From Paper to Practice: Sexuality Education Policies and Their Implementation in Ghana

Kofi Awusabo-Asare, Melissa Stillman, Sarah Keogh, David Teye Doku, Akwasi Kumi-Kyereme, Kobina Esia-Donkoh, Ellie Leong, Joshua Amo-Adjei and Akinrinola Bankole

Key Points

- Sexual and reproductive health (SRH) education is a key component in a multifaceted approach to address the sexual and reproductive health needs of adolescents.
- In senior high schools, SRH education topics are integrated into two core and two elective subjects, but those in the core subjects are limited in scope, and the overall approach emphasizes abstinence.
- Three-fourths of students were exposed to at least one topic in five key categories related to SRH education; only 8% of students reported learning about all of the topics that constitute a comprehensive curriculum according to international guidelines.
- Nearly all students had learned about abstinence, HIV, reproductive physiology and SRH rights in their classes; fewer than half had learned about contraceptive methods and practical skills, such as communicating in relationships, where to access HIV or STI services, how to use contraceptives or where to get them.
- Teachers reported challenges to teaching SRH topics effectively, including lack of time, lack of appropriate skills and inadequate teaching materials.
- Overall, schools in Ghana are implementing an advanced program compared with programs in other countries in the region. Yet broadening the range of topics to reflect international guidelines and promoting practical skills related to contraceptive use would improve the comprehensiveness and impact of the program, and better integrating topics into core subjects would standardize the information that all students receive.
- Improving and systematizing teacher training, and diversifying teaching approaches to encourage active student participation and promote practical skills, confidence and agency, are essential if SRH education is to be delivered accurately and effectively.
- Further steps should be taken to demystify and desensationalize sexuality among adolescents, and continued sensitization of the community, teachers and school heads is needed to ensure that adolescents are supported in learning SRH-related skills.

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Introduction

Timely provision of accurate and comprehensive information and life skills training regarding sexual and reproductive health and rights is essential for adolescents to achieve sexual health and rights and avoid negative health outcomes.[1–3] While sexuality education is just one component in a multifaceted approach to address, and ultimately improve, the sexual and reproductive lives of young people, it provides a structured opportunity for adolescents to gain knowledge and skills, to explore their attitudes and values, and to practice the decision making and other life skills necessary for making healthy informed choices about their sexual lives.[4–10] Abstinence-only education programs have shown little evidence of improving sexual and reproductive health (SRH) outcomes.[11,12] In contrast, comprehensive sexuality education programs that recognize that sexual activity can occur during adolescence, that seek to ensure the safety of such behavior and equip students with the knowledge and ability to make informed choices (including to delay sex), and that focus on human rights, gender equality and empowerment have demonstrated impact in several areas: improving knowledge, self-confidence and self-esteem; positively changing attitudes and gender and social norms; strengthening decision-making and communication skills and building self-efficacy; and increasing the use of condoms and other contraceptives.[13–19]

Adolescents' sexual and reproductive health

Addressing the sexual and reproductive health needs of adolescents is a priority for program planners and policymakers in Ghana. Despite efforts targeting young people, recent studies suggest a persistent need for SRH information and services, further emphasizing the need for high-quality sexuality education.

Sexual activity

Nationally, many adolescents (those aged 15–19), whether married or not, have had sexual intercourse (43% of females and 27% of males), and 26% and 14%, respectively, are currently sexually active (Table 1.1, page 6).[20] In Ghana, the median age at first intercourse is 18 for females and 20 for males, and among adolescents, 12% of females and 9% of males had initiated sex before the age of 15. In the three geographic regions included in the current study, a greater proportion of adolescent females had had sex before age 15 in Brong Ahafo (21%) than in Greater Accra (5%) or Northern (8%); among adolescent males, 23% had had sex before this age in Greater Accra, as had only 7% in Brong Ahafo and 3% in Northern.

Contraception, unplanned births and abortion

Contraceptive use is relatively low among adolescents in Ghana. Although 96% of females aged 15–19 have heard of at least one modern method, only 30% of those who are sexually active are currently using any contraceptive method, and 22% are using a modern one. Half of sexually active adolescent females in Brong Ahafo use a modern method (51%), as do 24% in Greater Accra and only 2% in Northern. Ninety-five percent of sexually active adolescent females who are unmarried want to avoid pregnancy within the next two years, but 62% have an unmet need for family planning, meaning they either want to postpone their next birth by at least two years or do not want any (additional) children, but are not using a method. Fourteen percent of all adolescents in Ghana have begun childbearing (i.e., have had a live birth or are currently pregnant), and three-quarters of their births in the past five years were reported as unplanned. This proportion was much lower in the Northern region (16%) than in Brong Ahafo (77%) or Greater Accra (72%). There is also evidence that adolescents are particularly vulnerable to having unintended pregnancies that result in abortions. Results from the Ghana Maternal Health Survey of 2007 show that 16% of pregnancies among those younger than 20 ended in abortion, whereas fewer than 10% of pregnancies among older women resulted in abortion.[21]

HIV prevalence and AIDS

There have been extensive media campaigns promoting HIV and AIDS awareness throughout Ghana. In addition, HIV prevention education has been incorporated into the school system and after-school programs. According to the 2014 Ghana Demographic and Health Survey (GDHS), 64% of females and 84% of males aged 15–19 know where to get condoms, but only 18% and 25%, respectively, have comprehensive knowledge about HIV and

AIDS.*[20] Knowledge varies considerably by gender and region: Males are more likely than females to report having comprehensive knowledge, and adolescents in Greater Accra demonstrate higher levels of knowledge than those in Brong Ahafo and Northern regions. Nationally, HIV prevalence has been lower than in other countries in the subregion, never exceeding 3.6% (reported in 2003). Rates of HIV infection among 15–24-year-olds over the years have remained below the national average, except in 2014, when the rate of 1.8% for this age-group surpassed the national average of 1.6%.[22] Data from the 2014 GDHS show that HIV prevalence is higher among women aged 15–24 than among their male counterparts (1.5% vs. 0.2%).[20]

The need for sexuality education in Ghana

The foregoing indicators point to the diverse SRH needs of adolescents across Ghana, as well as to the relevance and necessity for comprehensive sexuality education prior to the start of sexual activity. In recognizing that improving adolescents' access to high-quality information and services is essential for ameliorating negative health outcomes, key stakeholders in Ghana have proposed policies and programs regarding adolescent sexual and reproductive health, including those related to sexuality education. The Ministry of Education and the Ghana Education Service have collaborated with key agencies, notably the Ministry of Health and the Ghana Health Service, to provide sexuality education in schools. Topics related to SRH are integrated into core and elective subjects, and as co-curricular activities.[23] Although a range of these topics is included in primary, junior high and senior high school curricula in Ghana, the topics are limited in scope—there is a major focus on abstinence and, in some cases, a fear-based or negative perspective on sexuality. The policy environment and program structure are discussed in Chapter 3.

Scope of this report

Reviews of policies and curricula pertaining to sexuality education have shown that while many countries have established curricula, little is known about their use in schools—the degree of implementation, the mode and quality of the instruction, the existence of program monitoring and evaluation tools, the adequacy and quality of teacher training, the level of support for or opposition to the subject, and the effectiveness of existing programs in achieving desired knowledge and behavioral outcomes among students.[10,24–27] This report provides a detailed snapshot of how the policies related to sexuality education in Ghana are translated into practice and what students, teachers and heads of schools think about them. Data from official documents, key informant interviews and school-based surveys were used to examine how sexuality education programs in three regions were developed, implemented and experienced. This report presents findings on the development of policies and curricula, including the actors involved and challenges faced; how sexuality education is taught in classrooms; students' experiences and preferences; support for implementation, including teacher training and school environment factors; sources of SRH information outside of the classroom; and general opinions about such education among key stakeholders. The information presented is intended to provide the Ghana government and other stakeholders with a better understanding of sexuality education in schools, and ultimately to improve the quality and effectiveness of such education for both teachers and students.

*Comprehensive knowledge includes correctly identifying that HIV risk can be reduced by consistently using condoms and by having a single partner who is HIV-negative and who has no other partners, knowing that a healthy-looking person can have HIV and rejecting the two most common local misconceptions about HIV transmission (via mosquitoes and supernatural means).

TABLE 1.1

Sexual and reproductive health indicators for females and males, both nationally and by region, Ghana Demographic and Health Survey, 2014

Indicator	All		Brong Ahafo		Greater Accra		Northern Region	
	Female	Male	Female	Male	Female	Male	Female	Male
Marriage and fertility								
Median age at first intercourse†	18.4	20.0	18.0	20.1	19.0	20.3	17.6	20.6
Median age at first marriage‡	20.7	26.4	21.5	25.0	23.7	28.7	18.7	25.2
Total fertility rate (15–49)§	4.2	na	4.8	na	2.8	na	6.6	na
Age-specific fertility rate (15–19)††	76.0	na	105.0	na	30.0	na	93.0	na
Currently married/in union (15–19)	6.4	0.5	7.3	0.0	3.3	0.0	8.8	0.0
Has begun childbearing (15–19)	14.2	na	21.3	na	8.3	na	10.1	na
Recent birth was unplanned ‡‡	73.9	na	77.1	na	72.0	na	15.6	na
Sexual activity (15–19)								
Ever had sexual intercourse	42.8	26.6	60.0	28.4	30.4	32.3	28.3	15.3
Had sexual intercourse before age 15	11.8	9.3	21.3	7.1	4.5	22.5	8.1	2.6
Currently sexually active§§	26.2	13.8	37.0	16.3	14.7	19.6	22.9	8.2
Sexual health knowledge (15–19)								
Knows of a modern contraceptive*†	96.0	97.5	97.1	96.9	98.2	100.0	80.3	90.3
Knows where to get condoms	64.3	84.1	62.4	80.3	77.6	98.2	25.5	51.1
Has comprehensive knowledge of HIV/AIDS*‡	18.1	24.5	16.9	10.3	26.6	36.5	12.9	15.4
Contraceptive use among sexually active women (15–19)								
Currently using any method								
All	29.6	na	56.8	na	35.4	na	1.7	na
Married/in union	18.6	na	ds	na	ds	na	ds	na
Unmarried	33.2	na	64.8	na	35.0	na	2.8	na
Currently using a modern method*§								
All	22.2	na	51.2	na	24.1	na	1.7	na
Married/in union	16.7	na	ds	na	ds	na	ds	na
Unmarried	24.0	na	58.8	na	20.5	na	2.8	na
Has unmet need for family planning†*								
All	59.1	na	32.0	na	60.2	na	65.3	na
Married/in union	50.7	na	ds	na	ds	na	ds	na
Unmarried	61.8	na	33.6	na	59.3	na	82.9	na
Has demand for family planning†‡								
All	88.6	na	88.8	na	95.6	na	67.0	na
Married/in union	69.3	na	ds	na	ds	na	ds	na
Unmarried	94.9	na	98.4	na	94.4	na	85.7	na
Has HIV (15–24)	1.5	0.2	1.5	0.7	1.4	0.0	0.4	0.0

†Among women aged 20-49 and men aged 25-59. ‡Among women aged 25-49 and men aged 30-59. §The average number of live births a woman would have by the age of 50 if she were subject, throughout her life, to the age-specific fertility rates observed in each given year; calculation assumes no mortality. ††The annual number of births to women of a specified age or age-group per 1,000 women in that group. ‡‡For any birth in the past five years that was defined as mistimed or unwanted. §§Defined as having had sexual intercourse in the past three months or being currently married. *†Women were prompted for their recognition of the following methods: female and male sterilization, IUD, injectable, implant, pill, male and female condoms, lactational amenorrhea method, emergency contraception, rhythm/calendar method and withdrawal. The last two were excluded as modern methods. *‡Includes correctly identifying that HIV risk can be reduced by consistently using condoms and by having a single partner who is HIV-negative and who has no other partners, knowing that a healthy-looking person can have HIV and rejecting the two most common local misconceptions about HIV transmission (via mosquitoes and supernatural means). *§In addition to the methods listed for the knowledge of modern contraceptives measure (except for emergency contraception), women were asked about the diaphragm, foam/gel, other modern methods and other traditional methods. Rhythm/calendar, withdrawal and other traditional methods were excluded as modern methods. †*Unmet need for family planning is defined as currently married or sexually active and fecund women who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not currently using a method. †‡The sum of those who have an unmet need and those who are currently using a method. *Notes:* Median age at first intercourse, median age at first marriage, total fertility rate, age-specific fertility rate and initiation of childbearing are from the 2014 Ghana Demographic and Health Survey (GDHS); all other indicators were calculated using data from the 2014 GDHS. Figures are percentages unless indicated otherwise. na=not applicable. ds=data suppressed, for when DHS data are available for fewer than 20 respondents. *Source:* reference 20.

Study Methodology

The study on which this report is based was conducted as part of a multicountry study to assess the implementation of sexuality education in four countries from two regions (Latin America and Africa): Peru, Guatemala, Ghana and Kenya.* In each region, one country was chosen that is at a relatively more advanced implementation stage with its sexuality education program (Peru and Ghana), and another was chosen that is at an earlier stage (Guatemala and Kenya); these selections were based on reviews of policy documents and curricula, program evaluations and other regional reports,[10,19,24,28] as well as consultation with stakeholders and research partners. While a major aim of the overall study is to compare all four countries, this report presents findings only for Ghana.

*A large-scale study of the implementation of sexuality education curricula in schools in eight Asian countries has been undertaken by UNESCO, with technical support from the Population Council. No such multicountry studies are under way in Africa or Latin America.

Study objectives

The goal of this study was to provide a robust, comprehensive analysis of policies and curricula regarding SRH education in Ghana and their implementation in secondary schools, with a focus on three geographically and ethnically diverse regions: Greater Accra, Brong Ahafo and Northern. Specific objectives included documenting policies and curricula on SRH education, describing the implementation of these, assessing the comprehensiveness of the content, examining the opinions and attitudes of students and teachers regarding such education, and providing recommendations to inform the design and implementation of such programs in schools in Ghana and beyond.

Defining comprehensive sexuality education

The terminology used to describe sexuality education varies across countries; in Ghana, the term sexual and reproductive health education is widely employed, and

BOX 2.1

Definition of comprehensive sexuality education

UNFPA Operational Guidance for Comprehensive Sexuality Education

"UNFPA defines 'comprehensive sexuality education' as a right-based and gender-focused approach to sexuality education, whether in school or out of school. CSE is curriculum-based education that aims to equip children and young people with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality, in the context of their emotional and social development. By embracing a holistic vision of sexuality and sexual behaviour, which goes beyond a focus on prevention of pregnancy and sexually transmitted infections (STIs), CSE enables children and young people to: 1) Acquire accurate information about human sexuality, sexual and reproductive health, and human rights, including about: sexual anatomy and physiology; reproduction, contraception, pregnancy and childbirth; sexually transmitted infections and HIV/AIDS; family life and interpersonal relationships; culture and sexuality; human rights empowerment, non-discrimination, equality and gender roles; sexual behaviour and sexual diversity; and sexual abuse, gender-based violence and harmful practices; 2) Explore and nurture positive values and attitudes towards their sexual and reproductive health, and develop self-esteem, respect for human rights and gender equality. CSE empowers young people to take control of their own behaviour and, in turn, treat others with respect, acceptance, tolerance and empathy, regardless of their gender, ethnicity, race or sexual orientation; 3) Develop life skills that encourage critical thinking, communication and negotiation, decision-making and assertiveness. These skills can contribute to better and more productive relationships with family members, peers, friends, and romantic or sexual partners."[30]

we therefore use that terminology when referring specifically to Ghana throughout this report. While different definitions of comprehensive sexuality education (CSE) have been developed over time,[4,5,7,29] this study used the United Nations Population Fund (UNFPA) definition* (Box 2.1, page 7). On the basis of the UNFPA definition, this study explored SRH education in Ghana according to three dimensions: information and topics covered, values and attitudes nurtured, and life skills developed.

Assessing the comprehensiveness of topics offered

Because one aim of the study was to measure the comprehensiveness in the range of topics offered, we assessed this range according to international standards, in order to provide a baseline measure for developing policies or curricula in the future. The topics considered in this study reflect a broad approach that could reasonably be expected in Ghana, given cultural contexts. For example, we did not include topics such as sexual pleasure or desire, which are not culturally appropriate in the country setting. We did include abstinence, as this approach persists in many developing (as well as some developed) countries. Using various international guidelines, we identified five topic categories as key components of a comprehensive program (Box 2.2). The presence or absence of the topics in each category was used to measure comprehensiveness in the range of topics offered. We defined three levels: minimum, adequate and high. If at least one topic in each of the five categories was included, the range met at least a "minimum" level.† If nearly all topics (except one at most) in each of the categories were included, the range was considered at least "adequate." The range was deemed to meet a "high" level of comprehensiveness if all topics in each category were included. These levels of comprehensiveness are not mutually exclusive; for example, schools that meet an "adequate" level also meet the "minimum" level, but will be categorized at the highest level achieved.

In addition to these topics, our study examined concepts and messages that may be delivered—and the values, attitudes and life skills nurtured—as part of a comprehensive approach to SRH education (Box 2.3, page 9). These elements focus on gender, rights and empowerment, risk-reduction skills, interpersonal relationships and positive views on healthy sexuality. To gain a more

*This definition does not necessarily reflect the position of the Ghana government. †The individual topics included in the categories are based on international guidelines, but the levels of comprehensiveness were defined specifically for this study and do not refer to any international standards.

BOX 2.2

Key categories and topics that constitute comprehensive sexuality education

Category	Topics
Sexual and reproductive physiology	Puberty/physical changes in the body; reproductive organs; menstruation; pregnancy and childbirth
HIV/STI prevention	HIV and AIDS; other STIs; where to access STI/HIV services
Contraception and unintended pregnancy	Contraceptive methods; where to get contraceptive methods; how to use contraceptive methods; abortion
Values and interpersonal skills	Communicating within relationships; decision-making skills; sex in exchange for money or gifts; sexual behavior; abstinence/ chastity; moral issues related to sexuality
Gender and SRH rights	Sexual and reproductive rights; equality between men and women; prevention of violence and sexual abuse; sexual orientation

nuanced understanding of what is taught in the classroom and the tone in which the teaching is delivered, we assessed, among both students and teachers, the extent to which the concepts and messages were emphasized. We did not, however, include these concepts in our measure of comprehensiveness in the range of topics.

Limitations of the comprehensiveness measure

The measure we developed addresses only the range of topics taught, not other essential components that may determine the comprehensiveness of an SRH education program, such as integration of youth and community engagement into curriculum development, use of participatory teaching methods, safety of the learning environment, and links to SRH services and other initiatives that address adolescent sexual and reproductive health issues.[5,31,32] Moreover, the measure does not assess the depth or manner in which a topic is addressed. For example, our measure assessed whether a school teaches about contraception, but did not capture the accuracy of information, the value judgments conveyed or the time spent teaching about contraception.

Study design

This cross-sectional assessment evaluates the implementation of SRH education in three regions in Ghana. In addition to reviewing existing policies, curricula and other documents regarding adolescent sexual and reproductive health, the study collected data from three sources.

In-depth interviews with key informants. Informants were asked about their views on current SRH education policy; opinions about the design, structure, coverage and content of the program; experiences implementing it in the school system, including how to better support it and challenges faced; perceived sources of support for or opposition to implementation at the national, regional and school levels; and monitoring and evaluation frameworks in place.

Survey of senior high school heads and teachers. Researcher-administered surveys elicited participants' responses regarding the content of the curriculum; approach and format of SRH education in schools; teacher and student assessment methods; teacher training and support; school environment and perceptions of support for or opposition to the subject; and attitudes toward sexuality and SRH issues.

BOX 2.3

Concepts, messages and values conveyed in comprehensive sexuality education

Focus of the concept or message	Specific concepts and messages
Gender, rights and empowerment	How to make positive decisions and stick to them; recognizing forced sexual contact; respect for self and others regardless of gender or social status; the right of young people to have accurate information about relationships, and sexual and reproductive health
Risk reduction and prevention of HIV/STIs and unintended pregnancy	How alcohol and drugs affect behavior; signs, symptoms and ways to prevent transmission of HIV/STIs; ways to prevent pregnancy; explanations of how each contraceptive method works and the importance of using a method consistently and correctly
Interpersonal relationship skills	Men and women share responsibility for pregnancies; how to communicate/negotiate with a partner about using contraceptive methods and getting screened for HIV/STIs; the importance of disclosing HIV status to a partner
Healthy, positive approach to sex	Young people should protect themselves when having sex; sexuality is a natural, healthy and positive part of life

Survey of senior high school students. Self-administered surveys assessed students' exposure to SRH education; preferences regarding content, teaching approach and format of the information received; level of support for or opposition to sexuality education in schools; and attitudes toward SRH issues.

Sampling strategy

Key informant interviews

Twenty-five key informants were identified through consultation with a wide range of stakeholders involved in policy making, program implementation or advocacy regarding SRH education. Informants included Ministry of Education staff involved in the development of policies and curricula related to SRH education, as well as national stakeholders and individuals with international agencies and NGOs involved in implementation. Also included were individuals working for groups advocating for or opposing the provision of SRH education in schools, and leaders of community organizations (e.g., youth associations), parent-teacher associations, women's groups and religious groups.

Survey of schools

Selection of regions. For the school-based quantitative survey, a multistage sampling process was adopted. The first stage involved the selection of three out of Ghana's 10 regions, to represent geographically, ethnically and economically diverse areas. In accordance with the methodology used by the Ghana Statistical Service, the country was divided into three zones:

- Southern (regions that have coastal strips): Western, Central, Greater Accra and Volta;
- Middle (regions in the forest zone): Eastern, Ashanti and Brong Ahafo;
- Northern (regions in the northern savannah zone): Northern, Upper East and Upper West.

One region was selected from each zone. In the Southern zone, Greater Accra was purposively selected because it includes the national capital and, therefore, decision makers at the national, regional and local levels. For the other two zones, Brong Ahafo and Northern were randomly selected.

Selection of schools. The second stage involved the selection of schools in the three regions. Because the study targeted students aged 15–17, surveys were conducted in senior high schools.* Eighty-two schools were selected (Table 2.1, page 11); this number was based on a minimum required sample of 2,500 students, and a low-end estimate of 35 eligible students per school, using typical school and grade sizes.† For each region, the sample was stratified by school type (public or private) and coeducational status (mixed gender, females only or males only) to ensure a representative sample.‡ The six single-sex schools in each region were purposively selected.

Of these 82 schools, 13 were dropped from the original sample and replaced—seven in Northern (including two single-sex schools), four in Greater Accra and two in Brong Ahafo—for reasons such as being on break during the survey period or not having enough students between the ages of 15 and 17. Only two of the 13 schools were replaced because of refusal to participate: One was a private, all-male seminary school in the Northern region that did not allow questions about sexuality to be asked, and one was a public school in Greater Accra that refused because it had not received a letter from the regional director of education.

Selection of school heads and teachers. In each of the schools, the head of the school (or the assistant head if the head was not available) was automatically selected to complete the survey. In four schools, the heads or assistant heads were unable to make time after two or more researcher requests, and therefore only 78 schools are represented for indicators that rely on information from the school heads. Teachers were selected on the basis of their involvement in teaching SRH education topics to students in Form 2 or 3 (i.e., the second and third years of senior high school). Since these topics are integrated into biology, social studies, integrated science and management in living, teachers of these subjects were targeted in each sampled school. These teachers were identified through consultation with the school head, and up to five teachers per school were selected on the basis of availability on the day of the survey and an aim to cover the range of different subjects. In one school, no teachers were available, so only 81 schools are represented for indicators that rely on teacher-level data.

Selection of students. All students in Forms 2 and 3 and aged 15–17 were eligible for selection. These students

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*The education system in Ghana includes six years of primary, three years of junior high school, three years of senior high school and four years of postsecondary. Although SRH education begins in primary school, senior high schools were chosen for the study in order to assess the cumulative information that students had received at every level. †The sample size of 2,500 students was determined to enable the detection of a 10% difference among regions in a key outcome (comprehensive knowledge of HIV), at a 5% significance level with 90% power, assuming a design effect of 2 because of two-stage sampling. ‡School stratification was based on the size of each stratum as generated using the same criteria.

were selected because they were likely to have been exposed to at least one year of SRH education in high school and could therefore provide the information we sought to collect. Although this age range was targeted, students aged 13–14 and those older than 17 who were in Form 2 or 3 were not excluded from participating. One percent of students who participated were either younger than 15 or older than 17; three students—one in each region—refused to participate. To ensure equal representation of each school within its region, the number of sampled students per school was proportionate to school size. To minimize potential bias, all eligible students registered in Forms 2 and 3 at each school were gathered in a room and a ballot box was used to randomly select the desired sample of students. In one school, only one student was available at the time of the survey, so no student survey was done, and only 81 schools are represented for indicators that rely on student-level data.

Instrument development and data collection

The interview guide and questionnaires used in this study were developed by an international team of researchers; they drew from multiple instruments that have been used to assess aspects of SRH education both in and out of school.[1,2,29,32–37] Discussions were held with representatives from the Ministry of Education and various local organizations to gather necessary data or information that was used to refine the tools and make them country-specific.

Ethical clearance for the study was obtained from the institutional review boards of the University of Cape Coast and the Guttmacher Institute. Permission to conduct the study was obtained from the Director-General of the Ghana Education Service. Following the selection of the regions and schools, letters were sent to the three regional directors of education, informing them about the survey and requesting their support. Two responded favorably to the request and

TABLE 2.1

Number of schools included in the study, by selected characteristics, according to region

Characteristic	All	Region		
		Brong Ahafo	Greater Accra	Northern
School type				
Public	64	23	22	19
Private	15	3	6	6
Joint public/private†	3	2	0	1
School status				
Mixed gender	66	22	22	22
Females only	10	5	3	2
Males only	6	1	3	2
School administration				
Government-assisted public	57	17	21	19
Government-assisted religious	8	6	1	1
Government-assisted community	2	2	0	0
Private individual/NGO/CBO	7	1	6	0
Private community	6	2	0	4
Private religious	2	0	0	2
Total	82	28	28	26

†Because the structure of joint public/private schools more closely resembles that of public schools, these schools were analyzed together with public schools. *Note:* CBO=community-based organization.

in turn sent letters about the study to the selected schools in their respective regions. The regional director in Greater Accra did not respond to the letter, but the heads of schools in that region were shown the permission letter from the Director-General, which was sufficient to allow entry into their schools. Heads of all sampled schools were contacted by mail to solicit their support for and participation in the study; when necessary, follow-up contact was by phone and then by a visit from a member of the research team. Authorization from the school head was obtained before entering any school to field the surveys, and further authorization to survey students was obtained from each head; some heads solicited consent from school boards (where deemed necessary).

Informed consent was sought from all participants. To maintain students' anonymity, neither heads nor teachers knew which students completed the survey. Students were made aware that their decision to participate was completely voluntary and that their responses were anonymous; they were given the possibility to withdraw from the survey at any time and to skip any question they did not wish to answer. Students who chose not to participate were instructed to remain in the room and work quietly on something else while the others completed the survey. All information provided by respondents was treated as strictly confidential, and access was denied to anyone outside of the research team. Key informant interviews were conducted in English, audio recorded (with their consent) and transcribed, and quotations have been anonymized.

Most fieldwork took place from February to April of 2015. Because of scheduling issues, for one school in the Greater Accra region, the survey was conducted in June 2015, and a few opinion leaders in the Northern and Greater Accra regions were interviewed in September of that year.

Data management and analysis

Qualitative data were examined using thematic and content analysis in NVivo. Quantitative data were double-entered into Excel 2013 and transferred into SPSS 22 and Stata 14 for analysis. Descriptive analyses were conducted by type of school (public or private) for each region. To ensure that all estimates were representative at the regional level, sample weights were applied to account for the different probabilities of a school, student, teacher or head being selected to participate. We provide the unweighted sample sizes in the tables.

We present regional-level data in tables at the end of the report, but in the text we present summary measures of the three regions combined. Figures are used to depict key findings, and all data provided in the figures also appear in the tables. We note specific differences between regions, and by school type and gender, only when those differences are statistically significant and have programmatic or policy relevance. We report differences by gender for measures related to students' perceptions of school safety and out-of-school experiences with SRH education. All significance tests account for clustering at the student and teacher levels to ensure correct variance estimates. Pearson's chi-square tests were used to detect differences in proportions and percentage distributions among regions, between public and private schools, and between females and males. When "other" response categories accounted for more than 5% of responses for a particular variable, these responses were analyzed and recoded into existing or new categories.

