MEASURE Evaluation PRH

Working Paper Series

Improving Family Planning Service Delivery to Adolescents in Ghana: Evidence from Rural Communities in Central Ghana

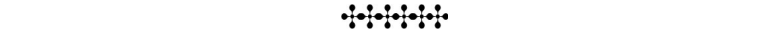
Yeetey Enuameh, Ellen Boamah, Obed Ernest Nettey, Charlotte Tawiah, Alex Manu, Abubakari Sulemana, Charles Zandoh, George Adjei, Emmanuel Mahama, Stephaney Gyaase, Samuel Afari-Asiedu, Seth Owusu-Agyei

October 2012

WP-12-128

MEASURE Evaluation PRH is funded by the U.S. Agency for International Development (USAID) through cooperative agreement associate award number GPO-A-00-09-00003-00 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Futures Group, Management Sciences for Health, and Tulane University. The opinions expressed are those of the authors and do not necessarily reflect the views of USAID or the U.S. government.

Carolina Population Center
University of North Carolina at Chapel Hill
206 W. Franklin Street
Chapel Hill, NC 27516
Phone: 919-966-7482
Fax: 919-966-2391
measure@unc.edu
www.cpc.unc.edu/measure



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Stephaney Gyaase
Samuel Afari-Asiedu
Seth Owusu-Agyei

Kintampo Health Research Centre

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Introduction

Adolescence is the period between the ages of 10 and 19 years when young individuals transition into adulthood.[2-3] This period is subdivided by some into early (10-14 years) and late (15-19 years) adolescence,[4-5] whereas others refer to early (10-13 years), mid- (14-15 years) and late (16-19 years) adolescence.[2] As per the 2000 population census, adolescents constitute a fifth (21.9%) of the total population of 18.8 million people in Ghana.[7] In the Kintampo North Municipality and the Kintampo South district, the area covered by this study, adolescents make up a fifth (20.2%) of the population of 136,356 people, which is similar to the national figures.[12]

Family planning (FP) aims at empowering individuals and couples to anticipate and attain their desired number of children whilst appropriately spacing and timing their births. This process is achieved mainly through the use of contraceptive methods and the treatment of involuntary infertility. The spacing and limiting of pregnancies has a great impact on a woman's health and well-being; as well as on outcome of each pregnancy.[1]

Background

Lifestyle choices made during adolescence could enhance or diminish future health states,[6] as young people are exposed to risks such as substance use, unprotected sexual behavior, and behavioral disorders. Risky behaviors, together with adjustment difficulties at a young age, are associated with negative outcomes such as early pregnancy with its related complications.[2]

Pregnancy rates among adolescents 15 to 19 years of age remain high in Ghana in spite of a decline from 14% in 2000 to 12.2% as of 2007.[7] The Brong Ahafo Region of Ghana, where this study was undertaken, recorded 13.4% adolescent births in 2007 as compared to 14.5% in 2000.[7] Records from the Kintampo Health and Demographic Surveillance System (KHDSS) show that 3% of all births in the Kintampo North Municipality and the Kintampo South district between 2005 and 2008 were from adolescent mothers.

Pregnancies and births among adolescents are mostly unplanned and are associated with higher maternal and infant complications/mortality as compared to their older compatriots. Encouraging FP uptake among adolescents is vital to reducing maternal mortality (United Nation's Millennium Development Goal [[MDG] 5) in this population as well as infant mortality (MDG 4).[8] Unplanned pregnancies among adolescents often result in unsafe abortions and pose higher risks of adverse outcomes for both the mother and the newborn: the maternal mortality ratio among adolescents is twice that of women in their twenties.[3] Infant and child deaths are higher among those born to adolescent mothers.[3, 10]

In the midst of such high levels of adolescent pregnancies, contraceptive use is low among this population in Ghana. According to the 2008 Ghana Demographic Health Survey (GDHS), knowledge of at least one type of contraceptive is generally low among adolescents aged 15 to 19 years,[7] the use of any contraceptive method is lowest in the 15- to 19-year cohort, with females at 19.5% and males at 14.7%.[7] Contraceptive use is known to prevent between 20% and 35% of maternal deaths, but social norms and limited FP supplies and social services prevent their correct and consistent use by adolescents in most low and middle income countries.[8] FP

Information and education for adolescents is limited to married adolescents.[7] A recent study of adolescent sexual and reproductive health (ASRH) needs in the Kintampo North Municipality and the Kintampo South district point to poor knowledge and use of contraceptive methods with the exception of the male condom.[9]

Justification of the Current Study

The Obaapa Vitamin A study over the past 10 years recruited about 200,000 females to receive vitamin A supplements. Female adolescents were recruited at age 10 and were followed until the age of 15. The outcomes monitored in the course of the study were pregnancies, births, and birth outcomes (maternal and neonatal mortality).[12] Through this study, the KHDSS accumulated a wealth of data on fertility and its determinants in the Kintampo North Municipality and the Kintampo South district ─ its traditional areas of coverage and beyond. Using quantitative data on FP from the KHDSS, together with qualitative data from focus group discussions (FGDs) and in-depth interviews (IDIs), the current study sought to move a step further by generating evidence to guide FP service delivery to adolescents in the two administrative districts.

Study and Research Objectives

The objective of the study was to identify the FP needs of the adolescent populace in the Kintampo North Municipality and the Kintampo South district and to define the best approach to satisfying their needs. This objective was addressed by responding to the following research questions.

1. What are the FP needs of adolescents?
2. Do adolescents view FP as important to their health and well-being?
3. What are (a) societal and (b) healthcare provider perspectives on FP services for adolescents?
4. What are the views of (a) adolescents, (b) society, and (c) healthcare providers as to how best to address adolescents' FP needs?

Methods

The KHDSS, which is administered by the Kintampo Health Research Centre (KHRC), constantly collects information on the health needs of the population from the Kintampo North Municipality and the Kintampo South district in the Brong Ahafo Region of Ghana. The KHDSS conducted an ASRH survey from August 2011 to November 2011. A sample of 2,641 was estimated, comprised of 1,805 females and 836 males aged 10 to 19 from a resident adolescent population of 34,886 (16,795 females and 18,091 males) within the KHDSS as of July 2011. The survey was designed to allow for a reliable estimation of sexual and reproductive health (SRH) behavior, contraception, fertility preferences, and knowledge and prevalence of self-reported sexually transmitted infections (STIs) within the study population.

Study Design

The study design for this project was cross-sectional employing a mixed-methods (quantitative and qualitative) approach. Data were collected from multi-informant sources (adolescents, community members, and healthcare providers in the study area).

