Adolescents' Sexual and Reproductive Health: Qualitative Evidence from Ghana

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Executive Summary

This report, based on in-depth interviews with 102 adolescents, is a sequel to focus group discussions[1] and a national survey of adolescents in Ghana[2] undertaken as part of a project entitled Protecting the Next Generation. The 102 in-depth interviews (IDIs) were conducted with in- and out-of-school males and females in urban and rural areas and some adolescents in potentially vulnerable circumstances. Among those in the last category were very young adolescents who were pregnant or had given birth, were working on the street, or were living in borstal homes or a refugee camp. The general aim was to understand their circumstances, perceptions and attitudes concerning certain aspects of their lives, especially their sexual and reproductive health. The specific objectives were to

- examine the nature and type of information adolescents receive on sexual and reproductive health issues (including puberty, HIV and other STIs, and preventing pregnancy);
- assess their health-seeking behavior and the factors that help or hinder seeking sexual and reproductive health services;
- understand the nature of their intimate relationships (which may or may not involve sexual intercourse); and
- examine factors influencing the ability of adolescents to deal with their sexual and reproductive health.

Aspirations

Formal education is important in the lives of adolescents and shapes their future outlook. In general, in-school adolescents, especially those in urban areas, were more anxious to obtain higher education and be employed in such professions as teacher, lawyer or journalist, compared with out-of-school adolescents in urban and rural areas; the latter group aspired to be in trading and low-level vocational jobs. In-school adolescents also tended to be self-confident, and felt that they could overcome obstacles confronting them through discipline and hard work. Out-of-school rural adolescents tended to report reliance on prayers and supernatural powers to enable them to succeed in life. The differences in aspirations and self-confidence to deal with issues in life, including those of sexual and reproductive health, indicate that programs developed for adolescents should target rural-urban and in- and out-of-school youth differently; programs for youth in rural areas should include strategies for building self-confidence.

Concerns

The two main concerns that emerged spontaneously from adolescents were those associated with formal education and earning income. Those who were in school were concerned about achieving a certain level of education and the ability of their parents/guardians to financially support them in school (e.g., purchase books and school uniforms). Those who were out of school were concerned about how they could further their education or regretted the fact that they were not in school in the first place.

When prompted, adolescents considered early and premarital pregnancy and HIV infection to be major problems which can be obstacles to a young person achieving his/her potential in life. Early pregnancy, they said, could lead a female to drop out of school or fail to achieve higher education, while HIV infection could lead to debilitating diseases and eventually to death. Respondents identified pregnancy to be a greater problem than HIV because they did not consider themselves to be at risk of infection. The few who considered themselves to be at risk of HIV infection, mostly females, indicated that they could be at risk from unfaithful partners. The concern about and attitudes towards premarital pregnancy as an obstacle to females' development provide an entry point for promoting programs that will lead adolescents to postpone sexual debut and pregnancy by practicing abstinence and

using condoms, both male and female, for dual protection among those who are sexually active. Programs to reduce the vulnerability of adolescents, especially young women, to early pregnancy and HIV infection should be packaged around the major concerns of education and livelihood.

Information on Sexual and Reproductive Health Issues

The school system, parents and other family members emerged as major sources of information about puberty. Virtually all the adolescents who were in school or had ever been to school reported receiving information about puberty before they experienced it, either from school or from a family member. Some adolescents, mainly out-of-school youth in rural areas, experienced puberty before they received any information or formal education about these body changes. Females who experienced menstruation before they had any information about it expressed the greatest worry and fear. The lack of information in rural areas on life-altering experiences likes menstruation will need to be addressed. There should be programs to ensure that every young person is introduced to puberty before he or she experiences it. Such programs could be implemented through the school-based or community-based activities.

Adolescents expressed the need for specific information on pregnancy and STIs, including HIV, in addition to the general information they received on these issues. Topics about which young people felt they needed further information were the proper use of male condoms, how to handle adolescent pregnancy and how to deal with persons living with HIV/AIDS. Respondents expressed the wish to receive such information from parents, teachers and health care workers. This is because adolescents perceived their parents to be caring and people who could be trusted, and teachers and health care workers as professionals who may have detailed information about sexual and reproductive health. To enable these professionals perform the roles young people expect of them, they should be supported through training and the provision of adequate resources and facilities.

Health-Seeking Behavior

Almost all the respondents reported ever having experienced a general health problem, the main problems being severe headaches, stomach problems and malaria. Only a few respondents reported any sexual and reproductive health problems: Yeast infections were reported among females and painful urination among males. Respondents reported using self-medication (often buying drugs from chemical (pharmacy) shops) or going to a clinic.

The major differences in health-seeking behaviors for reported general and sexual and reproductive health problems that emerged were between young and older adolescents, between rural and urban residents, and between youth on the street and those living with a parent or other adult. Younger adolescents said they would confide in parents, especially their mothers, and other adults about both types of health problems. They informed parents or were prepared to inform parents because they felt they could trust them and also they will be in a position to assist them to obtain health care. Adolescents in urban areas were more likely to use the formal health system while those in rural areas were more likely to use sources such as chemical shops and herbalists for general and sexual and reproductive health problems. Those living on the streets were the least likely to seek health care.

Regardless of whether adolescents had experienced a sexual or reproductive health problem, financial resources and fear of stigma were the two major barriers to obtaining health care. Empowering young people to seek care for sexual and reproductive health problems and mobilizing parents and communities to support them will be an important public good.

Residents in rural areas reported fewer sources for addressing their health problems compared with those in urban areas. Furthermore, young people living on the street in urban areas also constituted a group at risk for whom special programs would have to be designed to meet their needs.

Intimate Relationships

Some of the adolescents said they never had any intimate relationship at the time of the interview. Among the reasons given for not entering into any intimate relationship were being too young to engage in sex, fear of the reaction of parents, support from people not to engage in sex, fear of the effects of early pregnancy and childbearing on their education and fear of HIV/AIDS. Some had friends whom they considered to be intimate but had not ever had sex. Among those who had ever had sex, sexual debut occurred under various circumstances including mutual consent, coercion and rape. Only a few adolescents reportedly protected themselves during their sexual debut. Although most of the people who had ever had sex were aware of the protective effects of condoms, they did not protect themselves at sexual debut because it "just happened" and they did not have time to use any protection.

None of the females who had experienced coercive sex reported to any adult for help or support. One supportive source was the refuge in Accra for pregnant adolescents who were living on the street or had run away from home. The nature and magnitude of sexual coercion and its effects on young females requires further study. Programs should also be developed which aim, among other things, to promote the internalization of protective behaviors, such as the consistent use of contraceptives among those who are sexually active and support for those who experience sexual coercion.

Females and males were exposed to different pressures to have sex. Females reported direct pressure from male sexual partners and indirect pressure through teasing and name-calling from peers of the same sex to have sexual intercourse. Some of the female respondents reported that they gave in to such pressures from boyfriends for fear that their boyfriends might leave them for other girls if they refused. Males reported pressure from peers to have sex, but in all cases they reported being able to resist the pressure. In response to hypothetical questions about being pressured by a friend to have sex or drink alcohol, both males and females reported that they could resist pressure to drink alcohol. However, while all the males indicated that they could resist the pressure to have sex, some females indicated that they would give in to satisfy their male partner. The attitudes of those females reflect the vulnerability of females and the general notion among some males that with a little pressure, females can be made to change their minds about not having sex. In program terms, the "say no" campaign and strategies to build the confidence of females to defend their rights should be intensified.

Influences of Parents, Peers and Other Adults on Adolescents

Some adolescents reported that parents and other adults play important roles in safeguarding the sexual and reproductive health of adolescents. The reported roles included parents and guardians encouraging their children to avoid early sex, pregnancy and related problems; asking those in intimate relationships to end the relationship when they became aware of it; and helping adolescents to get care for sexual and reproductive health care problems. Some adolescents, though, acknowledged that while their parents and guardians played positive roles in their lives, they could not discuss sexual and reproductive health issues with them or talk to them about their intimate relations. Additional research is needed to understand better the nature of adult-adolescent communication about sexual and reproductive health issues.

Religious and social groups influence adolescents in two ways: through their teachings and, in some cases, through specific programs for adolescents. Although young people expressed interest in religion few of them reported being involved in sexual and reproductive health programs delivered by religious groups. We recommend that religious groups intensify existing programs and develop new ones for their members, given the importance of religion in the lives of adolescents. Very few of the adolescents were also involved in social clubs. It will be useful to promote other social clubs among young people in order to give them opportunities for networking and to learn from one another.

Conclusion

IDIs provided information on aspects of the lives of young people in Ghana. The adolescents' responses on their aspirations; concerns; health care–seeking behavior and barriers to care; and the influences of parents, other adults, peers and religious groups help to explain some of the observations in the quantitative survey. When taken together with results from the focus group discussions and the national survey, the IDIs help to enrich our understanding of Ghanaian adolescent sexual and reproductive health.

Chapter 1

Introduction

Twenty-five years into the epidemic, one major observation is that HIV/AIDS has hit young people (those aged 15–24 years) hard, especially those living in Sub-Saharan Africa and females in particular. In 2005, 4.3% of young women and 1.5% of young men in Sub-Saharan Africa were estimated to be living with HIV, prevalence rates higher than in any other world region.[3] As HIV in Sub-Saharan Africa is primarily spread through heterosexual intercourse, adolescents who are exposed to unprotected sex put themselves at risk of HIV infection. By engaging in unprotected sex, adolescents also risk unintended pregnancy. HIV and unintended pregnancy can have harsh consequences, especially for young women. Among the possible consequences of unintended pregnancy for adolescent females are health problems, being forced out of school, unsafe abortion, early motherhood and withdrawal of social support if the pregnancy occurs outside a formal union.

Young people aged 15–24 constitute one-fifth of the population of Sub-Saharan Africa and their state of health has significant implications for the future of individual countries and for the region as a whole.[4] Therefore, understanding the sexual and reproductive behaviors of young people—especially young women, who are particularly at risk—and the factors that protect or put them at risk of contracting STIs, including HIV, or experiencing unplanned pregnancy is critical.

This report is an analysis of in-depth interviews on sexual and reproductive health of young people in Ghana, with a focus on HIV, other STIs and unplanned pregnancy. The data were collected by the University of Cape Coast in conjunction with the Guttmacher Institute (New York, USA). The report is based on 102 in-depth interviews conducted among young people aged 12–19 of both sexes, who were both in and out of school and living in urban and rural locations; some adolescents were in particularly vulnerable situations: working or living on the streets, or residing in a borstal institute[5] (males only), a refuge for pregnant teenagers or a refugee camp. The specific objectives were to

- examine the type of information adolescents have had on sexual and reproductive health issues (including puberty, HIV and other STIs, and preventing pregnancy);
- assess their health-seeking behavior and the factors that help or hinder seeking sexual and reproductive health services;
- understand aspects of the nature of their intimate relationships (which may or may not involve sexual intercourse); and
- examine factors influencing the ability of adolescents to deal with their sexual and reproductive health.

This report is part of a five-year study of adolescent sexual and reproductive health known as Protecting the Next Generation: Understanding HIV Risk Among Youth. The project, which is being carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global search for strategies to confront the HIV/AIDS epidemic among adolescents by raising awareness of young people's sexual and reproductive health needs with regard to HIV/AIDS, other STIs and unplanned pregnancy; communicating the new knowledge to a broader audience, including policymakers, health care providers and the media at the national, regional and international levels; and stimulating the development of improved policies and programs that serve young people.

As part of the overall project, there was a comprehensive review of the existing social science research—both quantitative and qualitative—on adolescent sexual and reproductive health issues in Ghana.[6] Two important sexual and reproductive health needs of young people that emerged from the review were concerns with preventing HIV and other STIs and avoiding unwanted pregnancy. The results from the report informed the objectives and the focus of the overall project.

In addition to the in-depth interviews analyzed in this report, the project undertook focus group discussions among 14–19-year-olds (and published in a separate report), in-depth interviews with key adults (teachers, parents and health workers), and a national survey of 12–19-year-olds (also published as a separate report).[7] Combined, these sources provide comprehensive information on young people and respond to some of the knowledge gap identified in the review; they also provide information that can form the basis of programs and policies supporting young people's sexual and reproductive health.

This report is expected to increase knowledge about adolescent sexual and reproductive health in Ghana in four ways. First, it will contribute to the emerging evidence on the health-seeking behavior of adolescents. Describing the processes young people adopt in seeking health care (the kinds of sources, the sequence of steps, and supports and barriers they face) will facilitate a better understanding of their utilization of health care services that will in turn help clinic-based and informal-sector health providers (e.g., pharmacists and traditional healers) to meet the sexual and reproductive health needs of adolescents.

Second, much of what is known about the intimate relationships of adolescents is limited to a few specific indicators, such as ever having had sex or lifetime number of sex partners. This study adds to existing knowledge by providing information on the range of experiences of adolescents in romantic relationships, their choosing to be in a relationship, their interest in the opposite sex, the formation of relationships, and the pressures and expectations within relationships, including those that do not involve sexual intercourse. Emphasis is on aspects of intimate relationships that either expose adolescents to or protect them from STIs, including HIV, and unplanned pregnancy.

Family members, friends and community members play important roles in the lives of adolescents.[8] As some of the avenues for socialization and regular interaction, these people contribute to shaping the views, perceptions, attitudes and behaviors of young people, including aspects of sexual and reproductive health. The study explores the influences of parents, other family and community members and friends of the same or opposite sex on the sexual and reproductive health experiences of young people.

Finally, the stories of young people about their health problems and relationships also provide information about the larger context in which they lead their lives. This is to ultimately improve our understanding of why some young people take risks or are exposed to risks that lead to STIs, including HIV, and/or unplanned pregnancy, while others do not take or are able to avoid those risks.

This report is in eight chapters. The second chapter is a short background on adolescent reproductive health issues in the country, drawing on existing literature identified for the synthesis. Methods of data collection and analysis are indicated in Chapter 3. Chapter 4 deals with issues of puberty and knowledge of and challenges associated with premarital pregnancy and HIV infection. Chapter 5 is on general and reproductive health experiences, health-seeking behaviors and barriers to health care. Issues on intimate relationships and sexual debut are discussed in Chapter 6. Chapter 7 explores the aspirations and self-efficacy of adolescents and external influences on their sexual and reproductive health. The last chapter provides a summary of results and the policy and program implications.

Chapter 2

Background

The adolescent population (those aged 10–19 years) has consistently accounted for about one in five Ghanaians since 1960 (see Table 2.1). Within the last 40 years, the number of adolescents increased from 1.2 million in 1960 to 4.1 million in 2000—more than a three-fold increase. Hence, young people in Ghana constitute a sizable and numerous group whose sexual and reproductive health needs cannot be overlooked.

Over the last five years, the HIV/AIDS epidemic in Ghana has shown signs of decline. Nonetheless, the available evidence indicates that HIV/AIDS disproportionately affects females. In 2002, the estimated HIV/AIDS prevalence rate for all 15–24-year-olds was 3.4%[9] and in 2005 the estimated median HIV prevalence rates were 1.3% among females and 0.2% among males 15–24 years old.[10] Since 1986 when the first case was identified, more females than males have been diagnosed with AIDS. Initially, females accounted for over 70% of all diagnosed cases. With time, the proportion has declined to about three females per every two males. However, among those aged 15–19, females continue to dominate in the number of people diagnosed. For instance, the cumulative number of diagnosed persons from 1986 to 2001 among the population aged 15–19 was 951. Of that number, there were 807 females, accounting for 85% of those in the age-group.[11]

Between 1993 and 2003, median age at first marriage for females increased slightly from 19.0 years to 20.0 years and median age at first sex increased from 16.9 to 18.4. For males, median age at first sex increased from 18.4 in 1993 to 19.6 in 2003 and median age at first marriage declined slightly from 25.5 in 1993 to 25.0 in 2003. For both males and females, there is a time gap between when they first have sex and when they first get married: 1.6 years for females and about five years for males.

Finally, within the last decade, median age at first birth slowly increased from 20.1 in 1993 to 20.5 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.[12]

Overview of Other Research Studies

This section draws primarily on the synthesis of adolescent sexual and reproductive health in Ghana published in 2004 as part of this project. There have been a number of studies based on nationally representative or localized quantitative surveys, but few qualitative studies on the lives of adolescents in the country.[13] Reviewed as part of the project, the surveys show some changes over time in key outcomes, such as sexual risk-taking, sources of information and utilization of sexual and reproductive health services.[14] A few qualitative studies in various parts of the country have also provided insights into the lives of young people. For example, in focus group discussions with young people, Ampofo observed that society expects young women to be virgins before marriage and, therefore, those who engage in premarital sex are stigmatized while the same is not expected of boys.[15] Another study based on focus group discussions and in-depth interviews with 18–25-year-olds in Cape Coast found that sex before marriage was very much tied up with either financial or material returns.[16] Another analysis of 29 case studies of girls who had had unintended pregnancies, revealed that financial support and affection were the main reasons for starting a relationship.[17] This theme of financial or material gain as part of sexual relationships, with age-mates as well as older male partners, was also echoed in focus group discussions with 14–19-year-olds as part of the present study.[18]

Among the observed reasons for adolescents initiating sexual intercourse are pleasure, feeling like it, influence of their sexual partner and/or friends, and financial reasons. In a study of three districts in Ghana, Sallar[19] observed that 38% of adolescents had sex for the first time for pleasure, while 23% of males and 24%

of females had sex because of peer pressure. It was observed that due to the circumstances under which those first sexual experiences occurred, they were unable to protect themselves.

Sexual coercion of adolescents and the circumstances surrounding it are among the least studied social issues in Ghana. The few studies available, media reports and anecdotal evidence indicate that sexual coercion of young people, especially females, is a major problem. In a national survey of adolescents in 1998, 2% of males and 12% of females aged 15–24 reported that they were coerced the first time they had sex.[20] One of the circumstances surrounding sexual coercion is the assumption that males should be able to apply some pressure to obtain sex from females. About two-thirds of both females and males in the 1998 study who had ever had sex indicated that most girls did not really mean "no" when they say no to sex for the first time. Therefore, the male partner needed to apply some pressure to obtain sex.

