ENSIGN COLLEGE OF PUBLIC HEALTH

KPONG, EASTERN REGION, GHANA

SOCIO-DEMOGRAHPIC CHARACTERISTICS OF MALE PARTNERS OF PREGNANT ADOLESCENT GIRLS IN THE SOUTH DAYI DISTRICT.

by

DIANA ABENA COFFIE

(147100008)

A Thesis submitted to the Department of Community Health in the Faculty of Public Health in partial fulfilment of the requirements for the Award of the

MASTER OF PUBLIC HEALTH (MPH) DEGREE

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Supervisor: Dr. Frank Baiden

Co-supervisor: Dr. Belinda Nimako

Date submitted (June 2016)

DECLARATION

I hereby declare that except for reference to other people's wrok, which I have duely cited, this project submitted to the Ensign College of Public Health, Kpong is the result of my own investigation and has not been presented for any other degree elsewhere.

Name: Diana Abena Coffie (147100008) ……. .. ……

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Name: Dr. Frank Baiden …… …… …….

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Name: Dr. Christopher N. Tetteh …… ……..…….

(The Dean) Signature Date

ABSTRACT

Introduction

Over 15 million adolescent girls between the ages of 15 and 19 give birth globally each year. More than 50% of that number occur in developing countries with sub-Saharan Africa accounting for up to 45% of that estimate. Aldolescent pregnancy is a major health proble in rural Ghana. An improved understanding of the sociodemographic characteristics of male partners and the nature of their relationship with the pregnant adolescent will assist in the design of interventions targeted at male partners.

Method

A mixed-method study was conducted in the South Dayi District in the Volta region of Ghana to describe the socio demographic characteristics of the partners of pregnant adolescent girls and to explore the nature of the relationship that resulted in pregancy. Structured interviews were conducted with a convenient sample of pregnant adolescent. This was followed by in-depth interviews.

Results

Seventy-six pregnant adolescents were surveyed in eight health facilities. Their average age was 17years (standard deviation=1.2yrs). The majority of pregnancies were unplanned. Forty-seven percent and 22% of pregnant adolescents were staying with only their mothers or with the partner at the time of the pregnancy. The mean and range of the age difference between the male partner and the adolescent girl was 4.37years (SD=3.99) and -2 - 25yrs respectively. Forty-three percent had known the male partner for two years or more prior to the pregnancy and since the pregnancy 56% have been the biggest source of financial support. Economic deprivation and the urge for financial support was a major lure in the relationships that led to pregnancy.

Conclusions

Highlighting the consequences of making adolescent girls pregnant could be a detriment to other males. Social protection measures are needed to support single mothers with adolescents girls.

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GLOSSARY

HIV/AIDS – Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

UNAIDS - United Nations Programme on HIV/AIDS

IDI – In Depth Interview

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Above all, I give glory to God for His steadfast love that never ceases, for His mercies that never end, and for His grace that has brought me to the expected end.

- The staff of the South Dayi District Health Directorate for their support and assistance.
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- My field Assistant Mr. Felix Asem, for his immense support and resilience in the field.
- The directors of Narh-Bita Hospital for being supportive and understanding to accord me valuable time off official work throughout my two-year study program.

DEDICATION

To my darling and dear husband, Dr. Mawuli Coffie. To my three adorable children Edem, Dede and Makafui. I couldn't have reached this far without their support and understanding.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Adolescent pregnancy remains a major medical, social, and economic problem in many developing countries. Over 15 million girls aged 15 to 19 years and some 1 million girls under 15 years give birth every year, mostly in low- and middle-income countries (WHO Fact SheetNo. 364, 2014). Complications during pregnancy and childbirth are the second cause of death for 15-19 year-old girls globally. Adolescent pregnancy has been linked to several socio economic factors such as poverty, lack of education, and absence of parental supervision and control (Kathleen Ford et al, 2001).

The rate at which adolescent pregnancy is reported in our health institutions is alarming and until something is done about this, we will all be overtaken with over population, a major public health concern. According to the Ghana Demographic and Heath Survey conducted in 2014, 14% of adolescent girls in Ghana have begun childbearing at the age of 15-19 years (Kofi Awusabo-Asare et al, 2006).

The emphasis in adolescent pregnancy has mainly been on mothers while the male partners have remained unfocused and an understudied population. The aim of this study is to explore the socio demographic characteristics of the partners of pregnant adolescent girls in the South Dayi district and explore the circumstances and relationships resulting in pregnancy, and paternity patterns of the male partners.

The South Dayi District lies within latitudes 3020’N and 3.5005’N and on longitude 0017 and 0027’E. It shares boundaries with North Dayi and Afadzato South Districts to the north, Ho West District to the east and Asougyaman District in the south, while

the Volta Lake forms the western boundary. South Dayi comprises of four sub-districts namely: Dzake, Kpeve, Peki and Kpalime-Tongor sub-districts. The District covers a total land area of 358.3 square kilometers, which is 1.7 percent of the total land area of the Volta Region with about 20 percent of its land covered by the Volta Lake. The location was selected based on information from the local authority which seem to suggest a high incidence of adolescent pregnancies in the district.

1.2 Problem Statement

Adolescent pregnancy is not simply the result of a girl being promiscuous, or the failure to obtain and use contraception. According to Broecker and Hillard (2009), the phenomenon is traceable to social, cultural, educational, and economic factors which influence adolescent risk taking behaviors.

Ford et al (2001), estimated that over 15 million girls between the ages of 15 to 19 give birth every year, in poor countries. Broecker & Hillard (2009) observed that complication during pregnancy and child birth is a leading cause of death among adolescent girls. Interventions to address this trend have tended to focus on the pregnant girls excluding the male partners.

This is leading to decision bias in policy making and in the design of social and development interventions seeking to address the problem. This study therefore was aimed at shedding light on the often ignored but equally crucial aspect of the issue – the demographic characteristics of the male partners.

1.3 Rationale of Study

The rationale of this study was to explore the socio demographic characteristics of the male partners and circumstances in relationships leading to pregnancies among adolescent girls in the South Dayi District in the Volta Region of Ghana.

The goal was to describe the characteristics of the male partners and provide additional insight into the dynamics of the relationships and circumstances leading to the adolescent girl becoming pregnant. This may lead to improved understanding of the phenomenon and enhance the design of social and development interventions to address the issue.

1.4 Research Questions

Based on the literature review and interaction with practitioners in the field, the topic presents various aspects that require equal attention. In that regard, the study adopted the following questions as leading to a broader understanding of the occurrence:

1. What are the demographic characteristics of male partners?
2. What is the paternity patterns of male partners?
    - Adult male greater or equal to 20 years of age at the time of baby's conception
    - Teenage male less than 20 years of age at the time of baby's conception
3. What determines the fact that a pregnant adolescent girl will receive financial support from her partner?

1.5 General Objective:

The objective of this study was to explore the sociodemographic characteristics of the partners of pregnant adolescents, and the nature of the relationship that led to the pregnancy.

1.6 Specific Objectives:

Specifically, the objective of the study was to describe the age, occupation, religion, marital status, and ethnicity of the partners of pregnant adolescents and the nature of

the relationship, and contraceptive use. The following objectives were covered as part of the study;

1. Demographic characteristics of male partners of pregnant adolescents
2. Age of male partners relating to paternity patterns
3. Age difference between adolescent pregnant girls and their male partners and its influence on relationship dynamics (power play)
4. Knowledge and use of contraceptives and exposures to the risk of early pregnancy and sexually transmitted diseases.

1.7 Profile of Study Area

The study location was selected communities within the four sub-districts in the South Dayi District in the Volta region of Ghana. The location was selected based on information from the local authority which seem to suggest a high incidence of adolescent pregnancies in the district.

