THE IMPACT OF COVID-19 ON ADOLESCENT GIRLS IN GHANA: A MIXED-METHOD STUDY

March, 2022

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LIST OF ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CAPI	Computer-Assisted Personal Interview
COVID-19	Coronavirus disease of 2019
CSA	Child Sexual Abuse
CSE	Comprehensive Sexuality Education
DHIMS	District Health Information Management System
DSWCD	Department of Social Welfare and Community Development
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
JHS	Junior High School
KII	Key Informant Interview
MoE	Ministry of Education
SGBV	Sexual & Gender Based Violence
SHEP	School Health Education Programme
SHS	Senior High School
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UNESCO	United Nations Educational, Scientific Cultural Organisation
UNICEF	United Nations Children's Fund
VOC	Vocational Schools
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

One of the important and necessary socio-economic strategies being adopted by governments globally to contain the spread of the COVID-19 pandemic is school closures. In Ghana, schools were closed due to the outbreak of COVID-19 between March and December 2020. It has been argued that COVID-19 school closures and lockdowns are likely to increase the sexual and reproductive health and rights (SRHR) risks of adolescent girls (Eghtessadi, Mukandavire, Mutenherwa, Cuadros, & Musuka, 2020; Riley, Sully, Ahmed, & Biddlecom, 2020a). UNESCO warns that COVID-19 school closures around the world will hit girls hardest by increasing risk of sexual exploitation, early pregnancy and early and forced marriage as well as increased school drop-out rates which are expected to further entrench gender gaps in education. This research aims to understand the impact of COVID-19 induced school closures on adolescent girls' SRHR. Specifically, the study seeks to examine the effects of COVID-19 induced school closures on the incidence of child sexual abuse (CSA), adolescent pregnancy, child marriage and adolescent girls' use of sexual and reproductive health (SRH) services.

Problem statement

Already, available evidence points to gendered effects of school closures and lockdown during the COVID-19 pandemic. Girls in particular have been recognised as a vulnerable group in the COVID-19 pandemic (Hall et al., 2020). This is particularly evident in the SRH area, where adolescent girls are likely to disproportionately drop out of school due to an increased risk of pregnancy, sexual exploitation, and forced marriage (Affoum & Recavarren, 2020; Burzynska & Contreras, 2020; Cousins, 2020; Save the Children, 2020). In Ghana, anecdotal evidence points to an increase in adolescent pregnancy during the lockdown and school closures. For instance, estimates from World Vision Ghana (2020) indicates that in the Krachi West District, during COVID-19, the district experienced a nine-fold rise in teen pregnancy. Between March and May 2020, 51 girls were reported pregnant against six cases of teen pregnancy recorded in all of 2018 (Baker, 2020). There are also concerns that school closures in this COVID-19 pandemic may bolster gender gaps in education and girl empowerment dampening any progress already made (The Lancet Child Adolescent Health, 2020). It has been argued that most girls are likely not to return to school due to the possible spike in adolescent pregnancies and other SRH risks (Baker, 2020; Selbervik, 2020).

Given that COVID-19 lockdown and school closures are likely to increase adolescent pregnancy and limit the access to SRH services with obvious implications for adolescent girls' health and education outcomes, and the dearth of studies from low-and middle-income country settings, it is important to understand the extent of the problem and the measures required to promote adolescent girls' SRHR during and after the pandemic in Ghana. Indeed, a recent paper published in the Lancet Child and Adolescent Health noted that not much is known about the effects of school closures during COVID-19 on ASRHR and called for further research in this area to understand the scale of the problem (Burzynska & Contreras, 2020). In the area of uptake of SRH services, evidence from the Ebola outbreak indicates that there was a sharp reduction in contraceptive use and family planning visits in Guinea, Liberia and Sierra Leone (Bietsch, Williamson, & Reeves, 2020; Camara et al., 2017). Challenges in accessing SRH information and services will exacerbate girls existing reproductive health risks (e.g., pregnancy and childbirth complications which is one of the leading causes of death among girls aged 15-19 years old). Already, statistical models in the initial stages of the COVID-19 pandemic point to a reduction in the overall utilisation of reproductive, maternal and new-born health services (Roberton et al., 2020). This means that policy makers must consider not only the direct health effects of the COVID-19 pandemic but also the indirect effects of the pandemic and rapidly develop strategies to mitigate these.

This study thus aims to fill an important gap in knowledge and will be useful for informing child protection and public health and education policies and programming relating to mitigating the effects of school closures during the COVID-19 pandemic on SRHR of adolescent girls.

Overall and specific objectives of the research

This research aims to understand the impact of COVID-19 induced school closures on adolescent girls' sexual and reproductive health and rights. The study specifically seeks to examine the effects of COVID-19 induced school closures on the incidence of child sexual abuse, adolescent pregnancy, child marriage and adolescent girls' use of sexual and reproductive health services.

Research questions

To achieve the aim of the study, the following research questions were explored:

1. What is the effect of COVID-19 on adolescent pregnancy?
2. What is the effect of COVID-19 on adolescent girls' risk of child marriage?
3. What is the effect of COVID-19 on child sexual abuse/violence and reporting?
4. What is the effect of COVID-19 on adolescent girls' access to, and utilisation of SRH services?
5. What are adolescent girls' SRH help-seeking behaviours and preferences for SRH services during the COVID-19 outbreak?
6. What strategies are required to mitigate the negative effects of COVID-19 lockdown and school closures on adolescent girls' SRHR?

METHODOLOGY AND LIMITATIONS

This study employed a concurrent mixed-method design. The quantitative component used a cross-sectional survey to ascertain adolescent girls' SRH behaviours during the COVID-19 outbreak. The qualitative component was an in-depth exploration of the lived experiences of adolescent girls. Interviews were also held with community leaders, school-teachers and service providers including Community Health Nurses, Midwives, and Nurses who provide SRH services to adolescent girls.

To gain a balanced view of the impact of COVID-19 induced school closures on adolescent pregnancy and adolescent girls' SRHR, a maximum variation purposeful sampling strategy (Patton, 2014) was used to select two UNICEF supported districts: Asokore Mampong Municipal and Afigya Kwabre South District in Ashanti region. The Ashanti region was chosen for this study as it recorded the highest number of adolescent pregnancies in 2020 in Ghana (Mensah, 2021). Furthermore, the selected districts were part of by the COVID-19 lockdown imposed by the government on the Greater Kumasi Metropolitan Area in the Ashanti region between March 30 and April 20, 2020. To maximise variation, in each of the districts, communities exhibiting rural and urban characteristics were selected for the fieldwork. For the quantitative survey, within the study districts and sites, the research team used stratified purposeful sampling (Patton, 2014) to include both in and out of school adolescent girls. The survey was conducted on a random sample of 853 adolescent girls aged 13-19 (16.03 ± 2.04 years of age). In all, 60 in-depth interviews (IDI) and 12 focus group discussions (FGD) were conducted.

The research instruments (questionnaire and interview guides) were developed based on previous studies on the subject matter. The research instruments were peer-reviewed by UNICEF experts working on adolescent sexual and reproductive health, gender, and child protection. In addition, all items were tested in a pilot study with 50 adolescents. For the cross-sectional survey, self-reported computer-assisted questionnaires were administered between May and August 2021. All IDIs and FGDs took place at designated places and times most convenient for the participants. Both in-depth interviews, focus groups and questionnaire administration were by face-to-face with strict adherence to COVID-19 safety protocols. Key informant interviews (KIIs) were also held with community

leaders, schoolteachers and service providers including Community Health Nurses, Midwives, and Nurses who provide SRH services to adolescent girls. IDIs and FGDs were audio recorded with consent from the study participants.

Data on adolescent pregnancy and adolescent girls' SRH service utilisation variables of interest were extracted from the District Health Information Management System of the Ghana Health Service i.e., DHIMS-2 to Microsoft Excel 2016 for processing and cleaning. The variables of interest here included antenatal care attendance (new and revisits; adolescent pregnancies), family planning services uptake by adolescent girls and method, and SRH information services accessed. Relevant rates/proportions were computed. The Statistical Package for Social Sciences (SPSS version 26) was used to analyse the quantitative data. The qualitative data were analysed using thematic analysis approach (Braun & Clarke, 2006).

Ethical considerations

Ethical review board approval for the study was sought from the Humanities and Social Sciences Research Ethics Committee (HuSSRECC) at the Kwame Nkrumah University of Science and Technology (KNUST), Ghana. During the data collection, written informed consent or oral consent was sought from the study participants. Participants were informed that they have the right to withdraw from the study at any time during the interviews. A response plan was also put in place to deal with child safety issues.

Limitations

Quantitative survey

This is a cross-sectional survey during COVID-19 therefore, no causal inferences can be made about the "impact" of school closures– it can only tell us about the status of SRH among adolescents during COVID-19. Furthermore, the sample was drawn from two districts in Ashanti Region and may not be representative of the adolescent girls' population in Ghana.

Qualitative survey

As is customary with qualitative research, data collected through KIIs, IDIs and FGDs is self-reported and as such carries the potential for social desirability bias.

FINDINGS

Socio-demographic characteristics of respondents

A total of 853 adolescent girls aged 13-19 (16.03 ± 2.04 years of age) were surveyed. In terms of religion practiced by the adolescents, 62.3% were Christians while 37.4% were Muslims. Regarding disability, a majority of the adolescent girls (70.9%) did not have any form of disability. However, for those who had, the top four forms of disability were visual (13.2%), emotional (5.5%), learning (4.6%) and hearing (3.6%). A majority of the adolescent girls (78.3%) had both parents still alive while others had only their mother (14.5%) or father (4.1%) alive. The educational level shows that 52.4% had attained Junior High School (JHS) education followed Senior High School (SHS)/ Vocational School (VOC) (29.1%), primary (12.1%) and tertiary (0.4%). About 6.1% of the adolescent girls had never been to school. Currently, more than half of the adolescent girls (63.3%) reported being in school. A significant proportion of the adolescent girls (46%) rated their parents' supervision as medium while 42.7% rated it high.

The Effect of COVID-19 on Adolescent Pregnancy

Overall, the prevalence of teenage pregnancy during the COVID-19 lockdown and school closures in the sampled adolescent girls was 7%. This varied considerably between urban and rural districts. Data from DHIMS-2 in Afigya Kwabre South District revealed that adolescent pregnancies increased from 565 in 2018 to 602 in 2020. In both districts, increased teenage pregnancy was a recurring theme in the KIIs, FGDs and IDIs with the adolescent girls. A significant proportion of the adolescent girls (99.1%) indicated that the pregnancy was unplanned. Discussions with the health providers revealed that adolescent girls are five times more likely to terminate pregnancies than to keep them. The qualitative findings revealed that the drivers of increased pregnancy cases were idleness, poverty, and parental neglect. Among current pregnant adolescents, a significant proportion of them (45.16%) did not know which trimester they were in. A common theme from the interviews with the healthcare providers was that adolescent girls delayed antenatal care (ANC) attendance. Most of the adolescent girls were said to report for ANC during the second or third trimester. More than a quarter of the adolescent girls (40%) reported that they missed or delayed pregnancy care appointments during the COVID-19 lockdown and school closures. Of the 7% (N=60) adolescent girls who got pregnant during the COVID-19 lockdown and school closures, 10 of them reported terminating the pregnancy.

The Effect of COVID-19 on Adolescent Girls' Risk of Child Marriage

Overall, 20.8% of the adolescent girls (N= 177) reported that child marriage was discussed with them during the COVID-19 lockdown and school closures. 3.4% got married (N=29) while 17.4% did not get married (N=148). The COVID-19 lockdown and school closures were said to have accounted for 47.8% of child marriage discussions with adolescent girls. The main reasons for child marriage discussions with adolescent girls were financial difficulties (26.5%), early marriages being common in the community (26.5%), pregnancy (8.2%) and parental job loss (2.0%). Evidence from the interviews and focus groups support the quantitative evidence that the COVID-19 induced school closures, household poverty, pregnancy and parental neglect and economic insecurity, which limit parents' ability of parents to provide for their children as key drivers of child marriage. More than half (52.2%) of the adolescent girls indicated that they did not report child marriage discussions to anyone. However, in responding to a question on what adolescent girls would do if there was pressure from their parents for them to get married, the majority of them indicated that they would either report it to the Police (28.3%), run away from the house/community (19.0%) or report to religious leaders (11.2%).

The Effect of COVID-19 on Child Sexual Abuse/Violence and Reporting

Overall, the lifetime prevalence of sexual abuse was 32.5%. That is, three in 10 adolescent girls had ever experienced at least one type of child sexual abuse (CSA) in their lifetime. The prevalence of sexual abuse was significantly higher in rural Afigya Kwabre South district (35.8%) than urban Asokore Mampong (28.9%) ($p = 0.031$).

The prevalence of the various forms of CSA during the COVID-19 lockdown and school closures were sexual harassment (20.3%), pressurised sex (3.5%), attempted rape (14.5%), forced sex (1.9%) and forced exposure to pornography (14.8%). In all, a total of 19 rape[1] cases (pressurised sex and forced sex) were reported by the adolescent girls. Adolescent girls' vulnerability to CSA increased from 14.2% one year before the COVID-19 pandemic to 25.9% during the COVID-19 pandemic. The qualitative interviews and FGDs revealed that, adolescent girls were at increased risk of CSA during the school closures and the lockdown. Among the victims of CSA with physical contact with or without penetration, the most frequently reported places were another person's house (58.8%) and the victim's house (17.6%). The quantitative findings showed that the main relationship of the perpetrators of CSA to their victims were acquaintances (31.30%), romantic

1 Rape is defined here as sexual intercourse with a female of sixteen years or above without her consent.

partner (25.00%), neighbour (18.8%), peers (12.5%), family member (6.3%) and other (6.1%). Among adolescent girls who had experienced sexual violence, only 6.4% indicated ever reporting sexual abuse in the past 12 months. Of the girls who reported any incidence of CSA, they mainly reported it to their parents/guardian (50.0%), other family members (17.2%), teachers (12.1%), peers (8.6%) or the Police (5.2%). Discussions with some victims of CSA revealed that they lacked knowledge on support services available to victims. Participants mainly reported that victims needed to turn to their parents/guardians for support. One of the challenges faced by adolescent girls in reporting the case to the police was that they could not afford the process. Others also cited perceived bribery and corruption as the reasons for not reporting CSA to the police.

The Effect of COVID-19 on Adolescent Girls' Access to, and Utilisation of Sexual and Reproductive Health Services

Overall, 81.7% of the girls reported ever discussing SRH matters with someone. In responding to a question on the person that adolescent girls discuss SRH concerns with, girls indicated mothers (32.3%) followed by teachers (26.8%), friends (20%) and sisters (10.2%). During FGDs, mothers were identified as the most salient individuals. Most of the girls shared that their mothers have made a concerted effort to communicate to them their thoughts and feelings regarding sexuality, particularly on issues relating to menstruation and abstinence from sexual intercourse. This maternal viewpoint was often grounded in the mother's lived life experience (e.g., as a single mother), and it was clear that these mothers wanted a better life for their own daughters.

The SRH topics that were often discussed were pubertal development including menstrual hygiene (67.9%), pregnancy (42.2 %), sexual abstinence (32.7%), contraception (19.3%) and STIs (16.7%). Of the 18.3% girls who had never discussed any SRH related matters with anyone, the main reasons cited were shyness (35.3%), being uncomfortable discussing this subject (28.3%) and being stigmatised (14.40%).

Overall, 75% of the adolescent girls reported that they find it easy to obtain information on SRH. Of the 25% of the adolescent girls (N=261) who were unable to obtain information on SRH, the reasons were 'I feel shy' (57.5%), 'don't know where to obtain information' (22.2%), 'parents disapprove' (8%) of seeking SRH services, and 'no SRH services available' (3.8%).

Before COVID-19, the adolescent girls' main sources of information on SRH were from friends (30.10%), parents (17.5%), health provider/clinic (16.50%), TV (4.9%), social media (4.9%) and radio (1%). However, during the COVID-19 pandemic, adolescent girls' main sources of information on SRH were health provider/clinic (25.3%), friends (23.2%) and parents (18.90%), social media (8.4%), other internet sources (8.4%), and TV (5.3%). The adolescent girls' main preferred sources of information were health provider/clinic (30.6%), TV (14.0%) and the internet (12.4%). Comparison of the before and after COVID-19 pandemic sources of information indicates that following the COVID-19 outbreak and its attended preventive measures there was an increase in digital information sources such as social media (from 4.9% to 8.40%), TV (from 4.90% to 5.30%). During FGDs, most adolescent girls indicated that they turned to social media for information on SRH.

Sexual Behaviour

The majority of the girls (N= 623, 73%) reported that they were currently not in a relationship. One in four adolescent girls (25.7%) reported that they had never had sexual intercourse. Of those who had ever had sex, 69.4% reported that their sexual partners were much older than them while 30.6% said their sexual partners were their contemporaries. Among adolescent girls who have had penile-vaginal sex, 88.1% reported that their first intercourse was with a romantic partner/ boyfriend. Evidence from the interviews confirmed that the romantic partners of the girls, who in some cases provided the basic needs of the girls, demanded sex from them as a proof of their love and faithfulness. In relation to sexual activity over the past 12 months, 19.3% of the girls reported being engaged in sexual intercourse over the last 12 months. Most of the girls (95.3%), indicated

that sexual activity did not necessarily increase during the school closure and COVID-19 lockdown. However, evidence from the in-depth interviews show that some of the adolescent girls were engaged in transactional sex due to poverty.

Contraceptive Use

The findings show that adolescent girls have a high unmet need for contraception. In responding to a question on what is currently being done to delay or prevent pregnancy, 89.1% of the girls reported that they were currently not doing anything to avoid pregnancy. Of the 11% of the girls (N=115) who reported using contraception, the main contraceptive methods used were pills (40.0%), withdrawal method (14.8%), condom (20.90%), and natural/rhythm method (10.4%). Among the adolescent girls who were sexually active during the COVID-19 lockdown and school closures (N=219), 96.6%, reported that they did not use a condom the last time they had sex. This means that the majority of the sexually active adolescent girls are at increased rate of being infected with HIV and other STIs as well as becoming pregnant. The qualitative interviews and FGDs revealed that adolescent girls held some misconceptions about condom use. Condoms were perceived by some adolescent girls to reduce sexual pleasure and create discomfort – a view that the girls stressed were also widely held by their romantic partners. Other beliefs held by the girls were that drinking chilled water after sex, taking paracetamol, and eating fruits (i.e., blended pawpaw and pineapple) were effective in preventing pregnancy than using a condom.

The interviews and FGDs revealed that while some adolescent girls had basic knowledge of methods of contraception, misconceptions persist about types, modes of action and use of contraceptives. There was a general perception that contraceptive use in adolescence reduces fertility prospects. The girls believed that girls who use contraceptives will be unable to get pregnant when they eventually get married and need to have children. There was also religious beliefs and norms that using contraception is a sin.

Adolescent Girls' SRH Help-Seeking Behaviours and Preferences for Sexual and Reproductive Health Services During the COVID-19 Lockdown

The majority of the girls (91.6%) indicated that they never needed to seek medical care or services relating to SRH during the COVID-19 lockdown. The qualitative interviews and focus groups revealed that most of the girls were very sceptical about visiting health facilities to inquire about SRH services. They believed that if one visits a health facility for such assistance, she is generally referred to as 'a bad girl' or already engaged in some sexual acts. Interviews with healthcare providers confirmed this assertion. Of the 8.4% of the girls who needed to seek medical care for SRH issues, 95.2% were unable to get the needed support primarily due to limited access to health facilities and the COVID-19 lockdown. Of the 121 adolescent girls who reported seeking for help on SRH issues during the COVID-19 lockdown, their preferred sources of information were health provider/clinic (30.6%), TV (14.0%), internet (12.4%), social media (11.6%), parents (9.9%) and friends (6.6%).