Available data also suggest that a number of young people do not utilize formal health services for STIs, although they are aware of the services provided at hospitals and clinics. For instance, of those young people who had ever had sex and ever had an STI in the 1998 youth study, 75% of males and 57% of females sought treatment. The outlets used for treatment were drug stores (41% of males and 16% of females) and hospitals/clinics/health posts (39% of males and 49% of females). The rest used various outlets, including herbalists. One of the reported reasons for not utilizing formal health services is that such infections are not serious and therefore they will eventually go away. This reasoning may partly be due to the dearth of knowledge on STIs other than HIV among the youth. In the National Adolescent Survey of 2004, only 39% of 12–19-year-old girls and 43% of similar boys were aware of other STIs.[21]

Most studies on adolescents have focused on those in schools or living in households. Few studies have examined the challenges faced by young people who have fled from home and live on the streets, are incarcerated or are displaced because of warfare. Qualitative evidence on the circumstances of these special groups of adolescents is particularly limited. In a study of street children in Accra, Anarfi and colleagues described the sexual and reproductive health-related knowledge, attitudes and behaviors of street youth.[22] It was observed that street youth obtained information about sex from friends and the mass media. More than 90% of the females and 70% of the males had ever had sex. A quarter of the young women found on the street were also sex workers in addition to other activities they were doing to earn money.

Policies and Programs on Adolescent Sexual and Reproductive Health

Over the years, traditional and modern programs on adolescent sexual and reproductive health have concentrated on pregnancy and fertility-related issues. For females in particular, the education offered in the traditional system was both formal and informal and concentrated on motherhood, marriage and general domestic activities. When family life education was introduced into the school curriculum in the 1970s, emphasis was on fertility regulation. Prior to the outbreak of HIV/AIDS, there were very few programs in adolescent sexual and reproductive health on STIs. The first population policy of 1969 was silent on family planning and STI services for young people.

With the outbreak of HIV/AIDS in the mid-1980s, government ministries and agencies, nongovernmental organizations, community groups, traditional leaders and individuals have initiated interventions such as media campaigns, training of peer educators and community education campaigns to create awareness about the epidemic.[23] Programs and activities that were initially developed to foster awareness about traditional values and practices in some areas have been expanded to include a wide range of issues and involve mass media campaigns on HIV/AIDS. The Revised National Population Policy of 1994 recognized the need of young people to obtain information and services on sexual and reproductive health and, in 2000, the National Population Council published an Adolescent Reproductive Health Policy. This latter policy document has informed the development of the next generation of programs and activities on adolescent sexual and reproductive health. With the renewed interest in adolescent issues, nongovernmental organizations have initiated programs such as school- and community-based peer education, youth center activities, outreach activities, and the use of the mass media to increase awareness and knowledge about HIV/AIDS.

In response to the outbreak of the epidemic, the government set up the National AIDS Control Programme (NACP) in 1985, a year before the first case was diagnosed in the country, to coordinate all activities and advise government on the epidemic. Initially the mass media—radio, television and poster advertisements and drama series—targeted the general population but with specific programs for young people on sexual and

reproductive health issues. For young people other programs were developed, including the formation of "virgin clubs", a promotion of young women's empowerment program to prevent HIV infection and encouragement of school enrollment and continuation rates. The initial national response approached the outbreak of the epidemic as a health problem. But in 2001, a national multisectoral approach was adopted and the Ghana AIDS Commission (GAC) was established by Act 613 to coordinate all aspects of HIV/AIDS in the country.

These broad policies, programmatic efforts and the existing research evidence are the context within which the findings from these in-depth interviews with adolescents from a range of life experiences (rural, urban, in-school, out-of-school and in special situations, like living on the street) should be viewed.

Table 2.1. Trends in the number and percentage of 10–19-year-olds in Ghana, 1960–2000

Age-group	Number of people			
	1960	**1970**	**1984**	**2000**
Younger adolescents (10–14 years)	681,219	1,002,670	1,503,209	2,262,219
Older adolescents (15–19 years)	541,076	778,055	1,246,390	1,883,753
All adolescents (10–19 years)	1,222,367	1,780,725	2,749,599	4,145,972
	Percentage of total population			
Younger adolescents (10–14 years)	10.1	11.7	12.2	11.9
Older adolescents (15–19 years)	8.0	9.1	10.1	10.0
All adolescents (10–19 years)	18.1	20.8	22.3	21.9

Source: Central Bureau of Statistics, *1960 Population Census of Ghana, Volume 3: Demographic Characteristics*, Accra, Ghana: Central Bureau of Statistics, 1964; Central Bureau of Statistics, *1970 Population Census of Ghana, Volume 3: Demographic Characteristics*, Accra, Ghana: Central Bureau of Statistics, 1975; Ghana Statistical Service, *1984 Population Census of Ghana, Volume 3: Demographic Characteristics*, Accra, Ghana: Ghana Statistical Service, 1987; Ghana Statistical Service, *2000 Population and Housing Census, Summary Report of Final Results*, Accra, Ghana: Ghana Statistical Service, 2002.

Chapter 3

Methods of Data Collection and Analysis

This chapter provides information on the methods of data collection and analysis. The study involved 102 in-depth interviews (IDIs) with adolescents aged 12–19. Of the 102 interviews, 60 were conducted in urban areas and 40 in rural areas. Among the issues discussed are the selection of sites and interviewers and some of the challenges encountered in the field.

Target Population

Selection for the study was based on the following characteristics:

- age (12–14, 15–17 or 18–19 years of age);
- place of residence (urban or rural);
- schooling status (in- or out-of-school); and
- sex (male or female).

In addition, young people in special circumstances were identified as part of the 102 respondents. These were:

- three males and two females on the streets of Accra;
- four adolescent females with a child (married or unmarried);
- four females at a refuge for pregnant females on the street;
- three males at a borstal institute; and
- three males and three females at the refugee camp at Budumburam (on the Accra Cape Coast Road).

Table 3.1 shows the main characteristics of adolescents interviewed.

Interviews were conducted in English, Ga, Akan, Ewe, Mamprulli, Dagbani or Hausa, depending on the choice of the respondent. Mamprulli is the main language in West Mamprusi and Dagbani in Tolon-Kumbungu in the north. Hausa, although not a Ghanaian language, is spoken widely in the northern part of the country and among settler populations from the north and in urban areas in the south. In Kumasi, the main language is Akan and Accra, the national capital, has a mixture of nearly all the languages spoken in the country. The research team and the languages spoken by each person are listed in Appendix A. The conversations were taped, transcribed and translated into English.

Field Team and Training

As part of the initial preparation for the fieldwork, students of the University of Cape Coast were asked to apply to serve as research assistants. Students who took part in an earlier focus group discussion fieldwork with adolescents, conducted as part of the project, were automatically considered because of their knowledge of the goals and objectives of the project. Other applicants were screened and two males and two females who were new to the study were also selected for training. The assistants were selected on the basis of previous experience in data collection, ability to speak at least one of the dominant languages in the selected communities and composure during the interview.

The field assistants were grouped into two teams according to languages spoken: The Accra and Kumasi team consisted of those who could speak Akan, Ewe and Ga, and the Tolon-Kumbungu and West Mamprusi team were Mamprulli, Akan, Dagbani and Hausa speakers. There were five field assistants for Accra and Kumasi (three females and two males) and four (two males and two females) for the two northern districts. One male supervisor also assisted in conducting interviews in Accra and Kumasi.

Training sessions were conducted from August 25–29, 2003, and involved the nine assistants, four supervisors and two resource persons. The main items discussed were the goals and objectives of the Protecting the Next Generation project, forthcoming fieldwork, concept of and issues in undertaking an IDI, the interview guide (see Appendix B), social mapping, and the use of the screening and consent forms. The training also involved the translation of concepts and words into the various languages. This was meant to ensure common understanding of concepts in the languages

used. The guides were pretested in two selected suburbs of Cape Coast which have residents from different parts of the country.

Field Sites and Selection

The IDIs with out-of-school and in-school urban youth were conducted in Accra and Kumasi, the two largest cities in Ghana. Accra, located at the southeast coast, is the national capital and the administrative headquarters of the country. As the national capital, it attracts people from all over the country, including young people. The Greater Accra Region is 87% urbanized, and Accra had a population of 1,658,937 in 2000. Kumasi, the second largest city in the country (population, 1,170,270), is the commercial and administrative capital of the Ashanti Region. Located in the central part of the country, it has functioned as a transportation hub to and from the northern part of Ghana. Starting as the capital of the Asante Kingdom, it has become a major cultural and educational center.

The two metropolitan areas of Accra and Kumasi were zoned into high-, medium- and low-income residential areas, based on the classification of the Metropolitan Assemblies. Permission to enter the communities was obtained through letters and personal contacts with the Metropolitan Chief Executive and the assembly members[24] of selected areas. A social mapping approach was used for participant identification. With this approach, a number of representatives from the community (Assembly/Unit Committee members, teachers, religious leaders, youth leaders and selected young people) assisted the field team to identify eligible adolescents and constructed a social map of the location of their households in the community. Kumasi, in spite of its metropolitan status, still has traditional structures such as chiefs and queenmothers. Where necessary, these traditional leaders were also consulted. Adolescents who were identified were purposively selected and screened in their homes. In each age and sex category there were a specified number of respondents that were supposed to be interviewed (see Table 3.1).

Consent was first obtained from the adolescent and then from a parent or guardian (e.g., older sibling, uncle or aunt, trainer of an apprentice). In Kumasi, since the IDIs involved in-school adolescents, heads of institutions also gave their consent before schools were selected. In the selected schools, heads of institutions served as proxies for parents when the respondent was younger than 18 years and the parents were not available. This was mostly the case for students in boarding institutions. On average, interviews lasted for an hour and 20 minutes for younger adolescents and about two hours for older adolescents.

The IDIs with rural adolescents were carried out in Tolon-Kumbungu and West Mamprusi districts in the Northern Region, two of the most rural districts in the country. In 2000, 84% of the population in Tolon-Kumbungu and West Mamprusi lived in rural areas. These two districts were selected from the Northern Region in order to ensure that interviews were held across diverse areas in the country. Tolon-Kumbungu district was designated for IDIs with out-of-school youth because it has one of the lowest proportions of children in school in the Northern Region and in the country.

In Tolon-Kumbumgu and West Mamprusi, districts were zoned into urban, semiurban and rural areas, based on population size. Permission to enter the community was sought through letters and personal contacts with assembly members, chiefs and directors of education. As in Accra and Kumasi, a social mapping approach was used to identify eligible adolescents in the selected communities and the same procedure for screening and obtaining consent was followed. Assembly members, chiefs, teachers, religious leaders, youth leaders and selected young people assisted in this exercise. Also as in Kumasi, heads of schools and house masters gave consent for young adolescents who were in boarding houses and whose parents were not readily available. The interviews lasted on average 1 hour and 30 minutes.

Data Collection Challenges

The research team faced several challenges. First, the social mapping approach described above to identifying eligible adolescents was not very useful in Accra because, as a metropolitan area, people are not as closely knit as in villages and young people may not know one another. The youth in the selected clusters tended to be members of the same religious group or sports team, attend the same school or congregate in some areas in the community. It was, therefore, through such means that people were assembled for the identification and selection of eligible youth. Although Kumasi is also a metropolitan area, the city seems to retain some of its traditional characteristics, hence it was possible to assemble people and to use both modern and traditional channels to identify young people who were not residential students.

Another challenge was scheduling interviews. In the rural areas in the north, young people were available for interview mainly during market days and in the evenings. This was because the data collection period

coincided with the harvesting of groundnuts (peanuts), one of the crops that young people cultivate in the northern sector. Therefore, young people went to farm early and returned late in the evening. The situation was even more challenging in urban areas, where one had to book appointments for either early in the morning or late in the evening. Interviewers also faced parents and guardians who wanted to eavesdrop on the conversations. Some of the young people anticipated that and requested, in the course of conversation, for relocation. Finally, some members of the communities expressed dissatisfaction with the situation whereby researchers come to collect information without providing communities with any feedback. For this particular project, meetings with these communities on the key findings of the research are being planned.

In spite of these challenges, the data collection was successful, and all the targeted individuals were interviewed. The communities, especially in the northern sector, were very co-operative.

Analysis Approach

For analysis, a 90-code scheme grouped into seven categories (puberty, sexual relationships, health care seeking, aspirations, perceptions of risks and social influences on young people) around the main themes was developed. The 102 transcripts were coded using *QSR N6* (version 6) qualitative software. Text searches on relevant codes were read and matrices were prepared based on the substantive points for males and females. With each interview treated as a unit of analysis, summary texts were developed and recorded in relevant topical matrices. To ensure that coding was consistent, initially two people coded the same transcripts and the results were compared. After achieving a common understanding, the rest of the transcripts were coded by two of the four supervisors.

As with any qualitative data, the views described and discussed in this report reflect those of the young people who participated in the interviews. The IDIs were designed to capture the attitudes and experiences of young males and females in urban and rural areas, and who were either in or out of school, and quotes presented in the text are noted with these basic characteristics (including the designation "special case" if the adolescent was also part of a special group, such as those in the refuge for pregnant girls). As IDIs, the findings do not necessarily represent the views and experiences of young people in general or even adolescents in the communities where the fieldwork was conducted. Rather, they provide information on aspects of the lives of some young people, which when taken together with results from the focus group discussions and the national survey, will help build a picture on the views and experiences of adolescents in the country.

Table 3.1. Number of Ghanaian adolescents interviewed, according to background characteristics, 2003

	Females	Males
Total	57	45
Age		
12–14	16	15
15–17	19	15
18–19	22	15
Region and school status		
Rural (total)	24	18
In-school	9	9
Out-of-school	15	9
Urban (total)	33	27
In-school	9	9
Out-of-school*	24	18
Special groups		
Living/working in the street	2	3
Refuge for pregnant girls	4	—
Borstal institute residents	—	3
Refugee camp residents	3	3

* Includes adolescents who are part of the special groups (all of whom are out-of-school).

Chapter 4

Adolescents' Preparedness for Sexual and Reproductive Health Experiences

Adolescence involves bodily changes with their associated sexual and reproductive health dimensions, learning processes (both formal and informal) for expected new roles and responsibilities, and the development of self-awareness. Societies have always designed structures to educate young people and help them to achieve a smooth transition from childhood to adulthood. The challenge for society is ensuring that every young person receives the expected education and is equipped to make that transition.

This chapter explores the extent to which young people are prepared to handle bodily changes and associated sexual and reproductive health challenges. The main issues explored are how adolescents learn about puberty, pregnancy and HIV prevention, their sources of information and what they want to know more about. These issues are examined within the context of the general concerns that adolescents have in life.

Feelings About and Reactions to Puberty

Adolescents were asked to talk about when they first experienced pubertal changes and their reactions. The aim was to identify the preparedness of young people towards this important change in their lives. While the major pubertal development for females, menarche, is an event and therefore memorable, male pubertal development takes time to manifest itself and may not be clear cut. Two general patterns emerged about preparation for pubertal changes. There were those who had heard about puberty before they experienced it and those who had not. Responses indicate that those who had heard about puberty before they experienced it were able to understand what was happening to them and were not as fearful about the change. The case of a 14-year-old in-school girl indicates some of the views expressed by those in that category.

I: So how did you feel when you started menstruating?
R: Well, I was not scared when l started menstruating because I had already heard about it in school from my teachers.
—Female, urban, in school, 14 years old

The few adolescent males who had heard about puberty were even looking forward to it and stated they were very happy when they started experiencing the expected changes. According to them, they were happy about it and felt that they had now reached the period of adulthood. One out-of-school urban male expressed it thus:

I: How did you feel about these changes happening to you?
R: I became happy because I realized I am also growing into an adult.
—Male, urban, out of school, 19 years old

Those who had not been spoken to about puberty reported that they felt shy, frightened, anxious and embarrassed about the experience. Not in a position to understand the new experience, some of them reacted naively by thinking that if they took immediate action the problem would go away. Thus, one female adolescent who was unaware when she experienced her first menstruation explained that she did not comprehend what was happening to her.

I thought I was getting sick because I woke up one morning and realized that there was some blood in my pant. I took my bath but just after I had dressed up it happened again.
—Female, rural, out of school, 18 years old

Some of them also reported that they felt frightened, as in the following examples:

I: How did you feel about these changes?
R: I was frightened because I had never experienced it before.
—Male, rural, out of school, 19 years old

I: How did you feel about these changes happening to you?
R: Among the body changes I experienced was menstruation. The first time I experienced it I was afraid. I did not know what it was and I did not also want to inform my dad. May be he will think I have done something bad to my body. But when I showed it to him he told me that is normal but I should stay away from boys otherwise I will become pregnant.
—Female, rural, in school, 15 years old

I: How did you feel about these changes happening to you?
R: I was scared and I asked my mother what those changes were and she said I have now become an adult.
—Female, rural, out of school, special case, 12 years old

After the first experience, some became conscious of themselves and their new status, which then marked the beginning of changes in their behavior. According to some of them, especially the females, they could not expose themselves as they used to do. One female respondent remarked

I: And how did you feel when these changes started?
R: I felt shy especially about my breast and I could not stand naked in front of my parents.
—Female, rural, in school, 18 years old

Adolescents who had been educated on puberty were able to understand and appreciate what was happening to them and found the prior information useful. Alternatively, those who had not been informed about expressed fear and anxiety, reinforcing the need to provide family life education to young people before they experience puberty.

