

**Views of Adults on Adolescent
Sexual and Reproductive Health:
Qualitative Evidence from Ghana**

Kofi Awusabo-Asare
Akinrinola Bankole
Akwasi Kumi-Kyereme

Occasional Report No. 34
June 2008

Acknowledgments

This report was written by Kofi Awusabo-Asare, University of Cape Coast, Akinrinola Bankole, Guttmacher Institute and Akwasi Kumi-Kyereme, University of Cape Coast.

The authors are grateful to the University of Maryland Eastern Shore, Princess Anne, for offering Kofi Awusabo-Asare the Richard Bernstein Scholar award, which enabled him spend one academic year at the University.

The authors thank their fellow research colleagues, Christine Ouedrago and Georges Guiella, Institut Supérieur des Sciences de la Population (Burkina Faso); Alister Munthali and Sidon Konyani, Centre for Social Research (Malawi); Stella Neema and Richard Kibombo, Makerere Institute of Social Research (Uganda); Alex Ezeh, Eliya Zulu and Nyovani Madise, African Population and Health Research Center (Nairobi); and Ann Moore, Ann Biddlecom and Susheela Singh, Guttmacher Institute, for helping to design the guide for the in-depth interviews with adults, providing feedback on the results and offering insight on the interpretation presented in this report.

Many thanks are due to the interviewers and supervisors (including coauthor Akwasi Kumi-Kyereme), who were responsible for the success of the in-depth interviews.

The authors also thank Adansi Amankwaa, Albany State University, Ann Biddlecom, Guttmacher Institute,

Ann Moore, Guttmacher Institute, Yaw Oheneba-Sakyi, California State University, and Baffour Takyi, University of Akron, for their constructive comments and suggestions on an earlier draft of this report.

The research for this report was conducted under the Guttmacher Institute's project Protecting the Next Generation: Understanding HIV Risk Among Youth, which is supported by the Bill & Melinda Gates Foundation, The Rockefeller Foundation and the National Institute of Child Health and Human Development (Grant 5 R24 HD043610).

Suggested citation: Awusabo-Asare K, Bankole A and Kumi-Kyereme A, Views of adults on adolescent sexual and reproductive health: qualitative evidence from Ghana, *Occasional Report*, New York: Guttmacher Institute, 2008, No. 34.

To order this report, go to www.guttmacher.org.

©2008 Guttmacher Institute, a not-for-profit corporation advancing sexual and reproductive health worldwide through research, policy analysis and public education. All rights, including translation into other languages, are reserved under the Universal Copyright Convention, the Berne Convention for the Protection of Literary and Artistic Works and the Inter- and Pan American Copyright Conventions (Mexico City and Buenos Aires). Rights to translate information contained in this report may be waived.

Table of Contents

Executive Summary	5
Chapter 1: Introduction	9
Country Setting	10
Median Ages at First Sexual Intercourse, Marriage and Birth	10
HIV/AIDS Infection	10
Recent Laws and Policies on Population-Related Issues	11
Conclusion	11
Chapter 2: Methods of Data Collection and Analysis	13
Training	13
Selected Areas and Screening Respondents	14
Challenges	14
Data Processing and Analysis	15
Chapter 3: Opinions on Major Adolescent Sexual and Reproductive Health Issues	17
Sexual and Reproductive Health Problems	17
Teenage Pregnancy	17
Induced Abortion	18
HIV/AIDS	19
Other Sexual and Reproductive Health Problems	20
Conclusion	20
Chapter 4: Working With Adolescents on Sexual and Reproductive Health Issues	23
Premarital Teenage Pregnancy	23
Rape, Defilement and Incest	24
Abortion	25
HIV/AIDS	25
Major Barriers	25
Conclusion	27
Chapter 5: Attitudes of Health Care Providers	29
Sympathetic Providers	29
Less Sympathetic Providers	30
Judgmental Providers	30
Conclusion	31
Chapter 6: Meeting the Sexual and Reproductive Health Needs of Adolescents	33
Suggested Activities and Programmes	33
Collective Responsibility	36
Proposed Strategies for 12-14-Year-Olds	36
Conclusion	37
Table:	
6.1 Programmes, approaches and responsibilities for addressing the sexual and reproductive health needs of adolescents	38
Chapter 7: Conclusion	39
Key Findings	39
Areas for Further Activities and Research	40
Conclusion	42
References	43
Appendices: Study Design and Interview Guidelines	
IDI study design	45
IDI Guideline	47

Executive Summary

Adults, as parents/guardians responsible for the daily needs, and as people involved in the planning and implementation of services play important roles in the lives of young people. Their perceptions, attitudes and inclinations influence the nature and quality of services offered to young people, including those on sexual and reproductive health. Therefore, understanding the views and attitudes of adults regarding the sexual and reproductive health needs of young people is crucial to the effective and efficient meeting of such needs.

To provide policy makers and programme planners with evidence-based information on such issues, the Guttmacher Institute and the University of Cape Coast, conducted 60 in-depth interviews with parents, teachers, health care workers and community leaders, in two urban and two rural areas of Ghana as part of a wider project titled *Protecting the Next Generation*. This report examines results from the interviews. The aim of the study was to:

- Explore the perceptions of adults towards adolescent sexual and reproductive health-related issues;
- Examine the nature of adult-adolescent communication on issues related to sexual and reproductive health from the perspectives of the adults; and
- Assess how adults perceive their roles and responsibilities towards adolescents on sexual and reproductive health.

Understanding the views and perceptions of adults on young people is important in three broad ways. Evidence of the role adults play in the sexual and reproductive health-seeking behaviour is currently patchy especially for issues such as STI, including HIV/AIDS, pregnancy and abortion. Secondly, learning about the perceptions and experiences of adults towards young people can inform policies and programmes that aim at addressing their needs for sexual and reproductive health. Finally, exploring the views of adults about their encounters, fears, concerns and areas for action in

adolescent sexual and reproductive health is important as it can form the basis of programmes for the adults.

Opinion on Major Adolescent Sexual and Reproductive Health Issues

Irrespective of residence, the adults interviewed identified early pregnancy as the most prominent sexual and reproductive health problem facing young people. Many of the adults pointed particularly to unplanned pregnancy among school girls and its associated consequences such as dropping out of school and its long term effects on their lives. Some adults, particularly health care providers, also reported abortion as a major problem among young girls. That abortion was considered as a major sexual and reproductive health problem by adults reflects the concern with the issue in the country. Although the adults also considered HIV/AIDS as a sexual and reproductive health problem among adolescents, the view was not as pervasive as that of pregnancy. The relative importance the adults placed on these two threats may be due to the relatively low HIV prevalence in the country, and some element of denial in the communities due to the high degree of stigma attached to HIV positive status. The few adults who reported HIV as a problem linked the infection to the shame it brought to the family. To a number of the adults, HIV/AIDS infection is as a result of modern life styles.

Experiences of Adults Working With Adolescents

The adults identified three types of barriers associated with dealing with sexual and reproductive health issues among adolescents: the attitudes of parents and adults, attitudes of young people themselves and adult-adolescent communication gap. According to teachers and health care providers, there is strong resistance from some parents to others' attempts to correct their children and to provide them sexual and reproductive health information and services. They argued that some parents opposed these services because of the belief

that the exposure to them will lead to early sex while others intimated that the availability of condoms and other methods of family planning was the cause of sexual promiscuity among adolescents. The second issue, according to some of the adults, was the rebellious nature of young people, peer influence and poor upbringing which often constituted impediments to dialoguing with them on a wide range of issues, including sexual and reproductive health. Thus, some health care workers reported that some adolescents tended to rely on their peers rather than professional advice on sexual and reproductive health issues. There was also variance between the kind of information and services that experts considered to be important for young people and what young people themselves wanted: While there was emphasis on abstinence and fidelity as preventive measures, young people were interested in knowing more about contraception. The adults acknowledged adult-adolescent communication gap on sexual and reproductive health as was reported in the studies involving young people [*Occasional Reports* No. 22 and No. 30].

Attitudes of Modern Health Care Providers toward Adolescents Receiving Information and Services

One of the main obstacles impeding the access of adolescent to modern health care services is the attitude of providers; and these were manifested in the responses from the health care providers. Three broad types of attitudes emerged among modern health care providers: sympathetic, less sympathetic and judgmental. Those who were sympathetic created welcoming environments for young people in their facilities. The less sympathetic to the sexual and reproductive needs of adolescents tended to often turn away adolescents, especially those who came to seek services relating to abortion or STI. The third category involved providers who stereotyped young people either by imposing their own values on them or by projecting the behaviours of their parents or the community to them. These kinds of attitudes exhibited by health care providers resonate in the barriers to sexual and reproductive health reported by young people themselves.

Strategies for Meeting the Sexual and Reproductive Needs of Adolescents

The adults identified the meeting of the sexual and reproductive health needs of adolescents as a shared responsibility: parents, teachers, service providers,

community leaders and the mass media. For instance, the mass media (television, mobile cinema and published materials) was identified as a main source for the dissemination of credible and reliable information. Formal education generally and family life education in particular were considered to be important sources of information for sexual and reproductive health as well as offering opportunities for developing new perspectives and approaches to dealing with problems, such as reduced risk of unintended pregnancy and STI, including HIV. Communities and Assemblies were to provide recreational facilities, including youth and community centres and encourage club membership to create avenues for young people to utilize the energies, participate in group activities where they can discuss matters of mutual interest among themselves, including sexual and reproductive health, and provides opportunities to learn new skills. Parents were expected to provide advice, counselling and moral education as part of the package to meet the sexual and reproductive health needs of young people. Fulfilling these collective responsibilities will contribute to addressing the needs of young people and also help them to become responsible adults.

Policy and Programme Implications

Evidence in this reports confirmed the conventional wisdom that different groups of adults play major roles in the lives of young people which have significant influence on their lives. These adults also have their own challenges, including their acknowledged inability to discuss sexual and reproductive health with their children. Therefore:

- There is the need to re-consider the nature of programmes that invest resources in parents to meet the sexual and reproductive health needs of young people. Some of these adults would need to be sensitized on adolescent sexual and reproductive health issues;
- The Ghana Health Service should continue with its programme to train health care providers to be youth-friendly, concerning topics such as abortion and STI;
- Various approaches need to be developed to strategically target different groups of adults to motivate them to buy into and promote policies and programmes that are aimed at young people;
- Adults who provide services to young people on a regular basis, (e.g. teachers and health care

providers) need to have the resources to enable them to perform their roles;

- As recognized by the adults, District Assemblies should invest in facilities for young people to enable them to have avenues to interact among themselves;
- There is the need to continuously collect information on young people and adults as part of long-term strategy to learn and improve upon services for young people.

It is important to understand the perceptions and attitudes of adults who create the environment, design, implement and assess the sexual and reproductive health programmes for young people. Furthermore, as gatekeepers they need to be sensitized to understand and create the necessary environment and support for adolescent reproductive health programmes. Thirdly, adults need to be educated in order to become effective partners in the delivery of adolescent sexual and reproductive health policies and programmes as they constitute an important element in the search for programmes and activities that meet the needs and aspirations of young people.

