PROTECTING THE NEXT GENERATION

Protecting the Next Generation in Ghana

NEW EVIDENCE ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH NEEDS

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New Evidence on Adolescent Sexual and Reproductive Health Needs

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Executive Summary

Sexual activity among adolescents is a sensitive topic, and addressing youth's sexual and reproductive health in the public arena is challenging. However, the need for sexual and reproductive health services for adolescents—and the potential benefit of meeting that need—is great. Improving the sexual and reproductive health of adolescents is important not only from a public health perspective, but also from an economic one. Early marriage and childbearing, as well as the effects of HIV/AIDS among young people, can greatly undermine a country's socioeconomic development. Increased investment can both improve adolescent sexual and reproductive health and contribute to wider development goals by giving adolescents a chance to become healthy adults.

This report presents findings from a new body of research on adolescent sexual and reproductive health in Ghana. The findings are primarily derived from data collected in a 2004 nationally representative survey of young people aged 12–19, and in focus group discussions and in-depth interviews conducted in 2003 and 2004, respectively.

Females are more likely than males to have sex as teenagers, have early sex and have unwanted sex

- Among 20–24-year-old females, 8% had had sex before 15 years of age, 43% before age 18 and 71% before age 20. Among males, 4% had had sex before they were 15 years old, 26% before age 18 and 55% before age 20.
- Forty-seven percent of females aged 20–24, but only 13% of males, had married by age 20. More than 90% of adolescents aged 12–19 (and more than 80% of sexually experienced respondents) said that youth should remain virgins until they marry, yet among those who had ever had sex, only 15% of females and 5% of males had had their sexual debut with a spouse or live-in partner.
- Twelve percent of females aged 12–19 who had ever had sex and 5% of their male counterparts said that they had been forced (either physically or by threats) into having sexual intercourse on at least one occasion.

Many sexually active adolescents do not use contraceptives

- Among adolescents aged 15–19 who had had sex in the past three months, only 64% of all males, 51% of females not in a union and 38% of females in a union reported that they were using a modern contraceptive method. The male condom was the most commonly used contraceptive method.
- Among adolescents aged 15–19 who had ever had sex, those with more formal education reported higher levels of contraceptive use than their peers with less schooling.
- Among females aged 15–19 who were not in a union, almost one-third desired to wait for nine or more years before having a child.
- Forty-two percent of adolescents aged 15–19 who had ever had sex had already been pregnant. Among 15–19-year-old females who had already had a baby, only 24% had wanted to have a child at the time of their last conception.

Fear of pregnancy, not of STIs, motivates many youth to avoid sex or use contraceptives

- Adolescents aged 12–19 who had never had sex were more likely to cite fear of pregnancy, rather than fear of HIV or other sexually transmitted infections (STIs), as the main reason they had abstained from sex.
- Similarly, adolescents were more likely to use condoms spe-

cifically to protect against pregnancy rather than to protect against HIV and other STIs. Seventy-one percent of females aged 15–19 who had had sex in the prior year and 45% of their male counterparts said they used condoms only to protect against pregnancy, whereas just 5% of females and 38% of males used condoms only to protect against STIs.

Adolescents lack adequate knowledge about sexual and reproductive health issues

- Although awareness of contraceptive methods is high, most adolescents lack critical knowledge about how to avoid pregnancy. For instance, among those aged 15–19, only 28% of females and 21% of males were aware of a woman's fertile period, were able to reject several popular misconceptions about pregnancy and knew of at least one modern contraceptive method. The proportions were even lower among 12–14-year-olds.
- Nearly all adolescents were aware of HIV/AIDS. However, only about one-third of adolescents aged 15–19 and fewer than one-fourth of adolescents aged 12–14 could correctly identify ways of preventing the sexual transmission of HIV and could reject major misconceptions about HIV (e.g., that a healthy-looking person cannot be infected). Some 49% of females and 56% of males aged 15–19 had heard of STIs other than HIV/AIDS, as had 26% of females and 28% of males aged 12–14.

Adolescents get sexual and reproductive health information from many sources

- Ninety percent of adolescents who had ever attended school said it was important for family life education to be taught in schools, and about two-thirds of adolescents did not think that family life education encourages adolescents to have sex. Among 15–19-year-olds, 58% of females and 46% of males reported that they had received family life education; among 12–14 year olds, 41% of females and 28% of males said they had received such education.
- Adolescents preferred to receive information on sexual and reproductive health from professional sources, such as the mass media, teachers and health care providers, rather than from parents.

Adolescents have diverse sexual and reproductive health care needs

- Compared with their male peers, female adolescents are physiologically more vulnerable to poor reproductive health outcomes, such as STIs. Furthermore, other factors, such as early sexual debut, teenage pregnancy and unwanted sex, can compound the health risks from unprotected sex.
- Early marriage can also increase reproductive health risks for females, because married individuals have sex more often and are far less likely to practise contraception than unmarried individuals.
- Because most adolescents in Ghana attend school, school-based programmes can be an effective means of providing sexual and reproductive health information and services to adolescents. However, adolescents who do not attend school or who leave school before receiving family life education need access to information and services.

Adolescents prefer to obtain reproductive health care at clinics—but are often too shy to do so

- Among adolescents aged 15–19 who knew of any source for obtaining contraceptives, 63% of females and 56% of males said their preferred source was a public clinic or hospital; among those who knew of any source for obtaining treatment for STIs, 87% of females and 91% of males said they would prefer public clinics or hospitals.
- Among sexually experienced 15–19-year-olds who knew a source for contraceptives or STI treatment, 53% reported that feelings of shyness or embarrassment were a barrier to obtaining contraceptives, and 51% said that such feelings were a barrier to obtaining treatment for STIs.

Action is needed on many fronts to meet the sexual and reproductive health needs of adolescents

- It is vital that all adolescents who attend school receive comprehensive sexual and reproductive health education from trained teachers. Such education should begin at the upper primary level.
- Programmes that train peer educators, youth-friendly counsellors and community-based providers and that target hard-to-reach populations should be expanded.
- Comprehensive community-based programmes that provide sexual and reproductive health information and services to adolescents should be initiated or strengthened. Programmes should be coordinated with improved provider training.
- Because the fear of pregnancy, more than the fear of STIs, motivates adolescents to avoid sex or to practise safer sex, prevention efforts that integrate education on both might resonate more with adolescents than prevention programmes that focus solely on HIV and other STIs.
- To make sexual and reproductive health care accessible and inviting to adolescents, providers should be trained to offer youth-friendly services, facilities should accommodate the needs of adolescents and youth should be informed about where they can obtain services.
- The mass media should continue to be an integral part of prevention efforts.
- Stakeholders should explore ways to expand successful partnerships between traditional leaders, religious groups and the public health community, particularly in areas where access to information and services is limited.
- The National Population Council should be given sufficient resources to enable it to play its crucial role in coordinating adolescent sexual and reproductive health policies.

Chapter 1

Introduction

The sexual and reproductive health of adolescents is gradually becoming one of the top priorities for policymakers around the world. Since the 1994 International Conference on Population and Development in Cairo, numerous countries and organizations have attempted to improve the sexual and reproductive health of adolescents, in many cases as part of a strategy to improve the quality of overall health and to facilitate socioeconomic development. According to the World Health Organization, poor sexual and reproductive health accounts for one-third of the global burden of disease among women of reproductive age (15–44), and for one-fifth of the burden of disease among the population overall.[1(p.9)] The need for sexual and reproductive health services—and thus the potential benefit of addressing this need—is greatest in the world's poorest nations. In developing countries, meeting the need for contraceptive services would reduce the number of unplanned births by 72% and the number of induced abortions by 64%.[1(p.20)]

The AIDS epidemic in Sub-Saharan Africa provides a vivid illustration of the devastating impact that poor reproductive health outcomes have on populations. Almost two-thirds of all persons with HIV live in Sub-Saharan Africa, and nearly half of the two million new infections each year among young people occur in Sub-Saharan Africa.[2(p.3)] Although Ghana has not been as severely affected by the epidemic as some other countries in Sub-Saharan Africa, HIV nonetheless poses a significant problem for the country's health and socioeconomic development. In 2005, the estimated prevalence of HIV in Ghana among adults was 2.3%; among 15–24-year-olds, the prevalence was 1.3% for females and 0.2% for males.[2]

Moreover, although the median ages at which Ghanaians first have sex, marry and give birth have increased among younger generations,[3] early childbirth and unwanted pregnancy remain common. In the 2003 Ghana Demographic and Health Survey, more than one-third of women aged 20–24 reported that they had given birth before age 20.[3(p.62)] According to findings from the 2004 National Survey of Adolescents, the majority of women aged 15–19 who were pregnant or had already given birth would have preferred to delay their pregnancy.[4(p.78)] One reason that many young women wish to delay childbearing is that doing so affords them an opportunity to pursue educational and economic opportunities. Thus, to promote Ghana's socioeconomic development, the sexual and reproductive health of the country's adolescents needs to be a component of national development goals.

New evidence can guide national efforts to improve adolescent sexual and reproductive health

This report presents key findings from a new body of research that highlights the unmet sexual and reproductive health needs of 12–19-year-olds in Ghana. The results point to specific areas in which interventions for improving adolescent* sexual and reproductive health might be targeted, and suggest that increased and sustained investment in sexual and reproductive health care for adolescents may provide enormous returns. Importantly, the behaviours and attitudes that increase the risk that adolescents will contract HIV/AIDS are inextricably linked to those that result in other sexually transmitted infections (STIs) and in pregnancies (many of which are unintended and may lead to unsafe abortions). Comprehensively addressing the sexual and reproductive health care needs of adolescents can empower young

*Unless otherwise noted, in this report the term "adolescent" refers to 12–19-year-olds.

people to make informed decisions about their sexual behaviour and, in turn, help them to become healthy adults.

The research on which this report is based included focus group discussions with adolescents conducted in 2003; in-depth interviews with adolescents, teachers and health workers conducted between 2003 and 2005; and a nationally representative survey of adolescents aged 12–19 conducted in 2004 (for more details on data sources, see box on page 8). The results of these studies provide new, detailed information about adolescents' views on sexual and reproductive health, about their sexual and reproductive health needs and about ways to meet those needs. Particularly noteworthy is the inclusion of data about very young adolescents (those who are 12–14 years old), as their views and needs have not been extensively examined in prior research. Where relevant, the report draws on previously published analyses of the survey data, as well as on similar studies of other data sets, and also discusses important findings by other organizations and individuals to highlight the impact of interventions and to illustrate where and how adolescent health can be better supported.

Important elements for change are in place—but challenges remain

Survey and demographic findings reveal some of the challenges that Ghana faces in addressing the sexual and reproductive health needs of its young people—as well as some reasons to be optimistic. Adolescents aged 10–19 account for more than one-fifth of Ghana's population.[5] Slightly more than half of adolescents aged 12–19 live in rural areas,[4(p.23)] and almost half have attended secondary school.[4(p.24)] In the 2004 National Survey of Adolescents, nearly 90% of adolescents aged 12–19 were related to the head of the household (generally one or both parents, although one in 10 lived with grandparents, and another one in 10 with other relatives); however, fewer than half of adolescents (40% of females and 45% of males) lived with both biological parents.[4(p.24)] More than 95% of adolescents professed an affiliation with a religious denomination; 79% of females and 73% of males identified themselves as Christian, and 16% of females and 20% of males identified themselves as Muslim.[4(p.36)] Among those with a religious affiliation, almost nine in 10 indicated that religion was very important to them and that they attended religious services at least once a week. Moreover, in the 2004 survey, adolescents expressed great aspirations for their future. Most adolescents not only were attending school but desired to further their education.[4(p.32)]

Many of these findings (e.g., the relatively high levels of education) indicate the Ghana is well poised to address the diverse sexual and reproductive health care needs of adolescents. However, intervention attempts will also face some unique challenges. For example, because rural youth and those not attending school may have only limited access to sexual and reproductive health information, they may be less equipped than their peers in urban areas to make decisions about sexual behaviour. Interventions will also need to take into account married adolescents, whose needs differ from those of their unmarried peers, and females, who for a variety of social, economic and physiologic reasons bear a disproportionate share of the burden of the consequences of unprotected sex.

The government is making efforts to address the sexual and reproductive health needs of adolescents. Key government policies issued in recent years include the 2000 Adolescent Reproductive Health Policy and the 2001 National HIV/AIDS and STI Policy. The former sets specific targets for reducing the incidence of unintended pregnancy, childbearing and STIs among adolescents, as well as for improving educational levels, especially for girls.[6] The latter document has a special section promoting STI prevention, testing, support and care among adolescents.[7(p.34)] Nonetheless, some aspects of national policies have yet to be translated into programmes to achieve desired results. The evidence presented in this report highlights some of the challenges that remain and also presents policy options that can be used to address gaps between policy and reality.

A guide to this report

This report discusses in detail some of the challenges and opportunities for improving the sexual and reproductive health of adolescents in Ghana. Chapter 2 provides an overview of adolescent sexual behaviour, including findings on the prevalence of sex and contraceptive use. Chapter 3 examines adolescents' knowledge of sexual and reproductive health issues. The challenges involved in responding to the diverse sexual and reproductive health care needs of adolescents are highlighted in Chapter 4. Chapter 5 explores the variety of sources from which adolescents obtain information on sexual and reproductive health issues, and Chapter 6 addresses the potential role of the public health sector. The final chapter offers recommendations that can help policymakers, programme managers and other stakeholders improve adolescents' sexual and reproductive health.

Data Sources

QUANTITATIVE DATA

This report is based largely on data from two large national surveys. The 2004 National Survey of Adolescents was designed to investigate a wide range of issues related to sexual and reproductive health (especially the prevention of HIV infection) among adolescents aged 12–19. This nationally representative household survey was organised by the Institute of Statistical, Social and Economic Research at the University of Ghana, Legon, in collaboration with ORC Macro, the University of Cape Coast Department of Geography and Tourism, and the Guttmacher Institute; it was conducted between January and May 2004. The survey used a two-stage stratified sample design based on the frame used by the Ghana Statistical Service for the 2003 Ghana Demographic and Health Survey. The first stage involved selection of enumeration areas from urban and rural strata in the 10 regions of the country. In the second stage, households were randomly selected from the chosen clusters, and all 12–19-year-olds who had spent the night prior to the survey in the household (*de facto* residents) were eligible to be interviewed. A total of 4,430 adolescents aged 12–19 were interviewed (2,201 females and 2,229 males); the overall response rate among eligible adolescents was 89%. Further details about the study design and findings are available elsewhere.[1]

The second survey, the 2003 Ghana Demographic and Health Survey, was a nationally representative survey of 5,691 women aged 15–49 and 5,015 men aged 15–59. More than one-fifth of respondents (1,148 females and 1,107 males) were aged 15–19. The survey, which was fielded by the Ghana Statistical Service, was designed to gather information on a wide range of demographic, health and nutritional issues. The data cited in this report have been published previously.[2]

QUALITATIVE DATA

This report also draws on qualitative data collected by the Guttmacher Institute and the University of Cape Coast. Sixteen focus group discussions with 14–19-year-olds were conducted in 2003 to explore in depth adolescents' views on sexual and reproductive health issues—including abstinence, condom use and STIs—and to determine their preferred and actual sources of sexual and reproductive health information and services. Participants were selected from both urban and rural areas and comprised a mixture of male and female and in-school and out-of-school adolescents. Urban focus group discussions were conducted in Accra for out-of-school adolescents; discussions among those who were still in school were conducted in Kumasi, because students in the secondary (boarding) institutions in that city are from all over the country. For the rural focus groups, out-of-school adolescents were recruited in Tolon/Kumbungu, which has one of the lowest school enrolment rates in the country, and in-school adolescents were recruited in West Mamprusi. The selection of recruitment sites in the study reflected not only urban and rural environments but also Ghana's three ecological zones: the coastal, middle and northern savannah belts. Each discussion group had 8–12 participants and lasted for an average of 2–2.5 hours. The discussions were recorded, transcribed and translated from local languages into English. Results from these discussions, along with findings from similar focus groups conducted in Burkina Faso, Malawi and Uganda, have been published.[3]

In addition, 102 in-depth interviews were conducted in 2003 with adolescents of both sexes aged 12–19 to examine the context of and motivations behind the sexual and reproductive health behaviours of adolescents, and to explore issues that are difficult to assess in large-scale quantitative surveys that rely on close-ended questions. Sixty of the interviews were conducted in urban areas, and 42 in rural areas. The total includes 18 interviews with adolescents from at-risk groups: youth who worked or lived on the streets, resided in facilities for juvenile offenders or lived in refugee camps. The discussions were recorded, transcribed and translated from local languages into English. Further details about the methodology and findings are available elsewhere.[4]

Finally, to provide a better understanding of how adults perceive their roles and responsibilities regarding adolescent sexual and reproductive health, 60 in-depth interviews were conducted in 2005 with key adults in the lives of adolescents. These adults were parents, community leaders, teachers and health care providers. Results from the interviews will be published in a forthcoming report.

Chapter 2

What Adolescents Tell Us About Their Sexual Behaviour

Developing successful policies and programmes to address adolescents' sexual and reproductive health care needs requires an understanding of their current situation and the environment within which they are growing up. This is because adolescents' sexual and reproductive health behaviours, and their decisions about reproductive health, are influenced by the broad social, cultural and economic conditions they face in their lives. Among the most important of these behaviours are the initiation of sexual activity and the use contraceptives.