Adolescent girls' response to Referral Process

Providing referrals to formal support services constitute the standard multidisciplinary intervention offered to victims of abuse. In this study, of 114 adolescent girls who were eligible for referral to support services, 28 of them agreed to be referred. This indicates the difficulty of connecting abuse victims to formal and specific support in the social care setting. Discussions held with some participants who had suffered sexual abuse and were eligible for referral but refused to be referred revealed that their parents/guardians had settled the case with the perpetrators. Such informal resolution mechanisms were found to have left some of the participants being emotionally distressed as they lacked emotional counselling, safety planning, and welfare needs assessments and planning. There were also sociocultural barriers to seeking help including social norms that normalise sexual and emotional abuse and impose stigma on the victims. Some adolescent girls, for example, noted that they did not want to be tagged as victims of sexual abuse or 'bad girls' for fear of losing potential marriage partners in adulthood. Others indicated that reporting such cases to

formal institutions would make it 'a big case in the community' and bring shame upon themselves and their families. Interviews with some of the victims clearly showed the internalisation of negative stereotypes.

Strategies to Mitigate the Negative Effects of COVID-19 lockdown and School Closures on Adolescent Girls' Sexual and Reproductive Health and Rights

The key strategies for mitigating the effects of COVID-19 on adolescent girls' SRHR that emerged from the study are parent-girl child interventions, community-based interventions, internet/social media public health campaigns and maintaining learning and links to schools during closures.

Both the quantitative and qualitative evidence indicate that **parent-adolescent SRH-related communication** is one factor that could help mitigate the negative impact of pandemics on adolescent girls' SRHR. For instance, parents can provide information on safer sex behaviour, use of contraceptives and pregnancy care.

Community-based approaches to adolescent SRHR were emphasised by the participants as another strategy to improve adolescent girls' access to SRH services during the COVID-19 pandemic. Currently, there is a strong focus on adolescent SRH education within the school setting. While this is important, the COVID-19 induced school closures and their attendant effects on adolescent SRH means that there is the need to take a more comprehensive approach to adolescent SRHR.

The findings from this study further indicate that the adolescent girls, to some extent, turned to **the internet and social media as potential sources of information** on SRH services during the COVID-19 pandemic. This suggests that new digital media (e.g., the internet, text messaging, and social networking sites) offer a potential strategy for promoting adolescent girls SRHR during the COVID-19 pandemic.

Another important strategy to mitigate the negative effects of pandemics like COVID-19, is to **maintain learning and links to schools during closures and lockdown**. This is particularly important during school closures as school connections and links serve as pathways for adolescent girls at risk of or experiencing violence and abuse to seek support and/or report cases. Furthermore, a central theme across the interviews and focus groups with the adolescent girls was the need to keep up some learning or connection to schools during school closures. The findings show that a large proportion of the girls did not engage in any form of home-schooling during the COVID-19 lockdown and school closures. Parents who were interviewed re-echoed the concerns of the adolescent girls and called for state support to parents in terms of teaching and learning at the community level during school closures.

RECOMMENDATIONS

1. **Involving parents in adolescent SRH education.** The findings from the study show that parents especially mothers are primary source of information to adolescents when it comes to SRH issues. In some instances, however, parent-child relationship was problematic within the communities making it difficult for adolescents to share their respective problems with their parents. Currently, there seems to be no parent-girl-child intervention or a parent-centred intervention focusing on parents as champions of adolescent SRH. Parents are role models who shape adolescent and young people's perception of gender roles and influence the choices that they make about their sexual behaviour. It is therefore recommended that a Parent Education Programme be designed to improve parents' skills for educating and communicating with children and adolescents, especially about sexuality and reproductive health. The proposed parent

education programme will be most effective when it operates holistically within the socio-cultural context of changing family patterns and works through existing networks of learning institutions and community-based organisations.

2. **Effective and continuous education on contraception.** Most of the adolescents knew little about the contraceptives beyond prevention of pregnancy. Most of them held the perception that condoms are solely meant for preventing unplanned pregnancy but not sexually transmitted infections or diseases.

3. **Economic empowerment programme for adolescent girls.** To effectively empower adolescent girls against transactional and risky sexual behaviours, there is the need to consider supporting economic empowerment interventions targeting adolescents. This may be through direct initiatives such as gender-responsive cash plus transfer programmes or indirect initiatives such as skills for employability and programmes with peer mentors on future planning. A recent systematic review of cash transfer programmes in sub-Saharan Africa found that cash transfer programmes significantly reduced sexual debut, transactional sex, early marriage, and adolescent pregnancy among adolescents (Owusu-Addo et al. 2018).

4. **Intensification of community-based SRHR education.** In the face of continued resistance to in-school comprehensive sexuality education (CSE), community-based SRHR education remains the most viable option to deliver gender sensitive SRH education. There is therefore the need to intensify the community-based education programmes including the formation of community adolescent health clubs. This should be based on an 'empowerment approach' with a focus on gender norms and power relations recognising that these are crucial factors in safer sex negotiation and, more broadly, in the overall social and cultural environment in which adolescents make SRH decisions.

5. **Further research to document and understand the impact of COVID-19 on children's home-learning during the lockdown and school closures.** Participants (i.e., adolescent girls, parents, and teachers) made a causal anecdotal argument that the school closures affected learning and exposed girls to sexual violence and the risk of adolescent pregnancies and child marriage. However, it is unclear to what extent this has been the experience of all students, and particularly whether students from marginalised groups and rural communities participated in and benefitted from schooling at home in Ghana. Accordingly, it is recommended that research is conducted to specifically explore the perspectives and experiences of parents and children on the impact of COVID-19 on home-schooling using a retrospective methodology.

1.0 INTRODUCTION

1.0 INTRODUCTION

1.1. BACKGROUND

One of the important and necessary socio-economic strategies being adopted by governments globally to contain the spread of the COVID-19 pandemic is school closures. As of October 21, 2020, UN Educational, Scientific and Cultural Organisation (UNESCO, 2020) estimated that school closures affected 562 million children and young people in 33 countries, or 32.1% of total enrolment. In Ghana, schools were closed due to the outbreak of COVID-19 between March and December 2020. UNICEF estimates that as of September 22, 2020, over 8.2 million learners were affected by COVID-19 school closures in Ghana (UNICEF, 2020). While evidence from past epidemics suggests that closing schools can have a significant effect on reducing infection rates and flattening the curve (Viner et al., 2020), the potential negative consequences of this measure cannot be ignored. Prolonged school closures constitute one of the most disruptive forces in the COVID-19 era with ramifications for adolescent girls' sexual and reproductive health and rights (SRHR) (Burzynska & Contreras, 2020; Eghtessadi et al., 2020). School closures toppled life for children and families (Hoffman & Miller, 2020; Kinsey et al., 2020).

Furthermore, it has been argued that COVID-19 school closures and lockdowns are likely to increase the SRHR risks of adolescent girls (Eghtessadi et al., 2020; Riley et al., 2020a). UNESCO warns that COVID-19 school closures around the world will hit girls hardest by increasing risk of sexual exploitation, early pregnancy and early and forced marriage as well as increased school drop-out rates which will disproportionately affect adolescent girls, and further entrench gender gaps in education (UNESCO, 2020). This is supported by evidence from previous infectious diseases such as the 2014-2016 Ebola crisis in West Africa. For instance, school closures during the Ebola outbreak were found to be associated with 65% increase in adolescent pregnancy in some communities in Sierra Leone (Baker, 2020). It has been argued that many of the anticipated consequences of school closures induced by COVID-19 are themselves key risk factors for adolescents' health and wellbeing. These include adolescent engagement in risky sexual behaviours, sexual violence, coercion and exploitation, domestic violence (particularly violence against women and girls) (John, Casey, Carino, & McGovern, 2020; Riley, Sully, Ahmed, & Biddlecom, 2020b).

1. 2. PROBLEM STATEMENT

The need to promote and protect adolescent girls' (those aged 10-19 years) SRHR, information and services was highly embraced by governments across the globe at the International Conference on Population and Development (ICPD) held in Cairo in 1994 (Lyra & Medrado, 2014). This political commitment has however not been backed by adequate action as adolescent pregnancy remains common, particularly in sub-Saharan Africa and constitutes a major public health burden. It has been estimated that about 21 million girls aged 15-19 become pregnant every year with 12 million of them giving birth in low-and middle-income countries (Darroch, Woog, Bankole, Ashford, & Points, 2016). Estimates from the United Nations (2019) show that while globally, adolescent fertility has declined from 56 births per 1000 adolescent women in 2000 to 45 births in 2015 and 44 births in 2019, the level of adolescent fertility has remained high in sub-Saharan Africa, at 101 births per 1000 adolescent women. The situation is no different in Ghana where adolescent birth rate is 65 per 1000 live birth accounting for 14% of all births (Ghana Statistical Service, 2018). Complications associated with pregnancy and childbearing are the leading causes of death among teenagers (WHO, 2019). Teenage mothers are at high risk of poor maternal and infant outcomes including maternal and infant death, preterm birth or giving birth to an infant who has a low birthweight as compared to adult mothers (Dillon & Cherry, 2014).

Already, available evidence points to gendered effects of school closures and lockdown during the COVID-19 pandemic. Girls in particular have been recognised as a vulnerable group in the COVID-19 pandemic (Hall et al., 2020). This is particularly evident in the area of SRH, where adolescent girls are likely to disproportionately drop out of school due to an increased risk of pregnancy, sexual exploitation, and forced marriage (Affoum & Recavarren, 2020; Burzynska & Contreras, 2020; Cousins, 2020; Save the Children, 2020). In Ghana, anecdotal evidence points to an increase in adolescent pregnancy during the lockdown and school closures. For instance, estimates from World Vision Ghana (2020) indicates that in the Krachi West District, during COVID-19, the district experienced a nine-fold rise in teen pregnancy. Between March and May 2020, 51 girls were reported pregnant against six cases of teenage pregnancy recorded in all of 2018 (Baker, 2020). There are also concerns that school closures in this COVID-19 pandemic may bolster gender gaps in education and girl empowerment dampening any progress already made (The Lancet Child Adolescent Health, 2020). It has been argued that most girls are likely not return to school due to the possible spike in adolescent pregnancies and other SRH risks (Baker, 2020; Selbervik, 2020).

Given that COVID-19 lockdown and school closures are likely to increase adolescent pregnancy and limit the access to SRH services with obvious implications for adolescent girls' health and education outcomes, it is important to understand the extent of the problem and the measures required to promote adolescent girls' SRHR during and after the pandemic in Ghana. Indeed, a recent paper published in the Lancet Child and Adolescent Health noted that not much is known about the effects of school closures during COVID-19 on adolescent SRHR and called for further research in this area to understand the scale of the problem (Burzynska & Contreras, 2020). In the area of uptake of SRH services, evidence from the Ebola outbreak indicates that there was sharp reduction in contraceptive use and family planning visits in Guinea, Liberia and Sierra Leone (Bietsch et al., 2020; Camara et al., 2017). Challenges in accessing SRH information and services will exacerbate existing reproductive health risks faced by adolescent girls (e.g., pregnancy and childbirth complications which is one of the leading causes of death among girls aged 15-19 years old). Already, statistical models in the initial stages of the COVID-19 pandemic point to a reduction in the overall utilisation of reproductive, maternal and new-born health services (Roberton et al., 2020). This means that policy makers must consider not only the direct health effects of the COVID-19 pandemic but also the indirect effects of the pandemic and rapidly develop strategies to mitigate these.

This study thus, aims to fill an important gap in knowledge and will be useful for informing child protection, public health and education policies and programming relating to mitigating the effects of school closures during the COVID-19 on SRHR of adolescent girls.

1.3. OVERALL AND SPECIFIC OBJECTIVES OFTHE RESEARCH

This research aims to understand the impact of COVID-19 induced school closures on adolescent girls' SRHR. The study specifically seeks to examine the effects of COVID-19 induced school closures on the incidence of child sexual abuse, adolescent pregnancy, child marriage and adolescent girls' use of SRH services.

1.4. RESEARCH QUESTIONS

To achieve the aim of the study aim, the following research questions were explored:

1. What is the effect of COVID-19 on adolescent pregnancy?

2. What is the effect of COVID-19 on adolescent girls' risk of child marriage?

3. What is the effect of COVID-19 on child sexual abuse/violence and reporting?

4. What is the effect of COVID-19 on adolescent girls' access to, and utilisation of SRH services?

5. What are adolescent girls' SRH help-seeking behaviours and preferences for SRH services during the COVID-19 outbreak?

6. What strategies are required to mitigate the negative effects of COVID-19 lockdown and school closures on adolescent girls' SRHR?

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2.0 RESEARCH METHODOLOGY

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2.0 RESEARCH METHODOLOGY

2.1. CONCEPTUAL FRAMEWORK

The socio-ecological model (SEM) was used to inform the project design. The SEM illustrates multiple dimensions and complex human interactions that influence health behaviours (Lee, Bendixsen, Liebman, & Gallagher, 2017). The core principles of the model are: (1) there are multiple influences on an individual's behaviours (i.e., adolescent girls' SRHR amidst school closures), including factors at the intrapersonal level, interpersonal level, with increasing influence at levels of community, and public policy; (2) influences interact across these different levels or spheres of influence; and (3) multilevel approaches can be the most effective interventions for promoting adolescent girls' SRHR.

2.2. STUDY DESIGN

This study employed a concurrent mixed-method design (Schoonenboom & Johnson, 2017). To gain a full picture of adolescent girls' SRHR before and during the COVID-19 and its attendant lockdown and school closures, the quantitative component used a cross-sectional survey to ascertain adolescent girls' SRH behaviours during the COVID-19 outbreak. This included data about their sexual behaviours, sexual violence, the use of SRH services, SRH help-seeking behaviours, and preferences for SRH services during the COVID-19 outbreak. As adolescent girls live within a complex environment, specific survey questions were designed along the lines of the socio-ecological model to identify factors endangering adolescent girls' SRHR during the COVID-19 pandemic. The cross-sectional survey was complemented by SRH data from the District Health Information Management System (DHIMS-2) for the periods 2018, 2019 and 2020. Where available, data from March to December 2020 was extracted assessing for trends in adolescent pregnancy, sexual abuse, child marriage and adolescent girls' use of SRH services including utilisation of antenatal care and family planning. This time frame is chosen to correspond to the lockdown and school closure periods during the COVID-19 outbreak in Ghana. This data was compared to the equivalent periods in 2018 and 2019, two years before the COVID-19 pandemic, to demonstrate any significant changes in the utilisation and outcomes of these services during the COVID-19 outbreak.

The qualitative component was an in-depth exploration of the lived experiences of participants. Qualitative interviews and focus groups explored the lived experiences of adolescent girls regarding school closures, sexual violence, child marriage, how different aspects of SRHR were affected, and barriers and facilitators to accessing SRH services during the COVID-19 outbreak. Conceptually, the qualitative component draws on psychological and behavioural frameworks, in this case the socio-ecological model (Mukhtar, 2020) to gain a richer understanding of how adolescent girls' SRHR were affected by COVID-19 lockdown and school closures. Interviews were also held with community leaders, school-teachers and service providers including Community Health Nurses, Midwives, and Nurses who provide SRH services to adolescent girls.

2.3. SETTING

To gain a balanced view of the impact of COVID-19 induced school closures adolescent pregnancy and adolescent girls' SRHR, a maximum variation purposeful sampling strategy (Patton, 2014) was used to select two districts: Asokore Mampong Municipal and Afigya Kwabre South District in Ashanti region. The Ashanti region was chosen for this study as it recorded the highest number of adolescent pregnancies in 2020 in Ghana (Mensah, 2021). Furthermore, the selected districts were part of by the COVID-19 lockdown imposed by the government on the Greater Kumasi Metropolitan Area in the Ashanti region between March 30 and April 20, 2020. To maximise variation, in each of the districts, communities exhibiting rural and urban characteristics were selected for the fieldwork.

School closure and adolescent SRHR dynamics may differ between rural and urban settings. It was thus important to ensure that geographical variation among sites was represented in the study so as to capture any differential effect of the school closure on teenage pregnancy and adolescent girls' SRHR.

2.4. SAMPLING

For the quantitative survey, within the study districts and sites, the research team used stratified purposeful sampling (Patton, 2014) to include both in and out of school adolescent girls. The survey was conducted on a random sample of 853 adolescent girls aged 13-19 (16.03 ± 2.04 years of age).

The specific individuals were sampled from adolescent girls who were available on the dates of data collection in each study site. Assuming a population of approximately 100,000 adolescent girls, a sample size of 384 is sufficient to obtain a margin of error of 5% and a 95% confidence level (see: https://www.calculator.net/sample-size- calculator.html?type=1&cl=95&ci=5&p-p=50&ps=100000&x=92&y=23).

Due to the nature of qualitative research, the number of interviews per participant type varies depending on when saturation is reached (Saunders et al., 2018). In total 60 in-depth interviews and 12 focus groups with adolescent girls were conducted.

2.5. DATA COLLECTION METHODS AND PROCEDURES

The research instruments (questionnaire and interview guides) were developed based on previous studies on the subject matter. The research instruments were peer reviewed by UNICEF experts working on adolescent SRH and child protection. In addition, all items were tested in a pilot study with 50 adolescents in a pilot study. For the cross-sectional survey, self-reported computer-assisted questionnaires were administered between May and August 2021. All in-depth interviews (IDIs) and focus group discussions (FGDs) took place at designated places and times most convenient for the participants. Both IDIs, FGDs and questionnaire administration were face-to-face with strict adherence to COVID-19 safety protocols. Key informant interviews (KIIs) were also held with community leaders, school-teachers and service providers including Community Health Nurses, Midwives, and Nurses who provide SRH services to adolescent girls. The IDIs and FGDs were audio recorded with consent from the study participants. FGDs were restricted to a maximum of 5-6 participants to accommodate social distancing protocol. Throughout the fieldwork, field notes were taken to record daily events and experiences. Appendices 1 and 2 indicate the questionnaire and qualitative instruments, respectively.

Training of the enumerators and pre-testing of instruments

A 3-day training session was organised for the enumerators (10) and supervisors (3). Both the enumerators and supervisors were females. The training focused on the background to the study, gender equality and SRHR, gender responsive research, questionnaire overview, interview techniques, interviewing children, survey methodology, administration of consent forms and response plan, monitoring procedures, use of tablets for data collection, and research ethics. A major session of the training was devoted to practicing the Computer Assisted Personal Interview (CAPI) platform used for the quantitative data collection

The training included a pre-testing of the questionnaire to allow the enumerators to have a feel of the questions and possible revisions of aspects of the study instruments. The pre-testing was done in the Ashanti Region. Each enumerator interviewed at least an in-school as well as an

out-of-school respondents. A staff from UNICEF attended the training sessions in Kumasi and participated in the delivery of the training.

