KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH

SEX NEGOTIATION SKILLS OF IN-SCHOOL, YOUNG ADOLESCENT GIRLS IN EFFIDUASI, SEKYERE-EAST DISTRICT, ASHANTI REGION, GHANA

MONICA MOLARA OJUMU (B. Pharm Hons)

PG 5113410

November, 2015

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BY

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A thesis submitted to the Department of Population, Family and Reproductive Health, School of Public Health, College of Health Sciences in partial fulfilment of the requirements for the Degree of Master of Public Health (MPH) in Population, Family and Reproductive Health.

November, 2015

DECLARATION

I hereby declare that except for references to other people‘s work which have been duly acknowledged, this work is the result of the original research work taken by me under supervision. It contains no materials previously published by another person which has been accepted for the award of any degree elsewhere.

Signature …… **Date ……**

(Candidate)

Signature …….. **Date** ……..

(Academic Supervisor)

Signature ..... **Date**…….....

(Head of Department)

ABSTRACT

Adolescents who have gone through comprehensive sex education which includes sex refusal and negotiation skills are not likely to experience a pregnancy compared with those who are educated on abstinence only. It is important for adolescents who are not ready for sex to practise refusal skills and well-practised skills can be used automatically, without requiring a lot of thinking. The skills help adolescents to personalize sexual issues, which result in significant delays in the onset and the practice of safe sexual intercourse. The issues of adolescent sexual activity and reproduction are increasing in Africa. In Ghana, adolescent sexuality is of concern because some sections of the adult population do not endorse contraceptive use among sexually active adolescents. The Sekyere-East District in the Ashanti Region, has been recording increasing numbers of teenage pregnancies. By the year 2012, Effiduase sub-district recorded the highest teenage pregnancy of 31.9%, Nyanfa and Asokore sub-districts also recorded 9.7% and 8.9% respectively.

This study sought to find out from in-school young adolescent girls, aged 10-14 years in Effiduasi, in the Sekyere East District, what sex negotiation skills they practise as well as the factors that influence their sexual choices. The study employed a descriptive cross-sectional design. Self-administered questionnaire was developed and used for respondents. Four hundred and fifty (450) study participants were selected by Probability Proportional to Size (PPS) from all the basic schools in Effiduasi.

In this study, the worrisome figures that highlighted the importance of sex knowledge are that the mean age at which respondents first had sex was 11.77 years. Sex knowledge is the availability of a knowledge transfer mechanism from a passive to an active form that allows girls to personalize sexual issues and develop specific sex negotiation skills. Except in the case of rape, it can be deduced from the responses in this study that unwanted sex and

reproduction as teenagers are largely attributable to the feelings and opinions that they hold about sex.

The study also observed that self-esteem is an important reason and a key determinant for sex negotiation and sex refusal which delay first sexual intercourse and thus postpones pregnancy until the right time. Although, the mean age of having sex was 11.77 years, most of which cases was defilement, the study indicates self-esteem as one of the determinants for a strong level of sex refusal and sex negotiation skills among the participants.

It is recommended that sex education begin very early in a girl‘s life, starting from the home where parents and guardians develop firstly, a loving atmosphere and secondly, honest and clear communication with their daughters about sex and sex negotiation skills.

Effective policies on sex education and sex negotiation skills specifically tailored for young adolescents are either not available or hard to find. Such policies should be in place for educational institutions, non-governmental and religious organisations to implement in their various jurisdictions. The phrase ‘catch them young‘ is very relevant in the case of young adolescents.

DEDICATION

I dedicate this work to Nana Kofi and Dedo Doku, my beloved son and daughter, to all the adolescents out there who have taken a stand and are already practicing safe sex negotiation skills, to those who are yet to take a stand, and to parents and guardians of adolescents, may you find this work helpful.

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I am most grateful to Almighty God for life, strength and ability to complete this work. Without you, Lord, all we do is in vain.

I sincerely acknowledge my supervisor Dr Easmon Otupiri for his commitment to the conduct and write up of this dissertation. Thank you for the guidelines you gave, the times you took out of your busy schedule to read several times and make corrections. I am most grateful for the gentle rebukes, and for being patient with me.

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LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Ante-natal Care
AIDS	Acquired Immune Deficiency Syndrome
CHRPE	Committee on Human Research, Publication and Ethics
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
HIV	Human Immunodeficiency Virus
JHS	Junior High School
PNC	Post-natal Care
PPS	Probability Proportional to Size
SD	Standard Deviation
SIECUS	Sexuality, Information and Education Council of the United States
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
WORA	Women of Reproductive Age

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

Adolescent sexuality and reproduction are issues that have attracted worldwide recognition as social problems of development. Effective sex refusal and negotiation skills help adolescents to avoid sexual intercourse or unprotected intercourse (Evans & Smith, 1999). Sex education programs combine information on a variety of sexuality-related issues, including abstinence, contraception, safe sex, the risks of unprotected intercourse and how to avoid them, as well as the development of communication, negotiation, and refusal skills. Teenagers who have comprehensive sex education which includes sex refusal and negotiation skills are half as likely to experience a pregnancy as those who attend abstinence-only programs (Kohler, 2008). According to Kirby, effective sex education programmes are able to lower risky sexual behaviour by about one-third (Kirby, 2007).

It is important for young teens who are not ready for sex to practice refusal skills. Repeated practice leads to better self-confidence in using these skills when they are needed especially in situations that involve high level of emotions. A well-practiced skill can be used automatically, without requiring a lot of thinking (Reyna, 2004).

Compared with traditional knowledge-based sex education, focused behavioural-skill types such as sex refusal and negotiation skills have shown more promising results by postponing sexual involvement and reducing the risk of unprotected sexual intercourse. Such skills are active rather than passive strategies. They help adolescents to personalize sexual issues and develop specific negotiation and refusal skills needed in sexual relations. Effective sex refusal and negotiation skills

have been shown to result in significant delays in the onset of sexual intercourse. They also have moderate effect on improving upon the use of contraceptives among adolescents who are sexually active (Agha, Van Rossen & Ankomah, 2011).

The issues of adolescent sexual activity and reproduction are likely to become increasingly more important in Africa in the near future due to urbanization and the dramatic growth in secondary schooling. Adolescent sexuality in Ghana is of concern because some sections of the adult population, particularly some religious groups in the country do not endorse contraceptive use among sexually active adolescents (Kwakye, 2005).

In the Ghanaian society, the man traditionally initiates sexual activity while the woman is expected to respond positively. There are other ideologies and circumstances that prevent women from asserting their sexual rights by way of sex refusal or negotiation. Some of these ideologies or circumstances may be due to the belief that women were created to serve and submit to men, poverty, illiteracy, ignorance and a lack of a good or positive self-image.

An investigation into young adolescent girls‘ sex refusal and negotiation skills will be of considerable value for the girls in communities such as Effiduasi, where cultural and traditional values largely come into play where sexual relationships are concerned. This study aimed at assessing the sex refusal and negotiation skills used by in-school young adolescents girls in effiduasi, Sekyere East district.

1.2 Problem Statement

Teenage pregnancy in the Sekyere - East District is on the increase. In the year 2012, Effiduase sub-district recorded the highest teenage pregnancy of 31.9% with Nyanfa and

Asokore sub-districts recording 9.7% and 8.9% respectively (GHS- Sekyere East District Health Directorate, 2012). It is noteworthy that with the exception of periodical school health talks on general health issues, no programmes were found to be in place to address the issue of teenage pregnancy. Teenage pregnancy can be used as an indicator of how well adolescents are experienced in sex negotiation skills. The high level of teenage pregnancies reported in the sub-district is an indication of poor sex negotiation skills of adolescents in the district.

1.3 Rationale of Study

Reproductive health education begins with abstinence—the only completely certain way for young unmarried people to protect themselves against pregnancy, sexually transmitted diseases (STDs), human immunodeficiency virus and acquired immune deficiency syndrome (HIV and AIDS). To successfully practice abstinence and to avoid getting pregnant, young people need skills, including decision making, communication, negotiation, and refusal skills. When abstinence is taught as the only option for young people, they do not receive the information and skills that will help keep them safe when they become sexually active. Without this knowledge, young people are less able to make responsible choices.

Many adolescents engage in sexual intercourse with multiple partners and without condoms, thus placing them at risk of STDs including HIV. Among sexually experienced people, adolescents aged 15 to 19 years have some of the highest reported rates of STDs.

This study sought to find out the knowledge level of young in-school adolescent girls in the Sekyere East District regarding sex negotiation skills as well as the factors that influence their sexual choices. This information will help policy makers

in the district to tailor specific strategies with regard to adolescent sexual health in the district.

1.4 Conceptual Framework

The conceptual framework shows how the various variables affect sex negotiation skills among young adolescents. It is partly based on reasons for delaying or engaging in early sexual initiation among adolescents in Nigeria by Ankomah et al., (2011). The reasons were identified into four key themes regarding sex, these were found to be restraining factors, push factors, pull factors and coercive factors. Push factors were defined as any ―enabling‖ factors that were internal, ie, that originated in the adolescent or the immediate family. Pull factors offered attractions to engage in first sex; these were from an external source and included community, school as well as friendship and peer-related issues. Coercive factors were considered to be outside the control of the adolescent and bordered on illegal sexual violation. Finally, restraining factors were those that motivated adolescents to delay early sexual initiation.The pull factors were identified in the role the environment and socio- cultural beliefs, customs and practices play on young adolescents regarding their choices where sex is concerned. The media was said to have both positive and negative influence, in particular television, as it showcases educative programmes on sex and sexuality, however, movies as well as films were identified as a key catalyst for engagement in first sex particularly for males. The natural sex drive is made difficult to control by what is watched on television, films and movies and sticking to one‘s resolve is made even more difficult. Whereas there are customs and cultural practices that favour delayed sexual debut, many more myths and misconceptions provided some justification for early sex and such views are strongly held by adolescents, for example, it was believed that failure to have sex early would make one develop pimples, grow fat, become infertile in the future, or could even result in death. The push factors were found in the role parents and immediate family played. Parents were

considered as the primary shapers of their children‘s behavior, including sexual behavior. They have great influence over whether their wards abstain or otherwise. Parents could have either negative or positive influence on the sexual activity of their children. Children of ‘good’ parents have good home training and would grow up to be youth who abstain until marriage, while children (especially females) of ‘bad’ parents stand a higher chance of being pushed consciously or unconsciously by their mothers into early sexual initiation. Where parents did not appear to care or take interest in what adolescents did, sexual initiation was often earlier. Such a home environment went a long way toward pushing young persons to have early sex by breaking any resistance or resolve they may have. Parents or close family members, mainly as a result of poverty, expose female adolescents to early sex by asking them to engage in street trading or hawking goods in the neighborhood.