Sampling Procedure

For the quantitative arm of the study, sampling was random; whereas for the qualitative arm, it was purposive. Data for the ASRH survey were collected as part of a larger SRH survey conducted by the KHDSS, which randomly sampled females aged 15 to 49 as well as the male partners among those who were either married or living together. Males aged 15 to 24 were randomly sampled to augment the members of this age group who were not currently in any relationship. To cover the full spectrum of adolescents for the purposes of the ASRH study, a random sample of males and females aged 10 to 14 years was included. A total of 2,641 adolescents (10 to 19 years) were sampled, consisting of 1,805 females and 836 males.

For the main SRH survey, 1,305 females aged 15 to 19 years were initially sampled. However, for the purposes of the ASRH study, a sample size of 610 (554 estimated and a 10% anticipated loss to follow-up) was required from a population of 7,132 females aged 10-14 years, at a confidence interval (CI) of 95% and precision of +/-0.04. This sample was based on an estimated proportion of contraceptive use of 51% from the 2004 National Survey on Adolescents.[14] Similarly, 336 males aged 15 to 19 years had previously been sampled for the main SRH survey. At a CI of 95% and precision of +/-0.06, a sample size of 249 (226 estimated and a 10% anticipated loss to follow-up) was required for the ASRH study from a population of 8,016 males aged 10-14 years, using an estimated proportion of condom use of 68% based on the 2004 National Survey on Adolescents.[14] Finally, 1,000 adolescents of ages from 10 years to 14 year (500 of each sex) were further sampled for the ASRH survey.

Quantitative Methods

Quantitative data addressed research objectives 1 and 2. The data was extracted from material gathered through the administration of the KHDSS FP module. A structured questionnaire consisting of close ended questions was administered to adolescents in the study area. Relevant data on adolescents' FP needs and their views on FP with respect to their health and well-being were collated. The questions in the module were adapted from the 2008 GDHS[7] and A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs [11] and were revised to suit the population under study. The questionnaires were administered to the study participants by well-trained and experienced research assistants who have been collecting data from the community for the KHDSS over the past few years.

Qualitative Methods

The qualitative section of the study was approached from an interpretive paradigm, which was designed to provide deeper insight into societal and cultural factors that influence FP use by

adolescents in the study community. The objective was to study society and healthcare providers' attitudes on FP delivery to adolescents, which would provide a fair idea of how they would respond to FP being provided to adolescents. Secondly, the qualitative arm sought to assess how best adolescents' FP needs could be addressed. Data were collected through FGDs and IDIs using interview guides. Five FGDs and 11 IDIs were conducted in both English and the local language of Twi over the study period and were recorded on an electronic audio device together with hand-written notes. Qualitative data from adolescents, societal representatives (e.g., chiefs, religious leaders, opinion leaders, representative assembly members, elders in the community) and FP providers working in health facilities were collected to address research questions 3 and 4. Two FGDs were conducted for community opinion leaders and three for adolescents with each group having between eight and 12 participants. IDIs were done among health workers and community representatives until a level of saturation of information was attained. Participants in the FGDs and IDIs were sampled purposively.

Data Management and Analysis

Quantitative data were double-entered initially into Microsoft FoxPro with verification and consistency checks applied. The data were then verified for accuracy and transferred to STATA 11.0 for analysis. The main themes analyzed with the quantitative data were the FP needs of adolescents and FP's importance to their health and well-being. Means, medians, and proportions were used to describe characteristics and responses of respondents. Cross-tabulations were used to examine associations between variables.

Qualitative data were analyzed manually. Audio recordings of FGDs and IDIs were transcribed and those performed in the local language were translated verbatim into English with manual coding done by two researchers. The identified themes and related quotes were included in the study report. The topics of interest in the qualitative analysis were how best to address the FP needs of adolescents from the perspectives of adolescents, community representatives, and FP providers.

Ethical Review

The Kintampo Health Research Centre Institutional Ethics Committee (KHRC IEC) approved the study ahead of its implementation.

Study Results

Results of Quantitative Methods

After data cleaning, 2,128 responses out of an estimated 2,641 adolescents sampled (80.6% response rate) were included in the data analysis. These consisted of 1,415 (66.5%) females and 713 (33.5%) males.

1. Background characteristics of respondents

The findings below are based on information provided in table 1. Close to two-thirds of both female and male respondents in the study area reside in rural communities. Well over four-fifths (83.3%) of adolescent females and a little under three-fourths (76.4%) of adolescent males have a primary education or higher. About a third (34.4% females and 33.1% males) of early adolescents (i.e. persons between 10 and 14 years) had no education. An overwhelming majority (about four-fifths or 83.4% of females and nearly all or 96.7% of the male adolescents) had never been in a relationship. Close to 2% of females and less than 1% of males were married, whilst about 12% and 2% respectively were living together with their partners. As expected, for both sexes, marital status appears to be related to age, with much more of the 15 to 19 year-olds married/living together as compared to the 10 to 14 year-olds.

2. Age at first sex, first marriage and first birth

Table 2 provides the backdrop to the study findings. At the time of the study, 27.4% female and 8.8% male adolescents had already engaged in sex (not shown). The age at sexual debut/first sex for those adolescents who have already engaged in sex ranged from 10 to 19 years of age and the median age for both genders was 16. Close to one fifth of females' (18.0%) and a fourth of males' (26.1%) first sex occurred during the period of early adolescence.

The age at first birth among 7.9% of females who had already given birth ranged from 12 to 19 years, with a median age at 17 years. The age at first birth for the 0.6% males was from 16 to 19 years with the median at 17years. An overwhelming majority of births among females occurred in the late adolescence period (92.8%), whereas all births in the males occurred in the late adolescence.

Female adolescents in this study (15.6%) began their first marriages from age 12 with most of the marriages (28.5%) occurring by age 16 years. Male adolescents started their first marriages at age 14 years (4.0%) and peaked at age 15 (32%). A little over a tenth (12.7%) of female marriages occurred in the early adolescence period with very few (0.4%) males married over the same period.

3. Recent/lifetime sexual activity

Table 3 provides information on the lifetime sexual experiences of adolescents according to their age and marital status. Recent sexual activity was defined as having engaged in sexual intercourse in the past four weeks prior to the survey. Although a majority of them had never had sex, more female adolescents had been sexually active as compared to their male counterparts (28% females versus 10% males). It is also worth noting that early adolescents of both genders (98.5% females and 98.6% males) were much more likely not to have engaged in sexual activities as compared to their older peers (61.1% females versus 77.1% males). This is corroborated by the finding that females aged 15 to 19 years of age had been much more sexually active recently (18.8%), compared to 10 to 14 year-old females (0.5%); and males aged 15 to 19 had been much more sexually active recently (12.3%), compared to 10 to 14 year-old males (0.2%).

For both sexes, lifetime sexual activity varies by age and marital status. Whilst almost 40% of females of ages 15 to 19 years had previously been sexually active, less than 2% of 10 to 14 year-olds had ever had sex. For males, the age group figures were 22.9% and 1.4%, respectively. As might be expected, almost all adolescents who were married/living together, as well as those widowed, divorced, or separated had previously been sexually active for both sexes. However, about 15% of never married females had been sexually active compared to about 8% of males.