The South Dayi District lies within latitudes 3020'N and 3.5005'N and on longitude 0017 and 0027'E. It shares boundaries with North Dayi and Afadzato South Districts to the north, Ho West District to the east and Asougyaman District in the south, while the Volta Lake forms the western boundary. The District covers a total land area of 358.3 square kilometers, which is 1.7 percent of the total land area of the Volta Region with about 20 percent of its land covered by the Volta Lake. The district has a population size of over 52,000.

1.8 Scope of Study

The study sought to look at the demographic characteristics of the partners of pregnant adolescent girls.

1.9 Organization of Report:

The study is divided into six chapters. Chapter one gives the general background information of the study and the impact of adolescent pregnancy on adolescents' life. The chapter describes the problem statement, the rational and objectives of the study, and the profile and demography of the study site.

Chapter two presents a review of the topic and previous research done and its relevance to current research work relating to the same issue.

Chapter three assesses the scientific research methods employed, the study population and tools used in the data collection, analysis of the data and ethical implications of the methodology adopted.

Chapter four presents the results and outcomes of the study. Chapter five discusses the link between the objectives and the evidence of the study with appropriate references. It assesses the justification of the study.

Chapter six presents the summary conclusion of the issues, and recommendations.

CHAPTER TWO

2.0 LITERATURE REVIEW

The WHO recognizes adolescence as the period after childhood and before adulthood, from age 10-19 years in human growth and development. Around 1 in 6 persons in the world is an adolescent, implying that 1.2 billion of the world's population are aged 10-19 years (WHO Fact Sheet No. 364).

Adolescents can be referred to as the young key population who go through a time of physical, emotional and social transitions that have implications on their health that may hinder their ability to grow and develop to their full potential. Some of the health problems associated with adolescence can be attributed to their high risk behaviour or their developmental stages, or a combination of both (Kumi Kyereme et al, 2007). Among the numerous problems confronting young people, sexual and reproductive health are the most common health challenges teenagers experience.

The two adolescent sexual and reproductive health problems most often reported are, Adolescent Pregnancy and HIV/AIDS. The two are inter-linked. According to the latest estimates from UNAIDS, there were 36.9 million people living with HIV in 2014, up from 29.8 million in 2001, the result of continuing new infections, people living longer with HIV, and general population growth.

Women represent approximately half (51%) of all adults living with HIV worldwide. HIV is the leading cause of death among women of reproductive age. Gender inequalities, differential access to service, and sexual violence increase women's vulnerability to HIV, and women, especially younger women, are biologically more susceptible to HIV.

Young people, ages 15-24, account for approximately 30% of new HIV infections (among those, 15 and over). In sub-Saharan Africa, young women account for 63% of young people living with HIV. In 2010, young people aged 15-24 years accounted for 42% of new HIV infections in people aged 15 years and older.

Globally, close to 16 million girls and women aged 15 to 19 years give birth each year. Most of these pregnancies are unintended. Adolescent girls are at a high risk of pregnancy, and the risk of maternal mortality is highest in girls aged <15 years.
In a research by Kurth F et al (2010), the authors of the article 'Adolescence as risk factor for adverse pregnancy outcome in central Africa – A cross-sectional study, explored the risk of child delivery among adolescents and the effect of adolescent pregnancies on pregnancy outcomes in Gabon. The study offers insight into the challenges and complexities associated with adolescent pregnancies and outcome of such pregnancies. The study is important to my investigation because it provides an important perspective of the phenomenon of adolescent pregnancies.

Complications of pregnancy and childbirthmnn are the major cause of death in adolescent girls in most developing countries. The 2014 World Health Statistics indicate that the average Pregnancy and childbirth complications are the second cause of death among 15 to 19 year olds globally. Some 3 million unsafe abortions among girls aged 15 to 19 take place each year, contributing to maternal deaths and to lasting health problems. The average global birth rate among 15 to 19 year olds is 49 per 1000 girls, with the highest rates in sub-Saharan Africa.

In a study conducted by Kofi Awusabo-Asare et al on Adolescent Sexual and Reproductive Health in Ghana, the researchers stated that there has been a paradigm shift in the circumstances under which young people live and develop in the last four

decades in Ghana. There is a shift from traditional means of socialising and interaction among the youth to other new avenues such as the school system, social media, environmental and family dynamics that impacts their sexual and reproductive health. (Kofi Awusabo-Asare et al, June 2006). In a recent article published in the Joy News on adolescents below age 19 constituted about 15.1% of antenatal attendants in the year 2015. 11th February, 2016 concerning teenage pregnancies soaring in the Volta region, This information is relevant considering the fact that the location of this study was in the Volta Region and moreover exploring adolescent reproductive health issues.

Given the urgency and scope of the sexual and reproductive health impacts on adolescents, it is important to assess their current level of knowledge in sexual and reproductive health; social, cultural, educational and economic factors influencing their risky attitudes and behaviours; evaluate their contraceptive use and barriers to seeking reproductive health services and information; examine their vulnerability to HIV infection and transmission as well as other STIs.

A key factor that requires utmost attention but most often overlooked, is the male partners of adolescent girls. The male partners are often overlooked and inadequately represented in adolescent reproductive issues, (Jorge Lyra, Benedito Medrado 2014). This study evaluated the socioeconomic factors impacting adolescent pregnancy, demographic characteristics and paternity patterns of their male partners in order to understand the relationship desires of male and female partners.

In an observational cross-sectional study, Heavey and his team of researchers examined the relationship between pregnancy desire among female adolescents and their perception of desire for pregnancy in their male partners. The authors used Logistic regressions to examine the relationship between male and female pregnancy

happiness and desire. In their analysis, the authors explored the circumstances and relationship aspects of the adolescent pregnancies. The study leads to additional information on the social economic characteristics of the partners of the adolescent pregnant girls and its impact on the circumstances in the relationship leading to pregnancy.

According to Marsiglio (1993) in a similar study, males who reside in poor neighbourhoods and of a low socio-economic status are more likely to view being involved in pregnancy a normal phenomenon as this stirs up the feeling of masculinity in them as compared to men with good living conditions and of average educational status. In a similar study conducted by Robert F. Anda et al (2001), an association was drawn between boyhood exposures to physical or sexual abuse, domestic violence and male involvement in adolescent pregnancy.

In an article by Oringanje C et al, the authors examined the evidence of effect of interventions aimed at addressing uncertainty of the interventions. The authors developed the evidence based on findings collected through structured reviews and analysis of interventions. The article provides valuable insight into the significance of interventions to address the phenomenon of adolescent pregnancies. This is important in understanding occurrence of adolescent pregnancies and the possible strategies to reverse the trend in areas considered to have relatively higher levels of the phenomenon.

The objectives of this study was to describe the socio demographic characteristics of male partners, explore their paternity patterns and relationship dynamics through interviews with their adolescent female partners. This study neither explored the phenomenon of boyhood exposures to physical or sexual abuse and domestic violence

of male partners as a sociodemographic characteristic influencing adolescent pregnancy in the South Dayi District, nor did this trend surface in the interviews conducted. We anticipate that future studies on the topic will research into this.

CHAPTER THREE

3.0 METHODOLOGY AND STUDY DESIGN

3.1 Research Methods and Design

The study applied mixed method involving both quantitative and qualitative data. The statistical data from the quantitative analysis was complemented by qualitative analysis and experiential narratives to explain numbers and figures. The choice of mixed methods was to ensure all statistical data were placed within the right perspectives through narratives. It was expected that aside the statistical data, there could be important experiences and circumstances that could not be quantified which go a long way to explain why things happen the way they do with regards to the subject of the study. Therefore, by applying mixed methods, it was possible to provide adequate explanation to the statistical information.