A ‘bad’ mother will punish her daughter if she fails to make enough sales. This risky situation was exacerbated by the fact that many parents were unable or unwilling to tell their children directly to abstain from sex. Parents sometimes were not straightforward when giving advice, which ended up confusing adolescents.

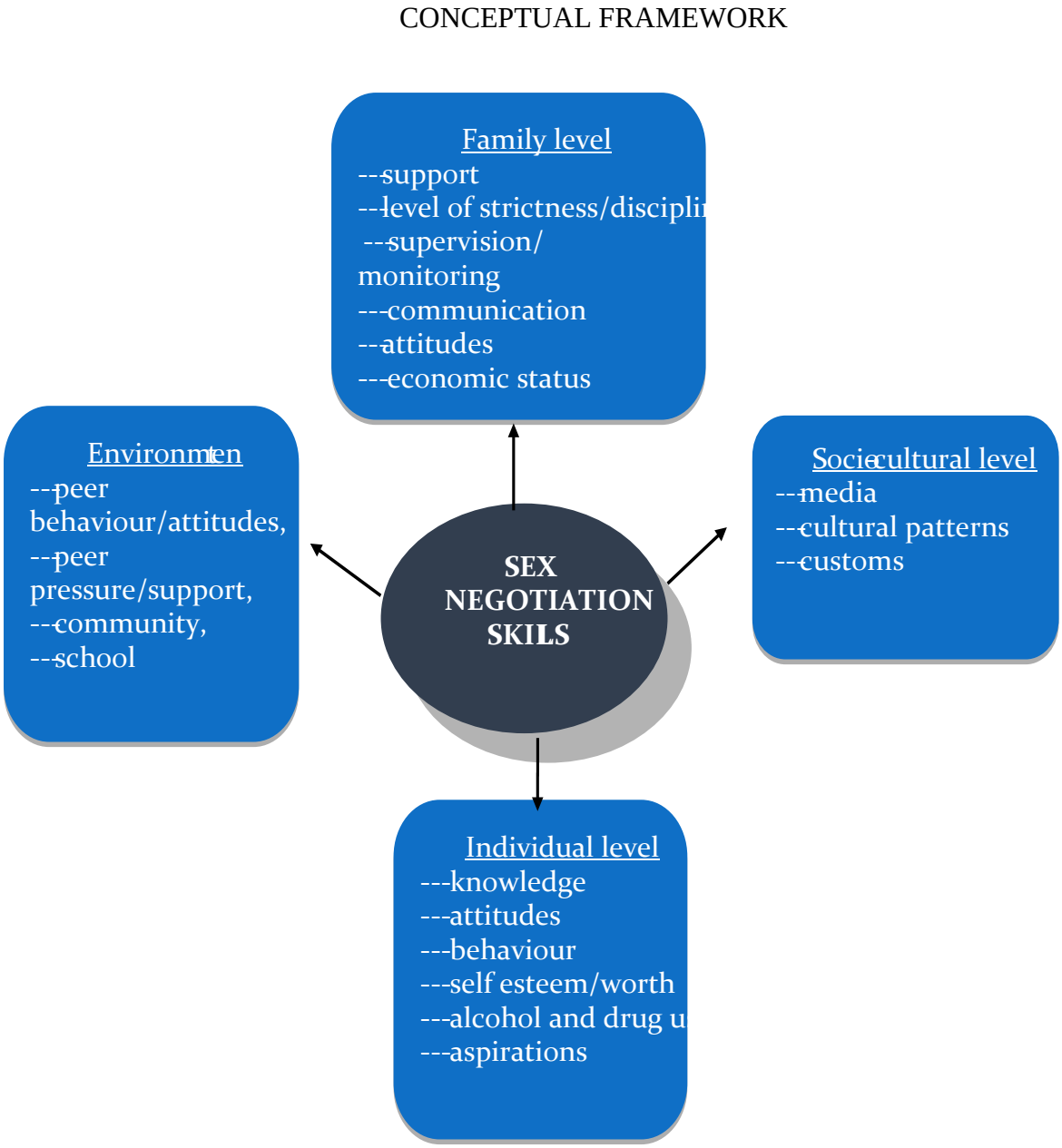
One major enticement to engage in early sex is rewards, both financial and material, that may be gained from trading first and subsequent sexual interactions for money or gifts. Rewards included cash, gifts, and, in educational establishments, favor relating to admission and examinations. Some saw sex as a means of ‘survival’, so abstinence was not an option for them.

Restraining factors were the ability to ‘be focused and determined’. One must have a clear reason why they were abstaining, and they must have something in mind they were pursuing.

The need to be determined and focused should not be left ‘within you’, to succeed, friends and peers should know so that the boys will ‘leave you alone’. There was the need to let boys know that you are not interested in sex and you like it that way. Boys were not to be given any chance to make advances,

This study focused on the family and individual level factors because it's the researcher's belief that the effects of these two factors on sex negotiation skills far outweigh that of the other factors where young adolescents are concerned.

Fig. 1.1 Conceptual Framework for Sex Negotiation Skills



Source: Ankomah et al., 2011

1.5 Research Question

What sex negotiation skills do young in-school adolescent girls in Effiduasi know and practice?

1.6 General Objective

To assess the sex negotiation skills of young in-school adolescent girls in Effiduasi in the Sekyere-East District of Ashanti Region.

1.7 Specific Objectives

1. To determine the level of knowledge and education the young in-school adolescent girls have about sex.
2. To assess their attitude (opinions, feelings and behavior) towards sex.
3. To determine what sex negotiation skills they know and practice.
4. To assess how they see themselves in terms of self-image or self-worth.

1.8 Profile of Study Area

The Sekyere East district of the Ashanti Region has Effiduasi as its district capital. It lies in the North Eastern part of the Region. Farming is the dominant occupation of the people in the district. A good number of young men and women are involved in various kinds of trading due to the district's proximity to Kumasi, the regional capital. The district has a total population of 65,574 with 4 sub-districts and 38 communities. Effiduasi has a number of junior, senior high schools, technical and vocational schools. (GHS-Sekyere-East District, (2012), Annual Health Report.) .

Effiduasi is the most populous sub-district with eight communities and a population of 23,607 which represents 36% of the total population of the Sekyere East District, while Mponua, with fifteen communities and a population of 9,836 representing 15% of the total population is the least populous. (Table 1.1)

Table 1.1: Population of sub-districts

Sub-district	Capital	Population	Percentage distribution (%)	No of communities
Effiduase	Effiduase	23607	36	8
Asokore	Asokore	17050	26	13
Nyanfa	Okaikrom	15082	23	10
Mponua	Seniagya	9836	15	7

Source: Ghana Health Service- Sekyere East District,(2012) Annual Health Report,Effiduasi.

For the purposes of this study, it is worthy of note that the district has 23,869 children of school going age being the most populous, representing 36.4% of the population, while adolescents also form a large chunk , 15,082 representing 23% of the population. (Table 1:2).

Table 1.2: District Health indicators

Indicators	**Population**	**Percentage distribution (%)**
Children 0-11months	2623	4
Children 12-23 months	2557	3.9
Children 24-59 months	5639	8.6
0-59months(<5yrs)	10820	16.5
WORA	15213	23.2
Expected pregnancies	2623	4
Expected delivery	2623	4
Adolescents	15082	23
School going age	23869	36.40
Aged 64+	4000	6.10

Source: Ghana Health Service- Sekyere East District,(2012) Annual Health Report,Effiduasi.

In 2013, only one 10-14 year old girl visited the hospital for family planning uptake compared with the numbers that got pregnant. Comparison of data for the two consecutive years give a fair picture of some of the reasons for increasing teenage pregnancy in the district.(Table 1.3)

Table 1.3: Adolescent ANC/PNC attendance, Deliveries and FP uptake, 2013

2013	10-14 years	15-19years
Ante-Natal	36	450
Deliveries	22	334
Post-Natal	41	307
Family Planning	1	175

Source: Ghana Health Service- Sekyere East District,(2013) Annual Health Report,Effiduasi.

In 2012, thirty-five 10-14year old girls visited the hospital for family planning uptake. (Table 1.4).

Table 1.4: Adolescent ANC/PNC attendance, Deliveries and FP uptake, 2012

2012	10-14 years	15-19years
Ante-Natal	14	439
Deliveries	34	297
Post-Natal	4	240
Family Planning	35	103

Source: Ghana Health Service- Sekyere East District,(2012) Annual Health Report, Effiduasi.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction and Definitions

This chapter reviews relevant literature associated with adolescent sexual health in relation to sex refusal and negotiation skills. The section tries to give meaning to the different concepts, and describes the different theories, used in this study based on available literature on adolescents‘ sexual behaviour. Although these theories and concepts will be used to design the discussion and questionaire for the data collection, the data collection itself will be open to new concepts and theories.