Sources and Nature of Information About Puberty

Traditionally, family members especially grandparents, parents and older siblings were responsible for educating young people about pubertal changes. This appears to be changing with time and the issue was explored in the study. Reponses indicate that teachers have become a major source of information about puberty, perhaps as a result of the introduction of family life education in the school curriculum. This is followed by mothers (reported mostly by females) as source of information about puberty. Nonetheless family members such as siblings, grandparents, uncles, aunts and sisters-in-law continue to provide information on puberty. Other sources of information are friends (especially older female friends of females), religious leaders and health care providers (e.g., doctors, nurses).

I: Before you experienced these body changes, were you told about them?
R: Yes, I heard about these changes at school
I: When was that?
R: I was in class six.
I: What did they talk about?
R: They said that from age 11, one would see changes in her body such as pubic hair, development of breast and menstruation.
—Female, urban, in school, 16 years old

I: Has any one ever talked to you about body changes that happen when a young person is becoming an adult?
R: Yes
I: Can you tell me about who talked to you and what you talked about?
R: My uncle told me about the changes that happen when a young person is growing into adulthood. . . .
—Male, rural, out of school, 14 years old

Within the school curriculum, students are expected to be introduced to some aspects of pubertal changes progressively from upper primary (ages 9–11) through junior secondary school (ages 12–14). If taught as expected, young people will be introduced to pubertal changes before they occur. The responses indicate that most of the in-school adolescents were introduced to pubertal changes before they experienced it. In the case of the out-of-school youth, the timing appeared to be mixed: Some were given information before they experienced it and others afterwards. As the case of a 14-year-old out-of-school female indicates, a discussion on puberty was initiated by her sister-in-law, but after she had experienced menarche.

I: Can you tell me the one who talked to you and what you talked about?
R: It was my brother's wife who talked to me about menstruation, how to dress up and also told me that during that stage I was capable of getting pregnant if I have sexual intercourse.
I: When were you first told about these changes?
R: When I had my first menstruation
—Female, urban, out of school, special case, 14 years old

At the time when rite of passage was performed within the traditional system, young people had an idea about the possible changes, since parts of the activities were in public. In that setting, providing education after the event only meant giving the young person detailed information as to what it entails. Now there are no public ceremonies in most communities that will prompt young people to learn about their own experiences. This implies that the school-based programs should be intensified to ensure that all young people who go through the basic system of education are introduced to information about pubertal changes, and that media messages and community programs should be developed for out-of-school youth before they experience those changes.

IDIs reveal that information given to adolescents on the expected changes was mainly on the physiological changes associated with the stage, its significance, especially feelings towards the opposite sex, and for females, personal hygiene. For most of the adolescents, the reported information given to them was about physical changes and the likely consequences if they had sex, as indicated below.

I: Has anybody talked to you about some of these body changes?
R: Yes, our teacher invited one man to come and talk to us on one entertainment day.
I: What did he talk about?
R: He talked about how a boy grows and how his body changes. He said with the boys, they grow beard, the voice breaks and then they begin to have some feelings towards the opposite sex.
—Male, rural, in -school, 14 years old

The responses indicate that even for those who had some education on puberty, adults tended to stress the negative consequences if they had intimate relationship or sex with the opposite sex. For the females in particular the messages were in the form of caution from initiating sex and pregnancy. For those who were talked to at home, there did not seem to be any structured system of education about puberty as was the case in the traditional system.

Sources and Nature of Information About HIV/AIDS

Actual sources

Since the early 1980s there has been a concerted effort to provide information on HIV/AIDS generally and to young people in particular. As a result, the education of adolescents on puberty, sexuality, pregnancy and marital duties now includes information on HIV/AIDS infection. The mode of providing information on HIV generally, and to young people in particular, has gone through at least four phases. Initially, the main source of information on the epidemic was the mass media. This was followed by a period of both mass media and community activities. The next phase has been the use of identifiable groups, such as the school system, religious bodies, clubs and associations, in addition to the mass media. Lastly, there is the growing interest in counseling, which focuses on the individual.[25]

In the interviews, teachers emerged as the main source of information on HIV/AIDS, which is unsurprising as most young people were either in school or had been to school. The next major source was health care providers (doctors, nurses and chemical sellers), some of whom had participated in the School Health Education Programme of the Ghana Education Service. The radio and television emerged as another major source of information about HIV/AIDS, especially for those in urban areas. Friends and family members were mentioned by just a few adolescents. Other sources of information were peer educators, religious leaders and HIV-positive persons in their communities.

I: Has anyone ever talked with you about HIV/AIDS?
R: Yes, our teacher told us about it when I was in Junior Secondary School one.
I: Did you benefit from the lesson taught by your teacher?
R: Yes, I learnt a lot from the lesson that is even the reason why I still have it in mind.
—Male, urban, in school, 16 years old

I: Has anyone ever talked with you about HIV/AIDS?
R: Yes.
I: Who talked to you about HIV/AIDS?

R: Our madam in school and health personnel talked to us about HIV.
I: What did they talk about?
R: They talked to us about how to protect ourselves from getting HIV/AIDS.
I: When was the first time you were talked to about HIV/AIDS?
R: That was when I was at the Junior Secondary School.
—Female, rural, in school, 18 years old

Some adolescents heard about HIV/AIDS from persons living with HIV/AIDS. In some communities persons living with HIV/AIDS have volunteered to talk openly about their status, in spite of the stigma and discrimination against them in the country.

I: Has anybody ever talked to you about HIV/AIDS?
R: Yes, an HIV-positive person came to our school to talk to us about AIDS.
I: What did he talk about?
R: He talked about how he became HIV positive and how he is now going round to educate other people about the dangers of HIV/AIDS. He also told us how his wife deserted him and his children because he was HIV positive.
—Male, rural, in school, 14 years old

While young people in urban areas and those in school appeared to have information from multiple sources, the situation for rural residents who are out of school seemed to be slightly different. In general, out-of-school rural residents tended to report discussions within the community as the source of information about HIV/AIDS.

I: Have you had a talk about HIV/AIDS before?
R: Yes.
I: Who talked to you?
R: Sometimes l just heard people discussing it.
I: What do these people say about AIDS?
R: I always hear them saying that it has no cure.
—Female, rural, out of school, 14 years old

What seems to be emerging is that young people are obtaining information from multiple sources, including professionals such as teachers and health personnel, people living with HIV/AIDS, the mass media, community activities and family members. However, adolescents in rural areas who are not in school appear to have less access to information on HIV/AIDS than their counterparts in urban areas and in the school system. This is not surprising, as the two rural sites are in areas with some of the lowest school participation rates in the country.

We aimed to find out the nature of information provided to youth on HIV/AIDS and whether it met their needs. According to adolescents, the bulk of the information on HIV/AIDS has been on the mode of transmission and the protective measures of abstinence, being faithful and using condoms, as in the quotation below:

I: Has anyone ever given you a talk about HIV/AIDS?
R: Yes.
I: Who talked to you about HIV/AIDS?
R: Our teacher.
I: What did he/she say?
R: He said that we should abstain from sex
—Female, rural, in school, 13 years old

I: What was the lesson actually about?
R: In short, he [the JSS teacher] said we should stay away from sexual intercourse, we should not use someone's used blade or that we should use condom if you can't stay without sex.
—Male, urban, in school, 16 years old

Preferred information and sources on HIV/AIDS
Adolescents were asked to indicate the type of information they would like to receive and their preferred sources of information about HIV/AIDS. In addition to the information on mode of infection and preventive measures currently provided in most programs, adolescents expect to receive information on the origin and prevalence of HIV/AIDS, how to relate to persons living with HIV/AIDS and some of the consequences of the epidemic.

I: What type of information do you really want about HIV/AIDS?
R: I want all those involved in the HIV/AIDS education programs to stress on the importance of using condoms during sex.
—Male, rural, out of school, 14 years old
I: What type of information do you really need about HIV/AIDS?
R: How AIDS started and how it got to Ghana.
—Female, rural, in school, 13 years old

I: What other things do you want to know more about?
R: I want to know what people living with AIDS go through before they die.
—Female, rural, out of school, special case, 18 years old

From the responses, parents emerged as a preferred source of information, in addition to teachers and health workers. In particular, adolescent females expected their mothers to talk to them about HIV/AIDS because they trusted them. They also preferred teachers and health care providers because they have more technical knowledge about the epidemic than their parents. Friends, people living with HIV/AIDS, volunteers, peer educators, the media and district assembly members were mentioned by only few of the respondents as sources of preferred information.

I: From whom do you expect to receive information about HIV/AIDS?
R: Nurses.
I: Why them?
R: Because they have been trained to deliver health services to the general public.
—Female, rural, in school, 15 years old

I: Are there people you can go to talk about AIDS?
R: There are people I can go to talk about AIDS. I will go to one of my teachers who teaches needle work because she is open and ready to listen to my problems.
—Female, rural, in school, 18 years old

I: Is your teacher the only one who has spoken to you about AIDS?
R: No, my mum has also told me before.
I: What did she say?
R: She said I shouldn't sleep with anybody, and I also shouldn't use anybody's blade.
I: Are there people you feel you can go to for talk about HIV/AIDS?
R: Yes, my parents and my teacher.
—Female, urban, in school, 13 years old

Information for adolescents on HIV/AIDS should consist of the current topics on modes of infection and preventive measures, such as abstinence, being faithful and using condoms; technical aspects of the infection, such as progression from HIV to AIDS; and the effects of stigma and discrimination. The evidence also indicates that adolescents want family members, teachers and health care workers to discuss sexual and reproductive health issues that affect their lives with them. They indicated that family members will be very sympathetic and honest with them. Teachers and health workers were considered to be professionals who have technical knowledge and can explain issues to them. Thus, adolescents expressed different expectations from family members and professionals.

Sources and Nature of Information About Pregnancy Prevention

With pregnancy prevention emerging as an issue in the interviews on puberty, adolescents were asked to indicate the sources of information and preventive measures they were aware of. From the IDIs, it appeared that most of the adolescents had been talked to about pregnancy prevention by their teachers or health care workers (doctors and nurses). Both females and males who were either in school or had just completed a level of education indicated teachers as a source of information. As in the case of HIV, some of the contact with health care workers occured in school activities as part of the School Health Education Programme of the Ghana Education Service. Most of the out-of-school adolescents who reported health workers as source of information were in a refuge for pregnant females on the street. Nurses from near-by clinics attended to their antenatal care needs. Very few of the adolescents reported personal (one-on-one) discussion about pregnancy prevention.

R: She ["our science madam"] said teenage pregnancy occurs in girls between the ages of 13–19 years.
I: What else?
R: She also said it is good to either abstain from sex or use a condom to prevent pregnancy.
I: Did you find this talk useful?
R: Yes.
M: In what way?
R: I got to know how teenage pregnancy occurs.
—Female, rural, in school, 13 years old

R: He [the teacher] said, as a young girl, immediately you start developing breasts. You should be careful with men because you can easily become pregnant. He told the girls to always insist that the boys use condoms anytime they are to have sex. But he also said it is always good to abstain.

I: Did you find these talks useful or not?
R: It was useful because our sisters normally go for 'Kaya yei' [girls who work in the streets carrying large loads on their heads and whose situation makes them vulnerable to exploitation] and we also tell them the dangers involved in having sex without a condom.
—Male, rural, in school, 14 years old

Although important, family members were not mentioned as much as teachers and health care workers as sources of information on pregnancy prevention. Some female adolescents mentioned mothers, siblings and other female relations as the people who had talked to them personally, either in one-on-one discussions or as part of family discussions (below). Fathers, friends and peers were rarely mentioned.

I: Has anyone ever talked with you about preventing pregnancy?
R: Yes, my mother.
I: Who else?
R: My mother's relatives.
I: What did they say?
R: Well, they did not want the girls in the house to go out, especially in the night.
I: How old were you when you were first told this?
R: When I was 15 years old.
I: Do you have siblings or relatives they speak to as well, or you're the only one they talked to?
R: Yes, I have and they talked to all of us.
I: Did you find the talks useful?
R: I did, but it was after I'd given birth.
—Female, urban, out of school, 18 years old

As was observed in the case of puberty, some of the adolescents, especially females, were talked to after they had experienced the event. The 18-year-old girl was talked to after she became pregnant at about age 15. It is likely that a number of girls have gone through the same experience.

In the interviews, the two most frequently mentioned preventive methods were the male condom and abstinence, reflecting the emphasis that has been given these two methods in educational campaigns for young people. Males commonly mentioned (male) condoms, and indicated teachers and health workers as the source of the information, while females mentioned abstinence. According to the females, most of the information from parents was on abstinence and including warnings to them about ensuring that they did not become pregnant. In particular, females reported being warned about the consequences of premarital pregnancy, such as dropping out of school. Rarely did parents discuss with them ways by which pregnancy could be prevented.

Among adolescents who spoke about abstinence, some explicitly mentioned sexual abstinence until marriage and others talked about sexual abstinence without any reference to marriage.

If you stay away from sex, you will be free from all these problems.
—Female, rural, out of school, 15 years old

For young people, messages have tended to stress premarital sexual abstinence, especially among females. The emphasis on premarital sex as part of the ABC campaign (abstaining, being faithful and using condoms) has led to the formation of virgin clubs in some schools and clubs/associations, especially for females, perpetuating gender-based attitudes about who should not engage in premarital sex.

Very few adolescents mentioned any contraceptive methods other than the male condom. Among the methods mentioned were the pill, injections (generically referred to as family planning "drugs" or methods) and rhythm. Female adolescents who mentioned contraceptive methods other than condoms were 17 years or older. Younger adolescents were more likely to mention abstinence. Thus, knowledge of contraceptive methods was associated with age.

We have to avoid casual sex and also use condom or any family planning method. People also say that they study their menstrual cycle to know the days they can get pregnant and those that are safe.
—Female, urban, out of school, 18 years old

I: Has anyone ever talked to you about how to prevent pregnancy?
R: Yes,
I: Where was that?
R: In town, we were sitting together and I heard them talking about how to prevent pregnancy.
I: And what did they say?
R: They said if one does not want to become pregnant one should go in for pills or condom to prevent pregnancy.
—Female, rural, out of school, 19 years old

Preferred information and sources on pregnancy prevention

Adolescents were also asked to indicate the type and sources of information they would want to receive about pregnancy prevention. In general, they wanted specific information about contraceptive methods and how those specific methods are used. For instance, a male adolescent indicated that

I want to know how to use the condom properly. People say if it is not properly put on it will burst.
—Male, rural, out of school, 15 years old

Some adolescents also wanted more information about abstinence within the context of being able to refuse unwanted premarital sex. With the formation of virgin clubs in some institutions and organizations, there is some interest in abstinence, especially among religious groups.

Adolescents expected to receive the information indicated from health care providers, teachers and parents. Health care providers were considered to be people trained in health issues and, therefore, to be knowledgeable about these issues. They were also people who could be relied upon for confidentiality. The reasons given are similar to those observed from earlier focus group discussions with adolescents.[26]

…they [medical doctors] know how it is for teenagers to be pregnant and also the difficulties involved.
—Female, rural, in school, 18 years old

…she [the nurse] works at the hospital; she knows better and has all the drugs for preventing pregnancy.
—Male, rural, in school, 15 years old

Teachers were also mentioned as a preferred source of information for pregnancy prevention primarily because they were considered to be knowledgeable about the subject.

He [teacher] has read a lot about issues related to pregnancies and therefore he can best advise us.
—Male, rural, in school, 17 years old

A number of adolescents, both males and females, also indicated that they wish to get information from their parents, especially their mothers, because their parents have gone through the same experience and so they should be able to share their experiences with them. Others also felt that their parents will be more honest with them than peers.

I: Has anyone ever talked with you about preventing pregnancy?
R: Yes.
I: Who talked to you?
R: My mother.
I: What did she talk about?
R: We talked about how to avoid unwanted pregnancy.
—Female, rural, in school, 15 years old

Some adolescents (mostly in urban areas) expected their parents to take more interest in them than they had done so far and felt their parents should have time for them, to advise and educate them about sex, and provide for some of their material needs. These statements capture the emerging situation in urban areas where some parents, especially fathers, are unable to make time for their children. Other possible sources of information mentioned were friends, older students, siblings, friends of parents, elderly people in the village and NGOs, such as Planned Parenthood of Ghana. Finally, some adolescents indicated that they did not want any more information because they already knew effective ways to prevent pregnancy (sexual abstinence or condoms) or did not think they needed it as they were not at risk of becoming pregnant.

Major Problems of Adolescents

The study also explored some of the general concerns of adolescents as a prelude to concerns with general health and sexual and reproductive health. The two major problems that emerged spontaneously were concerns about formal education and earning income. Two types of school-related concerns emerged. Those who were in school were concerned about achieving a certain level of education and the ability of their parents to pay for textbooks, other reading materials and school uniforms, and to pay supplementary fees such as for sports, entertainment, maintenance and minor equipment.[27]

My only worry now is how to continue with my education since my parents are always not able to pay for my school fees.
—Male, urban, in school, 17 years old

The second school-related concern was among those who dropped out of school, ended at a low level or never had any opportunity to attend school. They

were concerned with how they could further their education or achieve a certain level of formal education. For instance, some of them spoke of feeling ashamed of their current low level of schooling or inadequate skills in such aspects as their inability to speak English. The last group, those who had never been to school, regretted the fact that they did not get the opportunity to attend school. To them, formal education or learning a vocation in school enhances one's ability to support oneself and others in life.

My only problem is that I want to attend school because the small boys in this house can speak English whilst I cannot.
—Male, urban, out of school, 15 years old

I: What are some of the major problems facing you now?
R: At the moment I am not attending school, and that is my major problem.
I: And what else?
R: That's all
….
I: Why is schooling your major problem?
R: Because I also want to be somebody who can provide for her family (mother and father).
I: Is the desire to be in school your only problem? Why is it your only problem?
R: The people around here have been laughing at me because I don't go to school and it makes me sad.
—Female, urban, out of school, 13 years old

Some older adolescents also talked about their pressing need for money to enable them to afford basic necessities such as food, support other family members (mothers, grandmothers or children) or start a business or trade (such as money for tools or apprenticeship).

