Adolescent Sexual and Reproductive Health in Ghana: A Synthesis of Research Evidence

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Introduction

The welfare of young people has become a major focus for governments, policymakers and service providers. The spread of HIV/AIDS has posed a major challenge to nations in ensuring the welfare of the next generation, and the Republic of Ghana is no exception. In 2002 the estimated HIV/AIDS prevalence rate among 15–24-year-olds in Ghana was 3.4% and the median prevalence rate for the adult population increased from 2.3% in 2000 to 3.4% in 2002.[1] As part of the response to the HIV/AIDS epidemic and the threat it poses for young people, it is imperative to assess the current state of evidence in Ghana on young people's sexual and reproductive health, including the behaviors that put young people at risk and the factors that protect them.

This report provides a comprehensive overview of current knowledge on adolescent sexual and reproductive health issues in Ghana, with a focus on HIV prevention. It draws upon the existing body of social science research and includes both quantitative and qualitative studies. Its goal is to communicate key findings from existing research to a wide audience within the country. The specific objectives are:

- to synthesize key findings from the studies that have been done on adolescent sexual and reproductive health in Ghana;
- to identify information gaps in order to inform the development of future research in this area; and
- to highlight implications and priority areas to inform programs and policies and improve the sexual and reproductive health of youth.

The core issues reviewed are sexual behavior, marriage and childbearing, sexual coercion, abortion, contraceptive use (including condom use), knowledge related to HIV/AIDS and other sexually transmitted infections (STIs), attitudes and protective practices among young people, and health information and services. The main sources of information for the review are the 1993 and 1998 Ghana Demographic and Health Surveys (GDHS) that included young people aged 15 and older, the 1998 Ghana National Youth Reproductive Health Survey (GYRHS) that was administered to young people aged 12–24, and various other subnational surveys (see box). In addition, qualitative studies that focused on adolescent sexual and reproductive health in Ghana provide in-depth information that supplements the quantitative data. At the time of this report's publication, final results from the 2003 GDHS had not been released. A set of key indicators of young people's sexual and reproductive health knowledge and behaviors from the 1998 GDHS is included in two appendix tables for all females and males aged 15–19 and by specific subgroups.

This report is part of a larger, five-year study of adolescent sexual and reproductive health issues called *Protecting the Next Generation: Understanding HIV Risk Among Youth* (PNG). The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, healthcare providers and the media, in each country, regionally and internationally; and stimulating the development of improved policies and programs that serve young people. The research involves focus group discussions and qualitative interviews with adolescents, teachers and health workers as well as national surveys of adolescents. This synthesis is the first activity of the PNG project: It identifies important knowledge gaps and informs the project's communication and advocacy initiatives by providing an overview of current policies and interventions for youth.

Commonly Cited Data Sources

Ghana Demographic and Health Surveys (GDHS): The GDHS were conducted in 1988, 1993, 1998 and 2003. The GDHS are nationally representative surveys of women aged 15–49. Husbands of female respondents were included in the 1988 survey and men aged 15–59 were included in the 1993, 1998 and 2003 surveys. The surveys cover a large number of population, health and nutrition indicators. Many of the statistics cited in this report and included in the appendix tables are from analyses conducted by The Alan Guttmacher Institute using 1998 GDHS data. Statistics are also included from the GDHS country reports published by the Ghana Statistical Service.

1998 Ghana National Youth Reproductive Health Survey (GYRHS): The GYRHS was a nationally representative survey administered to 5,640 youth aged 12–24 (2,533 females and 3,107 males). This survey covered a range of sexual and reproductive health topics such as sexuality, pregnancy, abortion, STIs and HIV/AIDS, and preventive behaviors (see reference 53).

Study in Ketu South, Upper Denkyira and Offinso electoral constituencies in the Volta, Central and Ashanti Regions, respectively: In 1999, a survey was conducted among 1,415 adolescents (795 males and 620 females) aged 10–19 in selected electoral areas in Ketu South, Upper Denkyira and Offinso constituencies in Ghana. The study assessed knowledge about HIV/AIDS and other STIs, attitudes toward condom and use, self-efficacy, peer norms and sexual behavior (see reference 41).

Street children in Accra: Data were collected in 1996 among 1,147 street youth (60% males and 40% females) aged 8–19 in four market clusters in Accra. The 1,147 young people were interviewed using a survey questionnaire. In addition, four focus group discussions and 30 in-depth interviews were conducted. The study covered topics such as family background, accommodation and food arrangements, finances, health and hygiene, knowledge of HIV/AIDS and STIs, and attitudes toward and sources of HIV/AIDS information and sexual behavior (see reference 105).

Assessment of adolescent reproductive health needs in Ghana: This was a study conducted in 1995 to assess the reproductive health needs of adolescent in the Greater Accra, Central and Northern Regions. It involved interviews among 323 males and females aged 12–24, including adolescent street traders in Accra, and focus group discussions. In addition, there was a survey of nongovernmental organizations involved in youth activities, sector ministries, and religious and community leaders (see reference 67).

Coping with adolescent pregnancy: This study was based on qualitative data from 29 girls aged 13–19 who had experienced at least one unintended pregnancy in Ga Mashi District in Accra. The district is urban and most residents are in the lower socioeconomic class. The study used the 29 case studies to examine the factors leading to the initiation of sex, pregnancy and coping strategies adopted by the girls when they became pregnant (see reference 62).

Country Background

According to the 2000 Census of Population and Housing in Ghana, the population in that year was 18,912,079 over a land area of 238,000 square kilometers. Young people aged 10–24 accounted for 31% of the total population. This proportion of young people in the total population has remained fairly constant over the last three decades.[2] The main religious groups in Ghana are Christians (67%), Muslims (17%) and traditionalists (9%).[3] As of 2000, 44% of people lived in urban areas, which are defined as settlements with 5,000 people or more.

Ghana is a multiethnic country with over 50 ethnic groups. The main ethnic groups are the Akan, who account for nearly half of the population (49%), the Mole-Dagbani (17%), the Ewe (13%) and the Ga-Adangbe (8%).[4] Non-Ghanaians constituted 4% of the population in 2000 compared to 12% in 1960.[5] One major difference among the ethnic groups is that the Akan* practice a matrilineal system of inheritance while the other groups are patrilineal. Ethnic background has implications for some aspects of adolescent reproductive health, since practices such as initiation rites and marriage systems vary by ethnic affiliation. People continue to define themselves along these ethnic lines, although interethnic marriages are breaking down some of these affiliations.[6]

Ghana is a unitary state divided into ten political regions and 110 districts, with the district being the lowest level of political administration (Appendix Figure 1). At the time of this report's publication, there was an official move to increase the number of districts. The modern administration is superimposed on a system headed by chiefs and queenmothers who exercise traditional authority. Ecologically, the country consists of three broad zones, namely coastal savannah, the central forest belt and the northern savannah. The northern savannah accounts for about half of the total area of the country. The pattern of development in the country has followed this broad pattern with the level of socioeconomic development being higher in the coastal savannah and declining towards the north.[7] For example, the proportion of the population with formal education, which is over 90% in coastal areas such as the Greater Accra Region, is less than 50% in the northern savannah area.

Recent Economic History of Ghana

When Ghana attained independence in 1957, the country was hailed as the shining star of Africa. It had one of the best educational systems on the continent, a fairly well educated population and a buoyant economy. About two decades after independence, the country began to experience negative economic growth.[8] To reverse the situation, the government embarked upon a comprehensive economic reform in 1983 dubbed the Economic Recovery Programme (ERP). The initial stage of the ERP was the stabilization phase (1983–1986). In 1987, this was followed by the Structural Adjustment Programme (SAP) with the support of the International Monetary Fund, the World Bank and bilateral donors. While this phase was meant to stabilize the economy by reducing the persistently high rate of inflation and reducing the balance of payments problem, SAP was aimed at vigorously stimulating the economy. Although some amount of economic growth has been achieved through the policies of stabilization and adjustment, the policies have not been able to break the vicious cycle of poverty in Ghana.

Available statistics indicate that about 40% of Ghanaians live in poverty. The worst affected areas

* The Akan inheritance system has been described to be both matrilineal and patrilineal in character. See Agyeman DK and Casterline J, Social organization and reproductive behavior in southern Ghana, Population Council Working Paper, New York: Population Council, 2002, No. 167.

are the three northern savannah regions (the Upper East, Upper West and Northern Regions).[9] Nine out of 10 people in the Upper East, eight out of 10 in the Upper West, and seven out of 10 in the Northern Region were classified as poor in 1999, compared to five out of 10 in the Central and Eastern Regions.[10] The three northern regions have low school participation rates, especially for females, and high levels of poverty have been cited as a contributing factor.[11] The incidence of poverty is higher in rural than urban areas with about 84% of poor people residing in rural areas.[12]

The economic situation as manifested in the levels of poverty and some of the government policies have had implications for parents and young people. For instance, as part of SAP, the government withdrew subsidies for social services, particularly health and education, making parents bear more of the cost of education and health services for their children, which were previously free.[13] One result has been a decline in the proportion of young people in school in the last two decades. In addition, a number of people employed in the public sector were made redundant, creating stressful economic conditions for former civil servants and their children.[14]

Formal Education in Ghana

The broad government policy on education, as enshrined in Article 25 of the 1992 Constitution, seeks to achieve free and universal basic education[15] and to introduce functional literacy programs,[16] among other goals. According to the 2000 Population and Housing Census, 58% of the male and 48% of the female population aged three and older had ever been to school, and 4% or less had had any tertiary education.[17] After primary school, the proportion in school declines sharply, indicating early exit from the education system, especially for females. It is estimated that only 10% of the pupils who start from primary school continue on to any form of postsecondary (public) institution.[†,18]

Although primary school enrolment has increased in absolute terms in the last three decades, the proportion of children in primary school declined over the past two decades.[19] The gross enrolment ratio (GER), which is the proportion of pupils of all ages enrolled in primary grades 1–6 relative to the population of 6–11-year-olds, declined slightly from 79% in 1990–1991 to 77% in 1996–1997. In 1998, 38% of females aged 15–19 were in school compared to 49% of males (Appendix Tables 1 and 2, line 2). About two-thirds of both females and males (64% and 70%, respectively) had seven or more years of education (Appendix Tables 1 and 2, line 1). About 70% of students in senior secondary schools (15–18-year-olds) and tertiary institutions (aged 18 and older) are in boarding schools,[20] which belong to the government, private individuals or religious bodies. In boarding schools, different kinds of socialization take place, including what Masemann describes as the "hidden curriculum" in education.[21] For instance, it is in boarding schools that students establish new relationships, including those that lead to marriage.[22]

Social Context of Adolescence in Ghana

Although Ghana is a multiethnic country, there are common features in the traditional roles, status, responsibilities and socialization processes for adolescents. Among the various ethnic groups, 'adolescence' is the prepubertal stage after childhood within which the individual attains physical, sexual and social maturity. Historically, this stage began for women with menarche or initiation and ended with marriage or childbearing. For males, the period was marked by initiation or marriage. For instance, among the Krobo of the Ga-Adangbe and the Akan, puberty rites were performed for girls after menarche to signify their maturity. Known as *Dipo* among the Krobo and *Bragro* among the Akan, the initiation ceremony was a community affair and was held under the auspices of the queenmother. A girl who became pregnant before an initiation ceremony committed an offense and the maximum punishment was banishment from the community.[23] At this stage, young people were responsible for cleaning public places, such as paths to water bodies and farms, and for the security of the community.[24] In the past, as now, the process of socialization and preparation for adult life included informal training and apprenticeship. While girls were trained in personal hygiene, domestic activities, child care, vocational skills and the art of trading, boys were taught to be farmers, hunters, fishermen and craftsmen.