4. Pregnancy and birth rates by age groups

Table 4 provides information on pregnancies and births among adolescents. Most pregnancies and births occurred within late adolescence with more females ever being pregnant and having babies (16.7% and 11% respectively) as compared to males impregnating and fathering (2.8% and 1.4%, respectively). Pregnancy and impregnation rates (0.5% and 0.7%) and birth rates (0.5% and 0%) in early adolescence were low for both females and males, respectively.

5. Not being ready for a pregnancy and being willing to accept help to prevent it

Table 5 describes adolescents who did not want to be pregnant and those who would have accepted help in the form of FP services to prevent the pregnancy. A little over a third of females (35.5%) who had ever been pregnant had not been ready for the pregnancy (unintended), compared to about a fifth (18.2%) of males. Almost all females with an unintended pregnancy (33.1%) would have accepted help to prevent them, in contrast to half (9.1%) of their male counterparts.

Among the never-married females who had given birth, less than half (44.7%) had unintended pregnancies and most of them (42.1%) would have accepted help in the form of FP to prevent that pregnancy. About a third of females who were married/living together with their partners (34.5%) had unintended pregnancies and a majority (31.0%) would have accepted help to prevent it. A fifth of women (20.0%) who were widowed/divorced/separated had an unintended pregnancy and close to a fourth of them (26.7%) wanted help to prevent it. Half of pregnant females (50.0%) who were not married but were sexually active in the last 30 days prior to the study did not intended to be pregnant and over a third of them (37.5%) would have accepted some help in the form of FP to prevent it. Close to 40% of males who were married/living together who had impregnated a female did not intend to have the pregnancy and a fifth of them (20.0%) would have accepted help to prevent it.

6. Knowledge of FP methods

Table 6 presents information on the FP knowledge of adolescents. Knowledge of any method and modern methods of contraception was the same across age ranges and marital status. Females, however, were more knowledgeable (87.7%) than their male compatriots (82.0%). Both females and males (48.6% and 33.9% respectively) had less knowledge of traditional methods, but with females still ahead of the males. The younger adolescents, both female and male, were less knowledgeable as compared to their older compatriots when it came to all forms of contraception. Adolescents who had been in a relationship (married, living together, widowed, divorced or separated) had higher levels of knowledge as compared to those who had never been

in any relationship and were not sexually active. However, adolescents who had never been in any relationship but were recently sexually active had the highest level of knowledge among the study participants.

7. Ever use of FP methods

Table 7 shows those who had ever used FP methods. Contraceptive use of any method was generally higher among the older adolescents (24.9% in females and 14.1% in males) as compared to the younger ones (1.0% in females and 0.7% in males) and among the females as compared to the males. Similar to the knowledge of contraceptive methods, adolescents who were in or had been in some form of relationship (72% and 75% in married/living together females and males, respectively; 52.2% and 100% in widowed/divorced/separated females and males, respectively) had ever used contraceptives more frequently as compared to those who had never been in a relationship (8.6% females and 3.8% males). Among those who were in some relationships, males reported having ever used contraceptives more than females. Contraceptive use among respondents who had never been in relationships but were sexually active was slightly higher in males (56.5%) as compared to females (54.7%).

8. Current and intended use of FP methods

Table 8 provides information on females' current and intended use in the future, whereas for males it is about their most recent use and knowing where to access FP methods. By age groups, older female adolescents' current use of FP methods (12.9%) was greater than that of the younger ones (0.0%). Considering those in relationships, current use of FP methods in females who were married/living together was highest (38.3%), followed by those not married but recently sexually active (31.4%), the widowed/ divorced/separated (21.7%), and the least being the never being in relationships (4.2%). The use of a FP method at the last sexual encounter among female adolescents followed the same pattern as that for current use of the methods.

A greater percentage of older adolescent females stated their intention to use FP methods in the future (59.9%) as compared to their younger colleagues (38.3%). Widowed/divorced/separated females were most intent on using FP methods in the future (87.0%). Intent on using FP among recently sexually active was 75.6%, among those who were in relationships it was 71.5%, and intent to use a method in the future was lowest among those who had never been in a relationship, 50.8%.

The older adolescent male cohort knew more about places they could access condoms (71.5%) than their younger compatriots (40.8%). All of the widowed/divorced/separated male adolescents, as well as those not in a relationship but who were recently sexually active knew where to get condoms (100%), followed by the males who were married/in relationships (85.0%), and those who had never been in a relationship (52.1%).

About a tenth (12.0%) of the older male adolescents said they used a method at their last sexual encounter as compared to 0.2% of the younger ones. All of the widowed/divorced/separated (100.0%), a little under two-thirds (60.9%) of the never being in relationships but recently

sexually active, half of the married/in relationships (50.0%), and 3.3% of the never been in a relationship had used a method at their last sexual encounter.

9. FP method used at most recent sexual activity and preferred method for future use

Table 9 shows the distribution of FP methods used at last sex and preferred future FP method.

An overwhelming majority of adolescent females (41.1%) used no FP method at their last sexual encounter, followed by the male condom (20.9%), the rhythm method (16.6%) and the pill (13.8%). Methods that were less used among females were the injectable (3.6%), withdrawal method (2.4%), and the female condom (0.4%).

In the case of male adolescents, the majority used the male condom (65.1%) and a quarter of them (25.1%) used no method at all. The rhythm method, female condom, male sterilization, and the pill were each used by 2.3% of male adolescents.

The future FP method of choice for most females was the injectable (35.2%), followed by the pill (20.6%), male sterilization (9.9%), no intention to use any FP method (19.4%), and the male condom (5.9%) occupying fifth place in order of preference. Other less favored preferences were the IUD (2.0%), female condom (0.8%), diaphragm (0.8%), and the foam or gel (0.4%).

10. Main sources of FP information

Table 10 presents the main sources of FP information adolescents accessed in the last few months. The radio was the main source of information on FP for close to a third of both female and male adolescents (29.1% for females and 29.6% for males). The television (19.9% females and 15.4% males), socializing (19.1% females and 10.7% males) and reading from posters (10.2% females and 10.5% males) were among other sources of information. For females, magazines were the least popular source of information (3.8%) followed by shops (7.1%); whereas for men, shops (3.9%) were the least informative, followed by magazines (4.2%).

In the context of this paper, socializing for females was taking part in such activities as fetching water from outside a compound, going to farm or market, or visiting the hairdresser or the seamstress. Socializing for males included playing indoor games such as draught, ludo, or oware; or visiting alcohol drinking spots in the community.

