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EARLY SEXUAL RELATIONSHIPS AND AGE MIXING AMONG OLDER ADOLESCENTS LIVING IN AN URBAN SLUM IN GHANA

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ABSTRACT

Understanding Adolescents' sexual and reproductive health behaviour is paramount if the attainment of improved health outcomes and ultimately, the realisation of Sustainable Development Goals are to be achieved. However, the extant literature appears to be disproportionately focused on adolescents in the rural context. Using both qualitative and quantitative data collected from adolescents aged 15-19 years living in Kwesimintsim zongo – an urban slum, this paper attempts to examine early sexual relationships and age mixing among older adolescents. The results point to the presence of risky sexual behaviour among the respondents. Specifically it was found that about a fifth of the respondents were engaged in both early sexual relationships and age mixing. These findings provide useful insight on urban adolescents and their sexual reproductive health in Ghana and it is recommended that preventive measures such as educational campaigns be deployed to dissuade adolescents from engaging in these risky behaviours whose resultant social, psychological and economic costs affect the wider society.

Key words

sexual relationships; age mixing; older adolescents; urban slum

Background

Sexual and reproductive health behaviour is considered crucial in ensuring that young people experience a smooth transition into adulthood (Population Reference Bureau, 2013; Lloyd, 2005). This is because it has implications for improving the health outcomes of individual, especially reduction of unintended pregnancies and STIs including HIV and AIDS (Kabiru, Beguy, Zulu & Ezeh, 2010). Sexual and reproductive health behaviour refers to a range of behaviours in which individuals express their sexuality. These behavioural expressions are influenced by both biological and cultural elements and involve sexual arousal. It ranges from activities such as masturbation to sexual intercourse/intimate partner relations (including oral sex, non-penetrative sex) (Silva, Fonseca, Bagnoli, Cavalcanti, Soares, Baracat, 2010; Heilborn & Cabral, 2006).

Sexual and reproductive health behaviour of adolescents has the potential of contributing

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to the achievement of Sustainable Development Goals (SDG) on ending poverty in all forms, hunger and ensuring healthy lives and promoting well-being for all at all ages (UN, 2017). For instance, delays in age at first sex could lead to an increase in age at first birth with its attendant positive effects on levels of education, poverty and hunger reduction especially among females. Such merits notwithstanding, adolescents, especially girls in sub-Saharan Africa (SSA), are more vulnerable to sexual and reproductive health outcomes such as STIs including HIV and unplanned pregnancy than their male counterparts (Lloyd, 2005; Dixon–Mueller, 2008). Their vulnerability is due to socio-cultural and economic conditions such as poverty and powerlessness (Population Reference Bureau, 2013).

Evidence shows that adolescents in cities engage in sexual intercourse earlier than those in rural areas in sub-Saharan Africa (Doyle, Mavedzenge, Plummer & Ross (2012); Seme & Wirtu, 2009). Also, a study by Doyle et al., (2012) revealed the existence of multiple sexual partners relationships among adolescents aged 15-19 years. In their study, they observed that the proportion of 15-19 years who reported multiple sexual partnerships ranged between 4% in Ethiopia and 32% in Cote d'Ivoire among males and from 0.4% in Ethiopia and Niger to 12% in Liberia for females. There is also evidence on age mixing with evidence showing that 2% to 6% of female adolescents aged 15-19 years old had a partner aged 10 years older than them (Seme & Wirtu, 2009).

Young people living urban slums are particularly vulnerable to poor sexual and reproductive health outcomes due to contextual and structural factors that affect their ability to enjoy a healthy sexual and reproductive life (Kabiru, Beguy, Zulu & Ezeh, 2010; African Population and Health Research Centre (APHRC), 2012; Zulu, Dodoo, Ezeh, 2002). These urban slums are defined as settlements with households that are unable to provide one of the following basic living characteristics: durable housing of a permanent nature that protects against extreme climate conditions; sufficient living space, which means not more than three people sharing the same room; easy access to safe water in sufficient amounts at an affordable price; access to adequate sanitation in the form of a private or public toilet shared by a reasonable number of people; security of tenure that prevents forced evictions (UN-Habitat, 2007).

Studies that have compared adolescents living in urban slums with other city residents have found the former to be exposed to worse sexual and reproductive health outcomes. For instance, studies conducted in Nairobi showed that slum residents start sexual intercourse at earlier ages, have multiple sexual partners, and are less likely than other city residents to know of or adopt preventive measures against contracting HIV/AIDS (Kabiru, Beguy, Undie, Zulu & Ezeh, 2010; Zulu, Dodoo & Ezeh, 2002).