2.6. COVID-19 ADAPTATIONS

To ensure the safety of participants and the research team, all local and national guidelines regarding COVID-19 prevention protocols were strictly adhered to. Safety precautions adopted by the evaluation team included wearing masks (with a policy of "no mask no interview"). To enforce this, field teams provided free masks to participants who did not have masks at the point of interview. Other safety protocol field teams rigorously observed included hand hygiene, ensuring 1-meter distancing between the interviewer and study participants, and conducting interviews outdoors. The fieldwork was conducted in compliance with the Bureau of Integrated Rural Development's safety guide for conducing fieldwork during the COVID-19 pandemic (Bureau of Integrated Rural Development, 2020).

2.7. DATA ANALYSIS PLAN

Data on adolescent pregnancy and adolescent girls' SRH service utilisation variables of interest were extracted from the DHIMS-2 to Microsoft Excel 2016 for processing and cleaning. The variables of interest here included antenatal care attendance (new and revisits; adolescent pregnancies), family planning services uptake by adolescent girls and method, and SRH information services accessed. Relevant rates/proportions were computed. The Statistical Package for Social Sciences (SPSS version 26) was used to analyse the quantitative data. The qualitative data were analysed using thematic analysis approach (Braun & Clarke, 2006). NVivo 12 was used to aid qualitative data management and analysis.

2.8. RIGOUR

The use of methodological triangulation (questionnaires, interviews and focus groups) and data triangulation (multiple sites for data collection) in this study will strengthen the credibility and generalisability of the findings. Similarly, to ensure credibility and transparency in the research process, a memo was kept throughout the research process recording thoughts, feelings, insights, and ideas in relation to the study aims. The memo served as a reflective journal to aid research reflexivity. Additional strategies that were used to ensure trustworthiness and authenticity include data cleaning, verification of data through peer and member checking (e.g., seeking clarifications from participants during interviews, and discussion of codes and themes emanating from qualitative data during team meetings).

2.9. ETHICAL CONSIDERATIONS

Ethical review board approval for the study was sought from the Humanities and Social Sciences Research Ethics Committee (HuSSRECC) at the Kwame Nkrumah University of Science and Technology (KNUST), Ghana. During the data collection, written informed consent or oral consent was sought from the study participants whilst children under 18 years provided assent. Participants were informed that they have the right to withdraw from the study at any time during the interviews. UNICEF's guideline on ethical research involving children and young people (Graham, Powell, Anderson, Fitzgerald, & Taylor, 2013) guided the conduct of the interviews with children and young people.

3.0 RESULTS

3.0 RESULTS

3.1. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

A total of 853 adolescent girls aged 13-19 (16.03 ± 2.04 years of age) were surveyed. As shown Table 3.1, the predominant ethnic groups of the adolescent girls were Akan (55.8%) and Northern tribes (39.6%). In terms of religion practiced by the adolescents, 62.3% were Christians while 37.4% were Muslims. Regarding disability, a majority of the adolescent girls (70.9%) did not have any form of disability. However, for those who had, the top four forms of disability were visual (13.2%), emotional (5.5%), learning (4.6%) and hearing (3.6%). Regarding employment, 52.5% of the adolescent girls reported working and the nature of work was: learning a trade (29.9%), domestic work (27.7%), family business (22.2%), street hawking (7.3%) and kayayei (0.4%).

The educational level shows that 52.4% had attained JHS education followed SHS/VOC (29.1%), primary (12.1%) and tertiary (0.4%). About 6.1% of the adolescent girls had never been to school. Currently, more than half of the adolescent girls (63.3%) reported being in school (see Figure 3.1).

Table 3.1: Socio-demographic Characteristics of Adolescent girls

Characteristics	Frequency	Percent
Disability:		
None	622	70.9
Visual	116	13.2
Emotional	48	5.5
Physical	8	0.9
Hearing	32	3.6
Speech	2	0.2
Learning	40	4.6
Other	9	1.0
Highest educational level:		
No formal education	52	6.1
Primary	103	12.1
JHS	447	52.4
SHS/VOC	248	29.1
Tertiary	3	0.4
Religion:		
Christian	533	62.3
Muslim	320	37.4
Traditional	1	0.1
None	2	0.2
Ethnicity:		
Akan	476	55.8
Ewe	14	1.6

Characteristics	Frequency	Percent
Northern tribes	338	39.6
Other	25	2.9
Employment Status (currently working):		
Yes	448	52.5
No	405	47.5
Nature of Work (N=505)		
domestic work	140	27.7
street hawking	37	7.3
Kayayei	2	0.4
family business	112	22.2
learning a trade	151	29.9
Other	63	12.5

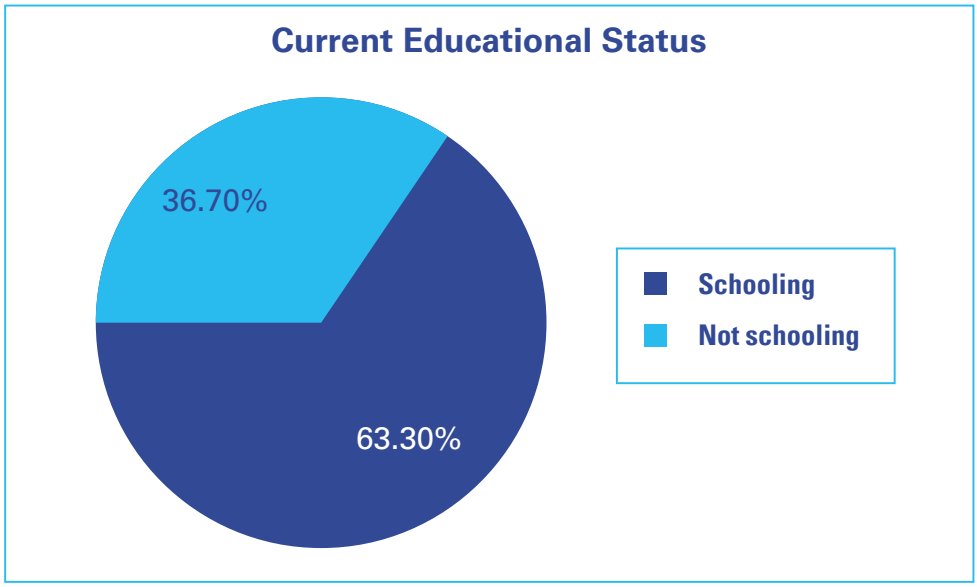

Figure 3.1: Current Educational Status of the Adolescent Girls.

3.1.1 Relationship between Adolescent Girls and their Parents

A majority of the adolescent girls (78.3%) had both either parents still alive while others had only their mother (14.5%) or only their father (4.1%) alive (Figure 3.2).

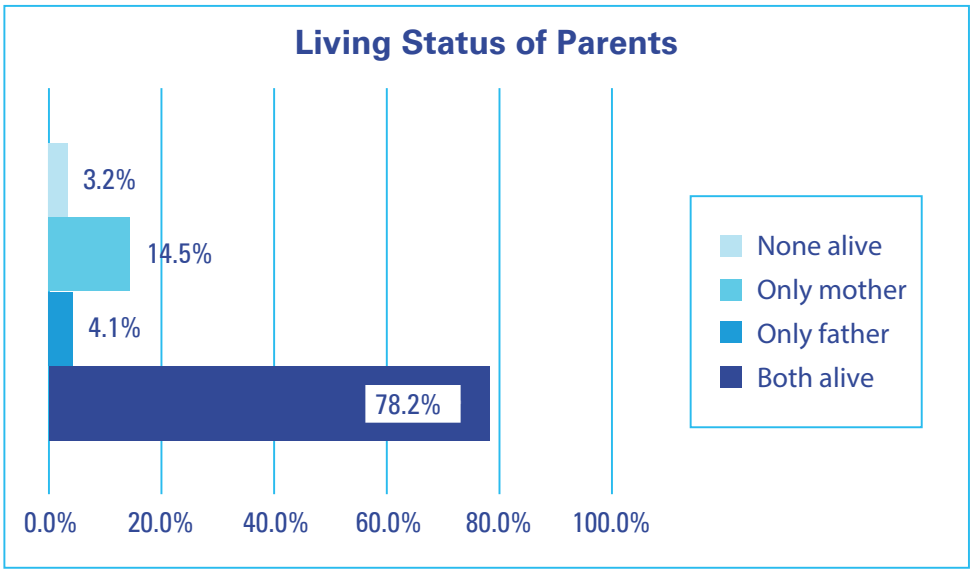

Figure 3.2: Living Status of Parents of Adolescent girls

In terms of living arrangements, 40.3% of the adolescent girls live with both parents. This is followed by mother only (25.8%) and another relative (24.5%). The number of adolescent girls living with a foster parent(s) was low (1.5%) (Figure 3.3).

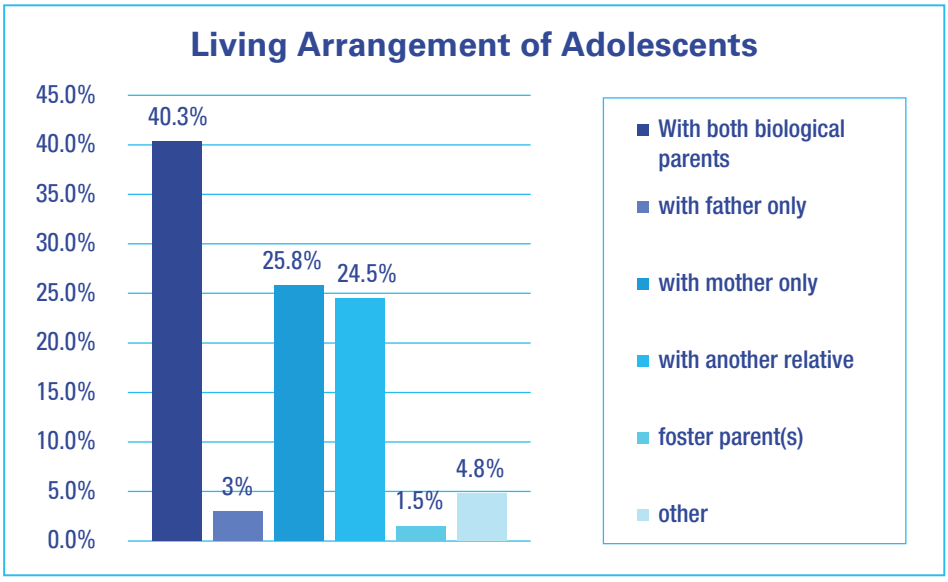

Figure 3.3: Living Arrangements of Adolescent girls

When asked about their relationship with their parents, most of the adolescent girls reported being either close (44.7%) or very close (43.7%) to their parents. Only a few 11.6% said they were not close to their parents.

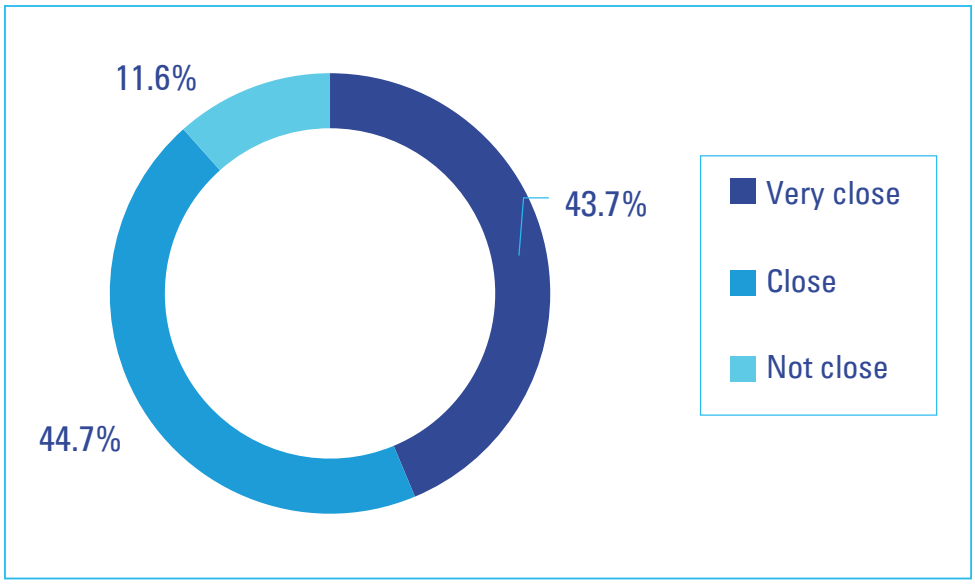

Figure 3.4: Adolescent Girls Relationship with Parents

A significant proportion of the adolescent girls (46%) rated their parents' supervision as medium while 42.7% rated it high. Within the districts, there were higher proportions of adolescent girls rating their parents' supervision as high as in Asokore Mampong (47.2%) as compared to Afigya Kwabre South (38.4%). Overall, about 11.4% of the adolescent girls rated parental monitoring as low. A higher proportion of adolescent girls in Afigya Kwabre South rated their parents' supervision as low (13.5%) as comparted to Asokore Mampong (9.2%).

Discussions with key informants and adolescent girls revealed that parental supervision can modify sexual decision-making among adolescent girls. Aspects of parental monitoring and supervision which are central and have implications for teens SRH behaviour identified include parental knowledge of adolescents' companions/friends, whereabouts, and activities, and a behaviour- specific form of supervision, including enforcement of rules about friends and dating. This suggests that parental monitoring may be an important aspect to be considered in an effort to improve the adolescents' SRH.

I think we should educate them [the girls] on sexual activities and other things and we should involve their parents so that they would talk to their wards on sexual education. Parental supervision and involvement are very important if we are to succeed. Even last time, I suggested to the school that we should educate them on family planning, because they are already doing it [having sex] so it better for them to know how to plan (School Teacher).

Table 3.2: Parental Supervision of Adolescent Girls

	Asokore Mampong		Afigya Kwabre South		Total/overall	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
High	196	47.2	168	38.4	364	42.7
Medium	181	43.6	211	48.2	392	46
Low	38	9.2	59	13.5	97	11.4
Total	415	100	438	100	853	100

Responding to a question on if their parents/guardians asked for their opinion during household decision-making, 48.4% of the adolescent girls answered sometimes, 18.3% said often, 17% said rarely and 16.1% said never. From Table 3.3, even though the parents/guardians 'sometimes' or 'often' ask for the opinion of the adolescent girls, a sizeable number of these parents either 'rarely' (19.3%) or 'never' (12.7%) listen when the adolescent girls share their opinions.

Table 3.3: My parents or guardians ask for my opinion on decisions taken in the household

	My parents or guardians ask for my opinion on decisions taken in the household		My parents or guardians listen when I share my opinion	
	Freq.	Percent	Freq.	Percent
Sometimes	413	48.4	459	53.8
Often	156	18.3	117	13.7
Rarely	145	17	165	19.3
Never	137	16.1	108	12.7
Don't Know	2	0.2	4	0.5
Total	853	100	853	100

During the interviews and focus groups, some adolescents raised concerns about their voices not being heard by their parents when making decisions at home.

My parents do not ask of my views on matters at home. I remember once I asked them why they never ask my opinion about anything that goes on at home, but they gave me no response. I am of the view that both children and adults all have the right to share their thoughts and opinions on issues. Because sometimes as adults you cannot always think for children, we also have a mind of our own. For instance, when I got pregnant, they didn't even want to hear my part of the story and did not understand what I was going through. (Adolescent nursing mother aged 17).

The majority of the adolescent girls (84.3%) reported feeling safe in their neighbourhood compared to 15.7%, who reported not feeling safe.

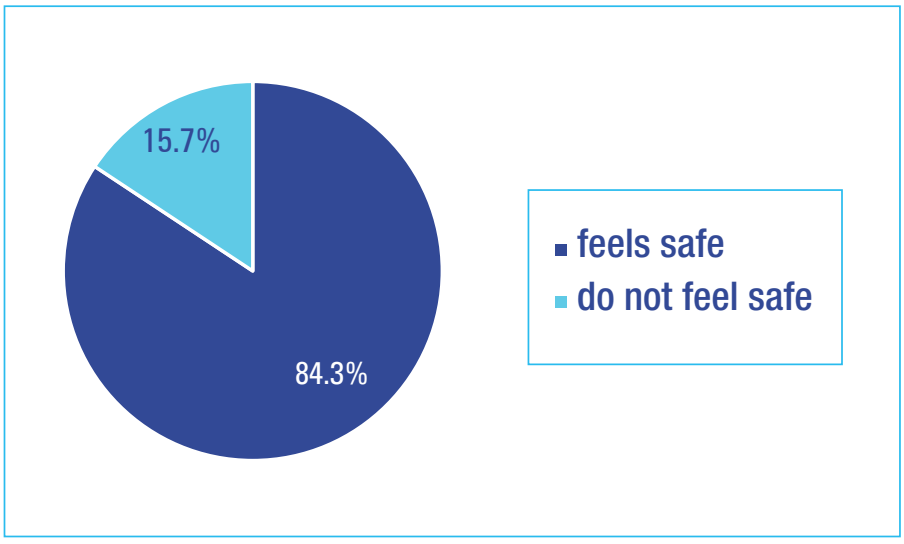

Figure 3.5: Assessing the Neighbourhood Environment of Adolescent Girls

3.1.2 General Health and Physical Activity Level

About 77.3% of the adolescent girls did not belong to any club. A high proportion of adolescent girls in Asokore Mampong (29.4%) reported being a member of a club compared to Afigya Kwabre South (16.4%).

Table 3.4: Club Membership of Adolescent Girls

	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Yes	122	29.4	72	16.4	194	22.7
No	293	70.6	366	83.6	659	77.3
Total	415	100	438	100	853	100

Most of the adolescent girls (41.5%) rated their health as very good, 31.1% as excellent, 23.6% as good and 3.6% as fair.

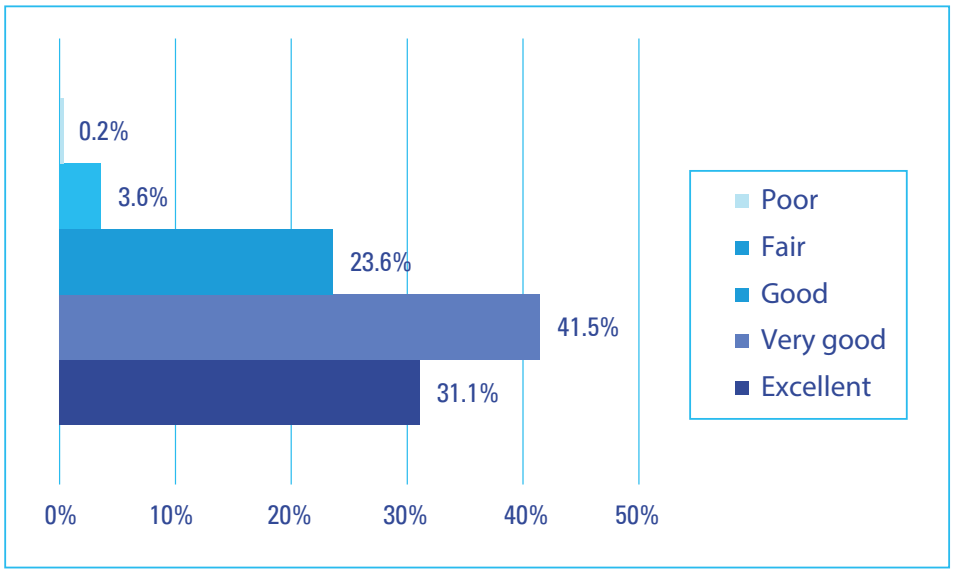

Figure 3.5: Rating of Adolescent Girls Health

More than half of them (51.8%) rated their health as much better now than a year ago while a small number of the adolescent girls (17.2%) rated their health as worse now compared to year ago.

