

Factors Influencing Sexual Behaviour of Senior High School Students at Cape Coast Metropolis in Central Region of Ghana

Christiana Asiedu (PhD, MPhil, MPH)

College of Health and Allied Sciences, School of Nursing and Midwifery, Department of Adult Health,
University of Cape Coast, Ghana.

Corresponding Author: Christiana Asiedu

Abstract:Background Adolescent is a period of transition characterised by risk taking behaviours, including sexual behaviour, which may have implications on their health. The study examined sexual behaviour among senior high school students in the Cape Coast Metropolis.

Methods The data was obtained from a cross-sectional survey. Through the multi-stage sampling method, 400 students were selected from three Senior High Schools whose ages ranged from 10-19 years. Descriptive and binary logistic regression were statistical techniques used to analysed the data. Data collected were processed using SPSS version 21.

Results: Form one students were less likely to engage in sexual intercourse than students in Form two (OR=0.30, 95% CI=0.15-0.63). Form two students are more engaged in sexual intercourse than form one students. Students who were living with both parents were less likely to engage in sexual intercourse than those who did not live with both parents (OR=0.480, 95% CI=0.240-0.963). Seven percent of the respondents ever visited a health facility/pharmacy to access sexual and reproductive health (SRH) services Attitude of service providers towards students who access SRH service was negative. These students were unwilling to access SRH services from those facilities in future. Nine percent of the respondents were ever pressurised by people to engage in sexual intercourse.

Conclusion Students, who have not already engaged in sexual activities, should be encouraged to abstain until they are of age. Those who are sexually active should be encouraged to use contraceptives to prevent sexually transmitted infections (STIs) and unplanned pregnancies.

Keywords: Sexual behaviour, senior high school students

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I. Introduction

In the united State of America, about 25% of 15 years old adolescents have had sexual intercourse, with the boys being more involved than girls [1]. Involving in sexual activity at an early stage may also lead to having more sexual partner besides, being exposed to sexually transmitted infections (STI) [1]. The percentage of females in Sweden, between the ages 16-17 years, with multiple sexual partners increased from 8% to 17%, in 2000 and 2007 respectively, and 11% to 17% in males within the same year [2]. At Dodowa, in Ghana, sexual behaviour of teenagers has greatly been influenced by the economic, social and cultural environment [3]. Unemployment, insufficient training and educational opportunities after basic school, lack of competence of school regulatory environment, poor parenting, lack of open communication about HIV/AIDS, perversion of *dipo* puberty rites, lack of positive role model is responsible for the dangers of sexual behaviours [3].

In some countries, research has proven that lack of reproductive health and knowledge on HIV/AIDS and service results in reproductive health behaviour in adolescents/ teenagers. Environmental influence has been an importance determining factor of adolescent reproductive behaviour [4]. The measure evaluation program has it that, "Any member of other factors may influence who has sex with whom and whether they use condoms, but the act that spreads the virus, in the overwhelming majorities of cases, is an act of unprotected sex" [4].

As an excuse of not using condoms, teenagers claim they are expensive regardless of the effort made by the national HIV prevention program to decrease the cost of condoms. In sexual relationship, it is complicated to agree on the use of condoms since it is regarded as a sign of lack of trust. Again, female teenagers who have received gifts or money find it difficult to agree on the use of condoms [4]. Embarrassment to buy condoms from adult providers, which may be caused by some discouraging attitudes from health providers and the dislike of condoms are other factors that prevent adolescents from using condoms. The consequence now is, engaging in sexual activities without the use of condoms which also results in the transmission STIs

Sexual behaviour in Nepal is affected by socio-demographic factors such as age, sex, education, ethnicity, culture and religion [5]. Engaging in sexual activities in an early stage, with more than a partner, and