Young people growing up in Ghana are faced with several opportunities such as exposure to mass media and education, however, these same opportunities present challenges such as early sexual activities and teenage pregnancy (Awusabo–Asare, Biddlecom, Kumi–Kyereme & Patterson, 2006). Early sexual activities exist among adolescents aged 15-19 years with 12% and 9% females and males having had ever had

sex by age 15 (Ghana Statistical Service (GSS), 2015). Awusabo-Asare and colleagues in their 2006 study on the other hand observed that differences in age at first sex begin to emerge at around age 14 for both males and females with more females than males having had first sex between ages 17-19 years (Awusabo–Asare, Biddlecom, Kumi–Kyereme & Patterson, 2006). Child bearing among adolescents in the country is not uncommon. For instance, 13% of adolescents aged 15-19 years had ever had a child (GSS, 2015) with a number of them been mistimed (Nabila & Fayorsey, 2002). These mistimed pregnancies coupled with low contraceptive use among sexually active adolescents could have implication for adolescent fertility and abortions among adolescents with potential social and demographic consequences for the adolescents and the country.

SRH-related issues have been quite thoroughly investigated in Ghana over the years. Studies conducted have investigated various aspects of adolescent reproductive health issues in Ghana at both the micro (Darteh, Kumi–Kyereme & Awusabo–Asare, 2016; Darteh & Nnorom, 2012; Henry & Fayorsey, 2002) and macro levels (Awusabo–Asare, Biddlecom, Kumi–Kyereme & Patterson, 2006; GSS, 2015; Amo–Adjei & Darteh, 2013; Kumi–Kyereme, Awusabo–Asare & Darteh, 2014; GSS, 2009). While these studies have provided valuable insight into the phenomenon, very few studies (Darteh & Nnorom, 2012; Darteh, et al., 2016) have focused attention on adolescents living in urban slums – a thematic area which remains unexplored but needs to be studied due to its distinctive features (Dodoo, Sloan & Zulu, 2003). This paper, therefore, examines early sexual relationships and age mixing among adolescents aged 15-19 years in an urban slum in the Western region of Ghana in an attempt to contribute to the discourse on sexual and reproductive health behaviour of adolescents.

Conceptual Framework

The study was guided by the Theory of Planned Behaviour (TPB). Ajzen (1991) modified the Theory of Reasoned Action (TRA) to include perceived behavioural control and named this modified version, the Theory of Planned Behaviour (TPB). According to the theory, intentions have three elements: attitude, subjective norms, and perceived behavioural control. Attitudes and subjective norms remained as defined in the TRA.

The concept of perceived behavioural control is defined as the degree of control of behaviour. The concept had two elements – control belief and perceived power. Control belief refers to the person's perceived obstacles and opportunities for performing a specific activity; and perceived power refers to a person's perceived degree of control over the behaviour. In the TPB, perceived behavioural control influences intentions and also has a direct influence upon behaviour (Ajzen & Madden, 1986). The notion of perceived behavioural control is close to the concept of self-efficacy derived from Bandura's social learning theory. Unlike the TRA, the TPB recognises that human behaviour is not 100 per cent volitional hence the addition of perceived behavioural controls to signify the deliberative and planned nature of behaviour.

Nevertheless, the TPB, has some limitations. The first is its failure to capture the entire scope of determinants of intention.

Determinants of intention are not limited to attitudes, subjective norms, and perceived behavioural control (Ajzen, 1991). Secondly, TPB is a predictive model in which an individual's action will be based on certain criteria such as attitudes and subjective norms. However, individuals do not always behave as predicted by those criteria because it is difficult to control the behaviour of individuals in the social environment (Chang, 1998).

The TPB's tenets can be employed as a guide to explore attitudes and perceived behavioural control in adolescent sexual reproductive behaviour. Personal attitudes such as the decision to have a boy/girl friend, and to engage in early intimate sexual relationshipor otherwise not are shaped by perceptions about the possibility of such behaviour leading to particular outcomes and whether the outcomes are evaluated positively or negatively. Perceived behavioural control – age mixing and its inherent perceived power – one's ability to negotiate safe sex and norms – a person's perception of other people's opinions regarding sexual behaviour.