11. Importance of FP to health and well being

Table 11 describes adolescents' views of the importance of FP services. On the whole, with the exception of younger adolescents and in a few instances among those who had never been in a relationship, more than half of each category of study participants agreed on the importance of FP in reducing unwanted pregnancies, reducing STI risk, improving maternal and child health, reducing maternal deaths, and ultimately improving the health and well-being of individuals.

12. Perceptions of FP use

Table 12 summarizes the perceptions adolescents have with respect to FP and some social issues. With the exception of females who were married/living together with their partners (57.5%), most respondents of both genders were of the view that FP is not the responsibility of women alone. The majority of the males who have never been in a relationship but were recently sexually active (78.3%) and of females who were widowed/separated/divorced (65.2%) thought FP makes women promiscuous.

The majority of study participants perceived having many children as dangerous to a woman's health (71.2%), thought it was better not to have many children (83.6%), and were of the view that smaller families were more likely to succeed in life (76.3%).

Results of Qualitative Methods

A total of 16 qualitative interviews were performed by the research team consisting of two FGDs with opinion leaders in the various communities, three FGDs with adolescents, four IDIs with opinion leaders of the communities, and seven IDIs with health workers linked to FP service delivery in the communities. Opinion leaders were all males, and both genders were represented among healthcare providers. The ages of the adult respondents ranged between 31 and 79 years. Adolescent females ranged between 13 and 17 years of age, whereas their male counterparts were between 13 and 19 years old.

The level of education of the adult population involved in the study was quite varied: there were those with no formal education, others with Middle School Leaving Certificates (MSLC) and Junior High School (JHS) certificates and diplomas. The adolescent population was currently in school, ranging from primary school class 6 to JHS form three (3).

Study participants were predominantly from the Bono and Mo ethnic groups that reside in the Kintampo North Municipality and the Kintampo South district in the middle belt of Ghana. There was a minority of study participants from migrant ethnic groupings of the Northern Region of Ghana that reside in the communities.

Themes that emerged from analysis of the interviews with respect to **perspectives on FP care delivery to adolescents** were as follows:

- Preventing and reducing unwanted teenage pregnancies is a good thing.
- FP could help adolescents achieve greater heights.
- Adolescents experience obstacles in accessing FP services.
- FP is not good for adolescents as they could be corrupted by the knowledge and become promiscuous.
- There are (perceived) complications with FP methods.
- Adolescents need to be introduced to various FP methods.

Themes that emerged from analysis of interviews with respect to **how best to address adolescents' FP needs** were as follows:

- There is the need to educate communities and adolescents on the benefits of FP.
- There is the need to educate communities and adolescents on FP methods and where they can be accessed.
- The state needs to commit to FP.
- Societal traditions and customs should be revamped/reinstituted to facilitate FP interventions.
- Religious leaders have a role to play in accepting FP services.
- FP services should be free and readily accessible.
- Education is needed to change poor healthcare provider attitudes.

The above themes are further discussed below.

Perspectives on FP care delivery to adolescents

1. Preventing and reducing unwanted teenage pregnancies is a good thing

Study participants believed it is good for adolescents to use FP as stated by a health worker:

> *It is good we introduce it to them (young people) because the person will not abstain from sexual relationship because he or she is young so once they are already doing it they would have to do family planning to avoid teenage pregnancy. Sometimes a young man impregnates someone and runs away from the community and because the girl does not want anybody to know she is pregnant, she tries all means to terminate the pregnancy and this brings a lot of problems.*

2. FP could help adolescents achieve greater heights

Persons involved in the study agree that FP could facilitate adolescents' achievement of life ambitions, such as completing school, learning a trade, etc. An opinion leader was of the view:

> *That (FP) will help the person to achieve her aim whether you are attending school or learning a trade. Maybe the person does not want to destroy her future; if she does not go for family planning she could get pregnant and that will prevent her from achieving her aim.*

3. Adolescents experience obstacles in accessing FP services

Study participants identified various obstacles to adolescents accessing FP services. One is the financial cost of accessing FP services as stated by an opinion leader:

> *If someone wants to do family planning he may be thinking about the cost, maybe she might not have the money to do it, for family planning you need not to be sick before you do family planning, so I believe if someone really wants to do it she can walk to pick a car and go, because we even walk a long distance to go to market, so I think the distance is not really a problem but then the money is the issue.*

Another is the stigma associated with sexually active adolescents seeking FP and the community's perception that they are bad or spoilt kids. An adolescent describing the situation said, "*They (adults) usually see (view) such a (young) person (going for FP) as a prostitute who does not want to give birth, so as to continue his or her prostitution."*

An opinion leader describes adolescents seeking FP as "*a lot of them are not good (spoilt)."* Adolescents feel healthcare providers do not make it any easier for them to access FP. "*When you are a child and you go to the drugs store that you need some of the family planning drugs, they will mistreat you and brand you as a spoilt child,"* said one person. A significant barrier is judgmental and discriminatory healthcare providers, who may deny adolescents FP services if they feel adolescents "are not old enough" or are unmarried and, thus, presumably, not needing FP. Some adolescents commented that health workers label adolescents seeking FP services as prostitutes. It is no wonder then that shyness and intimidation creates another barrier to access. Not only do many adolescents lack the confidence to inquire about FP, they feel nervous about the prospect of having to answer a health worker's many questions about their personal circumstances and motives for wanting to use FP. Another obstacle mentioned were health workers not abiding by the rules of confidentiality. One adolescent observed, *"Sometimes if you have a boyfriend or a girlfriend that your parents are not aware of and you decide to go and do family planning, the health worker will go and tell your parents.*" Some respondents, however, thought that healthcare providers do perform their roles credibly. This view was held by mostly opinion leaders, rather than adolescents who may have had different experiences as FP clients.

4. <u>FP is not good for adolescents as they could be corrupted by the knowledge and become promiscuous</u>

Some respondents were of the view that educating adolescents about FP could lead them into promiscuity instead of healthy behaviors. A male health worker stated:

> *As a child, once you have taught him/her, he will do it. So, for me, once the fellow is not up to the age...in my opinion, there is no need to teach him those things... For me, it should stop…when you render the education...the demonstrations that you will do.... in the course of educating, discloses certain things, you see? You see.... sometime ago, we went.... druggists went for a workshop concerning this very condom. When we went, they had carved a certain stick (laughs) exactly like our manhood and with that, they demonstrated how to wear a condom and after you have finished doing your own thing how you can remove it, you see? So if you go to stand in front of that 10 to 19 year old child to teach this, it will even draw the attention of the child to the thing, you see? So, for me.... this kind of education.... if the fellow is not up to the age of marriage, let us not teach them things like that.*

Despite beliefs about its potential to lead adolescents into promiscuity, some respondents recognized the need to promote FP to prevent maternal deaths. Even while condemning FP's role in "corrupting" adolescents, some acknowledged that "protecting the child…to live longer" was more important.

