UNIVERSITY OF CAPE COAST

TEENAGE PREGNANCY IN THE ASSIN-SOUTH DISTRICT

MICHAEL OWUSU

2011

UNIVERSITY OF CAPE COAST

TEENAGE PREGNANCY IN THE ASSIN-SOUTH DISTRICT

BY

MICHAEL OWUSU

DISSERTATION SUBMITTED TO THE INSTITUTE FOR DEVELOPMENT STUDIES OF THE FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF CAPE COAST IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR AWARD OF MASTER OF ARTS DEGREE IN DEMOCRACY, GOVERNANCE AND LAW

JANUARY, 2011

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: .....

Name: Michael Owusu

Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the University of Cape Coast.

Supervisor's Signature: ..... Date: .....

Name: Dr. Akwasi Kumi-Kyereme

ABSTRACT

Teenage pregnancy is a social problem that affects the social well-being of teenagers. Prevention of teenage pregnancy will help to improve the livelihood of teenagers and reduce the prevalence of some social vices in Ghana. This study sought to investigate the causes and consequences of teenage pregnancy in Assin-South District. Ninety pregnant teenagers or teenage mothers, 6 Head of Health Directorate and 6 Traditional Birth Attendants were interviewed for the study. Both in-depth interview guide and interview schedules were used to collect data from the field. Snow-ball and purposive sampling techniques were used to select respondents for the study.

The main findings of the study were as follows. Assin-South District has an inconsistent trend of teenage pregnancy. Teenage pregnancies are mainly caused by inadequate knowledge on contraceptives, peer pressure, low level of education, poverty and early marriage. School drop-outs, unemployment and single parenting are the predominant consequences of teenage pregnancy.

It is therefore recommended that Assin South District Health Directorate should provide much education on the use of contraceptives to teenagers in the district. The Assin South District Assembly should establish technical and vocational training centres to train teenage mothers to acquire artisanal skills for living, and parents must give priority to girl child education to limit early marriage and peer pressure influence.

ACKNOWLEDGEMENTS

I want to acknowledge every person who has contributed in diverse ways for the successful completion of this dissertation. I am deeply grateful to my supervisor, Dr. Akwasi Kumi-Kyereme for his guidance and useful suggestions. I am also grateful to Prof. Dominic K. Fobi for helping me to begin my academic career.

I wish to register my profound gratitude to Mr. Anthony Atta-Bosompem of the Development office, University of Cape Coast and Lawyer Kwadwo Addo Tuffour of Institute for Development Studies, University of Cape Coast for their kind support and advice. Special thanks go to Danquah-Smith (Butey) of Assin Foso and the late Mr. Andoh and wife (Abena Asiamaa) of Assin Takai. I am also thankful to Alex Adjei, Philip Twum-Barima, Emmanuel Dzahene and the entire Assin South District Health Management Team for their support. Finally, all my fellow graduate students and friends who assisted me in this study especially Collins Adjei Mensah and Naomi Effah, I say thank you very much for all that you have done for me.

DEDICATION

To my beautiful wife Celestina Amo-Broni, my mother Adwoa Wuo and my children.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

BECE	Basic Education Certificate Examination
EC	European Commission
GDHS	Ghana Demographic and Health Survey
GSS	Ghana Statistical Service
GYRHS	Ghana Youth Reproductive Health Survey
HDS	Health and Demographic Survey
IDI	In-depth Interview
JHS	Junior High School
SHS	Senior High School
SPSS	Statistical Product and Service Solution
TBAs	Traditional Birth Attendants
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the study

Teenage pregnancy is one of the social issues which has received much attention in the world. In United States, teenage pregnancy has an abstract meaning. It means, an under-aged girl becoming pregnant. The definition gets more specific in the United Kingdom (UK). In UK, if a girl before her 18th birthday becomes pregnant, then she will be called a teenage pregnant girl. In general the term is applicable to all those women who have not reached an age of majority, legal adulthood and is pregnant. This particular margin of being an adult woman varies from one place to another. Teenage pregnancy is a social issue in developed countries.

This is as a result of low educational levels and higher rates of poverty. In general, teenage pregnancy in developed countries takes place outside marriage. Young girls who indulge in teenage pregnancy cannot be responsible for it carry a social stigma in their various communities and cultures (Population Council, 2006). On the contrary in the developing world, teenage pregnancy is usually within marriage and thus socially accepted without any social stigma (Population Council, 2006).

The prevalence of teenage pregnancy has become very common in the Ghanaian society, especially among youth who are at the Primary and Junior High School (JHS) levels of education (Kunateh, 2009). During the 2009 Basic Education Certificate Examination (BECE), two teenage pregnant mothers were among the thousands of candidates that took their examinations in the Ho municipality in the Volta Region. The pupils had no choice than to take their pregnancies to the examination centres to write their final examinations. One of the victims was 13 years and the other 15, and they were all determined to write and pass the examinations (Kunateh, 2009).

Teenage pregnancy is caused by a lot of factors. According to Amoako (2005) the major contributing factor to teenage pregnancy is poverty. Many children in Ghana are victims of teenage pregnancy just because their parents do not have enough money to support their education or even provide three square meals for the family. Based on this, they are forced to engage in premature sex to earn some money to support their education or even provide three square meals for the family. Many other children also involve themselves in premarital sex because of their curiosity. It is a common knowledge that teen years present such a person with various challenges relation to sex. A few teenagers are able to overcome the challenges but in most cases, many of them fall into it (Amoako, 2005).

In most Ghanaian communities, children are not allowed to discuss sex issues openly, unlike the olden days when they received sex education through the performance of puberty rites. In contemporary times due to urbanization and

industrialization, these rites are seldom performed in addition to lack of parental guidance. At present, the only form of education these teenagers have from their parents or guardians is a warning to refrain from sex while the required parental guidance and discipline of adolescents is relinquished to teachers at school (Keller, Hilton & Twumasi-Ankrah, 1999).

Peer pressure is also another important factor that influences many adolescents to indulge themselves into premarital sex leading to teenage pregnancy. A study conducted by Afenyadu and Goparadu (2003) identified peer pressure influence as one of the very important factors driving the sexual behaviour of many male and female adolescents in the Dodowa community. The study also found out that six (6) out of every ten (10) teenage sexual activity might be due to peer pressure. The literature on adolescent sexuality shows that, regarding outcomes from sexual relations, pregnancy is often the primary issue to adolescents. The problems teenage mothers face appear to be more associated with the social context in which pregnancy occurs, rather than solely the number of teenagers having sex.

Statement of Problem

Teenage pregnancy and the consequent teen motherhood are among the major societal problems confronting the contemporary global community and Ghana is no exception. In Sub-Saharan Africa the issue of teenage pregnancy is very worrying. The regional average rate of births per 1000 females 15–19 years of age is 143, ranging between 45 in Mauritius to 229 in Guinea. This is very high

compared to the world average of 65. In some sub-Saharan African countries, one in five adolescent females gives birth each year. In some African countries 30–40 percent of all adolescent females experience motherhood before the age of 18 (Senanayake & Ladjali, 1994).

In Ghana, one report estimates that nearly one-third of the childbirths recorded in public hospitals occurred to women less than 19 years of age (Xinhua as cited in Keller, Hilton & Twumasi-Ankrah, 1999). The situation is worse in the rural areas and small-to medium-sized towns which are often under-represented in the hospital birth statistics. A survey conducted by the UN Regional Institute for Population Studies reported that aside being noted for its high maternal deaths, teenage pregnancy is also a worrying issue in the Central Region of Ghana, a factor that contributes to high maternal death rate in the region. One out of three girls aged 15 to 19 living in the region have had a child. In 2008, the Central Region's fertility rate was 5.4 percent, compared to the national fertility rate of 4.0 percent (Ghana Statistical Service, 2009).

A report by the Central Region Health directorate confirms that teenage pregnancy in the Region is very high. According to the report, teenage pregnancy especially among teenagers between the ages of 15-19 years was 14.7 percent between 2008 and 2009 (Asiedu-Addo, 2010).

Acknowledging the problem of teenage pregnancy, government, NGOs, and other interest groups have made efforts to arrest or alleviate the situation. Based on this, some projects have been initiated. For example, the Central Regional Health Directorate in partnership with the European Commission (EC)

and United Nations Population Fund (UNFPA) implemented a project dubbed "towards strengthening community-based Reproductive Health Services" in the region. Among the districts that the project covered was the Assin South District. One essential component of the project was to reduce the level of teenage pregnancies in the region (Nyame, 2009).

Despite these efforts, teenage pregnancy is still high in Central Region particularly Assin South district. For example, teenage pregnancy has affected youth development in Assin South, thereby denying the district of the needed manpower who would have contributed to the social, economic and political development of the district. It is in the light of this that this research is undertaken to investigate the causes and consequences of the teenage pregnancy menace in the Assin South District.

Objectives of the study

The main objective of this study is to investigate the causes and effects of teenage pregnancy in the Assin South District in the Central Region.

The specific objectives for the study were to:

- Investigate the factors accounting for teenage pregnancy in the district.
- Examine the trend of teenage pregnancy in the Assin South District.
- Assess the consequences of teenage pregnancy.

Research questions

- Is poverty a cause of teenage pregnancy?

- What is the trend of teenage pregnancy in the Assin South District?
- What are the consequences of teenage pregnancy?

Rationale for the study

Data supporting teenage pregnancy as a social issue in Ghana include lower educational levels, higher rates of poverty, and other poorer "life outcomes" in children of teenage mothers. Teenage pregnancy in the country carries a social stigma in the communities. For example, pregnant teenagers are often laughed at and seen as bad people. For these reasons, there have been many studies and campaigns which attempt to uncover the causes and limit the numbers of teenage pregnancies.

The study will investigate area-specific causes and consequences of teenage pregnancy and the researcher hopes this will help the appropriate authorities like the District Health Directorate make right decisions to deal with teenage pregnancy in the area. It is hoped that the study will add to existing knowledge and also form the basis for further research on teenage pregnancy.

Organisation of the study

The study is organized into five chapters. Chapter one contains the background to the study, statement of the problem, research questions, the objectives of the study and the rational for the study. Chapter two reviews relevant literature related to the study, and the conceptual framework for the study.

Chapter three describes the study design, target population, sampling procedure, sample size, the research instrument used, data and sources, data processing and analysis, and the ethical issues arising from the research. Chapter Four concerns itself with data analysis, and presentation and discussion of results while Chapter Five provides the summary, conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews available and relevant literature that informs the study. The chapter discusses issues relating to current levels of teenage pregnancy as well as the causes, and consequences associated with teenage pregnancy. The conceptual framework for the study is also discussed.

Incidence of teenage pregnancy

A report by Save the Children non-governmental organization found that annually, 13 million children are born to women under age 19 worldwide, more than 90 percent in developing countries (Therese, 2000). Complications of pregnancy and childbirth are the leading cause of mortality among women between the ages of 15 and 19 in such areas. The highest rate of teenage pregnancy in the world is in sub-Saharan Africa, where women tend to marry at an early age. In Niger, for example, 87 percent of women surveyed were married and 53 percent had given birth to a child before the age of 18 (Therese, 2000).

In the Indian subcontinent, early marriage sometimes means adolescent pregnancy, particularly in rural regions where the rate is much higher than it is in

urbanized areas. According to Mehta, Groenen and Roque (1998), the rate of early marriage and pregnancy has decreased sharply in Indonesia and Malaysia, although it remains relatively high. In the industrialized Asian nations such as South Korea and Singapore, teenage birth rates are among the lowest in the world.

UNICEF (2001) observed that in Europe since 1970 the overall trend has been a decreasing total fertility rate, an increase in the age at which women experience their first birth, and a decrease in the number of births among teenagers. Most continental Western European countries have very low teenage birth rates. This is varyingly attributed to good sex education and high levels of contraceptive use. In the case of the Netherlands and Scandinavia, Italy, Spain and Switzerland the low rate of teenage pregnancy is as a result traditional values and social stigmatisation.

The teenage birth rate in the USA is the highest in the developed world in addition to teenage abortion (UNICEF, 2001). The teenage pregnancy rate in the USA was at a high in the 1950s and has decreased since then, although there has been an increase in births out of wedlock. The teenage pregnancy rate decreased significantly in the 1990s; this decline manifested across all racial groups, although teenagers of African-American and Hispanic descent remain a higher rate, in comparison to that of European-American and Asian-Americans. Rebecca (2004) attributed about twenty five percent (25%) of the decline to abstinence and seventy five percent (75%) to the effective use of contraceptive. However, in 2006, the teenage birth rate rose for the first time in fourteen years. This could imply that teenage pregnancy rate are also on the rise, however the rise could also

be due to other sources: a possible decrease in the number of abortions or a decrease in the number of miscarriages, to name a few. The Canadian teenage birth according to Dryburgh (2002) has also trended towards a steady decline for both younger (15-17) and older (18-19) teens in the period 1992-2002.

