

**Adolescent Sexual and Reproductive
Health in Ghana:
Results from the 2004 National
Survey of Adolescents**

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Executive Summary

Introduction

Ten years after the International Conference on Population and Development, sexual and reproductive health issues concerning adolescents in Sub-Saharan Africa have become even more critical than in the 1990s. By the end of 2005, an estimated 4.6% of females and 1.7% of males aged 15–24 years in Sub-Saharan Africa were living with HIV and about one in 10 young women experienced a premarital birth by age 20. Given the situation, achieving a number of the targets under the Millennium Development Goals will include addressing the sexual and reproductive health needs of young people, who are considered the “window of hope” in the fight against the HIV/AIDS epidemic. In Ghana, the estimated HIV/AIDS prevalence rate among 15–24-year-olds was 3.4% in 2002, and the median prevalence rate for the adult population increased from 2.3% in 2000 to 3.4% in 2002. In the 2003 Ghana Demographic and Health Survey 0.3% of 15–19-year-olds and 1.2% of 20–24-year-olds tested positive for HIV, while the overall prevalence among 15–49-year olds was 2.2%. Within the last decade, median age at first birth in Ghana slowly increased from 20.1 years in 1993 to 20.5 years in 2003. Females aged 15–19 accounted for about 9% of all births in 2003.

Responding to adolescents’ sexual and reproductive health issues requires new information in diverse areas, such as their current levels of knowledge; attitudes and behaviors that put them at risk for HIV transmission or unwanted pregnancy; their differential risks of HIV transmission and unwanted pregnancy; barriers to seeking sexual and reproductive health information and services; and how they, especially very young adolescents, are currently responding to their sexual and reproductive health needs. To obtain new perspectives on the lives of young people that can be used to address their information and service needs, a nationally representative, household-based survey was conducted in 2004 among adolescents aged 12–19 years in Ghana. Known as the 2004 National Survey of Adolescents

(NSA), the survey included very young adolescents—12–14-year-olds—who are rarely taken into account by studies on sexual and reproductive health.

Key Findings

Background characteristics

About 97% of adolescents surveyed lived with an adult figure: either both or one biological parent, a family member or an unrelated member of a household. Of the adolescents aged 15–19, 3% of females and 1% of males were in a union. More than 90% of females and males were either in school or had attended school, a figure slightly higher than the national average for the age-group. Fewer than 1% of both female and male adolescents were in tertiary institutions at the time of the survey. Nonetheless, 54% of the females and 62% of the males expected to attain tertiary education. A particularly marked difference between the lives of females and males was found in their different levels of involvement in household chores. Whereas 82% of females, irrespective of age, reported being involved in household chores, only 47% of males took part in household chores. Females also had less time for recreation than males.

Nearly all the adolescents professed to belong to a religious faith, with three out of four of the respondents reporting Christian religion. For those with a religious affiliation, 84–88% indicated that religion was “very important” in their lives.

Close friends are commonplace among adolescents. On average, males reported four friends while females reported two friends of the same or opposite sex. Adolescents reported that their parents monitored their activities in terms of knowing where they are at night and who their friends are. Eighty percent of females and 73% of males had never tried alcohol. Among both females and males, two in five reported being very worried about getting HIV/AIDS.

Sexual activity and relationships

One-third of 12–14-year-old females and nine out of ten 15–19-year-olds had experienced menstruation. Three percent of females and 92% of males said they had undergone circumcision. The prevalence of circumcision among females, though low, points to the existence of female genital cutting in the country. Traditional ceremonies to usher children into adulthood are no longer practiced as before—only 5% of females and 4% of males said they had ever experienced any initiation rites—creating a vacuum in the socialization process for young people.

Our results indicate that 30% of females and 16% of males 15–19 years have ever had sex. The reasons for sexual debut included adolescents having “felt like it”, having expected money, and having been tricked or forced (especially among females). Females tended to be younger than their sexual partners at sexual debut.

Some younger females who had never had sex reported other sexual experiences, such as fondling and kissing. Twenty-four percent of females and 19% of males reported that they had ever been touched, kissed or fondled in an unwanted sexual manner, while 12% of females and 5% of males indicated that they had been physically forced or threatened to have sexual intercourse. Among the perpetrators of sexual coercion were acquaintances, boyfriends, family members, teachers and schoolmates.

Contraception

Knowledge about modern contraceptives was high, with 90% of both females and males having heard of at least one modern contraceptive method. On average, younger adolescents (aged 12–14) had heard of three and the older adolescents (aged 15–19) had heard of five contraceptive methods. The most common contraceptive method mentioned was the male condom (88% of females and 91% of males) followed by the female condom (70% females and 73% males). Although 79% of female and 67% of sexually-experienced female and male adolescents were aware that there was a certain period within which a woman could get pregnant if she had sex, only 30% of females and 15% of males who said they were aware actually knew the exact period.

The majority of adolescents who had ever heard of contraceptives expressed positive attitudes towards contraceptive methods: They did not think that providing contraceptive methods to younger adolescents would make them promiscuous. More than 50% of sexually experienced adolescents had ever used a contraceptive method, and nearly half reported using the male

condom. Among those who recently had sex, 51% of the females and 64% of the males used contraceptive methods within the three months prior to the survey. The proportions varied among those females in a union and those not in a union. Only 4% of females and 8% of males reported using traditional methods. Results did not show any clear pattern between duration of the intimate relationship with the last partner and contraceptive use. There appeared to be a positive association between communication about contraceptive use and usage: Among sexually-active adolescents who talked with their partners about contraceptives, 60% females and 59% of males reported using contraceptives compared to 27% of females and 45% of males who did not discuss contraceptives with their partner.

Pregnancy and childbearing

Adolescents’ knowledge about how pregnancy can occur is inadequate. For instance, only 37% of females aged 12–14 and 60% of those aged 15–19 knew that a woman can get pregnant the first time she has sexual intercourse; 22% of females and 26% of males 12–19 years thought that a girl could not get pregnant if she had sex standing up. All adolescents did not appear to have adequate knowledge about the specifics of how pregnancy occurs and how it can be prevented.

Among females aged 15–19, 13% had ever been pregnant and another 9% had ever had a child. There was evidence of early childbearing: Some 14% of females in a union gave birth before age 15. One-third of the females in a union and 51% of those not in a union did not want to have a child at the time they last conceived.

Anecdotal evidence suggests that induced abortion occurs among adolescents, but in the survey fewer than 1% of adolescents self-reported that they had ever ended or had been involved in ending a pregnancy, compared to nearly a third of females aged 15–19 who reported that they had close friends who ever tried to end a pregnancy. Common methods known for ending pregnancy were surgical abortion (known by almost one-third of females and males), herbal drinks (known by about 20% of females and males) and various mixtures with sugar (such as coffee and sugar or beer/malt and sugar).

HIV/AIDS and other STIs

Knowledge about HIV/AIDS was nearly universal. Among those who had heard of HIV/AIDS, over 90% knew that HIV can be transmitted through sexual intercourse with an infected person and 80% were aware

of mother-to-child transmission. Alongside the accurate knowledge about HIV/AIDS, some respondents held misconceptions about transmission, such as believing that the disease can be spread by sharing of food with an infected person or via mosquito bites. About 10% of adolescents reported that a man infected with HIV/AIDS can be cured if he has sex with a virgin.

About 20% of adolescents knew someone who was HIV positive and just over one-third knew of someone who had died or people said had died of AIDS. Between 51% and 63% thought that a female teacher who had HIV/AIDS should not be allowed to teach and 69% of females and 55% of males would want the HIV-positive status of a family member kept secret, indicating some level of stigmatization and discrimination against people living with HIV/AIDS.

Two in five 12–19-year-olds had heard of other STIs. Among adolescents who had heard of STIs, common specific symptoms known were burning pain when urinating (31% of females and 41% of males) and genital discharge (22% of females and males). Only 4% of females and 1% of males reported ever having experienced an STI. Thus, self-reporting of STIs was low among the youth.

Risk and protective behaviors

Reported self-perceived risk of HIV was also low among both females and males: About two out of three adolescents felt that they were not at risk, with higher percentages among the younger than the older adolescents. About half of the females (44%) and males (48%) who had had sex with their boyfriend/girlfriend within the last 12 months used condom. One of the most common reasons among unmarried adolescents for not using a condom was that they “felt safe.” There was not a strong association between receiving money or gifts for sex, and using a condom.

While about 70% of females and 80% of males agreed that condoms should be put on before sex, their knowledge about usage and attitudes towards condoms appeared to be inadequate. For instance, 60% of females and 48% of males felt it was embarrassing to buy or ask for condom, and more than 50% of females were not confident that they could ask their partner to use condom; Fifty-eight percent of males were not confident in knowing how to use a male condom.

Injection, body piercing and scarification are behaviors that can put adolescents at risk of HIV infection if instruments are recycled without proper sterilization. Thirty-six percent of females and 56% of males

reported piercing or scarification and 42–48% of females and males reported at least one injection in the last 12 months. Over 90% of the injections received were administered by a doctor or nurse. There was, however, inadequate information on issues surrounding body piercing and scarification. This is one area where further studies will be needed.

Sexual and reproductive health information and services

Since the mid-1980s, information has been provided on HIV/AIDS and contraceptives through the mass media, as well as the education and health systems. Results from the survey indicated that the main sources for information on HIV/AIDS and contraceptives among adolescents are—in order of descending prevalence—the mass media, school (teachers) and health workers, friends and family (an exception is for HIV/AIDS information for female adolescents where family was a slightly more common source than friends). While the main source was the mass media, adolescents, especially younger adolescents, preferred teachers and health workers as sources for information.

Although aware of where to obtain contraceptive methods and treatment for STIs, adolescents were unable to take full advantage of them due to barriers such as being embarrassed or feeling shy and being unable to afford the cost, as well as programmatic issues such as lack of privacy, inconvenient business hours and lack of same-sex service providers. These are issues that will need to be addressed in future programs.

Voluntary counseling and testing (VCT) has been introduced as part of HIV/AIDS preventive measures in the country. Over 80% of adolescents had heard of VCT, and nearly 80% of those who had heard of VCT knew where one could obtain a service. Of those who had heard, only 2% had ever been tested while 71% said they were willing to go for a test. The results indicate potential for the promotion of VCT among the youth.

Policy and Program Implications

The policy and program implications of the survey findings are the following:

Build on the importance of schooling by

- ensuring that young people achieve their objective of attaining higher education, while at the same time
- eliminating the gender-based difference in perception of education for females and males;
- encouraging parents/guardians and society to raise

girl child education to the highest level;

- intensifying the teaching of sex-related issues in schools and other nonfamilial settings;
- using formal and informal school systems to disseminate detailed information about how pregnancy can occur and be prevented; and
- intensifying the campaign on delaying sexual debut and pregnancy within the context of achieving universal basic education.

Strengthen links with other organizations by

- liaising with religious associations to develop programs for young people;
- utilizing peer networks as conduits for providing sexual and reproductive health and other services to young people; and
- promoting community structures and programs that will provide support to young people to enable them to make healthy sexual and reproductive health decisions.

Address continued gaps in knowledge by

- providing adolescents with detailed information that covers a wide range of issues, including pregnancy and what happens to males and females at various stages of physical development, and that dispels misconceptions about sexual acts that do not lead to pregnancy;
- improving information sources and services to promote the use of effective contraceptive methods among sexually-active adolescents in Ghana;
- developing programs that address existing misconceptions on modes of HIV infection and provide accurate and reliable information to young people on the epidemic;
- developing messages that address young peoples' low level of awareness and knowledge about other STIs;
- intensifying campaigns that deal with acceptance and support for people living with AIDS; and using the electronic media as much as possible to provide information to young people on contraceptives, reproductive health and VCT services. In addition, efforts should be made to promote the use of print media for information that needs to be kept and referred to in the future. Such an approach should be built into programs in the school system and into the informal education study packs for those who are out of school.

Deal with sexual violence and coercion by

- developing advocacy programs to address sexual coercion reported by females at various levels, including within communities and the education system.

Target the needs of specific subgroups of adolescents and adults by

- developing programs and activities to respond to the socioeconomic concerns indicated by some youth;
- developing programs that respond to the particular needs of younger and rural adolescents. As a subgroup, rural adolescents, particularly females, will need messages and programs that will help them protect themselves from HIV/AIDS;
- developing programs targeting parents in order to make it easy for them to support their children in sexual and reproductive health issues; and
- developing programs for health care providers that respond to adolescents' concerns about confidentiality, business hours, sex of the provider and service quality.

Overall, there is a need to intensify campaigns and improve services that will aid the prevention of pregnancy, unsafe abortion, HIV/AIDS and other STIs among young people. Given adolescents' current sexual and risk-taking behaviors, programs must continue to focus on increasing age at first sex, promoting positive attitudes toward condoms and improving the confidence of adolescents about the purchase and correct use of condoms for dual protection from pregnancy and STIs, including HIV/AIDS. Continued effort must be made in providing information and messages on abstinence, faithfulness and the effectiveness of condom use in preventing HIV/AIDS, with relative emphasis for various categories of adolescents: younger and older, rural and urban, sexually-experienced and not, and in union and not in union.

Chapter 1

Introduction

Adolescent sexual and reproductive health is a critically important policy and programmatic area in Sub-Saharan Africa. An estimated 4.6% of women and 1.7% of men aged 15–24 years were living with HIV at the end of 2005.¹ About one in 10 young women have had a premarital birth by age 20: 8% in West/Central Africa and 15% in South/East Africa.² While adolescents constitute part of the “window of hope” with regard to the HIV/AIDS epidemic, about half of all new HIV infections are estimated to occur among this generation of 10–24-year-olds.³ Given the urgency and scope of addressing the sexual and reproductive health needs of adolescents, it is important to assess their current levels of knowledge, attitudes and behaviors that put them at risk for HIV transmission or unwanted pregnancy; examine why some of them are at higher risk of HIV transmission and unwanted pregnancy than others; document the barriers to seeking sexual and reproductive health services and information; and provide new information about what very young adolescents know and do with respect to sexual and reproductive health.

In 2004, a nationally representative survey was conducted among adolescents in Ghana aged 12–19 years to obtain new evidence on the lives of young people which can be used to address their needs for information and service in sexual and reproductive health. The survey data covered a range of issues including adolescents’ views on sources of information on health and related services; sexual relationships and characteristics of partners; the consistency and correct use of condoms; exposure to and content of sex education in schools; and influences of family and peers. An important strength of the survey is that it contains information on very young adolescents (ages 12–14 years), a group about whom very little has been known up to now. The survey also included interviews with male adolescents, a group not often covered in surveys on young people.

The purpose of this report is to provide a comprehensive overview of sexual and reproductive health issues among 12–19-year-old females and males in Ghana based on information from the 2004 National Survey of Adolescents (NSA). Results are descriptive and relevant policy and programmatic implications are emphasized throughout the report.

The 2004 survey was part of a larger, five-year study of issues associated with sexual and reproductive health of adolescents called Protecting the Next Generation: Understanding HIV Risk Among Youth. The project, carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of the sexual and reproductive health needs of young people with regard to HIV/AIDS, other STIs and unwanted pregnancy, and communicating the new knowledge to a broad audience of policymakers, health care providers and the media in each country, and at the regional and international levels. The aim is to stimulate the development of improved policies and programs that serve the needs of young people.

In addition to the national surveys conducted, project data were collected through focus group discussions and in-depth interviews in all four countries. Fifty-five focus group discussions with 14–19-year-olds were conducted in 2003 with the aim of increasing understanding of the perceptions and beliefs that influence the behaviors of adolescents and their use of health information and services.⁴ Also in 2003, 102 in-depth interviews were conducted among 12–19-year-olds in order to understand the social context of young people’s sexual relationships and their health-seeking behavior. Finally, 60 in-depth interviews were conducted in 2005 among health providers, teachers and parents/guardians/adult community leaders on their experiences, responsibilities, and perceptions of adolescent sexual and reproductive health.

Reproductive Health Situation of Adolescents in Ghana

As part of this project, a comprehensive overview of current knowledge on adolescent sexual and reproductive health issues in Ghana, with a focus on HIV prevention, was conducted drawing upon the existing body of social science research, including both quantitative and qualitative studies.⁵ Overall, the conditions under which young people grow and live have changed considerably within the last 40 years in Ghana. Formal education has created new avenues for marriage partner selection, which was previously the responsibility of family members. Moreover, the traditional socialization process is no longer the main avenue for socializing young people. Institutions such as the school system, religious bodies, mass media and government establishments have become other important avenues for the socialization of young people.

Two important sexual and reproductive health needs of young people in Ghana are preventing HIV and other STIs and avoiding unwanted pregnancy. In 2002 the estimated HIV/AIDS prevalence rate among 15–24-year-olds in Ghana was 3.4% and the median prevalence rate for the adult population increased from 2.3% in 2000 to 3.4% in 2002.⁶ HIV prevalence figures from the 2003 Ghana Demographic and Health Survey were lower: Some 0.3% of 15–19-year-olds and 1.2% of 20–24-year-olds tested positive for HIV, and the overall prevalence rate among 15–49-year olds was 2.2%.⁷ Within the last decade, median age at first birth in Ghana slowly increased from 20.1 years in 1993 to 20.5 years in 2003. Although, the contribution of adolescents to total fertility declined from 11% in 1993 to 8% in 2003, the level of adolescent fertility continues to be high, with 24% of females aged 18–19 either pregnant or having already given birth.⁸

To respond to the reproductive health needs of young people, the government of Ghana developed an adolescent reproductive health policy in 2000 and a national HIV/AIDS and STI policy in 2004. Although a number of programs are underway to meet the sexual and reproductive health needs of young people, services tend to be inadequate and unevenly distributed.⁹ The challenge is to develop programs and activities that meet the growing needs of adolescents. Thus, one of the main aims of the National Survey of Adolescents is to contribute to the search for strategies that will contribute to the achievement of the objectives of the adolescent reproductive health and HIV/AIDS policies.

Chapter 2

Data Collection

This chapter describes the methods of data collection of the National Survey of Adolescents, which provides data on 12–19-year-olds in Ghana. This nationally representative household survey on the sexual and reproductive health of adolescents was organized by the Institute of Statistical, Social and Economic Research of the University of Ghana, Legon, in collaboration with ORC Macro, the Department of Geography and Tourism of the University of Cape Coast and the Guttmacher Institute. The survey was conducted between January and May 2004.

Questionnaire Design and Content

The survey used two instruments, namely a household screener and a questionnaire for the adolescents. The purpose of the screener was to obtain basic information on household structure and also to identify eligible 12–19-year-olds for individual interview. The household screener was used to list and document sociodemographic characteristics, such as age, sex, relationship to head of household and education, for all the members of and visitors to the selected households. In addition, the household screener was used to collect information on each household's access to drinking water and sanitation, environmental conditions, land ownership and possessions.

The adolescent questionnaire collected information on a wide range of issues about the lives of young people. A conceptual framework of adolescent sexual and reproductive health (Chart 2.1) guided the content of the survey questionnaire and ensured that data on the social environment, knowledge, attitudes, sexual and reproductive experiences, and key behavioral outcomes (e.g., condom use, current sexual activity) were obtained. The adolescent survey questionnaire comprised the following sections:

- Background characteristics of respondents: education, work, and religion;

- Family and social group information: contact with and characteristics of biological mother and father, existence of mother- and father-figures in household, membership and office-holding in social groups or clubs;
- Reproductive experiences: age at puberty, birth history, fertility preferences, knowledge and experiences of pregnancy (including how pregnancy occurs), and abortion;
- Experiences with, content of and format of sex education;
- Contraceptive methods: knowledge of, information on and use of services (including questions about correct use of and attitudes about male condoms), and perceptions of different sources of contraceptive methods;
- Marriage/union formation and sexual activity: marital status/partnerships, experience with sexual intercourse, and, for 12–14-year-olds, other kinds of sexual activities;
- History of sexual relationships: characteristics of sexual relationships and contraceptive methods used with the first sex partner and up to three sex partners in the 12 months prior to the survey, receiving money or material goods in exchange for sex, reasons for abstaining from sex for those who had never had sex or did not have sex in the 12 months prior to the survey;
- HIV/AIDS: knowledge and sources of information, knowledge of and experience with voluntary counseling and testing;
- Other STIs: knowledge of and experiences with other STIs, information on sources of services and perceptions of different sources for STI treatment;
- Sociocultural practices: experiences and timing of initiation rites, circumcision, recent experiences with injections, communication with family and others about sex-related matters and attitudes about sexual activity;
- Worries and fears: financial deprivation and other issues during childhood, substance abuse, HIV, preg-

- nancy, present financial situation and related issues; and
- Physical and sexual abuse: knowledge and experience of abuse.

Because the last section of the interview was the most sensitive, its application was treated differently than the rest of the questionnaire. Extra precautions were taken to ensure the privacy and confidentiality of responses to this section, which contained several questions about sexual abuse and family physical abuse. If there was only one eligible respondent, that respondent was given the complete survey including the section on physical and sexual abuse. When there was more than one eligible 12–19-year-old in the household, a table at the end of the household screener was used to randomly select one adolescent to answer the complete survey, including the sensitive questions. All other eligible adolescents in the household were interviewed, but the section on physical and sexual abuse was not administered. Only one adolescent per household was selected to receive this section so that respondents could be assured that other adolescents in the same household would not know that the respondent had been asked these questions, thus enabling respondents to speak more freely than they might have done otherwise on these sensitive issues. Interviewers also had to complete a separate filter check for privacy before administering this final section: If anyone over three years of age was within listening distance, the interviewer did not administer the questions.

The Guttmacher Institute, in collaboration with the University of Cape Coast (Ghana), Institut Supérieur des Sciences de la Population (Burkina Faso), Makerere Institute of Social Research (Uganda), Centre for Social Research (Malawi) and the African Population and Health Research Center (Kenya), designed the content of the survey instruments. The household screener and the adolescent questionnaire were developed in stages. First, the staff of the Guttmacher Institute reviewed 27 existing survey questionnaires used to measure different aspects of adolescent sexual and reproductive health. On the basis of the review, the individual questionnaire was developed. For instance, questions for standard measures of household amenities, knowledge of contraceptives and usage, and experience of sexual intercourse were drawn from recent Demographic and Health Survey (DHS) instruments from ORC Macro. Five questions about the correctness of condom use were based on items from the Indiana University Kinsey Institute for Research in Sex, Gen-

der and Reproduction's Condom Use Errors Survey for Adolescent Males (August 26, 2001 version). The second stage involved a meeting with all research partners from the six institutions above in November 2002. The group provided input into the content areas and specific measures that should be obtained from a national survey of adolescents. ORC Macro also provided input into the structure of the survey instruments and provided comments on the content.

After having been drafted, the screener and the questionnaire were pretested extensively for content and form. Fifteen mock interviews were conducted in March 2003 to estimate a range for the duration of interviews. Drafts of the survey instruments were sent to 19 external reviewers for comment in April 2003. Further revisions were made in light of the input from external reviewers and low-priority items were removed from the survey, based on the time estimates from the mock interviews, which ranged in length from 60 and 118 minutes.

Preliminary findings from 55 exploratory focus group discussions (FGDs) conducted between January and March 2003 in Burkina Faso, Ghana, Malawi and Uganda were also used in revising the adolescent survey questionnaire. Overall, the group discussions indicated that young people in the four countries were generally comfortable talking about sexual activity and sexual relationships. For the survey, this finding led to the development of detailed questions about sexual behaviors and partner characteristics. Recommendations from the Uganda and Malawi FGDs, in particular, were to make survey questions very specific to the type of sexual activity because young people mentioned a wide range of behaviors under the general phrase "sexual activities," including talking together, visiting with boyfriends or girlfriends, and forced intercourse. In the Burkina Faso FGDs, 14–16-year-old females did not appear to be comfortable talking about sexual activity. As a result, questions were included specifically for 12–14-year-old adolescents about awareness of specific sexual activities. Follow-up questions about personal experiences were asked only if the participant indicated an awareness of the relevant sexual activity. Country-specific questions about how pregnancy occurs were also derived from the exploratory FGDs.

A pilot survey was conducted in September 2003 in Ghana to obtain estimates of the average duration of an interview, examine the receptivity of 12–14-year-olds to the set of questions developed for them, and to check on skip patterns and field protocols, including the random selection of one eligible adolescent per household

for the last section of the questionnaire. The Institute of Statistical, Social and Economic Research of the University of Ghana, Legon, conducted the pretest with 292 adolescents aged 12–19. The instrument was further revised based on comments from interviewers in a lengthy debriefing meeting (and recorded on tape so that other colleagues could listen to the comments) and by examining frequency distributions of the pilot survey results. One of the strategies was to ensure that most of the contents of the survey were comparable across all four countries. Both the screener and the survey instrument were translated into Akan, Ewe, Ga-Dangbe and Dagbani, the most widely spoken local languages in Ghana. The approach adopted for the translation was to first translate the questionnaires into the Ghanaian languages and then back into English. The retranslated English versions were compared to the original ones to ensure the two were the same.

The Institute of Statistical, Social and Economic Research conducted another pretest of the household screener and adolescent questionnaire in English and the selected Ghanaian languages. This was done in December 2003 and January 2004. The lessons learned from the pretest were used to finalize the survey instruments, field protocols and translations. The household and adolescent questionnaires are available from the report authors upon request.

Field Procedures

Training of field personnel took place at the University of Ghana and was integrated with pretest activities in December 2003 and January 2004. The interviewers trained were generally young, aged 18–25 years. Training was extensive and was based on standard DHS training protocols for conducting an interview, making callbacks and completing survey questionnaires. The training manual used was also derived from the core DHS Interviewer's Manual and included explanations of each question in the 2004 National Survey of Adolescents questionnaires. After the training, interviewers who successfully completed and performed well in the training were selected for the survey.

Eight field teams implemented the survey and the total survey staff included 37 interviewers, eight field editors and eight field supervisors. Each team's field supervisor was responsible for all field logistics, ranging from obtaining sample maps and household listings to securing accommodations for the field team and managing the work load of interviewers. Field editors were to observe at least one full interview every day (with the consent of the respondent), edit all complet-

ed questionnaires in the field and conduct regular review sessions with each interviewer and advise them of any problems found in their questionnaires.

All adolescents aged 12–19 who were de facto residents in the selected households were eligible for interview. If a household or a respondent was initially not available, an interviewer made at least three attempts at contacting the household and eligible adolescents for interview, with each visit made at a different time of day and on different days. The rationale was that the interviewer must vary the times visited in order to meet the household or individual adolescent. Interviewers were assigned to interview adolescents of the same sex because of the personal nature of the topics covered and the young age of the respondents (which might make issues around sexual activity even more sensitive than if the respondents were older and married). Interviews between an interviewer and respondent of the opposite sex only occurred when there was no interviewer of the same sex who spoke the language spoken by the respondent. While no formal evaluation of same-sex interviews is possible since there was not a randomly-assigned group of opposite-sex interviews, the level of missing data for sensitive questions was very low with this strategy of same-sex interviews (e.g., 1% or less of respondents refused to answer or had missing data for other reasons to the question if they had ever been touched, kissed, grabbed or fondled in an unwanted sexual way).

Before the interview, informed consent was obtained from each adolescent. In addition, for adolescents aged 12–17 years, consent was obtained from his or her parent or guardian before proceeding with the interview. Two different informed consent forms, one for the parent or guardian and another for the eligible adolescent, were used.

Data entry and processing began shortly after interviewing started and was carried out using the software package CSPro. CSPro is an interactive data entry system that checks acceptable codes for a question, follows skips and filters in the questionnaire, and verifies the consistency of data as they are entered. The questionnaires were entered by geographic cluster, with each cluster being assigned to one data-entry operator.

Consistency checks were developed and performed in two stages: simple and complex checks. The simple consistency checks were handled at the data-entry stage while the more complex consistency checks were carried out using machine editing. Guidelines were also developed on how to resolve inconsistencies detected during data entry and in the editing process, as well as

the action to take if the inconsistencies could not be resolved through an examination of the responses to other pertinent questions in the questionnaire.

With data entry starting during the field period, it became possible for field-check tables to be generated to examine data quality. Depending on the size of the sample and the speed of data entry, the tables were produced every two to three weeks to measure:

- response rates for households and eligible adolescents;
- age displacement (to determine whether interviewers were intentionally displacing the ages of young people from the eligible range (12–19 years) to an ineligible age (11 and younger or 20 and older);
- knowledge of male and female condoms so as to ensure that interviewers clearly distinguished between the two methods;
- awareness of the sources of contraceptive methods and treatment for STIs (this was meant to check whether interviewers were intentionally coding respondents to skip past questions about service providers);
- the number of 12–14-year-old respondents who had ever heard of sexual intercourse and the number of 15–19-year-old respondents who had ever had sexual intercourse; and
- presence of others within hearing distance prior to the administration of the last module that was asked of only one eligible adolescent per household (to check if some interviewers were skipping this section because of the nature of the questions).

The chief data processing officer of ORC Macro, Guttmacher Institute staff and the staff of the University of Ghana worked together to interpret the tables and identify problems. If data collection problems were discovered at the team level, tabulations were produced by interviewers to determine whether problems were team-wide or restricted to one or two team members. When any problem was identified, immediate remedial action was taken.

Table 2.1 provides a summary of issues about the interview: average length of an interview, privacy of interview and how well the interviewer thought the respondent understood the survey questions generally. The duration of an interview can be used to indicate the burden on a respondent in answering questions. In the National Survey of Adolescents, 45 minutes was considered to be the ideal period for administering a questionnaire. From Table 2.1, the average length of an in-

terview was 57 minutes for females and 54 minutes for males. The time was considered to be adequate and assumed not to have put undue strain on respondents.

Ensuring privacy of the interview was considered absolutely critical; therefore, interviewers were trained to conduct interviews in places or ways that would assure privacy for adolescent respondents. The rationale was that the presence of particular people wandering about or sitting within hearing distance during the interview could influence responses. Therefore, interviewers were requested to indicate if somebody was within hearing distance during any point of the interview. Section 12, which contained especially sensitive questions, was not to be administered if anyone older than 3 years was within hearing distance of the interview. For this section on abuse, separate information on the presence of others was recorded.

There appeared to be a high rate of privacy, as over 90% of adolescents were interviewed in places or ways that ensured that no person was within hearing range at any point during the interview. The persons who were reported to be present at some point were other children (for 5% of female respondents and 2% of male respondents) and adolescents (for 4% of female respondents and 2% of male respondents). Partner or parent interference was minimal for both the male and female adolescents (Table 2.1). For the sensitive questions, only 3–4% of eligible respondents were in situations where someone aged three years or older was present or within hearing distance (data not shown), in which case the sensitive questions were not administered.

Finally, the interviewers' assessment of the level of understanding among respondents provides a general indication of the comprehension of survey questions. Because the survey focused mainly on sexual and reproductive health, it was important to assess whether there were differences in responses to questions by age and sex. As indicated in Table 2.1, the interviewers reported marked differences in understanding between the older and younger adolescents. For instance, interviewers thought that 66% of females and 55% of males aged 12–14 years understood the questions very well compared to 77% of females and 73% of males aged 15–19 years. In this table (and in those that follow), percentages may not sum to 100 because of rounding or totals may exceed 100 because multiple responses are possible.

Sample

The sample for the 2004 National Survey of Adolescents covered the population residing in all private

households in the country. The survey used a two-stage stratified sample design based on the frame used by the Ghana Statistical Service for the DHS. The first stage involved the selection of regional clusters from urban and rural clusters in the 10 regions of the country. In the second stage, households were selected from the chosen subsectors. A total of 9,445 households were listed (4,025 (43%) urban and 5,420 (57%) rural) and screening interviews were completed with 85% (Table 2.2).

A total of 4,430 persons aged 12–19 years were interviewed in the 2004 Ghana National Survey of Adolescents (2,201 females and 2,229 males). The survey achieved a 98% response rate for the household screener, with a slightly higher response rate for rural compared with urban households. Within the 9,445 households there were 4,840 adolescents eligible for interview. The response rate for the eligible adolescents was 92% for both the urban and rural areas. Overall, the response rate was 88% for urban adolescents and 91% for rural adolescents. Slightly higher response rates in rural areas compared to urban areas were also observed in other studies in the country, such as the 2003 Ghana Demographic and Health Survey (GDHS).¹⁰

Of the 4,840 adolescents aged 12–19-years listed in the household screener, 656 were usual members but were not in the household the evening before the survey interview (i.e., they were *de jure* but not *de facto* household members). Among those absent, 45% were in boarding schools; in other words, 5% of all 12–19-year-olds listed in households were missed because they were in secondary or tertiary boarding schools or colleges. Another 18% were on vacation or visiting and 16% were staying in other houses. The “other” category accounted for 15% and included children who had left home. This pattern of boarding house residence and residence in other households has been observed in other studies.¹¹

Table 2.3 presents information on the number of eligible adolescents identified and interviewed, the corresponding response rates and the specific reasons for not being able to complete an interview by age-group and sex. The response rate was over 90%. Only 1% of eligible female and male adolescents refused to participate in the survey. The most common reason for non-response was not being at home during any of the contact attempts made by the interviewer (4% of females and males); parents/guardians refused to allow their wards to take part in the interview in fewer than 1% of cases.

Comparing results from the 2004 survey to external

data sources provides a useful means for assessing the extent to which data from the 2004 survey sample population may be similar to or differ from other national surveys. Table 2.4 shows several key characteristics of 15–19-year-old females and males in the 2004 National Survey of Adolescents and the 2003 GDHS. One would expect some differences between the two surveys due to the different context and content of the survey questionnaire, interview effects and sampling error. Nonetheless, the differences in most of the indicators selected for comparison between the 2003 GDHS and the 2004 NSA were minimal.

The major difference was in the proportion of adolescents who ever had sex. Whereas 39% of 15–19-year-old females in the 2003 GDHS had had sex at the time of the survey, the corresponding percentage was 30% in the 2004 NSA. The proportions of males who ever had sex were closer: 20% for the GDHS and 16% for the NSA. There was also a 5% difference between the surveys’ results as to the proportion of females who had ever been in a union. The wording of questions was the same in both surveys for the marriage and sexual intercourse questions for 15–19-year-olds, but the organizations implementing the surveys were different, the content of the questionnaires was different and younger interviewers were used in the 2004 NSA than in the 2003 GDHS, all of which could have had an effect on reports of sexual behavior. Differences in point-prevalence estimates for measures of sexual behavior among adolescents have also been documented in the United States for surveys conducted in the same year.¹² However, as a national survey on aspects of sexual and reproductive health, the 2004 NSA provides detailed information on sexual and reproductive health of adolescents, thus complementing results from the 2003 GDHS and the trends over time in behaviors that the DHS documents.

TABLE 2.1 Percentage of adolescents by duration of interview and others present during interview, and percentage distribution of adolescents by interview characteristics, all according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=917) | 15–19 (N=1178) | Total (N=2095) | 12–14 (N=942) | 15–19 (N=1215) | Total (N=2157) |
| Mean duration of interview (minutes) | 54.9 | 57.8 | 56.5 | 53.5 | 55.0 | 54.4 |
| Presence of other people within hearing range during interview* | | | | | | |
| No person within hearing range | 89.9 | 91.3 | 90.6 | 95.0 | 95.9 | 95.5 |
| Spouse/partner | 0.2 | 0.1 | 0.1 | 0.0 | 0.1 | 0.0 |
| Mother | 1.2 | 0.7 | 0.9 | 1.3 | 0.5 | 0.8 |
| Father | 0.3 | 0.0 | 0.1 | 0.6 | 0.4 | 0.5 |
| Brother/sister | 1.4 | 0.8 | 1.1 | 1.0 | 0.7 | 0.8 |
| Other adolescents | 3.5 | 3.6 | 3.5 | 1.8 | 2.1 | 1.9 |
| Other children | 4.9 | 4.4 | 4.6 | 2.5 | 1.4 | 1.9 |
| Other adults | 4.1 | 3.5 | 3.8 | 1.0 | 0.8 | 0.9 |
| Interviewer rating of respondent's understanding of survey questions | | | | | | |
| Very well | 65.9 | 76.5 | 71.9 | 55.3 | 72.9 | 65.2 |
| Well | 30.0 | 20.9 | 24.9 | 39.7 | 25.4 | 31.6 |
| Not very well | 4.1 | 2.5 | 3.2 | 5.0 | 1.7 | 3.1 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 2.2 Percentage distribution, numbers and response rates of households and respondents, according to residence, 2004 National Survey of Adolescents

| Result | Residence | | Total |
|--|-----------|-------|-------|
| | Urban | Rural | |
| Selected households | | | |
| Completed (C) | 83.0 | 86.6 | 85.1 |
| Household present but no competent respondent at home (HP) | 2.8 | 0.8 | 1.6 |
| Refused (R) | 0.9 | 0.3 | 0.5 |
| Household absent (HA) | 4.9 | 5.8 | 5.4 |
| Dwelling vacant, destroyed or not found (DV) | 8.4 | 6.7 | 7.3 |
| Other (O) | 0.0 | 0.0 | 0.0 |
| Total | 100.0 | 100.1 | 99.9 |
| Number of sampled households | 4,025 | 5,420 | 9,445 |
| Household response rate (HRR)* | 95.8 | 98.8 | 97.5 |
| Eligible de facto adolescents | | | |
| Completed (EAC) | 91.5 | 91.7 | 91.6 |
| Not at home (EANH) | 5.0 | 3.3 | 4.1 |
| Postponed (EAP) | 0.0 | 0.0 | 0.0 |
| Respondent refused (EAR) | 1.0 | 1.0 | 1.0 |
| Parent/caretaker refused (PEAR) | 0.5 | 0.1 | 0.3 |
| Partly completed (EAPC) | 0.7 | 0.2 | 0.4 |
| Incapacitated (EAI) | 0.6 | 1.2 | 0.9 |
| Other (EAO) | 0.8 | 2.4 | 1.7 |
| Total | 100.0 | 100.0 | 100.0 |
| Number of adolescents | 2,164 | 2,676 | 4,840 |
| Eligible adolescent response rate (EARR)† | 91.5 | 91.7 | 91.6 |
| Overall response rate (ORR)‡ | 87.6 | 90.6 | 89.3 |

*The household response rate is calculated as: $HRR = (100 \times C) / (C + HP + R)$

†The eligible adolescent response rate is calculated as: $EARR = (100 \times EAC) / (EAC + EANH + EAP + EAR + PEAR + EAPC + EAI + EAO)$

‡The overall response rate is calculated as: $ORR = (HRR \times EARR) / 100$

TABLE 2.3 Percentage distribution of adolescents, by interview characteristics, according to sex and age, 2004 National Survey of Adolescents

| Result | Female | | | Male | | |
|---|--------|-------|-------|-------|-------|-------|
| | 12–14 | 15–19 | Total | 12–14 | 15–19 | Total |
| Eligible de facto adolescents | | | | | | |
| Completed (EAC) | 92.5 | 91.2 | 91.8 | 92.3 | 90.8 | 91.4 |
| Not at home (EANH) | 3.0 | 4.3 | 3.8 | 3.1 | 5.3 | 4.4 |
| Postponed (EAP) | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Parent/caretaker refused (PEAR) | 0.5 | 0.4 | 0.5 | 0.2 | 0.1 | 0.1 |
| Respondent refused (EAR) | 0.6 | 1.2 | 1.0 | 1.4 | 0.7 | 1.0 |
| Partly completed (EAPC) | 0.4 | 0.7 | 0.5 | 0.2 | 0.4 | 0.3 |
| Incapacitated (EAI) | 0.7 | 0.9 | 0.8 | 0.7 | 1.2 | 1.0 |
| Other (EAO) | 2.2 | 1.3 | 1.7 | 2.1 | 1.4 | 1.7 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Number of adolescents | 1019 | 1381 | 2400 | 1051 | 1389 | 2440 |
| Eligible adolescent response rate (EARR)* | 92.5 | 91.2 | 91.8 | 92.3 | 90.8 | 91.4 |

*The eligible adolescent response rate is calculated as: $EARR = (100 \times EAC) / (EAC + EANH + EAP + EAR + PEAR + EAPC + EAI + EAO)$

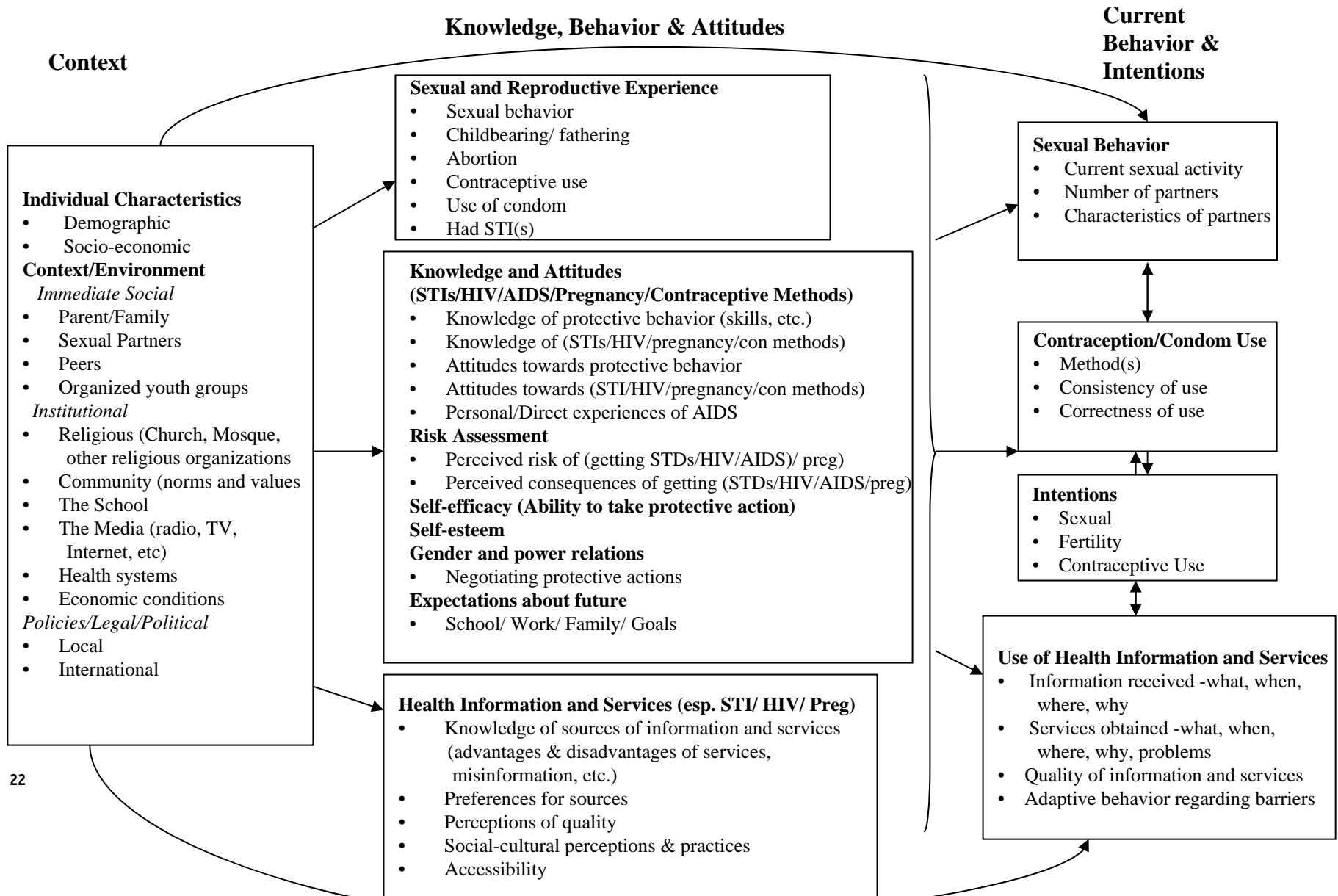
TABLE 2.4 Comparison of respondent characteristics of 15–19-year-olds across surveys: 2003 Ghana Demographic and Health Survey (GDHS) and 2004 National Survey of Adolescents (NSA)

| Characteristic | Female | | Male | |
|------------------------------------|-----------------------|----------------------|-----------------------|----------------------|
| | 2003 GDHS (N=1148) | 2004 NSA (N=1238) | 2003 GDHS (N=1107) | 2004 NSA (N=1258) |
| Urban-rural residence | | | | |
| Urban | 54.8 | 50.3 | 45.5 | 46.1 |
| Rural | 45.2 | 49.7 | 54.5 | 53.9 |
| Ever in a union | | | | |
| No | 86.3 | 90.9 | 99.0 | 98.6 |
| Yes | 13.7 | 9.1 | 1.0 | 1.4 |
| Ever had sexual intercourse | | | | |
| No | 61.1 | 70.3 | 80.1 | 84.5 |
| Yes | 38.9 | 29.7 | 19.9 | 15.5 |
| Ever had a child | | | | |
| No | 89.7 | 91.0 | 99.5 | 99.5 |
| Yes | 10.3 | 9.0 | 0.5 | 0.5 |

Note: Ns are weighted for the 2003 GDHS and 2004 NSA.

Chart 2.1

Conceptual Framework of Adolescent Sexual and Reproductive Health



Chapter 3

Context of Adolescents' Lives

This chapter presents information on the demographic background and the sociocultural context within which young people lead their lives. The background of young people and the sociocultural milieu in which they live and grow have implications for their choices, which in turn affect aspects of their lives, such as sexual and reproductive health. Among the demographic issues covered are education, work, and family composition and interactions. Family, peers and other social aspects of the lives of adolescents have been shown to influence their protective and risk behaviors. In addition, wealth quintiles are included as indicators of socioeconomic background of the respondents. These basic characteristics of the adolescents provide the background for interpreting findings on sexual and reproductive health presented later in the report.

Sociodemographic Background of Respondents

Family formation, especially at an early age, has implications for the sexual and reproductive health of a person. Table 3.1 shows that 7% of 15–19-year-old females are in a union (married or living with a man), while fewer than 1% of males are in unions. There were no 12–14-year-olds who reported being in a union.

Fifty-one percent of females and 55% of males interviewed were living in rural areas. The regional and ethnic group distributions of adolescents are also shown in Table 3.1. The distribution of respondents by region of residence follows the pattern of overall population distribution in the country, except for the Eastern Region—the region with the third-largest population in the country—which accounts for a disproportionately low percentage of the female sample. The ethnic composition of the population interviewed was also similar to that of the country as a whole. Overall, the Akan ethnic group accounts for more than half of the total adolescent population in the country. The next largest groups are the Ewe who account for 14% of the females and 13% of the males in the sample and the Mole-Dagbani who account for

10% and 15%, respectively, of female and male adolescents in the sample. Other Ghanaians accounted for 13% of the females and 14% of the males, indicating the diverse ethnic composition of the population of the country.

The last panel of Table 3.1 provides information on the wealth quintiles for the households of the adolescents interviewed, using the protocol from the Demographic and Health Surveys on housing quality, household expenditure and assets as proxy for wealth.¹³ Based on principal components analysis, factor loadings were calculated for each selected variable, which are then used to derive a wealth index value for each household. If wealth were to be equally distributed, the proportion of households in each quintile would be 20%, as implied in the concept of quintile.

Family Formation and Living Arrangements

Adolescents are mostly dependent on parents or other significant adults. In Ghana there are various living arrangements for young people. These range from living with biological parents, grandparents and other relations such as uncles, aunts or older siblings, to living with unrelated members of the household as house help or apprentices, to residing in their own households in a marital union. The relationship of the adolescent to the head of the household is one measure of living arrangements. All things being equal, adolescents living with both parents will have access to more resources than those living with nonrelatives as house help or apprentices, or those who reside as household heads themselves. Also, the sexual and reproductive health issues facing adolescents who have already started families of their own (i.e., married adolescents and those who have already given birth to a child) are often quite different from those facing unmarried adolescents or those who are yet to begin childbearing.

Seven percent of females aged 15–19 years were in a union, with or without a child, compared with 0.6% of the males. Of the females in a union, 43% lived with

a husband or partner. This is not unusual, since marriage does not necessarily lead to coresidence in some parts of the country.¹⁴ The early marriage of females and subsequent early childbearing are some of the challenges associated with the promotion of girl-child education.

Of the adolescents interviewed, fewer than half lived with both biological parents (40% of the females and 45% of the males) and another one-fourth of females and males lived with their mother only (Table 3.2). Few young people lived with their biological father only (5% of females and 9% of males). About two out of three females (64%) and males (70%) lived in households as a son or daughter to the head of household, and 12–13% lived as grandchildren and about one in 10 lived as “other relative” to the head of household. Overall, nearly 90% of adolescents were related in some way to the head of household. Only 1–3% lived as house help or were otherwise unrelated to the head of household. These observations point to the general pattern among various ethnic groups in the country whereby young people live not only with parents but also with other relatives. Furthermore, except for the 3% of 15–19-year-old males who were heads of households, adolescents lived in households with adult figures. Charts 3.1 and 3.2 indicate that 68% lived with mothers and 55% with fathers. Another 11% visited their mother and 15% visited their father at least once a week.

Both biological parents of almost nine out of 10 adolescents were alive at time of the survey and fewer than 1% had lost both parents (Table 3.3). While 9% of both female and male adolescents had lost their father but not their mother, only 2% of females and 3% of males had lost only their mothers, indicating higher mortality for fathers partly due to late age at marriage for males leading to large age differences between spouses (see Chapter 4). Thirteen percent of females and 12% of males who lost their fathers were younger than five years old when their fathers died and one-third were between 12 and 17 years of age. The numbers for those whose mothers had died are small; therefore, these are not reported. Among those with at least one deceased biological parent, about half lived with a biological mother and 5% of females and 12% of males lived with a biological father. Finally, 39% of orphaned female adolescents and 33% of orphaned males lived with no parent figure. Given the levels of orphanhood and the living arrangements observed in Table 3.2, where most adolescents live as a relative of the head of household, orphanhood does not necessarily lead to

living with unrelated people or to heading one’s own household among the adolescents interviewed.¹⁵

Schooling: Experiences and Expectations

The notional age for starting primary school in Ghana is six years. Basic education consists of nine years of schooling: six years of primary school and three years of junior secondary school (JSS). The basic nine-year schooling is compulsory, and, therefore, anybody who completes only the primary level is considered not to have obtained basic education. Primary school education is designed for children aged 6–11 and JSS for 12–14-year-olds. Basic education is followed by three years of secondary education, either in a senior secondary school (SSS), a vocational school or a technical school. The age range for this level is 15–17 years. The tertiary level consists of all postsecondary education (e.g. polytechnic, university, teacher and nurse training). Sexual and reproductive health is part of the social studies curriculum as family life education at the basic and senior secondary school levels. The aim is to use the formal educational system to teach various aspects of family life and, through that, positively influence sexual and reproductive health behavior. Table 3.4 shows the educational attainment, enrollment and expectations for future educational attainment among adolescents by age group and sex. In addition, there is information about any vocational training received because the skills adolescents acquire at this stage also have an impact on their future livelihood.