Within the traditional system, it was the responsibility of parents and other community members to bring up children. Among some of the ethnic groups, there was a general belief that

[†] Public institutions account for over 90% of admissions at the tertiary level. These include nursing training colleges, teacher's colleges, agricultural institutes, polytechnics and universities.

biological parents were not necessarily the best people to bring up children and therefore children could be raised by other adults. For instance, among the Dagomba of northern Ghana, an adolescent could be handed over to a foster parent, usually from the patriclan, to be trained.[25] There were other arrangements such as adoption, which involved the transfer of children to an adoptive parent, in most cases a maternal relative, until marriage or later in life.

There were also distinct male and female roles and responsibilities, especially with respect to labor. Females were responsible for household chores while males were responsible for public activities, and some evidence suggests that adolescents today still hold to these traditional gender norms quite strongly.[26] In some areas, this differentiation in roles extended into living arrangements. For instance, among the Ga and the Akan, marriage did not necessarily lead to cohabitation; rather, husband and wife could live in separate houses or separate sections of the same compound, and this included young males and females.[27] Among the patrilineal Mole Dagbani, couples lived together in compounds but with separate areas for males and females. In such settings, young males and females were socialized separately. This pattern, which continues to exist in some areas, is partly responsible for some of the observed strong male-female differences in ways of life. Within the traditional structure, there was no distinct residence transition such as moving away from the childhood home to live on one's own, as observed in other countries.[28]

The traditional system in Ghana supported early marriage and childbearing. Available evidence suggests that about half a century ago marriage and childbearing closely followed puberty, and first sex took place largely within marriage.[29] According to Fortes, Ashanti girls married by age 16,[30] and Busia and Acquah observed early sex and childbearing in Sekondi-Takoradi and Accra, respectively.[31] Using the 1960 postenumeration survey, Aryee and Gaisie estimated the singulate age at first marriage to be 17.7.[32] Earlier marriages were characterized by arrangement via family members, elopement and betrothal.[33]

Traditionally, young females were expected to be virgins at first marriage but that was not expected of males. Particularly among older family members, virginity was an honor to the family of the female and a way to gain the respect of the family of the would-be husband.[34] This was part of the double sexual standard for males and females, whereby parents expected their daughters to be virgins but not their sons. Furthermore, parents and society implicitly approved of multiple sexual partners for young males but not for females.

Another aspect of the traditional system was that childlessness was abhorred. A woman without children was equated with a man: having an inability to bear a child.[35] For example, to encourage prolific childbearing, the Akan and the Ga publicly honor a woman who gives birth to 10 children. Among the matrilineal Akan, the woman presents a ram to the man, thanking him for increasing the matriclan by 10, and among the patrilineal Ga, the man gives the ram to the woman for the same reason.

Over the last three decades, some of the traditional arrangements have undergone changes as a result of modernization, urbanization, migration and formal education. One outcome of these changes is that some of the responsibilities of the extended family and the community to socialize adolescents, including the selection of future marriage partners, have been eroded.[36] As part of the changes, state organs such as ministries, departments and agencies, the school system, religious bodies, and the media have emerged as socialization agents in addition to the family. Therefore, a young person growing up in Ghana now will be confronted with four overall value systems of socialization with their associated normative behavior:[37]

1. Traditional value system: Virginity is cherished and young people are expected to have sex only within marriage.
2. Religious value system: This is governed by the teachings of the two foreign religions in the country, namely Islam and Christianity. As with the traditional value system, young people, especially females, are expected to be virgins at marriage.
3. Legal value system: This is defined by the laws of the country, such as those found in the 1992 Constitution, the Children's Act of 1998 and other legal documents.
4. Romantic love value system: This is characterized by romantic ideas of friendship and love.

Previously, young people were socialized in the traditional value system, and sexual intercourse and childbearing were within marriage. With the introduction of Christianity in the early part of the 1500s and Islam about a century later, the religious

moral system, which is similar to the traditional one in many respects, became an important influence in the lives of some young people. However, with changes that resulted from urbanization, education and migration, any one of these four value systems may operate in the life of a young person. In rural areas and in some urban enclaves, young people are likely to be confronted with the traditional or the religious value system. In urban areas and among people with formal education, the romantic love value system is likely to be the dominant one, especially for those who have experienced boarding school education. Superimposed on the other three systems is the legal value system, which is based on national laws, but which rarely influences the lives of young people in the country.

Adolescent Sexual and Reproductive Experience

We now turn to results from studies on adolescent sexual and reproductive health conducted in the last two decades in Ghana. We focus specifically on first sexual intercourse, marriage, sexual partnerships and coercion, childbearing, abortion, contraceptive use and HIV/AIDS and other STIs.

First Sexual Intercourse

Data on first sexual intercourse for both males and females are available in the 1993 and 1998 Ghana Demographic and Health Surveys (GDHS). Prior to that, nationally representative survey data on first sexual intercourse had been compiled for females only. Among 15–19-year-olds in the 1998 GDHS, 38% of females and 19% of males had ever had sexual intercourse (Appendix Tables 1 and 2, line 6). The figure for females in the 1993 GDHS was 59%, indicating a substantial decline among adolescent females in the proportion who have had sex within that age group.[38] Among adolescent men, 33% had ever had sex in 1993 and 19% had ever had sex in 1998, indicating a substantial decline during the 1990s.[39]

Nationally, among women aged 20–24, the median age at first intercourse has increased from 16.9 to 17.4 between 1993 and 1998; for males aged 20–24, the median age increased from 18.4 to 19.5 (Appendix Tables 1 and 2, line 8).[40] Thus, on average, females begin sexual intercourse about two years earlier than males.

Several small scale or subnational studies also examine the timing of sexual initiation. Because these studies use a number of different measures and cover particular areas or groups, their findings cannot be directly compared with those of national surveys. In a study of 1,415 males and females aged 10–19 in Ketu South, Upper Denkyira and Offinso electoral constituencies, Sallar observed that the median age of first sexual intercourse for males and females aged 10–19 in these three areas in Ghana was 16.[41] By age 15, 47% of the males and 38% of the females had ever had sex. Among adolescents aged 12–20 studied in Kumasi and Accra, it was observed that the median age at first sexual experience was 16 for both boys and girls in the sample.[42] In a study of 1,782 unmarried young people aged 15–19 in the Greater Accra and Eastern Regions, Agyei and others found that 67% of males and 78% of females had ever had sex, and the mean age at sexual debut among those who had ever had sexual intercourse was 15.5 for males and 16.2 for females.[43]

In a 1991 study of 400 single females aged 18–25 in Cape Coast, 86% of the respondents had ever had sexual intercourse, and 42% of these had had sex before age 16.[44] Similar studies carried out in 2000 in Accra, Kumasi and Agomanya have reported median ages of 18, 17 and 16 among single female youth and 17 among males in Accra and Kumasi.[45]

In a survey of 1,038 students (471 females and 567 males) aged 13–18 in nine senior secondary schools, 50% of the adolescents considered chastity as an ideal to attain and thought that it was realistically attainable.[46] Yet 42% of the male students and 15% of the female students surveyed had had sexual intercourse. The average age at first sexual experience was 15 (the youngest was 8, a case of defilement; the oldest was 23). Half of the sexually experienced students had their first sexual experience between ages 14 and 17, and 25% had their first sexual experience at age 13 or younger. Reasons given for engaging in sexual intercourse included pressure from peers, deception by partners, experimentation, and satisfaction of sexual desires.[47]

Both national and local area studies show that better educated youth begin sexual activity at a later age than those who are less educated. Although some inconsistencies are found with respect to gender and urban-rural differences; this is probably due to particularities of specific areas and groups, but the

inconsistencies should perhaps be explored in future studies.

Marriage

Traditionally, women in Ghana married early, and marriage was nearly universal. In the 1993 and 1998 GDHS, 25% and 16% of females aged 15–19 had ever married, respectively. (Marriage was defined to include consensual union and cohabitation.) However, in 1998 the proportion married was 71% among women aged 20–24, and by age 30–34 only 2% of females had never married. For men, the proportion ever married was only 3% among 15–19-year-olds and 26% among 20–24-year-olds.[48] From the 2000 Population and Housing Census, about 6% of males and 7% of females aged 12–17 were either married or in a consensual union.[49]

Available evidence suggests that the median age at first marriage for females aged 20–24 has increased over the last two decades, from 18.7 in 1988 to 19.0 in 1993 to 19.3 in 1998.[50] Yet even with the increasing age at first marriage, over half of Ghanaian young women marry while still in their teens (56% married before age 20 in 1998). Among males, the median age at first marriage is much older than among females and hardly changed—25.5 in 1993 and 24.8 in 1998 among men aged 30–34 (Appendix Tables 1 and 2, line 13).[51]

Comparing median ages at first sex and first marriage, young females on average experienced sex about 2 years before marriage in 1993 and 1998 (Table 1). For males, the gap is even larger—about 7 years in 1993 and 5 years in 1998 on average—between first sex and first marriage. This relatively large time period between first sexual intercourse and marriage poses a set of risks, including unwanted pregnancy, STIs and HIV/AIDS, to which young people are potentially exposed. For example, among 20–24-year-old Ghanaians in 1998, 51% of females and 49% of males had had premarital sex by age 20 (Appendix Tables 1 and 2, line 9).

Table 1. Median age at first sexual intercourse and at first marriage in 1993 and 1998

	1993	1998
Females (aged 20–24)		
Median age at first sexual intercourse	16.9	17.4
Median age at first marriage	19.0	19.3
Difference	2.1	1.9
Males (aged 20–24)		
Median age at first sexual intercourse	18.4	19.5
Median age at at first marriage*	25.5	24.8
Difference	7.1	5.3

* Median age is calculated for men aged 30–34 because medians could not be determined for younger age groups, in which half of the men had not yet married.

