

UNIVERSITY FOR DEVELOPMENT STUDIES TAMALE

PERCEPTIONS AND CHALLENGES OF SEXUALITY

EDUCATION AMONG SENIOR HIGH SCHOOL STUDENTS

AND TEACHERS WITHIN TAMALE METROPOLIS



BY

NAAH JUDE

UDS/MPH/0053/18

2021



UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF GRADUATE STUDIES

**PERCEPTIONS AND CHALLENGES OF SEXUALITY EDUCATION
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WITHIN TAMALE METROPOLIS**

BY

JUDE NAAH (B.A POPULATION AND HEALTH)

UDS/MPH/0053/18

**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY
HEALTH AND FAMILY MEDICINE, SCHOOL OF PUBLIC HEALTH,
UNIVERSITY FOR DEVELOPMENT STUDIES IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF A
TWO YEAR MASTER OF PUBLIC HEALTH DEGREE (GLOBAL
HEALTH) IN DEPARTMENT OF COMMUNITY HEALTH AND
FAMILY MEDICINE**

FEBRUARY 2021



DECLARATION

Student declaration

I hereby declare that this thesis is my own work towards the award of a master of public health degree and that, to the best of my knowledge it does not contain any material previously published by another person nor material which has been presented for the award of any degree in this university or elsewhere, except for reference to other people's work which have been duly acknowledged.

Name of student Jude Naah

Signature

Date

Supervisor declaration

I hereby declare that the preparation and presentation of the thesis was supervised in accordance with the guidelines on submission of thesis/dissertation laid down by the University for Development Studies.

Name of Supervisor Anthony Amalba (Ph.D.)

Signature

Date



ABSTRACT

Sexuality education in schools is known to be important but individuals have different perceptions about it and its existence in schools is also fraught with challenges. The aim of the study was to examine the perception and challenges of sexuality education among senior high school students and teachers within Tamale Metropolis. The study adopted a mixed method approached with a cross sectional design. A multistage sampling technique was used to select 267 students who answered the questionnaires and purposive sampling was used to select 6 teachers who were interviewed. Statistical Package for Social Sciences (SPSS) version 25.0 was used to analyse the quantitative data and the qualitative data were analysed manually using thematic analysis. It was found out that respondents had good knowledge on SRH and bad attitude towards contraceptives and abortion. Contraceptive usage and ever had sex was significant ($p < 0.04$). Mother was the most important and preferred source of information on SRH. Sexuality education was viewed as important and helps improve knowledge on sexual and reproductive health and do not promote promiscuity but concentrate only on abstinence. Fear of being tagged as a bad girl or boy, religious contradictions, name calling, discomfort and shyness were challenges faced by students. Lack of teaching and learning materials, time and curriculum design, personal beliefs, cultural values, over excitement of students and lack of special training were challenges faced by teachers. Teachers should be trained and equipped with the needed materials to teach sexual and reproductive health topics.



DEDICATION

I dedicate this thesis to my parents, Mr Ignatius Naah and Mrs Olivia Angboli and my siblings.



ACKNOWLEDGEMENT

First, I am grateful to the Department of Community Health and Family Medicine of the University for Development Studies for giving me the opportunity to carry out this work. My sincere appreciation goes to Dr. Amalba Anthony, my supervisor, for the passionate support and useful criticisms towards this work. I must also acknowledge Ms. Jemima Bamuri Kuseh and Fati Issah for their support during data collection.

I am also grateful to the Tamale Metropolitan Education Directorate and head teachers and teachers of the various schools for their support and assistance during the data collection.



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LIST OF ABBREVIATION

ICPD	International Conference on Population and Development
UN	United Nations
WHO	World Health Organisation
STI	Sexually Transmitted Infection
sSA	sub-Saharan Africa
HIV	Human Immune Virus
UNAIDS	United Nations Programme on HIV and AIDs
SBSHE	School Base Sexual Health Education
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
SHS	Senior High School
GSS	Ghana Statistical Service
GDHS	Ghana Demographic and Health Survey
GMHS	Ghana Maternal and Health Survey
PPAG	Planned Parenthood Association of Ghana
IPPF	International Planned Parenthood Foundation



PFLE	Population and Family Life Education
ARH	Adolescent Reproductive Health
RHD	Reproductive Health and Development
AYSRH	Adolescent and Youth Sexual and Reproductive Health
GSPHDAYP	Ghana Strategic Plan for the Health and Development of Adolescents and Young People
SE	Sexuality Education



CHAPTER ONE

INTRODUCTION

1.1 Background

The dire problems accompanying with adolescence and issues of social change with sexuality which developed world encountered within the last century is now confronted by developing countries (Lloyd, 2005). In response to these issues of increasing number of adolescent and the sexual and reproductive health (SRH) challenges they face, international organizations have taken a number of measures to control this problem. The International Conference on Population and Development (ICPD) Programme for Action in 1994, popularly known as the Cairo Action called on government and other governing bodies to provide sexuality education to adolescent's to improve their well-being and indicated the services to be provided (UN, 1995 as cited in Haberland and Rogow, 2014).

Globally, about one million cases of sexually transmitted infections (STIs) occur regularly and people who live with treatable STIs such as Gonorrhoea, Syphilis, Chlamydia and Trichomonas is estimated to be around 500 million (WHO, 2012). Gottlieb et al., (2014) opined that, there is an incidence rate of 241 per 1000 cases of STIs in sub-Saharan African among individuals aged 15-49, which is known to be one of the highest in the world. In sub Saharan Africa, one out of six deaths among adolescents is attributed to Human Immunodeficiency Virus (HIV). It is estimated that, about 70% of the global burden of HIV patients live in sub Saharan Africa and 80% of women with HIV aged 15-24 live in sub



Saharan Africa (WHO, 2015). Individuals aged 15-24 account for 50% of all new HIV infections (Fonner et al., 2014) and more than 90 % are sexually transmitted. Thus, sexually active young people in sSA, including young women, are at high risk of HIV infection and therefore needs education to know the risk factors associated with them.

Several strategies has been put in place to reduce the risk of sexually transmitted infections including HIV among adolescents. According to Mavedzenge, Luebeck and Ross, (2014), these interventions include adolescent-friendly health centres that helps to prompt the usage of prevention services; school-based health services; conditional cash transfers to encourage young people to remain in school or to avoid risky sexual behaviours. Others also are, preventive education in schools; services delivered in youth centres, including condom distribution; various community-based interventions; and unconditional cash transfers (Mavedzenge, Luebeck and Ross, 2014).

School-based sexual health education (SBSHE) is perhaps a complete and possibly all-inclusive of the methods. It has the ability to effectively promote sexual health among adolescents and young adults at the population-level (Schaalma et al., 2004) and reducing the spread of STIs, including HIV (Gallant and Maticka, 2004). There has been evidence from an evaluation on how effective school based sexual health education has helped in the number of sexually transmitted infection related outcomes. And therefore it's recommended to be implemented widely (Mavedzenge et al. 2014). In sub Saharan Africa, school-based sexuality education evaluations have provided varied conclusions. Most of



these studies had led to reduction in issues of improvement of protected sex but same has not been said about new or old STIs (Gallant and Maticka, 2004).

The International Technical Guidance on Sexuality Education, UNESCO (2009) defined sexuality education as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality Education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. Breuner and Mattson, (2016) also defined sexuality education as the teaching about human sexuality, including intimate relationships, human sexual anatomy, sexual reproduction, sexually transmitted infections, sexual activity, sexual orientation, gender identity, abstinence, contraception, and reproductive rights and responsibilities.

Sexuality education goes beyond teaching of children and adolescents about body parts. It covers healthy sexual development, gender identity, interpersonal relationships, affection, sexual development, intimacy (Martino et al, 2008), gender based violence, human rights, decision making and sexual health (including HIV and AIDs, STIs, condom use, unintended pregnancy) (UNFPA, 2014). It should include accurate information on a range of age-appropriate topics; should be participatory; and should foster knowledge, culturally appropriate, attitudes, values and practical skills to enable adolescents to develop positive views of their sexuality (Awusabo-Asare et al., 2017). Sexuality education should not be an educational experience only found in the educational



setting, but it should be experienced through different political, social and cultural settings (Bhana, Crewe and Aggleton, 2019). Thus, sexuality education is not school specific but must be part of the social, political and cultural milieu as well.

According to UNESCO (2011), the accomplishment of sexuality education programmes are mainly dependent on the setting in which they are established and applied. This is because sexuality education is a sensitive issue in many countries due to the idea that sexuality education fuels early sexual debut or promote promiscuity of which is false (UNESCO, 2011). Therefore, due to this belief, sexuality education programmes needs to be well planned and involve a wide range of advocacy and public education.

In Africa, controversy surrounds the teaching of sexuality education in schools despite its importance. The problem is not about teaching of sexuality education but what to teach the students. The content has been a contest. For instance, there are societal expectations that issues of sexual orientation, condom use and others must not be taught but issues of chastity, morality, and abstinence must not only be taught but emphasized. This controversy stems from the cultural and religious worldview of the African society (Awusabo-Asare, 2015; van der Geuten et al., 2015a).

A study by Berne and Huberman (2000) indicated that, developed nations such as Germany, France and The Netherlands had an open and flexible approach to sexuality education. Their focus was on positive aspects of sexual relationships, sexual relationships and communication alongside empathy and corporate



responsibility on a societal level. The study indicated that, there were lower cases of unwanted pregnancies and sexually transmitted infections in these countries and also, adolescents had their sexual debut at a later stage in their life (Berne and Huberman (2000). A study by Allen (2007) indicates that, sex and relationship education which focuses on the negative aspect of sex and relationship education impacts adolescents and this can affect the efforts made in the fight against preventing diseases and pregnancy. Other studies (Allen, 2007; Helmer, Senior, Davison, and Vodic, 2015; Macintyre, Montero Vega, and Sagbakken, 2015) had found out that, educating adolescents on sex and relationship with focus on the consequences of sexual activity fail to meet the needs of students. Adolescents do not make good choices due to their limited access to information on sexual practices, pleasure and desire.

A study by Underhill, Operario and Montgomery, 2007 indicated that there is lower risk of pregnancy and STIs among students who receive comprehensive sex or HIV education than those who received abstinence only or no sex education in other high income countries and the United States. “Abstinence-plus” initiatives are all-inclusive and encourage abstinence. It also promote condom use and other safer-sex practices (Underhill et al., 2007). “Abstinence only” education is commonly fear-based.

Curriculum-based sexual and reproductive health education has a long history in Ghana, and several policy and programme developments have shaped its current provision (IPPF, 2018). Reproductive health in Ghana has being integrated in a number of subjects in schools. Notable among them are Hygiene



and Civic, Life Skills, Population and Family Life Education within Social Studies, Religious and Moral Studies, integrated science. At the SHS level, sexuality education is incorporated within two core subjects (social and integrated science and two elective subjects (biology and management in living) (Awusabo-Asare et al., 2017). Sexual health education was introduced in schools because according to Awusabo-Asare et al., (2006), nearly 90% of young people are enrolled in school

Ghana is known for its blend of cultural, religious and geographical context which has made it sensitive for which issues of sexual health is seen as forbidden (Mack, 2011). There is strong evidence for the positive consequences of curriculum based sexual education on improving adolescents' knowledge and their attitudes on SRH (UNESCO, 2018). Research has also shown that curriculum-based sexuality education programmes can contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, decreased number of sexual partners, reduced risk-taking, increased use of condoms, and increased use of contraception (UNESCO,2018). The issue of sexuality education is not about only when to have sex but issues of partner selection, contraceptive use and reproductive health outcomes are also included (Grossman et al, 2014).

1.2 Problem Statement

According to the 2010 population and housing census, about one-third of the Ghanaian population of 24.4 million is 10-24 years (GSS, 2010). Among this



group, that Croce-Galis (2004) indicated are likely to make wrong reproductive health decisions and are exposed to risky sexual behaviours. Nationally, 11.8% females and 9.3% males aged 15-19yrs have had sex by age 15 years with 14.2% already begun child bearing (GDHS, 2014) and with an induced abortion rate of 17 per 1000 women (GMHS, 2007 as cited in UNFPA, 2016). In the case of Northern region, 8.1% females and 2.6% males aged 15-19years have had sexual intercourse by age 15 years with 10.1% females already begun child bearing (GDHS, 2014). About 2% of females aged 15-19 years who are sexually active do not use any form of contraceptive with 65.3% of them (15-19years) having unmet needs of family planning (GDHS 2014). According to the 2014 GDHS, the fertility rate in Northern region among 15-19years stood at 93 per 1000 women.

Studies have been undertaken with respect to sexuality education in Ghana. The study by Awusabo-Asare et al., (2017) looked at the policy environment and the implementation of sexuality education in Ghana with Nyarko et al., (2014) also looked at parental attitudes to sexuality education in lower primaries. A number of studies have been conducted on sexuality education on students in northern Ghana, specifically Upper East (Aninanya et al., 2015; van der Geuten et al., 2015a, van der Geuten et al., 2015b) and Northern Region (Yakubu et al., 2019) but all these studies evaluated the effectiveness of sexuality education not challenges and views on sexuality education in schools.. There is limited knowledge regarding the perceptions students and teachers on sexuality education in senior high schools and the challenges in their implementation. The high rate of teenage pregnancy in the region is seen to be as a result different



reasons but notable among them could be as a result of limited knowledge about SRH issues among the youth. This study seeks to unearth some of the factors contributing to the high figures.

1.3 Justification

There have been different views on issues of sexuality education not only in Africa, but the world. These differences are affected by a number of factors. While others base theirs on empirical research evidence, others are backed by religious and cultural grounds. Schaalman and colleagues indicated that, school-based sexuality education is far the best form of intervention for adolescent in fighting sexually transmitted infections, including HIV (Shaalman et al., 2004). Also, a broader perspective of the relevance of sexuality education is to increase adolescent knowledge on sexual health choices and reduce their risk of risky sexual behaviour (UNESCO, 2018). Despite this, others are of the view that, exposing adolescents to sexuality content rather promotes promiscuity. With the view that their exposure to sexuality education will make them end up experimenting (Ankomah, 2001, Awusabo-Asare et al., 2017) and that is not backed by scientific proof (Nyarko et al., 2014). Individual who lack access to sexuality education are the ones who have a higher chance of being pregnant at their teen age.

Within the African setting, issue of sexuality education is seen to conflict with cultural norms and as Nyarko et al (2014) indicated, the mere mention of sex is prohibited. Despite all these cultural and religious beliefs, adolescence



involvement in sexual activity are on the rise and due to their low knowledge on sexual health issues; they are prone to sexually transmitted infections including HIV. The burden of these infections is borne by adolescents in sub-Saharan Africa (Gotlieb et al., 2014) and therefore much attention needs to be given to sex education.

There has been a dissenting view with regards to sexuality education in Ghana from the religious and traditional leaders and other non-governmental organisations whose focus is on adolescent sexual reproductive health. The inclusion of school based sex education in educational curriculum dates back to independence despite the misunderstanding. Recent works of non-governmental organisations such as Marie Stopes, Planned Parenthood Association of Ghana (PPAG), and other health workers (mostly community health nurses) in educating adolescents to know their reproductive health needs is really great. Even though Tamale is a Muslim dominated community of which sex among Muslims is a taboo (Athar, 1996 as cited in Nyarko et al., 2014) adolescent pregnancy is on the ascending and therefore adolescents need to know much about their reproductive health. Therefore, this study seeks to know the knowledge, attitude and practice of students on sexual issues, their views and challenges associated with sexuality education. This study to an extent be an evaluation of the impact of the sexuality education and their challenges.



1.3 Research Questions

1.3.1 General Research Question

What are the perception and challenges of sexuality education among Senior High School students and teachers within the Tamale Metropolis?

1.3.2 Specific research questions

What is the level of knowledge, attitude and practice on sexual health issues among students and teachers?

What are perceptions of students and teachers within Senior High Schools in the tamale Metropolis on sexuality education?

What challenges affect the effective running of sexual health education programmes in Senior High Schools within the Tamale Metropolis?

1.4 Objectives

1.4.1 General objective

To examine the perception and challenges associated with sexuality education among students and teachers within Senior High Schools in the Tamale Metropolis.

1.4.2 Specific Objectives

To assess the knowledge, attitudes and practices on sexual health issues among students and teachers.



To know the perception of students and teachers on sexuality education within SHS in the Tamale Metropolis

To investigate the challenges affecting the effective running of sexuality education programmes in schools within SHS in the Tamale Metropolis.

1.5 Significance of the Study

The study will inform policy makers on the essence of school based sexual health. It will also help policy implementers to know what to do since it will serve as a guide. The study will add to the existing pool of knowledge and will serve as reference for further studies in areas of school based sexual health. The study will also help know the impact of existing sex education programs and the challenges teachers faces in delivering.

1.6 Theoretical Framework

The Social Ecological Model (SEM) is a theory-based framework for knowing the multidimensional and shared effects of personal and environmental factors that influences young people's SRH. Thus, it focuses on the interplay between five constructs and how their interaction influences young people's sexual health.



Figure 1.1: Relationship between social ecological factors and sexual and reproductive health



Source: Adapted from the Center for Disease Control (retrieved on November 11, 2019).

Individual: The individual represents the person's background characteristics such as age, gender, religion, ethnicity, culture and the goals and expectations that influences their knowledge, attitudes and practice of sexual and reproductive health.

Interpersonal: The interpersonal factors are friends or peers, religious affiliations or cultural background that affects the behaviour of an individual. These can be a formal or non-formal systems or social network connection.



Community: Within the context of the study, the community linkage must be between parents, community leaders and school authorities on the appropriate way or procedure that will help in sexual health education.

Organizational: Social institutions with rules and regulations for procedures that affect how, for example, sexuality health education in schools are provided to students and teachers. These institutions and organisations are the schools, parent-teacher associations, the teachers associations as well as the students' representative council.

Policy environment: Local, state, national and global laws and policies, comprising policies concerning the distribution of resources for sexual health education in schools and access to adolescent reproductive health services or lack of policies that requires sexual health educations in schools. Also, this includes policies on curriculum design and training of teachers on sexual and reproductive health.

Individuals live in a social ecological system, altering individual-level behaviours and bringing in new social norms demand providing an environment that will accept it. That is, facilitating change and removing barriers that constraint variations at the household, community, organizational, and policy levels. For example, if a program's goal is to examine the need for school based sexual health education, then (1) students and teachers must understand why it is important to learn or teach sexual health and be motivated to practice what they are being taught, (2) teachers and students must have access to teaching and



learning materials on sexual health, (3) teachers and/or school authorities must be trained and equipped to provide lessons on sexuality, and (4) communities must embrace and own the importance of sexuality education to their wards and demand for it to be taught in schools, and create a social norm around sexuality education..

The social Ecological model is best fit for the study because, individual characteristics such as their knowledge, attitudes or perception towards a health condition influences their decision to take measures. The knowledge and attitudes of students and teachers will influence their decision about sexual health and also the essence of sexuality education in schools. Also, the model lays emphasis on the impact of relationship and where one finds him or herself influences their behaviour. The views of an individual about a health condition is likely influenced by the community he or she finds her or himself and the company (friends) around that person. Whiles other communities may view sexuality education as a positive way of improving reproductive health issues, others may view it from a different perspective. The availability of organizations or institutions to help in the effective implementations of sexuality health education policies and identifying the challenges associated with it either from the religious perspective or cultural perspective.



1.7 Scope of the Study

The study was to examine the perception and challenges of sexuality education among teachers and students. The study was conducted within the Tamale Metropolis of Northern Region.

1.8 Study Limitation

The study was limited to only in-school adolescents and as such generalization of findings to all adolescents would be a problem. Also, the study was limited by the corona virus pandemic as it extended the data collection period to a month due to closure of senior high schools. The extension led to financial constraints on the part of the researcher and the research team. Also, during data collection, school authorities were reluctant which led to refusal of some school authorities for the study to be conducted within their school. The focus group discussions were affected as students and authorities were not willing for students to come close for discussions.

1.9 Organization of the Study

The study was divided into six chapters. Chapter 1 contained information on the background, problem statement, justification, objectives, research questions, significance and limitations of the study. Chapter 2 reviews some relevant literature in respect of the research topic. Chapter 3 outlines the study area and methodology used in collecting the data. Chapter 4 contains presentations and analysis of the data collected. Chapter 5 contains the discussion of the analysed data and Chapter 6 contains the summary of the major findings



thereby drawing conclusion thereon and recommendations was made in line with the findings and conclusions.



CHAPTER TWO

LITERATURE REVIEW

This chapter seeks to review other studies which are related to the study. The literature reviewed is in line with the objectives of the study.