I need to provide some financial support for my mother. Anytime I go to her room and she complains of hunger, I feel sad because I have to provide for her.
—Male, rural, in school, 18 years old

This need was particularly the case among those on the street and in the refuge center for pregnant girls. The two major problems mentioned—achieving a certain level of formal education and ability to earn income—are issues of general concern and highlight the importance adolescents attach to formal education and their concern for their personal development, as well as both immediate and future survival.

Views on HIV/AIDS Infection as a Challenge

Only one of the respondents spontaneously mentioned HIV/AIDS as a major concern. Therefore, to explore their concerns about HIV/AIDS, respondents were prompted to compare the epidemic with the other concerns mentioned in their lives. When prompted, almost all the adolescents said that HIV/AIDS infection would make it impossible for them to achieve their objectives in life. According to them, personal problems, such as poor education and inadequate income, could be overcome with time and that their consequences were not as fatal as AIDS, which can lead to death.

AIDS is something that can easily kill you or destroy your future…I'm saying so because your teacher will only ask you to go home for not having school uniform and with that you can still live but with HIV, you are going to die since it has no cure.
—Male, rural, in school, 18 years old

In spite of the recognition of the long-term problems associated with HIV/AIDS, their views about the epidemic were more in terms of how it spreads rather than as a personal problem. Very few considered themselves to be at risk of infection, and those who did were more likely to be females than males. Those females felt they could be at risk from unfaithful partners.

R: I think AIDS too is a major problem for somebody like me.
I: What makes you feel that way?
R: Because for somebody like me maybe one day a man can lure me with money and have sex with me and I can contract HIV/AIDS through that.
—Female, urban, out of school, 16 years old

For some of them HIV infection is becoming a reality in their communities: Some had seen persons living with HIV/AIDS in their communities or as part of the school education programs. Therefore, their concern with HIV/AIDS arose from these personal encounters.

…I have witnessed the sad end of some HIV/AIDS patients. So when I am going to wed, I will have to go and have an HIV/AIDS test with my partner. He may have the disease or I may have the disease myself.
—Female, rural, out of school, 18 years old

The observation of female adolescents about their vulnerability to infection through marriage has also been observed in other studies which point to the fact that marriage can be a risk factor for females in Ghana as in some other African countries.[28]

A few adolescents, mostly males, also talked about the stigma and discrimination associated with HIV/AIDS infection, and spoke in judgmental terms. According to this group, since HIV/AIDS is associated with promiscuity, any person with HIV/AIDS was considered to have led an immoral life. They felt that if they were HIV positive they will be judged and stigmatized.

I: What do you think about people who have HIV/AIDS?
R: These people did not listen to the advice of their parents and that is why they are paying for the price of their behavior.
—Male, rural, in school, 18 years old

I: What do you think about people who have HIV/AIDS?
R: They have multiple sexual partners that is why they have HIV/AIDS.
—Male, rural, out of school, 15 years old

Some adolescents were of the view that the current challenges confronting them were likely to be worse than HIV/AIDS infection. Such people tended to think that they were not at risk of HIV, usually because of their own behavior or the fidelity of their partner.

I: Did you ever think you were at risk of HIV/AIDS or other sexually transmitted diseases?
R: No, I did not because the boy was very faithful to me.
—Female, rural, out of school, special case, 12 years old

I: When you had sex with her, did you feel you were at risk of HIV/ AIDS or any other STIs? Or even impregnating her?
R: No. I am the first person to have slept with her so I don't think she has any disease.
—Male, urban, out of school, special case, 17 years old

I: When you had sex with him did you ever think you were at risk of pregnancy, HIV/AIDS or any other kinds of STIs?
R: No, I did not know that I could get STIs or become pregnant without protecting myself. Even when I was pregnant I did not know until I fell sick and was taken to hospital before I was told I was pregnant. Moreover, I even menstruated in that month.
—Female, urban, out of school, special case, 18 years old

In spite of the general information and programs about HIV/AIDS infection, a number of adolescents did not consider themselves to be at risk of infection and had sex without protection or thinking about the consequences. This presents a challenge to programmers, who will need to develop educational programs that will help young people recognize their vulnerability to HIV infection.

Views on Premarital Pregnancy as a Challenge

As with HIV/AIDS, adolescents did not spontaneously mention premarital pregnancy as a major concern. When asked directly, adolescents, both females and males, described premarital pregnancy as a problem but more so for females than males. Among the reasons given were the effects of early pregnancy on the education of a young female, inadequate preparation for the new responsibility of motherhood and the possibility of being a financial burden to herself, the child and her parents.

Adolescents who identified premarital pregnancy and childbirth to be a problem for females said that such females invariably dropped out of school, making it difficult for them to achieve their potential in life.

I: What comes to your mind when you hear about someone having a baby before marriage?
R: If you are a student and you became pregnant you have to stop your education and that is going to affect your future.
—Male, rural, in school, 17 years old

While a female will drop out of school when she becomes pregnant, males who become fathers can continue their education without consequence. Although the policy of the Ministry of Education is for females who become pregnant to go back to school after delivery, a number of them do not go back because of the stigma associated with early pregnancy and the ridicule they face in school.[29]

Those who associated premarital pregnancy and childbirth with possible financial hardship argued that the woman may not be able to care for herself and a

child. To them, this would lead to inadequate care in terms of food, clothing and support for both the mother and child.

The mother will find it difficult to cater for the child because she has no job. Sometimes the mother may have just only one cloth which is very bad.
—Female, urban, in school, 15 years old

When you see the cloth on the baby, it's like a rag.
—Female, urban, out of school, 18 years old

Such young mothers are also likely to face problems with their parents or guardians and boyfriends and be left with the problem of fending for themselves and the child as in the case of the girl described in Box 4.1.

Respondents described adolescent fathers as likely to be still under the care of their parents or not in any stable jobs and, therefore, in the same poor financial situation as the unmarried mothers. If that is the case, they will not be able to contribute to the upkeep of the mother and the child, as pointed out by a 17-year-old male:

R: The relationship will not last as the boy will not get enough money to cater for the girl.
I: What makes you think that way?
R: This is because in most cases both the boy and the girl are not earning any income. They are still being catered for by their parents.
—Male, rural, out of school, 17 years old

There were different views about females and males involved in premarital childbearing. Some adolescents appeared to be judgmental and described unmarried adolescent parents as people who were either curious about sex, were too anxious to have sex, could not control their "emotions" (sexual desires), did not listen to their parents, had sex without protection or who just had sex with a lot of people.

I: I think they have made a mistake (cough) because sometimes it is due to the fact that they were too curious to have sex.
—Male, urban, in school, 19 years old

There were gender biases in views of adolescents towards females and males who have been involved in premarital pregnancy. This finding is consistent with some of the results from the focus group discussions with adolescents.[30] Unmarried mothers were described

Box 4.1: Difficult choices

Mamuna, a 16-year-old female from the Eastern Region, was faced with difficult life choices when her mother died and the father lost his job. To help support her siblings and father, she stopped schooling at junior secondary school and traveled to Accra. Her intention was to find work and earn some income that would enable her to support her father and help keep the rest of her siblings in school. In Accra, she was first employed as house-help by a man she met on arrival and later moved to live with a woman who sold plantain leaves (used for wrapping fermented maize) on the street.

While in Accra, she entered into a relationship with an 18-year-old man. According to her, initially they used condoms (at his insistence) during sex. They later had sex without condoms and she became pregnant. She did not think she could become pregnant at that one particular period when they had sex without a condom because they had had sex without a condom before and she did not become pregnant. When she informed him of the pregnancy, he urged her to abort it. She refused to do so, because according to her, one of her sisters died from abortion when she was a young girl. Because she refused to abort the pregnancy, the boy also refused to accept responsibility for the pregnancy and her upkeep. To make matters worse, she was asked to leave the house where she was staying because the woman she was living with said that her husband would be upset to have an unwed, pregnant girl living with them. Another woman met her on the street, took her in and later directed her to an institution for pregnant girls on the street.

Mamuna hopes to continue selling goods on the street till she delivers. Two of her main concerns now are how she will be able to take care of herself and the baby after delivery, as well as continue to sell on the street. Her intention is to continue selling on the street, save enough money to enable her continue to support her siblings in school and also support herself as an apprentice dressmaker.

as "bad" because they could not wait to be married and had sex before marriage. Some of them considered such girls as people who had sex with a number of males.

R: People like that may become pregnant because of peer influence or by their own willingness, which is very bad. The person is bad because if you know very well that you are not ready to marry you are not supposed to have sex with somebody.
I: What makes you think that way?
R: Because they are too young to have children. Because if you are not married you are not supposed to have a child that is why I said they are bad.
—Female, rural, in school, 18 years old
I always think that that person had had sex with many men . . . Because she does not know the father of the child.
—Female, rural, in school, 13 years old

Adolescent fathers were not judged in the same way as mothers. Males were described as "bad" for denying paternity but not for engaging in premarital sex.

Some female adolescents were less inclined to judge unmarried mothers because, according to them, they could have been victims of unusual circumstances, such as those of the girl described in Box 4.1 or coercion or rape.

I: What comes to your mind when you hear about someone having a baby before marriage?
R: What comes to my mind is that she has been impregnated by someone who failed to accept responsibility for the pregnancy.
—Female, rural, out of school, special case, 17 years old

Summary and Conclusion

A number of challenges emerge from the narratives for both policy and programming. Some adolescents experienced puberty without any information or formal education on what they should expect. This was particularly the case with out-of-school youth in rural areas. What emerges is a gap in the education of young people on pubertal issues mainly between in-school urban youth and out-of-school rural youth. There is a need to re-package programs to reach as many adolescents as possible. Community-based activities should be used to reach out-of-school adolescents in rural areas who have less access to information.

The two main concerns that emerged spontaneously from adolescents were problems associated with formal education and earning income. When prompted, adolescents considered pregnancy and HIV/AIDS to be major problems that could prevent a young person from achieving his or her potential in life. Early pregnancy was considered to be a problem for females, as it may lead to dropping out of school early. Only a few females considered themselves to be at risk of HIV infection. In spite of that recognition, some of them had had sex without protection. The rest presented the problems associated with HIV infection in the broad context of its spread and the stigma associated with it. The concern for and attitudes towards premarital pregnancy should be entry points for promoting the dual protection of condoms. Programs to reduce the vulnerability of adolescents, especially females, to early pregnancy and HIV infection should be packaged around the major concerns of education and livelihood.

Adolescents expressed the need for specific information on pregnancy and STIs, including HIV, in addition to the current general information on these issues. They expressed the wish to receive information on sexual and reproductive health from teachers and health care workers. Programs on adolescent sexual and reproductive health should also include strategies that promote the internalization of behaviors that protect their health, such as the consistent use of contraceptives among those who are sexually active. For this to be achieved, these professionals will need to be supported through training and the provision of facilities to enable them to provide adequate and reliable information in a youth-friendly atmosphere.

Chapter 5

Health Problems and Care-Seeking Behavior

This chapter explores perceptions of and responses to general, as well as sexual and reproductive health, problems. The intention is to understand adolescents' concerns about health generally and reproductive health in particular, their health-seeking behavior and the perceived reactions of adults and health care providers to their health needs.

General Health Problems

Adolescents were asked about the last time they needed health care and the type of health problem they had. Almost all adolescents described having had a health problem, often recently, and problems ranged from severe headaches, stomach problems and malaria (the more common ailments) to injuries, eye and mouth problems, and the need for antenatal care (though pregnancy-related complications were not mentioned). Two of the respondents experiencing injuries attributed them to the heavy loads they had to carry for work.

I: When was the last time you needed care for a health problem?
R: That was last month.
I: What was the problem?
R: I had chest problem because of the heavy load I used to carry when I was doing kaya yei[31] *in Accra.*
—Female, rural, out of school, 15 years old

This is a person who had returned to her village in the Northern Region after a period in Accra as a head porter. The job, involving the carrying of heavy load over distances, is bound to have some effect on the health of the young women. Although there have been studies on *kaya yei,* few studies have explored the health implications of this work.

Among those who needed antenatal care were pregnant females at a refuge in Accra for pregnant street youth. Such young pregnant females, some of whom had run away from home, had different needs in addition to antenatal care.

I: When was the last time you needed help for a health problem?
R: When I was pregnant. I visited the hospital on two occasions for antenatal care. However, some time ago, I went to a village for some herbal medicine when my stomach was paining me.
—Female, rural, out of school, special case, 12 years old

Getting pregnant at age 12 raises questions about circumstances under which the pregnancy occurred, the person responsible and the care the young woman receives. Even if she received medical care, being pregnant at this age carries risks to her health and that of the unborn child. She was found in a home for pregnant adolescents, one of the few refuges for such girls. These are young people with little family support while facing the difficult situation of being young, unmarried and pregnant.

Only seven of the 102 adolescents interviewed said they have not fallen sick or that they could not remember the last time they had been sick. While adolescence and young adulthood are generally very healthy time periods in life, the illness and injuries young Ghanaians spoke about serve as a reminder that adolescents do not pass through this stage of life without having health care needs. The general health problems reported are some of the common health problems affecting Ghanaians. For instance, malaria is the leading cause of ill health in the country, and accounted for 43% of all cases reported at health centers and hospitals from 2000 to 2004.[32]

Health-seeking behavior

Adolescents who reported any health problem used the formal health system (hospital or clinic) and self-medication (e.g., using drugs from pharmacy shops or herbs). About half of respondents who had had a health

problem visited either a clinic or a hospital. Most adolescents used the formal health system for ailments such as malaria and stomach upset.

I had stomach trouble and I was vomiting and my father took me to the hospital where I was given some drips.
—Female, rural, out of school, 14 years old

There were those who self-medicated by purchasing over-the-counter drugs from pharmacy shops for common ailments such as headaches. In some rural areas, though, the pharmacy shop may be the immediate outlet for treating diseases such as malaria and worms.

R: Yes, I experienced some pains in my stomach and also had headaches.
I: What did you do?
R: I bought some painkillers and some de-wormers.
I: What do you do when you fall sick?
R: I always go to the drugstore.
—Male, urban, out of school, 13 years old

Few adolescents mentioned herbs and herbalists as sources for health care. This may be because young people prefer to use formal health outlets. One pattern that emerged was the use of herbal treatment either as a first step or concurrently with formal health care, as in the case of the pregnant girl in the refuge mentioned earlier and also described in Box 5.1.

A separate study in one district suggests that people use self-medication in the first instance for non–life threatening diseases, followed by the use of a formal health facility. Finally, if the health problem persisted, people resorted to faith healing either by a fetish priest or at a Christian/Moslem healing camp.[33]

Family members emerged as the most important actors influencing the health-seeking behavior of adolescents—especially the parents and guardians of younger adolescents. Family members were the first to be informed of health problems and, in most cases, determined the health care approach to use, accompanied the adolescent to a health facility or purchased drugs from pharmacy shops and other outlets.

It was my mother who went to buy it for me but I cannot remember the type of medicine she bought for my cough.
—Male, urban, in school, 16 years old

I: When was the last time you needed health care?
R: That was in the year 2001 when I was seriously sick and my aunt who is a nurse took me to the hospital.
M: What was the problem?
R: They said it was typhoid fever and I was admitted at [name] hospital for three days.
—Female, rural, in school, 18 years old

The out-of-school youth in both urban and rural areas talked about using formal outlets like hospitals and clinics than those who were in school. For those in the urban areas, the major reason was cost, while for those in rural areas, the constraint was access to such services within the area. The first line of action, therefore, was self-medication, which was in some cases followed by the formal health care system.

I: Have you ever fallen sick before?
R: Yes, I have.
I: What was the problem?
R: I had stomach ache.
I: What did you do?
R: I told my uncle and he gave me some herbs and the following day I was sent to [name] hospital.
—Male, rural, out of school, 19 years old

The situation of some of the females interviewed under the special case category was different. Those adolescents interviewed at the refuge for pregnant adolescents who had run away from home or had become pregnant while working on the street (see Box 4.1) reported receiving health care through the refuge.

A few adolescents also talked about their inability to afford the cost of health care at health centers, an issue also observed in the national survey in 2004. Until recently, people paid for the cost of services at the time of receiving health care at a hospital or clinic. This cost-recovery system for treatment (known as "cash and carry") has now been replaced with a national health insurance scheme. The scheme, when fully op-

Box 5.1: Stages in seeking health care
A 13-year-old out-of-school female in an urban area reported a skin disease to her parents. As a first step, her sister applied a preparation of lime and other herbs to the rashes. The problem persisted after using the preparation on five different occasions, at which point her mother took her to a hospital for treatment.

erational, will cover various common health problems, including sexual and reproductive health issues. Currently antenatal care is free for a number of visits.

I go to the [name] hospital . . . It is because I have a brother who works there so the cost is moderate.
—Male, urban, in school, 16 years old

There were no obvious differences between female and male adolescents in health-seeking behavior. However, there appeared to be slight differences between adolescents in rural and urban areas. Adolescents in the urbanized southern sector of the country were more likely to visit a clinic or hospital for treatment than those in the rural north. This is partly due to the skewed health care facilities in the country. For instance, the population-doctor ratio was 6,550 persons per doctor for Greater Accra Region and 13,237 for Ashanti Region, compared with 81,338 for Northern Region in 2004.[34] There are also inequities between districts within the same region.[35] Due to the paucity of health facilities in rural areas, people in such areas patronize drug stores. Thus, an adolescent in the Accra or Kumasi has a higher chance of visiting a health center than one in the Northern Region. There was also evidence of self-medication either as part of the care process, or as the main method of treatment. These processes and sequences will need to be further explored and understood as part of the health-seeking behavior of adolescents and whether they are similar to or different from those of adults.