3.2 Data Collection Techniques and Tools

The study involved 76 pregnant adolescents and adolescent mothers with infants less than a year old. All participants were between ages 15-19 years. Participants were selected from eight catchment areas within the four sub districts. Pregnant adolescents were identified and selected from the health facility registers or data. The Community Health nurses and Community Volunteers helped to invite the teenage girls to voluntarily participate in the study. Some of the identified pregnant adolescent girls were traced to their homes via the home addresses recorded in the health facility registers. In some instances, new adolescent pregnant registrants were identified during their visit to the ante natal clinic and enrolled. All participants were interviewed using Structured Questionnaires (semi-open ended questionnaires) to collect socio demographic information about their male partners and sociodemographic characteristics of the respondents. The semi open-ended questions served as a guide to

the line of conversation rather than a systematic question and answer session. The questionnaire included questions on basic information on household profile and a listing of the demographic characteristics such as age, sex, ethnicity, religion and education. It maintained boundaries for the interview to avoid the risk of the conversation drifting from the original focus.

The qualitative aspect was a face to face conversational interview capturing the in-depth experiences of the participants in their own words. The goal was to elicit in-depth responses from participants and make the interview process more conversational. The content involved data on the lives of teenagers and included information on social environment, knowledge, attitudes, sexual and reproductive experiences of respondents. Information on the relationship dynamics that existed between the girls and their male partners was also explored.

Hand written notes was read to each participant to ensure it reflected their view during the interview.

Audio and video recording device (mobile phone). A Samsung Android mobile phone and an Apple IPad were be used to record the interviews and also take photos or video excerpts. Participants were informed at the time of the interview and with their consent given.

3.3 Study Population

The study included a broad range of pregnant teenagers and teenage mothers with infants less than 1year old within the four sub-districts in South Dayi. Considering the fact that pregnant youths aged 15-19 are looked upon as vulnerable (Emancipated Youths) or may be uncomfortable to share their lived experiences, parents/guardians were included to speak on their ward's behalf or provide additional information or

corrections where necessary. This however was not required during this study and in the field, as all participants were willing and eloquent enough throughout the course of the study. Parents /guardians were cooperative to let their wards do this on their own. The male partners who were available and willing to speak about their experiences and relationship with their female partners were included as well in the qualitative study. Health personnel from the various health facilities within the sub-districts were allowed to share their views and related experiences.

3.4 Sampling

The study employed a convenience sampling approach using information obtained from the district health data. Participants were selected from eight catchment areas within the sub districts namely, Dzake, Peki, Kpalime Tongor, and Kpeve Adzokoe.

3.5 Pre-testing

This study did not require pre-testing as the tools employed were based on previous similar studies.

3.6 Data Management and Analysis

Entry of data was done using Statistical software, version 12. Descriptive statistics and frequencies were used to describe demographic characteristics of study participants and their male partners. Demographic characteristics included, geographical location; age; ethnic background; educational status; employment status; marital status; religion; cultural orientation.

3.7 Ethical Consideration

This study involved human subjects and therefore required the highest standards of ethical consideration. Ethical approval was obtained from the GHS Ethical Review

Board. Institutional approval was obtained from the District Health Director and heads of the health facilities of the South Dayi District where the study was conducted. Considering the age group of the participants and the nature of the study, Parental/Guardian consent was obtained. The study entailed interviews and collecting data from adolescents between the ages of 15 – 19 on issues relating to their sexual and reproductive health. The ethical standards in this type of study required preserving the rights of the participants, and confidentiality of the information they provided. I took the following steps to ensure the preservation of ethical standards:

- I obtained participant and parent/guardian consent. Signed individual informed assent/consent was received from each participant before administering questionnaires.
- Participants enrolled in the study had the choice to participate or not and were not at any time coerced into the research or to provide information.
- I used basic language that is understandable to the participants and did not create any ambiguity in their minds as to the purpose and rationale of the study.
- I provided all the necessary facts about the research to participants in order ensure informed consent for all participants.
- Ensure participant confidentiality. Vulnerable persons were allowed to have witnesses. I employed the services of a translator in the event where language became a barrier.
- Privacy was ensured for all participants during the collection of information. Interviews were conducted in a well ventilated and conducive environment. I assured participants not to divulge or make known to any unauthorized persons or to the public any information in the course of this study that could identify the persons who participated in the study

- I ensured that participants are protected physically, socially and mentally by using safe research methods (structured questioners, in-depth interviews)
- No compensation was awarded for participating in this study. Participants' contributions were however highly appreciated.

3.8 Limitations of Study

The limitation to this study was the language barrier. I had to employ the services of an interpreter in the collection of information during both quantitative and qualitative interviews because majority of the respondents did not speak fluent English and I do not speak local vernacular.

3.9 Assumptions

My opinion prior to the field was that the male partners of the adolescent pregnant girls will be significantly older than the adolescent females. The age difference between male partners and the adolescent girls was not significantly wide apart. That female adolescent promiscuity and poverty, as I presumed will be major determinants of adolescent pregnancy.

My notion that the male partners will usually decline being responsible for the pregnancy of their partners and shun them.

CHAPTER FOUR

4.0 STUDY RESULTS AND FINDINGS

4.1 Quantitative Analysis

4.1.1 *Socio Demographic Characteristics of Respondents*

A total of 76 respondents from eight health facilities were interviewed in eight primary health care facilities. (Table 4.1)

Table 4.1. Distribution of Respondents by Facility

Facility	Respondents	Frequency
Abui-Tsita CHIP	3	3.95
Dzake HC	6	7.89
Dzemani EP Clinic	37	48.68
Peki Adzokoe	4	5.26
Peki Govt Hospital	4	5.26
Tsanakpe HC	7	9.21
Tsatee CHIP	5	6.58
Wegbe HC	10	13.16
Total 76	76	100.00

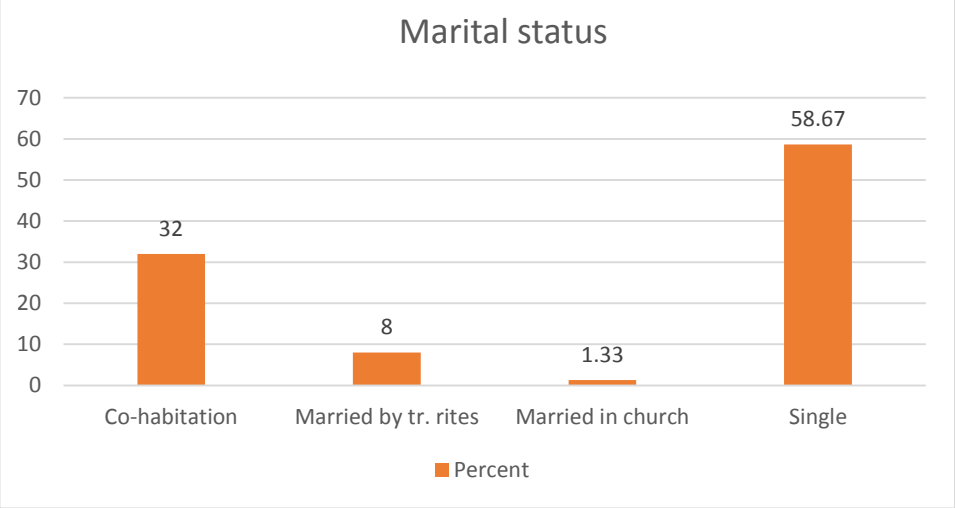
The youngest participant was aged 15 years while the oldest was 19 years. The median and mean ages were 17years and 17.1 years (with a standard deviation of 1.2 years) respectively. The mean age at the time of pregnancy was 17 with a standard deviation of 1.2

Table 4.2. Highest Educational Level

EDUCATIONAL LEVEL	FREQUENCY	PERCENT
No Education	5	6.58
Primary	25	32.89
JSS	42	55.26
Sec/Higher	4	5.26
Total	76	100

At the time of pregnancy all the adolescent girls interviewed were in school except for 5 of the girls who had no form of formal education.

Figure 4.1 Marital Status



While the majority of interviewed adolescents were living with their mothers at the time of pregnancy, 22.36% of them were living with their partners. Only 17.10% were living with both parents at the time pregnancy occurred. (Table 4.3)

Table 4.3 Person Staying with at Time of Pregnancy

OPTIONS	FREQ.	PERCENT
Mother only	36	47.36
Both parents	13	17.10
Partner	17	22.36
Other	10	13.15
Total	76	100

At the time of the survey, an equal number of pregnant adolescents were staying with mother only (39.47%) and partner (39.47%). Some (14.47%) were staying with both parents, while a few (6.57%) were staying with other relations.