2.1 Concept of Sexuality Education

The concept of sexuality education is not a contemporary one. It dates back to the 20th century in Sweden in 1955. It has a history of more than half a century. The idea of sexuality education has seen a number of modifications as a result of the educational and health needs of the past. In recent times, the key element of sexuality education of the past still exist and has not changed regardless of the changes in educational guidelines and health needs. In the 1960s to 1970s, the focus was on prevention of unplanned pregnancy, in the 1980s, it shifted to prevention of HIV and responsiveness of sexual abuse in the 1990s and finally in the 2000s, sexuality education is about prevention of chauvinism, homophobia and internet abuse. Lately, issues of sexual roles and inequalities are instrumental components of sexual education (European Expert Group on Sexuality Education, 2016).

“Sexuality education is defined as learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. It starts in childhood and develops through adolescence and adulthood. Its purposes is to help and guide sexual progression or growth. Sexually education progressively prepares and provide children and young people with information, skills and positive values to



know and appreciate their sexuality, have non-violent and pleasing relationships and take charge of their own and other people's sexual health and well-being (WHO, 2010)".

The quality of sexuality is backed by globally recognised human rights. This right is the right to information which is suitable to health needs of an individual. This right has been established by a number of international committees. The United Nations Committee on the Rights of the Child, the Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination against Women, and the United Nations Convention on the Rights of Persons with Disabilities are the internationally recognised committees which backs this right of access to information. Also, sexuality education was championed by the International Conference on Population and Development's (ICPD) 1994 Programme of Action. The essence of sexuality education has been highlighted in the Right to Education, a United Nation's Special Report submitted to the United Nations General Assembly in 2010 dedicated entirely to sexuality education and by the European Court of Human Rights in 2011 (European Expert Group on Sexuality Education, 2016).

Sexuality education has a range of benefit if provided in a conducive and supportive environment. Studies have shown that sexuality education within countries have resulted in reduction in teenage pregnancies, abortion, sexually transmitted infections, and HIV and AIDS among young people between the ages of 15-24 years. It has also helped strengthen skills and increase confidence to deal



with challenges and empower individuals to form healthy and more meaningful relationships (European Expert Group on Sexuality Education, 2016).

The expression of sexuality and sexual norms is affected by gender inequalities and social norms. The control or power in sexual relationships is held by men with women having less authority over their sexual relationship. Pressure from peers makes young men behave in male sexual stereotypes and involve themselves in unhealthy behaviours. Positive attitude is influenced by a good and quality sexuality education (Tanton et al. 2015). Also, sexuality education can impact the values and change the power relations in sexual relationships. That is, preventing intimate partner abuse and encouraging or promoting mutual respect and understanding in relationships.

The quality of sexuality education as evident in some European countries. Apter's (2011) study in Finland, and that of Haldre et al., (2012) in Estonia and other countries do not encourage young men and women to involve in sexual relationship at an early age but rather delay young men and women sexual debut and make them engage in sexually responsible (United Nations Education Scientific and Cultural Organisation, 2009; Van Keulen et al., 2015).

Sexuality education is not harmful to teenagers (UNESCO 2009). It covers a variety of areas designed to suit the level of growth of the child, thus, age-appropriateness. For instance, children aged 4-6 years are taught topics on emotions, names of body parts and friendship. Although, these areas are good to adolescents and other age groups to know, but it is being taught at different levels



and with different content and approach. As the individual progresses to higher educational stage, lessons on puberty, contraceptives or birth spacing issues are taught. For most young people, the ideas of social relationships which they were taught during early life are what they depend on or transfer to their sexual relationship. “Children are aware of and recognise these relationships long before they act on their sexuality and therefore need the skills to understand their bodies, relationships and feelings from an early age” (UNESCO 2009).

2.2 Historical Background of Sexuality Education in Ghana

Ghana has long recognized the essence of sexuality education as a way of solving the sexual needs of people between 10 -24 years. Previously, it was provided by elders and traditional leaders in communities. Sexual health education was introduced into the educational system when formal education was introduced. The structured syllabus in the school system made it possible for individuals aged 10-24 years to be aware of their sexual life and have skills which is important in their lives. Attention was given to reproductive physiology, self-restraint before marriage, preventing the negatives of sex before marriage and generated roles in society because both community and school provided the information on reproductive health. Different terminology has being used to describe the concept of school based reproductive health education over the years in Ghana. Such of those terminologies are; Population and Family Life Education (PLFE), Adolescent Reproductive Health (ARH), Reproductive Health for young people, and Reproductive Health and Development (RHD).





The school based sexual and reproductive health education and the community sexual health education have their backing from national policies or Ghana's belongings to an international treaty. The population policy of 1964, which had its revisions in 1994 and the 1992 constitution of the Fourth Republic of Ghana provided the backing for population programmes. One of the objectives (objective 4.3.7) of the 1994 population policy states: "To educate the youth on population matters which directly affect them such as sexual relationships, fertility regulation, adolescent health, marriage and child-bearing, in order to guide them towards responsible parenthood and small family sizes". This objective brought about the birth of the Adolescent Reproductive Health Policy in 2000 which was later revised in 2016 and it's now known as Sexual and Reproductive Health Policy for Young People in Ghana. Other policies as the Adolescent and Youth Sexual and Reproductive Health (AYSRH) in 2009 by Ghana health service, which was known as the Ghana Strategic Plan for the Health and Development of Adolescents and Young People (GSPHDAYP): 2009-2015 (Ghana Health Service, 2009). All these national policies are backed by Article 37(4) of the 1992 constitution of the Fourth Republic of Ghana.

Before independence and after independence up to 1971, reproductive health topics were found in Hygiene and Civics. Hygiene and Civics was made up of human biology, civic responsibilities and personal hygiene. Environmental or social studies was introduced which covered topics such as the family, sexual and reproductive health, sexuality with attention on abstinence. In 1976, components of SRH were taught during before the service training in Teacher Training

Colleges. Life skill was introduced in 1987, which also had aspects of SRH. The School Health Education Programme (SHEP) was introduced as a supporting curricular activity in 1992. In 1998, life skills was represented by social studies and extended to comprise HIV and AIDS. The revised version of the SHEP to include psychosocial skills, HIV issues, Disaster Management Reduction, Nutrition Management and also Guidance and Counselling became known as e-SHEP (Awusabo-Asare et al., 2017). The approach adopted by Ghana is the integrated approach as against the standalone approach (Valerio et al., 2008). Thus, SRH education is incorporated into topics across all levels of education.

2.3 Adolescents Sexual and Reproductive Health in Ghana

Adolescents in Ghana are confronted with sexual and reproductive issues as documented; from sexual activity to contraception, unplanned births, abortion, HIV prevalence and AIDS.

2.3.1 Sexual Activity

Nationally, 43% of females and 27% of males aged 15-19 years, married or not had engage in sexual intercourse and with 26% of females and 14% of males of the same age group are sexually active (GDHS, 2014). The median age at first intercourse in Ghana is 18.4 years for females and 20 for females. More females (12%) adolescents have had sex before age 15 than their male (9%) counterparts of the same age group. Whiles Brong Ahafo had 21% of females and 7% males of its adolescents initiating sex before age 15, Northern region had 8% females and 3% males (GDHS, 2014).



2.3.2 Contraception, unplanned births and abortion

Contraceptive use is comparatively low in Ghana. Even though 96% of females 15-19 years know of a modern contraceptive method, only 22.2% of those sexually active women are using any of the modern contraceptive method. Among the unmarried sexually active female adolescents, 24% are presently using a modern contraceptive method while about 62% have unmet needs for family planning despite them being sexually active. In Ghana, 14.2% of females aged 15-19 years has begun childbearing and 73.9% of their births are unplanned (GDHS, 2014). Other studies have shown that adolescents are exposed to having unplanned pregnancies that results in abortions. The 2007 Ghana Maternal Health Survey showed that 16% of pregnancies in young people less than 20 ended up in abortion (GMHS, 2007).

2.3.3 HIV prevalence and AIDS

Statistics from Ghana Demographic and Health Survey 2014 shows that 64% of females aged 15-19 and 84% of males of the same age have information on where to get condom but only 18% females and 25% of males have comprehensive knowledge about HIV and AIDS. Over the years, rates of HIV infection among 15-24 years old have remained below the national average. But in 2014, the average of the same age group (1.8%) exceeded the national average of 1.6% (National AIDS Control Programme, 2013). The GDHS (2014) indicated that, HIV prevalence is higher among women (1.5%) aged 15-24 than among their male (0.2%) counterparts.



2.4 Sources of Sexual and Reproductive Health Information among Adolescents

A study in Uganda by Nobelius and colleagues opined that, adolescents feel they lack information on three levels. These levels are SRH issues, the bargaining for safe sex and relationship, and becoming adults. Also, each of the category, adolescents have a favourite choice of individuals for information. This is because they believe the source in each category must have vast knowledge and command over the kind (Nobelius et al., 2010). Nobelius et al., (2010) reiterated that, family, peers and media were seen as having insufficient knowledge or not good sources by adolescents. It was further indicated that, adolescent believed information concerning their sexuality must be from qualified community and media-based educators but not health facility based educators. Also, information on how to bargain for sex and sexual relation must be from up-skilled traditional source; and information on transitional to adulthood must be from family, church and community leaders (Nobelius et al., 2010).

In their study, Bleakley and colleagues examined the association between adolescents' sexual beliefs and source of information by sampling 459 youth. They found out that, friends, teachers, mothers and media were the frequently used sources of information. The study further indicated that information from family, and religious leaders influenced the sexual activity to be prolonged to later life as opposed to friends and media which increases the chance of having sexual intercourse (Bleakley et al., 2009).



Baheiraei et al., (2014) in 2011 randomly sampled 915 adolescents aged 14-18 to know what sources they turn to about their health concerns. They found out that mothers and same-sex friend were the primary source of information. The media was also found to be a preferred source, comprising books (39.6%) and internet (37.9%). Younger adolescents wanted parents as their source of information and older adolescents preferred friends (Baheiraei et al., 2014). The study concluded that some of these sources must be integrated to deliver evidence-based health information.

In their qualitative study among adolescents in West Gonja in Northern region of Ghana, Kyilleh, Tabong and Konlaan (2018) found out that most adolescents resorting to their peers and mass media for SRH information. Kyilleh and colleagues reiterated that these sources make adolescents exposed to wrong information and in such case make wrong decisions based on the wrong information given (Kyilleh, Tabong and Konlaan, 2018). Other studies are of the view that parents could be the most reliable source of information but they (parents) are repressed by socio-cultural issues that prevents them from talking about SRH issues with their kids (Owusu, Blankson and Abane, 2011; Nwalo and Anasi, 2012).

Using a 2004 survey collected from Ghana, Burkina Faso, Malawi and Uganda, Bankole and colleagues found out adolescents know about their SRH from multiple places. In Ghana and Burkina Faso, mass media was the most sought after source followed by teachers and schools in Ghana and family



members in Burkina Faso. For Malawi and Uganda, mass media, schools and friends are the leading sources of information (Bankole et al., 2007).

A public health assessment in Ghana by Esantsi et al., (2015) to understand the reproductive health needs of adolescents in selected slums found out that school was the major source. For issues on puberty and reproduction, schools were the main preferred source. Majority of the respondents indicated that it was easy to discuss with their mother important things (Esantsi et al., 2015).

2.5 Knowledge, Attitude and Practice of Sexual Health among Students and Teachers

2.5.1 Knowledge on sexual and reproductive health

Adolescents encounter a number of challenges regarding their SRH issues. Knowledge on issues relating to contraception, HIV and AIDs, STIs, abortion, are mostly low and serve as a barrier to sexual health services. Sexual health knowledge is important because it can help prevent teen pregnancies, unsafe abortions, school dropouts due to teen pregnancies and spread of HIV/AIDS and STIs among secondary school students. Sexual health knowledge is therefore, very essential for an education sector to implement (Chacko et al., 2007; Herman et al., 2013). Health literacy can be improved through knowledge on sexual health. Health literacy is vital in achieving ideal health (Muhanga and Malungo, 2017). The level of sexual health knowledge is instrumental in HIV prevention,



unplanned pregnancy, abusive sexual activity and achieving Universal Access targets for prevention, treatment, care and support (UNAIDS 2006).

The 2014 Demographic and Health Survey reports that, only 18% females and 25% males who are within their late adolescent age have informed knowledge about HIV and AIDs, of which knowledge is known to vary considerably with gender and region (GDHS, 2014). This observation is similar to these findings Pelucchi et al., (2010) which indicated that knowledge is influenced by gender especially for HPV and Boamah et al., (2014) indicated that, males have higher knowledge on contraceptive than females. Duong, Debpuur and Khan (2008) found similar observation with regards to STI. In contrast, Martin and Mak (2013) found difference between knowledge of males and females regarding sexual health and but this difference was not statistically significant.

Munakampe, Zulu and Michelo (2018) found out adolescents in low and middle income countries have insufficient knowledge about SRH. The study iterated that, their limited knowledge was as a result of their limited access to contraception and abortion services.

Another study by Sharma et al., (2019) among 130 (99 females and 31 males) of different race (White, Black/Africans-American, Latino,/Hispanic, Asian) found out that both males and females lacked knowledge about IUD despite its awareness. Hong and colleagues study among college students in Beijing found out that, college students have insufficient knowledge and lack ways to prevent risky sexual behaviours (Hong et al., 2012).



A cross sectional study in Nepal among 504 secondary school students found out that, only 38.1% of the respondents had good knowledge about sexually transmitted infections while 61.9% had poor knowledge about STIs. Students from the faculty of science had good knowledge as compared to others from other faculties and this was as a result of the subjects taught at the faculty of science (Thapa and Chand, 2018).

Boamah and colleagues conducted a cross-sectional survey among 793 males and females adolescents (15-19) in Kintampo from October 2019 to May 2011 using a mixed method approach. They found out that, at least knowledge on a contraceptive method was high (88.9%) among males (92.1%) and females (86.6%) adolescents. Their knowledge was high on condom. They indicated that, the general knowledge on contraceptive type was not encouraging (Boamah et al., 2014). The low level of contraceptive knowledge in Ghana apart from male condom is reported in other studies (Awusabo-Asare et al., 2004; Awusabo-Asare., 2007) and the reason could be as a result of condom being the most appropriate contraceptive among unmarried adolescents (Boamah et al., 2014).

Westwood and Mullan's study in England among 155 teachers of 19 mixed secondary schools reported that, teachers lack knowledge on SRH to deliver on sexually transmitted infections. Also, teachers had insufficient knowledge on SRH and this affected their teaching on emergency contraceptives despite their overall SRH knowledge being good (Westwood and Mullan, 2011).



In a descriptive study conducted in Ambala District, Haryana among 70 teachers who were conveniently sampled from five different government schools on their knowledge and attitude on SRH. A structured knowledge questionnaire was used and its reliability coefficient was found to be 0.67 by the Kuder-Richardson method. The result was that, about 63% of the teachers had an average level of knowledge on issues of SRH. Sankhyan and colleagues reiterated that, the teachers had sufficient knowledge on topics such as reproductive organs and puberty. Also, the concept of SRH was the next area where teachers had sufficient knowledge on but they had insufficient knowledge on contraceptives. The study concluded by highlighting the essence of training and awareness creation with respect to SRH (Sankhyan et al., 2019).

A descriptive cross-sectional study in Nigeria found out that, knowledge of STI among different study participants was poor ranging from 26.7% for HIV and AIDS to 4.1% for chlamydia. Also, the study found out that, knowledge on STI preventive practices was poor as only 49% of the participants could identify at least one STI practice and more than 50% had misconceptions about STI. The authors reiterated that, 4 out of every 5 participant had inadequate knowledge on STI (Ekpenyong et al., 2019). The study recommended intensifying STI in school curricular.

A 2017 study in Cape Coast on knowledge, attitude and practice about STI among 400 non-medical university students found out that, knowledge on clinical features of gonorrhoea and AIDS was high but that of syphilis was low. Also, knowledge on STI prevention was high (more than 90%) (Acheampong, 2017).



2.5.2 Attitude toward sexual and reproductive health

The attitude toward behaviour is the degree to which a person has a favourable or unfavourable evaluation of that behaviour (Asare, 2015). Attitudes are formed through life experiences and are learned behaviours from others. In contemporary language, attitudes are defined as complex, multidimensional constructs comprising cognitive, affective, and behaviour components.

The favourable or unfavourable evaluation of sexual behaviours of male and female college students happened to have appeared in recent years (Larry, 2004). A study by Martin and colleague among 201 college students on their sexual knowledge and attitude found a significant difference between boys and girls students in their sexual attitude. Male students were less open-minded than their female counterpart who was more progressive in their sexual attitude. The study indicated males were unsure (Martin and Mak, 2013).

In a qualitative study conducted in DR Congo among 224 adolescents between the ages of 15-24 in urban and rural areas on their attitude towards sexual and reproductive health found out that, adolescents have negative attitudes towards pregnancy due to the fear and its potential financial, social, educational, and health impact (Muenda et al., 2018).

Svensson, Baer and Silva (2019) study in Sweden among students found out that, respondents of the study were not in support of rape, sexual violence or coercion, and crimes resulting from sexual activity and as such had poor attitude. The study further concluded that, other kinds of sexual crimes which looked



confusing to students should further targeted into the educational policies (Svensson, Baer and Silva, 2019).

A community based study conducted by Ekpenyong and colleagues at Ikot Omin involving 115 adolescents on their STI knowledge and attitude found out that, adolescents have poor attitude towards STIs. In their study, they found out that, attitude was poor as only 24.4% of respondents felt that condom use protects against STI and 21.8% felt condoms should be worn during sexual intercourse (Ekpenyong et al., 2019).

An analysis of a secondary data of a cross-sectional knowledge, attitude and practice survey conducted among 3,011 boys and 3,214 girls adolescents in the Kassena-Nankana district on SRH in 2005. It was aimed at sex differences in STI prevention. Duong, Debpuur and Kahn (2008) found out that, males had positive attitude towards condom use than females. The study indicated that, males (70%) are likely to insist on condom use during intercourse and are confident about condom use as compared to females (61%) It was recommended that, there is the need for different education on STD prevention for difference sex (Duong, Debpuur and Khan, 2008).

In their institutional study, Ayalew et al., (2019) recruited 416 students (168 males, 248 females) to know their knowledge and attitude towards SRH rights and associated factors. Ayalew and colleagues found out that, 53.4% of the respondents had favourable attitudes towards SRH rights, however, the knowledge of students, their participation in reproductive and health clubs, and discussing sexual health issues with parents were predictors of attitude of students



towards SRH. The study concluded that, promoting talks with parents, involvement in SRH clubs may encourage attitude towards SRH (Ayalew et al., 2019).

Attitude formation is a result of learning, modelling others, and our experiences with people and situations. On the other hand, the favourable attitudes might have been formed by the foundation of knowledge, because attitude is formed over a lifetime through an individual's socialization process (Albarracin, Johnson and Zanna, 2014). In view of this, Santos, Ferreira and Ferreira (2018) found out that among young adults, the consistent use of condom is not as a result of knowledge but attitudes towards condom use. Thus, students forms adequate attitude independent of knowledge. The study also found out that although the association between attitudes and knowledge are positive, there is difference in sex. Men tend to have strong attitudes based on their knowledge on that SRH issue as compared to women men and women (Santos, Ferreira and Ferreira, 2018).

2.5.3 Sexual practice of students

A study by the Guttmacher Institute found out that, out of the 53 million adolescent in their late adolescents age in Sub-Saharan Africa, less than one-fourth (12.1 million) are sexually active and need contraceptives. The study further indicated that, 4.6 million of the 12.1million adolescents aged 15-19 are using modern contraceptives and the frequently used contraceptive was the condom accounting for 40%, then injectable and pills (Guttmacher Institute, 2017). The high patronage of condom usage among adolescents has also been



documented in a study in Northern Ghana by Yidana et al., (2015). Similar observation is made by Abma and colleagues in the United States where both males (76.8%) and females (97.5) most commonly used contraceptive is condom (Abma and Martinez, 2017). Eighty nine per cent (89%) of all modern contraceptive use among adolescents were pill and condoms (Biddlecom et al., 2018).

In their study on the factors that influence contraceptive use among adolescent girls and young women in South Africa, Makola et al., (2019) found out that more than three-fourth (78%) of the respondents uses some form of contraceptive. they further found out that contraceptive usage was influenced by secondary education, having sexual partner for more than five years and age of first sexual intercourse (15 years and above).

In the United States, Abma and colleagues conducted a study on the sexual activity and contraceptive use among adolescents aged 15-19 using data from the National Survey of Family Growth (2011-2015). They found out that 42.4% and 44.2% of females and males adolescents were sexually active, respectively. They further indicated that, use of contraceptives at first sexual debut among females (99.4%) is higher than males (83.6%). Males (16%) were found to have had their first sexual debut at the early adolescent years than females (11%) but at late adolescent ages, the probability is similar (Abma and Martinez, 2017). In a study Ghana, one-fourth (25%) of respondent have had sex and with majority (61%) of those who have had sex initiating intercourse at 10-17 years and the rest (39%) at age 18 years (Gadegbeku and Akoto-Bamfo, 2014).