Table 3.5 Comparison of Current Health to that of a Year ago

Assessment	Freq.	Percent
Much better now than one year ago	442	51.8
About the same, somewhat worse now than one year ago	147	17.2
Somewhat better now than one year ago	221	25.9
Much worse than one year ago	43	5
Total	**853**	**100**

Promoting participation in physical activity among adolescent girls is a public health priority. WHO recommends at least 60 minutes of moderate to vigorous intensity physical activity daily for children and adolescents aged 5–17 years to achieve physical activity benefits. In line with the WHO's recommendation, the prevalence of physical activity among the girls surveyed in this study was 3.5%. The majority (52.1%) of adolescent girls reported they had never engaged in physical activity in last seven days.

Table 3.6: Number of Days Exercise

	Asokore Mampong		Afigya Kwabre South		Total/overall	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
1 day	38	9.2	40	9.1	78	9.1
2 days	50	12	40	9.1	90	10.6
3 days	46	11.1	33	7.5	79	9.3
4 days	26	6.3	32	7.3	58	6.8
5 days	34	8.2	26	5.9	60	7
6 days	7	1.7	7	1.6	14	1.6
7 days	15	3.6	15	3.4	30	3.5
never	199	48	245	55.9	444	52.1
Total	415	100	438	100	853	100

As shown in Figure 3.7, the majority (75.1%) of the adolescent girls reported exercising less than 3 times a week. Of those who reported exercising more than 3 times a week, the majority (30.8%) were from Asokore Mampong compared to Afigya Kwabre South (19.2%).

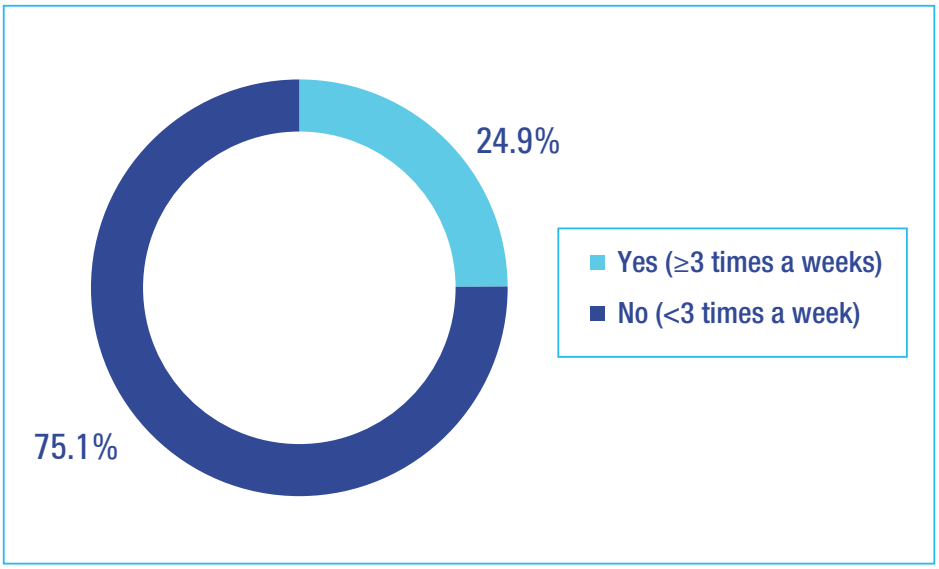

Figure 3.7: Regular Practice of Physical Activity

Sedentary behaviour based on screen time is associated with health problems such as increased risk of obesity, hypertension, hypertriglyceridemia, psychosocial problems and low self-esteem in adolescents (WHO 2020). The prevalence of excessive screen time (as defined as three or more hours a day) among the adolescent girls was 47%. The prevalence was high among adolescent girls in Afigya Kwabre South (48.9%) compared to those in Asokore Mampong (45.1%)

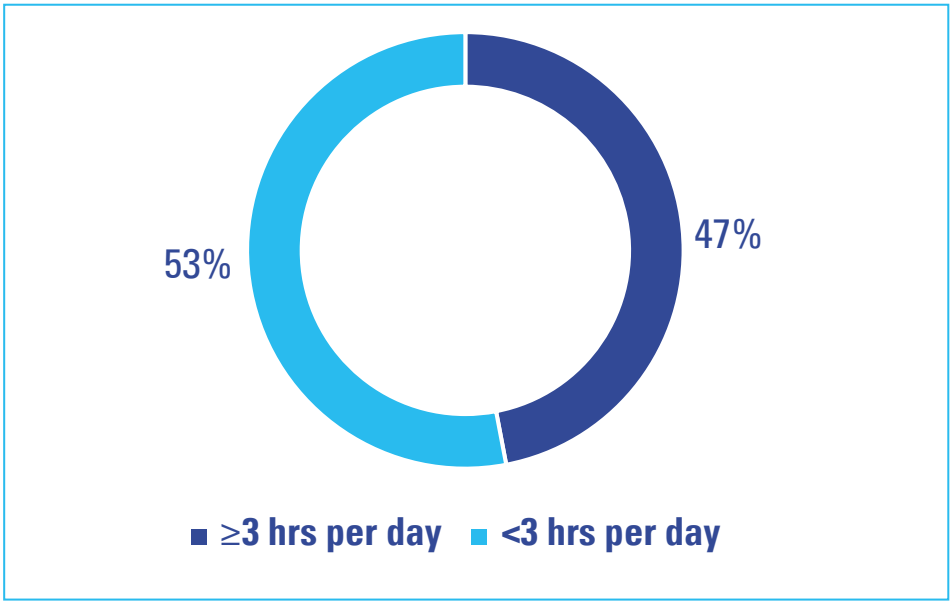

Figure 3.8: Screen time during a typical day

3.2THE EFFECT OF COVID-19 ON ADOLESCENT PREGNANCY

Overall, as shown in Figure 3.9, the prevalence of teenage pregnancy during the COVID-19 lockdown and school closures in the sampled adolescent girls was 7%. This varied considerably between urban and rural districts. In Asokore Mampong, which is an urban district, the prevalence was 2.7% (N=11) while in Afigya Kwabre, a rural district, the prevalence was 11.2% (N=49).

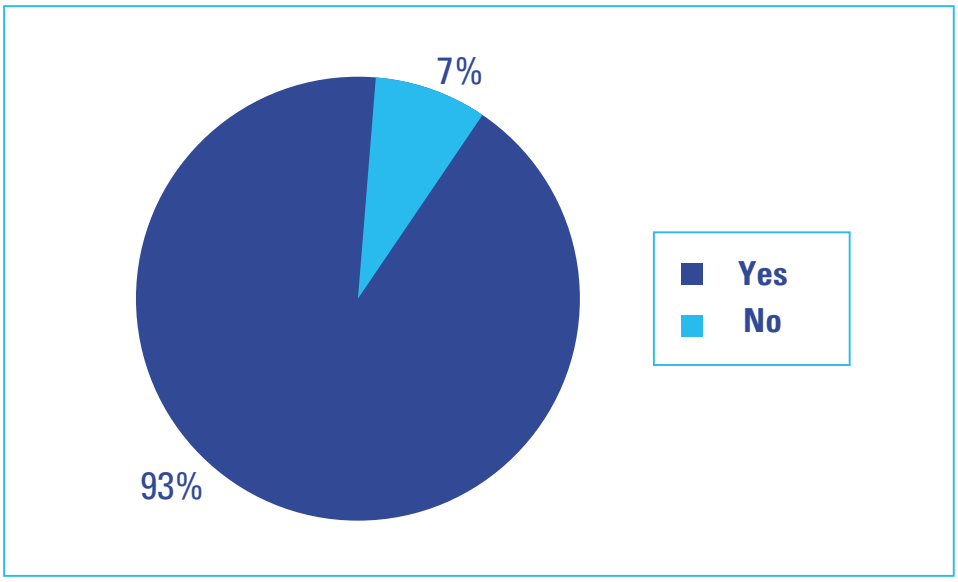

Figure 3.9: Percentage of Adolescent Girls who got Pregnant within the last 12 months

Data from DHIMS-2 in Afigya Kwabre South District lends support to the survey findings as adolescent pregnancies increased from 565 in 2018 to 602 in 2020 (see Figure 3.10). In the case of Asokore Mampong, data from DHIMS-2 showed that adolescent pregnancies declined from 310 in 2018 to 216 in 2020. In both districts, however, increased teenage pregnancy was a recurring theme in the KIIs, FGDs and IDIs with the adolescent girls.

Before COVID, teenage pregnancy was there, but it wasn't very high especially with students. But after COVID, there have been many cases of teenage pregnancies in this school (Adolescent girl aged 16, SHS 2 student)

Teenage pregnancy has been in existence for a while now, but I think the rate has increased since the inception of the outbreak of COVID-19 (Adolescent JHS Student aged 19).

I got pregnant during the lockdown. As for me, education is important so am back to school. So, if you're pregnant there is no way for you to stay at home, you can still come to school and learn hard. Maybe the child that you are going to give birth to is the one coming to look after you in future or do something better for our country Ghana (Adolescent girl aged 14, JHS 2 student).

The cases were more during the lockdown and school closures… Almost every house in this community, you'll find a teenager who has a baby. They were exposed to some of these guys. It might account for that the lockdown, school closure, they were just in the house doing nothing, roaming from morning to evening. So, when some of the males got these young ladies that accounted for the huge difference (Healthcare provider – Midwife).

A significant proportion of the adolescent girls (99.1%) indicated that the pregnancy was unplanned (Figure 3.11)

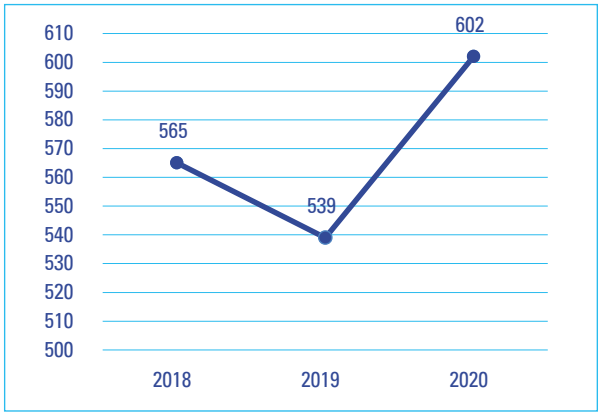

Figure. 3.10: Adolescent pregnancies (10-19 years).

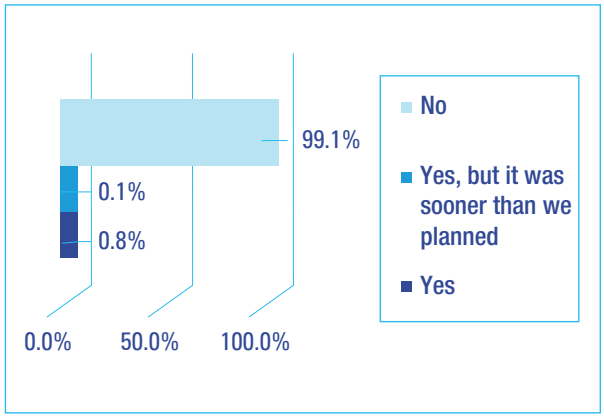

Figure 3.11: Planned Pregnancy

The qualitative findings revealed that the drivers of increased pregnancy cases were idleness, poverty, and parental neglect. Most of the adolescent girls noted that their parents' work was negatively affected by the COVID-19 outbreak and preventive measures, especially the lockdown. Others expressed that they became idle during and school closures, which made them more vulnerable to the advances of the boys/men.

Most girls were influenced negatively during the lockdown and school closure because we were not engaged in learning activities. Many girls were taken advantage of by guys especially due to poor economic background. Due to this, after school reopening, a lot of girls have dropped out as a result of pregnancies. One important thing this, the lockdown and school closure killed some of the girl's interest in schooling, so they have also dropped out. Basically, I can't give an actual figure. But those close to me are three. One is pregnant and two are learning trade. (Adolescent girl aged 17, SHS 2 student).

It was during the school closures that most of the girls became pregnant in this community. When the president lifted the lockdown most of the girls who were in school were not able to go back to school because they were pregnant… Also, parents who are educated enough in this community do not allow their children to go out, so it is difficult to see them in trouble – getting pregnant in most cases. Other factors include poor parental care or child neglect, which is common in this community…because some parents in this community are illiterate, they let their children roam, which promotes teenage pregnancies (Parent and community leader).

One aspect of preventing these pregnancies is that their parents must also be involved. Broken homes and then those aspects. When you get to the house, most times, the home also influences the girls. Because, if my sister goes out and doesn't come home, and the parents do not do anything about it... these pregnancies will occur (Healthcare provider – Nurse).

It was during the COVID-19 school closures that's when we discovered two girls being pregnant. And then one lady also got pregnant but unfortunately for her, she got a miscarriage. One lady is in form three, a final year student and the age is 18 or 19. The other one is about 14 years old and she's in form two. And the one that got miscarriage, Linda is also in form two. And they will be 14 or 15 years. While COVID-19 contributed to this, I think lack of parental care and financial problems are also factors (School-teacher, SHEP Coordinator).

Some teachers and healthcare providers appreciated the government's policy on allowing pregnant adolescent girls to return to school but expressed concerns that the policy may have an intended outcome of increased adolescent pregnancies.

I will say there has been increased cases of teenage pregnancies this year compared to the years before mostly due to the COVID-19 lockdown and school closures. And then one aspect is also the new policy from the government. When we went to the schools, they were like the government allows pregnant students to still come to school. There's nothing you can do about it. But previously, you couldn't come to school with pregnancy. But now the law allow students to come to school with pregnancy. It makes students feel ok to get pregnant and come to school with it. But initially, when you get pregnant, you will be hiding it. And again, when schools were closed, the cases have increased. When you go to the communities, the cases are there but they are not reporting to our facility (Healthcare provider – Midwife).

Most of the adolescent girls (75%; N=45) were very unhappy when they found out that they were pregnant (Figure 3.12). It came up strongly during the interviews and focus groups with the adolescent girls that, most of their colleagues who got pregnant during the lockdown and school closures did not return school.

My mate, she dropped out of school when she got pregnant because our colleagues were making fun of her. She said after delivering she will come back to school. She got pregnant when the schools were closed. She is seven months into her pregnancy now. As for me, if you're pregnant, you come to school and learn because it's not a crime. (Pregnant teen aged 14 who has returned to school).

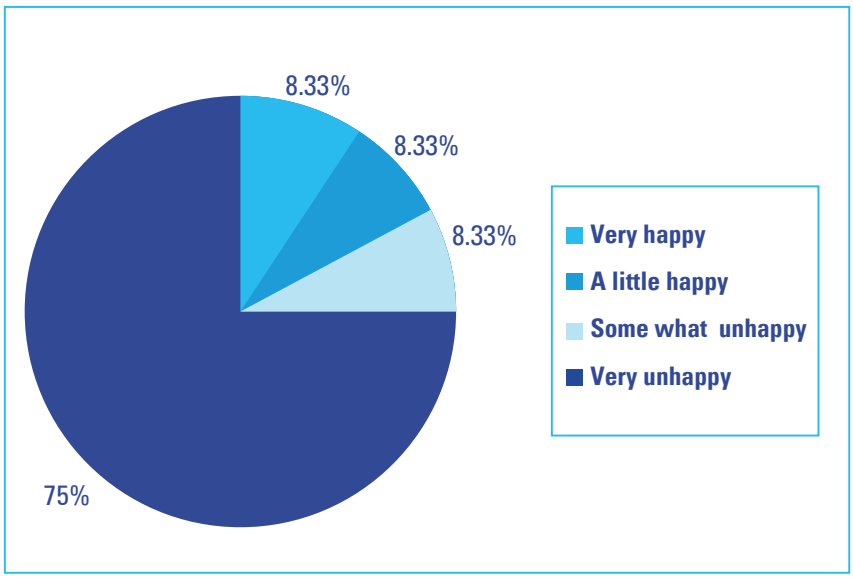

Figure 3.12: Adolescent girls' response to getting pregnant

3.2.1 Pregnant Adolescent Girls Access' to Health Care during the COVID-19 Pandemic

Among current pregnant adolescents, a significant proportion of them (45.2%; N=27) did not know which trimester they were in. The lack of awareness of the gestation period of pregnancy may have implications for the uptake of ANC services.

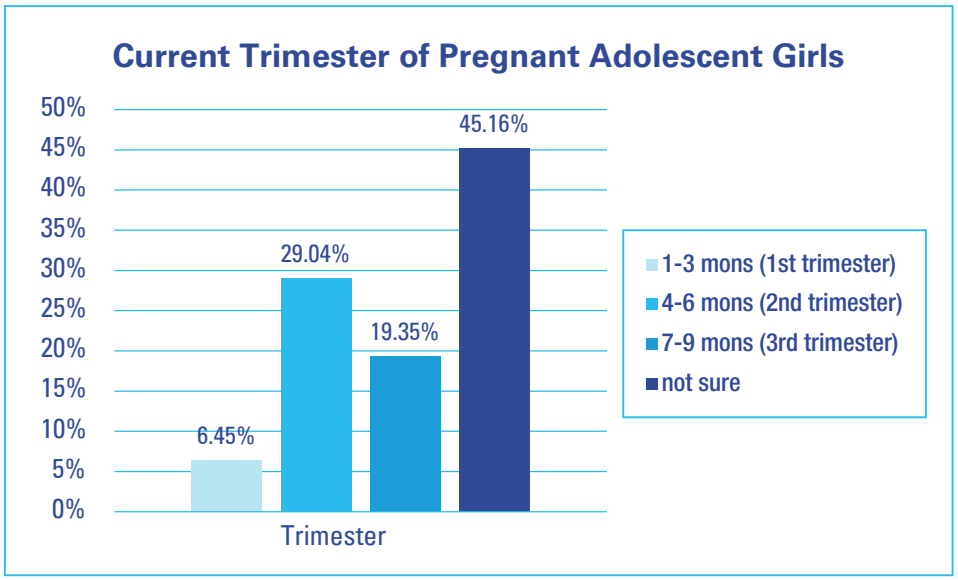

Figure 3.13: Current Trimester of Pregnant Adolescent Girls

A common theme from the interviews with the healthcare providers was that adolescent girls delayed antenatal care attendance. Most of the adolescent girls were said to report for ANC during the second or third trimester.

Comparing the adolescents who come for family planning services and come to deliver, I think there is some form of apathy on the part of the adolescents compared to adults. Most of them actually stay home for a very long time and report to the ANC very late, some get into their second and third trimesters before coming to ANC. Sometimes, they are not of age, and they are already pregnant, so they try to hide it until they can't hide it anymore (Healthcare provider – Midwife).

More than a quarter of the adolescent girls (40%) reported that they missed or delayed pregnancy care appointments during the COVID-19 lockdown and school closures. The reasons for missing pregnancy appointments were because they were afraid of getting COVID-19 at the hospital/health care centre or appointments rescheduled due to COVID-19.

When asked about the level of satisfaction regarding the health care services, majority of the adolescent girls (58.5) % reported being satisfied the services received.