In Ghana, pregnancies involving women under the age of 18 years entail risks to the mother and the child. Women who get pregnant at a younger age are more likely to have prolonged and obstructed labour. They are also more likely to delay seeking necessary prenatal care due to the shame and stigmatization associated with early pregnancy. In the 1998 Ghana Demographic Health Survey (GDHS), about eighty percent (80%) of the females could not/did not seek prenatal care. Out of the eighty percent (80%) females, females aged less than 20 years constituted the majority with females aged 35 years and above constituting less. The 2008 GDHS however revealed that teenage mothers who receive antenatal care have increased to 97 percent but some teenagers still do not receive antenatal care (Ghana Statistical Service, 2009). On the average, teenage mothers experience higher levels of morbidity and mortality than children of older women. Some young girls who get pregnant may seek unsafe abortions for several reasons (Ghana Statistical Service, 2009).

Among the reasons given are that the pregnancy may be unplanned, the partner may disown the pregnancy, pressure from parents and/or the male partner, financial problems, for fear of social sanctions and shame associated with premarital sex and pregnancy. Teenagers may not seek treatment for post-abortion complications until their situation has worsened because of the cost involved, fear

of the implications of reporting an abortion and lack of information about health services. Some of the outcomes of post-abortion complications are infertility and, in extreme cases, death. Beyond the physical problems, there is post-abortion trauma which needs to be recognized and treated (Ghana Statistical Service, 1998).

Causes of teenage pregnancy

Many factors have been found as the main causes of teenage pregnancy. Among these factors are early marriage, adolescent sexual behaviour, peer pressure influence, uncontrolled sex feelings, contraception, age discrepancy in relationships, sexual abuse, socio-economic factors and childhood environment.

In some societies, early marriage and traditional gender roles are important factors in contributing to the rate of teenage pregnancy. According to Therese (2000), in some sub-Saharan African and other African countries, early pregnancy is often seen as a blessing because it is proof of the young woman's fertility. This is because in most societies sterility is viewed with contempt and shame, therefore, it is desirable for a woman to prove her fertility before the marriage is clinched. Adolescent pregnancy, whether within marriage or not, is therefore accepted by many societies. In Islamic societies the situation is viewed in an entirely different light. Sex before marriage is widely condemned and families are much in favour of very early marriages to avoid pregnancies outside of wedlock. Surveys carried out in some Sahelian countries offer alarming examples. In Niger, for example, according to the 1992 Health and Demographic

Survey (HDS), forty seven percent (47%) of women aged between 20 and 24 were married before the age of 15 and eighty seven percent (87%) before the age of 18, and 53 percent had also had a child before the age of 18 (Therese, 2000).

Mehta et. al. (1998) have also noted that early marriages are more profound in rural areas than in urban areas. They gave an example that in the Indian subcontinent, early marriage and pregnancy is more common in traditional rural communities compared to the rate in cities. In societies where adolescent marriage is uncommon, young age at first intercourse and lack of contraceptive use may be factors in teen pregnancy (Moore, Miller, Sugland, Morrison, Glei & Blumenthal, 2007). In India, although the legal age at marriage is 18 for females and 21 for males, early marriage continues to be the norm (by age 15 as many as twenty six percent (26%) of females are married). By the age of 18 years, this figure rises to fifty four percent (54%). Most reproduction in India occurs within marriage, so the low age at marriage automatically links to early onset of sexual activity, and thereby fertility (Gupta, 2000).

In the Arab world, patterns of early marriage prevail. Marriage often translates into immediate childbearing as women and their families are anxious to prove the fecundity of the newlywed. There is some evidence of a decrease in the prevalence of early marriage, yet for some countries the figures still show that a significant group of females less than 20 years old are married, reaching thirty seven percent (37%) in Oman and nineteen percent (19%) in the United Arab Emirates (Zurayk, Sholkamy, Younis & Khattab, 1997). Most Policy Studies

institutes have observed that teenage pregnancies in the developed world appear to be unplanned (Dryburgh, 2002; Kost, Henshaw & Carlin, 2010).

Adolescent sexual behaviour is one of the key issues that have been found to cause teenage pregnancy. According to information available from Alan Guttmacher Institute (2005), sex by age 20 is the normal age across the world, and countries with low levels of adolescent pregnancy accept sexual relationships among teenagers and provide comprehensive and balanced information about sexuality. However, in a Kaiser Family Foundation (2005) study of U.S teenagers, twenty nine percent (29%) of teens reported feeling pressure to have sex, thirty three (33%) of sexually active teens reported "being in a relationship where they felt things were moving too fast sexually", and twenty four percent (24%) had "done something sexual they did not really wanted to do". Several polls have indicated peer pressure as a factor in encouraging both girls and boys to have sex (Colin, 2003). Inhibition-reducing drugs and alcohol may encourage unintended sexual activity (Waddington, 2007).

A lot of teenagers indulge in early sexual behavior due to peer pressure. Teenagers growing in largely promiscuous societies tend to date far earlier than others in slightly more conventional setups. This is due to the fact that they feel the great need to be 'hip' and 'accepted' by their circle of friends. The only way they could probably achieve that would be by having a boyfriend or girlfriend or at least by dating and indulging in sexual acts often. This kind of rash behavior could lead to unintended pregnancies (Fox, 2010).

Uncontrolled sex feelings by teenagers also cause teenage pregnancy. Most teenagers experience sudden and hitherto unknown emotions and feelings during their early puberty. They feel a natural sense of rebelling against the set norms as well. All this, coupled with a sudden sense of new-found freedom and sexuality, results in many of them giving vent to their feelings through sexual expressions and experiences. Of course, most countries stress on sex education in schools, but yet, some teenagers involve themselves in unsafe sex, which could lead to unwanted pregnancies. This is one of the most vital reasons for teenage pregnancies at this time (Fox, 2010).

Inadequate use of contraceptives causes teenage pregnancy. Adolescents may lack knowledge of, or access to, conventional methods of preventing pregnancy, as they may be too embarrassed or frightened to seek such information (Ferguson, 1997). In other cases, contraception is used, but proves to be inadequate. Inexperienced adolescents may use condoms incorrectly or forget to take oral contraceptives. Besharov and Gardiner (1997) have found out that contraceptive failure rates are higher for teenagers, particularly poor ones, than for older users. Reversible longer term methods such as intrauterine devices, subcutaneous implants, or injections (Depo provera, Combined injectable contraceptive), requires less frequent user action, lasting from a month to years. These may prevent pregnancy more effectively in women who have trouble following routines, including many young women. This simultaneous use of more than one contraceptive measure further decreases the risk of unplanned pregnancy, and if one is a condom barrier method, the transmission of sexually

transmitted disease is also reduced. In Ghana, Results from the 1998 Ghana Youth Reproductive Health Survey (GYRHS) indicated that seventy six percent (76%) of females aged 15–19 and 88 percent males of that age were aware of at least one modern family planning method. Among 12–14-year-olds, thirty three percent (33%) of females and 6 percent of males knew of at least one modern family planning method. Condom was the most reported method known (77% of males and 66% of females knew the method) (Awusabo-Asare, Abane & Kumi-Kyereme, 2004).

Hsu (1996) has found out that teenage pregnancy occurs as a result of age discrepancy in relationships. Studies by Hsu (1996) in the U.S indicate that age discrepancy between the teenage girls and the men who impregnate them is an important contributing factor. According to Hsu, teenage girls in relationships with older boys, and in particular with adult men, are more likely to become pregnant than teenage girls in relationships with boys of their own age. They are also more likely to carry the baby with them rather than have an abortion. A review of Californian's 1990 vital statistics by Hsu (1996) also revealed that men older than high school age fathered seventy seven percent (77%) of all births to high school-aged girls (ages 16-18), and 51 percent of births to junior high school-aged girls (15 and younger). Men over age 25 fathered twice as many children of teenage mothers than boys under age 18, and men over age twenty fathered five times as many children of junior high school-aged girls as did junior high school-aged boys.

A 1992 Washington state study of five hundred and thirty five (535) adolescent mothers found that sixty two percent (62%) of the mothers had a history of being raped or sexually molested by men whose ages averaged 27 years. This study found that, compared with non abused mothers, abused adolescent mothers initiated sex earlier, had sex with much older partners, and engaged in riskier, more frequent, and promiscuous sex. Studies by the Population Reference Bureau and the National Center for Health Statistics found that about two-thirds of children born to teenage girls in the United States are fathered by adult men age 20 or older.

Sexual abuse is one factor that has received a lot of attention in relation to teenage pregnancy all over the world. Studies have found that between 11 and 20 percent of pregnancies in teenagers are direct results of rape, while about sixty percent (60%) of teenage mothers had unwanted sexual experiences preceding their pregnancy. Before age 5, a majority of first-intercourse experiences among females are reported to be non-voluntary. The Guttmacher Institute found that sixty percent (60%) of girls who had sex before age 15 were coerced by males who on average were six years their senior. One in five teenage fathers admitted to forcing girls to have sex with them (Cullinan, 2003).

According to Saewyc, Magee and Pettingell (2004), multiple studies have indicated that there is a strong link between early childhood sexual abuse and subsequently teenage pregnancy in industrialized countries. To them, up to seventy percent (70%) of women who gave birth in their teens were molested as

young girls; by contrast, twenty five percent (25%) for women who did not give birth as teens were not molested.

Boyer and Fine (1992) collected data on the sexual histories of five hundred and thirty five (535) adolescent females in Washington State who were pregnant or had delivered. Of these women, fifty five percent (25%) had (ever) been molested; 42 percent had been the victim of attempted rape; and 44 percent had been raped. Studies done by Kenney, Reinholtz and Angelini (1997) on teenage pregnancy also revealed that sexual abuse as one of the main causes of teenage pregnancy. Out of 900 adolescent females who were engaged in the study by Kenney et al. (1997), almost thirty six percent (36%) reported one or more forms of sexual abuse before age 18, including twenty percent (20%) who had been raped.

In many countries, sexual intercourse between a minor and an adult is not considered consensual under the law because a minor is believed to lack the maturity and competence to make an informed decision to engage in fully consensual sex with an adult (Hsu, 1996). Sex with a minor in developed countries is considered statutory rape, although what constitutes statutory rape differs by jurisdiction (Hsu, 1996).

Socio-economic factors play significant role in teenage pregnancy. Poverty is one socio-economic factor that is associated with increased rates of teenage pregnancy (Besharov & Gardiner, 1997). UNFPA (2003) has emphasized that economically poor countries such as Niger and Bangladesh have far more teenage mothers compared with economically rich countries such as Switzerland

and Japan. Uren, Sheers and Dattani (2007) have also noted that in the UK, about half of all pregnancies of girls under 18 years are concentrated among the thirty percent (30%) of most deprived population, with only fourteen percent (14%) occurring among the least deprived population. In Italy, the teenage birth rate in the well-off central regions is only 3.3 per 1,000 (UNICEF, 2001). There is little evidence to support the common belief that teenage mothers become pregnant to get benefits, welfare and council housing. Most teenagers knew little about housing or financial aid before they got pregnant and what they thought they knew often turned out to be wrong (Policy Studies Institute, 1998).

Diane (1997) confirmed that youth living in poverty have a teen pregnancy rate which is five times above the average rate. Young women from low income families are getting pregnant at a higher rate than those from middle and upper income families. Poverty rates among youth living in large urban centers rose substantially between 1990 and 1995. Social researchers have noted a growing “underclass“ in Canada comprised of individuals who have less and less access to economic security and opportunity. The Canadian Council on Social Development also reports growing income disparities between the poorest and the richest in Canada as a cause of teenage pregnancy.

The environment in which teenagers find themselves can also cause teenage pregnancy. Women exposed to abuse, domestic violence, and family strife in childhood are more likely to become pregnant as teenagers, and the risk of becoming pregnant as a teenager increases with the number of adverse childhood experiences. According to Tamkins (2004), one-third of teenage

pregnancies could be prevented by eliminating exposure to abuse, violence, and family strife. The researchers note that “family dysfunction has enduring and unfavorable health consequences for women during the adolescent years, the childbearing years, and beyond”. When the family environment does not include adverse childhood experiences, becoming pregnant as an adolescent does not appear to raise the likelihood of long-term, negative psychosocial consequences. Studies have also found that boys raised in homes with a battered mother, or who experienced physical violence directly, were significantly more likely to impregnate a girl.

Ellis et. al. (2003) have found that girls whose fathers left the family early in their lives had the highest rates of early sexual activity and pregnancy, such as behavioral problems and life adversity. Early father-absent girls were still about five times more likely in the United States and three times more likely in New Zealand to become pregnant as adolescents than were father-present girls.