Number of Sexual Partners

Data on lifetime and current sexual partnerships give an indication of the level of sexual networking, although some studies have raised concerns about the reliability of data on lifetime sexual partnerships and the completeness of reporting on sexual partners.[52] According to 1998 GDHS data, 17% of sexually experienced 15–19-year-old males had had two or more partners in the 12 months prior to the survey (Appendix Table 2, line 11). In another 1998 national study, Tweedie and Witte reported that 79% of females and 68% of males aged 12–24 in the 1998 Ghana Youth Reproductive Health Survey (GYRHS) had one current sexual partner while 3% of females and 10% of males reported having had two or more sexual partners within the three months prior to the survey.[53] Among those who had ever experienced sex, 60% of females and 39% of males reported one lifetime sexual partner, 38% of females and 53% of males had two to three lifetime partners, and 1% of females and 5% of males reported four or more lifetime sexual partners.[54] In a 1999 study of three local areas in Ghana, Sallar observed that among adolescents aged 10–19 with previous sexual

experience, 77% reported one sexual partner, 15% reported 2–4 partners and the rest had five or more partners within the 12 months preceding the survey.[55] Although the time periods and samples for the two studies are different, the results point to a fairly high level of multiple partnerships among young men in Ghana.

The outbreak of HIV/AIDS has presented new views of sexual risk-taking behavior. On the one hand, the outbreak of HIV/AIDS has transformed sexual behaviors that had been implicitly approved of as a normal part of maturing (e.g., young men having multiple sex partners) into practices that potentially make young people vulnerable to infection.[56] Sallar reported that of 539 young people (312 males and 227 females) in the study population aged 10–19 who had ever had sex, 63% of the males and 61% of the females were aware that their regular sexual partners had other sexual partners.[57] Thus, they continued to be in sexual relationships with people who had other sexual partners. On the other hand, improving young people's sense of self-efficacy provides hope for meeting these challenges. For example, a study in Ghana of factors associated with risk and protective behaviors among adolescents showed a strong relationship between perceived self-efficacy and lower numbers of lifetime sex partners and current sex partners.[58]

Sexual Partnerships

Very few studies in Ghana have examined the sexual partnerships of young people, among them the 1998 GYRHS. The study showed that some young people engaged in same-sex as well as heterosexual sexual relationships: About 1% of males and females aged 12–24 report that they had ever had sex with a same-sex partner.[59] From the same data, the average age of the respondents' first sexual partner was 16.5 for adolescent males and 20.7 for adolescent females. Sallar also observed that among those who ever had sex, 67% of males and 55% of females aged 14–19 had their first sexual experience with someone their own age.[60] In the 1998 GYRHS, most first sex partners were boyfriends or girlfriends of the young people. About four out of every five adolescents who had ever had sex reported that they had first sexual intercourse with a boyfriend or girlfriend. Less than 1% said that their first sex partner was a "sugar mommy" or "sugar daddy" (i.e., an older adult who gives the young person gifts, money or other items in exchange for sex); however, 12% of young females and 5% of young males said they had ever been paid for sex.[61] Based on 29 case studies in Accra of 13–19-year-old females who had experienced at least one unintended pregnancy, Henry and Fayorsey found that obtaining financial support and affection were the main reasons for starting a relationship.[62] The financial support from boyfriends was an integral part of a relationship and was used for daily needs, including food, medical expenses, school fees and clothing.

Adolescents' reasons for having sexual intercourse range from pleasure to peer pressure to financial reasons. In a study of three districts in Ghana, Sallar reported that 38% of adolescents had sex for the first time for pleasure while 23% of males and 24% of females had sex because of peer pressure.[63] In the 1998 GYRHS, 62% of males and 38% of females reported that they had sex because they wanted to do so; the first sexual experience "just happened" for another 34% of males and 47% of females.[64] The available evidence suggests that some of the first sexual experiences occurred under circumstances that adolescents, especially females, had not prepared for; therefore, they may not have been able to protect themselves against infection or pregnancy.

Sexual Coercion

An infrequently researched topic is sexual coercion. There have been reports in the media about rape and defilement of young girls as well as pressures from parents or guardians, including money, threats or alcohol, on their children to have sex.[65] According to the 1998 GYRHS, 2% of males and 12% of females were forced into their first sexual experience, with 0.5% of males and 0.6% of females reporting that their first sexual intercourse was with a family member.[66]

A study of adolescent traders in Accra revealed that 2% of males and 12% of females reported that the first time they had sex they were forced; moreover, 8% of males and 25% of females who had ever had sex reported having been coerced to have sex at some point in time.[67] Awusabo-Asare and others in a study among young people aged 12–24 in junior secondary, senior secondary and university in the Central Region, observed that among 415 adolescents who had had sex with their boyfriend or girlfriend, 19% reported that they were forced; of the 211 who had had sex with schoolmates, 13% reported being forced; of the 234 who had had sex with neighbors, 13% said they were forced; and of the 101

who had had sex with teachers, 6% reported that they were forced.[68] A qualitative study in urban Accra based on 29 case studies of girls aged 13–19 found that about one-third of the girls described their first sexual experiences as involving force, deception or rape.[69] Many of the girls who were forced at their first sexual intercourse were "still with the same boys and even had children with them."[70]

Another dimension of sexual coercion is the perception among males, and even many females, that women do not mean what they say when they say "no" to sex. Approximately two-thirds of both males and females aged 12–24 in the 1998 GYRHS who had ever had sex stated that most girls did not really mean "no" when they said "no" to sex. Such attitudes can translate into an acceptance of sexual violence, because a substantial proportion of adolescent males do not appear to believe that girls really mean what they say and therefore with a little "pressure" a girl could be made to change her mind. Tweedie and Witte reported that 13% of males and 14% of females who had ever had sex indicated that it is acceptable for a boyfriend to beat his girlfriend when she does not provide sex.[71] Unpublished data from the Women and Juvenile Unit of the Ghana Police Service also suggest that sexual coercion of young females is a problem. In 2002 and 2003, 28 and 24 defilement cases, respectively, were reported to the Cape Coast office of the Unit. In addition, there were five cases of rape in 2002 and nine cases in 2003 (ages of the victims not indicated).[72]

Adolescent Childbearing

The median age at first birth in Ghana has steadily risen from 20.0 to 20.9 from 1988 to 1998 among 25–29 year old women.[73] The age-specific fertility rate among 15–19-year-olds has declined from 124 births per 1,000 women in 1988 to 90 births per 1,000 women in 1998.[74] This decline was part of a general fertility decline in Ghana, and teenage fertility still accounted for about 10% of total fertility in 1998, as was the case in 1988.[75]

The 1998 GDHS shows that 14% of 15–19-year-old females were pregnant or ever had a child (Appendix Table 1, lines 14 and 15). Results from the 1998 GYRHS show that 22% of females aged 12–24 who had ever had sex had experienced at least one pregnancy, and 40% of males who ever had sex said they had made someone pregnant.[76] According to Nabila and Fayorsey's study of 1,571 young people aged 12–20 in Accra and Kumasi, by age 17, 60% of those who had ever had sex had become pregnant or made someone pregnant.[77]

In one study, teenage pregnancy was observed to be high among adolescents in the Eastern and Greater Accra Regions. In a sample of 829 unmarried females in these two regions, more than one out of every three adolescents who had ever had sex had become pregnant at least once, and the incidence of pregnancy was higher in urban than in rural areas.[78]

A survey in the Ablekuma subdistrict of Accra of 1,307 adolescent females and males aged 13–19 showed that 120 of the women were pregnant at the time of the survey.[79] Among the pregnant teenagers, 27% had complications such as general weakness, bleeding and anemia. In a quasi-experimental study of problems associated with adolescent pregnancy in Ghana, Adjei and Ampofo studied 198 cases of females who were pregnant before age 20 and the same number of respondents who became pregnant after age 20 as a control group.[80] Both groups were pregnant women seeking antenatal care at Korle-Bu Teaching Hospital. They observed that among the main study group, 60% did not want their pregnancy, compared to 38% of those in the control group. Half of the partners of those in the main study group but only 31% of the partners of those in the control group did not want the pregnancy. However, 41% of those who were pregnant before age 20 had ever had an abortion, compared to 57% of those in the control group.

In general, childbearing varies by demographic characteristics such as age, residence and education. In the 1998 GDHS, 15% of females aged 15–19 in rural areas had ever given birth compared to only 7% of females the same age in urban areas (Appendix Table 1, line 14).

Higher education is also associated with delayed childbearing. In 1998, 16% of 15–19-year-old females who had less than seven years of education had ever given birth compared to 9% of those with seven or more years of education (Appendix Table 1, line 14).

Abortion

Among the ethnic groups in Ghana, there is a social stigma associated with abortion.[81] In a classic study, Bleek explored the ethical dimensions of abortion among the Akan and concluded that abortion was considered to be a major crime against the society.[82] According to the laws of Ghana, abortion is legally permissible if the pregnancy is a result of rape or

incest or if the pregnancy is a threat to the health of the mother or the fetus. As a result, abortions are underreported.[83]

There are a few facility-based studies and household surveys with data on abortion in Ghana. Data from a national 1998 survey (GYRHS) show that 11% of males and 16% of females aged 12–24 who ever had sex reported ever being involved in terminating a pregnancy.[84] Of those who had been involved in terminating a pregnancy, 77% of females and 72% of males aborted just one pregnancy, and the majority of these respondents were not married (67% and 86%, respectively).[85] There was a general perception that the level of abortion was high: 58% of females who had had sex considered abortion to be common among teenage girls who get pregnant and 31% knew of at least one unmarried teenage female friend who had had an abortion.[86]

In an earlier study of abortion complications in Accra, Ampofo observed that nearly one in four cases was among 15–19-year-olds.[87] A large-scale 1997–1998 study of women in southern Ghana who experienced a recent pregnancy showed an abortion ratio of 19 abortions per 100 pregnancies for all women; 60% of women who had had an abortion were younger than 30.[88] A study in one section of Accra found that 20% of the 120 respondents who were pregnant at the time of the survey had visited a health institution to terminate their pregnancy.[89] Agyei and others reported that 47% of young unmarried women in the Greater Accra and Eastern Regions of Ghana who had ever been pregnant had terminated a pregnancy.[90]

The pattern throughout Sub-Saharan Africa suggests that pregnant adolescents who seek abortions are more likely to resort to self-induced abortions or untrained abortionists, which may lead to complications.[91] Data from the 1998 GYRHS show that more than half of adolescents who reported ever being involved in an abortion said that the last abortion was at a hospital or clinic (64% of females and 58% of males) and about one-third said that the last abortion was at home (30% of females and 39% of males).[92] In addition, the study raised the question as to when in the abortion process youth go to a hospital or clinic, because the relatively high percentage of respondents who reported going to a hospital or clinic for the last abortion may have included those who were seeking treatment for complications of abortions performed in other contexts. In the 1997–1998 study in southern Ghana, 38% had relied on help from a pharmacist and 11% had self-medicated, while only 12% had obtained an abortion from a physician.[93] Afenyadu and Goparaju have also reported that young females use harmful but inexpensive methods to terminate pregnancies.[94] In contrast, a recent qualitative study of 13–19-year-old females in Ga Mashi District, Accra, who had experienced at least one unintended pregnancy found that most girls used clinics and hospitals for their abortions (23 of the terminated pregnancies were clinic abortions and five were herbal).[95] In the same study, all the respondents said that their first pregnancy and most of the subsequent ones were not planned; 23 out of 49 pregnancies reported by respondents were aborted in order to delay childbearing and to space children; and the main reasons given for opting for abortion were to improve sources of financial support and the respondent's employment.[96]

Reasons for obtaining an abortion given by young women included the wish to continue education, lack of financial means to support a child and a man's denial of paternity.[97] Some studies have also observed the fear of community sanctions and the shame associated with pre-marital childbearing.[98] Programs to address unintended pregnancy and abortion among young people in Ghana should consider society's views of abortion as one of the challenges young people face in meeting their sexual and reproductive health needs.