Sexual and Reproductive Health Problems

Few adolescents reported any severe sexual and reproductive health problems that warranted a visit to hospital or clinic. The main sexual and reproductive health problem reported by females was yeast infection (referred to as "white"), and these were mainly in urban areas, while the males reported minor ailments such as painful urination. In general, adolescents informed an adult person or friend if they observed any problem. Females tended to inform their mother, older sister or grandmother about the situation, while the males informed friends or grandmothers.

I first complained to my mum but all she said was that I should reduce the intake of sugar. She did not make any attempt to take me to the hospital but told me to insert Angel cream,[36] but I have never used it. I wish I could go to hospital for medical care.
—Female, urban, in school, 18 years old

My grandmother bought some tablets and Mercy cream which I used [for skin rashes on his thighs, near his penis].
—Male, urban, in school, 17 years old

While some of the adolescents disclosed their sexual and reproductive health problems to their parents or other family members, others indicated that they felt embarrassed about the condition and could not inform parents or family members. These adolescents informed their friends.

R: I was feeling pains in my penis when I wanted to urinate.
I: When did this happen?
R: It is about a year now.
I: Who did you first talk to about it?
R: I told my friend first.
I: Why did you tell your friend?
R: Because my friend knows my secret. . . . I did not want others to know about it.
—Male, rural, in school, 18 years old

Some studies among street youth in Accra have observed sharing of information and support for sexual and reproductive health problems.[37] Our interviews similarly revealed that young males on the street helped their friends in dealing with their sexual and reproductive health problems, in some cases by recommending drugs for them.

Sources for treating sexual and reproductive health problems

The sources used by adolescents who reported sexual and reproductive health problems included visits to clinics or hospitals, purchase of drugs from pharmacy shops and use of herbs or herbal preparations from mobile sellers. As was the case when dealing with general problems, some adolescents used multiple sources. A few did not seek health care for their problems because they did not consider the problems to be serious.

I: What were the reasons you didn't seek care at all [for itching on private parts around menstruation]?
R: Because my private part itches every month when I am about to menstruate, I thought it was normal and I am not sure it can be treated.
I: What would have made things easier for you?
R: By buying drugs.
I: Why don't you go to hospital?

R: I think it is not a serious problem, because after my menses it goes away.
—Female, urban, out of school, 17 years old

A few of them did not seek health care because they would not be able to pay for treatment or they felt too shy or embarrassed to disclose the nature of the problem to anybody.

According to the respondents, parents—especially mothers—play active roles in seeking care for sexual and reproductive health problems of their children. This is particularly the case if the adolescent involved is a female, as illustrated in Box 5.2. But parents are given the opportunity to play that role if they are seen to be communicative on a wide range of issues, including sexual and reproductive health. According to the 15-year-old girl, she informed her mother because she trusted her and felt comfortable discussing issues on sexual and reproductive health with her.

Intentions to Seek Care

Adolescents who reported that they had never experienced any sexual or reproductive health problem were asked to indicate the actions they would take if they had any sexual and reproductive health problem. They reported that they will seek health care and the outlets for care mentioned were visiting a hospital or clinic, using herbal medicine, purchasing drugs at a pharmacy shop and using a combination of these sources. Asked about why they will seek help, one male in a rural setting indicated the following:

R: I would just go straight to the hospital or the clinic near our school and inform the medical doctor or nurse about it.
I: How sure are you that you could do that?
R: For sickness you do not have to feel shy because if you decide to hide it, you will make the situation worse.
—Male, rural, in school, 18 years old

Most of the adolescents responding to the question indicated they would seek help at a clinic or hospital. This may indicate that adolescents prefer the formal health care system to the alternatives available. It may indicate that when adolescents think about this kind of hypothetical situation, they simply think in terms of the formal health care sector or they imagine that the problem would be serious and only a doctor would know what to do. This trust in health personnel as the people who can adequately deal with their health problems appears in a number of the responses.

I: Where would you go if you had a sexual and reproductive health problem?
R: I will go to a hospital.
—Female, rural, out of school, 14 years old

Those who indicated that they will use herbal treatment or purchase drugs at a pharmacy shop indicated that they would do so because these sources are reliable and are used for a wide range of health problems in their community. Some also indicated that they trust the people who provide herbal treatment, while others said they would opt for these sources because they were less expensive than formal health outlets. A small group felt that they will self-medicate because the sexual and reproductive health problems they would encounter would not be serious enough to warrant going to a clinic or hospital. A few also said they would use multiple strategies for treatment: first self-medication and if the problem persisted, they would report to a clinic or hospital.

Some adolescents were prepared to confide in parents or guardians about sexual and reproductive health problems because, according to them, parents have the resources to pay for the cost of treatment or would accompany them to a health facility. Some adolescents also reported that they would inform parents because they felt that they would know what could be done, direct them to a source where they can access care, or provide them with the needed emotional and financial support.

R: I would go to hospital.
I: Will you be confident enough to go to hospital on your own?

Box 5.2: Role of adults in the health seeking behavior of adolescents

A 15-year-old in-school girl experienced yeast infection, stomach ache and bodily pains. She informed her mother of her health problems because, according to her, she trusts her and feels comfortable discussing such issues with her. Her mother accompanied her to the hospital for treatment the following day. The adolescent was satisfied with the care she received, and since then she has not experienced any yeast infection. Because she was absent from school that day, she sent a message to her mates about her ailment and her friends visited her at home.

R: No, I will tell a friend or my father.
I: Why won't you go alone?
R: If I go alone and I am asked to buy some medicine I would not be able to pay for it, so I will go with my father. . . .
I: But what could make it easier for you to be able to go to hospital alone or be able to deal with such a problem?
R: If I know I will be treated free of charge then I will go alone.
—Female, rural, in school, 16 years old

Maybe if she [mother] knows anything about it or how to cure it she would do it for me . . . By telling my mother, she will help me cure it because she loves me.
—Female, urban, out of school, 15 years old

In spite of the expressed willingness to inform other people about their sexual and reproductive health problems, privacy remained important to adolescents. Many stated that they were prepared to inform somebody, such as a parent or guardian, but they also indicated that they would expect that person not to disclose the problem to anyone except a health worker. Young people were prepared to inform a parent or another person for at least three reasons. The first is that it is parents or guardians who have the resources to pay for any treatment. Second, some felt that if they did not inform anybody and get help, the problem could get worse. Third, they reasoned that parents and other adults have gone through the same experience and therefore will be able to provide the necessary assistance and support.

R: I will first show it to my father so that he would take me to the herbalist.
I: How sure are you that you could do that?
R: If you hide your sickness, you will never find any cure to it. So I believe I can show it to anyone who can cure my sickness.
I: What would make it easier for you to deal with such a problem?
R: Because the herbalist is my father's friend, I do not think he would inform any other person.
—Male, rural, out of school, 14 years old

The need for privacy was based on the fact that premarital sexual and reproductive health problems are most often associated with promiscuity.[38] Therefore, adolescents did not want to experience the social stigma of having a premarital sexual and reproductive health problem. A 15-year-old female summarized the situation as follows:

I: What would make it easier for you to deal with such a problem?
R: I pray that I should contract such a disease whilst I am in my husband's house.
—Female, rural, out of school, 15 years old

One of the major differences in health-seeking behavior was between those who were on their own, such as street youth, and those living with parents or an adult. Those who lived with their parents or an adult were more likely to inform them and obtain health care through them. Those who were living on their own tended to speak first of self-medication, and of seeking professional help if the first treatment was ineffective. Some of the adolescents in the latter group adopted that approach mainly because of cost (see below on barriers).

Another major difference was between adolescents who actually experienced sexual and reproductive health problems versus adolescents who had never experienced a problem and instead talked about what they would do. Adolescents who dealt with sexual and reproductive health problems tended to use a variety of sources, and they usually spoke about it in terms of being relatively minor or normal; for example, the numerous female adolescents who talked about having yeast infections. Adolescents who had not yet experienced a sexual and reproductive health problem spoke in terms very familiar to treatment for general health problems: they would involve their parents and they would seek help from a clinic or hospital. Their responses implied that this type of problem would be a serious one requiring the help of the formal health care sector. They also held to the view that if other people (like parents or doctors or nurses) are not told about the health problem, then treatment would not happen.

Barriers to Getting Health Care

This section summarizes the barriers associated with health-seeking behavior of adolescents for general as well as sexual and reproductive health problems. The barriers identified can be classified into economic and psychosocial. The major barrier identified, by those who had ever experienced a health problem and those who were yet to experience a problem, was money to pay for the cost of treatment, especially if it involved the formal health care sector. For adolescents living with parents and other adults, this need for resources to pay for treatment partly influenced their decision to in-

form such adult figures. Among those on their own, the problem of cost of the formal health care system made them self-medicate and seek professional advice only when the problem persisted.

R: I will go to the hospital.
I: How confident are you that you could do that?
R: If I have money, I will go to the hospital but if I have no money the nurses will beat me up. [respondent laughs]
—Female, rural, out of school, 18 years old

Cost as a major barrier to seeking health care, was similarly observed in the 2004 National Survey of Adolescents (also see under general health). The problem has arisen because the health insurance system which has been started has yet to reach full national coverage. Therefore, people are expected to pay for the cost of health care up front.*

The other important barrier mentioned is the social stigma associated with premarital sexual and reproductive health problems. Since premarital sex is often denied or condemned when it occurs, young people who experience STIs may find it difficult to seek health care at a hospital or clinic or to inform an adult. This barrier, although not indicated as often as that of finance, appeared to be important for adolescents. As indicated earlier, the decision to inform adults was partly due to the fact that they controlled the resources for treatment. This implies that if such adolescents had their own resources they would not likely disclose the problem to other people.

I: What will make it easier for you to be able to deal with such a problem?
R: I will not let my mother to hear.
I: Oh, why?
R: Because if she hears of it she will beat me.
—Female, rural, in school, 13 years old

The only problem here is money. If you have the money you can go to the hospital without the knowledge of your house people. You can also go and see an herbalist to help you with some herbs.
—Male, rural, in school, 14 years old

*An April 2007 newspaper account described poor women's babies being detained at a tertiary hospital because of nonpayment of delivery fees and the loopholes that still exist in Ghana's health system around services and how costs are to be handled (Public Agenda, Accra, April 27, 2007).

Summary and Conclusion

The available evidence suggests that adolescents, especially the younger ones, are prepared to confide in parents, particularly their mothers, and other adults about their general and reproductive health problems. Adolescents felt they could trust these adults and that they would help them to obtain treatment.

The major differences in health seeking behaviors—using clinics and hospitals versus other sources of care, relying more on friends versus family—were between rural and urban residents and between youth on the street and those living with adult figures. Adolescents in urban areas were more likely to use the formal health care system while those in rural areas were more likely to use sources such as pharmacy shops and herbal treatment for sexual and reproductive health problems. Such locational disadvantage can be addressed through community health delivery systems. Young people living on the street constitute a group that has little or no support from adult figures and did not mention as much as other adolescents using formal health services for sexual and reproductive health problems. Therefore, programs should be developed to meet the special needs of this category of young people along the lines of the refuge for pregnant girls.

Regardless of whether adolescents had experienced a sexual and reproductive health problem or not, financial resources and fear of stigma were the two major barriers to obtaining health care. The first concern arises from the continuing cost-recovery system in health care. In response to the problem of cost, the government has introduced a national health insurance system. To enable young people benefit from the scheme, parents and older adolescents (18–19-year-olds) should be encouraged to register with the scheme. Also, stigma associated with adolescent sexual and reproductive problems should be addressed as part of community-based health services for the youth.

Understanding the health care–seeking behavior of adolescents and the barriers they face in accessing care for sexual and reproductive health problems are important dimensions of Protecting the Next Generation, since available evidence points to other STIs as cofactors for HIV infection; the health care system is also an important point for intervening with contraceptive methods (in addition to the condom) for adolescents who want to prevent pregnancy. Empowering young people to seek care for sexual and reproductive health problems and mobilizing parents and communities to assist in that direction is an important public good.

Chapter 6

Intimate Relationships

One of the characteristics of adolescence is the desire to enter into intimate relationships. Some adolescents enter into relationships early while others delay. This chapter examines the reasons that adolescents give for entering or not entering relationships, and among those in intimate relationships, aspects of their first intimate relationship, which may or may not have involved sexual intercourse, and for those who had ever had sex, the circumstances surrounding their sexual debut.

Reasons for Never Having Had a Boyfriend or Girlfriend

In general, factors such as age, location, educational status, fear of pregnancy and parental control were found to influence the decision of adolescents to enter into intimate relationships. A number of adolescents interviewed were yet to enter into any intimate relationships and the reasons they gave varied. Most of the younger adolescents (12–14 years) indicated that they were not old enough to be involved in such relationships. Others stated that they were in school and that their education was important to them at this stage—they did not want to have sex, get pregnant and drop out of school. Another reason given was that they were under the care of their parents and did not want to incur their displeasure by having a boyfriend or girlfriend. The two examples below are typical of the reasons given.

I: Do you have a boyfriend?
R: No.
I. What are some of the reasons why you have never had a boyfriend?
R: Some boys are very dangerous and if you play with them, they will impregnate you.
—Female, rural, in school, 13 years old

I: What are some of the reasons why you have never had a girlfriend?
R: Because I am still a student and I have to complete my education before I think about a girlfriend . . .
—Male, rural, in school, 14 years old

The older adolescents (15–19 years), especially the females, indicated that they had not entered into any intimate relationship because they did not want to become pregnant or get HIV or another STI. Thus, as indicated by one 18-year-old female:

I do not want to have a boyfriend now because I am still young, and more to the point, if I have a boyfriend and become pregnant I may drop out of school or I may become infected with HIV/AIDS, gonorrhea and others which may affect my life.
—Female, rural, in school, 18 years old

Other reasons that females gave for not having a boyfriend were that they are restricted at home and not given any opportunity to go out in the evenings. Others indicated that they were waiting for someone to come along and marry them. Thus:

I: When do you expect to have your first boyfriend?
R: I will wait till someone comes my way to marry me.
I. For how long will you wait if nobody comes your way to marry you?
R. Well, I will wait up till 25 years.
—Female, urban, in school, 16 years old

The main reasons the older males gave for not having girlfriends were that they would not be able to take care of a girlfriend since they were not working and therefore not earning any income to take care of themselves. Some reported that they would not be able to provide for a family if the girl got pregnant. With the exception of the very young, none of the males reported parental restriction.

I: When do you expect to have your first girlfriend?
R: When I'm fully grown and know that I can now take care of a girl.
—Male, rural, out of school, 15 years old

Some of the males had not entered into any relationship because, according to them, they lacked the confidence to talk to girls: They felt shy talking to females who were not their relations or did not know how to go about proposing to a girl.

I: Have you ever had a girlfriend?
R: No.
I: What are some of the reasons why you have never had a girlfriend?
R: I feel shy to stand in front of a lady to propose love to her.
—Male, rural, out of school, 15 years old

There were differences between older females and males in the reasons for not entering into any intimate relationship. In general, adolescent females were more likely to be restricted by parents for fear that they will get pregnant or because they were expected to wait to be courted. The latter is part of the societal expectation that females be passive in sexual matters. Males stressed personal development or emotional maturity (does not know how to talk to a girl) and economic maturity (inability to support a girlfriend or family) as reasons for not having a girlfriend.

In addition to the gender differences, there were differences in the responses between in- and out-of-school adolescents. Those in school, especially the males, tended to say that as students they were not expected to enter into any relationship, and indicated they might have a first boyfriend or girlfriend after completing a certain level of education and working.

I: So, when do you expect to have your first boyfriend?
R: When I am about 20 years then I will look for a boyfriend.
—Female, rural, out of school, 14 years old

I: When do you expect to have your first girlfriend?
R: After completing school and getting a good job, I can then go in for a girlfriend.
—Male, rural, in-school, 14 years old

Thus, out-of-school males who were yet to enter into any relationship tended to stress the need for them to earn income and be financially capable of taking care of a family before entering into any intimate relationship.

Reasons for Never Having Had Sex

With sexual intercourse as the major mode of transmission of HIV infection in Sub-Saharan Africa, there has been some concern about the timing and circumstances surrounding sexual debut. This concern partly motivates the campaigns on abstinence for adolescents and the formation of "virgin clubs" in Ghana. The study explored the reasons for not initiating sexual intercourse. This information is important for the design of programs for increasing age at sexual debut. The reasons both males and females gave for not initiating sexual intercourse were similar to those given for not entering into any intimate relationship, namely being too young to be involved in sex (underage), fear of becoming pregnant or impregnating a girl, and fear of contracting STIs, including HIV. Females were more likely to stress pregnancy while the males tended to stress maturity.

I: Have you ever had sex before?
R: No, I have never had sex.
I: What are the reasons why you have not had sexual intercourse?
R: It is not good. You can get pregnant or contract sexually transmitted disease like HIV/AIDS.
I: What else?
R: I want to be in school and not get pregnant.
—Female, rural, in school, 12 years old

I: Have you ever had sexual intercourse?
R: I have never had sex with any girl before.
I: What are some of the reasons why you have not had sexual intercourse before?
R: I am not mature to go in for a girlfriend and should I have one, I cannot give her money because I am not working.
—Male, rural, in school, 14 years old

In addition, some male and female adolescents indicated that they had never had sex because sex before marriage was against their religious beliefs.

I: Why have you not had sexual intercourse?
R: Because my religion forbids sex outside marriage.
—Male, rural, out of school, 15 years old

The study also tried to find out from those who had never had sex if they had ever felt like having sex. Some of the respondents indicated that although they had never had sex, they sometimes felt that they should try and satisfy their curiosity. In spite of the expressed curiosity, they had not gone ahead and done so. Some of the adolescents (both males and females) indicated that as much as they were curious about having sex, they had not tried it because they are happy with their current state. One young male who reported having the urge to have sex also added that he resisted the urge:

I: How do you feel about not having had sexual intercourse before?
R: Sometimes I feel like having sex and see how it is but I often hesitate.
—Male, rural, in school, 17 years old

Those who had never had sex were further asked as to when they will initiate sex. In general, there appeared to be some differences between those in school and those out of school in the timing of sexual debut. The in-school adolescents tended to link their sexual debut with completing a certain level of education (both males and females) and with marriage (females). Out-of-school males in rural areas defined their time frame for sexual debut around economic stability—having a room, owning a farm, or getting a job and earning income.