Chapter 1

Introduction

Understanding the sexual and reproductive behaviours of young people and the factors that put them—especially young women—at risk of HIV infection, sexually transmitted infections (STIs) and unwanted pregnancy is critical. Youth aged 15–24 account for 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.¹ Appropriate information and services can encourage young people to adopt protective behaviours, thereby reaping immediate and long-term benefits for themselves and society.

This report is part of a larger study of adolescent sexual and reproductive health called Protecting the Next Generation: Understanding HIV Risk Among Youth. The project, carried out in Burkina Faso, Ghana, Malawi and Uganda, seeks to contribute to the global fight against the HIV/AIDS epidemic among adolescents by raising awareness of their sexual and reproductive health needs with regard to HIV, other STIs and unwanted pregnancy; communicating new knowledge to a broader audience, including policymakers, health care providers and the media in each country, as well as regionally and internationally; and stimulating the development of improved policies and programmes that serve young people. As important gatekeepers of reproductive health information and services for adolescents, adults influence the nature and types of information and services that young people obtain. To understand the perceptions of, attitudes towards and experiences with adolescent sexual and reproductive health behaviour, we conducted 60 in-depth interviews with key adults (teachers, health care providers, parents and community leaders) in urban and rural locations. This report examines results from these interviews. The main objectives of the report are to

- explore the perceptions of adults towards adolescent sexual and reproductive health-related issues;

- examine the nature of adult-adolescent communication on issues related to sexual and reproductive health from the perspectives of the adults; and
- assess how adults perceive their roles and responsibilities concerning adolescents' sexual and reproductive health.

Understanding key adults' views and perceptions will contribute substantially to knowledge about young people's situation in three ways. First, evidence of adults' role in adolescents' health-seeking behaviour is scanty—we know very little about how adults facilitate or hinder adolescents seeking help for a health problem, especially for ailments such as HIV/AIDS and other STIs that are often stigmatized. Describing the role key adults play in the lives of adolescents as they attempt to seek health care enables a better understanding of how to address access to health care and how to better equip and prepare health care providers (e.g., doctors, nurses, pharmacists, drug shop employees and traditional healers) to meet the sexual and reproductive health needs of adolescents.

Second, since adults have influence on adolescents' lives in various ways, learning about the perceptions and experiences of adults towards young people will help to inform policies and programmes that aim to address their sexual and reproductive health needs. Therefore, increasing the body of knowledge on the adults' perspectives on adolescent sexual and reproductive health allows those interested in influencing such outcomes the opportunity to also better address the concerns of adults.

Finally, in-depth interviews allow for detailed expressions of adults' views on young people's lives and circumstances. Therefore, findings in this report will improve understanding of the interface of the perceptions, attitudes and behaviours of adults towards adolescent sexual and reproductive health in Ghana. It will also point to strategies that can be adopted to assist adults to enable them support young people.

Country Setting

According to the 2000 Census of Population and Housing, the population of Ghana is 18.9 million and inhabits a land area of 238,000 square kilometres. A large proportion of the population is younger than 15 (41%) and a small proportion is aged 65 and older (5%). Young people aged 10–19 account for about one-fourth of the total population. As of 2000, 44% of people live in urban areas, which are defined as any settlement with 5,000 people or more. Non-Ghanaians constitute 4% of the population, compared with 12% in 1960.²

There are over 50 ethnic groups, the main groups being the Akan, who account for nearly half of the population (49%), the Mole-Dagbani (17%), the Ewe (13%) and the Ga-Adangbe (8%). One major difference among the ethnic groups is that the Akan practice a matrilineal system of inheritance, while the other groups are patrilineal. The main religious groups in Ghana are Christians (67%), Muslims (17%) and traditionalists (9%). Because Ghana is a former British colony, English is the official language and it is spoken alongside over 40 different languages and dialects. About 53% of the population aged 15 and older is literate in either English or a local language, and 34% is literate in both.³ Socially, there is respect for old age, a state in life which goes with roles and responsibilities in the community. This is particularly the case in rural areas.

Politically, Ghana is a unitary state divided into 10 administrative regions and 138 districts, the district being the lowest level of political administration. Existing side by side with the modern administrative structure is a traditional system headed by chiefs (and queen mothers, in some areas), who exercise local authority.

Ecologically, the country consists of three broad zones, namely the southeastern coastal savannah, the southwestern coastal and central forest belt and the northern savannah. The northern savannah accounts for about half of the total area of the country. Development in the country has followed this broad pattern with the level of socioeconomic development being higher in the coastal areas and declining towards the north. For instance, the Greater Accra Region is the most developed, while the three northern regions are the most deprived in terms of economic well-being, school participation rates (especially for females), patient-doctor ratios and infrastructure.⁴

Median Ages at First Sexual Intercourse, Marriage and Birth

The median age at first sexual intercourse is 18 years for women aged 25–49 and 20 years for men aged

25–59. That is, by age 18, half of women and one out of four men have ever had sexual intercourse. While there has been a slight increase in the median age at first sex for women over the last decade, that of men has decreased, implying slight changes in aspects of reproductive health behaviour in different directions for males and females.⁵

Marriage is universal and early in Ghana, especially for females. In the 1998 and 2003 Ghana Demographic and Health Survey (GDHS), 16% and 14%, respectively, of females aged 15–19 had ever married (marriage was defined to include consensual union and cohabitation). In 2003, the proportion of women aged 20–24 who were married was 58%, and about 95% of 30–34-year-old women had ever married. The evidence suggests a slight increase over the past decade in median age at first marriage among women aged 20–49. Men tend to marry at a later age than women. For example, the proportion of ever-married men was only 1% among 15–19-year-olds, and 24% among 20–24-year-olds. About half of men are married by age 25, compared with more than four in five women of the same age.⁶ Females tend to be 5–9 years younger than their husbands.

Median age at first birth for women aged 25–29 is 21 years. For older age-groups, median age at first birth is around 20 years, suggesting a slight increase in age at first birth in the most recent period. Further evidence of this trend can be observed in the percentage of first births occurring at age 18 or earlier, a rate which was 25% among women aged 45–49 and only 15% among the 20–24-year-olds. A comparison of data from the 1993, 1998, and 2003 GDHS for the same age-groups also points to the general trend of rising age at first birth.⁷

HIV/AIDS Infection

The number of persons infected with HIV in Ghana has risen steadily since the first case was reported in 1986. In 1994, an estimated 118,000 Ghanaians were living with HIV/AIDS and the number tripled to more than 404,000 in 2004.⁸ HIV infection levels among women attending antenatal clinics rose steadily to a peak of 3.6% in 2003 and declined to 3.1% in 2004 and 2.7% in 2005.⁹ The 2003 GDHS showed that, HIV prevalence in Ghana differs slightly between urban (2.3%) and rural areas (2%) and among regions, with prevalence rates among pregnant women ranging from 1.2% in the Northern Region to 4.7% in the Eastern Region.¹⁰ The peak period of reported infection among women is 25–29 years and among males is 30–34 years.¹¹ Given the long incubation period of HIV, it is

possible that many older adolescents and young adults with AIDS were infected when they were younger teenagers.

Recent Laws and Policies on Population-Related Issues

Since 1992, with the adoption of the Fourth Republican Constitution, a number of laws and acts have been passed on population-related issues, based on Section 37(4). Among them are the revised National Population Policy (1994), the Reproductive Health Policy and Standards (1996), the Adolescent Reproductive Health Policy of 1998, Children's Act, and the HIV/AIDS/STI Policy of 2004. Other recent laws, such as the Domestic Violence Law of 2007, are all aimed at promoting human rights and well-being. Thus, there are relevant laws and policies that can support positive adolescent reproductive health. The challenges, however, are the translation of these laws and policies into programmes and activities, as well as understanding and enhancing the social and cultural milieu in which young people live and grow.

Conclusion

Investing in young people is one of the public goods that families, communities, governments and international organizations can offer.¹² These institutions provide opportunities for young people to achieve their aspirations. But to achieve this also involves understanding the perceptions, roles and responsibilities of some of these immediate stakeholders in the lives of young people. By improving the environment for young people, adolescents and their families can take advantage of the situation as they pass through the five transitional phases of learning, working, forming families, exercising citizenship and navigating health risks into adulthood.

Chapter 2

Methods of Data Collection and Analysis

The data for this report were derived from 60 in-depth interviews (IDIs) with key adults who interact with adolescents. This data collection effort was the fourth such research activity in a project entitled Protecting the Next Generation: Understanding HIV Risk Among Youth. The first dataset explored the perceptions, attitudes and experiences of in-school and out-of-school youth aged 14–19 through focus group discussions. The next two datasets were obtained from 12–19-year-olds through in-depth interviews and a survey on various aspects of their sexual and reproductive risk and protective behaviours and needs. This last effort is designed to provide information on the sexual and reproductive health of adolescents from the perspective of adults who interact with young people regularly and who influence the sexual and reproductive health and health-seeking behaviours of adolescents.¹³

The 60 adults were purposively selected on the basis of their roles as parents, teachers, health care providers and community leaders. They were considered to be people who interact with and/or provide information and services to adolescents on a wide range of issues, including sexual and reproductive health. The respondents consisted of the following:

Health care providers (HCP):	20 interviews
Teachers:	16 interviews
Parents/adult community leaders:	24 interviews

Of the 60 respondents, 30 were selected from two rural districts in the northern part of the country, 15 from the Ashanti Region and another 15 from Greater Accra. The intention was also to interview equal numbers of males and females. However, this was not possible, and the researchers interviewed 21 males and nine females in the rural districts and 16 males and 14 females in the urban areas. Some of the rural areas had no schools or health centres and where these facilities existed, the teachers and health care workers were primarily male, hence the preponderance of males in the rural areas.

The health care workers were also selected from private and public institutions in both areas. The teachers were selected from public and private non-religious-based schools in the urban areas but from only public schools in the rural areas, where no private ones existed. All parents selected lived with a young person aged 12–19.

The interviews were conducted in May 2005 and covered four broad areas: perceptions of the current situation of adolescent sexual and reproductive health, views on who should be responsible for meeting the information and service needs of adolescents' sexual and reproductive health, personal experiences in dealing with these issues, and possible strategies for meeting the adolescents' needs. Some of the respondents performed multiple roles, such as being a parent, teacher and community leader.

Interviews were conducted either in English, Ga, Akan, Ewe, Mamprulli, Dagbani or Hausa, depending on the area and which language the respondent was most comfortable with. Mamprulli and Dagbani are the two main local languages spoken in the two districts selected in the Northern Region. Hausa, although not a Ghanaian language, was added because it is spoken widely in the three northern regions and among migrant populations from these regions in other parts of the country. Akan is the main local language spoken in Ashanti, while the indigenous language of Accra, the national capital, is Ga. Nonetheless, as the national capital, nearly all the languages spoken in the country are represented there.

Training

Four graduate students, two males and two females, from the Department of Geography and Tourism, University of Cape Coast, constituted the interview team. The four students were selected on the basis of their previous experience in data collection and ability to speak English and the dominant languages in the selected communities.

The training session was conducted by two supervisors and one resource person. The main items discussed were

- Objectives of the Protecting the Next Generation project;
- Conducting qualitative interviews in general and in-depth interviews in particular, and the objectives and demands of in-depth interviews;
- Reviewing the IDI guide; and
- Using the screening and consent forms.