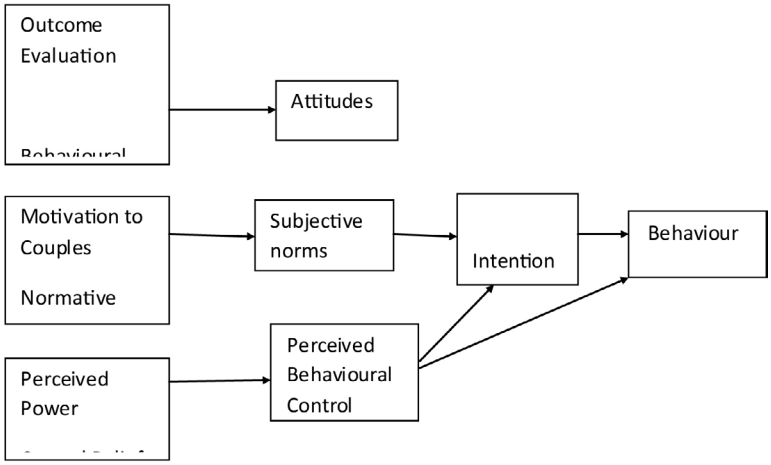

Figure 1: Theory of Planned Behaviour

Source: Ajzen (1991)

Data and Methods

Study Area

The study was conducted in Kwesimintsim Zongo. It is a slum community in the Effia-Kwesimintsim sub-Metro of the Sekondi-Takoradi Municipal Assembly (STMA) and is located along the Takoradi-Agona highway. The community is about 10km from Takoradi, and located Sawmill and Apremdo communities. The community has been in existence for over 200 years (Sekondi-Takoradi Metropolitan Assembly (STMA), n.d.). Kwesimintsim zongo is sub-divided into two, namely Sabong Zongoand Sofo Zongo. It is almost half the size of Takoradi and a densely populated community. At the time of the survey, the population of the area was estimated to be 10,775 (Personal Communication from Ghana Statistical Service, 2009). It has an average household size of six, which is higher than that of the Metropolis' average of four. The community had more females (51%) than males (49%) as the case was in the country.

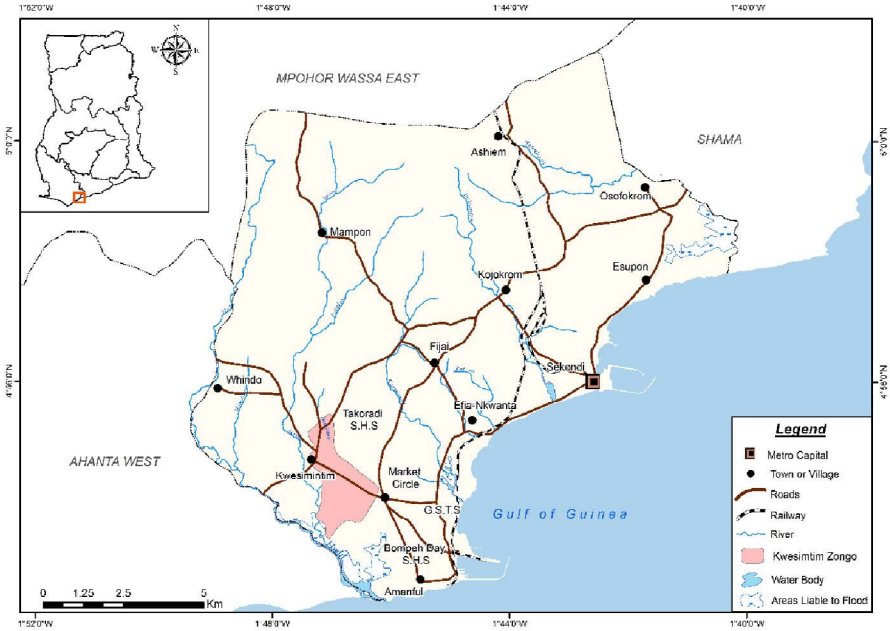

Figure 2:
Map of Sekondi-Takoradi Metropolitan Area showing Kwesimintsim Zongo
Source: Geographic Information Systems (GIS) Unit, Department of Geography and Regional Planning, University of Cape Coast

The community has lost its natural vegetation due to human settlement development. The community is a low-lying area with little or no rock formations. Two major rivers (River Ayilley and River Nvale) run through the community to Sawmill and Apremdo surburbs. Due to the low lying nature of the area, the community experiences flooding whenever there is a heavy downpour with its associated damage and loss of property (STMA, n.d.).

There are 1800 buildings with 5% consisting of storey buildings. Houses are built with different materials and are dominated by compound and semi-detached types. The walls of houses are basically built with sandcrete, landcrete/bricks. Most of the houses have exposed foundations, cracks and are neither cemented nor painted. About a third of the community members owned the houses, 54.9% rented houses and 13.5% lived in rent free houses or were living in family houses. The community has eight public toilets and one septic tank toilet (STMA, n.d.). One could observe indiscriminate defecating in open spaces and gutters in the area.