Overall, the evidence thus far suggests that adolescents continue to be vulnerable to early sexual intercourse, which results in early and unplanned pregnancies and in some cases leads to unsafe abortion. Addressing these problems requires creating an atmosphere characterized by openness at the household and community levels; providing avenues in and out of school for teaching adolescents ways of protecting themselves; providing the services they need, for example to prevent pregnancy; and providing counseling concerning sexual relationships. By adopting these strategies, it will be possible to reach young people early with information and services.

Contraceptive Use

Various studies conducted in Ghana show that the awareness of young people about contraceptives and where to obtain them is high. Results from the 1998 GYRHS indicate that 76% of females aged 15–19 and 88% of males that age were aware of at least one

modern family planning method.[99] Among 12–14-year-olds, 33% of females and 6% of males knew of at least one modern family planning method. The condom was the most reported method known (77% of males and 66% of females knew the method). In the 1998 GDHS, the proportion of both males and females aged 15–19 who knew at least one modern method was over 80%. However, adolescents' knowledge of some specific methods is superficial. For example, data from the 1998 GYRHS show that while 49% of females aged 12–24 and 25% of males that age know of the pill, 21% of females and 46% of males who know the method do not know that it has to be taken daily for it to be effective.[100]

In spite of the general recognition of the importance of meeting the reproductive health needs of young people and the high level of awareness among adolescents of modern methods of contraception, contraceptive use among them is generally low. Thirteen percent of all 15–19-year-old females and 35% of married females had ever used a modern family planning method in 1998.[101] Effective contraceptive use even among those at risk of pregnancy is relatively low. In 1998, of the females and males aged 15–19 who where currently sexually active, only 20% and 37%, respectively, were using some form of modern contraceptive (Appendix Tables 1 and 2, line 19). Tweedie and Witte observed in the 1998 GYRHS that 77% of female and 85% of male sexually experienced adolescents had ever used any contraceptive method, and 64% of the females and 74% of the males had ever used a modern contraceptive method.[102] The male condom was the most popular contraceptive ever used (58% of female and 71% of male respondents) while the least ever used contraceptive methods were the IUD and diaphragm among females (about 1% for each method). In the study by Agyei and others, 96% of unmarried females and 98% of unmarried males aged 15–19 were aware of at least one contraceptive method.[103] However, contraceptive use was relatively low and the most commonly used methods were the condom and the pill.

Condom Use

In an era of HIV infection, use of the condom as protection against STIs in addition to its use as a family planning method has become important. As with other modern contraceptives, adolescents' awareness of the male condom is high, but despite the fact that it is one of the most commonly-used methods, overall levels of condom use are still low. In 1998, 71% of females and 88% of males aged 15–19 who had ever had sex knew where to obtain a condom (Appendix Tables 1 and 2, line 16) and 29% of females and 55% of males aged 15–19 who had experienced sex had ever used male condom (Appendix Tables 1 and 2, line 18). Moreover, 12% of currently sexually active young females reported current condom use, as did 27% of currently sexually active males (Appendix Tables 1 and 2, line 20). These proportions are slightly higher when looking at condom use at last intercourse among those who have had sex in the last 12 months: 16% among women and 28% among men (Appendix Tables 1 and 2, line 21). Among those using condoms at last sex, approximately half of 15–19-year-old females and one-quarter of 15–19-year-old males used a condom to prevent the transmission of HIV/AIDS.[104]

A study of street youth in Accra aged 8–19 showed that although 83% of the respondents knew about condoms, only 28% of the sample had ever used condoms and 21% had used condoms in the three months prior to the survey.[105] An earlier study by Anarfi and Antwi found that 90% of 10–24-year-olds knew of condoms but 34% had ever used them.[106] All those who used condoms reported that they were used to prevent STIs, and 4% specifically mentioned HIV/AIDS. Thirty-three percent of the respondents did not use condoms because they did not like the method and another 11% felt that condoms did not give any protection. In a study in Yilo-Krobo District[‡] among males aged 15–24 who had ever had sex, 65% had used condoms at least once and 21% used the condom at last intercourse.[107] Young males who perceived themselves to be at high risk were more likely to use condoms at their last sexual encounter than those who did not perceive themselves to be at high risk. In a study in three districts in Ghana, 68% of the respondents aged 10–19 and who had ever had sex indicated that condoms

[‡] The Eastern Region of Ghana has the highest reported HIV prevalence rate in Ghana (8%) as of 2002 (see reference 1). Some Krobo women have been associated with commercial sex within and outside the country. See Anarfi J, Sexual networking in selected communities in Ghana and the sexual behaviour of Ghanaian female migrants in Abidjan, Cote d'Ivoire, in: Dyson, T, ed., Sexual Behaviour and Networking: Anthropological and Socio-cultural Studies on the Transmission of HIV, Liege, Belgium: Editions Derouaux-Ordina, 1992, pp. 233-247.

could be used for protection against STIs but only 41% had ever used condoms.[108] Of those who had ever used condoms (137 males and 87 females), 28% reported that they used them to prevent pregnancy, 6% to prevent STIs and 12% for HIV prevention; the remainder used them to prevent two or more of these outcomes.[109] Adomako identified condoms as the most preferred method of contraception and for protection against STIs among secondary school students in Ghana.[110] In her study involving nine senior secondary schools in Ghana, 52% of the respondents who had ever had sex indicated that they had ever used a condom as a birth control method. Current use of contraceptives among those who had had sex was 46% for condoms, 16% for spermicides and 2% for the pill.[111]

The acceptability of condoms is still fraught with challenges. In the 1998 GYRHS, 44% of both males and females who had never used condoms did not consider a girl who carried a condom in her purse to be "wise."[112] Moreover, 43% of males who had never used condoms said they would not be able to buy condoms because it was too embarrassing.[113] Another study of 12–24-year-olds in three Ghanaian towns found that 65% of respondents thought it inappropriate for males to carry condoms and 78% thought it inappropriate for females to carry condoms.[114] A study of students in the Central region aged 12–24 found that over 40% of the respondents agreed with the statement that a girl who carried a condom in her purse was a "bad" girl.[115]

In a study on adolescent sexual and reproductive health behavior among junior secondary and senior secondary school students and out of school youth, Afenyadu and Goparaju reported that 60% of respondents used condoms selectively.[116] Another study of young people (12–24-year-olds) showed that while almost all of them knew of condoms, only 48% could identify any of the four elements of correct condom use.[117] In the era of HIV/AIDS, reported levels of condom use—whether ever use or current use—are still low. Moreover, the evidence is thin on consistency and correct use of condoms among adolescents in Ghana. Therefore, new strategies are needed to increase the acceptability and effective use of condoms, especially in high risk sexual encounters.

While condom use is one effective, protective mechanism for sexually active people, the vast majority of sexually-active adolescents are not using condoms. One reason for the low level of condom use is that young people do not feel confident in insisting on condom use in a relationship. In the 1998 GYRHS, among those who had heard of condoms, 27% of males and 30% of females said they could not insist on using a condom if their girlfriend or boyfriend did not want to use one.[118] Moreover, about one-third of both male and female adolescents said they could not refuse to have sex if their girlfriend or boyfriend did not want to use a condom. The confidence that young people have to use condoms, an effective means of preventing the spread of HIV, is still far too low. Two studies in Ghana showed a strong positive, influence of perceived self-efficacy on current condom use[119] and more consistent condom use.[120]

Adolescent Knowledge, Attitudes and Experiences with HIV/AIDS and Other STIs

HIV/AIDS Situation in Ghana

The first case of HIV/AIDS was reported in Ghana in March 1986. Since then, the cumulative number of reported AIDS cases has risen from 42 at the end of the 1986 to 52,916 as of December 2001.[121] Initially, the proportion of males to females living with AIDS was one male to five females. However, the gap has narrowed, with females accounting for 61% of the cumulative AIDS cases from 1986 to 2001. The largest share of AIDS cases is among 25–29-year-olds among females and 30–34-year-olds among males, indicating that females are infected earlier than males. Among adolescents in Ghana, 66 and 69 cases of AIDS were reported for 10–14-year-olds, while 111 and 104 cases of AIDS were reported for 15–19-year-olds in 2002 and from January to September, 2003, respectively.[122] The median HIV/AIDS prevalence rate for the adult population has increased from 2.3% in 2000 to 3.4% in 2002.[123] In 2002, the estimated HIV/AIDS prevalence rate among 15–24-year-olds in Ghana was 3.4% and among 15–19-year-olds it was 2.3%.[124]

Knowledge and Attitudes Toward HIV/AIDS

In response to the outbreak of the epidemic, the government embarked on educational programs to inform people about HIV/AIDS. Currently, general awareness about HIV/AIDS is nearly universal, with 97% of both females and males aged 15–19 reporting in 1998 that they had heard of HIV/AIDS (Appendix Tables 1 and 2, line 24). However, there are important gaps in young people's knowledge about HIV/AIDS. For example, 24% of young females and 21% of young males in the 1998 GDHS did not know of any specific ways through which HIV could be transmitted.[125] Only 65% of young females and 71% of young males agreed to the statement that "a healthy looking person can have the AIDS virus" (Appendix Tables 1 and 2, line 29). These rates were the lowest among all the age groups in the 1998 GDHS. Other misperceptions have been reported by McCombie and Sallar.[126]

About one-quarter of both females and males aged 15–19 who have heard of HIV, believe they are at some risk of getting HIV (Appendix Tables 1 and 2, line 25); thus, the vast majority of adolescents in Ghana do not consider themselves at any personal risk of HIV/AIDS. Eighty percent of students in junior secondary schools through university in the Central Region did not consider themselves to be at risk of HIV infection in the next month or year.[127] In the 1998 GYRHS, among those who had ever had sex, 76% of the females and 71% of the males indicated that they were not likely to contract HIV/AIDS.[128]

In terms of behavior change, a study of youth aged 10–19 found that 61% said they had changed their behaviors since they heard of HIV/AIDS.[129] Other studies indicate that young people have positive attitudes toward preventive behavior. Anarfi observed that street children in Accra responded positively to the messages heard about HIV/AIDS and that 41% agreed that HIV/AIDS was dangerous, while 23% indicated that AIDS was real.[130] A key challenge in Ghana is to monitor behavior change over time in tandem with HIV/AIDS interventions, family life education and specific media campaigns targeting youth.