For some school-level indicators, especially those related to policies or program structure, we considered school heads' responses to be representative of the entire school. However, for most school-level indicators, we relied on teachers' and students' responses, as they are more familiar with classroom practice. For questions asked of teachers, but presented at the school level, we classified a school response as "yes" if one or more teachers responded affirmatively; if one teacher in a school was teaching an aspect of SRH education, then we considered it offered in the school to some capacity. For questions asked of students and presented at the school level, we classified a school response as "yes" if at least 20% of students responded affirmatively to a particular question. We did not choose a higher cutoff because we wanted to ensure that a school was counted as offering a topic even if only a few students reported it, since only one of the grades surveyed may have covered it, or not all students may have taken that particular class. We required at least 20% of students because—while the average number of students per school in our sample was 36—some schools were very small and some indicators were based on a subsample of students. Capturing responses from at least 20% of students ensured that we were basing our estimates on the responses of more than one student per school in the very small schools.

In sections that present both teacher-level and student-level data, the teachers' responses cannot be directly compared with those of students, even though in most cases we asked teachers and students similar questions. Topics related to sexual and reproductive health are included in different subjects and taught differently by multiple teachers, and we did not track which students were taught by which teachers. Rather, the teachers' responses reveal the overall experience of teachers who cover the various topics, and the students' perspectives show the overall experience with SRH education among the student body.

Throughout the report, we present students' and teachers' experiences as they occurred in schools during normal school hours. Students are also exposed to SRH information through a number of channels outside of the formal school setting, such as peer educators, media, parents and extracurricular activities (see Chapter 6). While such exposure can influence students' attitudes and knowledge regarding SRH education, we do not expect it to influence their responses to school-based questions nor affect our assessment of classroom practice. Summaries of key findings are presented at the ends of Chapters 3–7.

Characteristics of samples

In the 82 sampled schools, we surveyed 78 school heads, 346 teachers and 2,990 students. Three-fourths of the schools were public, and most enrolled both females and males. A majority of the teachers in the study were male (61%), and seven in 10 had taught topics related to SRH education for three or more years. Of the sampled students, six in 10 were female, 80% were in Form 2, and the majority were aged 16 (35%) or 17 (56%). One–fourth of students (27% of males and 23% of females) had had sexual intercourse. For more details on characteristics of the survey respondents, see Table 2.2 for school heads, Table 2.3 for teachers (page 14) and Table 2.4 for students (page 15).

TABLE 2.2

Percentage distribution of school heads by selected characteristics, according to region

Characteristic	All	Region		
		Brong Ahafo	Greater Accra	Northern
	(N=78)	(N=27)	(N=26)	(N=25)
Gender				
Male	83.1	93.1	63.6	96.6
Female	16.9	6.9	36.4	3.4
No. of years as head at current school				
<1	3.2	2.9	5.7	0.0
1–4	57.9	70.6	50.0	50.4
>4	37.7	25.5	44.3	46.2
Missing	1.2	1.0	0.0	3.4
Taught SRH topics at current school				
No	75.2	85.3	63.8	76.9
Yes	24.8	14.7	36.2	23.1
Religion				
Catholic	10.6	10.8	4.7	18.9
Protestant	31.2	43.6	35.4	6.7
Pentecostal	24.6	17.6	46.4	3.4
Other Christian	12.2	19.1	13.5	0.0
Muslim	21.4	8.8	0.0	71.0
Total	100.0	100.0	100.0	100.0

Note: Percentages may not add to 100.0 because of rounding.

TABLE 2.3

Percentage distribution of teachers by selected characteristics, and percentage by position, subject and form, according to region

Characteristic	All	Region		
		Brong Ahafo	Greater Accra	Northern
	(N=346)	(N=117)	(N=115)	(N=114)
Gender				
Male	61.4	72.2	45.4	79.7
Female	38.2	27.2	54.6	19.8
Missing	0.3	0.6	0.0	0.6
No. of years teaching overall				
<5	20.0	32.2	12.4	20.0
5–9	14.4	14.3	12.4	18.6
10–19	39.8	31.6	39.6	50.1
≥20	22.9	21.9	29.7	10.8
Missing	2.9	0.0	6.0	0.6
No. of years teaching SRH topics at current school				
<1	3.4	4.8	2.8	2.7
1–2	25.4	33.7	15.9	33.7
3–4	28.8	30.1	26.7	31.4
≥5	40.9	29.2	53.9	29.9
Does not teach such topics	0.9	0.4	0.6	2.0
Missing	0.6	1.8	0.0	0.4
Religion				
Catholic	21.2	31.6	13.7	23.1
Protestant	21.5	24.2	26.5	8.2
Pentecostal	27.7	23.1	41.9	5.7
Other Christian	10.2	11.8	13.2	2.5
Muslim	18.5	8.4	3.6	60.0
Other	0.9	0.9	1.2	0.0
Missing	0.1	0.0	0.0	0.6
Total	100.0	100.0	100.0	100.0
Position†				
Class teacher	30.7	43.2	28.7	19.3
Teacher (general)	72.2	62.0	75.7	77.9
School counselor	4.1	3.1	6.2	1.1
House master/mistress	9.1	8.9	8.3	10.9
Head of department	5.6	6.8	2.8	9.9
Other	3.5	5.5	2.8	2.4
Missing	0.1	0.0	0.0	0.6
Subject†				
Biology	24.3	22.4	28.2	19.1
Integrated science	24.4	21.0	26.3	24.8
Social studies	43.5	41.2	45.1	43.0
Management in living	18.4	17.3	18.1	20.5
Religious and moral education	3.3	4.7	3.4	1.4
Physical education	1.2	0.0	2.3	0.4
Other home economics	5.8	1.8	8.1	6.1
Other	5.6	8.6	5.2	2.8
Missing	0.1	0.0	0.0	0.6
Teachers who cover SRH by form†	(N=343)	(N=117)	(N=114)	(N=112)
Form 1	63.3	54.0	72.6	56.3
Form 2	64.4	61.0	68.1	61.3
Form 3	55.8	52.3	60.1	51.6

†Multiple responses were allowed. *Note:* Percentages may not add to 100.0 because of rounding.

TABLE 2.4

Percentage distribution of students by selected characteristics, and percentage who have had sexual intercourse and by residence, according to region

Characteristic	All	Region		
		Brong Ahafo	Greater Accra	Northern
	(N=2,990)	(N=951)	(N=856)	(N=1,183)
Gender				
Male	40.1	41.2	40.8	38.7
Female	59.7	58.7	59.0	61.0
Missing	0.2	0.1	0.2	0.3
Age				
10–14	0.4	0.3	0.3	0.6
15	7.7	5.4	8.9	8.5
16	34.6	29.4	42.1	32.8
17	56.3	64.5	47.5	57.0
≥18	0.6	0.3	0.9	0.7
Missing	0.3	0.1	0.4	0.5
Form				
Form 2	80.0	84.0	72.6	82.6
Form 3	19.5	15.7	26.8	16.7
Missing	0.5	0.3	0.6	0.7
Religion				
Catholic	11.4	19.2	5.2	10.3
Protestant/other Christian	54.0	66.8	85.3	20.3
Muslim	33.4	13.0	7.8	68.3
Other	0.6	0.6	0.8	0.6
No religion	0.1	0.0	0.4	0.0
Missing	0.5	0.5	0.4	0.5
Total	100.0	100.0	100.0	100.0
Current residence†				
With parent	83.7	87.8	81.0	82.6
With other family member/guardian	28.6	27.0	29.3	29.2
Boarding school	53.9	48.9	35.0	72.2
Other‡	9.3	8.9	4.8	13.0
Missing	0.2	0.1	0.2	0.2
Has had sexual intercourse	24.8	33.9	20.1	21.4
Males	27.1*	32.1	26.8	23.2
Females	23.3	35.2	15.6	20.3

*Difference between males and females was significant at p<.001. †Multiple responses were allowed. ‡Including on their own, with friends or with partner. *Note:* Percentages may not add to 100.0 because of rounding.

CHAPTER 3

Sexual and Reproductive Health Education in Ghana

This chapter describes the policy environment driving sexual and reproductive health education in Ghana, the structure and organization of the program, the actors involved in curriculum development, and challenges to program development and curriculum design, and includes commentary on program comprehensiveness. This information is drawn from a desk review of policy documents and syllabi currently used in secondary schools in Ghana.

The legal and policy environment

Curriculum-based sexual and reproductive health education has a long history in Ghana, and several policy and program developments have shaped its current provision (Box 3.1, page 17).[38–44] At the national level, there is a legal framework as well as a supportive policy environment for the development and implementation of SRH education. However, while several policies and commitments address adolescents' rights, and issues related to SRH, fewer directly address SRH education in schools. In 2000, the government published its first *Adolescent Reproductive Health Policy* (ARHP), which adopted a multisectoral approach to addressing adolescent reproductive health issues.[45] The policy explicitly encouraged and led to the inclusion of a reproductive health component in the educational curriculum at the primary, junior high and senior high school levels. In 2013, the *National HIV and AIDS, STI Policy* advocated for the inclusion of age-appropriate SRH education in the school curriculum, which includes lessons on HIV/AIDS and other STIs.[46]

Ghana has agreed to several international declarations (e.g., the Abuja and Maputo Declarations) that have informed governmental decisions and actions on SRH, including specific changes relating to improving access to services and information for adolescents. The 2000 ARHP was revised in 2015 and renamed the *Sexual and Reproductive Health Policy for Young People in Ghana*.[47] The vision for the new policy is "to have young people who are well informed about their sexual and reproductive health and rights, and are healthy."

Actors involved in curriculum development

The Ministry of Education and the Ghana Education Service, with support from the Ministry of Health, implement the School Health Education Programme in schools, which was developed in collaboration with a number of ministries and NGOs.* The development of national in-school curricula for the basic education system is the responsibility of the Curriculum Research and Development Division of the Ministry of Education. The Division works in consultation with various national and regional bodies—including the Ghana Health Service, the Ghana Education Service, the Ghana National Association of Teachers, the National Association of Graduate Teachers, the education units of religious bodies that administer schools, the National Youth Authority, traditional leaders, civil society organizations and various Parent-Teacher Associations (PTAs)—to ensure the quality of the content developed, as well as to secure buy-in from necessary government entities and other key stakeholders.

Two groups that have significant influence at the local level are the Board of Governors and PTAs. The former constitutes the highest level of authority in the management of schools and consists of representatives from the community, teachers, the PTA, the owners or administrators of the school, past students, the Ghana Education Service and other members selected for their specific expertise. Although schools in Ghana operate with the same curriculum and syllabi, the Board, particularly in religious and private schools, influences the scope and topics to be taught and regulates co-curricular activities, including those regarding sexuality. The role of PTAs is to contribute to congenial school and academic environments, to foster effective teaching and learning, to provide resources (such as buses, classrooms and dormitory accommodation) in some schools and to support extracurricular activities. Through their activities and representation on the school Board, PTAs can influence the topics taught, especially in potentially controversial areas such as SRH education.

*The institutions involved are the Ministry of Water Resources, Works and Housing, Ministry of Local Government and Rural Development, Ministry of Women and Children's Affairs, Ministry of Food and Agriculture, Department of Social Welfare, World Vision International, Plan Ghana, Care International, Water Aid and Planned Parenthood of Ghana.

BOX 3.1

Landmarks in the development of sexual and reproductive health

Year	Landmark
Up to 1957	Teaching of civics and hygiene (covered human biology, personal hygiene and civic responsibilities)
1957	Ghana wins independence from British administration
1957–1966	Pronatalist view about population issues; continued with the program in the pre-independent period
1967	Planned Parenthood Association of Ghana (PPAG) established
1969	A government policy on population is published—*Population Planning for National Progress and Prosperity;* Ghana becomes one of three African countries with a population policy
1970s	PPAG pioneered in-school teaching of adolescent sexual and reproductive health
1972	Introduction of environmental/social studies syllabus, covering aspects such as sexual and reproductive health, the family, reproduction and sexuality, with an emphasis on abstinence
1976	Aspects of sexual and reproductive health introduced into pre-service training in Teacher Training Colleges
1987	New Structure of education introduced and with it the development of the life skills syllabus
1992	School Health Education Programme (SHEP) initiated as co-curricular activity
1994	1969 national population policy revised
1998	Life skills syllabus replaced with social studies, and the syllabus expanded to include issues on HIV and AIDS
2000	*Adolescent Reproductive Health Policy* issued, which explicitly encouraged and led to the inclusion of a reproductive health component in the educational curriculum at junior and senior high school levels
2001	Start of the Strengthening HIV/AIDS Partnership in Education (SHAPES I and II) program, which aimed at improving the teaching of adolescent sexual and reproductive health
2003	SHEP officially launched
2006	HIV Alert program officially launched
2007	Three-year senior high school program changed to four years
2010	Four-year program reverted to three years
2013	*National HIV and AIDS, STI Policy* advocated for the inclusion of age-appropriate sexual and reproductive health education that includes lessons on HIV/AIDS and other STIs into the school curriculum
2014	SHEP revised and improved to become the Enhanced School Health Education Programme (E-SHEP)
2015	1994 national population policy revised
2015	The 2000 *Adolescent Reproductive Health Policy* revised as *Sexual and Reproductive Health Policy for Young People*

Curriculum content and structure

Although this study focuses on the senior high school level, the primary school and junior high school levels—where students are, on average, between 7 and 14 years old—are important entry points to begin addressing topics related to appropriate touching, sexual and reproductive health and rights, and gender equality.[3] The exposure of students to SRH education in primary school is also advantageous given the high levels of enrollment in lower compared with upper levels. In the 2014–2015 academic year, 48% of 15–17-year-olds attended senior high school, while 85% of those aged 12–14 attended junior high school.[48,49] This suggests that a comprehensive program introduced at the lower level may be even more impactful.

Sexual and reproductive health education, as defined in this study, is not explicitly included as a stand-alone, examinable subject in the Ghana national curriculum. Instead, the Ghana education system has adopted a cross-curricular approach, in which some topics related to SRH have been included in specified school subjects.[50] Basic SRH education topics are introduced in the fourth year of primary school, a level at which all subjects, including those that cover SRH topics, are compulsory. In senior high school, however, the topics are integrated into two core, compulsory subjects (social studies and integrated science) and two elective subjects (biology and management in living). There are also two main co-curricular programs that offer additional activities outside of the regular curriculum, either during or after school: the School Health Education Programme (SHEP) and the HIV Alert program. Both programs operate in all schools in Ghana; they target students in primary and junior high schools in particular, but are also offered in senior high schools with support from the Ministry of Health and the Ghana Health Service.[23,51] The cross-curricular and co-curricular approach makes it possible to spread the coverage of SRH topics across selected subjects, yet it precludes the opportunity to have a focused program that covers all aspects of a comprehensive SRH education program.

In-school SRH education at the senior high school level

For a complete list of topics included in the social studies, integrated science, biology and management in living curricula for senior high school, see the Appendix (page 76).[42,52–54] Topics range from definitions and explanations of adolescence, sexual and reproductive health and rights, and biological changes in the body to gender relations and contributions of youth, but there is a strong emphasis on negative and irresponsible behaviors of adolescents, as well as a focus on the benefits of abstinence. While social studies includes a broad range of topics, those covered in integrated science and biology are more basic. The management in living curriculum addresses the most extensive list of SRH topics, including abortion (in the context of how illegal abortion affects adolescents), family planning, STIs and decision making. However, this subject is not compulsory; it is offered as part of the home economics elective program, which is generally attended by only a small group of students, and mainly females.

The number of academic units allocated to each of the subjects over the three senior high school years varies and is lowest for social studies (23 units) and highest for biology (75 units; Table 3.1). Although biology and integrated science are prominent in the curricula, they have the fewest units dedicated to SRH-related topics. Each lesson (i.e., coverage of a topic area) could span one or two periods, and each period typically lasts 30–35 minutes.

HIV Alert Program

The HIV Alert program was launched in 2006 as a co-curricular activity in primary, junior high and senior high schools and in Colleges of Education. Developed by the Ghana Education Service with support from the United Nations International Children's Emergency Fund (UNICEF) for the in-school component and from UNFPA for the out-of-school arm, this program emphasizes the prevention of HIV infection and the importance of related issues, such as chastity and abstinence. The main target group for this program is 5–15-year-olds in primary and junior high schools. The program exists in Colleges of Education as part of the pre-service training for teachers who will cover this material at the primary and junior high school levels.

TABLE 3.1

Number of units in the national syllabus dedicated to SRH-related topics in the focus subjects, and number of periods subjects are taught per week

Subject	Year 1		Year 2		Year 3		No. of periods per week
	SRH-related	Total	SRH-related	Total	SRH-related	Total	
Social studies	1	8	4	9	2	6	3
Integrated science	1	23	1	18	0	11	5
Biology	0	23	2	29	2	23	6
Management in living	6	16	4	15	0	7	6

Sources: references 42 and 52–54.

Enhanced School Health Education Programme

The School Health Education Programme, initiated in 1992 but officially launched in 2003, was established as a joint mandate of the Ministry of Education and the Ministry of Health; it aims to provide co-curricular health education, such as the HIV Alert program, to students in primary and junior high schools (aged 5–15). SHEP was established as one of the follow-up actions to Ghana's commitment to the Jomtien World Declaration on Education for All and ratification of the United Nations Convention of the Rights for the Child. The goal of SHEP is to guide children in school to acquire the knowledge, skills and attitudes needed to achieve lifelong health.[23] Specific objectives include providing effective school health education, ensuring safe and healthy learning environments, providing health services and using schools as an entry point to implement health policies.

With support from UNICEF, UNFPA and the United Nations Educational, Social and Cultural Organization (UNESCO), SHEP was revised and expanded in 2014 and renamed Enhanced SHEP (E-SHEP), with the subtitle *Life Skills Based School Health Education*.[55] E-SHEP subsumed the HIV Alert curriculum and consists of four broad areas: values and psychosocial skills development; reproductive health, HIV and AIDS; issues of time management and goal setting; and the roles of teachers, peer educators and community members (Box 3.2). E-SHEP has a teacher-led component, in which some teachers are trained to provide co-curricular education, including counseling, in sexual and reproductive health in schools; a peer-led component, in which adolescents are trained to deliver information to their peers in schools and in communities; and a community-led component, which takes place in the community using trained community members.

BOX 3.2

Enhanced School Health Education Programme

- Values
- Psychosocial skills
  - —self-esteem
  - —assertiveness
  - —negotiation
  - —nonverbal and verbal communication
  - —the POWER Model
- Adolescent reproductive health
  - —adolescent growth and development
  - —adolescent sexual and reproductive health
  - —adolescent sexuality and sex education
  - —norms, ethics and adolescent sexuality
- Basic facts about STIs
  - —basic facts and HIV infection and AIDS
  - —major factors that influence the spread of HIV infection (sexual abuse, drug abuse, gender issues)
  - —knowing your HIV status
  - —people living with HIV and AIDS
  - —stigma and discrimination
- Goal setting and time management
- The adolescent and social media
- My role as a teacher/peer educator

Sexual and reproductive health education yes, but how comprehensive?

Current evidence suggests that participatory SRH education programs that include content on gender equality, power relations and human rights are more likely to be associated with positive SRH outcomes than are those that do not.[15] According to the UNFPA definition of comprehensive sexuality education used in this study (see Chapter 2), CSE should "equip children and young people with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality," and practical skills, gender and rights are featured prominently.[30] Research also shows that abstinence-only programs that do not acknowledge that adolescents may be sexually active are not effective in improving sexual and reproductive outcomes in adolescents.[11,12]

In Ghana, the integration of SRH topics into core and elective subjects, as well as co-curricular activities, has resulted in most junior high and senior high school students being exposed to basic SRH education concepts in school. However, a limited range of topics is covered as part of the compulsory school subjects. Topics such as communication and interpersonal skills, which are imperative for adolescent development, are included in the management in living elective curriculum and the HIV Alert module, and contraception topics are included in management in living and biology electives, but neither of these subjects is taken by all students. Other pertinent issues—such as negotiation skills, ability to manage risks, how to use and where to access contraceptives, gender and marriage, body autonomy, gender-based violence and gender equality—are not included in the compulsory social studies curriculum. Furthermore, issues involving young males are not given as much attention as those involving females. For instance, beyond the physical maturation of young males (semenarche), the challenges of male development and behavior (e.g., the societal macho image) are not addressed.

Another challenge to effective SRH education lies in the tone of the presentation. In Ghana schools, SRH information is often presented from a negative or reactive perspective. Indeed, the introduction to the adolescent reproductive health section in the social studies curriculum states:[42]

"As adolescents mature and become sexually active, they face serious health risks. Many adolescents face these risks with too little factual information, too little guidance about sexual responsibility and too little access to health care. There is consequently a rampant wave of the following: (1) adolescent pregnancies, (2) adolescent denial of paternity of pregnancies, (3) child abandonment and (4) irresponsible sexual relationships."

The curriculum adopts a fear-based perspective when discussing challenges that adolescents face rather than emphasize their unique opportunities and needs at this stage. The emphases in the SRH-related topics are directed at problematizing sexual behaviors among adolescents; premarital sex is described as one of many irresponsible behaviors and as being the cause of negative health and social outcomes. The same approach is used in the management in living curriculum, which covers a broad range of topics but still casts a negative light on some topics related to adolescent sexual behavior (see Appendix, page 76). The teaching of issues related to human rights is focused on the perpetration of human rights abuses, rather than on a respect for human rights. Throughout the syllabi, the negative consequences of actions dominate the presentation of topics.

Moreover, the SRH-related components in the various curricula focus heavily on the importance of abstinence and the dangers of sexual activity, and pay little attention to healthy sexual behaviors, such as negotiation skills and contraceptive and condom use, which adolescents will need to know about in the future. The argument has been that this approach is in line with the beliefs and expectations of Ghana society, and therefore this approach reflects what adolescents need. However, this argument ignores the fact that some adolescents do engage in sex outside of marriage for whatever reason, and need to be supported with the necessary information and resources to enable them to protect themselves and make healthy decisions.

One key informant—a government official from the Greater Accra region—argued for the importance of maintaining the current content of the curricula within the norms of traditional society "because as a society we are very religious, we believe in morals and so we want the young ones to know what the values of society are." However, other informants expressed the importance of enhancing SRH content, and of including relevant topics that adolescents face. Some proposed that topics should be added to the SRH education syllabus and that these should be included in the core curriculum rather than as electives:

"I think they are all relevant [topics]. Actually, we have gone further to develop a manual for school on adolescent reproductive health, and it has a few more topics than that. We have something on drugs, and the other issues that are pertinent to the adolescents, and more on values and assertiveness.... We are trying to give [adolescents] an enhanced school health education that looks at all the issues that they face."

—Government official, Greater Accra region

"I think these topics are very brilliant, but one that you have in the elective, but not in the core subject, is decision making. I think it's quite critical that we [include] it as one of the core topics."

—Respondent from an NGO

Summary of findings

- Ghana has a supportive policy environment for SRH education. The *Adolescent Reproductive Health Policy,* revised in 2015, led to the inclusion of a reproductive health component in the curriculum in junior high and senior high schools.
- In 2013, the *National HIV and AIDS, STI Policy* advocated for the inclusion of age-appropriate SRH education (including HIV and other STIs) in the school curriculum.
- National basic education curricula are developed by the Curriculum Research and Development Division in consultation with government bodies, teachers' associations, religious groups, youth associations, traditional leaders and civil society organizations; at the school level, the Board of Governors and Parent-Teacher Associations can also influence the topics that are taught.
- SRH education is not a stand-alone subject in the national curriculum. Topics are integrated into different subjects, some of which are core (compulsory) and others elective; topics in elective subjects tend to be more comprehensive.
- SRH education is taught from primary 4 through senior high school. Primary school is an ideal entry point for comprehensive SRH education, given the high level of school enrollment and the compulsory nature of all subjects at that level, coupled with the fact that some young adolescents are already engaging in sexual activity and need accurate and age-appropriate information to stay healthy.
- Curricula focus heavily on the promotion of abstinence and exclude coverage of healthy sexual behaviors. Information is often presented from a negative perspective by emphasizing challenges that young people face rather than opportunities, and problematizing sexual

behaviors among young people. The teaching regarding human rights is focused on the perpetration of human rights abuses, rather than on respect for human rights.

- There are two co-curricular programs for students in primary, junior high and senior high schools. The Enhanced School Health Education Programme provides health education through teacher-led, peer-led and community-led components, ensures safe and healthy learning environments, and provides health services. The HIV Alert program specifically emphasizes HIV prevention.
- While the integration of SRH topics into multiple subjects and co-curricular activities means that most students are exposed to basic SRH concepts in school, the range of topics covered as part of the core curricula is limited, as many key topics—such as negotiation skills, accessing and using contraceptives, gender-based violence and human rights—are covered only in elective subjects or co-curricular activities.

Sexual and Reproductive Health Education In the Classroom

Several aspects of sexual and reproductive health education contribute to its effectiveness, including its placement in the curriculum, pedagogical approach, timing and quality of delivery, and the comprehensiveness of the skills and information it imparts.[3] This chapter presents findings on the implementation of SRH education in schools, relying on the surveys with school heads, teachers and students to describe the organization of the program, the timing and format of teaching, curriculum content, teaching methods, student preferences, class environment, and monitoring and evaluation systems in place.

Organization, timing and format

While all surveyed schools teach topics related to SRH education as part of the national curriculum, 43% also cover these topics as a co-curricular activity (Table 4.1, page 54). Some school heads reported that their SRH education program had no supporting group (34%) or was independently run by the school (29%), but nearly one-third (30%) said the program was taught under SHEP and one-fifth (19%) cited the HIV Alert program. Most schools, according to students, had various outside individuals come in to teach topics related to SRH education, such as health providers (91% of schools), religious persons (77%) and peer educators (64%). These individuals were more likely to teach SRH in public schools than in private schools, especially peer educators (87% vs. 39%). Health personnel from the Ghana Health Service are important in the teaching of SRH education, and are permitted to provide counseling but not clinical services for contraceptives on school premises (personal communication with the Ghana Health Service, the Ghana Education Service and NGOs, 2015).

According to the national syllabus, the time allocation for teaching social studies, which includes topics related to SRH education, is three periods per week (see Table 3.1, page 18), which translates to 16–21 hours per term.* According to reports from teachers, fewer than a third of schools designate more than 10 hours to SRH education in Form 2 (31%), and only one-fourth dedicate this much in Form 3 (Figure 4.1, page 23).† The regional variation in the reported allocation in Form 3 could be attributed to the approach of individual schools or teachers rather than to the national standards set in the curriculum. Among students in coeducational schools who had been exposed to SRH education, 86% reported that all topics were taught to males and females together, 12% reported that some were taught together and some separately, and 3% said all were taught separately (Table 4.2, page 55). A higher proportion of males than of females preferred to have all topics taught together (85% vs. 76%).

As described earlier, SRH topics are integrated into school subjects, and some are introduced in primary school, where all subjects, including those that cover SRH topics, are compulsory. Across the study regions, more than three-fourths of students had been exposed to SRH education by the time they completed Class 6, the end of primary school. Most of the remaining students were first exposed to SRH education during junior high school, and 97% of all students reported some exposure prior to starting senior high school. One-fourth of the sampled students (mostly aged 15–17) had already had sexual intercourse—27% of males and 23% of females at the time of the survey; the findings suggest that many had likely received some SRH education in school or from HIV Alert or SHEP prior to initiating sexual activity. However, among those who were introduced to SRH education topics in either primary or junior high school, about half (48–50%) would have liked to have started learning even earlier; 44% were satisfied with the timing, and the remainder would have liked to have started later. As expected, most students (95%) learned about SRH as part of social studies, followed by integrated science (72%)—both being core subjects at the junior high and senior high school levels (Figure 4.2, page 24).

*In general, periods are 30–35 minutes long, and hence the three periods total 90–105 minutes per week; over an 11- to 12-week term, this amounts to 16.5–21 hours per term. †The number of hours dedicated to SRH education was estimated using teachers' reports of the amount of time dedicated specifically to teaching related topics (as defined in the study). While this estimate provides an idea of the overall number of hours, we do not know which particular topics are given more time or attention.

Content of curricula

Topics offered

Teacher perspectives. According to teachers, schools teach most topics related to SRH education (Table 4.3, page 56).* The topics that were the least commonly taught were where to obtain contraceptive methods (84%), communicating within relationships (88%) and decision-making skills (92%), and each was more likely to be taught in public than in private schools (98% vs. 68%, 99% vs. 76% and 99% vs. 84%, respectively). Public schools were also more likely than private ones to cover all topics in the values and interpersonal skills and contraception and unintended pregnancy categories.