Female adolescents start sex earlier than male adolescents

According to the 2003 Ghana Demographic and Health Survey, 8% of females aged 20–24 had sex before they were 15 years old, 43% had sex before they were 18 and 71% had sex before they were 20 (Table 2.1).[3] The corresponding percentages for males were considerably lower: Four percent had sex before reaching 15 years of age, 26% had sex before age 18 and 55% had sex before age 20. One reason for this disparity is that a significantly higher proportion of females than of males married as teenagers (47% vs. 13%). However, the higher levels of sexual activity among female adolescents at every age suggest that the factors that influence adolescent sexual behaviour may be different for males and females.

Findings from the 2004 National Survey of Adolescents provide further details about the sexual activity of adolescents. Among respondents aged 12–19 who had ever had sex, 95% of males and 85% of females had had their sexual debut outside of marriage or a live-in union.[4(p.59)] Among 15–19-year-olds who had ever had sex, 76% of females and 67% of males had had their first sexual intercourse with a noncohabiting boyfriend or girlfriend. The most common reason that adolescents aged 12–19 gave for having their first sexual experience was that they had "felt like it": Seventy-one percent of males and 45% of females gave this reason.

The number of sexual partners that an individual has had and the type of relationship that he or she has had with those partners have important implications for reproductive health. Among survey respondents aged 15–19 who had ever had sex, 78% of females and 60% of males reported having had just one sexual partner during their lifetime.[4(p.61)] Among all 15–19-year-olds, 16% of females and 10% of males had had sex

TABLE 2.1

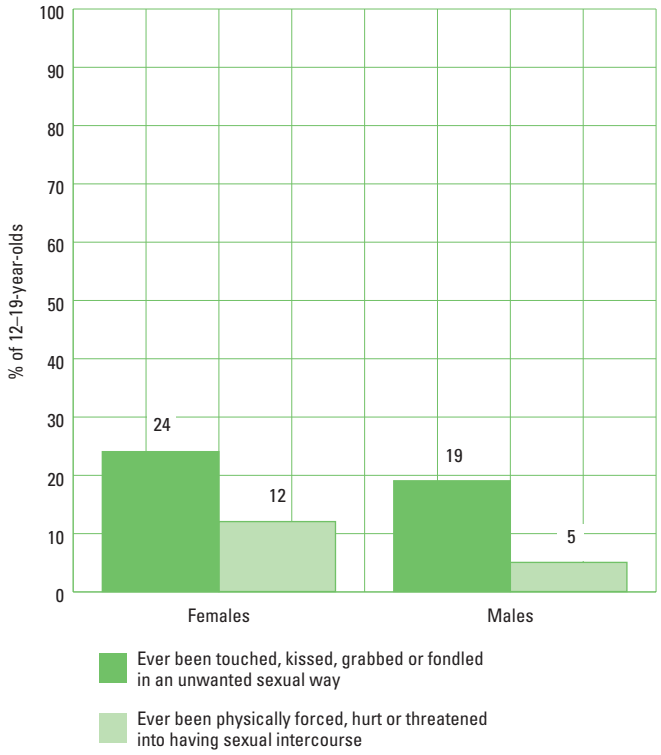
Percentage of females and males aged 20–24 who had had sex, married or had a child by a specific age, 2003

Event	Females	Males
FIRST SEX		
Before age 15	7.5	3.9
Before age 18	43.1	25.7
Before age 20	70.5	54.5
FIRST MARRIAGE		
Before age 15	5.9	u
Before age 18	27.9	u
Before age 20	46.8	13.3
FIRST CHILD		
Before age 15	1.4	u
Before age 18	14.9	u
Before age 20	34.6	u

Note u=unavailable.
Source Reference 3.

FIGURE 2.1

Female adolescents were more likely than their male peers to have experienced coercive sex.



Notes Respondents were asked about coercive sex only if no one aged three or older was present or within hearing range. Only one eligible adolescent per household was questioned about coercive sex.

Source Reference 4 (Table 4.11).

with a noncohabiting partner during the past 12 months.[8,9] On the other hand, 8% of females and 5% of males aged 15–19 who had ever had sex had not had sex in the past year.

Another important issue is coercive sex, which is not only undesirable but inherently risky, because contraceptive use is usually not an option for the coerced person. In the 2004 National Survey of Adolescents, females reported higher levels of unwanted sexual attention and coercive sex than males (Figure 2.1).[4(p.64)] Among adolescents aged 12–19, one in four females (24%) and one in five males (19%) said that they had been touched, kissed, grabbed or fondled in an unwanted sexual way. In addition, 12% of females and 5% of males reported that they had ever been forced into having sexual intercourse. Females who had been coerced into sex reported that the perpetrators were most often acquaintances, whereas males who had been coerced most often cited girlfriends as the perpetrators.

Adolescents say that abstinence is important—but few postpone sex until marriage

Although the majority of adolescents agree that they should remain virgins until they marry, their actual sexual behaviour does not conform to this ideal. In the 2004 National Survey of Adolescents, more than 90% of both females and males—and more than 80% of those who had ever had sex—endorsed the idea that adolescents should remain virgins until marriage,[4(p.58)] yet only 15% of females and 5% of males who had ever had sex reported that their first sexual experience had been with a spouse or live-in partner.[4(p.59)] Among those who had never had sex, the major motivation for abstinence was to avoid pregnancy and STIs (including HIV), rather than to preserve their virginity until marriage.[10(p.7)]

Many adolescents who have sex do not practise contraception

Despite the fact that unprotected sex can have life-changing or life-threatening consequences (unintended pregnancy or HIV, for example), the level of contraceptive use among adolescents is not as high as it could be. Among male adolescents aged 15–19 who had had sex in the past three months, 64% reported that they were currently using any modern contraceptive method (Figure 2.2).[4] Figures for females were lower: 51% of those not in a union, and 38% of those in a union, were using a modern method. The most commonly used method among 15–19-year-olds who had ever had sex was the male condom, used by 53% of males, 40% of females not in union and 16% of females in union.[4(p.74)] Other commonly used methods were the pill (14% of females in union and 9% of those not in union) and rhythm (3% of females and 4% of males).

As the most widely available and used method of contraception among adolescents, the male condom merits special attention from programme planners and educators. Male condoms are generally more accessible to adolescents than other modern methods because they are less expensive. Consistent and correct condom use offers effective protection against both pregnancy and STIs, including HIV.

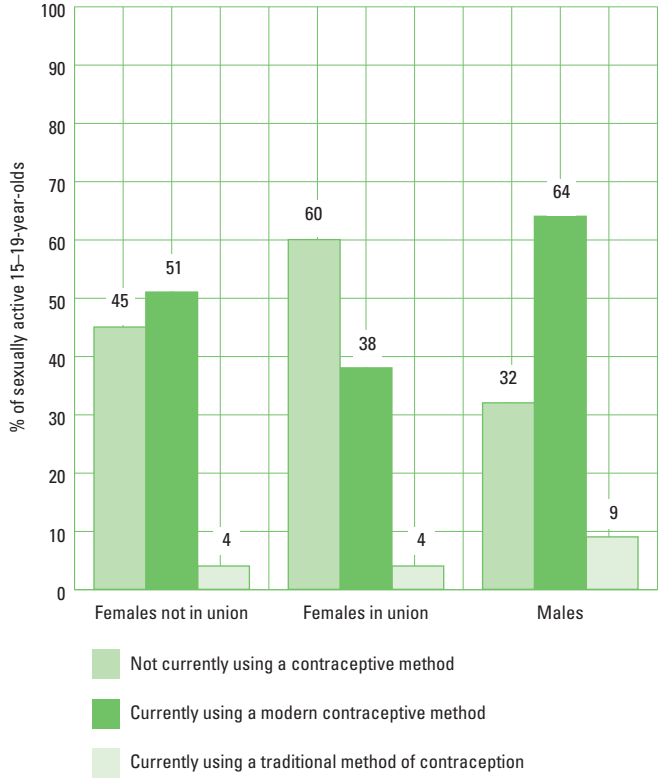
However, because condoms are a male-controlled method, young women face a clear disadvantage in negotiating their use. In focus group discussions, young women often said that safer sex is the responsibility of the female partner; similarly, many young men said that it is the female's responsibility to ask that a condom be used.[10(p.29)] Yet females reported that they had difficulty insisting on condom use—or refusing to have unprotected sex. Among males aged 12–19 who had had sex in the past year, just half had used a condom the last time they had had sex (Figure 2.3).[9] Condom use was somewhat higher among those who had had multiple partners in the past year: About two-thirds had used a condom at last sex.

Adolescents who discuss contraceptives with their partner tend to use them

Survey results show that when adolescents communicate with their partner about contraceptives, they are more likely to use them. This is especially true for female adolescents. Among adolescents aged 15–19 who had talked with their last sex partner about contraceptive methods, 61% of females and 59% of males used a method; among

FIGURE 2.2

Only two-thirds of sexually active male adolescents—and even fewer females—said they currently used modern contraceptives.



Note Totals may exceed 100 because some respondents were using both modern and traditional methods.
Source Reference 4 (Table 5.5).

those who had not talked about contraceptives with their partner, the proportions were 28% of females and 51% of males.[4(p.75)] These findings suggest that improving adolescents' communication skills, as part of a reproductive health programme, may help to promote contraceptive use and safeguard the health of young people. One young woman noted that her conversations with her partner played a role in her decision to practise contraception:

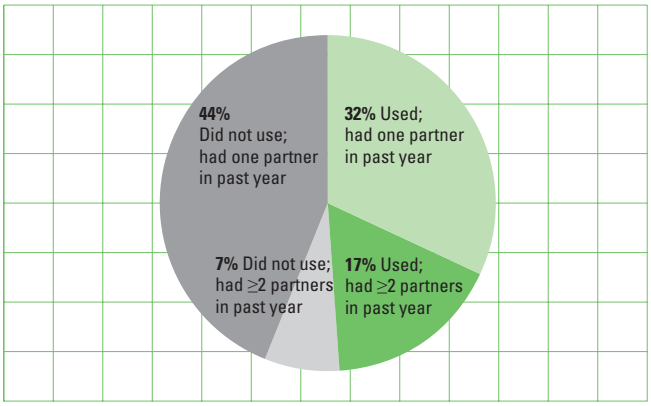
> *We usually talk about further education and marriage. . . . We agreed that we shall prevent pregnancy. I initiated this decision because I want to complete my schooling, and also I do not want to experience my father's wrath. Again, I [made] this decision because of diseases like AIDS and gonorrhoea. . . . Because of fear of pregnancy, during sex I encourage [my boyfriend] to use condom.*[11]
>
> *—Female, aged 18, urban, in school*

Most female adolescents want to delay childbirth, and many have unintended pregnancies

The majority of female adolescents, regardless of their marital status, express a desire to delay childbearing. This is important because the risks of pregnancy and childbirth are greater for young adolescents than for older adolescents and adults. Adolescents' physiologic immaturity—in some cases compounded by poor nutrition—puts them at elevated risk for complications during labour and delivery. In addition, the health outcomes of infants born to adolescents tend to be poorer than those of infants born to older mothers (e.g., they have lower birth weights and higher rates of mortality).[12]

FIGURE 2.3

Among young men aged 12–19 who had had sex in the past year, only half used a condom at last sex.



Source Reference 9.

Many adolescents not only wish to delay childbearing, but wish to delay it for a substantial period of time. In the 2004 National Survey of Adolescents, half of females aged 15–19 who were not in a union desired to wait at least five years before having a child, and almost one-third wanted to wait at least nine years.[4(p.82)] More than two-thirds of 15–19-year-old females who were pregnant at the time of the survey reported that they had not wanted the pregnancy at that time or had not wanted to become pregnant at all.[4(p.78)] And among 15–19-year-olds who already had a baby, only 24% had wanted to have a child at the time of their most recent pregnancy.

Despite these wishes, adolescent pregnancy is common. Overall, 42% of 15–19-year-olds who had ever had sex had been pregnant.[8] Among 15–19-year-old females in a union, the majority were mothers or mothers-to-be: At the time of the survey, 66% had given birth and 16% were pregnant.[4(p.81)] Only 2% of all females aged 15–19 had had a child before age 15; however, among those in a union, one in 10 had given birth before age 15.[4(p.78)]

Adolescent pregnancy varies by residence and economic status. Almost half (48%) of females aged 15–19 who had ever had sex and lived in rural areas had been pregnant,

compared with one-third (35%) of those in urban areas.[8] Among females aged 15–19 who had ever had sex and whose household wealth fell in the highest quintile, only 15% had ever been pregnant, compared with 47% of those in the three middle quintiles and 49% of those in the lowest quintile.

The risks associated with pregnancy may be especially great for adolescents whose pregnancies are unplanned, because they may be less able or less motivated than those with planned pregnancies to get needed prenatal care. This is particularly true for unmarried adolescents, for whom an unintended pregnancy may also lead to withdrawal of social support.[4(p.77)] Furthermore, in response to unintended pregnancy, some adolescents have abortions, including unsafe abortions.[4(p.79)] Abortion is permitted when a woman's life or her physical or mental health is threatened, when the pregnancy is the result of rape or incest, or when the fetus may have a serious abnormality or disease.[13] A 2003 study on the sexual experiences of adolescents in three Ghanaian towns found that 70% of young women who had experienced a pregnancy had attempted to have an abortion.[14(p.6)] Although fewer than 1% of female respondents in the 2004 National Survey of Adolescents reported ever having had an abortion, almost a third (29%) of those aged 15–19 and about one in nine (12%) of those aged 12–14 said that a close friend had tried to end a pregnancy.[4(p.83)]

In response to findings from the 1998 Ghana Demographic and Health Survey indicating that the incidence of early pregnancy loss (primarily due to induced abortion) was twice as high among females aged 15–19 as among those in other age-groups, and twice as high among urban teenagers as among their rural counterparts, an in-depth study of 29 adolescent females in Accra was conducted in 2002.[15(p.2)] The authors noted that female adolescents may be more likely than older women to experience complications from abortion, for reasons that include the tendency to delay getting an abortion (late procedures are riskier than earlier ones) and having less access to surgical abortions because of high fees and other barriers. Most adolescents in the study reported seeking an abortion at a hospital or clinic; some, however, had tried to terminate the pregnancy using home remedies or herbs before obtaining a clinical abortion.[15(p.10)] One health worker noted:

> *Right now, everybody's focus is on HIV/AIDS, [and they are] forgetting about how fatal . . . abortion and STIs can be. A lot of young women are dying from abortion and suffering from serious complications; thus, all these should be addressed.*[16]
>
> —*Female health care worker, aged 58, urban*

In the 2004 National Survey of Adolescents, surgical abortion was the most well-known method of pregnancy termination among adolescents aged 12–19; it was cited by 33% of females and 30% of males. However, many respondents mentioned various unsafe or ineffective methods (including herbal drinks, sharp objects and a mixture of sugar with either Guinness beer or a malt drink), and about half did not know any method of terminating a pregnancy.[4(p.83)]

Fear of pregnancy, not of STIs, motivates many youth to avoid sex or use contraceptives

Regardless of their age and sex, survey respondents who had never had sex were more likely to cite fear of pregnancy than fear of contracting STIs/HIV as the paramount reason for avoiding sex. Forty-two percent of females and 32% of males who had never had sex listed fear of pregnancy as the main reason they had abstained, whereas 18% of females and 30% of males cited avoiding STIs/HIV. Fear of pregnancy was also the primary motivator among adolescents who were sexually experienced but had not had sex in the past year.[4(p.56–57)]

Similarly, fear of pregnancy, more than fear of HIV and other STIs, had motivated adolescents to practise contraception. Females, in particular, were more likely to say that they used condoms to protect against pregnancy than to protect against HIV and other STIs. Among adolescents aged 15–19 who had had sex in the prior year and who used condoms, 71% of females and 45% of males reported that they used condoms to protect against pregnancy, whereas only 5% of females and 38% of males said they used condoms to protect against STIs/HIV.[4(p.76)] Consistent with these findings is a recent study that concluded that efforts to promote condom use among females may be more effective if the emphasis is on pregnancy prevention than if it is on prevention of STIs, because young women might find it easier to negotiate condom use with their partner if the purpose is to protect against pregnancy rather than against HIV.[17]

Education is associated with better sexual and reproductive health outcomes

Throughout the world, education is associated with positive sexual and reproductive health outcomes (later first sex, later first birth and more contraceptive use), especially for females. In Sub-Saharan Africa, education is associated with higher levels of contraceptive use among sexually active females aged 15–19,[12(p.209)] and female adolescents with higher levels of education are less likely than their less educated peers to have sex at an early age, to marry at an early age or to have a child at early age (the last is true for males as well).[18]

Similarly, among respondents in the 2004 National Survey of Adolescents who had ever had sex, those with higher levels of education were more likely than their peers with less schooling to have used contraceptives (Figure 2.4).[19] For example, among females aged 15–19, fewer than half (45%) of those with 1–6 years of schooling reported having ever used a contraceptive method, compared with 72% of those with seven or more years of schooling. Thirty-three percent of females aged 15–19 with 1–6 years of schooling

had ever used a male condom, whereas 56% of those with seven or more years of schooling had done so. The findings were similar among males.