2.1.2 Definitions of Sexuality Education

Globally, the content of sexuality education curricula varies widely by region, by school district, and sometimes, by classroom. The highly charged political debate concerning sex education could lead most people to believe there are hard and fast divisions between educational approaches. In fact, there are multiple programme designs, many of which resist clear classification, or share components of seemingly opposing approaches (Feijoo, 2001).

According to Valleroy et al. (2000) sexuality education in the schools is a hot button issue in part because it is closely intertwined with social and parental interpretations of right and wrong, and with people‘s feelings about religion and personal autonomy. Yet sex education is also intended to serve a very practical public health purpose – to reduce STIs, HIV, AIDS, and unintended pregnancy among the country‘s young people. These are goals of sex education that virtually everyone agrees on. The debate centers on a question of methods (i.e., how to prevent negative health outcomes) and the ancillary goals of advocates on all sides (e.g., teaching particular moral values, or encouraging autonomous decision making).

Table 2.1: Major Paradigms in Sex Education

Abstinence-Plus Education	**Abstinence-Only Education**
Abstinence-plus education programs explore the context for and meanings involved in sex. □Promote abstinence from sex □Acknowledge that many teenagers will become sexually active □Teach about contraception and condom use □Include discussions about contraception, abortion, STI's and HIV	Abstinence-only education includes discussions of values, character building, and, in some cases, refusal skills. □Promote abstinence from sex □Do not acknowledge that many teenagers will become sexually active □Do not teach about contraception or condom use □Avoid discussions of abortion, cites STI's, HIV and unwanted pregnancy as reasons to remain abstinent

Source: Valleroy et al, 2000

2.1.3 The Historical and Social Context of Adolescence in Ghana

Although Ghana is a multi-ethnic country, there are common features in the traditional roles, status, responsibilities and socialization processes for adolescents. Among the various ethnic groups, adolescence is the stage after childhood within which the individual attains physical, sexual and social maturity. Historically, this stage began for women with menarche or initiation and ended with marriage or childbearing. For males, the period was marked by initiation or marriage. For instance, among the Krobo and Akan, puberty rites were performed for girls after menarche to signify their maturity. Known as 'Dipo' among the Krobo and 'Bragro' among the Akan, the initiation ceremony was a community affair and was held under the auspices of the queen mother. A girl who became pregnant before an initiation ceremony committed an offence and the maximum punishment was banishment from the community. At this stage, young people were responsible for cleaning public places, such as paths to water bodies and farms, and for the security of the community (Sarpong, 1977).

Using the 1960 post- enumeration survey, Aryee & Gaisie (1981), estimated the age at first marriage to be 17.7 years. Earlier marriages were characterized by arrangement via family members, elopement and betrothal. Traditionally, young females were expected to be

virgins at first marriage but that was not expected of males. This was part of the double sexual standard for males and females, whereby parents expected their daughters to be virgins but not their sons. Another aspect of the traditional system was that childlessness was abhorred. A woman without children was equated with a man as in having an inability to get pregnant and bear a child.

Over a period of three decades, some of the traditional arrangements have undergone changes as a result of modernization, urbanization, migration and formal education. One outcome of these changes is that some of the responsibilities of the extended family and the community to socialize adolescents, including the selection of future marriage partners, have been eroded (Mensah et al 1999). As part of the changes, state organs such as ministries, departments and agencies, the school system, religious bodies, and the media have emerged as socialization agents in addition to the family.

Encouraging adolescents to delay intercourse, and also to use contraception if and when they have sex, is more effective than approaches that focus solely on abstinence or solely on contraception. The younger adolescents are when they begin having sex, the greater their risk of negative consequences. Early sexual intercourse experiences often are psychologically or physically coercive. Evidence suggests that by knowledge about social pressures, negotiation, and refusal skills, many adolescents are capable of postponing their sexual involvement. Reproductive health education begins with abstinence—the only completely certain way for youth to protect themselves against pregnancy, STDs, HIV and AIDS. To successfully practise abstinence, young people need skills, including decision making, communication, negotiation, and refusal skills. This, in recent times, appears to be dominated by adolescents and the youth in search of jobs in the cities and large towns. Separation of these young persons from their parents is likely to result in the steady breakdown of traditional, parental and social controls on the lifestyles of the young migrants. Because of

difficulty in getting jobs in their places of destination, many female adolescents may be tempted to take up risky sexual behaviours as a matter of survival. Another aspect of risk that young females go through is defilement (Kwankye, 2005). It is therefore important to investigate sex refusal and negotiation skills among adolescents in the Sekyere East district.

2.2 The level of knowledge and education the young adolescent girls have about sex

2.2.1 The shift away from abstinence - only sex education

There are many different organisations in the United States of America advocating abstinence-only sex education in schools. These and other proponents of abstinence-only education argue primarily that sex before marriage is inappropriate or immoral and that abstinence is the only method which is hundred percent effective in preventing pregnancy and STIs. Many abstinence-only advocates are deeply concerned that information about sex, contraception and HIV can encourage early sexual activity among young people (Hubbard, 1998). These advocates credit the decrease in teenage pregnancy largely to the advancement of the abstinence-only message. These proponents argue that sex education is not simply an issue of morality, but a matter of public health concern. The problems that have become so entrenched in our country, such as AIDS, illegitimate births, poverty, increasing crime and the breakdown of the nuclear family, can all be attributed to the debilitating effects of a public policy that condones sex without love or responsibility. In addition, abstinence-only advocates argue that traditional values and religious faith, which they believe are consistent with the abstinence only message, have measurable positive effects and that religion acts as a deterrent to early sexual activity (Alan, 2001).

2.2.2 Emphasis on Comprehensive Sex Education

A wide range of national organizations based in the United States of America support comprehensive sexuality education. Most proponents of comprehensive sex education argue

that sexuality education should encourage abstinence but should also provide young people with information about contraception, STD‘s and HIV prevention (hence the title ―abstinence-plus‖ programing). According to the Sexuality, Information and Education Council of the United States (SIECUS), comprehensive school-based sexuality education that is appropriate to students‘ age, developmental level, and cultural background should be an important part of the education program at every age. SIECUS defines a comprehensive sexuality education program as one that respects the diversity of values and beliefs represented in the community and will complement and augment the sexuality education children receive from their families (SIECUS, 2001).

Comprehensive sex education proponents argue that by denying teens the full range of information regarding human sexuality, abstinence-only education fails to provide young people with the information they need to protect their health and well-being. Surveys of young people and their sexuality indicate that students who have sex education – regardless of the curriculum – know more and feel better prepared to handle different situations and make better decisions than those who have not. Advocates point to study’s findings that the public support the provision of contraceptive information to teens by wide margins. For example, in the United States, a survey commissioned by the National Campaign to Prevent Teen Pregnancy and released in 2001 found that 95% of adults and 93% of teens said ―it is important that teens be given a strong abstinence message from society,‖ but 70% of adults and 74% of teens said that advising abstinence while also giving young people information about contraception is not a mixed message. SIECUS reports that ―the vast majority of americans support sexuality education,‖ and cites several polls, including a 1999 national survey finding that 93% of all americans support the teaching of sexuality education in high schools, and 84% support sexuality education in middle and junior high schools (SIECUS, 2001).

Comprehensive sex education advocates also like to cite studies that find that providing teens with contraceptive information does not encourage early sexual activity. Reviewing the evidence on comprehensive approaches to sex education, it is clear that evidence gives strong support to the conclusion that providing information about contraception does not increase adolescent sexual activity. Comprehensive sexuality advocates argue that, in fact, much of the decrease in the teen pregnancy rate was due to lower pregnancy rates among sexually experienced young women. An analysis of the decline in teen pregnancy in the 1990s published by the Alan Guttmacher Institute shows that approximately 25% of the decrease was due to a lower proportion of teenagers who were sexually experienced, while 75% of the decrease can be attributed to lowered pregnancy rates among those young women who were sexually experienced. For many sex education advocates, the abstinence- plus approach acknowledges the central fact that at least half of high school students report having had intercourse, and that this substantial portion of the population needs information in order to protect themselves (Alan Guttmacher Institute, 2001).

2.3 Adolescent attitude (opinions, feelings and behaviour) towards sex

2.3.1 Theory of Reasoned Action – Ajzen and Fishbein (1980)

Ajzen and Fishbein have conceptualised the intention towards certain behaviours, in this case to have relationships and perform sexual behaviour, in their ‘Theory of Reasoned Action‘.

This theory aims to explain individual‘s behaviour by different determinants. It argues that individual behaviour is immediately caused by behavioural intention, i.e. the intention to perform certain behaviour. Subsequently, behavioural intention is determined by two variables: ‘attitude toward the behaviour‘ and ‘subjective norm‘ (Ajzen & Fishbein 1980).

‘Attitude towards the behaviour‘ can be defined as ‘a person‘s judgment that performing the behaviour is good, or bad, that he is in favour of or against performing the ‘behaviour‘ or

_the sum of expectancy multiplied by the value of the products‘ (Ajzen & Fishbein, 1980; Bohner & Wänke, 2002,). This means that a person can have different expectations about the products, i.e. consequences of behaviour. For example, in the case of having sex, ‘If I have sex, I will get pregnant‘, and, ‘If I have sex, I will have a good time‘. The subjective value attached to each expectancy multiplied by the subjective likelihood that each consequence will happen, will predict the overall attitude towards the behaviour. In this example, if the person values having a good time and getting pregnant equally and the person is sure that he or she will have a good time but regards the likelihood of getting pregnant very low, then the person will probably have a positive attitude towards having sex. But if the person regards the likelihood of getting pregnant as high as having a good time when having sex, and he or she values getting pregnant as more important than having a good time, the person will probably have a negative attitude towards having sex.