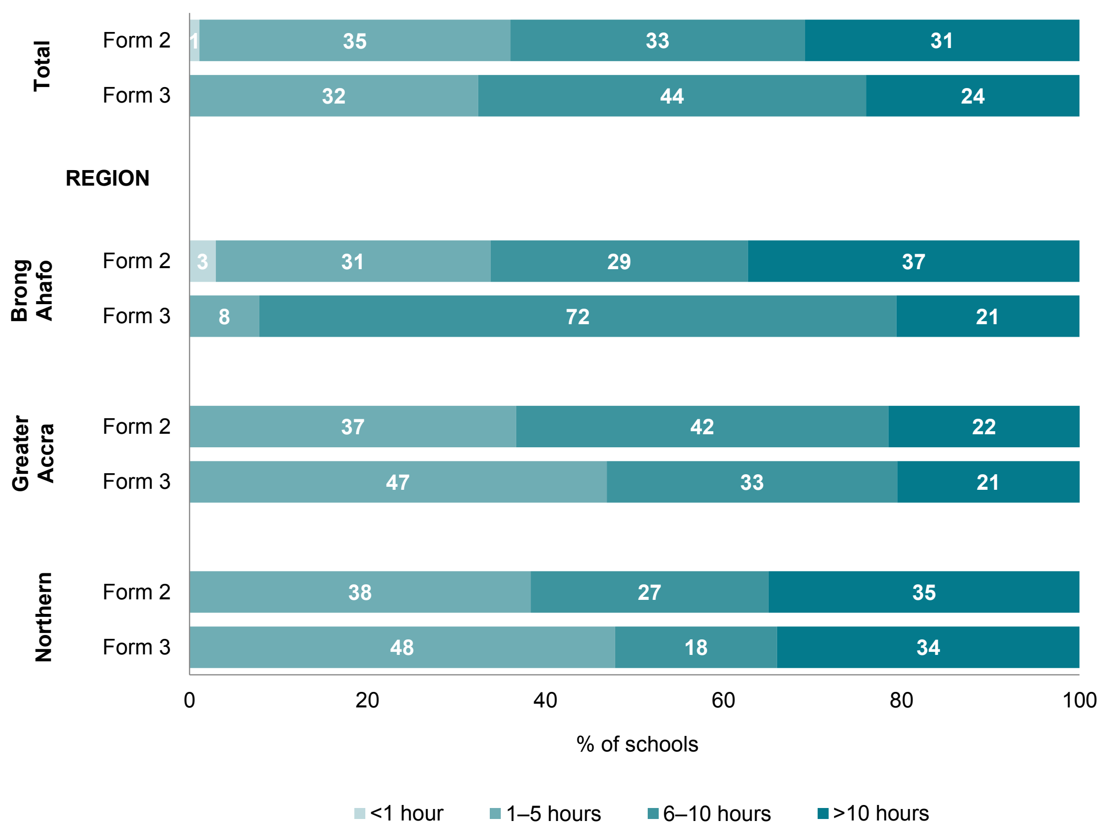
On the basis of our methodology described in Chapter 2, the comprehensiveness of the range of topics taught was deemed at least "minimum" from the teachers' perspectives in 99% of schools, at least "adequate" in 89% of schools and "high" in 83% of schools (Figure 4.3, page 25). Private schools were less likely than public ones to score a "high" level of comprehensiveness (68% vs. 96%).

Student perspectives. While we cannot directly compare student and teacher responses, student perspectives on SRH education topics taught in their classes tell a slightly different story. The topics that students reported most commonly learning about were puberty and physical changes, reproductive organs, abstinence and HIV/AIDS (92–97%; Table 4.4, page 57; Figure 4.4, page 26). Students also commonly reported learning about sexual and reproductive rights (87%), menstruation (87%), pregnancy and childbirth (81%), STIs other than HIV (74%), prevention of violence and sexual abuse (71%), and abortion (66%). Nearly half said they learned about contraceptive methods (49%), where to get HIV/STI

*Measures based on teachers' responses may be biased in either direction because of overreporting or underreporting, or because of reliance on one teacher's response at a school regarding a noncompulsory course.

FIGURE 4.1

The number of hours spent on SRH education topics per term in Forms 2 and 3 vary by region.



Note: Percentages may not add to 100 because of rounding.

services (47%), equality between men and women (47%) and communicating within relationships (45%); somewhat fewer learned how to use methods (40%) and where to get them (36%). Regardless of region or school type, most students (62–71%) who had learned about a particular topic wanted to learn more, implying that the extent to which topics are currently taught is inadequate (Table 4.5, page 58). The five topics with the largest gap between the proportion of students who learned about the topic and those who wanted to learn more are presented in Figure 4.5 (page 27).

Most students (72%) reported learning about all topics in the category of sexual and reproductive physiology, but far fewer learned about all topics in HIV and STI prevention (40%), gender and SRH rights (27%), contraception and unintended pregnancy (24%), and values and interpersonal skills (19%; Figure 4.6, page 28).

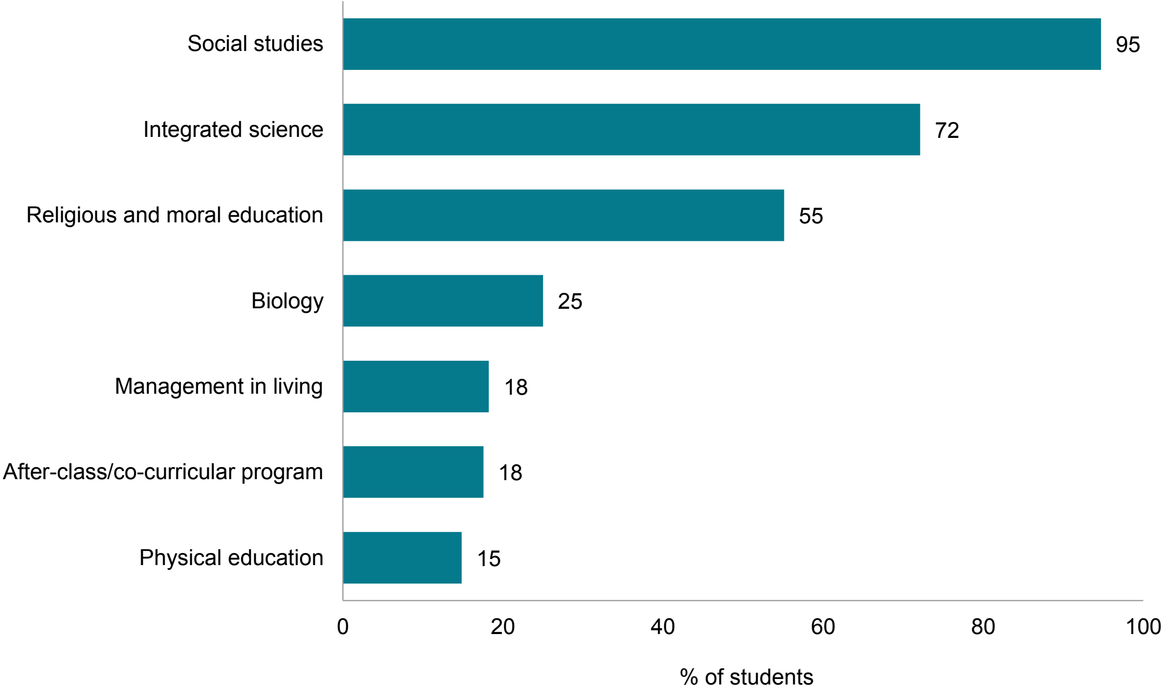
According to students' reports, the comprehensiveness of the range of topics covered appeared to meet at least the "minimum" for 74%; it was at least "adequate" for 19% of students and "high" for only 8% (Figure 4.7, page 29). While teacher and student responses are not directly comparable because we do not know which teachers taught which students, or in what grades teachers were teaching particular topics, it is nonetheless notable that the comprehensiveness of topics covered from the student perspective was much lower than the level reported by teachers. Some students may underreport what they have learned in an effort to make the case for needing more SRH education, yet it is equally likely that they might overreport topics covered in an effort to impress the fieldworkers or prove that they have been attending class and paying attention. These two potential biases would cancel each other out. Teachers, on the other hand, may have an incentive to overreport the number of topics they are teaching if they believe these topics are part of the curriculum and that they should be taught. Although the greater comprehensiveness reported by teachers may be partly due to teachers covering some topics in grades that students have not yet reached, this is unlikely to explain the large discrepancy.

Concepts and messages conveyed

Teacher perspectives. The information provided by teachers confirmed that the messages most of them delivered on SRH education were focused on abstinence, and this approach set the tone for what students were learning (Table 4.6, page 59). Most teachers reported very strongly emphasizing that young people should avoid having sex before marriage (85%) and that having sexual relationships is dangerous (83%) or immoral (81%) for young people. Overall, 56% of teachers very strongly conveyed

FIGURE 4.2

Most students learn about SRH education topics as part of social studies and integrated science classes.



to students that they should protect themselves during sex by using condoms, and this emphasis varied by region: 75% in the Northern region, 64% in Brong Ahafo and 42% in Greater Accra. Teachers across the regions reported very strongly emphasizing that homosexuality is unnatural (68%) and that abortion is immoral (78%). Nonetheless, 78% reported very strongly conveying that young people have the right to know everything about relationships and sexual and reproductive health.

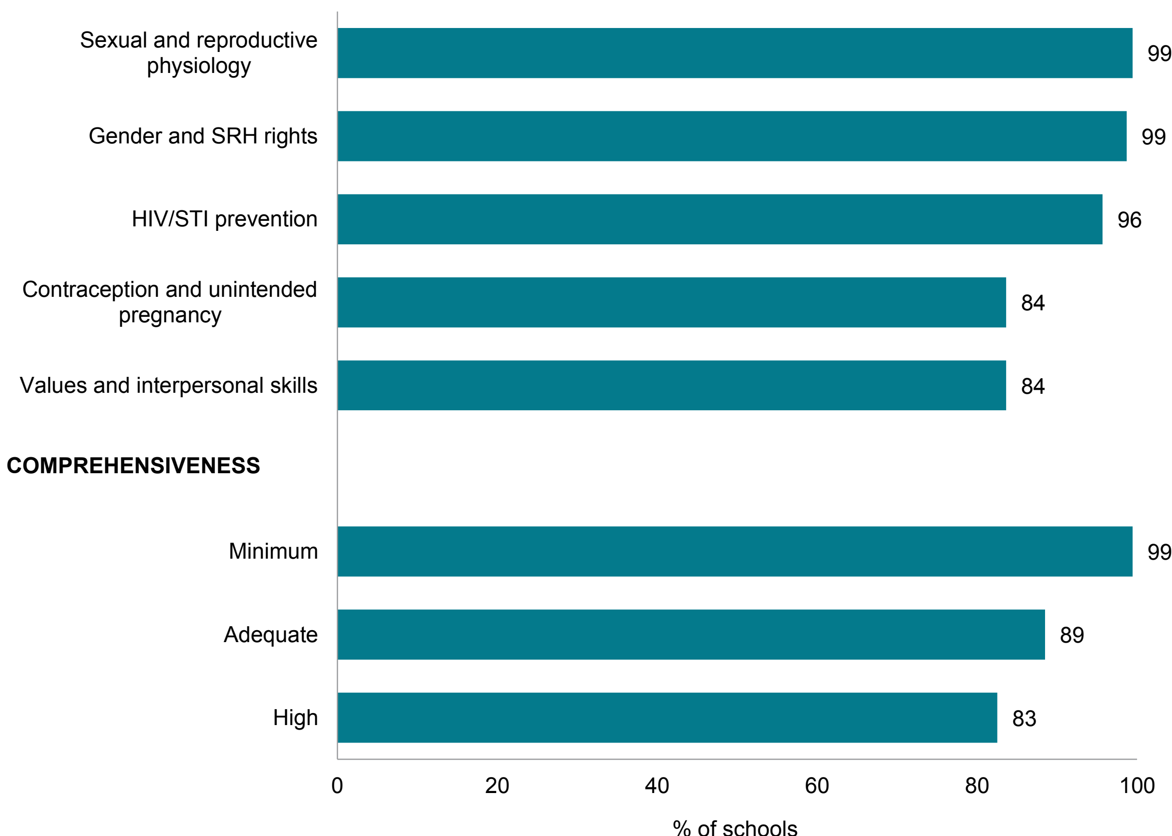
Nearly all teachers said they covered contraceptive methods (97%) and abstinence (96%) in their SRH education classes. Virtually all (99%) taught about condoms, and most covered the rhythm or calendar method (87%) and the pill (83%; Table 4.7, page 60; Figure 4.8, page 30).

While most teachers reported covering contraceptives, the quality of the information provided varied. A number of messages related to the effectiveness of contraceptives in preventing infection with STIs or HIV and avoiding pregnancy were conveyed. Notably, 24% of teachers who taught about contraceptives emphasized in their classes that they are not effective in preventing pregnancy (Figure 4.9, page 31). The proportions of teachers reporting this message varied by region, from 14% in Brong Ahafo and 17% in Northern to 33% in Greater Accra. Nearly nine out of 10 teachers (86%) who taught about condoms emphasized that condoms alone are not effective in pregnancy prevention, and a third taught that condoms are not an effective means of STI/HIV prevention (34%; Figures 4.10 and 4.11, page 31). Teachers in Greater Accra were more likely to convey this message (43%) than were those in the Brong Ahafo (25%) or Northern (26%) regions. Among teachers who covered abstinence, 82% emphasized that it was the best or only method for preventing STI/HIV infection and pregnancy (Figure 4.12, page 31).

Student perspectives. Encouragingly, most students indicated that they had learned about the signs and symptoms of STIs and HIV (89%), ways to prevent HIV (91%) and pregnancy (87%), and respect for self and others regardless of gender or social status (87%; Table 4.8, page 61). While a major aim of SRH education is to impart the practical skills and knowledge needed for adolescents to navigate their sexual and reproductive lives, only a third to half of students reported being taught

FIGURE 4.3

Schools teach SRH education at various levels of comprehensiveness, with less overall focus on certain topic categories.



practical skills such as how to talk to a partner about getting tested for HIV (49%), how to recognize forced sexual contact (40%), what to do when one becomes pregnant or gets someone pregnant (36%), or how to communicate with a partner about contraceptive use (46%). There were significant regional variations in students' exposure to these fundamental lessons.

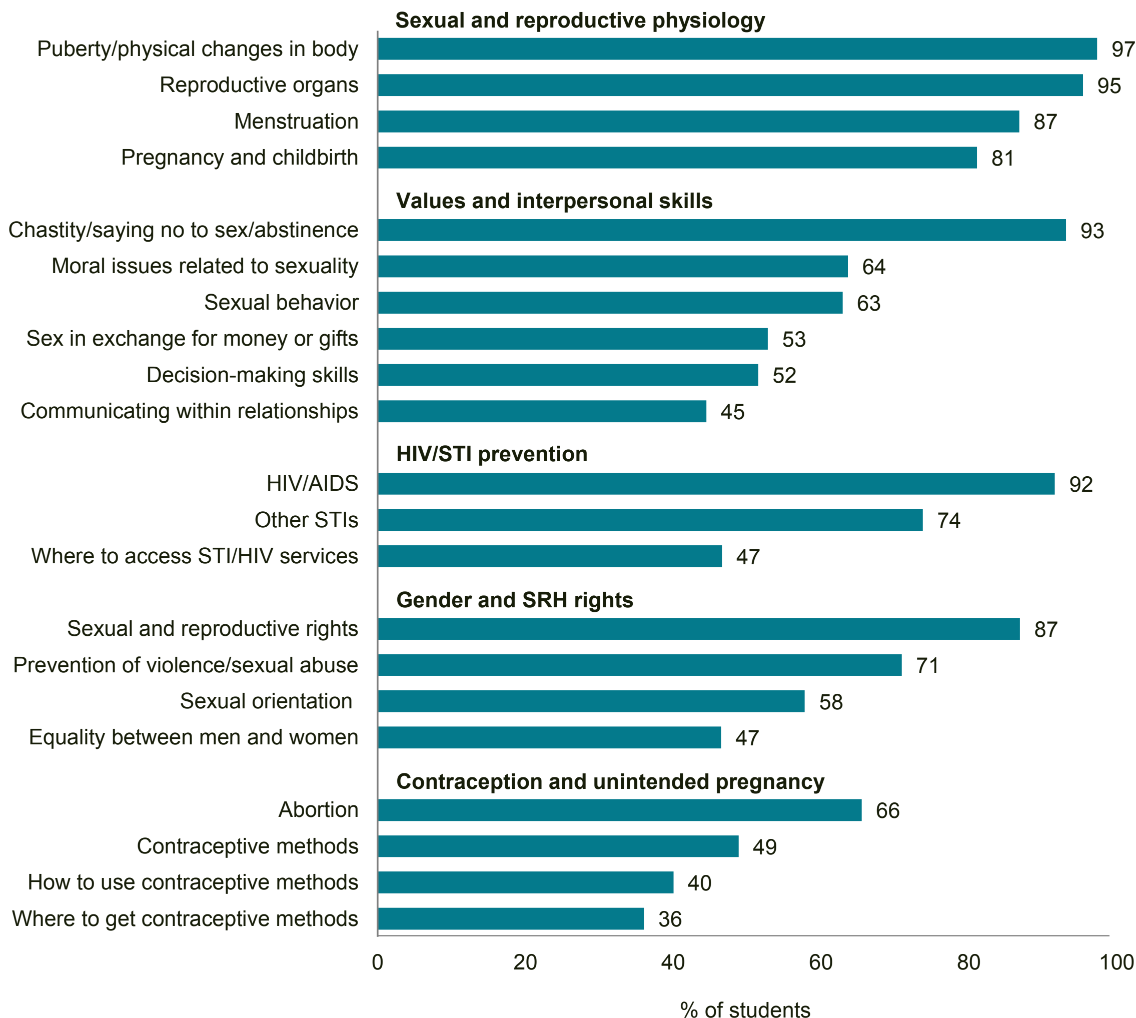
Comprehensive SRH education programs recognize that adolescents can be sexually active, and seek to teach them how to exercise their sexual and reproductive rights safely and responsibly. Generally, however, teachers' reports of using reactive approaches as proposed in the syllabus appeared to be corroborated by students. Three out of every four students reported that the content of their SRH education very strongly conveyed the message that having sex is dangerous for young people (72%) and that sex should be delayed until after marriage (75%). Sixty-eight percent said they heard a very strong message that it was best to avoid sex, but if they did engage in sex, they should use condoms. For all of these messages, significant student reporting differences were seen across regions, and for the last message, a difference was also observed between students attending public versus private schools.

Teaching methods

The use of less didactic teaching methods that involve students as active participants—such as group learning, peer engagement and learner-centered methodologies that aim to build students' values and critical thinking skills—is increasingly being recognized for the positive

FIGURE 4.4

Students are less likely to learn about topics regarding contraception and unintended pregnancy than topics in other categories.



influence on learning and education broadly, suggesting that reliance on lectures alone may be insufficient to effectively impart knowledge in a classroom. All teachers interviewed indicated that they used lectures or talks to teach topics in SRH education; many also reported using assignments (97%) and quizzes (81%) in their classrooms (Table 4.9, page 62). Three-fourths of teachers employed charts or drawings, and 60% reported using creative, participatory learning activities, such as role playing, theater, debates, art projects, dance, poetry and storytelling, while 39% reported practical demonstrations (e.g., how to use a condom). Notably, 81% of students said they wanted teachers to use creative, participatory learning activities in their classes (Table 4.10, page 62).

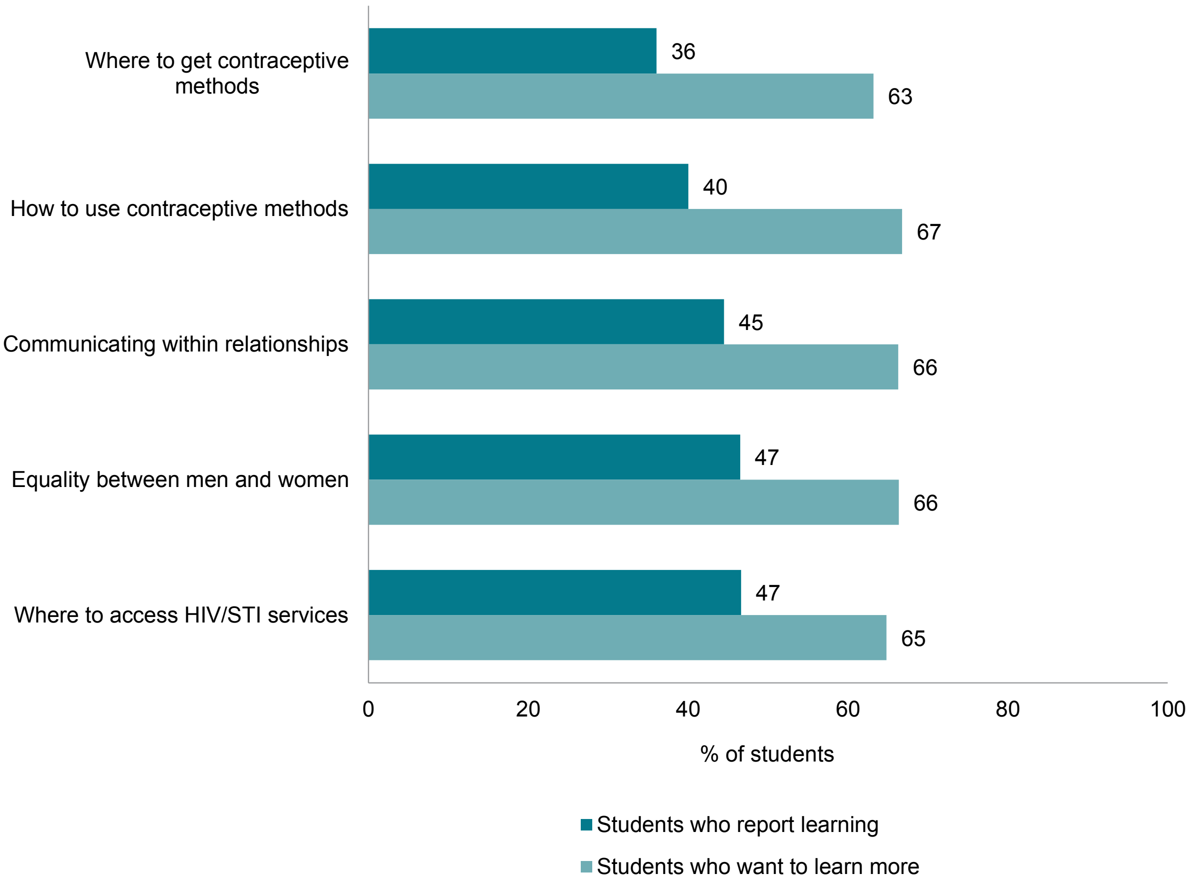
Forty-four percent of the teachers who cover contraceptive methods physically showed methods to students so they could see how they work (Table 4.11, page 63). Four out of 10 reported showing students the proper way to use a condom via printed materials or film, or physically demonstrated the proper way to use one. Linking information to sexual and reproductive health services outside of the classroom is an essential component of a comprehensive SRH education program; 69% of teachers gave information about where students could obtain contraceptive methods or counseling, and this guidance was more commonly reported by teachers in public than in private schools (73% vs. 54%).

Class environment

The success of a curriculum in promoting student learning can be greatly impacted by the classroom environment.[56] Teachers face a multitude of challenges when teaching topics related to SRH education. The most common problems reported across the surveyed regions were related to logistics: Seventy-seven percent of teachers reported a lack of resources or teaching materials, and 49% reported a lack of time to teach SRH topics; smaller proportions cited moral or religious contradictions, embarrassment, or opposition from the community or students

FIGURE 4.5

There are gaps between student reports of learning a topic and reports of wanting to learn more about that topic.



(Table 4.12, page 64; Figure 4.13, page 32).

Students' perceptions of the class environment during SRH education varied. Eighty-two percent who had learned about SRH topics expressed excitement about studying the issues, yet half said the classes were too crowded and 40% said students were embarrassed to talk about the topics. Perceptions of teachers' authority and competence can also play a role in students' learning experience. One-fifth had the impression that their teacher was embarrassed to talk about SRH topics, and one-tenth perceived that their teacher did not know enough about the topics (Figure 4.14, page 32).

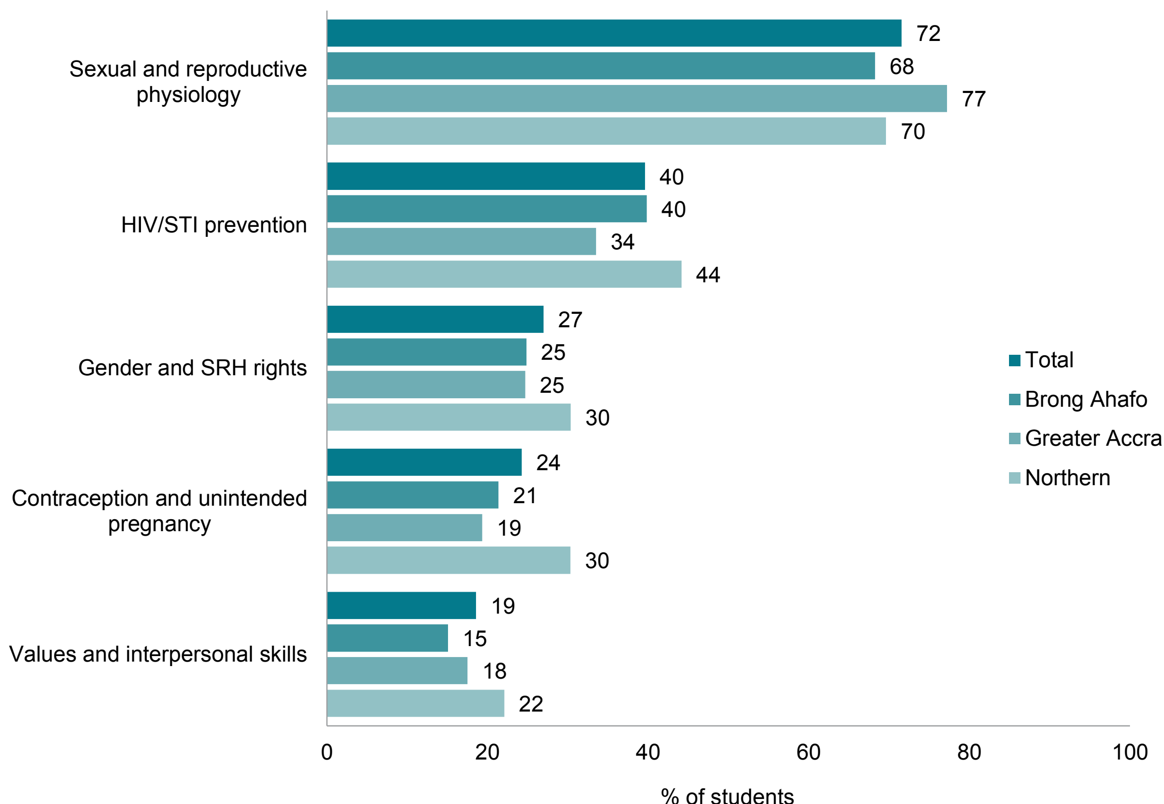
For an SRH education program to achieve its intended goals, an open, frank and warm environment is required.[57] Adolescence is a transitional time during which many questions about the body, sexuality, relationships and a range of other SRH topics will be raised. Students need the freedom to express doubts and ask questions about these issues in order to absorb and connect with what they are learning.[58] However, students may face challenges in the classroom: Overall, only 27% stated that they felt they had always been able to ask SRH-related questions in classes. Among those who reported that they had wanted to ask at least one SRH question in class but had not, 41% cited embarrassment as the reason. One-third cited time constraints or worry that they would embarrass or offend someone, or feared the teacher or other students would shut them down. Reports of the obstacles cited by students varied by region.