Voluntary Counseling and Testing (VCT)

Until the beginning of 2002, information about voluntary HIV counseling and testing had not been widely disseminated in Ghana. Nonetheless, some studies have explored the means through which one can identify one's HIV status. For instance, Sallar observed that 82% of youth were aware of a blood test to establish one's HIV status.[131] A Ghana AIDS

Commission appraisal of institutions and organizations in 2001 that were active in HIV/AIDS-related programs found that 121 of the 222 total promoted VCT.[132] However, it is unclear the degree to which the testing and counseling services are both provided by the organizations that say they promote VCT. Many of these services are concentrated in urban areas: For example, 36% of all Ghanaian HIV/AIDS organizations are concentrated in the Accra and Tema metropolitan areas.[133] From December 2003 onward, activities on VCT began to be intensified as part of the program to provide antiretroviral drugs to people living with HIV/AIDS in Ghana.

Knowledge and Experiences with Other STIs

Other STIs, such as gonorrhea, syphilis, herpes, genital warts and chlamydia are important health concerns in Ghana. Adolescents are at higher risk of exposure to STIs than adults because of their immature reproductive systems, misconceptions and lack of knowledge about STIs.[134] Yet not much is known about the incidence and prevalence of STIs among young people. Results from the 2002 report on STI attendees at clinics estimated the prevalence of syphilis to be 0.6% among 15–24-year-olds.[135] The problems in obtaining accurate information about STIs are numerous. People are afraid to report STI symptoms for fear of being labeled promiscuous.[136] STIs are also likely to be underreported because such infections are not considered to be major problems.[§] Misconceptions about STIs also exist: For example, 51% of males and 37% of females interviewed on the streets of Accra stated that one could get an STI through witchcraft,[137] through juju (voodoo) as punishment for adultery, or, for females, as a result of "eating lots of sweets."[138] As an indirect way to determine the prevalence rate of STIs among young people, one study asked adolescent respondents to mention the number of people they knew who currently or previously had an STI: Twenty-seven percent of males and 22% of females reported that they knew one or more people who ever had an STI. [139]

After HIV/AIDS, the most commonly known STI among adolescents is gonorrhea, of which 41% of 15–19-year-old females and 46% of males are aware, followed by syphilis, of which about one in 10 adolescents are aware of it.[140] Sallar reported that 74% of adolescents had heard of gonorrhea and 51% had heard of syphilis.[141] Awusabo-Asare and Anarfi reported that in 1993 97% of males and 94% of females aged 15–24 had heard of an STI.[142] Of that number, 29% of the males and 5% of the females reported ever contracting STI. In a study among street youth aged 8–19, 59% could not mention any other STI besides AIDS.[143] Results from another study of street youth showed that 98% had heard of a least one STI.[144]

Data suggest that although young people are aware of formal medical services for STI diagnosis and treatment, when they are confronted with an STI, the vast majority do not actually utilize formal medical services. In the 1998 GYRHS, 94% of both males and females reported a hospital or clinic as the place one can go for STI treatment, followed by drugstore (27% of males and 19% of females).[145] Of those who ever had sex and ever had an STI, 75% of males and 57% of females sought treatment; the most common sources for treatment were drugstores (41% of males and 16% of females), hospitals/clinics/health posts (39% of males and 49% of females) and pharmacies (19% of males and 21% of females).[146] Major reasons for not seeking professional medical treatment for an STI were that the infection was not serious and that the infection "just went away."[147] A study of 1,147 street youth in Accra showed that of those who ever contracted an STI (58 males and 27 females), 43% of the males and 15% of the females self-medicated, 35% of the males and 22% of the females sought treatment from a druggist and only 18% went to a hospital or health center.[148] A young person reporting infection is likely to face hostility at government hospitals. Some of them do not seem to appreciate the gravity of STIs and therefore treat the infection with any antibiotic and in some cases use alcohol (palm wine and *akpeteshie*[**]) as a medium for the drug.[149] The knowledge-practice gap on STI treatment is similar to that observed with family planning in Ghana: Awareness of effective sources of care does not necessarily translate into actual use.

[§] The Akan word for gonorrhea literally translates to "coming of age." Therefore, among some circles contracting gonorrhea then shows that you have been initiated into sex.

[**] This is local gin distilled from either palm wine or sugar cane.

Information Sources for Adolescent Sexual and Reproductive Health

Over the last two decades, the electronic media has gradually replaced print media as the main source of information on a wide range of issues, including sexual and reproductive health. Prior to the print revolution, traditional forms of transmitting information, such as interpersonal communication from older men and women in the community, friends, drama and community meetings, were the main avenues.

Various studies on the sources of information on sexual and reproductive health for young people show that many sources are utilized, with one form or the other dominating, depending upon location. According to results from the 1998 GDHS, 26% of 15–19-year-olds had heard of family planning from both radio and television, 16% from radio only and another 5% from television only. Thirty percent of the young people also reported any print source and 27% reported posters only. Of the people who were exposed to radio messages on family planning, 75% approved of the messages.[150] Results from the 1998 GYRHS show that less than half of adolescent males and females had heard or seen anything about family planning in the mass media or via community fora or performance in the 6 months prior to the survey, despite the fact that half or more watch TV or listen to the radio at least once a month.[151]

Data from the 1998 GDHS on sources of information for HIV/AIDS indicate that the main source for young people is the mass media. Among those aged 15–19 who have heard of AIDS, radio (66% for females and 68% for males, respectively), workplace (52% for females and 50% for males) and TV (49% for females and 46% for males) were reported as sources of information.[152] Only 2% of the females and 3% of the males reported health workers as sources of information, and the print media (e.g., newspapers and pamphlets) were reported by 13% of females and 18% of males aged 15–19.[153] Friends and relatives were reported by 7% of females and 5% of males. The 1998 GYRHS found that 62% of males and 59% of females had seen or heard messages about HIV/AIDS in the mass media in the 6 months prior to the survey, and that disproportionately more adolescents were exposed to messages about HIV/AIDS via media sources than via community groups.[154] The evidence suggests that the mass media continues to be the main source of information for young people about HIV/AIDS, compared to interpersonal contacts such as those being promoted through peer education, seminars, religious preaching and community fora.

The relatively weak reliance on interpersonal communication with parents or family members for sexual and reproductive health information is brought out in other studies. Focus group discussions with young people showed that adolescents thought that older people, especially parents, do not know answers to questions about sexual and reproductive health, and that a young person would be branded as "bad" by their parents for even asking about these issues.[155] Boys in particular were more uncomfortable talking with a mother or father about sexual matters than were girls, and fathers were in general perceived as being less available and less patient than mothers.[156] Data from a national survey show relatively low levels of communication between adolescents and their parents about delaying sex or condoms: Romantic partners and best friends were the most common types of people with whom Ghanaian adolescents talked about these topics.[157]

Special Groups at Risk

This section briefly describes some of the groups of young people who may be particularly at risk of or affected by HIV/AIDS but who are often missing from existing studies of youth, especially those that draw on data from household-based surveys.

Street Youth

Any visitor to Ghana in the last two decades is confronted with the presence of young people living or working in the streets of the major cities. There is a pool of unemployed youth involved in low-paying and menial jobs, such as selling small items (e.g., snacks or fruits), shining shoes and carrying goods, which is known as head portage or *Kaya yei*.[158] Available information suggests that most of these children come from rural areas and migrate to the urban areas to seek jobs in the formal sector, which often are in short supply as a result of the overall economy.[159] Tanle has observed that every year young females from rural areas in the northern savannah belt migrate to the major urban centers in the south, such as Accra and Kumasi, to perform chores like pounding *fufu*[††] and head portage.

Aged between 15 and 24 and mostly illiterate, some of these young people engage in unprotected sex with different sexual partners. In his study of street youth, Anarfi observed that 52% of the males and 54% of the females had ever had sex but only 29% of those had regular sexual partners.[160] Anarfi and Antwi also noted that some of the street children were sexually active and had multiple sexual partners: Some were involved in sex for survival, among whom a number had contracted an STI at least once.[161] Tanle made a similar observation among migrant adolescent women from the Upper West Region to Accra and Kumasi.[162] Although the phenomenon exists and the number of street youth seems to be increasing, there have been few studies to understand the problems of these young people, especially with respect to their reproductive health needs. Recognizing this gap, the government, with the support of the United Nations Children's Fund (UNICEF) and other developmental partners, has initiated a project to rehabilitate street youth in selected cities.

Trokosi System

A number of practices exist in Ghana that compromise the liberties and rights of young females. One such practice is the Trokosi system. In parts of the Volta and Greater Accra Regions, a girl can be sent to a shrine to serve the "god" in atonement for a crime committed by a member of the family. This is done to "avert" any catastrophe befalling the family for the crime committed by that member. The person who atones for the crime must be a girl and a virgin. If not redeemed, such a person can serve the shrine for the rest of her life, and there is evidence of women aged 50 or older who have served at such shrines throughout their lifetimes. Redemption consists of the family pacifying the shrine through a long and expensive process of purification and the payment of compensation to the aggrieved family. If not redeemed, the young woman becomes a property of the shrine and the priest in charge is obliged to father children with her on behalf of the gods. Children from such liaisons, who in turn serve at the shrine, are expected to be catered for by the woman's family of origin.[163] Denied their personal liberties, including schooling and the right to marry, the plight of such females has been of national concern lately, and a nongovernmental organization (NGO), International Needs, in collaboration with various government agencies, has started a program to liberate such women. The continued existence of this practice puts a number of females at risk of unintended pregnancy, STIs and sexual abuse.

[††] This is a meal prepared by pounding plantain and cassava.

HIV/AIDS Orphans

Although Ghana is at the stage of a general HIV/AIDS epidemic, there is little information about the plight of HIV/AIDS orphans apart from their numbers. This is partly due to the stigmatization of infected persons that exists in Ghana[164] and a lack of focused research. In 2001, orphans were estimated to constitute 10% of all Ghanaian children (about 759,000 children).[165] Of those orphaned, 27% (204,000 children) are estimated to have been orphaned as a result of HIV/AIDS. By 2010, the proportion of orphans in Ghana is expected to decline, but the proportion of all orphans who lost their parents to HIV/AIDS is expected to rise.[166] A national appraisal of organizations involved in HIV/AIDS programs found that 55 (or nearly one-quarter of all HIV/AIDS organizations in Ghana in 2001) reported providing care for orphans.[167]

Policies and Programs

Policies

This section reviews some of the laws, policy documents and the national bodies whose activities have implications for the sexual and reproductive health of young people. The 1992 Constitution of Ghana defines a child as any person younger than 18.[168] Thus a person becomes an adult after attaining age 18. The Adolescent Reproductive Health Policy of Ghana is directed at the population aged 10–24.[169]

At the international level, Ghana supports the activities of UNICEF and is signatory to a number of conventions and declarations on children. For instance, Ghana was the first country to ratify the Convention on the Rights of the Child. Domestically, various Ghanaian governments have enacted laws, established institutions and produced policy documents that address issues associated with children and young adults. The Ghana National Commission on Children (GNCC) is the body set up by the government to coordinate and collaborate with other institutions, especially UNICEF, on all matters associated with children.