Solid waste is disposed of into refuse containers at a fee of 10 pesewas whilst liquid waste is disposed of indiscriminately in open spaces. The community has access to five refuse containers and coupled with irregular lifting, lead to spill over of waste, creating bad odour and attracting flies and rodents to the sites. There are access roads leading to various parts of the community, they are hardly motorable. The main source of energy for cooking is charcoal (50%) and about 20% of households use firewood. Use of wood-based fuel is due to its easy access (STMA, n.d.). About 92% of the energy supply

for lighting comes from electricity, 7.2% from kerosene and 0.02% from gas lamp. Solar energy accounts for 0.06% and about 0.54% has no light (GSS, 2002). The community depends on four sources of water (rain, wells, pipe borne water and the stream) for their domestic consumption. There are numerous standpipes in the community from which the residences draw water. An average household of 6 would spend about GH₵0.40 a day on water (GSS, 2002).

The situation depicts an area with inadequate access to safe water, sanitation, poor housing, among others which are inherent in the definition of slums by UN-Habitat (UN-Habitat, 2007). This area was selected for the study because it is located in a region with one of the worse reproductive health outcomes in Ghana (see NACP & GHS, 2013). Also, the city of Sekondi-Takoradi happens to be the capital of the region that hosts the country's oil find, a sure condition to fuel the influx of new migrants into the areas.

Study design and sampling

Primary data from adolescents' living in Kwesimintsim zongo – a slum community in Takoradi, the regional capital of the Western region of Ghana was used for this paper. The study broadly targeted adolescents aged 10-19 years living in Kwesimintsim Zongo. The estimated population for the Kwesimintsim Zongo was 10775 in 2010 (GSS, 2010). Based on this, the population of adolescents' was estimated at about 2155 (20% of estimated population). A total of 902 adolescents aged 10-19 years were interviewed. However, for the purpose of this paper, data on adolescents aged 15-19 years is used. The paper uses data from adolescents aged 15-19 years. This is because available evidence suggests that these adolescents are sexually active (see Ghana Statistical Service (GSS), 2015; Doyle et al., 2012; Seme & Wirtu, 2009; Awusabo–Asare, Biddlecom, Kumi–Kyereme & Patterson, 2006). A total of 420 (204 males and 216 females) adolescents' living in the community was used for the study. A multi-staged sampling technique was used to select the study population. The 2010 Population and Housing Census divided the suburb into 15 Enumeration Areas (EAs). These 15 EAs were grouped into five clusters with each having between one to six EAs. Using simple random sampling, a total of eight EAs were selected from the five clusters. Three EAs were selected from the cluster with six EAs; two were selected from the cluster with four EAs and one EA each of the 3 remaining clusters. Samples were allocated to each EA, based on proportional allocation Structures in each selected EA were listed. Using the EA bases as reference points, every 3rd structure/house was systematically selected in each cluster. Members in the households in the selected structures/houses were listed. Using the household lists, adolescents aged 10-19 years living in the area were identified and this constituted the sampling frame for the study. Simple random sampling was then used to select households with adolescents for the study. In situations where there were more than one adolescent in the household, the person whose name was mentioned first was chosen to respond to the questionnaire. A questionnaire, which had both open and closed ended questions, was used to obtain data from the respondents. In designing the

questions, a literature search was conducted on the topic to identify relevant questions and concepts on sexual and reproductive health among adolescents. Questions from different studies Kumi-Kyereme et al., 2007 and Awusabo-Asare et al., 2006 conducted on reproductive health in general and adolescent reproductive health informed the current study. The rationale for adopting and adapting aspects of questionnaires used in previous studies was to ensure that the variables used conformed to standardised meaning and measurements. Also, it was to ensure reliability and validity. Adolescents aged 15-19 years were made to complete consent forms whilst consent for those aged less than 15 years was sought from their parents and guardians. Subjects who were used in the study were assured of anonymity and confidentiality. Data processing including data entry and cleaning was done using the Statistical Product for Service Solutions (SPSS) version 15. The management and analysis were done using STATA version 14. The study uses socio-demographic variables such as sex, age, highest education level, ethnicity, religion and marital status. Other variables used in the study are: ever had a boy/girl friend – coded 1=Yes, 2=No; age at first intimate relationship – coded 11-19 years, current intimate relationship - coded 1=Yes, 2=No ; ever had sex – coded 1=Yes, 2=No ; age at first sex – coded 11-19 years and age at first sexual partners – coded <10 years, 10-14 years, 15-19 years and 20+ for the quantitative analyses. The T-test was used determine whether statistical differences existin the means males and female adolescents regarding their intimate sexual relationships. Qualitative data was collected through focus group discussions. Focus group discussions (FGDs) were conducted among adolescents aged 15-19 years. Four focus group discussions were conducted among males and females 15-19 (2 for each sex). The purpose of the focus group discussion (FGD) was to obtain qualitative data to support aspects of the quantitative study. Among the issues discussed were the general conditions pertaining in the area, sexual relationships and partnership types and sexual behaviours. Each focus group discussion consisted of between 8 and 10 adolescents. The discussions were at the premises of a basic school in the community and on the average each FGD lasted for about an hour.