Activities included role-playing and translating the interview guide into the various Ghanaian languages to be used. This was considered crucial in view of the problems associated with the potential misinterpretation of concepts.¹⁴ Time was also devoted to the ethics of research, the concepts of informed consent and the use of the screener to identify the various categories of interviewees.

Selected Areas and Screening Respondents

The districts selected for the adult IDI were the same places where the focus group discussions and in-depth interviews with young people were held in earlier phases of the project. These were Accra and Kumasi Metropolitan areas in the Greater Accra and Ashanti Regions, respectively, and two rural districts in the Northern Region.¹⁵ These districts were selected because earlier data collection among young people had taken place in the districts. The intention, therefore, was to be able to relate the general issues emanating from both the adults on adolescent sexual and reproductive health to those of the youth.

Before the study, permission to enter the communities was sought through letters and personal contact with personnel of the four selected metropolitan/district assemblies. In addition, local representatives such as Assembly/Unit Committee members,¹⁶ chiefs or their representatives, regional and district education officers, regional and district health directorates, and religious leaders were consulted. They provided information on where to find some of the target groups who were not easy to identify. For instance, the chiefs or their representatives helped to identify traditional healers in the two rural districts.

Eligible respondents were identified through contacts. For instance, a list of teachers who are expected to teach population and family life education was obtained from the district or the submetropolitan education office. From this list, schools were selected and

potential teachers were screened and selected for interview. Where two or more teachers qualified to be interviewed in a school, the one who had been teaching longer was selected. With respect to health workers, a list of health facilities was obtained from the district health directorate of all health centres and the health facilities were ranked according to how frequently they provide services to young people. Some facilities were then selected and at each, the person responsible for young people was interviewed. Where there was no specific person, the most senior health worker was interviewed on the assumption that she or he has worked with the most young people.

Two main procedures were adopted for identifying and selecting parents and adult community leaders. The urban areas of Accra and Kumasi were zoned into three submetropolitan divisions based on the classification of the Assembly into low, medium and high socioeconomic residential areas. One submetropolitan area was then selected from the three zones. Subareas in each selected submetro were then listed in alphabetical order and one area was selected from the list for interviewing. Where there was no facility, such as a health centre, in the subarea, the facility in that submetropolitan area was used.

In the rural districts of the north, four settlements were purposively selected based on size—the district capitals and three other small settlements. Each of the selected settlements was zoned into four, and numbers were allocated according to size. This was done to ensure that respondents were selected from across different communities. Community leaders, the assembly members and young people of selected areas were consulted in order to identify adults that young people generally feel free to interact with.

Consent to participate in the interview was obtained from all the participants. Where the person could read in English, she or he was given the consent form to read and sign if she or he agreed to participate in the interview. For those who could not read and write in English or their own language, the form was read to them in their language, and if they agreed to participate they signed with a thumbprint.¹⁷ On average, interviews lasted one hour and 30 minutes.

Challenges

Among the main challenges were requests for monetary rewards, duration of the interview and finding an acceptable time to conduct the interview.

- *Requests for monetary rewards.* Some of the respon-

dents asked for monetary rewards, either before or after the interview, in the two districts in the Northern Region. This was in spite of the initial explanation that this was a purely research activity. The problem stems from the fact that some of the NGOs in this region pay respondents for an interview. Facilitators were asked to explain to respondents why in this project people could not be paid for participating in the interview. In all the cases, the potential respondents accepted the explanation and agreed to be interviewed.

- *Duration of the interview.* The duration of the interviews ranged from one hour 15 minutes to about two hours. Some of the respondents found the duration of the interview to be too long. As a result of the long duration, there were interruptions in some cases, further lengthening the interview. This was particularly the case with some of the females who had to combine the interview with their normal activities.

- *Scheduling interviews.* Some interviews were held quite late at night (between 9 and 11 p.m.), particularly interviews with respondents in the urban centres. With some of them holding full-time jobs in the formal sector, they had to be interviewed at home after work. These cases were very challenging for both the interviewers and the interviewees, as some of the respondents returned home very late. There were many callbacks for such people and some of them were interviewed after three or four visits.

In spite of these challenges, the target of 60 respondents was achieved, and some of the parents expressed their delight at being given the opportunity to discuss issues concerning their teenagers.

Data Processing and Analysis

The data collected were transcribed and the interviews that were done in Ghanaian languages were then translated into English. Using N6, a qualitative software data analysis programme, the data were coded for analysis. Text searches on relevant codes were read and matrices incorporating the substantive points for males and females were prepared. With each interview treated as a unit of analysis, summary texts were developed and recorded in relevant topical matrices.

Chapter 3

Opinions on Major Adolescent Sexual and Reproductive Health Issues

Adults provide the environment within which children grow up.¹⁸ As parents and custodians of tradition, norms and mores of the society, adults have influence on young people and their opinions shape the discourse on all issues. Furthermore, the perceptions of health care workers, teachers, community leaders and other professionals are important since these adults conceptualize what constitute sexual and reproductive health problems for young people, and they also design and implement programmes to address them. This section explores the opinions of adults on what they consider to be the major adolescent sexual and reproductive health problems in their communities.

Sexual and Reproductive Health Problems

The two adolescent sexual and reproductive health problems most commonly reported (either spontaneously or when probed) by the adults interviewed were unintended pregnancy and HIV/AIDS. Other problems indicated were induced abortion, other STIs and promiscuity. Some of the adults also indicated that alcohol and drug abuse, financial problems, unemployment, migration of young women from the northern part of the country to the south and the negative influence of the modern media exacerbated the sexual and reproductive health problems.

While recognizing that some of these problems are common to all adolescents, some adults indicated that younger and older adolescents face slightly different problems. To these respondents, younger adolescents (12–14 years) are still under the influence of their parents and, therefore, less prone to pregnancy and other problems. They are also not physically mature, so they are less likely to engage in sex compared with older adolescents (15–19 years). This sentiment was expressed by a rural community leader in the following statement:

For the younger ones, they are less exposed and less experienced in the sex. Also, they still fear

their parents and hence the parents have better control over them. They are, therefore, not much involved in premarital sex and hence record less unintended pregnancies and STDs compared to the older adolescents

—Rural male community leader 40

Others were of the view that due to their age, those aged 12–14, especially the females, are ignorant of reproductive health-related issues and, therefore, older people tend to take advantage of their ignorance. According to the respondents, young adolescent girls can easily be lured into having sex. This issue came up in the discussions with adults in urban areas.

There were also those who felt that both the younger and the older adolescents were equally exposed to risk and were involved in premarital sex and, therefore, needed to be targeted equally.

Interviewer (I): How does the issue differ for younger girls and boys who are less than 15 years old compared to older adolescents?

Respondent (R): They are not different. You come to the clinic and see a girl as young as 12 years being pregnant, so I don't see any difference.

—Urban female health worker, 47 years

The general view was that both younger and older adolescent females are at risk of unwanted sex and therefore need to be educated. It was noted that the education on reproductive health should start early in order to forestall some of the problems identified.

Teenage Pregnancy

Teenage pregnancy was considered to be a major problem for females and, in particular, those in school. According to respondents, a young woman who becomes pregnant while in school is forced to drop out, and most of those who drop out are unable to return to school after delivery.¹⁹ Many respondents felt that this issue is

less serious for young men, as they may deny responsibility for unintended pregnancies and can continue with their education even if they accept responsibility for a pregnancy. As a parent and a health worker pointed out:

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

—Rural mother, 45 years

Girls carry pregnancy, take care of babies and suffer with it. Boys only make the girls pregnant. If the boy is unemployed, he may ignore the girl . . . Depending on how both families handle the case, the boy may or may not be allowed to further his education.

—Rural male health worker (drug store), 32 years

Some argued that teenage pregnancy is a problem for young females because they may not be physically and emotionally mature enough to carry a pregnancy and may also be economically dependent. Therefore, they may have medical, social and economic problems during the period of pregnancy. If they carry the pregnancy to term, they may not have the skills to adequately take care of a child. Being children themselves, some of them would have to be cared for by their parents and other members of the household. Mothers in rural areas were particularly concerned about the implications of early pregnancy for females, as indicated in the following statement:

Some of them are still young that they cannot take good care of their babies. When they are carrying the babies they look like maidservants²⁰ . . . Girls may also not have the means to care for the baby properly.

—Rural female parent, 45 years

Some respondents in the rural communities did not consider unintended pregnancy among out-of-school or married older adolescents to be a problem. To them, one cannot consider the pregnancy of a married woman to be unintended, since every married person is expected to have sex and get pregnant. This was expressed as follows:

For the married ones unintended pregnancy does not exist. Having many children is a pride in this community; hence the issue of unintended preg-

nancy does not exist among the married men and women. For them, every pregnancy is wanted. Unintended pregnancy is found with the unmarried young men and women.

—Rural male parent, 50 years

Accordingly, it is premarital pregnancy and birth which are problematic. Premarital pregnancy is associated with shame²¹ and leads to additional responsibilities for the parents and other family members of the pregnant young woman.

In this community, it is a pride to have many children, even though they are poor. So for the married ones, pregnancy is accepted at any time. The problem is with the unmarried ones, especially girls involved in the kaya yei business [women head porters].

—Rural female health worker, 52 years

To discourage premarital births, some of the communities have instituted measures such as banning any public ceremony which legitimizes out-of-wedlock pregnancy and childbirth. Such a ceremony, known as outdooing, usually occurs eight days after birth and involves naming of the child and giving presents to the mother. One of the community leaders explained that the practice seems to have some positive impact, as indicated in the statement:

R: About three to five years ago it [premarital pregnancy] was a problem in this community, but now it is not. It is no more a major issue because the elders have instituted some measures to curb it.

I: What are these measures?

R: First, no outdooing ceremonies for such births. Second, the boy will be made to marry the girl, irrespective of his age—whether he is two years old or 100 years old. And the moment it's established that you've ever had sex with the girl, you can't refuse the pregnancy . . . Then parents of both the boy and girl will be charged by the chief for negligence of duty.

—Rural community leader, male, 68 years

Induced Abortion

Induced abortion was mentioned as a way unintended pregnancy is sometimes resolved. According to respondents, some of the abortion methods girls resort to when they become pregnant could compromise their health and future fertility. One rural health care work-

er alluded to the fact that the girls become pregnant and abort the pregnancy without anybody knowing about it. As pointed out by a rural female health worker, “they do not even come to us for advise”, implying that these young women do not seek professional advice, and the extent of abortion among this group is not even known. Among the methods reportedly used by young people to induce a pregnancy were drinking a concentrated sugar solution or coffee.

HIV/AIDS

HIV/AIDS was also reported to be a major sexual and reproductive health issue for adolescents because, unlike pregnancy, HIV/AIDS can affect males and females equally. However, comments on HIV/AIDS were less frequent compared with those on teenage pregnancy, especially from community leaders. With HIV/AIDS considered to be less of a problem in their areas most of the discussions were in general, rather than in specific terms.

The major concern expressed about HIV infection in communities is the stigma and discrimination associated with the epidemic. This corroborates the position of the Ghana AIDS Commission which has identified stigma and discrimination, leading to isolation in some cases, as some of the challenges facing the preventive efforts.²² Respondents’ concern was shame and disgrace for other family members, as well as for the infected person, as indicated in the dialogue:

I: Why is HIV/AIDS a major issue?