1992 Fourth Republican Constitution

Section 28 of the 1992 Constitution states:

1. Parliament shall enact such laws as are necessary to ensure that: (This article has five sub-sections).
2. Every child has the right to be protected from engaging in work that constitutes a threat to his health, education or development.
3. A child shall not be subjected to torture, or other cruel, inhumane or degrading treatment or punishment.
4. No child shall be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other belief.
5. For the purpose of this article "child" means a person below the age of eighteen.

These clauses have informed subsequent actions of government, including the establishment of the Ministry for Women and Children's Affairs, which has cabinet status; the unit for Girl-Child Education, headed by a Minister of State; and the enactment of various laws.

1998 Children's Act

The rationale of the 1998 Children's Act, among other things, was to raise consciousness about the status and well-being of children. The law sets out the obligations and responsibilities of parents and the state to children, indicates the minimum age at which a child can marry and prohibits acts that will be inimical to the physical and mental development of children. In spite of the existence of this law, some children are married off early, are denied formal education and experience sexual assault and child labor. For example, less than 25% of children in the three northern regions had had any formal education as of 2000,[170] some girls continue to be in servitude for crimes committed by members of their families (the *Trokosi system*) and female genital cutting is practiced in some parts of Ghana.[171]

1999 National Youth Policy

On July 21, 1999, a National Youth Policy (NYP) was officially launched in Accra. The purpose of the NYP, among other things, is to establish the identity and status of Ghanaian youth within the framework of government policy. The main guidelines of the NYP are national integration, cultural identity and youth empowerment. The policy recognizes major challenges facing youth, such as education, health, HIV/AIDS, teenage pregnancy, early marriage, drug and alcohol abuse, violence and other harmful behaviors. To address these problems, the government aims to empower young people so that they can have a say in decisions that affect them.

Consequently, the National Youth Council, under the auspices of the Ministry of Education, Youth and Sports, has the responsibility to educate young people and in collaboration with young people develop and implement programs.

2000 Adolescent Reproductive Health Policy

The Government of Ghana published an adolescent reproductive health document in 2000, with the broad objective of promoting a healthy environment and policy framework within which young people can obtain information and services on reproductive health and exercise their reproductive rights. The monitoring and evaluation of the objectives of the policy are the responsibilities of the National Population Council, the highest advisory body to government on population issues. The targets in the policy document are:[172]

- to motivate young people to increase the age of the onset of sexual activity, which is currently around 12, to older than 15 by 2010;
- to reduce the proportion of females who marry before age 18, which is currently at 37%, by 50% by 2010 and by 80% by 2020;
- to reduce the proportion of females younger than 20 who give birth by 50% by 2010 and by 80% by 2020;
- to reduce the incidence of STIs, including HIV/AIDS, among 15–24-year-olds by 50% by 2010;
- to reduce the incidence of abortion among young people by 50% by 2010;
- to ensure that 30% of students who do not enter senior secondary school obtain vocational and technical training by 2010; and
- to increase the proportion of 15–19-year-old women with secondary and higher education to 50% of the eligible population by 2010 and to 80% by 2020.

In addition, key decision-makers such as parliamentarians, representatives of district assemblies, chiefs, queenmothers, educators, parents and other adults are to be sensitized on aspects of family life education and adolescent reproductive health issues.

One drawback to the current policy is that there are no formal structures for monitoring or identifying spatial and sociodemographic variations in the targets. Additionally, some of the existing laws can impede the implementation of some of the targets in the policy. For example, abortion in Ghana is legal only in the case of rape or defilement or a threat to the health of the mother or child. As a result, there is little information on the abortion experiences of young people, especially measuring any change over time in levels of abortion.

2001 National HIV/AIDS and STI Policy

As part of the response to the HIV/AIDS epidemic, the government produced a policy in 2001 to guide programs and activities. The policy established the Ghana AIDS Commission under the Office of the President and charged the new body with the responsibility of coordinating all activities on HIV/AIDS in the country. Among other issues, Section 3.2.10 on young people seeks to:

- review national policies with the view to promoting those policies that reduce the vulnerability of young people to HIV/AIDS and STIs.
- promote the genuine participation of young people in an expanded national response to HIV/AIDS and STI prevention and control.
- encourage the establishment of structures that will support peer and youth groups in the community to contribute to local and national responses to HIV/AIDS and STI prevention and control.
- mobilize parents, policymakers, media and religious organizations to influence public opinion and policies with regard to HIV/AIDS/STIs and young people, such as improving the quality and coverage of in-school and out-of-school programs.
- ensure the expansion of the access of young people to youth-friendly facilities and services, including HIV and STI prevention, management and testing, counseling and the provision of care and support services.
- ensure the care and support of young people living with HIV/AIDS, AIDS orphans and young people whose parents are HIV positive.
- strengthen the integration of HIV/AIDS education into the curriculum of formal schooling beginning at the primary school level.[173]

Political commitment at the highest level to adolescent reproductive health and HIV/AIDS issues is evidenced in the number of policies that have been developed in the last ten years on these issues and the establishment of the Ghana AIDS Commission to advise government and to advocate for focused

programs in HIV/AIDS. However, some aspects of the policies are yet to be translated into programs and activities, creating a gap between intentions and actions. The challenge, therefore, will be to ensure the translation of all policy objectives into effective programs and activities.

Programs

Initially, provision of family planning services in Ghana did not include young people. In 1967, Planned Parenthood Association of Ghana (PPAG) was established and began to provide family planning services for married couples in Accra. PPAG's coverage was later extended to the Central and Ashanti Regions. In 1969, Ghana became the third country in Sub-Saharan Africa to develop a population program with the aim of providing family planning information and services to couples who needed them. The exclusion of young people from clinics that specialize in family planning services existed in Ghana until 1994, when the Population Policy was revised. The outbreak of HIV/AIDS added further momentum, and young people's reproductive needs began to be explicitly taken into account. To meet the objectives and targets set in the various policies outlined above, the government of Ghana, NGOs and community-based organizations initiated programs and activities on sexual and reproductive health, including HIV/AIDS, that were meant to reach young people.

Family planning services and supplies are available from a number of other sources as well. The 1998 GDHS shows that about half of all users of modern contraceptive methods obtained their supplies from the public sector (e.g., government hospitals, government health centers, family planning clinics, mobile clinics and fieldworkers) and the other half did so from the private sector (e.g., private hospitals, private clinics and drugstores). Although a variety of sources exist, youth may not have access.

Currently, sexual and reproductive health services for young people are in the broad areas of media campaigns, specific services, such as counseling, and services in both informal and formal settings, such as the school system. Since the outbreak of HIV/AIDS there have been media campaigns initially targeting the general population. The view was that "nobody should die out of ignorance." Subsequent campaigns were generally developed around the "ABC" concepts of abstinence, being faithful to one partner (monogamy) and condom use, with an emphasis on abstinence for young people. One visible aspect of the abstinence campaign for young people is the formation of "Virgin Clubs" in various parts of the country.

Another set of media campaigns, developed by the Ghana Social Marketing Foundation (GSMF) with the support of the U.S. Agency for International Development (USAID), has focused on the promotion of condom use on radio and television advertisements, such as the slogan "if it is not on, it is not in," and promotion of brand names of condoms such as Champion and Panther. The GSMF has also supported TV series on sexual and reproductive health issues that target young people, including "Things We Do for Love." Although these programs have been popular with young people, there have been occasional arguments from religious bodies and traditional rulers that these media campaigns and television series promote promiscuity.[174] Comparing data from the 1998 GDHS and a 2001 survey conducted to assess the impact of the campaigns, GSMF and partners documented high exposure to the media activities and found that exposure to the media messages was positively associated with more favorable attitudes towards abstinence and delaying first sex among young men and women (see http://www.jhuccp.org/africa/ghana/stopaids.shtml).

As part of its mandate to promote quality sexual and reproductive health services for young people, the Ministry of Health (now called the Ghana Health Service) has initiated and implemented youth-focused services at some health centers. In 1996, PPAG redefined its mandate and designed and implemented youth-specific programs by building youth-friendly service centers in the Greater Accra, Central, Volta, Ashanti and Northern Regions.[175] These centers provide a range of sexual and reproductive health services for young people, including information, counseling, family planning and postabortion care (the last is for the general population).

The African Youth Alliance (AYA), a consortium of organizations backed by UNFPA, Pathfinder and Program for Appropriate Technologies in Health (PATH), is active in 20 districts in Ghana and provides HIV/AIDS-related information and services that specifically target young people. For example, AYA is working with PPAG, a key partner, to implement behavior change communication activities in 16 districts (see http://www.ayaonline.org/Ghana/

ghanaprojects.htm). Among these activities are peer education and outreach, livelihood development skills programs, and community advocacy. AYA is also working with at least 9 other organizations to implement related activities: It is collaborating with the Reproductive Health Unit within the Ministry of Health to develop youth-friendly service sites, working with the Christian Health Association to train staff to better meet the needs of youth, and working with the Ghana Education Service to provide counseling and age-appropriate life planning skills education to in-school youth.

To utilize the potential of schools as a place for information dissemination, sexual and reproductive health has been introduced into the social science syllabi of both primary and secondary institutions in Ghana. Students are expected to be introduced to topics in sexual and reproductive health under the rubric of "family life education." At the basic level, a school health program has been introduced to complement the sexual and reproductive health topics and cover practical aspects of personal hygiene and environmental studies. To respond to the need for qualified teachers for family life education within the school system and for community education, the University of Cape Coast started a degree program in population and family life education in 1996. However, there are no follow-up programs for teachers already in the field or for the training of pretertiary teachers.

Beginning in mid-2003, a USAID-supported program to help young women aged 11–15 develop self-efficacy, decision-making and other skills to protect themselves from HIV infection and stay in school was launched by the Ghana Education Service's Girls Education Unit as part of the Stop AIDS Love Life national program. The program focuses on stories about how an adolescent role model named Sara and her friends handle different situations (e.g., staying in school, sexual harassment and teenage pregnancy). The program also provides for the training of 900 district Girls Education Unit officers and teachers to help form "Sara Clubs" in schools and help facilitate "Sara" activities in communities.

In addition, there are a number of programs for groups, such as street youth, religious youth (e.g., the Young Women's and Young Men's Christian Associations, the Catholic Youth Association and Moslem Youth) and female porters.[176] To ensure that the concerns of religious groups are taken into consideration, PPAG, in collaboration with the National Population Council and with the support of UNFPA, is coordinating a sexual and reproductive health project involving the various religious denominations in the country. The aim is to assist religious groups in developing and implementing sexual and reproductive health services in accordance with religious principles and teachings.