In a qualitative study conducted in Jamestown, Ghana, Bain and colleagues interviewed thirty adolescents between 13-19 years who had ever been pregnant on their pregnancy decision making. They found out that adolescents had knowledge on contraceptives but none of the respondents was using any form of contraceptive before they became pregnant. The study further indicated that, adolescents who had ever had abortion performed it under unsafe condition. The use of concoction and other herbal medicine was used to perform abortion (Bain et al., 2019).

Kyilleh, Tabong and Konlaan (2018) conducted a qualitative study among in school and out of school adolescents aged 10-19 on their reproductive health knowledge and choice in West Gonja District in Northern region, Ghana. The study found out that respondents see having sexual partner an engaging in sexual intercourse as normal. And engaging in sexual intercourse was seen as a fertility test, assurance of love and bait for marriage and as a result the intercourse was unprotected. The study further found out that, adolescent engages in unsafe abortion practices by drinking concoction, inserting herbs into vagina and boiling pawpaw leaves to abort pregnancy (Kyilleh, Tabong and Konlaan (2018). The use of mixture of tablets, grinded bottles, Guinness drink were identified as local ways of aborting pregnancy in Jamestown (Bain et al., 2019).

Nyarko (2015) used data from the 2008 Ghana Demographic and Health Survey to know the contraceptive prevalence among female adolescent. The study found out that, female adolescent contraceptive usage was influenced by



education, knowledge of ovulation cycle, visit to a health facility, work status and marital status.

2.6 Views of Students and Teachers on Sexual Health Education

A Kenyan study among parents and teachers to know what they think about sexuality education and sexual infection screening of school going adolescents who are in school. The study results found out that, both teachers and parents were contented with their girls participating in research and being contacted by research teams by providing information to the girls in school through their meetings. Thus, there should be meetings with girls in schools to aid them to have information (Wanje et al., 2017).

In their study in Sweden, Tikkanen, Abellsson and Forsberg (2011) indicated that 20% of respondents aged 15-25 saw sexuality education as being upright. Sex education in schools was seen to be a source of information on contraception and STIs after the internet and youth friendly clinics for young people. However, this has changed over the period.

A review by Pound, Langford and Campbell (2016) among young people on their views and experience of sexuality education showed that schools have not done enough despite the importance of sex and relationship education (SRE). Students viewed sexuality education as making them embarrassed and feel unease, and it exposes their vulnerability. For instance, male students were reported as vulnerable and showed disturbing behaviour in class as a way to disguise their distress. Adolescents saw sex education as representing sexuality as



a matter to be taken care of and promote good behaviour. The study further found that schools found it difficult to believe some of the students are sexually active. Therefore, it was a private issue in adolescents' lives and they fail to talk over sexuality education. Pound et al., (2016) further iterated that adolescents in general, regarded their educators as not competent or qualified in teaching sex and relationship education. This was as a result of lack of training and their personal belief of being embarrassed to teach such topics. Students had no trust in teachers to maintain privacy and to an extent were thought to be influenced by their virtue and misjudge students based on diverse values. The respondents of the recommended that sex and relationship experts are to teach sex and relationship education. This group of people were viewed not all that judgemental, knowledgeable and better at providing education on relationship and sex (Pound et al., 2016).

In knowing how adolescents view sex education, Unis and Sällström (2019) conducted a qualitative study using a phenomenographic approach among 32 adolescents aged 18-19 years who are in their third year of upper secondary school in three communities in Sweden. The findings of the study showed many topics viewed as relevant by students were not taught in sex and relationship education classes. Such topics include sexual pleasure and desire and as a result students intend to look for theses information elsewhere. The study also opined that, SRE was viewed as a relevant subject due to its impact on the future lives on students. Therefore it was concluded that SRE must meet the needs and preference of students (McIntyre et al., 2015; Unis and Sällström (2019)). There



must be partnership between schools and health workers who students see as trustworthy source of knowledge to teach sex and sexuality education.

A study by Awusabo-Asare et al., (2017) found out that teachers and students are of the view that the content of what the teachers teach tend to be more reactive and focused primarily on abstinence. The emphasis on the idea that sexual relationships are dangerous and immoral for young people and should be delayed till they marry. The study also showed that, students expressed excitement about SRH education and 81% of students are of the view that they prefer teachers to use a more practical approach, creative, participatory learning activities and lectures (Awusabo-Asare et al., 2017). In a study in Bolgatanga, van der Geugten et al., (2015a) found out that students found SRH programmes important and interesting.

Using a secondary data from Guttmacher Institute and University of Cape Coast which involves 3002 students, 346 teachers, and 15 key stakeholders across three regions in Ghana; Greater Accra, Brong Ahafo And Northern Region, Esiah-Donkoh et al., (2017) found out that, students are of the view that sexuality education should be taught to prevent STIs (80.9%) and 75% for unwanted pregnancy. Esiah-Donkor and colleagues reiterated that, teachers and policy makers and implementers (70%) are of the view that abstinence was an important message to be emphasized in classroom as this is consistent with the content of the curricula and syllabi and this view is said to reflect societal beliefs and expectations Esiah-Donkor et al., (2017).



Kamuren, Kamara and Ntabo (2017) study among high school students in Eldoret Municipality in Kenya on how students perceive the essence of sexuality education among 325 students. It was reported that 79.4% of the respondents knew the essence of sexuality education and 64.3% were not in agreement with the belief that teaching sex education will expose them to engage in pre-marital sex. Students hold positive views and indications to embrace sex education in schools but were unsure if teachers are sufficiently ready to teach sex education (Kamuren, Kamara and Ntabo, 2017).

Powell and Selwyn (2007) in their studies found out that lessons taught in schools were widely criticized by young people as paying more attention to the biological aspect of sex and relationship and there is no participatory component. The study also indicates that young people see a decreasing commitment by sex and relationship education by teachers as they (young people) grows older (Powell and Selwyn, 2007). In another studies, Kimmel et al., (2013) found out that young people expressed their differing satisfaction with school based sexuality education as a result of feeling unease with the teaching methods and limited content covered. The study respondents identified trust and privacy, trustworthiness, and independence as the ideologies for youth-centered sexuality education (Kimmel et al., 2013).

2.7 Impact of Sexual Health Education Programmes

Sexuality education has a proven record of reducing adolescent risky sexual behaviours and promotes sexual health (Wellings et al., 2006). An



evaluation of 83 sexuality education programmes by Kirby et al., (2006) found sexuality education to positively affect the sexual behaviours of young people. Sex education programmes were considered important to adolescents irrespective of their nationality or where they live (World Bank Report, 2008). It has been identified as significant in reducing the risky sexual behaviours of adolescent in developing countries who are of school going age (Kirby, Obasi and Laris, 2006). Sexuality within European countries such as Switzerland and Netherland has shown to have led to reduction in teenage pregnancies and birth and sexually transmitted infections among individuals aged 10-19 years (UNICEF, 2001). This is not underestimating the importance of societal, family, cultural and health service factors which has also contributed to the low rates of STIs and teenage pregnancies among adolescents.

To know if sex education programme reduce the risky sexual behaviours of school going adolescents, Esere (2008) randomly sampled 24 school-going adolescents. It was found out that, there were substantial differences in at risk sexual behaviour of the two groups; treatment group and control group. There was increase in knowledge on sexual health among the treatment group after the intervention than the control group. The study concluded that, comparing both groups, the education intervention programme helped reduce at risk sexual behaviour in adolescents (Esere, 2008).

An evaluative study by van der Geugten and colleagues to know students' knowledge, attitude and behaviour on SRH before and after a reproductive health programme in Bolgatanga used a quasi-experiment and pre-post intervention



design among 312 students before and 272 students after the SRH programme. It was found out that, student's answered half of the SRH questions on the questionnaire before the programme and after the programme there was small but significant improvement in knowledge of students (Van der Geugten et al., 2015b)

In a cluster randomized control trial study in Northern Region of Ghana, Yakubu and colleagues sampled 363 adolescents aged of 13-19 from six randomly selected senior high schools (3 for intervention group and 3 for control group). At baseline of the study, there was no difference between knowledge and attitude of respondents on SRH issues. However, after the educational intervention, there was significant difference in sexual abstinence between control and intervention group (OR=13.89, 95% confidence interval (2.46-78.18, $P<0.003$). The study concluded that the intervention as guided by the Health Belief Model improved abstinence and the knowledge of adolescents on pregnancy prevention among intervention group (Yakubu et al, 2019).

In a community-randomized trial in the Upper East Region of Ghana, Aninanya et al (2015) randomly selected twenty six communities and grouped them into intervention and comparison group. A total 2,664 adolescents aged 15-17 were recruited at baseline into the study for a period of three years. The study results indicate that, participants who were exposed to school based curriculum, out of school outreach are more likely to use STI services, use perinatal services, and antenatal services as compared to those who are not exposed to school based curriculum and out of school outreaches (Aninanya et al., 2015). The study



concluded improved service utilization by young people. This approach was more effective than community mobilization and training of providers In youth friendly services provision only (Aninanya et al., 2015).

Lekshmi, Parel and Linsu (2018) conducted a pre experimental pilot study among school going adolescents at Andhra Pradesh, India to know the impact of SRH education. The study results showed that at baseline, knowledge of adolescents was between poor and good but after implementing educational programme, the knowledge level increased from poor to good and excellent. The study concluded that, there was significant difference between the pre and post-test level of knowledge regarding sex awareness (Lekshmi, Parel and Linsu, 2018).

2.8 Challenges Associated With Sexuality Education In Schools.

A study showed Canadian health teachers acknowledged they felt uncomfortable teaching sexuality education in the classroom and they therefore need assistance. They attributed this situation to not being support by parents, the community members and the school in which they teach. (Vamos and Zhou, 2009).

The factors influencing teachers' readiness to teach sexuality education and how they see sexuality education was studied by Cohen, Byers and Sears, (2012). It was reported that teachers identified several factors that serve as a barrier and preventing them from teaching sexual health education. These factors



make them not to have the zeal to teach sexual health education (Cohen, Byers and Sears, 2012).

Walker and Milton (2006) showed that teachers also had worries about their own beliefs and value system concerning sexuality and sexual health education. Teachers indicated they have doubt and feel ashamed to teach sexual issues with students. For instance, content of sex education topics is not suitable for certain age group as reported by basic school teachers. The teachers' willingness to talk about issues of sexuality education with students is affected by their inner and personal struggle that they have ever experienced. (Cohen et al., 2012). The two studies (Walker and Milton, 2006; Cohen et al, 2012) emphasized on the need for programmes to train teachers that would ease the worries they experience. Both studies iterated that teachers educational policies should be implemented that would help them to handle with the levels of distress they and students feels.

Mervyn (2012) studied the experiences teachers had gain over the years teaching sexuality education. The study reported that lack of resources and lack of training to help teachers in the aspect of teaching sexuality education were the challenges experienced by teachers. The study further reported that there was lack of collaboration between interested parties in the effective implementation of sexuality education programmes.

A review of literature also shown that how parents react is a major factor that hinders teachers desire to comfortably and competently teach sex education



to their students (Francis, 2010; Cohen, Byers and Sears, 2012). In one study, it was shown that there is much nervousness when sexuality issues are taught. As a result, teachers are of the fear that it might promote promiscuity and parents blamed them (Francis, 2010). Walker and Milton echoed this worry in their study when they indicated that teachers are really afraid parents may see them as being the ones polluting their kids with sexual ideas and fantasies once they are taught sexual issues. Thus, teachers are the perpetrators of the kids' bad sexual lifestyle (Walker and Milton, 2006). It was recommended that there should be partnership between the community leaders, family, parents and schools when introducing students to sexual health contents.

A study by Donkor and Lariba (2017) in Bawku on the impact of sex education on teenage pregnancy among 139 respondents found out that, all teachers who took part of the study identified teaching resources as a key challenge in teaching sex education. They reiterated that, sex education do not exist as a subject in the curriculum but rather integrated into other subjects such as integrated science, management in living, social studies and biology. Donkor and Lariba (2017) further found out that, other challenges such as sex education is limited in substance, lack of special skills by teachers in delivering sex education, and lack of curriculum to guide the teachers to effectively teach the subject.

Awusabo-Asare et al., (2017) on their nationwide study across three regions in Ghana; Greater Accra, Brong Ahafo and Northern region found out that, the main challenges reported by teachers as affecting the effective implementation of the school based sexuality education teaching materials and



lack of time. The study indicated that, fewer stated moral or religious contradictions, embarrassment, or opposition from the community or students. For students, it was found out that the challenge they face were embarrassment of asking questions about SRH, time constraints or fear that they will be shut down by teachers or students, and worry of offending someone Awusabo-Asare et al., (2017).

In examining the opinions of students and educators in Bolgatanga on SRH programmes, Van der Geugten and colleagues found out that barriers affecting the implementation of the programmes were traditional and cultural influences, lack of funding and poor scheduling of the programme within the schools (Van der Geugten et al., 201b).



CHAPTER THREE

GEOGRAPHY OF STUDY AREA AND METHODOLOGY

This chapter explains the study area study designs, the research approach, the kind and type of data to be collect and the instruments to use and the sample and sampling procedure. It also describes how the collected data can be analysed and the ethical issues associated with the study.

3.1 Study area

In 2004, the Tamale Municipal Assembly upgraded to a metropolitan through a legislative instrument (LI 2068). The metropolis is one of the six metropolitan assemblies in the country at present. Also, it is the only metropolis in the three regions in the north. Tamale is the metropolitan capital and also the regional capital of the Northern Region.

The Tamale Metropolis is located at the central part of the Northern Region. It is bounded by Mion District on the east, East Gonja on the South, Central Gonja on the South-west and Sagnarigu District the north and west. An estimated land size of 646.90180sqkm is considered to be the size of the metropolis (GSS-2010). The Metropolis lies between latitude 9°16 and 9° 34 north and longitudes 0° 36 and 0° 57 west, geographically.

The population of Tamale Metropolis, according to the United Nations World Population Prospects is projected to be 642,000 in 2020. There are more females (50.3%) than males (49.7%) in the metropolis (GSS, 2010). The metropolis has a broad base of the age pyramid. This is because, about 36% of the



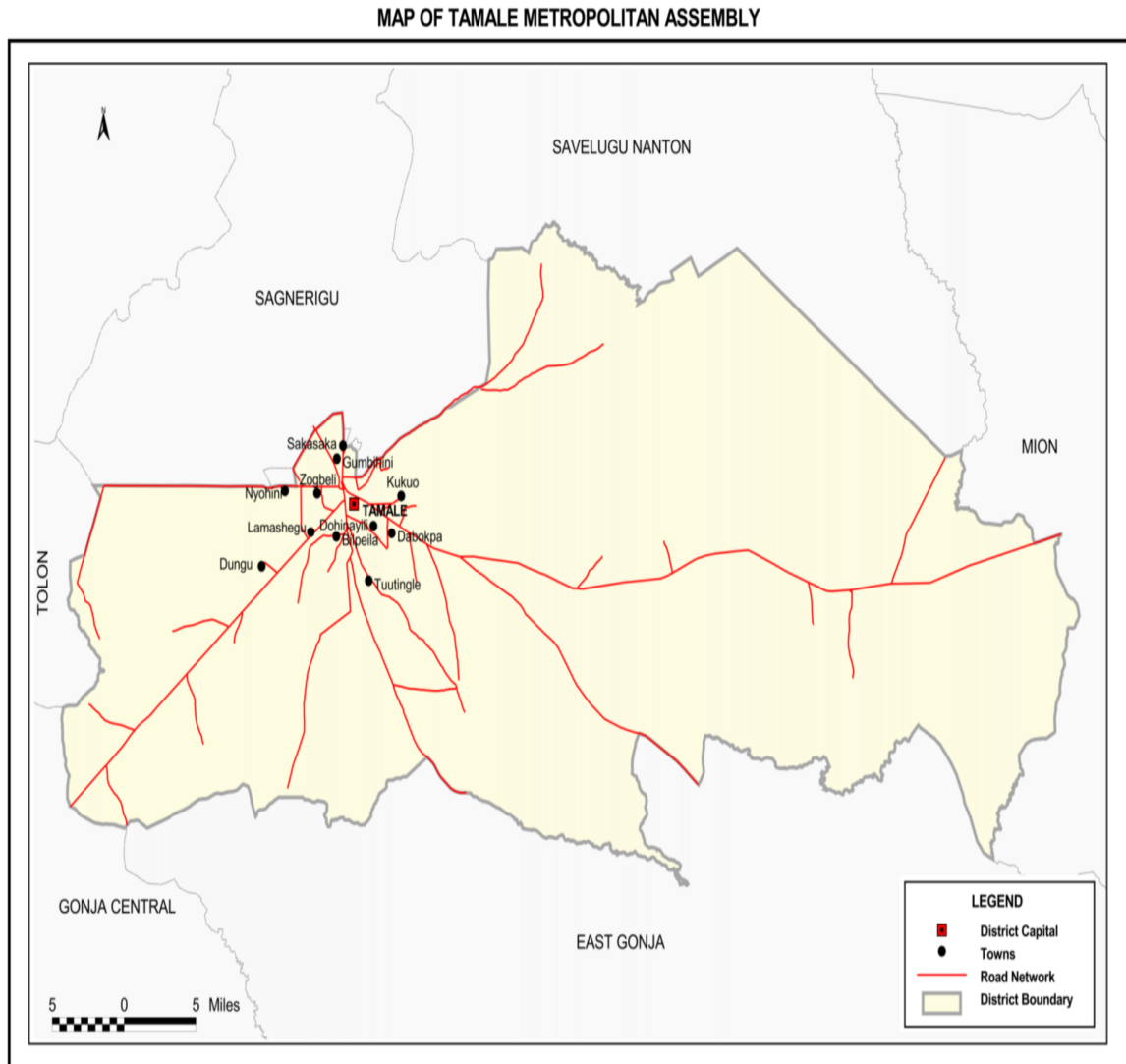
metropolis' population is below 15 years, making it youthful and less elderly (60 years and beyond) with the elder population representing 5.1%.

Due to its location, it is strategically known for its potential market for local goods from the commerce sectors and the agricultural sectors of neighbouring districts. This comparative advantage it has as compared to other neighbouring districts, the metropolis stands to benefit from the markets within the neighbouring countries such as Burkina Faso, Niger, Mali and the northern part of Togo within West Africa. Also, goods en-route to the southern sector of Ghana from these neighbouring countries passes through the metropolis

There are a number of private and government Secondary, Junior, Primary and kindergarten Schools in the metropolis. This has resulted in 60.1% of the population being literate and 39.9% illiterate. The proportion of male literates is 69.2% and females (51.1%) (Ghana Statistical Service, 2010).



Figure 3.1: Map of Tamale Metropolitan Assembly



3.2 Research design

Bell and Bryman (2007) contends that research design provides a structure for the collection and analysis of data. It is the blue print of the research and involves the plan to collecting and analysing information needed to answer research questions. It shows what the research aims to achieve and how to achieve it. The cross-sectional design was used for the study. This design was adopted because it helps in collecting information at a single point in time. Also, the design was chosen because the objective of the study was to assess knowledge, attitudes, practices, beliefs and views or perceptions and the cross-sectional design is useful in assessing these variables. Also, cross sectional design was chosen because it is relatively; easier to conduct, quick, saves time and less expensive as compared to longitudinal study design. Cross sectional is used in this study to provide snapshot of the variables at a specific point in time while the sample is a representation of the population.

3.3 Research approach

Research approach is defined strategies and actions of a study that extent the procedures from broad assumptions to a thorough ways of collecting data, analysing them and giving meaning to the analysed data (Creswell. 2013). A mixed method approach was adopted. For this approach, quantitative and qualitative data are collected and integrated thereby providing what Creswell (2014) term as a more complete meaning of a research problem than either approach alone. Creswell (2010) stated that mixed methods is more than simply the collection of two independent strands of quantitative and qualitative data.



Essentially, mixed methods involve the connection, integration, or linking of quantitative and qualitative data and intersection of both data strands.

The mixed method approach was employed because the weakness of one approach will be complemented by the other. Thus, the quantitative part of the study has a weakness of collecting data on the lived experiences of respondents due to its deductive or predetermined way of collecting data. This will be complemented by the qualitative data which collects data on individual lived experiences and values and qualitative data uses inductive form of reasoning as a complement to the deductive reasoning of quantitative approach.

Also, the qualitative data, which are mostly presented in quotes from interview, was complemented by quantitative data which are numeric. The qualitative data quotes were used to support the statistical findings of the quantitative data. The mixed method helped in triangulation of data, methods and others and evaluation was improved by complementing each other (qualitative and quantitative), errors related to each approach are lessened or corrected by the other and this helps in issues of validity and reliability.

3.4 Study population

The study population for the study was senior high school students and teachers within the Tamale Metropolis.

3.5 Sampling and sampling procedure

A multistage sampling technique was employed in the study. This technique can employ different sampling techniques at different stages of the



sampling process or selection process. Due to this, it provides a true representation of the study population.