Adolescents say that education is key to their future success

In in-depth interviews, adolescents recognised that formal education offers the key to a better life. They felt that through formal education they could achieve higher status in society and get better jobs. As one young man pointed out:

> *I do not have any other objective in mind other than to continue with my education. . . . I want to be like the United Nations Secretary General.*[11]
>
> *—Male, aged 19, urban, in school*

Similarly, a young woman noted that:

> *I want to be at a teacher-training college. . . . If I become pregnant or infected with HIV, [I would not be able to do this]. . . . I hold education dear in my life.*[11]
>
> *—Female, aged 13, rural, in school*

Adolescents also acknowledge that pregnancy and STIs can prevent them from achieving their goals. The challenge is ensuring that adolescents stay in school longer. Although more than 90% of adolescents interviewed in the 2004 National Survey of Adolescents had ever attended school, only 61% of 15–19-year-old females and 58% of 15–19-year-old males had had at least seven years of schooling.[4(p.32)]

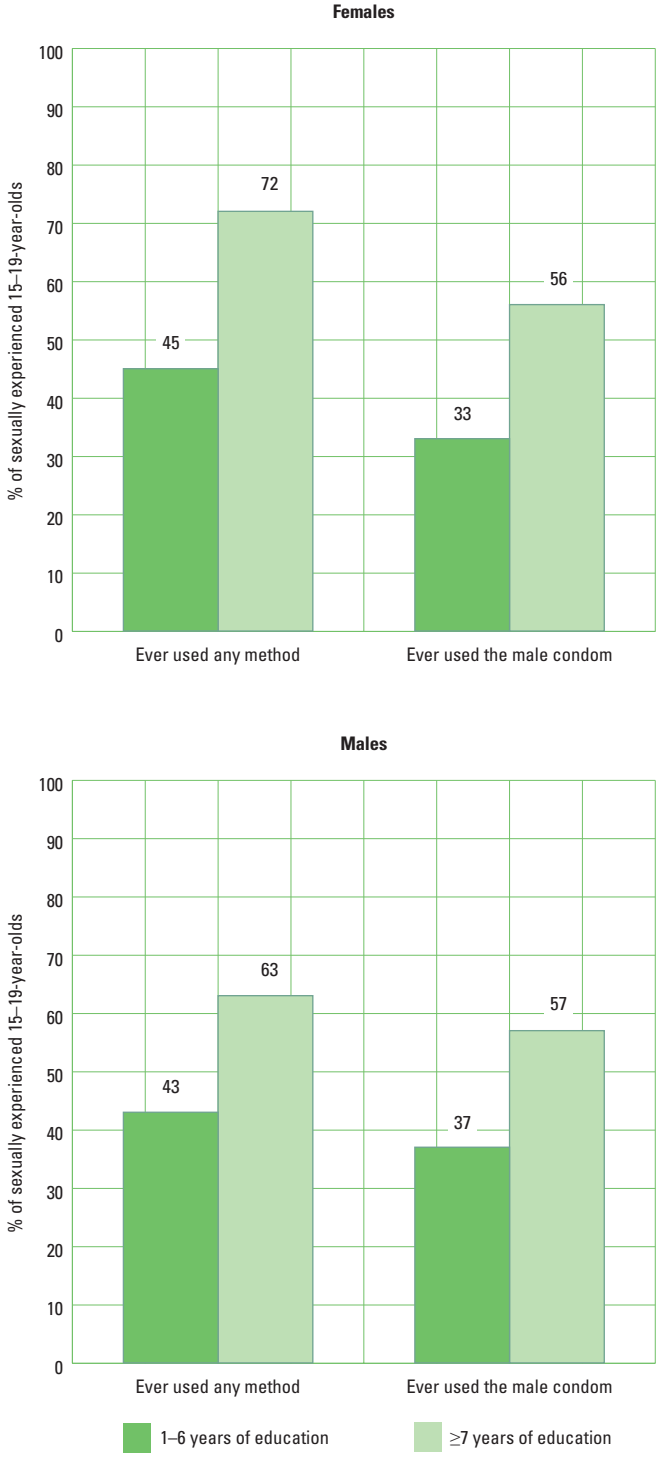
Among adolescents who were not in school, more than a third (35% of females and 41% of males) said they had left school because they had completed an expected level of education, and about one in four (25% of females and 22% of males) because they could not pay the ancillary costs associated with schooling.[4(p.33)] Urban adolescents were more likely than their rural counterparts to have left school because they reached a terminal point, whereas rural youth were more likely than urban adolescents to have left because they were not interested in continuing.[4(p.25)]

General recommendations: What can we do?

Encouraging adolescents to delay initiating sex until a later age and to use effective contraceptives when they do have sex will help adolescents protect themselves against pregnancy and STIs. In addition, efforts to improve adolescent health should emphasise positive influences on adolescent sexual behaviour, such as formal education and positive communication between partners, while at the same time confronting issues such as unwanted sex, unintended pregnancy and abortion. Helping adolescents acquire and use communication and negotiation skills can empower them to manage their sexual behaviour and protect their health by enabling them to refuse unwanted sexual advances and to negotiate contraceptive use within relationships.

FIGURE 2.4

Among 15–19-year-olds who had ever had sex, those with seven or more years of education had higher levels of contraceptive use than those with less schooling.



Source Reference 19.

Chapter 3

Adolescents' Knowledge Is Broad but Not Deep

After more than two decades of mass media education and school-based programmes on sexual and reproductive health, one might expect young people to be well informed about issues such as sexuality, pregnancy and STIs. But the depth of adolescents' knowledge about sexual and reproductive health is often inadequate.

Adolescents fear pregnancy, but many do not know how it occurs or how to avoid it

Given that fear of pregnancy is one of adolescents' top reproductive health concerns,[4(p.41)] it is reassuring that most young people are aware of contraceptive methods. For instance, in the 2004 National Survey of Adolescents, more than 90% of respondents reported that they had heard of at least one modern contraceptive method.[4(p.70)] The best-known modern methods were the male condom (familiar to 88% of females and 91% of males), the female condom (70% of females and 73% of males), the injectable (57% of females and 56% of males) and the pill (53% of both females and males).[4(p.70)] The high level of knowledge about the female condom is partly due to nationwide promotional campaigns.[4(p.67)] About one in five adolescents were aware of emergency contraception, a highly effective method that is used after intercourse.[4(p.88)] (For findings about the sexual and reproductive health knowledge of very young adolescents, see box on page 16.)

However, adolescents' familiarity with contraceptives is not matched by depth of knowledge on such matters as how pregnancy occurs. Knowledge about sexual and reproductive health was assessed in the survey using a composite measure based on respondents' awareness of a woman's fertile period, ability to reject several popular misconceptions about pregnancy (e.g., knowing that a female can get pregnant as a result of her first sexual experience) and familiarity with at least one modern method of contraception. Among adolescents aged 15–19, only 28% of females and 21% of males had this detailed knowledge about pregnancy prevention.[20,21] Among 12–14-year-olds, only 12% of females and 6% of males had this level of knowledge.

Adolescents were also asked to indicate their confidence in their ability to use the male condom, which is the most commonly used method of protection in this age-group. In general, adolescents expressed little confidence that they could properly use a condom. Among 15–19-year-olds, only 29% of males said that they were "very confident" that they knew how to use a condom correctly, and just 31% of females said they were very confident that they could get a male partner to use a condom.[4(p.100)] Almost half of 15–19-year-olds (46% of males and 48% of females) admitted that they were "not at all" confident about using a male condom.

Other findings underscore the fact that adolescents have received little instruction in using condoms and often have misconceptions about them. Among 15–19-year-olds, just 48% of females and 57% of males who knew of the male condom said they had ever seen a formal condom demonstration, and 31% of both males and females did not know that condoms should be used only once.[4(p.99)] Twenty-nine percent of females and 39% of males in this age-group believed that using a condom was a sign that one did not trust one's partner.[4(p.100)]

Near universal HIV/AIDS awareness does not translate into comprehensive knowledge

As they do with contraceptives, adolescents express almost universal awareness of HIV/AIDS (a finding echoed in other national survey data).[3] Yet, once again,

they frequently have misconceptions, in this case about HIV transmission and prevention. Among survey respondents aged 12–19 who were aware of HIV/AIDS, more than 90% of both males and females knew that HIV can be transmitted by having sex with an infected person, sharing razors or other sharp objects, getting an injection with a needle used by someone else or receiving a blood transfusion.[4(p.88)] Two-thirds of females aged 12–19 (67%) and almost three in four males (73%) knew the three main ways to avoid a sexually transmitted HIV infection—abstain, be faithful and use a condom.[20,21] Yet sizable minorities of adolescents continued to hold misconceptions, according to a composite measure of HIV prevention knowledge recommended by the World Health Organization (WHO).[22] Only about one-third of adolescents aged 15–19 and fewer than one-fourth of those aged 12–14 could both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV.[20,21]

Furthermore, in the focus group discussions, adolescents said that they predominantly used physical symptoms to identify a person with HIV and to make determinations about whether they needed to use a condom to protect against HIV.[10(p.24)] Adolescents who rely on this strategy—in other words, those who believe that a healthy-looking person cannot be infected with HIV—may unknowingly expose themselves to risk of infection.

Lack of knowledge about other STIs may influence decisions about condom use

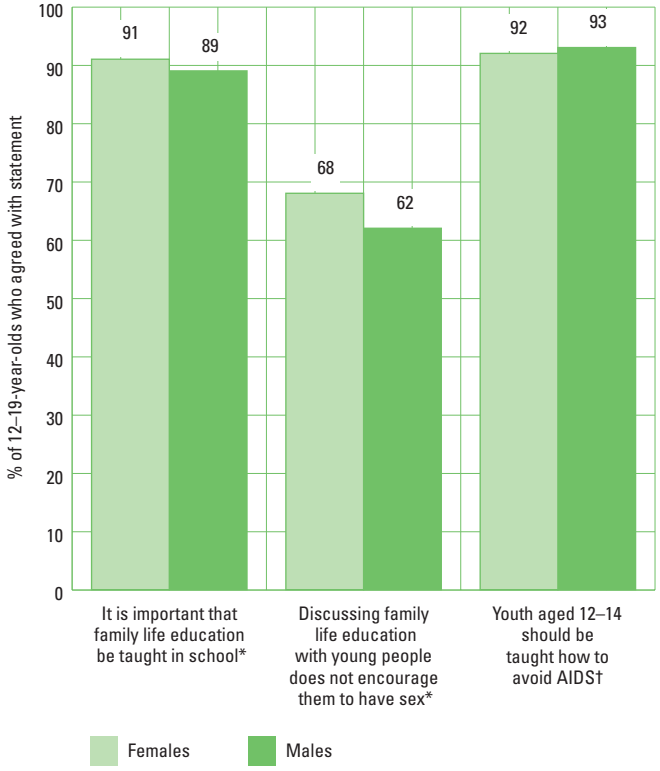
Left untreated, STIs other than HIV can have significant negative consequences, including infertility and increased susceptibility to HIV. However, many adolescents do not have as much knowledge of other STIs as they do of HIV/AIDS. Among 15–19-year-old survey respondents, only 49% of females and 56% of males had heard of at least one STI other than HIV/AIDS.[20,21] Discussions with adolescents revealed that, as with HIV, physical manifestations influenced their perceptions of who has another type of STI and their decisions about whether to use a condom.[10(p.24)] This raises concerns because many cases of STIs are asymptomatic.

Adolescents express a strong desire for sex education in schools

School-based sexual and reproductive health education is an effective way to reach a large number of adolescents in Ghana because more than 90% of adolescents attend school.[4(p.32)] In a review of prevention interventions for young people in developing countries, WHO concluded that there was strong evidence to recommend the large-scale implementation of effective, curriculum-based interventions led by adults.[23] Another review, involving 83 studies, analysed sex education curricula used in schools, clinics and community settings, and found no increase in sexual activity among adolescents who attended the programmes.[24(pp.5–6)]

FIGURE 3.1

Young people aged 12–19 overwhelmingly supported family life education.



*Among those who had ever attended school.
†Among those who had heard of AIDS.
Source Reference 4 (Table 9.3).

Family life education was introduced in Ghana on a pilot basis during the 1970s and implemented nationwide in 1987 at the basic and secondary school levels as part of the new education system's social studies curriculum.[4(p.110)] The programme was given a policy backing in the revised National Population Policy of 1994.[4(p.110),13] The objective of the family life education programme was to use the formal education system to teach various aspects of family life and, by doing so, to positively influence the sexual and reproductive health behaviour of adolescents.

Evidence indicates that adolescents want sexual and reproductive education to be available in school. In the 2004 National Survey of Adolescents, 91% of females and 89% of males aged 12–19 who had ever attended school agreed that it is important for family life education to be taught in schools (Figure 3.1).[4] About two-thirds of adolescents thought that family life education does not encourage adolescents to have sex. Furthermore, 92% of females and 93% of males who knew of AIDS said that youth aged 12–14 should be taught how to avoid AIDS.

The survey results point to a gap between national sex education policies and their implementation. Although family life education is supposed to be available to all

The Youngest Adolescents Are Prime Targets for Prevention Efforts

Although a nationally representative survey conducted in 1998 included adolescents as young as 12,[1] most studies of adolescent sexual and reproductive health in Ghana have focused on older adolescents. To fill the gap in knowledge about very young adolescents (those aged 12–14), the 2004 Natioinal Survey of Adolescents specifically targeted this age-group. Because the prevalence of sexual activity among adolescents increases rapidly after age 14,[2(p.65)] especially among females, it is vital that policies and programmes address the needs of young adolescents. Educating them before they have sex can equip them to make informed decisions about their sexual behaviour once they become sexually active.

According to the National Survey of Adolescents, fewer than half of 12–14-year-olds (42% of females and 49% of males) lived with both biological parents; 68% of females and 73% of males were sons or daughters of the household head; and 15–16% of both females and males were grandchildren of the household head.[2(p.30)] Almost nine in 10 of all 12–14-year-olds were in school.[2(p.32)]

As with their older counterparts, the young adolescents were asked about their knowledge of sexual and reproductive issues. The results indicate that although very few adolescents aged 12–14 had ever had sex, they were keenly aware of sexual activity. For instance, 77% of females and 72% of males had heard of kissing, and 83% of females and 82% of males had heard about sexual intercourse.[2(p.55)] Fewer than 2% of 12–14-year-olds had ever had sexual intercourse, but one in five reported having at least one close friend who had done so (Table 3.1).[1,3–5] In addition, 6% of females and 3% of males said they had been coerced into having sex.*

Although most of these youngest adolescents had some knowledge about sexual activities, they lacked essential information about how pregnancy occurs and how to avoid unintended pregnancy and STIs. Only 12% of 12–14-year-old females and 6% of males knew at least one method of contraception and could reject several major misconceptions about avoiding pregnancy.[4,5]

Although 94% of both females and males aged 12–14 had heard of HIV/AIDS, only 26% of females and 28% of males could name at least one STI other than HIV (Table 3.1).[2(p.88)] Moreover, fewer than one in four adolescents in this age-group (21% of females and 23% of males) could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV.[1,3,4] Young adolescents did, however, express a desire for information about how to protect themselves. Ninety-one percent of females and 93% of males who had heard of AIDS thought that adolescents should be taught how to avoid HIV/AIDS.[2(p.118)] Importantly, 88% of females and 85% of males who had ever attended school thought that it was important for sex education to be taught in schools.

In-depth interviews revealed that some young adolescents wanted general information about pregnancy-related issues, whereas others wanted specific information—for example, how to use contraceptive methods, avoid unwanted sex or say no to sexual intercourse before marriage.

Because the vast majority of adolescents aged 12–14 attend school, school-based family life education offers enormous potential for improving young people's knowledge of sexual and reproductive health issues. However, only 41% of females and 28% of males reported having had family life education in school.[3,4] These figures may be low because respondents were still relatively young; nonetheless, the fact that more than 98% of these young adolescents had not yet had sex underscores the importance of reaching them with family life education. To ensure that policies do not miss an important opportunity to promote healthy choices, they should include very young adolescents in sexual and reproductive health education programmes and activities.

*The reason that the proportion of respondents who said they had been coerced into having sex was greater than the proportion who had ever had sex most likely is that adolescents who had been sexually abused did not consider those experiences as sex per se.

TABLE 3.1

Percentage of adolescents aged 12–14 who had had sex, and percentage with knowledge of HIV and other STIs, by gender

Measure	Female	Male
SEXUAL ACTIVITY		
Ever had sex	1.7	1.3
Ever coerced into having sex*	6.2	2.5
Had a close friend who had had sex†	21.3	20.1
KNEW AN STI OTHER THAN HIV	25.5	27.5
KNEW WAYS TO PREVENT HIV TRANSMISSION		
Abstain from sex	81.8	84.0
Have sex only with one uninfected, monogamous partner	77.6	80.1
Use a condom correctly at every sexual intercourse	67.8	74.4
KNEW ABC METHOD OF AVOIDING HIV‡	60.2	67.3
HAD ADEQUATE KNOWLEDGE OF HIV TRANSMISSION§	20.9	23.4

*Respondents were asked about coercive sex only if no one aged three or older was present or within hearing range. Only one eligible adolescent per household was questioned about coercive sex.
†Among unmarried respondents only.
‡ABC=Abstain, be faithful and use condoms.
§Knew that the risk of HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a person cannot get HIV from sharing food with an infected person.
Sources References 1 (Tables 4.2, 4.11, 7.1 and 7.2), 3–5.

students, only 58% of females aged 15–19 and 46% of males in that age-group reported that they had received family life education in school (Figure 3.2).[4] In addition, teacher training for the programme has not progressed as expected. For example, according to national data collected by the Ministry of Education and Sports, in 2002–2003, only 3% of teachers were trained in HIV/AIDS education based on a life-skills approach (a component of family life education), and just 26% of schools were providing such education.[25(p.8)]

The timing of sex education is important if such education is to be effective—ideally, adolescents should have information before they experience puberty or initiate sex—and here the data are more encouraging. In the 2004 National Survey of Adolescents, nine in 10 adolescents aged 15–19 who had attended family life education talks or classes had done so before they had had sex.[4(p.110)]

General recommendations: What can we do?