Monitoring and evaluation

Because there is no stand-alone SRH education program in Ghana, there is no clear standardized mechanism for monitoring or evaluating its teaching on a national level. Rather, any oversight of the SRH education topics is done under the monitoring or evaluation of the subject in which the topics are integrated. Our survey of schools assessed whether teachers were evaluated for their teaching of SRH education at the school level (e.g., by school administrations or heads), despite the lack of a national-level monitoring system. Heads of schools are expected to be the frontline personnel for educator assessments, and more than half (53%) said they assessed their teachers several times a term, while nearly a third (30%) admitted that they had never evaluated their teachers regarding SRH topics (Table 4.13, page 65). School heads who had evaluated their teachers reported doing so through

FIGURE 4.6

Students are more likely to learn about all topics in some categories than in others.



classroom observation (85%), oral assessment (56%) or written assessment (37%). Only 14% of heads used student feedback or inspected teachers' lesson plans as a means of assessment.

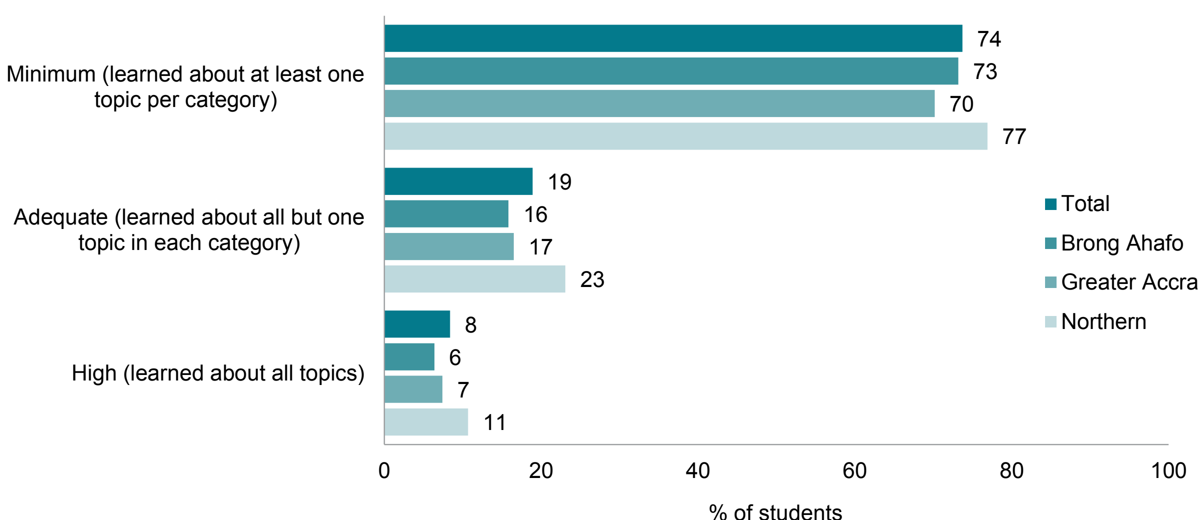
According to teachers, students are more commonly assessed on their knowledge (in 100% of schools) than on attitudes (88%) or practical or life skills (83%). Public schools were more likely than private ones to assess students' practical or life skills and attitudes regarding sexual and reproductive health. Student evaluation on practical or life skills also varied by region, from 59% in Brong Ahafo to 95–100% in the Northern and Greater Accra regions.

Summary of findings

- SRH education is taught in all schools as part of the national curriculum, and as a co-curricular activity in 43% of schools. Health providers, religious persons and peer educators commonly come into schools to teach SRH education topics.
- Nearly all students had received some SRH education by the time they completed junior high school (97%), and nearly half of students would have liked to have started earlier than they did.
- While 83% of teachers claimed to teach all topics that constitute a comprehensive SRH education, only 8% of students reported learning about all of them.
- Nearly all students had learned about topics related to physiology, abstinence and HIV; the majority also commonly reported learning about sexual and reproductive rights, STIs other than HIV, prevention of violence and sexual abuse, and abortion. However, fewer than half of students had learned about contraceptive methods or practical skills, such as where to access HIV/STI services, communicating in relationships, how to use contraceptives and where to get them.
- Teachers and students both agreed that messages conveyed by teachers tended to be reactive and focused primarily on abstinence, with an emphasis that sexual relationships are dangerous and immoral for young people and should be delayed until after marriage.
- While nearly all teachers reported covering contraceptives, the nature of the information varied, with most teachers emphasizing that condoms are not effective in preventing pregnancy (86%). Some also taught that condoms are not effective for STI/HIV prevention (34%), and that contraceptives are not effective in preventing pregnancy (24%).
- Among teachers who cover contraceptive methods, about four in 10 show students the methods, and seven in 10 provide information on where to obtain contraceptive services.
- All teachers used lectures and talks to teach SRH topics; more than half used creative, participatory learning activities, and fewer used practical demonstrations; 81% of students said they would like to engage in more of these types of approaches.
- The main challenges reported by teachers were lack of resources or teaching materials and lack of time; fewer reported moral or religious contradictions, embarrassment, or opposition from the community or students.
- While students expressed excitement about SRH education, many had been unable to ask a question in an SRH education class because of embarrassment, time

FIGURE 4.7

Only a small proportion of students report learning about all topics in a comprehensive program.



constraints, worry that they would embarrass or offend someone, or fear that the teacher or other students would shut them down.

- Since SRH topics are integrated into examinable subjects, coverage of the syllabus implies coverage of these topics. However, there are currently no tools to specifically monitor or evaluate the teaching of SRH education.
- Students are more commonly assessed on SRH knowledge than on attitudes or practical skills.

FIGURE 4.8

Almost all teachers who cover contraceptives teach about condoms.

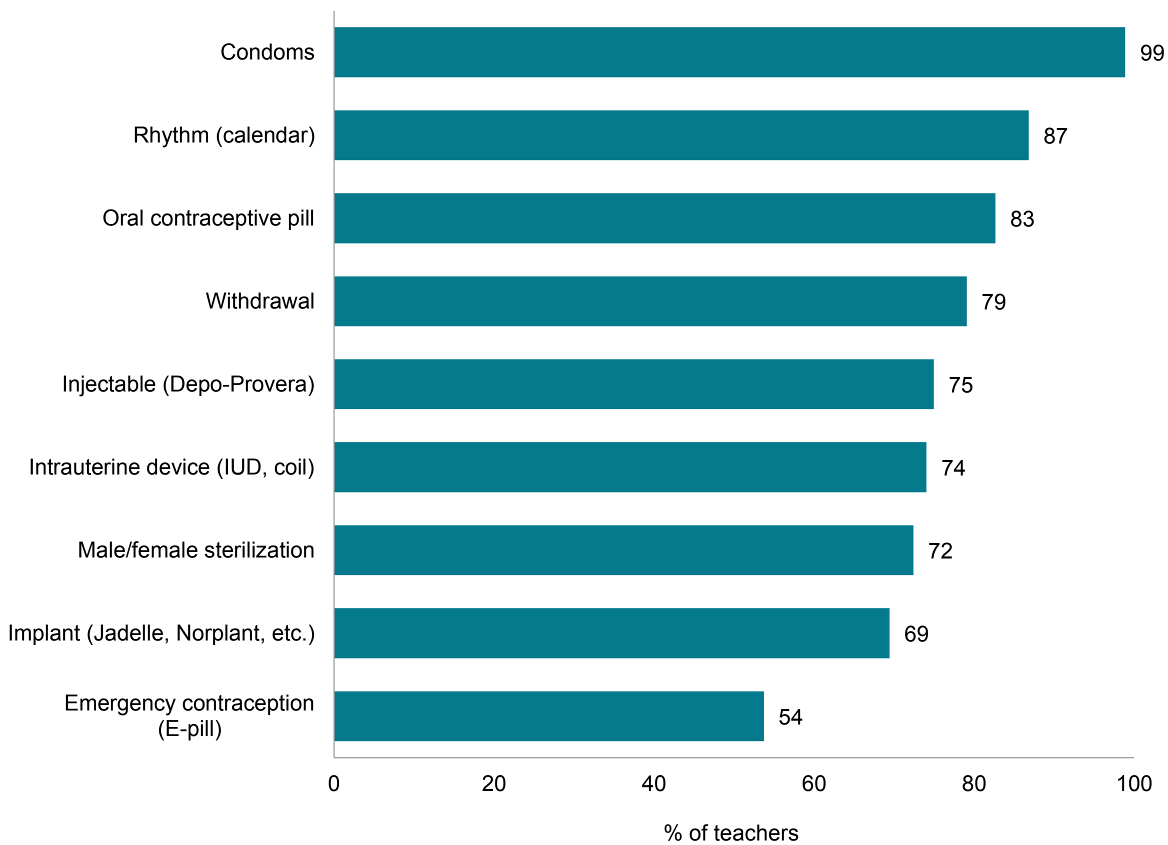


FIGURE 4.9

The majority of teachers who cover contraceptives emphasize that they can be effective for pregnancy prevention.

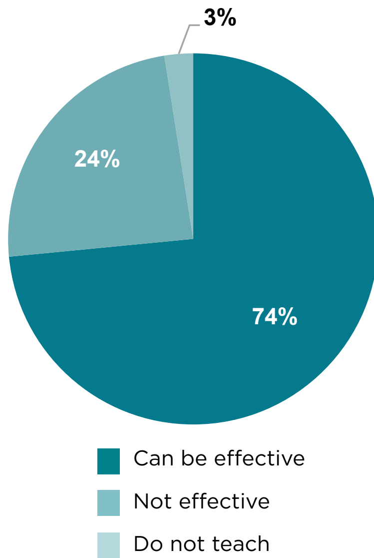


FIGURE 4.10

Most teachers who cover condoms emphasize that condoms alone are not effective for pregnancy prevention.

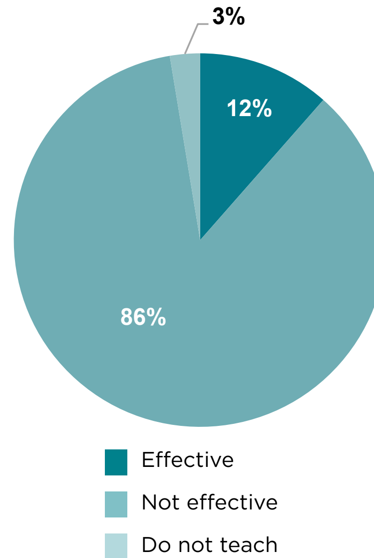


FIGURE 4.11

The majority of teachers who cover condoms emphasize that they can be effective for HIV/STI prevention.

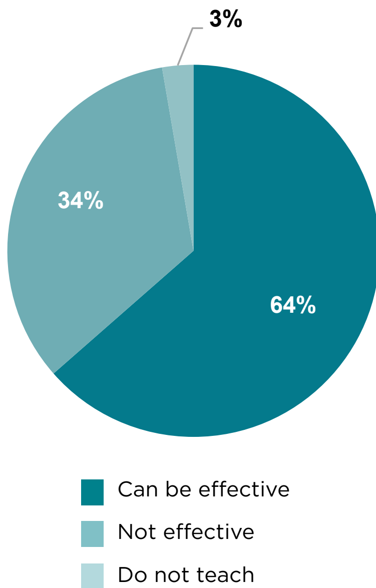
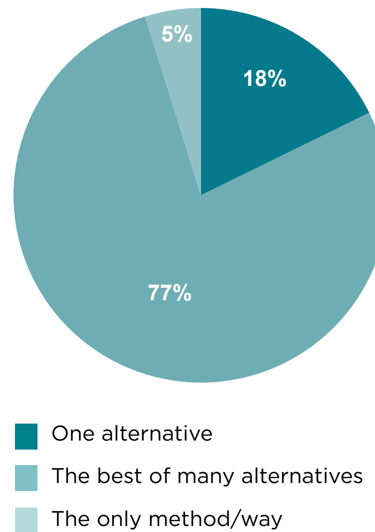


FIGURE 4.12

The majority of teachers who cover abstinence emphasize that it is the best or only method for preventing STIs and pregnancy.



Note: Percentages do not add to 100 because of rounding.

FIGURE 4.13

The most common issues teachers face in teaching SRH education are a lack of resources and time.

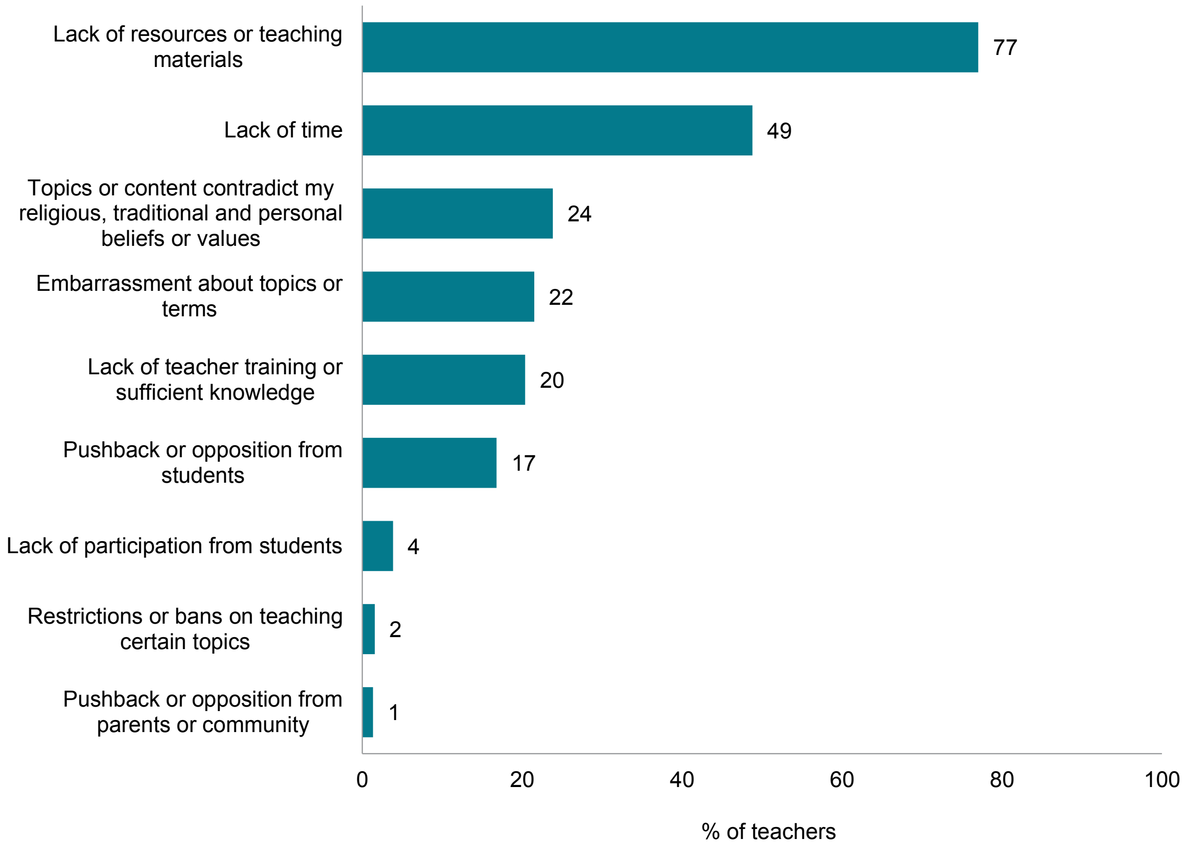
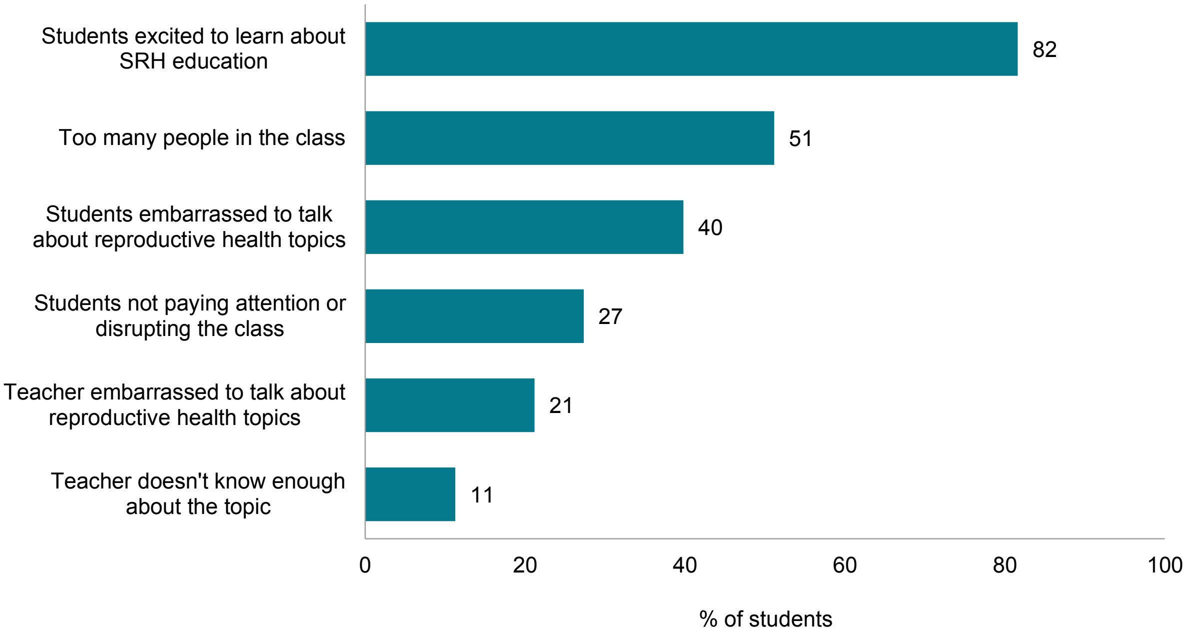


FIGURE 4.14

Students are excited to learn about SRH education but still face obstacles in the classroom.



CHAPTER 5

School System Support for Sexual and Reproductive Health Education

Improving the content of curricula, ensuring that teaching methods are adequate and conducive to learning, and establishing monitoring systems to ensure quality are essential to improving sexual and reproductive health education in schools, but the quality of the teaching ultimately depends on the preparedness, confidence, knowledge and skills of teachers. Adequate training in the content, teaching methods and approach to SRH topics is essential for teachers. An enabling and safe school environment has also been identified as a key component to a successful SRH education program.[30] This chapter presents quantitative and qualitative findings on these issues.

Teacher training

All teachers in Ghana, regardless of subject or level, are required to undergo pre-service training. SRH topics are included to a certain extent in pre-service and in-service training, but as mentioned earlier, there is not training designed specifically to prepare teachers to cover these topics. According to our survey of school heads, 78% of schools require that teachers receive pre-service training before teaching SRH topics, but in-service training is required in only 16% of schools. About one-fifth of schools (21%) do not require any specific training for teachers to cover such topics, since those teachers would have received some training in their own disciplines (not shown). Among the teachers surveyed, 78% had received pre-service training in an SRH education–related subject (Table 5.1, page 66; Figure 5.1, page 34). Only 39% of teachers had received any in-service training on the topics, with just 14% having received such training within the past three years (Figure 5.2, page 34).

Eighty-four percent of teachers who had received either pre-service or in-service SRH education training reported that the training covered at least one topic in each of the five thematic SRH categories (a "minimum" level of comprehensiveness in the range of topics covered). Fifty-five percent had received training on nearly all topics in each category (an "adequate" level), and 40% had received some training in all topics (a "high" level; Table 5.2, page 67). Half of teachers who received either pre-service or in-service training reported that they had not received any training in teaching methods, despite most training institutions having adopted the concurrent approach whereby teachers are supposed to be exposed to both the content and teaching methodologies at the same time. Eighty percent of teachers who received pre-service training said they would benefit from a separate pre-service training specifically for SRH education, and between 80% and 94% of teachers who received any training wanted more hours of training in general and more training on certain topics.

Some key informants indicated that teachers who are expected to cover these topics may be inadequately and unevenly prepared. The two major universities devoted to the pre-service training of senior high school teachers—the University of Cape Coast and the University of Education, Winneba—approach the training of SRH education teachers differently. For example, teachers-in-training at the former university are trained in individual subjects chosen by the teachers themselves (e.g., geography, economics, biology, physics). While the training is comprehensive within each subject, it is feasible that a teacher would graduate fully prepared to teach geography, for example, but then be asked to teach social studies once employed at a senior high school and not be adequately prepared. The University of Education, however, has a specific program dedicated to social studies and has adopted the integrated approach as employed in the junior and senior high school curricula. These two approaches have implications for teachers' level of preparation for teaching SRH topics.[43] As pointed out by one respondent:

"Well, at times some of us who are teaching in the classrooms have not been trained up to the university level to teach social studies. For instance, if you had studied geography, economics or government, it is felt that you can easily handle social studies.... So you have to read and tell [students] what you have read."

—*Teacher and PTA member, Brong Ahafo region*

In recognition of this situation, the Ministry of Education and the Ghana Education Service have been organizing in-service training programs for teachers on SRH topics, such as the 2001 USAID-supported Strengthening HIV/AIDS Partnership in Education (SHAPE I and II) program.[59] However, there are also challenges with in-service training because of a lack of standardization across schools and sustainability issues as a result of inadequate funding. One policymaker commented on the implementation of in-service training:

"We do in-service training for those who are teaching. But this [occurs] in bits and pieces. It is done when funds are available….We have trained 9,868 teachers from 14 districts as part of in-service. We are also training teachers in the districts in the Brong Ahafo region. The aim is to train the teachers on how to acquire knowledge and skills to enable them to teach."

—*Policymaker, national level*

Currently, Colleges of Education—where teachers are trained for the junior high school level—offer a stand-alone subject on HIV education that is based on the HIV Alert program. Teachers attending such colleges receive concentrated training on topics related to HIV and AIDS, but receive little training on other essential SRH topics.

Teaching support

Support and resources available to teachers

The logistical and moral support that teachers receive is vital for the overall quality of teaching and learning. Most teachers reported having access to materials describing the scope and sequence of instruction, as well as the goals, objectives and expected outcomes of SRH education (89–94%; Table 5.3, page 68). Sixty-eight percent of teachers received support from their colleagues, while nearly half (49%) turned to internet resources, including social media, to assist them in teaching SRH topics. Ninety-two percent of school heads said they supported teachers covering SRH in some way, including by organizing meetings with them to discuss or resolve issues (61%), inviting teachers to talk to them separately about concerns (58%) and voicing support at board, PTA or community meetings (46%).

However, teachers said they wanted additional assistance in various forms to help them teach more effectively (Table 5.4, page 69); the most commonly cited needs were for more teaching materials and strategies (79%) and more factual information and training (44–45%; Figure 5.3, page 35). Teachers also requested more assistance in different topics (Table 5.5, page 70), the most-cited being contraceptive methods, use of methods and HIV/AIDS (Figure 5.4, page 36).

Teachers' perceptions of support

In teaching SRH education, support from authority figures and other stakeholders is important.[60] While most teachers perceived their school heads and other teachers to be supportive or very supportive of their teaching SRH topics (90% and 94%, respectively; Figures 5.5 and 5.6, page 37), nearly one-third (31%) perceived parents to be unsupportive (Figure 5.7, page 37). Very few teachers, however, felt outside pressure that negatively affected their teaching of SRH topics (not shown).

School environment

The school environment provides the framework within which teaching and learning occur. In Ghana, SRH issues are rarely discussed in public, and so it is important that a safe environment, free of fear and intimidation, is created in schools so that young people can discuss these important matters in the classroom. Despite the existence of national regulations that protect the rights of children and youth within schools,[61,62] only slightly more than half (52%) of school heads indicated that their schools had

FIGURE 5.1

Most teachers who cover SRH education have received some pre-service training.

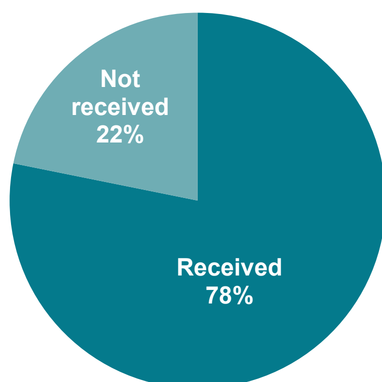
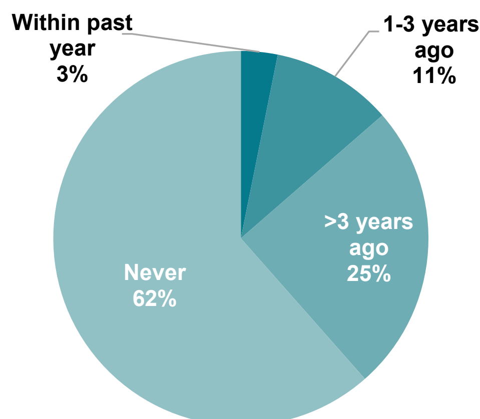


FIGURE 5.2

Fewer than half of teachers who cover SRH education have received in-service training.



child protection policies (Table 5.6, page 71).

The Ghana Education Service has an explicit code of ethics for teachers,[63] which protects students by prescribing expected behaviors and the sanctions for flouting them. Yet 12% of school heads reported that their schools did not have a specific policy to address sexual harassment of a student by a teacher. Ten percent indicated that they had no policy on sexual harassment between students. Among schools that did carry out disciplinary action for harassment, most followed a process of giving several warnings, followed by suspension and potentially expulsion or termination if the case was proven. This creates a potentially unsafe environment, especially for females, because sexual harassment in school has been well noted as a major barrier to education. Another barrier for female students is dropout as a result of getting pregnant.[64] The Ghana Education Service's policy is that individuals who become pregnant should be allowed back into the same school following childbirth.[65] However, this policy may not do enough to support those who become pregnant, as it does not provide sufficient support for female students during their pregnancy. Only 26% of schools (mixed gender and females only) would allow someone who became pregnant to continue her studies, while 57% of schools would ask her to stay home until she gave birth, and 17% would require her to transfer or would expel her. The general practice, because of stigma and embarrassment, is for her to be assisted in transferring to a different school following childbirth.

Students' perceptions of their own emotional and physical safety in school were mixed (Table 5.7, page 72). One-fourth of students reported never feeling safe to express themselves in front of students or teachers in school, and half said they sometimes or always feared ridicule by other students and teachers; four in 10 said they sometimes or always feared physical harm. Fear of physical harm was more prevalent in the Northern region than in Brong Ahafo and Greater Accra. While there were safety concerns among males, females were more likely to perceive their school environment as being unsafe: They were more likely than males to never feel safe expressing themselves in front of others (28% vs. 22%) and to sometimes or always fear physical harm (42% vs. 34%; Figure 5.8, page 38).

Summary of findings

- In general, teachers are required by the Ghana Education Service to undergo pre-service training. While 78% of school heads reported that their schools require teachers who cover SRH education topics to receive pre-service training, only 16% require in-service training. About a fifth of all schools require neither type of training.
- Seventy-eight percent of teachers reported receiving pre-service training that covered some topics related to SRH; 80% said they would benefit from a separate pre-service training specifically for SRH education.
- Only 39% of teachers had received any in-service training, and fewer than 15% had received any such training within the past three years. The varied sources for both pre-service and in-service training suggest that training might not be standardized across the country.
- Among teachers who had received any training, fewer

FIGURE 5.3

Teachers report needing additional assistance to teach SRH education.