First, senior high schools within the metropolis were clustered into private and public schools. Cluster A were the public schools and cluster B were the private schools. Three (3) schools were selected randomly from cluster A and two (2) were randomly selected from cluster B. In all, five (5) senior high schools within the Tamale metropolis were randomly selected for the study. During the data collection, data was collected from only three schools. The two private schools did not give the permission for the study to be conducted with one indicating the schools head teacher has travelled and will be back within two months' time. The other private school had no second years at the time of data collection and the final years were busy preparing for their final exam and there was no free period to collect data, as stated by the head teacher of the school. One of the public schools rescinded our request with no definite reason. The schools used for the study were, Vitting Senior High School, Ghana Senior High School (GHANASCO), and Business Senior High School (BISCO).

Secondly, after having the permission to collect the data from these schools, the classes were divided into group A and B. Group A were second year students and group B were third year students. A class from each year group was represented with the exception Ghana Senior High School which was represented by only second year students because the final year students were writing their mock exams during the time of data collection and they were not allowed by the school authorities to undertake the study.



Thirdly, classes were randomly selected from each year group using the lottery method. For each school, three classes were randomly selected for the study. A total of nine (9) classes from the three schools were used for the entire study. These classes were from General Science, General Arts, Business and Home Economics departments. All students in the selected classes formed the sample for the questionnaire administration.



Table 3.1 Representation of sample size for questionnaire administration

Schools		Programmes	Frequency	Total
Business Senior High School	Second year	Business	29	84
		Home economics	33	
	Third year	Science	22	
Ghana Senior High School	Second years	Home economics	33	91
		General arts	25	
		Home economics	33	
Vitting Senior High School	Second years	General arts	25	92
		Home economics	29	
	Third years	Home economics	38	
Total sample for questionnaire administration				267



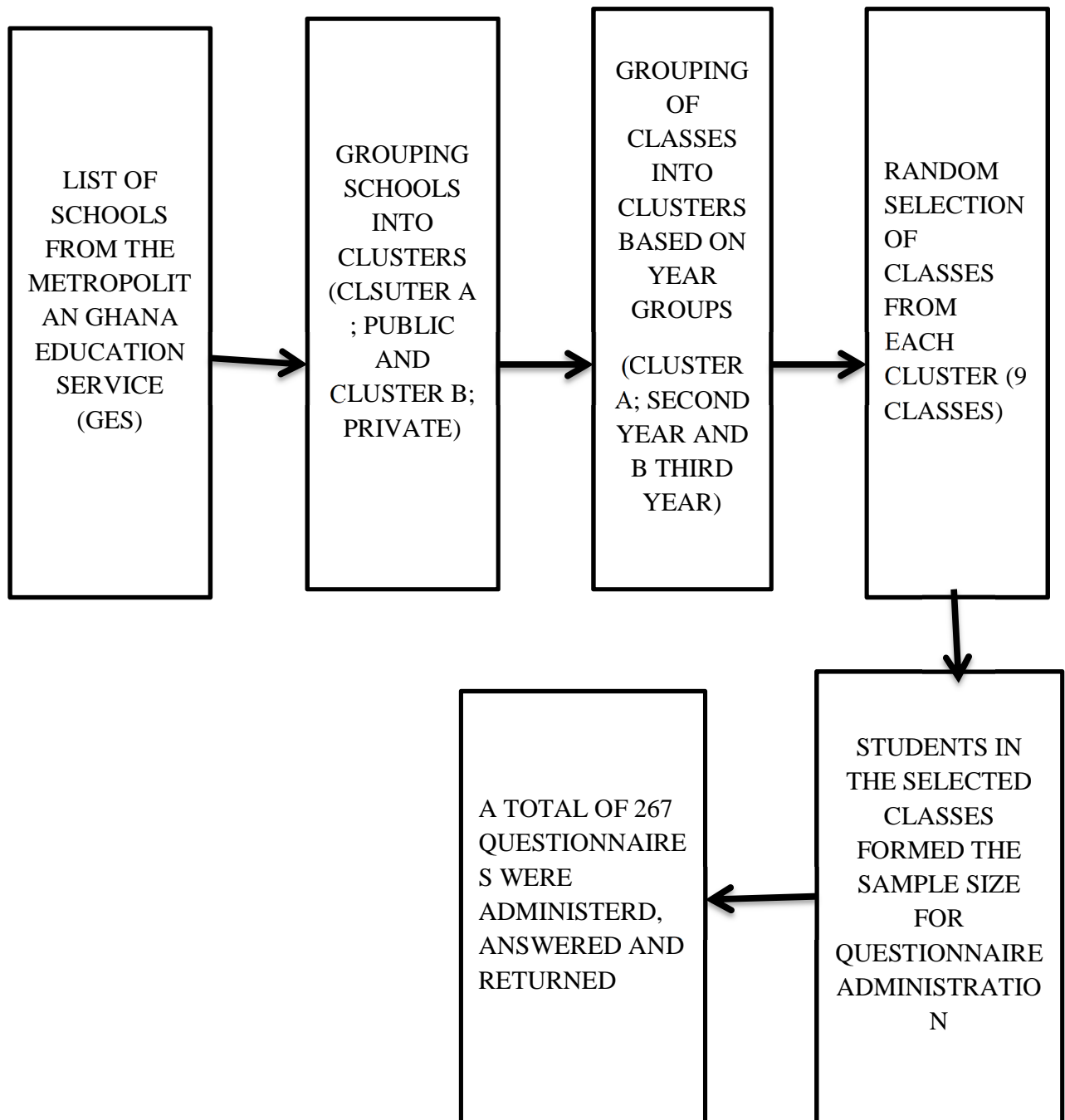
For the focus group discussion, two students were randomly selected from each class, making a total of six students. The six students are all participants who had already been selected for the individual questionnaire survey. This category of students were used because they were able to provide information which was not captured in the questionnaire since they have already answered questions in the questionnaire and know the issues which were not captured in the questionnaire. A total of three (3) focus group discussions were made, one (1) for each school. Each focused group was made up of six (6) respondents.

For the key informant interview, teachers who teach subjects, such as integrated science, management in living, social studies and biology were selected. This category of people was selected because sexuality education in Senior High Schools in Ghana has been integrated in the aforementioned subjects. And this category of people has the knowledge on the research topic and it is important to the study. Two teachers were selected from each school for the interview.

In all, a total of 273 respondents were used for the study. This was made up of 267 students' respondents who answered the questionnaires and 6 teachers who were interviewed. The six teachers were subject teachers of social studies, management in living and biology.



Figure 3: Diagrammatic Representation of the Sampling Procedure



Source: Authors construct 2020

3.6 Research instrument

Research instruments are the tools for data collection and are dependent on the type of problem under investigation (Chao, 2014). Creswell (2012) asserts that for one to consider the instrument to use, there needs to be a consideration of what the research aims to attain, since the strategy involved in data gathering and the data itself go a long way to inform what is to be found. Structured questionnaire was used to gather information from the students, for key informants, a semi structured interview guide was used to gather information, and focus group discussion to collect information from students. All the research instruments had informed consents attached to them and was written in English language.

A structured questionnaire was used to gather information from students and the questionnaire were self-answered by the students and self-administered by the researcher. It was designed in line with the objectives of the study. It was divided into four sections A, B, C and D. The first section, A collected information on the demographic characteristics of respondents, section B collected information on the knowledge, attitude and practice; section C collected information on views on sexuality education and section D collected information on challenges associated with sexuality education. Part of the questions was adopted from John Cleland's illustrative questionnaire for interview-surveys with young people and the Demographic and Health Survey of Ghana, 2014.



The semi-structured interview guide was used in interviewing students in a focused group discussion and teachers as key informants. A semi structured interview guide was used because of its flexibility nature. Thus, it allows the researcher to probe and know more about the issue and also identify new information which was not captured on the guide. It was developed in line with the objectives of the study. It captured information on views on sexuality education, knowledge, attitude and practice of sexuality education and challenges associated with sexuality education.

3.7 Data source

The study used two sources of data; primary and secondary. The primary data used information collected from questionnaire administration, and interviewing. The secondary data dealt with information which has already being published or available. These data can be obtained from books, articles, conferences, references, reports, periodicals, web, and records

3.8 Inclusion criteria

The study included all students within senior high school who are unmarried. This is because it is believed that they are not in formal sexual commitment relationship and are likely to delay sex if the education is really impactful. Also, the study included students in the second and third year because they have at least more than a year education and might have learned about certain sexual health topics whiles in school. For the teachers, due to the integration of sexual health education into subjects such as biology, management



in living, integrated science and social studies, teachers who teach these subjects qualify for the study.

3.9 Exclusion criteria

The study excluded all students who do not want to participate voluntarily. Also, all married students were exempted from the study and first year students as well. Teachers who do not teach integrated science, biology, social studies or management in living were excluded.

3.10 Pre-test of study instruments

The research instrument for the study was pretested within one of the school which was not selected for the study. This was done to correct all errors embedded in the research instrument.

3.11 Data processing and analysis

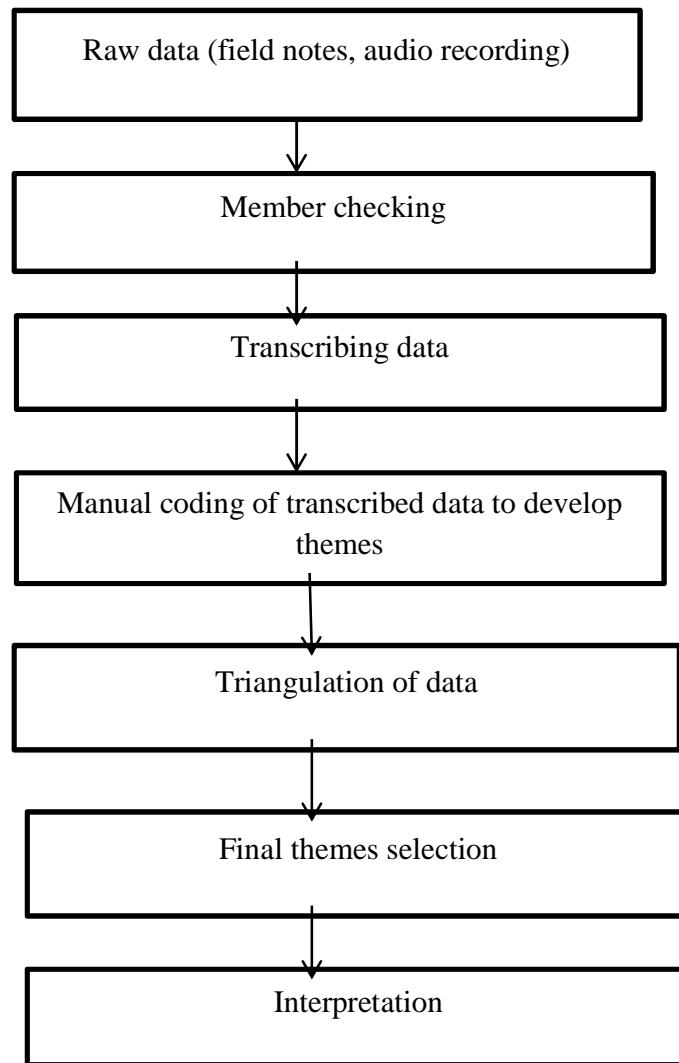
Data presentation and analysis for the quantitative data was with descriptive tools. The statistical analytic tools of percentages were used to provide a more comprehensive presentation for analysis and interpretation. Data collected was edited, encoded and analysed, and presented in the form of statistical tables, charts and graphs with the help of Statistical Package for Social Sciences (SPSS) version 25.0. A chi square analysis was performed to establish an association between the dependent and independent variables. A p-value of < 0.05 was considered statistically significant.



For the qualitative data, the interviews were audio taped recorded and field notes were taken. Member checking was done by letting respondents listen to the interview again after each interview to make clarification on what they said. The recorded interview was then transcribed. After transcription, each respondent was giving a pseudonym as a unique way of identifying them. Also, during the interview, field notes were taking with regards to facial expressions and other non-verbal reactions of respondents used as reference where necessary. The transcribed data was coded manually by the researcher using thematic analysis approach. The coding was done to develop themes from the transcribed data. At this stage, triangulation of the data was done to ensure its trustworthiness. Colleagues were allowed to listen to the interview and recode and develop common themes using thematic analysis. The themes were then compared and final selection was made and interpreted and also supported with quotes from the respondent's interview.



Figure 3.3: Diagrammatic Representation of Data Analysis and Handling of the Qualitative Data



Source: Authors construct

3.11.1 Reliability

Saunders et al., (2009) defines reliability as the extent to which your data collection techniques or analysis procedures will yield consistent findings. This



study made good use of Cronbach's alpha in the test for reliability. Cronbach's alpha is the most popular measure of true reliability of a survey Hinton et al, (2005). To achieve this test, it was imperative that, sources of information and empirical data were explicitly documented and referenced.

3.11.2 Validity

Validity refers to whether the results show and reflect the issue to be investigated. As a result of this, Saunders et al., (2009) argues, the relationship between two variables is not merely a causal relationship. Two types of validity were considered in the study; construct and face validity. Saunders et al., (2009) defines construct validity as the extent to which the variables to be measured by the operational measures are truly or really measured. This can be testified by evidence connecting the research questions and objectives to the collection of the data and the achievement of the objectives of the study. The research design was robust and comprehensive and as such, the variables to be measured ensured to be measured. According to Saunders et al., (2009), face validity measures the content of the concept for a research. The face validity of the study was performed during the pilot stage of the study. To ensure this, individuals with much knowledge and experience were contacted to for the design of the study and the design of the concepts to measure. It was then agreed that, the questions measured the concepts measured at the face level.



3.12 Ethical consideration

An introductory letter was obtained from the Department of Community Health and Family Medicine, School of Medical Sciences, University for Development Studies, Tamale to the Metropolitan Office of Ghana Education Service. The Ghana Education Service Regional office approved the study and permission letter was given to conduct the study. The permission letter from the Ghana Education Office was sent to the heads of all the selected schools to inform them about the study. The head teachers gave their permission to conduct the study in their school. Two schools resigned the offer.

Informed consent was sought from all participants and issue of anonymity and confidentiality was assured. The decision to participate in the study was made to participants as voluntary and they can stop when they wish to and also their responses were anonymous.



CHAPTER FOUR

RESULTS AND ANALYSIS

This chapter presents the results and analysis of the study based on the research questions. The background characteristics of respondents are also presented. The quantitative data are support with qualitative responses from responses through interview.

4.1 Socio-demographic characteristics of respondents

From Table 4.1 a total of 267 students answered the questionnaire with majority (90.6%) of them within the ages of 16-20 years with 5.6% and 3.7% within the ages of 21-25 and under 15 years respectively. With regards to gender of the respondents, 54.3% were females. Majority (80.1%) of respondents were Muslims and about one-fifth (19.9%) were Christian. The study was made up of second and third year SHS students. Majority (77.5%) of these students were second year students. Respondents were selected from different programmes within the schools. Home economics students (62%) constituted the majority, followed by General Arts with about 19% with General Science and Business been about 8% and 11% respectively.



Table 4.1 Socio-demographic characteristics of respondents

Variable	Frequency	Percentage (%)
Age		
< 15 years	10	3.7
16-20 years	242	90.6
21-25 years	15	5.6
Total	267	100
Gender		
Males	122	45.7
Females	144	54.3
Total	267	100
Religion		
Christian	53	19.9
Muslim	214	80.1
Total	267	100
Year group		
Second year	207	77.5
Third year	60	22.5
Total	267	100
Programme of study		
Home economics	166	62.2
General science	22	8.2
General arts	50	18.7
Business	29	10.9
Total	267	100



4.2 Knowledge, Attitudes and Practice of Sexual and Reproductive Health

4.2.1 Knowledge on sexual and reproductive health

Knowledge on sexual and reproductive health is very important because it influences one's attitude towards sexual health and sexual health practices. Through the focus group discussions of students and the in-depth interviews with teachers, students and teachers, knowledge on sexual and reproductive health were ascertained. Respondents indicated that, sexual and reproductive health covered issues of contraceptives, abortion, pregnancy and abortion. Respondents conceptualized sexual and reproductive health as:

Basically, it is about having knowledge on sex, the use of contraceptives, abortion and pregnancy
(Female Management in living teacher)

Another respondent indicated that, sexual and reproductive health concentrated on puberty, and basically developmental changes associated with boys and girls.

It is about puberty and its related things, for example, the start of puberty for adolescents and the need to be aware of certain changes that will occur to them and how probably to respond to it
(Male social studies teacher).



4.2.1.1 Knowledge on contraceptives

From the table 4.2, majority (95.5%) of respondents knew about contraceptives. Respondents had knowledge on the reason for using contraceptives.

Contraceptives help to prevent unwanted pregnancies and sexually transmitted infections (female student, FGD, 1).

Among these respondents, condom (98.8%) was the most heard contraceptive. About 54% of respondents had heard of emergency contraceptive pills. Pills and calendar method constituted 51% each. Withdrawal method was known by about 45% respondents and implant method was known by about 43% of respondents. The least heard contraceptive methods were intra uterine device (IUD) (23.1%) and Lactational amenorrhea method (14.9%). Respondents had this to say about the type of contraceptives ever heard about.

I have heard of condoms, emergency contraceptives, withdrawals errrm....I think these are the only three I know about (Female Student, FGD 2)

Condoms, postinor 2, Lydia (types of emergency contraceptives pills) are what I have heard about (male student, FGD 3).



Contraceptives such as condoms, the pills, vasectomy, IUD are the type of contraceptives we have (Female management in living teacher)

4.2.1.2 Knowledge of sexually transmitted infections (STIs)

The table further presents information on knowledge on sexually transmitted infections (STIs). All respondent (100%) had knowledge about STIs and had heard of at least one type of STIs and the signs and symptoms of STIs. Among the types of STIs, all (100%) respondent had heard about HIV and AIDs. Gonorrhea was known by 87% of respondents. Syphilis was 62.2% with over half (53%) of the respondents had heard of candidiasis. only 17.2% of the respondents had heard of chlamydia.

Respondents had knowledge on the different types of sexually transmitted infections. Respondents had knowledge about gonorrhoea, syphilis, HIV and AIDs and candidiasis.

For sexually transmitted infections, I know of syphilis, gonorrhoea, HIV and AIDs...I also know of white (candidiasis) but I don't know if it is part of the infections (Female student, FGD 1).

Respondents' knowledge on the signs and symptoms of STIs were also asked. About 78% of the respondents knew pain during urinating as a sign and symptom of STIs. Itching around the genitals was known by 67% and half (50.6)



knew of discharge from genitals as a sign and symptom of STIs. Nearly half (49.4) knew that sores on genitals was a sign and symptom of STIs.

For the signs and symptoms of sexually transmitted infections, respondents indicated that, for HIV and AIDS, the infected individual grew lean, lost appetite, and became weak. For gonorrhoea, syphilis and candidiasis, respondents indicated that some of the signs and symptoms were itching around genitals, discharges from the genitals with bad smell.

For HIV and AIDS, the person will grow lean and have less appetite (female student, FGD1)

...candidiasis there will be itching around the genitals, discharges from the genitals. The discharge has a bad smell so some people put on pad (female student, FGD 1)

A friend had gonorrhoea from his girlfriend...he told me that he feels pain in his penis when he is urinatingsomething like pepper in his penis (male student, FGD 3)



Table 4.2 Knowledge on Sexual and Reproductive Health

Variable	Yes (%)	No (%)	Total (%)
Ever heard of contraceptive	255(95.5)	12(4.5)	267(100)
Method of contraceptive ever heard (N=255)			
Condom	252(98.8)	3(1.2)	255(100)
Emergency contraceptive pills	137(53.7)	118(46.3)	255(100)
Injection	78(30.6)	177(69.4)	255(100)
Pills	130(51.0)	125(49.0)	255(100)
Withdrawal	114(44.7)	141(55.3)	255(100)
IUD	59(23.1)	196(76.9)	255(100)
Implants	110(43.1)	145(56.9)	255(100)
Sterilization	94(36.9)	161(63.1)	255(100)
Calendar method	130(51.0)	125(49.0)	255(100)
Lactational amenorrhea method	38(14.9)	217(85.1)	255(100)
Ever heard of STI	100 (267)	0(0.0)	267(100)
Type of STI ever heard (N=267)			
Gonorrhea	233(87.3)	34(12.7)	267(100)
Syphilis	166(62.2)	101(37.8)	267(100)
Chlamydia	46(17.2)	221(82.8)	267(100)
Candidiasis	142(53.2)	125(46.8)	267(100)
HIV and AIDs	249(100.0)	(0.00)	267(100)
Signs and symptoms of STIs			
Pain during urinating	208(77.9)	59(22.1)	267(100)
Sores on genitals	132(49.4)	135(50.6)	267(100)
Discharge from genitals	135(50.6)	132(49.4)	267(100)
Itching of genitals	179(67.0)	88(33.0)	267(100)



4.2.1.3 Knowledge on abortion

Respondents knew about abortion. It was indicated by respondents that; individuals performed abortion as a result of unwanted pregnancy or the fear of school dropout. A respondent had this to say:

Maybe if a girl has unprotected sex and it leads to pregnancy, the girl would like to terminate the pregnancy because she is still schooling and she doesn't want to be a school dropout (female student, FGD2).