According to Table 3.4, 91% of females and 94% of males had ever attended school, of which 71% and 77% of female and male adolescents, respectively, were currently attending school. Among those aged 12–14 years (expected to be in JSS), 68% of females and 74% of males had primary school as their highest level of school attended and a further 25% and 21% of females and males, respectively, were at the SSS level. Among those aged 15–19 years, about two out of every three had SSS as the highest level attended, indicating higher average school attainment among the study population than the national average.¹⁶ While fewer than 1% of both female and male adolescents were in tertiary institutions at the time of the survey (perhaps due to the age range of 12–19 years), 54% of the females and 62% of the males expected to achieve higher education. The difference in expectation between males and females reflects the societal expectation of higher education for males than females.

In the survey, respondents were asked if they had had any skills training. Among those aged 15–19 years,

18% of females and 19% of males had received some vocational training, either in a vocational or technical institute within the formal school system or through an apprenticeship system.

In Table 3.4, nearly a third of the females and 23% of the males were not enrolled school at the time of the survey. The reasons for which these were not enrolled are given in Table 3.5. Thirty-five percent of the females and 41% of the males were not in school because they had completed an expected level, such as basic education (primary and JSS). Another 8% of females and 11% of males were not in school because they were not interested in continuing to stay in school. About one in four female and male adolescents who were not in school stopped attending because they could not pay the ancillary costs associated with schooling (tuition is free for Ghanaians).¹⁷ Other reasons why students left school were not being a good student, being ill, lacking school materials, working at home, and having a parent who was sick or had died. Seven percent of females aged 15–19 years left school due to pregnancy.

Some notable differences by urban and rural residence (data not shown) are that more urban than rural adolescents had left school because they had reached a terminal point (“completed schooling/had enough”) while more rural than urban adolescents left because they were “not interested.” There were no consistent patterns by urban-rural residence and sex for leaving school. For example, higher proportions of females in rural areas (28%) than in urban areas (22%) stopped schooling due to inability to pay ancillary fees, whereas there were more males in urban areas (26%) than rural areas (19%) who could not pay their required fees.

Chart 3.3 shows the proportion of adolescents still attending school among those who ever attended school by current age and sex. The percentages of adolescents continuing in school decline sharply for both females and males after age 15, a terminal point for some JSS pupils, and after age 17 years, a terminal point for some SSS students.

Table 3.6 indicates that two out of every five females and males who ever attended school started school at or before age six, the notional age for starting schooling in Ghana, and another 12% at age seven. The latter demonstrates that not all children start schooling at the notional age. About one in five did not know when they started schooling. Although repetition is not allowed in the Ghanaian school system, 2% of both females and males who were currently attending school said they repeated their last grade. Ninety-nine percent

of the respondents reported that they were either currently attending or had last attended a mixed-sex (co-educational) school.

The Education Act of 1961 (Act 87) indicates, among other things, that education should be the responsibility of the government.¹⁸ With the promulgation of that act, all existing schools that were set up by religious institutions and individuals were absorbed into the national system. However, religious institutions were allowed to continue to manage their schools. Although religious groups and individuals have established private schools over the last two decades, state schools continue to dominate the school system. As shown in Table 3.6, 59% of females and 55% of males had either attended or currently attended government-aided nonreligious schools, and 28% of females and 33% of males were in government-aided religious schools. Only 12–13% of adolescents attended private schools. Basic schools are predominantly day schools and this explains why 97% of the respondents reported that they had been day students. The boarding system is mainly at the SSS level and beyond, where the schools are fewer and serve students from all over the country.

Time Use and Work

The general expectation in Ghanaian homes is that children will be involved in household chores and family economic activities as part of their preparation towards life. Students are expected to combine schooling and household work, while those who are not in school are expected to learn a trade. Females who do not attend school are taught housekeeping. About 40% of adolescent females and males reported that they spent part of their time studying, and the proportions are higher for younger compared with older adolescents (Table 3.7). Similar proportions of female and male adolescents said they worked on the family farm or in the family business (42% of females and 47% of males). Whereas 82% of females, irrespective of age, were involved in household chores, only 47% of males took part in household chores. Differences by sex are also reflected in the proportion of adolescents who reported that they had time to play with friends: Thirteen percent of females reported having time, compared with 28% of males. Thus, while similar proportions of female and male adolescents reported having usually spent their days studying and/or working on family farm or business, more females were involved in household chores than males and fewer female than male adolescents had time to play with friends.

Similar proportions of females and males were in school, either working (32% of females and 38% of males) or not working (40% of females and 40% of males) (Chart 3.4). However, there were differences by age and work status among those who were either in school or not in school. Older adolescents were more likely to be out of school and working than the younger ones. Among both the females and males, 23% of those aged 15–19 were out of school and working, compared with 8% of those aged 12–14. Furthermore, 19% of females and 9% of males aged 15–19 years were out of school and not working. When adolescents were working or helping with the family business or farm, most did so away from home (76% of females and 85% of males).

Among those who were working or helping with the family business or farm, 80% of females and 74% of males aged 12–14 years were not paid for the work that they did compared to 62% of females and 53% of males aged 15–19 years. Among all adolescents, 73% of females and 64% of males had not done anything for money in the 12 months preceding the survey. The evidence reflects the situation that young people are not expected to be paid for working in household establishments or family-run farms and businesses. Among those who worked for money or reported doing something for money in the past 12 months, 43% of females and 61% of males aged 15–19 said they alone decided on how to spend their money, but only 19% of females and 33% of males aged 12–14 years did so. For the younger adolescents, parents/guardians decided for 74% of females and 63% of males on how to spend the money they earned. Among those working in family businesses, the distinction of their “own money” versus “money from parents” is difficult to make, hence the tendency was for parents/guardians to dictate how the money their children earned should be used.

The age and gender dimensions of education, work and use of resources have implications for the lives of young people. The results indicate that adolescent females spend more time on household chores and less time on leisure than male adolescents.

Social Time and Monitoring

The level of connectedness that an adolescent has with members of his/her immediate family has been found to be important in relation to sexual and reproductive health. Beyond the family, affiliation with a religious group and involvement in club activities can provide social support to adolescents. The results in Table 3.8 show that 97% of females and 95% of males professed

affiliation with a religious denomination, with 79% of females and 73% of males reporting Christian religion. Sixteen percent of females and 20% of males reported Islam. The pattern of religious affiliations of adolescents is similar to that reported in the 2000 Population and Housing Census.¹⁹ For those with a religious affiliation, 88% of females and 84% of males indicated that religion was “very important” to them. Only 1% of both females and males reported that religion was not important in their lives. Among those with a religious affiliation, about nine in 10 adolescents attended religious services at least once a week.

Social clubs provide young people with avenues for recreation and socialization. Recognizing the benefits of social clubs for young people, governments and other organizations have promoted the establishment of clubs for young people. In the national survey, adolescents were asked if they belonged to a social group or club. As shown in Table 3.8, one out of three females and one out of five males belonged to any social group or club. The percentages varied by age, with more 15–19-year-olds than 12–14-year-olds reporting membership of a social club. Among those involved in social clubs, 70% of females and 46% of males were in a church or Muslim youth group or a choir. For the males, 24% were members of a football team, the most popular sport in Africa. Fewer than 1% of the females were involved in sports. Twenty percent of females and 27% of males in social clubs held an office or leadership position within their clubs.

Monitoring, defined narrowly to mean parents/guardians knowing where their children are likely to be at any point in time and who the friends or playmates of their children are, is an important component of parenting. Evidence from the United States, for example, shows that parental monitoring is negatively associated with adolescent risk behaviors (such as premarital sexual intercourse or substance use).²⁰ In addition to parents, teachers also play an important role in monitoring the lives of young people in school. Young people were asked to indicate their views on the monitoring they receive from their parents/guardians and, among those in school or ever attended school, from teachers. For adolescents who were married, the questions were asked with respect to before they were married, in order to better understand the degree of involvement parents had when the adolescents were unmarried.

Table 3.9 indicates a higher rate of monitoring of female adolescents than males. For instance, 76% of females compared to 61% of males reported that their

parents always knew where they went at night and 72% of females and 55% of males reported that their parents always knew what they did with their free time. Fewer than 10% of female and male adolescents reported that their parents did not know where they went at night or how they used their free time, with more males reporting this than females. For both females and males, more young adolescents than older adolescents felt they were being monitored. In short, Ghanaian parents are more likely to be concerned about the movements and whereabouts of their daughters than sons and younger children than the older ones.

The pattern of monitoring by rural-urban residence and sex is mixed (data not shown). For males, more adolescents in rural than urban areas reported that their parents always knew where they went at night, what they did with their free time and who their friends were. For females, the proportions who reported that their parents always knew where they went at night or what they did with their free time were higher for those in urban (80% and 77%, respectively) than rural areas (72% and 68%, respectively). Adolescents felt that their teachers almost always kept an eye on them to make sure they were not getting into trouble. Thus for males, living in a rural environment meant higher monitoring by parents and teachers, possibly due to the limited space within which people operate compared to urban areas. For female adolescents, perceived monitoring was generally high, with the patterns by rural-urban residence more mixed than that of males.

Peers and friends have been found to play important roles in the lives of young people in diverse ways, such as providing advice, support and reinforcement of behavior. These influences are likely to vary by age and the sex of the peer or friend, whether they are of the same or opposite sex. In Ghana, where over 90% of adolescents in school or who have ever been to school were in mixed (coed) schools, the issue of mixed and same-sex influences on behavior is of interest. Results from the survey indicate that about 95% of both females and males said they have close friends. On average, female and male adolescents had three and four close friends of the same sex respectively (Table 3.10). Nearly half of females and 56% of males had close friends of both sexes, and this varied by age with the proportions being higher for older than younger adolescents. Forty-five percent of females and 39% of males had close friends of the same sex.

Sex-related matters tend to be sensitive and, consequently, are rarely discussed in some settings. Traditionally, grandparents and paternal aunts were mainly

responsible for discussing sex-related matters with young people. With changes in the social system, resulting from formal education, migration and modernization in general, these traditional channels for discussing sex-related issues have been replaced by formal ones, involving nonfamily members. As shown in Table 3.11, 49% of females had discussed sex-related issues with a nonfamily member and 46% had been talked to by a family member. For males, the gap is much wider: Forty-six percent had been talked to about sex-related matters by a nonfamily member, compared with 28% who had been talked to by a family member. Among family members, mothers were identified most frequently as the person who spoke to the respondent, especially by females (33% of females, compared with 16% of males), distantly followed by fathers (13% of females and 12% of males). As indicated in Chart 3.5, two out of three females and four out of five males had not been talked to by either a father or mother about sex-related issues. Table 3.11 also shows that males reported friends of the same sex as the most common source of sex-related information (24%), followed by teachers (20%); while 20% of females received information from friends of the same sex, and 25% from teachers. The nationally representative evidence confirms a complete shift in Ghana from family members to nonfamily members as avenues for discussing sex-related issues.

Alcohol and Drug Use, Physical Abuse and Current Worries

Using alcohol or drugs lowers inhibitions and predisposes a person to take risks that he/she would otherwise not have taken under normal circumstances. Behaviors such as sexual debut or unprotected sex can be influenced by alcohol or drug use. Table 3.12 shows that 80% of females and 73% of males had never tried alcohol and nearly all female and male adolescents had not tried any drugs. Because of the social inappropriateness of drug use, it is likely that the level of alcohol and drug use is underreported. Among those who had ever tried alcohol, about one-fourth of both female and male 15–19-year-olds first drank alcohol before age 15. About one-third of both female and male adolescents who ever drank alcohol said they had gotten “drunk” within the last 12 months.

Some studies have documented the effects of adverse childhood experiences (such as physical or sexual abuse) on behaviors later in life such as domestic violence, risky sexual behavior and depression.²¹ In the survey, adolescents were asked whether they experi-

enced any physical violence such as being hit hard enough to leave marks or cause injury before 10 years of age. Sensitive questions such as domestic violence were asked of only one person in each household to ensure confidentiality. It must also be noted that an event such as domestic violence before age 10 may not be remembered unless it was sufficiently traumatic.

Light punishment of children for misdemeanors is known to exist in various forms and among all ethnic groups in the country. But over the last decade or two, there have been public outcries against severe domestic violence and physical punishment in the school system. There is now a move to outlaw severe physical violence, especially within homes. Currently, a draft bill on domestic violence is in circulation for observations and comments from the general public.²² Among other things, the bill distinguishes between punishment for acts of omission/commission and excessive or severe violence that affects the victim. If passed, the law will make all forms of domestic violence an offence.

Of the 1346 females and 1,326 males who were interviewed about childhood physical abuse, 23% and 20% respectively reported that they had ever experienced severe punishment that left a mark or led to injury (data not shown). The proportions which reported severe punishment in childhood (before age 10) were 20% for young and old adolescent males, and 24% for older and 21% for younger adolescent females. Among those reporting some form of violence, 13% of both female and male adolescents reported having been hit “very often” and another 23–26% reported having been hit “somewhat often.” The survey evidence points to the existence of severe physical punishment or abuse of children in Ghana. Overall, about one in three adolescents reported that they were hit hard somewhat often or very often in childhood.

Table 3.13 shows the levels of worry young people have about a set of issues. Derived from available literature, the issues identified were concerns about health, food, money, pregnancy and HIV/AIDS. Each issue was read out to the respondent, who was in turn asked if she or he was “very worried,” “worried” or “not worried at all.” Understanding the concerns of young people can provide pathways through which programs and policies might be channeled to address sexual and reproductive health issues. The questions were asked towards the end of the interview. The main concerns of male adolescents were getting money (54%), followed by their own health (48%) and HIV/AIDS infection (48%), and these were higher for older than younger adolescents in each case. For fe-

male adolescents, the main concerns were HIV/AIDS infection (55%) and their own health (53%). Thus, the concerns of males and females tend to differ slightly but not in substantial ways.

Policy and Program Implications

This background information about young people provides some indicators for policy and programming. First, both young females and males wish for higher education; therefore, government, civil society and parents should work towards assisting young people to achieve this objective. Second, the level of involvement of female adolescents in household chores as compared with males is an issue that will need to be addressed, given the implications of the practice on the time available for females for studying and recreation. Third, there is the pervasiveness of religion in the lives of young people and this should be one of the conduits for developing programs for young people. Fourth, young Ghanaians have friendship networks—often mixed-sex—and these networks can be utilized to provide sexual and reproductive health and other services to young people.

It is generally recognized that high levels of formal education are associated with positive sexual and reproductive health outcomes. When an adolescent leaves school at an early stage, it is likely to negatively affect his/her future livelihood partly because of a relatively low level of overall educational attainment and, for females, possible early exposure to the risk of pregnancy. Therefore, it is especially important for parents, guardians and society to encourage females to pursue higher education.

With the observed shifts from family to nonfamilial members as sources for discussing sex-related issues, the policy of teaching sex-related issues in schools and other nonfamilial settings should be intensified. Finally, the areas of concern indicated by the youth should form the basis for the development of programs for and with them.

TABLE 3.1 Percentage distribution of adolescents, by basic sociodemographic characteristics, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|----------------------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=956) | 15–19 (N=1237) | Total (N=2193) | 12–14 (N=973) | 15–19 (N=1253) | Total (N=2226) |
| Current union status | | | | | | |
| Not in union | 100.0 | 93.0 | 96.1 | 100.0 | 99.4 | 99.7 |
| In union | 0.0 | 7.0 | 3.9 | 0.0 | 0.6 | 0.3 |
| Residence | | | | | | |
| Urban | 46.9 | 50.3 | 48.8 | 42.7 | 46.1 | 44.6 |
| Rural | 53.1 | 49.7 | 51.2 | 57.3 | 53.9 | 55.4 |
| Region | | | | | | |
| Western | 10.0 | 8.1 | 8.9 | 8.2 | 10.7 | 9.6 |
| Central | 8.2 | 7.8 | 8.0 | 8.4 | 7.9 | 8.1 |
| Greater Accra | 12.1 | 15.7 | 14.1 | 8.2 | 11.8 | 10.2 |
| Volta | 11.8 | 9.3 | 10.4 | 9.7 | 9.4 | 9.5 |
| Eastern | 7.0 | 6.1 | 6.5 | 8.3 | 8.1 | 8.2 |
| Ashanti | 21.4 | 23.7 | 22.7 | 24.5 | 19.4 | 21.6 |
| Brong Ahafo | 15.2 | 14.6 | 14.9 | 13.2 | 14.0 | 13.6 |
| Northern | 6.5 | 6.7 | 6.6 | 10.0 | 9.0 | 9.4 |
| Upper East | 5.3 | 5.7 | 5.5 | 5.9 | 6.3 | 6.1 |
| Upper West | 2.4 | 2.5 | 2.5 | 3.5 | 3.5 | 3.5 |
| Ethnic group | | | | | | |
| Akan | 51.7 | 51.4 | 51.5 | 49.8 | 49.5 | 49.6 |
| Ga-Adangbe | 6.8 | 6.2 | 6.5 | 4.8 | 6.0 | 5.5 |
| Ewe | 14.2 | 13.0 | 13.5 | 12.7 | 12.2 | 12.5 |
| Mole-Dagbani | 10.0 | 10.3 | 10.2 | 14.6 | 15.0 | 14.8 |
| Guan | 1.3 | 0.4 | 0.8 | 0.3 | 0.6 | 0.4 |
| Other Ghanaian | 12.4 | 14.0 | 13.3 | 14.6 | 13.8 | 14.2 |
| Non-Ghanaian | 1.3 | 1.9 | 1.6 | 1.1 | 0.6 | 0.9 |
| Kassena/Kassem | 0.4 | 0.7 | 0.6 | 1.1 | 1.1 | 1.1 |
| Kusasi | 1.9 | 2.0 | 2.0 | 0.9 | 1.0 | 1.0 |
| Household wealth quintile | | | | | | |
| Lowest | 15.9 | 15.8 | 15.8 | 19.3 | 16.8 | 17.9 |
| Second | 18.4 | 18.0 | 18.2 | 21.2 | 20.4 | 20.7 |
| Third | 20.6 | 19.9 | 20.2 | 18.7 | 20.7 | 19.8 |
| Fourth | 22.4 | 21.7 | 22.0 | 22.7 | 21.7 | 22.1 |
| Highest | 22.7 | 24.7 | 23.8 | 18.1 | 20.5 | 19.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Ns are weighted.

TABLE 3.2 Percentage distribution of adolescents by union status, childbearing and living arrangements, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=956) | 15–19 (N=1236) | Total (N=2192) | 12–14 (N=973) | 15–19 (N=1252) | Total (N=2225) |
| Union and childbearing status | | | | | | |
| In union, ever had child | 0.0 | 4.6 | 2.6 | 0.0 | 0.2 | 0.1 |
| In union, never had a child | 0.0 | 2.3 | 1.3 | 0.0 | 0.4 | 0.2 |
| Not in union, ever had child | 0.1 | 4.4 | 2.5 | 0.0 | 0.2 | 0.1 |
| Not in union, never had a child | 99.9 | 88.7 | 93.6 | 100.0 | 99.2 | 99.6 |
| Lives with spouse/partner* | | | | | | |
| No | -- | 57.0 | 57.0 | -- | -- | -- |
| Yes | -- | 43.0 | 43.0 | -- | -- | -- |
| Coresidence with biological parents | | | | | | |
| Lives with both biological parents | 42.4 | 38.8 | 40.4 | 48.6 | 41.8 | 44.8 |
| Mother only | 23.9 | 23.8 | 23.8 | 20.6 | 22.8 | 21.8 |
| Father only | 5.3 | 4.0 | 4.5 | 9.2 | 8.6 | 8.9 |
| Neither biological parent, respondent in a union | 0.0 | 4.1 | 2.3 | 0.0 | 0.2 | 0.1 |
| Neither biological parent, respondent not in union | 28.5 | 29.3 | 28.9 | 21.7 | 26.5 | 24.4 |
| Relationship to head of household | | | | | | |
| Head | 0.0 | 1.2 | 0.7 | 0.0 | 2.7 | 1.5 |
| Spouse | 0.0 | 2.6 | 1.5 | 0.0 | 0.0 | 0.0 |
| Son or daughter | 67.5 | 61.8 | 64.3 | 72.8 | 68.0 | 70.1 |
| Son- or daughter-in-law | 0.1 | 0.7 | 0.5 | 0.0 | 0.0 | 0.0 |
| Grandchild | 15.4 | 11.8 | 13.4 | 15.7 | 9.8 | 12.4 |
| Parent-in-law | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| Brother/sister | 2.3 | 3.9 | 3.2 | 2.0 | 5.1 | 3.8 |
| Other relative | 9.6 | 12.7 | 11.4 | 7.4 | 10.7 | 9.2 |
| Adopted | 0.2 | 0.2 | 0.2 | 0.2 | 0.0 | 0.1 |
| Fostered | 0.0 | 0.2 | 0.1 | 0.0 | 0.4 | 0.2 |
| Stepchild | 1.8 | 1.8 | 1.8 | 1.1 | 1.5 | 1.3 |
| House help | 1.4 | 1.2 | 1.3 | 0.3 | 0.2 | 0.3 |
| Not related | 1.7 | 1.8 | 1.7 | 0.5 | 1.6 | 1.1 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who are currently in union. Sample sizes: females 12–14 (N=0); females 15–19 (N=86); males 12–14 (N=0); males 15–19 (N=8). Note: Ns are weighted. "--" = N is 24 or fewer.

TABLE 3.3 Percentage distributions of adolescents aged 12–17 years, by orphanhood characteristics, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|------------------|-------------------|------------------|------------------|-------------------|
| | 12–14 (N=957) | 15–17 (N=833) | Total (N=1790) | 12–14 (N=977) | 15–17 (N=852) | Total (N=1829) |
| Orphan status | | | | | | |
| Both biological parents alive | 90.1 | 86.8 | 88.5 | 89.5 | 83.3 | 86.6 |
| Mother died, father alive | 1.7 | 1.9 | 1.8 | 2.4 | 4.1 | 3.2 |
| Father died, mother alive | 7.8 | 10.4 | 9.1 | 7.6 | 11.4 | 9.3 |
| Both biological parents died | 0.4 | 0.8 | 0.6 | 0.6 | 1.2 | 0.9 |
| Respondent's age when mother died* | | | | | | |
| ≤5 | -- | -- | [20.9] | [25.0] | [8.9] | 15.1 |
| 6–8 | -- | -- | [11.6] | [7.1] | [15.6] | 12.3 |
| 9–11 | -- | -- | [14.0] | [25.0] | [17.8] | 20.5 |
| 12–14 | -- | -- | [34.9] | [17.9] | [24.4] | 21.9 |
| 15–17 | N/A | -- | [4.7] | N/A | [11.1] | 6.8 |
| Don't know | -- | -- | [14.0] | [25.0] | [22.2] | 23.3 |
| Respondent's age when father died† | | | | | | |
| ≤5 | 8.9 | 16.0 | 12.7 | 13.8 | 10.2 | 11.7 |
| 6–8 | 15.2 | 6.4 | 10.4 | 17.5 | 13.9 | 15.4 |
| 9–11 | 36.7 | 12.8 | 23.7 | 23.8 | 13.0 | 17.6 |
| 12–14 | 13.9 | 26.6 | 20.8 | 13.8 | 21.3 | 18.1 |
| 15–17 | N/A | 21.3 | 11.6 | N/A | 25.0 | 14.4 |
| Don't know | 25.3 | 17.0 | 20.8 | 31.3 | 16.7 | 22.9 |
| Coresidence with parent figures among adolescents with a deceased biological parent‡ | | | | | | |
| Lives with 2 parent figures | 0.0 | 0.9 | 0.5 | 3.9 | 1.4 | 2.4 |
| Mother figure only | 1.0 | 4.5 | 2.9 | 3.9 | 4.2 | 4.1 |
| Father figure only | 1.0 | 0.9 | 1.0 | 0.0 | 0.7 | 0.4 |
| Lives with biological mother | 56.3 | 47.7 | 51.7 | 50.5 | 47.2 | 48.6 |
| Lives with biological father | 5.2 | 4.5 | 4.8 | 10.7 | 12.7 | 11.8 |
| Lives with no biological parents or parent figures | 36.5 | 41.4 | 39.1 | 31.1 | 33.8 | 32.7 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to adolescents whose mother died. Sample sizes: females 12–14 (N=21); females 15–17 (N=22); males 12–14 (N=28); males 15–17 (N=45). †Limited to adolescents whose father died. Sample sizes: females 12–14 (N=79); females 15–17 (N=94); males 12–14 (N=80); males 15–17 (N=108). ‡Limited to adolescents with a deceased biological parent. Sample sizes: females 12–14 (N=96); females 15–17 (N=111); males 12–14 (N=103); males 15–17 (N=142). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 3.4 Percentage distributions of adolescents, by schooling characteristics, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=955) | 15–19 (N=1238) | Total (N=2193) | 12–14 (N=977) | 15–19 (N=1259) | Total (N=2236) |
| Ever attended school | | | | | | |
| No | 7.4 | 9.9 | 8.8 | 5.4 | 6.9 | 6.3 |
| Yes | 92.6 | 90.1 | 91.2 | 94.6 | 93.1 | 93.7 |
| Currently attending school | | | | | | |
| No | 11.9 | 41.7 | 28.7 | 9.9 | 32.5 | 22.7 |
| Yes | 88.1 | 58.3 | 71.3 | 90.1 | 67.5 | 77.3 |
| Schooling completed (years) | | | | | | |
| None | 8.8 | 10.1 | 9.5 | 7.0 | 7.1 | 7.1 |
| 1–3 | 21.3 | 5.0 | 12.1 | 26.6 | 8.5 | 16.4 |
| 4–5 | 35.0 | 11.6 | 21.8 | 34.7 | 12.7 | 22.3 |
| 6 | 18.3 | 12.3 | 14.9 | 17.3 | 13.1 | 15.0 |
| 7 | 12.3 | 15.2 | 13.9 | 9.2 | 15.6 | 12.8 |
| 8 | 3.9 | 13.7 | 9.4 | 4.7 | 13.3 | 9.6 |
| 9+ years | 0.5 | 32.2 | 18.4 | 0.5 | 29.5 | 16.9 |
| Highest level of school attended | | | | | | |
| None | 7.4 | 9.9 | 8.8 | 5.4 | 6.9 | 6.3 |
| Primary | 67.5 | 24.6 | 43.3 | 73.8 | 29.2 | 48.7 |
| Secondary | 25.0 | 65.2 | 47.7 | 20.8 | 63.8 | 45.0 |
| Higher | 0.0 | 0.3 | 0.2 | 0.0 | 0.2 | 0.1 |
| Expectations for highest level of schooling | | | | | | |
| No expectation of further schooling | 7.2 | 27.1 | 18.4 | 5.0 | 16.8 | 11.6 |
| Primary | 1.0 | 0.4 | 0.7 | 0.6 | 0.2 | 0.4 |
| JSS/middle | 11.9 | 6.6 | 8.9 | 11.0 | 7.2 | 8.8 |
| SSS/secondary | 23.5 | 14.0 | 18.1 | 21.0 | 14.7 | 17.5 |
| Higher | 56.3 | 51.9 | 53.8 | 62.4 | 61.2 | 61.7 |
| Ever received vocational training | | | | | | |
| No | 96.4 | 82.4 | 88.4 | 91.8 | 80.6 | 85.4 |
| Yes | 3.6 | 17.6 | 11.6 | 8.2 | 19.4 | 14.6 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Ns are weighted.

TABLE 3.5 Percentage distribution of adolescents who have stopped schooling, by main reason for stopping, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---------------------------------------|-----------------|------------------|------------------|-----------------|------------------|------------------|
| | 12–14 (N=42) | 15–19 (N=390) | Total (N=432) | 12–14 (N=45) | 15–19 (N=318) | Total (N=363) |
| Main reason for leaving school | | | | | | |
| Could not pay school fees | [31.0] | 24.1 | 24.8 | [20.0] | 22.6 | 22.3 |
| Lack of school materials | [11.9] | 2.1 | 3.0 | [6.7] | 3.1 | 3.6 |
| Completed schooling/had enough | [0.0] | 38.5 | 34.7 | [4.4] | 45.6 | 40.5 |
| Pregnant/made someone pregnant | [0.0] | 7.2 | 6.5 | [0.0] | 0.3 | 0.3 |
| Got married | [0.0] | 0.0 | 0.0 | [0.0] | 0.0 | 0.0 |
| Illness | [4.8] | 4.4 | 4.4 | [2.2] | 1.6 | 1.7 |
| Work at home | [11.9] | 1.8 | 2.8 | [20.0] | 3.1 | 5.2 |
| Not interested | [14.3] | 7.7 | 8.3 | [13.3] | 10.7 | 11.0 |
| Not a good student | [7.1] | 7.4 | 7.4 | [4.4] | 6.6 | 6.3 |
| Got a job | 0.0 | 0.0 | 0.0 | [0.0] | 0.3 | 0.3 |
| Vacation/holidays | N/A | N/A | N/A | N/A | N/A | N/A |
| Parent sick/died | [0.0] | 1.0 | 0.9 | [0.0] | 0.6 | 0.6 |
| Teacher | [0.0] | 0.8 | 0.7 | [0.0] | 1.3 | 1.1 |
| Other reason | [14.3] | 4.1 | 5.1 | [22.2] | 3.1 | 5.5 |
| Don't know | [4.8] | 1.0 | 1.4 | [6.7] | 0.9 | 1.7 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. [] = N is 25–49.

TABLE 3.6 Percentage distribution of adolescents who ever attended school, by schooling characteristics, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=882) | 15-19 (N=1116) | Total (N=1998) | 12-14 (N=920) | 15-19 (N=1160) | Total (N=2080) |
| Age first attended school | | | | | | |
| ≤6 | 40.2 | 43.8 | 42.2 | 42.4 | 43.6 | 43.1 |
| 7 | 12.2 | 12.3 | 12.3 | 13.2 | 11.8 | 12.4 |
| 8 | 8.8 | 10.1 | 9.6 | 7.6 | 9.2 | 8.5 |
| ≥9 | 15.5 | 12.2 | 13.7 | 13.0 | 15.3 | 14.3 |
| Don't know | 23.1 | 21.6 | 22.3 | 23.8 | 20.1 | 21.7 |
| Repeated last grade* | | | | | | |
| No | 97.7 | 97.8 | 97.8 | 98.1 | 98.2 | 98.1 |
| Yes | 2.3 | 2.2 | 2.2 | 1.9 | 1.8 | 1.9 |
| Current or last school was coed | | | | | | |
| No | 1.0 | 3.0 | 2.1 | 0.3 | 1.9 | 1.2 |
| Yes | 99.0 | 97.0 | 97.9 | 99.7 | 97.9 | 98.7 |
| Current or last school type | | | | | | |
| Government-aided, not religious | 55.6 | 62.0 | 59.2 | 51.8 | 57.7 | 55.1 |
| Government-aided, religious | 28.3 | 27.4 | 27.8 | 33.6 | 32.9 | 33.2 |
| Private, not religious | 9.4 | 6.8 | 7.9 | 9.5 | 6.1 | 7.6 |
| Private, religious | 6.7 | 3.9 | 5.1 | 5.1 | 3.3 | 4.1 |
| Living arrangement at current or last school | | | | | | |
| Day student | 99.5 | 94.5 | 96.8 | 99.8 | 95.1 | 97.2 |
| Boarder | 0.5 | 5.5 | 3.2 | 0.2 | 4.9 | 2.8 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those currently attending school. Samples size: females 12-14 (N=844); females 15-19 (N=721); males 12-14 (N=879); males 15-19 (N=850). *Note:* Ns are weighted.

TABLE 3.7 Percentage distribution of adolescents, by time use and work characteristics, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=958) | 15–19 (N=1237) | Total (N=2195) | 12–14 (N=976) | 15–19 (N=1259) | Total (N=2235) |
| Usual daily activities (outside of school)* | | | | | | |
| Studying | 44.1 | 35.8 | 39.4 | 42.1 | 37.6 | 39.6 |
| Household chores | 81.9 | 81.2 | 81.5 | 53.9 | 41.4 | 46.9 |
| Work on family business/farm | 46.0 | 39.4 | 42.3 | 47.2 | 45.9 | 46.5 |
| Work to get money | 4.8 | 10.5 | 8.0 | 4.2 | 16.2 | 11.0 |
| Playing with friends | 14.0 | 12.9 | 13.4 | 30.4 | 26.1 | 27.9 |
| Idling | 4.0 | 6.3 | 5.3 | 8.8 | 9.6 | 9.3 |
| Other | 1.5 | 3.6 | 2.7 | 2.1 | 4.1 | 3.2 |
| Work and school status | | | | | | |
| In school, working | 41.8 | 23.8 | 31.7 | 42.7 | 34.0 | 37.8 |
| In school, not working | 46.3 | 34.4 | 39.6 | 47.3 | 33.4 | 39.5 |
| Not in school, working | 7.5 | 23.2 | 16.4 | 7.6 | 23.2 | 16.3 |
| Not in school, not working | 4.3 | 18.5 | 12.3 | 2.4 | 9.4 | 6.3 |
| Place of work† | | | | | | |
| Home | 21.8 | 25.6 | 23.9 | 15.5 | 14.8 | 15.1 |
| Away from home | 78.2 | 74.4 | 76.1 | 84.5 | 85.2 | 84.9 |
| Remuneration‡ | | | | | | |
| Cash only | 12.1 | 24.6 | 19.0 | 12.3 | 28.4 | 21.9 |
| Cash and kind | 4.3 | 7.8 | 6.2 | 5.5 | 10.4 | 8.4 |
| In kind only | 3.6 | 5.5 | 4.7 | 8.0 | 7.9 | 7.9 |
| Not paid | 80.0 | 62.1 | 70.2 | 74.2 | 53.3 | 61.7 |
| Did anything for money in past 12 months | | | | | | |
| No | 77.7 | 70.0 | 73.4 | 77.9 | 53.5 | 64.2 |
| Yes | 22.3 | 30.0 | 26.6 | 22.1 | 46.5 | 35.8 |
| Who decides how money will be spent‡ | | | | | | |
| Respondent | 19.4 | 43.0 | 34.4 | 32.6 | 61.0 | 53.4 |
| Spouse/partner | 1.9 | 1.1 | 1.4 | 0.0 | 0.5 | 0.4 |
| Respondent and spouse/partner jointly | 1.4 | 4.6 | 3.4 | 0.9 | 0.9 | 0.9 |
| Parents/guardians | 74.4 | 48.4 | 57.8 | 63.3 | 35.0 | 42.6 |
| Sibling | 1.9 | 2.2 | 2.1 | 2.8 | 2.2 | 2.4 |
| Someone else | 0.9 | 0.8 | 0.9 | 0.5 | 0.3 | 0.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. †Limited to those who are working or helping with family business/farm. Sample sizes: females 12–14 (N=436); females 15–19 (N=531); males 12–14 (N=464); males 15–19 (N=688). ‡Includes those who work for money or reported doing something for money in past 12 months. Sample sizes: females 12–14 (N=211); females 15–19 (N=370); males 12–14 (N=215); males 15–19 (N=585). *Note:* Ns are weighted.

TABLE 3.8 Percentage distributions of adolescents, by religious and social group participation, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1239) | Total (N=2196) | 12–14 (N=978) | 15–19 (N=1258) | Total (N=2236) |
| Religion | | | | | | |
| Catholic | 16.3 | 18.9 | 17.8 | 17.0 | 16.5 | 16.7 |
| Protestant | 21.1 | 19.6 | 20.3 | 14.6 | 15.8 | 15.3 |
| Pentecostal/Charismatic | 36.3 | 33.0 | 34.4 | 32.0 | 31.0 | 31.4 |
| Other Christian | 6.0 | 7.4 | 6.8 | 9.0 | 9.9 | 9.5 |
| Muslim | 14.8 | 16.5 | 15.8 | 19.5 | 20.0 | 19.8 |
| Traditional Religion | 1.6 | 1.1 | 1.3 | 1.6 | 1.7 | 1.7 |
| No Religion | 3.3 | 2.4 | 2.8 | 5.4 | 3.7 | 4.5 |
| Other | 0.6 | 1.0 | 0.8 | 0.8 | 1.4 | 1.1 |
| Importance of religion* | | | | | | |
| Very important | 88.6 | 87.4 | 87.9 | 84.7 | 83.9 | 84.2 |
| Somewhat important | 10.5 | 11.7 | 11.2 | 14.8 | 15.1 | 15.0 |
| Not important | 0.9 | 0.9 | 0.9 | 0.5 | 1.0 | 0.8 |
| Frequency of religious service attendance* | | | | | | |
| More than once a week | 37.4 | 45.3 | 41.9 | 31.5 | 38.2 | 35.3 |
| Once a week | 55.6 | 47.9 | 51.2 | 59.2 | 49.6 | 53.7 |
| At least once a month | 4.5 | 3.8 | 4.1 | 6.0 | 6.9 | 6.5 |
| Less than once a month | 1.3 | 1.7 | 1.5 | 2.2 | 4.2 | 3.3 |
| Not at all | 1.2 | 1.2 | 1.2 | 1.2 | 1.1 | 1.1 |
| Belongs to any social group or club | | | | | | |
| No | 74.0 | 62.9 | 67.8 | 84.0 | 75.7 | 79.3 |
| Yes | 26.0 | 37.1 | 32.2 | 16.0 | 24.3 | 20.7 |
| Holds an office or leadership position in club† | | | | | | |
| No | 84.0 | 77.5 | 79.8 | 82.1 | 69.2 | 73.5 |
| Yes | 16.0 | 22.5 | 20.2 | 17.9 | 30.8 | 26.5 |
| Type of social club or group† | | | | | | |
| Church/Muslim youth | 43.7 | 59.3 | 53.8 | 38.3 | 39.9 | 39.4 |
| Football/netball | 0.4 | 0.9 | 0.7 | 22.7 | 24.3 | 23.8 |
| Choir | 13.0 | 18.2 | 16.4 | 6.5 | 6.6 | 6.6 |
| Drama | 6.9 | 4.6 | 5.4 | 2.6 | 4.3 | 3.7 |
| Anti-AIDS | 5.2 | 3.7 | 4.3 | 1.3 | 3.6 | 2.8 |
| Red Cross | 2.4 | 2.0 | 2.1 | 1.3 | 2.3 | 2.0 |
| Girl/Boy Guide | 7.3 | 3.7 | 5.0 | 1.9 | 1.3 | 1.5 |
| Wildlife Society | 2.0 | 2.2 | 2.1 | 12.3 | 3.9 | 6.8 |
| Youth Brigade | 3.6 | 3.7 | 3.7 | 3.2 | 3.3 | 3.3 |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who have a religious affiliation. Sample sizes: females 12–14 (N=925); females 15–19 (N=1207); males 12–14 (N=922); males 15–19 (N=1222). †Limited to those in social groups or clubs. Sample sizes: females 12–14 (N=244); females 15–19 (N=454); males 12–14 (N=154); males 15–19 (N=303). Notes: Ns are weighted.

TABLE 3.9 Percentage distribution of adolescents, by parent and teacher monitoring, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=927) | 15–19 (N=1214) | Total (N=2141) | 12–14 (N=976) | 15–19 (N=1257) | Total (N=2233) |
| Parents/guardians know where respondent goes out at night* | | | | | | |
| Do not know | 3.8 | 6.8 | 5.5 | 7.2 | 10.6 | 9.1 |
| Sometimes know | 16.0 | 20.6 | 18.6 | 27.4 | 31.4 | 29.6 |
| Always know | 80.3 | 72.6 | 75.9 | 65.5 | 58.0 | 61.3 |
| Parents/guardians know what respondent does with free time* | | | | | | |
| Do not know | 4.5 | 7.5 | 6.2 | 8.7 | 10.8 | 9.9 |
| Sometimes know | 19.3 | 23.8 | 21.8 | 31.5 | 38.5 | 35.5 |
| Always know | 76.2 | 68.7 | 72.0 | 59.8 | 50.7 | 54.7 |
| Parents/guardians know who respondent's friends are* | | | | | | |
| Do not know | 8.4 | 8.8 | 8.6 | 8.1 | 9.2 | 8.7 |
| Sometimes know | 18.8 | 22.3 | 20.8 | 32.4 | 36.9 | 34.9 |
| Always know | 72.8 | 68.8 | 70.5 | 59.5 | 53.9 | 56.4 |
| Teachers keep eye on students to make sure they are not getting into trouble† | | | | | | |
| Almost always | 76.4 | 72.4 | 74.2 | 75.4 | 72.0 | 73.5 |
| Sometimes | 20.8 | 25.2 | 23.2 | 21.5 | 25.7 | 23.9 |
| Almost never | 2.4 | 1.7 | 2.0 | 1.0 | 1.4 | 1.2 |
| Don't know | 0.5 | 0.7 | 0.6 | 2.1 | 0.9 | 1.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*For married adolescents, the question refers to parental knowledge before respondent got married. †Limited to those who ever attended school. Sample sizes: females 12–14 (N=886); females 15–19 (N=1117); males 12–14 (N=920); males 15–19 (N=1172). Note: Ns are weighted.

TABLE 3.10 Percentage distribution of adolescents, by characteristics of friendship networks, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=957) | 15-19 (N=1237) | Total (N=2194) | 12-14 (N=975) | 15-19 (N=1255) | Total (N=2230) |
| Number of close female friends | | | | | | |
| 0 | 3.6 | 5.4 | 4.6 | 46.6 | 37.1 | 41.2 |
| 1 | 19.5 | 23.8 | 22.0 | 12.3 | 15.2 | 13.9 |
| 2 | 26.6 | 27.1 | 26.9 | 18.6 | 17.8 | 18.1 |
| 3 | 21.3 | 18.8 | 19.9 | 10.2 | 11.5 | 10.9 |
| 4 | 11.4 | 9.7 | 10.4 | 3.1 | 4.8 | 4.0 |
| 5+ | 17.2 | 14.8 | 15.9 | 7.9 | 12.4 | 10.4 |
| Don't know | 0.3 | 0.4 | 0.4 | 1.4 | 1.3 | 1.3 |
| Average number of close female friends | 3.1 | 2.8 | 2.9 | 1.4 | 2.0 | 1.7 |
| Number of close male friends | | | | | | |
| 0 | 60.7 | 41.0 | 49.6 | 1.9 | 1.5 | 1.7 |
| 1 | 13.1 | 19.6 | 16.8 | 13.1 | 13.0 | 13.0 |
| 2 | 13.5 | 16.1 | 15.0 | 18.2 | 19.6 | 19.0 |
| 3 | 6.0 | 9.3 | 7.8 | 19.4 | 17.7 | 18.5 |
| 4 | 2.1 | 5.0 | 3.8 | 13.5 | 13.8 | 13.7 |
| 5+ | 4.4 | 8.5 | 6.7 | 30.9 | 31.7 | 31.4 |
| Don't know | 0.2 | 0.5 | 0.4 | 2.9 | 2.6 | 2.7 |
| Average number of close male friends | 1.0 | 1.7 | 1.4 | 4.1 | 4.2 | 4.2 |
| Sex composition of friendship networks | | | | | | |
| No close friends | 4.0 | 5.5 | 4.8 | 5.2 | 4.5 | 4.8 |
| Only male | 0.2 | 1.0 | 0.6 | 43.8 | 35.3 | 39.0 |
| Only female | 57.1 | 36.3 | 45.4 | 0.3 | 0.4 | 0.4 |
| Both male and female | 38.7 | 57.3 | 49.2 | 50.7 | 59.7 | 55.8 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Ns are weighted.

TABLE 3.11 Percentage of adolescents, by types of people who talked about sex-related matters with adolescents, according to sex and age, 2004 National Survey of Adolescents*

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1237) | Total (N=2194) | 12–14 (N=976) | 15–19 (N=1256) | Total (N=2232) |
| Persons who have ever talked to respondent about sex-related matters | | | | | | |
| Any family member | 39.8 | 49.9 | 45.5 | 21.8 | 33.1 | 28.2 |
| Any nonfamily member | 40.8 | 54.9 | 48.7 | 34.6 | 54.9 | 46.1 |
| Spouse/cohabiting partner | 0.3 | 0.4 | 0.4 | 0.1 | 0.1 | 0.1 |
| Mother | 29.2 | 35.3 | 32.6 | 14.2 | 16.9 | 15.7 |
| Father | 11.4 | 14.0 | 12.8 | 10.1 | 13.2 | 11.9 |
| Brother | 2.3 | 4.2 | 3.4 | 3.8 | 9.2 | 6.9 |
| Sister | 9.1 | 13.2 | 11.4 | 2.2 | 4.5 | 3.5 |
| Aunt | 6.5 | 11.0 | 9.0 | 0.8 | 3.7 | 2.4 |
| Uncle | 2.5 | 4.1 | 3.4 | 1.5 | 5.3 | 3.6 |
| Cousin | 0.5 | 1.0 | 0.8 | 0.6 | 0.7 | 0.7 |
| Grandmother | 7.1 | 7.1 | 7.1 | 3.3 | 2.2 | 2.7 |
| Grandfather | 0.8 | 0.9 | 0.9 | 0.8 | 0.5 | 0.6 |
| Other family member | 0.3 | 0.9 | 0.6 | 0.1 | 0.5 | 0.3 |
| Girlfriend | 1.9 | 4.3 | 3.2 | 0.0 | 1.0 | 0.6 |
| Boyfriend | 0.2 | 4.0 | 2.3 | 1.0 | 0.7 | 0.9 |
| Male friend | 3.2 | 7.0 | 5.4 | 15.7 | 31.1 | 24.4 |
| Female friend | 14.9 | 24.2 | 20.2 | 1.3 | 5.9 | 3.9 |
| Teacher | 24.2 | 26.3 | 25.4 | 16.9 | 23.0 | 20.3 |
| Health care provider | 3.1 | 4.9 | 4.1 | 3.0 | 4.7 | 3.9 |
| Religious/church leader | 8.3 | 9.4 | 8.9 | 3.8 | 6.8 | 5.5 |
| Other nonfamily member | 2.0 | 3.7 | 3.0 | 1.5 | 2.7 | 2.2 |

*Totals may exceed 100.0 because multiple responses are possible. *Notes:* Ns are weighted.

TABLE 3.12 Percentage distribution of adolescents, by alcohol and drug use, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=958) | 15-19 (N=1236) | Total (N=2194) | 12-14 (N=976) | 15-19 (N=1257) | Total (N=2233) |
| Ever tried alcohol | | | | | | |
| No | 84.8 | 75.6 | 79.6 | 79.1 | 68.1 | 72.9 |
| Yes | 15.2 | 24.4 | 20.4 | 20.9 | 31.9 | 27.1 |
| Refused to answer | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Age when had first alcoholic drink* | | | | | | |
| ≤11 | 31.7 | 8.9 | 16.3 | 30.4 | 9.0 | 16.2 |
| 12-14 | 34.5 | 16.4 | 22.3 | 38.2 | 18.8 | 25.3 |
| 15-19 | 0.0 | 50.0 | 33.9 | 0.0 | 56.0 | 37.1 |
| Don't know age | 17.2 | 8.9 | 11.6 | 10.3 | 7.0 | 8.1 |
| Refused to answer | 16.6 | 15.8 | 16.0 | 21.1 | 9.3 | 13.2 |
| Has gotten "drunk" in last 12 months* | | | | | | |
| No | 75.6 | 63.8 | 67.6 | 74.4 | 58.5 | 63.4 |
| Yes | 24.4 | 36.2 | 32.4 | 25.6 | 41.5 | 36.6 |
| Ever tried any other type of drug | | | | | | |
| No | 99.1 | 99.0 | 99.0 | 98.4 | 98.0 | 98.2 |
| Yes | 0.8 | 1.0 | 0.9 | 1.6 | 1.9 | 1.8 |
| Refused to answer | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who ever had an alcoholic drink. Sample sizes: females 12-14 (N=145); females 15-19 (N=304); males 12-14 (N=204); males 15-19 (N=400). Note: Ns are weighted.

TABLE 3.13 Percentage distribution of adolescents, by levels of worry about different issues, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=958) | 15–19 (N=1237) | Total (N=2195) | 12–14 (N=977) | 15–19 (N=1258) | Total (N=2235) |
| Worry about own health | | | | | | |
| Very worried | 34.2 | 36.1 | 35.3 | 22.0 | 31.1 | 27.1 |
| Somewhat worried | 16.2 | 19.1 | 17.8 | 22.1 | 20.5 | 21.2 |
| Not worried | 49.5 | 44.4 | 46.6 | 54.8 | 47.9 | 50.9 |
| Don't know | 0.1 | 0.4 | 0.3 | 1.1 | 0.6 | 0.8 |
| Worry about getting enough to eat | | | | | | |
| Very worried | 25.6 | 23.6 | 24.5 | 14.7 | 21.0 | 18.3 |
| Somewhat worried | 17.1 | 19.8 | 18.6 | 17.3 | 15.6 | 16.3 |
| Not worried | 57.2 | 56.4 | 56.7 | 67.2 | 63.3 | 65.0 |
| Don't know | 0.1 | 0.2 | 0.1 | 0.7 | 0.2 | 0.4 |
| Worry about getting money | | | | | | |
| Very worried | 23.3 | 32.7 | 28.6 | 22.6 | 37.3 | 30.9 |
| Somewhat worried | 20.0 | 20.8 | 20.4 | 25.4 | 21.8 | 23.4 |
| Not worried | 56.7 | 46.4 | 50.9 | 50.9 | 40.4 | 45.0 |
| Don't know | 0.0 | 0.2 | 0.1 | 1.0 | 0.4 | 0.7 |
| Worry about getting (someone) pregnant | | | | | | |
| Very worried | 30.0 | 38.5 | 34.8 | 22.7 | 33.9 | 29.0 |
| Somewhat worried | 8.0 | 12.8 | 10.7 | 9.5 | 9.1 | 9.3 |
| Not worried | 60.6 | 47.9 | 53.5 | 65.6 | 56.2 | 60.3 |
| Don't know | 1.4 | 0.8 | 1.0 | 2.3 | 0.8 | 1.4 |
| Worry about getting HIV/AIDS | | | | | | |
| Very worried | 37.4 | 48.4 | 43.6 | 36.4 | 43.6 | 40.5 |
| Somewhat worried | 9.7 | 12.1 | 11.0 | 8.3 | 7.3 | 7.8 |
| Not worried | 50.6 | 38.2 | 43.6 | 53.4 | 48.0 | 50.4 |
| Don't know | 2.3 | 1.4 | 1.8 | 1.8 | 1.0 | 1.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Ns are weighted.