I: O.K., when do you expect to have sex for the first time?
R: Maybe when I am married after university education.
—Female, rural, in school, 16 years old

I: When do you expect to have sexual intercourse for the first time?
R: That is when I am about 20 years old.
I: Why then?
R: By then I will have my own room and also my own farm.
—Male, rural, out of school, 15 years old

First Intimate Relationship Not Involving Sex

A few of the interviewees reported that they were in an intimate relationship which did not involve sexual intercourse. Of those who did, the circumstances for meeting their partner included staying together in the same house,[39] living in the same area and playing together, or meeting in unusual situations which made them become friends. The school system was also a common avenue for meeting people and selecting a partner. In particular, mixed senior secondary schools, which are boarding schools in most cases, bring together in a limited space a number of males and females. Even for the single-sex schools, there is a practice whereby schools form partnerships with other single-sex schools,[40] creating conditions for interaction between young men and women. The two examples illustrate the circumstances under which adolescents met their partners.

I: How did you come to know each other?
R: We grew up together in this town and so we know ourselves very well.
I: How did it begin?
R: He met me once and proposed to me that he will like to marry me in future and l agreed.
—Female, rural, out of school, 18 years old

I: How did you come to know each other?
R: She was the first girl I met when I went to my classroom on my first day in that school. I asked her about her course and it happened that she was offered the same course that I was given. When one of our teachers came in, he asked us to introduce ourselves and through the introduction we got to know each other and we became friends from that time.
—Male, rural, in school, 19 years old

In general, the partners of the males were about 2–5 years younger and the couples were living in the same neighborhood, attending the same or nearby schools, or working together on the street, as in the case of some of the out-of-school urban youth. The partners of the females were about 3–5 years older and were working and lived in different areas of town. For the students, activities within the relationship included studying together, attending school functions and meeting with friends. Among those with partners out of school, the relationship involved talking and going out together.

Some adolescents, especially those who were in school, preferred to keep their intimate relationships secret, especially from parents. Respondents were asked to indicate the people who were aware of their intimate relationship. Most of the adolescents in relationships reported that at least one person was aware of the relationship. Friends were more likely to know about the relationship than any one else. In a few other cases, parents and other family members such as siblings and uncles were aware of the relationship.

I: Did anybody know about your relationship?
R: My friends and siblings were aware of our relationship.
I: What about your mother?
R: She was not aware of it.
—Female, urban, out of school, 15 years old

I: Did anybody know about your relationship?
R: Yes, my friends
I: What about your parents?
R: Yes, they also knew about it.
—Male, rural, out of school, 18 years old

Only a few, mostly females, reported that nobody knew about their relationship. They did not want their parents or other family members to know because they felt they were too young and that members of the family will not approve of the relationship. Others kept the relationship secret because they felt that they will feel embarrassed if other people knew about it. The reactions of family members who became aware of the relationships were mixed. Siblings tended to support the relationships but older family members tended to advise adolescents to end the relationship.

I: What were the things you could talk about together with your girlfriend?
R: We advised each other on faithfulness.
I: What were the things you could not talk about?
R: Issues like sexually transmitted infections.
I: What kind of decisions did you make?
R: We agreed to keep the relationship secret.
—Male, urban, in school, 18 years old

I: Did anybody know about your relationship?
R: Yes, my friends and my brother.
I: What were their reactions?
R: Before I talked to the girl I discussed it with my brother and he said she was a good girl and that I can take her as my friend but not to have sex with her but rather I should study hard and help her in her studies.
. . . . . .
I: What about your parents?
R: They only heard about it but my father was not in agreement and asked me to end my relationship with the girl.
—Male, rural, in school, 17 years old

Some of them were still in their first intimate relationship, while for others the relationship had ended by the time of the interview. Most of the reported relationships lasted for 1–3 years. Among the reasons for ending intimate relationships was pressure from family members, especially parents, when they became aware of the relationship (as above). In general, parents were not particularly in favor of their children, sons or daughters, entering into intimate relationships while still in school or under their care. For the females in particular, parents and guardians were concerned about the possibility of pregnancy, as indicated below.

R: I used to have a boyfriend, but my aunt said I should not play with him because if I play with him he will "spoil" me.
I: What do you mean by the boy will "spoil" you?
R: My aunt said I will become pregnant if I play with him.
—Female, urban, out of school, special case, 16 years old

Some of them had ended the intimate relationships on their own for personal reasons, among them being the alleged bad behavior of partner such as having another boyfriend, the influence of friends to end a relationship, religious (Christian) beliefs and migration of the boyfriend or girlfriend.

I: How long did this relationship last?
R: About one year.
I: What happened after that?
R: As I said earlier, she was running after some boys and I decided to leave her alone. Since then I haven't gone in for a girlfriend again.
—Male, rural, out of school, 17 years old

R: …there was one pastor who came to preach to us in school, and he said that some people are in a relationship, but they are not doing anything, so I felt guilty, so since then we've broken up [with her first boyfriend], but we're still friends.

I: How long did it last?
R: 3 years, because we started dating when I was in JSS 3
—Female, urban, in school, 19 years old

First Sexual Relationship

A number of females, but few males reported that they had ever had sex. Among those who had ever had sex, most of them experienced their sexual debut at age 15 years or older. Most females were about 5–10 years younger than their first sexual partners (age-range 20—30) while the males were about the same age or up to 5 years older than their first sexual partners. Most of the first sex partners of female adolescents were either workers, colleagues on the street, and schoolmates who had just completed school or who were still students. The first partners of the adolescent males were either schoolmates or other females in the same community.

I: When was the first time you had sexual intercourse?
R: When I turned 17.
I: Who was the person you last had sex with?
R: My girlfriend . . . she was 14 years old and a student.
—Male, urban, out of school, special case, 17 years old

I: When was the first time you had sexual intercourse?
R: When I was 16 years old.
I: How did it happen?
R: We moved together as friends for sometime until that night he proposed to me and we had sex.
. . . . . .
I: What was he like?
R: He was a driver's mate and 19 years old.
—Female, urban, out of school, special case, 18 years old

Adolescents met their first sexual partners at various places, including market centers, hair dressing salons, social gatherings, at school and through friends.

I: How did you come to know each other?
R: It was the girl [my girlfriend] who told her friend that she has realized I am fond of friends so she is also interested in becoming a friend. It is through this that we went to the extent of befriending each other.
I: Did anyone know about your relationship?
R: Yes
—Male, urban, in school, 19 years old

As pointed out earlier, schools, especially boarding schools, have become an avenue for meeting people of the same and opposite sex. In rural areas and among the street youth, the market center is also an important meeting place. Among the busiest places in Ghana are market centers and lorry parks attached to markets. For cities such as Accra and Kumasi, the market areas are busy throughout the day for seven days a week. Studies of street youth in Accra have observed various forms of sexual networking among the males and females. These include liaisons between female sellers, head porters (kaya yei) and those who supply items to the sellers on one hand, and male drivers and their mates, male porters and other workers around markets and lorry stations on the other.[41] In rural communities, markets rotate and occur either once, twice or three times in a week, depending upon the size of the settlement and the catchment area; they have become important meeting places for young people.

The circumstances under which young people experienced their sexual debut ranged from mutual consent to trickery, coercion and rape. For those who had

Box 6.1: Plight of a 14-year-old girl who was raped and became pregnant

The experience of a 14-year-old out-of-school girl who lives in an urban area typifies the consequences of nonconsensual first sex. Two teacher training college students who were in her school for teaching practice rented a room in her father's house. As they were teachers in her school and staying in her father's house, she assisted in some household chores for them such as fetching water for them and at times cooking their meals. On the last night of their stay, one of them, a 25-year-old, requested her to come and help him pack his things. He was alone at that time because his colleague had left two days earlier. While she was in the room helping him, he raped her. She could not report the incident to her parents because her father had already warned her about her running of errands for them. She became pregnant through the rape. She informed her mother about the pregnancy and she gave her money to enable her travel to where the teachers came from and inform him about the pregnancy.

sex through mutual consent, the event seemed to be planned.

I: What were the sexual things you did together?
R: Both of us decided to try sex for the first time. I told her I had not had sex before and she also said the same. Then we had sex on that day for the first time.
—Male, urban, in school, 19 years old

For some of them, especially females, sexual debut was through rape as in the case of the 14-year-old girl who was raped by her teacher and became pregnant (Box 6.1). Similar incidents involving teachers and adults taking advantage of young girls have been reported in some studies in the country.

The study also explored the place and the circumstances under which first sexual experience took place. For most of the females, first sexual intercourse happened in the house of the partner or that of the partner's friend. Among the males, first sexual intercourse occurred in one partner's house, or in unusual settings such as in a kiosk, school veranda or abandoned building (These findings are similar to those from the focus group discussions.).[42]

I: When was the first time you had sexual intercourse?
R: When I turned 17.
I: Where did this happen?
R: It occurred at the girl's house.
—Male, urban, out of school, special case, 17 years old

The adolescents who had ever had sex expressed various feelings about their sexual debut. Some indicated that they were happy, some regretted it afterwards, some got worried and others indicated that they did not have any feeling due to the circumstances under which it occurred.

I: When was the first time you had sexual intercourse?
R: When I was 16 years old.
. . .
I: How did you feel about it then?
R: I felt happy but had some abdominal pains immediately after the sexual intercourse. Also, I was happy because my friends have been teasing me that because I do not have a boyfriend, I will behave like a fool.
—Female, urban, out of school, special case, 18 years old

Among those who reported that they regretted having had sex at the time it occurred, one of their main reasons was that they had had sex too early in life and felt that they were not old enough to get involved in sex at the time they did.

I: What were some of the things you did together?
R: We met only once and had sexual intercourse.
I: How did you feel about this relationship?
R: I regretted for having had sexual intercourse with her.
I: Why?
R: I think I had sex too early.
—Male, rural, in school, 18 years old

Those who were coerced or raped felt cheated, defiled or hollow after the incident, as indicated below.

I: Did you ever feel pressured by him to do something that you thought would put you at risk?
R: Yes, he forced me to have sex with him.
I: How did you feel about it?
R: Nothing.
—Female, urban, out of school, special case, 17 years old

Some adolescents were aware of the risks involved in having unprotected sex, such as pregnancy and STIs, including HIV. Although aware of the risks involved, they did not take any precautions. Some of them reported that since it was the first time that both of them were having sex, they were not at risk. Others depended on the promises of their partners to be faithful, while another group indicated that they never thought of any risks at the time of having sex. For those who did not think about the risks involved, they indicated that the sexual act was unplanned and it "just happened."

I: Have you had sexual intercourse before?
R: Yes, with this boy.
I: How did you feel afterwards?
R: It was so nice.
. . . . . .
I: What happened?
R: I was always worried about pregnancy, especially when I first had sex, until I experienced my next menstruation.
—Female, rural, out of school, 19 years old

There were a few who used a condom even at sexual debut with the intention of protecting themselves from pregnancy. In general, those who reportedly protected themselves were concerned more with pregnancy than with STIs, including HIV.

I: What kind of decisions did you make? Like before you had sex . . . ?
R: The first time we used a condom in order to prevent pregnancy, and thereafter he used condom until the last time he did not use it and I became pregnant.
—Female, urban, out of school, special case, 18 years old

Although adolescents were aware of the implications of unsafe sex, some of the very few who had initiated sex did not protect themselves. Thus, there appeared to be a gap between knowledge and practice of safe sex among some adolescents.

Summary and Conclusion

The evidence available indicates that some adolescents had delayed entering into intimate relationships or initiating sex. Among the reasons for the delay were fear of the reaction of parents, the negative effects of early pregnancy and childbearing on their education, and of HIV infection on their lives, especially for females; males were also concerned about their inability to take care of a girl or be responsible for a pregnancy. These reasons from adolescents themselves for postponing intimate relationship and sex should form the basis of educational programs for young people.

Parents and other adults seem to play important roles in the sexual and reproductive health of adolescents. Some parents asked adolescents to end their intimate relationships when they got to know about it. Others encouraged their children to avoid pregnancy and related problems. The potentially positive role of parents and other adults in the lives of young people should be fully explored and encouraged in sexual and reproductive health programs.

Sexual debut occurred under several circumstances: mutual consent, coercion and rape. There were gender differences in these circumstances, particularly as coercion and rape were reported only by females. There appears to be no support systems for females who experience coercive sex and these are worth considering in the design of programs. Coercion and rape reflect deep-seated problems in the status of girls and this will need to be addressed at various levels in the school system and in communities. Further research is needed to determine the nature, magnitude and effects of sexual assault and coercion among young females.

Only a few adolescents reportedly protected themselves during their sexual debut, reportedly due to the circumstances under which it occurred. Programs for adolescents should include activities which help young people to internalize the practice of safe sex during first and subsequent sexual intercourse.

Chapter 7

Influences on the Ability to Protect Sexual and Reproductive Health

The period of adolescence involves the development of self-consciousness, aspirations and networks of friends. During the process of self-development, an adolescent is also influenced by family members and friends, family background, location, education and occupation status. This chapter examines the persons and factors adolescents consider to influence their ability to protect their sexual and reproductive health, focusing on what they aspire to be in the future and how they hope to achieve those aspirations.

Aspirations

In general, there were marked differences in the aspirations of in-school and out-of-school adolescents, irrespective of sex. Both males and females who were in school, whether in urban or rural areas, aspired to be teachers, journalists, parliamentarians, international civil servants, graphic designers and lawyers; that is, they opted for professions that demand higher education. The out-of-school adolescents reported vocation-related professions and occupations, such as hairdressing and dressmaking among females and community or religious leadership, driving and trading among males. Even where the two groups mentioned the same profession, such as religious leadership, the in-school adolescents gave higher positions, such as being a bishop, whereas the out-of-school wanted to be preachers. The variation in aspirations by school status depicts the differences in career horizons for the two categories of adolescents. There were no marked differences by sex in the interests of in-school youth.

The assumption is that the higher the aspiration of the individual, the higher the likelihood that the person will take precautions to ensure that their objective in life is achieved. When asked to indicate the obstacles that would prevent them from achieving their aspirations, adolescents mentioned the following: early marriage and pregnancy, HIV infection, lack of discipline (such as spending time with girls or watching films) and financial constraints. The solutions to the obstacles identified were in many cases straightforward (avoiding early sex, being disciplined or getting serious with studies); other solutions were religious, and included praying to God and consulting oracles. The religious-based responses were given mainly by female and male adolescents in rural areas.

I: What do you want your life to be like in the next five years?
R: I wish I could be a hairdresser or a seamstress by five years time.
I: What can make this possible for you?
R: Money is what I need to make it possible.
I: What do you think can make it impossible?
R: Early marriage, but I hope to avoid that.
—Female, rural, out of school, 14 years old

I: What do you want your life to be in the next five years?
R: I want to be healthy so that I can finish reading the Holy Koran and become a good Arabic teacher in future.
I: What will make these things happen?
R: If I work hard and also pray to God.
—Male, rural, out of school, 18 years old

I: Now tell me what you will like your life to be like in the next five years.
R: I want to be at a teacher training college.
I: What could make this more or less likely to happen?
R: If I learn hard I can reach where I want to go.
I: But what do you think will not allow you to get to the training college by five years time?
R: If I become pregnant or infected with HIV/AIDS.
I: How do you think you can overcome these obstacles?
R: If I abstain from sex.

I: What things do you hold dear in your life?
R: I hold education dear in my life.
—Female, rural, in school, 13 years old

Adolescents' role models included Kofi Annan, as an international civil servant; heads of state, such as President John Agyekum Kufour of Ghana, the first lady and ministers of state; influential community members such as teachers and traditional and religious leaders; and others considered to be successful or rich in their areas. There were marked differences by gender and education in the type of role models identified. Almost all the females and males identified same-sex role models. In-school adolescents mentioned international and national figures as role models, while the out-of-school respondents, especially those in rural areas, identified local people as role models.

I: Who do you most want to be like?
R: I want to be like the first lady of Ghana.
—Female, rural, in school, 13 years old

I: Who do you most want to be like?
R: I want to be like the United Nations Secretary General.
—Male, urban, in school, 19 years old

I: Who do you most want to be like?
R: I want to be like one female teacher in Tamale.
I: Why do you want to be like her?
R: She is very rich and I also want to be rich.
—Female, rural, out of school, 14 years old

I: Who do you most want to be like?
R: I want to grow up to be like the Tolon-Naa[43]
I: What things make you want to be like Tolon-Naa?
R: He is a wealthy man and very caring.
—Male, rural, out of school, 18 years old

There were a few adolescents who indicated that they did not have any role models—either they had not thought about the issue or they had nobody in mind. This is typified in the responses of two 18-year-old out-of-school special cases.

I: What things do you hold most dear in your heart?
R: My relationship with my partner.

I: Who do you want to be like?
R: I do not want to be like anybody.
—Female, rural, out of school, special case, 18 years old

I: Who would you want to be like in future? I suppose you know people you would want to be like.
R: Yes, I know some important persons. But I do not have any specific person I would want to be like in future.
I: Sure?
R: Yes, I have not thought about it.
—Female, urban, out of school, special case, 18 years old

The adolescents interviewed gave a range of ambitions, recognized the constraints and were prepared to put in efforts to enable them achieve their objectives. Among the striking features of their responses were the relatively low aspirations of both males and females in rural areas and the possible reliance on supernatural means to achieve objectives.