Low educational expectations have been pinpointed as a risk factor. A girl is more likely to become a teenage parent if her mother or older sister gave birth in her teens. Majority of respondents in a 1988 Joint Center for Political and Economic Studies survey attributed the occurrence of adolescent pregnancy to a breakdown of communication between parents and child and also to inadequate parental supervision (Allen, Bonell & Strange, 2007).

Foster care youth are more likely than their peers to become pregnant as teenagers. The national Casey Alumni Study, which surveyed foster care alumni from 23 communities across the United States, found the birth rate for girls in

foster care more than double the rate of their peers outside the foster care system. A University of Chicago study of youth transitioning out of foster care in Illinois, Iowa, and Wisconcin found that nearly half of the females had been pregnant by age 19. The Utah Department of Human Services found that girls who had left the foster care system between 1999 and 2004 had a birth rate nearly 3 times the rate for girls in the general population (Uhlich Children's Advantage Network, 2006).

Outcomes of teenage pregnancy

Poor medical outcome is one of the problems that teenage mothers face. Maternal and prenatal health is of particular concern among teens that are pregnant or parenting. The worldwide incidence of premature birth and low birth weight is higher among adolescent mothers. Research indicates that pregnant teens are less likely to receive prenatal care, often seeking it in the third trimester of it all (Makinson, 1985). Report by the Alan Guttmacher Institute (1999) indicated that one-third of pregnant teens receive insufficient prenatal care and that their children are more likely to suffer from health issues in childhood or be hospitalized than those born to older women. However, studies by Raatikainen, Heiskanen, Verkasalo and Heinonen (2006) revealed that young mothers who are given high-quality maternity care have significantly healthier babies than those that do not. Many of the health-issues associated with teenage mothers, many of whom do not have health insurance, appear to result from lack of access to high-quality medical care. Many pregnant teens are subject to nutritional deficiencies from poor eating habits common in adolescence, including attempts to lose weight

through dieting, skipping meals, food faddism, snacking, and consumption of fast food (Gutierrez & King, 1993).

Peña, Sánchez and Solano (2003) have confirmed that inadequate nutrition during pregnancy is an even more marked problem among teenagers in developing countries. Complications of pregnancy result in the deaths of an estimated 70,000 teen girls in developing countries each year. Young mothers and their babies are also at greater risk of contracting HIV. The World Health Organization (WHO) estimates that the risk of death following pregnancy is twice as great for women between 15 and 19 years than for those between the ages of 20 and 24 years. The maternal mortality rate can be up to five times higher for girls aged between 10 and 14 years than for women of about twenty years of age. Illegal abortion also holds many risks for teenage girls in areas such as sub-Saharan Africa.

In addition to this, risks for medical complications are greater for girls 14 years of age and younger, as an underdeveloped pelvis can lead to difficulties in childbirth. Obstructed labour is normally dealt with by Caesarean section in industrialized nations. However, in developing regions where medical services might be unavailable, it can lead to eclampsia, obstetric fistula, infant mortality, or maternal death. For mothers in their late teens, age in itself is not a risk factor, and poor outcomes are associated more with socioeconomic factors rather than with biology (Mayor, 2004).

Socio-economic and psychological outcomes are also among the consequences that affect teenage mothers. Being a young mother in an

industrialized country can affect one's education. Teen mothers are more likely to drop out of high school. Recent studies, though, have found that many of these mothers had already dropped out of school prior to becoming pregnant, but those in school at the time of their pregnancy were as likely to graduate as their peers. One study in 2001 found that women who gave birth during their teens completed secondary level schooling 10-12 percent as often and pursued post-secondary education 14-29 percent as often as women who waited until age 30 (Hofferth, Sandra, Reid, Lori, Mott & Frank, 2001). According to Bill (2007), teen mothers are more likely to drop out of high school than girls who delay childbearing. Only forty percent (40%) of teenagers who have children before age 18 go on to graduate from high school, compared to seventy five percent (75%) of teens from similar social and economic backgrounds that do not give birth until ages 20 or 21.

Teenage motherhood in an industrialized country can affect employment and social class of teenage mothers. Less than one third of teenage mothers receive any form of child support, vastly increasing the likelihood of turning to the government for assistance (Bill, 2004). The correlation between earlier childbearing and failure to complete high school reduces career opportunities for many young women. One study found that, in 1998, sixty percent (60%) of teenage mothers were impoverished at the time of giving birth. Additional research found that nearly fifty percent (50%) of all adolescent mothers sought social assistance within the first five years of their child's life (Bill, 2004).

A study of hundred (100) teenage mothers in the United Kingdom found that only eleven percent (11%) received a salary, while the remaining eighty nine percent (89%) were unemployed. Most British teenage mothers live in poverty, with nearly half in the bottom fifth of the income distribution. Teenage women who are pregnant or mothers are seven times more likely to commit suicide than other teenagers. John Ernisch at the institute of social and economic research at Essex University and Roger Ingham, director of the centre of sexual health at Southampton University – found that comparing teenage mothers with other girls with similarly deprived social-economic profiles, bad school experiences and low educational aspirations, the difference in their respective life chances was negligible (Bill, 2004).

Males (2008) has observed that teenage motherhood may actually make economic sense for poorer young women as some research suggests. Males further stressed that by age 35, former teen moms had earned more in income, paid more in taxes, were substantially less likely to live in poverty and collected less in public assistance than similarly poor women who waited until their 20s to have babies.

Women who became mothers in their teens (freed from child-raising duties by their late 20s and early 30s to pursue employment while poorer women who waited to become moms were still stuck at home watching their young children) wound up paying more in taxes than they had collected in welfare. Eight years earlier, the federally commissioned report “Kids Having Kids” also contained a similar finding, though it was buried; “Adolescent child bearers were

slightly better than later-childbearing counterparts in terms of their overall economic welfare (Maynard, 1996).

According to Kalmuss and Namerow (1994), one-fourth of adolescent mothers will have a second child within 24 months of the first. Factors that determine which mothers are more likely to have a closely-spaced repeat birth include marriage and education: the likelihood decreases with the level of education of the young woman-or her parents- and increases if she gets married.

Facing an unplanned teen pregnancy can be hard. The effects of teenage pregnancy are not limited to having to decide whether or not to keep the baby, how to cope with motherhood or whether to make an adoption plan. One of the most immediate effects of teen pregnancy is how the growing baby immediately begins the process of carrying a child and preparing for childbirth, a teenager needs to consider the effect that her physical activities may have on her developing baby. A variety of activities common to teens may have a negative effect on a developing baby:

- Drinking alcoholic beverages
- Smoking cigarettes or marijuana
- Lack of sleep, and
- Unhealthy eating patterns

Other physical changes that take place as her uterus expands may impact on things as simple as clothing choices or her ability to safely participate in sports. This means that an average teenage girl will need to speak with her doctor about what activities need to be limited during her pregnancy as well as what changes

she might need to make to her diet (Banerjee, Pandey, Dutt, Sengupta, Mondal, & Deb, 2009).

Apart from the problems that teenage mothers faces, the children of teenage mothers also encounter some problems. Early motherhood can affect the psychosocial development of the infant. The occurrence of developmental disabilities and behavioral issues is increased in children born to teen mothers (Hofferth & Reid, 2002). Crockenberg (1987) has suggested that adolescent mothers are less likely to stimulate their infant through affectionate behaviours such as touch, smiling, and verbal communication, or to be sensitive and accepting toward his or her needs. Another found that those who had more social support were less likely to show anger toward their children or to rely upon punishment. Death is another big problem that may occur on the babies of teenage mothers. Babies of teenage mothers are more likely to die in the first year of life than babies of women in their twenties and thirties as a result of health problems such as low birth weight. The risk is highest for babies of mothers under age 15. In 2005, 16.4 out of every 1,000 babies of women under age 15 died, compared to 6.8 per 1,000 for babies of women of all ages (Mathews & MacDorman, 2008).

Poor academic performance in the children of teenage mothers has also been noted, with many of them being more likely than average to fail to graduate from secondary school, be held back a grade level, or score lower on standardized tests. Daughters born to adolescent parents are more likely to become teen mothers themselves (Bill, 2007).

Family members of the teenage mothers also have their fair share of the consequences of teenage pregnancy. In East (1996) view, teen pregnancy and motherhood can influence younger siblings. One study found that the younger sisters of teen mothers were less likely to emphasize the importance of education and employment and more likely to accept sexual initiation, parenthood, and marriage at younger ages; younger brothers, too, were found to be more tolerant of non-marital and early births, in addition to being more susceptible to high-risk behaviors.

A study by East and Jacobson (2001) discovered that those with an older sibling who is a teen parent often end up babysitting their nieces and nephews and that young girls placed in such a situation have an increased risk of getting pregnant themselves. Social workers play an important role in family issues. They work with the families to address common problems and health issues in order to promote a positive outcome for both the family and the body.

Another vital problem associated with teenage pregnancy is teenage parenting. In some cases, the father of the child is the husband of the teenage girl. The conception may occur within wedlock, or the pregnancy itself may precipitate the marriage (the so-called shotgun wedding). In countries such as India the majority of teenage births occur within marriage (UNICEF, 2001).

In other countries, such as the United States and the Republic of Ireland, the majority of teenage mothers are not married to the fathers of the children (Fagan, Barnett, Bernd & Whiteman, 2003). In the UK, half of all teenagers with children are lone parents, forty percent (40%) percent are cohabitating as a couple

and ten percent (10%) are married. Teenage parents are frequently in a romantic relationship at time of birth, but many adolescent fathers do not stay with the mother and this often disrupts their relationship with the child. Research has shown that when teenage fathers are included in decision-making during pregnancy and birth, they are more likely to report increased involvement with their children in later years. In the U.S, eight out of ten teenage fathers do not marry their child's mother (Fagan et al., 2003).

However, "teenage father" may be a misnomer in many cases. Studies by the Population Reference Bureau and the National Center for Health Statistics found that about two-thirds of births to teenage girls in the United States are fathered by adult men age 20 or older (Fagan et al., 2003). The Alan Guttmacher Institute (2005) reported that over forty percent (40%) of mothers aged 15-17 had sexual partners three to five years older and almost one in five had partners six or more years older. A 1990 study of births to California teens reported that the younger the mother, the greater the age gap with her male partner. In the UK, seventy two (72%) of jointly registered births to women under the age of 20, the father is over the age of 20, with almost 1 in 4 being over 25.

Conceptual framework for the study

The study adopted the Fishbone model proposed by Kaoru Ishikawa. The Fishbone model, also known as cause and effect model or Ishikawa diagram, is used to systematically list all the different causes that can be attributed to a

specific problem (or effect). A cause-and-effect diagram in Figure 1 can help identify the reasons why a process goes out of control.

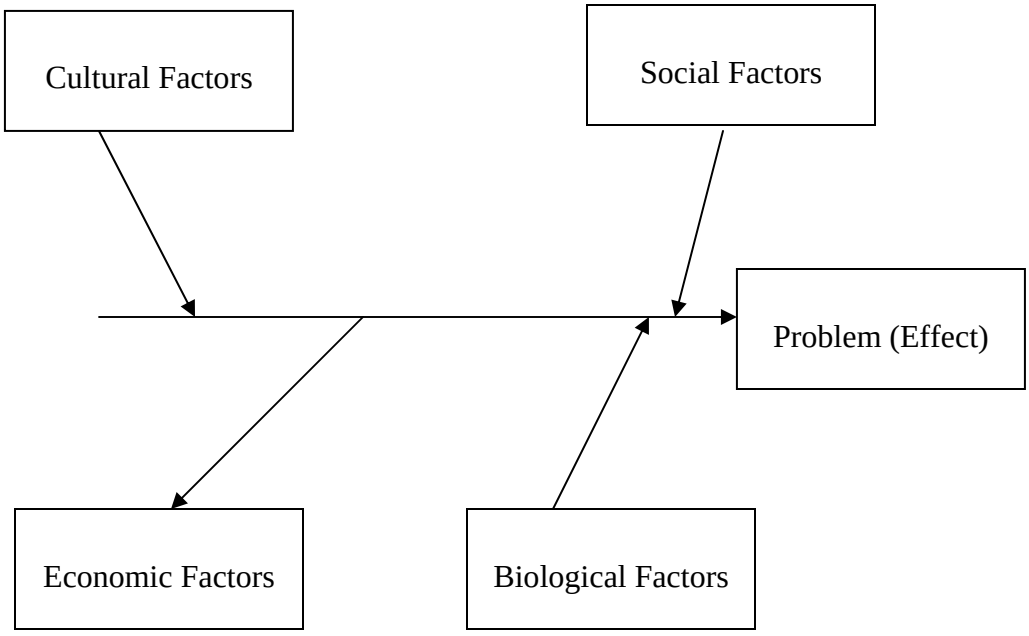

Figure 1: Fishbone Framework

Source: Adopted from Ishakawa (1983)

A Fishbone model helps to identify, sort, and display possible causes of a specific problem or quality characteristic. It graphically illustrates the relationship between a given outcome and all the factors that influence the outcome. Using the Fishbone model helps a researcher to;

- Identify the possible root causes, the basic reasons, for a specific effect, problem, or condition.
- Sort out and relate some of the interacting among the factors affecting a particular process or effect.