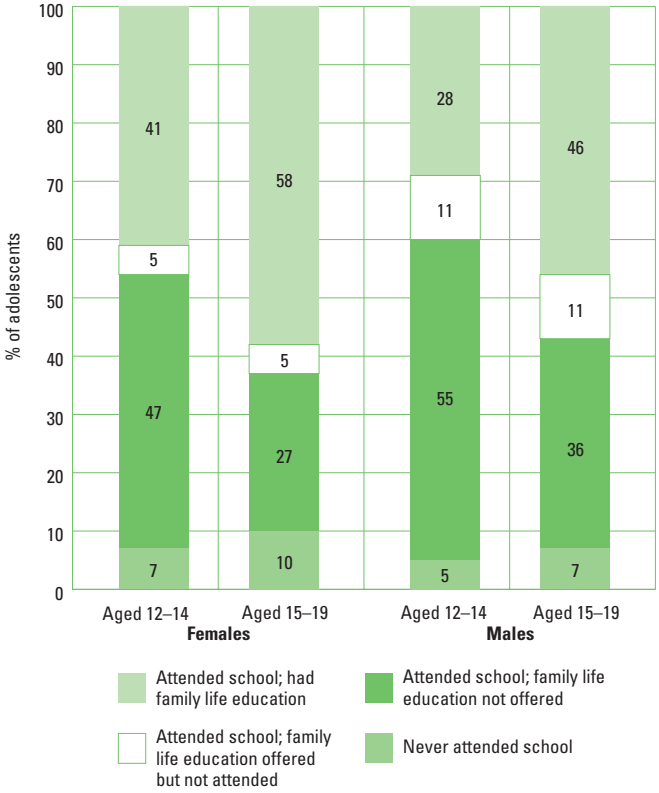
Comprehensive and accurate information about sexual and reproductive health issues can increase adolescents' knowledge and counter their misconceptions—and in doing so, can help adolescents safeguard and improve their health. Although knowledge does not guarantee that adolescents will change their sexual behaviour, it can empower them to make informed decisions about their reproductive health and may increase the odds that they will choose to protect themselves from unintended pregnancy and from HIV and other STIs when they become sexually active. Evidence shows that it is possible to use school-based interventions to improve adolescents' sexual and reproductive health behaviours.[26]

HIV/AIDS programmes should be integrated with all sexual and reproductive health care programmes. The national spotlight on HIV/AIDS is understandable, given the devastation caused by the epidemic. However, the same behaviours that lead to HIV infection contribute to unintended pregnancy and infection with other STIs. Adolescents should have adequate knowledge about these reproductive issues as well. Fear of pregnancy appears to be more of a factor than HIV in motivating adolescents to avoid sex or to practise safer sex, suggesting that prevention efforts that emphasise protection against pregnancy in addition to HIV might serve the needs of adolescents better than programmes aimed at HIV prevention alone.

If possible, interventions should expand access to comprehensive sexual and reproductive health information, including material on puberty, pregnancy, contraception, abstinence, delaying sexual debut and the range of STIs. In addition, programmes should encourage the use of modern contraceptives among youth who have initiated sex and should teach them the communication and negotiation skills that can help them avoid unsafe or unwanted sex.

FIGURE 3.2

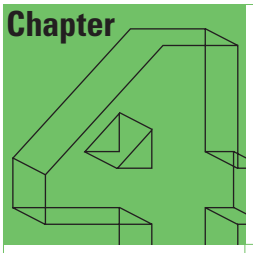
Many adolescents had never had school-based family life education.



Source Reference 4 (Chart 9.1).

Because more than 90% of adolescents attend school, providing youth with comprehensive, school-based sexual and reproductive health education from trained teachers could greatly improve their knowledge about these issues—and provide an opportunity to reach adolescents with sexual and reproductive health information before they have sex. However, it is important to ensure that adolescents who are not in school also have access to comprehensive sexual and reproductive health education.

Chapter



Adolescents Have Diverse Sexual and Reproductive Health Care Needs

Adolescents' sexual and reproductive health care needs vary widely and are influenced by such factors as gender, age and place of residence. Understanding and responding to the diverse needs of young people are essential to the development and successful implementation of programmes to improve reproductive health.

Female adolescents are exposed to greater reproductive health risks than male adolescents

The potential negative consequences of unprotected sex are greater for female adolescents than for male adolescents. This is because women are physiologically more vulnerable than men to HIV infection, as a greater area of a woman's mucous membranes is exposed during sex.[27] As a result, compared with men, women have higher rates of STIs other than HIV, which in turn increases their risk of HIV infection itself. Early sexual debut can further increase a young woman's health risks, because an adolescent's vaginal mucosa are not yet fully mature. A recent analysis of HIV prevalence in Ghana found that having had sex at a young age was strongly associated with HIV-positive serostatus among females. For example, women who had had sex by age 15 were 2.4 times as likely to be HIV-positive as were women whose sexual debut occurred at a later age.[28(p.6)] Similarly, pregnancy and childbirth are more dangerous for very young adolescents than for adults because of their physiological immaturity.[12(p.509)]

It should also be noted that females (especially those who are unmarried) bear much of the social consequences of unintended pregnancy. Seven percent of female adolescents aged 15–19 who dropped out of school did so because of pregnancy.[4(p.33)] If a young woman is unable to continue her education after delivery, the experience limits her future economic opportunities. As one parent pointed out:

If a girl becomes pregnant, the burden of the pregnancy falls on the girl alone. The boy can continue with his education, but the girl will have to stop schooling in order to take care of her child.[16]

—Female parent, aged 45, rural

Early marriage can increase the risk for poor reproductive health outcomes

Another group with distinct reproductive health challenges is adolescents who marry at an early age. In Ghana, marriage generally marks a transition into adulthood and family formation. Although the cultural traditions that once encouraged early marriage have changed—indeed, couples are now legally required to be at least 18 years old to get married—early marriage persists. Recent data indicate that 28% of women aged 20–24 had married before age 18, and 47% had married before age 20.[3] Often these young wives are married to men who are significantly older than they are. In the 2004 National Survey of Adolescents, females aged 15–19 who were in a union were about three times as likely as those not in a union to have a sexual partner who was 10 or more years their senior (20% vs. 7%).[4(p.62)] The fact that young women in unions tend to have older partners elevates their risk, because the age difference hinders their ability to negotiate for safer sex.[29(p.2)]

Although marriage is often thought to protect a young woman's sexual and reproductive health, in some cases it can increase her risk (relative to that of unmarried, sexually active peers). This is because female adolescents in unions have sex more often[30(p.22)] and are far less likely to use contraceptives than their unmarried counterparts.[4(p.74)] In the 2004 National Survey of Adolescents, only 16% of female adolescents in unions reported that they and their partners were currently using the male condom, compared with 40% of female adolescents not in unions.[4(p.68)]

The expectation that women will bear children soon after marrying may partially explain this difference; however, given that many married women express a desire to delay childbearing, it is possible that a large age gap between partners may make some young women feel less able to negotiate the use of protection (or the timing of sex and pregnancies).[4(p.50)]

In addition, unprotected sex with a partner who has had multiple sexual partners can increase a young woman's risk for STIs. According to data from the 2003 Ghana Demographic and Health Survey, 16% of married or cohabiting men had had sex with a person other than their spouse within the past year.[3(p.225)] This may partly explain why married and formerly married women had the highest rates of HIV infection in Ghana.[28(p.12)] Thus, early marriage and large age differences between partners may be important factors in the sexual and reproductive health of married female adolescents.

Comments from in-depth interviews underscore the risks that young married women face:

> *The married woman cannot suggest to the husband to use [a] condom, even if she is fully aware that her husband has other sexual partners.*[16]
>
> *—Female health care provider, aged 52, rural*

> *In my opinion, when the married man decides to be promiscuous, the woman suffers, because she ends up with all kinds of infections. This is due to the fact that sex in marriage is usually unprotected for childbearing reasons; therefore, the woman bears the brunt of the man's promiscuity.*[16]
>
> *—Female health care worker, aged 49, urban*

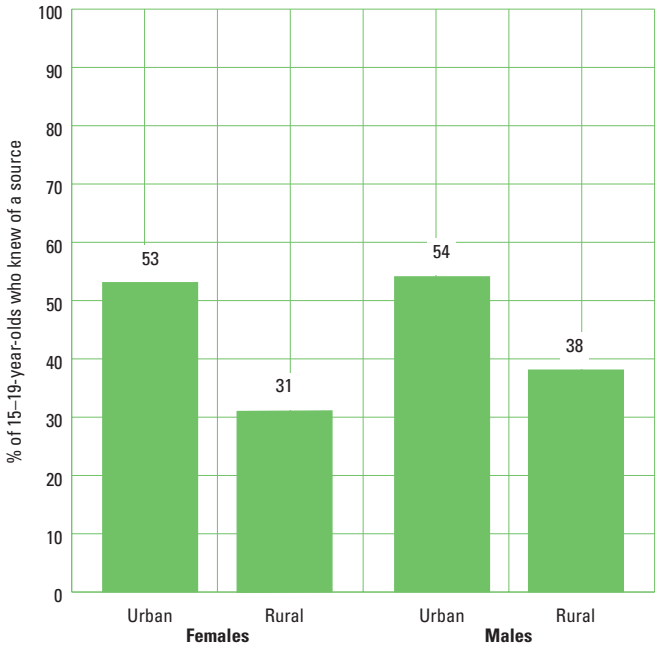
Rural adolescents are less knowledgeable than their urban peers about reproductive health

The sexual and reproductive health needs of adolescents who live in rural areas differ from those of urban adolescents. Whether in or out of school, young people in rural areas have more limited access to information and services than those in urban areas; as a result, rural youth face greater challenges in meeting their reproductive health needs. Because more than half of adolescents live in rural areas,[4(p.7)] addressing their needs is critical to the success of national efforts to improve sexual and reproductive health information and services for adolescents.

Data from the 2004 National Survey of Adolescents on sexual and reproductive health knowledge reveal the need for programmes targeted to rural youth. Among 15–19-year-olds in rural areas, only 21% of females and 14% of males had critical knowledge about pregnancy, as measured by their awareness of a woman's fertile period and their ability to reject popular misconceptions about pregnancy, compared with 35% of females and 28% of males in urban areas.[20,21] Similarly, the proportion who could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV was far lower in rural than in urban areas, among both females (21% vs. 43%) and males (27% vs. 48%).[20,21]

FIGURE 4.1

Adolescents in urban areas were more aware of sources for contraceptives than were their peers in rural areas.



Sources References 20, 21.

In addition, knowledge of how to access reproductive health care services was consistently lower among adolescents in rural areas than among their urban counterparts. Knowledge about where to obtain contraceptive services was especially lacking for adolescent females in rural areas. For instance, among females aged 15–19, 53% of those living in urban areas but only 31% those living in rural areas knew of at least one source for contraceptives (Figure 4.1).[20,21] Among males aged 15–19, 54% of those in urban areas and 38% of their rural counterparts knew of at least one source.

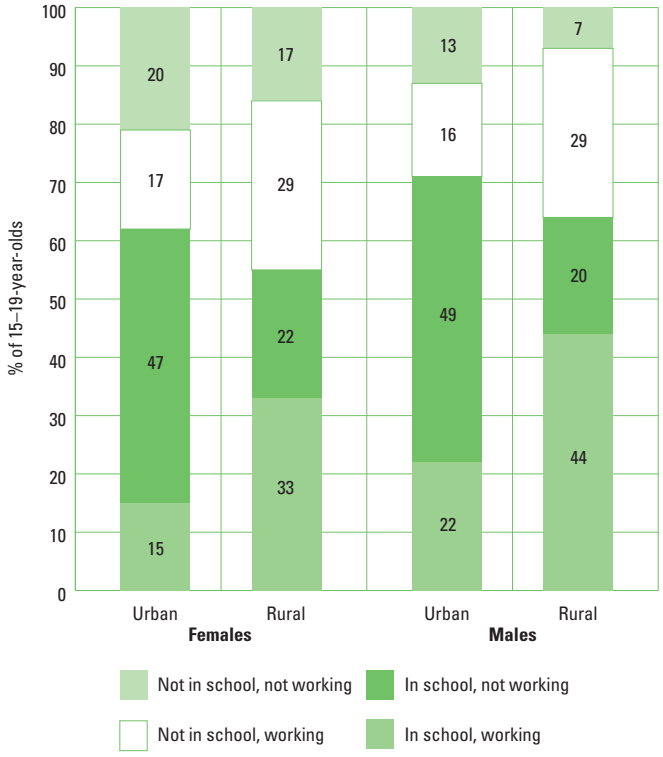
The challenge of reaching out-of-school youth

The most convenient and efficient way to educate large numbers of adolescents about sexual and reproductive health issues is through school-based programmes. However, some adolescents do not attend school at all; perhaps more importantly, many of those who attend school leave before they reach the grades in which family life education is taught. In the 2004 National Survey of Adolescents, among respondents aged 15–19, those in rural areas were more likely than their urban peers to be out of school (Figure 4.2, page 20),[19] whether they were female (46% vs. 37%) or male (36% vs. 29%).

Not only is it harder to reach youth when they are not attending school, but the lifestyle of many out-of-school

FIGURE 4.2

Rural adolescents aged 15–19 were less likely than urban adolescents to be attending school.



Source Reference 19.

adolescents puts them at risk for STIs and unwanted pregnancy. Studies of youth who live on the street in urban areas (street youth) offer extreme but illustrative examples of the sexual and reproductive health challenges that out-of-school adolescents face. A small study of street youth in Accra found that 95% of females and 78% of males had had sex[31(p.141)] and that most knew that STIs were sexually transmitted.[31(p.147)] However, misconceptions and misinformation about transmission are common. For instance, in one study, 51% of females and 31% of males attributed the transmission of STIs to witchcraft.[32] Another study of street youth in Accra found that 93% of those interviewed had heard of AIDS and were aware that AIDS cannot be cured, but one-quarter could not name any mode of transmission.[33] In the same study, 83% of youth knew about condoms, but only 28% had ever used one.[33(p. 300)] Other research has documented that some street youth engage in unprotected sex with multiple partners as a way to survive.[31]

For some out-of-school adolescents, such as those in urban areas, the physical presence of service providers does not necessarily translate into accessibility. For instance, the facility's hours of operation may not be convenient for them (e.g., out-of-school youth may need to be at work during clinic hours), or they may not be able to afford the cost of services. The challenges are ensuring that youth know how and where to obtain information and services, that these services are affordable and available at convenient times, and that young people are motivated to use the services.

General recommendations: What can we do?

In revealing the diverse sexual and reproductive health care needs of adolescents, recent research suggests the importance of utilizing a combination of strategies to target interventions to the specific needs of particular groups of adolescents (e.g., males or females, married or unmarried, rural or urban, in-school or out-of-school). In a systematic review published by the World Health Organization, researchers examined studies on programmes to prevent HIV/AIDS in young people in developing countries, and concluded that there was evidence to recommend widely implementing community-based interventions that target adolescents (including the groups outlined in this chapter) using existing structures and organizations.[23]

Expanding community-based sexual and reproductive health programmes not only increases young people's access to information and services but can build community support for addressing their sexual and reproductive health needs. Many promising models for community-based interventions have been implemented across Ghana, and these could offer a starting point for the development and implementation of new programmes. One useful model is the collaboration between the African Youth Alliance and 20 of the country's 138 municipal and district assemblies; as a result of this effort, the assemblies integrated adolescent sexual and reproductive health care into their district plans and have provided funding to implementing partners.[34]

Another project, run by the Planned Parenthood Association of Ghana (PPAG), works with stakeholders in targeted communities to help them obtain the skills necessary to offer sexual and reproductive health information and services for adolescents. The programme has trained teachers and health care providers and even built clinics in some communities. It has also promoted sexual and reproductive health activities and mobilised the community to support adolescent programmes. Another PPAG project, the Young and Wise Programme, is a comprehensive community-based programme that trains providers to educate youth on sexual and reproductive health care issues, provides clinical services to young people, trains peer educators and organises youth entertainment to build fellowship among adolescents.

Finally, expanding the use of peer educators and community-based education programmes for adolescents and adults can help address the challenge of reaching adolescents with limited access to sexual and reproductive health information and services. A 2003 study found that youth who talked with peers about reproductive health were more likely to adopt protective behaviour against STIs and pregnancy than those who did not talk with peers. Youth in rural areas were twice as likely as urban youth to have spoken with peers, suggesting that peer education programmes may be especially effective in rural areas.[35]

Chapter 5

Adolescents Get Information From a Variety of Sources

Adolescents in Ghana place a high value on receiving accurate information about sexual and reproductive health. They obtain their information from a variety of sources, including school-based sex education, parents, friends, community members, health care providers and the mass media. An understanding of the advantages and disadvantages of the various information sources that adolescents use and prefer can inform efforts to improve young people's knowledge of sexual and reproductive health issues.

Information from parents and friends is valued—but adolescents prefer other sources

Traditionally, many ethnic groups in Ghana organised elaborate puberty rites for young women. During the initiation rituals, females (and in some areas, males as well) were introduced to various aspects of sexual and reproductive health, such as personal hygiene, spousal duties and community norms. The responsibility for this education rested primarily with grandparents and community leaders; friends also played an important role in providing information and support. Parents generally did not take part in educating their children about sex and reproduction, although they provided general information and served as a support system at various stages in life. (This tradition, in which family and community members educate adolescents about sexual and reproductive matters, still exists in some rural areas.)