The field assistants recruited participants of the qualitative component of the study with assistance from some youth leaders of the area. These participants were not included in the survey. The recorded FGDs were transcribed and manually analysed thematically. Ethical clearance for the study was sought from the Ethical Review Board of the University of Cape Coast. Also, subjects who were used in the study signed consent forms and were assured of anonymity and confidentiality.

Results and Discussion

Of the 420 adolescents interviewed, 49% were males and the rest females. The mean age of the respondents was 16.9 years (16.8 years for males and 17.0 years for females) (data not shown). Forty-six per cent of the males and 39% of the females had completed Junior High School (JHS), with 39% and 49% males and females respectively completing Senior High School (SHS).

Thirty-two per cent of the respondents were Fantes with 20 per cent been Asantes (Table 1). The respondents were predominantly Christians belonging to one Christian denomination or the other compared to 16 per cent Muslims. Only two per cent of the respondents were married (Table 1).

Table 1. Socio-demographic background of respondents

Variables	Sex		
	Males (N=204)	**Females (N=216)**	**Total (N=420)**
Highest level of education			
No education	2.4	1.4	1.1
Primary	11.3	9.7	43.7
Junior High School	45.6	38.9	32.6
Senior High School	39.2	48.6	22.0
Tertiary	1.5	1.4	0.6
Ethnicity			
Fante	45.1	30.1	32.2
Ashante	12.8	21.3	20.1
Ewe	3.4	7.9	6.9
Ga-Adangbe	4.4	3.2	4.0
Nzema	5.4	6.5	5.7
Ahanta	7.8	10.2	11.1
Mole-Dagbani	18.1	17.1	17.1
Non-Ghanaian	3.0	3.7	2.9
Religious Affiliation			
Catholic		9.3	11.0
Protestant	9.8	21.3	21.3
Pentecost/Charismatic	22.1	46.3	42.0
Other Christians	42.6	9.3	8.4
Muslims	4.9	12.9	16.3
Others	17.2	0.9	1.0
Marital Status	3.4		
Married	0.5	5.1	2.3
Not married	99.5	94.9	97.7

Intimate sexual relationships

Perceptions about the possibility that the behaviour will lead to particular outcomes and whether the outcomes are evaluated positively or negatively have the possibility of influencing adolescents attitudes towards intimate sexual relationships (Ajzen, 1991). Forty percent of females and 30% of males had ever had a boy/girl friend. More than a quarter of the adolescents (30% females and 24% males) indicated that they had their first intimate sexual relationship by age 17 with a mean age at first intimate sexual relationship been 15.9 years (16.2 years for females and 15.6 for males). Seventy-four percent of the adolescents who had ever had a boy/girl friend (73% females and 75% males) indicated that they were in a relationship at the time of the survey (Table 2). A t-test conducted to determine whether there were any differences in sexual relationship of male and female adolescents show a significant proportion of male (M=1.7 SD=0.456) than female (M=1.6 SD=0.491) adolescents had ever had a girl/boy friend (t (414)= 2.2861, p=0.0228).

Table 2: Intimate sexual relationship

Variables	Females	Males	Total	T-test
Ever had a boy/girl friend				2.286**
Yes	39.8	28.9	34.5	
No	60.2	71.1	65.5	
N	216	204	420	
Age at first intimate relationship	N=86	N=59	N=145	-2.475**
11	0.0	3.4	1.4	
12	0.0	13.6	5.5	
13	2.3	1.7	2.1	
14	7.0	3.4	5.5	
15	20.9	18.6	20.0	
16	10.5	18.6	13.8	
17	29.7	23.7	26.9	
18	24.4	10.2	18.6	
19	5.8	6.8	6.2	
Current intimate relationship				-0.273
Yes	73.3	74.6	73.8	
No	26.7	25.4	26.2	
N	86	59	145	

A significant gender difference was observed in the decision to ever have a boy/girlfriend among males and females. The gender difference friend is consistent with findings of Kabiru & Ezeh, 2007 who observed gender difference in adolescents sexual experiences. This observation by itself does not necessary warrant any concerns or fears provided the relationships would be platonic. However, if these young men get intimate; they ran the risk of been exposed to the risk of premarital sexual relationships.