R: It is in the sense that it is a disgraceful disease. When you get it, it brings disgrace to the family.

I: Why do you say so?

R: It is a disease no one wants in their house. When you get it, no one likes you any longer, probably only your mother and sisters. Other members of the family will shun you because they think when they share a cup with you they can be infected. Also, someone marrying from the family will face a lot of problems because he or she will be told there is AIDS in the family, shaming them.

—Urban mother, 42 years

Rural communities considered HIV/AIDS to be a problem that exists in other areas, such as Accra and Burkina Faso, as indicated in the statement:

I haven’t come across a case about HIV/AIDS in this community. The few I have heard about came from Burkina Faso. The women go as far as Oua-

gadougou to do business. Recently, it was rumoured that two of such traders died of AIDS. But these were adults not teenagers.

—Rural female health care provider, 54 years

One of the implications of the statement is that some of the communities do not accept the existence of HIV/AIDS in their community or appreciate the overall implications of the epidemic. To them, the epidemic is far removed from their lives and they may not recognize the importance of prevention activities. The few reports on HIV/AIDS infection in both rural and urban areas were from health personnel who had dealt with cases at their facilities.

Some respondents identified different implications of HIV infection for married and unmarried adolescents. As has been reported by Akwara and others,²³ sexually active females who are not in union are usually considered to be less at risk than the married ones because the former can suggest the use of condoms to their partners without encountering problems. The power dynamics and expectation of pregnancy in marriage may make it difficult for married women to insist on using condoms.

The married woman cannot suggest to the husband to use condom, even if she is fully aware that her husband has other sexual partners.

—Rural female health care provider, 52 years

The view also includes that young women in marriages stood a higher chance of being infected if the husband or another wife (in a polygynous marriage) had extramarital relationships. In such a case, it is possible for one of them to contract HIV and infect the rest of the people in the marriage. As pointed out by one community leader:

A married woman may flirt and can infect her husband and her rivals without knowing. In a polygynous marriage, if you tell your husband that your other rival is flirting with men, he will think you are jealous, but by the time that the truth comes out she might have infected all the other rivals.

—Rural female community leader, 40 years

I: How do these issues differ for married young men and women compared to the unmarried?

R: In my opinion, when the married man decides to be promiscuous, the woman suffers because she ends up with all kinds of infections. This is due to

the fact that sex in marriage is usually unprotected for child bearing reasons. Therefore, the woman bears the brunt of the man's promiscuity.

—Urban female health care provider, 49 years

A study in Ghana in the 1990s observed that some married females were not prepared to protest against the infidelity of their husbands for economic and social reasons; and among those who protested, the traditional system was used to even punish them for protesting against the behaviour of the husband.²⁴ Such practices may possibly account for the observed higher probability of HIV-infection among married than unmarried females.

Other Sexual and Reproductive Health Problems

Other major adolescent sexual and reproductive health problems mentioned (mostly by health workers and teachers) were other STIs and casual sex. However, according to them, the young people themselves did not consider STIs to be serious problems and, therefore, do not seek professional help. Some of them reported at health centres only when they had serious problems, as in the following observation from a health worker:

Young people will normally not take STI to clinics for treatment. They would rather self-medicate, which is dangerous. Thus, by the time they seek proper care, it has reached its maturity stage and become full-blown with complications.

—Urban female health worker, 59 years

Because most young people do not report cases of STIs at health centres, the health care workers were unable to estimate the magnitude of the problem in their areas, although one urban health worker described them as “very prominent”. (The few records that were available at some facilities did not indicate age of attendees.)

The other problem mentioned was casual sex. The respondents in urban areas who mentioned casual sex attributed it to breakdown of traditional norms and practices within the urban setting. To them, modernization, the anonymity of the urban lifestyle and the desire for material things have led to increase in casual sex and unwanted pregnancy among young people. The adults, in most cases, contrasted the behaviour of today's young people with theirs when they were young and concluded that young people today are less disciplined than in the past. The statement from one female community leader reflects the views expressed:

In the olden days, when puberty rites were performed, it held the adolescents in check. As these rites are no longer being practiced, the young ones indulge in indiscriminate sexual acts, resulting in teenage pregnancy...With the unmarried people, they virtually carry the whole world on their shoulders. They are involved in all kinds of vices, indiscriminate and casual sex, drinking, stealing, etc.

—Urban female community leader, 59 years

The adults in rural areas in the north associated sexual immorality and promiscuity with females who migrate to the south (Accra and Kumasi in particular) to work as headporters (*kaya yei*) and later return to the community. A rural female health worker, age 52, pointed out the problem as follows:

Our district has one of the largest number of boys and girls from the northern part of Ghana who migrate to the south to engage in all kinds of menial jobs...While in the south, because they [were] not under anybody's control, some of them, especially the girls, indulge in commercial sex as a means of earning additional income. When they eventually return to their home villages, some of them continue with such immoral behaviour.

The perception of the unacceptable sexual behaviour of returned *kaya yei* to their places of origin has emerged in other studies.²⁵

Adults in both the rural and urban communities attributed the problem of casual sex among young people to modernization, urbanization and migration. To them, these factors have led to the erosion of the traditional norms that once regulated the lives of young people. Suggested solutions included restoring the traditional puberty rites and engaging young people in productive activities. In the northern areas, the adults were particularly concerned with strategies to ensure that young people in their areas stayed and worked there, rather than migrating to the south. But given the unequal development between the northern and southern sectors of the country, the migration of young people from the north to the south is going to continue.

Conclusion

Teenage pregnancy, especially among young women in school, emerged as the major adolescent reproductive health problem. However, among adults in rural areas pregnancies to married adolescents could not be described as unwanted, since once a woman is married,

she is expected to get pregnant and give birth. Adolescent pregnancy was only classified as unwanted if the female involved was not married. The definition of the wantedness of a teenage pregnancy, which is tied to marital status, has implications for the provision of family planning and pregnancy information and services for adolescent females.

The adults also did not consider HIV infection among young people to be a major problem compared with unplanned pregnancy. Most of the discussions on HIV were in general terms and cases were far removed from their local areas. In the rural areas, the few who mentioned HIV/AIDS considered it to be a problem in urban areas and among people with a history of travel outside their area, a perception which existed in the whole country at the early stages of the epidemic and continue to exist. Where HIV was reported to be a problem, it was associated with stigma and discrimination. The view of key adults that unplanned pregnancy among adolescents is a more pressing problem than HIV corroborates the finding among adolescents that pregnancy prevention is the most prominent reason they give for using condoms at last intercourse.²⁶

The adults viewed modernization to be responsible for observed sexual and reproductive health problems. In addition, adults in the rural north attributed such problems to returned young females who had migrated to the south. These are issues that will have to be discussed alongside any programmes on sexual and reproductive health for adolescents. The findings also suggest that any educational programme should integrate risks of pregnancy and HIV infection; should also address the attitudes of adults towards early marriage and pregnancy of young females and the north-south migration of young people.

Chapter 4

Working with Adolescents on Sexual and Reproductive Health Issues

One of the core issues explored in the study was asking key adults for some of the most difficult adolescent sexual and reproductive health issues that they have encountered and how they resolved them. The key problem discussed in this chapter are teenage pregnancy (especially among those who are in school), rape, defilement, incest, abortion, HIV/AIDS and the communication gap between parents and young people on sexual and reproductive health issues.

Premarital Teenage Pregnancy

Premarital teenage sex and pregnancy was the most frequently reported problem among respondents in both urban and rural areas. Premarital teenage sex and pregnancy have always been considered to be problems among various ethnic groups. For instance, among the Akan²⁷ and the Krobo, adolescent females who became pregnant before they have gone through rite of passage were ostracized, as this was considered taboo and brought shame to the parents of both the girl and the boy.²⁸ Premarital sex and pregnancy are construed to be the result of improper upbringing. With the advent of formal education, becoming pregnant while in school exacerbates the problem, since pregnant females are asked to leave school. Therefore, resolving issues associated with teenage pregnancy among school-going females was one of the dominant sexual and reproductive health problems.

I: As a community leader, what is the most difficult adolescent sexual or reproductive health issue you have encountered?

R: An unintended pregnancy issue involving a girl and the son of her father's best friend.

...

I: What was the source of the difficulties?

R: Because their fathers were friends, it was very difficult to settle the matter amicably without damaging the relationship between the two families. Another difficulty was that the girl was in her final

year and was about to write her examination and, therefore, whether she should be pardoned or the school rules should be applied. The latter option meant dismissal from the school.

—Rural male community leader, 74 years

Some of the adults also dealt with male students who had impregnated girls and had denied responsibility for fear that their parents would divert the resources for their education into caring for the pregnant girl and the unborn child. Some of the adults reported having had to intervene and resolve such problems.

I: Is there another difficult adolescent sexual or reproductive issue that you have encountered?

R: Yes, teenage pregnancy. A young boy impregnated a young girl but did not want to accept responsibility, so the mother took the girl to the boy's house to live with them.

—Rural mother, 51 years

I: What is the most difficult adolescent sexual or reproductive health issue you have encountered?

R: A pregnancy case involving two students . . .

I: What was the source of the difficulties?

R: The boy tried to deny any knowledge of the pregnancy and the father of the girl threatened sending the case to the police station. . . . I wanted the case to be resolved at the level of the school.

I: How did you cope with the situation?

R: Finally the case had to go to the Department of Social Welfare, where the boy accepted responsibility for the pregnancy.

—Rural male teacher, 37 years

A number of issues emerge from the narrations. Some of the adults reportedly encountered teenage pregnancies both in and out of school situations. Community leaders who resolved pregnancy-related problems had to contend with the pregnancy of girls who

were still in school, the social problem that the pregnancy created and the concerns of the parents of the girl. Teachers who were involved in resolving pregnancy-related problems of students had to consider the welfare of their students, the concerns of the parents of the girl, and the implications for discipline in the school, especially if the solution gives the impression that male students can get away with such behaviours. The girl who became pregnant in her final year of school was permitted by the authorities to write her examination. This enabled her to complete her schooling and also took care of the concerns of her father.

Different approaches were also adopted to resolve some of the pregnancy-related problems that had occurred. These included mediation using the traditional system, using the formal system (social welfare) and the individual approach of physically taking the pregnant girl to go and live in the family house of the boy who impregnated her. While the actors claim to have resolved the issues through the approaches adopted, it was not possible to follow up on the long-term implications of the resolutions. Therefore, there is need to study similar cases in the future to ascertain the nature and desirability of the outcomes.

Rape, Defilement and Incest

Sexual coercion of females, including defilement, rape and incest, was one of the major sexual and reproductive health problems reported by health care providers and teachers in urban areas. The various narrations point to the fact that the victims had not discussed their experiences with any family member. The teachers were informed in school, while the health care workers got to know about the issues when the victims reported at their facility. Two examples illustrate the diversity of the problems associated with the reporting and management of rape cases:

R: I had to deal with a 14-year-old who had been impregnated by her uncle.

I: Did you face any barriers in dealing with the situation the way you wanted?