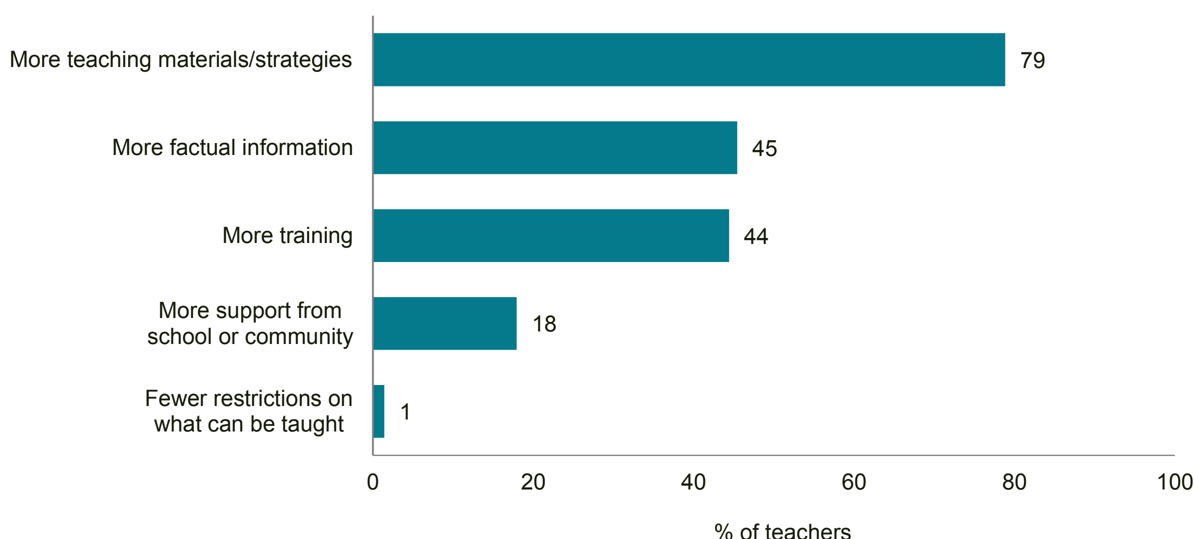
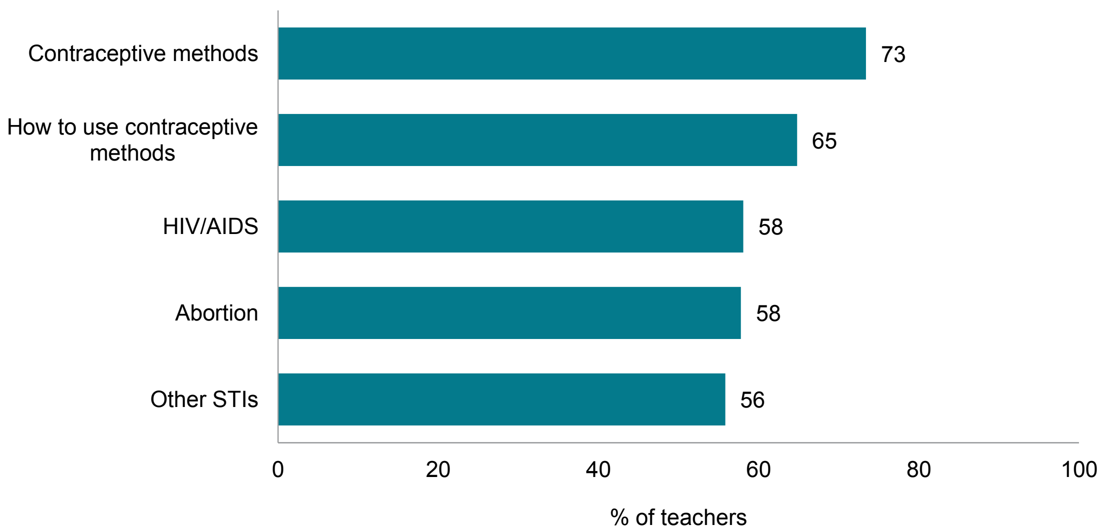


FIGURE 5.4

Teachers report needing more assistance to teach certain topics more effectively.



than half had been trained on all topics that constitute a comprehensive SRH education curriculum, and more than half reported that the training had not included lessons on teaching methods. Key informants revealed that pre-service training is difficult to conduct because of the integrated nature of SRH education, and that in-service training lacks cohesion or sustainability because of funding challenges.

- The availability of resources and support is vital for the quality of teaching. Most teachers had access to documents describing goals, objectives and expected outcomes of SRH education, but far fewer reported having access to a teaching manual or lesson plans.
- While most teachers felt supported by the school heads and other teachers in their teaching of SRH education, almost one-third perceived that parents were unsupportive.
- Although clear policies are in place to address harassment and pregnancy in schools, many schools do not fully implement these policies, which contributes to an unsupportive and potentially unsafe school environment, especially for females. In addition, females were more likely than males to report feeling unsafe in expressing themselves or to fear physical harm.

FIGURE 5.5

The majority of teachers think school heads are very supportive.

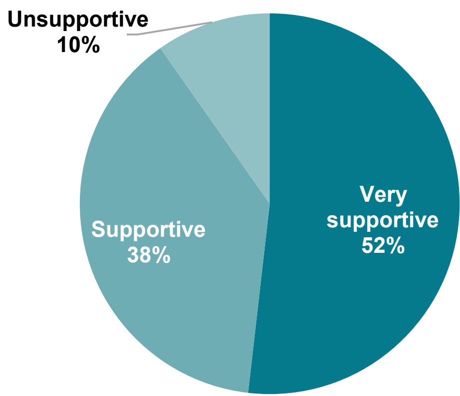


FIGURE 5.6

Nearly all teachers think other teachers are supportive.

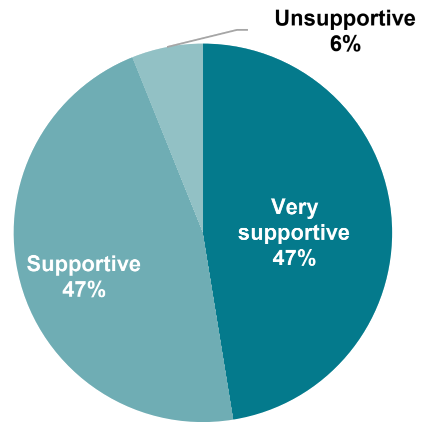


FIGURE 5.7

Many teachers think parents are supportive, but a third think otherwise.

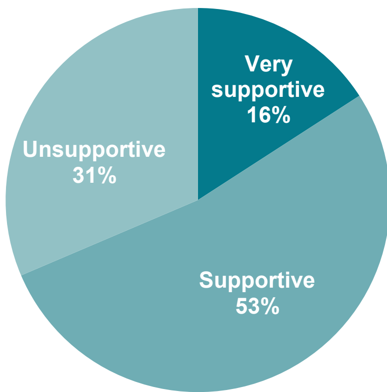
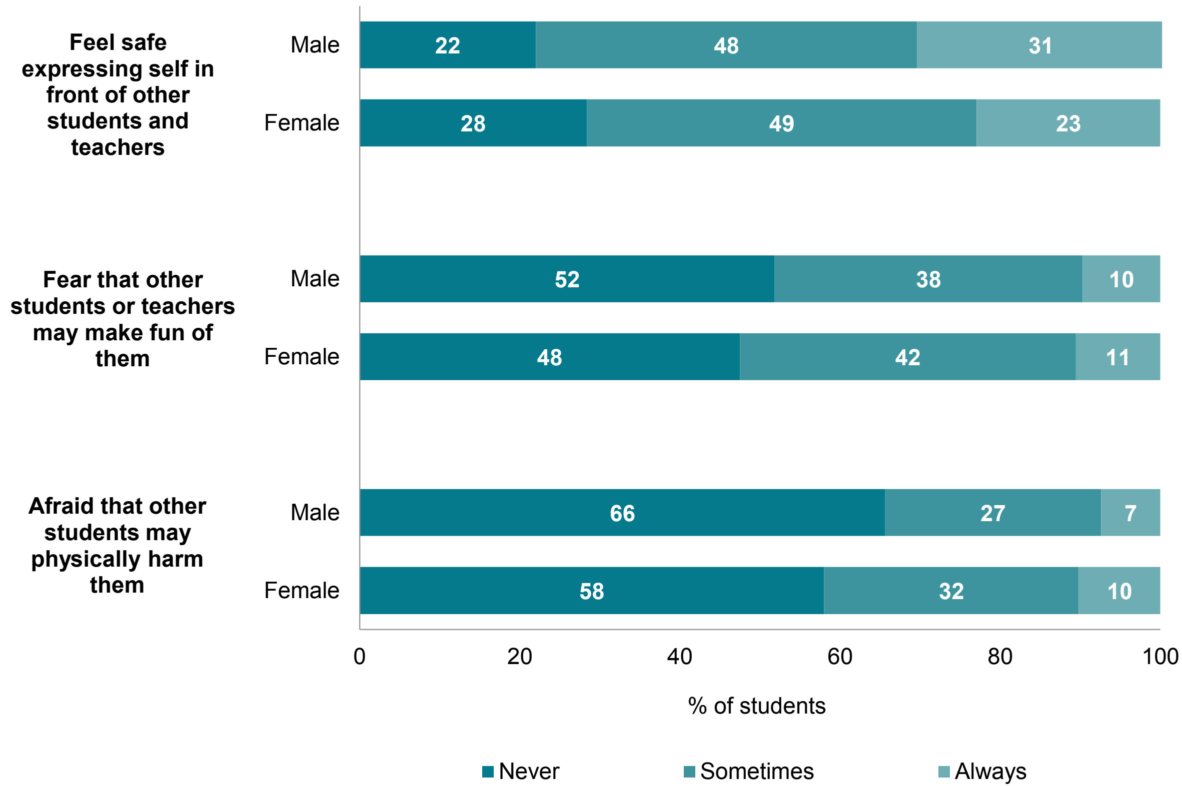


FIGURE 5.8

Female students more often report fearing for their emotional and physical safety in school.



Note: Percentages may not add to 100 because of rounding.

Out-of-School Sources for Sexual and Reproductive Health Information

Evidence suggests that while school may be an ideal setting for sexual and reproductive health education, many adolescents receive additional information about these topics outside of the classroom. Information provided outside of schools is an avenue through which to reach out-of-school youth and, especially if the school system is restrictive in terms of content, may also be an important complement to school-based curricula. In Ghana, where the content of the in-school SRH education curriculum is determined at the national level, out-of-school sources for SRH information are more likely to be context-specific and to include nuanced cultural and moral norms of the area.

Understanding what sources are most used and most trusted by adolescents has important programmatic implications.[66] Perceptions of the quality of information and the importance people place on different types of information depend, to a large extent, on the source and the medium through which the information is delivered,[67] and people pay particular attention to information when they consider the source to be credible. This chapter presents qualitative and quantitative findings on alternative sources of SRH information used by adolescents and on out-of-school activities that complement the SRH education they receive in school. While the study explored the various sources of information and types of activities in which students participated outside of school, as well as the frequency with which they participated, we did not assess what topics were covered or the quality of the information adolescents received. These areas merit further research.

Alternative sources

Students navigate a constellation of competing and sometimes conflicting sources of SRH information outside of school, ranging from family members to media sources. A notable 98% of students reported receiving information on SRH topics from media sources, including books, pamphlets, the Internet, radio, TV and social media; another 80–86% of students said they received information from friends, mothers or other family members, and 71–79% identified after-school programs, peers, outreach workers, or health or youth centers (Table 6.1, page 73). Females were more likely than males to have received information from their mothers, other family members, friends, after-school programs, peers, outreach workers, or health or youth centers. Mothers were identified as the most-used source outside of school (42%), and females were more likely than males to report this (53% vs. 26%; Figure 6.1, page 40). The second-most-used source was fathers (19%), and males were more likely than females to turn to their fathers (23% vs. 16%).

Among students who had participated in out-of-school activities, the most frequently cited were peer education groups (65%), debates (55%), and seminars or talks (50%; Figure 6.2, page 41). Students in the Greater Accra region were the least likely to have participated in debates, and the most likely to have attended seminars or talks; overall, females participated in activities slightly more frequently than did males (Figure 6.3, page 42).

Key informants reported that various channels are used in Ghana to educate adolescents and young people on SRH issues within their communities. Some respondents underscored the importance of parents in providing SRH education for young people. They argued that it was ultimately the parents' responsibility, and that the role of a teacher is to complement that of parents. While the role of parents is certainly important in educating their children, available evidence suggests that some parents shy away from teaching about sensitive issues, often because of a lack of capacity, expertise and confidence to discuss these topics, or because of cultural taboos regarding sexuality.[68–70] In Ghana, euphemisms are commonly used as a "taboo avoidance technique" to present culturally sensitive concepts, such as those related to SRH, in ways that create fear but avoid the real issues (e.g., that initiating sex before a rite of passage will lead to a death in the family).[71] This avoidance technique, while perhaps culturally appropriate, may miss the intent and purpose of communicating important information about SRH issues.

Traditionally, SRH education for females was considered to be the responsibility of Queen mothers* and female elders in the community, and for males it was the male elders' responsibility during puberty rites. Because of socioeconomic changes that have occurred in the country, the traditional system is no longer practiced as it used to be, and such individuals may no longer be the

*Queen mothers are traditional female leaders, who have played an important role in local government throughout Ghana's history. In certain areas, each town has a Chief and a Queen mother who rule alongside the modern political system.

most appropriate teachers.[72,73] Although the roles of parents and community leaders in the socialization of young people have diminished, these individuals will continue to be important in providing SRH education informally, and societal investment is therefore needed to help build their capacity to deliver critical and culturally sensitive information accurately, with confidence and in an appropriate manner. One such attempt to modernize the content and delivery of SRH information provided to young people within the traditional system is a collaboration between the Ghana Health Service, the Planned Parenthood Association of Ghana and some Queen mothers, with support from UNFPA, to deliver culturally appropriate, accurate and comprehensive information—a program known as Time with Grandma and Grandpa.[74] Civil society organizations (CSOs) have also been providing SRH education in community settings, and one key informant recounted the support they had received from influential religious and traditional leaders in their communities:

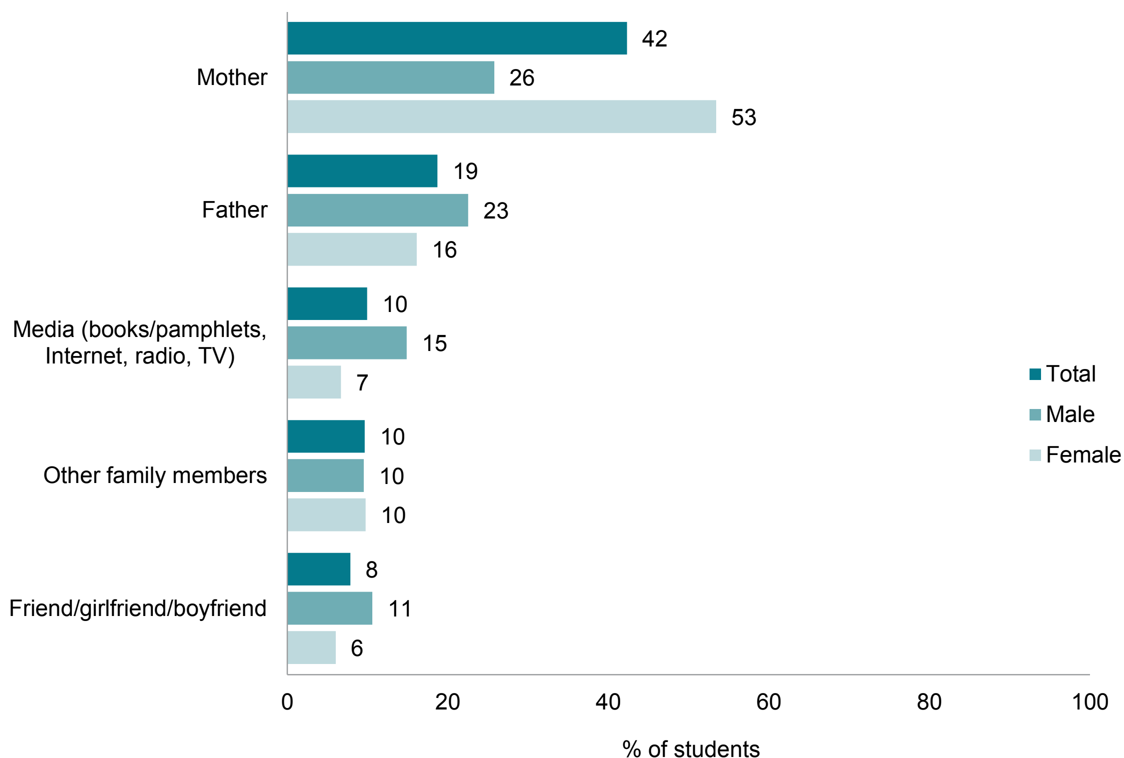
"Well, we have a lot of religious leaders coming in to support our programmes, and this has helped us so much with both the religious and traditional barriers that we were facing in some of the communities we work in. We have chief Imams coming to talk on radio about reproductive health issues. We have religious leaders who have been very supportive, and some even assist in some of the training programs on reproductive health. The President of the National House of Chiefs is an advocate for reproductive health."

—*Respondent, Planned Parenthood Association of Ghana*

Outside the traditional system, the Ghana Health Service and some youth-serving organizations, such as Curious Minds, have developed online information systems and social media applications that focus on delivering SRH education. According to key informants, there are also CSOs and individuals in communities who support co-curricular activities in their areas. Several of the leading CSOs in the country are the Planned Parenthood Association of Ghana, the Adventist Development and Relief Agency, Marie Stopes International (Ghana) and Ipas. These groups often complement the classroom teaching and co-curricular activities in schools and serve as resources or partner with school authorities to undertake specific programs on SRH education, such as the Abstinence/Virgin Clubs in schools and communities. HIV Alert also has a community-led program that involves community members in the delivery of SRH information

FIGURE 6.1

Students report consulting their parents the most for sexual and reproductive health information outside of school.



to adolescents within their areas.

While information from CSOs may be accurate and contribute positively to adolescents when delivered effectively, a review of materials and activities employed by some community-based groups revealed inaccurate and misleading information.[75] Student peers have also emerged as a major source for SRH education, although their effectiveness in delivering SRH information has been questioned.[76,77] As one respondent from a development organization in Accra noted, some information received from peers may be inaccurate:

"Many [students] get information from their peers, which [is] not right. So, teaching it in school [means] the information they get [is] more authentic [and] makes the teacher-pupil relationship ... stronger. Teaching it in school [allows] peer-to-peer discussions [to] have a better focus, because some people can give you wrong ideas about sex, and if you are not careful, you will fall for it."

—*Development partner, Accra*

Summary of findings

- The delivery of accurate information regarding sexual and reproductive health outside of school is essential for reaching out-of-school youth, can address topics not covered in school curricula and may be more context-specific.
- The majority of students had received SRH information through the media, friends, mothers and other family members. Mothers were most frequently cited by both females and males as the top source for SRH information, followed by fathers.
- While parents play a major role in educating children, some parents shy away from teaching about sexuality because of inadequate knowledge, lack of confidence to discuss such topics or cultural taboos; efforts should be made to sensitize and educate parents so that they can fulfill this important role.
- Community elders still play an important role in delivering SRH information to young people, and SRH organizations are working with elders to modernize the content and delivery of the information they provide.
- Civil society organizations provide additional SRH education nationally and locally, mostly through the Internet and social media, as well as through promoting co-curricular activities.

FIGURE 6.2

Students receive sexual and reproductive health information through various activities they participate in outside of school.

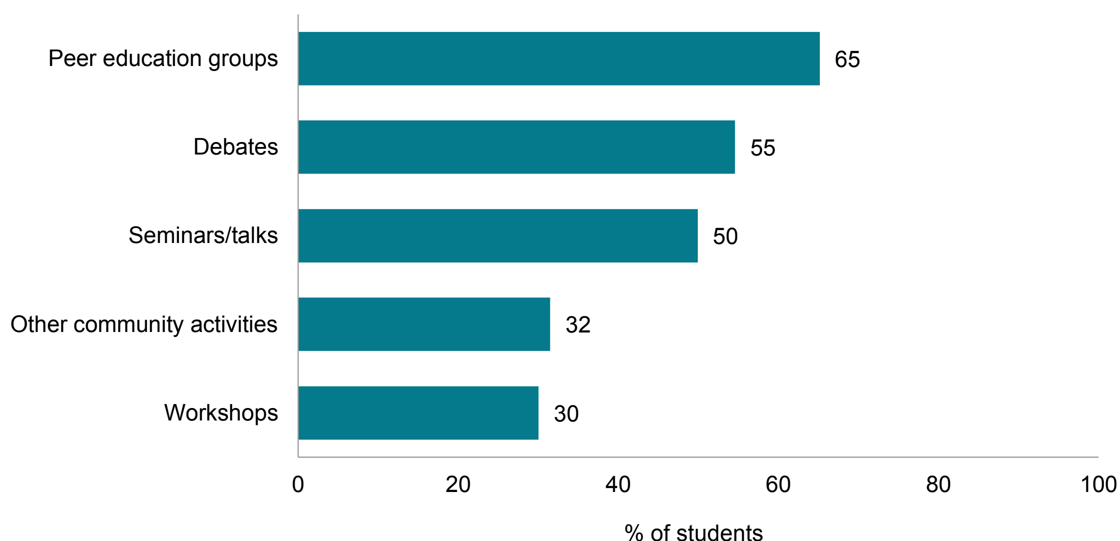
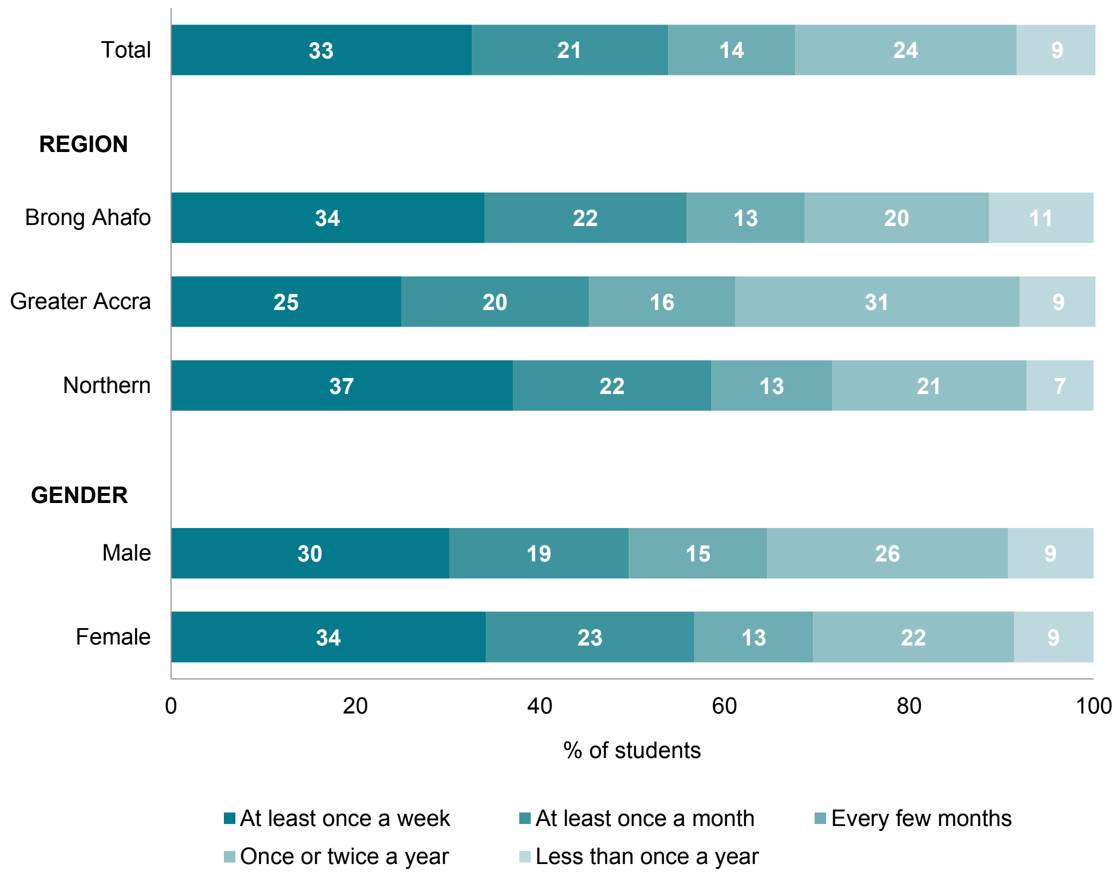


FIGURE 6.3

Most students participate frequently in out-of-school activities from which they receive information on sexual and reproductive health.



CHAPTER 7

Opinions About Sexual and Reproductive Health Education

To gain a holistic understanding of the context in which sexual and reproductive health education is taught in Ghana, and of the support or opposition that such programs generate, it is important to explore the opinions of both students and teachers regarding SRH education, as well as the perspectives of the wider community. Generally, students' opinions on this subject are influenced directly and indirectly by the community, school setting, religious affiliation and the media, as well as by the interrelationships among these factors.[78] This chapter presents quantitative and qualitative findings on students' and teachers' opinions and community perspectives.

Students' opinions

Students were asked what SRH topics were taught and what they wanted to learn more about. From their responses presented in Chapter 4, between 60% and 70% of students wanted to learn more about each topic; proportions stating this were higher in the Northern region than in Brong Ahafo and Greater Accra. All students believed that SRH education should be taught in schools (Table 7.1, page 74). The main reasons for their support were the need to know how to prevent STIs, including HIV and AIDS (80%), and to avoid unwanted pregnancies (75%). Nearly half of students said their parents did not teach them about SRH topics at home (Figure 7.1, page 44). Large proportions cited other reasons, and there was variation among the three regions. In general, students' opinions regarding the SRH education they received were positive: Almost all (95%) reported that it had been useful or very useful in helping them in their personal lives. Furthermore, 77% said they enjoyed classes that include SRH topics more than those on other subjects.

School heads' and teachers' opinions

Nearly all school heads and teachers supported SRH education, although they were not asked to distinguish between the types or the moral stances of programs (e.g., whether focused on abstinence or comprehensive), or to specify the range of topics that should be included. From teachers' responses presented in Chapter 4, it is likely that some favored an abstinence-based approach, which belies a lack of support for a comprehensive program. Subsequent questions about specific topics brought some nuance to the picture: Most teachers were in support of most topics being taught, though some opposed discussing the topic of sex in exchange for money (21%) or how to use or where to access contraceptives (11–14%). Among teachers who opposed certain topics, the main reason for their opposition was that some topics were not age-appropriate; among teachers who supported SRH education, the main reasons were that students needed to understand how their bodies work and how to prevent unwanted pregnancies and STIs, including HIV (not shown).

When asked about the main messages that SRH education should impart, 76% of teachers agreed with the statement that "abstinence is the best way to prevent pregnancy and STIs/HIV," 52% agreed that "messages provide information about STI/HIV transmission and where to access services" and 47% agreed that "young people should not have sex before marriage." One-third of teachers placed emphasis on messages about avoiding unintended pregnancy, including accurate information about contraceptives. Even less emphasis was placed on messages that promote gender equality, recognition of forced sexual contact, self-confidence and practical skills within relationships.

Available evidence suggests that programs that have a positive impact on students emphasize practical skills; when teachers were asked about what SRH education seeks to impact in students, only 51–62% identified opinions, self-confidence and practical skills (Figure 7.2, page 45).

The attitudes held by teachers and school heads may influence their teaching of SRH education, and in turn impact students' learning experience and ultimately shape their attitudes, knowledge, behavior and sense of agency. The majority of teachers believed that young people should be taught that healthy sexuality is a normal part of growing up (99%), and that it is important to tell students how to access SRH services (92%) and how to use contraceptives to avoid pregnancy (86%; Table 7.2, page 75). School heads and teachers alike, however, also held conservative attitudes toward sexuality among adolescents. Eighty-six percent of heads and 94–96% of teachers believed that males and females should remain virgins until marriage, and nearly all believed that sexual relationships should only be between men and women. Notably, about half of each group (54% of teachers and

45% of heads) believed that making contraceptives available to young people would encourage them to engage in sexual intercourse. The evidence base, however, shows that there is no link between improved access to contraceptives and increased sexual activity among adolescents, despite this common misconception.[2,5] To the contrary, providing SRH education in a timely manner, before adolescents are sexually active, can help prepare them to protect themselves from negative SRH outcomes when they do become sexually active. Finally, 26–36% of school heads and teachers believed that young women should not under any circumstance be allowed to have an abortion for an unwanted pregnancy, and that young people who carry condoms are bad, promiscuous or unfaithful.

Perspectives of government, civil society and community members

The views regarding SRH education among key informants were mixed: Responses ranged from full support, to support but with a focus on abstinence (i.e., that contraceptives should not be covered), to the opposition of teaching of SRH in schools. Several respondents with favorable views observed the following:

"I do not see anything bad about [teaching SRH education]. My point is that if you expose [students] to the issues and let them know, they will take precautions. Prevention is better than cure."