- Analyze existing problems so that corrective action can be taken.

This model was chosen for the study because it comes nearer in capturing all the variables needed for the study. It also suited the study and helped to achieve the objectives of the study. In relation to this study, the social factors for teenage pregnancy that were considered were peer pressure influence, low level of education, sexual abuse, inadequate knowledge on contraceptives, non use of contraceptives, broken homes and age discrepancy in relationship.

Culturally, some ethnic groups and religions across the world based on their cultural practices and doctrines respectively accept early marriages and this is assumed to influence the rise of teenage pregnancy in the world. In addition to this, family neglect was also considered as one of the cultural factors that causes teenage pregnancy.

Under the economic factors, poverty was the main factor that is presumed to influence teenagers to get pregnant early. It is assumed that because of poverty, some families or parents fail to provide some basic needs to their children especially the teenagers. Finding alternative means of getting these basic needs compel female teenagers to take boyfriends and without taken the necessary sex precautions normally end up with female teenagers having unplanned children.

The last factor that the conceptual framework for the study highlights is biological factors. With respect to the current study, biological factors that were assumed to cause teenage pregnancy were death of parent(s) or lack of control of sexual desire. Parents serve as breadwinners in almost all nuclear families, the death of one or both biological parents of a teenager at a difficult position. Such

teenager or teenagers loses all the advices, protection, and provision of basic needs that were provided by their parent(s). The outcome of this is that female teenagers engaged themselves in social vices and immoral social behaviours which lead to teenage pregnancy. In addition to this, female teenagers during their early puberty ages develop natural feelings and emotions for sex. Failure to control this feeling often leads to unplanned pregnancies.

All these factors cause teenage pregnancy. The effects of this teenage pregnancy are school drop-out, unemployment, health problems, single parenting, inadequate nutrition, family neglect and engagement in social vices.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter discusses the various methods and techniques that were employed in the study. It describes the study area, research design, data and sources, target population, sampling size, sampling technique, research instruments, Fieldwork, data analysis and ethical issues. The chapter ends with challenges from the fieldwork.

Study Area

The Assin South District is among the seventeen (17) districts of the Central Region of Ghana. Nsuaem-Kyekyewere is the district capital. The district shares common boundaries with Twifo Hemang Lower Denkyira on the West, Abura Asebu Kwamankese District on the South, Asikuma Odoben-Brakwa and Ajumako Enya-Esiam on the East and Assin North Municipal to the Northern border (Figure 2). The district has six sub-district health directorates which are Ongwa, Nsuta, Enyinabrim, Assin Manso, Jakai and Nyankumasi Ahenkro.

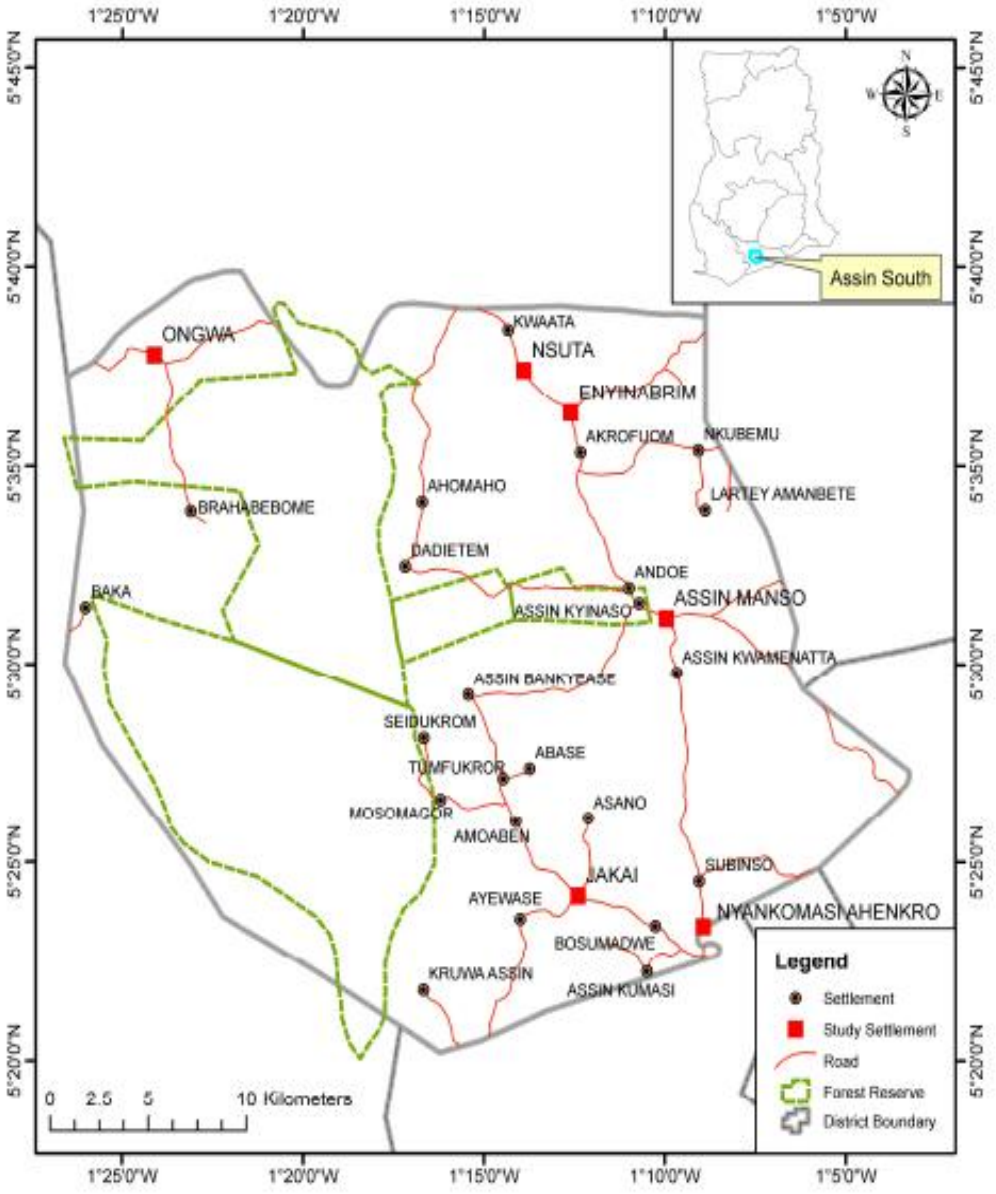

Figure 2: Map of Assin-South District showing selected communities for the study.

Source: Department of Geography and Regional Planning, UCC (2010)

According to the 2000 Population and Housing Census reports, Assin South District has a total population of 98,228 representing about 6% of the total population of the Central Region. It is one of the least populated districts in the Central Region. Akans expecially Fante's dominate the population of Assin South district with Fante and Twi being the most widely spoken languages in the area. The district also has a youthful population which is not different from Ghana's population structure (Assin South District Mutual Health Insurance Scheme, 2006).

There are nine (9) health facilities which are under the Ghana Health Service in Assin South District. In addition to this, it has one District Hospital and one Missionary Hospital. Directorate of Health Service headed by District Director of Health is also situated in the district (Assin South District Mutual Health Insurance Scheme, 2006).

Agriculture is the major economic activity in the Assin South District. Majority of the inhabitants in the area are farmers. According to Assin South District Mutual Health Insurance Scheme (2006), 72% of the economically active population in the district is employed in agriculture, followed by 20.6% in services and 7.2% in manufacturing sector.

Research Design

The study used the mixed method approach. Neuman (2003) supports the use of mixed method technique. According to him, combining different methods in a study is the best because it is better to look at something from several angles than to look at it from only one way.

Mikkelsen (1995) has identified two forms of triangulation which are "within method" triangulation and "between method" triangulation. Within method triangulation involves using the same method on different occasions whilst the between method triangulation is where different methods are used in the same study. The study used the between method triangulation. In this study, both interview schedule (quantitative method), and interview guide were used to collect data from the field.

The mixed method technique was used based on the distinctive advantage it offers. Decrop (1999) has observed that triangulation opens the way for richer and potentially more valid interpretations. It helped the researcher to gain better understanding of the phenomenon under study and also helped to complement the strength of qualitative and quantitative methods (Depoy & Gitlin, 2005).

Target Population

The target population for the study constituted the following:

- Teenage mothers or Pregnant teenagers
- Heads of health facilities
- Traditional Birth Attendants (TBA)

The teenage mothers and expectant mothers were involved in the study because the study sought to investigate the real causes and the problems of teenage pregnancy and this information could be best be retrieved from the pregnant teenagers and teenage mothers. The heads of the health facilities and traditional birth attendants were also considered because of the key roles they play in the healthcare system in Ghana. The pregnant adolescents or mothers seek medical services at various public health centres before and after their pregnancy. Some of the pregnant adolescents who do not attend the public health centres rely on the services of traditional birth attendants when they are in labour or immediately after delivery. So the involvement of the heads of health directorates and traditional birth attendants helped the researcher to get pertinent information in relation to teenage pregnancy.

Data and sources

The study relied on both primary and secondary data. The primary data were obtained from the field survey. The primary data were collected using interview schedule and interview guide (Appendices I and II). The secondary data on the other hand were obtained from the Assin South District Health Directorate.

Sampling procedure and sample size

Non probability sampling techniques were relied upon for the study. Purposive sampling was used to select heads of each of the six sub-district

directorates in Assin South district (Figure 2). Ninety teenage mothers or expectant mothers (comprising of 15 respondents each in the six sub-districts) were selected through the snow-ball sampling technique.

One teenage mother or a pregnant teenager was identified, which through her other teenage mothers were selected until the sample size for the study was achieved. In addition to this, twelve (12) key informants were also purposively included in the study. The key informants were made up of (6) heads of health directorates and six (6) traditional birth attendants in Assin South district.

Research instruments

In line with the mixed method approach which were employed in the study, interview schedule and interview guide were used to collect primary data from the field. Since most teenage mothers are often school dropouts' (Amoako, 2005), interview schedule was used to collect data from them. This enabled the teenage mothers who were mostly school dropouts to participate in the study. Questions in the interview schedule were translated into Fante and Twi which are widely spoken in the area. The interview schedule was structured with both close-ended and open ended questions. It was divided into two broad parts. The first part dealt with socio-demographic characteristics of the respondents whilst the second part focused on the causes, consequences and other related issues of teenage pregnancy. The interview guide on the other hand was used to gather information from the twelve (12) key informants. It had three sections. The first section was on the causes and trends of teenage pregnancy. The second section

captured the health related issues and consequences of teenage pregnancy whilst the third section was the measures and mechanisms that can be put in place to address teenage pregnancy. Both the interview schedule and the interview guide were designed to ascertain the causes and consequences of teenage pregnancy in Assin South district.

Fieldwork

A week prior to the actual fieldwork, the research instruments were pre-tested in Assin-North district which shares a boarder with the study area. During the pre-test, the interview schedule was administered on ten teenage mothers and in-depth interview was conducted for three key informants. The pre-test helped to restructure some of questions in the interview schedule and in-depth interview guides. The actual fieldwork for the study took place between 28th June and 27th July, 2010. In all, one-month was used to collect data from the field. The first two weeks were used to administer the interview schedules among the pregnant teenagers or teenage mothers whilst the remaining two weeks were used to conduct in-depth interviews for selected heads of health directorates and TBA's in the Assin-South District. The interview schedules were undertaken in the morning from 7:00 am to 10:00am and in the evening from 4:00pm and 6:00 pm. This was because it was around this time that most of the respondents were available.

Data analysis

Data collected from the field were first cross-checked to ensure that they were correct and have no mistakes in them. Completed interview schedules were coded and inputted into the computer. The Statistical Product and Service Solutions (SPSS version 16) was employed to analyze the data. Summations, averages, tables, graphs, charts and proportions were used to present the results. In analyzing the data from the In-Depth Interviews (IDI's), the recorded information from the key informants were transcribed, categorized under specific themes and used for analysis.