Until quite recently, domestic violence, including sexual abuse and defilement, had been given little attention.[177] Recognizing the developmental, health and legal dimensions of the issue, the government set up a Women and Juvenile Unit within the Ghana Police Service to deal with domestic and sexual violence. This unit has become one of the barometers for assessing violence against young people, especially females, in Ghana.

Conclusion

Since the International Conference on Population and Development (ICPD) of 1994, reproductive health has taken center stage in population programs in a number of countries. For Ghana, the period coincided with the revision in 1994 of the first population policy, which was originally produced in 1969. To respond to the reproductive health needs of young people, the government developed an adolescent reproductive health policy in 2000 and a national HIV/AIDS and STI policy in 2001. These new developments are part of the government's response to the recommendations of ICPD in 1994.

The conditions under which young people grow and live have changed considerably within the last 40 years in Ghana. Formal education has created new avenues for marriage partner selection, which was previously the responsibility of family members. Moreover, the traditional socialization process is no longer the main avenue for socializing young people. Institutions such as the school system, religious bodies, mass media and government establishments have become other important avenues for the socialization of young people.

Research Gaps

This summary of key findings from existing research on adolescent sexual and reproductive health issues has brought forth the following challenges to researchers and can help inform policy-making and program planning:

- Progress toward national policy goals for the sexual and reproductive health of young people—particularly behavior change goals that lessen the risks adolescents face in the wake of the HIV/AIDS epidemic in Ghana—cannot be assessed sufficiently with the available data. The challenge is to measure the risk and protective behaviors of Ghanaian adolescents (both male and female) systematically over time in order to assess how well the country is meeting the sexual and reproductive health needs of the next generation.

- Very little information exists on the health-seeking behaviors of young people when confronted with an STI, including HIV/AIDS. According to the evidence that is available, the vast majority of young people are aware of the professional sources for STI treatment, yet many do not utilize professional medical services when confronted with these types of problems. The challenge remains to explain why there is this gap between awareness of formal medical services for STI diagnosis and treatment and actual utilization, and what specific changes could increase utilization. These are critical steps to help lessen the increased risk that HIV/AIDS poses for those who suffer from an STI.

- Much of the existing evidence shows the levels and patterns in risky sexual and health behaviors and outcomes among adolescents, but there is very little evidence to explain *why*. Firm answers that address the question "why?" are critical to designing and implementing effective sexual and reproductive health programs to protect young people. The challenge is to maximize the information from surveys and integrate information from other sources of data (e.g., adolescents' detailed accounts of their own experiences with STIs) that can shed light on the factors that matter most in their decisions and actions.

- There is a dearth of information about the implementation, monitoring and, most importantly, the evaluation of interventions aimed at improving the sexual and reproductive health of Ghanaian youth. For example, a systematic review of rigorously evaluated

adolescent reproductive health interventions in developing countries listed not one intervention in Ghana.[178] Interventions, such as a recent USAID-funded study led by a research team at the Navrongo Health Research Centre, are now being launched with designs that ensure rigorous evaluations of what promotes sexual and reproductive health among young people and what does not.

Priorities for Policies and Programs for Youth

The available evidence shows a large gap between the age at first sex and the age at first marriage: On average, first sexual intercourse takes place about 2 years before first marriage for young women and about 5 years before first marriage for young men. This large gap puts adolescents at risk of unintended pregnancy and STIs, and therefore necessitates a call to action for strategies that will help protect young people. While a variety of efforts are underway to improve the sexual and reproductive health of young people in Ghana, there are a number of issues facing the country in this vital area.

- As a signatory to a number of international treaties and conventions on children, Ghana has reacted positively to some of the challenges facing young people in such diverse areas as universal basic education, the legal protection of women and children, the reproductive health needs of young people and HIV/AIDS. However, a number of the intentions have not been translated into actual programs or services. For instance, universal basic education has not been attained and, as indicated in the youth policy, young people are seldom consulted on issues that affect them.

- Existing health information and services for young people are uneven. Current programs for young people in Ghana seem to concentrate more on information provision than on services. As pointed out by Erulkar, the sexual and reproductive health services provided for young people in Ghana do not adequately respond to their needs as measured in several surveys.[179] For example, although the majority of young people are aware of HIV/AIDS, many programs continue to focus on awareness creation. Sexual and reproductive health services for young people also tend to be concentrated in urban areas such as Accra, Kumasi and other regional capitals, and a few semiurban areas. Finally, the school-based family life education program, although universal in the school system, is not given the same level of attention in schools throughout the country and needs strengthening in terms of the training of pretertiary teachers, the provision of teaching and learning materials and support services for retraining.

- Although most young people are aware of contraceptive methods, including the male condom, method use remains relatively low. Moreover, lack of adequate knowledge among adolescents about the correct usage of contraceptive methods indicates that even if more young people were to use such popular methods as the pill and condom, the effectiveness of those methods against pregnancy and STIs would most likely be reduced by incorrect use. The resulting challenge is for more widespread and better education in school and through public campaigns, including the redesign of messages and information campaigns and materials to include more specific information on effective and correct use of condoms and other contraceptive methods.

- Media accounts of rape and defilement abound in spite of the laws, but there are few reliable statistics; in addition, some harmful sociocultural practices such as female genital cutting and female bondage continue to exist.[180] For instance, in northern Ghana, female genital cutting "is a precursor to marriage. Even if a woman is not circumcised before her marriage, she is likely to be so immediately after marriage."[181] These are practices that compromise the reproductive health and rights of young women.

- Due to the poor economic situation in Ghana, where about 40% of the population lives in poverty, many young people have migrated to the major cities of Accra, Kumasi and Sekondi-Takoradi. Some are engaged in activities, including sexual networking, that expose them to HIV infection and pregnancy.[182] Greater mobility and weakened social supports and monitoring for these young generations of Ghanaians make health information and service provision even more challenging.

Promoting adolescent sexual and reproductive health means addressing the remaining gaps in what we know and understanding both how the situation has changed over time and the reasons why. The strategies for meeting these challenges are of concern to government and traditional leaders, program managers, parents and young people themselves. The end goal, if achieved, will be a secure, healthy future for Ghana's next generation.

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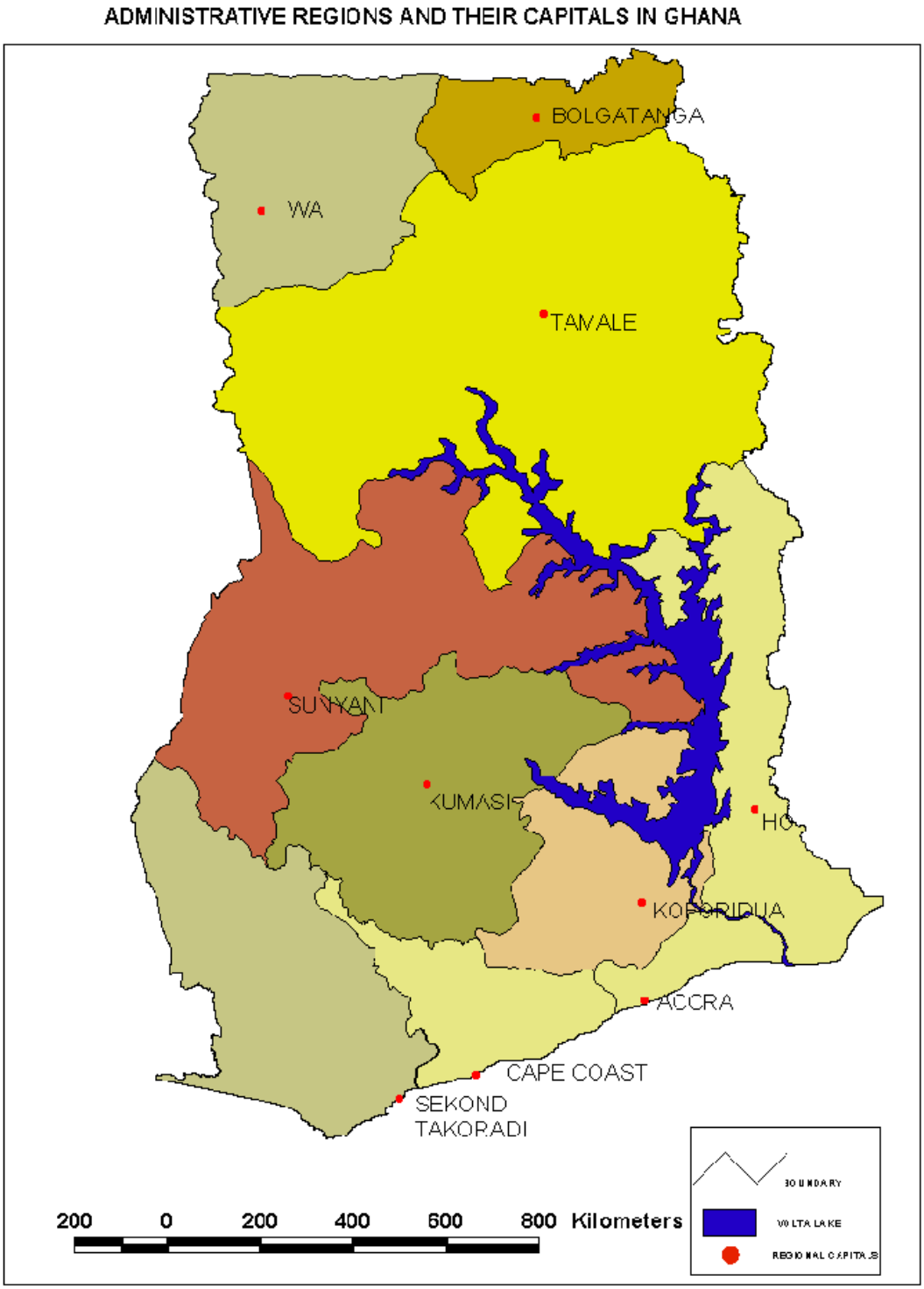
Appendix Figure 1. Map of Ghana



Appendix Table 1: Selected background characteristics and measures of sexual and reproductive behavior of adolescent women aged 15–19* in Ghana, 1998