Chart 3.1 Frequency of contact with biological mother among adolescents with a living biological mother, 2004 National Survey of Adolescents

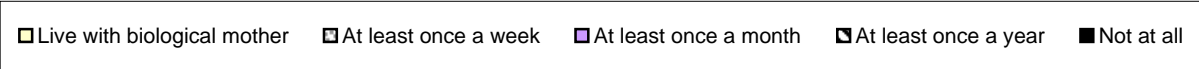
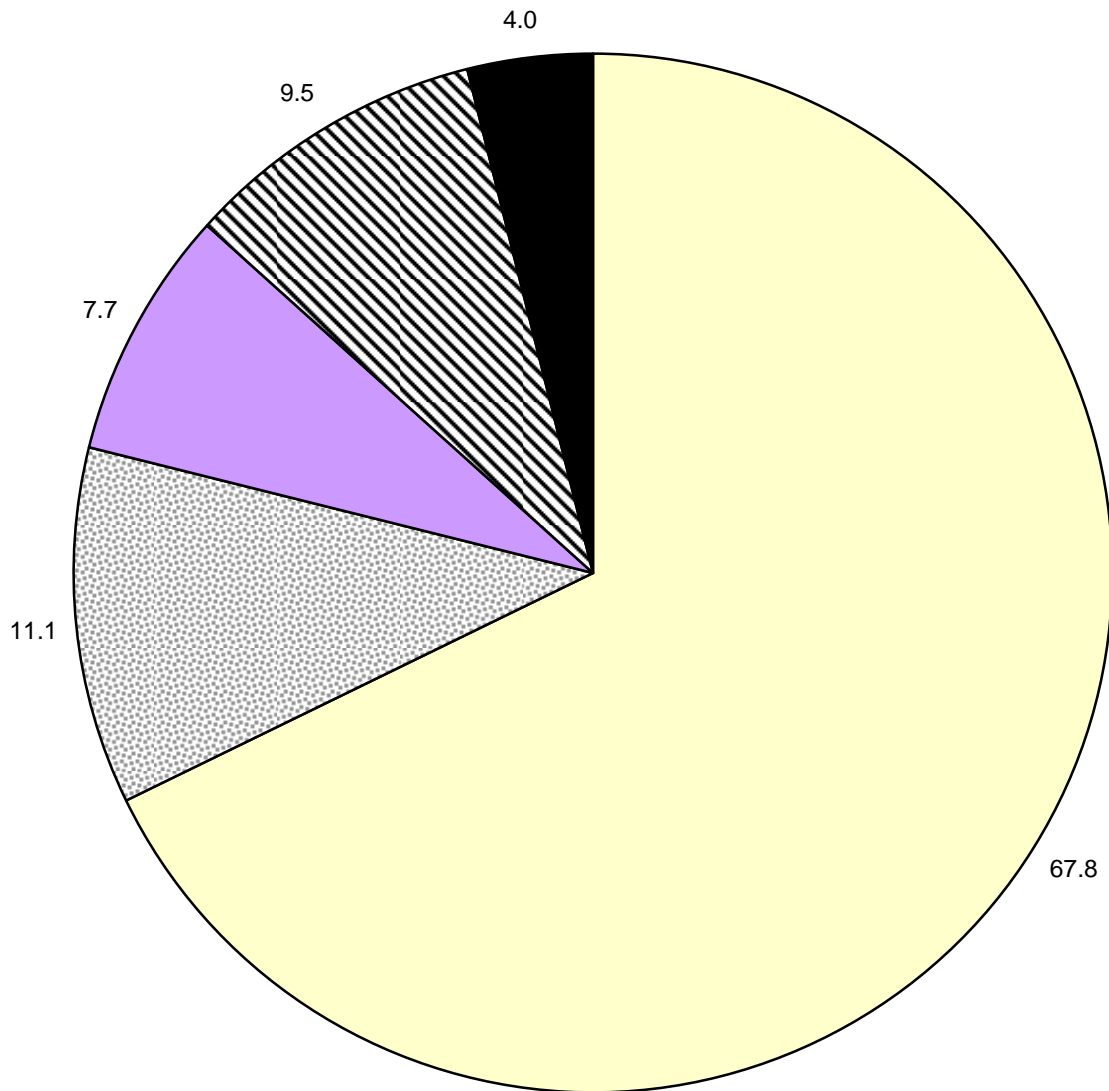
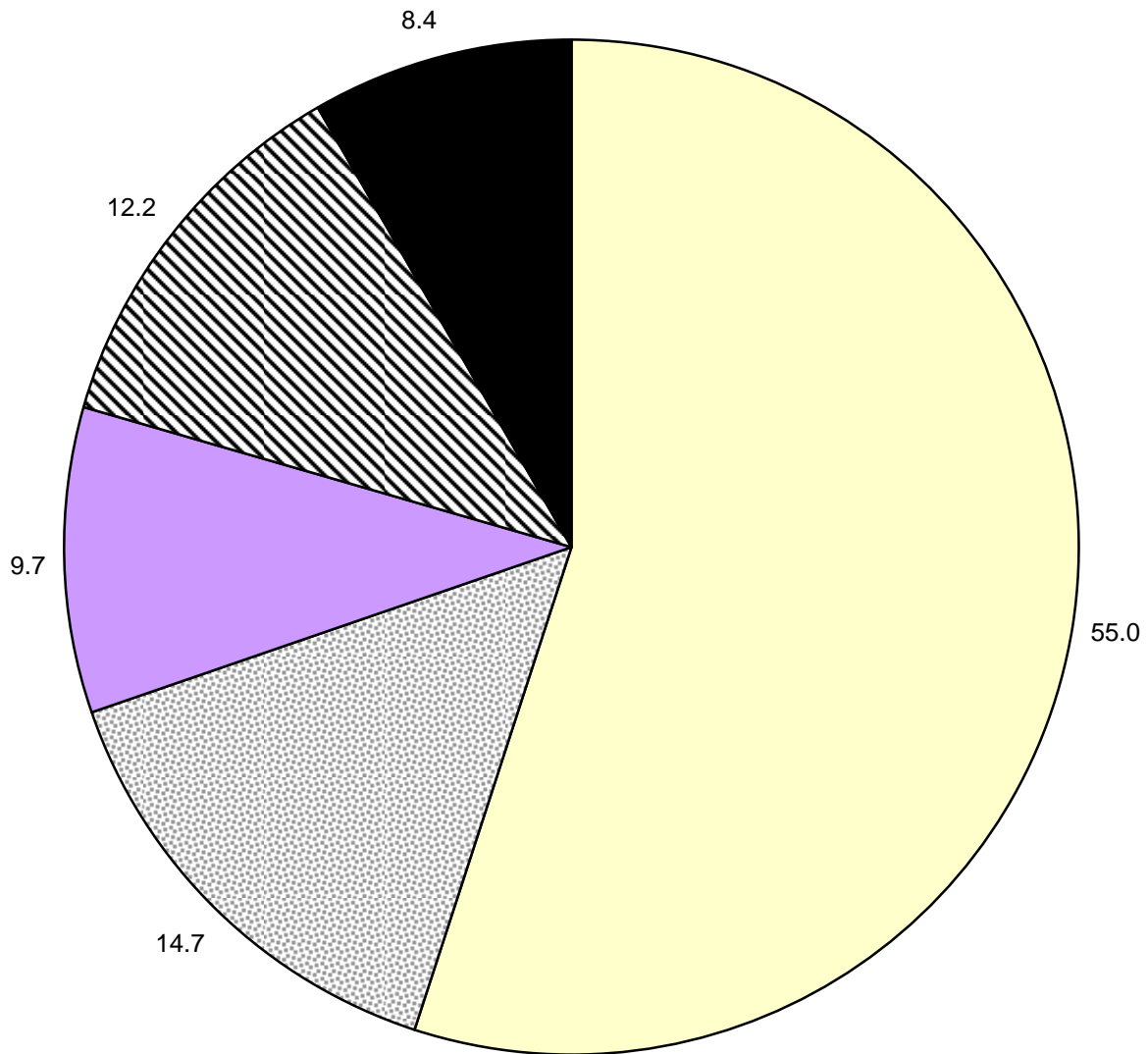
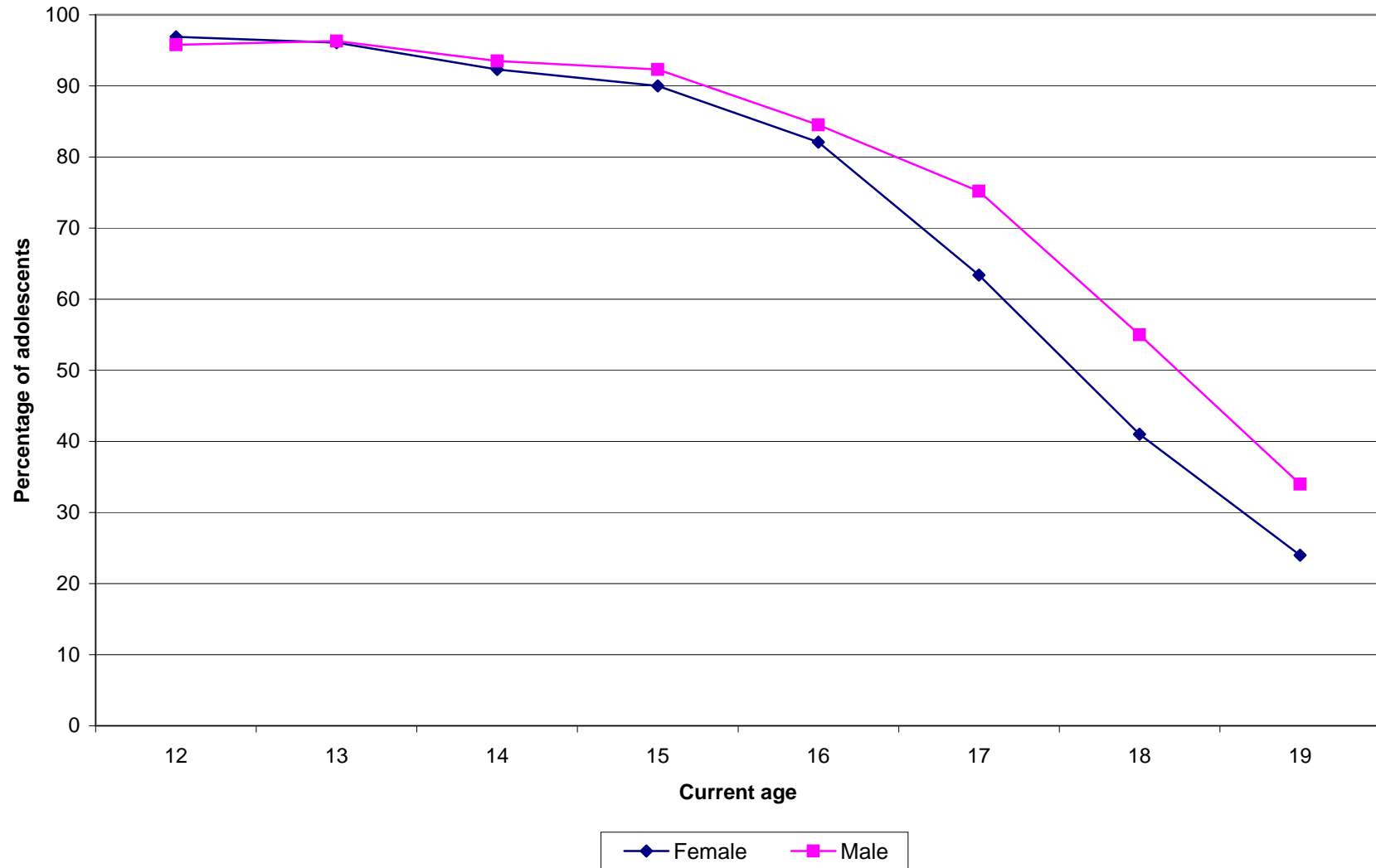


Chart 3.2 Frequency of contact with biological father among adolescents with a living biological father, 2004 National Survey of Adolescents



| | | |
|-------------------------------|------------------------|-------------------------|
| □ Live with biological father | ▨ At least once a week | ■ At least once a month |
| ▩ At least once a year | ■ Not at all | |

Chart 3.3 Percentage of adolescents currently attending school among those who ever attended school, according to current age and sex, 2004 National Survey of Adolescents



**Chart 3.4 Work and school status of adolescents, according to sex,
National Survey of Adolescents, 2004**

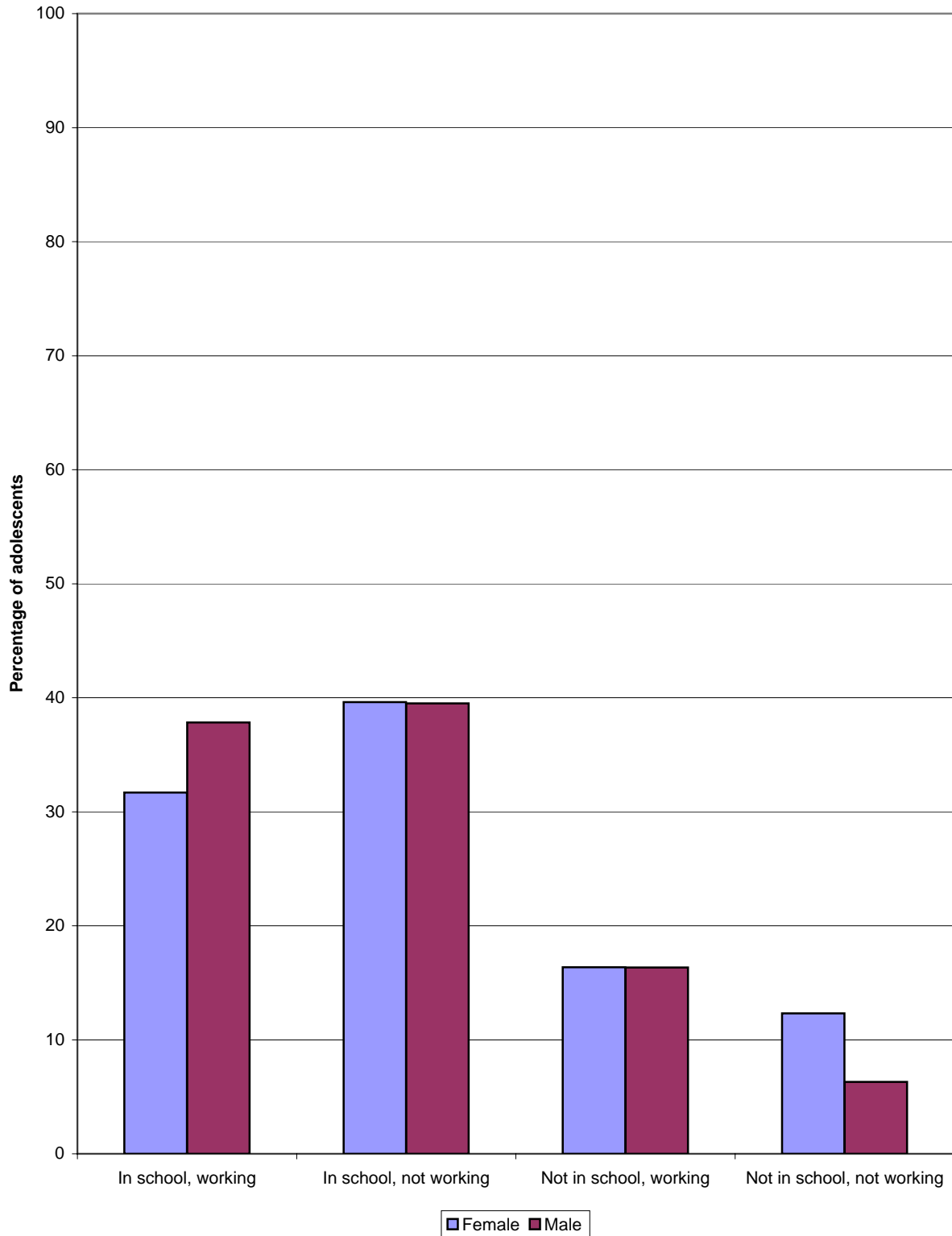
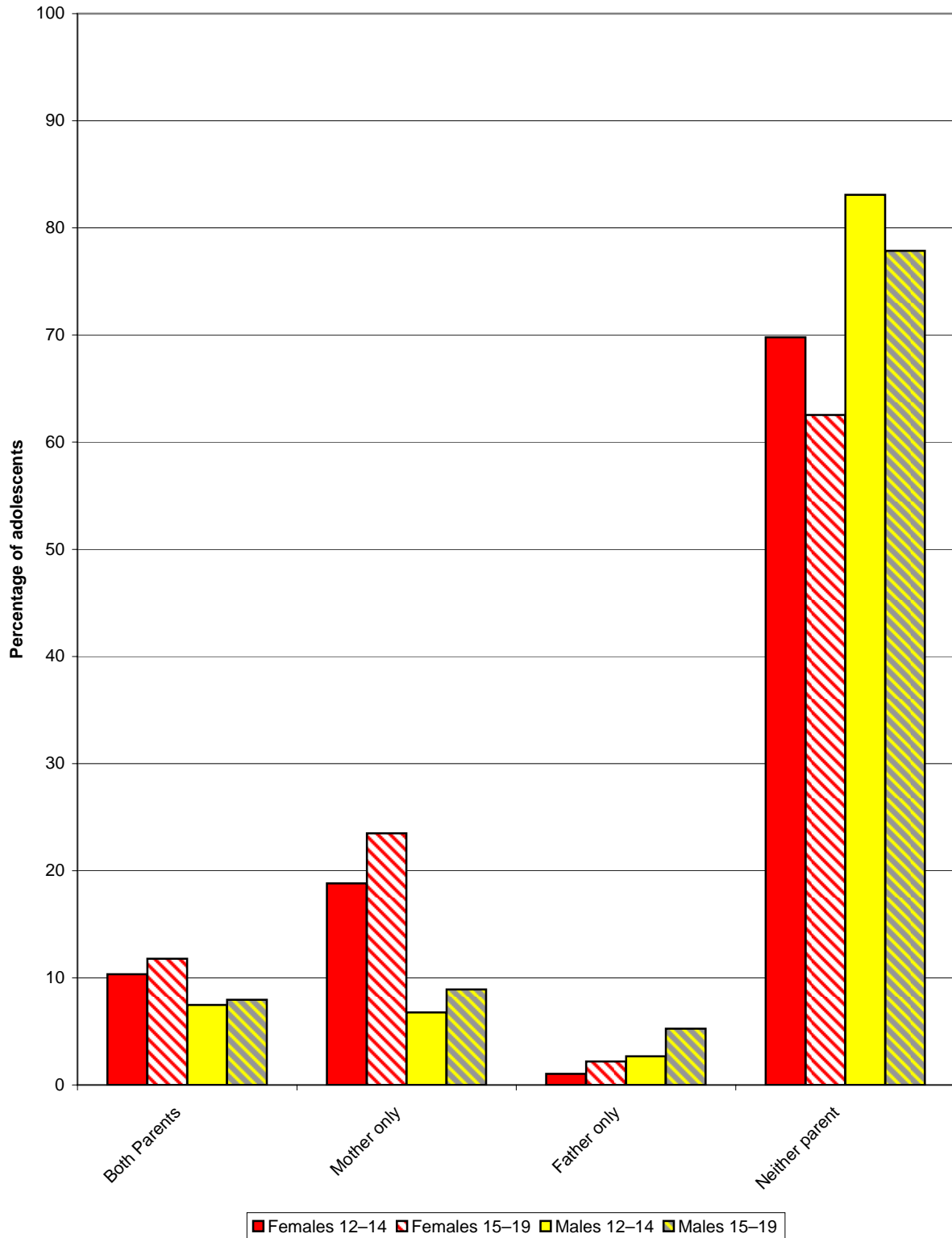


Chart 3.5 Communication with parents about sex-related matters among adolescents, according to sex and age, 2004 National Survey of Adolescents



Chapter 4

Sexual Activity and Relationships

Among the important features of adolescence are the physiological and psychosocial changes that are associated with sexual maturity. Also associated with sexual maturation are the development of self and the desire for intimate relationships. To ease young peoples' transition into this stage of life, various societies have developed systems, such as initiation rites and age sets (i.e., a group of individuals of similar age who share a common social identity and generally go through age-related rites and rituals together). This chapter describes the experiences of young people in Ghana regarding their awareness of bodily changes (for girls this includes menstruation and development of breasts, while for boys this involves growing of pubic hair, deepening of the voice and experiencing a "wet dream"), the support systems that are available, and awareness and/or experiences of a range of sexual activities and relationships, including the timing of first sexual intercourse, characteristics of the first and most recent sex partners, and number of sex partners. The chapter also deals with aspects of sexuality, such as the exchange of sex for money or other goods and experiences of sexual abuse and coercive sexual intercourse among female and male adolescents.

Puberty and Initiation Rites

Key physiological developmental events are first menstruation for females and a range of signs of puberty for males. A life table method is used to calculate median age at first pubertal changes. This is considered superior to alternative methods because it includes years of exposure prior to the event (puberty) and differentiates those who have experienced the event from those yet to experience it (puberty).²³ As shown in Table 4.1, 31% of females aged 12–14 years and 91% of those aged 15–19 years had experienced first menstruation by the time of the survey. For males, 30% of those aged 12–14 years and 88% of those aged 15–19 years had experienced pubertal changes. With the median ages of female menstruation and male pubertal changes being

15 years, the results indicate similar ages at maturation for both females and males.

Both male and female circumcision has been reported in various studies in Ghana. However, while male circumcision is widespread, female circumcision is limited to a few areas in the country.²⁴ The results from the national survey indicate that only 3% of females and 92% of males had experienced circumcision at the time of the survey (Table 4.1). Among those who have been circumcised, 80% of females (74% of 12–14-year-olds and 84% of 15–19-year-olds) and 87% of males were circumcised during the first year of life. Although only 3% of females had been circumcised, its mere occurrence should be of concern to society, especially policymakers and implementers of programs.

Traditionally, various ethnic groups organized elaborate puberty rites for females but not males. Among the rites are the Bragro of the Akan and the Dipo of the Krobo.²⁵ It was during the initiation rites that the young female was introduced to aspects of sexual and reproductive health, as well as wifely responsibilities. In the 2004 survey, only 5% of females had experienced initiation rites, with slightly higher percentages among 15–19-year-olds than 12–14-year-olds. The low percentage of female adolescents reporting any form of initiation rites points to the decline of the practice in the country. Four percent of adolescent males reported going through initiation rites. Traditional rites of passage have been abandoned but have not been replaced with any other practice to perform the same functions as the initiation rites. With the outbreak of HIV/AIDS, some traditional leaders have called for the reintroduction of puberty rites for females as a strategy to prevent premarital sex.

Sexual Activity and Awareness

In the past, the onset of menstruation for females was interpreted as a sign of maturity and therefore readiness for marriage. Although considerably reduced, there are certain areas in the country where the onset of men-

situation is still linked to marriage. Under these circumstances, females marry early, leading to the onset of sexual activity and family formation. Currently, changes brought about by formal education, migration and modernization have created conditions for a more significant time lapse between menarche, initiating sex and marriage.

In the survey, 15–19-year-old adolescents were asked if they had ever had sexual intercourse and those who had ever had sex were asked series of questions about their experiences. To increase our understanding of the level of sexual development and awareness among younger adolescents (most of whom had not yet experienced sexual intercourse), a separate battery of questions were asked of unmarried 12–14-year-olds about whether they had ever heard of certain specific sexual behaviors such as kissing, fondling and sexual intercourse, whether they knew of any close friends who had engaged in these behaviors, and whether they themselves had ever engaged in the behaviors. If the respondent had never heard of the sexual activity, she or he was not asked the two follow-up questions about experiences of that sexual activity. The wording of the question on awareness of each sexual activity was as follows:

- “Now I am going to ask you some questions about what young people might do together. Have you ever heard of kissing?”
- “Have you ever heard of fondling? By this I mean someone’s private parts, breasts or other parts of the body being touched in a sexual way.”
- “Have you ever heard of sexual intercourse? By this I mean a penis in a vagina.”

Ever had sexual intercourse and relationship status

According to the 2003 Ghana Demographic and Health Survey, the median age at first sex for females 20–49 years of age is 18.2 years.²⁶ Results from the survey, as shown in Table 4.2, indicate that 30% of females aged 15–19 years had ever had sex compared to fewer than 2% of females aged 12–14 years. Among males, 16% of those aged 15–19 years and 1% of 12–14-year-olds had ever had sex. Among traditionalists, Christians and Muslims, it is expected that first and subsequent sex will occur within marriage, especially for females. Of those who had ever had sex among the females aged 15–19 years, only 9% had ever been in a union (i.e., married or living with a man as if married) and 21% experienced sex outside of a union. The few 12–14-year-olds who had ever had sex also did so outside a formal

union. Thus, the majority of the reported sexual experience among Ghanaian adolescents took place outside marriage, contrary to expectation.

In the survey, adolescents were asked if they had entered into any intimate relationships independent of sexual intercourse. Among females, 97% of 12–14-year-olds and 64% of 15–19-year-olds had never had a boyfriend. Among males, 98% of 12–14-year-olds and 78% of 15–19-year-olds had never had a girlfriend.

Sexual activity

Among both females and males, 12–14-year-old adolescents had mostly heard of sexual intercourse, kissing and fondling. Eighty-three percent of females and 82% of males had heard of sexual intercourse and about one in four of those adolescents knew a close friend who had experienced it (Table 4.2). Only 2% said they themselves had ever had sexual intercourse. Seventy-seven percent of females and 72% of males had heard of kissing; 23–24% of females and males who had heard of kissing knew close friends who had done it; and only 4% of females and males who had heard of kissing said they themselves had ever done it. Sixty-six percent of younger adolescent females had heard of fondling compared to 55% of males; about one in three females and males who knew about fondling knew close friends who had done it; and only 7% of females and 8% of males who had heard of it reported that they themselves had experienced fondling.

Reasons for never having had sexual intercourse

As shown in Table 4.3, the paramount reason given for never having had sexual intercourse by both female and male adolescents was fear of getting pregnant or making someone pregnant (42% of females and 32% of males). The second most common reason for never having had sexual intercourse among females was because they wanted to wait until marriage (40%), while for males it was to avoid HIV/AIDS and other STIs (30%). The third and fourth most frequently reported reasons for the females, respectively, were to avoid HIV/AIDS and other STIs (18%) and that they were too young (16%). Avoiding sex for the sake of schooling was reported by 6–7% of females and males. Female adolescents, even the 12–14-year-olds, who were abstinent appeared to be more concerned about avoiding pregnancy than the possibility of contracting HIV/AIDS or other STIs. Male adolescents who were abstinent seem to be equally concerned about pregnancy and HIV/AIDS and other STIs.

Encouragement not to have sexual intercourse

One of the support systems for young people with regard to sexual and reproductive health is the encouragement that they receive from family, friends and significant others to avoid sexual intercourse. In the 2004 National Survey of Adolescents, young people were asked if they had ever been encouraged not to have sex and, if yes, by whom. As indicated in Table 4.3, about half of females and 42% of males reported that they had had encouragement from others not to engage in sexual intercourse. Percentages were lower for younger than older adolescents, perhaps because others do not see very young adolescents as being ready yet for sexual intercourse.

Among those adolescents who had never had sex and who received encouragement from others to remain abstinent, almost two-thirds of females reported their mother as the person from whom they received encouragement, while half as many (29%) reported having been encouraged by their father. For males, the percentage reporting mother (49%) was close to the percentage reporting father (42%). Other individuals who encouraged females not to have sex were teachers (28%) and other female family members (26%), while for the males it was male friends (35%) and teachers (21%).

Sexual activity in the past year and the past three months

As was shown in Table 4.2, 30% of females and 16% of males aged 15–19 years and only 1–2% of females and males aged 12–14 years had ever had sexual intercourse. However, it is useful to examine how recent the sexual intercourse happened (Table 4.4). Of those aged 15–19 years who had ever had sex, half of both females and males did so in the three months prior to the survey.

The principal reason for not having sex in the last 12 months, among those who had ever had sex, is the fear of getting pregnant or making someone pregnant (49% of females and 47% of males). Thirteen percent of females and 45% of males who did not have sex in the last 12 months were abstinent to avoid STIs, including HIV/AIDS. One in four females reported that they were waiting until marriage, compared with only 13% of males. Fear of becoming pregnant is a major motivating factor for not engaging in sexual intercourse, especially for females, among adolescents who had not yet had sexual intercourse (Table 4.3) and those who had had sex but not in the last 12 months. This observation relates to what Bleek²⁷ refers to as the ethical dimension of pregnancy and abortion among Ghanaian females. Pregnancy, which becomes obvious when it occurs unless one goes for abortion, compared with

STIs, which can be treated and or concealed, seems to be a major issue of concern among adolescents. Therefore, sexual and reproductive health programs should not displace pregnancy prevention in favor of HIV avoidance, but advocate for dual protection, especially for females (whose main reason for abstinence is to avoid getting pregnant).

Attitudes towards sexuality

The respondents were asked a series of questions about their attitudes towards sexuality. These included virginity until marriage for females and males and the circumstances under which sex occurs. On attitudes towards virginity until marriage, 88% or more of all adolescents—females and males, older and younger—agreed that young women and young men should remain virgins until they marry (Table 4.5). Among those who had ever had sex, the proportion agreeing that young women should remain virgins until marriage was 87% of females and 84% of males while the proportions agreeing that young men should remain virgins until marriage was similar to that of the females (82% of females and 85% of males). The overall results point towards minimal differences in virginity expectations for females and males, and that the “double standard” of expecting young women to be virgins until marriage but to allow young men to have premarital sex is not an attitude held by Ghanaian adolescents in general nowadays.

More than one-third of all adolescents agreed that people do not plan for sex, it just happens. Forty percent of those aged 15–19 held that attitude, as opposed to about a third of the younger adolescents. Among those who had ever had sex, 44% of females and 53% of males agreed that sex was usually unplanned.

First Sexual Intercourse

The timing of first intercourse is an indicator of the onset of exposure to risk of both pregnancy, HIV and STIs. Age is very likely to be related to knowledge of risks and means of protection, as well as to the ability to seek and obtain information and services. In this sense, older adolescents are likely to be better equipped than younger ones to deal with problems of sexuality when first intercourse occurs.

Timing of first intercourse

Chart 4.1 shows adolescents' age at first sex, based on the life table method. Very few adolescents experienced sexual intercourse before age 13. Differences between males and females begin to emerge around age

14 years, when the proportion of females experiencing first sex increases, reaching almost 10% by age 15 and accelerating steeply afterwards to 17% by age 19. For males, the proportion who had experienced sex increases much more gradually and reaches 8% by age 19, about half the proportion among females. As observed elsewhere, females experience first sex far earlier than males.²⁸

Relationship with first sexual partner and reasons for sex

The persons with whom young people had their first sexual experience and the reasons for initiating sex are given in Table 4.6. Among those who had ever had sex, 76% of females and 65% of males had their first sexual intercourse with a boyfriend and girlfriend, respectively. In addition, 26% of males but only 7% of females had their first sexual experience with a casual acquaintance. Seven percent of females and fewer than 1% of males had their first sex within marriage. Another 8% of females and 5% of males had first sexual intercourse with a live-in partner. That is, over 90% of females who ever had sex did so with persons with whom they had a close relationship. Among males who had ever had sex, almost three-quarters had their first sexual experience with someone with whom they had a close relationship and the rest were with casual acquaintances or others (excluding sex workers). Nearly 100% of the first sexual experiences reported by males and 93% reported by females were outside marriage.

The main reasons females gave for having their first sexual experience were that they “felt like it” (45%), because of marriage or upon marriage (12%), they held an expectation of money/gifts (12%), they were forced (11%) or their partner insisted (8%). While slightly more adolescents said they had sex for reasons of marriage than those who said their first sex partner was a spouse, this could be explained by some respondents classifying their first sex partner as a live-in partner or boyfriend (and thus not yet married) but the first sex was part of the marriage process. The last reason—“partner insisted”—in some cases may have involved some coercion, since sexual coercion (especially within marriage) is not likely to be reported as such. Among males, the main reasons were also that they “felt like it” (71%), they were influenced by friends (10%) or that their partner insisted (9%). Only 2% of males reported “force.” Gender differences in reasons for having first sexual experiences are worth noting, especially the proportion of females who experienced forced sex and possible coercion.

Characteristics of first sexual experience

Traditionally, males are expected to be older than their wives or sexual partners. Furthermore, males (and not females) are expected to initiate sex. An older woman marrying a younger man is generally not acceptable and is frowned upon. Age differences between adolescents and their first sexual partners are given in Table 4.7. Three in five 15–19-year-old females who were in a union had first sexual partners who were five or more years older, including 20% had partners who were 10 or more years older. In contrast, 38% of females not in a union had first sexual partners who were five or more years older, and another 37% had sexual partners who were 1–4 years older. Sixty-seven percent of males had first sex with partners of the same age or younger, compared with 4% of females. The wide age difference between married women and their partners has implications for spousal communication, including communication about sexual and reproductive health.

Recognizing that sexual intercourse can occur not only through mutual understanding, but also through coercion or force, young people who had had sex were asked to indicate their willingness to have sex at their sexual debut. Sixty-seven percent each of females in a union and males willingly agreed to have sexual intercourse at the time they first had it. Another 17% of females in a union and 20% of males were somewhat willing. Of females not in a union, 43% said they were very willing and 26% were somewhat willing to have sex for the first time. Nearly one in three females not in a union, 16% of those in a union and 13% of males said they were unwilling participants in their first sexual intercourse. The results point out that both married and unmarried young people experience coerced sex.

Available evidence suggests that first sexual encounters are rarely protected because they occur spontaneously in many cases. Among females aged 15–19 years, nearly 60% of those who were not in a union, 83% of those in a union and 68% of males the same age did not use any method to protect themselves against pregnancy or infection when they had sex for the first time. Among females aged 15–19 years who were not in a union and males, 28% and 26% used only the male condom, respectively (panel 3 of Table 4.7). Circumstances surrounding sexual debut still present challenges in terms of protection against pregnancy or infection, willingness to have sex (both within and outside formal unions), and the age differences between sexual partners.

Sexual Partners

The number of sexual partners one has within a given time period can be used to indicate exposure to HIV and other STIs. In addition, the type of relationship and age difference between partners, the duration of the relationship, exchange of money or gifts, and alcohol consumption at the time of intercourse constitute co-factors of risk of pregnancy and STIs. Table 4.8 indicates that 78% of females and 60% of males who had ever had sex reported only one lifetime sexual partner. Another 18% of females and 21% of males had two lifetime sexual partners and 4% of females and 19% of males had three or more lifetime partners. Within the 12 months prior to the survey, 29% of females and 35% of males who had ever had sex did not have sex, and 66% of females and 49% of males had only one sexual partner within the period. The percentage of adolescents who had three or more sexual partners in the 12 months prior to the survey was less than 1% for females and 4% for males. Overall, female adolescents who had ever had sex reported fewer sexual partners than males over their lifetime and within the 12 months prior to the survey, an observation that has been made in other studies in sexual networking and partnerships in West Africa.²⁹

Characteristics of last sexual relationship

Sixty-eighty percent of females and 71% of males who had had sex in the 12 months prior to the survey did so with a boyfriend or girlfriend; 8% of females not in a union and 24% of males had sex with a casual acquaintance (Table 4.9). All adolescent females in unions had sex with their husbands or live-in partners. The results indicate that while adolescent females predominantly reported that sexual intercourse occurred within stable relationships (i.e., husband, live-in partner or boyfriend), about one in four males had sexual intercourse in the last 12 months with a casual acquaintance, an activity that might put them at greater risk for STIs, given the possible heightened exposure to a wide network of sex partners.

Age difference with last sex partner

The pattern of age difference between female respondents and their last sex partners in the 12 months prior to the survey is similar to that described for the first sex partner (Table 4.7). Among females aged 15–19 who were in a union, 20% had partners who were 10 or more years older, and two-thirds of all females who had had sex in the 12 months prior to the survey were 1–9 years younger than their partners (Tables 4.7 and 4.9). About

17% of females did not know the age of their sex partner. As males grow older, more of them have sex with female partners who are their age or younger: Some 75% of males who had sex within the 12 months leading up to the survey had sex with either an age mate or a younger female, compared with 66% of males in this category with regard to their first sex partner.

Duration of relationship

Female adolescents, even those not in a union, tend to have longer-lasting relationships than males. For instance, among adolescents who had had sex in the 12 months prior to the survey, 28% of 15–19-year-old females not in a union, compared with 50% of 15–19-year-old males, had sex only once or were in a sexual relationship lasting three months or less with their last sex partner. Furthermore, 41% of the same group of females and 28% of males were in relationships lasting for 1–2 years, and another 15% of females and 8% of males were in relationships that lasted for two or more years (Table 4.9).

Gifts or money received for sex from last sex partner

Exchange theory has been used to explain the level of sexual networking among young people who are not in stable relationships. The argument is that some females enter into sexual relationships with the expectation of receiving money or gifts in exchange for sex. Among adolescents who had sex in the 12 months prior to the survey with a partner who was not a spouse or live-in partner, 73% of females and 28% of males reported that their last sex partner gave them gifts or money in exchange for sex (Table 4.9, panel 4). As shown further in Table 4.10, among adolescent who had had sex with someone other than a spouse or cohabiting partner, 73% of females and 33% of males said they received gifts or money from any of their sexual partners in the 12 months prior to the survey. The most common item received in exchange for sex was money (reported by 94% of females and 53% of males who had had sex with someone other than a spouse or cohabiting partner); other items reported were clothing (62% of females and 28% of males) and food (20% of females and 39% of males). Thus, money seems to underlie “transactional sex” among both female and male adolescents, and the practice is fairly widespread among females. Given that most female adolescents who had ever had sex but were not in a union were in sexual relationships with a boyfriend, and that those relationships tended to be of relatively long duration, the meaning of getting money in exchange for sex needs to be better under-

stood in terms of its impact on protective behaviors (such as using condoms in sexual encounters).

Alcohol use at last sex

Use of alcohol as a prelude to sex in the 12 months prior to the survey appears to be low among adolescents, especially among females. Ninety-two percent of females and 88% of males did not consume any alcohol at last sex (Table 4.9). The highest reported use of alcohol was 9% among the sex partners of males, as reported by males. This is an area that will need further studies, since more males reported that their female partners used alcohol in the 12-month period than female adolescents themselves reported having done.

Other Sexual Practices

While sexual intercourse remains one of the most important experiences to understand, given its direct link to unwanted pregnancy and the transmission of HIV and other STIs, several other sexual behaviors are linked to HIV and other STIs as well. Using anecdotal evidence, some have argued that young women use anal sex as a substitute for vaginal sexual intercourse in order to avoid the risk of pregnancy and/or to preserve their virginity. Questions about anal sex were considered to be especially sensitive in the survey and were asked only of one randomly chosen eligible adolescent per household if nobody older than age three was within listening distance. Three questions were asked about anal sex: whether respondents had ever heard of anal sex, whether they knew of any close friends who had experienced anal sex and whether they themselves had ever experienced anal sex. If the respondent had never heard of anal sex, she or he was not asked the two follow-up questions.

The survey evidence on anal sex indicates that awareness of the practice varies by age and sex (data not shown): Some 34% of females and 55% of males aged 12–19 had heard about anal sex. The percentages were higher among 15–19-year-olds of both sexes than among younger adolescents, and were higher among males than females. One in four 12–14-year-old females said they had heard of anal sex. Among those who had heard of it, 16% of both females and males said they knew close friends who had had anal sex and 2% of females and males said they themselves had ever had anal sex. In the 1998 Ghana Youth Reproductive Health Survey (GYRHS), 8% of 12–24-year-old males and 5% of 12–24-year-old females who had ever had sex had heard of anal sex.³⁰ Anal sex is rarely discussed when dealing with sex among young people and the re-

sults from both the National Survey of Adolescents and the GYRHS point to the existence of the practice. This is another area where future studies will be needed.

Sexual Abuse and Coercion

As observed from Tables 4.6 and 4.7, and from other recent evidence from Ghana and elsewhere, sexual coercion exists among both adolescents and adults. For young people in particular, sexual coercion has long lasting and profound negative sexual and reproductive health consequences.³¹ Due to the sensitivity of this topic, questions on sexual coercion were asked of one randomly selected eligible adolescent per household. Twenty-four percent of females and 19% of males said that they had ever been touched, kissed, grabbed or fondled in an unwanted sexual way, and twice as many older female and male adolescents than younger adolescents reported this (Table 4.11).

Sixteen percent of females and 7% of males aged 15–19 years reported that they had ever been physically forced, hurt or threatened into having sexual intercourse. Among females who had ever been coerced into sex, the majority of perpetrators were acquaintances (23%), friends (14%), strangers (14%) and boyfriends (11%). About one in five female adolescents reported parents, siblings or other family members—particularly uncles—as people who had ever physically forced, hurt or threatened them into having sexual intercourse. Two percent and 4% of females reported teachers and schoolmates, respectively. The results indicate that almost 80% of those who coerced female adolescents were known to the victim. However, in Ghana the concept of “stranger” does not necessarily imply a person who is not known to the victim; it can also refer to a person who may be living in the community but is not a native of the area. Among males who had ever been sexually coerced, the most common perpetrators were girlfriends (34%), friends (22%) and acquaintances (21%). Three percent reported coercion from a family member.

Policy and Program Implications

Issues associated with pubertal changes and sexual debut are important in the lives of young people. Traditionally, these events ushered children, especially females, into adulthood and were occasioned by elaborate ceremonies. The 2004 National Survey of Adolescents results indicate that these traditional ceremonies are no longer practiced as they used to be, creating a vacuum in the life of young people. The results also indicate that a number of females and males start sexual intercourse

early, some (most often females) within the context of coercion. The association of sexual intercourse, particularly among adolescent females, with gifts and money is also observed in the data. Early sexual experience without protection, commonly observed in the data, has implications for sexual and reproductive health programs and welfare of young people.

The results indicate that many adolescents, especially females, and including those who had never had sexual intercourse, were concerned more with avoiding pregnancy than HIV/AIDS and other STIs. Yet most programs emphasize avoiding STIs, including HIV/AIDS. The next generation of programs should respond to the concerns of the youth by emphasizing the use of condoms for dual protection and by providing slightly different emphases for females and males.

Encouragement is important for achieving positive reinforcement and/or behavioral change. With the erosion of traditional support systems for young people, it will be useful to develop structures that will support young people in making healthy sexual and reproductive health decisions.

The likelihood of having sexual intercourse for females increases steeply after age 14. Given this observation, it will be important for sex education to begin early in order to increase the proportion of females postponing first sex.

The observed age difference between married women and their partners is likely to have implications for spousal communication, including communication about sexual and reproductive health. The stability of intimate relationships is also important for building trust and faithfulness. It is therefore necessary for this to be stressed in advocacy programs.

That 16% of female 15-19-year-olds report experiencing sexual coercion, especially by teachers or schoolmates, is also an issue that will need to be addressed within the education system generally.

TABLE 4.1 Percentage distribution of adolescents, by experiences of and age at first menstruation or other pubertal changes, circumcision and initiation rites, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=955) | 15–19 (N=1237) | Total (N=2192) | 12–14 (N=977) | 15–19 (N=1258) | Total (N=2235) |
| Experienced menstruation/male puberty changes | | | | | | |
| No | 69.5 | 9.5 | 35.7 | 70.4 | 12.1 | 37.6 |
| Yes | 30.5 | 90.5 | 64.3 | 29.6 | 87.9 | 62.4 |
| Median age at first menstruation/male puberty changes | | | | | | |
| | N/A | N/A | 14.8 years | N/A | N/A | 15.1 years |
| Age first experienced menstruation/male puberty changes* | | | | | | |
| ≤10 | 1.7 | 1.2 | 1.3 | 4.2 | 1.4 | 2.0 |
| 11 | 6.5 | 1.5 | 2.6 | 4.9 | 0.5 | 1.4 |
| 12 | 27.8 | 10.3 | 13.9 | 28.1 | 8.9 | 12.9 |
| 13 | 47.4 | 17.7 | 23.8 | 38.2 | 13.3 | 18.5 |
| 14 | 13.7 | 26.9 | 24.2 | 16.7 | 24.1 | 22.6 |
| 15 | 0.0 | 24.7 | 19.6 | 0.0 | 28.1 | 22.3 |
| 16 | 0.0 | 10.8 | 8.6 | 0.0 | 11.6 | 9.2 |
| 17+ | 0.0 | 2.9 | 2.3 | 0.0 | 4.4 | 3.5 |
| Don't know | 2.7 | 4.0 | 3.8 | 8.0 | 7.7 | 7.8 |
| Experienced circumcision | | | | | | |
| No | 97.2 | 97.1 | 97.1 | 8.4 | 7.1 | 7.7 |
| Yes | 2.8 | 2.9 | 2.9 | 91.6 | 92.9 | 92.3 |
| Age experienced circumcision† | | | | | | |
| ≤1 | 74.1 | 83.8 | 79.7 | 86.8 | 86.2 | 86.5 |
| 2–5 | 3.7 | 2.7 | 3.1 | 4.3 | 3.6 | 3.9 |
| 6–11 | 7.4 | 8.1 | 7.8 | 1.8 | 2.1 | 2.0 |
| 12–14 | 11.1 | 0.0 | 4.7 | 0.2 | 1.0 | 0.7 |
| 15–19 | N/A | N/A | N/A | 0.0 | 1.0 | 0.6 |
| Don't know | 3.7 | 5.4 | 4.7 | 6.9 | 6.0 | 6.4 |
| Experienced initiation rites | | | | | | |
| Yes | 2.7 | 6.7 | 5.0 | 3.0 | 4.1 | 3.6 |
| No | 91.0 | 88.7 | 89.7 | 89.4 | 91.7 | 90.7 |
| Don't know | 6.3 | 4.6 | 5.3 | 7.6 | 4.2 | 5.7 |
| Age first experienced initiation rites‡ | | | | | | |
| ≤10 | [7.7] | 3.8 | 4.8 | [24.0] | [6.7] | 12.9 |
| 11 | [0.0] | 0.0 | 0.0 | [24.0] | [8.9] | 14.3 |
| 12 | [46.2] | 11.5 | 20.2 | [20.0] | [4.4] | 10.0 |
| 13 | [15.4] | 15.4 | 15.4 | [20.0] | [2.2] | 8.6 |
| 14 | [11.5] | 19.2 | 17.3 | [12.0] | [24.4] | 20.0 |
| 15 | [0.0] | 15.4 | 11.5 | [0.0] | [22.2] | 14.3 |
| 16 | [0.0] | 11.5 | 8.7 | [0.0] | [6.7] | 4.3 |
| 17+ | [0.0] | 14.1 | 10.6 | [0.0] | [17.8] | 11.4 |
| Don't know | [19.2] | 9.0 | 11.5 | [0.0] | [6.7] | 4.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who have experienced the event. Sample sizes: females 12–14 (N=291); females 15–19 (N=1119); males 12–14 (N=288); males 15–19 (N=1104). †Limited to those who have been circumcised. Sample sizes: males 12–14 (N=887); males 15–19 (N=1167). ‡Limited to those who have experienced initiation rite. Sample sizes: females 12–14 (N=26); females 15–19 (N=78); males 12–14 (N=25); males 15–19 (N=45). Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.2 Percentage distribution of adolescents, by relationship status and sexual activity, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1223) | Total (N=2180) | 12–14 (N=977) | 15–19 (N=1248) | Total (N=2225) |
| Ever had sexual intercourse | | | | | | |
| No | 98.3 | 70.3 | 82.6 | 98.7 | 84.5 | 90.7 |
| Yes | 1.7 | 29.7 | 17.4 | 1.3 | 15.5 | 9.3 |
| Relationship status | | | | | | |
| Ever in union | 0.0 | 9.2 | 5.2 | 0.0 | 1.4 | 0.8 |
| Never in union, ever had sex | 1.7 | 20.5 | 12.3 | 1.3 | 14.1 | 8.5 |
| Never in union, never had sex: | | | | | | |
| Ever had a boyfriend/girlfriend | 1.6 | 6.6 | 4.4 | 1.0 | 6.1 | 3.9 |
| Never had a boyfriend/girlfriend | 96.8 | 63.6 | 78.1 | 97.6 | 78.3 | 86.8 |
| Sexual activity* | | | | | | |
| Kissing: | | | | | | |
| Heard of it | 76.7 | N/A | 76.7 | 71.6 | N/A | 71.5 |
| Know close friends who have done it† | 22.6 | N/A | 22.7 | 23.8 | N/A | 23.7 |
| Have done it† | 4.1 | N/A | 4.1 | 3.9 | N/A | 3.9 |
| Fondling: | | | | | | |
| Heard of it | 66.1 | N/A | 66.1 | 55.4 | N/A | 55.4 |
| Know close friends who have done it† | 33.0 | N/A | 32.9 | 31.6 | N/A | 31.8 |
| Have done it† | 7.1 | N/A | 7.0 | 8.3 | N/A | 8.3 |
| Sexual intercourse: | | | | | | |
| Heard of it | 83.4 | N/A | 83.4 | 82.4 | N/A | 82.3 |
| Know close friends who have done it† | 25.9 | N/A | 25.8 | 24.7 | N/A | 24.7 |
| Have done it† | 2.0 | N/A | 2.0 | 1.6 | N/A | 1.6 |
| Relationship status and sexual activity among 12–14-year-olds | | | | | | |
| Ever had sex | 1.7 | N/A | 1.7 | 1.3 | N/A | 1.3 |
| Never had sex, but had boyfriend/girlfriend | 1.6 | N/A | 1.6 | 1.0 | N/A | 1.0 |
| Never had sex and never had boyfriend/girlfriend, but have (been) kissed or fondled | 4.6 | N/A | 4.6 | 5.1 | N/A | 5.1 |
| Never had sex, never had boyfriend/girlfriend, never (been) kissed or fondled | 92.2 | N/A | 92.2 | 92.5 | N/A | 92.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Only unmarried 12–14-year-olds were asked these sexual activity questions. Sample size is (N=1913). †Limited to those who have heard of the specific sexual activity. Notes: Ns are weighted.