Sexual behaviour and partnerships

Studies have linked early age at first sexual intercourse and behaviours of public health concerns such as unprotected sexual intercourse, improper condom use and multiple sexual partner relationships (Wight, Plummer & Ross, 2012; Louie, de Sonjose, Diaz, Castellsague, Herrero et al., 2009; Kaestle, Halpern, Miller & Ford, 2005; Kaestle, Halpen, Miller & Ford, 2005; Gupta & Mahy, 2003). The result shows that about 19% females and males respectively had ever had sexual intercourse. The mean age at first sex was 15.5 years (15.1 for females and 16.2 among males). Twenty-five percent (17% of females and 33% of males) of the adolescents had first sex at age 15. Another 24% of them had first sex at age 18 years (Table 3).

Table 3 : Ever had sex, age at first sex and sexual partners

Variables	Females	Males	Total
Have you ever had sex			
Yes	19.4	19.1	19.3
No	80.6	80.9	80.7
N	216	204	420
Age at first sex			
11	0.00	5.13	2.5
12	2.4	7.7	4.9
13	2.4	7.7	4.9
14	7.1	10.3	8.6
15	16.7	33.3	24.7
16	2.6	9.5	6.2
17	23.0	23.1	23.5
18	33.3	10.3	22.2
19	4.8	0.0	2.5
N	39	42	81
Age of first sexual partner			
>10	25.0	27.0	26.0
10-14	0.0	16.2	7.8
15-19	30.0	56.8	42.9
20+	45.0	0.0	23.4
N	40	37	77

Perception on age at first sex was assessed in the focus group discussions. The adolescents perceived an early age of first sex among their colleagues. For instance, a young male had this to say on age at first sex:

"... most of these young people who engage in these sexual relationships are of the ages 13 – 16 years," – 15 year old male

The views of the young male was supported by an older female who indicated that:

"...those who engage in sex are mostly in the teenage group that is from age 13 years ..." – 18 year old female.

Both the survey and qualitative results reveal early sexual activities among the respondents. Early age at sexual intercourse could lead to a number of negative reproductive health outcomes such as unplanned pregnancies, unsafe abortions and sexually transmitted infections (Wight, Plummer & Ross, 2012; Louie, de Sonjose, Diaz, Castellsague, Herrero et al., 2009; Kaestle, Halpern, Miller & Ford, 2005; Kaestle, Halpen, Miller & Ford, 2005; Gupta & Mahy, 2003). Although the pattern of sexual activity among young people in this study and that of Beguy et al., (2013) are similar, the proportions are markedly different. Beguy and colleagues observed in their study among adolescents in slums of Nairobi that about 20% of males and 25% of the females reported sexual activity (Beguy, Mumah, Wawire, Muindi, Gottschalk, & Kabiru).

The difference in proportions might be due to the normative beliefs concerning the opinions of the people and their evaluation of the opinions (Ajzen & Fisbein, 1980). Since this early age at sexual intercourse could lead to a number of negative reproductive health outcomes such as unplanned pregnancies, unsafe abortions, sexually transmitted infections and multiple sexual partnerships it is important to put in place measures that could cause adolescents to delay sexual intercourse.

The mean age of adolescents' first partner was 15.7 years for males and 20.6 years for the females (data not shown). Fifty-seven percent of the females and 10% of males indicated that their first partner was aged 18-22 years and 9% of the females and 67% of males indicated that their partner(s) were aged 13-17 (Table 3). The results of the focus group discussion supports the existence of age mixing among the adolescents in the community. The results indicate that both males and females were of the view that adolescents were involved in relationships with older partners. For instance, a male adolescent had this to say about the age of partners:

"...the boys in such relationships are normally older that their girls..." – 15 year old male.