not using condoms frequently, which are largely affected by the socio-demographic characteristics is common in Nepalese society and risky sexual behaviour is among the usual ways of HIV and other STIs transmission in Nepal[5]. Sexual intercourse in students who are not sexually active can be curtailed by family planning and promoting sex education and also encouraging the use of contraceptives among those who are sexually active [6]. A lot young adults rely on service centres used by people in the community regardless of the age, in order to enjoy the benefit of STI treatment, prenatal care, and family planning. Unfortunately, they encounter several obstacles that prevent them from accessing these facilities. Services to young adults who are married, those who already have children, or those who have attained certain ages, are usually restrained by Community-based health services [7]. Seeking consent for the use of services that may require that a parent or a husband be present so as for the adolescent girl to have access family planning methods or safe abortion services which is accepted, is also a hindrance to young people. Often times, these regulations expose the lives of young people to danger through these main hindrances to service accessibility[8]. Other compelling factors for young adults may include inconvenient location, lack of confidentiality, attitudes from service providers, the intuition that health centres do not provide service for adolescents and attitudes from service providers. Lastly, youths are more restrained in finances than others in their community, so that they will perhaps not be completely accessed if reproductive health (RH) and contraceptive services are expensive [8]. Over the years, clinics which are school based have proven to be enhancing the attainment of required services that may cause a change in behaviour among students. Research on multiservice health centres in schools shows that students use them for issues that are more sensitive such as reproductive health, sexual abuse, and mental health and not only for primary issues [9].

Again, some school-based health clinics have produced positive changes in sexual/ reproductive health outcomes. Girls enlisted in a school-linked pregnancy prevention program didn't engage in sexual activities seven months before their enrolment [10]. Comments from health providers show that school health centres can enhance school suspension, school attendance and dropout rate [10].

In a study comprising six school-based health centres in Kenya, there was no statistically significant effect on school wide pregnancy rate[11]. The degree of pregnancy decreased by 30% among girls who were involved in sexual education promoted by medical and contraceptive services and individual and counselling within three years during the school-linked pregnancy prevention program. The rate of pregnancy went up by 58% among girls who were not involved in this program. Consequently, a lot of societies do not support the idea of premarital sex, adolescent then do not have enough education on reproductive sexual health care. [12]. The use of modern contraceptives among young people is minimal, and declines with economic status. Less than 5% of the adolescent who are poor use modern contraceptives.

As a proof of young women not having equal authority in agreeing on safer sex, they always comment of reduced contraceptive usage than men. Due inconvenient locations and hours, limited contraceptive choices and supplies, lack of privacy and confidentiality, and perhaps most importantly, negative or judgmental provider attitudes, most adolescent find it difficult to visit the clinics. The rate at which young people obtain information and services may also be restrained by laws and policies. In traditional societies, there is a ban on the public discussion of public sexual issues which has been a threat in advocating for them. Such include the fact many young people are sexually active before marriage. [13]. To know how young people, get reproductive health services pertaining to their knowledge in contraceptives and the dangers involved in sexual activities before marriage, numerous studies have been carried out. The fear of not keeping some secrets is also a major reason. Adolescent males and females fear telling people about their indulgence in sex and this makes them unwilling to be part of the target group to talk about their sexual activities. [14].

A vast part of the literature on young people and sexual and reproductive health services has emphasized certain hindrances of adolescents in getting access to services. Lack of privacy and confidentiality and age restrictions, shame about their needs, negative attitudes of providers, confidentiality and age restrictions and the fear that others might get to know of their visit are the main obstacles young people are faced with. [3] With RH education, there is a general concern that the availability of school contraceptive program will increase the rate of sexual activity among adolescents. [11]. Within the six school-linked based health centres, few levels of sexual activity were found in schools with SBHCS that ensures that contraceptives are available compared with those that did not. [15]. Likewise, in judging whether the promotion of condoms and distribution enhances sexual activity among Latino teenagers in the United State, there was no effect on the beginning of sexual activity for females.

Sexual activity was low among vocational school students in Thailand who received health education training and contraceptives but ensured the use of contraceptive when they have sex. [16]. A close assessment indicates that students from schools with clinics use contraceptives more often than those from schools without clinics. On the other hand, conclusions cannot be made about most of the data pertaining to the link between school-based clinics and condom usage. Giving contraceptives was not enough to guarantee their usage; the researcher found a reduced condom usage among students in the three schools that have school- based clinics

providing condoms. [17]. This is due to the fact that students in the United State have different sources apart from schools the schools through which the get access to condoms and contraceptives. [11; 18].The study therefore sought to investigate the factors influencing sexual behaviour of senior high school students at Cape Coast Metropolis in Central Region of Ghana

II. Methods

Research Design

The study was a descriptive cross-sectional survey that quantitatively explored various aspects of the sexual and reproductive health of the senior high school students in the Cape Coast Metropolis[15]. The design enabled the study to also describe the characteristics of the students surveyed and their perspectives on the research questions posed [15].