TABLE 4.3 Percentage distribution of adolescents who never had sexual intercourse, by reasons for never having had sexual intercourse and encouragement received, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=775) | 15–19 (N=859) | Total (N=1634) | 12–14 (N=789) | 15–19 (N=1052) | Total (N=1841) |
| Reasons for never having had sexual intercourse* | | | | | | |
| Don't have a partner | 3.5 | 5.8 | 4.7 | 3.5 | 5.7 | 4.8 |
| Wait until marriage | 35.9 | 43.3 | 39.8 | 23.8 | 27.4 | 25.9 |
| Afraid to get pregnant/make someone pregnant | 38.4 | 45.2 | 42.0 | 24.8 | 38.0 | 32.4 |
| Avoid STIs/AIDS | 15.1 | 20.1 | 17.7 | 24.5 | 33.7 | 29.7 |
| Too young | 20.5 | 12.0 | 16.0 | 33.5 | 21.2 | 26.5 |
| Schooling reasons | 8.4 | 5.8 | 7.0 | 4.4 | 6.9 | 5.9 |
| Religious reasons | 0.6 | 3.0 | 1.9 | 2.3 | 4.6 | 3.6 |
| Because of parents | 0.9 | 1.0 | 1.0 | 0.6 | 1.0 | 0.8 |
| Not interested | 0.3 | 1.2 | 0.7 | 1.3 | 1.2 | 1.2 |
| No reason | 2.3 | 0.7 | 1.5 | 1.3 | 0.5 | 0.8 |
| Sex is bad/feel ashamed | 0.8 | 0.8 | 0.8 | 2.9 | 1.0 | 1.8 |
| Other | 4.3 | 7.2 | 5.8 | 5.3 | 8.3 | 7.0 |
| Don't know | 6.1 | 3.6 | 4.8 | 8.5 | 4.1 | 6.0 |
| Receive any encouragement from others not to have sexual intercourse | | | | | | |
| A great deal | 31.3 | 34.6 | 33.0 | 23.4 | 27.6 | 25.8 |
| A little | 15.9 | 15.6 | 15.7 | 13.8 | 18.5 | 16.5 |
| None | 52.3 | 48.1 | 50.1 | 61.8 | 53.3 | 56.9 |
| Don't know | 0.5 | 1.7 | 1.2 | 1.0 | 0.6 | 0.8 |
| From whom receive encouragement* † | | | | | | |
| Girlfriend/boyfriend | 3.3 | 2.1 | 2.6 | 0.7 | 1.7 | 1.3 |
| Mother | 69.9 | 59.1 | 64.1 | 52.9 | 47.3 | 49.4 |
| Father | 31.1 | 28.0 | 29.4 | 46.0 | 39.0 | 41.7 |
| Brother | 8.7 | 9.8 | 9.3 | 11.0 | 12.5 | 11.9 |
| Sister | 18.6 | 18.7 | 18.6 | 5.8 | 6.4 | 6.2 |
| Other female family member | 27.2 | 21.5 | 24.2 | 10.0 | 9.1 | 9.4 |
| Other male family member | 7.1 | 8.9 | 8.1 | 5.5 | 5.8 | 5.7 |
| Female friends | 21.0 | 29.9 | 25.8 | 2.4 | 8.5 | 6.2 |
| Male friends | 6.0 | 14.3 | 10.4 | 25.1 | 40.5 | 34.7 |
| Teacher | 30.3 | 25.2 | 27.6 | 27.2 | 17.4 | 21.1 |
| Church/mosque | 15.6 | 17.3 | 16.5 | 10.3 | 10.8 | 10.6 |
| Other | 4.9 | 10.3 | 7.8 | 4.1 | 4.6 | 4.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. †Limited to those who receive any encouragement from others not to have sexual intercourse. Sample sizes: females 12–14 (N=367); females 15–19 (N=428); males 12–14 (N=291); males 15–19 (N=482) Notes: Ns are weighted.

TABLE 4.4 Percentage distribution of adolescents, by sexual activity status and reasons for not having had sex in the last 12 months, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1223) | Total (N=2180) | 12–14 (N=977) | 15–19 (N=1249) | Total (N=2226) |
| Sexual activity status | | | | | | |
| Never had sex | 98.3 | 70.3 | 82.6 | 98.7 | 84.5 | 90.7 |
| Ever had sex, no sex in last 12 months | 0.8 | 8.2 | 5.0 | 0.6 | 5.3 | 3.2 |
| Had sex in last 12 months, not in last 3 months | 0.1 | 6.9 | 3.9 | 0.1 | 3.0 | 1.7 |
| Had sex in last 3 months | 0.7 | 14.6 | 8.5 | 0.6 | 7.3 | 4.4 |
| Reasons for not having had sex in last 12 months* | | | | | | |
| Don't have a partner | -- | 5.2 | 4.8 | -- | 93.8 | 90.1 |
| Wait until marriage | -- | 24.2 | 23.5 | -- | 13.8 | 12.7 |
| Afraid to get pregnant/make someone pregnant | -- | 49.0 | 48.5 | -- | 50.8 | 46.5 |
| Avoid STIs/AIDS | -- | 12.6 | 12.7 | -- | 47.7 | 45.1 |
| Too young | -- | 3.1 | 2.9 | -- | 1.5 | 1.4 |
| Schooling reasons | -- | 3.2 | 2.9 | -- | 4.6 | 4.2 |
| Religious reasons | -- | 2.1 | 2.9 | -- | 9.2 | 8.5 |
| Because of parents | -- | 2.1 | 1.9 | -- | 1.5 | 2.8 |
| Not interested | -- | 1.0 | 1.0 | -- | 0.0 | 0.0 |
| No reason | -- | 1.0 | 1.9 | -- | 0.0 | 0.0 |
| Sex is bad/feel ashamed | -- | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Other | -- | 24.2 | 24.3 | -- | 26.2 | 25.4 |
| Don't know | -- | 3.2 | 4.9 | -- | 1.5 | 2.8 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. Limited to those who ever had sex but not in the last 12 months. Sample sizes: females 12–14 (N=8); females 15–19 (N=96); males 12–14 (N=6); males 15–19 (N=65). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.5 Percentage distribution of adolescents, by attitudes about sexual activity, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1236) | Total (N=2193) | 12–14 (N=976) | 15–19 (N=1259) | Total (N=2235) |
| Young women should remain virgins until they marry | | | | | | |
| Agree | 92.8 | 92.0 | 92.3 | 95.0 | 92.8 | 93.7 |
| Disagree | 4.3 | 6.0 | 5.2 | 3.0 | 6.1 | 4.7 |
| Don't know | 2.9 | 2.0 | 2.4 | 2.0 | 1.1 | 1.5 |
| Young men should remain virgins until they marry | | | | | | |
| Agree | 90.8 | 88.4 | 89.5 | 94.0 | 92.6 | 93.2 |
| Disagree | 5.7 | 8.9 | 7.5 | 3.8 | 6.2 | 5.1 |
| Don't know | 3.4 | 2.7 | 3.0 | 2.3 | 1.2 | 1.7 |
| Usually people do not plan to have sex, it just happens | | | | | | |
| Agree | 29.9 | 38.9 | 35.0 | 28.5 | 41.2 | 35.6 |
| Disagree | 31.7 | 42.7 | 37.9 | 36.2 | 41.9 | 39.4 |
| Don't know | 38.3 | 18.4 | 27.1 | 35.3 | 16.9 | 25.0 |
| Young women should remain virgins until they marry* | | | | | | |
| Agree | -- | 86.2 | 86.5 | -- | 82.5 | 83.6 |
| Disagree | -- | 12.7 | 12.4 | -- | 17.0 | 15.9 |
| Don't know | -- | 1.1 | 1.1 | -- | 0.5 | 0.5 |
| Young men should remain virgins until they marry* | | | | | | |
| Agree | -- | 81.8 | 82.3 | -- | 83.4 | 84.5 |
| Disagree | -- | 17.1 | 16.6 | -- | 16.6 | 15.5 |
| Don't know | -- | 1.1 | 1.1 | -- | 0.0 | 0.0 |
| Usually people do not plan to have sex, it just happens* | | | | | | |
| Agree | -- | 44.1 | 44.4 | -- | 53.9 | 53.2 |
| Disagree | -- | 49.0 | 48.7 | -- | 41.5 | 41.0 |
| Don't know | -- | 6.9 | 6.9 | -- | 4.7 | 5.9 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who ever had sex. Sample sizes: females 12–14 (N=16); females 15–19 (N=362); males 12–14 (N=13); males 15–19 (N=194). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.6 Percentage distribution of adolescents who ever had sexual intercourse, by relationship with first sex partner and main reason for having sex, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|-----------------|------------------|------------------|-----------------|------------------|------------------|
| | 12–14 (N=16) | 15–19 (N=363) | Total (N=379) | 12–14 (N=12) | 15–19 (N=194) | Total (N=206) |
| Relationship with first sex partner at time of first sex | | | | | | |
| Spouse | -- | 7.2 | 6.9 | -- | 0.5 | 0.5 |
| Live-in partner | -- | 8.3 | 8.4 | -- | 5.2 | 4.9 |
| Boyfriend/girlfriend | -- | 76.3 | 75.5 | -- | 67.0 | 65.0 |
| Casual acquaintance | -- | 6.6 | 7.1 | -- | 24.7 | 26.2 |
| Commercial sex worker | -- | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Other | -- | 1.7 | 2.1 | -- | 2.6 | 3.4 |
| Main reason for sex with first partner | | | | | | |
| Married/upon marriage | -- | 12.1 | 11.6 | -- | 1.0 | 1.0 |
| Felt like it | -- | 44.8 | 44.7 | -- | 71.9 | 70.7 |
| Partner insisted | -- | 8.2 | 8.2 | -- | 7.8 | 8.8 |
| Influence from friends | -- | 2.5 | 2.6 | -- | 9.4 | 9.8 |
| Expectation of gifts/money | -- | 12.1 | 12.4 | -- | 0.0 | 0.0 |
| Wanted to get pregnant | -- | 1.4 | 1.3 | -- | N/A | N/A |
| Was forced | -- | 10.7 | 11.3 | -- | 1.6 | 2.0 |
| Other | -- | 3.0 | 2.9 | -- | 6.8 | 6.3 |
| Don't know | -- | 5.2 | 5.0 | -- | 1.6 | 1.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.7 Percentage distribution of adolescents who ever had sexual intercourse, by characteristics of first sex, according to sex, age and union status, 2004 National Survey of Adolescents

| Characteristic | Female | | | Total (N=376) | Male | | |
|---|-----------------|----------------------------------|-----------------------------|------------------|-----------------|------------------|------------------|
| | 12-14 (N=16) | 15-19 Not in union (N=305) | 15-19 In union (N=55) | | 12-14 (N=11) | 15-19 (N=190) | Total (N=201) |
| Age difference with first sex partner | | | | | | | |
| Partner is 10+ years older | -- | 9.5 | 20.0 | 10.9 | -- | 1.1 | 1.5 |
| Partner is 1-4 years older | -- | 37.4 | 18.2 | 35.6 | -- | 20.5 | 21.4 |
| Partner is 5-9 years older | -- | 28.5 | 45.5 | 29.8 | -- | 1.6 | 3.5 |
| Partner is older, don't know specific age | -- | 1.0 | 0.0 | 1.9 | -- | 2.6 | 2.5 |
| Partner is same age or younger | -- | 4.3 | 1.8 | 3.7 | -- | 70.0 | 67.2 |
| Don't know | -- | 19.3 | 14.5 | 18.1 | -- | 4.2 | 4.0 |
| Respondent's willingness to have first sex | | | | | | | |
| Very willing | -- | 43.3 | 67.2 | 46.9 | -- | 67.4 | 67.0 |
| Somewhat willing | -- | 26.0 | 17.2 | 23.1 | -- | 20.7 | 20.4 |
| Not willing at all | -- | 30.8 | 15.5 | 30.0 | -- | 11.9 | 12.6 |
| Methods used at first sex | | | | | | | |
| Condom only | -- | 27.9 | 12.1 | 24.7 | -- | 28.0 | 26.2 |
| Condom and other method | -- | 4.3 | 0.0 | 3.5 | -- | 1.6 | 1.5 |
| Other method only | -- | 8.5 | 5.2 | 8.6 | -- | 4.1 | 3.9 |
| No method | -- | 59.3 | 82.8 | 63.2 | -- | 66.3 | 68.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.8 Percentage distribution of adolescents who ever had sexual intercourse, by the number of lifetime and recent sex partners, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|-----------------|------------------|------------------|-----------------|------------------|------------------|
| | 12–14 (N=16) | 15–19 (N=363) | Total (N=379) | 12–14 (N=12) | 15–19 (N=196) | Total (N=208) |
| Number of lifetime sex partners | | | | | | |
| 1 | -- | 77.4 | 77.6 | -- | 59.7 | 60.1 |
| 2 | -- | 18.2 | 18.2 | -- | 22.4 | 21.2 |
| 3 | -- | 2.8 | 2.6 | -- | 7.1 | 7.7 |
| 4+ | -- | 1.7 | 1.6 | -- | 10.7 | 11.1 |
| Number of sex partners in last 12 months | | | | | | |
| 0 | -- | 27.6 | 28.5 | -- | 34.2 | 35.0 |
| 1 | -- | 67.1 | 65.7 | -- | 48.7 | 49.0 |
| 2 | -- | 5.0 | 5.5 | -- | 12.4 | 11.7 |
| 3 | -- | 0.3 | 0.3 | -- | 4.1 | 3.9 |
| 4+ | -- | 0.0 | 0.0 | -- | 0.5 | 0.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.9 Percentage distributions of adolescents who had sexual intercourse in the last 12 months, by characteristics of last sex partner, according to sex, age and union status, 2004 National Survey of Adolescents

| Characteristic | Females | | | | Males | | |
|---|----------------|----------------------------------|-----------------------------|------------------|----------------|------------------|------------------|
| | 12-14 (N=9) | 15-19 Not in union (N=191) | 15-19 In union (N=62) | Total (N=262) | 12-14 (N=7) | 15-19 (N=129) | Total (N=136) |
| Relationship to last sex partner in last 12 months | | | | | | | |
| Spouse | -- | 0.0 | 56.5 | 13.4 | -- | 0.8 | 0.7 |
| Live-in partner | -- | 0.0 | 43.5 | 10.3 | -- | 5.4 | 5.1 |
| Boyfriend/girlfriend | -- | 88.5 | 0.0 | 67.6 | -- | 71.3 | 70.6 |
| Casual acquaintance | -- | 7.9 | 0.0 | 6.1 | -- | 22.5 | 23.5 |
| Commercial sex worker | -- | 0.0 | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Other | -- | 3.7 | 0.0 | 2.7 | -- | 0.0 | 0.0 |
| Age difference with last sex partner in last 12 months | | | | | | | |
| Partner is 10+ years older | -- | 6.9 | 19.7 | 9.9 | -- | 0.8 | 0.7 |
| Partner is 1-4 years older | -- | 36.0 | 24.6 | 34.1 | -- | 13.1 | 14.6 |
| Partner is 5-9 years older | -- | 30.2 | 41.0 | 32.6 | -- | 0.0 | 2.2 |
| Partner is older, don't know specific age | -- | 1.6 | 0.0 | 1.5 | -- | 1.5 | 1.5 |
| Partner is same age or younger | -- | 6.9 | 0.0 | 4.8 | -- | 77.7 | 74.5 |
| Don't know | -- | 18.5 | 14.8 | 17.2 | -- | 6.9 | 6.6 |
| Duration of relationship (months) | | | | | | | |
| Had sex one time only | -- | 14.3 | 0.0 | 10.9 | -- | 19.8 | 18.8 |
| 3 months or less | -- | 13.2 | 8.3 | 13.2 | -- | 30.5 | 33.3 |
| 4-11 months | -- | 16.4 | 26.7 | 18.2 | -- | 13.0 | 12.3 |
| 1 year | -- | 19.0 | 21.7 | 20.2 | -- | 16.8 | 15.9 |
| 2 years | -- | 21.7 | 15.0 | 19.8 | -- | 11.5 | 11.6 |
| More than 2 years | -- | 15.3 | 28.3 | 17.8 | -- | 8.4 | 8.0 |
| Gifts or money received for sex from last sex partner in last 12 months* | | | | | | | |
| Received gifts or money | -- | 72.7 | -- | 72.8 | -- | 28.7 | 27.8 |
| No gifts or money | -- | 27.3 | -- | 27.2 | -- | 71.3 | 72.2 |
| Alcohol use at last sex in last 12 months† | | | | | | | |
| Respondent drank alcohol at last sex | -- | 0.6 | 0.0 | 0.4 | -- | 2.6 | 2.5 |
| Partner drank alcohol at last sex | -- | 5.9 | 4.8 | 5.9 | -- | 7.0 | 9.1 |
| Both respondent and partner drank alcohol at last sex | -- | 0.6 | 1.6 | 2.1 | -- | 0.9 | 0.8 |
| No alcohol at last sex | -- | 92.9 | 93.5 | 91.6 | -- | 89.5 | 87.6 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Question not asked if most recent partner was the first sex partner ever and had sex only one time or if partner was a spouse or cohabiting partner. Sample sizes: all females 12-14 (N=7); females 15-19 not in union (N=150); females 15-19 in union (N=0); males 12-14 (N=7); males 15-19 (N=101). †Question not asked if most recent partner was the first sex partner ever and had sex only 1 time. Sample sizes are: female, 12-14 (N=8); females 15-19 not in union (N=169); females 15-19 in union (N=62); males 12-14 (N=7); males 15-19 (N=114). Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 4.10 Percentage distribution of adolescents who had sexual intercourse with partners who were not spouses or cohabiting partners in the last 12 months, by experiences of sex in exchange for money or other items, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Females | Males |
|--|------------------|------------------|
| | 12–19 (N=160) | 12–19 (N=109) |
| Money or other items received in exchange for sex with any partner in last 12 months* | | |
| No gifts or money | 26.9 | 67.0 |
| Received gifts or money | 73.1 | 33.0 |
| Money or other items received in exchange for sex† | | |
| Money | 94.0 | [52.8] |
| Food | 20.3 | [38.9] |
| School fees | 6.8 | [0.0] |
| Drugs (including glue) | 5.1 | [0.0] |
| Alcohol | 0.0 | [0.0] |
| Shelter/rent | 0.8 | [0.0] |
| Clothes | 61.9 | [27.8] |
| Transport | 1.7 | [0.0] |
| Jewelry/cosmetics | 16.2 | [2.8] |
| Entertainment (e.g., video games) | 2.6 | [0.0] |
| Other | 5.1 | [17.1] |
| Total | 100.0 | 100.0 |

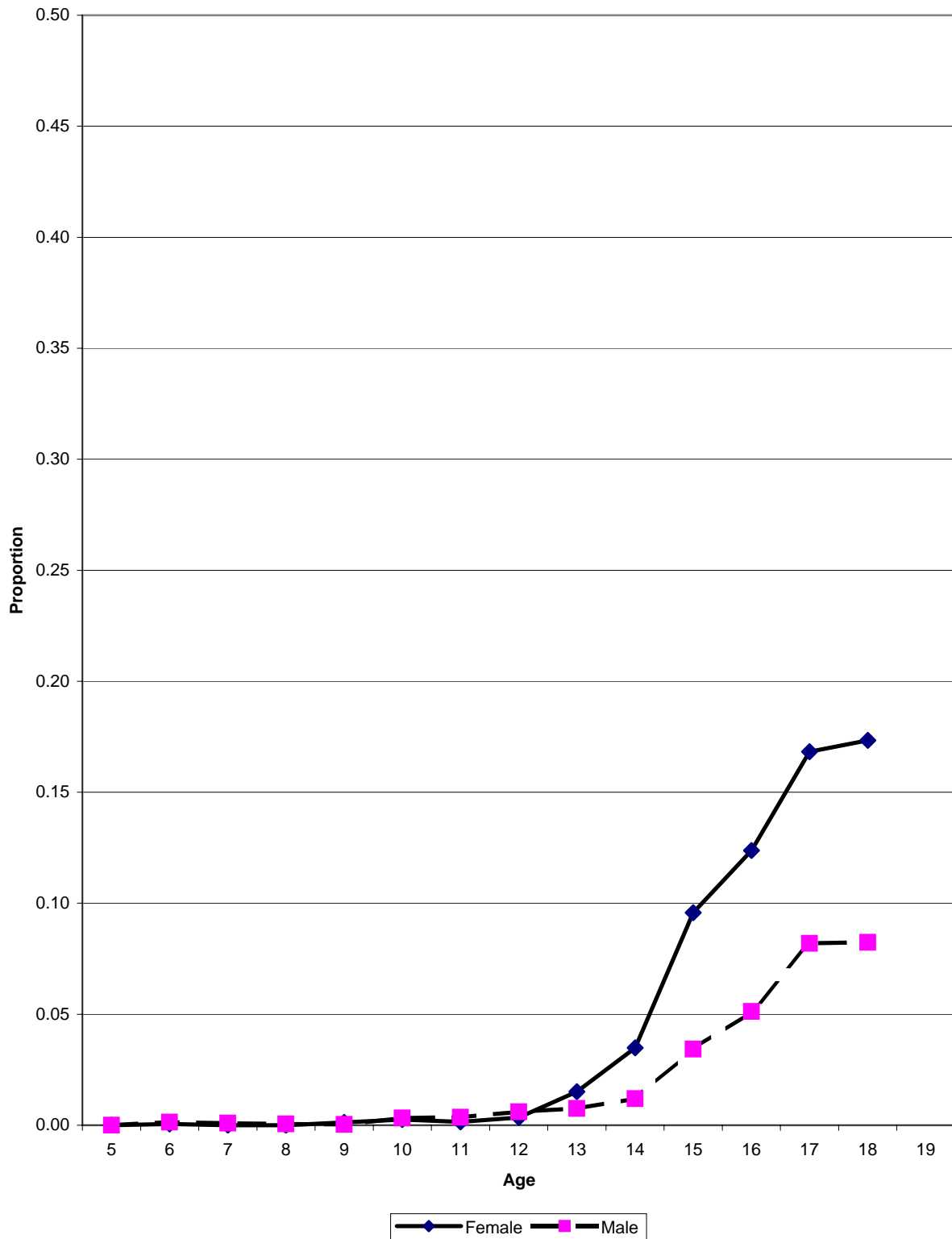
*Question not asked if most recent partner was the first sex partner ever and had sex only one time, or if partner was a spouse or cohabiting partner. †Totals may exceed 100 because multiple responses are possible. Question asked only of those who received something in exchange for sex and responses are for up to three recent partners in the last 12 months. Sample sizes: females 12–19 (N=117); males 12–19 (N=36). Notes: Ns are weighted. [] = N is 25–49.

TABLE 4.11 Percentage distribution of adolescents, by experiences of sexual abuse and coercion, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|------------------|-------------------|------------------|------------------|-------------------|
| | 12–14 (N=583) | 15–19 (N=769) | Total (N=1352) | 12–14 (N=589) | 15–19 (N=756) | Total (N=1345) |
| Ever been touched, kissed, grabbed or fondled in an unwanted sexual way* | | | | | | |
| Yes | 13.0 | 32.4 | 24.0 | 10.7 | 24.7 | 18.6 |
| No | 86.6 | 66.7 | 75.3 | 88.3 | 75.0 | 80.8 |
| Refused to answer | 0.2 | 0.0 | 0.1 | 0.5 | 0.1 | 0.3 |
| Don't know | 0.2 | 0.0 | 0.1 | 0.2 | 0.1 | 0.1 |
| Missing | 0.0 | 0.9 | 0.5 | 0.3 | 0.0 | 0.1 |
| Ever been physically forced, hurt or threatened into having sexual intercourse* | | | | | | |
| Yes | 6.2 | 16.3 | 11.9 | 2.5 | 7.1 | 5.1 |
| No | 93.8 | 83.7 | 88.1 | 97.1 | 92.6 | 94.6 |
| Refused to answer | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 | 0.1 |
| Don't know | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Missing | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.1 |
| Relationship of person(s) to respondent, among those forced into having sex† | | | | | | |
| Spouse or live-in partner | [0.0] | 1.6 | 1.3 | -- | 1.9 | 1.5 |
| Boyfriend/girlfriend | [0.0] | 13.6 | 10.6 | -- | 28.8 | 34.3 |
| Friend | [2.8] | 17.6 | 14.3 | -- | 26.9 | 22.4 |
| Parent | [0.0] | 2.4 | 1.9 | -- | 0.0 | 0.0 |
| Sibling | [5.4] | 0.8 | 1.9 | -- | 0.0 | 0.0 |
| Uncle/aunt | [13.5] | 8.0 | 9.3 | -- | 0.0 | 0.0 |
| Other family | [5.6] | 8.8 | 8.1 | -- | 3.8 | 3.0 |
| Schoolmate | [24.3] | 4.8 | 9.3 | -- | 7.5 | 8.8 |
| Acquaintance | [8.3] | 27.4 | 23.1 | -- | 21.2 | 20.9 |
| Teacher | [0.0] | 1.6 | 1.2 | -- | 0.0 | 0.0 |
| Stranger | [19.4] | 12.9 | 14.4 | -- | 5.8 | 4.5 |
| Neighbor | [5.6] | 4.8 | 5.0 | -- | 3.8 | 4.5 |
| Other | [16.2] | 4.8 | 7.4 | -- | 1.9 | 2.9 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Questions asked of only one eligible adolescent per household and only if no one over the age of three was present or within hearing range. †Multiple responses possible and sample limited to those who said they had ever been forced into having sexual intercourse. Sample sizes: females 12–14 (N=36); females 15–19 (N=124); males 12–14 (N=15); males 15–19 (N=52). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

Chart 4.1 Proportion of adolescents who have had their first sexual experience (life table estimates), by age and gender, 2004 National Adolescent Survey



Chapter 5

Contraception

Knowledge and awareness constitute the first phase of the Steps to Behavioral Change Model³² and are therefore an essential stage in the process of deciding whether to use a contraceptive method. This chapter describes the knowledge and use of contraceptive methods by young people and the contraceptive used at last sex. In addition, current contraceptive use and recent use are discussed with regard to those adolescents who have ever had sex and those who had sex within the 12 months prior to the survey. Results on sources of contraceptive information and services are presented in Chapter 9.

Knowledge of Contraceptive Methods

Respondents were asked to name all the methods they had heard of that a male or female could use to delay or avoid a pregnancy. For methods not mentioned, the interviewer then described the method and asked directly if the respondent had heard of it. This approach was adopted so that information obtained could be comparable to that obtained in Demographic and Health Surveys implemented in Ghana. Table 5.1 shows the proportion of adolescents who know any method, the proportion who knew each contraceptive method (including the male and female condom) and the average number of methods known.

More than 90% of adolescents had heard of at least one modern contraceptive method. Knowledge about contraceptives varied by age: Among adolescents aged 12–14 years, 84–85% had heard of contraceptive methods, compared with 95–97% of those aged 15–19. While over 90% of adolescents had heard of modern methods, about one-third (31% of females and 36% of males) reported knowing any traditional contraceptive methods.

On average, 12–14-year-olds had heard of three modern contraceptive methods, while 15–19-year-olds knew of five. The modern methods commonly known are the male condom (88% of females and 91% of males), the female condom (70% of females and 73%

of males), the pill (53% of females and 53% of males) and the injectable (57% females and 56% males). The high level of awareness of the female condom is partly due to nationwide promotional campaigns.³³ The level of knowledge about the female condom observed here is similar to that found for all adults in Ghana.³⁴ About one in five adolescents were aware of emergency contraception (gender differences were not great but the percentage more than doubled between the 12–14 and 15–19 age-groups).

About one in three female and male older adolescents reported knowing traditional methods such as rhythm/periodic abstinence and withdrawal. Abstinence as a specific method to avoid pregnancy was spontaneously mentioned by fewer than 1% of respondents. It must be pointed out that this method was not directly asked about in the interview—separate from rhythm or periodic abstinence—compared to the other methods.

Knowledge of the Fertile Period and the Withdrawal Method

Tables 5.2 and 5.3 show knowledge of the fertile period and withdrawal among adolescents who had ever had sex. While 92–94% of females and males who had ever used rhythm knew that there are certain days when a woman was more likely to get pregnant, only 28% of the 51 female adolescents who had used the rhythm method could identify the high-risk time correctly. There were very few cases of males who had used the rhythm method and, therefore, the frequency distribution is not shown. Among those who had ever used the withdrawal method, only 14% of females and 21% of males were aware that there was some risk of pregnancy with the use of the method (Table 5.3).

Attitudes About the Impact of Contraception on Sexual Behavior

One of the arguments against making contraceptive method information available to young adolescents is

that providing such information to adolescents will encourage them to have sex. In the survey, adolescents who had ever heard of any contraceptive methods were asked whether they thought that making family planning methods available to young people would encourage them to have sexual intercourse. Sixty-three percent of females and 54% of males did not think that having family planning methods available would encourage young people to have sex (data not shown). Differences were very small between age groups. About one in three adolescents thought that making methods available would encourage sex and about one in ten were unsure. That one-third of adolescents who knew of a method had the view that contraceptive access can encourage young people to have sex is an issue that will need to be addressed.

Ever-Use of Contraceptive Methods

Respondents who had ever had sex were asked to indicate any contraceptive method that they had ever used either to prevent pregnancy, STIs (including HIV) or both. Information on the use of methods was derived from questions about ever-use and current use of contraceptive methods and separate questions about methods used per partner for up to three sex partners in the 12 months prior to the survey. The results are indicated in Table 5.4.

More than half of adolescents who had ever had sex (59% of females and 53% of males) had ever used a contraceptive method. Among all adolescents who ever used a method, 45% of females and 47% of males said they had used the male condom. Other commonly used methods were withdrawal (11% of females and 14% of males), rhythm (13% of females and 12% of males) and the pill (11% of females and 6% of males). There is a pattern of slightly higher reports of female-initiated methods (pill, female condom) by females and male-initiated methods (male condom, withdrawal) by males.

Current Contraceptive Use

Table 5.5 shows current use of contraceptives among adolescents who had sexual intercourse in the three months prior to the survey. Current use was defined as having used a method with any sexual partner in the three months prior to the survey to prevent pregnancy, STIs or both. Multiple responses were possible for the general categories of “modern” and “traditional” methods, and the frequency distributions for current use of specific methods rank more effective methods (e.g., pill and injectables) over less effective methods (e.g.,

withdrawal) if two or more methods were reported.

Among adolescents who had ever had sex, 51% of females and 64% of males used contraceptive methods within the three months prior to the survey. Forty-seven percent of females and 60% of males reportedly used modern methods, compared with only 4% of females and 8% of males who reported traditional methods. As in the case of ever-use of methods, the male condom constituted the most widely used contraceptive method among those who had ever had sex: Thirty-four percent of females and 50% of males were currently using a male condom. The male condom was reported more by female adolescents not in a union (40%) than those in a union (16%). Other methods that were reported were the pill (9% of females not in a union, 14% of females in a union and 7% of males), and injectables and rhythm, each used by 4% or fewer.

Contraceptive Use and Relationship Characteristics

The study also sought to find out the types of relationships within which contraceptive methods were used at the last sexual intercourse. Contraceptives were used more commonly among female adolescents with boyfriends (53%) than those with husbands (14%) or live-in partners (26%) (Table 5.6). Among male adolescents, approximately 50% used contraceptives with girlfriends and 51% with casual acquaintances.

The results do not show any clear pattern in contraceptive use by duration of the intimate relationship with the last sex partner. For example, 59% of the females and 52% of the males who had sex only once used a contraceptive method at that time. Among those who had sex with a partner they had known for three months or less, 44% of females and 47% of males used contraceptives the last time they had sex. Among females, the proportion using contraceptives does not always decrease as the duration of relationship increases. There were few cases of long duration relationships among males and, therefore, the frequency distributions are not shown.

There appears to be a positive association between communication about contraceptive methods and contraceptive use among adolescents who have ever had sex, especially females. Among adolescents who talked with their last sex partner about contraceptive methods, 60% of females and 59% of males used a method at last sex, compared with 27% of females and 45% of males who did not talk about methods with their partner.

Table 5.7 provides information about which partner proposed that a male condom should be used at the last time a condom was used. Forty-one percent of females

and 65% of males reported that they themselves suggested a male condom should be used the last time one was used. About one in four females who used the male condom indicated that their partner suggested it should be used, compared with 11% of males who said their partner suggested the use of a male condom. About one in five females and one in ten males said the decision to use a male condom was jointly made.

Seventy-two percent of females and 45% of males who used condoms reported that the condom was used to prevent pregnancy alone. Another 38% of males and 5% of females used a condom for protection against STIs, including HIV/AIDS. About one in six condom users said they used a condom for dual prevention against pregnancy and STIs. Thus, male condom users were equally occupied with prevention of pregnancy and STIs, while females were more concerned with pregnancy prevention.

Policy and Program Implications

More than 90% of adolescents had heard of at least one contraceptive method—mainly the male condom—and, even among 12–14-year-olds, four in five knew of a method. However, knowledge about emergency contraception (an important back-up method for adolescents to have on hand in case of unprotected sex) is not widespread, indicating that both the method and information about it need to be disseminated more widely. The high level of knowledge about contraceptives in general has been observed in other studies, such as the Ghana Demographic and Health Surveys. Although knowledge is high for some methods, usage is low. A further challenge, therefore, is improving the use of effective contraceptive methods among sexually active adolescents in Ghana.

About one in two females and one in three male adolescents who had ever had sex did not protect themselves. Among those using contraceptives, the male condom was the most commonly used method, and was used primarily to protect against pregnancy. Program resources should leverage this success. Specific ways to improve male condom use are addressed in Chapter 8.

TABLE 5.1 Percentage distribution of adolescents, by knowledge of contraceptive methods, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=957) | 15-19 (N=1238) | Total (N=2195) | 12-14 (N=976) | 15-19 (N=1259) | Total (N=2235) |
| Knowledge of any method | | | | | | |
| No | 15.6 | 4.8 | 9.5 | 14.9 | 3.3 | 8.4 |
| Yes | 84.4 | 95.2 | 90.5 | 85.1 | 96.7 | 91.6 |
| Knowledge of any modern method* | 84.4 | 95.1 | 90.4 | 85.0 | 96.7 | 91.6 |
| Female sterilization | 25.6 | 46.5 | 37.4 | 30.0 | 53.2 | 43.1 |
| Male sterilization | 13.9 | 28.6 | 22.2 | 17.5 | 35.0 | 27.4 |
| Pill | 38.2 | 64.0 | 52.7 | 39.1 | 62.9 | 52.5 |
| IUD/coil | 12.6 | 30.9 | 23.0 | 11.9 | 31.8 | 23.1 |
| Injectables | 41.7 | 67.8 | 56.5 | 39.8 | 67.6 | 55.5 |
| Implants | 10.9 | 24.7 | 18.7 | 10.7 | 23.0 | 17.6 |
| Male condom | 81.1 | 93.1 | 87.9 | 83.5 | 96.0 | 90.6 |
| Female condom | 57.4 | 79.7 | 70.0 | 59.3 | 83.9 | 73.2 |
| Foam/jelly | 4.8 | 17.2 | 11.8 | 8.0 | 20.4 | 15.0 |
| Emergency contraception | 7.7 | 26.6 | 18.4 | 10.5 | 27.6 | 20.1 |
| Mean number of modern methods known | 2.9 | 4.8 | 4.0 | 3.1 | 5.0 | 4.2 |
| Knowledge of any traditional method* | 14.9 | 44.0 | 31.3 | 18.9 | 49.3 | 36.0 |
| Rhythm or periodic abstinence | 12.4 | 35.9 | 25.6 | 11.2 | 36.9 | 25.7 |
| Withdrawal | 6.2 | 29.3 | 19.2 | 13.4 | 39.8 | 28.3 |
| Abstinence | 0.3 | 0.8 | 0.6 | 0.4 | 0.2 | 0.3 |
| Herbs | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | 0.5 | 2.2 | 1.5 | 0.7 | 1.7 | 1.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. *Notes:* Ns are weighted.

TABLE 5.2 Percentage distribution of sexually experienced 12–19-year-olds, by knowledge of fertile period, according to ever-use of rhythm method and sex, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|---------------------------|-------------------------|---------------|--------------------|-------------------------|---------------|
| | Never used rhythm (N=328) | Ever used rhythm (N=51) | Total (N=379) | Never used (N=181) | Ever used rhythm (N=25) | Total (N=206) |
| Knows there are certain days when a woman is more likely to get pregnant | | | | | | |
| Yes | 76.5 | 94.1 | 78.9 | 63.5 | [92.0] | 67.0 |
| No | 9.1 | 3.9 | 8.4 | 10.5 | [0.0] | 9.2 |
| Don't know | 14.3 | 2.0 | 12.7 | 26.0 | [8.0] | 23.8 |
| Time when woman more likely to get pregnant* | | | | | | |
| Just before period begins | 19.0 | [19.1] | 19.1 | 14.0 | -- | 16.1 |
| During period | 5.6 | [4.3] | 5.4 | 21.9 | -- | 24.1 |
| Right after period has ended | 33.7 | [46.8] | 35.8 | 32.5 | -- | 31.4 |
| Half way between periods | 30.2 | [27.7] | 29.8 | 16.7 | -- | 15.3 |
| Other | 0.4 | [2.1] | 0.7 | 0.9 | -- | 0.7 |
| Don't know | 11.1 | [0.0] | 9.4 | 14.0 | -- | 12.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who say there are certain days when a woman is more likely to get pregnant. Sample sizes: female, never used (N=252); female, ever used (N=47); male, never used (N=114); male, ever used (N=23). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 5.3 Percentage distribution of sexually experienced 12–19-year-olds, by knowledge of pregnancy prevention, according to ever-use of withdrawal method and sex, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|----------------------------------|--------------------------------|------------------|----------------------------------|--------------------------------|------------------|
| | Never used withdrawal (N=337) | Ever used withdrawal (N=43) | Total (N=380) | Never used withdrawal (N=177) | Ever used withdrawal (N=29) | Total (N=206) |
| A girl can get pregnant if a boy withdraws before ejaculating | | | | | | |
| Yes | 21.1 | [14.0] | 20.3 | 20.3 | [20.7] | 20.4 |
| No | 54.9 | [81.4] | 57.9 | 67.2 | [75.9] | 68.4 |
| Don't know | 24.0 | [4.7] | 21.8 | 12.4 | [3.4] | 11.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. [] = N is 25–49.

TABLE 5.4 Percentage of adolescents who ever had sexual intercourse, by ever-use of contraceptive methods for any reason, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---------------------------------|-----------------|------------------|------------------|-----------------|------------------|------------------|
| | 12–14 (N=17) | 15–19 (N=363) | Total (N=380) | 12–14 (N=13) | 15–19 (N=193) | Total (N=206) |
| Ever use of any method | | | | | | |
| Yes | -- | 59.8 | 58.7 | -- | 56.5 | 52.9 |
| No | -- | 40.2 | 41.3 | -- | 43.5 | 47.1 |
| Any modern methods* | -- | 52.3 | 51.6 | -- | 52.8 | 49.5 |
| Female sterilization | -- | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Male sterilization | -- | 0.3 | 0.3 | -- | 0.5 | 0.5 |
| Pill | -- | 11.3 | 11.3 | -- | 6.7 | 6.3 |
| IUD/coil | -- | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Injectables | -- | 3.0 | 2.9 | -- | 2.6 | 2.4 |
| Implants | -- | 0.3 | 0.3 | -- | 0.5 | 0.5 |
| Male condom | -- | 44.9 | 44.5 | -- | 49.7 | 46.6 |
| Female condom | -- | 3.0 | 3.9 | -- | 1.6 | 1.5 |
| Foam | -- | 0.3 | 0.3 | -- | 0.0 | 0.0 |
| Emergency contraception | -- | 1.9 | 1.8 | -- | 1.0 | 1.0 |
| Any traditional methods* | -- | 20.6 | 19.7 | -- | 20.7 | 19.4 |
| Rhythm or periodic abstinence | -- | 13.8 | 13.2 | -- | 13.0 | 12.1 |
| Withdrawal | -- | 11.8 | 11.3 | -- | 14.5 | 13.6 |
| Herbs | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | -- | 0.6 | 0.5 | -- | 0.0 | 0.0 |

*Multiple responses are possible. Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 5.5 Percentage of adolescents who had sex in the last three months, by current use of contraceptive methods for any reason, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | | Male | | |
|--|--------|-------------------------|--------------------|---------|-------|--------|--------|
| | 12–14 | 15–19 | | Total | 12–14 | 15–19 | Total |
| | (N=7) | Not in union (N=133) | In union (N=50) | (N=191) | (N=6) | (N=93) | (N=99) |
| Current use of any method | | | | | | | |
| Yes | -- | 54.9 | [40.0] | 50.8 | -- | 67.7 | 63.6 |
| No | -- | 45.1 | [60.0] | 49.2 | -- | 32.3 | 36.4 |
| Current use modern method* | -- | 51.5 | [38.0] | 47.1 | -- | 64.1 | 60.2 |
| Female sterilization | -- | 0.0 | [0.0] | 0.0 | -- | 0.0 | 0.0 |
| Male sterilization | -- | 0.0 | [0.0] | 0.0 | -- | 1.1 | 1.0 |
| Pill | -- | 9.0 | [14.0] | 10.0 | -- | 7.5 | 7.1 |
| IUD | -- | 0.0 | [0.0] | 0.0 | -- | 0.0 | 0.0 |
| Injectables | -- | 2.2 | [6.0] | 3.2 | -- | 1.1 | 1.0 |
| Implants | -- | 0.0 | [0.0] | 0.0 | -- | 0.0 | 0.0 |
| Male condom | -- | 40.3 | [16.0] | 34.2 | -- | 52.7 | 49.5 |
| Female condom | -- | 0.0 | [0.0] | 0.0 | -- | 0.0 | 0.0 |
| Emergency contraception | -- | 0.0 | [0.0] | 0.0 | -- | 1.1 | 1.0 |
| Current use traditional method* | -- | 4.5 | [3.9] | 3.7 | -- | 8.6 | 8.1 |
| Rhythm or periodic abstinence | -- | 3.7 | [4.0] | 3.2 | -- | 4.3 | 4.0 |
| Withdrawal | -- | 0.0 | [0.0] | 0.0 | -- | 0.0 | 0.0 |
| Other | -- | 0.0 | [0.0] | 0.0 | -- | 0.0 | 0.0 |

*Multiple responses are possible for general categories "modern" and "traditional." The frequency distributions for current use of specific methods rank more effective methods (e.g., pill and injectables) over less effective methods (e.g., withdrawal) if two or more methods are reported. *Notes:* Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 5.6 Percentage of adolescents who had sexual intercourse in the last 12 months and used any contraceptive method at last sex, by relationship characteristic, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|----------------|------------------|------------------|----------------|------------------|------------------|
| | 12–14 (N=9) | 15–19 (N=252) | Total (N=261) | 12–14 (N=7) | 15–19 (N=130) | Total (N=137) |
| Relationship to last sex partner | | | | | | |
| Spouse | -- | [14.3] | [14.3] | -- | -- | -- |
| Live-in partner | -- | [25.9] | [25.9] | -- | -- | -- |
| Boyfriend/girlfriend | -- | 55.4 | 53.4 | -- | 52.7 | 51.0 |
| Casual acquaintance | -- | -- | -- | -- | [55.2] | [50.0] |
| Commercial sex worker | -- | -- | -- | -- | -- | -- |
| Other | -- | -- | -- | -- | -- | -- |
| Duration of sexual relationship (months) | | | | | | |
| Had sex one time only | -- | [60.7] | [58.6] | -- | [52.0] | [52.0] |
| 3 months or less | -- | [48.4] | [44.1] | -- | [53.7] | [46.8] |
| 4–6 months | -- | -- | -- | -- | -- | -- |
| 7–11 months | -- | [50.0] | [50.0] | -- | -- | -- |
| 1 year | -- | [45.8] | 45.1 | -- | -- | -- |
| 2 years | -- | 51.0 | 50.0 | -- | -- | -- |
| More than 2 years | -- | [27.7] | [27.7] | -- | -- | -- |
| Ever talked with partner about contraceptive methods | | | | | | |
| Had sex one time only (not asked question) | -- | -- | [52.0] | -- | -- | -- |
| Yes | -- | 60.6 | 60.0 | -- | 58.6 | 58.6 |
| No | -- | 27.7 | 26.7 | -- | 50.9 | 45.0 |
| Don't know | -- | -- | -- | -- | -- | -- |

Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 5.7 Percentage distributions of adolescents who had sexual intercourse in the last 12 months and used a male condom, by characteristics of condom use at last sex, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|----------------|-----------------|-----------------|----------------|-----------------|-----------------|
| | 12–14 (N=1) | 15–19 (N=98) | Total (N=99) | 12–14 (N=0) | 15–19 (N=63) | Total (N=63) |
| Who suggested use of male condom | | | | | | |
| Had sex one time only | -- | 13.3 | 13.1 | -- | 12.7 | 12.7 |
| Participant | -- | 40.8 | 41.4 | -- | 65.1 | 65.1 |
| Partner | -- | 27.6 | 27.3 | -- | 11.1 | 11.1 |
| Joint decision | -- | 18.4 | 18.2 | -- | 11.1 | 11.1 |
| Refused to respond | -- | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Reason for using male condom | | | | | | |
| Prevent pregnancy | -- | 71.4 | 71.7 | -- | 45.3 | 45.3 |
| Prevent HIV and other STIs | -- | 5.1 | 5.1 | -- | 37.5 | 37.5 |
| Prevent both pregnancy and STIs | -- | 16.3 | 16.2 | -- | 17.2 | 17.2 |
| Other | -- | 3.1 | 3.0 | -- | 0.0 | 0.0 |
| Don't know | -- | 4.1 | 4.0 | -- | 0.0 | 0.0 |
| Total | -- | 100.0 | 100.0 | -- | 100.0 | 100.0 |

Notes: Ns are weighted. "--" = N is 24 or fewer.

Chapter 6

Pregnancy and Childbearing

Historically, all ethnic groups in the country have encouraged early marriage and childbearing. One of the strategies for early marriage, especially for females, was betrothal. Females were given out for marriage after puberty rites, which occurred immediately after menarche. Evidence from studies about half of a century ago shows that early marriage and childbearing were common.³⁵ For instance, Fortes observed that Ashanti girls typically married and gave birth by age 16.³⁶ Similar early ages at first marriage and childbearing have been observed among the Ewe, Krobo and Mole-Dagbani.³⁷ Although Ghana has undergone social change, early marriage and childbearing continue to exist, especially in rural areas and poor urban enclaves.

Early pregnancy or childbirth can be dangerous to the mother and to her child. This is because very young females may not be physiologically mature enough to give birth. In some cases, physiological immaturity may be compounded by poor nutrition, especially among poor young women, and these risks occur regardless of marital status. In addition, pregnancy, especially among the unmarried, may be unplanned and this may lead to withdrawal of social support which can further complicate a woman's situation. One of the responses may be unsafe abortion with its attendant problems.

This chapter presents key findings on a number of issues related to adolescent pregnancy and childbearing, including the extent of knowledge and perceptions about how pregnancy occurs, the level of early childbearing, preferences regarding the timing of recent and future births, knowledge about abortion and personal experiences of abortion.

Knowledge About How Pregnancy Happens

With the introduction of family-life education in the school system in the 1970s, initially through the efforts of the Planned Parenthood Association of Ghana, and in communities through peer education, young people are expected to show an understanding of issues associated with pregnancy and childbearing. Table 6.1 pres-

ents information on young people's knowledge of how pregnancy occurs and the fertile period during the menstrual cycle. All adolescents, males and females aged 12–14 and 15–19 years, were asked these questions. The assumption is that knowledge about how pregnancy occurs can influence the use of contraceptives to prevent pregnancy.

The results indicate that 37% and 60% of females aged 12–14 and 15–19, respectively, were aware that a woman can get pregnant the first time she has sexual intercourse. Thirty-seven percent of 12–14-year-old males and 53% of 15–19-year-old males were aware of this fact. Twenty-two percent of females and 27% of males 12–19 years old thought that a girl could not get pregnant if she had sex standing up. Another 58% of females and 45% of males aged 12–14 years reported that they did not know whether a girl could get pregnant if she had sex standing up.

Almost one in four younger females and males believed that a girl will not get pregnant if she washes herself immediately after sex. Even among the females aged 15–19 years, only 44% knew that a woman could get pregnant if she washed herself after sex and 35% indicated that they were unsure. Similarly, 40% of females and 57% of males aged 15–19 years thought that withdrawal, described as when “a boy withdraws before ejaculating or coming,” prevented pregnancy. More than 70% of females and 55% of males aged 12–14 years said they did not know. As indicated in Chapter 5, among those who had ever used withdrawal, few were aware that this method carried some risk of pregnancy.

Two in three female adolescents and fewer than half of older male adolescents stated that they knew that there were certain days when a woman was more likely to get pregnant; even fewer young adolescents knew of the fertile period (34% of females and 18% of males 12–14 years old). Yet, despite the fact that 67% of 15–19-year-old females indicated they knew of the fertile period, only 26% knew the correct specific time that a woman could get pregnant (Table 6.1, panels 5 and 6).

As the level of formal education increased, the proportion of adolescents who were unable to report on how pregnancy occurs or did not know of the fertile period declines (data not shown). For example, 25% of females and 36% of males with no formal education thought that a girl could not get pregnant the first time she had sexual intercourse compared to 16% of females and 26% of males with secondary education. The percentage of adolescents who said they “did not know” to questions about pregnancy also declined with increased formal education.

In general, fewer of the younger adolescents were likely to know about when in a woman’s menstrual cycle pregnancy was more likely to occur or how pregnancy can be prevented than older adolescents, but no age-group of adolescents appeared to have adequate knowledge about the specifics of how pregnancy occurs or how it can be prevented.

Pregnancy and Childbearing Experiences

The level of childbearing among adolescents, the extent to which childbearing occurs before marriage and the level of childbearing before age 15 are important indicators of adolescent sexual and reproductive health. Data from the Ghana Demographic and Health Surveys show that the age-specific fertility rate among females aged 15–19 has declined from 125 births per 1,000 15–19-year-olds in 1988 to 74 births in 2003. The proportion of 15–19-year-old males who report having ever made someone pregnant or fathered a child is extremely low (less than 1%), and, therefore, not discussed in detail here. This section examines the experiences of females 15–19 years old with childbearing experience. The focus is on those aged 15–19 years because very few 12–14-year-olds become pregnant or give birth.

Overall, 13% of females aged 15–19 years had ever been pregnant and 9% had ever had a child (Table 6.2). Among the small group of females in a union (only 7% of 15–19-year-olds—see Chapter 3, Table 3.1), 66% had ever had a birth and 16% were pregnant at the time of the survey. Among those not in a union, only 7% had ever been pregnant (5% ever had a child and 2% were currently pregnant). There was some further indication of unprotected premarital sex as 41% of 15–19-year-olds who had already given birth did so before they married. Seventy percent of them were not currently in a union and 13% of those were in a union at the time of birth. Very early childbearing (having a birth before age 15) occurred among only 2% of 15–19-year-old females. However, among those who were in a union,

one in 10 had a birth before age 15. Dealing with early pregnancy will also have to address the issue of early marriage, which puts young girls at risk of pregnancy.

Equally important for adolescents is the wantedness of a pregnancy. The last two panels of Table 6.2 show that, among 15–19-year-old females who are currently pregnant, more than two-thirds did not want the pregnancy at that time or did not want to become pregnant at all. Among those who already had a baby, only 24% wanted to have a child at the time they last got pregnant. Most importantly, 33% of females in a union and 51% of those not in a union did not want to have a child at that time when they last got pregnant, while 42% of those in a union and 25% of those not in a union wanted to wait until later. The results show that there is a need to help young people avoid early pregnancy.