R: Definitely. I had problems from her family. The issue was about whether the girl should have an abortion or not and I had a strong opinion about it... She should not be having her uncle's child. It is not healthy. She was a bright kid and should be given an opportunity in life.

...

I: What was the source of the difficulty you faced?

R: The family. After all, she was their child and I

was a stranger. But how on earth can a 14-year-old be a mother? Even those in their twenties are failing at it.

I: How did you cope with it?

R: It has not been resolved.

—Urban female health worker, 49 years

I: What is the most difficult adolescent sexual or reproductive health issue you have encountered?

R: A case where one girl . . . was raped by her uncle.

I: What were the barriers you faced in dealing with this situation as you would have wanted it?

R: There was her uncle; and, again, shyness and mistrust made her keep this to herself for a while. Mistrust in that she felt I would tell the other teachers.

—Urban male teacher, 30 years

The two reports illustrate some of the dilemmas teachers and health care providers face in dealing with rape, defilement and incest in the communities in which they operate, including resulting pregnancy and the question of abortion. In both cases, the other family members tried to protect the offender (not shown in the quotes).

A health care worker also reported that she once treated a schoolgirl who had been raped but was not prepared to disclose her experience to her parents and siblings.

A young girl about 15 years came with her brother to me here and said that she had been to . . . hospital, yet she was still sick. When I examined her I realized that she had been raped... So I asked of the boy who raped her and she mentioned the name and where he resided. I asked if the parents are aware and she said no. I asked if I should tell the brother and she said no, but she will do it herself. I insisted that the brother should know it so that he informs the parents for the necessary action to be taken.

—Urban male health care provider, 55 years

As the examples of the 14- and 15-year-old girls show, the victims had not informed their parents or any other adult of their experiences. The adults who were privy to the experiences were of the view that the young people were not prepared to disclose their experience to others as a result of shyness and mistrust. The reluctance of girls to report sexual coercion, which can delay

health-seeking behaviour, also came up in the in-depth interviews with adolescents. Therefore, community education on the recently passed Domestic Violence Law should include strategies to assist victims to report such cases. This is also one area where more research will be needed to unravel some of the problems associated with rape/defilement and resultant pregnancy.

Abortion

Abortion among adolescents has emerged as one of the reproductive health problems in the country.²⁹ In the study, a number of the adults, especially the health care providers interviewed, mentioned abortion among adolescents as one of the problems they have encountered and attributed it to pre-marital pregnancy. As pointed out by a female rural health care provider, “Abortion issues come up. As a health worker, girls come to me saying ‘Madam, I’m pregnant and I want to terminate it’ ... Then I tell them that I am not in a position to do it. I don’t even know how to do it, and I don’t know how you can do it. So I cannot help you, and they go away.”

Abortion often serves as a means of resolving pre-marital and unwanted pregnancy.³⁰ Because abortion is illegal in Ghana,³¹ community members become aware of an abortion in the community when the person involved reports at a health centre or when an unsafe abortion leads to serious medical complications, which ends in hospitalization or even death. Given the evidence, unsafe abortion among adolescents should be targeted as a major reproductive health issue for which more information and action will be needed.

HIV/AIDS

Although HIV/AIDS was not considered to be a major problem generally, there were reported cases of HIV/AIDS infection from both rural and urban health care providers and community members (Chapter 3). Among the major problems the respondents reportedly dealt with, in addition to the infection itself, were stigma and discrimination against persons living with AIDS and their family members. For fear of stigmatization and discrimination some families had kept HIV/AIDS infection a secret in their household. This may partly explain the inadequate information in communities about the magnitude of the epidemic. This is a major challenge to HIV/AIDS education which has also been identified under the Second HIV/AIDS Strategic Framework: 2006–2010.³²

Major Barriers

The three main barriers identified by key adults in dealing with adolescent sexual and reproductive health matters are resistance from parents, attitudes of adolescents themselves and the communication gap between adolescents and adults.

- *Resistance from parents.* According to health care providers and teachers, one of the major barriers to dealing with adolescent sexual and reproductive health issues in their communities is the attitudes of parents. Some are not cooperative in addressing sexual and reproductive health problems. According to respondents, these parents are of the view that if adolescents are introduced to sexual and reproductive health issues they will engage in premarital sex. For example, some parents think that it is the availability of condoms and other family planning methods through health care providers that have made some of the young people promiscuous, and these parents have reacted angrily to condom distribution in some cases, as the following quotes illustrate:

I attended a function at [a secondary school], and at the end of the programme, condoms were distributed. The parents who were at the function became very angry.

—Urban male teacher, 30 years

I: What types of information/services do the PPAG [Planned Parenthood of Ghana] and hospital nurses provide for the adolescents?

R: They provide them with information on HIV/AIDS, teenage pregnancy, family planning and the use of condom, which I don’t like at all.

I: What don’t you like about the condom?

R: Not only the condom, but contraceptives in general. It is the use of these contraceptives that is spoiling our children. It is because of the condom and family planning medicines that the children don’t fear going into sex. The video shows and TVs also contribute to the growing sexual promiscuity among the adolescents. The children learn and practice these bad sexual behaviours from the dirty films they watch from these places.

—Rural father, 64 years

Health care providers and teachers indicated that such accusations came particularly from older adults in rural areas who felt that the socioeconomic changes (modernization) are contributing to the unacceptable

behaviour of young people in their areas. Such adults argue that teachers and health care workers undermine their traditional ways of life and corrupt the youth in their communities by talking openly about sex. These misunderstandings had led to conflicts in some of the study communities.

Some community leaders also blamed parents for complicity in the behaviour of their daughters. According to them, some parents defend what might be considered to be unacceptable behaviour of their children, especially daughters. Key informants who reported such experiences attributed it to “ignorance:”

R: The mother insulted me. It is a barrier so I couldn't achieve what I wanted. I called the parents and informed them that their daughter was going wayward, and the mother did not allow me to complete what I was saying and she started insulting me.

I: What is the source of this difficulty?

R: Maybe the mother is ignorant or she likes the way her daughter behaves

—Urban female teacher, 46 years

There have been media reports of parents who have taken action against teachers who have tried to discipline their children in school.³³ This conflict between parents and teachers, as well as between parents and health care providers, could be a major barrier to providing community-based sexual and reproductive health services to adolescents.

•*Attitudes of adolescents.* Some adults identified the attitudes of adolescents as barrier to the provision of sexual and reproductive health information and services. The concern, identified by some community leaders, parents, teachers and service providers is the rebellious nature of young people, the influence of their peers and poor upbringing. These factors, according to them, combine to make it difficult to address the problems of adolescent sexual and reproductive health. An urban female health care provider and a parent summarized their observations as follows:

R: Most teenagers are rebellious. They do not listen to advice. They go and get pregnant and get STIs, and the burden falls on us to treat these diseases; also, the children they have end up on the streets.

I: What are some of the reasons why you experienced these barriers?

R: It is the teenage mind and stage—they are rebellious.

—Urban female health care provider, 49 years

R: Teenagers always prefer to deal with issues on their own, opting for abortion even before anyone gets wind of it. The fact that the boys will not even stay at home is a big barrier.

I: What is the source of these difficulties?

R: The fact that these kids drop out of school and the issue of inadequate parental control.

—Urban father, 40 years

Some of the professionals, especially the health care workers, complained that adolescents do not accept the professional advice they give them and that they rely on peers. These observations were reported by health workers in both rural and urban areas, as illustrated in the following statement:

Adolescents do not often accept the correct information we give them about their sexuality. When you educate them on their sexual behaviour, they go back and repeat the wrong things that their peers taught them. Some of them say they cannot enjoy sex when they use condoms.

—Rural health care provider, 32 years

Some of the adults felt that young people do not want to accept what the adults tell them. It appears the adults expect young people to behave and accept things in the same way that they did when they were young, and this does not appear to be the situation.

•*Adult-child communication gap.* Some of the professionals reported a gap between what they considered to be the information and services that adolescents needed and what the adolescents wanted to have. According to some of the respondents, young people accept what their peers tell them rather than what they, as professionals, consider to be appropriate for them. For instance, one health worker reported that despite emphasis on preventive measures such as abstinence and fidelity in their education campaigns, some of the adolescents are interested in other preventive measures, such as contraceptive use.

R: At an adolescent health programme, a young girl asked whether she could use condom. . . . That was a very challenging thing and she wanted me to teach her how to use it but I told her to come to

[place] . . . because I have to get a condom and demonstrate to her.

...

I: What made it challenging?

R: We are trying to form Virgin Clubs in their schools, so if the girl wanted to use condom, then it is a problem. We are trying to tell them not to have sex, and she is insisting on the use of condom. . . .

I didn't know how to convince her not to have sex.

—Urban female health provider, 47 years

The apparent gap between what the professionals consider to be the best information for young people and what young people themselves would like to know constitutes one of the challenges in education campaigns. Some of the adults seem to think that they can control the type of information that adolescents should have on sexual and reproductive health. But given the multiple sources of information, some of the young people may have more information than the adults think they have. The results, thus, point to the need for dialogue between young people and professionals on the fashioning of information and services for young people.

While many parents, community leaders and providers recognize the need for comprehensive information and services on sexual and reproductive health for young people, some of them consider the topic to be sensitive.³⁴ As a result, they approach discussions of sexuality with care, especially with children of the opposite sex. Fathers generally reported feeling more comfortable talking to their sons about sexual matters than their daughters and attributed this reluctance to cultural expectations of same-sex dialogue on sexual and reproductive health issues. As one father pointed out:

It is not easy dealing with adolescents. You need to be patient and very tactful especially when it comes to sexual matters. The culture doesn't allow us to talk to children about sex, especially the opposite sex. Also, some of these adolescents are very rude and disrespectful. Hence, it is not easy talking to adolescents outside your family, except those who are friends to your children or those who are your friends' children.

—Rural father, 50 years

Mothers tended to report talking to both their sons and daughters on sexual matters, but spend more time talking to their daughters. Women reported taking that responsibility because they argue that when premarital

pregnancy occurs, it is always the girl who suffers and the girl's mother is blamed.

Some parents reported feeling comfortable talking about social issues, education and morality, but not specifically about sexuality. When they do talk about sexuality with their children, they talk only about abstinence. As one parent remarked, "For my children, I talk about abstinence and nothing else. For other children, I also add that if they can't abstain, then they should use condoms." He also added:

I don't like talking about the use of condoms, but once in a while I'm forced to because they see and hear of it on television. However, I stress that it is not safe at all, and using it means you will have early sex and will therefore not grow into healthy and responsible adults.

—Rural father, 50 years

This parent-child communication gap on sexual and reproductive health has emerged from both the quantitative survey and the in-depth interviews with adolescents as one of the major challenges in health education.³⁵ The apparent inability of some parents to discuss sexual and reproductive health information with their children and other young people suggests that parents are probably not one of the best sources of information on sexual and reproductive health for the youth.

•*Other barriers.* Another major barrier identified by the adults in both rural and urban areas is financial problems. They argued that although financial problems are not directly a sexual and reproductive health problem, they lead some girls to enter into early relationships and prevent them from seeking proper health care when they encounter any problems. Some of the teachers and health care providers reported paying for the cost of health care and other services needed by adolescents.