More recently, the 2004 National Survey of Adolescents revealed that parents and friends are a common source of information on sexual and reproductive health issues for adolescents, but they are not among the most preferred sources. Survey respondents viewed parents as good sources of information, but also as being unable to address their needs in a nonjudgemental manner.[10(p.34)] Females were about twice as likely as males to have talked about sex with their mothers; for both females and males, conversations with fathers were less frequent than conversations with mothers (Figure 5.1, page 22).[4] Friends were deemed a less reliable source of information than parents were, but adolescents said that friends were more approachable and tended to be nonjudgemental,[10(p.35)] as the following remarks indicate:

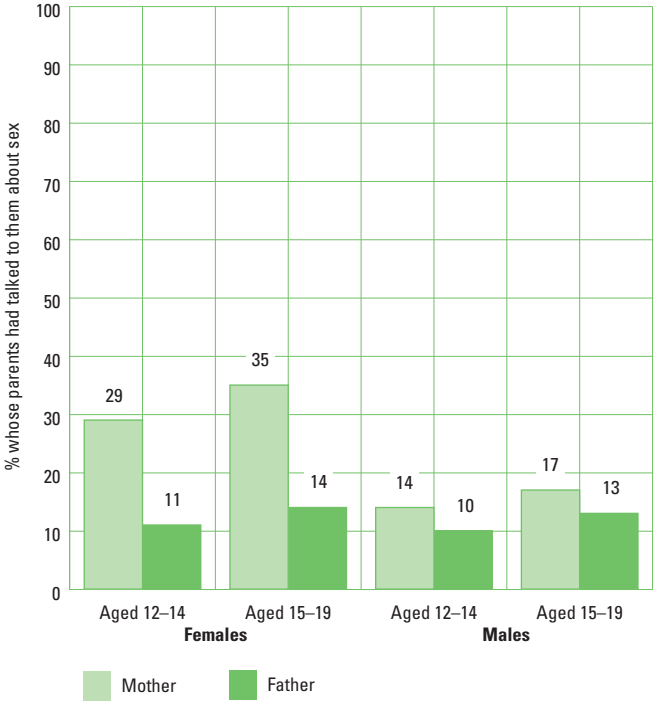
> *I think some people ask their peers [about sex] because when they ask their parents, [their parents] might think they want to indulge in such things. [Their parents] will think they are naughty, so they turn to their peers, who are not experienced in that field.*[10]
>
> *—Male, focus group for 14–16-year-olds, urban, in school*

> *Participant 1: In some homes, it is a taboo to mention anything connected with sex. In such homes, young people do not talk about their problems. They keep quiet at home and then talk to friends instead.*
>
> *Participant 2: We like [talking to] our friends, because we feel shy talking to our parents.*[11]
>
> *—Females, focus group for 14–16-year-olds, urban, in school*

Although communication between adolescents and parents about sex is limited, a recent study analysing parents' views of HIV/AIDS education in schools found that parents want to be more involved in educating their children about sexual and reproductive health issues. The researchers conducted focus group discussions with parents about a school-based HIV prevention programme called Strengthening HIV/AIDS Partnerships in Education 2 (SHAPE 2).[36] The programme trained peer educators to provide sexual and reproductive health information

FIGURE 5.1

Almost one-third of young women said their mothers had talked to them about sex, but few young men said either parent had talked to them.



Source Reference 4 (Table 3.11).

through clubs, talks, skits and other means; it also trained teachers in each school to provide support for the peer educators. Parents interviewed about the programme approved of peer education and were nearly unanimous in their support of HIV/AIDS education, as they feared that a lack of knowledge could endanger their children's future. Parents also requested more advice for themselves about counselling skills, apparently to improve their ability to discuss sensitive topics with their children.

Findings from a study that compared the impact of peer and adult communication suggest that peers can be an important influence on adolescent behaviour. The study found that youth who talked with parents, but not peers, about HIV were no more likely than those who did not talk to anybody to protect themselves against HIV infection (e.g., by not sharing razors). However, those who spoke with both peers and adults were twice as likely as those who talked with no one to report engaging in protective behaviours.[35]

Parents often help their children obtain treatment for sexual and reproductive health problems by accompanying them to a health facility, buying medicine or paying for treatment. When adolescents who had never had sexual and reproductive health problems were asked what they would do if faced with such a problem, most of them said that they would inform their parents—not just because the parents could pay for treatment, but also because parents would know what to do about the problem:

> *Maybe if [my mother] knows anything about it or how to cure it, she would do it for me. . . . She will help me cure it because she loves me.*[11]
>
> *—Female, aged 15, urban, out of school*

For the few adolescents who had actually sought treatment for reproductive health problems, money was a significant barrier; they notified their parents because they needed help paying for services. As one young man said:

> *The only problem here is money. If you have the money, you can go to the hospital without the knowledge of your house people.*[11]
>
> *—Male, aged 14, rural, in school*

Adolescents prefer receiving information from the media, teachers and health care workers

Where available, adolescents prefer to receive information about sexual and reproductive health from professional sources, such as the mass media, teachers and health care providers, because they feel that these are the most informed sources.[4(p.115)] Among adolescents aged 15–19, the media are the most preferred and most used source of information on sexual and reproductive health, followed by teachers and health care providers (Figure 5.2).[19]

From an educational standpoint, the use of the media to convey information to adolescents (and adults) has the advantage of reaching a large number of people simultaneously. However, adolescents noted that they have no opportunity to ask questions when receiving information from the media.[10] In addition, not everyone has access to certain types of media, and some people have no media access at all.

Radio topped the list of media most frequently used by adolescents aged 12–19. Forty percent of females and 43% of males reported that they listened to the radio almost every day, and another 34% of females and 37% of males said that they listened to the radio at least once a week.[4(p.116)]

Television is not as widely available as radio. Although 57% of females and 56% of males watched television at least once a week, about one in four adolescents (27% of females and 25% of males) did not watch television at all.[4(p.109)] The Internet barely ranked as a source of information for adolescents: About half of adolescents who had ever attended school had not heard of the Internet, and only 6% of females and 11% of males had ever used the Internet for any purpose. Adolescents do not commonly obtain information on sexual and reproductive health issues from newspapers: More than 60% of both females and males do not read newspapers at all.

Traditional leaders and religious organizations are a source of information for some adolescents

Although the traditional system of initiation rites is no longer widely practised, in a few areas community leaders have refined and reintroduced aspects of the traditional initiation rites. For instance, queenmothers* in the Ejisu Juaben District of Ashanti work with the staff of the Ghana Health Service to teach aspects of sexual and reproductive health (such as abstinence, contraception and STIs) to young girls undergoing initiation rites. In the Manya Krobo District of the Eastern Region, queenmothers have initiated programmes on HIV/AIDS for infected persons, provided support for AIDS orphans and worked with the district health team to educate girls about HIV/AIDS.[37–40] In both cases, the traditional rites of passage have been revised with the support of the health system.

Organised religion plays an important role in Ghanaian society, and some religious organizations are actively involved in health care delivery. For example, the Christian Health Association of Ghana (CHAG), a group of religious-based health institutions, provides 30% of the country's health care services and has worked with the African Youth Alliance (AYA) to help provide youth-friendly sexual and reproductive health services in 10 districts.[41(p.33)] Initially, CHAG indicated that it would not be able to partner with AYA, because the religious beliefs of some CHAG members clashed with AYA's emphasis on improving access to contraception. However, after careful negotiations and compromise, an agreement was reached, and CHAG adopted an adolescent sexual and reproductive health agenda. In areas where only religious organizations offer health services, the project has helped to provide youth-friendly professional and supervised services to adolescents. In addition, the project shows that religious organizations can offer sexual and reproductive health information and services to adolescents within the context of their religious beliefs.

General recommendations: What can we do?

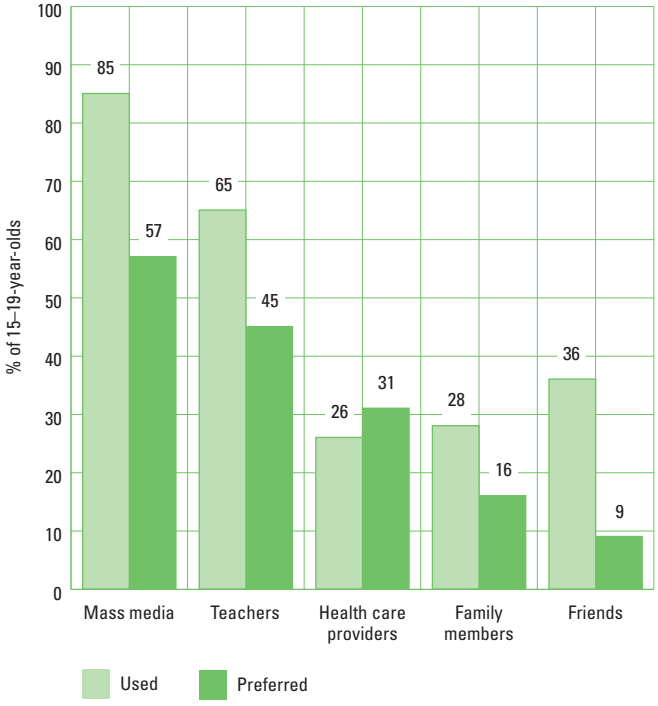
The fact that adolescents obtain sexual and reproductive health information from a variety of sources is a tremendous asset to efforts to improve adolescent health, because it increases the opportunities to reach greater numbers of adolescents. Maximizing the potential of existing sources of information, and thinking creatively about how to reach young people, can go a long way toward improving adolescents' access to information.

As the preferred and most widely used source of information for adolescents, the mass media should continue to be an integral part of efforts to address young people's sexual and reproductive health care needs. However, adolescents also value and trust information from teachers and health care workers, which underscores the importance of providing these professionals with the skills, facilities and support systems that will make it possible for them to offer the services that adolescents desire.

Some nongovernmental organizations have implemented successful sexual and reproductive health programmes for adolescents. One such programme, a collaboration between AYA and Planned Parenthood Association of Ghana, created advocacy networks composed of community stakeholders (parents, other family members, youth and religious groups, traditional leaders) who sought to build community support and commitment to increasing adolescents' access to information on sexual and reproductive health. In an evaluation of the project, the Ghana Health Service and some nongovernmental organizations acknowledged that the networks facilitated their own work.[34(p.22)] The approach used in this project, which can serve as a valuable model for delivering community-driven

FIGURE 5.2

The mass media and teachers were 15–19-year-olds' preferred and most used sources of information on sexual and reproductive health.



Source Reference 19.

*A queenmother is a traditional leader and is normally the mother, sister or maternal cousin of the chief.

sexual and reproductive health information and services, may be especially effective for helping difficult-to-reach groups of adolescents.

Although parent-child communication about sexual and reproductive health did not emerge as a major means of providing adolescents with the information they need, policies and programmes should continue to explore how to involve parents in efforts to meet the sexual and reproductive health care needs of adolescents. Because parents are a major influence on their lives, adolescents are likely to respond to sexual and reproductive health programmes for which they find support in their home and community. Although parents want what is best for their children, some of them feel that they do not have the skills or sufficient knowledge about sexual and reproductive health to communicate effectively about these issues with their children. Educating adults about sexual and reproductive health matters through advocacy networks or community-based education can equip them to become valuable resources for their children; in the process, these efforts may strengthen parental support for improving adolescent sexual and reproductive health.

The recent revival of initiation rites by some traditional leaders (with the support of health professionals and non-governmental organizations) serves as another model worth considering, especially in rural communities. Providing up-to-date information, materials and training to traditional leaders can help improve and expand these efforts. In turn, stakeholders should examine the traditional teachings to identify particular aspects that could be incorporated into interventions.

Given the central role of religion in the lives of adolescents in Ghana, there is a need to continue dialogue between the religious and public health communities in order to find common ground for helping adolescents access sexual and reproductive health information and services. Stakeholders should look for opportunities to build upon promising partnerships between religious groups and the public health community.

Chapter 6

The Public Health Care Sector Can Do More

As the backbone of national efforts to provide sexual and reproductive health care services, Ghana's public health sector can play a leading role in the effort to improve health care delivery to adolescents. As noted in Chapter 5, adolescents report that health care workers are one of their most preferred sources of information on sexual and reproductive health. The challenge is how to utilise the potential inherent in the public health care system to provide youth-friendly sexual and reproductive health care services.

Many adolescents prefer using clinics for reproductive health services

In the 2004 National Survey of Adolescents, among respondents aged 15–19 who knew of any source for obtaining contraceptives, 63% of females and 56% of males said they would prefer getting contraceptives from a public clinic or hospital, rather than from private facilities, pharmacies, schools or other sources.[4(p.121)] The preference for government clinics and hospitals was even stronger with regard to treatment for STIs: Among those who knew of any source for obtaining treatment for STIs, 87% of females and 91% of males said they would prefer to obtain care from public clinics or hospitals.[4(p.129)]

However, the data for adolescents aged 15–19 who had ever had sex suggest that many adolescents lack in-depth knowledge about how to obtain key sexual and reproductive health services. Although the majority of adolescents who had ever had sex knew of one or more modern methods of contraception (only 1% had never heard of any method), nearly half (44%) did not know where to obtain them (Figure 6.1).[19] The knowledge necessary to obtain treatment for STIs was lacking as well: Forty percent of 15–19-year-olds who had ever had sex

FIGURE 6.1

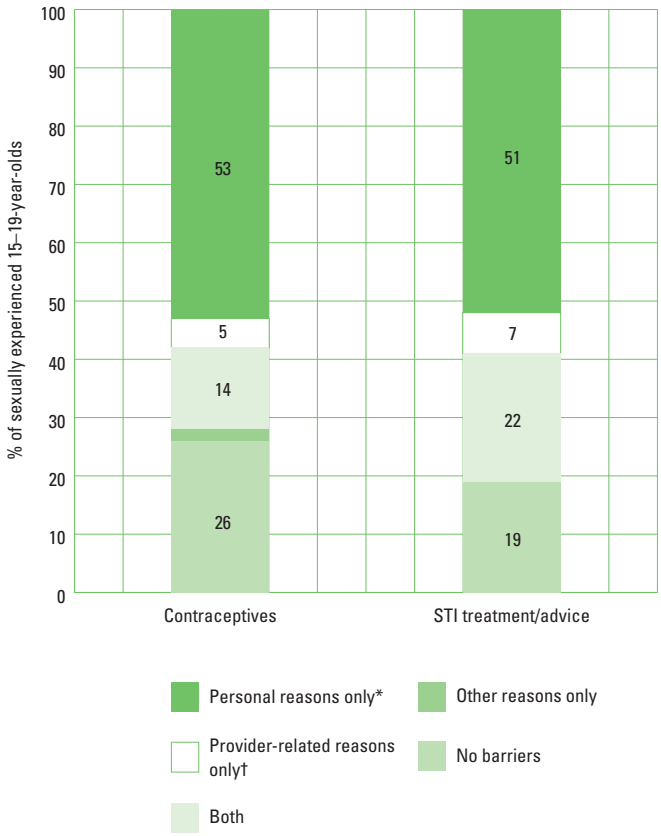
Many 15–19-year-olds who had ever had sex did not know where to get contraceptives or treatment for STIs.

*Other than HIV

Source Reference 19.

FIGURE 6.2

Personal reasons were a major barrier to obtaining contraceptives or STI treatment among sexually experienced 15–19-year-olds who knew a source for services.



*Adolescent was afraid or fearful, embarrassed or shy, or too young.
†Facility had inconvenient hours or days, did not respect privacy, did not treat adolescents nicely, was too costly or did not have a provider of the adolescents' sex; adolescent did not know where facility was located or how to get there, or was unable to go alone; treatment for STIs was not effective.
Source Reference 19.

had never heard of any STI (apart from HIV), and another 17% knew of at least one STI other than HIV but did not know where to obtain relevant services.

However, many respondents did know of sources for services and often had a preference about where to obtain them. Thirty-five percent of adolescents aged 15–19 who had ever had sex said that public or private clinics or hospitals were their preferred source for obtaining contraceptives, and 40% said that these facilities were their preferred source for obtaining treatment for and advice about STIs.[4] Relatively few respondents said that they preferred other sources (drug shops, healers, street vendors, friends or school counsellors) for obtaining contraceptives (21%) or STI services (3%).

Consistent with this preference for clinics and hospitals, at least three in four adolescents aged 15–19 who knew of a public facility and knew at least one contraceptive method or STI believed that they would be treated with respect at a public clinic or hospital, that their personal information would be kept confidential and that they would be able to get to the facility easily.[4(p.122, 130)] These results suggest that adolescents have confidence in the public health system—and that programmes to improve adolescents' sexual and reproductive health should take advantage of this confidence.

Adolescents' embarrassment and shyness hinder utilization of services

There are many factors that may hinder adolescents from obtaining sexual and reproductive health services. These barriers can be broadly classified into provider-related reasons and personal reasons. Provider-related reasons include inconvenient hours or days, lack of respect for client privacy, rude conduct, high costs, lack of a same-sex provider, inability to find or get to a provider and (for STI services) ineffective treatment. Personal reasons include being afraid, feeling embarrassed or shy, and being too young to receive services.