Respondents had knowledge about safe abortion and the conditions under which one could abort a pregnancy. They reiterated that; they would recommend one to go in for abortion if only the child posed as a risk to the health of the mother.

The only time I will advise someone to go in for abortion is if the health of the mother is at risk. The person might die with the baby or during delivery, for that I will advise her to go for abortion (female student, FGD1).

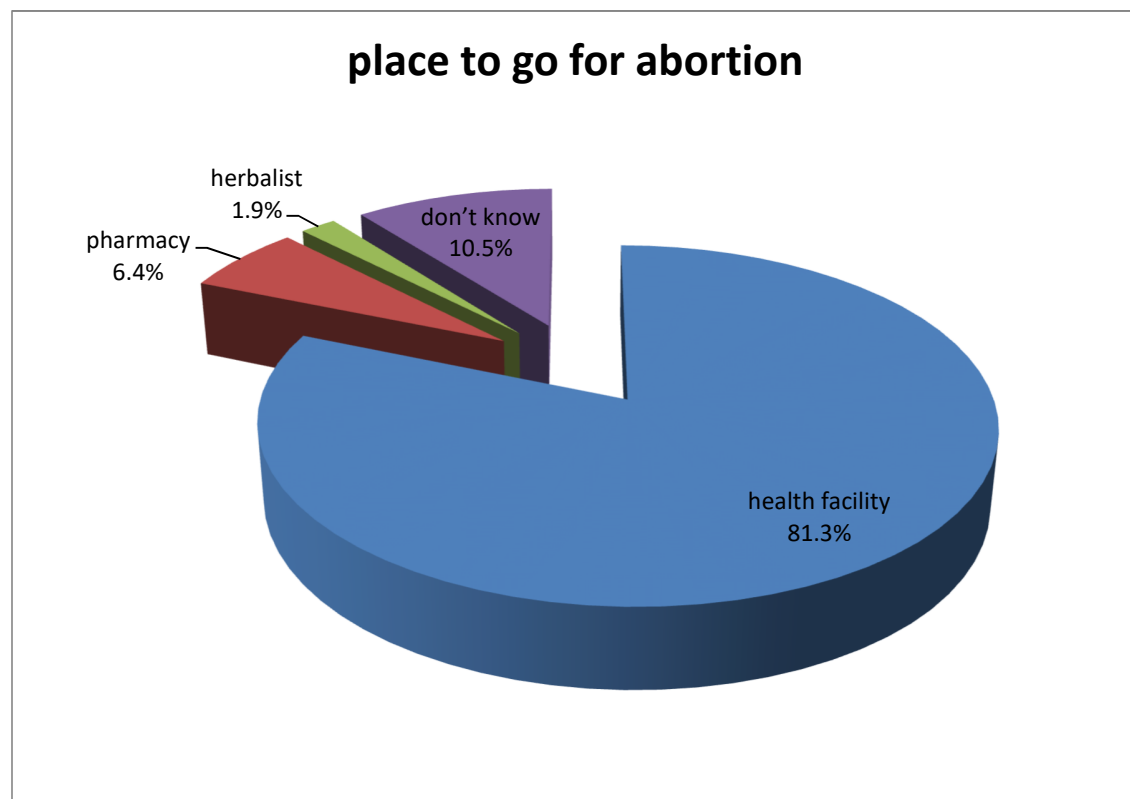
4.2.1.4 Knowledge on place of abortion

Knowledge on the place for abortion among respondents was ascertained.

Majority (81.3%) of respondents identified the health facility as the place to go for abortion and this was followed by pharmacy (6.4%). About 11% of respondents didn't know where to go for abortion.



Figure 4.1: knowledge on place of abortion

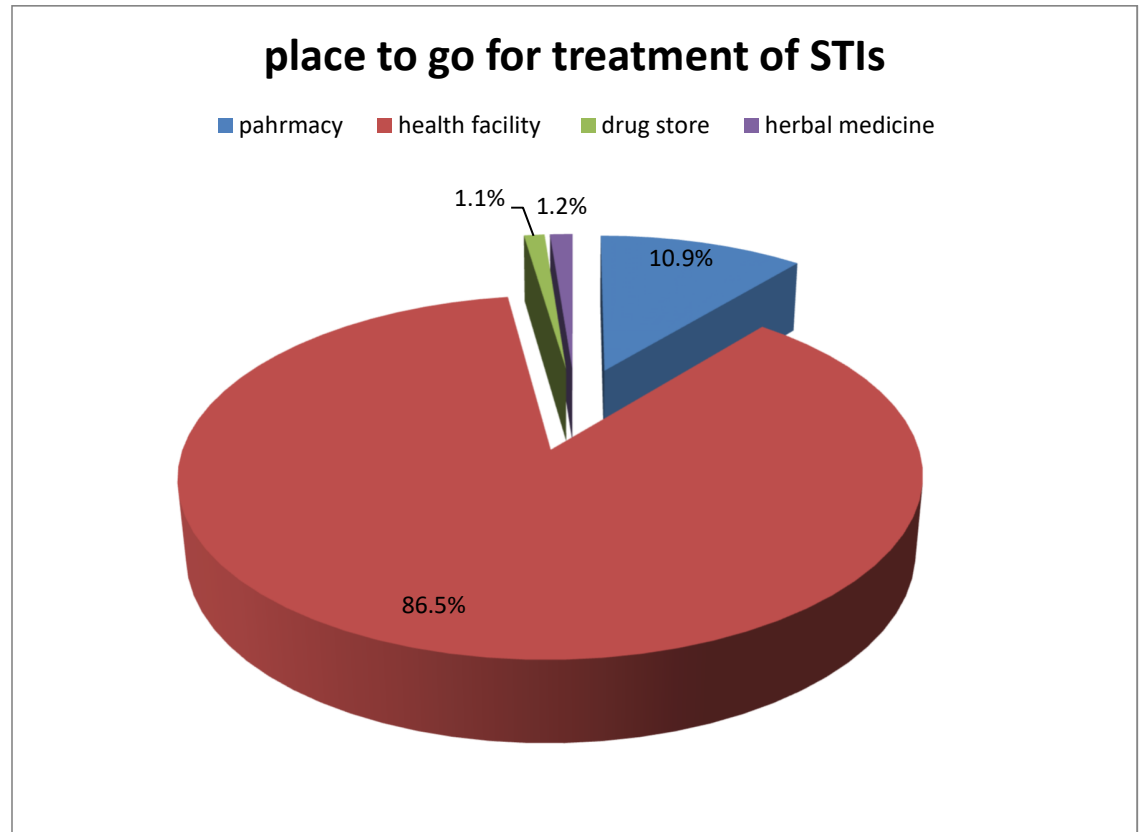


4.2.1.4 Place to go for treatment of sexually transmitted infections (STIs)

The study investigated the knowledge on the place to go for treatment when infected with STIs. About 87% of respondents identified health facility as the place they would seek for treatment when infected with STI. About 11% chose the hebalist as the place for treatment of STI.



Figure 4.2: Place to go for treatment of sexually transmitted infections (STIs)



4.2.2 Practice of Sexual and Reproductive Health

From table 4.5 below, 22.1% of respondents had ever used contraceptive and 77.9% of the respondents had not used any form of contraceptive. Among those who had ever used contraceptive, condom(67.8%) was the most used contraceptive. About 41% of respondents had ever used an emergency contraceptive pill. About 29% and 14% of respondents had ever used withdrawal method and injections respectively. Pills and implants made up 5.1% each. Intra



uterine device (IUD), sterilization, lactational amerrhoea method and calendar method were other methods which were not used by respondents.

For the use of contraceptives, respondents indicated that, condoms were used to prevent pregnancies and STIs and it was inserted in the vagina or placed on the penis. And emergency contraceptives were taken after sexual intercourse to prevent fertilization of eggs.

Frankly speaking I have never used it but from what I have heard, you put it on before having sex and immediately after sex you remove it and throw it away. It prevents unwanted pregnancy and STIs (female student, FGD 3)

The emergency contraceptive is used when you have unprotected sex...it is like a medicine then you take it so may be if there is going to be any fertilization it will stop it (female student FGD 2)

The study further investigated whether respondents had ever experienced any signs and symptoms of STIs. The most (40.1%) common signs and symptoms ever experienced by respondents was itching around genitals. Twenty seven per cent (27.0%) of respondents had ever experienced pain during urinating as a sign and symptom of STIs. Sores on genital organ and discharge from genitals had been experienced by 13.1% and 16.5% of respondents respectively.



Table 4.3 Practice of Sexual and Reproductive Health

Variables	Yes (%)	No (%)	Total (%)
Ever used contraceptive	59(22.1)	208(77.9)	267(100)
Type of contraceptive ever used			
(N=59)			
Condom	40 (67.8)	19(32.2)	59(100)
Emergency contraceptive	24(40.7)	35(59.3)	59(100)
Injections	8(13.6)	51(86.4)	59(100)
Pills	3(5.1)	56(94.9)	59(100)
Withdrawal	17(28.8)	42(71.2)	59(100)
IUD	0	59(100)	59(100)
Implants	3(5.1)	56(94.9)	59(100)
Sterilization	0	59(100)	59(100)
Calender method	0	59(100)	59(100)
Lactational amerrhoea method	0	59(100)	59(100)
Ever experienced signs and symptoms of STIs			
Pain during urinating	72(27)	195(73)	267(100)
Sore on genital organ	35(13.1)	232(86.9)	267(100)
Discharge from genitals	44(16.5)	168(59.9)	267(100)
Itching around genitals	107(40.1)	18(67.4)	267(100)



4.2.2.1 Abortion practices

It was indicated by respondents that individuals used various ways and means to get rid of their pregnancy. The methods included the use of energy drinks, herbal medicines, grinded bottles mixed with drink, and coffee.

I have heard of people's mixing coffee with energy drinks, others also mixed powdered broken bottles to food or drink and taking it (female students, FGD2)

People mix herbal medicines in "duula" and insert in their anus to terminate pregnancies (male student, FGD 3)

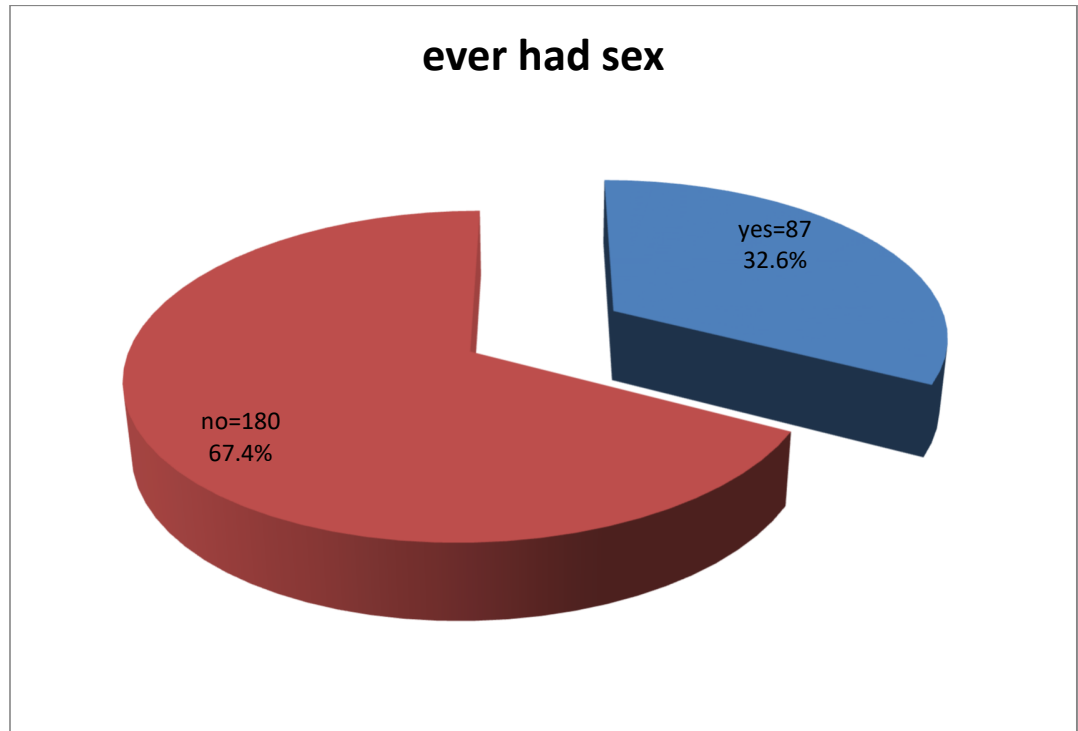
A friend went to the drug store and bought a drug called megaborn and mefaborn. She abused those drugs and also postinor 2. She said it will destroy the pregnancy (female student, FGD 1)

4.2.2.2 Ever had sex

The sexual practices of respondents was ascertained to know the percentage of respondents who had ever had sexual intercourse. It was found out that, about one-third(32.6%) of respondents had ever had sex while 67.4% of the respondents had never had sex.



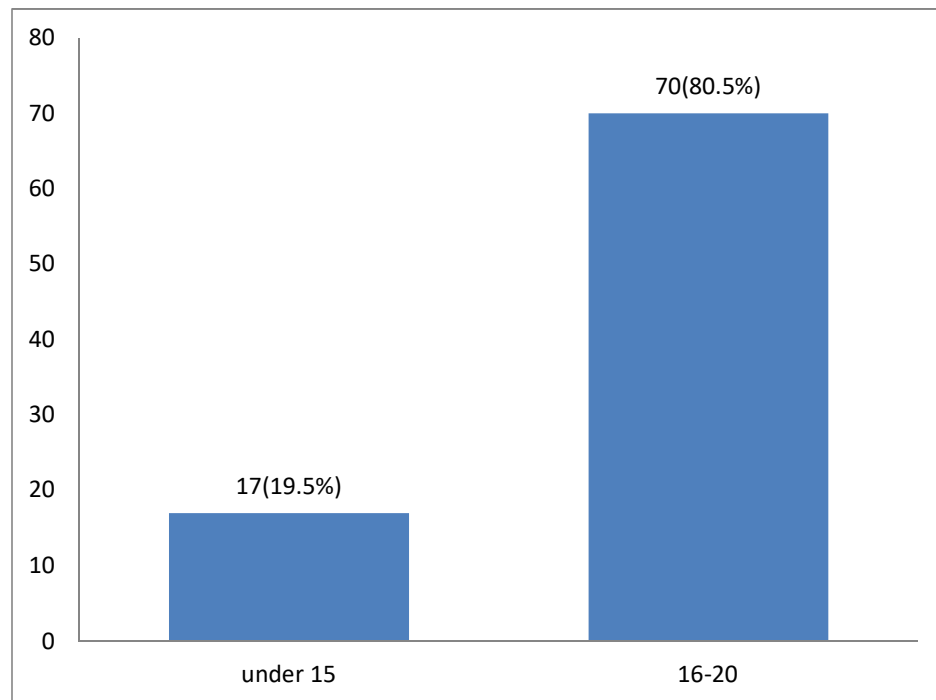
Figure 4.3 Ever had sex



4.2.2.3 Age at intercourse

Among those who had ever had sex, majority (80.5%) had their first sexual intercourse at age 16-20 years and 19.5% of them had their first sexual intercourse at age 15 years or younger.

Figure 4.4 :Age at first intercourse



4.2.2.4 Age at first sexual intercourse by gender of respondents

From table 4.6, among those who had ever had sex, more than half (51.7) were females and 48.3% were males. With regards to age at intercourse, majority (64.7%) of males who had ever had sex had their first sexual intercours at age 15 and below as well as 35.7% of females who had ever had sex. More than half of females (55.7%) who had ever had sex had their first sexual intercourse at age 16-20 years with 44.3% of males had their first sexual intercourse within the same age range. The median age at intercourse for both males and females is 17years.



Table 4.4: Age at first sexual intercourse by gender of respondents

Variables	Males (%)	Females(%)
Ever had sex	42(48.3)	45(51.7)
Age at intercourse		
Under 15	11(64.7)	6(35.3)
16-20	31(44.3)	39(55.7)
Median age at intercourse	17.0	17.0

4.2.3 Attitudes towards sexual and reproductive health

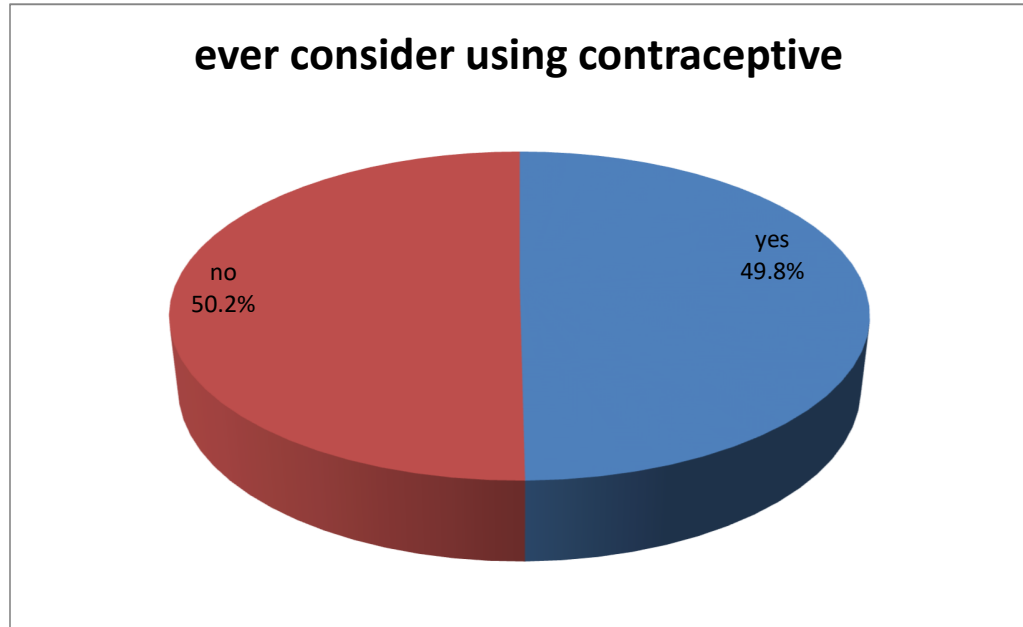
4.2.3.1 Ever consider using contraceptive

The study sought to know the attitudes of respondents towards contraceptives. Nearly half (49.8%) indicated they would consider using contraceptive in their life. Respondents indicated that, they would use contraceptives if they get married

for me I will not use contraceptive even if I get married. my religion goes against that (female FGD 2)



Figure 4.5: Ever consider using contraceptive



From table 4.10, over half (51%) of respondents agreed to the effectiveness of condom preventing pregnancy and STIs even though about 72% knew it was not hundred per cent safe and could split. About 63% were in support of the misconception that contraceptive could cause infertility. Majority (61.4%) of respondents indicated they would not go in for abortion when pregnant and 80.5% were not in support of unsafe abortion with 91.0% agreeing that unsafe abortion could lead to serious health consequences. That is; respondents had negative attitudes towards unsafe abortion. About 90% had negative attitude to sexual intercourse due to the fear of becoming pregnant and dropping out of school.



Table 4.5: Attitude towards Sexually and Reproductive Health

Statements	Agree (%)	Don't know (%)	Disagree (%)	Total (%)
Condoms are not effective ways of preventing HIV and AIDS and pregnancy	80 (30.0)	50(18.7)	137(51.3)	267(100)
Contraceptives can cause infertility	167 (62.5)	69 (25.8)	31 (11.6)	267(100)
STIs do not need treatments, they can go on their own	14 (5.2)	39 (22.1)	194(72.7)	267(100)
Women are responsible for contraceptive use	97 (36.3)	71 (26.6)	99 (37.1)	267(100)
I will go in for abortion if I become pregnant while in school	59 (22.1)	44 (16.5)	164(61.4)	267(100)
Abortion is safe when you perform it by yourself	19(7.1)	33(12.4)	215(80.5)	267(100)
Parent are the best source of sexual and reproductive health information	173(64.8)	33(12.4)	61(22.8)	267(100)
Condom can split and cause pregnancy	204(76.4)	39(14.6)	24(9.0)	267(100)
A woman can get pregnant on her first sexual intercourse	217(81.3)	31(11.6)	19(7.1)	267(100)
Pregnancy will lead to school drop out	239(89.5)	10(3.7)	18(6.7)	267(100)
Unsafe abortion can lead to serious health consequences such as death	243(91.0)	11(4.1)	13(4.9)	267(100)



4.2.1.5 Bivariate analysis of respondents socio demographic characteristics and knowledge on contraceptives

A bivariate analysis performed between the socio demographic characteristics of respondents and their knowledge on contraceptive. Respondents within the age group of 16-20 (95.9%) were more likely to have heard about contraceptives as compared to their colleagues within the ages of 21-25 (93.3%) and below 15 years and below (90%). The relationship between age of respondents and knowledge on contraceptive was not significant ($P < 0.60$).