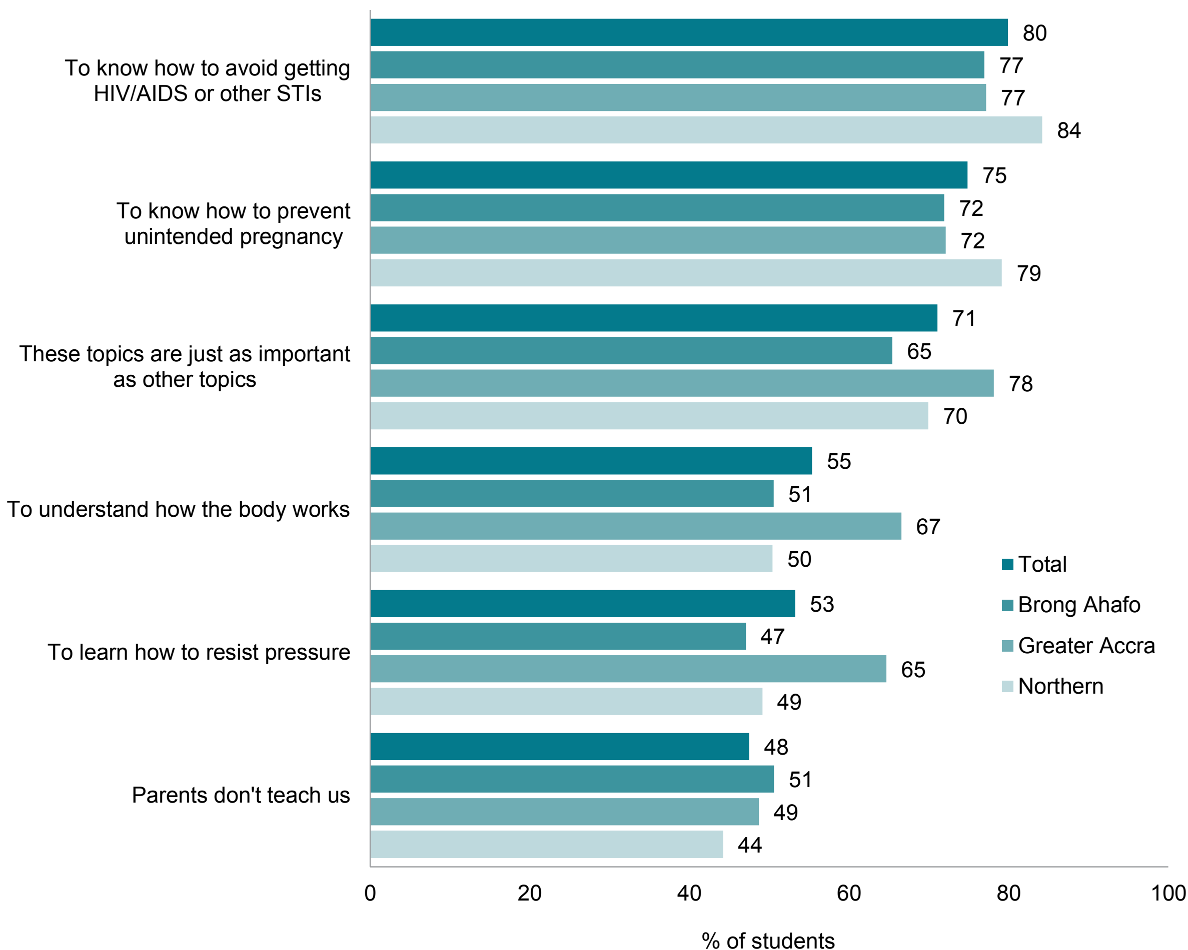
—PTA member, Northern region

"[Students] need to know about their sexuality; how they will relate to the opposite sex. Sometimes the girls need to understand ... how different they are from the opposite sex.... I think they need to understand themselves ... so that they can stay [in school] to study towards their goal."

—Religious leader, Brong Ahafo region

FIGURE 7.1

Students give various reasons for why SRH education should be taught.



"Well, I believe that young people ... are sexual beings. At one point in time, they should express their sexuality. The choice not to have sex is also an expression of sexuality, so I believe that it is important for young people to know their body, it is important for young people to understand the feelings they have so that they are able to deal with the issues better."

—NGO official, Greater Accra region

Other key informants (including some government respondents) were supportive of SRH education but emphasized abstinence, and also supported the view that the topics of contraception and sexual relations should not be taught. These opinions echo the traditional and religious views of the communities in which some schools are situated. Opinions of government officials are particularly important, as these individuals determine the content of the curriculum and how it should be taught. A number of respondents expressed their concerns:

"In fact, [SRH education] has got immense importance. [Adolescents] should be made aware of ... that stage of their physiological development and the changes that they should expect, and ... by knowing more about that, they would be able to manage their health [and] personal hygiene, [and understand] the proper functioning of the sex organs and the effects of not abstaining from sex, [as well as] the contraction of these deadly diseases like HIV and the rest."

—School board member, Brong Ahafo region

"It's good we teach them how to relate with each other, both male and female, and also teach them the hazards in those kinds of activities such as sexual intercourse."

—Traditional leader, Northern region

"The children need to know themselves, the changes they go through to become adolescents and how their bodies work, so that when they see certain changes in their bodies they [will] understand and act accordingly.... They must understand the effects of engaging in early sex, like contracting sexually transmitted infections, and they must pay attention to the need for abstinence and the dangers of having sex at a certain age. If you are not married and you start having sex, some of the dangers, such as teenage pregnancy, childbirth, abortions, and how these can retard their progress in school, must be taught them."

—Government official

Finally, some key informants (mainly religious leaders) opposed the teaching of SRH education to young people:

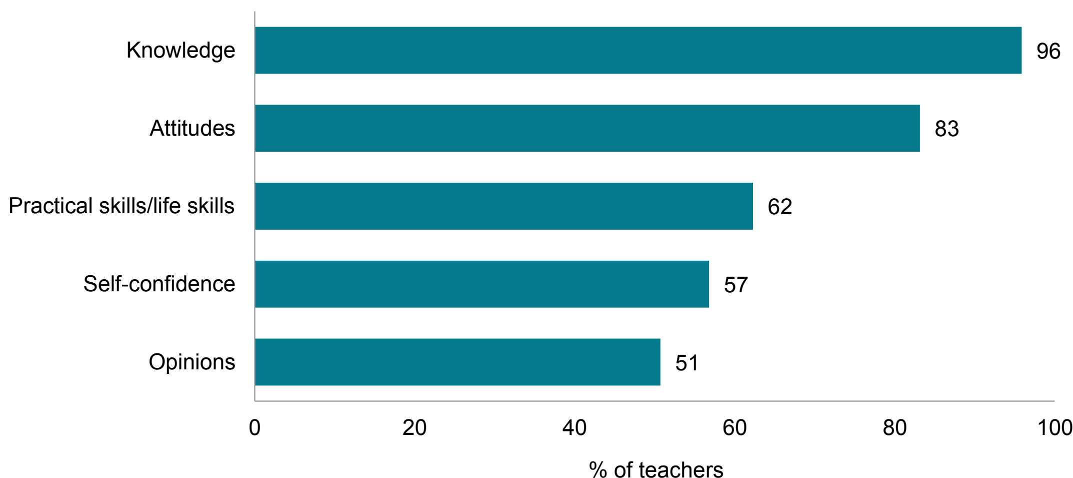
"If you teach them in the schools now, it will not help them.... It will bring teenage pregnancy.... It is not helping because before the girl [completes her] education, she will know ... about these things, so when she takes that [knowledge] to marriage, she cannot [be faithful] to her husband."

—Religious leader, Northern region

"Simply [telling] the children that they should do it, and if they do it, they shouldn't be pregnant, is not good enough. The thing they should have told the children is that doing that is not good, not teaching him/her how to

FIGURE 7.2

Teachers believe that SRH education should primarily impact students´ knowledge and attitudes.



protect himself/herself. Whenever you teach them how to protect themselves, it simply means you are encouraging the person to do the thing."

—*Religious leader, Northern region*

"Actually, I am from a purely Zongo [Muslim migrant] community. The Imams do not encourage [the teaching of sexual relations and contraception]."

—*PTA member, Northern region*

Although some informants clearly opposed SRH education, the overall consensus was that sexuality topics should be taught. One major and continuing challenge in the field of SRH education, however, is the widespread support for promoting abstinence as the main means of pregnancy and STI prevention. The results provide an opportunity for further dialogue through which stakeholders can reach agreement upon what topics should be taught and what services should be offered through in-school SRH education.

Summary of findings

- All students support the teaching of SRH education in schools, and commonly cite the need to know how to prevent STIs, including HIV, and how to prevent unwanted pregnancy. Nearly all found the teaching to be useful or very useful in their personal lives, and almost half said they do not receive this information from their parents.
- Most teachers supported the teaching of most topics related to SRH education; those who opposed certain topics (e.g., sex in exchange for money, or how to use and where to access contraceptives) did so mostly because they were deemed to not be age-appropriate.
- While school heads and teachers believed in the importance of teaching students that healthy sexuality is a natural part of life, that they should know where to access SRH services, and that contraceptives should be used to avoid pregnancy, the majority believed that the most important messages to impart to students were those that promote abstinence.
- Most teachers believed that sexual and reproductive health education should impact students' knowledge and attitudes; fewer believed that it should impact practical skills or self-confidence.
- While some community members fully support comprehensive SRH education, others (mainly religious leaders) oppose it, with the most prevalent reason being the fear that teaching young people about these topics will encourage them to engage in sex, despite strong evidence to the contrary.
- Other stakeholders, including some who influence curriculum development and its implementation, support a more restrictive and fear-based approach to SRH education that emphasizes abstinence and focuses on the negative consequences of premarital sex.

Conclusions and Recommendations

Various forms of sexual and reproductive health education have been taught in Ghana's schools over the last several decades. Findings from this study demonstrate the government of Ghana's strong commitment to providing SRH education, as reflected in the development and revisions over time of policies and curricula related to adolescent SRH, as well as in the support from teachers, school heads and the community. However, challenges remain—from the national policy-making and program-planning level down to the classroom implementation level.

Schools in Ghana are implementing an advanced program compared with programs in other countries in the region—and in the process addressing many critical and sensitive issues—but the fear-based orientation in the teaching of these topics and the negative perspective on adolescent sexuality are significant barriers to a successful SRH education program. In the classroom, while teachers express interest in covering the topics, some struggle to teach topics they consider to be sensitive and others struggle with a lack of time, resources and skills. There is great potential for an effective learning experience regarding SRH education, and therefore steps should be taken to demystify and desensationalize adolescent sexuality, to improve the comprehensiveness of the SRH education offered in the core curricula (in line with international standards) and to ensure the proper implementation of curricula. In addition, it is essential that teacher training be improved to adequately prepare educators with the skills needed to teach SRH education so that the full benefits can be reaped by adolescents.

Lessons from the classroom

Support for SRH education in schools

The findings suggest that in all three regions there is strong support for SRH education in both the school system and community settings. A number of adolescents reported turning to their parents as trustworthy sources of information, in addition to relying on school sources, and therefore steps should be taken to support parents and community members in these responsibilities. Key informants indicated that teachers are currently the primary educators for topics related to SRH, and thus it is equally important that they be supported. Many teachers said they receive support from their school heads, fellow teachers and some community members, and some perceived opposition from parents. Students had very favorable views about school-based SRH education: Almost all considered it useful or very useful in their personal lives, many enjoyed their classes related to SRH more than other classes, and most demonstrated enthusiasm and a desire to broaden their knowledge on a range of topics. Many influential key informants maintained that teaching is crucial, since it provides young people with the needed knowledge, attitudes and skills to enable them to make informed decisions now and in the future regarding their sexuality. However, some informants believed that the content should focus on promoting abstinence rather than covering key topics that would constitute a comprehensive program.

The Ghana Health Service and the Ghana Education Service, the two main government bodies responsible for providing information and services to young people, collaborated to deliver SRH education through the School Health Education Programme and HIV Alert program. Yet it emerged that these bodies had different perspectives on the provision of SRH services to in-school youth. While the Ghana Education Service believed that young people should receive only counseling services in school, the Ghana Health Service has argued for the introduction of some direct services on school premises. This difference in perspective will need to be addressed in the development of any comprehensive in-school SRH education program.

Content and quality of instruction

The most current evidence suggests that SRH education programs that include content on gender equality, power relations and human rights are more likely to be associated with positive SRH outcomes than are those that do not.[16] Some aspects of comprehensive SRH education can be identified in the social studies curriculum, but many more key SRH topics are included in the management in living elective, and many students do not attend these classes. Nevertheless, in addition to learning about most topics related to reproductive physiology and HIV, most students reported learning about many critical SRH issues, such as sexual and reproductive rights, prevention of violence and sexual abuse, STIs (including those other than HIV, which often do not receive adequate attention) and abortion. However, the emphasis in the core

social studies curriculum, as well as in the School Health Education Programme and its HIV Alert component, is on abstinence. Comprehensive programs include coverage of content and life skills regarding delaying the initiation of sex, but should not focus primarily on abstinence to the detriment of topics related to HIV, other STIs and unintended pregnancy, as such an approach has proven ineffective in improving adolescent SRH outcomes.

Teachers did report providing information on contraceptive methods, but the nature of the information varied: The majority of teachers emphasized the ineffectiveness of condoms in preventing pregnancy, one-fourth taught students that contraceptives were not effective in preventing pregnancy, and another third told students that condoms were not effective in preventing STIs, including HIV infection. Few students reported learning about how to access or use contraceptive methods, while most expressed a desire to learn more about these topics, as well as communication skills related to them. This strongly suggests that students desire information and strategies, beyond abstinence, that will assist them in achieving safe and healthy sexual lives.

Approach and timing of SRH education

According to the UNFPA definition, the successful implementation of comprehensive SRH education requires the use of more participatory pedagogical methods than those to which schools or teachers may be accustomed, and should encourage critical thinking and skills-based learning. As seen in the school survey, more than half of teachers used creative participatory activities—such as role playing, theater, debates, art projects, dance, poems and storytelling—in their classes related to SRH, and four in 10 reported that they showed condoms and other contraceptives in class (via printed material, film or physical demonstration) to demonstrate how they work. However, teachers were less likely to emphasize practical skills or self-confidence in their teaching of SRH education than the acquisition of knowledge. While improving student's level of knowledge is certainly essential, the promotion of healthy attitudes and opinions, confidence and practical skills is also critical.

Experts recommend that age-appropriate SRH education be started early in schools, well before sexual initiation.[3] Too often, this education is offered too late: As shown in this study, 23% of females and 27% of males had already had sex at the time of the survey, some before they were taught the skills and knowledge they need to practice safe sex and lead healthy sexual and reproductive lives. Differences in school enrollment at the lower and upper levels also provide a rationale for providing SRH education earlier: Between 85% and 90% of children and adolescents attend primary and junior high schools, while fewer than half attend senior high school. Although many students had first been exposed to SRH education in primary and junior high schools, the topics covered at those levels are basic and do not adequately cover information on safe sex practices or on communication skills or assertiveness.

Attitudes toward SRH education

The opinions of teachers and school heads, which we would expect to influence the tone of SRH teaching, were generally positive and revealed that they believed students should be taught about healthy sexuality and learn how and where to access SRH services, including contraceptive methods to avoid pregnancy. However, in the classroom, many teachers employed a fear-based approach, which manifested itself in the vilification of premarital sex and other sexual behaviors. Some teachers and school authorities argued that this approach was in line with the beliefs and expectations of society that sex should occur only within marriage. While recognizing that cultural and religious values play crucial roles in informing the teaching of social values (including SRH education), the prevailing situation restricts the topics covered and the approach used. Despite evidence that learning about contraceptives and discussing topics related to sexuality do not increase sexual activity among adolescents, a minority of key informants, particularly those affiliated with religious groups, opposed the teaching of SRH education on the basis that it would encourage adolescents to behave inappropriately. Some teachers and school heads also held the misconception that teaching about contraceptives would encourage students to have sex.

Teacher preparedness

Teacher training is critical to the delivery of a successful program.[79] While the SRH education curriculum in senior high school is integrated, pre-service teacher training is not necessarily integrated, thus creating a potential mismatch between what teachers learn and what they are expected to teach in the classroom. In the current pre-service teacher education system, only the University of Education, Winneba, has a program specifically focused on social studies. Hence, most of the teachers who reported having received pre-service training in SRH education had done so within their respective subjects, which likely did not include important topics related to sexuality.

In-service training to upgrade and update the knowledge of teachers is necessary, but lacks cohesion, standardization and sustainability. Of the teachers who had received pre-service or in-service training, fewer than half reported that it included all the SRH topics or lessons on teaching methods. We found that teachers want to be better prepared to teach critical topics, and they identified

the need for further training in many areas, especially contraceptive methods, STIs other than HIV and abortion. Teachers cited numerous challenges to teaching SRH education, such as lack of resources, teaching materials and classroom time, and the majority requested more hours of training, more training or separate training on SRH-specific topics, and further training in teaching methods. Few teachers reported experiencing moral or religious contradictions, embarrassment or opposition from the community or students, and this suggests that many of the challenges could be addressed by improving training and investing more resources in SRH education as a way to recognize its centrality in the education system.

Perceived safety of the school and class environment

The success of an SRH education program also depends on it being implemented in a safe environment where adolescents can freely express themselves without fear of harassment or reprisal. The Ghana Education Service has important policies to protect adolescents and to address harassment in school—by students or teachers—that aim to provide a safe and welcoming environment for teaching and learning. Despite the existence of these policies, however, only one-fourth of students reported that they always felt safe expressing themselves in front of students and teachers during an SRH education class, and half reported that they sometimes or always feared that students or teachers would tease them or physically hurt them. Often, teachers who harass students, and students who harass their peers, are given several warnings before being asked to leave the school; in some cases, this may protect the interests of the offender and not the victim, potentially negatively contributing to the safety of the school environment.

Unlike in many other settings, where female students who become pregnant while in school would be expelled and not permitted to return, the policy of the Ghana Education Service is more supportive in allowing them to continue their studies before and after giving birth. However, there is both real and perceived stigma regarding adolescent pregnancy that challenges the implementation of this policy. Most schools ask females to stay home during pregnancy, and in fact they may avoid school in any case because of intolerance from peers and teachers. While school heads indicated that readmitting students to the same school presented a dilemma because the administration might be seen to be encouraging pregnancy, they indicated that the students' interests were their primary concern. Nonetheless, many school heads said that the new mothers rarely returned to the same school following childbirth, and were assisted in relocating to another school.

Emerging challenges

There is now a proliferation of sources beyond the school and the home for education and socialization regarding sexual and reproductive health.[75] Social media, community education and religious groups have become major sources of information for young people on a variety of issues, including SRH education. A number of community-based organizations also provide SRH education and other non-curriculum–based interventions in some localities. These outside and localized programs make it difficult to assess the success or shortcomings of in-school programs.[80] Furthermore, the assessment of the quality of information received outside of school from these various sources also presents a challenge.

The way forward

This study's findings provide a window of opportunity to review the content and strategies for the teaching of SRH education in Ghana. It is clear that the government has been open to educational reforms, and policies do exist to support the provision of school-based SRH education, which is strongly supported at the school and community levels. While the content of the curricula in the core subjects is limited in scope, the wide range of topics included in the subject management in living is indeed promising, and could provide the basis for establishing uniform guidelines for SRH education. The Ghana government has recognized that high-quality, comprehensive SRH education is essential for the healthy development of adolescents and their transition to adulthood. Because sexual and reproductive health education is guided by policies at multiple levels—from national to local school administrative guidelines—political and social leadership is needed at each level to support the development and implementation of a more comprehensive and sustainable program. Appropriate coordination and synergy are also needed among the different government agencies involved, such as the Ghana Health Service and the Ghana Education Service, to ensure better utilization of available resources.

Coordinated efforts among ministries, school authorities and civil society organizations, as well as with adolescents, are warranted in order to:

1. Ensure that the development of policies, guidelines and curricula is based on the growing body of evidence documenting the characteristics of successful comprehensive SRH programs and the positive impact that they can have on adolescents when designed and delivered appropriately.

2. Improve and expand upon SRH education provision at the primary and junior high school levels. Given that 85–90% of children attend primary and junior high school, but fewer than half of students proceed to senior high school, and

given the significant proportion of students who are sexually active by the age of 15, the program must ensure that students receive important age-appropriate information and skills prior to becoming sexually active.

3. Integrate more critical, sensitive and progressive SRH topics into the core subjects at the senior high school level—thus recognizing their centrality to the healthy development of adolescents and their transition to adulthood—and allocate sufficient time for teachers to cover those topics.

4. Improve the comprehensiveness of the curriculum content and diversify the teaching methods used in the classroom to more accurately reflect the UNFPA definition of comprehensive sexuality education, and so place more emphasis on promoting practical skills, confidence and agency among students; eliminate fear-based and moralistic messages; and increase the focus on gender, rights and strategies for preventing unintended pregnancies that teach about a broad range of contraceptives (including long-acting methods) and negotiating skills within relationships.

5. Improve the synergy between pre-service teacher training and the structure of the school system, so that teachers receive pre-service training that adequately prepares them to teach topics in the integrated educational approach employed in primary and secondary schools. In-service training needs to be standardized so that all teachers have up-to-date information, are familiar with the best teaching approaches, and receive the support and resources necessary to have confidence in their knowledge to effectively and accurately teach sensitive topics related to SRH education.

6. Further engage in dialogues among stakeholders, including community opinion leaders and members of school boards, regarding the scope, available evidence and changing paradigms in SRH education. The dialogue should emphasize the need for a comprehensive approach and support for the teaching of a broad range of topics that go beyond abstinence.

7. Invest further in materials to assist teachers and promote the teaching of SRH education. At the local level, school heads, in collaboration with teachers, community leaders and local governments, can marshal human and financial resources to support SRH programs in their communities.

8. Develop monitoring and evaluation systems specifically for SRH education, and for assessing the effectiveness of school-based SRH education and the commitment with which the curriculum is implemented.

9. Strengthen existing referral links between schools and youth-friendly SRH service delivery points, so that adolescents have better access to resources outside of schools.

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Tables

TABLE 4.1

Percentage of schools by selected aspects of SRH education, as reported by school heads, students and teachers, according to region and school type

Aspect	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
ACCORDING TO SCHOOL HEADS‡	(N=78)	(N=27)	(N=26)	(N=25)	(N=64)	(N=14)
SRH education included in curriculum						
Only as part of national curriculum	56.6	38.2	62.5	77.7	62.4	50.1
As extracurricular activity and as part of national curriculum	43.4	61.8	37.5	22.3	37.6	49.9
Implementation mandate level						
Ministry of Education	48.6	39.7	45.8	65.7	48.3	49.0
School administration	48.8	54.4	53.2	34.3	46.7	51.0
Individual teacher	2.6	5.9	1.0	0.0	5.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Entity under which SRH education taught†						
HIV Alert Program (government)	18.7	18.6	14.9	24.5	26.9	9.6
School Health Education Programme (government)	30.1	39.7	27.3	20.1	34.8	25.0
NGO	19.1	6.9	19.2	35.2	21.4	16.4
Independent	28.7	51.0	15.8	16.8*	26.9	30.7
Community	8.4	22.1	0.0	0.0	2.1	15.4
None	33.8	28.4	37.6	42.2	34.6	32.9
ACCORDING TO STUDENTS	(N=81)	(N=28)	(N=28)	(N=25)	(N=67)	(N=14)
Outside individuals who teach SRH education†						
Health provider	91.2	100.0	77.6	97.8*	98.6	82.9*
Religious person	76.7	62.7	78.7	94.7	88.4	63.7*
Peer educator	64.4	52.0	66.4	79.9	86.8	39.2**
ACCORDING TO TEACHERS	(N=81)	(N=27)	(N=28)	(N=26)	(N=67)	(N=14)
Hours dedicated to SRH education each term						
Form 2						
<1	1.1	2.9	0.0	0.0	2.1	0.0
1–5	34.9	30.9	36.7	38.3	31.0	39.4
6–10	33.1	28.9	41.8	26.7	20.4	47.4
>10	30.8	37.3	21.5	34.9	46.5	13.2
Form 3						
<1	0.0	0.0	0.0	0.0*	0.0	0.0
1–5	32.4	7.8	46.9	47.8	32.7	32.1
6–10	43.6	71.6	32.6	18.2	36.4	51.8
>10	24.0	20.6	20.5	34.0	30.9	16.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. **p<.01. ***p<.001. †Multiple responses were allowed. *Notes:* For percentage distributions, significant differences were across the distributions. Percentages may not add to 100.0 because of rounding.

TABLE 4.2

Percentage of students who have learned about SRH education topics, by reported organizational aspects, according to region and school type

Aspect	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
ALL STUDENTS	(N=2,990)	(N=951)	(N=856)	(N=1,183)	(N=2,696)	(N=294)
Subject in which SRH education taught†						
Biology	25.0	34.3	24.9	18.1 ***	25.6	21.4 ***
Integrated science	72.1	70.2	70.3	74.9	72.5	69.9 **
Physical education	14.8	12.2	13.9	17.5 *	15.1	13.2 ***
Social studies	94.7	94.6	96.7	93.2 **	95.4	90.3 ***
Management in living	18.2	13.0	13.3	25.9 ***	18.7	15.3 ***
Religious and moral education	55.1	52.6	62.5	51.4 ***	57.2	41.1 ***
After-class/co-curricular program	17.6	13.2	24.1	15.8 ***	18.3	12.2 ***
Other	1.8	1.9	1.7	1.7	1.8	1.9 ***
None	0.5	0.1	0.7	0.6	0.2	2.0 ***
STUDENTS WHO LEARNED ABOUT TOPICS	(N=2,978)	(N=950)	(N=850)	(N=1,178)	(N=2,691)	(N=287)
Grade level in which SRH education first received						
Primary: Class 4	23.7	22.3	20.8	27.0 ***	23.8	23.3
Primary: Class 5	17.4	17.4	14.7	19.6	17.4	17.4
Primary: Class 6	35.9	37.6	38.6	32.5	36.1	34.4
Junior High: Form 1	12.8	13.1	15.6	10.3	13.0	11.1
Junior High: Form 2	5.0	3.9	5.8	5.1	5.0	5.1
Junior High: Form 3	2.2	1.9	2.7	2.1	2.3	1.9
Senior High	3.0	3.8	1.8	3.4	2.5	6.7
Desired timing of SRH education						
Students who started learning in primary school	(N=2,291)	(N=742)	(N=627)	(N=922)	(N=2,071)	(N=220)
Would have liked to start earlier	49.5	51.7	33.3	59.5 ***	49.0	53.1
Would have liked to start later	6.7	8.3	2.1	8.8	6.5	7.8
Satisfied with timing	43.9	40.0	64.6	31.7	44.5	39.2
Students who started learning in junior high school	(N=603)	(N=182)	(N=208)	(N=213)	(N=546)	(N=57)
Would have liked to start earlier	47.6	50.7	35.5	57.8 ***	44.9	68.0 *
Would have liked to start later	8.5	9.6	2.9	13.4	9.1	3.9
Satisfied with timing	43.9	39.7	61.6	28.8	46.0	28.1
Students who started learning in senior high school	(N=81)	(N=24)	(N=15)	(N=42)	(N=71)	(N=10)
Would have liked to start earlier	60.2	45.5	ds	71.0	59.4	ds
Would have liked to start later	5.6	4.8	ds	8.6	7.8	ds
Satisfied with timing	34.2	49.7	ds	20.5	32.8	ds
STUDENTS WHO LEARNED IN COEDUCATIONAL SCHOOLS	(N=2,548)	(N=814)	(N=725)	(N=1,009)	(N=2,295)	(N=253)
Setting for SRH education activities						
All taught with males and females together	85.6	85.0	82.2	88.3 **	85.0	89.4
Some taught together, some separately	11.8	11.3	15.4	9.7	12.5	7.6
All taught separately	2.6	3.7	2.4	1.9	2.5	3.0
Preference for SRH education activities						
Males	(N=1,005)	(N=337)	(N=278)	(N=390)	(N=917)	(N=88)
Prefer all taught with males and females together	85.0 ***,‡	83.9	80.4	88.8 *	85.0	85.2
Prefer some taught together, some separately	11.1	11.7	15.6	7.7	11.3	9.0
Prefer all taught separately	3.9	4.4	4.0	3.5	3.7	5.8
Females	(N=1,536)	(N=475)	(N=445)	(N=616)	(N=1,371)	(N=165)
Prefer all taught with males and females together	76.3	76.1	70.3	80.9 **	76.3	76.7
Prefer some taught together, some separately	14.7	14.6	20.6	10.5	14.8	14.0
Prefer all taught separately	9.0	9.3	9.1	8.6	8.9	9.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. **p<.01. ***p<.001. †Multiple responses were allowed. ‡Male and female distributions were significantly different. *Notes:* For percentage distributions, significant differences were across the distributions. Percentages may not add to 100.0 because of rounding. ds=data suppressed, for when data are available for fewer than 20 respondents.