2.3.2 Theory of Planned Behaviour – Ajzen (1991)

Ajzen named this adjusted model, with the added determinant ‘perceived behavioural control‘, the ‘Theory of Planned Behaviour‘, this study will use the ‘Theory of Planned Behaviour‘ to study the intention to have relationships and to perform sexual behaviour because the theory gives a clear overview of the different concepts that construct individuals‘ intentions to perform certain behaviours.

Most studies have focused on intentions instead of actual behaviour because students may be hesitant to discuss their actual behaviour or they may not have experienced any sexual behaviour yet. However, discussing their attitudes, subjective norms, perceived behavioural control and intentions to perform certain behaviour may be easier and, therefore, could reveal more information concerning these topics, moreover, as shown by the Theory of Planned Behaviour, these determinants should be good predictors of their actual, future behaviours.

2.4 Overview of sex negotiation skills

2.4.1 Basic skills in sex negotiation for adolescent girls

In a study by Ankomah et al., (2011), it was observed that participants who were abstaining from sexual intercourse had some practical skills and strategies they employed to remain abstinent. Those abstaining appeared to be more confident, had greater determination to remain so, and had appropriate skills they employed when under peer pressure. Some girls mentioned that a key strategy was to avoid visiting boys since the boys 'cannot come and meet you and have sex with you in your father's house'. In their study, many adolescent female participants emphasized that the need to be determined and focused should not be left within, pointing out that if it's dormant it won't work. They pointed out that to succeed, girls need to let friends and peers know that they are determined so that the boys will 'leave you alone'. They mentioned the need to let boys know that they are not interested in sex and that they like it that way. They advised not giving the boys any chance to make advances.

The findings of Ankomah et al., (2011), are supported by several other studies in Africa, (Karim et al., 2003; Gueye et al., 2001; Klepp et al., 1996), which suggest that higher levels of self-esteem are a key determinant in sex refusal skills thus delaying first sexual intercourse. Although the study by Ankomah et al., (2011) provided data on understanding the reasons for early sexual initiation and why some adolescents continue to remain abstinent, as a qualitative study, the results were not representative and therefore cannot be generalised to apply to all adolescents. It is important to note that poor sex refusal and negotiation skills among adolescents could lead to pregnancy (Nabila, 1996). According to the 2008 Ghana Demographic and Health Survey, adolescent childbearing has potentially negative medical and social consequences. Births to teenage mothers (age 15-19 years) have been found to have the highest infant and child mortality in Ghana. This may be due to the

young mothers being more likely to experience complications during pregnancy and delivery when compared with older mothers. This results in higher morbidity and mortality for both themselves and their children. In addition, early childbearing may truncate a teenager‘s capacity to pursue educational opportunities as 10% of teenagers in Ghana have already had a child and another 3% are pregnant with their first child. In addition, urban teenagers were observed to differ from their rural counterparts. About 11% of adolescents in urban areas have begun childbearing, compared to 16% in rural areas. It was also clear that childbearing decreases substantially as education increases. About 31% of adolescents with no education had begun childbearing, compared with just 1% of teenagers with secondary or higher education. By wealth status, adolescent childbearing decreased from 21% in the second wealth quintile to 4% in the highest wealth quintile. This finding suggests that poverty is an important consideration in understanding adolescent childbearing in Ghana according to the 2008 Ghana Demographic and Health Survey report.

2.4.2 Family Support in Sex Negotiation

Many adolescents are unable to communicate with their parents about their sexual health issues. A family's silence on sex education can indirectly give the message that sexuality is bad and should not be discussed. With no other clear source of knowledge and values, adolescents often look to the popular media and their peers for information.

Family involvement in adolescent sexual health can create more opportunities for dialogue between adolescents and adults and help refute the myths about sexuality that young people often hear from the media and from their peers. Schools supplementing the education provided by the family can also help adults overcome the difficulties they face when they are the only providers of information and guidance.

2.4.3 Access to and Use of Protection

Condoms are recognized as an especially important form of contraception, because they are currently the only form of contraception that prevents the transmission of most STDs. Although many adolescents have used a condom at some point in time, comparatively few use them during every act of intercourse. According SIECUS

(2001) , in 1995, only 44% of 15 to 19 year-old males in America used a condom during every act of intercourse during the previous 12 months. It is believed that consistent use of condoms will be attained among adolescents who are proficient with sex negotiation skills.

2.4.4 Other Social Factors that influence Sex Refusal

A study by Ankomah et al, (2011) explored the key factors that motivate some unmarried adolescents to engage in early sex and reasons why some delay. In the study, several reasons for early premarital sex were identified. The 'push' factors included situations where parents exposed young female adolescents to street trading. 'Pull' factors, particularly for males, included the pervasive viewing of locally produced movies, peer pressure and, for females, transactional sex (where adolescent girls exchange sex for gifts, cash, or other favors). Also noted were overtly coercive factors, including rape. There were also myths and misconceptions that were given to justify early sexual initiation. Reasons cited for delay included religious restriction against premarital sex, disease prevention (especially HIV and AIDS) and fear of pregnancy. The differences observed between sexually active and abstinent adolescents were that the latter were more confident, had greater determination, and most importantly, deployed refusal skills to delay first sex. As such, health promoters need to focus attention on educating adolescents in the skills needed to delay sexual debut.

2.4.5 Case Studies of Adolescent Sex Refusal and Sex Negotiation

In a sexual health study of adolescent experiences in Ghana, Glover, (2003), found that more than half of the respondents had ever had sexual intercourse (52%), with the adjusted odds for females being 1.6 times compared to those for males and the odds for apprenticed youth being 3.2 times compared to in-school youth. The odds of having had sex in the previous month were elevated for females to 2.0 times, both sexes however tended to accept violence towards women, with in-school youth recording the lowest level of acceptance. Nearly all respondents (99%) knew of condoms, but fewer than half (48%) could identify any of four elements of correct use. Females and sexually inexperienced youth were the least informed.

Furthermore, Glover, (2003), discovered that 66% of respondents considered it unacceptable for males to carry condoms, and 75% considered it unacceptable for females. 25% of males and 8% of females reported having had a sexually transmitted infection and 33% of sexually experienced females reported having ever been pregnant. Of those, 70% reported having had or having attempted to have an abortion. Effective sex refusal and negotiation skills are required in averting these staggering statistics of STIs and abortions in Ghana (Glover, 2003).

Early age at sex exposes adolescents to reproductive health risks. In Zimbabwe, it has been explained that, stereotyped sexual norms and peer pressure encourage young males to prove their manhood and enhance their social status by having sex (Kim et al., 2001). On the other hand, young women were socialized to be submissive and not to discuss sex, thereby leaving them to be unable to refuse sex or insist on condom use. There is an inverse relationship between mean age at first pregnancy and the number of times pregnancy was observed. This means that the earlier an adolescent becomes pregnant for the first time, the more likely she is to have more subsequent pregnancies. Thus, if first pregnancy is postponed, it is possible that the number of pregnancies that may occur to them in their adolescent ages could be

reduced (Kwankye, 2005). This finding is to a large extent consistent with a Guatamalan study where there was an observed association between early childbearing and higher pregnancies (Buvinic, 1998).

Findings in another study by Glover et al., (1999), revealed that coercion and deceit were well-known and common elements of sexuality for the adolescent study participants. The pressures to have sex were very strong. Friends, siblings, parents, teachers, prospective employees, doctors, clergy and others were cited by the participants as a party to these pressures. Moreover, some young women expressed the belief that sex is good for their health and condoms can be bad for their health. Discussions with participants suggested that abortion may be a viable option of contraception for some young women (Glover et al., 1999).

In a study by Fiscian et al., on adolescent sexual characteristics, most of the 61 participants, were aged 12-14 years and about 8% reported being forced to have sex. 69% of participants were very worried about becoming HIV-infected and slightly more (74%) were worried about teenage pregnancy. Regarding economic pressures, 38% were very worried about having money for things they wanted.

2.5 How adolescent girls see themselves in terms of self-image or self-worth

2.5.1 Age at First Sexual Intercourse

Age at first marriage is sometimes seen as a proxy for a woman‘s first exposure to intercourse but the two events need not occur at the same time. According to the 2008 GDHS, because women and men may engage in sexual relations prior to marriage, age at first sexual intercourse is a more reliable indicator of a woman‘s exposure to the risk of pregnancy than age at first marriage. Women are more likely to experience first sexual intercourse at an earlier age than men. 8% of women and 5% of men reported having sexual

intercourse by age 15years. By age 18years, more than 44% of women and 26% of men have had sexual intercourse. 63% of women and 78% of men aged 15-19 have never had sex.

It was observed that women with secondary or higher education begin sexual relations at least three years later than women with primary education alone. Similarly, women in the highest wealth quintile experience first sexual intercourse at least a year later than women in the lower wealth quintiles. In the absence of contraception, the risk of pregnancy is related to the frequency of intercourse. Information on sexual activity, therefore, can be used to refine measures of exposure to pregnancy. In the four weeks preceding the survey, 12.6% of women aged 15-19 were sexually active and 16.3% were sexually active in the past 12 months but not in the past four weeks, and 16% had not had sex for more than one year. About 62.7% of women within this adolescent age group had never had sexual intercourse according to the 2008 GDHS.