Knowledge on contraceptive differ by gender. Females (97.9%) were more likely to have knowledge about contraceptive as compared to males (92.6%). The relationship between the sex of respondent and knowledge on contraceptive was significant ($p < 0.04$). Therefore, the gender of respondents had influence on their contraceptive knowledge.

For religion, Muslims (95.8%) were more likely to have knowledge on contraceptive as compared to Christians (94.3%). The relationship between religion and knowledge on contraceptives was not significant ($p < 0.60$). Thus, religion did not influence an individual's knowledge on contraceptives.

Third year students (96.7%) were more likely to have knowledge on contraceptive compared to second year students (95.2%). The relationship between year group and knowledge on contraceptive was not significant ($p < 0.60$).



General science students (100%) were more likely to have knowledge on contraceptive as compared to Home Economic students (95.8%), General Art students (95.2%), and Business students (92.0%). The relationship between programme of study and knowledge on contraceptive was not significant ($p < 0.40$).

Table 4.6: Bivariate analysis of respondents socio demographic characteristics and knowledge on contraceptives

Variables	N=(267)	Ever heard of contraceptive	
		Yes (%)	No (%)
Age			X^2 (P-value)
< 15 years	9(90.0)	4(10.0)	0.945(0.623)
16-20 years	232(95.9)	10(4.1)	
21-25 years	14(93.3)	1(6.7)	
Gender			4.349(0.037)
Males	113(92.6)	9(7.4)	
Females	142(97.9)	3(6.5)	
Religion			0.209(0.647)
Christian	50(94.3)	3(5.7)	
Muslim	205(95.8)	9(4.2)	
Year group			0.243(0.622)
Second year	197(95.2)	10(4.8)	
Third year	58(96.7)	2(3.3)	
Programme of study			2.829(0.419)
Home economics	159(95.8)	7(4.2)	
General science	29(100)	0(0)	
General arts	21(95.5)	1(4.5)	
Business	46(92.0)	4(8.0)	



4.2.1.6 Bivariate analysis of respondents socio demographic characteristics and knowledge on STIs

From table 4.4 below, all respondents (100%) 15 years and below and 21-25 years (100%) had knowledge on STIs and 98.8% of those within 16-20 years had knowledge on sexually transmitted infection. The association between respondents age and knowledge on STIs was not significant ($p < 0.80$). That is, age did not influence one's knowledge on STIs.

Knowledge on STIs by gender was also determined. Females (100%) had more knowledge on STIs than males (97.5%). The association between sex of respondent and knowledge on STIs was not significant. Knowledge on STIs was not influenced by the sex of an individual.

From the table, Christians (100%) were more likely to have had knowledge on STIs as compared to Muslims (98.6). association between religion and knowledge of STI was not significant ($p < 0.30$). Religion did not determine ones knowledge on STIs.

For year group, all (100%) third year students had knowledge on STIs while 98.6% of second years had knowledge on STIs. The association between year group and STIs knowledge was not significant.

For programme of study, business students (100%) had more knowledge on STI than home economics (99.4%), general science (98.0%), and general arts (95.5%). Programme of student did not influence ones knowledge on STIs.



Table 4.7: Bivariate analysis of respondents socio demographic characteristics and knowledge on STIs

Variables	N=(267)		knowledge on STIs	χ^2 (P-value)
	Yes (%)	No (%)		
Age				0.313(0.855)
< 15 years	10(100.0)	0(0)		
16-20 years	239(98.8)	3(1.2)		
21-25 years	15(100.0)	0(0)		
Gender				3.606(0.058)
Males	119(97.5)	3(2.5)		
Females	145(100)	0(0)		
Religion				0.751(0.386)
Christian	53(100.0)	0(0)		
Muslim	211(98.6)	3(1.4)		
Year group				0.879(0.348)
Second year	204(98.6)	3(2.3)		
Third year	60(100.0)	0(0)		
Programme of study				3.400(0.334)
Home economics	165(99.4)	1(0.6)		
General science	49(98.0)	1(2.0)		
General arts	21(95.5)	2(4.5)		
Business	29(100.0)	0(0)		



4.2.2.5 Bivariate analysis of respondents socio demographic characteristics and ever had sex

From table 4.7, 40% of respondents within 21-25 years had ever had sex and 33.5% of those within 16-20 years had also had sex. For respondents 15 years and below, none (0%) had ever had sex. The association between age and ever had sex was not significant. That is, sexual intercourse was not influenced by age.

Also, 34.4% of males had ever had sex as compared to 31% of females. Engaging in sexual intercourse was not influenced by the gender of respondent.

For religion, 37.7% of Christians had ever had sex and 31.3% of Muslims had also had sex. The association between religion and ever had sex was not significant. That is, religion did not influence sexual practice.

For year group, 46.7% of third year students had ever had sex and 28.5% of second year students had also ever had sex. The association between year group and ever had sex is significant ($p < 0.01$). Year group or level influenced sexual activity.

For programme of study, business students (37.9%) were more likely to engage in sex as compared to other students in home economics (35.5%), general science (28.0%), and general arts (13.6%).



Table 4.8 Bivariate analysis of respondents socio demographic characteristics and ever had sex

Variables	N=(267)	EVER HAD SEX	
		Yes (%)	No (%)
Age			5.295(0.071)
< 15 years	0(0)	10(100.0)	
16-20 years	81(33.5)	161(66.5)	
21-25 years	6(40.0)	9(60.0)	
Gender			0.347(0.556)
Males	42(34.4)	80(65.6)	
Females	45(31.0)	100(69.0)	
Religion			0.799(0.371)
Christian	20(37.7)	33(62.3)	
Muslim	67(31.3)	147(68.7)	
Year group			6.987(0.008)
Second year	59(28.5)	148(71.5)	
Third year	28(46.7)	32(53.3)	
Programme of study			5.113(0.164)
Home economics	59(35.5)	107(64.5)	
General science	14(28.0)	36(72.0)	
General arts	3(13.6)	19(86.4)	
Business	11(37.9)	18(62.1)	

4.2.2.6 Association between ever used contraceptive and ever had sex

From table 4.8, 59.8% of those who had ever had sex had ever used one type of contraceptive and 40.2% had ever had sex but had not used any form of



contraceptive. The association between contraceptive usage and having sex is significant ($P < 0.01$).

Table 4.9: Association between ever used contraceptive and ever had sex

Variables	N=(267)	Ever used contraceptive	
	Yes (%)	No (%)	χ^2 (P-value)
Ever had sex			106.395(0.000)
Yes	52(59.8)	35(40.2)	
No	7(3.9)	173(96.1)	

4.2.2.7 Bivariate analysis of respondents socio demographic characteristics and ever used contraceptive

From table 4.9, 33.3% of respondents within the age group of 21-26 years had ever used contraceptive and 22.3% within the 16-20 age group had ever used contraceptive. for the respondents 15 years and below, none (0%) had ever used contraceptive.

From the table, males (22.1%) and females (22.1%) had ever used contraceptive. The association between contraceptive usage and gender of respondents was not significant. Use of contraceptive was not influenced by sex.

For religion, Christians (28.3%) had ever used contraceptive and 20.6% of Muslims had also ever used contraceptive. Use of contraceptive was not influenced by the religion of respondent.



The year group had no association with contraceptive usage ($p < 0.30$). Third years (26.7%) had ever used contraceptive and second years (20.8) had ever used contraceptive.

Home economics students (25.9%) had ever used contraceptive as compared to general science (18.0%), business (17.2%), and general arts (9.1%). There association between contraceptive usage and programme of study was not significant.



Table 4.10: Bivariate analysis of respondents socio demographic characteristics and ever used contraceptive

Variables	N=(267)		Ever used contraceptive
	Yes (%)	No (%)	
Age			3.943(0.139)
< 15 years	0(0)	10(100.0)	
16-20 years	54(22.3)	188(77.7)	
21-25 years	5(33.3)	10(66.7)	
Gender			0.000(0.990)
Males	27(22.1)	95(77.9)	
Females	32(22.1)	113(77.9)	
Religion			1.479(0.224)
Christian	15(28.3)	38(71.7)	
Muslim	44(20.6)	170(79.4)	
Year group			0.939(0.333)
Second year	43(20.8)	164(79.2)	
Third year	16(26.7)	44(73.3)	
Programme of study			4.444(0.217)
Home economics	43(25.9)	123(74.1)	
General science	9(18.0)	41(82.0)	
General arts	2(9.1)	20(90.9)	
Business	5(17.2)	24(82.8)	

4.2.3.2 Bivariate analysis of respondents socio demographic characteristics and attitudes towards contraceptives

From table 4.11, majority (66.7%) of respondents aged 21-25 years had intentions of using contraceptive and half (50%) of the respondents 15 and below considered



using contraceptive. Less than half (48.8%) of respondents 16-20 years also considered using contraceptive.

Majority of males (61.5%) had the intention of using contraceptive as compare to females (40%). The association between gender of respondents and ever considered using contraceptive was significant ($p < 0.01$).

More than half (58.5%) of Christians considered to have ever used contraceptive as to Muslims (47.7%).

For the year group, over half (53.3%) of third year students considered using contraceptives in their life as to second years (48.8%).

For programme of study, the intention to ever use contraceptive was higher (68.0%) among general science students as compared to general arts students (59.1%), business students (48.3%) and home economics students (43.4%). The association between programme of study and intention to ever use contraceptive was significant ($p < 0.02$).



Table 4.11 Bivariate analysis of respondents socio demographic characteristics and attitudes towards contraceptives

Variables	N=(267)	Ever consider using contraceptive	
		Yes (%)	No (%)
Age			χ² (P-value)
< 15 years	5(50.0)	5(50.0)	1.812(0.404)
16-20 years	118(48.8)	124(51.2)	
21-25 years	10(66.7)	5(33.3)	
Gender			12.223(0.000)
Males	75(61.5)	47(38.5)	
Females	58(40.0)	87(60.0)	
Religion			1.992(0.158)
Christian	31(58.5)	22(41.5)	
Muslim	102(47.7)	112(52.3)	
Year group			0.384(0.536)
Second year	101(48.8)	106(51.2)	
Third year	32(53.3)	28(46.7)	
Programme of study			10.154(0.017)
Home economics	72(43.4)	94(56.6)	
General science	34(68.0)	16(32.0)	
General arts	13(59.1)	9(40.9)	
Business	14(48.3)	15(51.7)	



4. 3 Source of Information On Sexual And Reproductive Health

From table 4.9 below, 47.6% indicated that, their mother was the most important source of information for them with regards to sexual and reproductive health. The next most important source was friends (17.2), followed by sister (8.2%), school teacher (6.7%), brother (6.7%), father (6.4%), doctors (4.1%), books (2.2%), and Fims/videos/media (0.7%).

For the preferred source of information on SRH, 41.9% of the respondents preferred their mothers as source of sexual and reproductive information, followed by friends (12.4%), father (11.6%), school teacher (10.5%), sister (10.1%), brother (6.4%), doctor (4.5%), books (1.5%), and Fims/videos/media (0.7%).

Table 4.12 Source of information on sexual and reproductive health

Source	Most important (%)	Preferred (%)
School teacher	18(6.7)	28(10.5)
Mother	127(47.6)	112(41.9)
Father	17(6.4)	31(11.6)
Brother	18 (6.7)	17(6.4)
Sister	22 (8.2)	27(10.1)
Friends	46(17.2)	33(12.4)
Doctors	11 (4.1)	12(4.5)
Books	6(2.2)	4(1.5)
Fims/videos/media	2 (0.7)	2(0.7)
Others	0(0)	1(0.4)
Total	267 (100)	267(100)



4.4 Perceptions on Sexuality Education

On their views on sexuality education, respondents indicated that teaching of sexuality education in schools was very important because it would help them to prevent STIs, unwanted pregnancy, control their sexual desires, increase their knowledge on contraceptive usage and reduce the ignorant level of students with regards to sexual and reproductive health issues.

The views of students on sexual health education were asked. Statements about sexuality education was asked and students were to agree, disagree or not sure/don't know about the statements. Majority (94%) of students agreed to the statement that sexuality education helps them to have knowledge about STIs prevention. Respondent indicated that, as students they lacked knowledge on sexual and reproductive health issues especially sexually transmitted infections and with them having education on that, they would know how to prevent it.

....it is very necessary to learn about sexuality education in school because like as we are in a mixed school, some of us the girls we are lacking knowledge and if you don't know much about sexual and reproductive health, for example the candidiasis for instance, some of us didn't know it was a sexually transmitted infection so now that we know you will know the means and ways of preventing it (female student, FGD 2)



With regards to issue of sexuality education promoting promiscuity, 43.1% of students disagreed while 32.2% were not sure of it. Majority (76.8%) of students were comfortable with sexuality education. About half (47.9%) of the students viewed the teaching of sexuality education as concentrating only on abstinence and majority (80.1%) agreed that sexuality education helped them to prevent unwanted pregnancy.

*If you teach them sexuality education, they have the knowledge and they are also able to protect themselves. most often at this their adolescent age, we teach them the use of contraceptives like the use of condoms, and tell them if you have sexual intercourse and use contraceptive, the chance of you getting pregnant is very slim. We give them that education and due to that they are able to prevent themselves even though some of them enter into sexual relationships, they are able to prevent unwanted pregnancies and abortion (**Female Management in Living teacher**).*

About two-thirds (65.5%) of respondents were of the view that the mode of teaching of sexuality education should be practical and 43.5% believed that sexuality education did not cover all topics on sexual and reproductive health. Respondents indicated that illustrative materials were not used by teachers in teaching.



...yeah, they do have but they don't use it when they come to class to teach because they feel that might spoil us (Female student, FGD 2).

A teacher respondent indicated that, most of the things taught were just with words, there were no physical materials to support the teaching.

....for the past years I have been teaching these topics (sexual and reproductive health), mostly it's just the words. I don't get physical materials to support myself and I don't think that is good (Male social studies teacher).

Respondents also indicated that sexual and reproductive health education helped them to control their sexual desires.

Since I have knowledge about myself, I know how to control myself because I know the consequences of pregnancy and I don't want to be a father at this age. So even if I want to engage in sex, I think about these things and stop (male student, FGD 3)

Sexual health education was viewed by a teacher respondent as a way of reducing the ignorance of students towards sexual and reproductive health issues.

.....the ignorance level of the students towards sexuality is too much, and that is why some of them are being misled even by those who are not educated. for instance, there was



*a time I was teaching and a student told me that you can have sex on multiple occasions without being pregnant using certain methodologies such as the withdrawal method and I was quick to let him know that it is not hundred per cent because sperms can even move out of you without even knowing (**Male social studies teacher**).*

Student respondents indicated that:

*Some of the guys will be touching you and if you don't know anything about it, it will be ignorant of you to engage in sexual intercourse with him (**Female student, FGD2**).*

*Some of us we didn't know if you do this (have unprotected sex) this will happen (become pregnant) but because of sexuality education, our teachers have thought us what to do and what not to do (**Female student FGD, 1**).*



Table 4.13 Perception on sexuality education

Statements	Agree (%)	Not sure /don't know (%)	Disagree (%)	Total (%)
Sexuality education helps students to know about STI prevention	251(94.0)	13(4.9)	3(1.1)	267(100)
Teachers are equipped to teach sexuality education	172(64.4)	31(11.6)	64(24.0)	267(100)
There are a number of illustrative materials used in teaching	132(49.4)	64(24.0)	71(26.6)	267(100)
Teaching sexuality education promotes promiscuity	66(24.7)	86(32.2)	115(43.1)	267(100)
Students are comfortable with sexuality education and can express themselves during class	205(76.8)	21(7.9)	41(15.4)	267(100)
Most of the topics taught by teachers are on abstinence	128(47.9)	45(16.9)	94(35.2)	267(100)
Sexuality education prevents unwanted pregnancy	214(80.1)	27(10.1)	26(9.7)	267(100)
Teaching must be more practical and teachers must be participatory.	175(65.5)	34(12.8)	58(21.7)	267(100)
Sexual education topics do not cover all aspect of sexual and reproductive health	116(43.4)	54(20.2)	97(36.3)	267(100)
Teachers do not have the skills to teach sexuality education	88(33.0)	43(16.1)	136(50.9)	267(100)

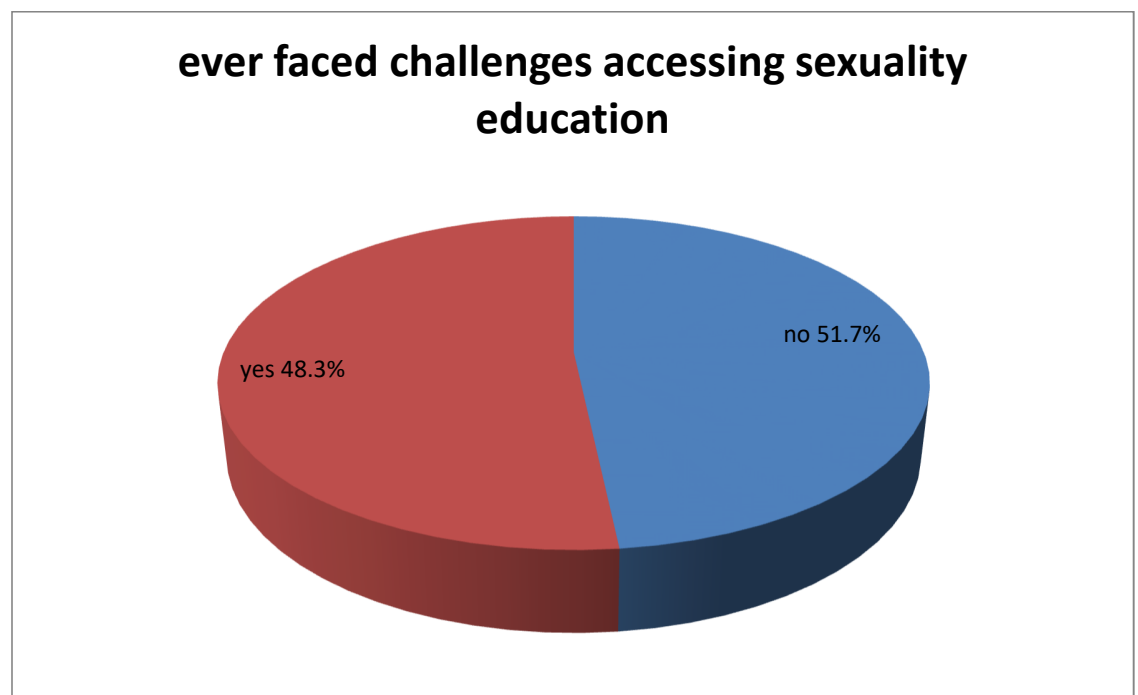


4.5 Challenges of Sexuality Education

4.5.1 Ever faced challenges in accessing sexuality education

The study found out that, 48.3% of respondents had ever faced a challenge in accessing sexual and reproductive health education while in school.

Figure 4.6: Ever faced challenges in accessing sexuality education



4.5.2 Challenges faced by students in accessing sexuality education

Among those who had ever faced a challenge in accessing sexual and reproductive health education, some of the challenges identified were; fear of being tagged as a bad girl or boy (39.5%). Respondents indicated that they did not contribute to class discussions on sexuality education because their mate would see them as bad girls and call them with names.



*...because sometimes when they (students) talk about it, their colleagues will think they know much about it and they are into sexual practices (**Female management in living teacher**)*

*sometimes, when you talk much during this class (sexual and reproductive health topics period), your friends will tagged you or call you names that you are a bad girl or you have done it before that is why you are asking to confirm (**Female student, FGD 1**)*

Also, respondents indicated that some of the teachings contradicted with their religious beliefs. From table 4.14; about 14% respondents indicated that teaching contradicted with religious beliefs.

*Yes, like the spacing of the children. In Islam it is not allowed so it contradicts. In Islam you should just give birth and it is God who takes care of the kids not you (**Female student, FGD2**).*

Respondents also indicated that, as a result of name calling, most people didn't want to ask questions during reproductive health period. From table 4.14, 26.4% of respondents felt embarrassed to ask questions due to name calling. Your colleagues will start calling you names or tease you because



you asked questions about gonorrhoea thinking you have it that is why you asked the question.

*....may be if you are not even having it (gonorrhoea) as she said, they will start calling you by that name (**Female students, FGD 1**)*

Other challenges such as discomfort and shyness, fear of shutting down by teachers (14%), and worry of offending someone (6.2%) were also some of the challenges.