In the 2004 National Survey of Adolescents, embarrassment and shyness in particular emerged as significant barriers to the utilization of sexual and reproductive health care services. Among 15–19-year-olds who had ever had sex and who knew a source for contraceptives or STI treatment, 53% said that feelings of fear, embarrassment or shyness (or being too young) were the only barrier to their obtaining contraceptives, and 51% said that these reasons were the only barrier to their accessing STI services (Figure 6.2).[19] By contrast, 26% of the adolescents reported no barriers to accessing contraceptives, and 19% reported no barriers to accessing STI services. One young woman advised:

> *Doctors and nurses should be taught how to be friendly toward young people like us. At times, they treat you like you are not a human being.*[10]
>
> *—Female, focus group for 17–19-year-olds, urban, out of school*

Adolescents who knew at least one contraceptive method considered drug shops to be readily available and the most affordable source for obtaining contraceptives. However, they felt that providers at drug shops were less likely to keep information confidential and to treat them with respect than were staff at government and private clinics.[4(p.123)]

The potential role of voluntary counselling and testing for HIV

Voluntary counselling and testing (VCT) has been adopted as a strategy to build support services for people who want to know their HIV status.[13] VCT has been introduced in all 10 of Ghana's regional hospitals, and there are plans to extend it to all 138 district hospitals.[4(p.114)] To encourage more people to utilise VCT, government hospitals and clinics charge clients only a token fee for these services.[42] It

appears that messages stressing the benefits of knowing one's HIV status and the possibility of getting help are resonating with adolescents, because a majority of those who had ever had sex knew of the test and wished to be tested, according to the 2004 National Survey of Adolescents.[19] However, only 4% of sexually experienced adolescents had ever had an HIV test (Figure 6.3). Two-thirds of adolescents who had ever had sex had heard about the HIV test and knew where to get VCT, but had never been tested, suggesting that issues other than lack of knowledge may influence the decision to be tested.

General recommendations: What can we do?

To meet adolescents' sexual and reproductive health care needs, providers and facility staff need to create a youth-friendly service environment. Efforts to motivate adolescents to use services will be best received if young clients can be assured that the services they seek will meet their needs and that providers will treat them with respect and confidentiality.

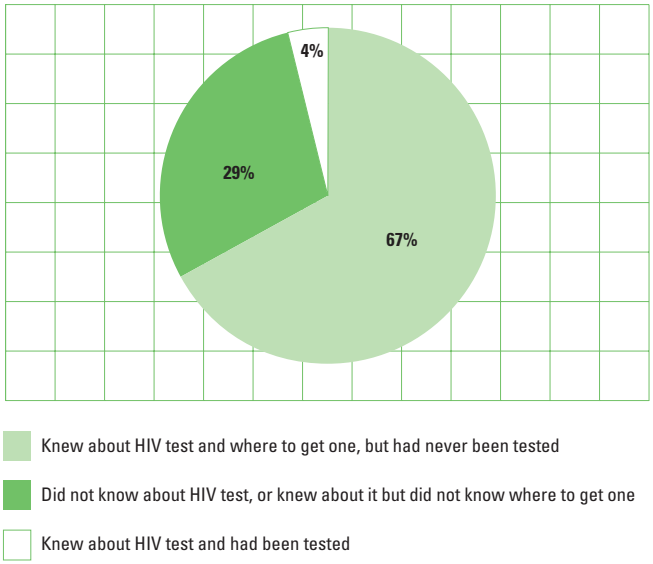
In a report published by the World Health Organization that analysed evidence from developing countries, the authors recommended that interventions that involve training of service providers, that make facilities more accessible to adolescents and that include community participation be implemented immediately on a large scale.[23] Community participation not only can help expand the reach of the health care sector but, as noted in Chapter 4, also can build local support for efforts to improve adolescents' access to sexual and reproductive health services.

A critical component of delivering sexual and reproductive health care to adolescents is training health care providers and pharmacy staff to deliver information and services to adolescents without stigmatizing youth who are sexually active. The training should include gender-based perspectives, so that the interests and needs of both males and females can be addressed. Other important components of improving health care delivery include making facilities accessible to adolescents (e.g., providing the services that youth need at convenient hours), informing adolescents where they can obtain services and letting them know what services are available.

The Reproductive and Child Health Unit of the Ghana Health Service is responsible for family planning services and has made it a priority to increase the availability and appropriate utilization of family planning services. A recent trend analysis highlighted both the progress that has been made and the challenges that remain in improving the delivery of family planning services.[43] Key findings included a dramatic improvement in the proportion of family planning providers who received in-service training on family planning counselling, from 38% in 1993 to 60% in 2002, and substantial improvements in the availability of STI information and services. However, the report noted that the proportion of facilities that offer condoms as a contraceptive method has declined, from 96% in 1993 to 91% in 2002. In addition, although almost all facilities (96%) were offering family planning services five or more days a week, fewer than half (47%) were fully equipped for examinations of family planning clients, and there has been some deterioration in the reliability of stock supply of contraceptive methods. The Reproductive and Child Health Unit should take these findings into account, as well as expand implementation of youth-friendly sites.

FIGURE 6.3

Most adolescents who had ever had sex knew about the HIV test and where to get one, but very few had ever been tested.



Source Reference 19.

Chapter 7

Conclusions and Recommendations

The studies in the Protecting the Next Generation project provide an illuminating view of numerous aspects of adolescent sexual and reproductive health in Ghana: sexual behaviour, contraceptive use, depth of knowledge about reproductive health issues, preferred and actual sources of information, reproductive health care needs and perceptions about the public health system. Adolescents say they are eager for information that can help them choose healthy lifestyles, and they view unintended pregnancy and HIV as obstacles to their future success.

The research also sheds light on the many unmet sexual and reproductive health care needs among adolescents. Meeting these needs is not only an important public health goal, but also an essential component of efforts to achieve the development goals enumerated in Ghana's Second Poverty Reduction Strategy and in the United Nations Millennium Development Goals. Four of the Millennium Development Goals—namely, promoting female empowerment, achieving universal basic education, improving maternal health and combating HIV/AIDS and other key diseases—are closely tied to adolescent sexual and reproductive health. Committing resources to improving adolescent sexual and reproductive health thus constitutes an important investment in the future of the country.

Fortunately, many of the elements that are critical for addressing the sexual and reproductive health care needs of adolescents are already in place. For example, there are a number of government policies—such as the Adolescent Reproductive Health Policy, the National Population Policy, the HIV/AIDS and STI Policy, and the National Youth Policy—that include goals and strategies for improving adolescent sexual and reproductive health. There are also favourable social and demographic indicators: More than 90% of both male and female adolescents attend school; the median ages at first sex, first marriage and first childbirth have increased among younger generations; and the prevalence of HIV among adolescents is relatively low compared with that in other African countries.

Nonetheless, there are gaps between good intentions and achieving positive results. Certainly, much more can be done, not only by the government, but by nongovernmental organizations, professional associations and other stakeholders. Below, we offer recommendations for improving the sexual and reproductive health of adolescents.

Recommendations

Provide adolescents with comprehensive sexual and reproductive health information—before they become sexually active. Adolescents do not have adequate knowledge about sexual and reproductive health issues. Abstinence and the delaying of sexual debut can reduce the likelihood of sexual risk-taking that may lead to poor reproductive health outcomes. However, adolescents need to be prepared for when they begin having sex. Ensuring that they have access to comprehensive and accurate information about sexual and reproductive health issues can increase their knowledge and counter misconceptions, thus equipping them to make informed decisions about their reproductive health. Because the prevalence of sexual activity increases dramatically after age 14, especially for females, it is important that young adolescents be included in sexual and reproductive health programmes. School-based family life education offers a prime opportunity to target the majority of young adolescents, because so many attend school. To this end, the following steps should be taken:

- Comprehensive sexual and reproductive health education programmes should include up-to-date information about puberty, abstinence, pregnancy, contraception and the range of STIs.

- Programmes should also help adolescents acquire the communication and negotiation skills that can promote healthy sexual behaviour.
- The Ghana Education Service should ensure that family life education is available to all students at the upper primary level and above.

Integrate HIV prevention programmes with other sexual and reproductive health programmes. It is the fear of pregnancy, rather than the fear of HIV, that most motivates adolescents to avoid sex or to practise safer sex. This suggests that prevention efforts that emphasise avoiding pregnancy in addition to HIV may resonate more with adolescents than prevention programmes that focus on HIV alone. Therefore, the Ghana Education Service, the Ghana Health Service, health care providers, community-based programmes, mass media and other stakeholders should incorporate HIV programme content into sexual and reproductive health programmes instead of having separate HIV programmes.

Integrate skills training into sexual and reproductive health programmes. Because communication between partners is positively associated with contraceptive use, sexual and reproductive health care programmes should help adolescents acquire and use communication and negotiation skills related to sexual relationships, including the ability to avoid unwanted sex and to negotiate the use of contraceptives. Promoting communication between partners can also enable young women to exercise control over their sexual health and teach young men to accord women respect and autonomy. Projects that have made skills training a central component of adolescent sexual and reproductive health can serve as useful models for programme planners. For example, the African Youth Alliance collaborated with the International Federation of Women Lawyers to train key stakeholders to serve as advocates for gender and sexual and reproductive health issues.[34(p.32)] A UNICEF-supported programme launched in 2003 by the Girls Education Unit of the Ghana Education Service uses an animated role model named Sara to help females aged 11–15 develop self-efficacy, decision-making and other skills to protect themselves from HIV infection and stay in school.[44(p.26)] To facilitate further progress, the following steps should be taken:

- The Ghana Education Service should ensure that skills training is integrated into family life education curricula and teacher training programmes.
- The Ghana Health Service, nongovernmental organizations, community leaders and other stakeholders involved in developing and implementing community-based programmes should incorporate skills training into their efforts.

Train more teachers and improve teacher training for family life education. Levels of school attendance among adolescents in Ghana are very high. Therefore, ensuring that all adolescents who attend school receive comprehensive sexual and reproductive health education from trained teachers could greatly improve adolescents' knowledge about these issues. There are a number of measures that would facilitate this process:

- The Ghana Education Service should review and update the curricula at colleges that train family life education teachers. It also should train more teachers to teach family life education classes at the basic level, and it should intensify its in-service training for teachers already in the field.
- In addition, the Ghana Education Service should expand its collaboration with the Ghana Health Service to increase the effectiveness of the School Health Education Programme.
- The family life education programme at the University of Cape Coast should be encouraged to train teachers for senior secondary schools, technical and vocational institutes and teacher training colleges. This will help ensure that there are sufficient individuals to train teachers and other personnel to provide family life education at primary and secondary institutions.

Coordinate education efforts with the mass media. The mass media are adolescents' preferred and most widely used source of sexual and reproductive health information, and therefore are a good vehicle for informing them about sexual and reproductive health issues. In particular, local radio stations have become important sources of information. The media's educational efforts should be coordinated with interventions in other sectors to achieve maximum effect and avoid conflicting messages.

For these reasons, relevant government agencies and ministries, policymakers, health care providers, nongovernmental organizations and researchers should work in partnership with the mass media (particularly radio) to continue to provide current and reliable information to adolescents and to develop interactive programmes (e.g., call-in shows, role-plays). Such programmes might address sexual and reproductive health in general or focus on a specific topic targeted to a particular community.

Improve the capacity of the health care sector to serve adolescents. Adolescents express confidence that the public health care sector can meet their sexual and reproductive health care needs, but they say that feelings of embarrassment and shyness are significant barriers to utilization of services. To help adolescents feel more comfortable, it is vital to improve providers' communication skills as well as the capacity of health care facilities to offer youth-friendly sexual and reproductive health care and to make this care accessible to adolescents (e.g., by providing information on where to get services). Training programmes should teach providers the skills they need to deliver information and services to adolescents without stigmatizing youth who are sexually active. To achieve these goals, the Ghana Health Service should

- continue to train health personnel to provide youth-friendly services;
- reexamine the operations of health care facilities that target young people, help make these facilities more accessible to adolescents (perhaps by implementing flexible hours of operation) and expand efforts by the Ghana Health Service's Reproductive and Child Health Unit to increase the number of youth-friendly service sites;
- develop community outreach programmes in collaboration with health professional associations and nongovernmental organizations to increase adolescents' utilization of services;
- inform adolescents about the availability and location of these services and encourage their use; and
- widely disseminate youth-friendly training tools to health care facilities, health professional associations and organizations that serve young people. For example, the Ghana Health Service partnered with the African Youth Alliance to develop several training tools, including a list of essential and supporting elements for providing youth-friendly services, a facility assessment tool to help professionals create a youth-friendly environment and a manual designed to train providers to offer quality sexual and reproductive health care to adolescents.[41]

In addition, health-related professional associations—namely, the Ghana Medical Association, the Ghana Registered Nurses Association, the Ghana Registered Midwives Association and the Pharmaceutical Society of Ghana—should be encouraged to

- incorporate adolescent sexual and reproductive health issues, and the provision of youth-friendly services, into all training programmes;
- enlist retired members to assist community-based efforts to meet adolescent sexual and reproductive health care needs; and
- train providers to take advantage of every opportunity to address adolescent sexual and reproductive health care needs.

Finally, organizations such as the Planned Parenthood Association of Ghana (PPAG) and the Christian Health Association of Ghana have made the provision of youth-friendly sexual and reproductive health services a priority—and they should continue to do so. PPAG has established youth-friendly service centres in the Greater Accra, Central, Volta, Ashanti and Northern regions.[44(p.25)] The Christian Health Association of Ghana has worked with the African Youth Alliance to provide support for youth-friendly sexual and reproductive health services.[41(p.33)] These initiatives can serve as good models for efforts to increase the number of youth-friendly service sites. In addition, the National Population Council, in collaboration with the Ghana Health Service, should engage metropolitan, municipal and district assemblies to support youth-serving community-based programmes. The budgets of municipal and district assemblies should include specific lines for adolescent sexual and reproductive health, as was done with the African Youth Alliance–supported project.

Build community capacity to improve adolescents' access to information and services. Comprehensive community-based initiatives can be an effective way to address the challenges of providing sexual and reproductive health services to adolescents—and, in doing so, they can create sustained community commitment to adolescent sexual and reproductive health. A report published by the World Health Organization recommended implementing community-based interventions that target adolescents and noted that community interventions are generally most successful when they are coordinated with improved provider training.[23] Projects such as PPAG's Young and Wise programme and the organization's teacher and provider training offer promising models for interventions. There are a number of steps that can promote community-based initiatives:

- The National Population Council, in collaboration with the Ghana Health Service, should encourage and support the Christian Health Association of Ghana and other youth-serving organizations in their efforts to continue and expand successful adolescent sexual and reproductive health initiatives.
- The Ghana Health Service should work with the Ghana AIDS Commission, the National Population Council and nongovernmental organizations to expand programmes that train peer educators, youth-friendly counsellors and community-based service providers. Programmes should focus on training personnel who can reach adolescents who have specific unmet needs, such as pregnant women, married women and out-of-school youth (especially street youth and those in rural areas).
- The Ghana Health Service and nongovernmental organizations should continue to support the efforts of traditional leaders in some communities to improve adolescent health, by ensuring that they are provided with current, reliable information and needed supplies.
- Given the important role of religion in the lives of adolescents, stakeholders should continue to explore opportunities to build upon promising partnerships between religious groups and the public health community in developing adolescent sexual and reproductive health programmes.
- Youth groups should be involved in planning, implementing, monitoring and evaluating programmes in their areas and at the national level.
- Community leaders and nongovernmental organizations should continue to engage and educate parents. This will not only help parents become valuable sources of information for their children, but will also strengthen parental support for adolescent sexual and reproductive health programmes and activities.

Strengthen the policy implementation framework. The National Population Council is responsible for coordinating all population-related activities in Ghana and should spearhead all initiatives on adolescent and reproductive health in the country. In addition, the National Population Council should

- work with stakeholders to prioritise and implement the programmes and activities outlined in the Adolescent Reproductive Health Policy;
- collaborate with relevant stakeholders to expand successful programmes;
- ensure that adolescent reproductive health issues are mainstreamed into national and district planning activities; and
- seek sufficient resources to enable it to perform its assigned role effectively.

Protecting the next generation is possible

As befitting a country that recently marked its 50th anniversary as an independent nation, Ghana has the right environment to protect the next generation of adolescents—and the present one as well. The need to develop and implement strategies that can have a lasting impact on the sexual and reproductive health of adolescents is particularly vital given that more than one-fifth of Ghanaians are between the ages of 10 and 19. Rising to this challenge will require a renewed commitment from the government, community leaders, health care providers, parents, teachers and adolescents themselves. In return, however, sustained investment in the sexual and reproductive health of adolescents will not only help young people become healthy adults, but will facilitate Ghana's socioeconomic development and help the country achieve the Millennium Development Goals.