Ethical issues

Ethical issues were not left out during the field work. Proper permission was obtained from the Assin South district and health authorities before the field work was embarked on. Concerning the administration of the interview schedule consent were sought from the parents and guardians of the pregnant teenagers/ mothers and the teenage mothers themselves before they were interviewed. In addition to this, the researcher identified himself to the respondents to avoid false impression. The purpose of the study and the nature of the interview schedule were also made known to the respondents. Participation in the study was not compulsory and anonymity of respondents was respected. During the field work all forms of identification including respondents' names, addresses and telephone numbers were avoided.

Challenges from the field

The main challenge that was encountered during the fieldwork was unwillingness of some pregnant teenagers or teenage mothers to participate in the study. Most of the pregnant teenagers felt shy to participate. Much time was therefore taken to explain the purpose of the study in detail to them before they accepted to participate in the study.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter discusses the results and analysis for the study. Four broad areas are covered in this chapter. These areas are socio-demographic characteristics of the respondents, the trends of teenage pregnancy, factors influencing the occurrence of teenage pregnancy, and the consequences of teenage pregnancy in Assin-South District.

Socio-demographic characteristics of respondents

Socio-demographic characteristics help to give a true picture of the characteristics that the respondents possess. Although the study is not geared towards analysing the socio-demographic characteristics of pregnant teenagers or teenage mothers in Assin-South District but this background characteristic helped reveal the basic characteristics that teenage mothers have which facilitate comparism with other teenage mothers across the world. Socio-demographic characteristics covered in this study are age, education, marital status and religion.

Age of respondents

The age at which teenagers get pregnant or give birth is a problem that health practitioners have spoken a lot on (Asiedu-Addo, 2010). To find out the dominant age at which teenage girls get pregnant in Assin-South District, the selected teenage mothers were asked to indicate the age at which they first got pregnant. The majority of the respondents (30%) indicated that they first got pregnant when they were 18years. Table 1 gives a full account of the age distribution of the respondents.

Table 1: Age of respondents

Age	Frequency	Percent
13	3	3.3
14	1	1.1
15	8	8.9
16	18	20.0
17	18	20.0
18	27	30.0
19	15	16.7
Total	90	100

Source: Field survey, 2010

Beside age 18, the next age category that teenage girls often get pregnant are ages 16 and 17 (Table 1). Teenagers who are 14 years were the least group of pregnant teenagers in the study area. Eighteen years (18) being the dominant age at which most female teenagers get pregnant in Assin South District is contrary to

the observation made by Dryburgh (2002) on Canadian teenage mothers between 1992-2002. Dryburgh (2002) observation was that few teenage pregnancies in Canada occurred at age 18, but that was not the case in the study area. This might be due to over confidence on the side of teenagers. Teenagers at 18years feel that they are matured enough to indulge themselves in sexual activities which in the long run without protection end up in unplanned pregnancies.

Level of education

The level of education of teenagers plays a significant role in the prevalence of many teenage pregnancies across the world. Many a times people tend to believe that low educational level of female teenagers influence them to have sex early leading to pre-mature pregnancies at an early age (Kunateh, 2009). In Assin-South District, the level of education of many teenage mothers was low. The majority of teenage mothers (57.8%) had only acquired Junior High School (JHS) education with 6 percent obtaining Senior High School (SHS) education (Table 2).

Table 2: Educational distribution of respondents

Level of education	Frequency	Percent
No formal education	11	12.2
Primary	21	23.3
JHS	52	57.8
SHS/Tech./Voc	6	6.7
Total	90	100

Source: Field survey, 2010

The distribution in Table 2 is in contrast with the educational background of teenage mothers in Ghana where most of the teenage mothers have no formal education (Ghana Statistical Service (GSS), 2009).

Marital status

Results from 2008 GDHS show that majority of teenage pregnancy occurs to teenagers who have never married (GSS, 2009). Based on this, data were collected on pregnant teenagers in the study area to find out whether the marital status of pregnant teenagers conforms to the national trend or not. Table 3 gives a detailed account of the marital background of pregnant teenagers in Assin-South District.

Table 3: Marital status of respondents

Marital status	Frequency	Percent
Never married	69	76.7
Married	15	16.7
Separated	5	5.5
Divorced	1	1.1
Total	90	100

Source: Field survey, 2010

From Table 3, the majority of the respondents (76.7%) have not married before. About 17 percent of the respondents (16.7%) are married with only one person being divorced (1.1%). The marital status of the respondents is in line the findings of the 2008 GDHS but in sharp contrast with the observation made by

Therese (2000) which concluded that greater percentage of pregnant teenagers in Sub-Saharan Africa are married.

Religion

Religion has been found as one of the most socio-demographic variables that influence the prevalence of many teenage pregnancies across the world. A study by Therese (2000) on North African and other Sub-Saharan African countries revealed that majority of the teenage mothers are Muslims. To Therese (2000), Islam favours early marriage and this compels many teenagers to marry and give birth early. The current study, however, found out that the situation at Assin-South District was different (Figure 3).

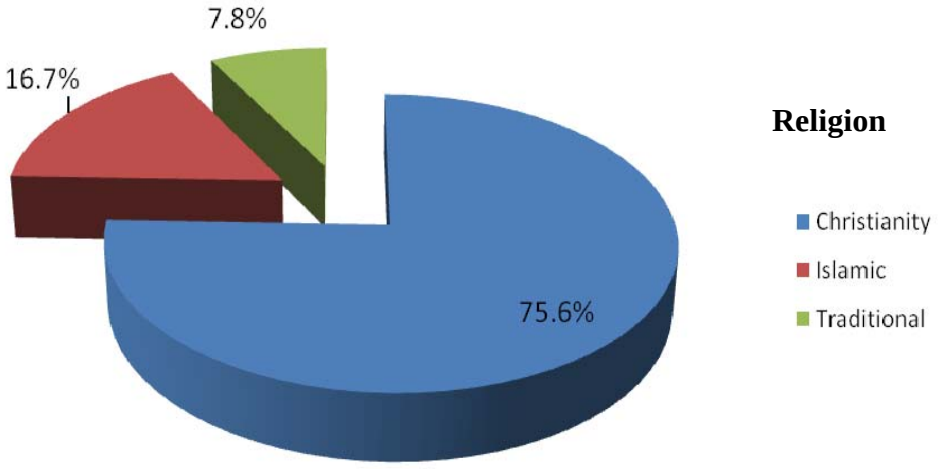

Figure 3: Religious status of respondents

Source: Field survey, 2010

In the Assin South district, the majority of pregnant teenagers were Christians (75.6%). Muslims were 16.7 percent with pregnant teenagers in the Traditional Religion having the least pregnant teenagers (7.8%) (Figure 3). The high number of pregnant teenagers being Christians follows the 2000 Population and Housing Census of the area where Christianity was the dominant religion in the area but this contrast with Therese's (2000) findings of more pregnant teenagers being Muslims in Sub-Saharan Africa.

Trends of teenage pregnancy in Assin-South District

In assessing the trends of teenage pregnancy in Assin-South District, the trends of teenage pregnancy in Central Region was first looked at before it was narrowed down to Assin-South District which is one of the districts in Central Region. Information from Ghana Statistical Service and Ghana Health Service regional annual reports were used. According to GDHS, from 1993 to 2008, the incidents of teenage pregnancy have been very high in the Central Region of Ghana. In each of the years that GDHS was conducted, Central Region recorded the highest percentage of teenage pregnancy than other regions in Ghana. Figure 4 shows the rate of teenage pregnancy in Central Region based on GDHS.

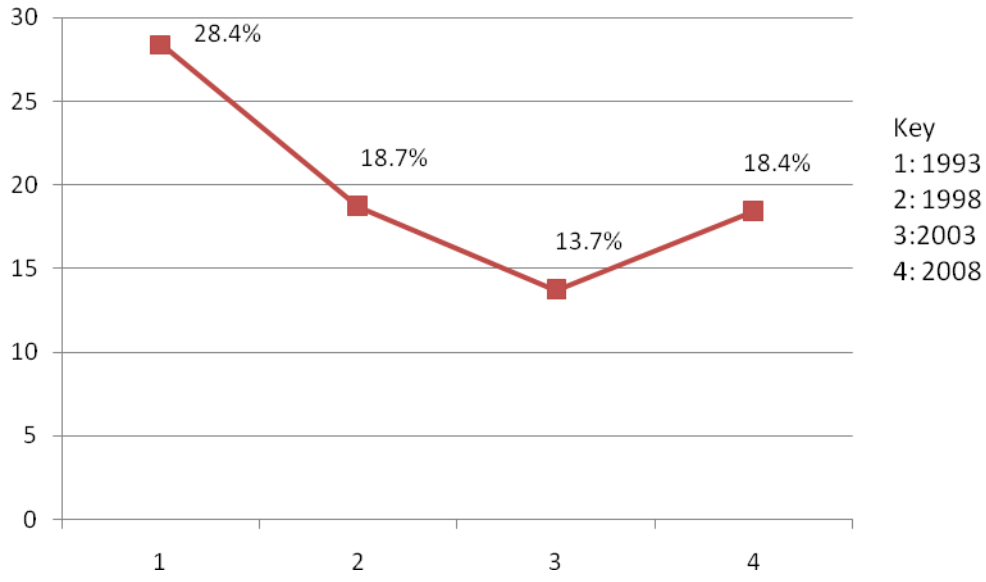

Figure 4: Trends of teenage pregnancy in Central Region

Source: Ghana Statistical Service (1994-2009)

From Figure 4, between 1993 and 2003, there was a decline in the incidents of teenage pregnancy. In 2008, the trend changed with the percentage of teenage mothers increasing to 18.4 percent. The 2008 results on teenage pregnancy in Central Region show there is high rate of teenage pregnancy in the region. Some districts have been identified as the hot spot areas of teenage pregnancy in the Central Region of Ghana. This led to the need to find out the trend of teenage pregnancy in Assin-South District which is one of the districts of Central Region.

In finding out the trends of teenage pregnancy in the study area, the heads of six health directorates in the study area were interviewed. All the six heads through an in-depth interviewed confirmed that there is an increasing trend of teenage pregnancy in Assin-South District. One head said:

> Teenage pregnancy is one problem which has been worrying the district for over 15 years now. Every year, Assin-South District records high rate of teenage pregnancy. Some efforts have been made to reduce the rate, for example educational campaigns have been embarked on to check the situation but still the rate of teenage pregnancy is always high in this area.

Another head of health directorate had this to say:

> Occurrence of teenage pregnancy is very high in this district. We have been leading the district list for teenage pregnancy in Central Region for some time. Currently, we are still topping the district chart for teenage pregnancy cases in Central Region.

The comments from the heads of health directorates said it all. Teenage pregnancy in Assin-South Districts is really increasing. To further find out the trend of teenage pregnancy in the study area, the Ghana Health Service 2009 regional annual report for Central Region was used. Figure 5 and 6 show the position of Assin-South District in the ranking of teenage pregnancy among districts in the Central region.