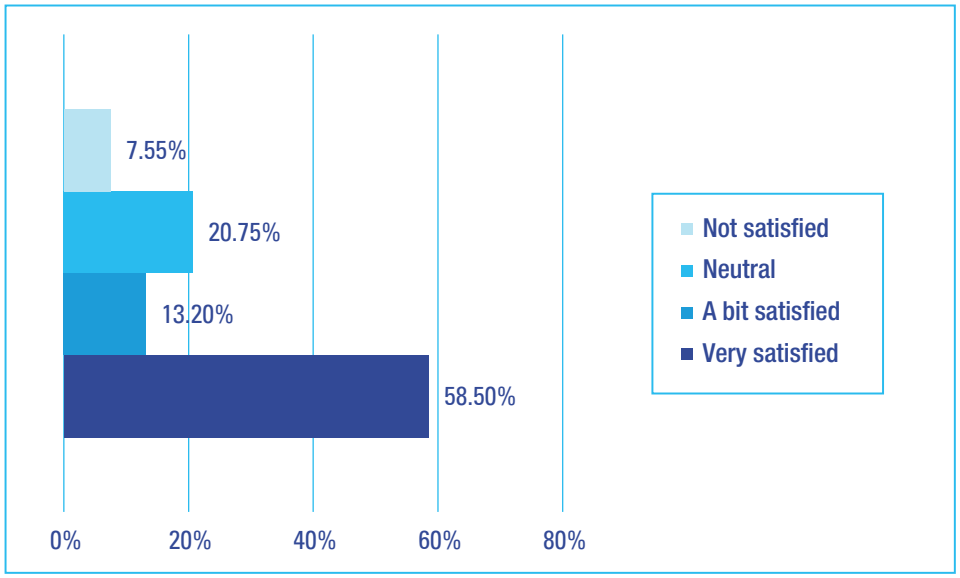

Figure 3.14: Satisfaction with pregnancy health care during the COVID-19?

3.2.2 Pregnant Adolescent Girls' Access to Delivery Services during COVID-19

A majority of the pregnant adolescent girls (83.3%) reported not having any concerns about their delivery. Of the adolescent girls providing data on where they delivered, 56.25% indicated the health facility for delivery while 43.8% delivered at home. The main reasons for giving birth at home were limited access to a health facility (69.24%), increased risk of COVID-19 in health facilities (15.38%) and the closure of the health facility (15.38%).

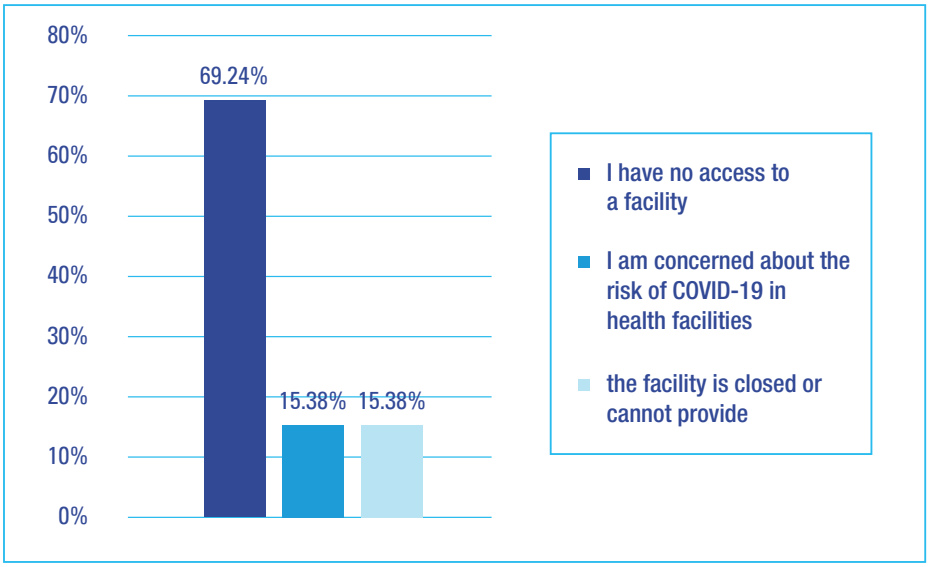

Figure 3.15: Reasons for Home Delivery

In responding to a question on missing post-natal care during the COVID-19 pandemic, 78.4% reported that they never missed nor delayed post-natal care appointments because of the COVID-19. Of those who missed or delayed post-natal care appointments (21.6%), the reasons were being afraid of getting COVID-19 at the hospital/health care centre and other reasons such as financial constraints and attitude of health care providers.

3.2.3Termination of Adolescent Girls Pregnancy.

Of the 60 adolescent girls who got pregnant during the COVID-19 lockdown and school closures, 10 of them reported terminating the pregnancy. Termination of pregnancy was more prominent in Afigya Kwabre South, where data from DHIMS 2 revealed that adolescent abortion increased from 18 cases in 2019 to 44 cases in 2020 (see Figure 3.16). In Asokore Manpong, data from DHIMS 2 showed that there was only 1 case of abortion in 2019 and no case in 2020.

Evidence from the KIIs held with the health providers in the Afigya Kwabre South support the quantitative findings of increased abortion cases among teenagers. A health provided recounted that adolescent girls were five times more likely to terminate pregnancies than to keep them:

Five is to one. That is those who terminate the pregnancy. Five, and then those who keep it's one, and mostly teenagers, for those who terminate the pregnancy. About 99% of those who terminate. After consulting with them, they just look at you and take their own decision. When you tell them to see the midwife and start ANC, they will not come. The next time you see them is when they come here bleeding or with some form of complications from trying to termination. They do not come for the comprehensive abortion theory (Healthcare provider, Kodie Community clinic)

Abortion is quite common among the adolescent girls here. The girl I was talking about was 17 years old and she had been involved in multiple abortions at that young age. Sometimes they come when they are in the process of aborting the pregnancy. It's just once a while that some come to the hospital for the procedure (Community Health Nurse, Ankase Hospital).

And I had another case, the girl is living with her sister and her sister's brother-in-law was sleeping with this girl. She got pregnant and the guy gave her medicine to take but she's only 12 or 13 years. So, when they came to the hospital we took a scan and we found out that it was an incomplete abortion (Midwife, Ankase Hospital).

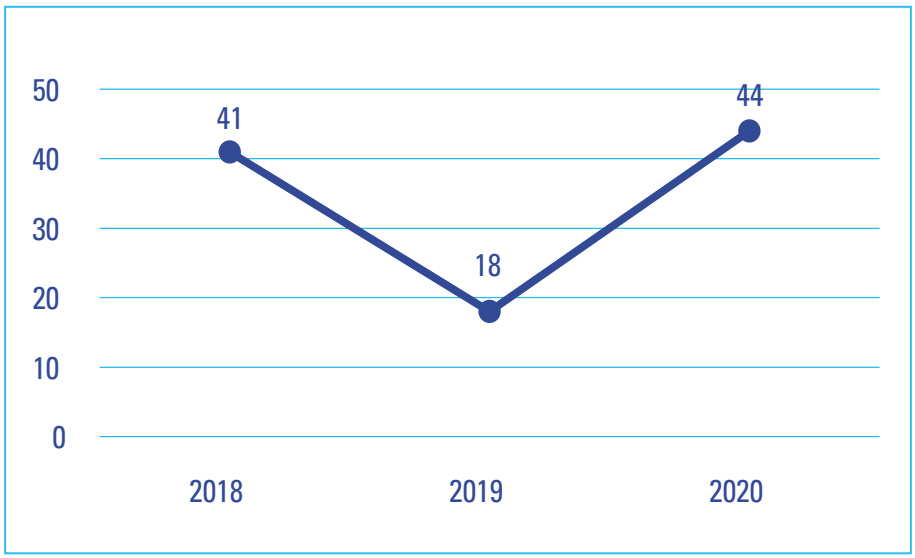

Figure 3.16: Number of abortion cases (10-19 years)

Of those who terminated their pregnancies, 8 cases were self-induced while 2 had the procedure performed at a hospital/health facility.

3.3THE EFFECT OF COVID-19 ON ADOLESCENT GIRLS' RISK OF CHILD MARRIAGE

Overall, 20.8% of the adolescent girls (N= 177) reported that child marriage[1] was discussed with them during the COVID-19 lockdown and school closures. 3.4% of the adolescent girls got married (N=29) while 17.4% did not get married (N=148).

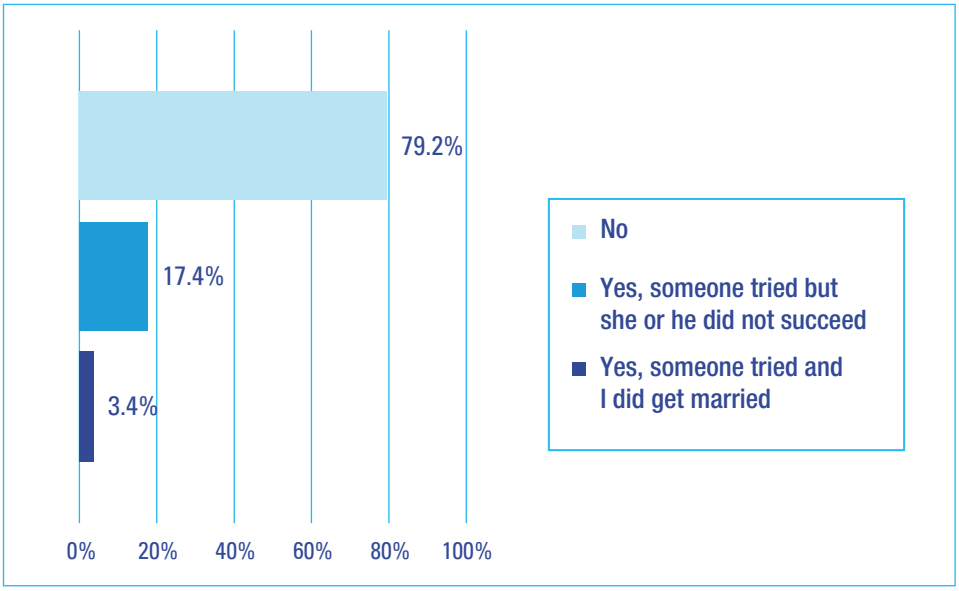

Figure 3.17: Discussions on Child Marriage

The COVID-19 lockdown and school closures were said to have accounted for 47.8% of child marriage discussions with adolescent girls. 12.4% of the adolescent girls reported that there was an increase in discussion on child marriage with them during the COVID-19 lockdown and school closures compared to the year before. The main reasons for child marriage discussion with adolescent girls were financial difficulties (26.50%), early marriages being a part of the community (26.50%), pregnancy (8.20%) and parental job loss (2.00%). Adolescent girls in Asokore Mampong reported child marriage as being common in their communities (39.4%) than Afigya Kwabre South (14.7%). Afigya Kwabre South recorded a higher proportion of pregnancy-induced marriages (14.7%) than Asokore Mampong (1.1%).

The lockdown made us stay home for a long period which affected our learning. Some of our colleagues have gotten pregnant and married within the lockdown. During lockdown, a friend of mine was forced to the North to marry during the lockdown and she has given birth (Adolescent girl aged 14).

Evidence from the interviews and FGDs support the quantitative evidence that the COVID-19 induced school closures, household poverty, pregnancy and parental neglect and economic insecurity, which limit parents' ability of parents to provide for their children as key drivers of child marriage. In the Asokore Mampong Municipality (predominantly Muslim communities), the girls were emphatic that child marriage is a commonplace due to social norms around the practice.

Yes, child marriage happens here. Some of the parents will put pressure on you to marry because your colleagues are married. They can even choose someone for you to marry though you might not love the person. I know a 14-year-old girl who was forced by her parents to marry, and she has now given birth (Focus Group, adolescent girls aged 13-19, Asokore Mampong).

1 Child marriage refers to formal marriages and informal unions that involve children below the age of 18 (UNICEF., 2005).

He [the man who impregnated me] told me he would come and ask for my hand in marriage so when my grandparents found out I was pregnant they called him and asked him when he was coming to perform the marital rights and he said after I give birth, so after the naming ceremony of our child he asked for a little time because times are difficult (Adolescent nursing mother aged 16)

More than half (52.2%) of the adolescent girls indicated that they did not report child marriage discussions to anyone (see Fig 3.18). However, in responding to a question on what adolescent girls would do if there was pressure from their parents for them to get married, the majority of them indicated that they would report it to the Police (28.3%), run away from the house/ community (19.0%) or report to religious leaders (11.2%) (see Table 3.7).

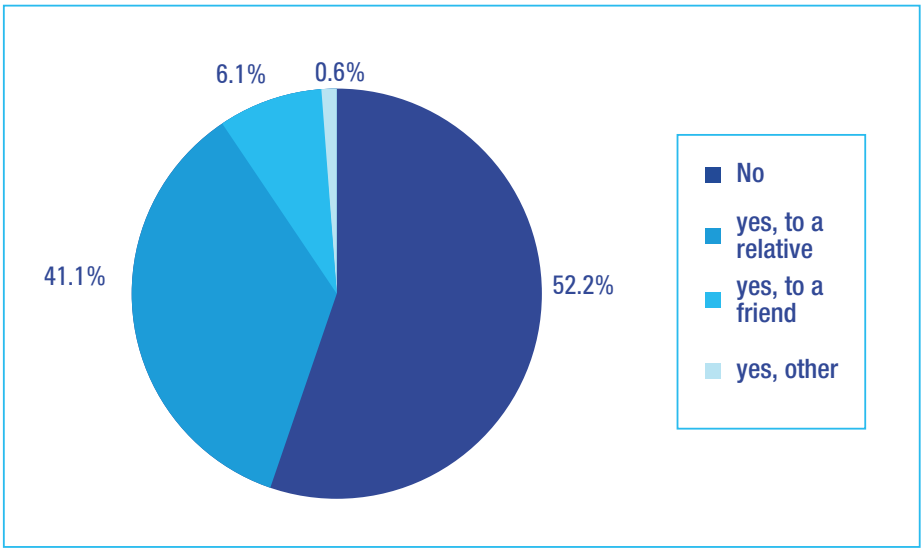

Figure 3.18: Reporting of Child Marriage Discussions

Table 3.7: Reaction to Parental Pressure to get Married

	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	N	Percent	N	Percent	N	Percent
Report to Police (DOVVSU)	84	23.30	126	32.98	210	28.30
Run away from the house/ community	71	19.67	70	18.32	141	19.00
Report to religious leaders	39	10.80	44	11.52	83	11.20
Report to school authorities	47	13.02	20	5.24	67	9.30
Will get married	26	7.20	24	6.28	50	6.73
Report to Social Welfare	8	2.23	8	2.10	16	2.20
Report to community leaders	17	4.71	22	5.76	39	5.20
Other	69	19.11	68	18.10	137	18.40
Total	361	100.00	382	100.00	743	100.00

3.4THE EFFECT OF COVID-19 ON CHILD SEXUAL ABUSE/ VIOLENCE AND REPORTING

In this study, child sexual abuse[2] (CSA) was put into four categories as follows: "CSA without physical contact"; "CSA with physical contact"; "physical contact with penetration" and "physical contact without penetration."

Overall, the lifetime prevalence of sexual abuse was 32.5%. That is, three in 10 adolescent girls had ever experienced at least one type of CSA in their lifetime. The prevalence of sexual abuse was significantly high in Afigya Kwabre South (35.8%) than Asokore Mampong (28.9%) (p = 0.031).

As shown in Table 3.8 the prevalence of the various forms of CSA during the COVID-19 lockdown and school closures were sexual harrassment (20.3%), pressurised sex (3.5%), attempted rape (14.5%), forced sex (1.9%), and forced exposure to pornography (14.8%). In all, a total of 19 rape[3] cases (pressurised sex and forced sex) were reported by the adolescent girls.

Adolescent girls' vulnerability to CSA increased from 14.2% before the COVID-19 pandemic to 25.9% during the COVID-19 pandemic. The qualitative interviews and FGDs revealed that adolescent girls were at increased risk of CSA during the school closures and the lockdown.

In this area men treat ladies as something of no value. Sexual abuse was dominant even before the COVID, but the cases became serious when the COVID came. We were on lockdown, and no one was going to school, sometimes parents do not have money, peer influence, you can follow your friend somewhere that your parents will not even know your whereabouts. The school closures contributed a lot this (Adolescent girl aged 17).

Yes, it increased during the COVID-19. Because of the school closures, you see the boys sitting under a tree and will be calling us. A girl even died from having sex with a guy... I think he added something to a drink and gave it to her to drink. Some guys deceived the girls with some materials like phone, laptop and the rest to have sex with them (Focus Group Discussion, Adolescent girls aged 13-19)

There is this man who has been calling me whenever I am walking alone but when he sees me with my mother, he doesn't call me. Some of the boys do like touching our private parts like our breast, buttocks and even our vagina (Adolescent girl aged 13).

Watching of pornography too. A friend of mine has a lot of them on her phone and she got pregnant because she always wants to practice it with her boy. Some guys will deceive you that they have this and that, but once you get pregnant, or they sleep with you, they will dump you (Focus Group Discussion, Adolescent girls aged 13-19).

Among the victims of CSA with physical contact with or without penetration, the most frequently reported places were another person's house (58.8%) and the victim's house (17.6%).

2 Child sexual abuse is defined as the activity in which an adult, taking advantage of his or her superiority, uses a minor to provide sexual pleasure, stimulation, or sexual gratification (Castro, Ibáñez, Maté, Esteban, & Barrada, 2019)
3 In Ghana, rape is defined here as the carnal knowledge of a female of sixteen years or above without her consent.

Table 3.8: Prevalence of CSA by type of abuse

CSA domain	Asokore Mampong	Afigya Kwabre	Overall sample	P-values
Child sexual abuse with physical contact without penetration:				
Touched in a sexual way in the past 12 months (sexual harrassment)	20.0	20.5	20.3	p <0.842
Physically forced to have sex against will but did not succeed in the past 12 months (Attempted rape)	12.8	16.0	14.5	p <0.192
Child sexual abuse with penetration:				
physically forced to have sex and did succeed in the past 12 months (Forced sex)	1.9	1.8	1.9	p <0.917
Pressurised to have sex in the past 12 months and did succeed (Pressurised sex)	3.6	3.4	3.5	p <0.880
Child sexual abuse without physical Contact:				
Forced to watch pornographic material	14	15.6	14.8	p <0.515
Forced to witness sexual exposure	3.4	3.2	3.3	p <0.885
Forced to show naked body	1.9	2.1	2.0	p <0.896
Taking pictures against your will	1	0.5	0.7	p <0.380
Published nude pictures on the internet or social media platforms	0.5	0.5	0.5	p <0.995

The evidence from the in-depth interviews with the adolescent girls revealed that the perpetrators of CSA were mostly adults over 18 years.

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The older ones because some of them have done it for a long time so they have the experience. Because they are older than you, you don't think bad about them. We were in a room watching TV with a friend. My parents had left after watching the TV so I asked him to also go for me to go and bath. When I came from the bathroom to the room, thinking he had left, I undressed to apply my pomade then he came out from nowhere and saw my nakedness. He used my towel to cover my mouth to have sex with me, but I resisted. (Adolescent girl aged 18)

It is the grown-up men, men in their 50's, 60's, 40's who harass us. If the person is a teenager like yourself, you can defend yourself, but the grown-up men are very strong (Focus Group Discussion, adolescent girls aged 13-19).

I attend the same church with a certain man, he was an elder in church, I took him as a brother. He teaches us the word and we used to go for evening service, so one day we were going to do decorations somewhere and we were only two girls and when I got somewhere I felt sleepy, so I went out and he didn't know I was out. We went with a sister, so she was lying in front and the man was in the middle between me and the sister. So, I noticed that whilst we laid down, he was touching the other sister in a sexual way which she did not like. (Adolescent girl aged 14).