A female respondent who corroborated this indicated that:

" ... the girls usually date older people ..." - 18 year old female

The adolescents further indicated that, sexual relationships involved partners of different ages with the females usually involved with older males and vice versa. The observation that females are having sexual intercourse before age 16 (the legal age of consent) creates a situation of concern since they are less likely to have the capability to make informed decisions. Age mixing could affect communication between partners due to imbalance in power relations thus affecting an individuals intentions and ability perform a behaviour (Ajzen, 1991). Also, these relationships could result in negative sexual

and reproductive health outcomes among adolescents (Awusabo–Asare, Biddlecom & Patterson, 2004; GSS, 2009).

Conclusions

This study sought to examine adolescents' attitude towards sexual and reproductive in an urban slum in Ghana. Since early age at sexual intercourse could lead to a number of negative reproductive health outcomes such as unplanned pregnancies, unsafe abortions, sexually transmitted infections and multiple sexual partnerships, it is important to put in place measures that could cause adolescents to delay sexual intercourse. The situation with age mixing could be a mediating factor for some negative reproductive health outcomes. Attention should be paid to reducing early sexual intercourse and age mixing among these adolescents; the associated reproductive health outcomes could negatively affect government's efforts at human capital development through the various policy interventions such as free secondary education and also, the attainment of SDG goal 3. To accrue the benefits from these policy interventions, there should be a sustained effort at discouraging early sexual debut and age mixing among adolescents in urban slums through social and behaviour change communications campaigns.

References

African Population and Health Research Centre (APHRC). (2002). *Population and health dynamics in informal settlements.* African Population and Health Research Centre. Nairobi, Kenya.

Ajzen, I. (1991). Theory of planned behaviour. Organisational Behaviour and Human Decisions Processes, 50, 179 – 211.

Amo-Adjei, J. & Darteh, E.K.M. (2013). *Drivers of Young People's Attitudes towards HIV/AIDS Stigma and Discrimination: Evidence from Ghana.* African Journal of Reproductive Health, [4] ((Special Edition); 17): 51-59.

Awusabo-Asare K., Biddlecom A., Kumi-Kyereme, A. & Patterson, K. (2006). *Adolescent sexual and reproductive health in Ghana: Results from the 2004 national survey of adolescents.* Occassional Report. 2006. New York: Guttmacher Institute.

Beguy, D., Mumah, J.,Wawire, S., Muindi, K., Gottschalk, L. & Kabiru, C.W. (2013). *Status Report on the Sexual and Reproductive Health of Ad olescents Living in Urban Slums in Kenya.* Nairobi: African Population and Health Research Centre.

Chang, M. K. (1998). *Predicting unethical behavior: a comparison of the theory of reasoned action and the theory of planned behaviour.* Journal of business ethics, 17 (16), 1825 - 1834.

Darteh, E.K.M. & Nnorom, C.P.N. (2012). *Sexual Behaviour and Condom use among adolescents living in poor areas in Brong Ahafo, Ghana.* Journal of Alternative Perspectives in the Social Sciences, 4 (3): 618-639.

Darteh, E.K.M., Kumi-Kyereme, A., & Awusabo-Asare, K. (2016). *Perception of Risk of HIV among Adolescents' Living in an Urban Slum in Ghana.* African Journal of Reproductive Health, 20 (1): 62-70.

Dixon-Mueller, R. (2008). How young is "too young "? Comparative perspectives on adolescent sexual, marital, and reproductive transitions. Studies in Family Planning, 39, 247–262.

Dodoo, F.N., Sloan, M., Zulu, E.M. (2003). *Space, context, and hardship: Socialising children into sexual activity in Kenyan Slums.* In Samuel Agyei -Mensah & John B. Casterline (eds.), Fertility and reproductive health in sub-Saharan Africa: A collection of micro demographic studies. Westport, Conc.: Greenwood Press.

Doyle, A.M., Mavedzenge, S.N., Plummer, M.L., & Ross, D.A. (2012). *The sexual behaviour of adolescents in sub-Saharan Africa: patterns and trends from national surveys.* Tropical Medicine & International Health. 17: 796–807. doi: 10.1111/j.1365-3156.2012.03005.x.

Fishbein, M., Middlestadt, S. E., & Hitchcock, P. J. (1994). *Using information to change sexually transmitted disease-related behaviours.* In Preventing AIDS (pp. 61-78). USA: Springer.

Ghana Statistical Service (GSS), Ghana Health Service (GHS), & ICF Macro. (2015). *Ghana Demographic and Health Survey 2014.* Accra, Ghana: GSS, GHS, and ICF Macro.

Ghana Statistical Service (GSS). *2010 Population & Housing Census: summary report of final results.* Ghana Statistical Service, Accra, 2012.