2.5.2 Sexual Self-Esteem

The research areas of psychology are expanding to incorporate both quantitative and qualitative research on various issues surrounding sexual self-esteem. Sexual self-esteem refers to the ―value that one places on oneself as a sexual being, including sexual identity and perceptions of sexual acceptability‖ (Mayer et al., 2008). While sexual self-esteem is linked to self-esteem in that it is one of the many components of the global concept of self-esteem, sexual self-esteem attempts to isolate and illuminate those feelings, thoughts, and experiences that an individual has about his or her sexual self. Discussing sexual self-esteem provides a medium for individuals to process and explore the sexual aspects of his or her life. Significantly, research studies are being completed that focus on both male and female genders as well as various populations and their sexual self-esteem. Even with the broad base of research, the concept has not yet been well represented in literature. Various approaches have been taken in studying sexual self-esteem in different populations such as studies on

sexual self-esteem and body image in spinal cord injury patients (Potgieter & Khan, 2005), surviving cancer patients and the importance of sexual self-concept (Andersen, 1999), sexual self-esteem as a predictor of sexual and psychological adjustment following a spinal cord injury (Mona, 1998), date rape and its relationships to trauma symptoms and sexual selfesteem (Shapiro & Schwarz, 1997), sexual victimization and the role of sexual self-esteem and dysfunctional sexual behaviours (Van Bruggen, Runtz, & Kadlec,. 2006), or sexual selfconcept and sexual risk-taking in 16-19 year olds (Breakwel & Millward,. 1997). While these studies have assisted in the forward movement of the concept of sexual self-esteem, the results pertain to very specific populations. Sexual self-esteem has also been researched with respect to condom use in college students (Squiers, 1998).

Mayer and colleagues completed qualitative research on the issue of damaged sexual self-esteem. Specifically, the researchers presented five cases which described a situation in which damaged sexual self-esteem disabled an individual. Two of the five cases presented by Mayer et al., 'describe situations that were adjudicated by courts of law' while the other three cases were ones that may be seen in a clinician's office at any point in time. Of the five cases, two were about males while the remaining three were based on female cases. Mayers et al., completed research on both genders and attempted to identify the effect that negative events may have on sexual self-esteem. The researchers present the argument that 'verbal statements or sexually insulting actions by another person' (Mayer et al., 2008), decrease the value that one places on oneself as a sexual being and produce a unique range of responses experienced by an individual with damaged sexual self-esteem.

Offman and Matheson (2004) appear to move beyond the research of Mayer et al. , (2008) and address the concept of negative sexual self-perceptions versus positive self-perceptions. Interestingly, both studies report on the damage that can be done to an individual's sexual self-perception or sexual self-esteem, each utilizing different methods to access this

information. Both studies address the impact that abusive or negative events may have on sexuality. Specifically, these articles provide relevant background to the present research study investigating what facilitates or hinders females in their sexual self-esteem. The above studies by Mayers et al., (2003) and Offman & Matheson., (2004) indicate that sexual selfesteem influences the way in which a girl relates to negative or positive sexual experiences throughout her life, that sexual self-esteem is interwoven with her overall sense of selfesteem, and that negative sexual self-esteem may become a disability.

2.5.3 Sexual Risk-Taking Behaviour

In many countries throughout the world, STD‘s and unplanned pregnancy have always occurred among adolescents, however, during the last few decades, the onset of adolescence initiation of sexual intercourse has occurred at decreasing ages in many countries while the average age of marriage has increased. Many adolescents began having sexual intercourse with multiple sexual partners prior to marriage and a significant proportion of young people have initiate sexual activity by age 15years. This facilitates STD and HIV transmission as well as unplanned pregnancies among others. Adolescents have the highest age-specific rates for some STDs. In America for instance, 40% of all reported chlamydia cases are among 15 to 19 year-old youth. Similarly, female teenagers have the highest age-specific rate of gonorrhoea.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

The research was a descriptive cross-sectional study in which a structured questionnaire was formulated for data collection. A cross-sectional design offers information about a population at a given point in time (Bless & Higson-Smith, 2000). This design was chosen as it was intended to gain immediate information about the level of knowledge and education, attitudes, sex negotiation skills the respondents know and practice and their sense of self-worth. The study design was therefore appropriate as it explored all the necessary information with regard to the study objectives.

3.2 Data collection techniques and tools

The structured questionnaire, comprising open and close-ended questions was used to elicit information from the 450 in-school study participants. The questionnaire were self administered and the study participants were expected to complete the questionnaire at a sitting and return same to the researcher. The questionnaire was first read in English and interpreted in the twi language before self-administration by participants.

3.3 Study population

The study population was in-school adolescent girls aged 10-14 years in all the basic schools in Effiduasi in the Sekyere-East district.

Inclusion criteria was adolescent girls aged 10-14 years, resident at Effiduasi in the Sekyere-East district who were in school and in primary class five to Junior High School class three, whose teachers have consented on their behalf.

Exclusion criteria was adolescent girls aged 10-14 years, resident at Effiduasi in the Sekyere-East district, who were not in school and who were not in primary class five to Junior High School class three and whose teachers have not consented on their behalf..

3.4 Sampling technique and sample size

The sample size was calculated using the formula (Araoye, 2003) below

$$n = \frac{Z^2 pq}{d^2}$$

Where:

n = desired sample size,

Z= reliability coefficient of

1.96

d = error allowance of 0.05,

p= proportion of population estimated to employ sex refusal and negotiation skills (0.5)

q = 1- p

$$\mathbf{n} = \frac{(1.96)^2 (0.50)(0.50)}{(0.05)^2}$$

n= 384

10% was added for non-response. Thus,

10/100 ×384 = 38.4;

384+38.4 = 422 . This was rounded up to 450

Thus a sample size of **450** participants was employed.

In-school adolescent girls aged 10-14years in all the basic schools in Effiduasi in the Sekyere-East District of the Ashanti Region were included in the research. Based on the registers obtained from the basic schools, a total of 450 girls were selected by Probability

Proportional to Size to participate in the study. Questionnaires were then administered to those who accepted to participate in the study.

3.5 Pre-testing

Pre-testing was done in the Ejisu-Juaben municipality because it shares similar demographic characteristics as the study area. This was done to ensure content validity, readability and ease of understanding by participants. It was discovered that though the respondents were literate, they found it difficult to understand some of the questions in the questionnaire.

Explanation of the questions was required and as a result, a few questions were simplified to give the participants a better understanding. For example, question 24 on the questionnaire was originally ‘what personality type are you?‘, this was changed to ‘ how would you describe yourself?‘ with six options of answers to choose from.

3.6 Data handling and analysis

All data remained confidential and were kept only for the purpose of the study. Names of respondents were not recorded on the questionnaire. Research assistants were adequately trained and prepared before they went to the field. This was to ensure the quality of data collected. Only the principal investigator and data manager had access to the collected data.

The data were analysed using STATA 11. Descriptive analyses were performed.

3.7 Ethical consideration

Ethical approval was sought from the Committee of Ethics and Human Research, at the School of Medical Sciences, Kwame Nkrumah University of Science and Technology. Permission was also sought from the District Director of Education and heads of the schools whose students partook in the study. Informed consent was also sought from participants after explaining the purpose of the study and the benefits to them.

3.8 Limitations of study

The main constrain of this research was limited coverage of the entire district since the research was carried out in the main town of the district-Effiduasi. The researcher had to depend on data gathered from the biggest town in the district to make the outcome of the research fairly representative of all communities in the Sekyere-East District.

3.9 Assumptions

The underlying assumption in this study is that adolescent girls will adopt effective sex negotiation skills which will translate into outcomes of confidence and improved self-image of girls which will bring about very minimal, if not zero, teenage pregnancies in the district.

CHAPTER FOUR

4.0 RESULTS

4.1. Introduction

This chapter discusses the results of the study in the form of tables and frequencies with percentages. This chapter is also divided into sub-headings to throw more light on questions asked on the field.

4.2. Background Information of Respondents

It is important to assess the background of respondents in order to ascertain the validity of information provided for this research work. This helps in ensuring that data are gathered from the appropriate sample of the study population. The study focused on young in-school adolescent girls aged 10 to 14 years. The age distribution was skewed towards the older age, thus 13 and 14 year- olds. From the survey, 129 (28.7%) respondents were 13years old while 152 (33.8%) respondents were 14years old. The respondents who were 10 years old were the least with 24(5.3%).

With the religious categories of respondents, 397 (88.3) respondents were Christians.
115 (25.6%) of the study participants were in class 5, while 88 study participants were in class 6 representing19.6%. Most of the study participants in Junior High School (JHS) were in JHS 1.
192 (42.7%) study participants have had their menses and out of this number 63 (33%) had their first menses at age 12 years and 96 (50%) had theirs at age 13 years.

Table 4.1: Background Information of Respondents

Variables	**Frequency**	**Percent**
Age (Years)		
10	24	5.3
11	55	12.2
12	90	20.0
13	129	28.7
14	152	33.8
Total	**450**	**100**
Religion		
Christian	397	88.3
Moslem	51	11.3
Other	2	0.4
Total	**450**	**100**
Class		
Class 5	115	25.6
Class 6	88	19.6
J. H. S. 1	156	34.7
J. H. S. 2	78	17.3
J. H. S. 3	2	0.4
Other	11	2.4
Total	**450**	**100**
Have had menses yet		
Yes	192	42.7
No	258	57.3
Total	**450**	**100**
If have had menses, age had first menses		
9	1	0.5
10	2	1.0
11	6	3.0
12	63	33.0
13	96	50.0
14	24	12.5
Total	**192**	**100**

Source: Field Data, 2013

Sexual background of respondents

Sexual background as reported by the study participants helps to assess the respondents who have had sex before and those who have not. 84 (18.7%) respondents said they have ever been approached for sex, however, 22 (4.8%) succumbed. The mean age at which respondents first had sex was 11.77 years., SD 2.16. The extreme ages (minimum and maximum) at which they first had sex were 6 and 14 years respectively. Most of the respondents, who've had sex, had their first sex at age 13 years.