Table 4.4 Who do you currently stay with?

OPTIONS	FREQUENCY	PERCENT
Partner	30	39.47
Mother only	30	39.47
Both Parents	11	14.47
Other	5	6.57
Total	76	100.00

The lowest age of the male partners was 17 years and the highest age was 42years. The mean was 22.4 with a standard deviation of 4.3.

The mean age difference between the male partner and the adolescent girl was 4.37years, that is, a standard deviation of 3.99.

The age difference between the female adolescents and the male partner ranged from -2 to 25years. Over all, in 72.46% of cases, the age difference was 5 years or less (table 4.5).

Table 4.5. Age Difference between Partner and Age of Female Adolescent at Time of Pregnancy

Age Difference	Frequency	Percent
Five or less	50	72.46
More than five	19	27.54
Total	69	100

*Seven of the females did not know the age of their male partners.

Most of the partners (91.55%) were Christians while only few (8.45%) belonged to other religions (table 4.6).

Table 4.6 Religion of Partner

Religion of partner	Frequency	Percent
Christian	65	91.55
Other	6	8.45
Total	71	100.00

*Five of the participants could not provide information on their partner's religion.

Skilled vocation/Artisans was the most common occupation (33%) of the partners. 14 (18.42%)of them were unemployed while 20 (26.31%) were into farming/fishing and 17 (22.36) were into other activities (table 4.7).

Table 4.7 Occupation of Partner

Occupation of partner	Frequency	Percent
Other	17	22.36

Farming/Fishing	20	26.31
Skilled vocation/Artisans	25	33.00
Unemployed	14	18.42
Total	76	100.00

Assessing ethnicity, 69 (91%) of the partners were Ewes while only 6 (9%) were of other ethnic groups.

Table 4.8 Ethnicity of Partner

Ethnicity of partner	**Frequency**	**Percent**
Other	7	9
Ewe	69	91.00
Total	76	100.00

Table 4.9 Highest Education of Partner

Highest Education of partner	**Frequency**	**Percent**
None	6	7.89
Primary	47	61.84
Post Primary	19	25.00
Don't know	4	5.26
Total	76	100.00

Majority of the male partners (61.84%) of had primary education, (25%) post primary and (7.89%) of them had no form of formal education. Four (5.26%) of the respondents did not know the educational background of their partners.

Table 4.9.1 Number of Children of Partner

Number of Children	**Frequency**	**Percent**
None	18	40.00
One Child	14	31.11
Two or more	13	28.89

Total	45	100.00

*The response rate for this question was 59%. 31 participants could not tell if their male partner had a child or not.

At the time of pregnancy of the adolescent girl, 18 (40%) of the partners did not have any children, while 14 (31.11%) and 13 (28.89%) had either one child or two or more children respectively.

Table 4.9.2 Does partner have another partner at the Time of Pregnancy

Option	**Frequency**	**Percent**
No	55	73.33
Yes	20	26.67
Total	75	100.00

*one participant could not provide an answer to this question.

While twenty (26.67%) of the male partners had another partner at the time of pregnancy, fifty-five (73.33%) of them had none.

Table 4.9.3 Who Partner was staying with at the time of Pregnancy

Options	Freq.	Percent
Alone	27	42.18
Parents	37	57.82
Total	64	100.00

*13 of the participants did not know whom their male partners lived with.

At the time of pregnancy of the adolescent girl, 27 (42.18%) of their male partners were living on their own while 37 (57.82%) stayed with their parents.

Table 4.9.4 Was Pregnancy Planned

Options	Frequency	Percent
No	66	86.84
Yes	10	13.16
Total	76	100.00

At the time of the interview, 66 (86.84%) of the respondents said their pregnancy was not planned while 10 (13.16%) responded in the affirmative.

4.1.3 Relationships

Table 4.9.5 How Long Have You Known Partner

Options	Frequency	Percent
One to two years	43	56.58
Two to three years	16	21.05
Three or more	17	22.37
Total	76	100.00

Most (56.58%)of the pregnant adolescent girls had known their partners for more than one year, (21.05%) for two to three years, and (22.37%) had known them for three or more years.

Table 4.9.6 Relationship between Families

Options	Frequency	Percent
No	54	71.05
Yes	22	29.95
Total	76	100.00

Majority 53(71.05%) of the pregnant adolescent girls at the time of the interview said there was no relationship between their family and that of their partner. Twenty-two (29.95%) said there was a relationship between the two families.

Table 4.9.7 Age at First Sex

Age	Frequency	Percent
Less than 15 years	16	21.06
15 to 16 years	37	48.68
More than 16 years	23	30.26
Total	76	100.00

At less than age fifteen, 16 (21.06%) of the adolescent girls interviewed had experienced first sex. Thirty-seven (48.68) had their first sex between 15 to 16 years, and twenty-three (30.26%) of them above 16 years.

Table 4.9.8 Knowledge of Time in Menstrual Cycle When Pregnancy is Likely

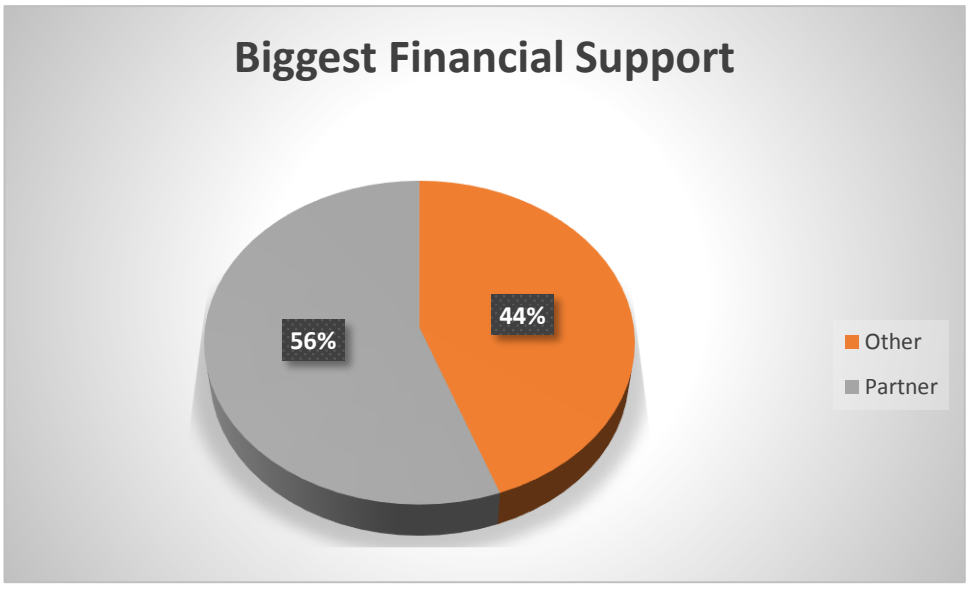
Knowledge of Cycle	Freq.	Percent
Wrong	59	77.63
Correct (Middle of the cycle)	17	22.37
Total	76	100.00

From the above (table 4.9.8), majority (77.63%) of the adolescent girls interviewed did not know their menstrual cycle and the period in the cycle when pregnancy is most likely to occur. A few (22.37%) of them were familiar with their cycle and knew when a woman was most at risk of getting pregnant.