Study Area

Major communities in the Cape Coast Metropolis include Abura, Pedu, Ola, UCC, Ekon, Kakumdo, Nkanfua, Effutu, Kwaprow, Akotokyere, Kokoado, EssuekyirAnto, Amamoma, Duakor, Nyinasin, Mpeasem and Amisano. Cape Coast is also the capital of the Central Region of Ghana. According to the 2010 census, Cape Coast Metropolis has a total population of 169,894. Out of this, males constitute 82,810 while females constitute 87,084 [19].

The Cape Coast Metropolis is recognized nationwide as the focal point of Ghana's secondary education. Cape Coast since the colonial era has been the hub of secondary education in Ghana, priding itself on being the custodian of some of the best and most prestigious schools and has since attracted the cream of school graduates [20]. The Metropolis boasts b of best secondary schools in the country. These include; Wesley Girls' High School, St. Augustine's College, Mfantsipim School, Adisadel College, Ghana National College and Holy Child Senior High School [21]. Hence, the metropolis was selected for this research.

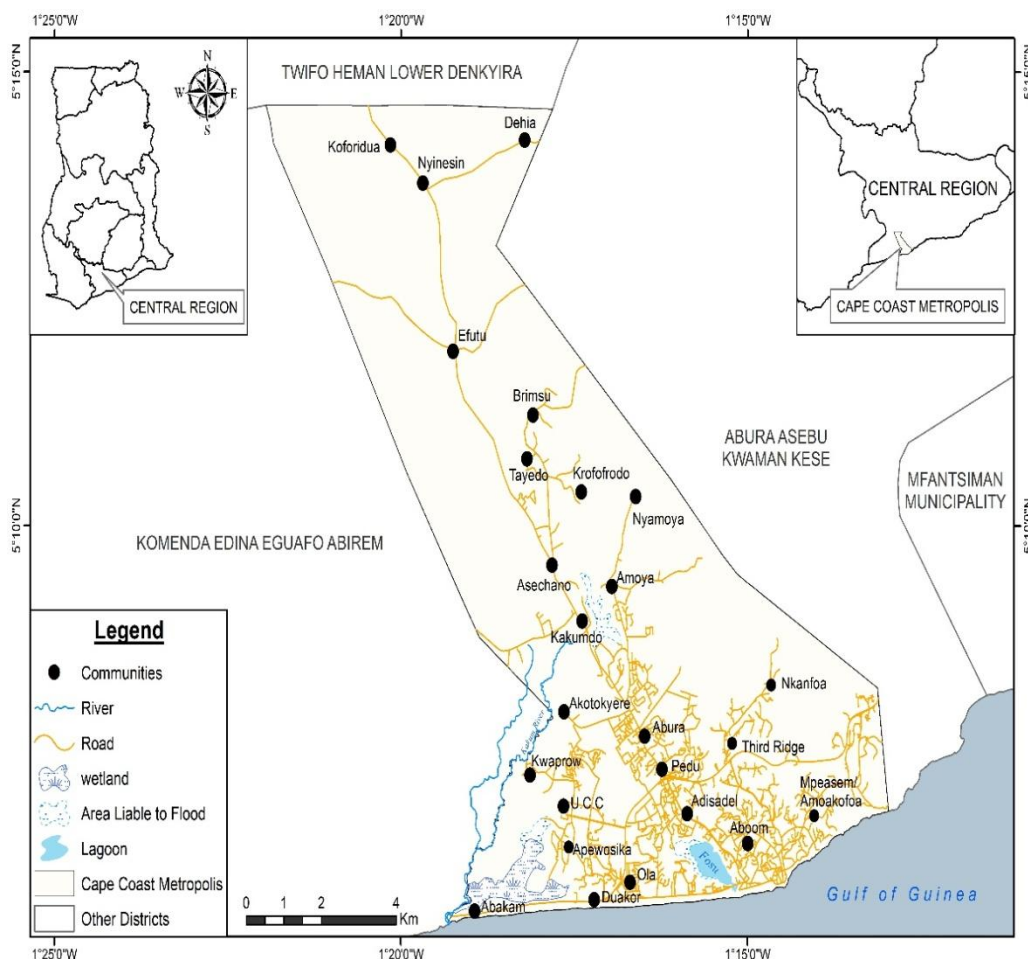


Figure 1: Map of Cape Coast Metropolis

Source: Department of Geography and Regional Planning, UCC (2015).