Self-Efficacy

Self-efficacy implies self-worth and the ability to defend what one stands for or withstand pressures. There is the general view that young people, when confronted with any unwanted approaches, should be able to stand up to the challenge. It is this assumption that underlies skill-building programs for adolescents. To assess the self-efficacy of adolescents, they were presented with two scenarios: being pressured by their closest friends to drink alcohol when they did not want to and being pressured to have sex when they did not want to.

In the case of pressures to drink alcohol, all the males and females insisted that they would refuse and either report the person to an adult or end the relationship. For pressure to have sex, there were differences in responses between males and females. Virtually all the adolescent males said that if they were confronted with pressure for sex from a friend they would not do it and would either leave the place, end the friendship, inform other friends about it or report the incident to whoever was around. Among females, some gave similar responses: leave the place, report him or break the relationship.

I: Suppose you had a boyfriend who wants to have sex with you and you did not want to, how would you deal with that situation?
R: I would not give in to that request.

I: What if he insists on having sex with you?
R: I would not agree and I will also end the relationship with him.
—Female, rural, out of school, 17 years old

I: Assuming you have a girlfriend who wanted you to have sex with her and you did not want to do it, how will you deal with that situation?
R: I will withdraw from the relationship.
I: What if she insisted?
R: I will leave her alone.
I: What else will you do?
R: I will leave her or inform my parents or her parents about it.
—Male, rural, in school, 14 years old

However, there were a few females who said that they will give in if the boy insisted and if the boy used a condom or proposed to marry them, as indicated below.

I: Suppose you have a boyfriend who wanted to have sex with you did not want to, how would you deal with such a situation?
R: I would agree to his request if he has ever proposed love to me before.
I: Why would you agree to this request but not the alcohol?
R: Because I am interested in marriage.
—Female, rural, out of school, 15 years old

I: Suppose you had a boyfriend who wanted to have sex with you when you did not want to, how would you deal with that situation?
R: I will not allow him.
I: What if he insisted, what would you do?
R: I won't do it, but if he forces me I will allow him.
—Female, urban, out of school, 17 years old

While a degree of caution has to be noted in interpreting these responses, since they are about supposedly hypothetical situations, the difference between males and some of the females is worth noting. All the males indicated that they would refuse to have sex if they did not want it, but some of the females were prepared to compromise when pressured to have sex. To deal with such pressures, there have been efforts to educate girls to insist on their right to say "no," but the evidence suggests that girls experience these pressures still and that the solution cannot only rest on their shoulders. Part of the program should be intensive education for males to respect females—in all contexts, including that of sex and sexuality—and to trust that when a female says "no" to sex she really means it.

External Influences

Reinforcement of behavior through social support and encouragement has been found to be important in helping individuals make positive decisions. In the context of adolescent sexual and reproductive health, encouragement from parents, other family members, friends and other adults can help adolescents adopt positive sexual and reproductive health behaviors. In the interviews, adolescents were asked if anybody had encouraged them to abstain from sex or if anybody had pressured them to enter into an intimate relationship or have sex. The next three sections discuss the influences of these individuals and groups on the sexual and reproductive health decisions of adolescents.

Boyfriends and girlfriends

It is expected that adolescents in intimate relationships will discuss future plans, as well as sexual and reproductive issues such as sex, marriage, pregnancy, STIs and protective measures like contraceptive use with their partners. Some of the adolescents in intimate relationships indicated that they had discussed sexual and reproductive health issues with partners. The discussion was either initiated by the respondent or his or her partner, and in some cases it led to major decisions on those issues.

In general, older in-school adolescents, irrespective of residence, who were about the same age as their partners were more likely than other adolescents to bring up discussions on issues and to influence decisions taken later on.

I: What do you usually talk about when you are together?
R: We usually talk about further education and marriage.
I: What kind of decisions did you make?
R: We agreed that we shall prevent pregnancy. I initiated this decision because I want to complete my schooling and also I do not want to experience my father's wrath. Again, I took this decision because of diseases like AIDS and gonorrhea.
—Female, urban, in school, 18 years old

I: What about decision to prevent pregnancy?
R: Yes, we took such a decision.
I: What did you decide to do?
R: We decided to adopt family planning practices

and that was why I did not become pregnant before this time.
I: What did you do?
R: I practiced family planning.
I: Did you both agree on that decision?
R: Yes, both of us did agree.
—Female, rural, out of school, special case, 18 years old

There were also the negative aspects of intimate relationships. Some females reported that they had been pressured by their sexual partners to have sex at a time when they did not want to have sex.

I: Did you ever feel pressured by him to do something that you thought would put you at risk of pregnancy or HIV/AIDS?
R: Yes he puts pressure on me to have sex with him. After much persuasion I gave in to him.
I: Why did you do that?
R: I did that because of the fear that he would go out.
—Female, urban, out of school, 19 years old

Pressure to have sex is one of the challenges that the females in intimate relationships kept bringing up.

Family and friends

Family members (including parents, grandparents, in-laws, siblings, aunts and uncles) and peers are known to influence the decisions of adolescents on sexual and reproductive health issues. The influence of family members are at two levels: latent and manifest. Young people are always aware of the presence of their parents and significant adults and their possible reactions to some of their decisions and actions. In particular, parents were found to influence the decision of adolescents to end relationships that they did not approve of (Chapter 6). Hence, some adolescents in intimate relationships did not want their parents to know due to their anticipated reactions.

I: Has anyone told you not to have sex?
R: Yes.
I: Who?
R: My mother.
I: What did she say?
R: She said I should avoid early sex if I want to complete my education successfully.
—Female, rural, in school, 18 years old

Parents and adults, being responsible for the general health, as well the sexual and reproductive health, of adolescents also directly influence their decisions and their actions. A number of adolescents reported that they had been encouraged not to have sex by their parents and other family members (see Box 7.1).

The core messages for both females and males who had ever been encouraged not to have sex were avoiding premarital sex in order not to get pregnant/impregnate a girl and jeopardize their future. More females than males reported being told about avoiding premarital sex or abstaining from sex. According to them, they were just told and discussions were very minimal.

I: Has anyone ever told you not have sex?
R: Yes, my father keeps on saying l should never have sex before marriage.
—Female, rural, out of school, 18 years old

I: Has anyone ever told you not to have sex?
R: Yes, my parents have warned me against sex outside marriage.
—Female, rural, in school, 16 years

Friends were also found to influence the sexual and reproductive health of adolescents, either positively or

Box 7.1 Case of a 19-year-old in-school female

Agnes, a 19-year-old in-school female in an urban area first heard about puberty from school and an older sister. She entered into a relationship at age 15 but ended it after three years when her pastor spoke against premarital intimate relationships in a sermon in church. The sermon made her feel guilty. According to her, although she was in a relationship, she is still a virgin at her age and she is very happy about that.

Many people have encouraged her to abstain from sex including her sister in-law, mother, siblings and friends. For instance, her sisters have told her that if she remains a virgin up to a certain age they will invite her to visit them abroad. Most of the time she is happy that she is still a virgin but sometimes she is curious to find out how it is but has been very cautious so far. She expects to have her first sexual intercourse at her wedding night. She would like to be a graphic designer or a journalist and somebody that other people can look up to.

negatively, in several ways. In some cases peers reportedly encouraged one another not to engage in sex, provided support and advice for problems, and were also the persons who were aware of the intimate relationships of their friends. They were also found to negatively influence adolescents through pressure to have an intimate relationship or sex, and these were through both direct and indirect means such as ridicule. The direct pressure took various forms, such as the example below.

I: Has some one ever forced you to have sexual intercourse?
R: Yes, I can remember but I did not do it.
I: Who was that person?
R: It was my friends at a place called [name].
I: In what way did they force you?
R: We were playing at night and my friends said "as a visitor they have to give me a girlfriend." They brought a girl and said they were performing 'amariya' [wedding ceremony usually performed by Moslems] for me. At that moment the boys suggested that I should have sex with the girl. I was not feeling well, so I did not do it.
—Male, rural, in school, 17 years old

The indirect means of pressure, which were more subtle, took the form of ridicule and ostracism. For instance, one female indicated that her peers considered her not to be a sociable person because she was not in a relationship, while one male also said that his peers felt that he was impotent because he was not in an intimate relationship.

I: So, tell me why don't you want to take a boyfriend?
R: I do not want to take a boyfriend because at age 15 my parents advised me to be serious with my study else I will have myself to blame. So, I have realized that if I take a boyfriend I will not learn and I have also heard that sexually transmitted diseases are now very common.
I: But have you ever wanted to have a boyfriend?
R: Not really, but a friend used to make mockery of me that I am just like 'gari'[44] *without sugar but when I associated myself with some of the boys she stopped making fun of me because she thought I have something doing with one of them.*
—Female, rural, in school, 18 years old

In general, discussions on the influences of family members on the sexual and reproductive health of adolescents were meant to lead to positive outcomes: avoiding any action that may lead to pregnancy or STIs. Boyfriends/girlfriends of adolescents also supported one another to take positive decisions on sexual and reproductive health, yet there were also descriptions by girls of feeling pressure from boyfriends to have sex. The influence of peers was also found to lead to both positive and negative outcomes. There were instances of peers providing support for their group members, while there were those who encouraged some of their members to enter into intimate relationships involving sexual intercourse. It is important to take cognizance of these strands of influences on the sexual and reproductive health of adolescents, especially for females.

Religious and social groups

According to the 2000 Population and Housing Census, Christians account for 69% and Muslims 15% of the population. As expected, most of the adolescents in this particular study were either Christian or Muslim. When asked about programs related to sexual and reproductive health, most adolescents indicated that their religious groups (both Christian and Muslim) had never talked about or organized any activity on HIV/AIDS or pregnancy prevention specifically for young people, but indicated that their leaders preached against immorality including premarital sex (Box 7.1).

I: What are some of the reasons why you have never had a boyfriend?
R: My religion does not permit that. We are also taught to abstain from sex till marriage.
—Female, urban, in school, 16 years old

I: Have you ever had sexual intercourse?
R: I have never had sex with any girl before.
I: What are some of the reasons why you have not had sexual intercourse before?
R: My religion forbids having sex with someone you are not married to . . .
–Male, rural, in school, 14 years old

Some adolescents indicated that their religious groups had organized HIV/AIDS- and pregnancy-related plays and film shows for their members. Some religious groups had established specific clubs, such as virgin clubs, HIV/AIDS clubs and Youth Alive Clubs to address sexual and reproductive health issues, while others had expanded the activities of existing clubs such as the YWCA/YMCA, Catholic Youth Associa-

tion, Girl's Guide and Boy's Brigade to include such issues. The exchange below provides an example of the activities of religious groups in adolescent sexual and reproductive health.

I: You have been mentioning your seminarian friend so let us talk about religion. I want to find out whether you belong to any religious group.
R: Yes, I am a Christian.
I: What denomination?
R: I am a Catholic.
I: How does this group help you to make decisions in your everyday life?
R: When we go to church, the priest preaches and advises the youth to be of good behavior. We have also formed groups in the church and we invite people to talk to the youth about how to live upright and morally acceptable life.
I: Has the church done something or an activity about HIV/AIDS or how to prevent pregnancy?
R: Yes, the church once invited an AIDS patient who came to talk to us about AIDS and also there is a group called Youth Alive Club, which talked about AIDS and pregnancy. The club has also staged plays in the church for people to know more about HIV/AIDS and how it is transmitted.
—Male, rural, in school, 14 years old

The few social groups reported by adolescents were mostly religious-based, hence the programs on HIV/AIDS and pregnancy of the groups were organized by the religious denomination of the group.

Summary and Conclusion

Formal education was found to be important in the lives of adolescents, providing them focus for their future. In general, in-school adolescents reported higher aspirations than out-of-school adolescents and those in urban areas had higher aspirations than those in rural areas. In-school adolescents tended to be self-confident, and felt that they could overcome obstacles confronting them through discipline and hard work. This was not particularly the case with young people in rural areas who had lower aspirations and also felt that they could achieve some of their objectives in life through supernatural means. Therefore, it would be important to develop programs which address their needs of such rural youth. Such programs should include dimensions such as confidence-building and aspiration.

All the males interviewed reported that they would be able to withstand pressure from friends who wanted them to drink alcohol or have sexual intercourse against their will. However, some females were prepared to give in to sexual intercourse if pressed by their boyfriends. In program terms, the say "no to sex" campaign and the building of the confidence of adolescent females to defend their rights should be intensified and accompanied by efforts to teach boys to value the rights of girls.

External influences from boyfriends and girlfriends, family members, peers and religious groups differed. Respondents' boyfriends and girlfriends were found to be supportive in some areas (e.g., discussions leading to consensus on using contraceptives), but negative in others. Parents showed interest and had a positive influence on the sexual and reproductive outcomes of some adolescents. The influence of friends ranged from support in avoiding sex, through subtle means such as mockery, to direct pressures to enter into intimate relationships that involved sex. It is important to utilize peer influence through peer education programs. Religious and social groups influenced adolescents in two ways: through their teachings and in some cases, through specific programs for adolescents. Religious groups would need to intensify existing programs and develop new ones for their members, given the importance of religion in the lives of adolescents.

Chapter 8

Conclusion and Implications for Policy and Programming

These in-depth interviews (IDIs) provide a window into the aspirations, views, experiences and concerns of adolescents on various aspects of sexual and reproductive health. Although there are signs that the overall HIV infection in the country is declining and that age at first sex for females has increased in the last two decades, adolescents face challenges that put them at risk of infection and early pregnancy. Among them are that some adolescents do not get information on basic issues such as puberty before they experience it and that some females face sexual coercion, including rape. There are also variations in views, experiences and responses to challenges by age, sex, education and rural-urban residence. This chapter provides a summary of the findings from the IDIs and their implications for policy and programming.

Concerns of Adolescents

The major concerns that adolescents expressed spontaneously were attaining a certain level of formal education, learning a trade and achieving financial self-sufficiency. Some of the in-school adolescents were concerned about the ability of their parents to continue to support them in school, while those who dropped out of school early or ended at a lower level regretted that they were unable to attain a high level of formal education or expressed their wish to return to school in future. Adolescents who had never been to school regretted never having had the opportunity. Out-of-school youth were also concerned with earning enough to learn a trade and to support themselves and their families. This concern for livelihood was particularly evident among young people who were on the street.

When prompted, adolescents indicated early pregnancy and HIV infection to be major concerns with economic, social and health implications. According to respondents, early and premarital pregnancy and HIV infection could be obstacles which would prevent them from achieving their future objectives, such as attaining high education or learning a trade. Thus, although premarital pregnancy and HIV infection were not mentioned spontaneously when respondents were asked about their major concerns, adolescents were aware of the consequences of negative reproductive health outcomes on their future. Those who considered premarital pregnancy to be a problem placed it within the context of females who become pregnant dropping out of school and, therefore, not being able to achieve their potential in education. They did not consider premarital pregnancy and marriage a problem for males because it did not affect their education or progress in life as much as it did females. Those who indicated HIV to be a problem situated the issues within the broad context of the spread of the epidemic and stigmatization.

Adolescents also perceived females who experienced premarital pregnancy to be "bad" girls who could not wait to be married. However, premarital fathers were not branded in the same way. They were considered to be bad if they refused to accept responsibility for the pregnancy or abandoned the mother and her child.

There were observed variations by education, location and life circumstances in the reported ability of adolescents to overcome problems. Formal education was an important factor in the lives of adolescents. In most cases, in-school adolescents reported higher aspirations and self-efficacy than those who were out of school. For instance, in-school adolescents aspired to occupations that demand higher education, such as being a parliamentarian, an international civil servant or a lawyer, while the out-of-school respondents aspired to be traders and hairdressers. Furthermore, in-school adolescents appeared to be self-confident and felt that they could overcome obstacles confronting them through discipline and hard work. The out-of-school rural residents tended to depend on supernatural means such as prayers to enable them succeed in life.

Implications

Strategies to address the sexual and reproductive health needs of adolescents should utilize their aspirations and should include the broad issues of providing formal education and some element of livelihood for those who are out of school. Additionally, adolescents tended to play down their risk of HIV infection. Changing this perception will require strategies that help young people to recognize their vulnerability and develop responses to address the issue.

Information About Puberty, Pregnancy and HIV Prevention

Parents and the school system emerged as the main sources of information on puberty. Virtually all the in-school youth received information on puberty before they experienced it. However, a few adolescents, mainly rural and out of school, did not receive any information about puberty before they experienced it. While those who had information were able to handle the experience, and in some cases even looked forward to it, those who had not been informed were fearful or anxious about the changes happening to them.

Some adolescents reported receiving information on sexual and reproductive health from parents, other adults, teachers and health care workers. Among the issues discussed with them were prevention of pregnancy, mode of infection of HIV, the fact that HIV has no cure and prevention ofHIV. The main preventive measures stressed for both pregnancy and HIV infection were using the male condom and abstaining from sex. Adolescents expressed the desire for more detailed and specific information on pregnancy and HIV, such as information on the plight of persons living with HIV/AIDS and ways of using the male condom properly. They expect to receive such information from teachers and health care workers, who were seen as professionals with reliable information, and parents, who were considered to be trustworthy and caring.

Implications

A program to provide information to young people—especially out-of-school youth in rural areas—on puberty and other sexual and reproductive health issues is needed. Among the strategies should be community-based health activities for out-of-school rural youth and the strengthening of the in-school family life education program. To enable teachers and health care workers to perform the tasks young people expect from them, these professionals would have to be further supported through training and adequate resources and facilities.

Health Care Experiences and Health-Seeking Behavior

The main general health problems reported by the adolescents were malaria, severe headaches and stomach problems. Only a few respondents reported any sexual and reproductive health problems and these were yeast infections among females and painful urination among males. Some of the respondents informed parents and other adults as part of the process of seeking health care. Some of the respondents who had problems did not inform anybody or seek help. Some of those who had not experienced any problem indicated that they would not inform any adult if they had sexual or reproductive health problems. For those who sought help or were prepared to seek help, the main outlets used or indicated were hospitals and clinics. Other strategies reported were self-medication using herbs and the purchasing of medicine from drug shops.