Table 4.9.9 Biggest Financial Support

Support source	Frequency	Percent
Other	28	44.44
Partner	35	55.56
Total	63	100.00

Figure 4.2

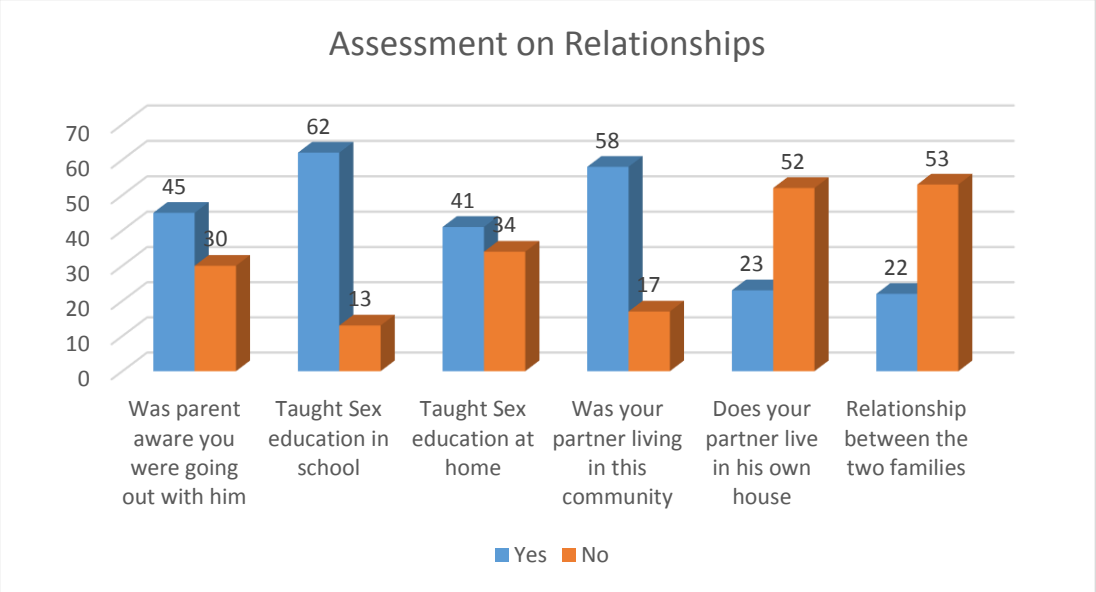


The biggest support source for the pregnant adolescent girls interviewed were their partners (56%), and (44%) were from other varied sources, (Figure 2, table 20).

Table 4.9.9.1 Assessment On Relationships

Question	Yes	No	Total
Was parent aware you were going out with him	45	30	75
Taught Sex education in school	62	13	75
Taught Sex education at home	41	34	75
Was your partner living in this community	58	17	75
Does your partner live in his own house	23	52	75
Relationship between the two families	22	53	75

Figure 4.3 Assessment on Relationships



4.2 Qualitative Analysis

4.2.0 Emerging themes

The responses to eight in depth interviews conducted, revealed the following themes:

4.2.1 Relationship Dynamics (Power Play)

Based on the in depth interview responses, the relationship between the teen pregnant girls and their partners showed a normal phenomenon of dating between the opposite sex. The respondents did not show any sign of physical abuse or being forced into the relationship as demonstrated above. In some instances, the relationship started on the premise of material gains. For instance, three respondents stated the following:

The first day I saw him, he asked me for my telephone number so he can call me. I gave it to him and he called me the following day and asked me to come. He told me he wants me to be his girlfriend and he want to marry me. At that time, he had completed JHS. But I told him I don't want to have sex now. (IDI – 18years Pregnant Adolescent)

*He was posted to this town to teach eh, eh, Brass Band, so I also joined the Band, and through that I got to meet him. He did not tell us that personally that he is having a wife and children. So later on before we got to know about that. (*IDI - 18 years Pregnant Adolescent)

*At times when am going to school they don't give me transportation. So at times when we vacate, the guy will give me money to sell, so that I can buy my provisions before going to school. That is why I go out with him. (*IDI – 19 years Pregnant Adolescent)

4.2.2 Circumstances in Relationships leading to Pregnancy

In other cases, participants explained some of the circumstances in the relationship that contributed to pregnancy. Most of the girls indicated that their parents were not able to provide for them and this made them willing to accept proposals for intimate relationships which are often made with some material attractions. Financial and material support from male partners, as well as socio economic pressures provided opportunities to early pregnancy, which also gave credence to the rampant occurrences of adolescent pregnancy in the South Dayi district. In one case a participant stated the following:

Panyin on the other hand said she also fell for a man for financial support. Not even a man, her own peer within that age group same, but he is a year older than her. He too has been giving her money which is even less than Kakra's own. The maximum she gets sometimes is 3 cedis. For me as a health worker, I see it as not their fault but due to the financial crises they were going through that led to what they did. Even though I would say their grandmother should have taken care of them, but she is also old, and the little she gets is what they feed on. So these girls in order to make ends meet is to go and sleep with any guy at all. (IDI - Nursing Officer).

First he did not propose to me that he will help me and I will also become his girlfriend. But when I started schooling he proposed to me. At first I was not accepting it but they talked to me that I should not say that, because I have stayed in the house for so long so I should accept his help. (IDI-18 years; Pregnant Adolescent)

Because she said when she gave birth to me, my father did not care for her, so that makes her dislike me. So, l plan that I will make the effort to complete school and then get a good job. Because of that I needed help to buy my books, and that led me to getting a boyfriend. (18 years; Pregnant Adolescent*)*

4.2.3 Reaction of Parent/Guardian

The responses also revealed a pattern in the reaction of parents or guardians to the situation of pregnancies. Generally, the responses demonstrated the displeasure and disappointments of the parents or guardians when their teenage daughters or wards become pregnant. Similarly, it was observed based on the responses, that the immediate reaction of parents or guardians is characterised by anger towards the adolescent girls and their male partners. As a result, some parents and guardians expressed their unwillingness to accept the responsibility of care for the pregnant adolescent girl. The following statements were made by some respondents to that effect:

> *They billed me and said I should pay. They billed me 250 Ghana cedis.*
>
> (IDI- 23years; Male Partner)

> *They were angry, because they did not know he will react as such. And when the pregnancy also came in, he was not ready to cater for me. So they were somehow angry and sad*. (18 years; Pregnant Adolescent)

> *He told his mother who said I should abort the baby because she had no money. (17 years; Pregnant Adolescent)*

4.2.4 Reaction of male partners

Observations of the responses by respondents revealed a trend of special attitude on the part of the male partners in cases of adolescent pregnancies. The data demonstrates two types of reactions: willingness of the male partner to support the pregnant adolescent girl and general acceptance of responsibility of the male partner towards the pregnancy. Respondents mostly confirmed a positive reaction from male partners. This further explains the readiness of the male partners to support their female partners

irrespective of complexity of the relationship. This is evidenced in the following comments:

Formerly, he was not working but started working since I became pregnant. he came here last week to see me. (IDI -18 years; Pregnant Adolescent*)*

Mmm, I plan that if I get some money then she can do some work to help the baby I have asked her and she said she wants to do nurses training. So I told her not to worry and that I will talk to my uncle and auntie so that they can help, even last week I discuss this matter. (IDI - 23 years; Male Partner*)*

Am planning to support her go back to school after the delivery because she wants to continue her schooling. Am working hard to get some more money. (IDI - 20 years; Male Partner)

He just said I should not abort it so I should leave it, that he will accept it.(IDI – 19 years; Pregnant Adolescent)

*I just told her that in our family, we do not abort so, she can keep it. She should not worry; however, it is now I will take care of it. (*23 years; Male Partner*)*

*Formerly, he was not working but started working since I became pregnant. (*18 years; Pregnant Adolescent)

On the other hand, some of the respondents indicated that their male partners rejected responsibility for the pregnancy and therefore unwilling to provide any support. For instance, respondents stated the following:

He said he is not ready to have a child, and so I should abort.