The main reasons respondents gave for having sex were observed to be rape (31.8%), were told they were beautiful and were loved (36.4) and were interested (22.6%)

Table 4.2: Sexual information about respondents

Variables	**Frequency**	**Percent**
Anyone approached you for sex?		
Yes	84	18.7
No	366	81.3
Total	450	100
Ever had sex		
Yes	22	4.8
No	428	95.2
Total	450	100
Age first had sex		
6	2	9.1
9	1	4.5
10	1	4.5
12	7	32.0
13	10	45.4
14	1	4.5
Total	**22**	**100**
If had sex before, it happened because		
Were forced or raped	7	32.0
Were told you are beautiful and he loves you	8	36.4
Were given money or gifts	1	4.5
Were interested and wanted to have sex	5	22.6
Other	1	4.5
Total	**22**	**100**

Source: Field Data, 2013

4.3 Level of knowledge and education respondents have about sex.

Majority (80%) of participants believed that abstaining from sex was the effective way of preventing pregnancy.

About 75% also said the only time it's okay to have sex is in a loving ,committed relationship like marriage and to have safe sex one must use condoms correctly and every time to avoid pregnancy and STI**.**

Table 4.3: Knowledge and education level of respondents on sex

Frequency	**Variables**	**Percent**
Effective way of preventing pregnancy Abstaining from sex	362	80.5
Wearing condoms	45	10.0
Using medicines (emergency contraceptives eg N tablets)	10	2.2
Others	33	7.3
Total	**450**	**100**
What is sex? When the man's penis enters the woman's vagina	360	80.0
When the man sleeps with the woman	32	7.1
When the man lies on the same bed with the woman	14	3.1
When the man touches the woman	12	2.7
Others	32	7.1
Total	**450**	**100**
When is it okay for someone to have sex? Whenever the person has the feeling to have sex	39	8.6
Whenever the person's partner or boyfriend wants sex	8	1.7
Whenever the person needs money, gifts, help or support	16	3.6
When the person is in a loving, committed relationship like marriage	337	75.0
Others	50	11.1
Total	**450**	**100.0**
What does it mean to have safe sex?		
When you use condom correctly every time to prevent pregnancy and STD	333	74.0
When you wash yourself well immediately after you have sex	26	5.7
When you wash yourself immediately before you have sex	25	5.6
Others	66	14.7
Total	**450**	**100**

Source: Field Data, 2013

4.4 Respondents' attitude towards sex

Majority of respondents do not have a boyfriend, have never had sex before and think it's a great idea to remain a virgin at their age. Again most of them stated that they're expected to remain virgins till they're married.

Table 4.4: Respondents' attitude towards sex

Variables	**Frequency**	**Percent**
Have a boy friend?	10	2.2
Yes	440	97.8
No	450	100
Total		
How often do you have sex?		
Have never had sex before	428	95.1
Have had sex before but have decided to stop	4	0.9
Have sex once in a while or regularly	18	4
Total	450	100
Opinion of a girl at your age who has never had sex		
Think it is a great achievement	360	80.0
Such a person is old fashioned	15	3.3
She is not having fun	28	6.2
Others	47	10.5
Total	450	100
What's your family's expectation of you concerning sex ?		
I am not sure of my family's attitude	40	9
My family expects me to abstain from sex till I'm married	310	69
My family expects me to be careful, so I will not get pregnant or get STD	78	17
My family does not seem to care whether I have sex or not	9	2
Others	13	3
Total	**450**	**100**

Source: field data 2013

4.5: What sex negotiation skills they know and practice

These are aspects of sex negotiation skills as reported by the study participants. Of those who were approached for sex 38% said a firm ‘no’. 36% reported to parents. Out of those respondents who have sex , about half of them always protected themselves, always insisted on protection, while a few either did not care about protection at all or left it for their partners to decide.

When it came to who decides whether to use protection or not, (50%) of respondents claim they made the decision and (50%) chose condoms.

About 73% are able to tell their partners when they don‘t want sex, while 18% don‘t because they don‘t want to lose their partners.

Table 4.5: Sex negotiation skills practiced by respondents

Variables	Frequency	Percent
Anyone approached you for sex?		
Yes	84	18.7
No	366	81.3
Total	**450**	**100**
If yes, what respondent did		
Firmly said no and immediately changed the conversation	32	38
Was interested and agreed	7	8
Did not know what to do or say	8	10
Was not interested and told parents or someone trusted	30	36
Others	7	8
Total	**84**	**100**
When you have sex do you protect yourself from pregnancy or STD?		
Always	11	50.0
Sometimes	7	31.8
No, never	4	18.2
Total	**22**	**100**
Who decides or decided whether to protect yourself or not?		
I make the decision, I insist on protecting myself	12	54.5
Partner makes the decision, I leave it to him	4	18.2
Both of us come to an agreement on whether to protect or not	6	27.3
Total	**22**	**100**
Who decides or decided what to use for protection? Myself	11	50.0
My partner	11	50.0
Total	22	100
What do or did you use to protect yourself? Condoms	11	50.0
Medicines (emergency contraceptives eg N tablets)	5	22.7
Others eg herbal concoctions,	6	27.3
Total	22	100
When you don't or didn't want sex with partner what do or did you do?		
I tell him I don't want it	16	72.7
I don't know how to tell him	2	9.1
I don't do anything because I don't want to lose him	4	18.2
Total	22	100

Source: Field Data, 2013

4.6: Self-image or self-worth

Majority of respondents (91%) don‘t do any antisocial practices like drinking and doing drugs. Over 80% have high aspirations for the future. Again, majority of respondents live in the nuclear family system, have their fathers as head of the family and say that their families expect them to abstain from sex till they’re married.

Table 4.6: Respondents 'self-worth or self esteem

Variables	Frequency	Percent
Which of these activities do you practice?		
Smoking cigarettes	2	0.4
Doing drugs like marijuana (wee)	1	0.2
Drinking alcohol	2	0.4
Quarrelling and fighting	34	8.0
I practice none of the above	411	91.0
Total	**450**	**100**
How would you describe yourself?		
Most of the time I'm warm and caring	186	41.3
Most of the time I'm happy	213	47.3
Most of the time I'm anxious and fearful	21	4.7
Most of the time I'm sad, depressed and lonely	12	2.7
Most of the time I'm aggressive and angry	15	3.3
Others	3	0.7
Total	450	100
What will you be doing by the time you are 24 years old		
I have not thought about it	45	10
I should be married with children	7	1
I should be in the university	299	66
I should have completed senior high school and working	72	16
I should have completed junior high school and learning a trade	16	4
Others	11	3
Total	450	100
How would you describe yourself?		
I am able to express my opinion without fear	66	15
I am among the top ten in my class, I'm a bright student	260	58
I'm shy, I find it difficult to say "no"	24	5
I like myself	44	10
I do not like some part of me	9	2
I easily make friends	24	5
I do not usually get along with my mates	15	3
Others	8	2
Total	**450**	**100**

Source: Field Data, 2013

Most of the respondents live in the nuclear family system with their fathers as heads of the family, and again, majority said their family expects them to abstain from sex till they're married. (Table 4.7).

Table 4.7: Respondent's Family Characteristics

Variables	Frequency	Percent
Family structure		
Father, mother and siblings	288	64
Father, step-mother and siblings	14	3
Mother, step-father and siblings	19	4
Single parent family	35	8
Extended family	71	16
Others	23	5
Total	450	100
The head of your family		
Father	320	71
Mother	34	8
Step father	12	3
Step mother	4	1
Uncle/aunt	23	5
Grandmother/father	51	11
Others	6	1
Total	450	100
The level of education of the head of your family		
Tertiary	181	40
Secondary school	91	20
Basic school	52	12
Did not go to school	9	2
Other	8	2
I do not know	109	24
Total	450	100
Occupation of family head		
Professional	123	27
Farmer	103	23
Business person	58	13
Office worker	59	14
Trader	41	9
Artisan	29	6
Others	37	8
Total	450	100

Source:Field Data, 2013

CHAPTER FIVE

5.0 DISCUSSIONS

5.1 Introduction

This chapter discusses the findings of the study in an objective oriented approach. Starting with the first objective, it presents the observations of the study as they relate or correlate with the observations in other studies. It also attempts to provide verified insight by indicating the concepts and theories that underpin the key findings of the study.

5.2 Level of sex education and sex knowledge available to adolescents.

With adolescent sexuality and reproduction gaining prominence both at the local and international level, Evans et al.(1999), established that effective sex refusal and negotiation skills has become the major means by which adolescents can avoid sexual intercourse or unprotected intercourse. In the context of this assertion, one critical variable worth evaluating is the level of sex education and sex knowledge available to the demographic cohort prone to unwanted sex and reproduction.

In this study, the worrisome figures that accentuate the importance of sex knowledge is that the mean age at which respondents first had sex was 11.77years (SD 2.16). The extreme ages (minimum and maximum) at which they first had sex were 6 years and 14 years. Most of the respondents had their first sex at the age of 13 years(45.4%) followed by 12 years (32%) . As much as 22.6% of the respondents who had had sexual intercourse before did that because they were genuinely interested. If a school girl at age 6 is getting involved in sexual intercourse, it is almost as if the findings of Evans et al., leaves a gap that warrants attention; the level at which girls should be schooled about sex. This study attempts to fill that research gap. The study affirms that sex education programs should combine information on a variety of sexuality-related issues, including abstinence, contraception, safe sex, the risks of unprotected sexual intercourse and how to avoid them, as well as the development of

communication, negotiation, and refusal skills. The study also further indicates that the age at which girls receive sex education and knowledge is also an absolute imperative to the lowering of risky sexual behaviour.

5.3 Access to sex education and knowledge

This study suggests in concurrence with Agha et al, (2011) that the inception point of any intervention regarding sex refusal and negotiation skills is to build an elaborate knowledgebase of the target group. However, this study also hastens to add that availability of information should not be taken to mean access to information. Compared with old-style knowledge-based sex education, focused behavioural-skills types such as sex refusal and negotiation skills have shown more promising results by postponing sexual involvement and reducing the risk of unprotected sexual intercourse. The availability of a knowledge transfer mechanism from passive to active form that allows girls to personalize sexual issues and develop specific negotiation and refusal skills is what this study refers to as access to sex knowledge. According to Agha et al, (2011) access to sex information is the major ingredient of sex refusal and negotiation skills. It also has a moderate effect on improving the use of contraceptives among adolescents who are sexually active (Agha et al, 2011).