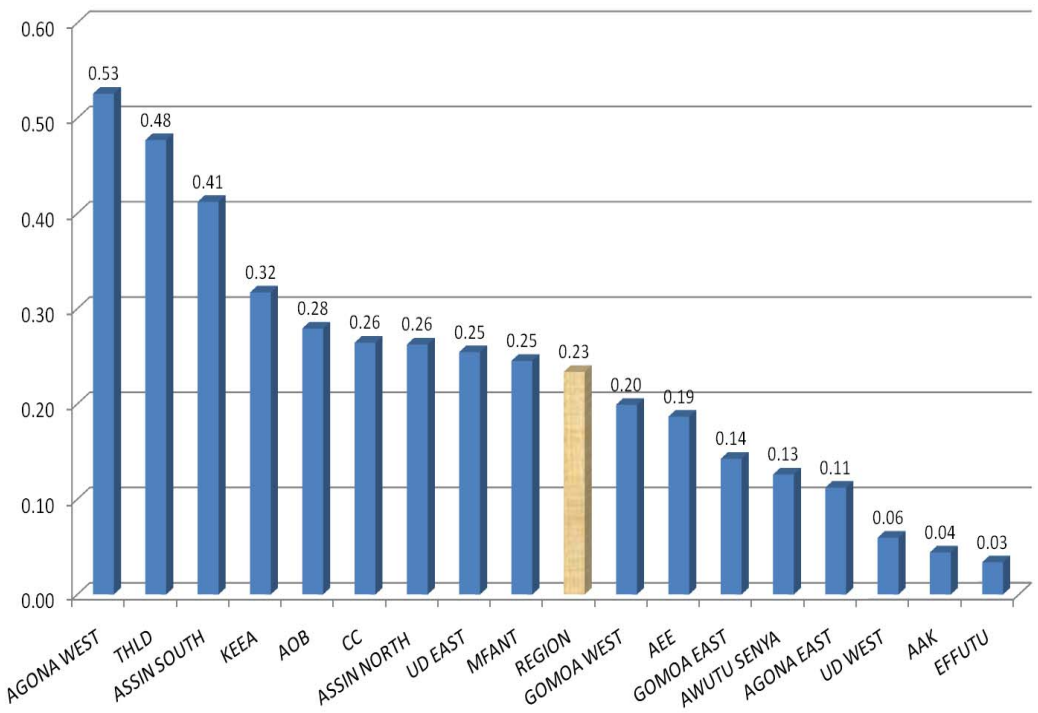

Figure 5: Early teenage pregnancy distribution for Central Region in 2009

Source: Ghana Health Service, 2010

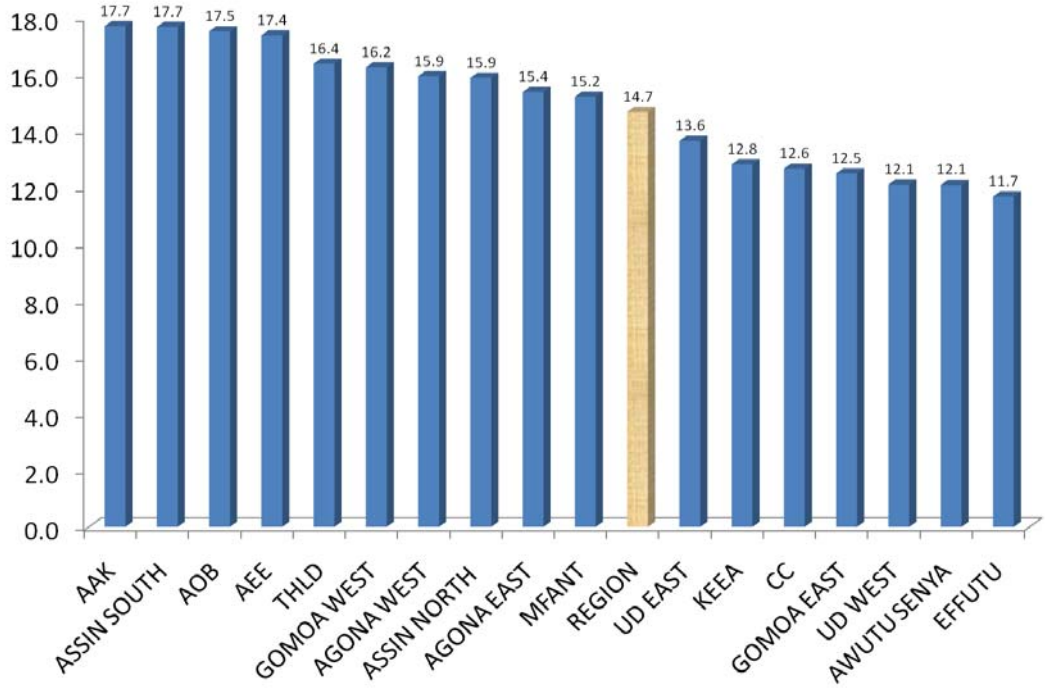

Figure 6: Late teenage pregnancy distribution for Central Region in 2009

Source: Ghana Health Service, 2010

Figures 5 and 6 show the intensity of teenage pregnancy in Assin-South District. In each of the figures, the rate of teenage pregnancy in Assin-South District was higher than the regional average. Whilst Assin-South recorded 0.41 percent for early teenage pregnancy, the regional figure was 0.23 percent. In the same vein, whilst Assin-South had 17.7 percent for late teenage pregnancy Central Region had an average figure of 14.7 percent. This clearly shows that Assin-South District has a high rate of teenage pregnancy among the districts in Central Region.

Factors influencing teenage pregnancy

Several factors have been identified as the causes of teenage pregnancy in the world. These factors range from cultural, economic, social and biological factors as shown in the conceptual framework for the study. A five point likert scale was used in the interview schedule (Appendix I) to ascertain the factors influencing teenage pregnancy. The following values were assigned to the responses: 1 for ‘very low’, 2 for ‘low’, 3 for ‘uncertain or undecided’, 4 for ‘high’, and 5 for ‘very high’. The factors have been categorized into two broad themes, social factors and other factors for easy explanation.

Social factors

According to Afenyadu and Goparadu (2003), social factors play significant role in inducing the youth into teenage pregnancy. This is because since teenagers do not have much experience in dealing with social matters it put them at a disadvantageous position or makes them vulnerable to some social factors which consequently lead to unplanned pregnancies. The social factors that were covered during the field survey were peer pressure influence, low level of education, sexual abuse, inadequate knowledge on contraceptives, non use of contraceptives, broken homes and age discrepancy in relationship.

Among the social factors, inadequate knowledge on contraceptives was the number one factor that causes the majority of teenage pregnancies in Assin-South District (Table 4). About 51.1 percent of the respondents rated inadequate knowledge on contraceptives as high in the district. This observation support Ferguson's (1997) assertion that inadequate use or knowledge on conventional methods of preventing pregnancies is the main cause of teenage pregnancy.

Table 4: Factors influencing teenage pregnancy

Factors	N	VH (%)	H (%)	U (%)	L (%)	VL (%)
Social						
Peer pressure influence	90	9.3	48.4	8.9	16.7	16.7
Low level of education	90	21.1	50.0	10.0	11.1	7.8
Sexual abuse	90	7.7	5.6	17.8	40.0	28.9
Inadequate knowledge on contraceptives	90	21.1	51.1	3.3	14.4	10.0
Non use of contraceptives	90	27.7	26.7	5.6	30.0	10.0
Broken homes	90	21.1	28.9	10.0	23.3	16.7
Age discrepancy in relationship	90	3.3	17.8	34.4	32.2	12.2
Economic						
Poverty	90	61.3	10.0	16.7	8.3	3.7
Cultural						
Early marriage	90	47.2	18.9	5.6	14.4	13.9
Family neglect	90	13.1	7.8	24.4	34.7	20.0
Biological						
Death of parent (s)	90	11.1	10.0	6.7	28.9	43.3
Lack of control of sexual desire	90	8.6	6.4	67.2	13.8	4.0

Source: Field survey, 2010

{N= number of respondents, VH= very high, H= high, U= uncertain, L= low, VH= very low}.

Next to inadequate use of contraceptives was low level of education. Fifty percent of the respondents admitted that low level of education is a cause of teenage pregnancy. Most of the pregnant teenagers or teenage mothers had only acquired Junior High School (JHS) education with others having only primary education. These levels of education were found not to be good enough to enable the teenagers to be much informed on the need to avoid teenage pregnancy, effects of teenage pregnancy and even expose them to various methods of preventing pregnancies. This might probably be the reason why many pregnant teenagers indicated that improper use of contraceptive is the number one cause of teenage pregnancy in the area. This finding is in line with Allen, Bonell and Strange (2007) view of low level of education of teenagers as a cause of teenage pregnancy.

Another important social factor that was found to cause teenage pregnancy was peer pressure influence (Table 4). About 48.4 percent of the respondents said that it was as a result of advice or influence from friends that encouraged them to take boyfriends and to some extent engaged in sexual relationships. In-depth interview conducted for sampled key informants confirmed this. One of the interviewees remarked:

> Most of the pregnant teenagers who access my health facility say that it was as a result of following friend's behaviour and advice that made them pregnant.

This result supports the observation made by Fox (2010) on teenage pregnancy that teenagers in order to be accepted by their friends or peers take

boyfriends or girlfriends or at least date and indulge in sexual acts which ends up in unwanted pregnancies. Sexual abuse (rape) was found to be one of the causes of teenage pregnancy in Assin-South district. Approximately eight percent (7.7%) of the respondents indicated that their pregnancy was as a result of rape. This means that teenage mothers or pregnant teenagers willingly indulge in the sexual activity that resulted in their pregnancies. The in-depth interviews conducted for key informants comprising Heads of Health Directorates and Traditional Birth Attendants came up with similar findings. All the 12 respondents said that teenage pregnancy in the study area is not as a result of sexual abuse but rather due to irresponsible behaviour of teenagers in the district. For example one key informant said:

> Our teenagers in the district are the cause of high rate of teenage pregnancy in the area but not rape. Only one or two cases of teenage pregnancy in Assin-South District occurred through rape. The teenagers out of curiosity or bad advice from friends end up having unwanted pregnancies.

Sexual abuse (rape) being suggested by Kenney et al. (1997) as one of the leading causes of teenage pregnancy does not hold in Assin-South District.

Other factors causing teenage pregnancy

Apart from social factors that caused teenage pregnancy in the study area, there were other factors (as shown in the conceptual framework) that were

responsible for the high level of teenage pregnancy in Assin South district. These factors included economic, cultural and biological factors (Table 4).

Among the other factors that influence teenage pregnancy, poverty had the highest responses (Table 4). The majority of the respondents (61.3%) put the blame of their pregnancy on poverty. According to most of the respondents, their parents find it difficult to provide most of their needs and in an attempt to find alternative way of achieving those needs they take boyfriends. These boyfriends upon giving assistance to their female partners use that opportunity to have sex with them which end up with the most of female teenagers having unplanned children. The 2008 GDHS concluded that poverty is one of the predominant factors that cause most teenage pregnancies in Ghana (GSS, 2009). What was observed in Assin-South District was in line with the findings of the 2008 GDHS. Poverty being a predominant cause of teenage pregnancy in the study area (Table 4) confirms Diane (1997) assertion that teenagers living in poverty especially in rural areas are mostly the victims of teenage pregnancy.

Similar results were obtained through the in-depth interviews. Out of the 12 interviewees, 10 pointed out poverty as the main cause of teenage pregnancy in the study area. For example one interviewee had this to say:

> Most of the female teenagers in this area cheaply give themselves to adults for sex in order to get money for their personal needs which are beyond their parents capacity.

Another interviewee who was also in support of poverty as the predominant cause of teenage pregnancy in the study area said this:

> In fact, poverty is really pushing many female teenagers into pre-marital sex leading to unwanted pregnancies. Since poverty is high in this community, most parents because of economic hardship when their children are in their teenage period (especially 17 to 19years) give them their free will to search for their own needs. This induces female teenagers to engage in pre-marital sex which unfortunately causes unplanned pregnancies.

Early marriage is another factor that causes much teenage pregnancy in Assin-South District (Table 4). About 47 percent (47.2%) of the sampled teenage mothers or pregnant teenagers accepted that it was through early marriage that they got pregnant or gave birth early. Some of the respondents said that their parents gave them out early for marriage in order to reduce their burden of financial hardships and also get money to support their well-being. This is consistent with Meht et al. (1998) view on teenage pregnancy. Meht et al. (1998) are of the view that early marriage give rise to teenage pregnancy in developing countries especially in Africa where poverty is eminent and there is much respect to cultural practices.

With respect to economic, cultural and biological factors influencing teenage pregnancy, apart from poverty and early marriage the other variables had little responses from the respondents (Table 4). While family neglect has 13.1 percent, death of parents and lack of control of sexual desire had 11.1 percent and 8.6 percent responses from the respondents respectively. This means that although

these factors influence teenage pregnancy, in Assin-South district their influence is minimal or insignificant.

Consequences of teenage pregnancy

Several authors have come up with findings on the consequences of teenage pregnancy (Fagan et al. 2003; George & Lee 1997 & Maynard, 1996) Examples of such consequences are school drop-out, single parenting, health problems, social vices, unemployment and many others. It is not all these factors that may prevail in the study area. To find out consequences or problems of teenage pregnancy that exist in the study area, respondents were given a list of problems that pregnant teenagers or teenage mothers face to comment on how each of the problems is affecting them. Figure 7 gives an overview of the consequences of teenage pregnancy in Assin-South District.