With discomfort and shyness, a teacher respondent indicated that students felt shy and did not want to open up during sexual and reproductive health lessons. They felt uncomfortable with the teaching and did not contribute to the lesson or brought out their views. The shyness prevented them from contributing to the issues been discussed in class.

*....sometimes, if you start to introduce such topics (sexual and reproductive health) most of the students feels shy and then they don't want to bring out their own view (**Male biology teacher**)*

.....some students are really shy when it comes to such topics. They won't even talk. It is just a few who will hijack the class and make it rousy. So those who are shy hide behind the rousiness class and may laugh and then coil back



unlike other topics they are active and mention the words as it is. If they going to ask you a question, they hide behind the words, for instance, when you do the thing... (laughs) (Male social studies teacher)

Students' respondents indicated that,

If they (teachers) are teaching it (sexual and reproductive health) some of us we don't feel free. If you want to ask a question you will be looking round to see if some of your friends are looking at you (Female student, FGD2).

I think the challenge some of the students face is that they feel shy. Some of them might want to ask questions about those things may be she is having experience like itching or pain. Because the teacher said gonorrhoea you will feel something like that, they might be feeling those things but they are shy to ask questions (Female student, FGD 1).



Table 4.14 Challenges faced by students in accessing sexuality education

Challenges faced	Frequency	Percentage (%)
Embarrassed of asking questions about SRH	34	26.4
Fear of shutting down by teachers	18	14.0
Worry of offending someone	8	6.2
Fear of being tagged as bad girl/boy	51	39.5
Teaching contradicts with religious beliefs	18	13.6
Total	129	100

4.5.3 Challenges faced by teachers in teaching sexuality education

Respondents indicated that lack of teaching and learning materials, lack of training, time and curriculum design, fear of being tag as a bad teacher or promoting promiscuity and shyness, personal beliefs, cultural values and over excitement of students during SRH period were identified as the challenges faced by teachers in their quest to teach sexuality education in schools.

For teaching and learning materials, respondents indicated that the use of illustrative materials by teachers during teaching periods could help them have better knowledge and understanding of what was being taught but that was not done. A student indicated that;



*The teachers do not have illustrative materials in teaching so they just mention the things (contraceptives)....I have heard of them but I have not seen them and don't know how they look like (**male student, FGD 3**)*

*We need the teaching materials. At times it is difficult to describe certain things, like the IUD and implants. Audio visuals can even be used to teach if the materials are not physically there. I think that will help well than use of words only. So, the teaching material is really a problem (**male social studies teacher**)*

Lack of training was also identified by respondent as a challenge. Teachers lacked training on sexual and reproductive health and thereby lacked in-depth knowledge to teach the students. None of the teachers' interview has had any form of training on sexual and reproductive health since they started teaching. Some indicated that, they were teaching based on the little knowledge they had during their tertiary education days.

*.....you see, I have being teaching social studies for the past 10 years but I have not attended any workshop on sexual and reproductive health. I have not gain any new knowledge with regards to that so I use my own knowledge and research from the internet to teach them but if I have had training once in every two years, new things come up and it can help me deliver well (**male social studies teacher**)*



Another respondent indicated that, because of lack of training and knowledge, she at times called in for health professionals to teach that aspect in management in living but due to trust, the students did not open up to them

*There was a time ago I invited a health professional to come and teach them contraceptives. it was a good thing because the health worker was knowledgeable than me but the problem was the students, their cooperation was not good so I stopped inviting them over (**Female management in living teacher**)*

Respondents also identified lack of time and curriculum design. Respondent indicated that the curriculum was not detailed enough to allow more contact hours with student when it came to issues of sexual and reproductive health. Also, it was identified that they (teachers) did not have the authority to say certain things but went by what the books and curriculum said. Respondent indicated that, their duty was to cover content and because of that they did not go into details when teaching sexual and reproductive health topics due to time. The curriculum was identified by respondent not to have covered all issues relating to sexual and reproductive health.

*It is one topic and may be sub-topics, for instance in SHS form three classes we have issues of population and within this that we teach them about contraceptives as a way to curb population growth. In form one class we have adolescent reproductive health as a full topic but it is not so detailed (**male social studies teacher**)*



*...I don't think so, there are some areas may be we need to look at but you cannot find them in our content or probably the teacher might not have enough time to dig deeper because we want to cover up content. Apart from that we are not that equipped in terms of knowledge to say certain things on authority, it is only what we have in the books (**male biology teacher**).*

Student respondents indicated that, one of the challenges faced by teachers in delivering sexuality education was as a result of the fear on the part of some teachers to be tagged as bad or promoting promiscuity and also, they were shy to teach sexual and reproductive health.

*Some of the teachers if they come to teach such topics they think the students will think they are bad and some of them also feels shy (**female student, FGD 2**).*

Another challenge identified by respondents was the issue of personal beliefs contradicting with what to deliver. Some teachers did not see the essence of teaching the students sexual and reproductive health.

.....we share experiences when it comes to sexual and reproductive health, among the teachers, some will have some issues like they don't feel comfortable we mentioning certain things to the students, like the coitus, why should we teach the child about the



coitus, what does it add up, these are their personal issues (male social studies teacher).

For cultural issues, respondents indicated that the cultural upbringing of individuals within societies which frown on elders educating younger ones on issues of sexuality affected their (teachers) delivery in the classroom.

Culturally, I think that is where the problem is...we were not train and did not hear our parents talk about issues of sex at home with us and so from that perspective, there are challenges in the classroom delivery...culture has not helped us in that regards (male biology teacher)

Respondents identified over excitement of students as a challenge in teaching sexual and reproductive health. Students were mostly excited when they were being taught sexual and reproductive health topics. Their over excitement led to asking of questions which was not necessary to the subject matter and that can lead the class from focusing on the issue at stake but discussing irrelevant issues.

The attitude of the students towards such topics has not been helpful. They become too excited and so it affects the delivery. They begin to ask you weird questions that are not so content in nature or that help the discussion but they just want to amuse themselves laugh over it and if you are not careful, you will digress (male social studies teacher).



The study also sought the views of students about what they thought was the challenge faced by teachers in teaching sexuality education. Some of the challenges identified were; lack of resources or teaching materials (67%), lack of special skills (40.8%), fear of being tagged as promoting promiscuity (31.8%), lack of time (25.8%), and lack of curriculum to guide teachers (20.6%).

Table 4.15 Challenges faced by teachers in teaching sexuality education

Challenges face by teachers	Yes (%)	No (%)	Total (%)
Lack of resources or teaching materials	179(67.0)	88(33.0)	267(100)
Lack of time	69(25.8)	198(74.2)	267(100)
Lack of special skills	109(40.8)	158(59.2)	267(100)
Lack of curriculum to guide teachers	55(20.6)	212(79.4)	267(100)
Fear of being tagged as promoting promiscuity	85(31.8)	182(68.2)	267(100)



CHAPTER FIVE

DISCUSSION

This chapter presents information on the discussion of the results of the study in comparison with other studies done on sexuality education. The discussion is in line with the objectives of the study. That is, it covers areas on the socio-demographic characteristics of respondents, knowledge, attitude and practice of sexual and reproductive health, views on sexuality education and challenges associated with sexuality education.

5.1 Socio-demographic characteristics of respondent

The mean age of respondents was 18 years with majority (90.6%) within the age group of 16-20 years. The high number of student respondents within this age group could be attributed to the age at which most students' starts (15 or 16 years) and complete (18 or 19 years) senior high school education in Ghana. More than half (54.3%) of the respondents were females and 80.1% were Muslims. According to the 2010 population and housing census, the study area has a female population of 50.3% and therefore the high number of females in the study could be attributed to the high number of females in the metropolis. Also, the high number of Muslim in the study was attributed to the dominance of Islam as the major religion in the study area. More than three-fourth (77.5%) of respondents were second year students and 62% of the respondents were home economics students.



5.2 Knowledge, attitude and practice of sexual and reproductive health (SRH)

5.2.1 Knowledge on sexual and reproductive health

The findings from the study indicated that both teachers and students had good knowledge about sexual and reproductive health in general. Similar observation was made by Westwood and Mullan (2011) in their study on sexual health knowledge among teachers. They found that, teacher's general knowledge on sexual health was good. In another study, Sankhyan et al., (2019) indicated that, majority (62.9%) of teachers in their study had average knowledge on reproduction and sexual health. In contrast to the students' knowledge on sexual and reproductive health, Munakampe, Zulu and Michelo (2018) study found students to have limited knowledge about sexual and reproductive health.

For knowledge on contraceptives, the study found out that about 96% had knowledge on contraceptive. That is, respondents had good knowledge about contraceptive but knowledge on various contraceptive methods was not encouraging. From the study, respondents had more knowledge on condom (98.8%) as compared to the other contraceptive methods. Boamah et al (2014) reported similar findings in their study in Kintampo, Ghana. They indicated that, general knowledge on contraceptive type was not encouraging but that of condom (88.9%) was encouraging. The high knowledge on condom as a contraceptive method according to Boamah et al (2014) was as a result of condom being the preferred choice of contraceptives for yet to marry adolescents. Similar



observations on low contraceptive knowledge in Ghana apart from condom have been reported by Awusabo-Asare et al (2007). The high knowledge on condom by adolescents could be as a result of the regular advertisement of condom in the print and electronic media.

On respondent's knowledge on sexually transmitted infections, we found in our study that, respondents had fair knowledge about STIs in general and the varying knowledge on the different types of STIs and signs and symptoms was not encouraging. Respondents had good knowledge on HIV and AIDs (100.0%) and gonorrhoea (87.3), average knowledge on syphilis (62.2%), and low knowledge on chlamydia (17.2). For the signs and symptoms, respondents have average (61.2%) knowledge. Ekpenyong et al (2019) found knowledge on chlamydia to be low at (4.1%) which is consistent with the findings of this study which found knowledge on chlamydia (17.2%) to be low. A study by Acheampong (2017) found knowledge on clinical features of STI (AIDS and Gonorrhoea) to be high but that of syphilis to be low. The current study found knowledge on STI symptoms to be average. The difference in level of knowledge on the signs and symptoms could be attributed to the study participants as Acheampong's study was among medical students who were presumed to have knowledge on STI clinical features. Also, respondents identified the health facility as the place to go for treatment of STIs.

The study also found out that, respondents had knowledge about abortion, reason for performing abortion, where it should be performed and the conditions to



perform abortion. The health facility was identified as the place to perform abortion and respondents also identified that the only condition to perform abortion was when the foetus pose as a threat to the health of the mother or pregnant woman. This was corroborated in a study by Abiola et al (2016) who indicated in their study that respondents had good knowledge about abortion.

In our study we found out that knowledge on contraceptive was influenced by the gender of respondent. Female respondents significantly had a higher knowledge on contraceptives compared to their male counterparts ($p < 0.04$). In contrast, the 2014 Demographic and Health Survey indicated that males (90.3%) are knowledgeable than females (80.3%) in Northern Region with regards to contraceptive. In contrast, a study in Kintampo, Ghana, found out that males had more knowledge on contraceptives compared to females (Boamah et al., 2014). A study by Martin and Mak (2013) however, found no statistical significance between gender and knowledge on sexual health. Other factors such as age, religion, year group and programme of study were not statistically significant.

It was found out that, none of the demographic characteristics; age, gender, religion, year group and programme of study were statistically significant with knowledge on STI. Females were more knowledgeable than males on STI. The study by Duong, Debpuur and Khan (2008) made a contrasting view that males have higher knowledge than females with respect to STIs. The varying knowledge between genders is confirmed in the 2014 Demographic and Health Survey and Pelucchi et al., (2010). Both studies indicated that knowledge varies by gender.



The study further found out that, despite science and home economics students having more contact hours on sexual and reproductive education than business students, business students had knowledge on STI than both science and home economics students. This finding contrast with a study by Thapa and Chand (2018). In their study, they found out that, faculty of science students has more knowledge on STIs than other faculties.

5.2.2 Attitude toward sexual and reproductive health

From the study, respondent had negative attitudes towards contraceptives. A little over half (50.2%) considered not to use contraceptives and their attitude were formed by their religious beliefs. Christians had positive attitude towards contraceptive usage than Muslims. Attitude toward condom use was fair due to its effectiveness in preventing HIV and AIDs and pregnancy. In the study by Ekpenyong et al., (2019) in Nigeria, only 24.4% of the respondent felt condoms are effective in preventing STIs. Attitude towards abortion was bad, specifically unsafe abortion and attitude on pregnancy was bad as well. Similar observation was found by Muenda et al (2018) that adolescents have negative attitudes towards pregnancy due to its social consequences and fear of becoming pregnant.

Gender and programme of study influence attitude towards contraceptive use. Males had strong attitude toward contraceptives use than females. A study by Santos, Ferreira and Ferreira (2018) found similar observation that men have strong attitudes on sexual and reproductive health as compared to women. They iterated that, the varying attitude with respect to gender is based on the knowledge



of men on SRH. Men (70%) have positive attitude towards condom use as compared to women (61%) as reported by Duong, Debpuur and Kahn (2008) in their study in Kassena-Nankana District. For programme of study; general science students have positive attitudes towards contraceptive usage as compared to other programmes. Other variables such as age, religion, and year group were not statistically significant. .

5.2.3 Sexual and reproductive health practice

From the study, we found out that contraceptive usage was low (22%) as compared to a study in South Africa where usage of contraceptive was high (78%) among respondents (Makola et al., (2019). The high number of contraceptive usage in their study could be attributed to their study involving both adolescents and young women. The commonly used contraceptive was condom and pills and injectable were the least used contraceptives. This observation was similar to a finding by the Guttmacher Institute. They found condom to be the most used contraceptive among adolescents (Guttmacher Institute, 2017). Other studies in Ghana and United States found similar observations (Yidana et al., 2015; Abma and Martinez, 2017).

From the study, it was found out that adolescents were involved in unsafe abortion practices. Mixing coffee with energy drink, mixing pounded broken bottles to food or drink, herbal concoction, abuse of drugs were the traditional ways adolescents used in aborting their pregnancy. A similar finding was found in a study in Jamestown, Ghana where adolescents used mixture of tablets, grinded



bottles, and alcoholic drinks to abort pregnancy (Bain et al., 2019). Other studies also found drinking of concoction, inserting herbs into vagina, and boiling of pawpaw (Kyilleh, Tabong and Konlaan, 2018), use of self-prescribed drugs, inserting sharp objects in the genitals (Atuhaire, 2019).

From the study, one-third of the respondents were sexually active. The median age at first sexual intercourse was 17 years for both males and females and this figure was lower than the median age at first intercourse for males (20.6 years) and females (17.6 years) in the Northern Region (GDHS, 2014). From the study, males engaged in sex at an early age (before age 15) than females. Similarly, Abma and Martinez (2017) found out that males initiated sex at a younger age than females. In contrast, a study in Ghana found females (12%) to initiate sex before age 15 than males (9%) nationally and females (8%) and males (3%) in Northern region (GDHS, 2014). Gadegbeku and Akoto-Bamfo (2014) found adolescents initiating sex between the ages of 10-18 years.

Third year students were sexually active than second year students ($p < 0.01$). An association was found between ever had sex and contraceptive usage and the association was significant. ($p < 0.001$). That is, the decision to use contraceptive was influenced by sexual experience. Respondents who had ever had sex were more likely (59.8%) to use contraceptive in their next sexual encounter. A study in United States made similar findings with respect to gender. They found out that females were more likely to use contraceptive during sex than males (Abma and



Martinez, 2017). Similar to the findings of this study, Makola et al., (2019) found age at first sexual intercourse to influence contraceptive usage.

A bivariate analysis between contraceptive usage and respondents' socio-demographic characteristics found no significant association between contraceptive usage and age, gender, religion, year group, and programme of study. Nyarko (2015) found education, knowledge of ovulation cycle, visit to a health facility, work status and marital status as factors that influence contraceptive usage among adolescents. The difference in variables can be attributed to the scope of the current studies.

5.3 Source of information on sexual and reproductive health

From the study, the most important source of information for adolescents on sexual and reproductive health was their family member. The most important family source was the mother followed by sister, brother and father. The most important source after family members was friends followed by school teachers, doctors, books and films/videos/media. For the preferred choice of information on sexual and reproductive health, family members were the most preferred choice with the mother been the most preferred choice followed by father, sister and brother. Friends were the most preferred choice after family followed by school teachers, doctors, books and films/video/media. Similar observation was found by Baheiraei et al., (2014) in their study which stated that mother and friends were the primary source of information but in contrast to the findings of this study, books and internet was found to be the preferred source of information



in their study. A study by Esantsi et al., (2015) in Ghana found school to be the major source and preferred source of information on puberty and reproduction. Esantsi et al (2015) indicated that mother was a preferred choice because it was easy to talk to them on important things. This was similar to the findings of this study.

5.4 Perception on sexuality education

From the study, respondents were of the view that sexuality education increased their knowledge on prevention of sexually transmitted infections (STIs) and helped them prevent unwanted pregnancy. A study by Esiah-Donkoh et al (n.d) found out that students were of the view that sexuality education should be taught to prevent STIs and unwanted pregnancy. Their findings confirm the findings of the current study.

We found in our study that majority (76.8%) were comfortable with sexuality education been taught in school. However, about 75.3% of respondents were not in support of the view that sexuality education promoted promiscuity. This finding was consistent with the findings of a study conducted in Kenya which found out that, about one-third (64.3%) of respondents disagreed to the idea that sexuality education exposed students to pre-marital sex (Kamuren, Kamara and Ntabo, 2017). Some respondents in this study were of the view that teachers' delivery on sexuality education concentrated more on abstinence. This was similarly reported by Awusabo-Asare et al., (2017) who indicated in their study that teacher's delivery concentrated more on abstinence and students were excited



about the sexuality education. In contrast, Kimmel et al., (2013) indicated that, students were of the view that they lacked comfort with the instruction methods in teaching sexuality education.

The study found out that students were of the view that teaching of sexuality education should be practical and involve the use of illustrative materials. Also, students were of the view that the topics taught did not cover all aspect of sexual and reproductive health. Similar observation was found by Awusabo-Asare et al., (2017) where students were of the view that teaching of sexuality education should be participatory and practical. Unis and Sällström (2019) study found out that students were of the view that sexuality education did not cover all aspect of sexual and reproductive health.

The study found out that, students were of the view that teachers had the skills to teach sexuality education but some were unwilling to share the knowledge with them. Other studies have found contrasting views. A study in Kenya found out that students were not sure if teachers were adequately prepared to teach sexuality education (Kamuren, Kamara and Ntabo, 2017). Another study indicated that, students viewed their teachers as not suitable to teach sexuality education as a result of their lack of training on sexual and reproductive health (Pound, Langford and Campbell, 2016). The study also found out that, sexuality education was viewed as a way of helping students reduce their ignorance about sexual and reproductive health and also control their sexual desires.



5.5 Challenges of sexuality education

5.5.1 Challenges faced by students

From the study, 48.3% of the students had ever faced challenges in accessing sexuality education in school. The study found fear of being tagged as bad girl or boy, teaching that contradicted their religious belief, embarrassed to asked question due to name calling, discomfort and shyness, fear of shutting down by a teacher and worry of offending someone were the challenges faced by students in accessing sexuality education. This was similarly reported in a study by Awusabo-Asare et al., (2017). A multi country review by Pound, Langford and Campbell (2016) found embarrassment and discomfort as some of the challenges faced by students during sexual and reproductive health classes.

5.5.2 Challenges faced by teachers

From the study, lack of teaching materials, lack of training, time and curriculum design and fear of promoting promiscuity were identified as some challenges faced by teachers in teaching sexuality education. Similar findings were found in a study by Mervyn (2012) who also identified lack of teaching materials and training as a challenge to teachers in teaching sexuality education. Awusabo-Asare et al., (2017) reported similar findings in their study in Ghana. Fear of being blamed by parents as promoting promiscuity was found in other studies as a challenge faced by teachers in teaching sexuality education (Walker and Milton, 2006; Francis, 2010). A study in Bawku made similar observations to the findings



of this study. The study found lack of special skills, lack of curriculum to guide teachers to effectively teach the subject and sex education had a limited content or substance (Donkor and Lariba, 2017).

The study also found personal beliefs, cultural values and over excitement of students during SRH classes as challenges faced by teachers. A study by Van der Geugten et al., (2014) found similar observations that traditional and cultural influences affected sexuality education implementation. Walker and Milton (2006) found personal beliefs of teachers as a challenge because teachers were embarrassed and uncomfortable to teach their students sexual issues.



CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

The study examined the perception and challenges of sexuality education among students and teachers within the Tamale Metropolis. The knowledge, attitude and practice of sexual and reproductive health, views on sexuality education and challenges faced in relation sexuality education were the objectives of the study.