This is an issue that has come up in all of the discussions on adolescent sexual and reproductive health (see Chapters 3 and 6). Any programme for dealing with adolescent sexual and reproductive health should address the broad issues of livelihood.

Conclusion

Almost all the problems the adults reported to have experienced had gender-specific repercussions: rape, defilement, pregnancy in school and abortion. In the cases of rape and defilement, the victims did not tell other people, indicating the lack of outlets for young rape victims to report their experiences. The existing

channels and mechanisms for reporting coercive sex and domestic violence include the Domestic Violence Victims Support Unit of the Ghana Police Service, but this facility is not available in all areas, especially in rural areas. Rape and defilement cases involving family members, in most cases, had not been pursued because the perpetrators were protected. And the fact that some of the defilement cases were committed by members of the household also makes it difficult for young females to report their experiences to other family members. For premarital pregnancies, some males often compound the burden on females by denying responsibility for the pregnancy. Sometimes a male may deny responsibility for pregnancy on the pretext that the woman was involved in sexual relations with other men. Nonetheless, none of them adopted the use of paternity test to settle the case. These social and gender dimensions of adolescent sexual and reproductive health need to be given immediate attention. Sexual coercion, in all its forms, is one area which needs to be addressed with a view to eliminating it. The general population, and young males in particular, should be educated to respect the sexual and reproductive rights of females.

Unsafe abortion also appears to be a major problem in Ghana, although not much is known about it because of its clandestine nature. To prevent unsafe abortions, young women must be encouraged to either abstain or engage in protected sex. Providing sexually active youth access to contraceptive information and services can help to prevent serious health problems, including death, due to unsafe abortion. Also there is need for research to know more about the magnitude of unsafe abortion, the characteristics of abortion seekers and the conditions under which women have abortions in Ghana.

The results indicate that parents are not likely to be the best people to be entrusted with the responsibility of discussing sexual and reproductive health with their children, as a number of them acknowledged that they felt uncomfortable discussing such issues. This discomfort may be because the traditional system entrusted such responsibility to grandparents and other adults. Nevertheless, given that parents play major roles in the lives of their children and parental monitoring tends to promote protective behaviour among adolescents,³⁶ programmes to help parents engage in open minded and constructive discussion with their adolescent children are desirable. To promote dialogue with young people, teachers, health care providers and NGOs should be encouraged to provide an enabling environ-

ment for adolescents to discuss such issues. In both urban and rural areas, teachers and health care workers are the adults who reported and had to deal with cases of coercive sex. These two professionals are frontline personnel who are trusted by young people, and this came up in the adolescent survey and the in-depth interviews. School based sexuality education and programmes that ensure adolescent friendly services in existing health facilities can go a long way to promote protective behaviour among young people.

There were different opinions on the factors contributing to the existing adolescent sexual and reproductive health problems. Modernization was considered to be a major underlying cause of the problems associated with the observed adolescent sexual and reproductive health problems. There was also disagreement among respondents about who was most responsible for adolescent's problems. Community members blamed teachers and health care workers for corrupting children by teaching about sex and providing contraceptive methods; the professional point fingers at parents and other community members for making it difficult for them to correct the behaviours of young people; health care providers blamed young people for ignoring their professional advice and instead listening to their peers. Therefore, there is the need for stakeholders to encourage dialogue and develop and provide acceptable sexual and reproductive health education to young people.

In spite of modernization and associated social and cultural changes, the traditional respect for elders and community leadership still exists, especially in rural areas. This is an asset that can be utilized to promote better handling of young people's sexual and reproductive health issues. The community approach may help to overcome the embarrassment that some parents reported when discussing sexual and reproductive health issues with their children. While parents and their children may be reluctant to talk to each other about sexual and reproductive matters, conversations between young people and other relatives such as aunts, uncles or even a trusted community leader may be productive.

Chapter 5

Attitudes of Health Care Providers

Since its inception at the end of the 1800s, the modern health system in Ghana has come to symbolize good, reliable and efficient health care. The attitudes of modern health care professionals are important, as they may influence the nature and quality of services offered. Depending on their attitude, health care providers can either facilitate the use of services or constitute a barrier to adolescents seeking sexual and reproductive health services. In in-depth interviews with adolescents, the attitudes of health providers in respecting adolescents as individuals, ensuring confidentiality and meeting their needs for information and services emerged as important considerations for young people who either sought or contemplated seeking health care.³⁷ This chapter examines the attitudes of modern health care providers towards adolescent sexual and reproductive health information and services.

The modern health care providers encountered in the rural communities were either nurses at public health centres or with nongovernmental organizations and pharmacy shop (drug store) attendants, some of whom were retired nurses. The dearth of health professionals reflects the inadequate state of health facilities in those rural communities in the Northern Region.³⁸ In the urban areas, the health care personnel interviewed were doctors, nurses and trained pharmacists.

Three broad attitudes emerge from the responses. These are those who are sympathetic to the problems that young people present at the clinic or hospital, those who are less sympathetic, and those who try to impose their views on young people seeking care, as well as other community members.

Sympathetic Providers

Some of the health care workers in both rural and urban areas appeared to be sympathetic to the sexual and reproductive health challenges and needs of adolescents, especially unplanned pregnancy and early marriage. In some cases, they intervened at the household level. An example of the nature of intervention in the sexual and

reproductive health needs of young people appears in the following narration:

I: Why did you consider [teenage pregnancy] to be a difficult issue?

R: The girl was not married and therefore she was not getting adequate feeding for herself. You know, poor feeding during pregnancy could lead to anaemia, which can cause death in pregnant women. She was worried about her condition. Such pregnancy issues are worrying to us, too, and that is why I said they are difficult issues. We don't want to record any maternal or fetal death.

I: How did you deal with the problem?

R: I invited the girl's parents and the boy's parents and told them of the girl's plight and advised them to give her a well-balanced diet to enable her recover from the anaemia. We the staff also visited her and ensured that she attended antenatal clinic regularly.

—Rural female health worker, 54 years

Empathetic providers were able to create a positive and welcoming image at their health facilities. Such providers formed a much needed bridge between the young people and their homes and also represented the youth-friendly face of the Ghana Health Service.

Some of the private and public providers used referral systems to assist young people to access health care at other facilities when their facility did not offer the services sought for. Referrals were reported to be used frequently in cases of abortion and STIs. For instance, one urban male provider referred a girl to another facility for counselling on abortion:

As a health provider, you have to probe further and also look at the body language. Sometimes you get to know that this person is hiding something. You probe further, establish confidence and then they tell you they are pregnant but have taken a drug

and are bleeding. In such instances, you know that if you send the person away, she will go and seek unqualified care, thereby creating more problems. You then have to advise her to consult a particular health provider experienced in abortion and counselling. These health care providers who perform abortions actually counsel them.

—Urban male health worker, 38 years

Less Sympathetic Providers

There were those health care providers whose modes of operation can be described as being less sympathetic towards adolescents who presented sexual and reproductive health cases at their facility. This manifested itself in practices such as turning away those who come to ask about services, including those related to abortion and STIs.

Abortion issues come up. As a health worker, girls come to me saying, “Madam, I’m pregnant and I want to terminate it.” Most often I find out whether they are attending school or not. If she is a school-girl, I tell her that instead of thinking about her studies, she has been thinking of sex. We have always been talking to you about condom, so why do you go into sex without [a] condom? Then I tell them that I am not in a position to do it [perform an abortion]. I don’t even know how to do it, and I don’t know how you can do it. So I cannot help you, and they go away.

—Rural female government health worker, 54 years

Anyone who comes with a gonorrhoea case, I tell him to go and bring the girlfriend(s). In fact, with the “gonorrhoea” cases it is boys who come up with such issues. If he brings the girlfriend(s), I put them on antibiotics for seven days. If it doesn’t go, I advise them to go to hospital. Some will say they don’t have girlfriends, they didn’t get it through sex. For such people, I always tell them: You’ll come back here with the same sickness and I’ll charge you again. If you treat yourself leaving your girlfriend, you’ll get the gonorrhoea again.

—Rural male health worker, 32 years

Technically, the approaches adopted by the providers are in line with the protocol of the Ghana Health Service for dealing with such issues. Given the law on abortion in the country, some health personnel are not prepared to deal with requests for abortion, hence the refusal to discuss the issue. In the case of STI

treatment, the protocol demands that the person seeking treatment should come along with his or her partner. But this is a situation where a young person who is already in distress is being denied a service because of the existing protocol. The observations indicate how rules may deny services to people when they need them (this may not happen to only young people) and suggest that some mechanisms should be developed to address the needs of young people without compromising public health procedures.

Judgmental Providers

Some health care providers were judgmental towards adolescents seeking reproductive health information and services. For instance, one rural male health worker argued that the production and distribution of condoms should be stopped: “Because condoms are available they don’t want to practice abstinence, which is the only surest way they can avoid catching the HIV/AIDS.” This attitude of the providers created a barrier between the provider and clients.

Another dimension relates to provider’s knowledge of behaviours in the community and the tendency to project those onto adolescents seeking services. For instance, some providers felt that the behaviour of the adolescents is similar to that of their parents and the community and therefore did not need any sympathy or special care. This attitude is reflected in the following statement:

In this community, mothers are the breadwinners of most households, and hence control the house. Like I said, some travel as far as to Ouagadougou to trade. They leave the house for many days. Girls imitate their mothers a lot, unfortunately, and the mothers don’t see anything wrong with their daughters being pregnant. So for the girls, they get support from their mothers and that is why unintended pregnancy is rampant.

—Rural female health worker, 54 years

Such personal assessment of communities tends to influence the nature of the interaction with the members and the service offered. For example, a provider who projects the behaviour of mothers onto their young girls as in the quote presented above is unlikely to provide nonjudgmental and friendly services to young people.

Some of the health care personnel were aware of the negative attitudes of their colleagues towards young people. Accordingly, they reported that some of their

colleagues are unable to communicate with young people in a friendly manner. To them, such attitudes alienated young people and could explain why some young people do not use their services.

R: Another problem is the attitude of health care providers towards these kids. They need to learn to talk to them nicely and make friends with them. In this way, they [adolescents] will talk freely. But if you are harsh and mistreat them, then it is a lost case.

I: What do you think would have helped you deal better with these difficulties?

R: If many people are broad-minded like me.

—Urban female health worker, 49 years

There was no systematic pattern between rural and urban respondents in their attitudes toward young people: There were both supportive and judgmental providers in both areas. The varying attitudes of modern health care providers toward young people have implications for addressing their sexual and reproductive health needs. To achieve the youth-friendly image that the Ghana Health Service is promoting, emphasis will have to be placed on re-educating providers at various levels. This will help to improve the service offered generally and to young people in particular.