Study Population

The population of the study consisted of the 10 government assisted Senior High Schools in the Cape Coast Metropolis. The schools are St. Augustine' College, Mfantshipim School, Wesley Girls High School, Holy Child Girls School, Adisadel College, Ghana National College, Academy of Christ The King, Oguaa Secondary Technical School and Aggrey Memorial AME Zion Secondary School. Males and females in three selected senior high schools (SHS) in the Cape Coast Metropolis were included. These were St. Augustine's College, Wesley Girls Senior High School, and Ghana National College.

Sample and Sampling Procedure

Sample size

Sample size of 400 was estimated from the target population. Krejcie and Morgan formula was used for estimating the sample size [22]. This formula was used because it is useful for estimating the sample size in a known population. It is given as:

$$S = \frac{X^2 NP(1-P)}{d^2(N-1) + X^2 P(1-P)}$$

Where:

S = required sample size.

X^2 = the table value of chi-square for 1 degree of freedom at the desired confidence level (3.841).

N = the population of adolescents aged 13-19 in selected senior high schools.

P = the population proportion (assumed to be .50 since this would provide the maximum sample size).

d = the degree of accuracy expressed as a proportion (0.05).

An adjustment of 10 per cent was made for non-response. This yielded a sample size of 425, which was sufficient to increase the power of the study but 400 was used. The Senior High Schools in the Cape Coast Metropolis were categorised into female only, male only and mixed schools. One school was selected through simple random sampling. Stratified sampling was used to select respondents from the schools that were selected from among the 10 senior high schools in the Metropolis. This was achieved by adopting the formula which is given as;

$$\frac{K}{N} \times n \text{ [23].}$$

Where:

K = Population of students in a school

N = Total population of all three schools

n = Sample size

The same formulae was adopted to select the number of respondents in each school [23].

Sampling Procedure

There were 10 government assisted SHSs in the Cape Coast Metropolis at the time of the study. Multi-stage sampling was adopted in the selection of respondents. First the schools were classified into three strata; single sex (male), single sex (female), and mixed schools. Three schools were then randomly selected from the clusters; one from each cluster, mixed, female and male.

After the three schools were selected, stratified sampling was again adopted to select the students that were included in the study. To achieve this, the school registers were used as the sample frame. Each school was divided into two strata (forms One and Two); Form Three students had graduated at the time of data collection for the study. Depending on the population of each year group, proportional stratified sampling was used to determine the sample size from each Form.

Research Instrument

Questionnaire was used for data collection. The questionnaire was developed based on the objectives of the study. It had two sections. Section A was based on the background characteristics and Sections B was based on sexual behaviour of the participants. While some questions were close-ended, others were open-ended. Responses of participants to the open-ended questions were, however, later categorized to make them close-ended for analysis.

A pre-test was conducted in order to be certain of the validity and the reliability of the instrument. This was an initial trial conducted before the final study. The test was conducted at the Winneba Senior High School located in the Winneba municipality. The school was chosen in Winneba because students in senior high schools in both Cape Coast and Winneba were likely to have similar socio-demographic characteristics, which influence sexual behaviour greatly.

Data Collection Procedure

After explaining the purpose of the study to the students, the questionnaires were distributed to the students who consented to participate in the study. The instruments were self-administered. The respondents were given the instruments to respond to, and the instruments were taken right after completion. The data collection took three weeks; 28th August – 17th September. An instrument took about 20 minutes for each respondent to complete. To avoid information contamination, data were collected during a single day in each selected school. Data collection took place in the absence of class teachers and efforts were made to ensure maximum comfort and privacy for the participants. Students sat apart from each other, and discussion was not allowed when completing the questionnaires, both to ensure privacy and to avoid shared responses. When they had finished, students were requested to put their completed questionnaires into a sealed cartoon box instead of giving them to the researcher. All the eligible respondents selected took part in the study. The completion rate was 100 percent. All items on the questionnaire administered were completed.