Desired Timing of Pregnancy or Birth

The timing of pregnancy or birth among adolescents vis-à-vis the time it is wanted reveals the level of unintended pregnancy or childbearing among adolescents. Ensuring that adolescents begin childbearing when they want to is important in adolescent sexual and reproductive health, and preventing unwanted childbearing is a key focus of current programs and policies. This section examines issues associated with the timing of pregnancy and childbearing among adolescents. Table 6.3 shows the desired timing of birth among the adolescents interviewed. According to the table, 29% of 12–14-year-old females said they would want to wait until marriage and 40% indicated that they would want to wait for nine or more years before starting childbearing. Of the 83 female respondents aged 15–19 years who were in a union, 28% desired to give birth to a child (or another child) within 1–2 years, while 23% expected to give birth in the next 5–6 years. Among females not in a union aged 15–19, almost one-third desired to wait for nine years or more and 28% wished to wait until they married. For males, the pattern for the two age-groups was similar to that for females. Five percent of females and 4% of males said they considered the timing of pregnancy to be “what God decides,” while 14% of females and 11% of males were not sure of when they would want to have a child or another child.

Abortion

According to Act 29 of the 1960 Criminal Code (and subsequent amendments), abortion can be conducted by medically qualified persons under three conditions in Ghana, namely when:

- the pregnancy is a threat to the physical and mental

health of the mother;

- the pregnancy is the outcome of rape, defilement of a mentally handicapped woman or incest; or
- there is substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease.

In the 2004 survey, adolescents were asked to indicate the methods they had heard of for terminating a pregnancy and whether they knew anybody who had tried to terminate a pregnancy. Given the social stigma against abortion, the practice is generally under-reported, especially among female adolescents for whom becoming pregnant outside of marriage is usually stigmatized as well. As a result, the percentage of adolescents who indicate that they have close friends who have tried to end a pregnancy can be considered as proxy for the level of abortion among adolescents. The responses are given in Table 6.4.

Overall, 47% of females and 55% of males did not know any ways through which abortion could be carried out. Among those aged 12–14 years, the levels were higher than among older adolescents: Some 58% of younger females and 69% of younger males did not know any way to terminate a pregnancy, compared with 39% of females and 44% of males aged 15–19 years. The results also indicated that 62% of adolescents in rural areas did not know of any way to terminate a pregnancy compared to 39% in urban areas (data not shown).

The most common method that was spontaneously mentioned by adolescents for pregnancy termination was surgical abortion (33% of females and 30% of males). Other methods reported were herbal drinks (19% of females and 20% of males), a mixture of sugar with Guinness beer or malt drink (10% of females and 6% of males), and using sharp objects to pierce the womb (2% of females and males).

Nearly one-third of females aged 15–19 years reported that they had close friends who had ever tried to end a pregnancy. Even among 12–14-year-old females, about one in ten indicated they had close friends who had tried to abort a pregnancy. Only 10% of males reported that they had close friends who had been involved or tried to abort a pregnancy. In contrast to reports about close friends, fewer than 1% of adolescents reported that they had ever tried to end (or had been involved in ending) a pregnancy. Of the 17 young women who said they had had an abortion, seven said it was a surgical abortion (five young women said they went to a public provider and two to a private

provider). Respondents could name multiple methods tried in their efforts to terminate a pregnancy. Six respondents tried tablets or pills (it is not clear what type) or herbal drinks, and two tried a mixture of sugar with Guinness, malt drink or coffee. Three said they purchased drugs from a pharmacy shop and one visited a traditional/spiritual healer. The use of unsafe methods by 10 of the 17 females points to the need for education on unsafe abortion and its implications for their future sexual and reproductive health.

Policy and Program Implications

In general, adolescents were aware of some aspects of pregnancy, but lacked detailed knowledge as to how and when pregnancy can occur. Therefore, there is a need to provide detailed information about pregnancy to adolescents that should cover a wide range of issues, including what happens to males and females at various stages of physical development and certain misconceptions about what does and does not lead to pregnancy. The school system provides an opportunity for conveying detailed information about how pregnancy can occur and can be prevented.

The desire for long delays before starting childbearing and the substantial level of unintended childbearing even among adolescents who were in unions indicate a strong demand for specific information about pregnancy prevention.

Of the 1,235 females aged 15–19 years interviewed, 7% were married or living with a man as if married. Although this number is relatively low, the results indicate that early marriage and teenage pregnancy is still an issue in the country. Achieving universal basic education is not going to be possible with early marriage and childbearing. Therefore, the campaign for delaying pregnancy should be intensified and connected with the goal of achieving universal basic education, particularly for females.

Abortion, including unsafe ones, occurs among adolescents. Few adolescents reported personal experiences with abortion, a factor that may be related to the stigma associated with the event. Nearly one in three older female adolescents knew of a close friend who had tried to end a pregnancy and awareness of ways to terminate pregnancies was relatively high. The stigma of abortion combined with the strong desire to delay childbearing implies that there is the need to improve education and services that help adolescents prevent pregnancy and unsafe abortion.

TABLE 6.1 Percentage distribution of adolescents, by perceptions of how pregnancy occurs, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1237) | Total (N=2194) | 12–14 (N=974) | 15–19 (N=1259) | Total (N=2233) |
| Can a girl get pregnant the very first time she has sexual intercourse? | | | | | | |
| Yes | 37.3 | 60.1 | 50.2 | 37.3 | 52.7 | 45.9 |
| No | 23.2 | 17.1 | 19.7 | 30.4 | 28.4 | 29.3 |
| Don't know | 39.5 | 22.8 | 30.1 | 32.3 | 18.9 | 24.8 |
| Can a girl get pregnant if she has sex standing up? | | | | | | |
| Yes | 20.5 | 38.1 | 30.4 | 28.0 | 46.8 | 38.6 |
| No | 21.9 | 21.3 | 21.6 | 27.1 | 25.9 | 26.4 |
| Don't know | 57.6 | 40.5 | 48.0 | 44.9 | 27.4 | 35.0 |
| Can a girl get pregnant if she washes herself thoroughly immediately after sex? | | | | | | |
| Yes | 24.5 | 44.2 | 35.6 | 25.9 | 49.6 | 39.3 |
| No | 21.5 | 20.8 | 21.1 | 23.7 | 22.6 | 23.1 |
| Don't know | 54.0 | 35.0 | 43.3 | 50.4 | 27.8 | 37.6 |
| Can a girl get pregnant if a boy withdraws before ejaculating or coming? | | | | | | |
| Yes | 12.4 | 20.6 | 17.0 | 12.5 | 18.3 | 15.8 |
| No | 14.7 | 40.3 | 29.2 | 32.2 | 56.6 | 46.0 |
| Don't know | 72.8 | 39.1 | 53.8 | 55.3 | 25.0 | 38.2 |
| Knows there are certain days when a woman is more likely to get pregnant | | | | | | |
| Yes | 33.7 | 66.6 | 52.3 | 18.4 | 47.5 | 34.8 |
| No | 18.8 | 12.3 | 15.2 | 14.9 | 14.7 | 14.8 |
| Don't know | 47.5 | 21.1 | 32.6 | 66.8 | 37.8 | 50.4 |
| Time when woman more likely to get pregnant* | | | | | | |
| Just before period begins | 15.5 | 19.1 | 18.1 | 18.3 | 18.5 | 18.4 |
| During period | 14.9 | 8.9 | 10.6 | 22.9 | 25.2 | 24.7 |
| Right after period has ended | 24.5 | 32.6 | 30.3 | 28.6 | 28.9 | 28.8 |
| Halfway between periods | 14.6 | 26.4 | 23.0 | 6.3 | 14.3 | 12.5 |
| Other | 0.3 | 0.6 | 0.5 | 0.0 | 0.2 | 0.1 |
| Don't know | 30.3 | 12.5 | 17.5 | 24.0 | 12.9 | 15.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who say there are certain days when a woman is more likely to get pregnant. Sample sizes: females 12–14 (N=323); females 15–19 (N=823); males 12–14 (N=175); males 15–19 (N=595). Notes: Ns are weighted.

TABLE 6.2 Percentage distribution of older adolescents, by pregnancy and childbearing status, according to sex and union status, 2004 National Survey of Adolescents

| Characteristic | Female 15–19 | | | Male 15–19 |
|---|--------------------|--------------------------|-------------------|-------------------|
| | In union (N=86) | Not in union (N=1149) | Total (N=1235) | Total (N=2226) |
| Ever been pregnant/made someone pregnant | | | | |
| No | 11.6 | 93.2 | 87.5 | 99.5 |
| Yes | 88.4 | 6.8 | 12.5 | 0.5 |
| Ever had a birth/fathered a child | | | | |
| No | 33.7 | 95.3 | 91.0 | 99.7 |
| Yes | 66.3 | 4.7 | 9.0 | 0.3 |
| Ever had a premarital birth* | | | | |
| No | 87.5 | 29.6 | 59.1 | N/A |
| Yes | 12.5 | 70.4 | 40.9 | N/A |
| Ever had a birth by age 15 | | | | |
| No | 86.0 | 99.0 | 98.1 | N/A |
| Yes | 14.0 | 1.0 | 1.9 | N/A |
| Currently pregnant | | | | |
| No | 83.7 | 98.4 | 97.4 | N/A |
| Yes | 16.3 | 1.6 | 2.6 | N/A |
| Wantedness of current pregnancy† | | | | |
| Wanted then | -- | -- | [31.0] | N/A |
| Wanted later | -- | -- | [37.9] | N/A |
| Not wanted at all | -- | -- | [31.0] | N/A |
| Don't know | -- | -- | [0.0] | N/A |
| Wantedness of last birth* | | | | |
| Wanted then | 23.1 | 24.5 | 23.8 | N/A |
| Wanted later | 42.3 | 24.5 | 33.3 | N/A |
| Not wanted at all | 32.7 | 50.9 | 41.9 | N/A |
| Don't know | 1.9 | 0.0 | 1.0 | N/A |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who ever had a birth. Sample sizes: female in union (N=56); female not in union (N=54). †Limited to those who are currently pregnant. Sample sizes: female in union (N=12); female not in union (N=17). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25–49.

TABLE 6.3 Percentage distribution of adolescents, by desired timing of next birth, according to sex, age and union status, 2004 National Survey of Adolescents

| Characteristic | Female | | | | Male | | |
|--|------------------|--------------------|--------------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=954) | 15-19 | | Total (N=2189) | 12-14 (N=974) | 15-19 (N=1257) | Total (N=2231) |
| | | In union (N=83) | Not in union (N=1150) | | | | |
| Desired time to wait before having a(another) child | | | | | | | |
| 1-2 years | 0.2 | 27.7 | 2.3 | 2.3 | 0.1 | 1.0 | 0.6 |
| 3-4 years | 0.4 | 18.1 | 3.7 | 2.8 | 0.3 | 3.5 | 2.1 |
| 5-6 years | 2.1 | 22.9 | 7.9 | 5.9 | 2.5 | 5.2 | 4.0 |
| 7-8 years | 5.0 | 4.8 | 11.5 | 8.4 | 2.5 | 10.5 | 7.0 |
| 9 or more years | 40.3 | 3.6 | 31.3 | 34.1 | 49.8 | 48.1 | 48.8 |
| What God decides | 5.6 | 6.0 | 3.7 | 4.6 | 5.1 | 2.6 | 3.7 |
| Wait until marriage | 28.9 | 2.4 | 28.2 | 27.5 | 24.1 | 20.0 | 21.8 |
| Don't want a(another) child | 0.3 | 2.4 | 0.3 | 0.5 | 0.4 | 0.7 | 0.6 |
| Don't know | 17.2 | 12.0 | 11.0 | 13.8 | 15.2 | 8.4 | 11.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Ns are weighted.

TABLE 6.4 Percentage distribution of adolescents, by knowledge and experience of abortion, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=958) | 15-19 (N=1238) | Total (N=2196) | 12-14 (N=977) | 15-19 (N=1258) | Total (N=2235) |
| Knowledge of ways to abort pregnancy* | | | | | | |
| Don't know any way | 58.2 | 38.8 | 47.3 | 68.7 | 43.9 | 54.7 |
| Surgical abortion | 24.5 | 39.0 | 32.6 | 18.8 | 39.0 | 30.2 |
| Herbal drink | 14.4 | 21.8 | 18.6 | 13.2 | 25.1 | 19.9 |
| Guinness or malt and sugar | 4.5 | 13.5 | 9.6 | 2.4 | 9.0 | 6.1 |
| Coffee and sugar | 0.6 | 3.4 | 2.2 | 1.0 | 3.2 | 2.2 |
| Use of sharp objects | 1.5 | 2.8 | 2.2 | 1.8 | 2.9 | 2.4 |
| Tablet or pills | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Massage | 0.0 | 0.2 | 0.1 | 0.0 | 0.2 | 0.1 |
| Jumping/falling | 0.0 | 0.2 | 0.1 | 0.2 | 0.0 | 0.1 |
| Ingesting glass | 0.6 | 1.7 | 1.2 | 0.9 | 1.2 | 1.1 |
| Soft drink and sugar/other | 1.6 | 2.3 | 2.0 | 0.1 | 1.4 | 0.9 |
| Other method | 5.2 | 7.6 | 6.6 | 2.3 | 6.0 | 4.4 |
| Have any close friends who ever tried to end a pregnancy | | | | | | |
| Yes | 11.5 | 28.8 | 21.2 | 5.1 | 14.2 | 10.2 |
| No | 87.2 | 70.6 | 77.9 | 93.6 | 85.3 | 88.9 |
| Refuse to answer | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Don't know | 1.3 | 0.6 | 0.9 | 1.3 | 0.6 | 0.9 |
| Ever tried to end a pregnancy/been involved in ending a pregnancy | | | | | | |
| No | 99.7 | 98.9 | 99.2 | 100.0 | 99.5 | 99.7 |
| Yes | 0.3 | 1.1 | 0.8 | 0.0 | 0.5 | 0.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

Chapter 7

HIV/AIDS and Other STIs

HIV/AIDS infection and other STIs present one of the major health challenges to young people in Ghana. Available data on AIDS cases in Ghana indicate that females aged 25–29 years report the highest level of infection in the country.³⁸ Assuming that infection takes about 5–10 years to manifest itself, it means that a number of young women were infected when they were in their teens. This chapter presents information on the levels of awareness and knowledge of adolescents about HIV/AIDS and other STIs, symptoms, preventive measures and their experiences.

Knowledge About HIV/AIDS Transmission and Prevention

Evidence from the 1998 and 2003 Ghana Demographic and Health Surveys show that over 95% of adolescents had heard about HIV/AIDS. Results from the 2004 National Survey of Adolescents (NSA) also indicate that 96–97% of adolescents were aware of HIV/AIDS (Table 7.1). The level of awareness is slightly higher among 15–19-year-olds (97% of females and 98% of males) than 12–14-year-olds (94% of females and males).

Among those adolescents who had heard of AIDS, over 90% knew that AIDS can be transmitted by sex with an infected person (96% of females and males), sharing razors or other sharp objects (96–97%), getting injections with a needle used by someone else (95–97%), or through blood transfusion (92%). There were slightly lower levels of knowledge among the 12–14-year-olds than among 15–19-year-olds. Of the three ways through which HIV can be transmitted from mother to child, 81% were aware of transmission during pregnancy, 74–75% were aware of transmission during breastfeeding and 65–67% were aware that AIDS can be transmitted during delivery. Overall, fewer adolescents were aware of the risks of mother to child transmission compared with other risk factors (Table 7.1). Alongside accurate knowledge, some adolescents also held misconceptions about the ways in

which HIV/AIDS can be transmitted. For instance, one in five adolescents reported that one could be infected through the sharing food with an infected person, 42% reported mosquito bites and 36% reported witchcraft. Differences by sex are minimal in all cases.

Regarding ways that HIV/AIDS transmission can be reduced, 83% or more of all adolescents (regardless of age and sex) mentioned abstinence and monogamy, and 78% of females and 84% of males reported consistent condom use as a risk reduction mechanism. More than four in five adolescents indicated that one could also prevent HIV/AIDS by not sharing certain objects—needles, toothbrushes and blades—with an infected person. The percentages reporting the protective value of condoms were lower than those reporting all other protective measures, especially among very young adolescents. Three in four adolescents correctly recognized the consistent use of condoms as a protective factor. The reported risk reduction mechanisms of abstinence, monogamy and consistent condom use by 15–19-year-olds in the NSA were slightly higher than those from the 2003 Ghana Demographic and Health Survey.³⁹ The difference could be attributed to the focus of the two surveys.

Nearly one in 10 adolescents (9% of females and 8% of males) reported that a man infected with the AIDS virus could be cured if he had sex with a virgin, and more than one in 10 responded that they did not know if this was true or not. Levels of awareness of preventive measures were consistently lower among adolescents in rural areas than among their urban peers, while higher percentages held incorrect beliefs about HIV transmission and prevention (data not shown). For example, about one-third of urban adolescents believed that AIDS can be transmitted by a mosquito bite, compared with more than one in two rural adolescents. Females in rural areas were the least knowledgeable of all adolescent groups about modes of transmission of HIV (data not shown).

Personal Knowledge About and Attitudes Toward People with HIV/AIDS

Knowing someone infected with any ailment makes the disease a real part of a person's life. It was surmised that knowing someone with HIV/AIDS could influence the attitudes of adolescents, as well as make them more cautious in their own risk and protective behaviors. Stigma may also influence the willingness of an individual to acknowledge risk and to get tested for HIV.

Several indicators of HIV/AIDS stigma were measured by asking about interactions with various individuals infected with HIV—a female teacher, a vendor of unprepared food and a family member. A female teacher was used in the scenario presented in the survey in order to eliminate influences from the separate issue of male teachers and sexual relationships with students.⁴⁰ As indicated in Table 7.2, about 20% of both female and male adolescents knew someone who had had HIV/AIDS and just over one-third knew someone who had died of AIDS or who people said died of AIDS. Slightly more of the older adolescents reported knowing someone with HIV/AIDS than the younger ones. This is not surprising as the younger ones are less likely to be informed of such infections in the household or the neighborhood.

HIV stigma is fairly common among adolescents. Between 51% and 63% of adolescents thought that a female teacher with AIDS should not be allowed to teach. Very young adolescents (12–14 years old) were more likely to express this view than 15–19-year-olds. About four in five adolescents also indicated that they would not buy fresh vegetables from a shopkeeper or food seller who they knew had the AIDS virus. Stigmatization appears to be deeply rooted as few adolescents responded “do not know” to any of the statements that measure AIDS stigma.

Consistent with the negative attitudes towards infected persons, 69% of females and 55% of males would want the HIV-positive status of a family member kept secret. Males (44%) were more willing to disclose the status of a family member than females (29%). The attitudes of the youth towards HIV/AIDS-infected persons are different for family members and nonfamily members. While adolescents were not willing to buy fresh vegetables from infected vendors, they were willing to care for an infected family member: Although a majority would want the status of an HIV-positive family member kept secret, 73% of females and 76% of males were willing to care for that family member. Older adolescents expressed more willingness than younger ones to care for an infected family member.

The difference in the willingness to assist was minimal between older males (79%) and females (76%).

Knowledge of Other STIs

Table 7.3 shows the proportion of adolescents who had heard of other STIs, the types of symptoms associated with the STIs they had heard of (an open-ended question) and whether they had experienced an STI or STI-related symptoms. The results indicate that between one-quarter and one-half of adolescents had heard of STIs other than HIV/AIDS. These proportions were far lower than those who had heard of HIV/AIDS. Similar observations have been reported in the 1998 Ghana Youth Reproductive Health Survey.⁴¹

Knowledge of other STIs increases markedly with age. Whereas only one in four female and male adolescents aged 12–14 had heard of other STIs, 49% of females and 56% of males aged 15–19 years old had heard of other STIs. The level of awareness of STIs was also higher among males than females. About one-third of the adolescents who had heard of other STIs could not indicate any STI symptoms. For those who spontaneously mentioned specific symptoms, the most frequently cited were burning pain when urinating (31% of females and 41% of males), genital discharge (22% of males and females), ulcers or sores on private parts (15% of females and 11% of males) and itching in private parts (15% of females and 9% of males). Symptoms least mentioned were lower abdominal pain (7%) and warts or growths on private parts (3%).

Experience of STIs

Given the fact that a number of STIs do not commonly manifest with noticeable symptoms, self-reporting of STIs is a much less valid indicator than clinical tests. Self-reporting, therefore, captures perceptions of STI experiences and should be interpreted as a rough estimate of the prevalence among the study population. In the 2004 survey, adolescents who had heard of STIs were asked whether they had ever had an STI, and also whether they had ever experienced two common symptoms (bad smelling, abnormal discharge or a genital sore or ulcer). Responses to each of these questions are presented separately, as well as the proportion who reported “yes” to any of these three questions. Based on the fact that it is those who have ever had sex who are at risk of STIs, the proportions reporting any of these symptoms among those who had ever had sex are also indicated in Table 7.3 (last panel).

Four percent of all 12–19-year-old females (2% of 12–14-year-olds and 4% of 15–19-year-olds) and 1%

of males indicated that they had ever had an STI (“yes” to a direct question). The symptoms reported were either a bad-smelling, abnormal discharge (7% of females and 2% of males) or a genital sore or ulcer (4% of females and 2% of males). When the three measures of STI experience and symptoms are combined, the proportion increases to about 11% of females and 4% of males. For those who had ever had sex, 21% of females and 5% of males reported ever having an STI or one of two common symptoms of an STI.

Policy and Program Implications

The high level of awareness of HIV/AIDS observed among 12–19-year-olds is consistent with results from other studies of adolescents in Ghana. This is not surprising, as more attention has been given to the epidemic than to any other infection. The challenges that remain are dispelling some of the existing misconceptions about the possible routes of infection and translating knowledge into behavioral change. Policymakers and development partners should continue to support efforts to provide accurate and reliable information to young people, as well as strategies for promoting behavioral change. Programs should speak directly to incorrect beliefs and seek to eliminate persistent misconceptions about the transmission, prevention and treatment of HIV/AIDS. In particular, the belief that a man infected with HIV can be cured if he had sex with a virgin must be addressed due to the serious implications of such a misconception for the girl-child.

The next generation of programs will need to target younger and older adolescents, rural and urban adolescents differently. As a subgroup, rural adolescents, particularly females, will need messages and programs that will help them protect themselves from HIV/AIDS. Adolescents must continue to receive messages on abstinence, faithfulness and the effectiveness of condom use in preventing HIV/AIDS, but with relative emphasis for different categories of adolescents. Campaigns on acceptance and support for people living with AIDS should be intensified, and programs both in and out of school should strive to reduce the level of rejection that young people expressed, as well as promote the positive attitudes of willingness to assist infected family members.

The low level of awareness and knowledge about other STIs among young people constitutes another challenge to be addressed. STIs’ potential for long-term damage to reproductive health and their status as co-factors for HIV infection mean that they must be taken seriously, given the young age of this group.

TABLE 7.1 Percentage distribution of adolescents, by awareness of and knowledge about HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=958) | 15–19 (N=1238) | Total (N=2196) | 12–14 (N=976) | 15–19 (N=1259) | Total (N=2235) |
| Ever heard of HIV/AIDS | | | | | | |
| Yes | 93.9 | 97.0 | 95.7 | 94.4 | 98.4 | 96.6 |
| No | 5.7 | 2.8 | 4.1 | 5.3 | 1.5 | 3.2 |
| Don't know | 0.3 | 0.2 | 0.2 | 0.3 | 0.1 | 0.2 |
| The AIDS virus can be transmitted by:*† | | | | | | |
| Having sex with persons who are infected with the virus | 93.8 | 97.2 | 95.7 | 93.8 | 97.8 | 96.1 |
| A mother to child during pregnancy | 76.9 | 83.5 | 80.7 | 76.7 | 84.8 | 81.3 |
| A mother to child during delivery | 59.9 | 72.0 | 66.8 | 59.4 | 68.9 | 64.9 |
| A mother to child during breastfeeding | 71.3 | 78.2 | 75.3 | 69.5 | 76.4 | 73.5 |
| Sharing razors or other sharp objects | 95.7 | 95.8 | 95.8 | 95.6 | 98.0 | 97.0 |
| Getting injections with a needle used by someone else | 93.3 | 95.7 | 94.7 | 95.6 | 97.7 | 96.8 |
| A blood transfusion | 89.6 | 94.7 | 92.5 | 88.3 | 94.3 | 91.8 |
| Sharing food | 23.1 | 16.6 | 19.4 | 26.2 | 16.1 | 20.4 |
| Mosquito bites | 43.1 | 41.3 | 42.1 | 44.4 | 39.7 | 41.7 |
| Witchcraft or supernatural means | 35.0 | 36.6 | 35.9 | 40.0 | 33.3 | 36.1 |
| Transmission of the AIDS virus can be reduced by:*† | | | | | | |
| Not having sex at all | 87.0 | 89.5 | 88.4 | 89.0 | 91.8 | 90.6 |
| Having just one partner who is not infected and who has no other partners | 82.6 | 88.9 | 86.2 | 84.9 | 90.5 | 88.1 |
| Using a condom correctly at every sexual intercourse | 72.2 | 82.1 | 77.8 | 78.9 | 87.1 | 83.6 |
| Avoiding sharing injections/needles | 88.2 | 91.0 | 89.8 | 90.2 | 94.0 | 92.4 |
| Avoiding sharing toothbrushes | 79.8 | 82.0 | 81.0 | 80.1 | 87.2 | 84.2 |
| Can a man infected with the AIDS virus be cured if he has sex with a virgin?* | | | | | | |
| Yes | 9.5 | 9.2 | 9.3 | 9.2 | 6.7 | 7.8 |
| No | 75.1 | 80.1 | 77.9 | 71.9 | 84.6 | 79.2 |
| Don't know | 15.5 | 10.8 | 12.8 | 18.9 | 8.7 | 13.1 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who have heard of the AIDS virus. Sample sizes: females 12–14 (N=896); females 15–19 (N=1196); males 12–14 (N=916); males 15–19 (N=1234). †Totals may exceed 100 because multiple responses are possible.

Notes: Ns are weighted.

TABLE 7.2 Percentage distributions of adolescents who have heard of AIDS, by personal ties to and attitudes about persons with HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=899) | 15-19 (N=1199) | Total (N=2098) | 12-14 (N=919) | 15-19 (N=1236) | Total (N=2155) |
| Personally knows someone who has the virus that causes AIDS | | | | | | |
| Yes | 17.1 | 21.5 | 19.6 | 19.2 | 21.6 | 20.6 |
| No | 81.8 | 77.6 | 79.4 | 80.6 | 78.2 | 79.2 |
| Don't know | 1.1 | 0.9 | 1.0 | 0.2 | 0.2 | 0.2 |
| Personally knows someone who has died from AIDS or who people said died of AIDS | | | | | | |
| Yes | 34.3 | 38.4 | 36.7 | 35.1 | 41.3 | 38.7 |
| No | 64.2 | 60.8 | 62.3 | 64.5 | 58.4 | 61.0 |
| Don't know | 1.4 | 0.8 | 1.0 | 0.3 | 0.2 | 0.3 |
| If a female teacher has the AIDS virus, she should be allowed to teach in school | | | | | | |
| Yes | 34.9 | 44.0 | 40.1 | 36.1 | 46.1 | 41.9 |
| No | 62.9 | 51.3 | 56.2 | 60.8 | 51.4 | 55.4 |
| Don't know | 2.2 | 4.8 | 3.7 | 3.0 | 2.5 | 2.7 |
| If knew shopkeeper or food seller had AIDS virus, would buy fresh vegetables from him/her | | | | | | |
| Yes | 10.6 | 13.2 | 12.0 | 19.0 | 25.2 | 22.5 |
| No | 88.9 | 86.3 | 87.4 | 80.9 | 74.3 | 77.1 |
| Don't Know | 0.6 | 0.5 | 0.5 | 0.1 | 0.5 | 0.3 |
| If a family member became infected with AIDS virus, would want it to be a secret | | | | | | |
| Yes | 71.6 | 67.4 | 69.2 | 56.4 | 54.2 | 55.2 |
| No | 27.1 | 31.0 | 29.3 | 42.2 | 45.0 | 43.8 |
| Don't know | 1.2 | 1.6 | 1.4 | 1.4 | 0.8 | 1.1 |
| If a family member became infected with AIDS virus, would be willing to care for him or her | | | | | | |
| Yes | 68.3 | 76.0 | 72.7 | 72.4 | 78.8 | 76.1 |
| No | 30.7 | 22.8 | 26.2 | 26.0 | 20.9 | 23.0 |
| Don't know | 1.0 | 1.2 | 1.1 | 1.6 | 0.3 | 0.9 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted.

TABLE 7.3 Percentages of adolescents, by awareness of and knowledge about STIs and symptoms experienced, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=957) | 15-19 (N=1237) | Total (N=2194) | 12-14 (N=977) | 15-19 (N=1258) | Total (N=2235) |
| Ever heard of STIs other than HIV/AIDS | | | | | | |
| Yes | 25.5 | 48.7 | 38.6 | 27.5 | 55.7 | 43.4 |
| No | 74.5 | 51.3 | 61.4 | 72.5 | 44.3 | 56.6 |
| Symptoms of STIs:* | | | | | | |
| Ulcer/sore on private parts | 11.6 | 16.6 | 15.1 | 7.2 | 12.1 | 10.8 |
| Genital discharge | 19.9 | 22.9 | 22.1 | 20.4 | 23.1 | 22.4 |
| Itching in private parts | 11.2 | 16.9 | 15.3 | 9.1 | 8.7 | 8.8 |
| Lower abdominal tenderness/pain | 5.4 | 8.2 | 7.4 | 2.3 | 5.2 | 4.4 |
| Warts or growths on private parts | 1.2 | 3.5 | 2.9 | 1.1 | 1.6 | 1.5 |
| Burning pain in urination | 27.8 | 32.8 | 31.4 | 34.0 | 43.3 | 40.7 |
| Other | 8.7 | 5.2 | 6.2 | 14.0 | 11.3 | 12.0 |
| Don't know | 34.9 | 34.4 | 34.6 | 42.3 | 27.3 | 31.4 |
| Ever had:* | | | | | | |
| An STI ('yes' to direct question) | 2.1 | 4.2 | 3.6 | 1.1 | 1.4 | 1.4 |
| A bad-smelling, abnormal discharge | 1.7 | 8.9 | 6.8 | 1.5 | 2.2 | 2.0 |
| A genital sore or ulcer | 1.3 | 5.2 | 4.1 | 1.1 | 2.3 | 2.0 |
| An STI ('yes' to direct question or experienced a specific symptom) | 4.6 | 14.1 | 11.4 | 2.6 | 5.1 | 4.4 |
| Among sexually-experienced adolescents, ever had:† | | | | | | |
| An STI ('yes' to direct question or experienced a specific symptom) | -- | 20.6 | 20.6 | -- | 4.5 | 5.1 |

*Limited to those who have heard of STIs. Totals may exceed 100 because multiple responses are possible. Sample sizes: females 12-14 (N=241); females 15-19 (N=598); males 12-14 (N=265); males 15-19 (N=693). †Limited to those who had ever had sex. Sample sizes: females 12-14 (N=5); females 15-19 (N=199); males 12-14 (N=4); males 15-19 (N=132). Notes: Ns are weighted. "--" = N is 24 or fewer.

Chapter 8

Risk and Protective Behaviors of Young People

In the era of HIV infection, the concept of risk-taking and protective behavior has gained currency beyond its original usage in population studies. In general, people take risks in various areas of life such as choice of school, partners and investment. One of the risks young people tend to take in life, for example, is the initiation of sexual intercourse, which may or may not be protected. In a number of cases, the adoption of protective measures, such as condom use during sexual intercourse, often depends on the nature of the relationship (e.g., whether the partner is a boyfriend/girlfriend or a casual partner), the relative powers of the persons involved in the relationship (e.g., whether the partner is significantly older or has given the adolescent money or gifts in exchange for sex) and whether alcohol was consumed around the time of sexual intercourse. This chapter provides an overview of adolescents' level of risk and protection against pregnancy and STIs (including HIV), and synthesizes information on risk and protective behaviors related to sex—particularly those concerning condom and alcohol use and the exchange of money or gifts for sex.

Self-Perceived Risk of HIV

Risk can be measured either subjectively, as the perception of the person involved (self-perceived risk), or objectively, using behavioral indicators. An individual's recognition of self-perceived risk can motivate him or her to take action to change or not to change behavior. On the other hand, objective measures of risk provide some of the basis for intervention programming and evaluation. Chart 8.1 shows adolescents' perceptions of their risk of contracting HIV, by age and sex, and Chart 8.2 shows self-perceived risk for 15–19-year-old females, by union status.

About two out of three female and male adolescents felt that they were not at any risk of contracting HIV. This varied by age with higher percentages among the younger adolescents (female 72% and male 70%) than the older ones (female 58% and male 57%). Among

those aged 15–19 years, 11% of females and 14% of males considered themselves at high risk of contracting HIV. Eighteen percent of females and 17% of males aged 15–19 years felt that they had a low chance of contracting HIV. About 5% of females and males could not indicate their level of risk. Self-perceived risk was further analyzed for females aged 15–19, with 61% of females not in a union and 53% of those in a union considering themselves not to be at risk of HIV. Ten percent and 12% of females not in a union and in a union, respectively, perceived themselves to have a high chance of contracting HIV. In addition, 18% of females not in a union and 24% of those in a union felt that they had a low chance of contracting HIV. In general, self-perceived risk was low for both males and females. But for female adolescents in a union, a higher percentage considered themselves to be at risk than those not in a union, although one would have expected the opposite. This observation, if it is the reality, indicates that adolescent females in union do not consider marriage to give them the protection that it is expected to provide. This is an area which will need further studies.

Profiles of Adolescent Sexual Behavior and Condom Use

Charts 8.3 and 8.4 present information on risk and protection for all adolescents, by type of relationship to sexual partner (cohabiting and noncohabiting partners). In addition, it focuses on adolescents who had had sex in the 12 months prior to the survey and risk to males and females by type of partner. Categories are based on standard behavioral indicators developed by the Joint United Nations Programme on HIV/AIDS and other organizations to guide the monitoring and evaluation of national AIDS prevention programs.

As observed in Chapter 4, the percentage of female adolescents who had ever had sex began to increase sharply after age 15, by which time only 7% had sex. Eighteen percent of 16-year-olds, 46% of 18-year-olds and 60% of 19-year-olds had ever had sex (Chart 8.3).

The percentage of female adolescents who had had sex but not in the 12 months prior to the survey increased from less than 1% among the 12- and 13-year-olds to 14% each among 18- and 19-year-olds.

Initiating sex at an early age puts young people at risk, and it puts them at further risk of pregnancy and infection if no protection is used. The results indicate that only 2% each of 18- and 19-year-old females had used condoms during sex with a spouse/cohabiting partner in the 12 months prior to the survey, while 6% of the 18-year-olds and 16% of the 19-year-olds had sex with a spouse/cohabiting partner and did not use condoms. On the other hand, 10% of the 18-year-olds and 13% of the 19-year-olds had protected sex with a noncohabiting partner in the 12 months prior to the survey, and 15% had sex with a noncohabiting partner in that time period, but did not use a condom. Of the females aged 19 years who had sex with a boyfriend, 14% used a condom but 29% did not.

The patterns by age at which male adolescents initiated sexual intercourse were similar to that for females, with the proportion who had ever had sex increasing sharply after age 16. Among 19-year-old males, 39% had ever had sex (Chart 8.4). For both males and females aged 19 years, 14–15% of those who had ever had sex did not have sex in the 12 months leading up to the survey. For the rest, the proportion of males who had ever had sex with different types of partners and who reported no condom use were lower than those for females. For instance, 11% of males and 15% of females aged 19 years had sex with a noncohabiting partner within the 12 months prior to the survey without using a condom.

Results presented in Charts 8.5 and 8.6 show condom use at last sex by number of recent sex partners for adolescents who had had sexual intercourse in the 12 months leading up to the survey. Among females who had sex in the that time period with only one partner, 32% used a condom, while 60% did not use a condom. Among male adolescents who had sex in that period with one partner, 32% used a condom, compared with 43% who did not use a condom (Chart 8.6). Of those who had sex with two or more partners, 17% of males and 5% of females used a condom, while 3% and 8%, respectively, of males and females did not use condom. More females than males were likely to use condoms if they had had sex with only one partner. The percentage of females with two or more partners who used a condom during sex, although small, was higher than those who did not use condom.

Condom Use at Last Intercourse

Table 8.1 shows the percentage of adolescents who used a male condom at last sexual intercourse by characteristics of the sexual relationship and whether there was an exchange of money and gifts for sex, or if alcohol was used at last sex by one or both partners. Only 11% of females in a union and 15% of those with a live-in partner used a condom at last sex. Among those who had had sex with a boyfriend, 46% used a condom. In the case of males, 48% who last had sex with a girlfriend in the 12 months prior to the survey used condom. Thus, there was the tendency for condoms to be used if sexual intercourse was with a boy/girlfriend. Condoms were also used more by females if the age difference between sexual partners was narrower (48% of females 1–4 years and 33% of females 5–9 years younger than their partners used condoms).

Duration of a relationship has implications for condom use. Partners will generally adopt a protective measure, such as condom use, in the early stages of a noncohabiting relationship. As shown in the third panel of Table 8.1, 61% of females aged 15–19 years who are not in a union and 52% of males of the same age who had sex only once used condoms. Thirty-two percent of females who had been in a relationship for three months or less used condoms, compared with 22% of females who had been in relationships for longer than two years. The data, therefore, suggest that condom use decreased with increased duration of noncohabiting relationships.

Receiving money or gifts in exchange for sex is also likely to influence condom use: Forty-four percent of females not in a union who had sex in exchange for money or gifts used condoms compared to 50% of those who did not receive money or gifts in exchange for sex. Among 15–19-year-old males, 45% of those who received money or gifts used condoms compared to 52% of those who did not receive anything in exchange for sex. There were too few cases in each group to draw conclusions about condom use among adolescents who consumed alcohol when they last had sexual intercourse, but 44% of 15–19-year-old females not in a union and 52% of males 15–19-year-olds who did not use alcohol used condoms at last sex.

Given that ethnic groups in Ghana are still relatively pronatalist, young married couples are expected to give birth just after marriage and, therefore, are not likely to use any protection against pregnancy or STIs. As shown in Table 8.2, 23% of females in a union did not use condoms at last sex because they wanted to become pregnant. A possibly related reason for 19% of

females aged 15–19 years in a union and 18% not in a union for not using condoms is that their partner refused to use a condom. It appears the influence of male partner was an important factor in condom use for female adolescents. Overall, 22% of females and 32% of males indicated that they felt safe in their relationships and, therefore, did not use a condom at last sex. Twenty-six percent of males did not use condoms at their last sexual act because they said they did not have condoms readily available. Thus, the possibility of using condoms during sex was influenced by partner and the circumstances under which sex occurred (i.e., either partner wanted to become pregnant/impregnate the girl, sex was spontaneous such that a condom could not be used or one was not readily available).

Consistent Use and Reported Problems with Recent Condom Use

To achieve the protective effect against pregnancy and STIs, including HIV, condoms must be used effectively and consistently. In most studies, condom use at last sex has been used as proxy for condom use at every act of sexual intercourse. In the 2004 National Survey of Adolescents, males were asked more detailed questions such as the frequency of sexual intercourse and condom use in the three months prior to the survey and for up to three different sexual partners. These questions were not asked of female adolescents on the assumption that males would provide more accurate reports of actual problems experienced in using male condoms and because female adolescents report fewer sex partners on average and the focus was on the use of the male condom among adolescents with multiple sexual partners. Those who reported “don’t know” or who refused to answer were coded as missing for questions on sexual intercourse and condom use.

The mean number of acts of sexual intercourse in the three months prior to the survey per young male was four. Thirty-nine percent engaged in only one sexual act in the that time period, while 20% and 14% engaged in two and three sexual acts, respectively. While the mean number of sexual acts was 4.2, the mean number of sex acts with condom use in the last three months was only 2.1 (Table 8.3). That is, condoms were used in half of the sexual acts that took place within the three months preceding the survey. Forty-three percent of males who had sex indicated that they did not use condom during sexual intercourse in that time period, 22% used a condom once only and 11% used a condom twice. Three percent of adolescent males used condoms more than 10 times. In all, 45% of

adolescent male sexual acts in the three months prior to the survey were protected by condoms. In contrast, 43% of sexual acts were not protected at all. About one in five male adolescents said they started having sex before putting on a condom or said that a condom they were using slipped off or broke during intercourse. In both cases, the protective effect of the condom was compromised.

Knowledge and Attitudes About Male Condoms

Consistent and effective use of a male condom to prevent pregnancy and the transmission of HIV may be influenced by attitudes toward condoms and the confidence one has about its usage. In the survey, adolescents were asked if they had ever seen a formal demonstration on how to use a condom and if they thought they could use a condom correctly. Experience with demonstrations of condom use varied by age and sex. More males than females and more 15–19-year-olds than 12–14-year-olds had observed a condom demonstration. Thirty-nine percent of females and 49% of males indicated that they had ever seen a formal condom demonstration (Table 8.4). Among males, the proportion of 12–14-year-olds who reported ever seeing a demonstration was 38%, compared with 57% for the 15–19 year age-group.

Sixty-nine percent of females and 80% of males agreed that condoms should always be worn before sexual intercourse starts, but the percentages were lower for 12–14-year-old females (61%) and males (73%) than the 15–19-year-old females (75%) and males (84%). About one in 10 females and males (13% and 12%, respectively) disagreed with the statement that a condom should be put on before sex (Table 8.4), indicating a misunderstanding of when condoms should be worn for sex.

About two in five females and two-thirds of males knew that condoms should be put on the penis only when it is erect or stiff. For males, the percentages who did not know this were 32% and 14%, respectively, for those aged 12–14 years and 15–19 years. Over 60% of females and males knew that condoms could be used only once (the percentages were lower among 12–14-year-olds than among older adolescents) (Table 8.4). The results show gap in knowledge about the proper use of the male condom among adolescents, especially the younger ones.

A positive attitude towards a product or an issue will generally predispose a person to use the product or identify with the issue. Thus, it would be expected that people with positive attitudes towards condoms are

more likely to use the product. Table 8.5 shows the attitudes of adolescents towards condoms. Over 60% of females and over 50% of males did not know whether the male condom reduces sexual pleasure and 18–20% of females and males were of the view that it did not reduce pleasure. One-quarter of females and about one-third of males agreed to the statement that using a condom was a sign that one did not trust the partner. Another third disagreed with the statement and the rest did not know.

About 60% of female adolescents and 48% of males felt that it was embarrassing to buy or ask for condoms; 24% of females and 35% of males did not feel that asking for or buying condoms could be embarrassing. Only 21% of males said they were very confident that they would know how to use a condom correctly, and 25% of females were very confident that they could ask their partner to use a condom. Fifty-three percent of females and 58% of males were not at all confident, and among the younger adolescents the percentages were even higher (females, 62%; males 75%) (Table 8.5). The results point to negative attitudes towards and lack of confidence in using condom among young people.

Recent Experiences with Cutting, Piercing and Injections

Some of the sociocultural practices that can potentially place adolescents at risk of HIV transmission are reusing sharp instruments or blades for piercing or scarification, which still occurs in some areas, and recycling needles for injections. The lack of health facilities in a number of small villages and communities has led to the hawking of drugs and injections by sometimes unqualified providers, who take advantage of society's attitudes that injections are the best form of treatment for various ailments. Piercing, which was traditionally done only for baby girls, has now become fashionable among both adult males and females. Although recent research evidence has shown that unsafe injections are not major modes of HIV transmission in Sub-Saharan Africa, and that sexual transmission remains the primary means by which HIV has spread in the continent,⁴² it is still important to know the potential role of sharp instruments in the transmission of HIV infection.

Table 8.6 shows the percentage of adolescents reporting that they received any cuts or piercing with blades or sharp instruments, or who received any injections in the 12 months prior to the survey. The questions on injections were based on World Health Organization injection practice indicators. The measures are

simply a rough proxy for exposure to potentially unsafe blades or other sharp instruments.

Thirty-six percent of females and 56% of males reported that they had experienced cuts (e.g., for scarification) or undergone piercing with blades or other sharp instruments in the 12 months prior to the survey (Table 8.6 panel 1). The percentages are slightly higher for the 12–14 age-group (females, 37%; males, 58%) than the 15–19 age-group for both females (35%) and males (55%). The higher percentages for males are contrary to the expected behavior, since piercing was traditionally done for females and not males, but the proportions also include cuts for purposes of scarification.

Ghana can be described as a country with an injection culture: People expect to receive injections, no matter the ailment. Taking advantage of the situation, drug sellers in both rural and urban areas give injections for various ailments. Forty-two percent of adolescent females and 48% of males reported having received injections in the 12 months preceding the survey. For adolescent females, about the same percentage of 12–14-year-olds (41%) and 15–19-year-olds (42%) reported injections, while for the males, 51% of younger adolescents and 46% of older adolescents reported injections. Thirty-nine percent of female and male adolescents received only one injection in the 12 months prior to the survey, and 28% and 25% of females and males, respectively, received two injections. About 7% received six or more injections within this time period.

Over 91% of the injections were administered by either a nurse (females, 65% and males, 58%) or a doctor (females, 26% and males, 33%), indicating that most injections take place in a supervised health system. Drug vendors administered injections to 2–3% of adolescents who had recently received injections, and another 1–2% reported a pharmacist as the source of the injection. Injections administered by professionals, such as nurses and doctors, are more likely to be safe. The use of sharp instruments outside the health system for injections, body scarification, piercing and genital cutting will need to be addressed.

Policy and Program Implications

Young people are among those at high risk of contracting HIV, yet they do not perceive themselves to be at risk and are, therefore, less likely to adopt protective measures. The results indicate a low self-perceived risk of HIV infection, early sexual debut, negative attitudes towards condoms and a lack of confidence in the pur-

chase and use of condoms. There is also inconsistent use of condoms among those who reported using them. Among the challenges emerging from the findings are positively promoting condoms and improving adolescents' confidence about purchasing and using them. Condom use will need to be promoted for dual protection from pregnancy and STIs, including HIV.

TABLE 8.1 Percentages of adolescents who had sexual intercourse in the last 12 months and used a male condom at last sex, by relationship type, age of partner, duration of sexual relationship, gifts or money received, and alcohol use, according to sex, age and union status, 2004 National Survey of Adolescents

| Characteristic | Females | | | | Males | | |
|---|----------------|----------------------------------|-----------------------------|------------------|----------------|------------------|------------------|
| | 12-14 (N=9) | 15-19 Not in union (N=186) | 15-19 In union (N=64) | Total (N=261) | 12-14 (N=7) | 15-19 (N=130) | Total (N=137) |
| % using condom, by relationship to last sex partner | | | | | | | |
| Spouse | -- | -- | [11.4] | [11.4] | -- | -- | -- |
| Live-in partner | -- | -- | -- | [14.8] | -- | -- | -- |
| Boyfriend/girlfriend | -- | 45.9 | -- | 44.3 | -- | 49.5 | 47.9 |
| Casual acquaintance | -- | -- | -- | -- | -- | [51.7] | [45.5] |
| Commercial sex worker | -- | -- | -- | -- | -- | -- | -- |
| Other | -- | -- | -- | -- | -- | -- | -- |
| % using condom, by age difference with last sex partner | | | | | | | |
| Partner is 10+ years older | -- | -- | -- | [32.0] | -- | -- | -- |
| Partner is 1-4 years older | -- | 52.2 | -- | 48.2 | -- | -- | -- |
| Partner is 5-9 years older | -- | 44.4 | [11.1] | 32.5 | -- | -- | -- |
| Partner is older, don't know specific age | -- | -- | -- | -- | -- | -- | -- |
| Partner is same age or younger | -- | -- | -- | -- | -- | 51.0 | 50.0 |
| Don't know | -- | [30.6] | -- | [23.4] | -- | -- | -- |
| % using condom, by duration of last sexual relationship (months) | | | | | | | |
| Had sex one time only | -- | [60.7] | -- | [58.6] | -- | [52.0] | [52.0] |
| 3 months or less | -- | -- | -- | [32.4] | -- | [51.2] | [44.7] |
| 4-11 months | -- | [51.6] | -- | [40.4] | -- | -- | -- |
| 1 year | -- | [47.2] | -- | 39.2 | -- | -- | -- |
| 2 years | -- | [46.2] | -- | 37.3 | -- | -- | -- |
| More than 2 years | -- | [30.0] | -- | [21.7] | -- | -- | -- |
| % using condom, by gifts or money received for sex* | | | | | | | |
| Received gifts or money | -- | 44.4 | N/A | 43.1 | -- | [44.8] | [43.3] |
| No gifts or money | -- | [50.0] | N/A | [44.2] | -- | 52.1 | 48.7 |
| % using condom, by alcohol use at last sex† | | | | | | | |
| Partner or respondent drank alcohol at last sex | -- | -- | -- | [25.0] | -- | -- | -- |
| No alcohol at last sex | -- | 44.2 | 16.9 | 36.5 | -- | 52.0 | 50.0 |

*Question not asked if most recent partner was the first sex partner ever and had sex only one time, or if partner was a spouse or cohabiting partner. Sample sizes: females 12-14 (N=8); females 15-19 not in union (N=146); females 15-19 in union (N=4); males 12-14 (N=7); males 15-19 (N=102). †Question not asked if most recent partner was the first sex partner ever and had sex only 1 time. Sample sizes are: female, 12-14 (N=7); females 15-19 not in union (N=166); females 15-19 in union (N=64); males 12-14 (N=7); males 15-19 (N=114). Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25-49.

TABLE 8.2 Percentage distribution of adolescents who had sex in last 12 months and did not use a condom, by reasons for nonuse of condoms* at last sex, according to sex, age and union status, 2004 National Survey of Adolescents

| Characteristic | Female | | | Total | Male | | |
|--|----------------|---------------------------------|-----------------------------|-------|----------------|-----------------|-----------------|
| | 12-14 (N=6) | 15-19 Not in union (N=93) | 15-19 In union (N=53) | | 12-14 (N=7) | 15-19 (N=58) | Total (N=65) |
| Wanted to get pregnant/make someone pregnant | -- | 2.2 | 22.6 | 9.2 | -- | 5.2 | 4.6 |
| Partner refused | -- | 18.3 | 18.9 | 19.7 | -- | 6.9 | 7.7 |
| Didn't have condom | -- | 6.5 | 9.4 | 7.2 | -- | 24.1 | 26.2 |
| Felt safe | -- | 24.7 | 18.9 | 22.4 | -- | 34.5 | 32.3 |
| Didn't know how to use | -- | 6.5 | 1.9 | 3.9 | -- | 12.1 | 10.8 |
| Other | -- | 17.2 | 9.4 | 15.1 | -- | 12.1 | 10.8 |
| Pregnant/partner pregnant | -- | 0.0 | 0.0 | 0.0 | -- | 0.0 | 0.0 |
| Don't know | -- | 24.7 | 18.9 | 22.4 | -- | 5.2 | 7.7 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Question not asked if respondent had sex only one time with first sex partner. Notes: Ns are weighted. "--" = N is 24 or fewer.