5. There are (perceived) complications of FP use

FP was thought to have adverse health effects as described by an adolescent, "*That is what we first talked about, maybe the person might have heard that a colleague have had complications due to this family planning for instance may be a swollen of one bottoms which has rendered the person disabled, or some even get heart diseases or feel dizzy when they take the injection. So these and some other … things discourage the young ones from engaging in family planning."*

6. Adolescents need to know the various FP methods and the limitations of each

Some respondents were concerned about the misperception that FP affords full protection for the user. They were concerned that FP seems to provide an erroneous sense of security to young people, and as such, they need to be educated as much as possible on the methods and their limitations. A healthcare provider noted:

> *Family planning is good but we have to be cautious…We tell them (adolescents) that if they can abstain from sex, then they do not need family planning. The fact that you have done the family planning does not mean you have protected yourself against HIV/AIDS, because family planning is not only condom, and the other method does not protect you against other sexually transmitted diseases. So whilst we educate people on family planning, we have to tell them about the STIs… Especially the young girl as soon as they do the family planning they think it is all over; they can do whatever they want.*

How best to address adolescents' FP needs

1. There is the need to educate communities and adolescents on the benefits of FP

Community education was seen by respondents as a means to get them to understand FP and thus reduce teenage pregnancies. A healthcare provider summarized by saying"*we need to talk to them (the school children and the community) and explain to them the benefits of family planning; it all about talking to them."*

2. There is the need to educate communities and adolescents on FP methods and where they can be accessed

Study participants were of the opinion that community members should be educated on FP methods and the importance of making them available and accessible to adolescents. A male health worker observed:

> *Family planning drugs are plenty in the system and I have never heard of shortage but for people to understand and do the family planning is a problem. They do not know why they should do the family planning so we have a lot to do. If possible, we should go into the communities, gather people and talk to them about the benefits of doing the family planning, radio announcements and one on one education. The numbers of people who know about it are really small and education and publicity is minimal.*

3. The state needs to commit to FP

Some adolescents saw the need for government to commit to FP programs through infrastructural developments and the enactment of supportive legislation. An opinion leader had this to say:

> *I think it mostly rests on the government, if the government is really serious to help these young ones then it should be able to make the drugs available at less or no cost at all, because somebody might be interested in it but may not have the money to pay, so that is what the government can also do to … help.*

4. Societal traditions and customs should be revamped/reinstituted to facilitate FP interventions

Study participants thought that the reinstitution of traditional values and rites of entry into adulthood could go a long way to enhance FP use among adolescents and reduce unwanted pregnancies. An adolescent said,*"'Kyiribra' (puberty rites) if they bring it back it will scare the young ones from getting pregnant so they will resort to using family planning."*

5. Religious leaders have a role to play in accepting FP services

Some respondents suggested that religious leaders in the communities should be made to take on roles to create awareness and acceptance of FP. A healthcare provider had the following suggestion:

> *In our community when we say someone is a leader, the rest of us follow him without challenging him. For example a religion like Islam, if the leaders could talk to their people for them to understand the family planning, they will also tell others about it. It is the leaders who will talk against it but if they don't do that, to their people it means the thing is good. The same can be done for the traditional healers; we should form an association for them so that we can talk to them about family planning.*

Other study participants, however, were of the view that religious leaders could not do much to change entrenched beliefs of community members with respect to not wanting to use FP.

6. FP services should be free and readily accessible

Free and readily accessible FP services were seen by respondents as a facilitator to successful FP programs. In the words of a healthcare provider, *"If it is available and then it's free, they (adolescents) will go and take it."* An opinion leader observed that with maternity services being free of charge and people having to pay for FP services, there was an incentive to have more babies instead of practicing FP.

7. Education is needed to change poor healthcare provider attitudes

An issue raised was the need for healthcare provider to change their approach to adolescents (as FP clients) by addressing them with respect and adhering to the principles of confidentiality.

8. Role of parents and elders of the community

Parents' role cannot be underestimated in adolescent's use of FP services, an opinion leader commented, "*I think it also depends on the sort of relationship that exists between you and your child, some of the children fear their parents to the extent that they can't discuss family planning matters with them.*" Another opinion leader's comments on how parents' support for their children could enhance their use of the services "*all will depend on the good parenting that we will give to our children, for instance if you have invested expensively in your child's education you would do all that you can and even advise her to do the family planning.*"

Discussion

In this study, close to one fifth (19.1%) of females aged 15 to 19 years were married/living together (in relationships) as compared to 6.7% of males of the same age group. These rates are higher than those in an earlier study among adolescents in Ghana, in which 7% of females were in relationships as compared to 1% of males. Less than 1% (0.4%) of female adolescents and 0.2% males aged 10 to 14 years of age were in relationships as compared to none in the earlier mentioned study.[14] According to the 2008 GDHS, 8.3% of females and 0.7% of males aged 15 to 19 years old were in relationships. Marital rates among adolescents in the study population seem to be higher than rates observed in earlier studies in the study population nationwide.

In an earlier study among Ghanaian adolescents and the 2008 GDHS, females experienced first sex earlier than males, in contrast to the current study where first sex began at an earlier age with more males becoming sexually active earlier in life than females.[7, 14] The 2008 GDHS showed that teenagers and unmarried women, among others, were less sexually active in the four weeks prior to the survey. In that same survey, the proportion of women frequently sexually active increased with age, as was the case in the current study with older female adolescents being much more active than their younger compatriots.[7, 14] As in the current study, females in the study by Awusabo-Asare and colleagues were much more sexually active than the males both recently and over the lifetime.[14]

Similar to the findings from the 2008 GDHS, pregnancies among teenagers were more common with increasing age. In the study by Awusabo-Asare and colleagues, less than 1% as compared to close to 3% in the current study of adolescent males had made a female pregnant. Among the females in that study, 13% had ever been pregnant and 9% had had a baby, whereas in the current study 16.7% had been pregnant and 11% had babies.[14] The above depicts higher pregnancy and birth rates among adolescents in the study area compared to the national figures. An overwhelming majority of female and a sizeable proportion of male adolescents in this study who had unwanted pregnancies would have accepted help to prevent it, a situation that calls for the need to provide more support to this cohort.

The knowledge of at least a contraceptive method and modern contraceptive methods among the study population was high, similar to the study by Awusabo-Asare and colleagues.[14] Knowledge of traditional methods however was not as high as the modern methods. Older adolescents in both studies were more knowledgeable than their younger peers. Knowledge also seemed to increase with age in both genders of the population; however adolescents in relationships were more knowledgeable than those not in relationships. In the 2008 GDHS, sexually active unmarried females had the highest level of knowledge of contraceptive methods, but in the current study females and males were equally knowledgeable.