Ethical Issues

The study was a school-based study. The students were in boarding school as a result consent was not possible to be sought from the parents but rather the school authorities, teachers and the students. Because the study participants were minors permission were sought from school authorities, teachers and finally the students. First introductory letters were obtained from the Department of Population and Health of the University of Cape Coast, which was presented to authorities of the three schools. This enabled the researcher to acquire approval from the selected schools to conduct the study. Secondly, the purpose of the student was explained to the class teachers and permission for using the students for the study was also sought. Furthermore, the purpose of the study was also explained to the students to obtain their consent form before they could participate in the study. They were informed that participation of the study was voluntary and that they have right to withdraw from the study at any point or decide to leave questions which sought to infringe on their privacy unanswered. All information obtained from the participants were kept confidential. The names of respondents were also not associated with responses provided to ensure their anonymity.

Data Analysis

Data collected from respondents was processed using Statistical Product for Service Solutions (SPSS) version 21. Percentages and logistic regression analysis were used to analyse the data. The logistic regression conducted determined the relationship between socio-demographic characteristics and sexual behaviour of the students. The logistic regression analysis was presented as odds ratios at 95% CI.

III. Results

A logistic regression analysis was conducted to examine the association between socio-demographic characteristics and having sexual intercourse (Table 1). The level of education of the student is a key factor that affects their involvement in sexual activities. Form one students were less likely to engage in sexual intercourse than students in Form two (OR= 0.30, 95% CI=0.15-0.63).

Form two students are more engaged in sexual intercourse than form one students. Students who were living with both parents were less likely to engage in sexual intercourse than those who did not live with both parents (OR=0.480, 95% CI=0.240-0.963).

The probability of engaging in sexual intercourse also increased by level of education of the students' fathers.

Table 1: Logistic regression analysis of association between socio-demographic characteristics and having sexual intercourse

Socio-demographic characteristic	Odds Ratio	95% C.I.	P-value
Form			
Form Two	Ref.		
Form One	0.303	0.146-0.630	0.001***
Age			
10-14	Ref.		
15-19	1.236	0.334-4.794	0.739
Sex			
Male	Ref.		
Female	0.458	0.188-1.117	0.086
Religion			
Christianity	Ref.		
Islam	0.453	0.059-3.473	0.446
Traditional Religion	0.402	0.135-1.195	0.101
Ethnicity			
Ga/Dangme	Ref.		
Akan	0.752	0.288-1.964	0.560
Ewe	0.601	0.177-2.047	0.416
Others	2.418	0.303-19.301	0.405

Living with both parents			
No	Ref.		
Yes	0.480	0.240-0.963	0.039*
Table 5 Continued			
Household size			
1-5	Ref.		
6-10	1.463	0.612-3.499	0.393
> 10	1.258	0.325-4.875	0.740
Mother's level of education			
No formal education	Ref.		
Primary	0.534	0.099-2.894	0.467
Secondary	0.322	0.061-1.694	0.181
> Secondary	0.464	0.087-2.463	0.367
Father's level of education			
No formal education	Ref.		
Primary	10.108	1.635-57.002	0.026*
Secondary	11.701	1.715-79.853	0.012**
> Secondary	14.203	2.284-88.339	0.004***

Source: Field work, 2015 * P<0.05 **P<0.01 *** P <0.001Ref=Reference category

Seven percent of the respondents ever visited a health facility/pharmacy to access sexual and reproductive health (SRH) services (Table 2).For respondents who went to health facilities to access reproductive health services, it was reported that attitude of service providers towards them (57%) was negative. Seventy-five percent of the respondents who said attitude of service providers was negative towards them indicated that they were not going to access SRH services from those facilities in future (Table 2).

Table 2: Visiting a health facility/pharmacy to access SRH services, attitude of service providers and revisit decision

Variable	Sex (%)		Total
	Female	Male	
Ever visiting a health/pharmacy to access SRH services (400)			
Yes	6.2	7.7	7.0
No	93.8	92.3	93.0
Attitude of health care providers (N=28)			
Positive	28.6	47.6	42.8
Negative	71.4	52.4	57.2
Respondent visiting those health facilities in future to access SRH services (N=28)			
No	71.4	76.2	75
Yes	28.6	23.8	25
Total	100	100	100

Source: Field work, 2015

Nine percent of the respondents were ever pressurised by people to engage in sexual intercourse (Table 3). Those who were ever pressurised mostly (60%) indicated that they were influenced by their sexual partners to have sexual intercourse.