TABLE 4.3

According to teachers, percentage of schools in which SRH education topics are taught, and the comprehensiveness in the range of topics, by region and school type

Category, topic and comprehensiveness	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=81)	(N=27)	(N=28)	(N=26)	(N=67)	(N=14)
Sexual and reproductive physiology						
Puberty/physical changes in body	99.4	100.0	100.0	97.8	100.0	98.8
Reproductive organs	99.4	100.0	100.0	97.8	100.0	98.8
Menstruation	99.4	100.0	100.0	97.8	100.0	98.8
Pregnancy and childbirth	100.0	100.0	100.0	100.0	100.0	100.0
All	**99.4**	**100.0**	**100.0**	**97.8**	**100.0**	**98.8**
HIV and STI prevention						
HIV/AIDS	100.0	100.0	100.0	100.0	100.0	100.0
Other STIs	100.0	100.0	100.0	100.0	100.0	100.0
Where to access HIV/STI services	95.7	100.0	89.8	97.8	100.0	90.8
All	**95.7**	**100.0**	**89.8**	**97.8**	**100.0**	**90.8**
Contraception and unintended pregnancy						
Abortion	99.4	100.0	100.0	97.8	100.0	98.8
Contraceptive methods	100.0	100.0	100.0	100.0	100.0	100.0
How to use methods	96.2	100.0	89.8	100.0	100.0	92.0
Where to get methods	83.6	79.9	77.7	97.8	97.9	67.6***
All	**83.6**	**79.9**	**77.7**	**97.8**	**97.9**	**67.6*****
Values and interpersonal skills						
Sexual behavior	100.0	100.0	100.0	100.0	100.0	100.0
Decision-making skills	91.9	80.9	99.0	97.8**	99.3	83.5***
Communicating within relationships	88.1	80.9	88.8	97.8	99.3	75.6***
Chastity/saying no to sex/abstinence	100.0	100.0	100.0	100.0	100.0	100.0
Moral issues related to sexuality	100.0	100.0	100.0	100.0	100.0	100.0
Sex in exchange for money or gifts	95.3	99.0	89.8	97.8	99.3	90.8*
All	**83.6**	**79.9**	**77.7**	**97.8**	**97.9**	**67.6*****
Gender and SRH rights						
Sexual and reproductive rights	99.4	100.0	100.0	97.8	100.0	98.8
Equality between men and women	99.4	100.0	100.0	97.8	100.0	98.8
Prevention of violence/sexual abuse	99.1	99.0	100.0	97.8	99.3	98.8
Sexual orientation	99.1	100.0	99.0	97.8	99.3	98.8
All	**98.7**	**99.0**	**99.0**	**97.8**	**98.6**	**98.8**
Comprehensiveness of coverage†						
Minimum	99.4	100.0	100.0	97.8	100.0	98.8
Adequate	88.5	80.9	89.8	97.8	100.0	75.6
High	82.5	77.9	76.7	97.8	95.8	67.6***

*p<.05. **p<.01. ***p<.001. †"Minimum" indicates at least one topic in each category; "adequate" indicates nearly all topics, except one at most, in each category; and "high" indicates all topics in each category. Levels are not mutually exclusive; for example, schools that meet the adequate level also meet the minimum level.

TABLE 4.4

Percentage of students who reported SRH education topics taught, and the comprehensiveness in the range of topics, by region and school type

Category, topic and comprehensiveness	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=2,990)	(N=951)	(N=856)	(N=1,183)	(N=2,696)	(N=294)
Sexual and reproductive physiology						
Puberty/physical changes in body	97.4	96.4	99.2	96.7***	97.2	98.3
Reproductive organs	95.4	94.8	97.4	94.5**	95.4	95.8
Menstruation	86.8	85.7	88.2	86.7	87.1	85.2
Pregnancy and childbirth	81.1	79.0	84.3	80.2*	81.6	78.1
All	**71.6**	**68.3**	**77.2**	**69.6*****	**72.2**	**67.4**
HIV and STI prevention						
HIV/AIDS	91.6	89.8	93.8	91.4*	91.5	92.8
Other STIs	73.8	72.2	78.3	71.4**	75.1	64.6**
Where to access HIV/STI services	46.6	47.0	37.6	53.3***	47.1	43.1
All	**39.6**	**39.8**	**33.5**	**44.2*****	**40.4**	**34.3**
Contraception and unintended pregnancy						
Abortion	65.5	65.9	61.1	68.6**	66.7	57.6*
Contraceptive methods	48.9	44.1	46.7	54.3***	48.3	52.6
How to use contraceptive methods	40.0	37.5	32.0	48.1***	40.0	40.0
Where to get contraceptive methods	36.0	31.5	29.6	44.5***	35.6	38.7
All	**24.3**	**21.4**	**19.3**	**30.3*****	**24.3**	**24.2**
Values and interpersonal skills						
Sexual behavior	62.9	59.9	64.9	63.8	62.5	65.6
Decision-making skills	51.5	45.5	52.0	55.7***	51.5	51.8
Communicating within relationships	44.5	40.7	40.8	50.2***	43.3	52.1*
Chastity/saying no to sex/abstinence	93.2	92.2	96.5	91.3***	93.1	93.5
Moral issues related to sexuality	63.6	55.9	66.4	67.4***	63.5	64.5
Sex in exchange for money or gifts	52.8	42.9	55.6	58.3***	54.0	44.7*
All	**18.6**	**15.1**	**17.5**	**22.1*****	**18.6**	**18.2**
Gender and SRH rights						
Sexual and reproductive rights	86.9	84.9	86.1	89.0*	86.8	87.7
Equality between men and women	46.5	45.0	41.4	51.5***	45.9	50.0
Prevention of violence/sexual abuse	70.9	69.7	71.8	71.1	71.0	70.5
Sexual orientation	57.8	54.3	56.5	61.4*	57.9	56.9
All	**27.0**	**24.8**	**24.7**	**30.4***	**27.3**	**24.7**
Comprehensiveness of coverage†						
Minimum	73.7	73.2	70.2	76.9**	73.6	74.5
Adequate	18.9	15.8	16.5	23.1***	19.0	18.3
High	8.4	6.4	7.4	10.7**	8.4	8.2

*p<.05. **p<.01. ***p<.001. †"Minimum" indicates at least one topic in each category; "adequate" indicates nearly all topics, except one at most, in each category; and "high" indicates all topics in each category. Levels are not mutually exclusive; for example, schools that meet the adequate level also meet the minimum level.

TABLE 4.5

Percentage of students who reported their desire to learn more about SRH education topics, by region and school type

Category and topic	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=2,990)	(N=951)	(N=856)	(N=1,183)	(N=2,696)	(N=294)
Sexual and reproductive physiology						
Puberty/physical changes in body	65.6	65.4	51.4	76.7^{***}	64.9	70.5
Reproductive organs	64.8	63.9	53.3	74.3^{***}	64.1	69.9
Menstruation	66.5	66.0	57.4	73.9^{***}	66.2	68.8
Pregnancy and childbirth	64.9	60.6	57.8	73.5^{***}	64.1	69.7
HIV and STI prevention						
HIV/AIDS	64.5	63.5	53.1	74.0^{***}	64.0	67.9
Other STIs	63.4	58.3	57.2	72.0^{***}	63.2	64.9
Where to access HIV/STI services	64.8	58.7	60.6	72.7^{***}	64.1	69.5
Contraception and unintended pregnancy						
Abortion	64.6	60.4	58.5	72.4^{***}	64.6	64.4
Contraceptive methods	67.2	59.9	65.1	74.2^{***}	67.2	66.8
How to use contraceptive methods	66.8	58.2	66.7	73.4^{***}	66.5	68.8
Where to get contraceptive methods	63.2	54.9	61.6	70.7^{***}	62.9	65.4
Values and interpersonal skills						
Sexual behavior	68.7	66.9	65.3	72.7^{**}	68.5	70.3
Decision-making skills	67.1	60.1	63.8	74.9^{***}	66.5	70.9
Communicating within relationships	66.3	59.8	65.7	71.6^{***}	66.4	65.8
Chastity/saying no to sex/abstinence	66.0	63.6	57.2	74.6^{***}	65.8	67.3
Moral issues related to sexuality	71.1	65.0	67.5	78.5^{***}	70.9	72.8
Sex in exchange for money or gifts	61.5	56.6	54.9	70.1^{***}	60.4	68.9^{*}
Gender and SRH rights						
Sexual and reproductive rights	65.5	62.3	57.0	74.4^{***}	64.9	69.3
Equality between men and women	66.4	60.8	61.4	74.4^{***}	66.1	68.0
Prevention of violence/sexual abuse	64.5	60.5	58.7	71.9^{***}	65.2	59.5
Sexual orientation	65.0	57.9	60.4	73.8^{***}	65.0	65.0

*p<.05. **p<.01. ***p<.001.

TABLE 4.6

Percentage distribution of teachers following a curriculum when teaching SRH education who reported the strength of messages taught, by region and school type

Strength of message	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Having sexual relationships is dangerous for young people						
Very strong	83.4	76.4	85.3	88.2	83.6	82.4
Not very strong	10.2	14.1	9.8	6.3	9.8	12.0
Not at all	6.4	9.6	4.9	5.4	6.6	5.6
Having sexual relationships is immoral for young people						
Very strong	80.8	72.8	87.1	78.4	79.1	87.5
Not very strong	11.8	17.7	8.2	11.5	12.5	8.7
Not at all	7.4	9.5	4.7	10.2	8.3	3.7
Young people have the right to know everything about relationships and SRH						
Very strong	77.5	71.2	77.1	85.9	76.0	83.5
Not very strong	16.7	19.1	18.5	10.1	17.2	14.9
Not at all	5.8	9.6	4.4	4.0	6.9	1.6
Young people should avoid having sex before they are married						
Very strong	85.0	79.3	88.7	84.9	86.4	79.6*
Not very strong	9.3	14.4	6.4	8.6	6.9	19.0
Not at all	5.7	6.3	4.9	6.5	6.7	1.4
Young people should protect themselves when they have sex (by using condoms)						
Very strong	56.4	63.9	42.2	75.1***	57.0	54.0
Not very strong	29.2	22.0	40.4	16.0	29.0	30.1
Not at all	14.4	14.1	17.4	8.9	14.1	15.8
Homosexuality is unnatural						
Very strong	68.3	64.5	71.6	66.5	68.4	67.8
Not very strong	14.2	14.7	14.0	13.9	15.1	10.6
Not at all	17.5	20.8	14.3	19.6	16.5	21.7
Abortion is immoral						
Very strong	77.7	76.2	80.6	73.7	78.4	74.7
Not very strong	14.6	11.4	15.9	16.1	12.7	22.1
Not at all	7.7	12.5	3.5	10.3	8.9	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. ***p<.001. *Note:* Significant differences were across the percentage distributions. Percentages may not add to 100.0 because of rounding.

TABLE 4.7

Percentage of teachers who covered contraceptives and various contraception messages in their SRH education classes, by region and school type

Topic and message	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
Those who teach SRH education	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Chastity/saying no to sex/abstinence	95.6	94.7	94.8	98.5	97.0	90.2
Contraceptives	96.6	98.5	96.1	95.1	97.3	93.8
Those who teach about contraceptives	(N=329)	(N=114)	(N=110)	(N=105)	(N=291)	(N=38)
Specific method†						
Condoms	98.9	100.0	99.2	97.0	99.5	96.3*
Oral contraceptive pill	82.7	84.8	82.2	80.7	85.0	73.1
Injectable (Depo-Provera)	75.0	75.6	72.2	79.7	77.8	63.2
Implant (Jadelle, Norplant, etc.)	69.4	66.1	69.8	73.1	71.8	59.5
Intrauterine device (IUD, coil)	74.0	72.9	73.1	77.4	77.2	61.0
Emergency contraception (E-pill)	53.7	48.1	54.8	58.6	51.8	61.6
Male or female sterilization	72.4	67.2	73.8	76.2	76.2	56.6*
Foam/gel/suppository	64.6	61.1	66.2	65.9	67.5	52.5
Sponge/diaphragm/cervical cap	61.0	58.6	60.1	66.1	65.5	42.4*
Rhythm (calendar)	86.8	83.7	87.8	88.7	86.2	89.2
Withdrawal	79.1	76.9	80.5	78.9	80.4	73.5
Other traditional methods	15.7	12.3	16.4	18.5	15.3	17.1
Emphasis regarding pregnancy prevention						
Contraceptives can be effective	73.5	84.9	63.4	79.4**	73.5	73.4
Contraceptives are not effective	24.0	14.3	33.4	17.4	24.1	23.7
Do not teach about contraceptives and pregnancy	2.5	0.8	3.2	3.1	2.4	2.9
Those who teach about condoms	(N=325)	(N=114)	(N=109)	(N=102)	(N=289)	(N=36)
Emphasis regarding pregnancy prevention						
Condoms alone are effective	11.5	12.8	8.5	15.7	11.9	9.6
Condoms alone are not effective	85.9	84.7	88.4	82.6	84.9	90.4
Do not teach about condoms and pregnancy	2.6	2.5	3.1	1.8	3.2	0.0
Emphasis regarding HIV/STI prevention						
Condoms can be effective	63.5	73.3	53.6	71.2*	62.2	69.4
Condoms are not effective	33.8	25.3	42.7	26.3	35.6	26.1
Do not teach about condoms and HIV/STIs	2.7	1.4	3.6	2.5	2.3	4.5
Those who teach about abstinence	(N=331)	(N=112)	(N=109)	(N=110)	(N=294)	(N=37)
Emphasis regarding prevention of STIs/pregnancy						
Abstinence is one alternative	17.7	21.1	19.6	10.2	17.4	19.2
Abstinence is the best of many alternatives	77.4	73.8	76.1	84.4	78.3	73.8
Abstinence is the only method/way	4.8	5.1	4.3	5.3	4.3	7.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. **p<.01. †Multiple responses were allowed. *Notes:* For percentage distributions, significant differences were across the distributions. Percentages may not add to 100.0 because of rounding.

TABLE 4.8

Among students exposed to SRH education, percentage who learned about selected messages and who reported the strength of messages, by region and school type

Message and strength	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=2,978)	(N=950)	(N=850)	(N=1,178)	(N=2,691)	(N=287)
Message†						
How to make positive decisions and stick to them	59.7	50.3	66.2	61.7***	59.9	58.4
Recognizing forced sexual contact	40.0	34.5	34.9	48.1***	39.7	42.2
How alcohol and drugs affect sexual behavior	72.7	69.0	66.5	80.4***	72.4	75.3
Respect for yourself and others, no matter gender or social status	87.2	83.6	87.7	89.6**	87.0	88.9
Signs and symptoms of STIs and HIV	88.5	88.6	86.0	90.4*	88.3	90.2
Ways to prevent HIV infection	90.9	91.4	87.1	93.3***	90.6	92.6
How to talk to a partner about getting an HIV test	48.8	51.5	28.3	62.4***	47.4	58.1**
Ways to prevent pregnancy	87.2	83.2	86.0	91.3***	87.1	88.1
How to communicate with a partner about using a contraceptive, including condoms	45.7	43.2	26.9	62.0***	44.1	56.7***
What to do if you get pregnant/get someone pregnant	35.9	35.3	23.6	45.8***	34.5	45.3**
Strength of message						
Having sex is dangerous for young people						
Very strong	71.6	67.7	72.7	73.8***	71.5	72.6
Not very strong	21.9	21.2	25.2	19.8	22.0	20.6
Not at all	6.5	11.1	2.1	6.4	6.5	6.8
Don't have sex before you are married						
Very strong	75.1	68.2	78.0	78.0***	75.2	74.1
Not very strong	20.6	25.5	19.4	17.7	20.5	20.8
Not at all	4.4	6.2	2.6	4.3	4.3	5.0
It is best that youth avoid having sex, but if they do, they should use condoms						
Very strong	67.8	68.7	56.7	75.5***	66.8	74.5*
Not very strong	24.0	23.5	31.0	19.1	24.6	19.9
Not at all	8.2	7.8	12.3	5.4	8.6	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. **p<.01. ***p<.001. †Multiple responses were allowed. *Notes:* For percentage distributions, significant differences were across the distributions. Percentages may not add to 100.0 because of rounding.

TABLE 4.9

Percentage of teachers who reported various classroom activities used in SRH education classes, by region and school type

Classroom activity	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Lecture/talk (including Q&A)	100.0	100.0	100.0	100.0	100.0	100.0
Assignments (i.e., essays)	96.6	97.6	95.1	98.2	96.7	96.1
Quizzes	80.5	83.5	77.9	81.8	81.5	76.4
Charts/drawings	75.4	72.1	81.1	68.4	78.0	64.7
Small-group discussions	73.1	69.4	78.1	67.8	77.9	52.7**
Creative, participatory learning activities†	60.2	58.9	63.1	55.9	60.7	57.8
Practical demonstrations (e.g., condoms)	38.5	34.6	35.8	48.4	40.0	32.2
Internet/social media	37.8	31.6	41.3	38.5	37.5	39.0
Audio-visual (film, video, radio)	17.0	18.6	17.1	14.6	18.6	10.1
Other	1.0	1.4	0.0	2.5	1.0	1.2

**p<.01. †Includes role playing, theater, drama, debates, art projects, dance, poems and storytelling.

TABLE 4.10

Percentage of students who reported various classroom activities and who wanted to engage in them, by region and school type

Classroom activity	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=2,978)	(N=950)	(N=850)	(N=1,178)	(N=2,691)	(N=287)
Reported activity						
Lecture/talk (Q&A)	70.4	65.7	74.7	70.8**	72.0	59.3***
Assignments (i.e., essays)	63.7	65.0	64.5	62.2	66.1	47.4***
Quizzes	37.7	37.6	22.6	49.4***	38.1	35.1
Charts/drawings	14.8	14.8	13.6	15.7	15.3	11.1
Small-group discussions	49.6	46.2	48.4	53.2*	50.6	43.0*
Creative, participatory learning activities†	63.5	66.4	56.6	66.6***	64.3	57.8
Internet/social media	29.6	35.3	25.8	28.3***	30.8	21.8**
Audio-visual (film, video, radio)	39.5	44.5	30.2	42.9***	39.6	39.0
Other	1.9	2.7	1.4	1.8	2.0	1.8
Wanted to engage in activity						
Lecture/talk (Q&A)	64.5	62.2	59.1	70.4***	65.3	59.2
Assignments (i.e., essays)	43.4	42.1	35.1	50.7***	44.7	34.1**
Quizzes	51.1	48.5	41.4	60.6***	51.8	46.4
Charts/drawings	22.6	18.1	26.9	22.7***	23.5	16.2*
Small-group discussions	54.9	54.1	51.2	58.3*	56.3	45.5**
Creative, participatory learning activities†	81.1	78.6	83.8	81.0*	81.7	77.1
Internet/social media	44.3	43.8	50.7	39.9***	46.1	32.3***
Audio-visual (film, video, radio)	58.7	61.6	62.0	53.9***	60.7	44.7***
Other	2.2	3.0	1.3	2.3*	2.4	1.2

*p<.05. **p<.01. ***p<.001. †Includes role playing, theater, drama, debates, art projects, dance, poems and storytelling.

TABLE 4.11

Percentage of teachers who reported use of teaching aids and classroom experiences, by region and school type

Teaching aid and classroom experience	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
Those who teach SRH education	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Teaching aid						
Written materials	91.4	90.4	94.0	87.7	90.3	96.1
Charts	54.7	52.2	57.2	52.8	55.7	50.2
Other audio-visual	15.1	18.7	14.4	12.0	15.7	12.9
Demonstration kits	19.7	23.8	18.4	17.2	21.6	11.8
Other	2.7	4.9	2.6	0.4	1.7	7.0
Classroom experience						
Questions are answered in front of others	97.2	98.6	96.6	96.5	97.0	98.0
Questions are answered in private	81.4	79.0	82.9	81.3	84.4	69.1
Teachers feel restricted by the school	4.6	4.2	5.0	4.5	5.3	1.7
Questions not answered because they feel inappropriate/ teacher feels uncomfortable/teacher does not know answer	30.3	24.6	34.7	28.7	33.9	15.2*
Those who teach about contraceptives	(N=329)	(N=114)	(N=110)	(N=105)	(N=291)	(N=38)
Show methods so students see how they work	43.7	32.1	51.0	43.6*	43.9	42.8
Show the proper way to use a condom (print or film)	40.7	37.9	41.8	41.9	43.1	30.8
Show the proper way to use a condom (demonstration)	37.4	32.9	36.0	45.7	38.9	31.4
Give information about services where adolescents can get methods/counseling	69.3	68.3	64.8	79.2	73.0	54.1*

*p<.05.

TABLE 4.12

Percentage of teachers and students who reported various SRH education classroom experiences, by region and school type

Classroom experience	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
Teachers who cover SRH education topics	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Classroom experience						
Embarrassment about topics or terms	21.5	27.6	13.0	30.6*	19.0	31.6
Topics/content that contradict religious, traditional and personal beliefs or values	23.8	26.2	17.3	33.9	21.9	31.3
Pushback/opposition from students	16.8	21.1	10.3	24.2*	17.0	15.9
Pushback/opposition from parents or community	1.3	0.0	0.9	3.9*	1.3	1.6
Lack of participation from students	3.8	7.0	0.8	5.9*	3.4	5.7
Lack of time	48.8	52.0	49.6	43.3	51.3	38.6
Lack of teacher training or sufficient knowledge	20.4	19.0	19.5	23.8	22.7	11.1
Lack of resources or teaching materials	77.0	83.4	71.4	80.3	77.6	74.6
Restrictions/bans on teaching certain topics	1.5	2.6	0.6	2.2	1.5	1.6
Other	0.8	0.0	1.6	0.0	1.0	0.0
Students who have received SRH education	(N=2,978)	(N=950)	(N=850)	(N=1,178)	(N=2,691)	(N=287)
Classroom experience						
Too many people in the class	51.1	56.7	32.6	61.1***	51.8	46.4
Students not paying attention/being disruptive	27.3	23.6	31.4	27.0**	27.7	24.7
Students embarrassed to talk about topics	39.8	33.7	40.9	43.6***	40.5	35.3
Students excited to learn about topics	81.6	81.0	88.9	76.5***	82.2	77.6
Teacher embarrassed to talk about topics	21.2	25.5	11.7	25.2***	20.6	25.3
Teacher doesn't know enough about topic	11.3	11.6	8.9	12.8*	10.9	13.4
Reason for not asking a question						
Too embarrassed	40.9	44.9	38.6	39.5*	40.5	43.3
Not enough time	32.9	33.6	26.8	37.0***	32.5	35.6
Thought the teacher would not know the answer	11.2	11.3	8.5	13.2**	11.3	10.3
Afraid to offend or embarrass someone	29.8	29.2	26.2	33.1**	29.4	32.9
Afraid the teacher/students would shut him/her down	29.9	31.9	29.4	28.8	29.5	32.5
Other students or the teacher were not listening	9.1	9.4	5.9	11.3***	8.9	10.1
Never had a question that did not ask	27.3	25.8	31.8	25.1**	27.8	24.2

*p<.05. **p<.01. ***p<.001.

TABLE 4.13

Percentage of schools that use various teacher and student evaluation measures for SRH education topics, by region and school type

Evaluation	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
ACCORDING TO SCHOOL HEADS	(N=78)	(N=27)	(N=26)	(N=25)	(N=64)	(N=14)
All schools						
Frequency of teacher evaluation						
Several times a term	52.7	66.7	29.4	66.0	46.3	59.9
Once a term (or several times a year)	14.5	12.7	17.2	13.1	16.6	12.1
Once a year or less	3.0	0.0	5.7	3.4	5.6	0.0
Never	29.8	20.6	47.6	17.6	31.4	28.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Schools where teachers are evaluated	(N=53)	(N=18)	(N=14)	(N=21)	(N=43)	(N=10)
Method of teacher evaluation						
Class observation	85.1	100.0	65.8	81.7	92.2	ds
Oral assessment (one-on-one conversation)	55.5	69.1	49.7	41.3	36.4	ds
Written assessment	36.9	43.8	15.4	47.0	46.3	ds
Other	13.9	6.2	32.2	8.1	16.6	ds
ACCORDING TO TEACHERS						
All schools	(N=81)	(N=27)	(N=28)	(N=26)	(N=67)	(N=14)
Method of student assessment						
Oral assessment	91.7	77.9	100.0	100.0	97.9	84.7
Written exam/test	100.0	100.0	100.0	100.0	100.0	100.0
Projects	39.8	34.3	45.0	40.3	64.4	12.1**
Practical demonstrations	47.4	54.4	29.8	62.6	68.7	23.5*
Presentations	68.1	67.2	73.5	61.6	78.3	56.5
Group work	71.1	57.4	88.8	65.8	78.0	63.3
Other	5.2	2.9	5.1	8.5	9.7	0.0*
Aspect of student learning assessed						
Knowledge	100.0	100.0	100.0	100.0	100.0	100.0
Attitudes	87.9	77.9	89.8	100.0	97.9	76.7*
Practical/life skills	83.1	58.8	100.0	94.7**	96.4	68.2**
Other	0.8	0.0	2.1	0.0	1.4	0.0

*p<.05. **p<.01. *Notes:* Percentages may not add to 100.0 because of rounding. ds=data suppressed, for when data are available for fewer than 10 respondents.

TABLE 5.1

Percentage of teachers who reported various aspects of pre-service or in-service training on SRH education, by region and school type

Aspect of training	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
Teachers who cover SRH education topics	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Received pre-service training	78.1	75.8	76.0	84.9	82.2	60.8**
Received in-service training						
<1 year ago	3.2	3.4	3.1	3.1	3.1	3.5***
1–3 years ago	10.5	6.8	13.5	9.3	10.1	12.4
>3 years ago	25.0	31.3	24.8	17.6	30.7	1.4
Never	61.3	58.5	58.7	70.0	56.2	82.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Teachers with pre-service training	(N=275)	(N=95)	(N=87)	(N=93)	(N=246)	(N=29)
Source of pre-service training†						
Pre-service education (e.g., teacher college)	43.9	42.5	44.3	44.8	46.4	29.9
University education	90.5	92.1	88.3	92.6	93.5	74.1**
Course at separate institute	7.5	2.0	12.4	5.2*	6.4	14.0
Assessment of pre-service training						
Very adequate	52.5	48.9	54.0	54.0*	53.3	47.8
Adequate	36.3	36.0	42.3	27.1	35.9	38.8
Inadequate	11.2	13.3	3.7	18.9	10.8	13.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Ways to improve pre-service training†						
More hours of training	80.4	80.9	70.4	96.6***	80.8	78.6
More training in certain topics	87.8	88.0	81.4	98.1**	87.6	89.0
Training in teaching methods	77.3	82.5	65.2	91.7***	79.0	68.0
Separate training on specific topics	79.6	75.5	73.3	94.7**	78.1	88.4
Teachers with in-service training	(N=132)	(N=47)	(N=51)	(N=34)	(N=123)	(N=9)
Assessment of in-service training						
Very adequate	41.3	48.0	34.1	52.0	40.9	ds
Adequate	43.7	35.8	54.0	25.2	45.3	ds
Inadequate	15.1	16.2	12.0	22.9	13.9	ds
Total	100.0	100.0	100.0	100.0	100.0	100.0
Ways to improve in-service training†						
More hours of training	84.1	74.5	84.6	97.2	82.4	ds
More training in certain topics	94.1	89.3	94.5	100.0	93.4	ds
Training in teaching methods	82.8	77.3	80.6	96.4	82.1	ds
Separate training on specific topics	87.2	79.5	86.5	100.0	85.8	ds
Teachers with in-service training within three years	(N=39)	(N=11)	(N=17)	(N=11)	(N=32)	(N=7)
Source of in-service training†						
National government	61.2	ds	57.8	ds	66.9	ds
School administration	18.5	ds	21.9	ds	23.8	ds
Separate institute/NGO/CBO	47.0	ds	59.9	ds	53.6	ds
Other	5.7	ds	10.1	ds	7.3	ds

*p<.05. **p<.01. ***p<.001. †Multiple responses were allowed. *Notes:* Percentages may not add to 100.0 because of rounding. ds=data suppressed, for when data are available for fewer than 20 respondents

TABLE 5.2

Among teachers who received any pre-service or in-service training on SRH education, percentage who had training in various topics and teaching methods, by region and school type

Topic and comprehensiveness	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=286)	(N=97)	(N=94)	(N=95)	(N=256)	(N=30)
Topic						
Puberty/physical changes in body	89.0	94.8	87.7	84.8	88.7	90.5
Reproductive organs	90.8	96.1	88.4	89.1	91.9	84.4
Menstruation	87.3	93.5	85.7	83.3	88.4	81.4
Sexual behavior	87.5	92.3	90.5	76.7**	87.5	87.1
Equality between men and women	75.5	85.7	69.9	74.3	76.2	71.4
Pregnancy and childbirth	86.7	93.9	83.0	85.4	88.0	79.9
Abortion	85.9	92.0	85.0	81.0	88.0	74.5
Contraceptive methods	88.1	90.4	87.7	86.1	88.8	83.8
How to use contraceptive methods	83.6	88.1	79.5	86.0	84.1	80.8
Where to get contraceptive methods	79.1	84.3	76.4	78.1	79.8	75.1
Sex in exchange for money or gifts	59.4	64.7	55.7	59.9	59.5	59.1
HIV/AIDS	95.4	97.4	94.1	95.6	96.6	88.9
Other STIs	93.6	98.1	90.5	94.2	94.4	88.9
Where to access STI/HIV services	87.8	93.0	87.1	83.2	87.3	90.4
Communicating within relationships	70.3	78.9	68.0	65.1	71.7	62.8
Decision-making skills	76.9	81.6	76.8	72.0	76.9	77.1
Prevention of violence/sexual abuse	73.9	76.0	68.4	81.4	75.8	63.7
Sexual orientation	72.6	76.7	68.2	75.8	72.9	70.7
Sexual and reproductive rights	81.3	84.3	78.3	83.3	81.0	82.8
Chastity/saying no to sex/abstinence	85.7	92.8	83.1	82.3	88.3	71.4
Moral issues related to sexuality	79.0	84.8	77.2	76.0	80.2	72.7
Comprehensiveness of topics included in training†						
Minimum	83.8	90.0	80.9	82.0	85.7	73.0
Adequate	55.2	65.6	48.3	55.8	56.7	46.3
High	40.4	47.6	35.8	40.5	42.8	26.9
Received training in teaching methods for SRH education	48.8	42.8	53.7	46.4	50.0	41.9

**p<.01. †"Minimum" indicates at least one topic in each category; "adequate" indicates nearly all topics, except one at most, in each category; and "high" indicates all topics in each category. Levels are not mutually exclusive; for example, schools that meet the adequate level also meet the minimum level.