APPENDIX TABLE 1A Selected social and demographic characteristics of 12–19-year-old females, by age-group, 2004 Ghana National Survey of Adolescents

Characteristic	All		% distribution by residence with biological parents				% whose parents/ guard-ians always know where they are at night*	% who attend religious services ≥weekly	% distribution by school and work status				% who have worked or done something for money in past year	% worried about getting pregnant	% worried about getting HIV/ AIDS
									In school		Not in school				
	No.	% (weight-ed)	Both	Mother	Father	Neither			Working	Not working	Working	Not working			
FEMALES AGED 12–19	**2,201**	**100.0**	**40.4**	**23.8**	**4.5**	**31.2**	**74.0**	**90.4**	**31.7**	**39.6**	**16.4**	**12.3**	**26.6**	**34.8**	**43.6**
RESIDENCE															
Rural	1,143	51.2	47.1	22.0	5.1	25.9	69.5	86.3	42.4	25.6	20.0	11.9	30.0	33.1	43.2
Urban	1,058	48.8	33.3	25.7	4.0	36.9	78.6	94.7	20.4	54.3	12.5	12.7	23.0	36.5	43.9
ATTENDING SCHOOL															
No	665	28.7	31.7	24.6	5.3	38.4	65.4	82.7	0.0	0.0	57.1	42.9	37.8	36.3	45.6
Yes	1,536	71.3	43.9	23.5	4.2	28.4	77.4	93.5	44.4	55.6	0.0	0.0	22.1	34.1	42.8
UNION STATUS															
Not in union	2,111	96.1	41.4	23.7	4.7	30.1	74.9	90.7	33.0	41.2	14.5	11.3	25.6	35.0	43.6
In union	88	3.9	15.1	24.4	1.2	59.3	53.5	82.6	0.0	2.3	61.6	36.0	52.3	27.6	41.9
HOUSEHOLD WEALTH															
Lowest quintile	386	15.8	46.2	21.9	6.4	25.4	69.0	75.9	34.3	21.8	25.0	18.9	31.0	24.9	33.7
Middle three	1257	60.3	39.8	27.3	4.1	28.8	71.9	91.5	38.0	34.9	17.1	10.0	29.2	37.8	47.8
Highest quintile	539	23.8	38.2	15.9	4.3	41.7	83.4	97.1	14.3	63.4	8.3	13.9	17.7	33.0	39.6
FEMALES AGED 12–14	**936**	**100.0**	**42.4**	**23.9**	**5.3**	**28.5**	**77.7**	**89.9**	**41.8**	**46.3**	**7.5**	**4.3**	**22.3**	**30.0**	**37.4**
RESIDENCE															
Rural	506	53.0	48.6	20.6	6.7	24.1	73.4	85.8	54.3	30.3	9.1	6.3	26.0	27.2	35.0
Urban	430	47.0	35.3	27.6	3.6	33.5	82.4	94.4	27.7	64.5	5.8	2.0	18.0	33.1	40.1
ATTENDING SCHOOL															
No	123	11.9	36.6	20.5	7.1	35.7	70.8	65.8	0.0	0.0	63.7	36.3	32.5	35.1	34.2
Yes	813	88.1	43.1	24.3	5.0	27.5	78.6	93.1	47.4	52.6	0.0	0.0	21.0	29.3	37.8
HOUSEHOLD WEALTH															
Lowest quintile	167	15.9	50.0	21.7	8.6	19.7	71.2	72.4	40.8	28.9	15.8	14.5	26.3	18.3	24.8
Middle three	540	61.3	40.5	27.1	5.2	27.2	75.6	91.5	50.3	39.9	7.2	2.6	26.6	33.9	41.4
Highest quintile	228	22.7	42.2	16.5	3.2	38.1	87.6	97.2	19.4	76.0	2.8	1.8	7.8	27.6	35.5
FEMALES AGED 15–19	**1,265**	**100.0**	**38.9**	**23.8**	**4.0**	**33.4**	**71.2**	**90.9**	**23.8**	**34.4**	**23.2**	**18.5**	**30.0**	**38.4**	**48.3**
RESIDENCE															
Rural	637	49.7	45.8	23.2	3.6	27.4	66.3	86.7	32.5	21.8	29.1	16.6	33.3	37.9	49.9
Urban	628	50.3	32.0	24.4	4.4	39.3	75.9	94.9	15.3	47.1	17.2	20.4	26.7	39.0	46.7
ATTENDING SCHOOL															
No	542	41.7	30.8	25.3	4.9	39.0	64.3	86.4	0.0	0.0	55.6	44.4	39.1	36.8	47.9
Yes	723	58.3	44.6	22.7	3.3	29.3	76.0	94.0	40.9	59.1	0.0	0.0	23.4	39.7	48.6
UNION STATUS															
Not in union	1,176	93.0	40.7	23.6	4.2	31.5	72.5	91.5	25.7	36.9	20.3	17.2	28.3	39.2	48.7
In union	88	7.0	15.1	24.4	1.2	59.3	53.5	82.6	0.0	2.3	61.6	36.0	52.3	27.6	41.9
HOUSEHOLD WEALTH															
Lowest quintile	219	15.8	43.2	22.1	4.7	30.0	67.2	78.6	29.2	16.7	32.3	21.9	34.9	30.2	40.6
Middle three	717	59.5	39.2	27.5	3.3	30.0	68.7	91.5	28.0	30.7	25.3	16.0	31.3	40.9	52.9
Highest quintile	311	24.7	35.0	15.3	5.3	44.3	80.5	97.0	11.0	54.2	12.3	22.6	24.6	36.9	42.5

*For married adolescents, the question refers to parental knowledge before respondent got married.

Source Unpublished tabulations of data from the 2004 Ghana National Survey of Adolescents.

APPENDIX TABLE 1B **Selected social and demographic characteristics of 12–19-year-old males, by age-group, 2004 Ghana National Survey of Adolescents**

Characteristic	All		% distribution by residence with biological parents				% whose parents/ guardians always know where they are at night*	% who attend religious services ≥weekly	% distribution by school and work status				% who have worked or done something for money in past year	% worried about getting someone pregnant	% worried about getting HIV/AIDS
									In school		Not in school				
	No.	% (weighted)	Both	Mother	Father	Neither			Working	Not working	Working	Not working			
MALES AGED 12–19	**2,229**	**100.0**	**44.8**	**21.8**	**8.9**	**24.5**	**61.2**	**85.0**	**37.8**	**39.5**	**16.3**	**6.3**	**35.8**	**28.9**	**40.4**
RESIDENCE															
Rural	1,307	55.4	51.3	19.9	7.7	21.0	64.2	82.4	49.6	24.4	20.9	5.1	41.9	27.5	37.5
Urban	922	44.6	36.7	24.2	10.3	28.9	57.5	88.3	23.3	58.2	10.7	7.8	28.3	30.7	44.0
ATTENDING SCHOOL															
No	513	22.7	44.9	17.8	9.1	28.3	52.8	75.5	0.0	0.0	72.1	27.9	59.3	34.0	42.6
Yes	1,714	77.3	44.7	23.1	8.8	23.5	63.7	87.8	49.0	51.0	0.0	0.0	29.0	27.4	39.7
HOUSEHOLD WEALTH															
Lowest quintile	469	17.9	57.7	15.4	8.6	18.4	66.1	79.1	40.7	19.3	32.2	7.8	46.5	19.6	28.2
Middle three	1,339	62.7	42.2	24.1	8.1	25.7	61.1	85.2	43.9	36.3	14.9	4.9	37.0	30.6	42.4
Highest quintile	407	19.4	41.5	19.7	11.8	26.9	56.7	89.6	14.9	68.4	7.0	9.8	21.8	32.9	45.4
MALES AGED 12–14	**967**	**100.0**	**48.6**	**20.6**	**9.2**	**21.7**	**65.4**	**85.7**	**42.7**	**47.3**	**7.6**	**2.4**	**22.1**	**22.6**	**36.3**
RESIDENCE															
Rural	594	57.3	55.4	18.0	7.6	19.1	70.1	81.8	55.8	29.9	11.1	3.2	27.3	22.4	33.3
Urban	373	42.7	39.4	24.0	11.1	25.5	59.0	90.9	25.2	70.7	2.9	1.2	15.3	23.0	40.3
ATTENDING SCHOOL															
No	111	9.9	51.5	10.3	9.3	28.9	56.7	59.8	0.0	0.0	76.3	23.7	41.2	13.3	21.6
Yes	856	90.1	48.2	21.7	9.1	20.9	66.3	88.5	47.4	52.6	0.0	0.0	20.0	23.7	38.0
HOUSEHOLD WEALTH															
Lowest quintile	220	19.3	58.3	15.5	7.0	19.3	72.7	74.9	45.2	25.0	22.3	7.4	34.8	12.3	20.3
Middle three	582	62.6	47.5	21.9	8.9	21.7	64.5	87.3	49.2	44.6	4.8	1.5	21.3	24.5	39.0
Highest quintile	159	18.1	43.2	19.9	12.5	24.4	60.2	91.0	17.1	81.1	1.7	0.0	10.8	27.8	43.8
MALES AGED 15–19	**1,262**	**100.0**	**41.8**	**22.8**	**8.6**	**26.7**	**57.9**	**84.5**	**34.0**	**33.4**	**23.2**	**9.4**	**46.5**	**33.8**	**43.6**
RESIDENCE															
Rural	713	53.9	47.9	21.7	7.7	22.7	59.2	82.9	44.4	19.9	29.1	6.6	53.9	31.7	41.0
Urban	549	46.1	34.7	24.2	9.7	31.4	56.4	86.2	22.1	49.1	16.2	12.6	37.8	36.3	46.7
ATTENDING SCHOOL															
No	402	32.5	43.3	19.6	9.0	28.1	51.8	79.2	0.0	0.0	71.1	28.9	63.6	39.1	47.7
Yes	858	67.5	41.0	24.4	8.4	26.1	60.9	87.0	50.5	49.5	0.0	0.0	38.2	31.3	41.6
HOUSEHOLD WEALTH															
Lowest quintile	249	16.8	57.4	15.3	10.0	17.2	60.0	82.9	37.0	14.2	40.8	8.1	56.7	25.7	35.1
Middle three	757	62.7	38.1	25.8	7.4	28.7	58.5	83.6	39.9	29.9	22.7	7.5	49.2	35.2	45.1
Highest quintile	248	20.4	40.2	19.5	11.3	28.9	54.3	88.3	12.9	59.6	11.0	16.5	29.3	36.3	46.5

*For married adolescents, the question refers to parental knowledge before respondent got married.

Source Unpublished tabulations of data from the 2004 Ghana National Survey of Adolescents.

APPENDIX TABLE 2A Sexual activity and risk and protective behaviours among 12–19-year-old females, by age-group, 2004 Ghana National Survey of Adolescents

Characteristic	All		% distribution by sexual activity				% who have ever been touched, kissed, grabbed or fondled in an unwanted sexual way*
	No.	% (weighted)	Never had sex	Have had sex but not in past 12 months	Had sex in past 12 months with spouse/ cohabiting partner	Had sex in past 12 months with non-cohabiting partner	
FEMALES AGED 12–19	**2,201**	**100.0**	**83.2**	**5.0**	**2.8**	**9.0**	**24.0**
RESIDENCE							
Rural	1,143	51.2	81.1	6.0	4.0	9.0	21.0
Urban	1,058	48.8	85.3	4.0	1.6	9.1	27.1
ATTENDING SCHOOL							
No	665	28.7	58.6	10.7	9.6	21.1	34.6
Yes	1,536	71.3	92.9	2.7	0.1	4.3	19.9
UNION STATUS							
Not in union	2,111	96.1	86.5	4.3	0.3	8.9	23.0
In union	88	3.9	1.2	21.4	65.5	11.9	47.3
HOUSEHOLD WEALTH							
Lowest quintile	386	15.8	80.7	6.4	5.6	7.3	17.4
Middle three	1,257	60.3	82.0	4.7	3.1	10.2	25.6
Highest quintile	539	23.8	88.2	4.6	0.4	6.8	25.0
FEMALES AGED 12–14	**936**	**100.0**	**98.2**	**0.8**	**0.0**	**0.8**	**13.0**
RESIDENCE							
Rural	506	53.0	98.2	0.8	0.0	1.0	9.3
Urban	430	47.0	98.2	0.9	0.0	0.9	17.4
ATTENDING SCHOOL							
No	123	11.9	97.4	0.0	0.0	2.6	14.6
Yes	813	88.1	98.3	0.9	0.0	0.7	12.7
HOUSEHOLD WEALTH							
Lowest quintile	167	15.9	98.7	0.7	0.0	0.7	8.3
Middle three	540	61.3	98.5	0.9	0.0	0.7	13.9
Highest quintile	228	22.7	97.7	0.9	0.0	1.4	13.7
FEMALES AGED 15–19	**1,265**	**100.0**	**71.2**	**8.3**	**5.0**	**15.5**	**32.4**
RESIDENCE							
Rural	637	49.7	66.5	10.4	7.4	15.7	30.7
Urban	628	50.3	75.8	6.2	2.8	15.2	34.1
ATTENDING SCHOOL							
No	542	41.7	49.8	13.1	11.8	25.3	37.5
Yes	723	58.3	86.3	4.9	0.3	8.5	28.6
UNION STATUS							
Not in union	1,176	93.0	76.4	7.4	0.5	15.7	31.3
In union	88	7.0	1.2	21.4	65.5	11.9	47.3
HOUSEHOLD WEALTH							
Lowest quintile	219	15.8	66.3	11.1	10.0	12.6	23.9
Middle three	717	59.5	68.2	8.0	5.7	18.1	35.4
Highest quintile	311	24.7	81.3	7.3	0.7	10.7	32.1

*Questions asked of only one eligible adolescent per household and only if no one older than three was present or within hearing range. †Among respondents who had ever had sex.
‡Respondent answered yes to a direct question about ever having had an STI or answered yes to having had a specific symptom. §Among respondents who had had sex in the past 12 months.
**Question not asked if most recent partner was a spouse or cohabiting partner, or if respondent had had sex only one time. †† No value is given when N≤24.

% who have ever been physically forced, hurt or threatened into having sexual intercourse*	% who have ever been pregnant†	% who have ever had an STI†,‡	% who used a contraceptive at last sex§	% distribution by number of recent sex partners and male condom use§				% whose last sex partner was ≥5 years older§	% who have had sex in exchange for money or gifts§,**
				One partner		≥2 partners			
				Used	Did not use	Used	Did not use		
11.9	**41.5**	**11.1**	**45.4**	**31.7**	**60.1**	**5.2**	**3.0**	**41.9**	**73.1**
11.0	47.2	9.3	47.9	35.1	57.4	3.4	4.1	41.2	78.2
13.1	34.1	13.3	42.6	27.6	64.2	7.3	0.8	42.7	68.3
15.4	55.3	9.8	39.1	27.8	65.7	3.5	3.0	46.3	71.8
10.7	9.6	14.7	63.8	42.5	46.6	9.6	1.4	29.3	76.8
11.8	27.3	11.9	53.6	36.8	53.4	6.9	2.9	34.1	74.7
16.4	89.4	8.2	20.6	15.4	81.5	1.5	1.5	64.2	33.3
8.9	47.1	3.0	28.3	23.9	67.4	2.2	6.5	45.7	75.0
11.2	47.1	10.7	46.3	31.7	61.7	3.8	2.7	40.6	74.5
15.9	13.3	21.0	58.3	32.4	48.6	18.9	0.0	39.5	64.0
6.2	††	††	††	††	††	††	††	††	††
5.4	††	††	††	††	††	††	††	††	††
7.1	††	††	††	††	††	††	††	††	††
6.3	††	††	††	††	††	††	††	††	††
6.4	††	††	††	††	††	††	††	††	††
6.0	††	††	††	††	††	††	††	††	††
5.6	††	††	††	††	††	††	††	††	††
8.1	††	††	††	††	††	††	††	††	††
16.4	**42.3**	**11.3**	**46.6**	**32.4**	**60.3**	**4.6**	**2.7**	**42.9**	**73.2**
15.3	47.8	9.8	48.6	35.7	56.6	3.5	4.2	41.9	78.7
17.3	34.6	13.3	44.1	28.6	64.7	5.9	0.8	44.2	67.9
16.8	55.4	9.9	38.9	27.8	66.0	3.6	2.6	46.5	71.6
15.9	8.8	15.7	69.8	46.3	44.8	7.5	1.5	31.4	76.0
16.4	27.4	12.3	55.9	37.9	53.3	6.2	2.6	35.5	74.7
16.4	89.4	8.2	20.6	15.4	81.5	1.5	1.5	64.2	33.3
10.3	49.2	3.1	29.5	25.0	68.2	2.3	4.5	45.5	73.7
16.0	47.0	11.1	46.8	31.8	61.5	3.9	2.8	41.5	73.8
20.4	14.5	21.1	63.6	35.3	50.0	14.7	0.0	44.1	63.6

Source Unpublished tabulations of data from the 2004 Ghana National Survey of Adolescents.

APPENDIX TABLE 2B **Sexual activity and risk and protective behaviours among 12–19-year-old males, by age-group, 2004 Ghana National Survey of Adolescents**

Characteristic	All		% distribution by sexual activity				% who have ever been touched, kissed, grabbed or fondled in an unwanted sexual way*
	No.	% (weighted)	Never had sex	Have had sex but not in past 12 months	Had sex in past 12 months with spouse/ cohabiting partner	Had sex in past 12 months with noncohabiting partner	
MALES AGED 12–19	**2,229**	**100.0**	**90.7**	**3.2**	**0.4**	**5.6**	**18.6**
RESIDENCE							
Rural	1,307	55.4	91.1	3.4	0.7	4.8	15.3
Urban	922	44.6	90.4	3.0	0.0	6.5	22.6
ATTENDING SCHOOL							
No	513	22.7	77.8	7.4	1.0	13.8	26.3
Yes	1,714	77.3	94.6	2.0	0.2	3.2	16.0
HOUSEHOLD WEALTH							
Lowest quintile	469	17.9	90.7	3.3	1.0	5.0	15.2
Middle three	1,339	62.7	90.6	3.1	0.4	5.9	16.7
Highest quintile	407	19.4	91.1	3.5	0.0	5.4	27.1
MALES AGED 12–14	**967**	**100.0**	**98.7**	**0.6**	**0.0**	**0.7**	**10.7**
RESIDENCE							
Rural	594	57.3	98.9	0.7	0.0	0.4	10.6
Urban	373	42.7	98.6	0.5	0.0	1.0	10.8
ATTENDING SCHOOL							
No	111	9.9	94.8	1.0	0.0	4.1	5.5
Yes	856	90.1	99.2	0.6	0.0	0.2	11.3
HOUSEHOLD WEALTH							
Lowest quintile	220	19.3	97.9	1.6	0.0	0.5	11.8
Middle three	582	62.6	98.9	0.3	0.0	0.8	9.7
Highest quintile	159	18.1	98.9	0.6	0.0	0.6	14.1
MALES AGED 15–19	**1,262**	**100.0**	**84.5**	**5.3**	**0.7**	**9.5**	**24.7**
RESIDENCE							
Rural	713	53.9	84.6	5.7	1.2	8.5	19.3
Urban	549	46.1	84.7	4.7	0.0	10.6	30.9
ATTENDING SCHOOL							
No	402	32.5	73.8	8.9	1.2	16.1	30.6
Yes	858	67.5	89.8	3.4	0.5	6.3	21.2
HOUSEHOLD WEALTH							
Lowest quintile	249	16.8	84.2	4.8	1.9	9.1	17.8
Middle three	757	62.7	84.2	5.4	0.6	9.8	22.8
Highest quintile	248	20.4	85.8	5.5	0.0	8.7	34.3

*Questions asked of only one eligible adolescent per household and only if no one older than three was present or within hearing range.
†Among respondents who had ever had sex.
‡Respondent answered yes to a direct question about ever having had an STI or answered yes to having had a specific symptom.
§Among respondents who had had sex in the past 12 months.
**Question not asked if most recent partner was a spouse or cohabiting partner, or if respondent had had sex only one time.
††No value is given when N≤24.
Source Unpublished tabulations of data from the 2004 Ghana National Survey of Adolescents.