Conclusion

The attitudes of health care providers toward adolescents using the formal health care system have emerged in a number of previous studies. The vast majority of them deal with the barriers young people perceive in obtaining sexual and reproductive health services, particularly from the formal health sector. Such barriers, the literature indicates, include fear that others might discover that they are seeking such services, feeling ashamed about their needs, negative attitudes of providers, lack of privacy and confidentiality, and age restrictions.³⁹ In the same vein, a study in Kenya and Zimbabwe among 10–19-year-olds found that adolescents considered health facility-related factors, such as level of confidentiality, short waiting time, low cost and friendly staff, as the most important factors when seeking services in such places.⁴⁰

In this study three broad attitudes emerged—sympathetic and supportive, unsympathetic and judgmental. In the 2004 Ghana Adolescents survey conducted under the larger project that included the in-depth interview on which this report is based, some young people expressed their preference for the formal health

care system. However, some of them reported that they felt too embarrassed, shy or afraid to seek services at some health facilities. These feelings may be due to the attitudes of the health workers and serve as barriers to seeking health care, especially for obtaining STI treatment, abortion and contraceptives.⁴¹ While the Ghana Health Service has initiated a programme to create youth-friendly services and a youth-friendly atmosphere at their facilities, the strategy will need to be revitalized to deal with various attitudes that create barriers. Also, there is a need for further studies on the dimensions of attitude-related problems in order to ensure youth-friendly services.

Chapter 6

Meeting the Sexual and Reproductive Health Needs of Adolescents

Adults were asked to indicate strategies that could be adopted to meet the sexual and reproductive health needs of adolescents. The responses have been grouped into suggested activities and programmes, individuals and groups who should be responsible for the actions to be taken, and programmes for younger adolescents (aged 12–14).

Suggested Activities and Programmes

Adults suggested the following strategies to meet the needs of adolescents: mass media to provide information, formal education and family life education, group and community activities, counselling and moral education.

• *Mass media.* Virtually all the respondents identified the mass media as a major channel through which sexual and reproductive health information should be provided for young people. The proposed media are television, mobile cinema and written materials, due to the wide circulation of these methods. No adults mentioned the traditional forms of mass education, such as drama and puppetry.

I: What do think should be done to help young people protect their sexual and reproductive health?

R: There should be education, television or cinema programme for them to see the effects of their actions. They should see what actually happens. Anyone jumping like a dog from one girl to the other should be advised very well. If this is done, everything will be okay.

I: What do you think can be done to help avoid unwanted or teenage pregnancy here, apart from education?

R: Parents, or all who are concerned with the training of children, social welfare, all departments, private agencies concerned with the training of children should help to deal with the situation.

—Urban male community leader, 56 years

Among the strategies suggested for government agencies are that they should be resourced in order to be responsive to the needs of young people. For instance, it was proposed that the Domestic Violence Victims Support Unit (formerly the Women and Juvenile Unit) of the Police Service should be supported to perform its assigned roles and responsibilities. Some parents indicated that teachers should be able to discipline young people who misbehave in school and in the community, as was the case in the past. And, finally, it was suggested that parents should be able to talk to their children about life and discipline them when they go wrong, and more importantly, they should be there for them as mentors and for guidance.

I: What do you think should be done to help young people protect their sexual and reproductive health?

R: We should keep on advising them to abstain from sex because they are not married. We can show them films on HIV/AIDS to scare them from sex.

—Rural mother, 50 years

Initially, the HIV/AIDS campaigns adopted the scare tactics of showing graphic pictures of the effects of the epidemic. This approach has been replaced with general information about the epidemic, preventive measures and strategies for preventing stigma and discrimination. Some of the adults interviewed felt this scare approach should be brought back. This is an issue that would need further discussion among public health educators.

• *Formal education and the teaching of family life education.* Another strategy suggested by a number of adults was providing broad formal education and teaching family life/sex education in schools. The argument was that schooling provides people with new perspectives and approaches to dealing with problems,

and for girls in particular, being in school helps to postpone the onset of sexual activity and marriage. To the respondents, teaching family life education means helping young people develop behaviours in life that will enable them to avoid early sex and thereby teenage pregnancy and STIs, including HIV. Respondents in urban areas tended to stress formal education and family life education more than any other group.

I: What do you think should be done to help young people protect their sexual and reproductive health?

R: All that needs to be done is to encourage these children to go to school to get an education, get them a community centre where they can learn through recreation. In this way they will not be involved in any bad habits or even indulge in casual sex, which has its own problems.

—Urban female community leader, 59 years

•*Provision of facilities.* Providing recreational facilities, such as youth and community centres, and encouraging young people to form youth clubs or join existing clubs was also mentioned by a number of parents and community leaders. According to the proponents, these centres will provide the youth with opportunities to discuss various issues among themselves, including sexual and reproductive health. The centres, if properly managed, will also teach the young people skills and at the same time keep them off the streets and away from other antisocial activities.

I: What do you think should be done to help young people protect their sexual and reproductive health?

R: Constant sex education. Youth clubs could be formed to engage children in various activities so that they could discuss their health issues at club meetings. Also, occasionally, mobile cinema vans should show films on HIV/AIDS to the adolescents to deter them from engaging in premarital sex.

—Rural male teacher, 26 years

Using recreational facilities as a conduit for providing sexual and reproductive health education to young people, channelling their energies and teaching them new skills has been tried in a number of settings and with differing results. However, the consensus in the literature, based on studies that have evaluated the impact of this approach, seems to be that it is costly and generally ineffective.⁴² Currently, there are limited

recreational and other facilities for young people in the country. Before putting more money and effort into this approach in Ghana, its effectiveness should be properly evaluated.

•*Parental advice and counselling.* Parental counselling was mentioned as one of the major strategies that can be adopted to promote positive sexual and reproductive health among young people. It is important for parents to create an atmosphere at home whereby they can have frank discussions with their children. One urban female health worker, age 58, who is also a parent, pointed out the following:

When my daughter menstruated, her big brother bought her a book explaining all the facts about bodily changes. We can thus furnish them with literature; talk to them and encourage them to talk to us. Talking is very important here because then we can explain to them about protecting themselves from HIV/AIDS, unwanted pregnancies and STIs.

Some argued that parents should be there for their children and not be absentee parents who visit irregularly, or even if present in the house have little contact with their children. It was also suggested that parents should learn to be good listeners. In both rural and urban adults, the responsibility of parents influencing the behaviours of their children and wards have proceeded along gender lines: Fathers are expected to be there for their sons and mothers should be able to teach their daughters good morals and all that they need to know as females.

This approach puts the onus of addressing sexual and reproductive health on parents and other responsible adults in the family. This was the practice in the traditional system and it is still practiced in some rural communities. However, the challenge is how these suggestions can work in view of the multiple sources of information and the reported inability of some parents to communicate with their children on sexual and reproductive health issues.

•*Moral education.* One broad area mentioned by parents, religious leaders and community leaders is providing moral education to the youth. They stressed the need to “advise young people to take good care of themselves and to lead decent lives.” Their view is that moral education is important in all aspects of life and not only in sexual and reproductive health, and that bringing up moral and upright young people will help

to also inculcate in them good sexual habits.

I: What do you think should be done to help young people protect their sexual and reproductive health?

R: They should be given good moral training. All parents should make it a responsibility and a duty to give good moral training to the children under their care.

—Rural male community leader, 74 years

[Adolescents] should be given moral education. Parents should have time to train their children to pick up good morals. If the young people are not given good moral training, all other things we will be doing to help them protect their sexual and reproductive health will fail. This is because the young people will always practice sexual promiscuity and it is this sort of sexual behaviour that endangers their sexual and reproductive health.

—Rural male health care provider, 35 years

Counsel them always on morality, using the teachings from the Koran and the Bible. Tell them to abstain or use condoms if they cannot abstain.

—Rural mother, 45 years

Although not directly indicated, the call for morality tended to gravitate towards traditional morality such as respect for old age and sex within marriage. There were those who argued for the reintroduction of puberty rites as a means for teaching traditional mores on sexual and reproductive health. While the traditional approaches served the needs of earlier generations, the call for such moral education now should also involve confronting some aspects of traditional practices, such as discrimination against females, double standards associated with male and female sexuality and all other forms of gender inequalities which put females at a disadvantage. Some of the sexual and reproductive health problems the adults identified, such as sexual violence and rape, emanate from gender relations in the communities which tend to ignore the human as well as reproductive health rights of females. Thus, moral education should stress equality and equity in gender relations and respect for sexual and reproductive health rights, especially for females.

•*Other strategies.* Some of the adults suggested that in order to meet the sexual and reproductive health of adolescents certain services should be provided for

young people, either through the general health service system or in facilities dedicated to serving young people. Among the services suggested are the provision of health centres with a range of health personnel (doctors, nurses and psychologists), the provision of condoms, and the provision of advice on abstinence that specifically target young people. Some of the faith-based health providers also proposed solutions such as spiritual intervention and prayers. They considered the problem of sexual and reproductive health as being beyond the individual. To them, reproductive health problems such as HIV/AIDS are due to moral decadence. Some of them proposed providing Koranic and Biblical teachings along with condoms to youth who cannot abstain from sex.

I: What do you think should be done to help young people protect their sexual and reproductive health?

R: The only solution is advice and prayers. Now we are aware that evil spirits have brought disobedience into the world. If we do not teach the children and advise them very well, they will deviate. Formal education is good; the informal one learnt in the house is very essential.

—Urban female faith healer, 64 years

I: What do you think should be done to help young people protect their sexual and reproductive health?

R: The only thing that can help these people is when they are led to the cross. Being led to the cross is taking Jesus Christ as your personal savior. Any person in this world who has accepted Jesus Christ as his/her personal savior is given the spirit of God to lead the right type of life.

—Urban male faith healer, 55 years

Given the role of religion in the life of both adults and young people in the country, strategies to address sexual and reproductive health should consider the influence of these institutions and how their potential can be harnessed to achieve desired results. Both Planned Parenthood Association of Ghana and the African Youth Alliance have implemented programmes with religious institutions on adolescent sexual and reproductive health, which can guide the development of future programmes.

As in the quantitative survey and the in-depth interview with young people,⁴³ poverty and the need for money were identified as some of the factors driving

some adolescents, especially females, into having sex in exchange for money or other things. In response, some adults suggested that parents should be encouraged to meet the basic needs of their adolescent children. In addition, they should show love and affection for them.

The strategies proposed reflect some of the general programmes on sexual and reproductive health for adolescents in the country. These insights and concerns should inform the programmes currently being implemented, as well as some of the programmes that will be developed for adolescent sexual and reproductive health.

Collective Responsibility

In general, key adult respondents indicated that meeting the sexual and reproductive health needs of adolescents should be a collective responsibility for all—parents, teachers, health care providers, community and religious leaders, nongovernmental organizations, district assembly members and the central government. Some respondents identified constituencies and charged them with specific responsibilities for addressing aspects of sexual and reproductive health problems. For instance, a number of the health care providers and religious leaders identified parents as the starting point. To them, the school system, the community and other agencies can only build on what children have obtained from their parents at home. Parents should therefore be the first line of action in addressing adolescent sexual and reproductive health needs by creating a congenial atmosphere at home and by providing the moral education that young people need in life.

Parents identified health care workers and community and religious leaders as people who should lead in addressing adolescent sexual and reproductive health information and service needs. Health personnel were identified for their knowledge and training while religious leaders were identified for the respect they command in communities. Community leaders were described as the eyes of the society and so should be able to identify and resolve community problems including the needs of adolescents.

Others identified teachers because they teach family life/sex education. Although the teachers felt that the curriculum was adequate for addressing the needs of young people, some of them indicated that they did not have the resources that enable them teach adequately. Thus, there appears to be a gap between the expectation of society for some of the providers, and what they have to work with.