The narratives above reveal the different circumstances in which adolescent girls were abused sexually in this study. The victims were mostly deceived, lured or pressurised by the perpetrators into the sexual abuse while others could not stand the power dynamics exerted by adults. The quantitative findings showed that main relationship of the perpetrators of CSA to their victims were acquaintance (31.30%), romantic partner (25.00%), neighbour (18.8%), peers (12.5%), family member (6.3%) and other (6.1%).

Maybe he plays with you already so one day he may just take advantage of that to make those advances towards you. Some can send you to bring something to his room and once you enter there, he will just close the door. I have had that experience. He asked me to go to his kitchen to do something for him. (Adolescent aged 18).

I know of a 15year old girl who was lured, and she has even given birth. I also know of two siblings the older one got pregnant, but the man did not accept the baby and the younger one went somewhere else to give birth. Sometimes bring out the monies they have to lure us, which makes us follow them (Adolescent girl aged 16).

I met him during the COVID era. I remember he was visiting our tailoring shop and he expressed his feelings for me and was pestering me for my call contact number. Initially I was hesitant, but he continued putting pressure on me and eventually gave it up and that's where we took it off and had sex (Adolescent girl aged 17).

Among adolescent girls who had experienced sexual violence (N=277), only 6.4% indicated ever reporting sexual abuse in the past 12 months.

Sexual abuse is very common just that it is done in secret. Sometimes if a man rapes someone and the perpetrator has money, he can bribe the parents to keep quiet about the issue. Also, some feel shy to go and report at the police station that their child has been raped (Focus Group Discussion Participant aged 16).

He told me he liked me, and I rejected his proposal. I have menstrual complications and he said he could get me some remedies. So, I have been going to his place for medicine and also, I'm very poor in academics so he decided to help. He asked me to buy honey to make the medicine and he did not use the honey for the medicine. So, I went to his place of abode, and he slept with me. He sent me again and after doing all he asked me to do, he slept with me again. I told him also about my two siblings who are not well, my brother who is having a hernia, and my younger sister with a hearing problem and he told me he would come and see them. I gave him the direction to the house, and he came, but he came late around 9:00 pm. It was late, so he slept in our house, and he had an affair with me for the third time. I did not tell anyone about it. (Pregnant adolescent girl aged 19).

This means that the experiences of the victims of CSA were shrouded in silence and hardly reported to the law enforcement agencies.

Table 3.9: Reporting of Sexual Abuse in the past 12 months

CSA Reported	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	Freq.	Percent	Freq.	Percent	Freq.	Percent
Yes	30	7.2	25	5.7	55	6.4
No	385	92.8	413	94.3	798	93.6
Total	415	100	438	100	853	100

Of the girls who reported any incidence of CSA, they mainly reported it to their parents/guardian (50.0%), other family members (17.2%), teachers (12.1%), peers (8.6%) or the police (5.2%). One of the challenges faced by adolescent girls in reporting the case to the police was that they could not afford the process as narrated by a healthcare provider:

Talking about this police issue, most of them will not even come because going to the police station for those forms to even buy, come to the hospital for them to sign. They see it to be a long process and even the person is not having money so you will go and be embarrassing her. (Healthcare provider).

Others also cited perceived bribery and corruption as the reasons for not reporting CSA to the police.

Because nowadays there is bribery and corruption in the system. For instance, if someone has been abused and the person goes to report at the police station, the perpetrator can go back doors and negotiate with the police, and he will be freed. Doctors also take bribe. Because to prove that someone has raped you, you need a doctor's report, the doctor can be bribed to falsify reports (Adolescent girl aged 15).

Some adolescent girls, however, simply refused to report abuse cases because they claimed to love the perpetrator and did not want them arrested.

When I got pregnant, my parents were very agitated and furious with me. They insisted I mention who had got me pregnant, but I didn't because they were threatening to arrest him. My extended family members came in especially my grandparents, but I stood on my grounds and told them the guy was in our village, but I am not going to mention any name, and I was ready to give birth to my child and not have an abortion because I was in love with him (Adolescent nursing mother aged 15).

Discussions with some victims of CSA revealed that they lacked knowledge on support services available to victims. Participants mainly reported that victims need to turn to their parents/ guardians for support. The following conversation between the Principal Investigator and some adolescent girls shed light on this.

Interviewer: Where do you think victims of CSA can seek help?

Interviewee 1: I think the person should draw closer to their parents, so that they can lead them

Interviewee 2: you can go to an elderly person in the community and tell the person the issue, the elderly person can find a way of talking to your parent without spreading the information

Interviewer: what about the hospital, social workers, police are they not options for help?

Interviewee: I don't think so.

3.5THE EFFECT OF COVID-19 ON ADOLESCENT GIRLS' ACCESS TO, AND UTILISATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

3.5.1 Access to Information on SRH

As shown in figure 3.19, overall, 81.7% of the girls reported ever discussing SRH matters with someone.

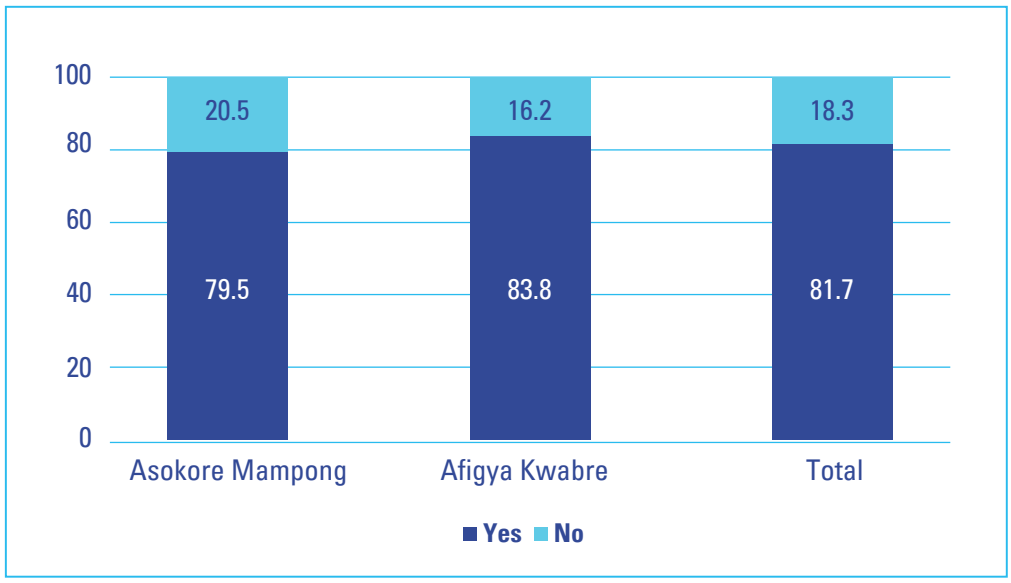

Figure 3.19: Ever discussed SRH matters with someone

In responding to a question on the person that adolescent girls discuss SRH concerns with, the majority of the girls indicated mothers (32.3%) followed by teachers (26.8%), friends (20%) and sisters (10.2%). During the FGDs, mothers were identified as the most salient individuals. Most of the girls shared that their mothers have made a concerted effort to communicate to them their thoughts and feelings regarding sexuality particularly on issues relating to menstruation and abstinence from sexual intercourse. This maternal viewpoint was often grounded in the mother's lived life experience (e.g., as a single mother), and it was clear that these mothers wanted a better life for their own daughters. The girls noted that the mothers used examples of girls who had become pregnant and now had responsibility for a baby as a way to teach them about making wise choices. Discussion on contraception and STIs was, however, conspicuously missing from the girls' accounts on the mother-girl-child discussion on SRH.

Table 3.10: The people adolescent girls discuss SRH-related matters with

	N	Percent	N	Percent	N	Percent
	N	Percent	N	Percent	N	Percent
Mother	176	32.0	152	32.7	328	32.3
Father	5	0.9	2	0.4	7	0.7
Brother	1	0.2	1	0.2	2	0.2
Sister	64	11.6	40	8.6	104	10.2
Friend	120	21.8	83	17.8	203	20.0
Doctor/Nurse	17	3.1	4	0.9	21	2.1
Religious leader	1	0.2	5	1.1	1	0.1
Social Worker	2	0.4	-	-	7	0.7
Teacher	138	25.1	134	28.8	272	26.8
Other	26	4.7	44	9.5	70	6.9
Total	550	100.0	465	100.0	1015	100.0

The SRH topics that were often discussed were pubertal development including menstrual hygiene (67.9%), pregnancy (42.2%), sexual abstinence (32.7%), contraception (19.3%) and STIs (16.7%). The increased uptake of discussion on pubertal development and menstrual health suggests that menstrual health and hygiene can be an entry point to provide girl-centred SRH information about menstruation, fertility, contraception, positive health behaviours and where to get help.

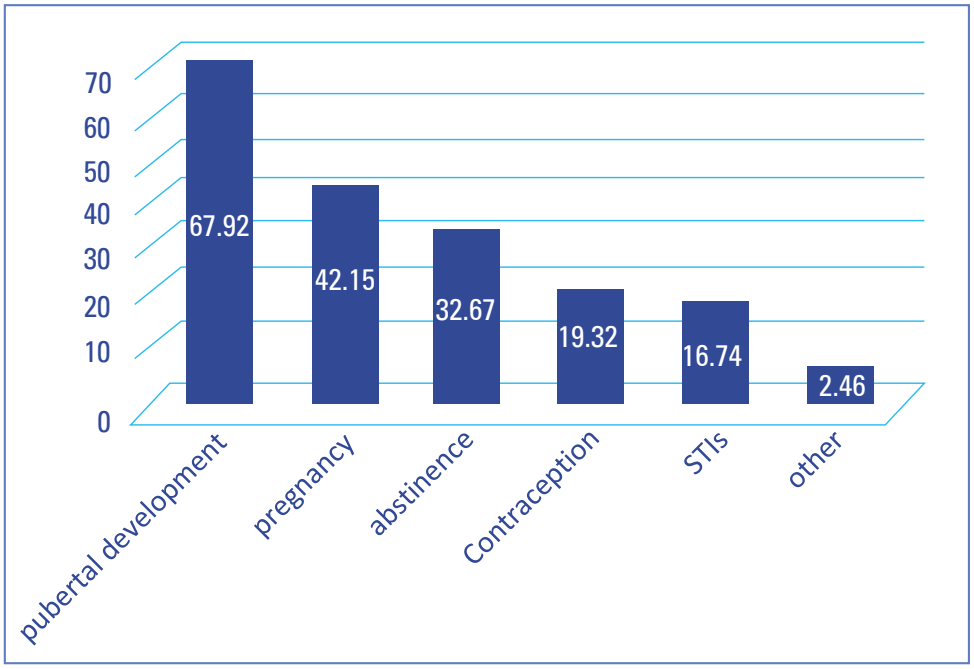

Figure. 3.20 SRH topics discussed (multiple responses allowed)

Of the 18.3% girls who had never discussed any SRH related matters with anyone, the main reasons cited were shyness (35.30%), uncomfortable discussing this subject (28.3%) and being stigmatised (14.40%).

Table 3.11: Reasons for not discussing SRH issues with anyone

Reasons	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	N	Percent	N	Percent	N	Percent
I feel shy	33	31.7	33	39.8	66	35.3
I will be stigmatised	13	12.5	5	6.0	18	9.6
I feel uncomfortable discussing this subject	27	26.0	26	31.3	53	28.3
My parents/guardian will not be happy	2	1.9	5	6.0	7	3.7
Not applicable	14	13.5	9	10.8	23	12.3
Other	15	14.4	5	6.0	20	10.7
Total	104	100.0	83	100.0	187	100.0

Overall, 75% of the adolescent girls reported that they find it easy to obtain information on SRH, while 25% do not.

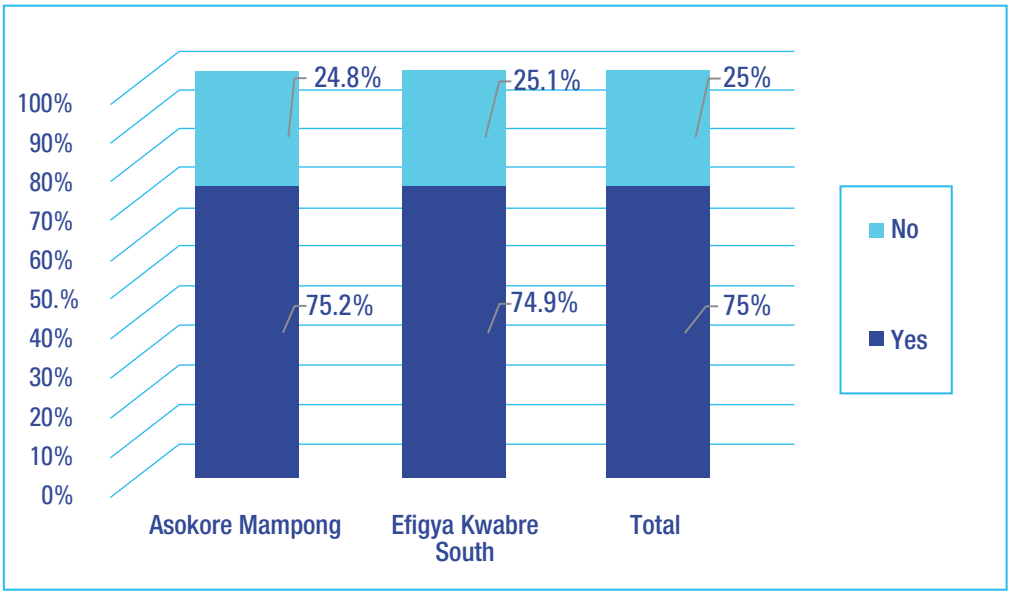

Figure 3.21: Easiness to Obtain Information on Sexual and Reproductive Health

Discussions with the health providers revealed that they occasionally organise an outreach program in schools to educate adolescents on SRH issues.

We also go for school health services outreach too, with this outreach, at the JHS level we normally educate them on teenage pregnancy and adolescent health promotion since they are mostly teenagers between the ages of 13 -17 years, some are even older. We further educate them on family planning because, most of these teenagers are sexually active and have a boyfriend, so we always advocate for safe sex and protection against unwanted pregnancies. After our sessions, these students can easily walk up to ask which family planning methods might work for them and our conversation with them starts from there. (Healthcare provider – Midwife).

Out of the 25% of the adolescent girls (n=261) who were unable to obtain information on sexual and reproductive health, the reasons were 'I feel shy' (57.5%), 'don't know where to obtain information' (22.2%), 'parents disapprove' (8%) of seeking SRH services, and 'no SRH services available' (3.8%).

Table 3.12: Reasons for not being able to obtain information on SRH

	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	N	Percent	N	Percent	N	Percent
Don't know where to obtain information	28	22.0	30	22.4	58	22.2
Parents disapprove	6	4.7	15	11.2	21	8.0
No services available	6	4.7	4	3.0	10	3.8
I feel shy	76	59.8	74	55.2	150	57.5
Other	11	8.7	11	8.2	22	8.4
Total	127	100.0	134	100.0	261	100.0

Before the COVID-19, the adolescent girls' main sources of information on SRH were friends (30.10%), parents (17.50%), health provider/clinic (16.50%), TV (4.9%), social media (4.9%) and radio (1%). However, during the COVID-19 pandemic, adolescent girls' main sources of information on SRH were health provider/clinic (25.30%), friends (23.20%) and parents (18.90%), social media (8.4%), internet (8.4%), and TV (5.3%). Overall, the adolescent girls' main preferred sources of information were health provider/clinic (30.6%), TV (14.0%) and the internet (12.4%).

A comparison of the before and after COVID-19 pandemic sources of information indicates that following the COVID-19 outbreak and its attended preventive measures there was an increase in digital information sources such as social media (from 4.90% to 8.40%), TV (from 4.90% to 5.30%). During the focus groups, most adolescent girls indicated that they turned to social media for information on SRH.

Now it's like everything is done on phone. Sometimes if you go on Facebook, the type of problem these young girls post, it's overwhelming. So that is where most of us young girls communicate and get our information from. I get it on phone. Sometimes. We hear some of these things on radio shows, Mama Effie and the rest. So, you can advise yourself also from people's experiences. (Adolescent aged 19)

While demand for online health information and content delivered on digital devices seem to have increased during the COVID-19 pandemic lockdown and school closures, presently, there is limited trustworthy, high-quality content available that is developed specifically for adolescent girls in Ghana. There is a need for digital platforms that help adolescent girls to gain better access to credible, reliable SRH information and support.

3.5.2 Sexual Behaviour

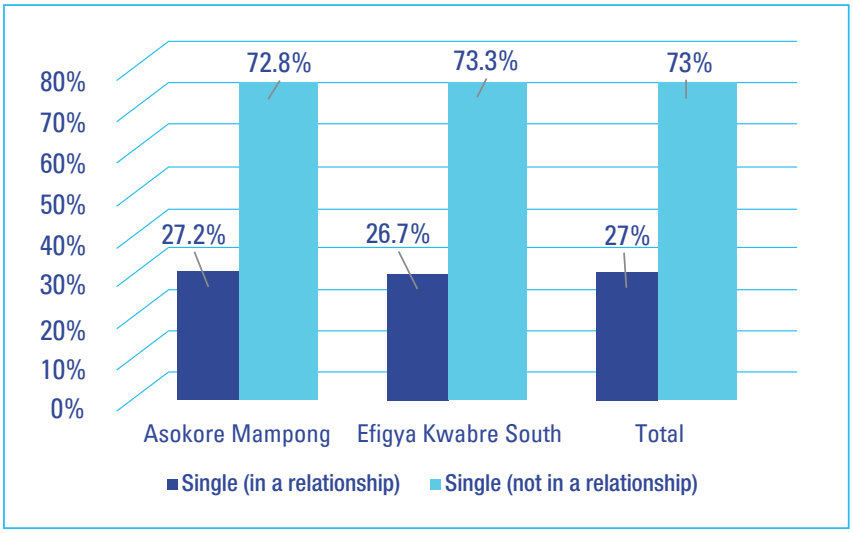

Figure 3.22: Relationship status of adolescent girls

The majority of the girls (N= 623, 73%) reported that they were currently not in a relationship while 27% reported being in a relation (N=230) (see Figure 3.22). One in four adolescent girls (25.7%), however, reported that they had ever had sexual intercourse (see Figure 3.23). The main reasons for having sex were curiosity (33.9%), expectations of a partner (25.9%) and it just happened (15.2%).