	Women 15–19																		
		Age		Education		Residence		Region										Media exposure at least once a week	
Measure	Total	15–17	18–19	<7 years education	> 7 years education	Rural	Urban	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo Region	Northern	Upper West	Upper East	None	Some
Unweighted number of cases	889	535	354	360	529	581	308	108	91	139	84	90	105	72	49	58	93	239	650
A. Background characteristics																			
1. Percent with ≥ 7 years of education	64	63	64	–	–	58	73	65	68	75	58	65	76	60	22	35	35	45	69
2. Percent in school	38	53	17	24	46	37	40	40	33	43	40	37	36	47	15	40	34	27	42
3. Percent currently working	30	19	46	46	21	32	27	26	28	25	21	35	34	31	50	50	35	40	27
4. Percent with some exposure to mass media	77	79	75	65	84	68	92	76	76	92	57	92	82	85	50	40	50	–	–
5. Percent living in urban areas	37	37	38	28	43	–	–	22	32	94	14	25	39	24	28	15	12	13	45
B. Sexual behavior																			
6. Percent ever had sexual intercourse	38	23	61	44	34	43	30	43	43	25	36	42	41	45	34	35	35	43	36
7. Among sexually experienced, percent had sex in last 3 months	58	62	56	63	54	59	55	72	44	63	60	36	58	54	†	57	82	58	58
8. Median age at first sexual intercourse among 20–24-year-olds	17.4	–	–	16.9	17.8	17.1	18.0	17.0	18.1	18.4	17.3	17.3	17.2	16.4	17.2	17.6	18.3	16.8	17.7
9. Percent had premarital sex before age 20 among 20–24-year-olds §	51	–	–	48	53	51	51	57	47	47	62	61	52	56	20	26	32	51	51
10. Percent sexually experienced by age 20 among 20–24-year-olds	83	–	–	88	80	87	78	89	81	70	86	92	84	93	90	79	72	88	82
11. Among sexually experienced, percent had ≥ 2 partners in the last 12 months	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
C. Union and fertility																			
12. Percent ever in union‡	16	7	30	23	13	20	11	14	19	7	12	23	25	16	27	25	15	24	14
13. Median age at first marriage among 20–24-year-olds	19.3	–	–	18.5	20.1	18.7	21.2**	19.0	19.6	22.4**	19.5	18.8	19.1	17.8	17.5	19.2	18.7**	18.4	19.8
14. Percent ever had a child	12	5	22	16	9	15	7	9	19	3	10	18	18	14	9	10	6	17	10
15. Percent currently pregnant	2	1	4	5	1	3	2	0	0	3	1	3	2	2	6	5	8	4	2
D. Contraceptive knowledge and use																			
16. Among sexually experienced, percent know where to obtain a condom	71	74	69	55	83	67	81	45	79	83	84	82	70	76	†	43	72	53	78
17–18. Among sexually experienced, percent ever used:																			
17. any modern method of contraception for family planning	33	36	32	23	40	28	43	30	36	39	33	32	38	34	†	13	22	18	38
18. the condom for any reason	29	33	27	18	37	26	37	33	29	39	33	32	24	22	†	14	35	16	34
19–20. Among sexually active, percent currently using:																			
19. any modern method of family planning	20	22	18	10	29	14	34	22	†	32	†	†	24	†	†	†	7	4	25
20. the condom	12	16	10	2	20	6	29	8	†	32	†	†	14	†	†	†	7	2	16
21. Among those who had sex in the last 12 months, percent used the condom at last intercourse	16	20	13	7	23	12	25	17	19	24	24	6	18	7	†	†	18	5	19
22. Among all, percent who approved of family planning	64	59	72	53	70	61	69	60	53	75	59	65	63	72	55	63	67	53	67
23. Among nonusers, percent who intend to use a method in the next 12 months	10	8	13	11	9	11	7	3	10	8	8	15	12	12	17	17	9	12	9
E. Knowledge and attitudes about HIV																			
24. Percent who have heard of HIV/AIDS	97	96	98	92	99	95	99	98	95	99	96	100	100	100	75	85	84	90	99
25. Among those who have heard of HIV, percent who believe they are at some risk of getting HIV/AIDS	29	26	34	31	28	26	33	9	19	37	29	27	35	21	43	47	63	27	29
26–28. Among all, percent who correctly identified that one can prevent HIV/AIDS by:																			
26. using the condom	22	19	25	12	27	19	27	18	17	31	15	23	23	28	9	5	25	13	24
27. abstaining from intercourse	14	15	11	10	15	13	15	22	10	12	8	14	21	10	9	10	4	5	16
28. limiting sexual partner to one	46	40	56	39	51	45	49	44	44	52	40	41	53	53	27	21	57	39	48
29. Among all, percent who know that it is possible for a healthy looking person to have the AIDS virus	65	62	69	48	74	60	73	69	53	74	54	62	80	75	33	45	60	47	70
F. Protective behavior																			
30–32. Among those who have heard of HIV/AIDS, percent whose knowledge of HIV influenced them to:																			
30. decide to abstain from sex	38	47	24	31	41	36	41	29	22	46	55	33	39	48	38	35	27	36	38
31. start to use condoms	6	4	9	3	8	6	7	11	8	6	2	7	5	1	0	0	15	2	7
32. reduce number of partners or limit to one	30	21	44	34	29	35	23	24	39	20	24	43	30	31	36	29	50	35	29

* Measure is among adolescent 15–19 unless otherwise stated.
† Unweighted N less than 20.
‡ Ever in union includes currently married, formerly married and cohabitating.
§ Premarital sex is the percent of all women/men aged 20-24 who had intercourse before age 20 and were never married at first intercourse.
**Among 25–29-year-olds because median not reached among 20–24-year-olds.

Appendix Table 2: Selected background characteristics and measures of sexual and reproductive behavior of adolescent men aged 15–19* in Ghana, 1998

	Men 15–19																		
		Age		Education		Residence		Region										Media exposure at least once a week	
Measure	Total	15–17	18–19	<7 years education	> 7 years education	Rural	Urban	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo Region	Northern	Upper West	Upper East	None	Some
Unweighted number of cases	327	197	130	114	212	235	92	45	35	38	48	30	31	19	21	22	28	78	249
A. Background characteristics																			
1. Percent with ≥ 7 years of education	70	64	79	–	–	64	82	71	74	78	76	82	80	†	23	29	47	39	77
2. Percent in school	49	62	29	37	55	48	52	52	47	50	57	61	42	†	31	29	47	46	50
3. Percent currently working	33	24	45	56	22	36	26	24	37	26	19	29	44	†	69	57	50	44	30
4. Percent with some exposure to mass media	81	78	84	61	89	76	91	78	95	100	72	97	81	†	54	38	60		
5. Percent living in urban areas	31	28	36	18	36	–	–	20	12	87	12	35	37	†	29	13	10	14	35
B. Sexual behavior																			
6. Percent ever had sexual intercourse	19	9	36	19	19	20	18	20	21	15	12	27	29	†	15	13	20	6	22
7. Among sexually experienced, percent had sex in last 3 months	76	†	75	90	71	83	†	†	†	†	†	†	†	†	†	†	†	†	75
8. Median age at first sexual intercourse among 20–24-year-olds	19.5	–	–	19.4	19.5	18.9	20.6	18.7	†	20.9	19.8	18.9	19.3	†	†	†	†	19.4	19.5
9. Percent had premarital sex before age 20 among 20–24-year-olds§	49	–	–	52	48	55	41	51	†	39	45	63	48	†	†	†	†	48	49
10. Percent sexually experienced by age 20 among 20–24-year-olds	56	–	–	55	55	64	43	65	†	42	52	63	55	†	†	†	†	65	55
11. Among sexually experienced, percent had ≥ 2 partners in the last 12 months	17	†	17	21	16	16	†	†	†	†	†	†	†	†	†	†	†	†	17
C. Union and fertility																			
12. Percent ever in union‡	3	1	7	5	2	4	1	2	2	2	0	6	6	†	7	0	0	0	4
13. Median age at first marriage among 25–29-year-olds	24.8**	–	–	22.9	25.0**	24.4	26.6**	24.5	†	24.8**	†	24.3	24.6	†	†	†	†	24.5**	24.9**
14. Percent ever had a child	1	0	2	2		0	1	0	0	0	0	3	0	†	7	0	0	0	1
15. Among those who have a sexual partner, partner currently pregnant	5	†	3	†	3	6	†	†	†	†	†	†	†	†	†	†	†	†	5
D. Contraceptive knowledge and use																			
16. Among sexually experienced, percent know where to obtain a condom	88	†	89	79	91	85	†	†	†	†	†	†	†	†	†	†	†	†	88
17–18. Among sexually experienced, percent ever used:																			
17. any modern method of contraception for family planning	48	†	57	47	49	51	†	†	†	†	†	†	†	†	†	†	†	†	48
18. the condom for any reason	55	†	61	55	56	60	†	†	†	†	†	†	†	†	†	†	†	†	55
19–20. Among sexually active, percent currently using:																			
19. any modern method of family planning	37	†	43	41	32	39	†	†	†	†	†	†	†	†	†	†	†	†	39
20. the condom	27	†	29	35	23	27	†	†	†	†	†	†	†	†	†	†	†	†	28
21. Among those who had sex in the last 12 months, percent used the condom at last intercourse	28	†	32	†	27	24	†	†	†	†	†	†	†	†	†	†	†	†	29
22. Among all, percent who approved of family planning	65	57	76	54	69	60	75	53	54	80	54	64	83	†	64	43	85	50	68
23. Among nonusers, percent who intend to use a method in next 12 months	12	7	22	10	13	10	14	15	10	10	8	19	21	†	8	14	12	5	14
E. Knowledge and attitudes about HIV																			
24. Percent who have heard of HIV/AIDS	97	97	99	91	100	96	100	100	98	100	98	100	97	†	92	88	85	89	99
25. Among those who have heard of HIV, percent who believe they are at some risk of getting HIV/AIDS	24	23	24	27	23	20	32	9	22	30	19	29	27	†	†	†	43	27	23
26–28. Among all, percent who correctly identified that one can prevent HIV/AIDS by:																			
26. using the condom	35	33	39	23	40	32	43	29	26	52	29	35	42	†	15	13	60	16	40
27. abstaining from intercourse	12	12	12	8	13	9	18	8	5	15	9	18	19	†	15	13	5	14	11
28. limiting sexual partner to one	41	34	52	33	45	41	42	49	47	48	33	38	39	†	23	14	53	36	43
29. Among all, percent who know that it is possible for a healthy looking person to have the AIDS virus	71	65	81	45	83	68	77	76	67	74	69	79	81	†	39	29	80	51	76
F. Protective behavior																			
30–32. Among those who have heard of HIV/AIDS, percent whose knowledge of HIV influenced them to:																			
30. decide to abstain from sex	50	61	34	47	51	51	50	49	29	48	75	50	43	†	†	43	47	59	48
31. start to use condoms	12	7	20	12	13	14	10	16	14	13	2	9	17	†	†	0	35	9	13
32. reduce number of partners or limit to one	21	12	36	22	22	22	22	22	33	18	11	18	24	†	†	0	47	16	22

* Measure is among adolescent 15–19 unless otherwise stated.
† Unweighted N less than 20.
‡ Ever in union includes currently married, formerly married and cohabitating.
§ Premarital sex is the percent of all women/men aged 20–24 who had intercourse before age 20 and were never married at first intercourse.
**Among 30–34 year olds because median not reached among 25–29 year olds.

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