TABLE 8.3 Percentage of males aged 12–19 who had sex in the last three months, by frequency of sexual intercourse, condom use and experiences with condom problems, 2004 National Survey of Adolescents

| Characteristic | Males (N=93) |
|--|-----------------|
| Number of acts of sexual intercourse in last 3 months | |
| 1 | 38.9 |
| 2 | 20.0 |
| 3 | 13.6 |
| 4 | 6.1 |
| 5 | 1.0 |
| 6 | 7.3 |
| 7 | 1.1 |
| 8 | 3.4 |
| 9 | 0.0 |
| 10 | 1.7 |
| 11+ | 6.8 |
| Total | 100.0 |
| Mean number of acts of sexual intercourse in last 3 months per sexually active young man | |
| Total | 4.2 |
| With a girlfriend or cohabiting partner | 3.8 |
| With other type of partner (casual acquaintance, commercial sex worker, other) | 0.4 |
| Number of times a male condom was used in last 3 months | |
| 0 | 43.2 |
| 1 | 22.2 |
| 2 | 10.7 |
| 3 | 6.2 |
| 4 | 5.6 |
| 5 | 0.0 |
| 6 | 7.2 |
| 7 | 1.0 |
| 8 | 0.0 |
| 9 | 0.0 |
| 10 | 0.5 |
| 11+ | 3.4 |
| Total | 100.0 |
| Mean number of times a male condom was used in last 3 months per sexually active young man | |
| Total | 2.1 |
| With a girlfriend or cohabiting partner | 1.9 |
| With other type of partner (casual acquaintance, commercial sex worker, other) | 0.2 |
| Proportion of acts of sexual intercourse where a male condom was used per sexually active young man | |
| 0% | 43.2 |
| 1–25% | 1.0 |
| 36–50% | 8.1 |
| 51–75% | 0.8 |
| 76–99% | 2.3 |
| 100% | 44.6 |
| Total | 100.0 |
| Ever started having sex without a male condom and then put one on later in last 3 months* | |
| No | [80.8] |
| Yes | [19.2] |
| Total | [100.0] |
| Ever had a male condom break or slip off during sex in the last 3 months* | |
| No | [79.4] |
| Yes | [20.6] |
| Total | [100.0] |

*Question not asked if partner was the first sex partner ever and had sex only one time.
Sample size: males (N=47). Notes: Ns are weighted. [] = N is 25–49.

TABLE 8.4 Percentage distributions of adolescents who have ever heard of a male condom, by knowledge about male condoms, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=769) | 15–19 (N=1141) | Total (N=1910) | 12–14 (N=796) | 15–19 (N=1185) | Total (N=1981) |
| Ever seen a formal condom demonstration | | | | | | |
| Yes | 26.3 | 47.6 | 39.0 | 37.7 | 57.0 | 49.3 |
| No | 72.6 | 51.7 | 60.1 | 60.6 | 42.9 | 50.0 |
| Don't know | 1.2 | 0.7 | 0.9 | 1.8 | 0.1 | 0.8 |
| Condom should always be put on before sexual intercourse starts | | | | | | |
| Agree | 61.3 | 74.8 | 69.4 | 73.4 | 83.9 | 79.7 |
| Disagree | 12.9 | 12.9 | 12.9 | 12.5 | 11.6 | 12.0 |
| Don't know | 25.8 | 12.3 | 17.7 | 14.0 | 4.5 | 8.3 |
| Condom should be put on only if the penis is fully erect or stiff | | | | | | |
| Agree | 25.6 | 51.8 | 41.3 | 54.5 | 75.8 | 67.2 |
| Disagree | 10.6 | 12.1 | 11.5 | 13.6 | 10.5 | 11.7 |
| Don't know | 63.8 | 36.2 | 47.2 | 31.9 | 13.7 | 21.0 |
| Condom can be used more than once | | | | | | |
| Agree | 10.2 | 9.3 | 9.7 | 14.8 | 17.1 | 16.2 |
| Disagree | 51.9 | 69.1 | 62.2 | 57.6 | 68.7 | 64.3 |
| Don't know | 37.9 | 21.6 | 28.1 | 27.6 | 14.1 | 19.6 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted.

TABLE 8.5 Percentage distribution of adolescents, by attitudes about male condoms, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=765) | 15-19 (N=1139) | Total (N=1904) | 12-14 (N=806) | 15-19 (N=1191) | Total (N=1997) |
| Condom reduces sexual pleasure | | | | | | |
| Agree | 7.8 | 20.2 | 15.2 | 16.6 | 35.9 | 28.1 |
| Disagree | 16.6 | 22.7 | 20.3 | 14.8 | 20.8 | 18.4 |
| Don't know | 75.6 | 57.1 | 64.5 | 68.6 | 43.2 | 53.5 |
| Using a condom is a sign of not trusting your partner | | | | | | |
| Agree | 19.1 | 29.3 | 25.2 | 27.4 | 39.2 | 34.5 |
| Disagree | 28.9 | 39.3 | 35.2 | 31.6 | 38.6 | 35.8 |
| Don't know | 52.0 | 31.3 | 39.6 | 41.0 | 22.2 | 29.7 |
| It is embarrassing to buy or ask for condoms | | | | | | |
| Agree | 61.7 | 58.2 | 59.6 | 49.6 | 46.7 | 47.9 |
| Disagree | 18.0 | 28.3 | 24.2 | 27.4 | 39.6 | 34.7 |
| Don't know | 20.3 | 13.5 | 16.2 | 23.0 | 13.7 | 17.4 |
| Level of confidence in getting male partner to wear a condom (females)/knowing how to use a condom (males) | | | | | | |
| Very confident | 15.9 | 30.7 | 24.8 | 8.4 | 28.6 | 20.5 |
| Somewhat confident | 22.1 | 21.6 | 21.8 | 16.1 | 25.4 | 21.6 |
| Not at all confident | 62.0 | 47.7 | 53.4 | 75.4 | 46.0 | 57.9 |
| Total | | | | | | |

Notes: Ns are weighted.

TABLE 8.6. Percentage distribution of adolescents, by recent experiences with other potential sociocultural risk factors, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=957) | 15–19 (N=1234) | Total (N=2191) | 12–14 (N=966) | 15–19 (N=1254) | Total (N=2220) |
| Received any cuts or piercing with blades or other sharp instruments in last 12 months | | | | | | |
| Yes | 37.2 | 34.8 | 35.9 | 58.4 | 54.9 | 56.4 |
| No | 62.8 | 65.2 | 64.1 | 41.6 | 45.1 | 43.6 |
| Received any injections in last 12 months | | | | | | |
| Yes | 40.6 | 42.2 | 41.5 | 50.8 | 46.3 | 48.3 |
| No | 59.4 | 57.8 | 58.5 | 49.2 | 53.7 | 51.7 |
| Number of injections received in last 12 months* | | | | | | |
| 1 | 44.0 | 35.2 | 38.9 | 40.4 | 37.1 | 38.6 |
| 2 | 25.2 | 29.6 | 27.7 | 24.5 | 24.5 | 24.5 |
| 3 | 16.7 | 16.0 | 16.3 | 16.8 | 17.1 | 17.0 |
| 4 | 6.9 | 7.7 | 7.4 | 6.5 | 6.4 | 6.4 |
| 5 | 2.8 | 4.2 | 3.6 | 4.9 | 7.8 | 6.4 |
| 6+ | 4.4 | 7.3 | 6.1 | 6.9 | 7.2 | 7.1 |
| Person who administered last injection received in last 12 months* | | | | | | |
| Doctor | 23.9 | 27.0 | 25.7 | 31.3 | 34.4 | 33.0 |
| Nurse | 67.6 | 62.6 | 64.8 | 58.2 | 58.0 | 58.1 |
| Pharmacist | 0.5 | 1.9 | 1.3 | 2.4 | 1.5 | 2.0 |
| Drug vendor | 2.3 | 1.9 | 2.1 | 2.8 | 2.9 | 2.9 |
| Self | 0.5 | 0.6 | 0.5 | 0.0 | 0.0 | 0.0 |
| Friends or family | 0.5 | 1.3 | 1.0 | 1.2 | 0.3 | 0.7 |
| Immunization team | 3.3 | 2.7 | 3.0 | 0.0 | 0.0 | 0.0 |
| Other | 1.3 | 1.9 | 1.6 | 4.0 | 2.8 | 3.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to adolescents who received an injection in the last 12 months. Sample sizes: females 12–14 (N=389); females 15–19 (N=520); males 12–14 (N=493); males 15–19 (N=580). *Note:* Ns are weighted.

Chart 8.1 Self-perceived risk of HIV among adolescents, by sex and age, 2004 National Survey of Adolescents

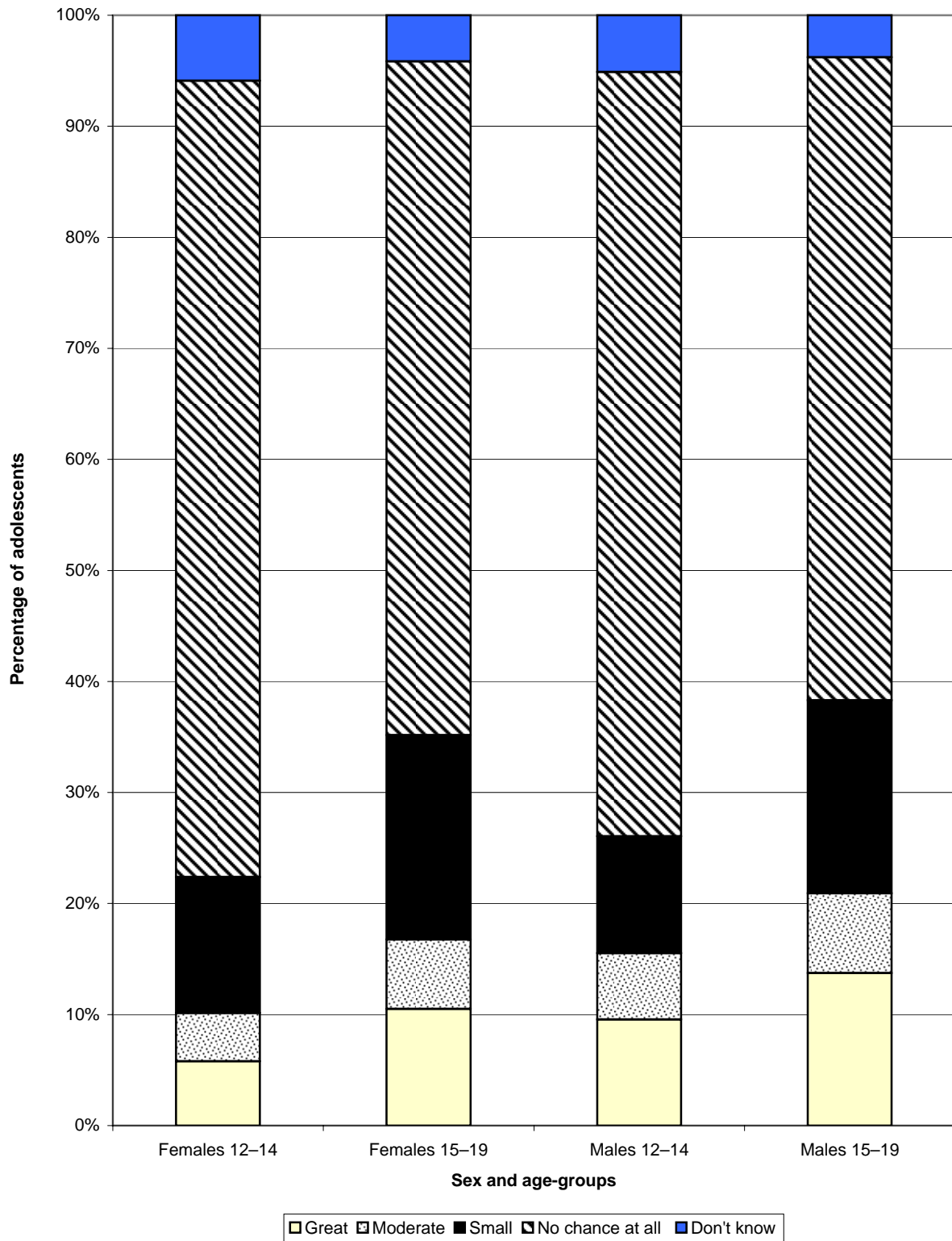


Chart 8.2 Self-perceived risk of HIV among 15–19 year-old females by union status, 2004
National Survey of Adolescents

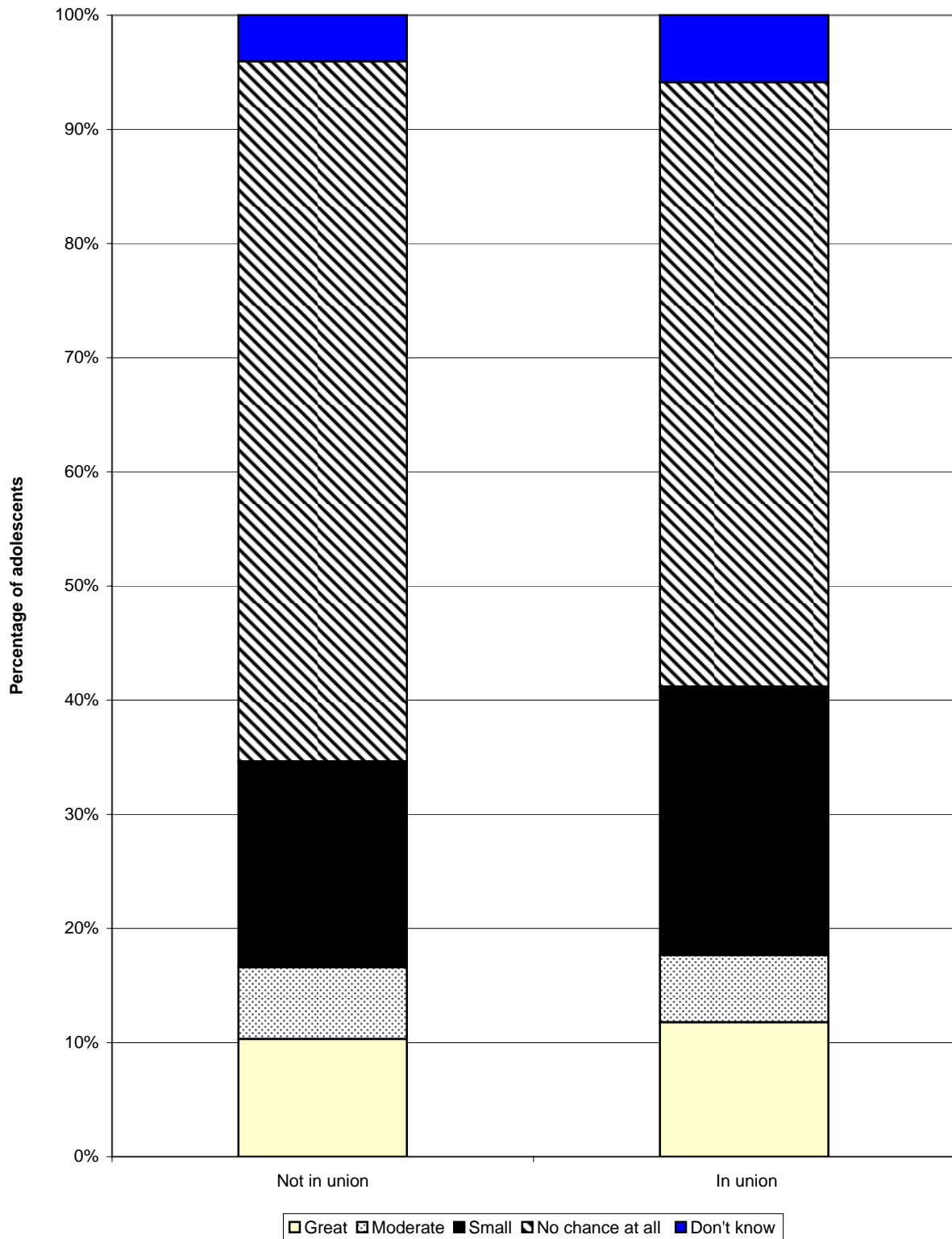


Chart 8.3 Sexual behavior and condom use at last sex among female 12–19-year-olds, 2004
National Survey of Adolescents

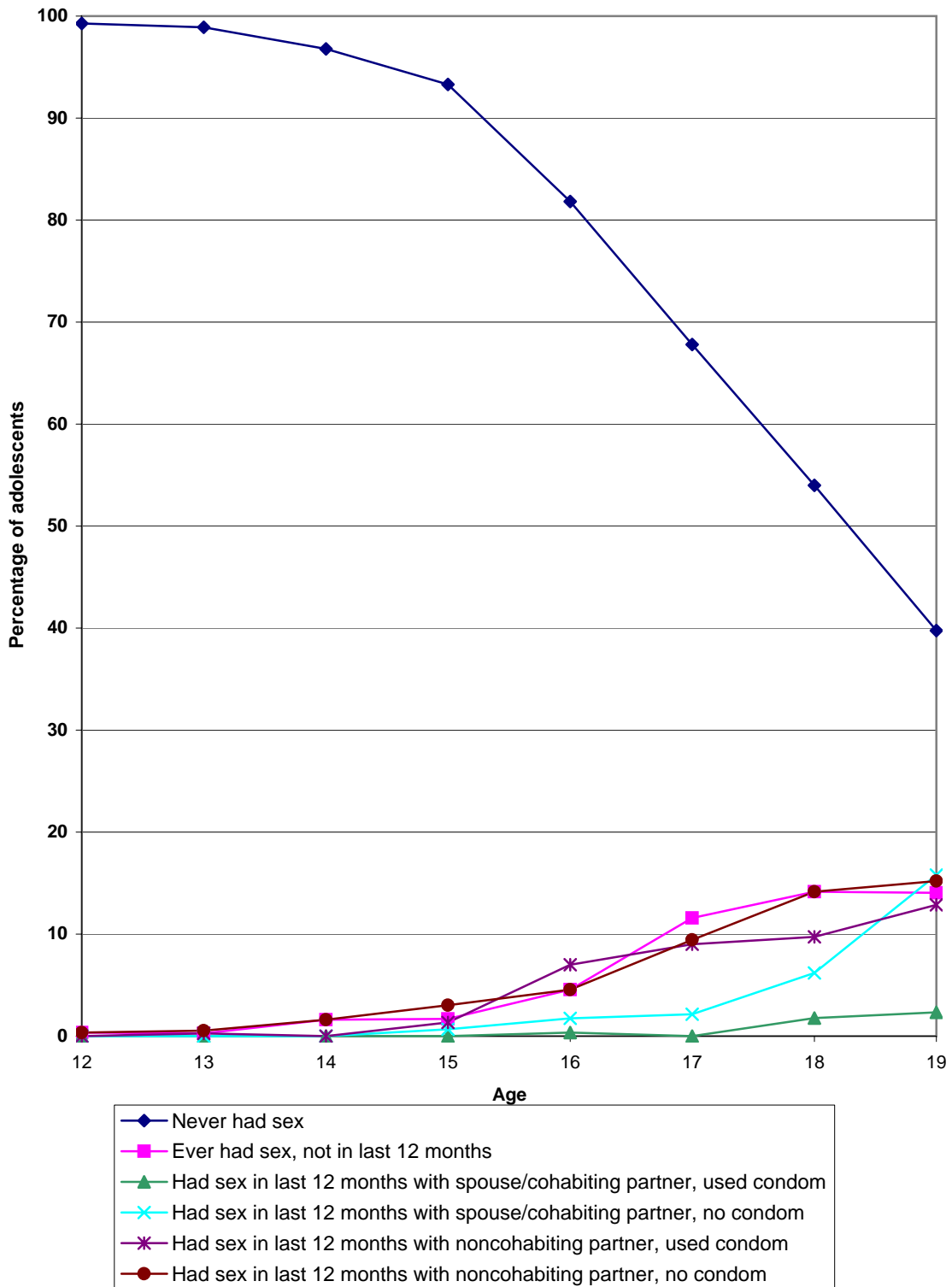


Chart 8.4 Sexual behavior and condom use at last sex among male 12–19-year-olds, 2004 National Survey of Adolescents

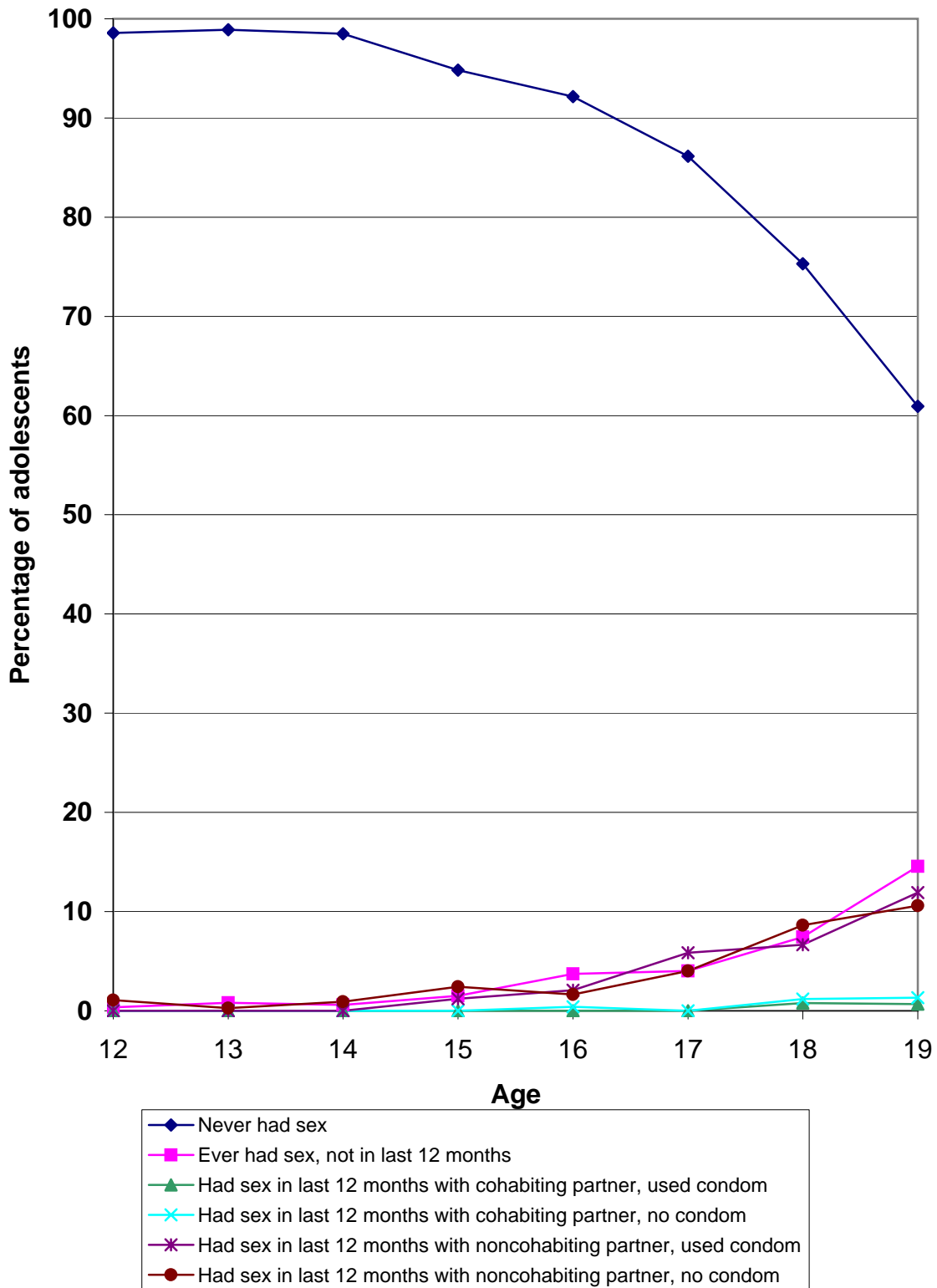
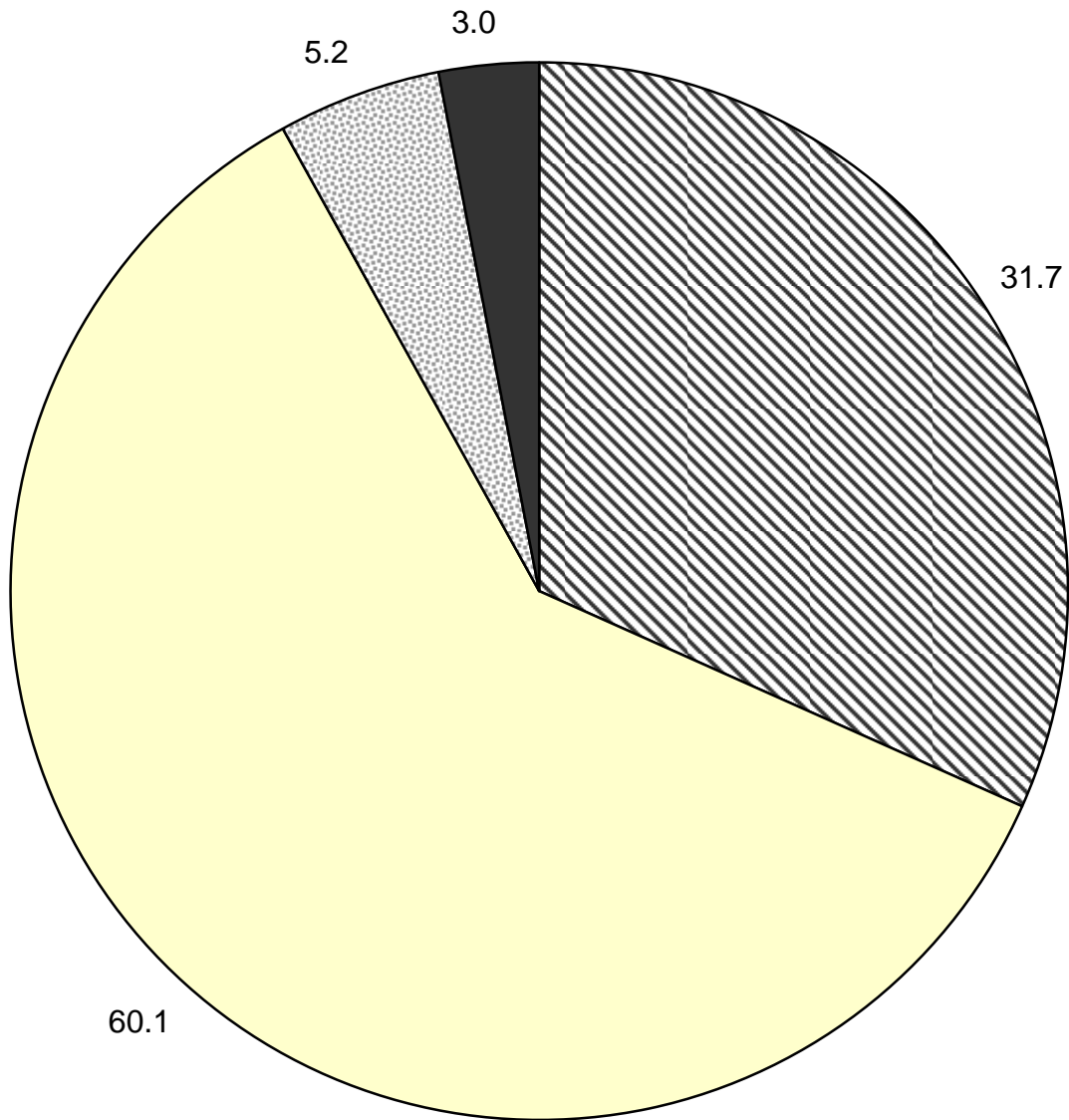
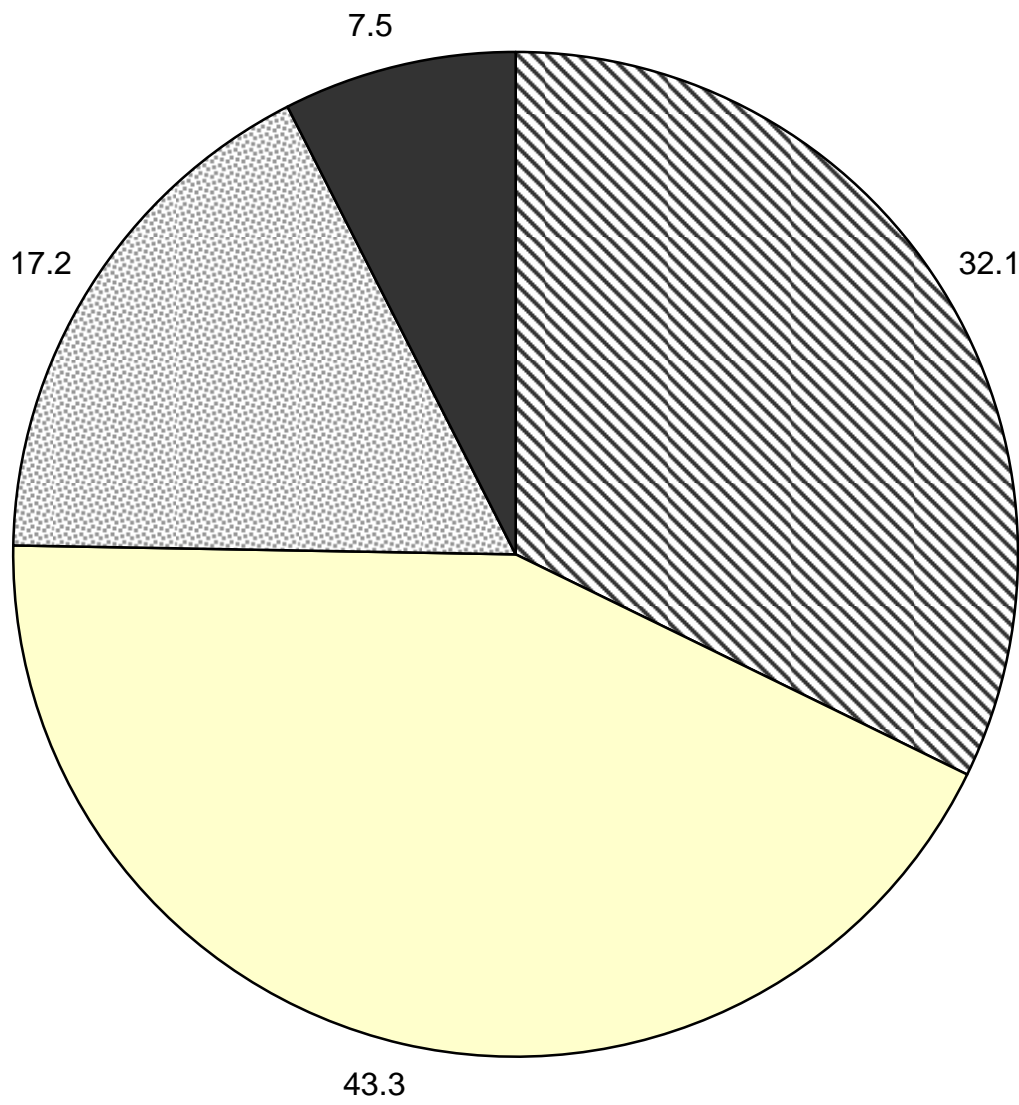


Chart 8.5 Sexual behavior and condom use at last sex among female 12–19-year-olds who had sex in last 12 months, 2004 National Survey of Adolescents



■ 1 partner in last 12 months, used condom □ 1 partner in last 12 months, no condom
■ 2+ partners in last 12 months, used condom ■ 2+ partners in last 12 months, no condom

Chart 8.6 Sexual behavior and condom use at last sex among male 12–19-year-olds who had sex in last 12 months, 2004 National Survey of Adolescents



| | |
|--|--|
| ▣ 1 partner in last 12 months, used condom | ▣ 1 partner in last 12 months, no condom |
| ▣ 2+ partners in last 12 months, used condom | ▣ 2+ partners in last 12 months, no condom |

Chapter 9

Sexual and Reproductive Health Information and Services

Sources of information on sexual and reproductive health range from mass media to small group discussions and individual consultation.⁴³ This chapter addresses sources of information on sexual and reproductive health and adolescents' levels of awareness, preferences, utilization and evaluation of information on health services and providers of contraceptive methods, STI treatment, HIV prevention and voluntary counseling and testing for HIV. Results are presented for modern and traditional providers, as well as for the public and private sectors, as these variations have implications for policy and programming. It also describes the barriers that adolescents face in obtaining information and treatment for different sexual and reproductive health problems.

Mass Media

The mass media—as a means of conveying information to adolescents and to the general public—has the advantage of reaching a large number of people simultaneously. For instance, radio advertisement reaches a larger number of people than can be reached in the classroom situation. Among the major disadvantages of mass media are that it is impersonal, it is not usually interactive, not everyone has access to certain types of media and some people do not have access to any form of mass media. The major forms of mass media explored in the survey are radio, television and newspapers, and there was one question about internet use.

As shown in Table 9.1, 40% of females and 43% of males reported that they listen to the radio almost every day and another 34% of females and 37% of males listen to the radio at least once a week. For both sexes, 15–19-year-olds report slightly higher levels of exposure than younger adolescents. Forty-eight percent of 15–19-year-old males said that they listen to radio everyday, compared with 36% of 12–14-year-olds. Currently, there are over eighty FM stations in the country. Therefore, most people, including most youth, have access to radio as source of information.

The second panel of Table 9.1 indicates that 57% of females and 56% of males watch television at least once a week. However, about one in four adolescents do not watch television at all. Television is not as widely available as radio, given that that only 48% of the population has access to electricity.⁴⁴

Newspapers and magazines are not commonly used media sources for adolescents: Only one out of three adolescents read newspapers or magazines. The figures are lower for 12–14-year-olds (29% for females and 27% for males) than 15–19-year-olds (38% and 44% for females and males, respectively). Overall, 42–44% of adolescents were exposed to two forms of mass media and an additional 27–30% were exposed to three types of mass media. Only 6% of females and 4% of males were not exposed to any of the three forms of mass media explored.

The Internet is emerging as a source of information worldwide. About half of Ghanaian adolescents had not heard of the Internet and only 6% of females and 11% of males had ever used the Internet (Panel 5 of Table 9.1). Awareness and use of the Internet was higher among older adolescents (females, 5%; males, 13%) than among those 12–14 years of age (females, 3%; males, 9%).

Both newspapers and the Internet are sources that are closely associated with literacy and urban residence. There are no newspapers in the various Ghanaian languages, which seriously limits newspapers as a potential source of information for young people in relation to radio and television, which are available in Ghanaian languages as well as English. The results suggest that the radio is the leading medium available to the majority of young people, due to the fact that it does not rely on electricity and is not associated with literacy. However, it will be useful to promote reading, particularly in local languages and English, so that some forms of information (such as newspapers) which should be retained for further reference can be transmitted to young people.

Experience with and Attitudes Toward Sex Education

In 1994, the government of Ghana published a revised National Population Policy and followed it with an Adolescent Reproductive Health Policy in 1996. One of the strategies in both policy documents was to teach family life education in pre-tertiary educational institutions. Prior to the publication of the two policy documents, organizations such as the Planned Parenthood Association of Ghana and the Ghana Education Service had introduced family life education in the school system on a pilot basis. Recognizing the implications of the HIV/AIDS epidemic for sexual and reproductive health, the teaching of family life education was intensified. The rationale for introducing family life education in the school system was that nearly 90% of children of primary school-going age attend school (as indicated in Table 9.2, 91% of females and 94% of males had ever attended school).

Among those who had ever attended school, 61% of females and 53% of males said that their schools offered classes or talks on sex education. For males and females, more respondents aged 15–19 years reported that sex education was offered in their schools (70% of females and 61% of males) than did 12–14-year-olds (50% females and 41% males). Of those who had ever had sex education, about half of females and 41% of males had received it before age 14 years. Ninety-three percent of female and male adolescents were introduced to sex education before they had their first sexual experience. As shown in Panel 6 of Table 9.2, 86% of female and 81% of male adolescents who participated in sex education classes or talks said they covered topics on pregnancy (how it happens and how to prevent it) and STIs. Abstinence, or how to say “no” to sex, was the most commonly reported topic covered, cited by 95% of females and 93% of males who ever attended a sex education class, meeting or talk.

Some 86% of both females and males reported obtaining most of their sex education from teachers at school. According to the respondents, the information was delivered through lectures (91% of females and 90% of males). There were no large differences in responses by age or sex in the reported methods used for teaching or the main resource person.

Although, according to national policy, sex education is expected to be taught in school, Chart 9.1 shows that more than half of all 12–14-year-olds did not have access to sex education, partly because it was not taught in their school. Among 15–19-year-olds, 58% of females and 46% of males had ever attended sex edu-

cation classes or talks. Also worth noting is the fact that 11% of males did not attend such classes when they were offered. The results point to a gap between sex education policy and its implementation.

Ninety-one percent of females and 89% of males who ever attended school agreed that it was important for sex education to be taught in schools (Table 9.3). The proportion that agreed to the statement was higher among 15–19-year-olds (females, 93%; males, 92%) than 12–14-year-olds (females, 88%; males, 85%). Despite this widespread support for teaching sex education in schools, there was still a minority (about one in four females and males who ever attended school) who felt that discussing sex education with young people would encourage them to have sex. This apparent contradiction for some adolescents (though not the majority) on the teaching of sex education in the school system would need to be addressed.

Over 90% of both female and male adolescents also indicated that young people 12–14-years old should be taught about how to avoid AIDS. However, 49% of females and 34% of males who had heard of both AIDS and the male condom did not think that 12–14-year-olds should be taught about how to use condoms to avoid AIDS. There was a marked difference by age and sex on this attitude, with males more inclined than females and older adolescents more inclined than younger adolescents to support teaching very young adolescents about condoms. The results point to the different attitudes in the society towards condom use, especially for young people.

Sources of Information and Services for Contraceptive Methods

Since the introduction of modern contraceptives, the mass media has been used to advertise these products. Contraceptive methods have also been delivered through the health system. The results indicate that 63% of female and 64% of male adolescents who knew of at least one method obtained information about contraceptive methods from the mass media (Table 9.4). Fifty-one percent of females and 55% of males reported a health worker or teacher as a source of information for contraceptive methods. About one in four adolescents obtained information from friends. When disaggregated, the radio (47% of females and 51% of males), television (45% for both females and males), a teacher (45% of females and 50% of males) and friends of the same sex (22% of females and 23% of males) emerge as the dominant sources of information. Parents are among the least-reported sources. The ob-

served patterns for sources of information about contraceptives are similar to those for discussion on sex-related issues (see Table 3.11).

While the main source of information about contraceptives was the media, the most preferred source for information was a teacher or health provider, as reported by 47% of females and 49% of males. Mass media was the second-most preferred source (34% of females and 41% of males). The results show that the current main sources of information about contraceptives are not always the preferred sources for young people.

Charts 9.2 and 9.3 show the sources of information for contraceptive methods by rural-urban residence. The mass media was the major source of information on contraceptives for 69% of females and 67% of males in urban areas, and 58% of females and 62% of males in rural areas. The results indicate the pervasiveness of the mass media as a major source for information on contraceptive methods for both urban and rural residents. Teachers and health workers emerge as the next major source of information, with more males and females in urban areas reporting a teacher or health worker as sources of information than rural residents. The proportion of respondents who got information from friends was higher for rural than urban residents for both females and males.

Among the ultimate aims of communication and education in reproductive health is to help people make informed choices and overcome barriers so that they can adopt new and/or more effective methods. Barriers to adopting contraceptive methods include societal/familial, program-based and individual barriers (Table 9.5). The barriers associated with the individual, namely feeling embarrassed or shy (56% of females and 45% of males) or afraid or fearful (25% of females and 18% of males) are the most pervasive barriers reported by adolescents to obtaining contraceptive methods. The main societal barrier reported was not being allowed to go out alone (1% for both females and males). The major programmatic barriers reported by 14% of females and 7% of males were unfavorable working hours, no same-sex service providers and lack of privacy. There are some slight gender differences: More females reported feeling embarrassed or shy than males and fewer females than males reported no barriers to obtaining contraceptives (females, 9%; males, 15%).

Table 9.6 shows sources of contraceptives reported by adolescents who knew of at least one method. Almost two-thirds of adolescents (63% of females and 61% of males) did not know any source for contracep-

tive methods. The percentages are higher for the 12–14 age-group (73% for females and males) than for 15–19-year-olds (females, 55%; males, 53%). The most common source reported is a government clinic or hospital (32% of females and 31% of males), and another 14% of females and 19% of males reported a drug store or pharmacy shop. Male-female variation in knowledge about sources of supply is minimal. The major differences occur between young people in urban and rural areas, especially among female adolescents. For instance, 46% of females in urban areas knew of at least one source, compared with only 28% in rural areas (data not shown). For males, 46% of those in urban areas and 33% of their rural counterparts knew of at least one source for contraceptive methods.

As shown in panel 2 of Table 9.6, government clinics or hospitals (the most known source) are also the most preferred source for obtaining contraceptive methods, as reported by 62% of females and 56% of males who knew of any source for obtaining contraceptives. Drug store or pharmacy shops were the second-most preferred source for contraceptives among both females (16%) and males (25%).

Adolescents expressed a high degree of confidence in government clinics or hospitals. The reasons they gave include the perceived confidentiality and accessibility (in terms of distance and cost) of services, and that they believed they would be treated with respect (Table 9.7). Eighty-three percent of both females and males who knew of a government clinic or hospital for obtaining contraceptive methods believed that any information they shared with staff would be kept confidential. More 15–19-year-olds (85%) than 12–14-year-olds (78%) thought this way, though the majority in both age-groups felt information would be kept confidential. Seventy-three percent of both females and males indicated that they would be able to get to a government clinic or hospital easily; one in four said they would not be able to get to a facility easily. Seventy-five percent of females and 81% of males indicated that they would be treated with respect in a government clinic or hospital.

Affordability has become a major issue in health delivery in Ghana. Since independence in 1957, health care delivery has moved from free service through cost recovery under the First Republic to the present health insurance scheme. Problems associated with an inability to pay up front for services led the present government to introduce the health insurance system. Sixty-four percent of female and 65% of male adolescents in the 2004 survey said that they would be able to pay for

the services at government clinics or hospitals (among those who knew of any such facilities and who knew of at least one contraceptive method). About one-third of both females and males indicated they would not be able to pay for services. The reported percentages were higher for the 12–14 age group for both females (44%) and males (35%) than for older adolescents (females, 27%; males, 28%).

While Table 9.7 provides information on the perception of adolescents on present services, Table 9.8 shows the assessment of preferred sources for contraceptives (government health facilities, private health facilities and drug stores) on the dimensions of confidentiality, accessibility in terms of distance and cost, and level of respect with which they would be treated. Over 70% of adolescents felt that information they provide would be kept confidential in all three types of facilities; the percentages were lowest for drug stores. Levels of accessibility in terms of cost and distance were lower for government hospitals than the two others for both males and females. Drug stores or pharmacy shops were considered to be the most readily available and affordable. The results point to the need to promote pharmacy shops that provide quality service, since they can be established in communities more easily and inexpensively than formal health facilities.

Only 35 (out of 2201) female adolescents and 91 (out of 2231) males said they had ever obtained contraceptives (Table 9.9), many fewer adolescents of the total who have ever used contraceptive methods. Part of the reason for this discrepancy may be because male condoms are the most common method used among adolescents and condoms can be obtained from other people (e.g., a friend or sibling or, for female adolescents, their male partners may have obtained the condom) Due to such small numbers it is difficult to identify any definite patterns. Nonetheless, the available data indicate that 26% of females obtained their supplies from government clinics/hospitals while 14% of males did so. Sixty-two percent of males who had ever gone to a place for contraceptive methods said they had gone to drug stores/pharmacy shops

Since family planning was officially introduced in 1962, the mass media has been used to promote its use. Over half of females (54%) and males (55%) had heard of messages about family planning on the radio, while 47% of females and 43% of males had received similar messages from television (Table 9.10). Leaflets or brochures were the least common source for both males and females. As indicated earlier, Ghana is a “listening population,” and therefore messages through the mass

media should concentrate on the radio and television.

With the emergence of the HIV/AIDS epidemic, specific messages have been designed for young people. Among the messages are “Life choices: it’s your life, it’s your choice,” “Obra ni wora bo (life is how you make it)” and “Contraceptives are safe and effective.” To assess coverage, adolescents were asked to indicate the family planning messages they had heard. One-third of females and males had had 3–7 exposures to family planning messages in recent months preceding the survey. Two-thirds of adolescents had heard the message “Obra ni wora bo” (64% and 62% of females and males, respectively). This was followed by 55% of females and 61% of males who had heard “Life choices: it’s your life, it’s your choice”. For all the messages, the percentages of older adolescents reportedly hearing or seeing the messages were higher than those of the younger adolescents. The least known message was “Contraceptives are safe and effective.”

One of the strategies in the maternal and child health program is to encourage pregnant women to use antenatal care at least once during pregnancy. In 2003, the government introduced free service for birth delivery at government hospitals and clinics.⁴⁵ The 2004 survey showed that, among 15–19-year-old females who had had at least one live birth, 80% of those not in a union and 86% of those in a union attended at least one antenatal care visit leading up to the last birth (data not shown). For such young pregnant people, attending antenatal clinics contributes to positive health outcomes and should be encouraged.

Sources of STI Information and Services

This section presents data on reported sources of STI information and services and the utilization of such services for treating STIs. Of those who reported knowing of any STI, the major source of information was either a teacher or health provider (66% of females and 64% of males) (Table 9.11). More female and male 12–14-year olds than older adolescents reported a teacher or health worker as a source. The least common sources for information about STIs were friends for females (11%) and family members for males (10%).

When disaggregated, 62% of females and 57% of males obtained information on STIs from a teacher and only 11% of the females and 17% of the males reported a health worker. The next most popular sources of information were television (43% of females and 38% of males) and radio (42% of females and 38% of males) (Table 9.11). The responses indicate that the young people received information about STIs mainly from

professionals, either a teacher or a health care provider, or the mass media.

The preferred sources of information for STIs were teachers, health workers and the mass media. Fifty-six percent of females and 57% of males preferred to receive information on STIs from either a teacher or a health worker, and 33% of females and 39% of males preferred the mass media for information about STIs. While more younger adolescents (12–14 years old) preferred a teacher or health worker for information on STIs than other sources, older adolescents preferred the mass media over other sources. The least preferred source for information on STIs was friends, as reported by 4% of both female and male adolescents.

Adolescents who did not know of any STI (apart from HIV/AIDS) were asked where young people could get information about infections people get from sexual contact. Table 9.12 shows that four in five female adolescents and 86% of male adolescents did not know of any source young people could go to for such information. Of those who did name a source, doctor/nurse/clinic was the most common source known by both females (13%) and males (9%).

Table 9.13 presents information on perceived barriers to obtaining advice or treatment for STIs. As indicated in the table, only 11% of females and 18% of males did not report any barriers. Among the barriers reported, personal reasons of either feeling embarrassed or shy were reported by 70% of females and 51% of males, followed by 27% of females and 15% of males who indicated that they were afraid or fearful about getting advice or treatment for STIs. As is the case with contraceptives, the individual factors such as feeling shy, embarrassed or fearful were the most prominent barriers to accessing services reported by adolescents. In view of the results, program implementers will need to pay attention to these personal issues.

Health establishments (government clinics or hospitals, private clinics or hospitals and NGO clinics) were the three most common and most preferred sources reported by adolescents for getting treatment for STIs. For example, more than two in three females and males reported government clinic/hospital as a place that one can go for the treatment of STIs, and, among those who knew of any source, 90% indicated government clinic/hospital as their preferred source for treatment (Table 9.14). Only 5% of females and 7% of males reported that they knew of a traditional or spiritual healer or herbalist as a source for STI treatment, and 1–2% of adolescents who knew of any source named these as their preferred source for STI treat-

ment. Almost one-third of both females and males did not know of any source for STI treatment.

Table 9.15 provides information on young people's perceptions of government clinics and hospitals as places to obtain STI treatment. Sources were evaluated on their confidentiality, level of respect with which they treat their patients, cost and physical accessibility. Eighty percent or more of adolescents who knew of a government clinic or hospital for STI treatment felt that this was a confidential source and that young people were likely to be respected there. About three of four adolescents thought it would be easy to get to a government clinic or hospital, and about two-thirds (71% of females and 62% of males) were of the view that they could pay for the cost. It appears that young people have confidence in the formal health system and that cost of treatment and physical accessibility are two issues that policymakers will need to address in order to improve the use of modern health facilities.

Overall, both female and male adolescents were of the view that information shared with staff of private clinics/hospitals would be kept more confidential than information shared at government clinics or hospitals (Table 9.16). For instance, among females who preferred private clinics for STI treatment, 96% thought that their information would be kept confidential, compared with 88% of females whose preferred source for STI treatment was government clinics and hospitals. On the other hand, more adolescents who preferred government clinics and hospitals thought it was easy to get there, compared with adolescents who favored private clinics. Differences in the perception of cost were minimal.

According to Table 9.17, only 91 females and 33 males reported that they had ever had an STI or experienced an STI symptom. Among those who had ever had an STI or symptom, only 34% of females and 15% of males ever went for treatment. Of those reporting for treatment, 45% of females used a government clinic or hospital while 23% used a drug store or pharmacy. Among those who did not go for treatment, 72% preferred a government clinic or hospital. Two-thirds of females and 85% of males who did not seek treatment did not do so because they were either embarrassed (27%, females; 21%, males), could not afford the financial cost (25% of both females and males), did not consider it to be a serious problem (10%, females; 7%, males) or had other reasons (28% females; 24% males). Embarrassment and feeling shy have emerged as two barriers to sexual and reproductive health care utilization among the youth. The results point to the

fact that improving the use of STI facilities would involve helping young people improve their self-esteem and ensuring a friendly and supportive service environment.

Sources of Information and Exposure to Mass Media Messages on HIV/AIDS

Since the inception of the HIV/AIDS epidemic, the mass media has been an important conduit used to educate the public about HIV/AIDS, and this is reflected in the sources of information about HIV/AIDS reported by adolescents (Table 9.18). Seventy-four percent of females and 82% of males cited the mass media as their source for information on HIV/AIDS. Slightly more males than females and slightly more 15–19-year-olds than 12–14-year-olds reported receiving information on HIV/AIDS from the mass media. The least common source of information reported was friends for females (16%) and any family member for males (16%), which is similar to the patterns observed in information sources for contraceptive methods and STIs.

Among specific sources of information on HIV/AIDS, the radio was the most popular for both females (62%) and males (72%), followed by teachers/school for females (57%) and television for males (57%). Friends of the same sex were mentioned by 16% of females and 19% of males followed by mothers (females 12% and males 7%) as sources of information on HIV/AIDS.