Table 3: Sexual pressure among the respondents

Variable	Sex (%)		Total (%)
	Female	Male	
Pressure from others to have sexual intercourse (N=400)			
Yes	4.1	13.5	9.0
No	95.9	86.5	91.0
Persons who pressurised respondents to have sexual intercourse (N=36)			
Sexual partner	75.0	46.4	52.7
Friends	25.0	46.4	41.7
Teacher	0.0	3.6	2.8
Uncle	0.0	3.6	2.8
Total	100	100	100

Source: Field work, 2015

IV. Discussions

Congruent to findings of the present study are the results of a study which showed that sexual behaviour is influenced by socio-demographic factors like education [5]. Findings of the study, however,

contradict the study that revealed that age, sex, ethnicity, culture and religion influence sexual behaviour [5]. A significant result of the research is that, students who stay with their mothers and fathers hardly engage themselves in sexual intercourse.

This highlights the role of the nuclear family in the upbringing of children particularly in relation to sexual and reproductive health issues, which helps to minimise the probability of engaging in sexual intercourse [24]. Doku, however, argued that traditionally, sex education by nuclear families is given to only girls, usually by their mothers or an elderly woman in the family during puberty rites. The students who were involved in SRH services claim that service providers never exhibited positive reactions towards them.

This behaviour of health workers is likely to prevent adolescents from visiting health facilities in future. Negative attitude of service providers was corroborated by some of the participants as the reason why they never visited any health facility to access any SRH service. Since most of the adolescents will not visit health facilities in future due to negative attitude of service providers, they are likely to lack the information needed to make informed sexual decisions and therefore being exposed to sexual risks including STIs [25;3]. Findings of the study relate to the conceptual framework of the argument that people perform behaviour if they feel they have a high degree of control over it [26]. Thus, students who engaged in sexual intercourse and other sexually related activities probably did so because they believed in their ability to carry such behaviours out and maintain control over them.

It was further noted that people's perception about controllability over a behaviour may have an important influence on the behaviour [26].

For instance, students who felt they had exceptional control over sex and sexually related activities were the ones who went in for more than one sexual partners and as such engaged in sexual intercourse with all or most of them.

The postulation that human beings are rational and make systematic decisions based on available information may be applied to students who either remained chaste or took one sexual partners [26]. These students were probably rationale enough to realise that engaging in sexual intercourse or taking more than one sexual partner had negative implications for unplanned pregnancy, sexually transmitted infections and even poor academic performance as it inhibits their concentration in class and ability to learn effectively.

The conceptual framework also predicts the occurrence of a particular behaviour, provided that behaviour is intentional [26]. In the present study, it is therefore argued that students who engaged in sexual intercourse, actually did so through planned processes and that the behaviours did not occur out of volition. Behavioural intention is influenced by a person's attitude toward performing a behaviour, and by beliefs about whether individuals who are important to the person approve or disapprove of the behaviour (subjective norm) [26]. The theory of planned behaviour assumes that all other factors; which in the case of the present study include attitude of health care providers and sexual pressure, operate through the models' constructs, and do not independently explain the likelihood that a person will behave a certain way [27]. Socio-demographic characteristics such as living with both parents and father's level of education, as found by the present study, however, have direct implications for sexual behaviour.

Most of the participants were not forced to engage in sexual intercourse. This finding is consistent with the conceptual framework of the study. That is a particular behaviour may occur provided that, the behaviour is intentional [26]. Thus, the students needed no pressure from anybody in order to engage in sexual intercourse. This therefore corroborates stipulations of the conceptual framework that behavioural intention is the most important determinant of behaviour [26].

V. Conclusion

Socio-demographic characteristics which influence students to have sexual intercourse include their educational level, living with both parents, and the level of education of their father. Most of the students do not visit health facilities to access any SRH services. Those who even visited were faced with negative attitude of service providers. Future utilization of sexual and reproductive health services cannot be guaranteed for those who encountered negative attitude of health care providers.

Declarations

Abbreviations

STI, sexually transmitted infections; WHO, World health organization; SRH, sexual reproductive health; HIV, human immunodeficiency virus; AIDS, Acquired Immune-deficiency Virus

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Authors' contributions

I conceived the study, the design, data collection, data analysis, interpretation, and write-up and in the preparation of the draft manuscript.

Competing interest

I declare that I have no competing interest.

Consent for publication

Not applicable.

Ethics approval and consent to participate

All procedures performed in study was in accordance with the ethical standards of the Ghana health service. The study was approved by the Authorities of the selected schools and department of population and health at the University of Cape Coast, Ghana. Written informed consent was sought from the study participants

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