No ( )

31) How many of your friends are in sexual relationship?

1) One ( ) 2) Two ( ) 3) Three ( ) 4) More than three ( ) 5) None ( )

32) What would be your advice to a friend who is pregnant?

1) Encourage her to deliver ( ) 2) Encourage her to abort ( ) 3) Any other specify …….

33. What are the challenges or consequences of teenage pregnancy?

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Thank you for your participation.

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