Although the main source of information on HIV/AIDS was the media for both males and females, the most preferred source reported was a teacher or health provider (49% for females and males). Teachers alone were mentioned by 36% of both female and male adolescents. Thirty-eight percent of females and 48% of males preferred the mass media.

Adolescents were asked to indicate if they had heard or seen any message on HIV/AIDS and the source of the information in the two to three months prior to the survey. About three-quarters of females and males reported receiving information about HIV/AIDS from the radio and almost two-thirds from television within the period (Table 9.19). Among the mass media sources for HIV/AIDS messages, the least reported sources were newspapers/magazines and leaflets/brochures. The results indicate that Ghanaian youth are more likely to receive messages from the electronic media (radio or television) than the print media. While it is important to continue to provide information on HIV/AIDS in the print media, it will also be important to identify

those who read and provide them with detailed information.

Nearly half of both females and males were reported having been exposed to 3–7 messages on HIV/AIDS messages in the two to three months preceding the survey. Fifteen percent of females and 13% of males indicated that they were not exposed to any information (second panel of Table 9.19). There were no substantial gender differences, rather older adolescents were often exposed to more messages about HIV/AIDS in the mass media than were younger adolescents.

Adolescents were asked about nine slogans/programs on the radio, television and in print. Of the nine, two of them—“Reach out, show compassion” and “Stop AIDS, love life”—were for the general public and the rest specifically targeted young people (Table 9.19, panel 3). About three in four adolescents (73% of females and 79% of males) had heard of the slogan “Stop AIDS, love life.” This slogan was aired on the radio and on television and also produced in poster form. The next most recognized was a television serial for young people known as Things We Do for Love, and which was reported by 58% of females and 60% of males. The least reported slogans were “Don’t go Mungo Park,”⁴⁶ “Think before you play” and “Reach out, show compassion.” The last slogan was also on television and in poster form. It would appear that the messages that either used multiple media (“Stop AIDS, love life”) or developed as a television series depicting the lives of young people had greater appeal to the youth than the rest.

HIV Voluntary Counseling and Testing

With the advent of the HIV/AIDS epidemic, strategies emerged for building confidence and support services for people who want to know their HIV status as part of the process of reducing the spread of the infection and reducing stigma and discrimination. One such strategy is voluntary counseling and testing (VCT). In Ghana, VCT has been introduced in all 10 regional hospitals and the intention is to extend it to all 138 district capitals. Table 9.20 indicates that 81% and 85% of females and males, respectively, had heard of a test for HIV. There are marked differences in the proportions who knew of VCT, with higher proportions of those aged 15–19 years having heard of the test than 12–14-year-olds. Among those who knew of the test, 78% of females and 77% of males knew where one could go to be tested. The most common source cited for getting an HIV test was a government clinic or hospital, named

by 93–95% of adolescents who knew a place to get tested. Another one-quarter of both females and males were aware that services can be obtained at private clinics. When respondents were asked to indicate the mode of payment for the test, 43% of females and 51% of males did not know whether a person had to pay for the test and another 24–27% said that one had to pay to get tested. Thus, the majority of adolescents who knew of a place to get an HIV test were not aware of the official policy that one should not pay for VCT services. That VCT services are free at government health facilities will need to be stressed in publicity campaigns and outreach programs for young people.

Chart 9.5 presents information on knowledge and experience with HIV and VCT. As observed in a number of studies in the country, knowledge about HIV/AIDS is nearly universal. In the present study, only 4% of females and 3% of males had never heard of HIV/AIDS (this percentage is slightly higher for 12–14-year-olds). Between 10% and 23% of adolescents did not know about a test for HIV, and another 17–21% did not know where to get such a test. Of those who had heard of HIV and knew where one could go for VCT, only 2% of both the females and males had gone for a test. The majority of adolescents (52–69%) knew where one could go but had not gone for testing.

Although only 3% of adolescents overall had ever been tested, 71% of those who had never been tested and knew about the HIV test stated that they wanted to be tested (Table 9.21). Among those who wanted to be tested, 25% of females and 20% of males had not gone to be tested because they said they were not sexually active, while another 32% of females and 33% of males did not consider themselves to be at risk for other reasons. Among those adolescents who did not want to be tested, 28% of females and 23% of males indicated that they did not want to go for a test because they were not sexually active, and 38% of females and 41% of males reported that they were not at risk for other reasons. Among those aged 15–19 years, 22% of females and 16% of males did not want to be tested because they did not want to know their HIV status. This fact highlights one of the challenges for HIV/AIDS education in the country. Messages on the epidemic will need to stress the benefits of knowing one's HIV status and the possibility of getting help if one knew his or her status at an early stage of infection.

Policy and Program Implications

The results from the study indicate the following:

- Knowledge of HIV/AIDS was nearly universal, but few young people were aware of other STIs (as has been observed in other studies).
- Electronic media was the main source of information on HIV/AIDS and few adolescents reported receiving information from the print media.
- Young people preferred to obtain information on sexual and reproductive health from professionals, such as teachers and health personnel, and the mass media;
- Among family members, mothers emerged as both common and preferred sources of information about contraceptive methods for both female and male adolescents;
- Two out of three adolescents who knew of at least one contraceptive method did not know about where to obtain a service.
- Among the barriers to the use of contraceptives and STI treatment are that young people feel too embarrassed or shy to use services. Cost was also a factor.
- Young people expressed confidence in government health facilities as much as in private ones.

The results indicate that implementers of programs and activities should:

- Devote some attention to education on other STIs, in addition to HIV, and their implications for the sexual and reproductive health of young people.
- Make efforts to use the channels young people themselves say they prefer for information and services on sexual and reproductive health.
- Develop programs targeting parents in order to make it easy for them to support their children in sexual and reproductive health issues.
- Use electronic media as much as possible to provide information to young people. In addition, efforts should be made to promote the use of print media for information that needs to be kept and referred back to. Such an approach should be built into programs in the school system and into informal education study packs for those who are out of school.
- Health providers should develop programs that appeal to adolescents in terms of confidentiality, hours of operation, sex of the provider and the quality of the services provided.

TABLE 9.1 Percentage distribution of adolescents, by exposure to mass media, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=954) | 15-19 (N=1236) | Total (N=2190) | 12-14 (N=974) | 15-19 (N=1257) | Total (N=2231) |
| Frequency of listening to the radio | | | | | | |
| Almost every day | 34.5 | 44.2 | 40.0 | 36.4 | 48.4 | 43.2 |
| At least once a week | 36.9 | 32.3 | 34.3 | 38.2 | 36.1 | 37.0 |
| Less than once a week | 13.5 | 13.1 | 13.3 | 15.6 | 9.6 | 12.2 |
| Not at all | 15.1 | 10.4 | 12.5 | 9.8 | 5.8 | 7.5 |
| Frequency of watching television | | | | | | |
| Almost every day | 26.5 | 29.4 | 28.1 | 18.8 | 24.0 | 21.7 |
| At least once a week | 30.2 | 28.2 | 29.0 | 33.9 | 34.3 | 34.1 |
| Less than once a week | 15.7 | 15.6 | 15.6 | 18.4 | 19.2 | 18.9 |
| Not at all | 27.6 | 26.8 | 27.2 | 29.0 | 22.4 | 25.3 |
| Frequency of reading a newspaper or magazine* | | | | | | |
| Almost every day | 2.5 | 3.4 | 3.0 | 2.0 | 5.7 | 4.1 |
| At least once a week | 17.8 | 20.3 | 19.2 | 14.2 | 22.6 | 18.9 |
| Less than once a week | 9.1 | 14.7 | 12.2 | 11.1 | 15.7 | 13.7 |
| Not at all | 70.7 | 61.6 | 65.6 | 72.8 | 55.9 | 63.4 |
| Number of mass media sources† | | | | | | |
| None | 7.0 | 5.7 | 6.3 | 5.2 | 2.6 | 3.8 |
| 1 | 25.7 | 21.7 | 23.5 | 25.5 | 18.4 | 21.5 |
| 2 | 43.4 | 42.3 | 42.8 | 46.9 | 42.8 | 44.6 |
| 3 or more | 23.8 | 30.2 | 27.4 | 22.3 | 36.2 | 30.1 |
| Ever used the internet* | | | | | | |
| Yes | 3.1 | 7.9 | 5.8 | 8.7 | 13.1 | 11.1 |
| No | 40.1 | 47.2 | 44.1 | 37.7 | 44.7 | 41.6 |
| Don't know internet | 56.8 | 44.9 | 50.2 | 53.6 | 42.3 | 47.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Question asked of those who ever attended school. Sample size: females 12-14 (N=883); females 15-19 (N=1112); males 12-14 (N=923); males 15-19 (N=1171). †Media sources include radio, television and newspaper. Note: Ns are weighted.

TABLE 9.2 Percentage of adolescents, by exposure to sex education and content and form of sex education, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=956) | 15–19 (N=1234) | Total (N=2190) | 12–14 (N=974) | 15–19 (N=1259) | Total (N=2233) |
| Ever attended school | | | | | | |
| No | 7.4 | 9.9 | 8.8 | 5.4 | 6.9 | 6.3 |
| Yes | 92.6 | 90.1 | 91.2 | 94.6 | 93.1 | 93.7 |
| Any of respondent's schools offered any classes or talks on sex education* | | | | | | |
| Yes | 49.7 | 70.0 | 61.0 | 41.4 | 61.2 | 52.5 |
| No | 49.3 | 28.9 | 37.9 | 54.6 | 36.3 | 44.4 |
| Don't know | 1.0 | 1.2 | 1.1 | 4.0 | 2.5 | 3.2 |
| Ever attended sex education classes or talks† | | | | | | |
| Yes | 89.3 | 92.3 | 91.2 | 70.9 | 80.4 | 77.1 |
| No | 10.7 | 7.7 | 8.8 | 29.1 | 19.6 | 22.9 |
| Age when first attended sex education classes or talks‡ | | | | | | |
| <12 | 21.4 | 2.4 | 9.1 | 22.7 | 2.6 | 9.0 |
| 12 | 36.5 | 8.9 | 18.7 | 29.7 | 5.2 | 13.0 |
| 13 | 29.6 | 14.2 | 19.7 | 32.0 | 13.2 | 19.1 |
| 14 | 10.5 | 24.0 | 19.2 | 11.2 | 24.1 | 20.0 |
| 15 | N/A | 25.0 | 16.1 | N/A | 21.1 | 14.4 |
| 16 | N/A | 15.8 | 10.2 | N/A | 17.9 | 12.2 |
| 17–19 | N/A | 7.8 | 5.0 | N/A | 13.7 | 9.3 |
| Don't know | 2.0 | 2.0 | 2.0 | 4.5 | 2.3 | 3.0 |
| Attended sex education classes or talks before first sex‡ | | | | | | |
| No | 0.8 | 10.5 | 7.1 | 1.2 | 10.1 | 7.3 |
| Yes | 99.2 | 89.5 | 92.9 | 98.8 | 89.9 | 92.7 |
| Subjects covered in classes/talks‡ | | | | | | |
| How pregnancy happens | 81.1 | 87.9 | 85.5 | 75.6 | 83.4 | 80.9 |
| Contraception/how to prevent pregnancy | 70.7 | 81.5 | 77.7 | 72.2 | 85.8 | 81.5 |
| Abstinence/say 'no' to sex | 92.6 | 95.8 | 94.7 | 92.2 | 93.6 | 93.1 |
| STIs or diseases | 89.2 | 94.0 | 92.3 | 86.3 | 95.3 | 92.4 |
| How classes/talks were conducted‡ | | | | | | |
| Lecture | 91.6 | 91.4 | 91.4 | 91.5 | 89.8 | 90.3 |
| Small group discussion | 9.7 | 11.0 | 10.5 | 6.3 | 10.8 | 9.3 |
| Role play | 5.6 | 5.7 | 5.7 | 4.8 | 4.2 | 4.4 |
| Video/film | 3.3 | 5.7 | 4.9 | 4.1 | 6.1 | 5.4 |
| Other | 0.8 | 1.8 | 1.4 | 2.6 | 1.0 | 1.5 |
| Don't know | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.1 |
| Who mainly led the classes/talks‡ | | | | | | |
| Teachers | 87.8 | 85.4 | 86.2 | 91.5 | 83.0 | 85.7 |
| Students | 1.5 | 1.1 | 1.3 | 0.7 | 1.6 | 1.3 |
| Nurses | 5.3 | 6.7 | 6.2 | 6.3 | 11.1 | 9.6 |
| Other | 4.8 | 6.7 | 6.0 | 1.5 | 4.2 | 3.3 |
| Don't know | 0.5 | 0.1 | 0.3 | 0.0 | 0.2 | 0.1 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who have attended school. Sample sizes: females 12–14 (N=886); females 15–19 (N=1112); males 12–14 (N=921); males 15–19 (N=1173). †Limited to those who reported any schools offered sex education classes or talks. Sample sizes: females 12–14 (N=439); females 15–19 (N=778); males 12–14 (N=381); males 15–19 (N=718). ‡Limited to those who ever attended a sex education class or talk. Sample sizes: females 12–14 (N=392); females 15–19 (N=717); males 12–14 (N=269); males 15–19 (N=577). Totals may exceed 100 because multiple responses are possible for subjects covered and how classes/talks were conducted. Note: Ns are weighted.

TABLE 9.3 Adolescents, by attitudes about sex education, condoms and AIDS instruction, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=885) | 15–19 (N=1114) | Total (N=1999) | 12–14 (N=921) | 15–19 (N=1171) | Total (N=2092) |
| It is important for sex education to be taught in schools* | | | | | | |
| Agree | 88.4 | 93.4 | 91.1 | 84.6 | 92.1 | 88.8 |
| Disagree | 8.1 | 4.7 | 6.2 | 7.6 | 5.7 | 6.5 |
| Don't know | 3.5 | 2.0 | 2.7 | 7.8 | 2.2 | 4.7 |
| Discussing sex education with young people encourages young people to have sex* | | | | | | |
| Agree | 29.6 | 22.3 | 25.5 | 26.7 | 27.6 | 27.2 |
| Disagree | 60.8 | 72.9 | 67.5 | 56.6 | 66.0 | 61.9 |
| Don't know | 9.6 | 4.9 | 7.0 | 16.6 | 6.3 | 10.9 |
| Youth 12–14 years old should be taught about how to avoid AIDS† | | | | | | |
| Yes | 91.1 | 91.8 | 91.5 | 93.1 | 92.4 | 92.7 |
| No | 7.3 | 6.7 | 7.0 | 6.4 | 7.0 | 6.8 |
| Don't know | 1.6 | 1.4 | 1.5 | 0.5 | 0.6 | 0.6 |
| Youth 12–14 years old should be taught about using a condom to avoid AIDS‡ | | | | | | |
| Yes | 44.1 | 52.0 | 48.8 | 56.8 | 66.8 | 62.7 |
| No | 53.4 | 46.2 | 49.1 | 38.9 | 31.3 | 34.4 |
| Don't know | 2.5 | 1.8 | 2.1 | 4.3 | 1.9 | 2.9 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Question asked of those who ever attended school. †Limited to those who have heard of AIDS. Sample sizes: females 12–14 (N=899); females 15–19 (N=1201); males 12–14 (N=921); males 15–19 (N=1240). ‡Limited to those who have heard of AIDS and male condom. Sample sizes: females 12–14 (N=715); females 15–19 (N=1062); males 12–14 (N=768); males 15–19 (N=1120). Note: Ns are weighted.

TABLE 9.4 Adolescents who know of at least one contraceptive method, by used and preferred sources of information for methods, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=803) | 15-19 (N=1167) | Total (N=1970) | 12-14 (N=822) | 15-19 (N=1206) | Total (N=2028) |
| Where respondent got information about contraceptive methods* | | | | | | |
| Any family | 17.3 | 18.4 | 18.0 | 14.8 | 12.5 | 13.5 |
| Any friends | 19.9 | 25.4 | 23.1 | 18.6 | 27.0 | 23.6 |
| Any teacher or health provider | 43.5 | 56.0 | 50.9 | 49.6 | 59.0 | 55.2 |
| Any mass media | 59.9 | 65.6 | 63.3 | 61.4 | 66.2 | 64.3 |
| Mother | 7.1 | 8.5 | 7.9 | 3.6 | 5.1 | 4.5 |
| Father | 2.1 | 2.1 | 2.1 | 3.9 | 3.2 | 3.5 |
| Spouse/partner | 0.0 | 0.7 | 0.4 | 0.0 | 0.1 | 0.0 |
| Brother | 1.0 | 1.8 | 1.5 | 4.5 | 3.7 | 4.0 |
| Sister | 3.0 | 4.8 | 4.1 | 1.2 | 0.9 | 1.0 |
| Other female family | 8.6 | 5.7 | 6.9 | 2.1 | 2.5 | 2.3 |
| Other male family | 1.2 | 1.8 | 1.6 | 5.2 | 2.8 | 3.8 |
| Female friends | 19.0 | 23.8 | 21.9 | 2.4 | 6.2 | 4.7 |
| Male friends | 3.7 | 7.6 | 6.0 | 17.8 | 26.5 | 22.9 |
| Teacher/school | 39.9 | 48.0 | 44.7 | 44.3 | 53.9 | 50.0 |
| Doctor/nurse/clinic | 7.3 | 15.8 | 12.3 | 10.3 | 14.0 | 12.5 |
| Traditional healer/herbalist/spiritual | 0.0 | 0.3 | 0.2 | 0.0 | 0.1 | 0.0 |
| Church | 3.7 | 6.9 | 5.6 | 3.2 | 5.1 | 4.3 |
| Community/neighborhood | 3.7 | 6.9 | 5.6 | 3.2 | 5.1 | 4.3 |
| Newspaper | 4.1 | 5.1 | 4.7 | 2.2 | 5.5 | 4.1 |
| Books/magazines | 5.1 | 5.4 | 5.3 | 2.8 | 6.6 | 5.0 |
| Radio | 41.2 | 51.8 | 47.4 | 49.4 | 51.7 | 50.8 |
| Television | 44.0 | 45.9 | 45.2 | 39.2 | 48.2 | 44.5 |
| Internet | 0.1 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 |
| Poster/billboard | 2.6 | 2.6 | 2.6 | 3.6 | 5.1 | 4.5 |
| Other | 9.3 | 8.4 | 8.8 | 10.5 | 12.7 | 11.8 |
| Don't know/unsure | 8.1 | 4.6 | 6.0 | 4.6 | 2.4 | 3.3 |
| Preferred sources for information about contraceptive methods* | | | | | | |
| Any family | 16.7 | 15.3 | 15.9 | 8.9 | 7.7 | 8.2 |
| Any friends | 4.9 | 7.3 | 6.4 | 3.9 | 6.3 | 5.3 |
| Any teacher or health provider | 46.0 | 47.3 | 46.7 | 48.6 | 48.8 | 48.7 |
| Any mass media | 31.0 | 36.3 | 34.2 | 40.1 | 40.8 | 40.5 |
| Mother | 13.8 | 12.4 | 13.0 | 4.6 | 5.4 | 5.1 |
| Father | 3.7 | 3.6 | 3.6 | 3.6 | 4.8 | 4.3 |
| Spouse/partner | 0.0 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 |
| Brother | 0.4 | 0.3 | 0.3 | 1.5 | 0.5 | 0.9 |
| Sister | 1.7 | 3.0 | 2.5 | 1.0 | 0.0 | 0.4 |
| Other female family | 2.8 | 2.1 | 2.4 | 0.5 | 0.3 | 0.4 |
| Other male family | 0.4 | 0.2 | 0.3 | 1.4 | 0.7 | 1.0 |
| Female friends | 4.4 | 7.1 | 6.0 | 0.7 | 1.7 | 1.3 |
| Male friends | 0.7 | 0.7 | 0.7 | 3.8 | 5.9 | 5.0 |
| Teacher/school | 33.9 | 27.7 | 30.2 | 38.3 | 34.1 | 35.8 |
| Doctor/nurse/clinic | 18.4 | 22.9 | 21.1 | 14.4 | 17.9 | 16.4 |
| Traditional healer/herbalist/spiritualist | 0.0 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 |
| Church | 4.6 | 4.9 | 4.8 | 4.3 | 6.1 | 5.3 |
| Newspaper | 0.3 | 0.6 | 0.5 | 1.0 | 2.2 | 1.7 |
| Books/magazines | 0.7 | 0.8 | 0.7 | 0.8 | 1.8 | 1.4 |
| Radio | 14.3 | 19.5 | 17.4 | 27.6 | 25.6 | 26.4 |
| Television | 19.5 | 22.4 | 21.2 | 21.3 | 22.2 | 21.8 |
| Internet | 0.0 | 0.1 | 0.1 | 0.4 | 0.7 | 0.6 |
| Poster/billboard | 0.0 | 0.1 | 0.1 | 0.1 | 0.5 | 0.4 |
| Other | 4.1 | 6.4 | 5.5 | 5.1 | 6.1 | 5.7 |
| Don't know | 13.0 | 6.7 | 9.2 | 9.5 | 5.8 | 7.3 |

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.5 Adolescents who know of at least one contraceptive method, by perceived barriers to obtaining methods, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|-------------------------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=795) | 15–19 (N=1164) | Total (N=1959) | 12–14 (N=823) | 15–19 (N=1202) | Total (N=2025) |
| Barriers* | | | | | | |
| No barriers | 8.9 | 9.6 | 9.3 | 9.6 | 18.1 | 14.6 |
| Not knowing where to go | 6.0 | 7.0 | 6.6 | 2.8 | 4.5 | 3.8 |
| Not knowing how to get there | 0.5 | 0.8 | 0.7 | 0.2 | 1.0 | 0.7 |
| Inconvenient hours/days | 0.3 | 0.3 | 0.3 | 0.7 | 0.7 | 0.7 |
| Privacy not respected | 2.1 | 6.5 | 4.7 | 0.7 | 2.1 | 1.5 |
| Not treated nicely by staff | 3.5 | 6.5 | 5.3 | 1.5 | 2.2 | 1.9 |
| Costly/not able to pay for services | 1.3 | 3.6 | 2.7 | 2.6 | 3.4 | 3.1 |
| No same sex provider | 0.0 | 2.2 | 1.3 | 0.0 | 0.2 | 0.1 |
| Not being allowed to go alone | 0.8 | 1.5 | 1.2 | 1.6 | 0.4 | 0.9 |
| Afraid or fearful | 24.5 | 25.9 | 25.3 | 16.5 | 18.3 | 17.6 |
| Embarrassed or shy | 48.9 | 60.4 | 55.7 | 39.1 | 49.3 | 45.2 |
| Too young | 3.3 | 1.8 | 2.4 | 3.4 | 1.2 | 2.1 |
| Feel bad/spoiled | 0.9 | 1.5 | 1.2 | 0.7 | 0.7 | 0.7 |
| Other | 3.5 | 3.9 | 3.7 | 1.8 | 4.5 | 3.4 |
| Don't know | 24.4 | 16.2 | 19.5 | 38.2 | 18.4 | 26.4 |

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.6 Percentage distribution of adolescents who know of at least one contraceptive method, by known and preferred sources for methods, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=804) | 15–19 (N=1168) | Total (N=1972) | 12–14 (N=825) | 15–19 (N=1207) | Total (N=2032) |
| Known sources for contraceptive methods* | | | | | | |
| Government clinic/hospital | 21.4 | 39.8 | 32.3 | 20.8 | 38.3 | 31.2 |
| Private clinic/hospital/doctor | 5.6 | 11.6 | 9.2 | 5.3 | 13.7 | 10.3 |
| NGO clinic | 1.2 | 1.8 | 1.6 | 0.6 | 2.7 | 1.8 |
| Drug store/pharmacy | 11.7 | 16.3 | 14.4 | 13.8 | 21.8 | 18.6 |
| Street vendor | 0.4 | 0.8 | 0.6 | 0.8 | 0.8 | 0.8 |
| Traditional or spiritual healer/herbalist | 0.6 | 0.7 | 0.7 | 0.0 | 1.0 | 0.6 |
| Friends | 1.6 | 2.9 | 2.4 | 1.1 | 3.2 | 2.4 |
| School/school counselor | 4.1 | 5.1 | 4.7 | 3.5 | 7.3 | 5.8 |
| Church | 0.6 | 1.2 | 1.0 | 0.2 | 1.7 | 1.1 |
| Parents | 1.0 | 1.2 | 1.1 | 0.4 | 1.2 | 0.8 |
| Other | 1.7 | 3.2 | 2.6 | 1.8 | 4.3 | 3.3 |
| No source known | 73.2 | 55.4 | 62.7 | 72.6 | 53.1 | 61.0 |
| Most preferred source for contraceptive methods† | | | | | | |
| Government clinic/hospital | 59.5 | 62.8 | 61.8 | 55.7 | 55.9 | 55.8 |
| Private clinic/hospital/doctor | 2.3 | 5.2 | 4.3 | 3.6 | 4.3 | 4.1 |
| NGO clinic | 0.0 | 1.5 | 1.1 | 0.5 | 0.5 | 0.5 |
| Drug store/pharmacy | 19.1 | 14.2 | 15.6 | 28.1 | 23.4 | 24.7 |
| Street vendor | 0.5 | 1.0 | 0.8 | 1.4 | 1.1 | 1.1 |
| Traditional or spiritual healer/herbalist | 0.0 | 0.4 | 0.3 | 0.0 | 0.5 | 0.4 |
| Friends | 1.9 | 2.7 | 2.4 | 1.4 | 1.4 | 1.4 |
| School/school counselor | 5.6 | 3.8 | 4.3 | 5.9 | 5.9 | 5.9 |
| Church | 1.9 | 1.3 | 1.5 | 0.0 | 1.2 | 0.9 |
| Parents | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | 6.5 | 4.2 | 4.9 | 2.7 | 5.3 | 4.6 |
| Don't know | 2.8 | 2.9 | 2.9 | 0.9 | 0.5 | 0.6 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. †Limited to those who know of any source. Sample sizes: females 12–14 (N=215); females 15–19 (N=521); males 12–14 (N=221); males 15–19 (N=564). Note: Ns are weighted.

TABLE 9.7 Percent distributions of adolescents who know of a government clinic or hospital and who know of at least one method, by perceptions of government clinics or hospitals as a source for contraceptive methods, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|------------------|------------------|------------------|------------------|------------------|
| | 12-14 (N=170) | 15-19 (N=456) | Total (N=626) | 12-14 (N=172) | 15-19 (N=458) | Total (N=630) |
| At government clinic or hospital, information shared would be confidential | | | | | | |
| Yes | 77.6 | 84.9 | 82.9 | 78.5 | 84.5 | 82.9 |
| No | 17.1 | 11.0 | 12.6 | 16.3 | 12.4 | 13.5 |
| Don't know | 5.3 | 4.2 | 4.5 | 5.2 | 3.1 | 3.7 |
| Would be able to easily get there | | | | | | |
| Yes | 66.7 | 75.7 | 73.2 | 69.2 | 74.0 | 72.7 |
| No | 33.3 | 24.3 | 26.8 | 29.1 | 25.8 | 26.7 |
| Don't know | 0.0 | 0.0 | 0.0 | 1.7 | 0.2 | 0.6 |
| Would be treated with respect | | | | | | |
| Yes | 72.9 | 76.3 | 75.4 | 78.9 | 82.4 | 81.4 |
| No | 20.0 | 19.3 | 19.5 | 14.0 | 12.9 | 13.2 |
| Don't know | 7.1 | 4.4 | 5.1 | 7.0 | 4.8 | 5.4 |
| Would be able to pay for the services | | | | | | |
| Yes | 52.6 | 67.8 | 63.6 | 57.6 | 68.1 | 65.2 |
| No | 43.9 | 27.2 | 31.7 | 34.9 | 27.6 | 29.6 |
| Don't know | 3.5 | 5.0 | 4.6 | 7.6 | 4.4 | 5.2 |
| Reported "no" to at least one dimension of service | | | | | | |
| | 60.8 | 52.1 | 54.5 | 58.1 | 52.0 | 53.7 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted.

TABLE 9.8 Percentage distribution of adolescents who know of at least one method, by perceptions of most preferred source for contraceptive methods, according to type of preferred source and sex, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|-----------------------|-------------------|----------------------|-----------------------|-------------------|----------------------|
| | Most preferred source | | | Most preferred source | | |
| | Govt (N=454) | Private (N=32) | Drug shop (N=115) | Govt (N=438) | Private (N=31) | Drug shop (N=193) |
| At (source), information shared would be confidential | | | | | | |
| Yes | 83.0 | [93.8] | 73.0 | 86.1 | [83.3] | 73.1 |
| No | 13.0 | [6.3] | 20.0 | 11.4 | [16.7] | 23.8 |
| Don't know | 4.0 | [0.0] | 7.0 | 2.5 | [0.0] | 3.1 |
| Would be able to easily get there | | | | | | |
| Yes | 74.0 | [83.9] | 86.1 | 75.5 | [62.5] | 62.4 |
| No | 26.0 | [16.1] | 13.9 | 23.6 | [37.5] | 37.6 |
| Don't know | 0.0 | [0.0] | 0.0 | 0.9 | [0.0] | 0.0 |
| Would be treated with respect | | | | | | |
| Yes | 78.3 | [80.6] | 71.3 | 82.6 | [83.9] | 59.6 |
| No | 17.5 | [12.9] | 22.6 | 11.4 | [16.1] | 38.3 |
| Don't know | 4.2 | [6.5] | 6.1 | 5.9 | [0.0] | 2.1 |
| Would be able to pay for the services | | | | | | |
| Yes | 65.6 | [67.7] | 73.9 | 64.4 | [64.5] | 76.7 |
| No | 31.1 | [32.3] | 20.9 | 31.2 | [35.5] | 21.8 |
| Don't know | 3.3 | [0.0] | 5.2 | 4.4 | [0.0] | 1.6 |
| Reported "no" to at least one dimension of service | | | | | | |
| | 52.1 | [50.0] | 50.4 | 51.0 | [74.2] | 64.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. [] = N is 25 to 49.

TABLE 9.9 Percentage of adolescents who have ever obtained a contraceptive method, by source of method, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| | 12-14 (N=7) | 15-19 (N=28) | Total (N=35) | 12-14 (N=16) | 15-19 (N=75) | Total (N=91) |
| Sources ever used to get contraceptive methods* | | | | | | |
| Government clinic/hospital | -- | [32.1] | [25.7] | -- | 17.3 | 14.3 |
| Private clinic/hospital/doctor | -- | [3.6] | [2.9] | -- | 2.6 | 2.2 |
| NGO clinic | -- | [0.0] | [0.0] | -- | 1.3 | 1.1 |
| Drug store/pharmacy | -- | [25.0] | [22.9] | -- | 63.2 | 62.0 |
| Street vendor | -- | [0.0] | [0.0] | -- | 2.7 | 5.5 |
| Traditional or spiritual healer/herbalist | -- | [0.0] | [0.0] | -- | 0.0 | 0.0 |
| Friends | -- | [7.1] | [5.7] | -- | 5.3 | 4.4 |
| School/school counselor | -- | [14.3] | [14.3] | -- | 6.7 | 8.8 |
| Church | -- | [17.2] | [13.9] | -- | 5.3 | 4.3 |
| Retail shops | N/A | N/A | N/A | N/A | N/A | N/A |
| Parents | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | -- | [10.7] | [22.9] | -- | 6.6 | 6.6 |
| Don't know | -- | [0.0] | [0.0] | -- | 0.0 | 0.0 |

*Totals may exceed 100 because multiple responses are possible. *Notes:* Ns are weighted. "--" = N is 24 or fewer. [] = N is 25 to 49.

TABLE 9.10 Percentage distribution of adolescents, by exposure to mass media messages about family planning, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=956) | 15-19 (N=1238) | Total (N=2194) | 12-14 (N=973) | 15-19 (N=1258) | Total (N=2231) |
| In the last few months has heard or seen messages about family planning*: | | | | | | |
| on the radio | 48.3 | 58.2 | 53.9 | 47.8 | 60.8 | 55.1 |
| on the television | 42.8 | 50.3 | 47.0 | 35.7 | 49.0 | 43.2 |
| in a newspaper or magazine | 13.5 | 19.3 | 16.8 | 10.8 | 24.2 | 18.4 |
| on a poster | 19.9 | 29.7 | 25.4 | 18.2 | 31.8 | 25.9 |
| in a leaflet or brochure | 7.4 | 15.9 | 12.2 | 6.6 | 15.3 | 11.5 |
| from a health worker | 13.9 | 25.2 | 20.3 | 14.5 | 25.4 | 20.7 |
| at a community or social club meeting | 9.6 | 20.1 | 15.5 | 12.1 | 18.7 | 15.8 |
| Number of exposures to family planning messages in recent months | | | | | | |
| No exposure | 36.3 | 24.3 | 29.5 | 37.1 | 23.7 | 29.5 |
| 1 exposure | 20.3 | 19.0 | 19.6 | 23.1 | 17.6 | 20.0 |
| 2 exposures | 18.4 | 20.3 | 19.5 | 16.6 | 18.6 | 17.7 |
| 3-7 exposures | 25.1 | 36.4 | 31.4 | 23.2 | 40.1 | 32.7 |
| Has heard the message "Life choices: it's your life, it's your choice" | | | | | | |
| Yes | 47.5 | 60.8 | 55.0 | 48.8 | 70.1 | 60.8 |
| No | 52.5 | 39.2 | 45.0 | 51.2 | 29.9 | 39.2 |
| Has heard the message "Make the choice that is best for you" | | | | | | |
| Yes | 30.1 | 47.0 | 39.7 | 32.0 | 53.9 | 44.3 |
| No | 69.9 | 53.0 | 60.3 | 68.0 | 46.1 | 55.7 |
| Has heard the message "Contraceptives are safe and effective" | | | | | | |
| Yes | 16.8 | 34.5 | 26.8 | 18.2 | 37.2 | 28.9 |
| No | 83.2 | 65.5 | 73.2 | 81.8 | 62.8 | 71.1 |
| Has heard the message "Obra ni wora bo" | | | | | | |
| Yes | 57.6 | 68.2 | 63.6 | 55.1 | 66.5 | 61.5 |
| No | 42.4 | 31.8 | 36.4 | 44.9 | 33.5 | 38.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because "yes" responses to multiple items are shown. Notes: Ns are weighted.

TABLE 9.11 Percentage of adolescents who know of any STIs, by used and preferred sources of information on STIs (apart from HIV/AIDS), according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|------------------|------------------|------------------|------------------|------------------|
| | 12-14 (N=204) | 15-19 (N=655) | Total (N=849) | 12-14 (N=269) | 15-19 (N=701) | Total (N=970) |
| Where respondent got information about STIs (apart from HIV/AIDS)* | | | | | | |
| Any family | 13.9 | 13.9 | 13.9 | 9.7 | 9.7 | 9.7 |
| Any friend | 7.0 | 11.9 | 10.5 | 8.2 | 17.8 | 15.2 |
| Any teacher or health provider | 74.3 | 62.2 | 65.7 | 68.8 | 62.1 | 63.9 |
| Any mass media | 54.5 | 63.3 | 60.8 | 50.7 | 57.8 | 55.9 |
| Mother | 12.0 | 7.9 | 9.1 | 4.9 | 5.5 | 5.3 |
| Father | 2.9 | 3.7 | 3.5 | 4.2 | 4.2 | 4.2 |
| Spouse/partner | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Brother | 0.8 | 1.5 | 1.3 | 1.5 | 2.3 | 2.1 |
| Sister | 2.5 | 2.2 | 2.3 | 2.3 | 0.7 | 1.1 |
| Other female family | 3.3 | 4.0 | 3.8 | 1.1 | 1.2 | 1.1 |
| Other male family | 0.0 | 1.3 | 1.0 | 2.3 | 2.0 | 2.1 |
| Female friends | 7.0 | 11.4 | 10.1 | 1.5 | 6.5 | 5.1 |
| Male friends | 1.7 | 4.5 | 3.7 | 7.5 | 16.6 | 14.1 |
| Teacher/school | 72.2 | 58.3 | 62.3 | 63.4 | 54.6 | 57.1 |
| Doctor/nurse/clinic | 11.6 | 10.7 | 11.0 | 14.3 | 17.9 | 16.9 |
| Traditional healer/herbalist/spiritual | 1.2 | 0.2 | 0.5 | 0.0 | 0.6 | 0.4 |
| Church | 3.7 | 7.5 | 6.4 | 2.6 | 5.3 | 4.6 |
| Community/neighborhood | 2.1 | 1.3 | 1.6 | 0.8 | 1.2 | 1.0 |
| Newspaper | 7.1 | 8.9 | 8.4 | 2.6 | 7.8 | 6.4 |
| Books/magazines | 9.9 | 9.0 | 9.3 | 7.2 | 10.4 | 9.5 |
| Radio | 32.8 | 45.9 | 42.1 | 30.6 | 41.4 | 38.4 |
| Television | 39.4 | 45.1 | 43.4 | 33.2 | 39.5 | 37.7 |
| Internet | 0.0 | 0.3 | 0.2 | 1.1 | 0.4 | 0.6 |
| Poster/billboard | 4.1 | 3.0 | 3.3 | 3.0 | 3.8 | 3.5 |
| Other | 7.1 | 8.4 | 8.0 | 9.1 | 10.0 | 9.7 |
| Don't know/unsure | 0.8 | 0.8 | 0.8 | 0.8 | 0.6 | 0.6 |
| Preferred sources for information about STIs* | | | | | | |
| Any family | 13.1 | 7.5 | 9.1 | 8.6 | 6.8 | 7.3 |
| Any friend | 2.9 | 4.3 | 3.9 | 3.3 | 3.9 | 3.7 |
| Any teacher or health provider | 65.6 | 52.2 | 56.0 | 60.2 | 55.8 | 57.0 |
| Any mass media | 24.2 | 36.8 | 33.1 | 32.3 | 41.2 | 38.8 |
| Mother | 12.0 | 6.6 | 8.1 | 5.1 | 4.9 | 4.9 |
| Father | 3.4 | 2.8 | 3.0 | 5.5 | 4.4 | 4.7 |
| Spouse/partner | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 |
| Brother | 0.0 | 0.2 | 0.1 | 2.0 | 0.7 | 1.1 |
| Sister | 2.1 | 0.9 | 1.2 | 1.2 | 0.1 | 0.4 |
| Other female family | 0.9 | 1.0 | 1.0 | 0.8 | 0.4 | 0.5 |
| Other male family | 0.0 | 0.7 | 0.5 | 1.2 | 0.4 | 0.6 |
| Female friends | 2.6 | 4.2 | 3.7 | 2.0 | 1.0 | 1.3 |
| Male friends | 1.3 | 1.0 | 1.1 | 3.1 | 3.7 | 3.5 |
| Teacher/school | 56.4 | 36.4 | 42.2 | 46.9 | 37.0 | 39.7 |
| Doctor/nurse/clinic | 18.4 | 22.9 | 21.6 | 22.0 | 25.0 | 24.2 |
| Traditional healer/herbalist/spiritual | 0.0 | 0.2 | 0.1 | 0.0 | 0.1 | 0.1 |
| Church | 3.8 | 6.8 | 5.9 | 3.1 | 5.2 | 4.6 |
| Community/neighborhood | 0.4 | 1.0 | 0.9 | 0.8 | 0.4 | 0.5 |
| Newspaper | 1.7 | 1.4 | 1.5 | 1.6 | 4.9 | 4.0 |
| Books/magazines | 1.7 | 2.1 | 2.0 | 3.1 | 2.2 | 2.5 |
| Radio | 12.0 | 19.6 | 17.4 | 20.2 | 24.3 | 23.1 |
| Television | 15.7 | 22.9 | 20.8 | 21.7 | 28.8 | 26.9 |
| Internet | 0.0 | 0.2 | 0.1 | 1.6 | 0.4 | 0.8 |
| Poster/billboard | 0.4 | 0.2 | 0.2 | 0.0 | 1.9 | 1.4 |
| Other | 5.1 | 4.9 | 4.9 | 6.7 | 7.0 | 6.9 |
| Don't know | 3.4 | 2.9 | 3.1 | 2.8 | 0.9 | 1.4 |

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.12 Percentage of adolescents who do not know any STIs, by perceived sources of information on STIs other than HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|------------------|-------------------|------------------|------------------|-------------------|
| | 12–14 (N=713) | 15–19 (N=634) | Total (N=1347) | 12–14 (N=707) | 15–19 (N=558) | Total (N=1265) |
| Sources of information on STIs other than HIV/AIDS* | | | | | | |
| Any family | 1.1 | 2.1 | 1.6 | 2.4 | 1.4 | 2.0 |
| Any teacher or health provider | 14.3 | 17.8 | 16.0 | 10.3 | 14.3 | 12.1 |
| Any mass media | 1.1 | 3.3 | 2.2 | 0.7 | 1.4 | 1.0 |
| No source known | 84.0 | 78.8 | 81.5 | 87.8 | 83.5 | 85.9 |
| Mother | 1.1 | 1.6 | 1.3 | 1.3 | 1.1 | 1.2 |
| Father | 0.4 | 0.6 | 0.5 | 1.3 | 0.9 | 1.1 |
| Spouse/partner | 0.0 | 0.3 | 0.1 | 0.0 | 0.0 | 0.0 |
| Brother | 0.1 | 0.0 | 0.1 | 0.4 | 0.5 | 0.5 |
| Sister | 0.0 | 0.3 | 0.1 | 0.4 | 0.2 | 0.3 |
| Other female family | 0.0 | 0.2 | 0.1 | 0.0 | 0.0 | 0.0 |
| Other male family | 0.0 | 0.0 | 0.0 | 0.3 | 0.2 | 0.2 |
| Female friends | 0.4 | 0.8 | 0.6 | 0.1 | 0.0 | 0.1 |
| Male friends | 0.3 | 0.0 | 0.1 | 0.3 | 0.7 | 0.5 |
| Teacher/school | 6.8 | 6.5 | 6.6 | 3.4 | 5.0 | 4.1 |
| Doctor/nurse/clinic | 10.8 | 14.4 | 12.5 | 8.1 | 10.8 | 9.3 |
| Traditional or spiritual healer/herbalist | 0.1 | 0.2 | 0.1 | 0.0 | 0.4 | 0.2 |
| Church | 0.7 | 2.1 | 1.3 | 0.4 | 0.4 | 0.4 |
| Newspaper | 0.3 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 |
| Books/magazines | 0.3 | 0.6 | 0.4 | 0.1 | 0.2 | 0.2 |
| Radio | 1.1 | 2.5 | 1.8 | 0.3 | 1.4 | 0.8 |
| Television | 0.4 | 1.7 | 1.0 | 0.1 | 0.7 | 0.4 |
| Internet | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Poster/billboard | 0.0 | 0.2 | 0.1 | 0.0 | 0.2 | 0.1 |
| Other | 0.8 | 1.3 | 1.0 | 0.6 | 0.5 | 0.6 |
| Don't know/unsure | 0.1 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 |

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.13 Percentage of adolescents who know of any STIs, by perceived barriers to obtaining advice or treatment for STIs, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|-------------------------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| | 12–14 (N=241) | 15–19 (N=597) | Total (N=838) | 12–14 (N=265) | 15–19 (N=693) | Total (N=958) |
| Barriers* | | | | | | |
| No barriers | 11.2 | 10.4 | 10.6 | 21.1 | 17.2 | 18.3 |
| Not knowing where to go | 2.5 | 4.4 | 3.8 | 1.1 | 2.7 | 2.3 |
| Not knowing how to get there | 0.0 | 1.2 | 0.8 | 0.8 | 0.9 | 0.8 |
| Inconvenient hours/days | 0.0 | 0.3 | 0.2 | 0.0 | 0.7 | 0.5 |
| Privacy not respected | 5.8 | 6.2 | 6.1 | 1.5 | 4.8 | 3.9 |
| Not treated nicely by staff | 7.5 | 5.9 | 6.3 | 1.1 | 2.6 | 2.2 |
| Costly/not able to pay for services | 6.2 | 6.5 | 6.4 | 5.7 | 10.2 | 9.0 |
| No same sex provider | 0.8 | 1.8 | 1.6 | 0.0 | 0.1 | 0.1 |
| Not being allowed to go alone | 1.7 | 1.3 | 1.4 | 1.5 | 0.3 | 0.6 |
| Afraid or fearful | 29.9 | 25.8 | 27.0 | 14.0 | 15.6 | 15.1 |
| Embarrassed or shy | 70.2 | 70.0 | 70.1 | 44.5 | 52.7 | 50.5 |
| Treatment not effective | 2.1 | 4.4 | 3.7 | 0.8 | 2.2 | 1.8 |
| Too young | N/A | N/A | N/A | N/A | N/A | N/A |
| Feel bad/spoiled | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | 5.8 | 4.4 | 4.8 | 3.0 | 7.8 | 6.5 |
| Don't know | 10.8 | 10.6 | 10.6 | 26.0 | 13.3 | 16.8 |

*Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.14. Percentage of adolescents who know of any STIs, by known and most preferred sources for STI treatment, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|------------------|------------------|------------------|------------------|------------------|
| | 12–14 (N=241) | 15–19 (N=596) | Total (N=837) | 12–14 (N=265) | 15–19 (N=692) | Total (N=957) |
| Known sources to get treatment for STIs* | | | | | | |
| Government clinic/hospital | 68.0 | 68.8 | 68.6 | 58.5 | 72.3 | 68.4 |
| Private clinic/hospital/doctor | 20.7 | 26.7 | 25.0 | 26.4 | 34.0 | 31.9 |
| NGO clinic | 1.7 | 4.2 | 3.5 | 2.6 | 2.7 | 2.7 |
| Drug store/pharmacy | 7.1 | 9.1 | 8.5 | 3.0 | 5.3 | 4.7 |
| Street vendor | 0.0 | 0.2 | 0.1 | 0.0 | 0.0 | 0.0 |
| Traditional or spiritual healer/herbalist | 4.1 | 4.9 | 4.7 | 4.2 | 7.7 | 6.7 |
| Friends | 0.4 | 1.7 | 1.3 | 0.0 | 0.6 | 0.4 |
| School/school counselor | 4.6 | 2.9 | 3.3 | 1.1 | 2.2 | 1.9 |
| Church | 0.8 | 0.8 | 0.8 | 0.4 | 1.4 | 1.1 |
| Parents | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | 0.8 | 0.3 | 0.5 | 0.8 | 1.2 | 1.0 |
| No source known | 32.0 | 29.7 | 30.3 | 40.0 | 25.8 | 29.7 |
| Most preferred source to get treatment for STIs† | | | | | | |
| Government clinic/hospital | 87.9 | 86.9 | 87.2 | 91.8 | 90.7 | 90.9 |
| Private clinic/hospital/doctor | 6.1 | 4.5 | 5.0 | 5.7 | 6.2 | 6.1 |
| NGO clinic | 0.0 | 0.7 | 0.5 | 0.0 | 0.0 | 0.0 |
| Drug store/pharmacy | 2.4 | 3.1 | 2.9 | 0.6 | 0.4 | 0.4 |
| Street vendor | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Traditional or spiritual healer/herbalist | 1.8 | 1.9 | 1.9 | 1.3 | 1.2 | 1.2 |
| Friends | 0.6 | 1.2 | 1.0 | 0.0 | 0.0 | 0.0 |
| School/school counselor | 1.2 | 0.5 | 0.7 | 0.0 | 1.0 | 0.7 |
| Church | 0.0 | 0.7 | 0.5 | 0.6 | 0.2 | 0.3 |
| Parents | N/A | N/A | N/A | N/A | N/A | N/A |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.4 | 0.3 |
| Don't know | 0.0 | 0.5 | 0.3 | 0.0 | 0.0 | 0.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Totals may exceed 100 because multiple responses are possible. †Limited to those who know of any source. Sample sizes: females 12–14 (N=165); females 15–19 (N=420); males 12–14 (N=158); males 15–19 (N=515). Note: Ns are weighted.

TABLE 9.15 Percentage distribution of adolescents who know of a government clinic or hospital and who know of any STIs, by perceptions of government clinics or hospitals as a source for STI treatment, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|------------------|------------------|------------------|------------------|------------------|
| | 12-14 (N=164) | 15-19 (N=407) | Total (N=571) | 12-14 (N=154) | 15-19 (N=500) | Total (N=654) |
| At government clinic or hospital, information shared would be confidential | | | | | | |
| Yes | 84.8 | 87.2 | 86.5 | 83.8 | 86.0 | 85.5 |
| No | 11.0 | 10.6 | 10.7 | 12.3 | 11.6 | 11.8 |
| Don't know | 4.3 | 2.2 | 2.8 | 3.9 | 2.4 | 2.8 |
| Would be able to easily get there | | | | | | |
| Yes | 75.2 | 77.1 | 76.6 | 74.2 | 75.8 | 75.4 |
| No | 24.2 | 22.4 | 22.9 | 24.5 | 22.8 | 23.2 |
| Don't know | 0.6 | 0.5 | 0.5 | 1.3 | 1.4 | 1.4 |
| Would be treated with respect | | | | | | |
| Yes | 81.1 | 79.6 | 80.0 | 76.0 | 80.0 | 79.1 |
| No | 13.4 | 17.5 | 16.3 | 20.1 | 16.8 | 17.6 |
| Don't know | 5.5 | 3.0 | 3.7 | 3.9 | 3.2 | 3.4 |
| Would be able to pay for the services | | | | | | |
| Yes | 66.5 | 73.2 | 71.2 | 54.8 | 64.3 | 62.1 |
| No | 30.5 | 20.9 | 23.7 | 36.8 | 28.5 | 30.4 |
| Don't know | 3.0 | 5.9 | 5.1 | 8.4 | 7.2 | 7.5 |
| Responded "no" to at least one dimension of service | | | | | | |
| | 47.6 | 45.9 | 46.4 | 58.1 | 49.8 | 51.8 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Note: Ns are weighted.

TABLE 9.16 Percentage distribution of adolescents who know of any STIs, by most preferred source for STI treatment, according to type of preferred source and sex, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|-----------------------|-------------------|---------------------|-----------------------|-------------------|--------------------|
| | Most preferred source | | | Most preferred source | | |
| | Govt (N=508) | Private (N=27) | Drug Shop (N=17) | Govt (N=612) | Private (N=40) | Drug Shop (N=3) |
| At (source), information shared would be confidential | | | | | | |
| Yes | 88.4 | [96.3] | -- | 86.3 | [90.0] | -- |
| No | 9.3 | [3.7] | -- | 11.3 | [10.0] | -- |
| Don't know | 2.4 | [0.0] | -- | 2.5 | [0.0] | -- |
| Would be able to easily get there | | | | | | |
| Yes | 78.1 | [66.7] | -- | 76.4 | [70.7] | -- |
| No | 21.3 | [33.3] | -- | 22.1 | [29.3] | -- |
| Don't know | 0.6 | [0.0] | -- | 1.5 | [0.0] | -- |
| Would be treated with respect | | | | | | |
| Yes | 83.2 | [85.2] | -- | 80.2 | [92.7] | -- |
| No | 13.2 | [14.8] | -- | 16.7 | [7.3] | -- |
| Don't know | 3.6 | [0.0] | -- | 3.1 | [0.0] | -- |
| Would be able to pay for the services | | | | | | |
| Yes | 73.4 | [70.4] | -- | 62.4 | [58.5] | -- |
| No | 22.4 | [29.6] | -- | 30.4 | [34.1] | -- |
| Don't know | 4.1 | [0.0] | -- | 7.2 | [7.3] | -- |
| Responded "no" to at least one dimension of service | | | | | | |
| | 43.1 | [48.3] | -- | 51.0 | [58.5] | -- |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25 to 49.