There were marked differences in the health care outlets and health-seeking behaviors between urban and rural residents, between older and younger adolescents and between adolescents living with parents or adult figures and those living on their own. Urban residents were more likely to use formal health services while rural residents were likely to use other sources, such as pharmacy shops and herbs. Secondly, younger adolescents indicated that they would inform parents about their state and seek help, but some of the older adolescents were not prepared to inform any adult. Finally, those living on their own were less likely to seek help compared with those who lived with an adult figure.

Regardless of whether adolescents had experienced a sexual and reproductive health problem or not, financial resources and fear of stigma were the two major barriers to obtaining care. Some of the adolescents did not or would not seek effective treatment because they thought that they or their families will not be able to afford the cost of services or drugs. Some also were not prepared to inform anybody about their sexual and reproductive health problems due to the negative implications of revealing that they had ever had sex.

Implications

The formal health sector emerged as the most common source of health care used by adolescents for general and sexual and reproductive health services. This was followed by drug stores. The formal health system will need resources to enable it to improve needed services for young people.

Cost as a barrier to the seeking of health care by adolescents is one area that the government should address

as part of the newly introduced health insurance scheme. Parents and older adolescents should be encouraged to enroll in the scheme so that they can obtain health care, including sexual and reproductive health services, without informing anybody.

The stigma associated with sexual and reproductive health problems for adolescents needs to be addressed in gender-sensitive educational programs for the youth themselves, parents, health personnel and community members. It is when there is openness that young people with problems will seek health care.

There is the need for special programs for disadvantaged youth, such as rural residents and those on the street in cities. Rural out-of-school residents, disadvantaged in the availability of information and access to health care, may need specialized outreach from community-based health programs. Out-of-school urban residents on the street also constitute a special group who will need a special health care program targeted at their needs.

Promoting Healthy Relationships

The status of adolescents varied from those who were not in any intimate relationship and had never had sex, those who were in an intimate relationship and had also never had sex to those who had had sex. Some adolescents never had sex because they felt they were too young, they feared pregnancy and HIV infection, they feared the wrath of parents (especially fathers), or they were supported/encouraged not to by parents, peers, other adults or their own religious beliefs. For in-school females, the fear of pregnancy was particularly related to fear of dropping out of school.

In general, those who were in intimate relationships considered their partners to be supportive. Nonetheless, some females reported coercion from boyfriends; none of the males reported any coercion from their girlfriends. Some of the females who had been pressured to have sex by their male partners reportedly gave in to the pressures for fear that their boyfriends might go in for other females. In hypothetical situations about pressure from friends to drink alcohol or to have sexual intercourse, all the females and males indicated that they would be able to withstand pressure to drink alcohol. In the case of sex, all the males reported that they could resist pressure from peers, but some of the females indicated that they would give in to the pressure if the male involved was prepared to use a condom or proposed marriage.

Although those who had ever had sex were aware of the implications of unsafe sex, a number of them had their sexual debut without protection. Thus, there was a gap between knowledge about and practice of safe sex.

Parents appeared to play important roles in shaping the sexual and reproductive health attitudes and experiences of adolescents. Concerned with the future of their wards, especially of female adolescents, parents advised their children against premarital sex and discouraged them from continuing with an intimate relationship when they become aware of it. Adolescents indicated that they trusted their parents and appreciated the positive role they played in their lives. However, some of them considered the role of the parents to be inadequate, as information to them about sexual and reproductive health was always in the form of "don'ts." Some adolescents did not want their parents to know about their intimate relationships or their sexual and reproductive health concerns because of the parents' possible negative reactions, such as asking them to break up with their partners.

Other adults who were reported to have influenced the sexual and reproductive behaviors were other family members and leaders of religious and social groups. Religious and social groups influence the behavior of adolescents through their teachings and sometimes specific programs on sexual and reproductive health, which respondents found useful.

Implications

The tendency of some females to give in to pressures from boyfriends to have sex, even if they were not prepared to, reveals the relative powerlessness of adolescent females and perpetuates the harmful notion for boys and older men that with a little pressure, females would change their minds and consent to sex. This gender-based power dynamic, which puts some females at risk of pregnancy and HIV infection, needs to be addressed through empowerment programs that build the self-confidence and self-efficacy of adolescent females and teaches boys to respect the rights of girls.

Sexual and reproductive health programs for adolescents should include strategies for promoting the internalization of protective behaviors, such as the consistent use of contraceptives among those who are sexually active.

The apparent contradiction between the acknowledgment of the positive roles of parents and guardians in the lives of some adolescents and their unwillingness to confide in them needs to be explored in subsequent research.

The potential of religious and social groups to promote and provide positive adolescent sexual and reproductive health should be explored through dialogue with these bodies.

Gender dimensions

Gender differences along some aspects of sexual and reproductive health emerged as a major issue in this study. Substantial differences appear between female and male adolescents in the ability to respond to sexual and reproductive health challenges and the negative consequences of not doing so. Females reported coercive sex, including rape, in and out of intimate relationships. However, there are limited support systems or services for females who experience various forms of sexual coercion and rape. What does exist is a refuge for pregnant teenagers—support for girls after an unintended pregnancy has already occurred. It will be necessary to provide a comprehensive program for females who experience sexual coercion. There is the Domestic Violence Victims' Support Unit of the Ghana Police Service to which cases of rape and other forms of sexual violence are reported and which works with the legal aid system, Department of Social Welfare, NGOs and others to provide protection and care. These should be strengthened and supported to provide preventive and support services for adolescent females, and promotion of these services should be undertaken in communities.

Some of the problems arise as a result of the social system which perpetuates gender insensitivity and inequality. To deal with the problems, the whole society should be mobilized. All strategies to address the sexual and reproductive health needs of adolescents must be explicitly responsive to issues where girls are at stark disadvantage compared with boys.

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24. An Assembly member is the elected representative of an electoral area in a Metropolitan/Municipal/District Assembly, the smallest administrative unit. Within each electoral area are units committees which are responsible for issues in their area.

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36. 'Angel' and 'Mercy' Creams are ointments prepared from herbs and are purported to cure a number of diseases, including minor sexual and reproductive health problems like yeast infection.

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39. Traditional housing architecture consists of large rectangular (in the south) or circular (in the north) structure with rooms opening into a big courtyard or area with an open compound. Such structures may house several households, some renting rooms from the owner.

40. The "twinning" involves a single sex school establishing a relationship with a school for students of the opposite sex. The process started at a time when the Christian Missionaries established separate schools for boys and girls. Therefore, the institutions had their male and female counterparts, for instance, Mfantsipim (Methodist Boys) and Wesley Girls; Holy Child School and St. Augustine's College.

41. Anarfi JK and Antwi P, 1995, op. cit. (see reference 22).

42. Amuyunzu-Nyamongo et al., 2005, op. cit. (see reference 1).

43. The Tolon-Naa is the Chief of Tolon Traditional area. In Ghana, traditional leaders still wield influence within their areas of jurisdiction, and in some areas they are more influential than local political leaders.

44. Gari is meal derived from grated, fermented and fried cassava. When gari is soaked in water for a few minutes it becomes soft. Sugar and milk are then added to taste. This is a popular meal with students. Gari without sugar is tasteless and therefore to be referred to as "gari without sugar" means you are unattractive or lifeless.

APPENDIX A

Characteristics of Ghana In-Depth Interview Field Team, 2003

Name	Sex	Age	Education	Languages Spoken
Southern Sector				
Candy Nai	F	22	Undergraduate	Akan, Ga, English
Salome Adjare	F	22	Undergraduate	Akan, Ga, English
Kingsley Abrokwa	M	22	Undergraduate	Akan, Ga, English
A. Manu-Moshie	M	24	Undergraduate	Akan, English
Elizabeth Agbettor*	F	26	Undergraduate	Akan, Ga, Ewe, English
Northern Sector				
Mahama Sadat Abdul*	M	25	Undergraduate	Mamprulli, Dagbani, Akan, English, Hausa
Ahmed Sibaway*	M	26	Undergraduate	Mamprulli, Dagbani, Akan, English, Hausa
Maloni Asibi*	F	30	Undergraduate	Mamprulli, Dagbani, Akan, English, Hausa
Rahinatu Fuseini*	F	27	Undergraduate	Mamprulli, Dagbani, Akan, English, Hausa
Supervisors				
Emmanuel Mensah*	M	31	Graduate	Akan, Ga, English, Ewe
Augustine Tanle	M	38	Graduate	Akan, Dagare, English
Edem Amenumey	M	33	Graduate	Akan, Ewe, English
A. Kumi-Kyereme	M	36	Graduate	Akan, English

* Assistants involved in an earlier project phase conducting focus group discussions with adolescents.

Appendix B
Adolescent Interview Guide

1. Brief background information

a. Family

- Who do you live with here?
- How long have you been living in this community?
- Are you married?
- Have you ever had/fathered a child?

b. Individual characteristics

- What is your age (at last birthday)?
- Are you a student in school?
- What do you usually do during the day?

2. Puberty and socialization

a. Body changes

- When a young person is growing into an adult, what are some of the changes in the body that happen?
- Have you experienced any changes in your body (pubic hair, voice breaking, menstruation, wet dreams, rapid growth, beards or breasts)?
  - o When did you first start experiencing body changes?
  - o How did you feel about these changes happening to you?

b. Information about puberty

- Has anyone ever talked to you about body changes that happen when a young person becomes an adult?
  - o Can you tell me about who talked to you and what you talked about?
  - o When were you first told about these changes?
  - o In what ways, if any, did you find these talks useful or not?

c. Initiation ceremonies

- Have you had an initiation ceremony?
  - o Can you tell me about your experience? (When? Where? What happened?) Who performed the ceremony? Why do you think the ceremony was done?
  - o What did you think about it? Would you recommend it for a younger family member or friend who has yet to go through it? Why or why not?
  - o In what ways, if any, did this change how you act towards (the opposite sex)? How about with (the same sex)?

3. Relationships

a. First boyfriend/girlfriend

- When did you have your first boyfriend/girlfriend, if ever?
  - o What is/was he/she like? (age, schooling).
  - o How did you come to know each other?
  - o Did anybody know about your relationship (Who? Who else? What were their reactions?)?
- What about your parents/guardians?
  - o What were the (sexual) things you did together?
  - o How did you feel about this relationship?
  - o What happened to this relationship?
  - o RELATIONSHIP ENDED: How long did this relationship last? What happened after that? Did you have other boyfriends/girlfriends?
- NEVER HAD A BOYFRIEND/GIRLFRIEND: [Optional question?] What are some of the reasons why you have never had a boyfriend/girlfriend?
- Have you ever wanted to have a boyfriend/girlfriend?
  - o What have you done, if anything, to try and get one? What was the outcome?
  - o When do you expect to have your first girlfriend/boyfriend?

b. First sexual experience

- When was the first time you had sexual intercourse (if ever)?
  - o How did this come to happen?
  - o How did you feel about it then (happy, curious, regrets)? How about now?
- NEVER HAD SEX: What are the reasons why you have not had sexual intercourse?
  - o Probe for fear of pregnancy, fear of sexually-transmitted diseases (like HIV/AIDS), religious reasons, no boyfriend/girlfriend, aspirations like staying in school.
  - o Has anyone pressured you to have sexual intercourse? Who? In what ways?
  - o Has anyone pressured you to not have sexual intercourse? Who? In what ways?
  - o How do you feel about not having had sexual intercourse? (happy, curious, regrets?)
  - o When do you expect/plan/anticipate to have sexual intercourse for the first time? Why then?

c. EVER HAD SEX: Current or last sexual relationship

- Let's talk about your relationship with the person you last had sexual intercourse with. What was he/she like? (age, schooling).
  - o What were the things you could talk about together?
  - o What were the things you could not talk about? Why couldn't you talk about these things?
- What kind of decisions did you make? What kinds of decisions were made by him/her?
  - o How about decisions to prevent pregnancy? What did you decide to do? How did you reach that decision? Did you both agree/disagree?
  - o How about protecting against sexually-transmitted infections? What did you decide to do? How did you reach that decision?
- When you had sex with him/her, did you ever think you were at risk of pregnancy, HIV/AIDS or any other kind of sexually-transmitted infection? (It is important to note that each of these conditions should be probed on separately because they mean different things to different adolescents)
  - o IF YES: What happened? How did you feel about it?
  - o IF NO: Why not?
- Did you ever feel pressured by him/her to do something that you thought would put you at risk for pregnancy, HIV/AIDS or any other kind of sexually-transmitted infection?
  - o IF YES: What happened? How did you feel about it?

4. Healthcare seeking

a. Health problems and steps in getting help

- Let's talk about the last time you needed care for a health problem. What was the problem? What did you do? Where did you go?
- Have you ever experienced a health problem such as pains or sores on your private parts? [IF NONE, ASK: Have you had any kind of reproductive health problem—anything sex or pregnancy-related?]
  - o When did this last happen?
  - o What was the matter the last time this happened? What do you think was the cause?
  - o Who did you first talk to about it? Why? Were there others? Who? Why?
  - o What did you do first? (Who did you go to? Why? What happened?)
  - o What did you do next? (How long was it before you did this? Who did you go to? Why? What happened?) GO THROUGH ALL THE STEPS TO GET CARE.
  - o Was there something you thought about doing but you could not? (What was that? What were the reasons you could not do it?)
  - o What could you have done to prevent this problem, if anything?

b. IF NO CARE SOUGHT

- What were the reasons you didn't seek care at all?
- What were the problems you had in trying to get care?
- What would have made things easier for you?

c. IF NO REPRODUCTIVE HEALTH PROBLEMS: Hypothetical health care situation

- If you had a problem with your private parts, how would you deal with the situation? [If too sensitive a reaction from young girls, consider "If you had a menstrual problem"]
- How confident/sure are you that you could do that?
- What would make it easier for you to deal with such a problem?

5. Risk Assessment and Perceptions

a. Risk assessment

- What are some of the major problems facing you now?
  - o Which one of these is the most critical? Why?
  - o How much of a problem do you think AIDS is for you compared to (*most critical problem named above, if not HIV*)? What makes you feel this way?
- What things do you think are "risky sexual behaviors"? (probe on having sexual intercourse without a condom; having more than one sexual partner)
  - o Why do you think these are risky?
  - o What do you think may happen to someone who does these kinds of things?
- What kinds of sexual behaviors do you think are not risky?
  - o Why do you think these are not risky?

b. Hypothetical risk situations

- Let's talk about some of the situations young people your age find themselves in. Suppose your closest friend wanted you to use alcohol and you did not want to: How would you deal with that situation? What if your friend insisted, what would you do?
- Suppose you had a boyfriend/girlfriend who wanted to have sex with you when you did not want to: How would you deal with that situation? What if he/she insisted, what would you do?

c. Perceptions

- *HIV/AIDS:* What comes to your mind when you hear about AIDS?
  - o What makes you think that way?
  - o What do you think about people who have HIV/AIDS?
  - o Do you personally know someone who has HIV/AIDS?
  - o What do you think you can do to prevent HIV/AIDS?
- *Premarital pregnancies:* What comes to your mind when you hear about someone having a baby before marriage?
  - o What makes you think that way?
  - o What do you think a person can do to prevent having a baby before marriage?

6. Information and communication

a. HIV/AIDS

- Has anyone ever talked with you about HIV/AIDS?
  - o Can you tell me about who talked to you and what you talked about? (when first happened, when last happened, what talked about, with whom)
  - o In what ways, if any, did you find these talks useful or not?
  - o IF EVER IN SCHOOL: Have you gotten any information about HIV/AIDS at school? (What was talked about? Condom? Delaying sexual intercourse? Staying a virgin until marriage? The importance of being faithful?) Who talked about these issues (guest speakers, head teachers, guidance and counseling teachers, class teachers, etc).
- Are there people you feel you can go to for information about HIV/AIDS?
- Whose information do you trust about HIV/AIDS and how to prevent it? Why? Have you talked with (this person/these people)?
- Are there times when you tried to get information and could not do so? What kind of information were you trying to get?
- What type of information do you really want about HIV/AIDS?

b. Pregnancy

- Has anyone ever talked with you about preventing pregnancy?
  - o Can you tell me about who talked to you and what you talked about? (when first happened, when last happened, what talked about, with whom)
  - o In what ways, if any, did you finds these talks useful or not?
  - o IF EVER IN SCHOOL: Have you gotten any information about preventing pregnancy at school? (What was talked about? Contraceptive methods? Delaying sexual intercourse? Staying a virgin until marriage?) Who talked about these issues (guest speakers, head teachers, guidance and counseling teachers, class teachers, etc).
- Are there people you feel you can go to for talk about preventing pregnancy?
- Whose information do you trust about preventing pregnancy? Why? Have you talked

with (this person/these people)?
- What type of information do you really want about preventing pregnancy? Why?

c. Other information
- What other things do you want to know more about? (probe on relationships)

7. Religious groups
- Do you belong to a religious group?
  - o What group?
  - o How does this group help you make decisions in your everyday life?
  - o Has this group talked about or done any activities that have to do with HIV/AIDS or preventing pregnancy (or anything else health-related)? What did they do?
  - o What do you agree with from what your religious group teaches about these things? What do you disagree with?
  - o If not in a group – why not?

8. Perceptions of Self and Aspirations

a. Perceptions of Self
- How do other people think about you?
  - o What do your peers think?
  - o Your family?
  - o Other people in your community?

b. Aspirations
- What do you want your life to be like in the next five years? (What about your education or work?)
  - o What could make these things more or less likely to happen?
  - o How do you think you can overcome the obstacles?
- What things do you hold most dear in your life?
- Who do you most want to be like? What things make you want to be like this person?
- What are the things in your life that you feel happy about?
- What are some things that you hope to achieve in your life?