But I told him that, am not ready to abort because I don't know the complication I will get through the abortion so I can't abort. Then he said he is having a wife so he is not

*ready for my child. I said ok, I will keep the child. But he gave me some medicines to take which did not work. (*18 years; Pregnant Adolescent)

*My father asked me to go and call him, but when I went there he told me to "gela" (meaning to go away) away! (*17 years; Pregnant Adolescent*)*

4.2.5 Use of contraceptives

The use of contraceptives emerged as part of the issues in the phenomenon of adolescent pregnancies. Respondents interviewed on contraceptives use pointed out that they have knowledge of the use of contraceptives but indicated less frequent use. The following statements were gathered as direct responses in answer to questions pertaining to contraceptive use;

> *At times I used to protect but at times I don't use it. I even forget at times. (23 years; Male respondent)*
>
> *Yes, when we started at first he was using the condom but when it got to a time he said he is no longer going to use the condom. (18 years; Pregnant Adolescent).*
>
> *First he was using condom, but this time he did not. I told him that he should use condom but he refused. (*17 years; Pregnant Adolescent)

4.2.6 Future of the relationship between male partners and pregnant adolescent girls when pregnancy sets in

The data from the interviews indicated varied responses of male partners and their commitment to the future of the relationship with the adolescent pregnant girls after pregnancy occurred. Some respondents confirmed that their male partners were willing to continue the relationship and expressed the interest to get married. On the other hand, the data revealed negative attitude of the male partners to the relationship with

some abandoning the relationship once pregnancy ensued. Samples of direct responses from respondents to that effect are expressed in the following statements:

Am planning to support her go back to school after she deliver the baby because she wants to continue her schooling. Am working hard to get some more money. (21 years; Male Partner)

He said after I deliver then he will come and see my father to perform the traditional rites. (18 years; Pregnant Adolescent)

*Am planning that am going to look after two of them, if they agree to give her to me I will marry her. (*23 years; Male Partner*)*

*Right now am thinking that after giving birth, he will tell me that he won't marry me, but as for me am thinking about it. (*18 years; Pregnant Adolescent*)*

*No, he does not come to our place anymore. When I call him too he says he does not have money, so I don't call him. (*18 years; Pregnant Adolescent*)*

CHAPTER FIVE

5.0 DISCUSSION

Adolescent sexual and reproductive health issues remain high in Sub Saharan countries (Kofi Awusabo-Asare et al) including Ghana. The purpose of this study was to describe the socio demographic characteristics of the male partners of pregnant adolescents and explore circumstances in relationships that led to pregnancy. Female pregnant adolescents were interviewed using sstructured questionnaires (semi-open ended questionnaires) to collect socio demographic information about their male partners and sociodemographic characteristics of the respondents.

5.1 Socio demographic characteristics of respondents

Results from the study revealed the age of respondents to be between age 15 to 19 years. This is consistent with other studies and literature (Kofi Awusabo-Asare et al, 2006) on sexual reproductive health of adolescents where this demographic group were usually the focus of attention.

This further suggest that, this age bracket of adolescent girls is often the most sexually active and thus more regularly adversely affected by the risk factors for early sexual activity. These findings are important as we see the same reflected among adolescent pregnant girls interviewed in the South Dayi district. This is also essential for interventions and the possible strategies to reverse the trend in the population considered to have relatively higher levels of the phenomenon. (Oringanje C et al, 2010)

Consequently, adolescent pregnancy has immense social and economic implications on the future of the girls, family and society in general. (WHO Fact Sheet No. 364) Majority (55.26%) of adolescent girls interviewed did not attain higher education

before getting involved in adolescent pregnancy. The onset of pregnancy disrupts the education of most of the girls. This jeopardizes their future in most cases, and limits their skilfulness and career opportunities and self-sustenance. A possible prerequisite to the vicious cycle of poverty.

Pregnancy in adolescence poses a high health risk to both the young mother and baby, presenting varied health risks such as maternal mortality, still birth, neonatal mortality, starvation and low birthweight. Broecker and Hillard (2009) in their research on adolescent pregnancy which has a lot of bearing on our study also indicated similar higher health risks in adolescent pregnancy.

In one of the study locations, a 17-year-old adolescent girl who had lost her pregnancy through a miscarriage said she had been starving because her parents had refused to give her food regularly at home during her pregnancy. A clear indication of family conflict and parental displeasure. Almost all the respondents confirmed to be affiliated to a religious faith but did not indicate a strong attachment to religion.

Performing the required marriage rites was not a pre requisite for male and female partners to live together. It was a common practice for male partners and their adolescent girlfriends to live together in the same house though, we found a mixture of opposing feelings towards cohabitation. About 44 adolescent girls involved in pregnancy did not live with their partners before the onset of pregnancy, they stayed with either a relative, both parents and a parent, most often with their mothers (figure 4.1).

However, the situation changes once pregnancy sets in. As indicated in (table 4.4) cohabitation with the male partner increases, which could be evident of the fact that partner support is an important determinant in adolescent pregnancy. The male partner

emerges as the biggest financial support to their female partners during and after their pregnancy, which points to the fact that socio economic factors plays a key role in adolescent matters pregnancy (Figure 4.2).

The question therefore is whether partner support is one of the major determinants of adolescent pregnancy? or will an adolescent pregnant girl get partner support because of her plight? as it invariably caters for most socio economic needs of the adolescent girls such as food, shelter, clothing, cosmetics, educational support, and seed money for trading or business, child support among others in rural Communities. Our findings show that this in itself is influenced by economic hardships, family dynamics, parental care and poverty. (Smith D.J 2007)

5.2 Demographic characteristics of male partners

Results from our analysis placed the, age range of the male partners between 17 and 42years. Over all, in 72.46% of cases, the age difference was 5 years or less (table 4.5). Our measure of age difference was to explore whether age difference between the male partner and the adolescent pregnant girl had any impact on the relationship between them leading to pregnancy and other related sexual and reproductive health issues.

Christine E. Kaestle et al (2002), in their research on sexual intercourse and age difference between female and adolescent male partners, observed an association of age gap between male partners and adolescent females in a sexual relationship. Their findings drew an association between age difference and age at first sexual intercourse.

They found that young females who had experienced their first sexual intercourse at an age less than 15 years and whose male partners were 5 years and above were at a higher risk of pregnancy, substance abuse and suicide. We must mention that substance

abuse and suicide issues were not part of this study. The effects of these adverse sexual behaviors, were less obvious among adolescent females whose age at first intercourse was 16 and older and whose male partner was 4 years or less.

This could suggest that the adverse effects of the age gap, are reduced with older adolescent females. This trend is evidenced in (table 4.5) where most male partners (72.46%) were up to five years older than their female partners. The findings are important to my investigation because it reveals important perspectives of the phenomenon of age difference between male partners and their female teenage partners, and its influence on adolescent pregnancies and other related issues such as contraceptive use.

In a male dominated environment such as in Ghana, male partner control plays a vital role in decision making in a romantic relationship. For instance, results from the qualitative analysis indicated that most of the male partners had a reluctant attitude towards the use of contraceptives and did not consider the consequencies of its non use. This phenomenon also offers an opportunity to consider the issue of age with a key focus on the male partner in policies and programs targeting adolescent pregnancy interventions.

Public health programs should begin to shift its attention from the female adolescent and place the focus on the sexual behaviours of male partners, especially older males. Health education programs should adequately target the needs of younger male partners who have also become apparent in this study. Further investigations will however be required in this area in future studies.

Similar to their female counterparts, most of the male partners belonged to a religious faith with majority being Christians (91.55%), which again suggests that religion

probably promoted certain beliefs and cultural values associated with family and child bearing behaviours (Burdette & Hill, 2009). In an in depth interview with a male partner, he confirmed that abortion was forbidden in his family.

The most common occupation of the male partners of adolescent pregnant girls interviewed was skilled vocation/Artisans. Some male partners were unemployed and others were into either farming/fishing or other activities (table 4.7). This is indicative of the normal phenomenon in most rural communities in Ghana. By virtue of its geographical location, South Dayi has most of its rural communities sited along the banks of the river Volta. It was common to find men and women (young/old) engage in farming, fishing, trading or into a vocational skill such as sewing, carpentry, driving or kente weaving.