In the current study, older adolescents used more contraceptives than their younger colleagues. Females also ever used much more than their male counterparts as was observed in a study among Ghanaian adolescents.[7] The trend was different among the unmarried sexually active, where males used more than females, which is consistent with the 2008 GDHS. Adolescents in relationships also used more contraceptives as compared to the never married. In the 2008 GDHS, unmarried sexually active females were seen to be the biggest users of contraceptives.

In the current study, the difference in adolescents' use of a modern method as compared to a traditional method of contraception was not as great as that observed with respect to their knowledge of the methods. A high proportion of females as compared to males never used a contraceptive method at their last sexual encounter. The male condom was however the most popular FP method followed by the rhythm method among both genders. High male condom usage was determined by a study of Ghanaian adolescents as well.[7] With respect to intended FP use among females, less used methods like injectables and the pill were mentioned with the male condom being the least preferred method. This possibly means young females would have preferred other options other than the male condom had they been given the choice, and as such, these should be made available and accessible to them. Close to a fifth of female adolescents did not intend to use FP at all in the future. Possible reasons for this situation could be the fear of perceived complications from contraceptive use, stigmatization from society and health workers or they could wish to be pregnant.

The electronic media (radio and television) were the most prominent sources of FP information for adolescents in the current study, though socializing plays a role also. A Ghanaian study[14] among adolescents portrayed the dominance of radio and television as a source of FP information, but highlighted other sources such as teachers and peers, though these were not mentioned in the current study. However, FP messages should be disseminated through the electronic media as well as using peer group approaches to ensure the information is reaching the target population.

The general assertion by respondents in this study was that FP plays an important part in the health and well-being of individuals. It is important to address the younger adolescents' and never-marrieds' less favourable view of FP's importance in the health and well-being of people.

Adolescents generally viewed FP in a positive light. It is however necessary to address negative attitudes such as FP fuelling promiscuity and the likes among certain groups of adolescents.

Limitations to the Study

This was a cross-sectional study to access the situation on the ground to advise further action on FP care to adolescents. Subjects for the FGDs and IDIs were purposively sampled from the communities and, as such. their views and suggestions could be skewed towards the needs of their populace.

Conclusion

The study set off to address four objectives. With respect to the FP needs of adolescents, marital rates among adolescents in the study area were above national figures. Adolescents initiated sex earlier in the study population with more males becoming sexually active ahead of their female counterparts contrary to previous study findings. Female adolescents in the study population were more sexually active than males in the short and long term prior to the study. Both adolescent females and males in the current study who had been pregnant or had impregnated before would have accepted help to prevent the pregnancy. Pregnancy and birth rates in the study population were higher than those found in earlier studies in Ghana. As expected, contraceptive knowledge and current use was less among the younger adolescents, and considering the higher marital, pregnancy and birth rates of the study population, much more needs to be done to make services accessible to them. This concern was amplified in the qualitative arm of the study held with community representatives, health workers and adolescents. Adolescents in the current study mostly used the condom followed by the rhythm method, however the future preferences of females such as injectables and pills points to gaps in accessibility. The obstacles to FP care mentioned during the qualitative data collection seem to explain the reasons behind the gap.

On the issue of FP's importance to health and wellbeing, most adolescents responded in the affirmative with younger adolescents in the minority with respect to that view. This might be due to their level of understanding and appreciation of FP services as they generally lagged behind their older compatriots with respect to FP knowledge and use. Most adolescents in the current study did not view FP as just women's business. Some groups of adolescents saw FP leading to promiscuity amongst adolescents, which does not augur well for getting them to use and support FP. The majority of the study population saw having many children as dangerous to the health of the mother and believed that it was better to have fewer children ─ a situation that could encourage them to engage in FP.

The FGDs and IDIs revealed the general attitude that FP is good and has several benefits for adolescents, with few respondents thinking otherwise. Adolescents stated many obstacles they face in their quest to access FP care, including poor attitudes and discrimination from healthcare providers, the community seeing adolescents practicing FP as spoilt, the perception that FP could corrupt the young population, concerns about healthcare worker approaches to care delivery, and perceived complications of FP.

Study respondents during the qualitative arm had some suggestions on how best to address FP needs of adolescents. They mentioned educating the community on how to access FP services, the benefits of its use, the need for commitment to FP programs from state institutions,

revamping traditional norms preventing teenage pregnancy, religious leaders and parental involvement, encouraging healthcare provider attitudinal change, and providing information to adolescents about the various FP methods and their limitations.

Recommendations

Stakeholders in the provision of FP services to adolescents made the following recommendations:

Healthcare providers ─ There is the need for a change in attitudes and practice towards adolescents. Providers require education on the needs of adolescents and how to best approach delivery of care to them.

Community ─ The community requires a change of attitude towards FP services to adolescents in seeing it not only as a program for the married. Community opinion leaders, religious leaders, chiefs and elders should be at the forefront of educational programs to change public perceptions. These leaders should facilitate programs leading to the reinstatement of traditional customs that discourage teenage pregnancies.

Healthcare policy makers ─ Consideration should be given to education of adolescents and the community as a whole about FP services, their availability and accessibility. There should also be education to de-stigmatize FP care to adolescents and provide information on its benefits. There should be a focus on educating healthcare workers about their responsibility to adolescents and put in mechanisms to ensure that they provide the appropriate services to their charges. For effective implementation of FP programs to adolescents, the necessary resources should be availed to program implementers.

Political leadership/ policy makers ─ Study respondents wish for legislation supporting FP services to adolescents and showing commitment to FP by providing resources to enhance care delivery.

Healthcare providers ─ Expand the provision of FP care to adolescents in the community as findings show the risk of pregnancy among them is higher compared to the national figures. Make accessible to adolescents varied forms of FP methods. Enhance education to younger adolescents on FP methods and their benefits and limitations, so they can make informed choices based on their needs. Program implementers should continue information dissemination on FP via electronic media outlets targeting adolescent populations.

The research community ─ This study has shown a higher level of marriage, pregnancy and delivery among adolescents in the study communities than the national average, as presented in the 2008 GDHS. Such focused studies in other communities should be engaged in focusing on adolescents to identify their situation and to implement a research into the claim that FP use by adolescents leads to promiscuity to address this concern.