TABLE 5.3

Percentage of teachers and school heads who reported accessibility and availability of resources for teaching SRH education, by region and school type

Accessibility and availability of resources	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
Teachers who cover SRH education topics	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Have access to general teaching support materials						
Goals, objectives and expected outcomes for topics	94.1	92.8	95.8	92.3	93.9	95.1
Teaching manual	57.9	58.2	62.0	49.2	55.2	68.5
Document describing the scope and sequences of instructions	89.1	96.9	82.1	93.3 ***	88.1	93.4
Lesson plans or learning activities	48.8	35.9	52.7	57.0 *	51.4	38.3
Teaching or learning materials	51.9	46.1	50.5	61.7	49.3	62.0
Plans/tools for how to evaluate or assess students	52.1	52.6	48.4	58.8	53.8	45.5
Have access to out-of-classroom resources						
Teacher support group	21.5	20.3	22.3	21.3	23.0	15.1
Support from colleague teachers	68.1	68.0	71.0	62.8	69.4	62.7
Support from experts/NGOs/CBOs/health professionals	27.9	23.1	27.8	34.2	31.6	12.8
Internet resources (including social media)	49.2	51.7	49.2	46.2	51.2	41.1
Use of methodological materials						
National textbook for students	95.8	88.7	100.0	96.4 **	97.0	90.6
National manual for teachers	34.4	38.5	35.5	27.2	36.4	26.1
Materials developed by local/district/regional authority	3.2	4.9	2.5	2.6	3.3	2.8
Materials developed by school	5.6	1.0	8.2	6.4	4.7	9.4
Materials developed by teacher	34.2	19.4	46.9	27.8 ***	35.1	30.5
Official materials developed in other countries/by international NGOs	7.1	6.8	9.5	2.7	7.4	5.6
Materials from in-country NGOs/CBOs	9.8	5.1	13.5	8.3	10.5	6.7
Media sources (e.g., Internet, TV, magazines)	36.3	36.4	38.4	32.0	37.3	32.0
School heads	(N=78)	(N=27)	(N=26)	(N=25)	(N=64)	(N=14)
Ways to support SRH education teachers						
Organize meetings to discuss/resolve issues or concerns	61.1	75.5	45.3	62.6	56.0	66.7
Support SRH education and its teachers at board meetings, PTA meetings and other community events	45.6	51.5	41.5	42.9	51.2	39.4
Encourage teachers to discuss concerns and try to help	58.1	85.3	29.3	59.6 ***	67.2	47.9
Invite outside experts to support teachers	37.9	41.7	35.1	36.5	40.3	35.3
Other	4.8	5.9	4.7	3.4	9.1	0.0 *
Any of the above types of support	91.6	100.0	79.7	96.6	98.4	84.1 *

*p<.05. **p<.01. ***p<.001.

TABLE 5.4

Percentage of teachers who reported a need for teaching support, and the perceived level of support for SRH education from various sources, by region and school type

Need and support	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
	(N=343)	(N=117)	(N=114)	(N=112)	(N=302)	(N=41)
Assistance required to teach more effectively†						
More factual information	45.4	49.0	42.3	47.3	46.9	39.4
More training	44.4	56.0	35.1	48.3*	45.3	40.7
More teaching materials/strategies	78.9	78.4	78.2	80.7	81.2	69.4
Fewer restrictions on what can be taught	1.4	3.3	0.5	0.9	1.7	0.2*
More support from school or community	17.9	23.4	16.0	14.9	19.2	12.9
Perceived level of support from sources						
School heads						
Very supportive	51.8	54.7	51.2	49.5	50.0	59.2
Supportive	38.4	36.7	37.2	42.9	39.7	33.0
Unsupportive	9.8	8.7	11.6	7.7	10.2	7.8
Other teachers at this school						
Very supportive	47.4	45.3	45.5	53.8	49.6	38.4
Supportive	46.5	49.6	46.9	41.9	45.1	52.1
Unsupportive	6.1	5.1	7.6	4.4	5.3	9.5
Parents						
Very supportive	15.9	22.3	8.7	21.2	16.9	11.7
Supportive	52.7	51.6	55.6	48.8	51.9	56.0
Unsupportive	31.4	26.2	35.7	30.0	31.2	32.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. †Multiple responses were allowed. *Note:* Percentages may not add to 100.0 because of rounding.

TABLE 5.5

Among teachers who cover each topic, percentage who said they require more assistance, by region and school type

Topic	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
Puberty/physical changes in body	33.1	34.7	24.5	48.3**	33.9	29.8
Reproductive organs	55.0	54.0	47.9	69.7*	55.1	54.5
Menstruation	38.0	34.1	35.9	46.6	36.3	45.3
Sexual behavior	35.2	29.4	32.7	47.5	37.4	25.3
Equality between men and women	32.9	16.5	36.1	44.4*	30.1	45.8
Pregnancy and childbirth	54.8	58.1	53.4	53.4	53.8	59.2
Abortion	57.8	62.6	58.2	51.0	59.3	50.9
Contraceptive methods	73.4	77.0	68.2	79.1	71.9	80.8
How to use contraceptive methods	64.8	66.2	61.6	69.2	66.0	59.5
Where to get contraceptive methods	48.4	55.5	42.1	51.4	48.9	45.7
Sex in exchange for money or gifts	26.7	27.4	22.0	34.5	26.4	28.6
HIV/AIDS	58.1	61.8	53.6	62.1	57.1	62.4
Other STIs	55.8	61.6	49.0	61.8	54.1	63.5
Where to access STI/HIV services	34.3	35.6	28.2	44.1	36.4	25.3
Communicating within relationships	34.7	29.7	32.8	44.8	34.1	37.3
Decision-making skills	32.0	26.1	28.1	47.0	33.1	28.0
Prevention of violence/sexual abuse	40.6	43.7	37.1	44.7	40.3	41.9
Sexual orientation	45.3	49.3	42.1	47.0	45.3	45.1
Sexual and reproductive rights	34.8	25.4	35.2	44.5	36.3	28.4
Chastity/saying no to sex/abstinence	25.3	24.1	24.5	28.3	25.5	24.5
Moral issues related to sexuality	25.8	28.0	18.5	37.4*	25.2	28.1

*p<.05. **p<.01.

TABLE 5.6

Percentage of school heads who reported various school policies, by region and school type

Policy	All	Region			School type	
		Brong Ahafo	Greater Accra	Northern	Public	Private
ALL SCHOOLS	(N=78)	(N=27)	(N=26)	(N=25)	(N=64)	(N=14)
School has a child protection policy	52.4	42.6	52.4	68.1	54.0	50.6
Policy for cases of harassment						
If teachers are found to be harassing students						
Immediately fired or transferred	15.1	4.0	27.3	14.1*	10.0	20.9
Given several warnings before they are fired	37.2	32.3	39.4	41.3	36.7	37.7
Temporarily suspended from teaching	33.1	54.5	9.5	35.0	34.2	31.9
Given a warning but are not fired or suspended	3.1	0.0	6.0	3.6	5.9	0.0
School does not have a policy	11.5	9.1	17.7	6.0	13.3	9.5
If students are found to be harassing other students						
Immediately expelled	8.4	4.9	10.2	11.1	8.8	8.0
Given several warnings before being expelled	56.1	73.5	47.0	43.6	43.0	70.8
Temporarily suspended from school	22.6	15.7	19.2	37.7	32.0	12.1
Given a warning but are not expelled or suspended	3.1	2.9	5.4	0.0	5.8	0.0
School does not have a policy	9.8	2.9	18.2	7.7	10.4	9.2
COEDUCATIONAL AND MALES-ONLY SCHOOLS	(N=68)	(N=22)	(N=23)	(N=23)	(N=54)	(N=14)
Policy if a male gets a female pregnant						
He would be allowed to continue his studies	51.1	54.1	61.0	32.0	47.0	55.3
He would be asked to stay home from school for a period of time	27.8	27.3	25.1	32.4	28.2	27.3
He would be sent away/transferred to a different school	20.8	18.6	12.9	35.5	24.1	17.3
Other	0.4	0.0	1.0	0.0	0.8	0.0
COEDUCATIONAL AND FEMALES-ONLY SCHOOLS	(N=72)	(N=26)	(N=23)	(N=23)	(N=59)	(N=13)
Policy if a female becomes pregnant						
She would be allowed to continue her studies	25.6	32.2	36.3	0.0	12.8	39.7
She would be asked to stay home from school until she had the baby	57.1	57.9	47.3	70.2	69.1	44.0
She would be sent away/transferred to a different school	17.2	9.9	16.4	29.8	18.1	16.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. *Notes:* Significant difference was across the percentage distribution. Percentages may not add to 100.0 because of rounding.

TABLE 5.7

Percentage of students who reported their perception of feeling safe at school, by region and gender

Perception of safety	All	Region			Gender	
		Brong Ahafo	Greater Accra	Northern	Male	Female
	(N=2,990)	(N=951)	(N=856)	(N=1,183)	(N=1,162)	(N=1,820)
Feel safe expressing themselves in front of other students and teachers at this school						
Never	25.6	28.2	24.3	24.6***	21.5	28.4***
Sometimes	48.3	46.6	54.2	45.0	47.6	48.7
Always	26.1	25.2	21.5	30.3	30.9	22.9
Fear that other students or teachers may make fun of them/tease them at school						
Never	49.2	52.4	44.1	50.8*	51.8	47.5
Sometimes	40.6	37.8	45.2	39.1	38.4	41.9
Always	10.2	9.8	10.7	10.1	9.7	10.6
Afraid that other students will physically harm them						
Never	61.0	64.4	67.4	53.8***	65.6	58.0**
Sometimes	29.9	25.4	26.5	35.8	27.0	31.8
Always	9.1	10.3	6.1	10.4	7.4	10.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. **p<.01. ***p<.001. *Notes:* Eight students were excluded from gender-specific indicators because they did not specify a gender. Significant differences were across the percentage distributions. Percentages may not add to 100.0 because of rounding.

TABLE 6.1

Percentage of students who received SRH education outside of school, by information source, activity and frequency, according to region and gender

Source, activity and frequency	All	Region			Gender	
		Brong Ahafo	Greater Accra	Northern	Male	Female
All students	(N=2,990)	(N=951)	(N=856)	(N=1,183)	(N=1,162)	(N=1,820)
Source†						
Father	55.1	51.5	50.3	61.4***	57.4	53.4
Mother	80.1	80.1	76.3	83.1**	69.8	87.1***
Other family members	85.4	84.5	81.2	89.4***	78.6	90.0***
Friend/girlfriend/boyfriend	86.2	87.3	84.2	86.9	82.8	88.5***
After-school program/peer/outreach worker	71.7	67.7	68.6	77.1***	67.3	74.8***
Religious figure	66.0	59.2	61.5	74.5***	68.2	64.4
Health center/youth center/other community center	78.6	83.7	66.7	83.8***	76.0	80.3*
Media (e.g., books/pamphlets, Internet, radio, TV)	97.5	97.4	97.9	97.4	97.9	97.3
Other	13.5	10.7	9.1	19.2***	11.9	14.5
Most used source						
Father	18.7	17.9	14.6	22.5***	22.5	16.1***
Mother	42.3	40.7	43.4	42.7	25.8	53.4
Other family members	9.7	10.3	10.0	8.9	9.5	9.8
Friend/girlfriend/boyfriend	7.9	9.0	7.3	7.4	10.6	6.0
After-school program/peer/outreach worker	2.0	2.8	2.1	1.3	3.3	1.1
Religious figure	4.7	3.8	5.2	5.0	7.0	3.2
Health center/youth center/other community center	4.4	6.5	2.7	4.1	5.8	3.3
Media (e.g., books/pamphlets, Internet, radio, TV)	9.9	8.9	14.2	7.5	14.9	6.7
Other	0.4	0.1	0.4	0.6	0.5	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Students who participated in out-of-school activities	(N=2,427)	(N=816)	(N=634)	(N=977)	(N=928)	(N=1,496)
Type of activity†						
Seminars/talks	49.9	48.6	64.1	41.2***	51.8	48.7
Workshops	30.0	26.5	17.0	41.7***	28.4	31.1
Debates	54.6	58.3	42.8	59.9***	56.6	53.4
Peer education groups	65.2	65.1	63.0	66.7	58.8	69.4***
Theater	13.6	15.9	14.5	11.3*	13.5	13.7
Role play	27.3	27.5	24.0	29.4	25.1	28.8
Other community activities	31.5	33.1	24.4	35.0***	32.4	30.8
Other	3.9	5.9	1.8	3.9**	5.3	3.1*
Frequency of participation						
At least once a week	32.6	34.0	24.5	37.1***	30.2	34.1*
At least once a month	21.3	21.9	20.3	21.5	19.4	22.6
Every few months	13.8	12.8	15.9	13.1	15.0	12.9
Once or twice a year	23.5	20.0	30.8	21.1	26.1	21.8
Less than once a year	8.9	11.3	8.6	7.2	9.3	8.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

*p<.05. **p<.01. ***p<.001. †Multiple responses were allowed. *Notes:* Eight students were excluded from gender-specific indicators because they did not specify a gender. Most students who answered "other" did not specify a source. Percentages may not add to 100.0 because of rounding.

TABLE 7.1

Percentage of students and teachers who reported various opinions and beliefs regarding SRH education, by region

Opinion or belief	All	Region		
		Brong Ahafo	Greater Accra	Northern
Among all students	(N=2,990)	(N=951)	(N=856)	(N=1,183)
Believe it should be taught	99.5	99.4	99.4	99.6
Students who have learned about sexuality education	(N=2,978)	(N=950)	(N=850)	(N=1,178)
Believe it has been useful/very useful in their personal lives	95.3	95.0	93.3	97.2
Degree of enjoyment of classes				
More than other subjects	76.6	74.2	71.0	77.2**
About the same as other subjects	17.2	18.0	22.9	15.9
Less than other subjects	6.2	7.9	6.1	6.9
Total	100.0	100.0	100.0	100.0
Students who believe sexuality education should be taught†	(N=2,973)	(N=945)	(N=851)	(N=1,177)
These topics are just as important as other topics	71.1	65.4	78.2	69.9**
Parents don't teach us	47.5	50.6	48.7	44.2*
We need to know how to prevent unintended pregnancy	74.9	71.9	72.1	79.1**
We need to know how to avoid getting HIV/AIDS or other STIs	79.9	77.0	77.2	84.2**
We need to learn how to resist pressure	53.2	47.1	64.7	49.1**
To understand how our body works	55.4	50.5	66.6	50.4**
Other reason	6.3	7.7	4.7	6.5
Teachers who cover SRH education topics	(N=343)	(N=117)	(N=114)	(N=112)
Aspects they seek to impact in students†				
Knowledge	95.9	95.9	95.1	97.2
Attitudes	83.2	75.5	86.1	86.9
Opinions	50.7	44.9	55.5	48.5
Practical skills/life skills	62.3	60.5	65.0	59.3
Self-confidence	56.8	52.1	58.5	59.2
Other	1.3	0.0	2.8	0.0
Most important message it should impart†				
That everyone deserves respect, no matter what gender, race or social status	31.7	32.1	38.2	18.3*
That sexual relations should always be consensual	17.0	22.2	14.2	15.9
Information about HIV/STI transmission and where to access HIV/STI services	52.3	59.5	46.0	55.7
Emphasis on avoiding unintended pregnancy, including accurate information about contraceptives and where to access services	32.0	48.4	20.5	34.7***
That abstinence is the best way to prevent pregnancy and HIV/STIs	75.7	72.7	73.8	83.3
That young people should not have sex before marriage	47.0	39.4	54.9	40.7
That sexuality is a natural, healthy and positive part of life	29.7	22.0	31.7	35.4
That address how the body works/personal hygiene	7.0	3.7	9.8	5.7
Importance of decision making, self-confidence and interpersonal relationship skills	3.4	3.5	4.0	2.0
Other	7.1	9.1	7.6	3.5

*p<.05. **p<.01. ***p<.001. †Multiple responses were allowed. *Note:* Percentages may not add to 100.0 because of rounding.

TABLE 7.2

Percentage of school heads and teachers who agreed with various attitudes regarding sex and relationships, by region

TABLE 7.2. Percentage of school heads and teachers who agreed with various attitudes regarding sex and relationships, by region

Attitude	School heads				Teachers			
	All (N=78)	Brong Ahafo (N=27)	Greater Accra (N=26)	Northern (N=25)	All (N=81)	Brong Ahafo (N=27)	Greater Accra (N=28)	Northern (N=26)
Females should remain virgins until marriage	85.6	80.9	85.1	93.3	95.5	94.4	98.6	90.7
Males should remain virgins until marriage	85.6	80.9	85.1	93.3	93.9	91.9	96.9	90.7
Important that youth are taught about healthy sexuality	100.0	100.0	100.0	100.0	99.4	99.5	99.1	99.8
Young people who carry condoms are bad/promiscuous/unfaithful	36.2	28.9	38.5	43.7	28.2	23.9	35.0	20.5
Making contraceptives available encourages sex	53.7	53.4	50.0	59.3	44.6	37.6	44.1	54.1
Important to teach students about contraceptive methods	82.7	92.2	69.9	86.9	85.8	93.6	76.4	94.4***
Important to tell students where to access SRH services	87.4	94.1	85.1	80.6	91.7	95.0	88.1	94.5
Students with HIV/AIDS should not be allowed in schools	9.8	6.9	0.0	28.1**	10.7	13.6	10.6	7.3
Abortion shouldn't be allowed for unwanted pregnancy	26.2	12.7	31.8	38.2	35.3	35.7	35.2	35.0
Sex should only be allowed between a man and a woman	98.9	97.1	100.0	100.0	98.2	96.4	99.6	97.5
Females who get pregnant should be expelled	25.2	29.9	10.2	40.2	18.7	20.0	17.8	18.7
Males who get a girl pregnant should be expelled	32.5	38.7	12.5	52.4	16.8	18.0	15.4	18.1
Males who carry condoms should be expelled	22.1	27.0	19.6	18.6	11.6	18.9	8.5	8.6
Females who carry condoms should be expelled	22.1	27.0	19.6	18.6	11.2	18.9	8.3	7.6*

*p<.05. **p<.01. ***p<.001.

Appendix

Senior High School Curricula Involving SRH Topics

A. SOCIAL STUDIES SYLLABUS

<table>
<tr><th>Year 1</th><th>Year 2</th><th>Year 3</th></tr>
<tr>
<td>Adolescent reproductive health
• Define and explain the following terms: adolescence, reproductive health, reproductive rights
• Explain how knowledge of reproductive features of the adolescent informs them about their health
• Identify some of the irresponsible behaviors of the adolescent and their consequences in Ghana
• Discuss safety measures for adolescent health (e.g., seek medical attention, consult parents and elders, undertake exercises)
• Examine the causes and implications of irresponsible behaviors of adolescents (e.g., STIs, HIV, unwanted pregnancy, school dropout)
• Identify ways and means of fostering good gender relations (e.g., mutual respect)
• Explain adolescent chastity and its related benefits (let students discuss the benefits of chastity; use value clarification on adolescent chastity)</td>
<td>Institution of marriage
• Explain and define marriage
• The purpose of marriage
• Preparation toward marriage
• Types of marriage (customary, religious, ordinance)
• Marriage residence patterns (patrilocal, matrilocal, neolocal, duolocal, etc.)
• Cases and problems of broken marriages
• Ways for sustaining marriages

Individual obligations in family
• Nuclear and extended family systems
• Composition and functions of families
• Roles and obligations of family members
• Importance of family as an institution
• Implications in supporting or abandoning the nuclear and extended families
• Inheritance systems: traditional and modern; positive and negative aspects; negative and positive aspects of intestate succession law and how the negative aspects can be addressed</td>
<td>Rights and responsibilities of individuals
• Meaning of rights and responsibilities
• Individual rights in the 1992 Constitution
• Factors leading to the curtailing of people's rights
• Reasons for performing responsibilities

Population growth and development
• Structure of Ghana's population
• Social and economic implications of Ghana's population structure
• Measures for breaking the vicious cycle of rapid population growth
• Efforts at implementing the 1994 Population Policy
• Why it has been difficult for Ghana to achieve MDGs 4 and 5
• Ideal family size</td>
</tr>
</table>

Appendix (continued)

Youth and national development • Explain the term “youth” • Examine some challenges the youth are encountering in their effort to contribute to national development and the way to overcome these challenges • State and describe some of the avenues for youth training in the country • Identify avenues by which the youth can gain employment • Analyze the contribution the nation expects from youth in national development (expectations include: quality education and skills needed for work in the present century, effective decision-making skills, healthy lifestyle, hard work, maintain a job and pay taxes, positive attitude to work, maintain good relationships, support national efforts and support others, have proper role models)	**Responsible parenting** • Distinguish between parenthood and parenting • Responsibilities of parents (responsible and irresponsible behaviors) • Ways children can cause parents to be irresponsible • Handling parent-child conflict **Socialization and our school environment** • Complementary roles of the school and family in character formation • Consequences of deviant behavior • Group and individual interest **Role of individual in community** • Explain community and levels of community • What is involved in community development • Community decision-making processes • Ways by which individuals can contribute	

Source: reference 42.

Appendix (continued)

B. INTEGRATED SCIENCE SYLLABUS

Year 1	Year 2	Year 3
Food and Nutrition • Classes of foods and food substances • Balanced diet • Effects of malnutrition • Food fortification and enrichment • Health benefits of water	**Reproductive system and growth in mammals** • Structure and functions of the mammalian reproductive system • Male and female circumcision • Fertilization and development of zygote (pregnancy) and birth in humans • Problems associated with reproduction in humans (e.g., miscarriage, ectopic pregnancy, infertility, impotence) • Sexually transmitted infections: HIV/AIDS, gonorrhea, herpes, chlamydia, syphilis, candidiasis; modes of infection and effects; and prolonged sickness and infertility • Phases of growth in humans and associated changes **Safety in the community** • Common hazards: diseases, pests and parasites • Unsanitary conditions, problems of waste generation and pollution • The role of health service organizations • Public health and sanitation • Public education	**Variations and inheritance** • Chromosomes and genes • Variations: meaning, causes and consequences • Sex determination, sex-linked characteristics • Blood groups and rhesus factor • Inheritance of blood groups and rhesus factor and its application • Sickle cell gene, sickle cell disease

Source: reference 52.

Appendix (continued)

C. BIOLOGY SYLLABUS ON REPRODUCTION
(Year 2, Section 4: Mammalian Anatomy and Physiology)

- Reproduction in mammals
- Reproductive system of male and female mammals
- Internal structure of the testis and ovary
- Gametogenesis
- Fertilization, development of embryo and birth
- Secondary sexual characteristics
- Birth control
- Meaning of antenatal care
- Antenatal visit requirements
- Nutrition and diet
- Exercise during pregnancy
- Benefits of the use of natural products for mother and child

Source: reference 53.

Appendix (continued)

D. MANAGEMENT IN LIVING SYLLABUS

Year 1	Year 2
SECTION 2: ADOLESCENT AND FAMILY LIVING **Unit 1: Developmental changes and adolescent sexualities** • Signs of reproductive growth in adolescent boys and girls • Consequences of the reproductive growth of the adolescent • Social, emotional and mental growth and changes that take place in adolescents • Menstrual cycle and menstruation and its implications	**SECTION 1: PARENTHOOD** **Unit 1: Preparation for parenthood and childbirth** • Childbirth ○ Processes of conception and pregnancy ○ Signs and symptoms of pregnancy ○ Need for antenatal care ○ Preparation for childbirth ○ Processes of childbirth ○ Postnatal care • Planning the family ○ Reasons to plan the family ○ Birth control methods
Unit 2: Premarital sex and adolescent pregnancy • Premarital sex and the factors that influence the behavior • Consequences of premarital sex and ways of prevention • Factors leading to adolescent pregnancy • Dangers associated with adolescent pregnancy and the consequences • Criminal abortion and its effects on adolescents	**Unit 2: Preparation for parenthood—childcare** • Developmental stages of a child • Care of a baby • Feeding needs of a baby • Common childhood ailments and prevention
Unit 3: Problems of adolescents • Substance abuse ○ Substances that are abused by adolescents ○ Reasons why adolescents engage in substance abuse ○ Effects of each of the substances on the adolescent ○ Impact of substance abuse on the family and nation ○ Ways of avoiding substance abuse • Problems of adolescents—female genital mutilation (FGM) ○ Explain FGM ○ Analyze problems associated with FGM ○ Suggest methods to stop FGM	**Unit 3: Parenting and parenthood** • Distinguish between parenthood and parenting • Roles of parents in development of child • Challenges of parenting • Responsibilities of parents
Unit 4: Marriage • Explain and define marriage • Purpose of marriage • Factors to consider when choosing marriage partner • Benefits of marriage • Courtship and dating (advantages and disadvantages) • Preparation before marriage • Premarital counseling	**Unit 4: Issues related to parenting and parenthood** • Child abuse and neglect • Effects of child abuse • Agencies providing support for child abuse and neglect • Child labor • Child rights and responsibilities • Effects of child labor on the child, family and nation • Generation gap

Appendix (continued)

Marriage in Ghana • Types of marriages • Marriage laws and prohibitions • Social and legal implications of marriage • Factors contributing to success or failure of marriages	
Unit 5: The family • Meaning and types of family (nuclear and extended family systems) • Functions of the family • Rights and responsibilities of family members • Family life cycle • Needs, goals and resources of families at various stages	**Unit 5: Family crisis** • Explain and give examples of family crisis • Effects of crisis on the family • Adjusting to family crisis • Various types of sexually transmitted infections • Nature of HIV/AIDS; how HIV is contracted/not contracted • Signs and symptoms of HIV/AIDS • Effects of HIV/AIDS on the individual, family and nation
SECTION 3: PRINCIPLES OF MANAGEMENT **Unit 3: Decision making** • Explain decisions and decision making • Using the decision-making process • Different types of decisions families make	**Family conflict** • Describe conflicts and its effects • Ways of resolving conflict

Unit 5: Communication in the family
• Communications and its importance
• Communication process
• Need for effective communication within the family
• Family crisis
  ○ Effects of family crisis
  ○ Adjusting to family crisis
• Family crisis—sexually transmitted infections
• Family crisis—HIV/AIDS
• Family conflict
  ○ Causes and effects
  ○ Ways of resolving conflicts	

Source: reference 54.

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