This perhaps also accounted for the low educational levels of the male partners of adolescent pregnant girls in the district, as most of the occupational opportunities and preferences do not require one to have a high level educational background or training. Over 61% of the male partners had attained primary level education and 25% of them post primary education (table 4.9).

This is also indicative of the fact that educational attainment did play a major role in romantic and sexual relationships in the rural setting. Ordinarily, most young people in the rural communities start their vocations at an early youthful age. This provides a livelihood and some income to most youths. It stirs up a sense of feeling of responsibility and independence among rural males.

We did not accord much attention to ethnicity as majority (91%) of the male partners were Ewes while only (9%) were of other ethnic groups, which was expected

considering the fact that South Dayi is in the Volta Region where the people are predominantly Ewes.

Of the 76 respondents interviewed, only 26.67% of that number confirmed their male partners had other female partners beside them at the time of pregnancy. Moreover, the male partners lived alone, 57.82% stayed with their parents (both or either) at the time their female adolescent became pregnant. This points to the fact that most of the male partners were not socio economically self-sufficient, however their provision of basic socio economic support in what ever form made them responsible enough for their women to depend on them.

Both quantitative and qualitative interview outcomes revealed that pregnancies were unplanned. However, majority of the male partners showed a positive attitude towards the unexpected outcome of the relationship which resulted in pregnancy. This was evident in the results of the in depth interviews where majority of the male partners reacted positively to knowing that pregnancy had occurred.

Some studies on male partner's attitude towards pregnancy found that males with low socio economic backgrounds, low education but of strong socio cultural settings often considered fatherhood as a sign of masculinity, (Massiglio (1993). Results from the in depth interviews indicated that in instances where parents and guardians exhibited anger and disappointment towards their daughters getting pregnant, male partners offered a sort of encouragement and assurance to be responsible for their partners pregnancy.

Although our data did not critically look into pregnancy wantedness from the start of the relationship between the male partner and female adolescent we can deduce from the IDI responses certain cultural, socioeconomic and sociodemographic factors that

imply that majority of the partners desired the pregnancy once it occurred. For instance, the male partners of the pregnant adolescent girls showed much willingness to offer continuous financial support during the pregnancy period and after delivery of the baby. This is an apparent evidence of a strong feeling of masculinity within a patrilineal society where the male partner both in marital and premarital environment is expected to provide and care for his household.

They freely took on the responsibility of care, and in some instances offered to enroll the adolescent girl in a vocation of her choice after successful delivery and weaning of the baby. Some male partners who were unemployed at the time their girlfriends became pregnant, made the effort to get a job so they could earn money. In a study conducted in South-eastern Nigeria along similar notion, Smith D.J. (2007) stated that men often want to prove their masculinity and status via their ability to provide some material and economic luxuries to their girlfriends. These observations were similar to that expressed in the course of our interviews.

This trend of the male partners providing the biggest financial support (table 4.9.9; figure4.2) further clarifies the socio economic, cultural and demographic factors underpinning adolescent pregnancy in the South Dayi district. We found most of the relationship factors mostly related to the male partners provision of basic financial and emotional support, cohabitation and in some instances, marriage. The readiness to support was more wide spread among male partners between ages 17 to 25. This trend was on the contrary among male partners of 25 years and above.

The difference in attitude as was observed in the study, stemmed from the fact that partners between ages 17 to 25 took pride in their masculinity (Massiglio,1993) to

becoming fathers, some for the first time, they had less domestic obligations and most likely to get help from their parents and other relations.

They generally demonstrated a positive attitude towards their female partners becoming pregnant in the course of their relationship attesting to pregnancy desire and acceptance among this age bracket. We observed that earlier discussions in this study about age difference between older adolescents and male partners had some sort of influence. Where the age differences were not wide apart, the adolescent pregnant girls received better attention from the male partner. Probably, the minimal age difference between partners reduced the influence of male dominance in the relationship.

The older male partners 25 years and over usually were already having wife/wives, children and other social commitments which limited their desire to additional responsibilities.

CHAPTER SIX

6.0 CONCLUSIONS

The purpose of this study was to describe the socio demographic characteristic of partners of adolescent pregnant girls and explore circumstances in relationships leading to adolescent pregnancy. The socio demographic characteristics of male partners does play a substantial role in adolescent pregnancy matters.

The findings of the study revealed that the surge in adolescent pregnancy in the South Dayi district is motivated by socio economic determinants such as male partner support, low level education, poverty, and family composition. The research has indicated male partners to provide basic but important socio economic support (56%) system for many pregnant adolescent partners.

The information on the socio demographic characteristics in this research has revealed that the male partners of pregnant adolescent women in the South Dayi district were neither men of high educational status nor of good socio economic standing, yet their influence in adolescent reproductive and sexual behaviour issues cannot be ignored.

Most of the male partners in this study did not attain high educational levels and are therefore limited to better employment opportunities and their self development as well as the development of their adolescent female partners.

Inspite of male partners adequate knowledge of contraceptives, there was less interest and indifference in attitude towards contraceptive usage. The age disparity and power play in romantic and sexual relationships are important drivers to consider in adolescent pregnancy phenomenon.

Additionally, these factors appear to enlighten further, male partner attitudes pertaining to adolescent pregnancy.

Male partners can contribute significantly to programs and interventions aimed at improving the reproductive health of adolescents especially in teenage pregnancy issues if actively involved.

RECOMMENDATIONS

Programs targeted at preventing adolescent pregnancy and its related issues, could consider putting the spotlight on male partners as well as the girls. The scope of health educational programs may be expanded to cover active male participation in order to create a healthy support base to cater for male reproductive and sexual needs.

The laws concerning adolescent reproductive health may consider strict enforcement of our defilement laws and empower social protection agencies in their activities in this regard.

Programs addressing adolescent reproductive health and sexual behaviour could make rigorous efforts to place emphasis on the knowledge and use of contraceptives to prevent adolescent pregnancy and sexually transmitted diseases. Health programs in this regard could also make a deliberate effort to reach out to young adolescent male groups in roder to create the awareness of the effects of early pregnancy on their lives.

As the saying goes, “education is the key to success and wealth,” and “knowledge is power.” The longer our young men stay in school and attain a reasonable level of education the better it will be to either delay or prevent early pregnancy among adolescents.

With longer duration and higher education, younger men, will be in a better position to understand the negative repercussions of early sex and its effect on their lives.

School programs and other educational activities may incorporate extra curriculum activities tailored to explore hidden talents and to provide varied skills to the young men in schools. Short term incentive-based programes in secondary school could be added to the school curriculum to provide more carrier options.

This way, education may be more desirable to them. This could be achieved through the combined efforts of the Ministry of Educaton, Ghana Health Service and the Ministry for Gender, Youth and Sports.

When programs address these deeper problems, we may see a sustained decline in adolescent pregnancy in communities within the South Dayi District.