Tables

Table 1: Background Characteristics of Respondents

	Female %			Male %		
	10-14 n= 413	15-19 n= 1002	10-19 n= 1415	10-14 n= 429	15-19 n= 284	10-19 n= 713
Place of residence						
Rural	69.1	62.3	64.3	69.8	69.1	69.5
Urban	30.9	37.9	35.7	30.2	30.9	30.5
District of residence						
Kintampo North	59.3	62.2	61.3	61.1	60.9	61.0
Kintampo South	40.7	37.8	38.7	38.9	39.1	39.0
Current educational attainment						
No education	34.4	7.7	15.5	33.1	6.7	22.6
Primary	63.9	57.9	59.6	63.9	68.3	65.6
JHS & higher	0.5	33.3	23.7	1.9	24.3	10.8
Missing values	1.2	1.1	1.2	1.1	0.7	1.0
Marital status						
Married	0.2	2.1	1.6	0.0	1.1	0.4
Living together	0.2	17.0	12.1	0.2	5.6	2.4
Divorced	0.0	0.3	0.2	0.0	0.4	0.1
Separated	0.0	2.0	1.4	0.0	0.4	0.1
Never being in a relationship	97.8	77.4	83.4	99.5	92.3	96.6
Missing values	1.7	1.1	1.3	0.2	0.4	0.3

Table 2: Distribution of Age at First Sex, First Birth, and First Marriage Relative to Current Age

	Age at first sex %		Age at first birth %		Age at first marriage %	
	Female n= 388	Male n= 63	Female n= 112	Male n= 4	Female n= 221	Male n= 25
10	0.3	7.7	0	0	0	0
11	0	3.1	0	0	0	0
12	1.8	9.2	1.8	0	1.4	0
13	5.4	1.5	1.8	0	4.5	0
14	10.5	4.6	3.6	0	6.8	4.0
15	25.4	13.8	8.9	0	24.0	32.0
16	26.4	18.5	21.4	25.0	28.5	24.0
17	18.5	23.1	22.3	0	17.2	24.0
18	8.7	13.8	23.2	50.0	14.5	16.0
19	2.3	1.5	17.0	25.0	3.2	0
Median age	**16**	**16**	**17**	**16**	**16**	**16**

Table 3: Distribution of Lifetime Sexual Experience by Gender, Age, and Marital Status

	Female %				Male %			
	Never n=1019	**Recently n=190**	**Not recently n=206**	**Total n= 1415**	**Never n=642**	**Recently n=36**	**Not recently n=35**	**Total n=713**
Age								
10-14	98.5	0.5	1.0	413	98.6	0.2	1.2	429
15-19	61.1	18.1	20.2	1,002	77.1	12.3	10.6	284
10-19	*72.0*	*13.4*	*14.6*	*1,415*	*90.0*	*5.0*	*4.9*	*713*
Marital status								
Never in a relationship	84.7	7.3	8.1	1,180	92.7	3.3	3.90	689
Married/living together	0.5	50.8	48.7	193	5.0	65.0	30.0	20
Widowed/ divorced/ separated	4.3	21.7	(3.9	23	0.0	0.0	100	2
Missing	94.7	5.3	0	19	100.0	0.0	0.0	2
Total	*72.0*	*13.4*	*14.6*	*1,415*	*90.0*	*5.0*	*4.9*	*713*

Table 4: Pregnancy and Birth Rates by Age

	Female %		Male %	
	Ever been pregnant n=171	**Ever given birth n=224**	**Ever impregnated n=22**	**Ever fathered n=8**
		Age range		
10-14	0.5	0.5	0.7	0.0
15-19	16.7	11.0	2.8	1.4
10-19	11.9	7.9	1.5	0.6

Table 5: Adolescents Who Have Ever Been Unprepared for Pregnancy and Would Have Accepted Help to Prevent Pregnancy Relative to Age, Marital Status, and Unmarried but Recently Sexually Active

	Female %		Male %	
	Not ready for pregnancy n=120	**Accept help to prevent pregnancy n=112**	**Not ready for pregnancy n=4**	**Accept help to prevent pregnancy n=2**
Age range				
10-14	50.0	50.0	0.0	0.0
15-19	35.3	32.9	25.0	12.5
10-19	35.5	33.1	18.2	9.1
Marital status				
Never being in a relationship	44.7	42.1	0.0	0.0
Married/ living together	34.5	31.0	40.0	20.0
Widowed/divorced/ separated	20.0	26.7	0.0	0.0
Total	35.5	33.1	18.2	9.1
Never being in a relationship but recently sexually active				
	50.0	37.5	0.0	0.0

Note: Percentages are based on females who have ever been pregnant and on males who have ever impregnated a woman.

Table 6: Adolescents Who Have Ever Heard of Family Planning by Age, Marital Status, and Unmarried but Recently Sexually Active

	Female %			Male %		
	Heard of any method n=1241	**Heard of any modern method n=1241**	**Heard of any traditional method n=688**	**Heard of any method n=585**	**Heard of any modern method n=585**	**Heard of any traditional method n=242**
Age range						
10-14	72.6	72.6	17.2	73.4	73.4	17.9
15-19	93.9	93.9	61.6	95.1	95.1	58.1
10-19	*87.7*	*87.7*	*48.6*	*82.0*	*82.0*	*33.9*
Marital status						
Never being in a relationship	86.8	86.8	43.8	81.7	81.7	32.4
Married/living together	99.0	99.0	78.8	95.0	95.0	85.0
Widowed/divorced/ separated	100.0	100.0	78.3	100.0	100.0	100.0
NK/NA/missing	15.8	15.8	5.3	2.0	2.0	0.0
Total	*87.7*	*87.7*	*48.6*	*82.0*	*82.0*	*33.9*
Never being in a relationship but recently sexually active						
	100.0	100.0	84.9	100.0	100.0	78.3

Note: NK = not known, NA = not applicable.

Table 7: Adolescents Who Have Ever Used Family Planning by Age, Marital Status, and Unmarried but Recently Sexually Active

	Female %			Male %		
	Used any method n=253	**Used any modern method n=194**	**Used any traditional method n=159**	**Used any method n=43**	**Used any modern method n=39**	**Used any traditional method n=19**
Age range						
10-14	1.0	0.7	0.7	0.7	0.5	0.2
15-19	24.9	19.1	15.6	14.1	13.0	6.3
10-19	*17.9*	*13.7*	*11.2*	*6.0*	*5.5*	*2.7*
Marital status						
Never being in a relationship	8.6	5.9	5.6	3.8	3.2	1.6
Married/ living together	72.0	58.5	44.6	75.0	75.0	35.0
Widowed/ divorced/ separated	52.2	43.5	26.1	100.0	100.0	50.0
Missing	5.3	5.3	5.3	0.0	0.0	0.0
Total	*17.9*	*13.7*	*11.2*	*6.0*	*5.5*	*2.7*
Never being in a relationship, but recently sexually active						
	54.7	44.2	32.6	56.5	52.2	26.1

Table 8: Current, Past, and Future Use of Family Planning by Age, Marital Status, and Unmarried but Recently Sexually Active