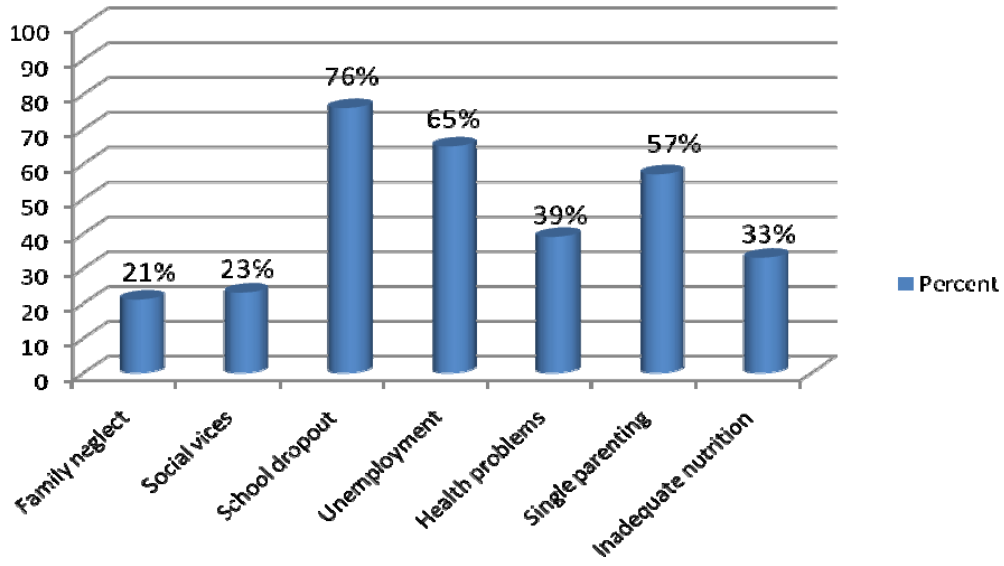

Figure 7: Consequences of teenage pregnancy

Source: Field survey, 2010

From Figure 7, three problems of teenage pregnancy are eminent in Assin-South District. These problems are school drop-out (76%), unemployment (65%) and single parenting (57%). Each of the three problems had more than 50 percent responses from the respondents. The findings on school drop-outs suggest that majority of the female teenagers after getting pregnant stop schooling abruptly. This was also established in the in-depth interviews. All the key informants interviewed confirmed that school drop-out is a major problem of teenage pregnancy that is worrying female teenagers in the Assin-South District seriously. One interviewee said:

> Teenage pregnancy has resulted in many school drop-outs in this area. Many female teenagers out of shame, when they get pregnant voluntarily withdrew themselves from school. After giving birth because of much attention that has to be given to their babies they find it difficult to continue their education, so their education ends abruptly.

This finding supports the observation made by Bill (2004) which concluded that there is a high correlation between teenage pregnancy and school drop-outs.

Unemployment was also high at Assin-South District. This might be due to the fact that most teenage mothers because they could not pursue their education to a higher level lack the requisite skills and experience to meet the demands of employers in the job market. With respect to single parenting, Fagan et al. (2003) through a study in UK and Northern Ireland found out that the majority of teenage mothers are not married to the fathers of the children. This

finding corroborated with what was found out in the study area. At the study area, most teenage mothers said that their parents are still taken care of them because the fathers of their children did not accept the pregnancy or they are not taking their responsibilities as fathers of the children.

Taking all the effects of teenage pregnancy into consideration, family neglect had the lowest responses. It constituted 21 percent of the responses. This suggest that most parents or families irrespective of their children having unplanned pregnancies or children believed that they still have to take full care of their children until they are married to a responsible man. All the effects of teenage pregnancy in the study area were in line with the conceptual framework of the study (Figure 1). According to the conceptual framework of the study, school dropouts, unemployment, single parenting and family neglect are the predominant effects that are normally associated with teenage pregnancy.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter sums up the whole study on teenage pregnancy in Assin-South District. It contains a summary of the objectives of the study, major findings, conclusions from the findings, and recommendations to improve on the rate of occurrence teenage pregnancy in Assin-South District.

Summary

The study sought to investigate the causes and effects of teenage pregnancy levels in the Assin South District in the Central Region. Specifically, the study was undertaken to:

- Investigate the factors accounting for teenage pregnancy in the District;
- Examine the trend of teenage pregnancy in the Assin South district; and
- Assess the consequences of teenage pregnancy.

Interview schedule and in-depth interview guide were the research instruments that were used to collect data from the field. Examples of the data collected from the field were factors that influence teenage pregnancy and

consequences of teenage pregnancy. Three categories of people constituted the target population for the study. These were teenage mothers or pregnant teenagers, heads of health directorates and traditional birth attendants.

A total of 90 teenage mothers or pregnant teenagers, 6 heads of health directorate and 6 traditional birth attendants were involved in the study. Snow-ball and quota sampling technique were used to select teenage mothers whilst purposive sampling was used to select the heads of health directorates and traditional birth attendants. Data were obtained from the teenage mothers through the use of interview schedules whereas IDI's were used to obtained data from the heads of health directorates and traditional birth attendants. The data for the study was analysed and presented using summations, percentages and charts.

The major findings of the study include the following:

- Most of the teenage mothers were in their late teenage ages. The majority of the teenage mothers were between the ages of 16 and 18years. A greater part of teenage mothers (30%) were 18 years old.
- The level of education of teenage mothers was low. Most of the teenage mothers had only acquired Junior High School education (57.8%) and primary education (23.3%).
- In line with GSS (2009), most teenage mothers in Assin-South had not married before. About 77 percent (76.7%) had never married with only 16.7 percent who were married.
- The rate of teenage pregnancy in Assin-South District was very high. The district is topping the list of late teenage pregnancy for the districts in

Central Region with 17.7 percent. With respect to early teenage pregnancy, Assin-South District is third with 0.41 percent.

- Peer pressure influence, low level of education and inadequate knowledge of contraceptive are the main social factors that influence teenage pregnancy in Assin-South District. For each of these factors, greater proportion of teenage mothers confirmed that it has an influence on their pregnancies. For example, 51.1 percent of teenage mothers said that inadequate knowledge on contraceptives influenced their pregnancies.
- Apart from social factors, poverty (economic factor) and early marriage (cultural factor) are also major causes of teenage pregnancy in Assin-South District. These are consistent with the findings of Meht et al. (1998) on teenage pregnancy.
- The predominant consequences of teenage pregnancy in Assin-South District are school drop-outs (76%), unemployment (65%) and single parenting (57%). The respondents indicated that these problems are worrying teenage mothers severely in the district.

Conclusions

Based on the findings of the study, the following conclusions could be made from the study:

- There is an inconsistent trend of teenage pregnancy in the Assin-South District. High proportions of female teenagers were found under both at the early and late categories of teenage pregnancy.
- Teenage pregnancies in Assin-South District are mostly caused by inadequate knowledge on contraceptives, peer pressure influence, low level of education, poverty and early marriage.
- Three main consequences of teenage pregnancy in Assin-South District are high school drop-outs, unemployment and single parenting.

Recommendations

In relation to the findings and conclusion of the study the following recommendations have be suggested:

- The Assin South health directorate should provide education on the use of contraceptives. Such education should focus much on sensitizing the teenagers on various forms or types of contraceptives and how each can be used properly. This will enable the teenagers to have protected sex thereby reducing the rate of unwanted pregnancies.
- The district assembly in collaboration with the Member of Parliament (MP) for Assin-South District should establish technical and vocational training centres to train unemployed teenage mothers. Majority of the

teenage mothers indicated they face the problem of unemployment. Setting up these training centres will enable the teenagers and the youth at large who because of teenage pregnancy cannot continue their education to acquire artisan skills and experiences that will help them to establish their own businesses for living. Such technical and vocational training should include dress making, sewing, hair dressing and many others.

- Parents must give priority to girl child education. Education of girls especially the teenagers must be taken serious by parents. Parents should provide the educational and basic needs that are needed for their girl child education. This will limit or prevent undue taken of boyfriends by female teenagers to get their needs. Given attention to girl child education will also help girls to stay much longer in school hence preventing early marriages by female teenagers. Females getting much education will help them to take inform decisions for their lives instead of always relying on friends advise (peer pressure influence). All these will help to curb teenage pregnancy.

Areas for further research

The current study focused on only one district, other studies can be on a broader perspective by looking at two or more districts in Central Region. This will facilitate easy comparison of the causes and consequences of teenage pregnancy.

REFERENCES

Afenyadu, D., & Goparadu, L. (2003). *Adolescent sexual and reproductive health behaviour in Dodowa, Ghana.* Washington DC: U.S. Agency for International Development.

Alan Guttmacher Institute (2005). *Sex and relationship.* New York: Alen Guttmacher Institute.

Alan Guttmacher Institute (1999). *Teen sex and pregnancy*. New York: Alan Guttmacher Institute.

Allen, E., Bonell, C., & Strange, V. (2007). Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomised trial of sex education and their implications for policy. *J Epidemiol Community Health 61* (1), 20–7.

Amoako, K. (2005). *Poverty, major contributing factor to teenage pregnancy.* Retrieved February 5, 2010 from www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.

Asiedu-Addo, S. (2010). *196 Pregnant girls in Central Region.* Retrieved May 3, 2010 from www.graphicghana.com/society%20and%20lifestyle/page.php?news.

Assin-South District Mutual Health Insurance Scheme (2006). *2006 progress report on health insurance scheme in Assin-South District.* Assin Manso: Assin-South District Mutual Health Insurance Scheme.

Awusabo-Asare, K., Abane, A. M., & Kumi-Kyereme, A. (2004). *Adolescent sexual and reproductive health in Ghana: A synthesis of research evidence.* Occasional Report No. 13.

Banerjee, B., Pandey, G., Dutt, D., Sengupta, B., Mondal, M., & Deb, S. (2009). Teenage Pregnancy: A socially inflicted health hazard. *Indian Journal of Community Medicine*, 34(3), 227-231.

Besharov, D. J., & Gardiner, K. N. (1997). Trends in teen sexual behavior. *Children and Youth Services Review*, 19 (5/6), 341–67.

Bill, A. (2007). *With one voice: America's adults and teens sound off about teen pregnancy.* A periodic national survey. Washington DC: National Campaign to Prevent Teen Pregnancy.

Bill, A. (2004). *With one voice: America's adults and teens sound off about teen pregnancy.* An annual national survey. Washington DC: National Campaign to Prevent Teen Pregnancy.

Boyer, D., & Fine, D. (1992). Sexual abuse as a factor in adolescent pregnancy and child maltreatment. *Family Planning Perspectives 24*, 4–11.

Colin, A. (2003). *Peer pressure and teen sex*. Retrieved January 30, 2010 from www. psychologytoday.com

Crockenberg, S. (1987). Predictors and correlates of anger toward and punitive control of toddlers by adolescent mothers. *Child Dev, 58* (4), 964–75.

Cullinan, K. (2003) *Teen mothers often forced into sex*. Retrieved January 31, 2010 from www.csa.za.org/article/article/25/1/.

Decrop, A. (1999), Triangulation in qualitative tourism research. *Tourism Management*, 20, 157 – 161.

Department of Geography and Regional Planning (2010). *Map of Assin South district.* Cape Coast: Department of Geography and Regional Planning, University of Cape Coast.

Depoy, E., & Gitlin, L. (2005). *Introduction to research: Multiple strategies for health and human services* (3rd ed.) St. Louis, MO: Mosby.

Diane, S. (1997). *Bonnyville teen pregnancy research report.* A report prepared for Bonnyville Healthy Babies Program and Lakeland Regional Health Authorities, Bonnyville.

Dryburgh, H. (2002). Teenage pregnancy. *Health Report,* 12 (1), 9-18.

East, P. L, & Jacobson, L. J (2001). The younger siblings of teenage mothers: a follow-up of their pregnancy risk. *Dev Psychol,* 37 (2), 254–64.

East, P. L. (1996). Do Adolescent pregnancy and childbearing affect younger siblings? *Family Planning Perspectives,* 28,148-153.

Ellis, B. J., Bates, J. E., Dodge, K. A., Fergusson, D.M., Horwood, J.L., Pettit, G.S., & Woodward, L. (2003). Does father absence place daughters at special risk for early sexual activity and teenage pregnancy? *Child Development,* 74 (3), 801-21.

Fagan, J., Barnett, M., Bernd, E., & Whiteman, V. (2003). *Prenatal involvement of adolescent unmarried fathers Fathering.* Retrieved January 12, 2010 from www. findarticles..com/p/articles/mi_m0PAV/is_3_1/ai_111268934.

Ferguson, S. L. (1997). The national campaign to prevent teen pregnancy. *Journal of Pediatric Nursing*, 12 (2), 120-121.

Fox, M. (2010). *What causes teenage pregnancy*? Retrieved July 25, 2010 from http://EzineArticles.com/?expert=Melissa_Fox.

George, R. M., & Lee, B. J. 1997. Abuse and neglect of children. In R.A. Maynard (Editions). Kids having kids: Economic costs and social consequences of teen pregnancy, pp. 205-230. Washington, DC: The Urban Institute Press.

Ghana Health Service (2010). *2009 Regional annual report for Central Region.* Accra: Ghana Health Service.

Ghana Statistical Service (2009). *Ghana demographic and health survey*. Accra: Ghana Statistical Service.

Ghana Statistical Service (1998). *Ghana demographic and health survey.* Accra: Ghana Statistical Service.

Gupta, J. A. **(**2000). *Windows of opportunity. The girl child in India at the dawn of the twenty-first century.* Geneva: World Health Organization.

Gutierrez, Y., & King, J. C. (1993). Nutrition during teenage pregnancy. *Pediatr Ann, 22* (2), 99–108.