Ghana Statistical Service (GSS), Ghana Health Service (GHS), ICF Macro. (2009). Ghana Demographic and Health Survey 2008. Accra, Ghana: GSS, GHS, and ICF Macro.

Gupta, N. & Mahy, M. (2003). *Sexual initiation among adolescent girls and boys trends and differentials in sub-Saharan Africa,* Archives of Sexual Behaviour, 32 (1), 41 – 53.

Heilborn, M.L. & Cabral, C.S. (2006). *Sexual practices in youth: analysis of lifetime sexual trajectory and last sexual intercourse.* Cad. Saúde Pública (22) doi 10.1590/S0102-311X2006000700 011

Henry, R., & Fayorsey, C. (2002). *Coping with pregnancy: Experiences of Adolescents in Ga Mashi.* Accra. Calverton MD: ORC Macro.

Kabiru, C.W., Beguy, D., Undie, C., Zulu, E.M., & Ezeh AC. (2010). *Transition into first sex among adolescents in slum and non-slum communities in Nairobi, Kenya.* Journal of Youth Studies, 13(4): 453-471.

Kabiru, CW & Ezeh, A. (2007). *Factors associated with Sexual Abstinence among Adolescents in Four Sub-Saharan African Countries.* African Journal of Reproductive Health, 11(3): 99-110

Kaestle, C.E., Halpern, C.T., Miller, W.C., & Ford, C.A. (2005). *Young age at first sexual intercourse and sexually transmitted infections in adolescents and young adults.* American Journal of Epidemiology, 161, 774 – 780.

Kumi-Kyereme, A., Awusabo-Asare, K., Darteh, E.K.M. (2014). *Attitudes of Gatekeepers towards Adolescent Sexual and Reproductive Health in Ghana.* African Journal of Reproductive Health, 18 (3), 142-153.

Kumi-Kyereme, A., Awusabo-Asare, K., Biddlecom, A. & Tanle, A. (2007) *Influence of social connectedness, communication and monitoring on adolescent sexual activity in Ghana.* African Journal of Reproductive Health, 11(3): 133-147.

Lloyd, C.B. (Ed.) (2005). *Growing up global: The changing transitions to adulthood in developing countries.* National Academies Press.

Louie, K. S., de Sanjose, S., Diaz, M., *Castellsague,* X., Herrero, R., Meijer, C. J., Shah, K.,

Franceschi, S., Muñoz, N., & Bosch, F. X. (2009). *Early age at first sexual Intercourse and early pregnancy are risk factors for cervical cancer in developing countries.* British Journal of Cancer, 100, 1191 – 1197.

Middlestadt, S.E., & Fishbein, M. (1990). *Factors influencing experienced and inexperience college women intentions to tell their partners to use condoms.* [Unpublished] 1990 Paper presented at the sixth International Conference on AIDS, 20 – 24th June, 1990, San Francisco, California.

Nabila, J., Fayorsey, C., & Pappoe, M. (2000). *Youth and Reproductive health in Africa: Assessment of adolescent reproductive health needs in Ghana.* Accra, Ghana: UNFPA.

Population Reference Bureau. (2013). *The World's Youth 2013 Data Sheet.* 2013.Washington DC.

Seme, A., & Wirtu, D. (2009). *Premarital sexual practice among school adolescents in Nekemte Town, East Wollega.* Ethiopian Journal of Health Development, 22 (2): 167-173.

Silva, J.S., Fonseca, A.M., Bagnoli, V.R., Cavalcanti, A.L., Soares, J.J., Baracat, E.C. (2010). *Sexuality in women with polycystic ovary syndrome: a pilot study.* Einstein (Sao Paulo), 8 (4): 397–403. doi: 10.1590/S1679- 45082010AO1836

United Nations. (2017). *Sustainable Development Goals to transform our world.* Retrieved from: http://www.un.org/sustainabledevelopment/sustainable-development-goals/

Vanlandingham, M. J., Suprasert, S., Grandjean, N., & Sittitrai, W. (1995). *Two views of risky sexual practices among northern Thai males: the health belief model and the theory of reasoned action.* Journal of Health and Social Behaviour, 195 - 212.

Wight D, Plummer M, Ross D. (2012). *The need to promote behaviour change at the cultural level: one factor explaining the limited impact of the MEMA kwa Vijana adolescent sexual health intervention in rural Tanzania.* A process evalua-

tion. BMC Public Health, 12 (1), 788.
Zulu EM, Dodoo FN, Ezeh AC. (2002) *Sexual risk-taking in the slums of Nairobi, Kenya,* 1993-98, Population Studies.56, 311-323.

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