When people hear sex information on the radio or television, they may not fully understand it due to language and the communication barriers, as such, they may react to the information the only way they understand it. This study observed that unfortunately for most girls, parents do not engage in open and honest communication with them about sex. 29% of the respondents indicated that their parents are open with them about sex. The remaining 71% of in-school young girls in Effiduasi are left to develop sex knowledge by their own means.

Arguably, this is not exactly a positive realization as far as sex negotiation skills are concerned.

5.4 Attitude towards sex and reproduction

Rapid urbanization in Ghana has been the result of natural population increase as well as inter and intra-regional movements. This, in recent times, appears to be dominated by adolescents and the youth in search of jobs in the cities and large towns. Kwankye, (2005) cuts it down to two main causalities; increasing family breakdown and scarcity of economic opportunities. He indicates that because of difficulty in getting jobs in their places of destination, many female adolescents may be tempted to take up risky sexual behaviors as a matter of survival. This study observes that this may not be as different in the Sekyere-East District. Teenage pregnancy in the Sekyere-East District is on the increase. In the year 2012, Effiduasi subdistrict recorded the highest teenage pregnancy of 31.9% with Nyanfa and Asokore subdistricts recording 9.7% and 8.9% respectively (Ghana Health Service-Sekyere-East District, 2012 Annual Health Report).

Instead of limiting it to the major causalities highlighted by Kwankye in 2005, this study postulates that there may be a plethora of causes of which attitude to sex is not the least. Attitude in the context of this study subsumes the opinions, feelings and general behavior towards sex and reproduction. Historically, adolescence in Ghana began with initiation and ended with marriage or childbearing. For instance, among the Krobo and Akan, puberty rites were performed for girls after menarche to signify their maturity. Known as ‘Dipo‘ among the Krobo and ‘Bragro‘ among the Akan, the initiation ceremony was a community affair and was held under the auspices of the queen mother. A girl who became pregnant before an initiation ceremony committed an offense and the maximum punishment was banishment from the community (Sarpong, 1977).

This study noted that opinions of girls at the adolescent stage have not changed much. About 75% of the respondents still believed that sex and reproduction should only take place between people who are in ‘a loving, committed relationship like marriage’. In support of

this claim, 80% of them believed that not indulging in early sex and remaining a virgin is 'a great achievement' in every girl's life. It is important to highlight that if girls aged 10 to 14 years have a feeling that being a virgin is a great achievement then there is a very high tendency for them to practice abstinence irrespective of their family status or economic background. Attitude to sex also includes the opinions of girls about the use of protection during sexual intercourse. The respondents in this study indicated that 74% of the girls know that using protection during sex is important in order to prevent pregnancy and STDs. That leaves a large number of school girls inadequately informed about protection. Except in case of rape, it can be deduced from these responses that unwanted sex and reproduction at the adolescent age is largely attributable to the feelings and opinions that they hold about sex.

5.5 Sex refusal and safe sex negotiation skills

This objective sought to assess the general capacity of girls to abstain from sex despite the economic difficulties, family break down and possibly in cases of rape attempts. It points out the fact that in the abundance of this skill or capacity, girls can get through the adolescent age without having to experience unwanted sexual intercourse or pregnancy. It is important to note that poor sex refusal and negotiation skills among adolescents could lead to pregnancy (Nabila, 1996).

A high point noted in this study is that 75% of respondents believe that sex and child bearing are closely related and they are both associated with marriage. What is unclear though is their perception of an acceptable age for marriage. Again, a significant number (8.6%) of respondents agreed that one should only have sex when they feel like it. This means if girls are able to know how to control their feelings, they will be able to resist the persuasions of their 'predators'. This study also affirms the concern of Glover (2003), largely of girls considering it unacceptable for females to carry condoms. This is an indication of their

perception of protection as well as their level of preparedness in case of an unwanted sexual advance in a situation where they are short of options.

According to the 2008 GDHS, adolescent childbearing has potentially negative medical and social consequences. Births to teenage mothers (age 15-19 years) have been found to have the highest infant and child mortality in Ghana. This may be due to the young mothers being more likely to experience complications during pregnancy and delivery as compared with older mothers. This results in higher morbidity and mortality for both themselves and their children. In addition, early childbearing may truncate a teenager‘s capacity to pursue educational opportunities. This finding suggests that poverty is an important consideration in understanding adolescent childbearing in Ghana. Effective sex refusal and negotiation skills are required in averting these staggering statistics of STIs and abortions in Ghana (Glover, 2003).

Again this study deduced that there is the likelihood for an inverse relationship between mean age at first pregnancy and the number of times pregnancy was observed. This means that the earlier an adolescent becomes pregnant for the first time, the more likely she is to have more subsequent pregnancies. About 9% of respondents who had had sex before indicated that they don‘t know how to tell their partners when they don‘t want sex. To further exacerbate it, about 18% do not negotiate about sex at all because they do not want to lose their sex partners. These figures are worrying because they apply in a situation where the girl is in an accepted relationship. It is important to imagine what such a girl is likely to negotiate when they are being forced to get involved in sex.

This study agrees with the notion that a depreciation in societal norms about sex is a major hit on sex refusal and negotiation. Aryee & Gaisie (1981), estimates that the age at first marriage in the 1960s was 17.7 years. Earlier marriages were characterized by arrangement via family members, elopement and betrothal. Traditionally, young females were expected to

be virgins at first marriage but that was not expected of males. Over time, some of the traditional arrangements have undergone changes as a result of modernization, urbanization, migration and formal education. Due to these changes 18.7% of the respondents (under age 15years) indicated that they have been approached for sex.

It is important to add that 10% of them did not know how to handle the request most importantly because they have not been introduced to how to refuse or negotiate a sexual advance. This study also observes from these responses that there exists a very high gap relating to the capacity of young school girls to resist sexual advances whether under duress or not. This gap, left unaddressed, has and will continue to result in the high numbers of unwanted pregnancies among young adolescent girls. This study observes that one important reason for sex negotiation is that it postpones pregnancy until the rightful time. If first pregnancy is postponed, it is possible that the number of pregnancies that may occur in their adolescent ages could be reduced. This finding is to a large extent consistent with a Guatamalan study where there was an observed association between early childbearing and higher pregnancies (Buvinic, 1998).

5.6 Self-worth and sex-refusal or sex negotiation

The primary objective of this study was to assess the sex refusal and safe sex negotiation skills of young in- school adolescent girls. It was determined that prominent among the variables that contribute to the increase or decrease in sex negotiation capacity is the self-image of the girls themselves. In spite of all external factors, some of which have been discussed above, the individual is at the center of the decision to have sex or not to have sex. This study confirms the fear that central to that decision is the self-worth, which is defined as the ‘value that one places on oneself as a sexual being, including sexual identity and perceptions of sexual acceptability’ (Mayer et al., 2008). Elements of self-worth that were

notable in the responses of this study include their emotional wellbeing, life aspirations, physical/biological development, alcohol and drug use, and many more.

With regard to physical development, it can be asserted that most of the respondents were underage, however, they had very positive life aspirations with regard to education and career. The number of respondents who said that someone has ever approached them to want to have sex with them is 84 (18.7%). Out of these 84 respondents who said someone has ever approached them to want to have sex with them, 32(38%) firmly said no and immediately changed the conversation.These positive figures are also attributable in part to good emotional wellbeing of the respondents. About 88% indicated that they feel warm and happy about themselves. The importance of self-image in sex negotiation is well illustrated by Mayer et al., (2003). They proposed that an individual‘s vulnerability to ‘verbal statements or sexually insulting actions by another person’ varies depending upon the person. Also, not only will the individual‘s reaction to the incident vary, but the impact that the negative event has on the person varies. For example, some individuals may feel shame or humiliation and will modify their behavior while others will experience a decrease in feelings of attractiveness and lose interest in sexual engagements. The impact of the negative event on the individual‘s sexual self-esteem may actually develop into a disability for some individuals. However, Mayer and colleagues do not suggest an explanation as to why this apparent disparity exists. Rather, they simply state that it exists. The findings of Ankomah et al, (2011), are supported by several other studies in Africa, (Karim et al., 2003; Gueye et al., 2001; Klepp et al., 1996), which suggest that higher levels of self-esteem are a key determinant in sex refusal skills thus delaying first sexual intercourse. It is worth noting that the elements of self-image are interwoven such that a high life aspiration influences a high emotional wellbeing which together influence sex refusal skills or capability.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Based on the results and discussions, this study presents the following conclusions;

Level of knowledge and education about sex

Most of the girls who were approached for sex are under age given that the age categories of respondents is between 10 to 14 years and a mean age of 11.77years. The extreme ages (minimum and maximum) at which they first had sex were 6 years and 14 years.

About 80% of the respondents had a good idea of what sex entails with 81% agreeing that abstinence from sex is the most effective means of preventing pregnancy at their age. This portrays a good level of knowledge about sex where the respondents are concerned.

Attitudes towards sex

A high proportion of the respondents expressed a positive attitude towards sex by indicating that one should only have sex when one is in a loving committed relationship like marriage and not when one feels like it. Majority of the girls did not have a boyfriend and were not engaging in sex. Of the minority who engaged in sex,(about5%), 1% have decided to put a stop to having sex.The main reasons for which respondents had sex were due to force or rape, were told they were beautiful and were loved. Only a few were lured with money and gifts and fewer still were interested and wanted to have sex.

Sex negotiation skills.

Out of those respondents who were approached for sex, 36% said a firm 'no' and immediately changed the conversation, 36% reported to parents, 8% were interested and agreed to have sex .50% of those who have sex said they insist on protection and use condoms. This indicates a strong level of sex refusal and sex negotiation skills. The other 50% who have sex either use medicines (eg N tablets), did not know what to say or do, or for fear of loosing their partners allow them to decide.