Hofferth, S. L., & Reid, L. (2002). Early Childbearing and Children's achievement and behavior over time. *Perspectives on Sexual and Reproductive Health, 34* (1), 41.

Hofferth S., Sandra L., Reid, Lori, Mott, & Frank, L. (2001). The effects of early childbearing on schooling over time. *Family Planning Perspectives,* 33 (5), 259-267.

Hsu, G. (1996). Statutory rape: The dirty secret behind teen sex numbers. *Family Policy,* 4, 1-16.

Ishakawa, K. (1983). *Cause effect diagramme.* Retrieved June 3, 2010 from www.12manage.com/methods_ishikawa_cause_effect_diagram.html

Kaiser Family Foundation (2005). *U.S teen sexual activity.* Washington DC: Kaiser Family Foundation.

Kalmuss, D. S., & Namerow, P. B. (1994). Subsequent childbearing among teenage mothers: the determinants of a closely spaced second birth. *Fam Plann Perspect,* 26 (4), 149–53, 159.

Keller, E. T., Hilton, D. B., & Twumasi-Ankrah, K. (1999). Teenage pregnancy and motherhood in a Ghanaian community. *Journal for Social Development in Africa,* 14(1), 69-84.

Kenney, J. W., Reinholtz, C., & Angelini, P. J. (1997). Ethnic differences in childhood and adolescent sexual abuse and teenage pregnancy. *Adolescent Health,* 21, 3–10.

Kost, K., Henshaw, S. & Carlin, L. (2010). *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*. New York: Alan Guttmacher Institute.

Kunateh, M. A. (2009). *Teenage pregnancy: The burden lies on Ghanaian teenagers.* Retrieved January 3, from www.ghanadot.com/news. ghanadot.kunateh.

Makinson, C. (1985). The health consequences of teenage fertility. *Fam Plann Perspect* , 17 (3), 132–9

Males, M. (2008). *The real mistake in 'teen pregnancy.* Retrieved March 4, 2010 from www.latimes.com/news/opinion/la-op-males132008jul13,0, 4392044.story.

Mathews, M. S., & MacDorman, M. F. (2008). Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set. *National Vital Statistics Reports,* 57 (2), 1-32.

Maynard, R. A. (1996). *Kinds having kids: A Robin Hood foundation special report on the costs of adolescent childbearing.* New York: Robin Hood Foundation.

Mayor, S. (2004). Pregnancy and childbirth are leading causes of death in teenage girls in developing countries. *BMJ*, 328, 1152.

Mehta, S., Groenen, R., & Roque, F. (1998). *Adolescent in changing times: Issues and perspectives for adolescent reproductive health in the ESCAP region*. A paper presented in international conference on Population and Development, Thailand, 24-27 March.

Mikkelsen, B. (1995). *Methods for development work and research.* London: Thousand Oaks.

Moore, K. A., Miller, B. C, Sugland, B.W., Morrison, D. R., Glei, D. A, & Blumenthal, C., (2007). *Beginning too soon: Adolescent sexual behaviour, pregnancy and parenthood. A review of research and Interventions.* Retrieved August 24, 2010 from http://aspe.hhs.gov /hsp/cyp/xsteesex.htm

Neuman, W. L. (2003). *Social research method* (5th ed). Boston: Pearson Education.

Nyame, K. (2009). *Central Region takes steps against teenage pregnancy.* Retrieved April 23, 2010 from http://discussions.ghanaweb.com/ viewtopic.php?t=101287&sid=88d6be049f790cb7b705b8ab83005faf.

Peña, E., Sánchez, A., & Solano, L. (2003). Profile of nutritional risk in pregnant adolescents (in Spanish; Castilian). *Arch Latinoam Nutr,* 53 (2), 141–9.

Policy Studies Institute (1998). *Teenage mothers: Decisions and outcomes - provides a unique review of how teenage mothers think.* London: University of Westminster.

Population Council (2006). *Unexplored elements of adolescence in the developing world.* Population Briefs

Raatikainen, K., Heiskanen, N., Verkasalo, P.K., & Heinonen, S. (2006). Good outcome of teenage pregnancies in high-quality maternity care. *Eur J Public Health,* 16 (2), 157–61.

Rebecca, W. (2004). *U.S teenage pregnancy drops for 10th straight year.* New York: Alan Guttmacher Institute.

Saewyc, E. M., Magee L. L., & Pettingell, S. E. (2004). Teenage pregnancy and Associated risk behaviour among sexually abused adolescent. *Perspective on Sexual and Reproductive Health*, vol. 36, num.3.

Senanayake, P., & Ladjali, M. (1994). Adolescent health: Changing needs. *Int J Gynecol Obstet* , 46, 137–143.

Tamkins, T. (2004) *Teenage pregnancy risk rises with childhood exposure to family strife.* Perspectives on Sexual and Reproductive Health, U.S.A

Therese, L. (2000). *Early marriage and motherhood in sub-saharan Africa.* Retrieved January 30, 2010 from www.en.wikipedia.org

Uhlich Children's Advantage Network (2006). *Fostering hope: Preventing teen pregnancy among youth in foster care*. Retrieved February 23, 2010 from www.thenationalcampaign.org/resources/reports.

UNFPA (2003). *State of world population*. New York: UNFPA.

UNICEF (2001). *A league of tables for teenage births in rich nations. Innocenti report card no.3.*, UNICEF Innocenti Research Centre, Florence. Retrieved April 7, 2010 from www.unicef-irc.org/publications/ pdf/repcard3e.pdf.

Uren, Z., Sheers, D., & Dattani, N. (2007). Teenage Conceptions by Small Area deprivation in England and Wales 2001-2002. *Health Statistics Quarterly,* 33, 34-39.

Waddington, D. E. (2007). *Teenage pregnancy: Risk-taking, contraceptive use, pregnancy and risk factors.* Master thesis submitted to the Department of Social Work, University of Göteborg.

Zurayk, H., Sholkamy, H., Younis, N., & Khattab, H. (1997). Women's health problems in the Arab world: A holistic policy perspective. *Int J Gynecol Obstet* , 58, 13-21.

APPENDICES

APPENDIX I

UNIVERSITY OF CAPE COAST

INSTITUTE FOR DEVELOPMENT STUDIES

INTERVIEW SCHEDULE FOR PREGNANT TEENAGERS/ TEENAGE MOTHERS

This interview schedule is designed to elicit information from pregnant teenager/ teenage mothers in the area. The information given will be strictly used for academic purposes. The information provided will be given the confidentiality it deserves. Thank you for agreeing to participate.

1. Sex : a. Male [ ] b. Female [ ]
2. Educational level attained?
   a. Primary Level [ ] b. J.H.S [ ] c. S.H.S [ ] d. Tertiary [ ]
   d. Other, please specify ……..
3. Age ……
4. Religious affiliation
   a. Christianity [ ] b. Islamic [ ] c. Traditional [ ]
   d. Other, please specify…….
5. Marital Status
   a. Never married [ ] b. Married [ ] c. Divorced [ ]
   d. Separated [ ] e. Other, please specify ……
6. Place of birth ……
7. Current occupation ……

CAUSES, CONSEQUENCES AND OTHER RELATED ISSUES OF TEENAGE PREGNANCY

8. Are you married? a. Yes [ ] b. No [ ]

9. Are your parents alive? a. Yes [ ] b. No [ ]

10. Are they still married?
    a. Yes [ ] b. No [ ]

11. With whom did you live when you got your first pregnancy?
    a. Both biological parents [ ] b. Father only [ ] c. Mother only [ ]
    d. Husband [ ] Other [ ] specify…….

12. Provide the occupation for the following
    a. Mother……..
    b. Father ……
    c. Guardian ……....

13. Do you still live with your Parent(s) /Guardian
    a. Yes [ ] b. No [ ]

14. To what extent did the following factors influenced your pregnancy?

Factors		Very High	High	Uncertain	Low	Very low
1	Early marriage					
2	Inadequate knowledge on contraceptives					
3	Non use of contraceptives					
4	Sexual abuse					
5	Poverty					
6	Low level of education					
7	Peer pressure influence					
8	Age discrepancy in the relationship					
9	Broken homes					
10	Family neglect					
11	Death of parent(s)					
12	Other, specify					

15. In the case of sexual abuse (rape), did you report the culprit to the appropriate authorities?

    a. Yes [ ] b. No [ ]

16. If No, state your reasons for not reporting?

    ……..

    ……..

    ……

    …….

17. How old was your partner when you first got pregnant?.....

18. Did you live with your parent(s)/guardian after you told them you were pregnant

    a. Yes [ ] b. No [ ]

19. If No, why did you leave, and where did you go to live?

    ……

    ……

    ……

    ……

    ……..

20. How did you feel when you realize that you were pregnant?

    ……

    ……

    ……

    ……

    ……

21. What first thought came into your mind when you got pregnant?

    ……

    ……

    ……

    ……

    ……

22. Did you receive any support from your parent after you got pregnant?

    a. Yes [ ] b. No [ ]

23. If Yes to q24, please specify the nature of support received?

    ……

    ……

    ……

    ……

    ……..

24. Did you receive any support from your community/friends after you got pregnant?

    a. Yes [ ] b. No [ ]

25. If Yes, please specify the nature of support received?

……

……

……

……

26. If No to Question 26, please explain why you didn't receive any help?

……

……

……

……

……

27. Did you visit the health facility to seek medical attention during your pregnancy period?

a. Yes [ ] b. No [ ]

28. If Yes, how did you finance the medical bills at the centre? Tick as many responses that apply.

a. I worked for it [ ] b. Funds from friends [ ] c. Through NHIS [ ]

d. Funds from parents [ ] e. Others, please specify ……

29. If No to Question 29, what source of medical attention did you seek?

a. Traditional medicine [ ] b. Drug recommended by friends [ ]

c. Drugs from the chemical shop [ ] d. Others, please specify ……..

30. Do you sometimes feel rejected by your loved ones after you got pregnant?

a. Yes [ ] b. No [ ]

31. Please explain your choice of answer under Question 32?

……

……

……

……

32. To what extent has your pregnancy affected you?

Consequences	**Very High**	**High**	**Normal**	**Low**	**Very low**
Inadequate nutrition					
School drop-out					
Unemployment					
Health problems					
Single parenting					
Family neglect					
Social vices					
Other					

33. Have you regretted being pregnant at this age?

a. Yes [ ] b. No [ ].

Explain ……..

……

……

……

……

34. What words of advice will give to your teenage friends in the area?

……
……
……
…….....

APPENDIX II

UNIVERSITY OF CAPE COAST
INSTITUTE FOR DEVELOPMENT STUDIES

Interview guide for health authorities.

Date of interview:

Place of interview:

Interviewer name:

Interviewee Gender:

Organisation/Institution:

Position/title:

This main objective of the study is to investigate the causes and effects of current teenage pregnancy levels in the Assin South District of Central Region. The information given will be strictly used for academic purposes. The information provided will be given the confidentiality it deserves. Thank you for agreeing to participate.

Causes and trends of teenage pregnancy

1. What do you think are the major causes of teenage pregnancy in Assin South district?

2. Is poverty the main cause of teenage pregnancy in Assin South District? Why

3. What is the trend of teenage pregnancy in this district?

4. What do you think has contributed to this trend?

5. Are you satisfied with the trend of teenage pregnancy in Assin South district? Why

6. Do you think teenage pregnancy is a problem in Assin South District? Explain

Health related issues and consequences of teenage pregnancy

7. Do teenage mothers or pregnant teenagers attend your facility?

8. If they do, how long does it take them to report such cases?

9. Has your outfit had delayed cases on teenage pregnancy?

10. If you've had delayed cases of teenage pregnancy, what were some of the health implications to the pregnant teenagers and the foetus?

11. Do teenage mothers or pregnant teenagers visit your outfit for regular check-ups? Why

12. Could you kindly explain some of the health issues you face with pregnant teenagers?

13. What do you think prevents some pregnant teenager from coming for regular check-ups?

14. What are some of the health consequences you think pregnant teenagers or teenage mothers face in Assin South District?

15. Apart from the health consequences what other consequences do teenage mothers faces in Assin South District?

MEASURES AND MECHANISMS IN PLACE

16. What measures has your outfit put in place to reduce the causes of teenage pregnancy in this area?

17. Do you organize community seminars or public education in the community to educate the young one's on teenage pregnancy?

18. Who is responsible to educate the children on Teenage Pregnancy?

19. What challenges does your outfit face in relation to teenage pregnancy in Assin South District?

20. What effects do these challenges have on teenage pregnancy in the district?

21. Rating from very good, good, normal, low and very low how can you rate the performance of your outfit in relation to teenage pregnancy issues in the district?