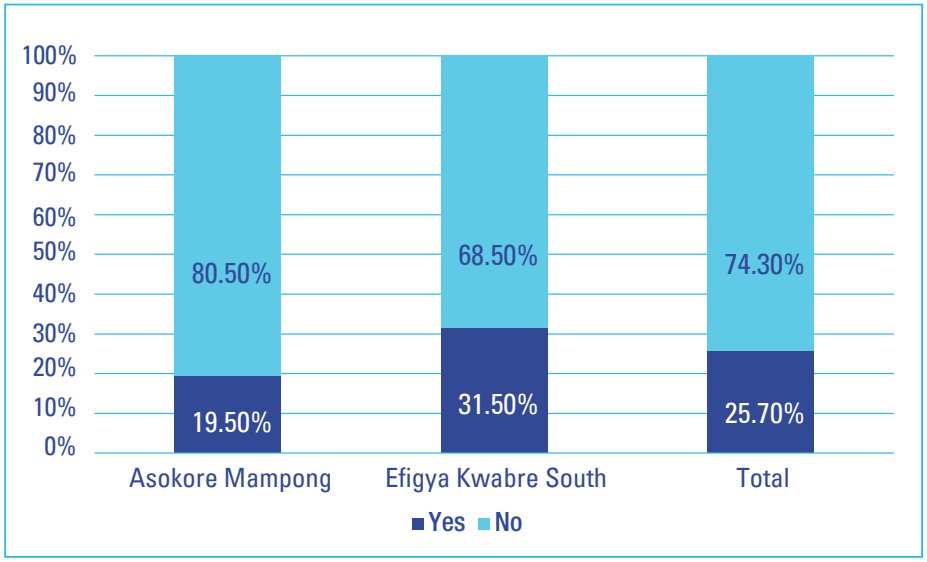

Figure 3.23: Ever had sexual intercourse

Among adolescent girls who had never had sex, the main reasons for not having sex were being too young to be involved (35.50%), fear of pregnancy (21.30%) and waiting until marriage (19.70%). In unpacking the reasons for not having sex further during the interviews and focus groups, most of the in-school girls indicated that they were only waiting to complete either their Junior High School or Senior High School education before initiating sexual activity.

I am in JHS 3 now, so I am waiting to complete school before I have sex. I'm really looking forward to it… Also my boyfriend is not here so if he comes…hmm it will be difficult not give in (Adolescent girl aged 16)

I am particularly waiting to finish writing my WASSCE examination, and after the results have been released, I won't mind having sex that very day if I know I passed into the teacher training (Adolescent girl aged 18).

Table 3.13: Main reason for not having sex

	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	N	Percent	N	Percent	N	Percent
I am too young to be involved	154	30.3	197	41.0	**351**	**35.5**
I don't have a partner	9	1.8	7	1.5	**16**	**1.6**
I'm waiting until marriage	110	21.7	85	17.7	**195**	**19.7**
I'm afraid to get pregnant	101	19.9	109	22.7	**210**	**21.3**
I want to avoid STI/HIV	20	3.9	20	4.2	**40**	**4.0**
Against my religion	43	8.5	15	3.1	**58**	**5.9**
Don't know	7	1.4	5	1.0	**12**	**1.2**
Decline	2	0.4	1	0.2	**3**	**0.3**
Other	62	12.2	41	8.5	**103**	**10.4**
	508	100.0	480	100.0	**988**	**100.0**

Of those who had ever had sex (N=219), 69.4% reported that their sexual partners were much older than them while 30.6% said their sexual partners were their contemporaries' mates. Among adolescent girls who have had penile-vaginal sex, 88.1% reported that their first intercourse was with a romantic partner/boyfriend. Evidence from the interviews confirmed that the romantic partners of the girls who in some cases provided the basic needs of the girls demanded sex from them as a proof of their love and faithfulness.

I didn't want to have sex at the age of 18. I used to reside in Accra, but it happened that I needed to come and learn a trade in Kumasi. Before leaving Accra for Kumasi, my boyfriend insisted I have sex with him as a way of proving I would remain faithful to him even in Kumasi, so I finally did it on 4th June 2020 (Adolescent girl aged 18).

In relation to sexual activity in the past 12 months, 19.3% of the girls reported being engaged in sexual intercourse over the last 12 months. Most of the girls (85.3%), indicated that sexual activity did not necessarily increase during the school closure and COVID-19 lockdown. However, evidence from the in-depth interviews show that some of the adolescent girls were engaged in transactional sex due to poverty.

COVID-19 affected our parents' work so times are hard. We go in for men we don't love as a result. Mostly this is for financial support. We all want someone who can sponsor us because it gets to a point buying a sanitary pad and pomade becomes a problem. If you don't really have support financially, you can't afford them. So, I can say COVID has encouraged most of us to be in a relationship in order to get financial support. Some even have mothers who pressure them to enter into relationships so that they can have financial support for the house (Adolescent girl aged 16)

How our parents treat us when we are young is not the same as of today. When I was young my parents used to give me money to buy biscuits and toffees without hesitating but now is not the same. They will tell you they don't have money, so you have to save or look for money (Pregnant adolescent girl aged 14).

I was not getting money to buy food and also any least mistake I do my mom throws my things outside the house so when she throws my things out then I also leave the house. This man was helping me financially…and you know there is no free lunch (Adolescent nursing mother aged 16).

He was the one taking care of my basic needs, and also taking care of my work expenses, and supporting me at work. He was very helpful, I remember once when my machine got spoilt at work, he was the one who helped me fix it. He also got me a new uniform for work. So, when he suggested we have sex, I didn't object, I agreed to it (Adolescent nursing mother aged 17).

These findings suggest that to effectively protect adolescent girls against forms of child sexual exploitation involving transactional sex and risk-taking sexual behaviours in pandemic conditions, there is the need to consider supporting economic empowerment interventions targeting adolescents. This may be through direct initiatives such as gender-responsive cash plus transfer programmes or indirect initiatives such as skills for employability and programmes with peer mentors on future planning.

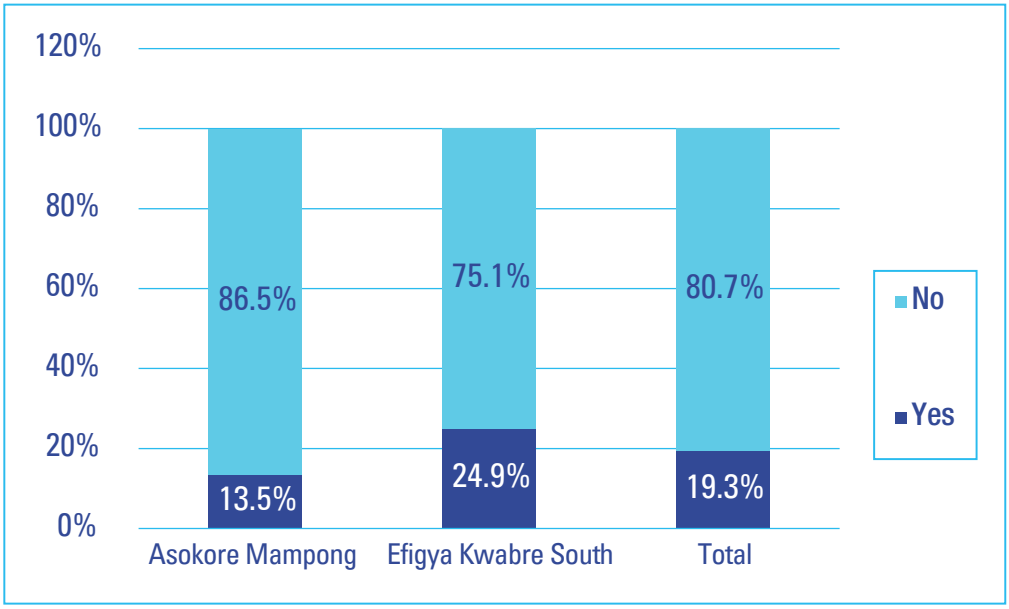

Figure 3.24: Engaged in sexual intercourse over the last 12 months

3.5.3 Contraceptive Use

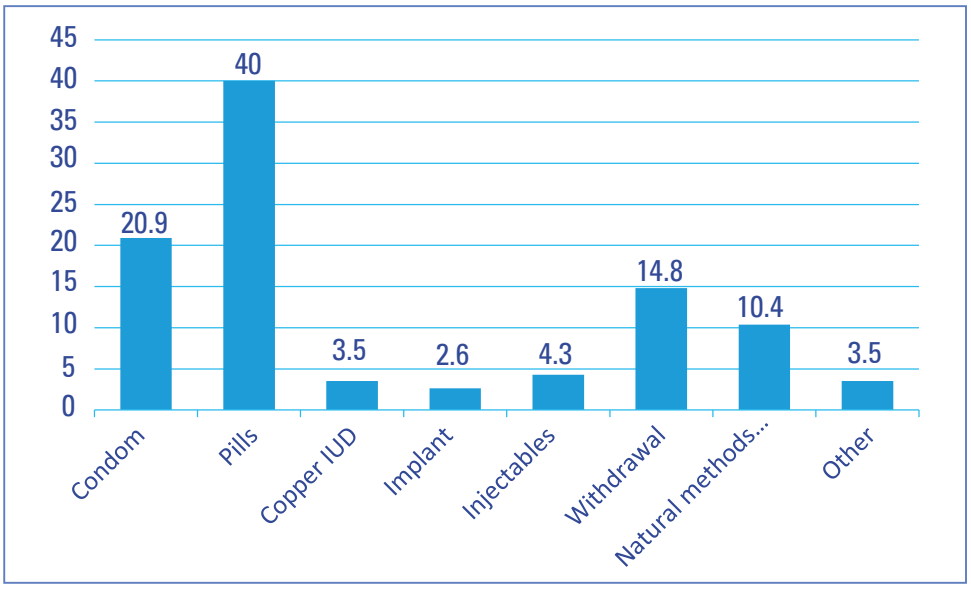

Figure 3.25: Contraceptive methods used by adolescent girls

The findings show that adolescent girls have a high unmet need for contraception. In responding to a question on what is currently being done to delay or prevent pregnancy, 89.1% of the girls reported that they were currently not doing anything to avoid pregnancy. As shown in Figure 3.25, of the 11% of the girls (N=115) who reported using contraception, the main contraceptive methods they used were pills (40.0%), condom (20.90%), withdrawal method (14.8%), and natural/rhythm method (10.4). Among the adolescent girls who were sexually active (N=219), 96.6%, reported that they did not use a condom the last time they had sex (see Figure 3.26).

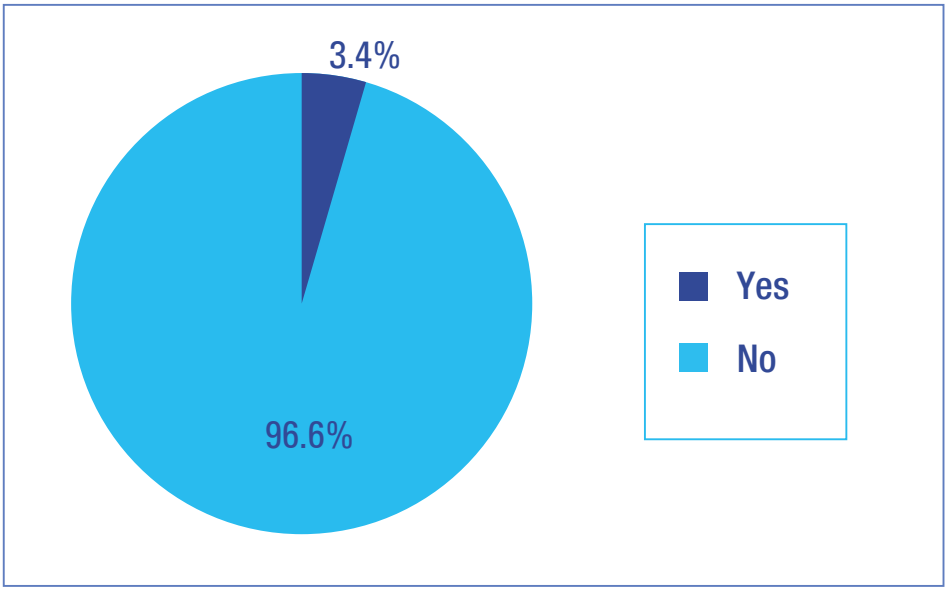

Figure 3.26: Usage of condom during last sexual activity

This means that the majority of the adolescent girls are at increased rate of being infected with HIV and other STIs. The qualitative interviews and focus groups revealed that adolescent girls held some misconceptions about condom use. Condoms were perceived by some adolescent girls to reduce sexual pleasure and create discomfort – a view that the girls stressed were also widely held by their romantic partners. Coitus interruptus (withdrawal method) was therefore considered preferable than condoms for prevention of pregnancy. Other beliefs held by the girls were that drinking chilled water after sex, taking paracetamol, and eating fruits (i.e., blended pawpaw and pineapple) were effective in preventing pregnancy than using a condom.

You see when you take chilled water right after sex and pee, the sperms will come out so pregnancy will not occur (Adolescent girl aged 15).

Also, you can also take paracetamol, drink a lot of water… this kills all the sperms…no pregnancy (Adolescent girl aged 16).

Furthermore, most of the girls indicated that their romantic partners preferred to have sex 'raw' – i.e., without using a condom and they did not see why they should say no to their partner's request.

Long-term family planning methods such as Intra Uterine Device (IUD) and implants were rarely mentioned as being used by the adolescent girls. The other methods cited as being used comprised traditional methods like drinking chilled water after sex and eating fruits.

The interviews and FGDs revealed that while some adolescent girls had basic knowledge of methods of contraception, misconceptions persist about types, modes of action and use of contraceptives. There was a general perception that contraceptive use in adolescence reduces fertility prospects. The girls believe that girls who use contraceptives will be unable to get pregnant when they eventually get married and need to have children. There was also religious beliefs and norms that using contraception is a sin.

I know some people who have done family planning and have had some complications. My cousin is an example. She has been feeling dizzy and falling sick all the time when she does family planning. I know it can also affect your ability to give birth if you do it as a young girl (Adolescent girl aged 19).

I would say most of the time, the side effect. Most of the adolescent girls have their built-up negative perceptions about the impact of these family planning options on their health and well-being and that prevents them from coming (Healthcare provider, Kodie)

Yes, I get a lot of problems when I did the family planning and I want to stop because my period has stopped coming ever since I took the injection (Adolescent nursing mother aged 16).

My sister advised me to take some drugs or opt for the family planning method to prevent pregnancy. But I see the family planning method to be a sin because God has created women to reproduce, and you are deciding to indirectly kill the unborn children by using it [contraception] hence it is a sin. My boyfriend wanted to use a condom during our sexual intercourse, but I insisted condom is also a way of committing the same murdering sin (Adolescent nursing mother aged 17).

The midwives and nurses who were interviewed confirmed such misconceptions and lamented over their effects on the uptake of contraception among adolescents who are sexually active. It was emphasised parents could play a key role on adolescent girls' uptake of contraception

Some of the mothers come with their teenage daughters because they feel shy to come all by themselves on the first visit. And because this is a small community, they all know themselves and so when she comes and an elderly person recognises her, they make comments like "a young girl like you, and you've become pregnant". This makes them feel uncomfortable to come to the clinic by themselves. So the parental factor is key here (Midwife, Ankase Hospital)

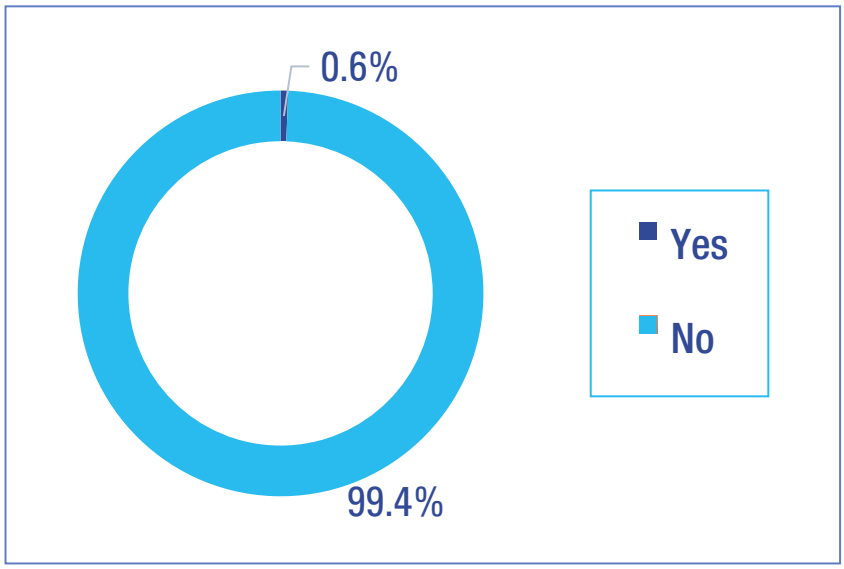

Figure 3.27: COVID-19 stopped or hindered you from seeking or obtaining contraception?

The majority of the girls (99.4%) reported that COVID-19 did not hinder them from seeking or obtaining contraception (see Figure 3.27). This was in sharp contrast to the discussions held with the health providers during KIIs, which revealed that uptake of contraception had gone down due to the COVID-19 pandemic.

Yes, uptake of SRH services reduced drastically, especially during the lockdown. Due to the rules and regulations that were placed during the lockdown on movements, it reduced uptake of reproductive health services and ANC services (Healthcare provider, Kodie).

The demand for sexual and reproductive health services has gone down for now. It's not that active compared to the previous years. The likely reason may be due to the COVID pandemic. The early months of the pandemic there were rumours around that when you even see someone you might contract the disease…so people were scared and hence did not come in that much for family planning services (Healthcare provider Anakase Hospital).

During the lockdown period when the COVID reached its peak, they thought because we have halted some of the services, so they weren't doing it. Most of them thought that we weren't offering their services. When the person comes here, they think it is not an emergency case, so she won't come and ask whether it is going on or not so the uptake dropped (Healthcare provider,

Pakoso Health Centre)

The COVID-19 affect me because I had to stay at home, and this was the same period in which I got pregnant. I was very scared of going to the hospital for ANC because we were not following the social distancing protocols even though we were in a nose mask and used hand sanitiser (Adolescent nursing mother aged 17).

For majority of the adolescent girls, Over the Counter Medicine (OTCM) and shops (41.5%) were the main source of contraceptive services during the COVID-19 lockdown and school closures (see Figure 3.28).

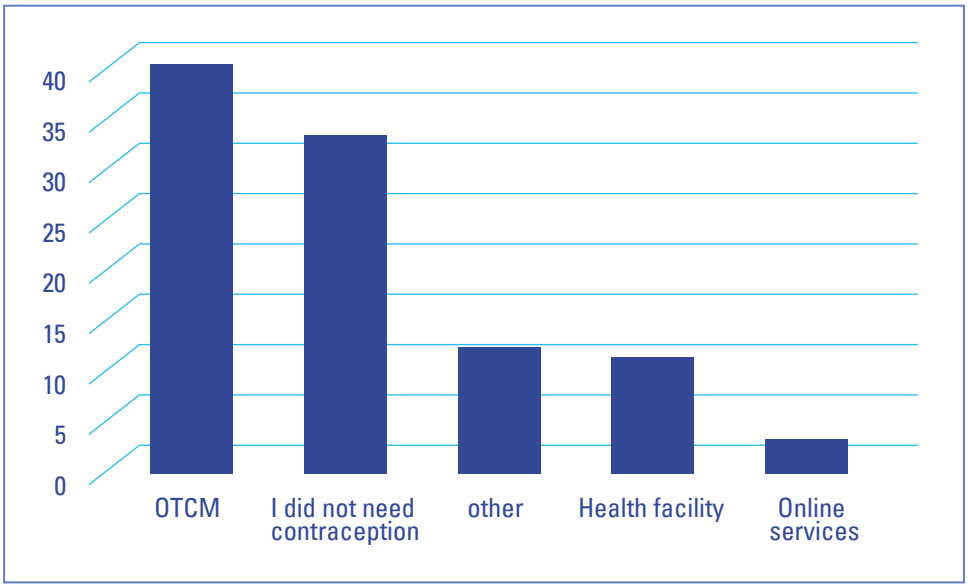

Figure 3.28: Sources of contraception during COVID-19

3.6. ADOLESCENT GIRLS' SRH HELP-SEEKING BEHAVIOURS AND PREFERENCES SRH SERVICES DURINGTHE COVID-19 LOCKDOWN

A majority of adolescent girls (91.6%) indicated that they never needed to seek medical care or services relating to SRH during the COVID-19 lockdown. The qualitative interviews and focus groups revealed that most of the girls were very sceptical about visiting health facilities to inquire about SRH services. They believed that if one visits a health facility for such assistance, she is generally referred to as 'a bad girl' or already engaged in some sexual acts. Interviews with healthcare providers confirmed this assertion.