% who have ever been physically forced, hurt or threatened into having sexual intercourse*	% who have ever gotten someone pregnant†	% who have ever had an STI†,‡	% who used a contraceptive at last sex§	% distribution by number of recent sex partners and male condom use§				% whose last sex partner was ≥5 years older§	% who have had sex in exchange for money or gifts§,**
				One partner		≥2 partners			
				Used	Did not use	Used	Did not use		
5.1	**5.9**	**3.4**	**50.4**	**32.1**	**43.3**	**17.2**	**7.5**	**2.9**	**33.0**
3.2	6.5	4.6	44.3	24.2	54.5	16.7	4.5	0.0	35.7
7.5	5.3	2.1	56.7	40.3	31.3	17.9	10.4	5.9	30.2
9.4	9.0	2.7	45.5	25.7	45.9	17.6	10.8	5.2	25.4
3.8	2.2	4.3	56.7	39.3	39.3	16.4	4.9	0.0	43.5
3.5	5.4	2.7	29.2	8.7	78.3	8.7	4.3	0.0	31.3
4.6	7.9	3.1	52.2	34.5	39.1	19.5	6.9	4.4	32.9
8.8	0.0	5.0	65.2	45.8	25.0	16.7	12.5	0.0	35.0
2.5	**††**	**††**	**††**	**††**	**††**	**††**	**††**	**††**	**††**
0.9	††	††	††	††	††	††	††	††	††
4.8	††	††	††	††	††	††	††	††	††
1.8	††	††	††	††	††	††	††	††	††
2.6	††	††	††	††	††	††	††	††	††
0.0	††	††	††	††	††	††	††	††	††
3.3	††	††	††	††	††	††	††	††	††
2.2	††	††	††	††	††	††	††	††	††
7.1	**6.3**	**3.1**	**53.1**	**33.9**	**40.2**	**18.1**	**7.9**	**0.8**	**34.3**
5.3	6.9	3.9	46.3	25.0	53.1	17.2	4.7	0.0	35.2
9.3	5.6	2.2	60.3	42.9	27.0	19.0	11.1	1.6	32.7
11.0	9.4	2.8	47.9	27.1	42.9	18.6	11.4	1.4	27.1
5.1	2.4	3.4	58.6	41.4	36.2	17.2	5.2	0.0	44.2
5.5	6.1	3.0	30.4	9.1	77.3	9.1	4.5	0.0	31.3
5.7	8.3	3.3	55.3	36.6	35.4	20.7	7.3	1.2	35.8
12.4	0.0	2.7	68.2	47.8	21.7	17.4	13.0	0.0	31.6

APPENDIX TABLE 3A	Knowledge and use of sexual and reproductive health information and services among 12–19-year-old females, by age-group, 2004 Ghana National Survey of Adolescents						
Characteristic	N	% distribution (weighted)	% who know there are certain days when a woman is more likely to get pregnant	% with adequate knowledge of pregnancy prevention*	% who know three main ways to avoid HIV†	% with adequate knowledge of HIV/ AIDS‡	% who know someone who has HIV or has died from AIDS
FEMALES AGED 12–19	**2,201**	**100.0**	**52.3**	**20.9**	**66.8**	**27.2**	**38.6**
RESIDENCE							
Rural	1,143	51.2	43.7	14.0	62.2	17.1	37.2
Urban	1,058	48.8	61.3	28.2	71.7	37.8	40.0
ATTENDING SCHOOL							
No	665	28.7	55.8	24.4	61.1	21.9	37.5
Yes	1,536	71.3	50.8	19.5	69.1	29.3	39.0
UNION STATUS							
Not in union	2,111	96.1	51.3	20.0	66.8	27.5	38.1
In union	88	3.9	76.7	45.3	67.4	19.8	50.0
HOUSEHOLD WEALTH							
Lowest quintile	386	15.8	31.7	6.7	50.3	10.5	33.1
Middle three	1,257	60.3	50.4	19.3	67.6	23.9	40.9
Highest quintile	539	23.8	70.2	34.6	75.1	46.5	37.2
FEMALES AGED 12–14	**936**	**100.0**	**33.7**	**11.7**	**60.2**	**20.9**	**35.5**
RESIDENCE							
Rural	506	53.0	24.7	5.9	54.4	12.6	33.1
Urban	430	47.0	44.0	18.4	66.8	30.3	38.3
ATTENDING SCHOOL							
No	123	11.9	19.3	5.3	25.4	5.3	33.3
Yes	813	88.1	35.7	12.7	64.9	23.0	35.9
HOUSEHOLD WEALTH							
Lowest quintile	167	15.9	13.8	2.0	40.8	9.9	22.9
Middle three	540	61.3	31.3	9.0	60.1	16.7	39.5
Highest quintile	228	22.7	54.1	25.8	73.7	40.1	34.1
FEMALES AGED 15–19	**1,265**	**100.0**	**66.6**	**28.0**	**72.0**	**32.0**	**41.0**
RESIDENCE							
Rural	637	49.7	59.5	20.7	68.8	20.7	40.6
Urban	628	50.3	73.8	35.3	75.2	43.2	41.3
ATTENDING SCHOOL							
No	542	41.7	64.0	28.9	69.1	25.5	38.4
Yes	723	58.3	68.6	27.5	74.1	36.7	42.7
UNION STATUS							
Not in union	1,176	93.0	65.9	26.8	72.4	32.9	40.2
In union	88	7.0	76.7	45.3	67.4	19.8	50.0
HOUSEHOLD WEALTH							
Lowest quintile	219	15.8	45.6	10.4	57.8	10.9	41.7
Middle three	717	59.5	65.9	27.5	73.7	29.7	41.9
Highest quintile	311	24.7	81.9	40.9	76.4	51.2	39.4

*Knew at least one modern method of contraception and also knew all of the following: that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sex; and that a woman can get pregnant if she has sex standing up.
†Abstain, be faithful and use a condom.
‡Knew that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a person cannot get HIV from sharing food with someone who is infected.

% who know of any STI other than HIV	% who have ever talked with a family member about sex-related matters	% who have attended sex education classes or talks in school	% who know a source for contraceptives	% who say cost is a barrier to obtaining contraceptives	% who say that feelings of shyness or embarrassment are a barrier to obtaining contraceptives	% who know a place to get an HIV test	% who have ever been tested for HIV§
38.6	**45.5**	**50.6**	**33.5**	**2.4**	**55.7**	**60.3**	**3.7**
26.3	38.7	40.7	23.4	2.0	46.1	52.6	4.2
51.6	52.7	60.9	44.2	2.8	65.7	68.4	3.0
38.6	40.9	34.9	33.8	2.9	55.7	51.6	3.8
38.7	47.3	56.9	33.4	2.2	55.7	63.8	3.5
38.4	45.8	50.8	33.2	2.3	55.7	60.5	4.4
45.3	39.5	44.2	43.0	4.7	57.0	57.0	2.4
18.6	35.4	27.8	19.8	1.2	41.4	46.4	2.9
34.0	42.2	49.6	29.5	2.6	53.3	57.8	4.5
62.9	60.0	67.4	53.1	2.7	71.6	75.5	3.2
25.5	**39.8**	**41.0**	**22.5**	**1.0**	**48.0**	**53.8**	**
12.6	34.5	31.3	14.6	0.4	37.8	45.2	**
40.1	45.9	52.0	31.4	1.8	59.6	63.6	**
7.0	18.6	5.3	8.8	0.0	39.8	22.8	**
28.0	42.7	45.9	24.3	1.2	49.1	57.9	**
9.2	29.4	21.7	11.8	0.0	27.6	34.6	**
19.6	36.8	38.9	19.1	1.4	47.0	51.4	**
53.0	55.3	59.9	39.4	1.4	65.0	73.4	**
48.7	**49.9**	**58.0**	**42.1**	**3.4**	**61.6**	**65.3**	**3.6**
37.6	42.1	48.5	30.7	3.4	53.0	58.9	3.9
59.9	57.6	67.4	53.4	3.4	70.1	71.7	3.2
45.5	45.7	41.6	39.3	3.5	59.3	57.9	3.8
51.1	52.8	69.8	44.1	3.3	63.2	70.6	3.0
49.0	50.7	59.0	42.1	3.3	62.0	66.0	4.3
45.3	39.5	44.2	43.0	4.7	57.0	57.0	2.4
26.6	40.1	32.8	26.6	2.1	52.3	55.7	3.1
45.7	46.6	58.3	37.9	3.6	58.4	62.9	4.2
70.1	63.3	72.8	62.9	4.0	76.5	77.1	3.5

§Among respondents who have ever had sex.
**No value is given when N≤24.
Source Unpublished tabulations of data from the 2004 Ghana National Survey of Adolescents.

APPENDIX TABLE 3B **Knowledge and use of sexual and reproductive health information and services among 12–19-year-old males, by age-group, 2004 Ghana National Survey of Adolescents**

Characteristic	N	% distribution (weighted)	% who know there are certain days when a woman is more likely to get pregnant	% with adequate knowledge of pregnancy prevention*	% who know three main ways to avoid HIV†	% with adequate knowledge of HIV/AIDS‡	% who know someone who has HIV or has died from AIDS
MALES AGED 12–19	**2,229**	**100.0**	**34.8**	**14.2**	**72.5**	**30.8**	**41.2**
RESIDENCE							
Rural	1,307	55.4	28.6	9.3	72.1	21.8	41.1
Urban	922	44.6	42.4	20.3	72.9	41.9	41.3
ATTENDING SCHOOL							
No	513	22.7	38.3	18.9	67.2	24.7	38.3
Yes	1,714	77.3	33.6	12.7	73.9	32.5	42.0
HOUSEHOLD WEALTH							
Lowest quintile	469	17.9	22.1	6.8	63.8	12.3	39.8
Middle three	1,339	62.7	34.1	11.8	75.8	31.7	41.8
Highest quintile	407	19.4	48.6	28.8	69.2	44.7	40.4
MALES AGED 12–14	**967**	**100.0**	**18.4**	**5.7**	**67.3**	**23.4**	**37.2**
RESIDENCE							
Rural	594	57.3	12.2	3.2	66.7	15.7	35.9
Urban	373	42.7	26.6	9.1	68.1	33.6	38.8
ATTENDING SCHOOL							
No	111	9.9	5.2	2.1	41.2	7.1	23.7
Yes	856	90.1	19.8	6.1	70.2	25.3	38.6
HOUSEHOLD WEALTH							
Lowest	220	19.3	8.0	1.6	54.5	7.5	38.0
Middle three	582	62.6	18.5	4.8	71.4	23.4	36.0
Highest	159	18.1	29.5	13.1	66.5	40.1	39.2
MALES AGED 15–19	**1,262**	**100.0**	**47.5**	**20.7**	**76.4**	**36.5**	**44.3**
RESIDENCE							
Rural	713	53.9	42.0	14.2	76.4	26.8	45.4
Urban	549	46.1	53.8	28.4	76.4	47.9	43.1
ATTENDING SCHOOL							
No	402	32.5	46.3	22.7	73.1	28.9	41.8
Yes	858	67.5	47.9	19.7	77.8	40.1	45.5
HOUSEHOLD WEALTH							
Lowest quintile	249	16.8	34.8	11.0	72.0	16.6	41.4
Middle three	757	62.7	46.2	17.2	79.2	38.2	46.2
Highest quintile	248	20.4	61.7	39.5	71.1	48.0	41.0

*Knew at least one modern method of contraception and also knew all of the following: that there are certain days when a woman is more likely to get pregnant; that a woman can get pregnant the very first time she has sex; and that a woman can get pregnant if she has sex standing up.
†Abstain, be faithful and use a condom.
‡Knew that HIV transmission can be reduced by having sex with only one, faithful, uninfected partner and also by using condoms; that a healthy-looking person can have HIV; that a person cannot get HIV from mosquito bites; and that a person cannot get HIV from sharing food with someone who is infected.
§Among respondents who have ever had sex.
**No value is given when N≤24.
Source Unpublished tabulations of data from the 2004 Ghana National Survey of Adolescents.

% who know of any STI other than HIV	% who have ever talked with a family member about sex-related matters	% who have attended sex education classes or talks in school	% who know a source for contra-ceptives	% who say cost is a barrier to obtaining contraceptives	% who say that feelings of shyness or embarrassment are a barrier to obtaining contraceptives	% who know a place to get an HIV test	% who have ever been tested for HIV§
43.4	**28.2**	**37.9**	**35.4**	**2.8**	**46.2**	**63.1**	**3.7**
31.4	24.3	32.9	28.2	1.7	40.8	55.8	4.2
58.3	32.9	44.0	44.3	4.1	52.8	72.1	3.0
44.0	28.1	32.0	34.6	2.8	45.7	57.2	3.8
43.2	28.2	39.5	35.6	2.8	46.3	64.8	3.5
24.9	27.0	21.4	21.2	0.8	31.7	48.2	2.9
40.4	25.6	39.6	35.5	2.4	46.7	62.4	4.5
69.9	37.5	47.1	48.1	5.3	57.9	78.5	3.2
27.5	**21.8**	**27.7**	**23.1**	**2.1**	**37.7**	**52.5**	******
17.9	18.8	22.7	16.8	0.7	32.2	44.5	**
40.5	25.9	34.2	31.4	4.1	45.2	63.3	**
14.4	16.7	5.2	9.3	0.0	20.6	24.7	**
29.0	22.4	30.1	24.7	2.4	39.6	55.5	**
14.4	21.9	13.4	10.1	0.5	20.7	34.2	**
24.2	19.2	28.5	23.7	1.8	41.2	52.5	**
53.4	30.7	39.8	35.6	5.1	44.9	71.6	**
55.7	**33.1**	**45.8**	**45.0**	**3.3**	**52.7**	**71.3**	**5.7**
42.6	28.8	41.3	37.6	2.4	47.9	65.1	5.8
71.0	38.1	51.0	53.6	4.3	58.3	78.5	5.6
51.0	30.7	38.4	40.6	3.4	51.6	64.8	5.6
58.0	34.2	49.3	47.0	3.2	53.3	74.4	5.8
34.3	31.8	28.6	31.0	1.4	41.7	60.5	6.1
53.1	30.5	48.3	44.6	2.9	51.0	70.2	3.3
81.3	42.2	52.0	56.6	5.5	66.8	83.5	10.8

APPENDIX TABLE 4	Adolescents' rights in Ghana related to sexual and reproductive health
Topic	Policy
ABORTION	Abortion is permitted only to save a woman's life; to preserve her physical or mental health; or in cases of rape, incest or fetal impairment.
CONTRACEPTION	■ "Counselling, IEC [information, education and communication] and, where necessary, family planning services are offered to various categories of adolescents in order to minimise problems relating to sexual and reproductive health, early marriage or parenthood and teenage pregnancies." ■ "Laws will be enacted, or where such laws already exist they will be enforced, to enhance the rights and access of children and youth to education, health, and employment."
SEX EDUCATION	■ The government shall "ensure that there is a consistent [programme] of information and education about HIV/AIDS and STIs among the general population, especially among women and the youth." ■ STI control programmes shall intensify "the promotion of condom use in school education"; programmes shall promote "abstinence, especially for the youth and unmarried persons." ■ The government shall "strengthen the integration of HIV/AIDS/STI education into the curricula of formal schools beginning at the primary level under the existing [Family Life Education], School Health Education and related projects that the Ghana Education Service is currently implementing."
STI TESTING	Ministries, departments and agencies shall "ensure the expansion of the access of young people to youth-friendly facilities and services, including HIV and STI prevention, management and testing, counselling and the provision of care and support services."
VOLUNTARY COUNSELLING AND TESTING FOR HIV	■ "Good quality voluntary counselling and confidential testing (VCT) for HIV shall . . . be made available and accessible to all who seek such services." ■ Ministries, departments and agencies shall "ensure the expansion of the access of young people to youth-friendly facilities and services, including HIV and STI prevention, management and testing, counselling and the provision of care and support services."

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4. Appendix Table 3A.

5. Appendix Table 3B.

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