	Female %			Male %	
	Currently using a method n=129	**Used a method at last sex n=154**	**Intention to use in the future n=758**	**Knows where to get condoms n=378**	**Used a method at last sex n=35**
Age range					
10 -14	0.0	0.2	38.3	40.8	0.2
15 – 19	12.9	15.3	59.9	71.5	12.0
10 – 19	*9.1*	*10.9*	*53.6*	*53.0*	*4.9*
Marital status					
Never being in a relationship	4.2	5.5	50.8	52.1	3.3
Married/ living together	38.3	42.5	71.5	85.0	50.0
Widowed/ divorced/ separated	21.7	26.1	87.0	100.0	100.0
Missing	5.3	5.3	5.3	0.0	0.0
Total	*9.1*	*10.9*	*53.6*	*53.0*	*4.9*
Never being in a relationship but recently sexually active					
	31.4	39.5	75.6	100.0	60.9

Table 9: Distribution of Family Planning Method Used at Last Sex and Future Intentions of Use

	Female %			Male %		
	10-14 n=4	**15-19 n=249**	***10-19 n=253***	**10-14 n=3**	**15-19 n=40**	***10-19 n=43***
Family planning method used at last sex						
Male sterilization	0.0	0.4	0.4	0.0	2.5	2.3
Pill	0.0	14.1	13.8	0.0	2.5	2.3
Injectables	0.0	3.6	3.6	N/A	N/A	N/A
Male condom	25.0	20.9	20.9	33.3	67.5	65.1
Female condom	0.0	0.4	0.4	0.0	2.5	2.3
Rhythm method	0.0	16.9	16.6	0.0	2.5	2.3
Withdrawal	0.0	2.4	2.4	0.0	0.0	0.0
Other	0.0	0.8	0.8	0.0	0.0	0.0
Used no method	75.0	40.6	41.1	66.7	22.5	25.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Preferred future family planning method						
Male sterilization	0.0	10.0	9.9	N/A	N/A	N/A
Pill	50.0	20.1	20.6	N/A	N/A	N/A
IUD	0.0	2.0	2.0	N/A	N/A	N/A
Injectables	0.0	35.7	35.2	N/A	N/A	N/A
Male condom	0.0	6.0	5.9	N/A	N/A	N/A
Female condom	0.0	0.8	0.8	N/A	N/A	N/A
Diaphragm	25.0	0.4	0.8	N/A	N/A	N/A
Foam/ Jelly	0.0	0.4	0.4	N/A	N/A	N/A
NK	0.0	2.4	2.4	N/A	N/A	N/A
Use no method	25.0	19.3	19.4	N/A	N/A	N/A
Total	100.0	100.00	100.0	N/A	N/A	N/A

Note: NK = not known, N/A = not applicable.

Table 10: Main Source of Family Planning Information over the Last Few Months by Age and Gender

	Main source of family planning information %					
	Radio n=412, *211*	**Television n=828, *110***	**Magazine n=54, *30***	**Poster n=144, *75***	**Shop n=101, *28***	**Socializing n=270, *76***
Female						
10-14	19.1	10.9	0.2	6.1	3.1	10.2
15-19	33.2	23.7	5.3	11.9	8.8	22.8
10-19	*29.1*	*19.9*	*3.8*	*10.2*	*7.1*	*19.1*
Male						
10-14	24.5	11.0	1.9	6.3	1.9	7.9
15-19	37.3	22.2	7.7	16.9	7.0	14.8
10-19	*29.6*	*15.4*	*4.2*	*10.5*	*3.9*	*10.7*

Note: Number of females in roman type*, number of males in italics*.

Table 11: Importance of Family Planning to Adolescents by Gender, Age, Marital Status, and Not Married but Sexually Active

	Importance of family planning to adolescents (%)				
	Reduce unwanted pregnancies n=905, *414*	**Reduce STI risk n=602, *293***	**Improve MCH n=829, *405***	**Reduce maternal deaths n=737, *371***	**Improve health and well-being n=843, *418***
Female					
Age range					
10-14	39.2	27.1	40.4	33.7	41.9
15-19	74.2	48.9	66.1	59.7	66.9
10-19	64.0	42.5	58.6	52.1	59.6
Marital status					
Never being in a relationship	60.9	41.0	56.8	49.7	57.1
Married/ living together	84.5	52.8	71.5	68.9	76.2
Widowed/ separated/ divorced	87.0	60.9	82.6	69.6	87.0
Missing	15.8	10.5	10.5	10.5	10.5
Total	*64.0*	*42.5*	*58.6*	*52.1*	*59.6*
Never being in a relationship but recently sexually active	89.5	65.1	83.7	75.6	82.6
Male					
Age range					
10-14	47.1	35.0	46.9	42.2	48.8
15-19	74.6	50.4	71.8	66.9	74.3
10-19	*58.1*	*41.1*	*56.8*	*52.0*	*58.6*
Marital status					
Never being in a relationship	57.6	41.1	56.0	51.5	57.9
Married/ living together	75.0	50.0	85.0	75.0	85.0
Widowed/ separated/ divorced	100.0	0.0	100.0	50.0	100.0
Missing	0.0	0.0	0.0	0.0	0.0
Total	*58.1*	*41.1*	*56.8*	*52.0*	*58.6*
Never being in a relationship but recently sexually active	5.7	60.9	87.0	87.0	95.7

Note: Number of females in roman type, *number of males in italics*.

Table 12: Adolescents Perception of Family Planning by Gender, Age, Marital Status, and Not Married but Sexually Active

	Adolescent perceptions of family planning %				
	Women's responsibility n=582, *231*	**Makes women promiscuous n=620, *303***	**Many children dangerous n=1008, *455***	**Better not to have more children n=1183, *549***	**Smaller families succeed n=1079, *509***
Female					
Age range					
10-14	30.8	28.8	59.6	69.2	62.2
15-19	45.4	50.0	77.1	89.5	82.0
10-19	41.1	43.8	71.2	83.6	76.3
Marital status					
Never being in a relationship	38.8	42.5	70.3	82.5	75.0
Married/ living together	57.5	53.4	81.3	95.3	88.6
Widowed/ separated/ divorced	43.5	65.2	82.6	95.7	87.0
Missing	15.8	5.3	15.8	15.8	15.8
Total	*41.1*	*43.8*	*71.2*	*83.6*	*76.3*
Never being in a relationship but recently sexually active	44.2	55.8	87.2	97.7	88.4
Male					
Age range					
10-14	30.3	36.1	57.6	70.6	64.8
15-19	35.6	52.1	73.2	86.6	81.3
10-19	*32.4*	*42.5*	*63.8*	*77.0*	*71.4*
Marital status					
Never being in a relationship	32.5	43.0	63.3	76.6	71.6
Married/ living together	35.0	30.0	85.0	95.0	70.0
Widowed/ separated/ divorced	0.0	50.0	100.0	100.0	100.0
Missing	0.0	0.0	0.0	0.0	0.0
Total	*32.4*	*42.5*	*63.8*	*77.0*	*71.4*
Never being in a relationship but recently sexually active	39.1	78.3	78.3	91.3	95.7

Note: Number of females in roman type*, number of males in italics*.

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