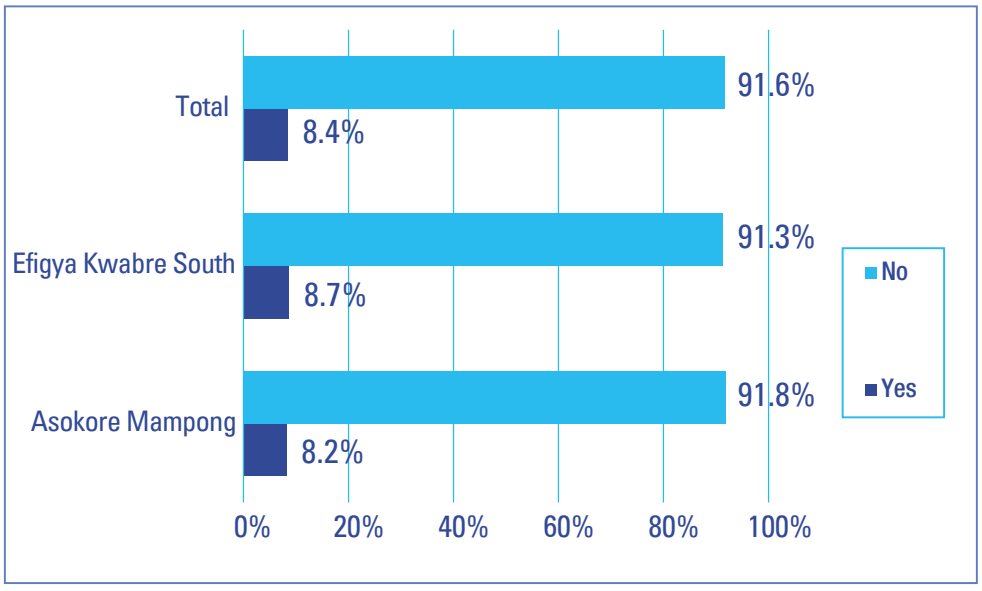

Figure 3.29: Ever needed to seek medical care or advice for any sexual or reproductive health problems

Of the 8.4% of the girls who needed to seek medical care for SRH issues (N=72), 95.2% were unable to get the needed support primarily due to limited access to health facilities and the COVID-19 lockdown. A healthcare provider at Parkoso Health Centre provided the following explanation during a KII:

During the COVID-19 lockdown, the rendering of the services dropped. Most of them thought that we weren't offering the services. During that lockdown period when the COVID-19 got to its peak, they were thinking we altered so many services. When the person comes here, they think theirs it is not an emergency case, so she won't come and ask whether we are providing the service or not. (Healthcare provider – Nurse).

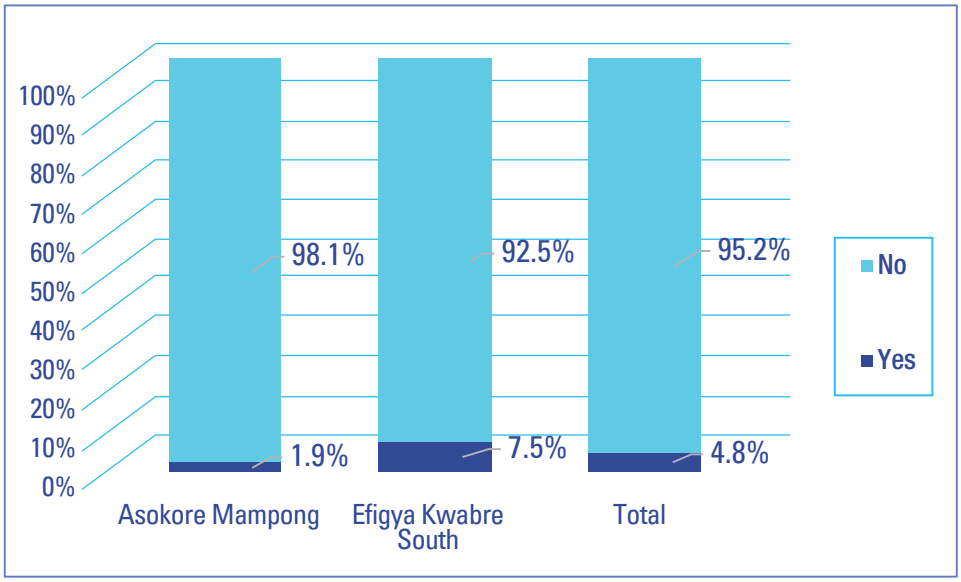

Figure 3.30: Received needed support during the COVID-19 lockdown?

Of the 121 adolescent girls who reported seeking for help on SRH issues during the COVID-19 lockdown, their preferred sources of information were health provider/clinic (30.60%), TV (14.00%), internet (12.40%), social media (11.60%), parents (9.90%) and friends (6.60%).

Table 3.14: Preferred sources of SRH information during lockdown

	Asokore Mampong		Afigya Kwabre South		Total (overall)	
	N	Percent	N	Percent	N	Percent
Health provider/clinic	13	20.3	24	42.1	**37**	**30.6**
Parents	5	7.8	7	12.3	**12**	**9.9**
Friends	5	7.8	3	5.3	**8**	**6.6**
TV	14	21.9	3	5.3	**17**	**14.0**
Radio	2	3.1	3	5.3	**5**	**4.1**
social media	10	15.6	4	7.0	**14**	**11.6**
Internet	9	14.1	6	10.5	**15**	**12.4**
Teachers	2	3.1	-	-	**2**	**1.7**
public health campaigns	2	3.1	4	7.0	**6**	**5.0**
Relatives	2	3.1	2	3.5	**4**	**3.3**
Boyfriend			1	1.8	**1**	**0.8**
Total	**64**	**100.0**	**57**	**100.1**	**121**	**100.0**

3.6.1 Adolescent girls' response to Referral Process

The help-seeking behaviour exhibited by adolescents who are victims of abuse is a primary concern for professionals in developing effective measures for abuse prevention and intervention. Providing referrals to formal support services constitute the standard multidisciplinary intervention offered to victims of abuse. It is acknowledged that during the survey respondents may recall frightening, humiliating or painful experiences, particularly relating to sexual abuse/violence, which may cause a strong emotional response. In the context of the collection of data on the impact of COVID-19 on adolescent girls' sexual and reproductive health and rights, child safety was a central consideration.

A response plan was put in place to address all child safety emerging issues that may arise during the survey according to which all respondents of the questionnaire and interviews were provided with a **Service Information Card** containing contact information of selected social service providers such as the district Department of Social Welfare & Community Development (DSWCD) and the range of services available to adolescents including counselling, HIV testing, pregnancy test, and justice services, and adolescent/youth friendly shelter, and helplines available in the district. After the interview, participants who meet any one or more of the following criteria were supported with a direct referral for counselling and/or case management services:

1. The participant becomes upset during the interview (e.g., tearful, angry, sad, shaking body etc.);

2. The participant shares at any point during the interview that she feels unsafe in her home/ community due to the risk of any form of abuse including sexual abuse/violence;

3. The participant voluntarily informs the interviewer that she has been previously subjected to sexual abuse/violence and has lacked access to justice and socio-economic services;

4. The participant is under the age of 18 and traded sex for money or goods in the past 12 months;

5. The participant requests access to sexual abuse/violence-related services, regardless of what they may or may not have disclosed during the questionnaire or interview.

Of 114 adolescent girls who were eligible for referral to support services in line with the above criteria, 28 of them agreed to be referred. This indicates the difficulty of connecting abuse victims to formal and specific support in the social care setting. Tables 3.15 and 3.16 provide further details on participants' referral process. Appendix 3 indicates the response plan used in the study.

Table 3.15: Participant eligible for referral

District	Was the participant eligible for the response plan referral?		Total
	Yes	No	
Asokore Mampong	52	363	**415**
Afigya Kwabre South	62	376	**438**
Total	**114**	**739**	**853**

Table 3.16: Referral of adolescent girls needing support

District	Would you like to be referred?		Total
	Yes	No	
Asokore Mampong	19	396	**415**
Afigya Kwabre South	9	428	**437**
Total	**28**	**824**	**852**

The major forms of abuse suffered by the participants in this study were sexual and emotional abuse. Discussions held with some participants who had suffered sexual abuse and were eligible for referral but refused to be referred revealed that their parents/guardians had settled the case with the perpetrators. Such informal response mechanisms were found to have left some of the participants being emotionally distressed as they lacked emotional counselling, safety planning, and welfare needs assessments and planning. There were also socio-cultural barriers to seeking help including social norms that normalise sexual and emotional abuse and impose stigma on the victims. Some of the adolescent girls, for example noted that they did not want to be tagged as victims of sexual abuse or 'bad girls' for fear of losing potential marriage partners in adulthood. Others also indicated that reporting such cases to formal institutions would make it 'a big case in the community' and bring shame upon themselves and their families. Interviews with some of the victims clearly showed the internalisation of negative stereotypes.

3.7. STRATEGIESTO MITIGATETHE NEGATIVE EFFECTS OF COVID-19 LOCKDOWN AND SCHOOL CLOSURES ON ASRHR

The key strategies for mitigating the effects of COVID-19 on ASRHRs that emerged from the study are parent-girl-child interventions, community-based interventions, internet/social media public health campaigns and maintaining learning and links to schools during closures.

Both the quantitative and qualitative evidence indicate that parent-adolescent SRH-related communication is one factor that could help mitigate the negative impact of pandemics on adolescent girls' SRHRs. It was reported that parents can provide information on safer sex behaviour, use of contraceptives and pregnancy care.

Yes, they do but we feel shy to get these contraceptives because we think people might raise their fingers against us that we are bad children. At times, the parents of some girls take them to the clinic for Family Planning services to be done for their children, which is encouraging…but sometimes these girls feel that their parents do not trust them, and they feel bad about it – so the parent factor is key to uptake of condoms and other contraception (Focus Group Discussion participant, adolescent girl aged 18).

Parents should educate children on menstrual cycle when they will ovulate and when to stay safe and have safe periods, what will happen if they have sex or these times and what to so that these children will be aware of the risks of teenage pregnancy (Adolescent girl aged 14).

The community starts from the home, it has to do with parents of the adolescent accepting the child and accepting the fact that the child is pregnant. Also giving some form of assurance to the child, that whatever the outcome is, they are going to support them in any way possible. The environment has to be a welcoming environment for adolescent to be able to carry the pregnancy till due time and to deliver as well (Healthcare provider, Kodie).

This makes it important to actively involve parents in all ASRHRs interventions. There are both practical and theoretical reasons why parents may be agents of sexual socialisation for adolescents and young people. From a practical perspective, parents may play a critical role in conveying SRH-related information and may exert significant influence on adolescents' sexual attitudes, values, and risk-related beliefs. In a recent systematic review, it was found that SRH-related communication with parents, particularly mothers, played a protective role in adolescent safer sex behaviour, and this protective effect was more pronounced for girls than boys (Widman et al. 2016).

Community-based approach to adolescent SRHR was emphasised by the participants as another strategy to improve adolescent girls' access to SRH services during the COVID-19 pandemic.

We have to engage the community. With the school closures, our approach has to be community-based. I think community engagement is the best way to go so that the opinion leaders will know how best they can help address this problem (Healthcare provider, Ankase Hospital).

Currently, there is a strong focus on adolescent SRH education within the school setting. While this is important, the COVID-19 induced school closures and their attendant effects on adolescent SRH means that there is the need to take a more comprehensive settings approach to adolescent SRHR. This includes the need to have a strong community-based approach to ASRHR education. Formation of community-based clubs, and the engagement of local actors in a whole system approach is critical to improving adolescent SRHR. Furthermore, in the face of continued resistance to in-school comprehensive sexuality education, community-based SRHR education remains the most viable option to deliver gender sensitive SRH education. Theoretically, community-based adolescent SRHR

interventions supported by contextual factors, such as existing local policies and guidelines related to SRHR, and socio-cultural norms are more likely to trigger mechanisms among the different actors and duty bearers that can encourage uptake of the interventions, and thus contribute to improving adolescents SRH needs and wellbeing.

The findings from this study further indicate that the adolescent girls, to some extent, turned to the internet and social media as potential sources of information on SRH services during the COVID-19 pandemic. This suggests that new digital media (e.g., the Internet, text messaging, and social networking sites offer a potential strategy for promoting adolescent girls SRHRs during the COVID-19 pandemic. There is the need to design and implement innovative adolescent girls' digital engagement strategies for increasing their agency and assets for improved SRHRs outcomes. Healthcare providers and adolescent girls interviewed expressed that the use of the internet and mobile phones to provide information on adolescent SRH services could potentially reduce the stigma associated with adolescents accessing these services in health facilities.

We can consider using text messages because these days most of them have phones (Healthcare provider, Pakoso).

Clearly, the new digital media presents new tools for engaging adolescents in sexual health promotion and risk reduction.

Another important strategy to mitigate the negative effects of pandemics like COVID-19, is to maintain learning and links to schools during closures and lockdown. This is particularly important during school closures as school connections and links serve as pathways for adolescent girls at risk of or experiencing violence and abuse to seek support and/or report cases. Furthermore, a central theme across the interviews and focus groups with the adolescent girls was the need to keep up some form of learning or connection to schools during school closures. The findings show that a large proportion of the girls did not engage in any form of home-schooling during the COVID-19 lockdown and school closures.

I heard they were having some classes on TV during the lockdown, but I could not watch them because we don't have a TV at home (Adolescent girl aged 15).

During the school closures we were at home doing nothing. It would have been helpful if we had someone teaching us at home to keep us busy…because we were not learning, most of our friends got pregnant and could not come back to school when school reopened (Adolescent girl 14, Focus Group participant).

Next time when they close the schools, they [the government] should help us to learn at home to keep us busy (Adolescent girl aged 13).

While the Ministry of Education and the Ghana Education Service organised classes, which were aired on TV and radio during the school closures, most of the adolescent girls at the focus groups reported that they did not benefit from the radio or televised educational lessons. There is also less evidence of home-schooling as most of the girls reported that they did not maintain their education through learning activities. Parents who were interviewed re-echoed the concerns of the adolescent girls and called for state support to parents in terms of teaching and learning at the community level during school closures. To better understand the specific learning strategies (either home-based or community-based) required to maintain adolescents' learning during pandemics and to avert their harmful effects on adolescents SRHRs, it is important to undertake a full-scale study to examine parents and children's perspectives on home leaning during the COVID-19 lockdown and school closures.

4.0 CONCLUSIONS AND RECOMMENDATIONS

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4.1. CONCLUSIONS

The overarching objective of this study was to examine the impact of COVID-19 on adolescent girls' SRHR. The study was conducted in 2 districts in the Ashanti Region. Quantitative and qualitative data were collected in these districts from adolescents – in-school and out-of-school, parents, community leaders, as well as health and education sector stakeholders. The findings support the hypothesis claiming that the COVID-19 pandemic and its attendant lockdown and school closures have had significant negative effects on adolescent girls' SRHRs. Both the quantitative and qualitative evidence points to increased adolescent pregnancies, reduced access to SRHs, increased incidence of CSA, and increased exposure of adolescent girls to child marriage during the COVID-19 lockdown and school closures. The findings show that the girls were exposed to vulnerabilities in terms of sexual exploitation and the risk of child marriage. The school closures did not only interrupt educational progress; they also curtailed normal social interaction and limited access of adolescent girls to essential services that they relied on, including school health programmes. These are important effects of school closures, in addition to increases in adolescent pregnancies, sexual abuse and discussions on child marriage. For most of the adolescent girls interviewed, schools serve as safe places, which keep them away from early pregnancies and exposure to sexual violence. The strategies required to mitigate the impact of COVID-19 on adolescent girls SRH identified in this study are parent-girl-child interventions, community-based SRH interventions, internet/social media public health campaigns on adolescent SRHR and maintaining learning and links to schools during closures.

4.2. RECOMMENDATIONS

In the light of the findings and conclusions from the study, the following recommendations are made to strengthen quality and focus of adolescents and youth interventions in the area of SRH:

1. **Involving parents in adolescent SRH education.** The findings from the study show that parents especially mothers are the primary source of information to adolescents when it comes to SRH issues. In some instances, however, parent-child relationship was problematic within the communities making it difficult for adolescents to share their respective problems with their parents. Currently, there seems to be no parent-girl-child intervention or a parent-centred intervention focusing on parents as champions of adolescent SRH. Parents are role models who shape adolescent and young people's perception of gender roles and influence the choices that they make about their sexual behaviour. It is therefore recommended that a Parent Education Programme be designed to improve parents' skills for educating and communicating with adolescents, especially about sexuality and reproductive health. The proposed parent education programme will be most effective when it operates holistically within the socio-cultural context of changing family patterns and works through existing networks of learning institutions and community-based organisations.

2. **Effective and continuous education on contraception.** Most of the adolescents knew little about the contraceptives beyond prevention of pregnancy. Most of them held the perception that condoms are solely meant for preventing unplanned pregnancy but not STIs or diseases. They also had various misconceptions about contraception meaning intensive education is required on this topic. Community-based interventions that elicit community buy-in and foster a more supportive environment by breaking through community-level sociocultural barriers that adolescents face in accessing family planning and contraceptive information and services would be critical.

3. **Economic empowerment programme for adolescent girls.** To effectively empower adolescent girls against transactional sex and risky sexual behaviours, there is the need to consider supporting economic empowerment interventions targeting adolescents. This may be through direct initiatives such as gender-responsive cash plus transfer programmes or indirect initiatives such as skills for employability and programmes with peer mentors on future planning. A recent systematic review of cash transfer programmes in sub-Saharan Africa found that cash transfer programmes significantly reduced sexual debut, transactional sex, early marriage, and adolescent pregnancy among adolescents (Owusu-Addo et al. 2018).

4. **Intensification of community-based SRHRs education.** In the face of continued resistance to in-school CSE, community-based SRHRs education remain the most viable option to deliver gender sensitive SRH education. There is therefore the need to intensify the community-based education programmes including the formation of community adolescent health clubs. This should be based on an 'empowerment approach' with a focus on gender norms and power relations recognizing that these are crucial factors in safer sex negotiation and, more broadly, in the overall social and cultural environment in which adolescents make SRH decisions.

5. **Further research to document and understand the impact of COVID-19 on children's home leaning during the lockdown and school closures.** Participants (i.e., adolescent girls, parents, and teachers) made a causal argument that the school closures affected learning making adolescent girls exposed to sexual violence and the risk of adolescent pregnancies and child marriage. However, it is unclear to what extent this has been the experience of all adolescents, and particularly whether adolescents from marginalised groups and rural communities participated in and benefitted from schooling at home. Accordingly, it is recommended that a study be conducted to specifically explore the perspectives and experiences of parents and children on the impact of COVID-19 on home-schooling.

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