Self-image.

With respect to self-image, the majority of respondents (88%) had a positive self-mage evidenced in their life aspirations and how they describe themselves. 58% see themselves as bright students while 66% aspire to being in the university by age 24years.

6.2 Recommendations

This study therefore recommends that;

The District Assembly

The District Assembly, in collaboration with the Education and Health Services in the district need to provide more effective policies and implementation mechanisms in the educational institutions and health facilities in order for girls to personalize sex issues and be able to develop good sex education and negotiation skills. Age appropriate sex education as a curriculum at all stages, starting from basic school levels is needful. There's also the need for health facilities in the district to institute adolescent units to champion the policies.

Non governmental organizations engaged in adolescent health and teenage pregnancy prevention.

These organizations could also activate their role by creating focused fora for young girls to be engaged about sex education and their sexuality. The supporting role of these organizations particularly in the area of capacity building need to be intensified.

Information, education and communication campaigns and programmes could target local information centres so as to provide a wider range of reaching the adolescents in the district.

Opinion leaders and community members

The opinion leaders and community members who attend workshops and seminars should be encouraged to organise such seminars and workshops in their various communities to enlighten the young girls about the need to be educated on their sexuality. The queen mothers and womens' groups in the various communities in the district should use their positions to mobilize these young girls for educational for a to sensitize them on sex education and negotiation issues.

Family level

Given the observed age at which girls get approached for sex and the possibility of rape and defilement, there is the need for sex education to begin at a very early age in a girl's life. It is very important for guardians and parents to develop honest, loving and open communication with their daughters at very early age thereby creating the atmosphere for sex education and negotiation skills. As parents and guardians do this, their young daughters' physical and emotional wellbeing is catered for thereby building positive self-image in the girls..

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APPENDICES

QUESTIONNAIRE

Hello, my name is Monica Molara Ojumu. I'm a student of the Community Health Department at the KNUST. This questionnaire is meant to assess sex refusal and sex negotiation skills among young girls like you. I will appreciate it if you will kindly answer the questions accurately, frankly and take your time to complete the questionnaire. This is strictly an anonymous exercise where the answers you give can never be traced back to you.
Your confidentiality is assured. Thank you.

NAME OF SCHOOL:

Public / private / Christian / Islamic / non-religious or non-denominational

SECTION A: BACKGROUND INFORMATION OF RESPONDENT

1- What is your age (as at your last birth day)?

[ ] 10 years

[ ] 11 years

[ ] 12 years

[ ] 13 years

[ ] 14 years

[ ] other (please state)

2- What is your religion?

[ ] Christian

[ ] Moslem

[ ] traditionalist

[ ] pagan

[ ] other (please specify)

3- What class are you in?

[ ] class 5

[ ] class 6

[ ] jhs1

[ ] jhs 2

[ ] jhs 3

[ ] other (please state)

4- Has anyone ever approached you to want to have sex with you?

[ ] yes

[ ] no

5- If yes, what did you do?

[ ] I firmly said ‘no‘ and changed the conversation immediately

[ ] I was interested and I agreed

[ ] I did not know what to do or say

[ ] I was not interested and i told my parents or someone I trust about it

[ ] other (specify)

[ ] N/A

6- Have you ever had sex?

[ ] yes

[ ] no

7- If yes, at what age did you first have sex?

[ ] State age ……..

[ ] N/A

8- If you have had sex before, did it happen because?

[ ] you were forced or raped.

[ ] you were told that you are beautiful and he loves you

[ ] you were given money or gifts

[ ] you were interested and wanted to have sex.

[ ] other (specify)

[ ] N/A

9- Do you have a boyfriend?

[ ] yes

[ ] no

10- In which group are you?

[ ] I have never had sex before (I'm a virgin)

[ ] I have had sex before but I have decided to stop

[ ] I have sex once in a while or regularly

11- If you have sex once in a while or regularly, do you protect yourself from getting pregnant or sexual transmitted disease?

[ ] always

[ ] sometimes

[ ] no, never

[ ] N/A

12- Who decides whether to protect yourself or not?

[ ] I make the decision, I insist on protecting myself.

[ ] my partner makes the decision, I leave it to him.

[ ] both of us come to an agreement on whether to protect or not.

[ ] N/A

13- Who decides what you use to protect yourself?

[ ] myself

[ ] my partner

[ ] N/A

14- What do you use to protect yourself?

[ ] condoms

[ ] medicines

[ ] other (please specify)

[ ] N/A

15- When you don‘t want to have sex with your partner what do you do?

[ ] I tell him I don‘t want to and I am able to make him respect my wishes

[ ] I don‘t know how to tell him

[ ] I don‘t do anything because I don‘t want to loose him

[ ] other (please specify)

[ ] N/A

SECTION B: INDIVIDUAL CHARACTERISTICS OF RESPONDENT

16- Have you had your menses yet?

[ ] yes

[ ] no

17- If yes, at what age did you have your first menses?

[ ] State age……..

[ ] N/A

18- What do you think of a girl of your age who has never had sex(a virgin)?

[ ] I think it is a great achievement

[ ] such a person is old fashioned

[ ] she is not having fun

[ ] other (please specify)

19- Which is an effective way of preventing pregnancy?

[ ] abstaining from sex

[ ] wearing condoms

[ ] using medicines

[ ] other (please specify)

20- What is sex?

[ ] when the man‘s penis enters the woman‘s vagina

[ ] when the man sleeps with the woman

[ ] when the man lies on the same bed with the woman

[ ] when the man touches the woman

[ ] other (please specify)

21- When do you think it is okay for someone to have sex?

[ ] whenever the person has the feeling for sex

[ ] whenever the person‘s partner or boyfriend wants sex

[ ] whenever the person needs money, gifts, help or support

[ ] when the person is in a loving, committed relationship like marriage

[ ] other (please specify)

22- What does it mean to have safe sex?

[ ] when you use condom correctly every time to prevent pregnancy and Sexually Transmitted diseases

[ ] when you wash yourself well immediately after you have sex

[ ] when you wash yourself well immediately before you have sex

[ ] other (please specify)

23- Which of these activities do you do?

[ ] smoking cigarettes

[ ] doing drugs like wee, cocaine

[ ] drinking alcohol

[ ] quarrelling and fighting

[ ] N/A

24- How would you describe yourself?

[ ] most of the time I'm warm and caring

[ ] most of the time I'm happy

[ ] most of the time I'm anxious and fearful

[ ] most of the time I'm sad, depressed and lonely

[ ] most of the time I'm aggressive and angry

[ ] other (please specify)

25- What will you be doing by the time you are 24 years old?

[ ] I have not thought about it

[ ] I should be married with children

[ ] I should be in the university or doing a tertiary programme

[ ] I should have completed senior high school and be working

[ ] I should have completed junior high school and learning a trade

[ ] other(please specify)

26- How would you describe yourself?

[ ] I am able to express my opinion without fear

[ ] I‘m among the top ten in my class, I‘m a bright student

[ ] I‘m shy, I find it difficult to say ―no‖

[ ] I like myself

[ ] I do not like some parts of me

[ ] I easily make friends

[ ] I do not usually get along with my mates

[] other (please specify)

SECTION C: FAMILY CHARACTERISTICS OF RESPONDENT

27- What is your family structure?

[ ] father, mother and siblings

[ ] father, step-mother and siblings

[ ] mother, step-father and siblings

[ ] single parent family

[ ] extended family (eg living with uncle, aunt or grandmother etc)

[ ] other (please specify)

28- Who is the head of your family?

[ ] father

[ ] mother

[ ] step father

[ ] stepmother

[ ] uncle/ aunt

[ ] grandmother/father

[ ] other (please specify)

29- What is the level of education of the head of your family?

[ ] tertiary (eg, university, teacher training or polytechnic etc.)

[ ] secondary school

[ ] basic school

[ ] did not go to school

[ ] other (please specify)

[ ] I do not know

30- What work does the head of your family do?

[ ] professional (eg, teacher, nurse or banker etc.)

[ ] farmer

[ ] business person

[ ] office worker

[ ] trader

[ ] artisan (eg tailor, carpenter or mason)

[ ] other (please specify)

31- What is your family‘s attitude towards you concerning sex?

[ ] I am not sure of my family‘s attitude

[ ] My family expects me to abstain from sex till I‘m married

[ ] My family expects me to be careful, so I will not get pregnant or STD

[ ] My family does not seem to care whether I have sex or not

[ ] other (please specify)

32- What sort of person is the head of your family?

[ ] strict, disciplinarian

[ ] open, communicative and easy to talk to about issues bothering you

[ ] supports, encourages and guides me

[ ] abusive, always insulting and shouting on me

[ ] shows interest in my affairs by monitoring my activities

[ ] other (please specify)

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL

COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS

Our Ref: CHRPE/AP/024/15

29th January, 2015.

Ms. Monica Ojumu Molara
Post Office Box UP 124
KNUST
KUMASI.

Dear Madam,

LETTER OF APPROVAL

Protocol Title *"Sex Negotiation Skills among In-School Young Adolescent Girls in Effiduase, Sekyere-East District, Ashanti Region."*

Proposed Site: *Effiduase, Sekyere East District, Ashanti Region.*

Sponsor: *Principal Investigator.*

Your submission to the Committee on Human Research, Publications and Ethics on the above named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 2nd November, 2011 from the Sekyere East District Education Office (study site) indicating approval for the conduct of the study in the District.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Proposal.
- Questionnaire.
- Focus Group Discussion Guide.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, renewable annually thereafter. The Committee may however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Thank you Madam, for your application.

Yours faithfully,

Rev. Prof. John Appiah-Poku
Honorary Secretary
FOR: CHAIRMAN

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