6.1 Summary

6.1.1 Socio-demographic characteristics

For the Socio demographic characteristics, a total of 267 students answered the questionnaire with majority (90.6%) of them within the ages of 16-20 years with 5.6% and 3.7% within the ages of 21-25 and under 15 years respectively. With regards to gender of the respondents, 54.3% were females. Majority (80.1%) of respondents were Muslims and about one-fifth (19.9%) were Christian. The study was made up of second and third year SHS students. Majority (77.5%) of these students were second year students. Respondents were selected from different programmes within the schools. Home economics students (62%) constituted the majority, followed by General Arts with about 19% with General Science and Business been about 8% and 11% respectively.



6.1.2 Knowledge, attitude and practice of sexual and reproductive health

6.1.2.1 Knowledge on sexual and reproductive health

From the study, respondents had knowledge on contraceptives (95.5%), sexually transmitted infections (100%), abortion. The most heard contraceptive was condom (98.8%) and Lactational amenorrhea method (14.9%) was the least known method. HIV and AIDS (100.0%) and gonorrhoea (87%) were the most known sexually transmitted infections with only 17.2% ever heard of chlamydia. Also, pain during urinating (77.9%) was the most known symptom of sexually transmitted infection. respondents had knowledge about safe and unsafe abortion and knew the health facility (81.3%, 86.5%) was the best place to go for abortion and treatment of sexually transmitted infections respectively.

Gender was found to be statistically significant (0.037) with knowledge on contraceptives with females (97.9%) been more knowledgeable than males (92.6%). Age of respondent (0.623), religion (0.647), year group of respondent (0.622) and programme of study (0.419) had no association with knowledge on contraceptives.

Also, there was no association between the age of respondent (0.855), gender (0.058), religion (0.386), year group (0.348), programme of study (0.334) and knowledge on sexually transmitted infections but females (100%) and Business students (100%) had more knowledge on STI as compare to their counterparts.



6.1.2.2 Attitude towards sexual and reproductive health

The study found attitudes towards contraceptives to be bad and respondents had misconception about contraceptives causing infertility (62.5%) and their decision was influenced by religion. Attitudes towards safe abortion were positive while unsafe abortion was negative. There was an association between gender (0.000), programme of study (0.017) and attitude towards contraceptive. Males (61.5%) and General science students (68.0%) have good attitude towards contraceptive usage.

6.1.2.3 Sexual and reproductive health practice

From the study, 32.6% respondents have had sex and 48.3% of them are males and 51.7% females. The median age at intercourse for both males and females was 17 years 19.5% had sex at age 15 and below and 80.5% at 16-20 years. The study also found out that, 22.1% of respondents had ever used contraceptives with the most used contraceptive been the condom (67.8%). There was an association between ever had sex and contraceptive usage (0.000) with more than half (59.8%) of those who have ever had sex to have ever used a contraceptive method.

The year group of students was statistically significant (0.008) with ever had sex. Other variables age of respondent (0.071), gender (0.556), religion (0.371) and programme of study (0.164) had no association with ever had sex. Also, there was no association between age (0.139), gender (0.990), religion



(0.224), year group (0.333), programme of study (0.217) and ever used contraceptive.

6.1.3 Source of information on sexual and reproductive health

From the study, the most important and preferred source of information on sexual and reproductive health was the mother (47.6% and 41.9%), followed by friends (17.2% and 12.4%) respectively. Sister (8.2%) was a most important source of sexual and reproductive health than school teacher (6.7%) and father (6.4%). However, with respect to the preferred source, father (11.6%) and school teacher (10.5%) were preferred more than sister (10.1%).

6.1.4 Perception on sexuality education

From the study, sexuality education was viewed as a way of gaining knowledge on sexually transmitted infections prevention and preventing unwanted pregnancy, helps in controlling sexual desires and reduce ignorance level towards sexual and reproductive health, and the teaching of sexuality was viewed as not promoting promiscuity. Also, sexuality education was viewed as concentrating only on abstinence and did not cover all topics on sexual and reproductive health, and it was viewed to be practical, participatory and illustrative materials must be used in teaching.

6.1.5 Challenges of sexuality education

From the study, 48.3% of respondents have ever faced challenge in accessing sexuality education. Among these group of respondents, fear of being



tagged as a bad girl or boy, teaching contradicting with religious beliefs, embarrassed to ask questions as a result of name calling, discomfort and shyness, and shutting down by teachers were the challenges faced by students.

For the teachers, it was found out that the challenges they face were, lack of teaching and learning materials, time and curriculum design, fear of being tagged as a bad teaching or promoting promiscuity and shyness, personal beliefs, cultural values, over excitement of students and lack of special skills.

6.2 Conclusion

Based on the findings of the study, it can be concluded that respondents had good knowledge on contraceptives, abortion and STI. Gender is associated with knowledge on contraceptive ($P=0.037$). Attitude towards contraceptive and unsafe abortion were poor but attitude towards safe abortion was good. Gender and programme of study is associated with attitudes towards contraceptive use. It is also concluded that, among the 32.6% of those who had ever had sex, 48.3% were males and 51.7% were females. Condom is the most used contraceptive. There is an association between ever had sex and contraceptive use (0.000). It can also be concluded that there is an association between year groups and ever had sex. It can be concluded that, the most and preferred choice of information on sexual and reproductive health was the mother, followed by friends. Also, it can be concluded that adolescents are comfortable with sexuality education and view sexuality education to increase their knowledge on STI and unwanted pregnancy prevention. It can also be concluded that, sexuality education is viewed as



promoting their knowledge, attitudes and practice of sexual and reproductive health in general. It can also be concluded that, the challenges faced by students in accessing sexuality education are fear of being tagged as a bad girl or boy, teaching contradicting with religious beliefs, embarrassed to ask questions as a result of name calling, discomfort and shyness, and shutting down by teachers. Also, it can be concluded that the challenges faced by teachers are lack of teaching and learning materials, time and curriculum design, fear of being tagged as a bad teaching or promoting promiscuity and shyness, personal beliefs, cultural values, over excitement of students and lack of special skills.

6.3 Recommendation

The Ministry of Health should collaborate with the Ghana Education Service to organize workshops on sexual and reproductive health to train all teachers not only teachers who teaches subject with sexual and reproductive health integrated in them.

In other to reduce the fear of parents blaming teachers for promoting promiscuity, there must be collaboration between parents, family and community when exposing students to sexual and reproductive health issues.

The Ministry of Education and other sexual and reproductive health partner agencies should invest in teaching and learning materials to assist teachers and improve the teaching of sexual and reproductive health education.



Restructuring of the curriculum design to make sexual and reproductive health a stand-alone subject or revise existing content within integrated subjects and increase content and time allocation.

School authorities should collaborate with local health workers to teach sexual and reproductive health education topics in schools as adolescents trust and have confidence in health workers with issues of their sexuality.



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APPENDICE

APPENNDIX A: QUESTTIONNAIRE FOR STUDENTS

SCHOOL OF GRADUATE STUDIES

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY MEDICINE AND FAMILY HEALTH-

TAMALE

PROSPECTS AND CHALLENGES OF SEXUALITY AMONG STUDENTS

AND TEACHERS WITHIN THE TAMALE METROPOLIS

Dear participant,

The aim of this study is to examine the prospects and challenges of sexuality among students and teachers within the Tamale Metropolis. It is a study in partial fulfilment for the award of a Masters of Public Health degree at the University for Development Studies (UDS), Tamale. The information obtained through this questionnaire is for academic purposes only. Please be assured that your participation in this project is completely voluntary and your responses would be treated with utmost confidentiality and anonymity. Your agreement to respond to these questions implies your consent to participate in this research process. Thank you for your cooperation and understanding.

SECTION A

Background characteristics of respondents

1. Age :



2. Sex

1. Male 2. Female

3. Religion

1. Christian 2. Muslim 3. Traditional 4. Others.....

4. Form

1. Form 2 2. Form 3

5. Programme of study

1. Home economics
2. General science
3. Business
4. General arts
5. Others (specify).....

SECTION B

Knowledge, attitude and practice on sexual and reproductive health

6. During puberty, boys and girls experience body changes?

1. Yes 2. No

7. Do both boys and girls menstruate during puberty?

1. Yes 2. No



During this period, boys and girls would like to learn about what is happening to them. They may consult teachers, friends, read magazines and others. I would like to know what has being the **most important and preferred source** for you?

Source	Most important (Q8)	Preferred (Q9)
School teacher		
Mother		
Father		
Brother		
Sister		
Friends		
Doctors		
Books/magazines		
Films/ video		
Other (specify)		

10. Have you ever heard of contraceptive?



1. Yes 2. No

11. Have you ever used contraceptive?

1. Yes 2. No

The table below is having some of the methods of contraceptive, indicate whether you have ever heard of it, ever use it and where you acquired it from.

Method	Ever heard (Q12)	Ever used (Q13)	
Condom	1. Yes 2. No	1. Yes 2. No	
Emergency contraceptive pills	1. Yes 2. No	1. Yes 2. No	
Injection	1. Yes 2. No	1. Yes 2. No	
Pills	1. Yes 2. No	1. Yes 2. No	



Withdrawal	1. Yes 2. No	1. Yes 2. No	
IUD	1. Yes 2. No	1. Yes 2. No	
Implants	1. Yes 2. No	1. Yes 2. No	
Sterilization	1. Yes 2. No	1. Yes 2. No	
Calendar/ rhythm method	1. Yes 2. No	1. Yes 2. No	
Lactational amenorrhea method	1. Yes 2. No	1. Yes 2. No	

Note : for the source, choose one of these

1. Over the counter licensed chemical chops
2. Pharmacy
3. Govt. Clinic/Health Centre/Hospital



4. Friend
5. Other.....
6. Don't know

15. If you need any method of contraceptive, which of the places will you go to?

1. Over the counter licensed chemical chops
2. Pharmacy
3. Govt. Clinic/Health Centre/Hospital
4. Friend
5. Other.....
6. Don't know

16. Which of the methods is good for young people?

1. Condom
2. Emergency contraceptive pills
3. Pills
4. Implant
5. Calendar/ rhythm method
6. Others (specify)

17. Would you ever consider using contraceptive?

1. Yes
2. No





18. Which of the contraceptive methods do you think prevents both pregnancy and sexually transmitted infection (STIs)?

1. . Condom
2. Emergency contraceptive pills
3. Injections
4. Implant
5. Others (specify)

19. Have you heard of sexually transmitted infections?

1. Yes
2. No

20. Which of the sexually transmitted infections have you heard before (choose as many as it apply).

1. Gonorrhea
2. Syphilis
3. Chlamydia
4. Candidiasis.
5. HIV and AIDs
6. Others (specify)

21. What are the signs and symptoms of sexually transmitted infections (STIs). Choose as many as you want).

1. Pain during urinating
2. Sores on genital organ
3. Discharge from genital organs
4. Itching around the genitals

22. Have you ever experience any of the signs and symptoms (tick as many)

Signs and symptoms	Yes	No

Pain during urinating		
Sore on genital organ		
Discharge from genitals		
Itching around genitals		

23. If you or a friend is experiencing any of the symptoms, where will you go or ask him/her to go for treatment?

1. Over the counter licensed chemical chops
2. Pharmacy 3. Hospital/health Centre/clinic 4. Herbal medicine
4. .Other (SPECIFY)

24. Have you ever had sex? (if no, skip to question number 28)

1. Yes 2. No

25. How old were you when you had sex?

26. Did the sex result in pregnancy? (if no, skip to question 28)



1. Yes 2. No

27. How old were you when you got pregnant?

28. What did you do when you got pregnant?

1. Had an abortion and continued with school. 2. Stopped school and gave birth.

29. In case you become pregnant and want to abort or any of your friends needs help on abortion, where will you advise her to go?

1. Over the counter licensed chemical chops
2. Pharmacy 3. Hospital/health Centre/clinic 4. Herbal medicine 4.
.Other (SPECIFY)

30. Can you list some of the materials or things girls used in aborting their pregnancies which you've heard of.....

The table below provides information on attitudes towards sexual and reproductive health issues. Tick either agree, not sure/ don't know or disagree.

Statements	Agree	Not sure/ don't know	Disagree
Condoms are not effective ways of preventing HIV and AIDS and pregnancy			



Contraceptives can cause infertility			
STIs do not need treatments, they can go on their own			
Women are responsible for contraceptive use			
I will go in for abortion if I become pregnant while in school			
Abortion is safe when you perform it by yourself			
Parents are the best source of sexual and reproductive health information			
Condom can split and cause pregnancy			
A woman can get pregnant on her first sexual intercourse			
Pregnancy will lead to school drop out			
Unsafe abortion can lead to serious health consequences such as death			



SECTION C

Perceptions on sexual health education

31. The following statement solicited information on what you think about sexuality education.

Statements	Agree	Not sure/ don't know	Disagree
Sexuality education helps students to know about STI prevention			
Teachers are equipped to teach sexuality education			
There are a number of illustrative materials used in teaching			
Teaching sexuality education promotes promiscuity			
Students are comfortable with sexuality education and can express themselves during class			
Most of the topics taught by teachers are on abstinence			



Sexuality education prevents unwanted pregnancy			
Teaching must be more practical and teachers must be participatory.			
Sexual education topics do not all aspect of sexual and reproductive health			
Teachers do not have the skills to teach sexuality education			

SECTION D

Challenges of sexual health education implementation

32. As a student, do you or any of your friends have any challenges towards assessing sexuality education? (If no skip to question 34)

1. Yes 2. No

33. Which of these challenges do you face?

1. Embarrassed of asking questions about SRH
2. Time constraints or fear that they will be shut down by teachers or students
3. Worry of offending someone



4. Fear of being tagged as bad girl
5. Teaching contradict religious beliefs
6. Others (specify).....

34. As a student, what are some of the challenges you think teachers face in teaching sexuality education?

1. Lack of resources or teaching materials
2. Lack of time
3. Lack of special skills by teachers in delivering sex education
4. Lack of curriculum to guide the teachers to effectively teach the subject.
5. Fear of being tagged by parents as promoting promiscuity
6. Others (specify).....

THANK YOU



APPENDIX B
INTERVIEW GUIDE FOR TEACHERS

SCHOOL OF GRADUATE STUDIES
UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF MEDICAL SCIENCES
DEPARTMENT OF COMMUNITY MEDICINE AND FAMILY HEALTH-
TAMALE

PROSPECTS AND CHALLENGES OF SEXUALITY AMONG STUDENTS
AND TEACHERS WITHIN THE TAMALE METROPOLIS

Dear participant,

The aim of this study is to examine the prospects and challenges of sexuality among students and teachers within the Tamale Metropolis. It is a study in partial fulfilment for the award of a Masters of Public Health degree at the University for Development Studies (UDS), Tamale. The information obtained through this interview guide is for academic purposes only. Please be assured that your participation in this project is completely voluntary and your responses would be treated with utmost confidentiality and anonymity. Your agreement to respond to these questions implies your consent to participate in this research process. Thank you for your cooperation and understanding.

1. As a teacher, how would you explain your understanding of sexual and reproductive health (probe for knowledge on contraception, sexually transmitted infections, pregnancy, abortion etc.)?



2. Since you became a teacher, has any student approached you with his or her sexual and reproductive health issue? (If yes, probe for the type of problem and how it was handled).
3. Due to the increasing rate of pregnancies and risky sexual behaviours among adolescents in Tamale and Ghana as a whole, do you think it is important to have sexuality education in schools? (Probe for reasons why it is important or not important).
4. How do you feel about the teaching of sexuality education in schools (Probe for personal reasons, religious beliefs and cultural beliefs)?
5. As a teacher, what topics on sexuality education do you teach your students (probe on contraceptives, STIs including HIV and AIDS, abortion, sexual relationships)
6. Do you think sexuality education cover all topics on sexual and reproductive health essential to students? (if yes, probe for reasons and if no, which areas needs to be added)
7. Have you received any training on sexuality education? (if yes, what was the training about and if no, how are you able to teach it).
8. In teaching sexuality education, what are some of the challenges you face? (probe for, lack of teaching materials, lack of time, lack of training, pressure from society, personal beliefs and religious beliefs, cultural beliefs).



9. What are some of the things which you think if done can help improve sexuality education in schools?
10. Do you have anything to add?

THANK YOU



APPENDIX C

FOCUS GROUP DISCUSSION GUIDE FOR STUDENTS

SCHOOL OF GRADUATE STUDIES

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY MEDICINE AND FAMILY HEALTH-

TAMALE

PROSPECTS AND CHALLENGES OF SEXUALITY AMONG STUDENTS

AND TEACHERS WITHIN THE TAMALE METROPOLIS

Dear participant,

The aim of this study is to examine the prospects and challenges of sexuality among students and teachers within the Tamale Metropolis. It is a study in partial fulfilment for the award of a Masters of Public Health degree at the University for Development Studies (UDS), Tamale. The information obtained through this interview guide is for academic purposes only. Please be assured that your participation in this project is completely voluntary and your responses would be treated with utmost confidentiality and anonymity. Your agreement to respond to these questions implies your consent to participate in this research process. Thank you for your cooperation and understanding.

1. What do you know about the following;



- a. Contraceptives (probe for types and how to use them) b. STIs including HIV and AIDS (probe for types and signs and symptoms) (c. abortion (probe for types; safe and unsafe and how they are performed). Also, probe about misconceptions.
2. Do you think it is necessary to learn about sexuality in schools? (If yes, probe for reasons and if no, probe for reasons).
3. As students, what are some of the benefits you think you have derived from school based sexuality education (probe for impact of sexuality education on their knowledge and attitude on contraceptives, STI, pregnancy, abortion, sexual decisions etc.).
4. Does sexuality education cover all topics on sexual and reproductive health essential to students? (if yes, probe for reasons and if no, which areas needs to be added)
5. How will you assess the performance of your teachers in their quest to teach sexual health education? (Probe; knowledgeable or not).
6. What are some of the challenges students face in the classroom when teachers are teaching sexual health topics? (Probe; discomfort, shy, contradicts with religious beliefs and personal beliefs, don't want to be tagged as stubborn, cultural beliefs).
7. What are some of the challenges you think teachers face in teaching sexual health education? (Lack of contact hours, lack of resources or teaching materials, cultural beliefs, religious beliefs, inadequate knowledge).



8. What measures do you think will help to improve sexuality education in schools?
9. Do you have anything to add?

THANK YOU



APPENDIX D

UNIVERSITY FOR DEVELOPMENT STUDIES
School of Medicine and Health Sciences
(Department of Community Health and Family Medicine)

Tel : 03720 - 93295
E-Mail :
Local : 5:7811/106.15
Internet: www.uds.edu.gh



Post Office Box TL 1883,
Tamale, Ghana, West Africa.

Office of the Head

30/06/2020

The Director
Ghana Education Service
Tamale Metropolitan Education Office
Tamale, Ghana.

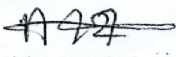
LETTER OF INTRODUCTION

Jude Naah

This is to introduce to you, Mr. Jude Naah, a Master of Public Health student of School of Medicine and Health Sciences, University for Development Studies. Mr. Naah is currently working on his thesis titled: *Perception and Challenges of sexuality education among Senior High School students and teachers within the Tamale Metropolis*. Mr. Naah wants to have access to talk to some Teachers and Students of selected Senior High Schools to enable him to carry out this important academic exercise. I would be grateful if you could grant him access and any other assistance he may need.

OFFICE OF THE HEAD

Thank you.


Yidana Adadow (PhD)
(HoD, CH&FM)
Dep. Of Comm. Health & Family Medicine
UDS-SMHS, TAMALE

cc: Vittin SHS
Dabokpa Technical/Vocational Institute
Business SHS
Ghana SHS (GHANASCO)
Tamale Girls SHS
Adventist SHS

APPENDIX E

GHANA EDUCATION SERVICE

*In case of reply the date and
reference number of this letter
should be quoted*

Our Ref: GES/NR/MEO

Your Ref:

Email: tmetroedu@gmail.com



REPUBLIC OF GHANA

Metropolitan Education Office
P. O. Box 6, E/R
Tamale, Northern Region
Tel: 037-2022090

Date: July 3, 2020

LETTER OF INTRODUCTION IN RESPECT OF MR. JUDE NAAH

This is to introduce to you Mr. Jude Naah, a Master of Public Health student of the University of Development Studies. He is conducting a research on the topic **“Perception and Challenges of Sexuality Education among Senior High School Students and Teachers in the Tamale Metropolis”** as part of the requirements leading to the award of Master of Public Health.

We would be very grateful if the Headmasters/Mistresses/Principals concerned accord the researcher all the needed cooperation and assistance.

Thank you in anticipation.


(AMATUS D. PUG-UU)

**METROPOLITAN DIRECTOR OF EDUCATION
TAMALE**

**ALL THE HEADMASTERS/HEADMISTRESSES/PRINCIPALS
SENIOR HIGH SCHOOLS
TAMALE METROPOLIS**

**Cc: The Regional Director
Ghana Education Service
Tamale**

**Mr. Jude Naah
Post Office Box TL 1883
Tamale, Ghana, West Africa**