TABLE 9.17 Percentage distribution of adolescents who have ever experienced STI symptoms, by self-reported treatment behavior, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|-----------------|-----------------|-----------------|----------------|-----------------|-----------------|
| | 12-14 (N=11) | 15-19 (N=80) | Total (N=91) | 12-14 (N=6) | 15-19 (N=27) | Total (N=33) |
| Ever gone for treatment for STI* | | | | | | |
| Yes | -- | 36.3 | 34.1 | -- | [14.8] | [15.2] |
| No | -- | 63.8 | 65.9 | -- | [85.2] | [84.8] |
| Service sources at last visit† | | | | | | |
| Government clinic/hospital | -- | [44.8] | [45.2] | -- | -- | -- |
| Private clinic/hospital/doctor | -- | [17.2] | [19.4] | -- | -- | -- |
| NGO clinic | -- | [0.0] | [0.0] | -- | -- | -- |
| Drug shop/pharmacy | -- | [24.1] | [22.6] | -- | -- | -- |
| Street vendor | -- | [0.0] | [0.0] | -- | -- | -- |
| Traditional or spiritual healer/herbalist | -- | [3.4] | [3.2] | -- | -- | -- |
| Friends | -- | [0.0] | [0.0] | -- | -- | -- |
| School/school counselor | -- | [3.4] | [3.2] | -- | -- | -- |
| Church | -- | [0.0] | [0.0] | -- | -- | -- |
| Other | -- | [6.9] | [6.5] | -- | -- | -- |
| Don't know | -- | [0.0] | [0.0] | -- | -- | -- |
| Reasons did not go for treatment‡ | | | | | | |
| Embarrassed | -- | 27.5 | 26.7 | -- | -- | [21.4] |
| Don't want partner to know | -- | 0.0 | 0.0 | -- | -- | [3.6] |
| Don't want other people to know | -- | 7.8 | 6.7 | -- | -- | [10.3] |
| Don't know where to go | -- | 3.9 | 4.9 | -- | -- | [6.9] |
| Cost | -- | 23.5 | 25.0 | -- | -- | [25.0] |
| Not a serious problem | -- | 11.8 | 10.0 | -- | -- | [7.1] |
| Not painful | N/A | N/A | N/A | N/A | N/A | N/A |
| Normal/natural condition | -- | 0.0 | 0.0 | -- | -- | [10.7] |
| Other | -- | 27.5 | 28.3 | -- | -- | [24.1] |
| Don't know | -- | 9.8 | 8.3 | -- | -- | [13.8] |
| Preferred service sources‡ | | | | | | |
| Government clinic/hospital | -- | 68.6 | 71.7 | -- | -- | [82.8] |
| Private clinic/hospital/doctor | -- | 0.0 | 0.0 | -- | -- | [24.1] |
| NGO clinic | -- | 0.0 | 0.0 | -- | -- | [0.0] |
| Drug shop/pharmacy | -- | 7.8 | 6.7 | -- | -- | [3.4] |
| Street vendor | -- | 3.9 | 3.3 | -- | -- | [0.0] |
| Traditional or spiritual healer/herbalist | -- | 5.9 | 5.0 | -- | -- | [0.0] |
| Friends | -- | 0.0 | 0.0 | -- | -- | [3.6] |
| School/school counselor | -- | 0.0 | 0.0 | -- | -- | [0.0] |
| Church | -- | 0.0 | 0.0 | -- | -- | [0.0] |
| Other | -- | 0.0 | 0.0 | -- | -- | [0.0] |
| Nowhere | -- | 11.8 | 10.0 | -- | -- | [3.4] |
| Don't know | -- | 2.0 | 3.3 | -- | -- | [0.0] |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who have ever had a STI. †Limited to those who have ever gone for treatment. Sample sizes: females 12-14 (N=2); females 15-19 (N=29); males 12-14 (N=1); males 15-19 (N=3). Multiple responses possible. ‡Limited to those who have not gone for treatment. Sample sizes: females 12-14 (N=9); females 15-19 (N=51); males 12-14 (N=5); males 15-19 (N=23). Multiple responses possible. Notes: Ns are weighted. "--" = N is 24 or fewer. [] = N is 25 to 49.

TABLE 9.18 Percentage of adolescents who know of HIV/AIDS, by HIV/AIDS information sources used and preferred, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=900) | 15–19 (N=1200) | Total (N=2100) | 12–14 (N=922) | 15–19 (N=1239) | Total (N=2161) |
| Where respondent got information about HIV/AIDS* | | | | | | |
| Any family | 23.0 | 22.6 | 22.8 | 16.5 | 16.1 | 16.2 |
| Any friend | 15.2 | 17.2 | 16.3 | 15.8 | 22.2 | 19.5 |
| Any teacher or health provider | 60.4 | 64.3 | 62.7 | 54.6 | 62.1 | 58.9 |
| Any mass media | 70.1 | 77.3 | 74.2 | 79.0 | 83.5 | 81.6 |
| Mother | 12.7 | 12.2 | 12.4 | 6.8 | 7.7 | 7.4 |
| Father | 5.6 | 4.5 | 5.0 | 6.3 | 6.8 | 6.6 |
| Spouse/partner | 0.0 | 0.3 | 0.1 | 0.0 | 0.1 | 0.0 |
| Brother | 2.1 | 1.9 | 2.0 | 3.9 | 4.4 | 4.2 |
| Sister | 3.3 | 3.7 | 3.6 | 1.7 | 1.1 | 1.4 |
| Other female family | 8.5 | 8.5 | 8.5 | 3.4 | 2.9 | 3.1 |
| Other male family | 3.0 | 4.3 | 3.7 | 5.0 | 4.3 | 4.6 |
| Female friends | 15.1 | 17.0 | 16.2 | 2.1 | 5.9 | 4.3 |
| Male friends | 4.3 | 5.5 | 5.0 | 15.7 | 22.0 | 19.3 |
| Teacher/school | 55.9 | 57.3 | 56.7 | 52.1 | 57.5 | 55.2 |
| Doctor/nurse/clinic | 11.5 | 18.3 | 15.4 | 11.0 | 17.2 | 14.5 |
| Traditional or spiritual healer/herbalist | 0.2 | 0.0 | 0.1 | 0.0 | 0.1 | 0.0 |
| Church | 8.1 | 15.1 | 12.1 | 6.3 | 8.3 | 7.5 |
| Community/neighborhood | 3.3 | 4.5 | 4.0 | 3.0 | 1.7 | 2.3 |
| AIDS campaign/club | 1.6 | 1.8 | 1.7 | 2.1 | 2.7 | 2.5 |
| Newspaper | 8.3 | 10.7 | 9.7 | 4.8 | 14.0 | 10.1 |
| Books/magazines | 8.6 | 8.9 | 8.8 | 4.7 | 9.6 | 7.5 |
| Radio | 55.3 | 66.2 | 61.5 | 69.2 | 73.5 | 71.6 |
| Television | 50.3 | 56.8 | 54.0 | 51.8 | 60.9 | 57.0 |
| Internet | 0.1 | 0.7 | 0.4 | 0.3 | 0.6 | 0.5 |
| Poster/billboard | 2.9 | 4.8 | 4.0 | 5.9 | 7.4 | 6.8 |
| Other | 9.6 | 8.6 | 9.0 | 10.1 | 12.2 | 11.3 |
| Don't know/unsure | 2.7 | 1.7 | 2.1 | 1.8 | 0.3 | 1.0 |
| Preferred sources for information about HIV/AIDS* | | | | | | |
| Any family | 12.8 | 11.2 | 11.9 | 7.3 | 6.1 | 6.6 |
| Any friend | 3.1 | 4.3 | 3.8 | 2.5 | 3.3 | 3.0 |
| Any teacher or health provider | 50.8 | 47.9 | 49.1 | 50.1 | 48.2 | 49.0 |
| Any mass media | 33.8 | 41.0 | 37.9 | 47.2 | 48.3 | 47.8 |
| Mother | 10.7 | 8.5 | 9.5 | 3.7 | 5.0 | 4.4 |
| Father | 3.0 | 3.2 | 3.1 | 3.5 | 3.6 | 3.6 |
| Spouse/partner | 0.0 | 0.3 | 0.1 | 0.0 | 0.1 | 0.0 |
| Brother | 0.8 | 0.3 | 0.5 | 0.8 | 0.4 | 0.6 |
| Sister | 1.4 | 1.3 | 1.3 | 0.5 | 0.2 | 0.4 |
| Other female family | 2.0 | 1.5 | 1.7 | 1.0 | 0.3 | 0.6 |
| Other male family | 0.2 | 0.5 | 0.4 | 1.6 | 0.6 | 1.0 |
| Female friends | 3.2 | 4.2 | 3.8 | 0.5 | 1.4 | 1.0 |
| Male friends | 0.2 | 0.7 | 0.5 | 2.4 | 3.0 | 2.8 |
| Teacher/school | 42.2 | 30.5 | 35.5 | 40.1 | 32.9 | 35.9 |
| Doctor/nurse/clinic | 17.5 | 24.1 | 21.3 | 16.1 | 19.6 | 18.1 |
| Traditional or spiritual healer/herbalist | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Church | 6.8 | 8.0 | 7.5 | 4.4 | 5.0 | 4.7 |
| Community/neighborhood | 0.9 | 1.0 | 1.0 | 1.1 | 0.2 | 0.6 |
| AIDS campaign/club | 0.7 | 0.7 | 0.7 | 0.5 | 1.1 | 0.8 |
| Newspaper | 1.3 | 1.0 | 1.1 | 1.3 | 3.2 | 2.4 |
| Books/magazines | 1.3 | 0.7 | 0.9 | 0.7 | 2.6 | 1.8 |
| Radio | 19.0 | 24.1 | 21.9 | 32.5 | 30.3 | 31.2 |
| Television | 18.0 | 24.7 | 21.9 | 23.9 | 26.9 | 25.7 |
| Internet | 0.1 | 0.1 | 0.1 | 0.5 | 0.5 | 0.5 |
| Poster/billboard | 0.2 | 0.3 | 0.2 | 0.3 | 1.2 | 0.8 |
| Other | 3.5 | 5.5 | 4.6 | 3.7 | 6.6 | 5.4 |
| Don't know | 7.5 | 4.1 | 5.6 | 5.2 | 2.5 | 3.6 |

*Totals may exceed 100 because multiple responses are possible. Note: Ns are weighted.

TABLE 9.19 Percentage of adolescents who know of HIV/AIDS, by exposure to mass media messages about HIV/AIDS, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|---|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=899) | 15-19 (N=1200) | Total (N=2099) | 12-14 (N=921) | 15-19 (N=1237) | Total (N=2158) |
| In the last few months has heard or seen messages about HIV/AIDS*: | | | | | | |
| on the radio | 69.0 | 78.3 | 74.3 | 73.1 | 79.0 | 76.5 |
| on the television | 60.6 | 62.8 | 61.8 | 55.3 | 64.0 | 60.3 |
| in a newspaper or magazine | 23.5 | 30.7 | 27.6 | 19.5 | 34.6 | 28.2 |
| in a poster | 30.7 | 42.0 | 37.2 | 30.4 | 43.6 | 37.9 |
| in a leaflet or brochure | 17.2 | 24.6 | 21.5 | 11.3 | 24.3 | 18.8 |
| from a health worker | 26.0 | 35.1 | 31.2 | 21.6 | 32.7 | 28.0 |
| at a community or social club meeting | 18.8 | 27.9 | 24.0 | 17.7 | 23.2 | 20.9 |
| Level of exposure to HIV/AIDS messages in recent months | | | | | | |
| No exposure | 17.6 | 13.3 | 15.1 | 15.2 | 11.6 | 13.1 |
| 1 exposure | 17.5 | 15.5 | 16.3 | 22.2 | 15.6 | 18.4 |
| 2 exposures | 24.1 | 17.1 | 20.1 | 23.3 | 18.1 | 20.3 |
| 3-7 exposures | 40.8 | 54.1 | 48.4 | 39.3 | 54.7 | 48.1 |
| Has heard the slogan*: | | | | | | |
| "Reach out, show compassion" | 36.4 | 44.1 | 40.8 | 36.0 | 48.9 | 43.4 |
| "Stop AIDS, love life" | 67.0 | 77.2 | 72.8 | 72.0 | 84.3 | 79.1 |
| "It pays to wait" | 47.0 | 61.5 | 55.3 | 50.2 | 63.6 | 57.9 |
| "Say no to casual sex" | 43.8 | 60.5 | 53.4 | 46.0 | 63.4 | 56.0 |
| "Change your life - No means no - think" | 47.9 | 59.0 | 54.3 | 50.5 | 63.1 | 57.8 |
| "Things we do for love" | 50.7 | 63.8 | 58.2 | 53.8 | 64.6 | 60.0 |
| "If it is not on, it is not in" | 46.8 | 60.0 | 54.4 | 45.5 | 64.3 | 56.3 |
| "Don't go Mungo Park" | 9.0 | 15.9 | 13.0 | 8.9 | 18.6 | 14.5 |
| "Think before you play" | 29.1 | 39.7 | 35.2 | 37.2 | 52.2 | 45.8 |

*Totals may exceed 100 because "yes" responses to multiple items are shown. *Note:* Ns are weighted.

TABLE 9.20 Percentage distribution of adolescents who know of HIV/AIDS, by knowledge about voluntary counseling and testing, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | 12–14 (N=900) | 15–19 (N=1201) | Total (N=2101) | 12–14 (N=922) | 15–19 (N=1239) | Total (N=2161) |
| Have heard that people can get tested to see if they are infected with HIV/AIDS | | | | | | |
| Yes | 75.3 | 85.8 | 81.3 | 77.9 | 89.7 | 84.6 |
| No | 24.7 | 14.2 | 18.7 | 22.1 | 10.3 | 15.4 |
| Knows of a place to get an HIV/AIDS test* | | | | | | |
| Yes | 76.0 | 78.5 | 77.5 | 71.4 | 80.8 | 77.1 |
| No | 24.0 | 21.5 | 22.5 | 28.6 | 19.2 | 22.9 |
| Places known for HIV/AIDS test† | | | | | | |
| Government clinic/hospital | 93.0 | 93.4 | 93.3 | 93.6 | 95.2 | 94.6 |
| Private clinic/hospital/doctor | 21.6 | 26.8 | 24.7 | 22.6 | 30.2 | 27.4 |
| NGO clinic | 2.7 | 3.6 | 3.3 | 2.5 | 2.2 | 2.3 |
| Drug shop/pharmacy | 1.2 | 0.9 | 1.0 | 0.2 | 1.1 | 0.8 |
| Mobile clinic | 1.9 | 0.9 | 1.3 | 0.6 | 0.8 | 0.7 |
| Stand alone testing center | 3.9 | 5.2 | 4.7 | 0.2 | 0.7 | 0.5 |
| Laboratory | 1.7 | 0.4 | 0.9 | 1.8 | 2.8 | 2.4 |
| Other | 0.8 | 0.2 | 0.5 | 1.6 | 0.9 | 1.1 |
| Does a person have to pay to get tested† | | | | | | |
| Yes | 27.6 | 26.4 | 26.9 | 25.4 | 22.9 | 23.8 |
| No | 26.4 | 33.1 | 30.5 | 19.8 | 27.6 | 24.8 |
| Don't know | 46.0 | 40.5 | 42.7 | 54.8 | 49.4 | 51.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Limited to those who are aware of a test for HIV/AIDS. Sample sizes: females 12–14 (N=678); females 15–19 (N=1030); males 12–14 (N=717); males 15–19 (N=1111). †Question asked of those who know of a place to get tested. Sample sizes: females 12–14 (N=515); females 15–19 (N=808); males 12–14 (N=512); males 15–19 (N=898). Totals may exceed 100 because multiple responses are possible. *Note:* Ns are weighted.

TABLE 9.21 Percentage distribution of adolescents who have never been tested for HIV and who know that a person can be tested, by desire to be tested reasons for not being tested, according to sex and age, 2004 National Survey of Adolescents

| Characteristic | Female | | | Male | | |
|--|------------------|------------------|-------------------|------------------|-------------------|-------------------|
| | 12-14 (N=674) | 15-19 (N=992) | Total (N=1666) | 12-14 (N=708) | 15-19 (N=1078) | Total (N=1786) |
| Want to be tested for AIDS virus | | | | | | |
| Yes | 71.5 | 70.2 | 70.7 | 68.1 | 72.7 | 70.9 |
| No | 28.3 | 29.3 | 28.9 | 30.4 | 27.3 | 28.5 |
| Don't know | 0.1 | 0.5 | 0.4 | 1.6 | 0.0 | 0.6 |
| Main reason have not been tested* | | | | | | |
| Not sexually active | 31.7 | 20.0 | 24.8 | 23.4 | 18.1 | 20.1 |
| Not at risk for other reasons | 28.1 | 34.0 | 31.6 | 32.1 | 34.2 | 33.4 |
| Do not know where to go | 6.5 | 8.0 | 7.3 | 7.2 | 5.9 | 6.4 |
| Costs too much | 9.0 | 11.3 | 10.3 | 12.0 | 17.0 | 15.1 |
| Can get infection from test | 0.2 | 0.3 | 0.3 | 0.4 | 0.0 | 0.2 |
| Don't want to know status | 3.5 | 4.1 | 3.8 | 1.7 | 3.4 | 2.8 |
| Someone might see me | 0.4 | 0.9 | 0.7 | 0.2 | 0.3 | 0.2 |
| Too young | 2.9 | 0.7 | 1.6 | 4.3 | 1.3 | 2.4 |
| No money for test | 3.8 | 5.1 | 4.5 | 2.9 | 3.6 | 3.3 |
| No time | 0.4 | 1.6 | 1.1 | 0.4 | 1.8 | 1.3 |
| Not infected | 1.0 | 0.1 | 0.5 | 2.7 | 2.0 | 2.3 |
| No reason | 6.0 | 6.2 | 6.1 | 5.4 | 4.7 | 5.0 |
| Other | 6.5 | 7.8 | 7.3 | 7.2 | 7.8 | 7.6 |
| Main reason do not want to be tested† | | | | | | |
| Not sexually active | 35.6 | 23.1 | 28.0 | 23.1 | 23.0 | 23.1 |
| Not at risk for other reasons | 40.3 | 35.7 | 37.5 | 40.0 | 41.6 | 40.9 |
| Do not know where to go | 1.0 | 0.7 | 0.8 | 2.7 | 1.7 | 2.1 |
| Costs too much | 0.0 | 1.4 | 0.8 | 2.7 | 2.4 | 2.5 |
| Can get infection from test | 2.6 | 2.4 | 2.5 | 5.3 | 4.1 | 4.7 |
| Don't want to know status | 6.8 | 22.1 | 16.1 | 7.6 | 15.5 | 12.0 |
| Someone might see me | 1.6 | 0.7 | 1.0 | 1.8 | 0.3 | 1.0 |
| Too young | 0.5 | 0.3 | 0.4 | 2.2 | 0.7 | 1.4 |
| Not infected | 3.7 | 2.7 | 3.1 | 2.7 | 2.7 | 2.7 |
| No reason | 3.7 | 4.4 | 4.1 | 4.4 | 3.8 | 4.1 |
| Other | 4.2 | 6.5 | 5.6 | 7.6 | 4.1 | 5.6 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Limited to those who want to be tested. Sample sizes: females 12–14 (N=480); females 15–19 (N=691); males 12–14 (N=483); males 15–19 (N=784). †Limited to those who do not want to be tested. Sample sizes: females 12–14 (N=191); females 15–19 (N=294); males 12–14 (N=225); males 15–19 (N=291). Note: Ns are weighted.

**Chart 9.1 Adolescents, by school attendance and exposure to sex education, according to sex and age
2004 National Survey of Adolescents**

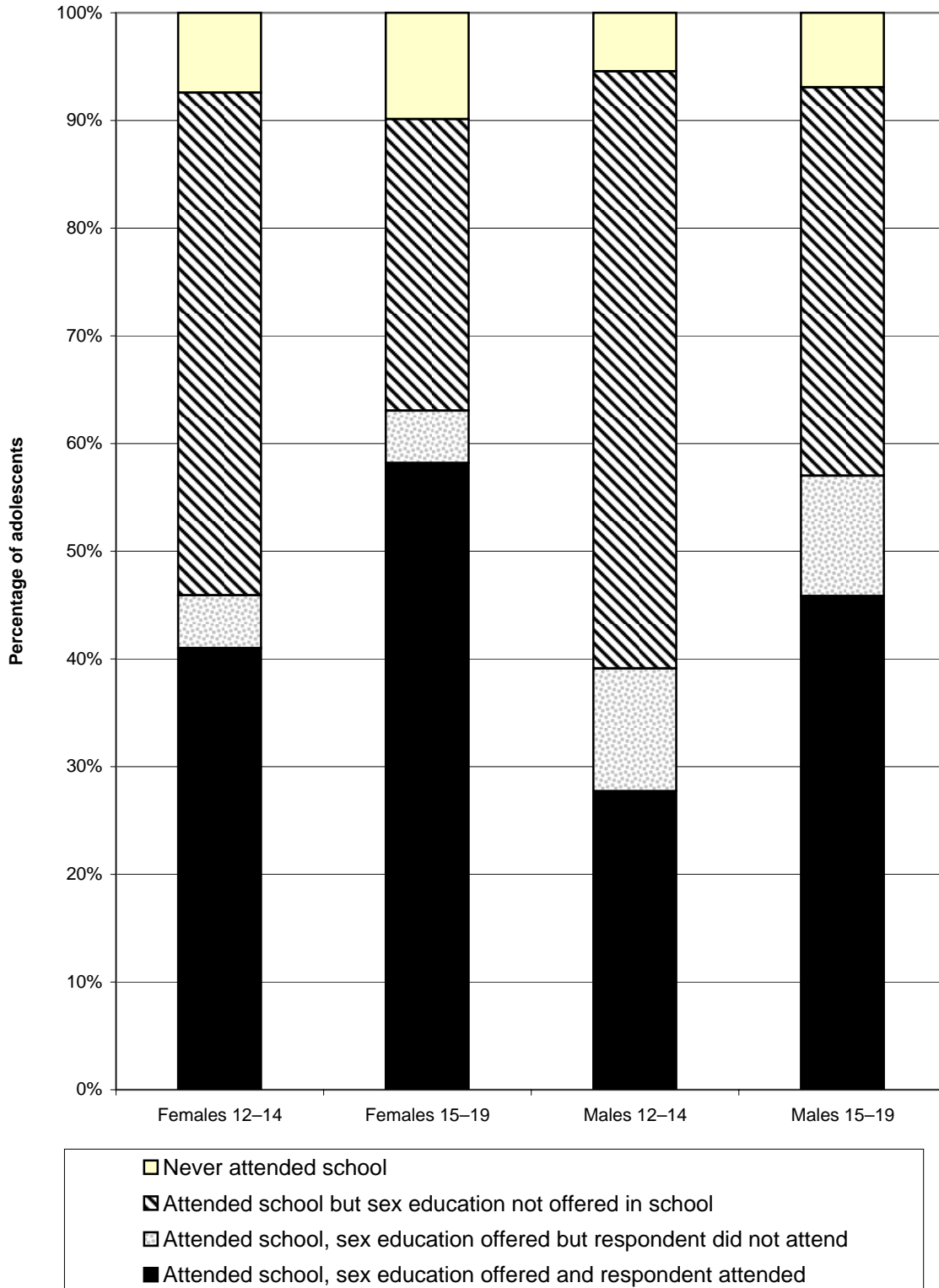


Chart 9.2 Female adolescents who know of at least one method, by urban-rural difference in sources for contraceptive method information, 2004 National Survey of Adolescents

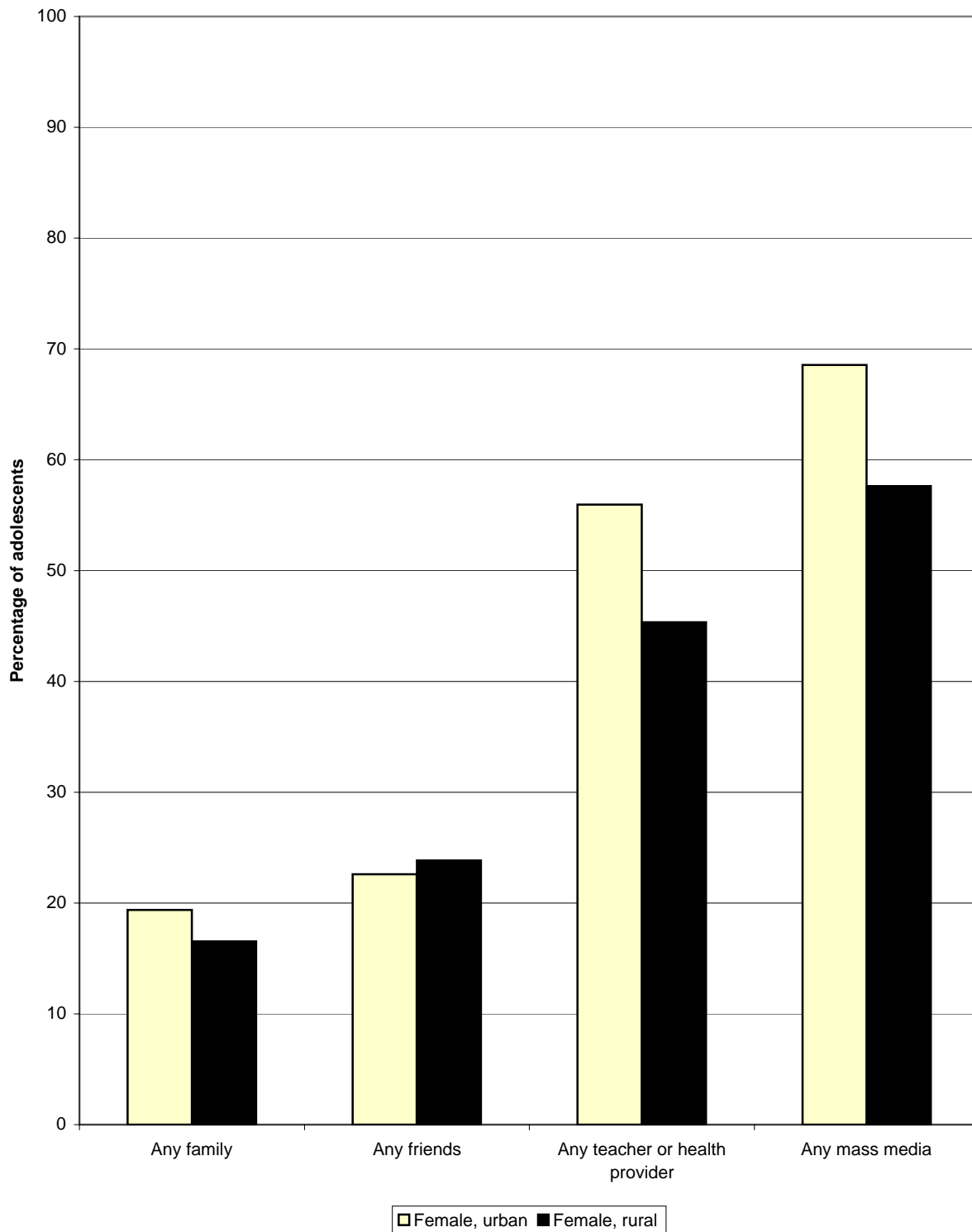


Chart 9.3 Male adolescents who know of at least one contraceptive method, by urban-rural difference in sources for contraceptive information, 2004 National Survey of Adolescents

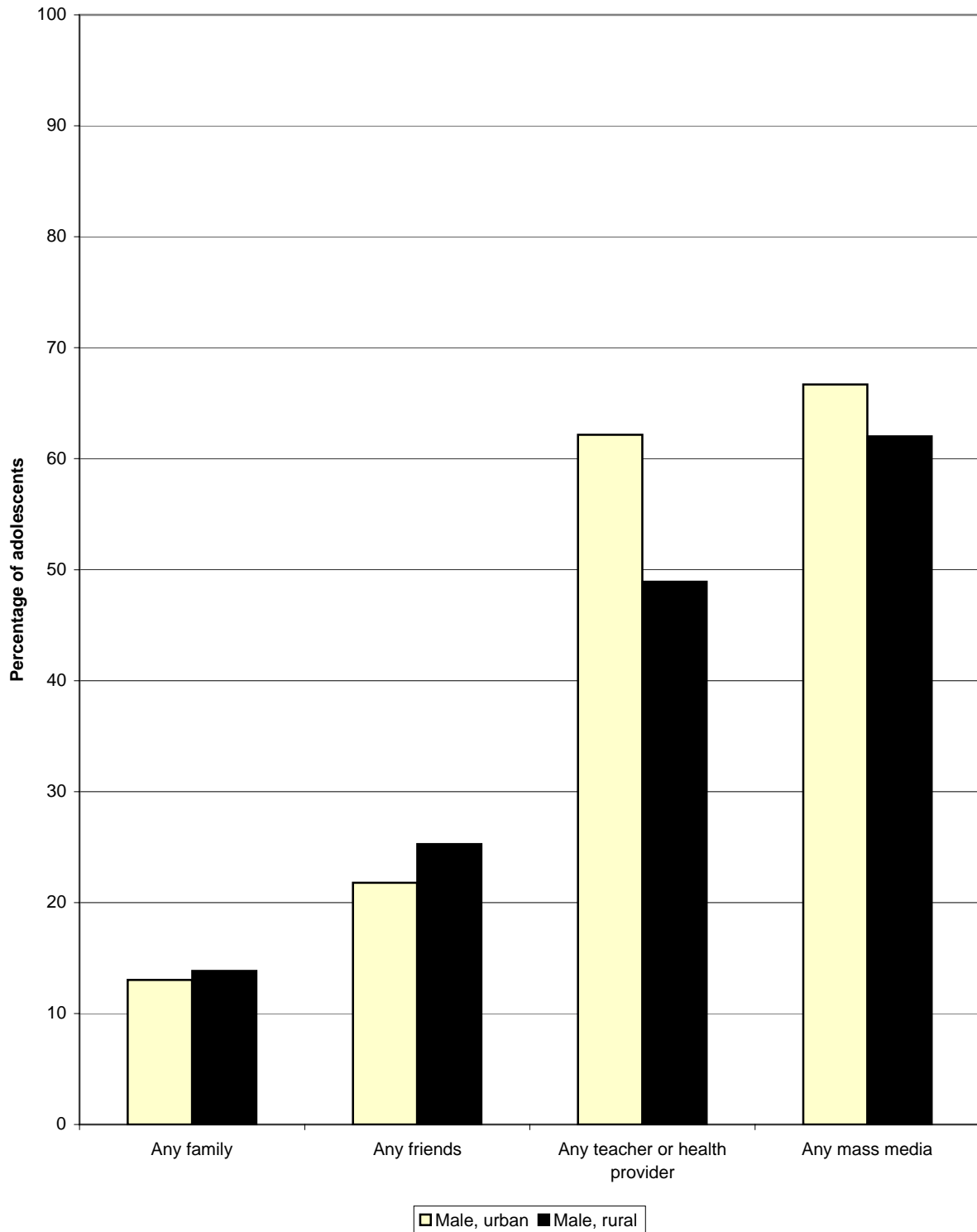


Chart 9.4 Adolescents who know of at least one method, by used and preferred sources of information on contraceptive methods, 2004 National Survey of Adolescents

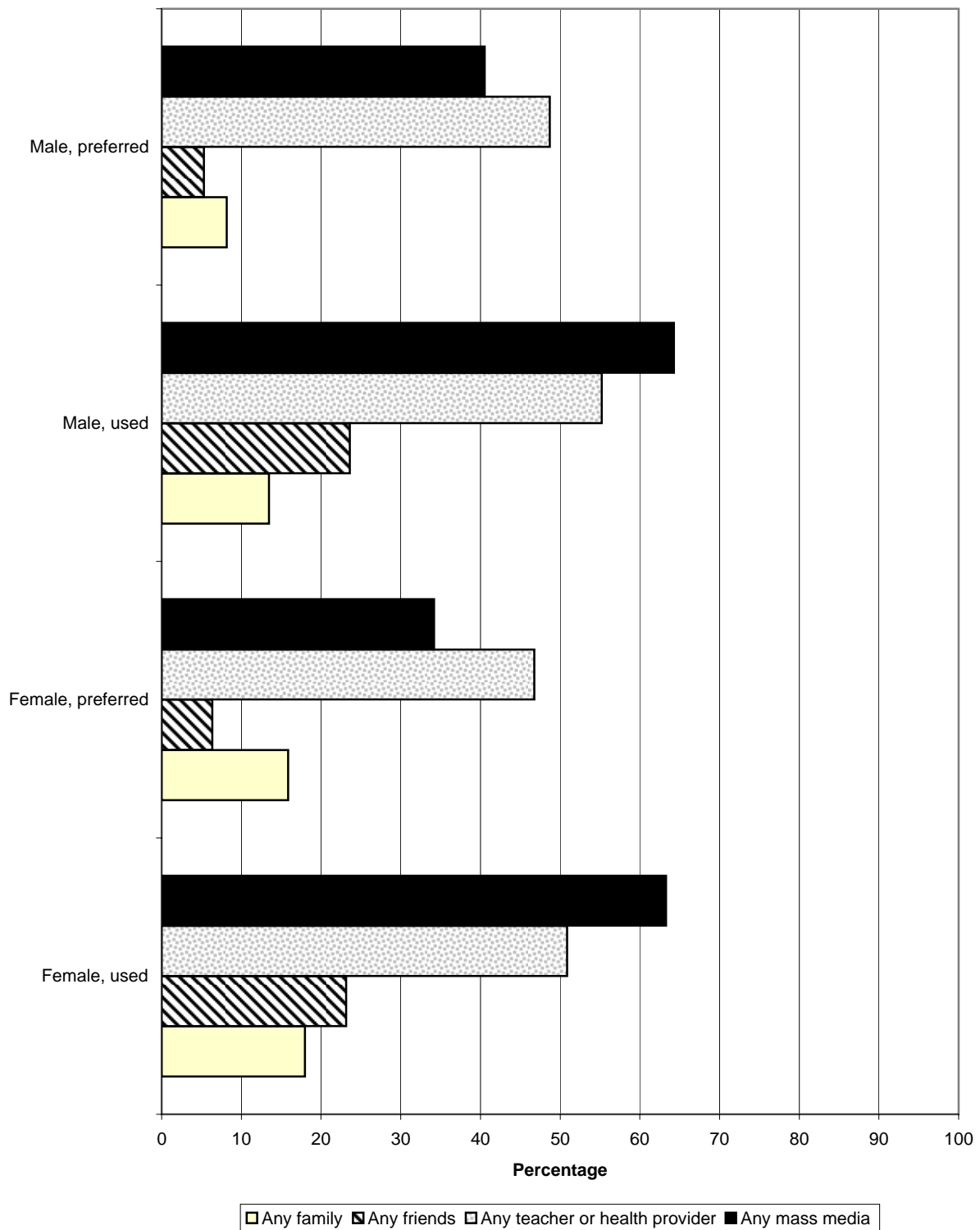
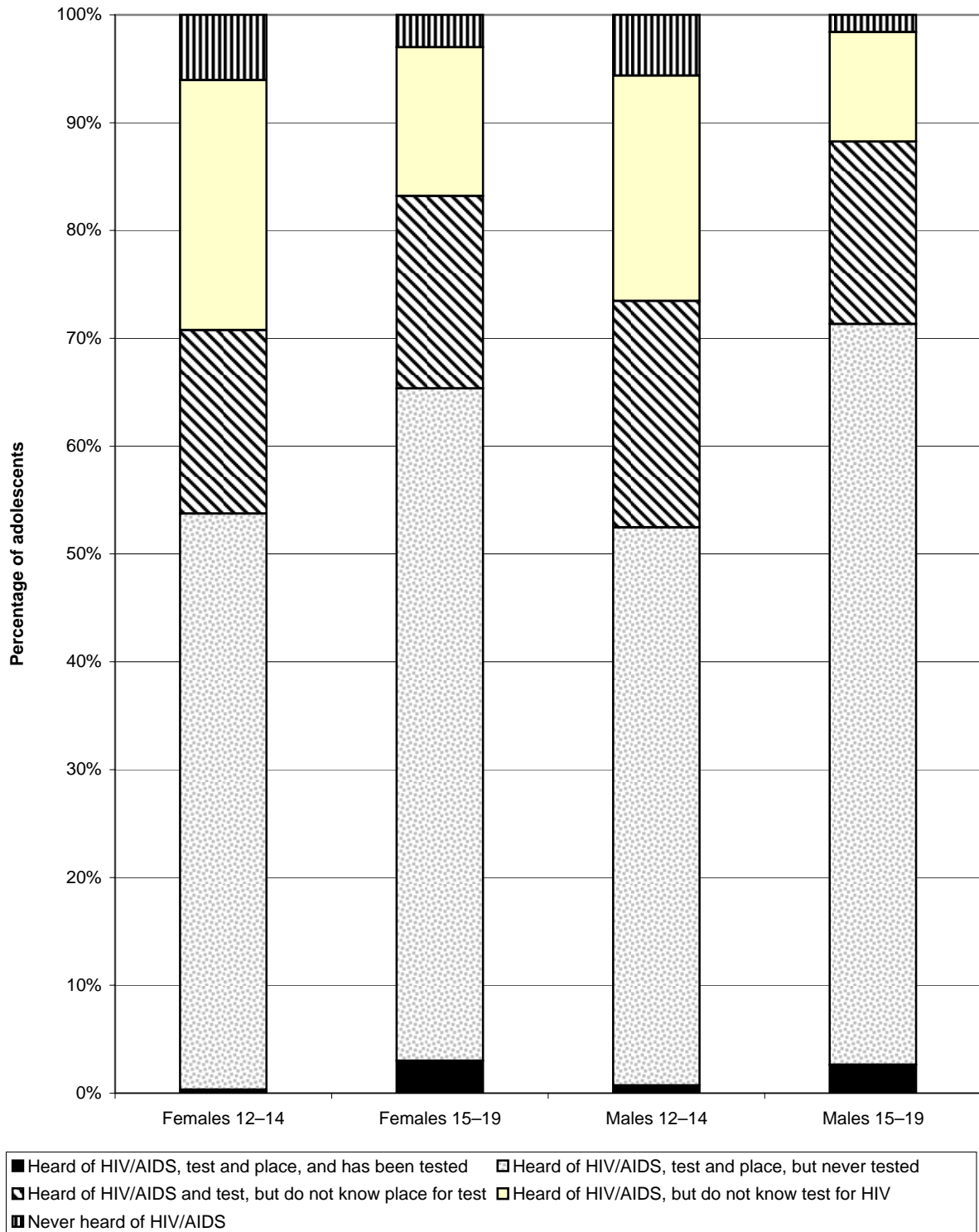


Chart 9.5 Adolescents, by knowledge and experience of voluntary counselling and testing, according to sex and age, 2004 National Survey of Adolescents



Chapter 10

Conclusion and Policy and Program Implications

Introduction

The results from the 2004 National Survey of Adolescents in Ghana reveal inconsistencies in adolescents' knowledge of, attitudes toward and practices of sexual and reproductive health: Adolescents are generally aware of HIV, pregnancy and means of protection, yet they are inadequately aware of the specifics. Gaps are also emerging between expected and actual behavior for the youth on a wide range of issues, including sexual and reproductive health. For instance, adolescents are aware of at least one contraceptive method, but they are not aware of where to obtain services. Furthermore, adolescents who are sexually active do not consider themselves at risk of STIs (including HIV), although only about 40% of recent sexual intercourse was protected. This chapter summarizes these and other observations and details the implications of the findings for policy and programming.

Background and Socialization

Results indicate that 90% of adolescents were either in school or had ever been to school, a proportion that is slightly higher than the national average for the age group. It is generally recognized that high levels of formal education are associated with positive sexual and reproductive health outcomes. When an adolescent leaves school early, it is likely to negatively affect his or her future livelihood, partly because of a relatively low level of overall educational attainment and possibly because of early exposure to the risk of pregnancy. While 0.2% and 0.1%, respectively, of the females and males were in tertiary institutions at the time of the survey, 54% of the females and 62% of the males expected to achieve higher education, indicating large differences in the expectations for higher education and the reality.

Traditional processes of initiation into adulthood such as Dipo and Bragro are no longer practiced as they used to be. Sexual and reproductive health education, long associated with these ceremonies and provided

within the home or community, has gradually shifted from familial to nonfamilial sources, such as the mass media, the school system and health personnel.

Over 80% of females reported being involved in household chores, compared with 47% of males. More males than females reported making time for recreation.

Adolescents consider religion to be important in their lives. Young Ghanaians also report close, often mixed-sex friendship networks, with an average of four close friends for males and two for females.

Young people voiced health and economic concerns. These included issues about health generally, fear of contracting HIV/AIDS and other STIs, concerns about money and concern about getting adequate food.

Implications

Among the policy and program implications are the following:

- Society must meet the challenge of helping young people achieve their objective of attaining higher education while at the same time eliminating the gender-based difference in expectations of education for males and females.
- Parents/guardians and society must encourage females to pursue higher education.
- Religious associations and peer networks should help form the conduits for developing programs for young people. In particular, these associations and networks can be utilized to provide sexual and reproductive health and other services to young people.
- With the observed shifts from family to nonfamilial members as sources for discussing sex-related issues, the policy of teaching sex-related issues in schools and other nonfamilial settings should be intensified.
- The socioeconomic concerns indicated by youth should form the basis for developing programs for and with them.

Sexual Activity and Relationships

Issues associated with pubertal changes and sexual debut are important in the lives of young people. Ninety percent of females and 88% of males aged 15–19 years had experienced pubertal changes. Results indicate that 30% of females and 16% of males aged 15–19 years had ever had sexual intercourse. The pace of exposure to sex for females increased sharply after age 15 years.

Only a third of younger adolescents (12–14 year old) had experienced pubertal changes. Therefore, they were less knowledgeable about sexual and reproductive health issues, such as when pregnancy occurs than older adolescents. Only 2% of females aged 12–14 years had ever had sex. A number of those who had never had sex reported other sexual experiences such as fondling and kissing.

The reasons for having sex for the first time included “felt like doing it”, anticipation of monetary and other rewards, being tricked and being forced. The sexual partners of females were, on average, much older (5 or more years older) and this was especially the case for married adolescents. For males, most of their sexual partners were the same age or younger. A large age difference between partners may be associated with unequal power within the relationship.

Twelve percent of females reported that they had ever been forced or threatened into having sexual intercourse. The perpetrators of the sexual coercion include acquaintances, boyfriends, family members, teachers and schoolmates.

Many adolescents, especially females, and including those who had never experienced sexual intercourse, were more concerned with avoiding pregnancy than with preventing HIV/AIDS and other STIs. Yet most programs emphasize avoiding STIs, including HIV/AIDS. More females and males in urban areas were exposed to sexual and reproductive health information than their counterparts in rural areas.

Adolescents reported having received encouragement to avoid early sex from parents, family members, other significant adults in their lives and friends. For females, support came mostly from mothers, sisters and other female family members, while for males, parents, friends of the same sex and teachers were the main actors who encouraged them to abstain from sex. Such encouragement is important for achieving positive reinforcement and/or behavioral change.

Implications

- With the erosion of the traditional support systems for young people for various reasons, it will be useful to develop structures that will provide support to young people to enable them make healthy sexual and reproductive health decisions.
- Early sexual experience without protection, as observed from the data, has implications for sexual and reproductive health programs and welfare of young people. Sex education must begin early in order to increase the proportion of females postponing first sex into later life.
- The next generation of programs on sexual and reproductive health should respond to the adolescents’ concerns about avoiding pregnancy and STIs by, for instance, promoting the use of condoms for dual protection. Furthermore, programs should have slightly different emphases for females and males, as well as rural and urban residents.
- The relatively high proportion of sexual coercion reported by females needs to be addressed at various levels, including within communities and the education system.

Contraception and Pregnancy

Over 90% of adolescents had heard of at least one contraceptive method. The most well-known method was the male condom, which was mentioned by four in five 12–14-year-olds. Although knowledge about contraceptives was found to be high (reported by more than 90% of males and females), only 59% of females and 53% of males who had ever had sexual intercourse had ever used any contraceptive methods. Among those using contraceptives, the male condom was the method most commonly used (45% of females and 47% of males who had ever had sexual intercourse), and it was used mostly to prevent pregnancy.

In general, adolescents were aware of some aspects of pregnancy, but lacked detailed knowledge as to how and when pregnancy can occur. A substantial level of unintended childbearing was observed among those who had ever been pregnant or had had a child, even among adolescents who were in unions. Adolescents who were yet to marry also expressed a desire for long delays before starting childbearing. These indicate a strong demand for specific information about pregnancy prevention.

Of the 1,235 females aged 15–19 years who were interviewed, 7% were married or living with a man as if married. Although this proportion is relatively low, it indicates that early marriage is still an issue in the

country. Achieving universal basic education is not going to be possible with early marriage and child-bearing.

Anecdotal evidence suggests that induced abortion, including unsafe abortion, occurs among adolescents. Yet, fewer than 1% of adolescents reported personal experiences with abortion. Therefore, friends' experiences provided an idea of the level of induced abortion among adolescents. Nearly one in three older female adolescents knew of a close friend who had tried to end a pregnancy, and about 50% of both males and females were aware of ways a pregnancy could be terminated.

Implications

Program efforts and resources should be used to build on adolescents' current knowledge of sexual and reproductive health issues. Among the areas will be to:

- Improve information sources and services to promote the use of effective contraceptive methods among sexually active adolescents in Ghana.
- Provide sex education that includes detailed information about pregnancy to adolescents and covers a wide range of sexual and reproductive health issues, including what happens to males and females at various stages of physical development and certain misconceptions about sexual acts that do not lead to pregnancy.
- Use the formal and informal school systems to provide detailed information about how pregnancy can occur and be prevented.
- Intensify the campaign for delaying sexual debut and pregnancy by pursuing the goal of universal basic education, particularly for females.
- Improve education and services for adolescents to prevent unintended pregnancy and unsafe abortion.

HIV/AIDS and Other STIs

Since the outbreak of the HIV/AIDS epidemic, there has been a concerted effort to make people aware of modes of infection and prevention and increase compassion towards infected persons. As a result, various studies, including the 2004 National Survey of Adolescents, have reported high levels of awareness of HIV/AIDS: Knowledge of HIV/AIDS among adolescents is almost universal. But alongside the high level of awareness are misconceptions about modes of transmission and prevention. Some of adolescents reported mosquito bites as a possible source of infection, while others were of the view that the infection can be cured by having sex with a virgin. There was also evidence

of possible stigmatization and rejection of infected persons.

Just half of 15–19-year-old males and females had heard of STIs other than HIV, and the proportions were even lower for younger adolescents and rural residents. Other STIs constitute cofactors for HIV infection and should therefore be taken seriously.

Fewer than 5% of females and about 1% of males had ever experienced an STI, according to their own reports. For those who had ever had sex, the proportions who reported having had an STI or STI symptoms were 21% for females and 5% for males. The results were from self-reporting and, therefore, may be affected by biases. Yet, the results point to the existence of STIs among young people.

Implications

Results from the National Survey of Adolescents show a dearth of knowledge about various dimensions of the HIV/AIDS epidemic and other STIs. The challenges for programming include:

- developing programs that address existing misconceptions on modes of infection and provide accurate and reliable information to young people on the epidemic;
- developing messages that address the low level of awareness and knowledge about other STIs among young people;
- intensifying campaigns that deal with acceptance and support for people living with AIDS;
- developing programs that respond to the particular needs of younger and rural adolescents. As a subgroup, rural adolescents, particularly females, are more likely to drop out of school and/or marry early than their urban counterparts and, therefore, will need messages and services that will help postpone sexual debut and also them protect themselves from early pregnancy and STIs, including HIV/AIDS; and
- developing messages and providing services for STI treatment and VCT.

Perception of Risk and Knowledge About HIV/AIDS and Other STIs

The results indicate a gap between perceived and actual risk: Adolescents have a low self-perceived risk of HIV infection but early sexual debut, negative attitudes toward condom use and lack of confidence in the purchase and use of condoms. Furthermore, about half of females and a third of males who had sexual intercourse in the three months prior to the survey did not protect themselves.

Although they are aware of contraceptive methods and where to get them, many adolescents reported that they were not confident enough to purchase condoms and were also not confident about using condoms correctly.

Implications

Given the observed perception of risk and the pattern of early sexual debut (especially among females), there will be the need for programs that aim at:

- assisting females to increase age at first sex;
- promoting a positive image towards condom use; and improving adolescents' confidence about the purchase and correct use of condoms for dual protection from pregnancy and STIs, including HIV.

Sexual and Reproductive Health Information and Services

Electronic media was adolescents' main source of information on HIV/AIDS and few adolescents reported receiving information from print media. Although the media was the main source of information on sexual and reproductive health, young people preferred to obtain such information from professionals, such as teachers and health personnel, rather than the mass media. Among family members, mothers emerged as both common and preferred sources of information about contraceptive methods for both female and male adolescents.

Two out of three adolescents who knew of at least one contraceptive method did not know about where to obtain it. Among the barriers to the use of contraceptives and STI treatment are that young people feel embarrassed or shy to use services. Cost of obtaining services and the distance to service points were also perceived to be barriers. Finally, young people expressed confidence in government health facilities as much as in private ones.

Implications

The results indicate that implementers of programs and activities should:

- devote some attention to education on other STIs, in addition to HIV, and their implications for the sexual and reproductive health of young people;
- make efforts to use the channels young people themselves say they prefer for obtaining information and services on sexual and reproductive health;
- develop programs targeting parents in order to make it easy for them to support their children in sexual and reproductive health issues;

- use the electronic media as much as possible to provide information to young people. In addition, efforts should be made to promote the use of print media for information that needs to be kept and referred to in the future. Such an approach should be built into programs in the school system and into informal education study packs for those who are out of school;
- health providers should develop programs that adolescents can identify with in terms of confidentiality, hours of operation, sex of the provider and the quality of the services provided; and
- adolescents must continue to receive messages on abstinence, faithfulness and the effectiveness of condom use in preventing HIV/AIDS, with relative emphasis for various categories of adolescents: younger and older; rural and urban; ever had and never had sex; and in a union and not in a union.

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