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APPENDIX A: DATA COLLECTION INSTRUMENT

Appendix A: Data collection questionnaire. Questionnaire No :__ __ __ __

Date (dd/mm/yy) :__ __ Time : __ ___ :__ __

Name of facility:_____ Code of interviewer : __ __

Gestational age (as recorded): ___ ___mths ___wks

Socio-demographic characteristics of respondent

1. Marital Status ☐1Married in church ☐2Married by tr. Rites ☐3Co-habitation ☐4Single ☐5Divorced ☐6Widowed ☐7Other:_____

2. Ethnic group ☐1Ewe ☐2Ga-Adangbe ☐3Akan ☐4Other:_____

3. Highest edu. Level ☐1Sec. or higher ☐2JSS ☐3Primary ☐4None

4. Religion ☐1Christian ☐2Muslim ☐3Traditionalist ☐4Other:_____

5. Were you in school at the time you became pregnant? ☐1Yes ☐2No
If yes, which class:_____

6. Were you engaged in any occupation when you got pregnant? ☐1Yes ☐2No

6b. If Yes, what were you engaged in?
_____

7. How many siblings do you have? _____

8. How old were you when you got (current) pregnant ___ ___ yrs

9. Before this pregnancy, had you been pregnant before? ☐1Yes ☐2No

10. How many children do you have? ___ ___

11. Where were you resident when you got (current) pregnant? ☐This town ☐Another town

12. Who were staying with when you got (current) pregnant? ☐1Both parents ☐2Partner ☐3Mother only ☐4Other relation:_____ ☐5Non-relation:_____

13. Who are you currently staying with? ☐1Both parents ☐2Partner ☐3Mother only ☐4Other relation:_____ ☐5Non-relation:_____

14. Who gives you the biggest financial support at this time? ☐1Self ☐2Partner ☐3Both parents ☐4My father ☐5My mother ☐6Other:_____

15. Do you presently engage in any activity that earns you money? ☐1Yes ☐2No

15b. If YES, before the pregnancy, were you engaged in this activity? ☐1Yes ☐2No

15c. About how much do you earn from this activity in a day? GHC:_____

15d. Can you briefly describe the activity? _____

Demographic characteristics of partner

1. Age of partner _____ yrs

2. Religion of partner ☐1Christian ☐2Muslim ☐3Traditionalist ☐4Other:_____

3. Occupation of partner at the time you got pregnant ☐1Unemployed ☐2Teacher ☐3Farmer ☐4Self-employed vocation ☐6Other:_____

4. Ethnic group ☐1Ewe ☐2Ga-dangwe ☐3Akan ☐4Other:_____

5. Highest educ. Level ☐1Univ ☐2Non-univ post SHS ☐3JHS ☐4None

6. Does he have another partner/wife when you became pregnant? ☐1Yes ☐2No

7. How many children has he got? _____

8. Who was he staying with when you got (current) pregnant? ☐1Alone ☐2Parents (either) ☐3Friend(s) ☐4Other relation_____

9. Did you plan to have a baby? ☐1Yes ☐2No

9b. If no, can you explain why you did not use protection? _____

10. Before you got pregnant did you know ☐1Yes ☐2No

when in your menstrual cycle you were most at risk to get pregnant?

Relationships

1. How long have you known your partner?	_____ yrs
2. Where did you first meet your partner?	_____
3. Can you briefly describe what you were doing when/how you first met your partner?	_____ _____ _____
4. Was your partner living in the same community as you when you got pregnant?	☐1Yes ☐2No
5. Does your partner live in his own house?	☐1Yes ☐2No ☐3 Not sure
6. Is there any relationship between the family of your partner and your family?	☐1Yes ☐2No ☐3 Not sure
7. How old were you when you first had sexual intercourse?	____ ____
8. How old were you when you first had sex without a condom?	___ ___
9. In the year prior to getting pregnant, how many sexual partners had you had?	___ ___
10. Did your parents/guardian know you were going out with him at the time the pregnancy occurred?	☐1Yes ☐2No
11. Prior to getting pregnant, were you ever taught in **school** about sex and the risk of pregnancy?	☐1Yes ☐2No ☐3 N/A – Not in sch.
12. Prior to getting pregnant, were you ever taught at **home** about sex and the risk of pregnancy?	☐1Yes ☐2No
13. In which month of (current) pregnancy are you?	____ *months*
14. Which of these contraceptive methods do you know about?	Male condom ☐1Yes ☐2No Female condom ☐1Yes ☐2No IUD ☐1Yes ☐2No Injectable ☐1Yes ☐2No Implant ☐1Yes ☐2No Exclusive breastfeeding ☐1Yes ☐2No
15. At what point in a woman's menstrual cycle is she most at risk of getting pregnant?	☐1Just after menses ☐2About middle of the cycle ☐3 Just when menses is about to come. ☐4 Don't know

APPENDIX B: QUALITATIVE DATA INTERVIEW GUIDE

1. How did you feel the first time you got to know you were pregnant?
2. What was your partner's reaction when you told him you were pregnant?
3. Parents \ family\ in-laws saying about what has happened?
4. Are you ready to be a mother \ father?
5. What are your thoughts about marriage now?
6. Please tell me about your partner and what he is currently doing?
7. What help are you getting from your partner? (How he treats you now)
8. What do you know about protection or contraception?
9. If you could go back in time, what would you do differently?
10. What advice would you give to a teenager like yourself wanting to date or get pregnant?
11. What were your goals or plans before you became pregnant? Will those plans change now?

APPENDIX C: INFORMED CONSENT FORM

Introduction:

Mrs. Diana Abena Coffie a Graduate Student at the Ensign College of Public Health in Kpong, is conducting a study on the Socio-demographic characteristic of partners and circumstances in relationships leading to pregnancies among adolescents in the South Dayi district in the Volta region of Ghana.

Thank you for agreeing to participate in the study and to contribute to building additional knowledge in this area. You or your ward has been selected because of her situation as a pregnant young lady. As part of the process, this form is to ensure that you or your ward have voluntarily consented to participate in the study.

Background of the study:

Research has shown that, adolescent pregnancy is not simply the result of a girl being promiscuous, or the failure to obtain and use contraception, but is instead inexorably linked to many social, cultural, educational, and economic factors influencing adolescent risk taking behaviours.

The rationale of this study will be to explore the socioeconomic factors impacting adolescent pregnancy, demographic characteristics and paternity patterns of their male partners. The goal is to describe the socio demographic characteristics of the male partners and provide additional insight into the dynamics of the relationships and circumstances leading to the pregnancies.

Procedures:

The student researcher will visit selected communities and hold individual interviews. If you consent through this form, you or your ward will be asked to

participate in an individual interview regarding socio-demographic characteristic of partners and circumstances in relationships leading to pregnancies among adolescents. Please note that the interview will be audio taped for analysis by the student researcher. You are free to provide additional information or correction if you so desire.

Voluntary Nature of the Study:

You or your ward's participation in this study is voluntary. This means that I will respect you or your ward's decision of whether or not you want to be in the study. No one will treat you differently if you decide not to be in the study. If you or your ward decide to join the study now, you can still change your mind at the time of the interview. If you or your ward feel stressed during the interview you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:

The interview will take approximately 45 minutes to complete and will involve a detailed discussion of your ward's lived experiences, socio-demographic characteristic of partners and circumstances in relationships leading to pregnancies among adolescents.

The main benefit of the study is that it will inform the development of interventions to reduce such occurrences among adolescents in our communities. It may also give insight to the effective mechanisms to support adolescents who are affected by such circumstances. Additionally, the study will provide knowledge for engaging stakeholders in the discourse of improving adolescent's health in our communities.

Compensation:

Although participants will not be compensated, you or your ward's participation will be greatly appreciated.

Confidentiality:

Any information you or your ward provide will be entirely confidential. The student researcher will not use your information for any purposes outside of this research project. Also, the student researcher will not include you or your ward's name or anything else that could identify you or your ward in any reports of the study.

Contacts and Questions:

You or your ward may ask any questions you have. Or if you have questions later, you may contact the student researcher via telephone (+233-55-459-7011) or email (abenacoffie@gmail.com). If you or your ward want to talk privately about your rights as a participant, you can call Dr. Frank Baiden (Telephone No. +233-20-459-1181), the Head of the Epidemiology Department of the Ensign College of Public Health or Dr. Belinda Nimako, District Director of Health Services, South Dayi (Telephone No. +233-20-630-0878). They are representatives supervising this study and can discuss related questions with you or your ward. You may also contact the administrator of the Ethics Committee at the Ensign College of Public Health (Telephone No.+233-24-576-2229).

The researcher will give you or your ward a copy of this form to keep.

Statement of Assent / Consent:

I have read the above information and I feel I or my ward understand the study well enough to make a decision about our involvement. By signing below, I or my ward agrees to the terms described above.

Printed Name of Participant / Parent or Guardian

Date of consent

Participant's / Parent or Guardian Written Signature

Researcher's Written Signature