The government was seen as a major player in the provision of services because it has a wide range of re-

sources and operates throughout the country. Therefore, the government was expected to take the lead in providing the resources needed for addressing the needs of young people, including their sexual and reproductive health.

The range of programmes identified, the approaches to be adopted and those who should take responsibility for the actions are indicated in Table 6.1.

Proposed Strategies for 12-14-Year-Olds

Respondents were asked to indicate whether there should be different programmes for young adolescents (aged 12–14 years). There were those who felt that young adolescents were not old enough to learn about sex. Some of them argued that the young adolescents who had not experienced puberty will not be able to appreciate some of the issues addressed in sexual and reproductive health education. Others argued that both the younger and the older adolescents were going through the same experiences and therefore should be introduced to sexual and reproductive health but different strategies appropriate for their should be developed.

The dominant view, though, was that young adolescents should be given sexual and reproductive health education appropriate to their age, such as education on puberty before they experience it and, for the females, issues of menstruation and personal hygiene. For instance, the teaching of family life education in schools should be intensified in such a way that all young people in school will receive adequate information on sexual and reproductive health up to the junior high school level.

Most of the key adults indicated that the 12–14-year-olds were more vulnerable than the older adolescents. Therefore, for the younger adolescents, sexual and reproductive education should be part of the overall formal education, training, moral education and counselling. In addition, some key adults and parents should be sensitized and or trained to monitor the very young adolescents in the community such that some people do not take advantage of them.

I: Should things be done differently when helping younger and older adolescents?

R: Yes. I think the younger ones should be counselled to abstain rather than being taught to protect themselves

—Urban male teacher, 30 years

The younger ones should be trained and protected before they become older adolescents. In that way they will become more responsible.

—Urban female community leader, 59 years

Some argued for different programmes for young males and females, since they face different sexual and reproductive health challenges, even from an early age. According to some community leaders and health care workers, females face problems such as sexual coercion, rape, STIs and abortion, which, in their view, males do not experience.

Conclusion

Adults acknowledged that adolescent sexual and reproductive health behaviours are complex and that meeting the needs associated with them requires a multiprong approach that should involve parents, teachers, health care providers, NGOs, community and religious leaders, and the government. Strategies suggested to address adolescent sexual and reproductive health problems included the use of the mass media, monitoring, moral education, formal education, the teaching of family life education and the provision of recreational facilities. These insights from adults provide an opportunity to mobilize them in support of programmes that address the sexual and reproductive health needs and rights of adolescents. A range of programmes for adolescent sexual and reproductive health have been implemented in the country over the last decade. The next step will be a comprehensive review of all adolescent reproductive health programmes that have been implemented and for national consensus to be reached on good practices and those that have potential, so that they can be packaged for large-scale implementation.

The recognition that younger adolescents are more vulnerable than older ones and should be given reproductive health education also provides a window of hope for teaching family life education from the junior high school level (adolescents aged 12 and older).

While recognizing that females experience more challenges than males during early adolescence and therefore need to be given special attention, it is also important to target young males in order to help them understand the challenges females face and also for them to recognize and accept the sexual and reproductive health rights of females. By providing sexual and reproductive health education early, adolescents will be able to appreciate the different sexual and reproductive health trajectories for males and females at this and subsequent stages in life.

Table 6.1: Programmes, approaches and responsibilities for addressing the sexual and reproductive health needs of adolescents

Programme	Approach	Responsibility
Mass media	Public cinema, radio broadcast, TV, providing literature	Government (district and national), NGOs
Teaching of family life education	School system	Teachers and the Ghana Education Service, religious groups
Recreational facilities	Youth centres, formation of clubs	NGOs, religious groups, district assemblies and central government (Ministries of Youth and Sports)
Counselling/advising	Individual counselling	Religious groups, NGOs, parents, health care workers, community leaders
Moral education	Discussions in the family and in churches/mosques	Religious groups, NGOs, parents, community leaders
Provision of services	Health centres for youth	Government and NGOs
Spiritual intervention	Prayers	Religious leaders

Chapter 7

Conclusion

This report, as part of the Protecting the Next Generation project, presents findings from the perspective of adults that have implications for meeting the sexual and reproductive health needs of adolescents in Ghana. The results, which present new information from adults, address one of the gaps in knowledge about adolescent sexual and reproductive health, which is the view of adults. This information also complements information from adolescents and points to specific areas of intervention that can improve adolescent sexual and reproductive health programmes.

Adults are key actors who shape the environment within which children grow and develop, and they have a collective responsibility to address the needs of young people.⁴⁴ As parents, community leaders, teachers and health care providers, adults design and implement programmes and activities for young people. Therefore, their attitudes and perceptions influence the type and nature of information and services that are offered to adolescents. Understanding their attitudes, perceptions and concerns should provide insights that can inform the development of sexual and reproductive health programmes for young people.

This chapter summarizes key findings and provides recommendations on how to harness the actual and potential roles of various adults to address adolescent sexual and reproductive health needs in the country.

Key Findings

Key findings from the in-depth interviews with adults complement those of adolescents in the following areas:

Complementing issues raised by young people

- Adolescent pregnancy emerged as a major sexual and reproductive health problem. In particular, the adults considered pregnancy among girls who were in school to be a major problem because it disrupted the education and threatened the future of the girls.

- Health care providers identified abortion among young females as one of the major health problems that they encounter. Some of the reported abortion cases were associated with incest or rape. However, respondents were unable to gauge the magnitude of abortion, as it was rarely reported.

- Rape, defilement and incest are hidden problems that are rarely discussed. The few cases that emerged were reported by health care workers and teachers, who became aware because they were the people trusted by the victims. None of the victims had informed a family member of their ordeal.

- HIV/AIDS was not considered to be a major problem in all the areas. There appeared to be a syndrome of denial of HIV/AIDS in some communities. The few who mentioned HIV/AIDS considered it within the context of the stigma and shame that an infection brought to the family of the infected individual. These results are consistent with those obtained from the studies on adolescents.

- Parents acknowledged that they were unable to discuss sexual and reproductive health issues with their adolescent children. Fathers tended to defer any discussion on sexual and reproductive health to mothers or friends. Mothers reported discussing issues with their adolescent children, especially daughters. The results confirm the existence of the communication gap reported in the adolescent study between parents and their children on sexual and reproductive health issues

- Modern health care providers exhibited a variety of attitudes in their dealings with young people, ranging from sympathetic and supportive to less supportive to judgmental. Health care workers whose attitudes fell into the last two categories may be partly responsible for some of the barriers to obtaining sexual and reproductive health care services that adolescents reported.

New issues that emerged

- Among respondents from rural areas, marital status, and not age, was the defining factor in the wantedness of an adolescent pregnancy. Marital pregnancy, irrespective of the age of the mother, was categorically defined as wanted.
- The major adolescent sexual and reproductive health problems that adults identified revolved around pregnancy: pregnancy among schoolgirls, rape, defilement and males who refused to accept responsibility for impregnating girls. There were distinct rural-urban patterns: In the rural areas, the main problems were cases of pregnancy with girls in school and denial of paternity by the males responsible for the pregnancy, while in urban areas, the major problems were rape, defilement and incest.
- Reported rape, defilement and incest cases had not been resolved because the victims were not prepared to disclose the identity of the perpetrators. Where identity of the perpetrator was known in defilement and incest cases, family member tried to protect the perpetrator.
- In rural areas, community leaders continue to play major roles in resolving social problems. As respected members of their communities, they serve as mediators on a wide range of issues, including sexual and reproductive health.
- To discourage premarital pregnancy, some rural communities had instituted measures such as the banning of public ceremonies for adolescents who give birth outside of marriage.
- The various categories of adults blamed one another and young people for the existing adolescent sexual and reproductive health problems in their areas. Teachers and health care professionals blamed parents and communities for not disciplining their children and also preventing them from teaching adolescents about sexual and reproductive health. Parents and community leaders accused teachers and health care workers for distributing contraceptives and teaching about sex, which they believe to have led to sexual permissiveness among young people. Health care workers, some teachers and community leaders attributed their inability to discuss sexual and reproductive health issues with young people to the behaviour of the youth, accusing them of “being rebellious.”
- Adults acknowledged the complexity of adolescent sexual and reproductive health behaviours and needs. They therefore proposed a multipronged approach involving all adults in their capacities as par-

ents, teachers, health care providers, community and religious leaders, and members of NGOs and government agencies.

Areas for Further Activities and Research

The results from the adult survey have profound implications for policy, planning and further research. Among them are:

- *Programme-related issues.* Adolescent sexual and reproductive health programmes and activities should be designed around pregnancy, which emerged as the major problem. The issue of pregnancy, especially as it relates to schooling, may serve as a powerful tool for mobilizing adults to address a range of sexual and reproductive health issues within the various communities.

Addressing adolescent sexual and reproductive health was considered to be a shared responsibility (Chapter 6). Therefore, adults should be mobilized to play their respective roles and responsibilities in the provision of information and services to young people. This is because community leaders are still important as agents for solving adolescent sexual and reproductive health problems and providing leadership for activities. This potential should be tapped to develop community-based programmes. Some communities have initiated programmes to deal with premarital teenage pregnancy. Such community-initiated activities should be encouraged to provide area-specific approaches to dealing with adolescent sexual and reproductive health. They should, however, also be studied for their effectiveness and their implications for the rights of young people.

The Ghana Health Service, recognizing the important role of health workers in promoting youth-friendly adolescent sexual and reproductive health, has embarked on a programme to sensitize their personnel. In spite of the exercise, some health care workers continue to exhibit negative attitudes towards young people seeking sexual and reproductive health care. Therefore, programmes should be ongoing to ensure that the much-needed youth-friendly sexual and reproductive health services are available at all health facilities.

- *Attitudes toward teenage pregnancy.* In some of the rural communities, adults defined the wantedness of adolescent pregnancy and childbearing within the context of marriage. Pregnancy among young adolescents, despite its negative health implications, was not considered to be a problem if the young woman was married. This presents a major challenge to any programme

or policy aimed at promoting later age at marriage and childbearing among young people in such communities. Therefore, to mitigate challenges, policies or programmes should be presented in the context of the health, social and economic consequences of early marriage, pregnancy and childbearing.

- *Gender and age dimensions.* Gender underlies most of the problems that were reported in both rural and urban areas. As victims of rape, defilement and early pregnancy, young women were the predominant subjects in the reports of teachers, health care providers and community leaders. This gendered dimension of adolescent sexual and reproductive health has emerged in a number of studies.⁴⁵ To protect the rights of individuals, especially of females, within the family, the government has passed the Domestic Violence Law (Act 732 of 2007) which covers rape, defilement and sexual harassment. This law should be widely publicized in the country by the media, teachers, health care providers and religious leaders. Also, structures should be put in place to implement various components of the law, especially the clauses dealing with strategies to assist rape and defilement victims.

There is need for more studies of sexual coercion of young females and the associated problems in various social and cultural settings in order to better understand their magnitude and their implications for the victims as well as how to eliminate it. This appears to be a hidden sexual and reproductive health problem.⁴⁶

School-based family life education curriculum provides an avenue for the teaching of reproductive health to adolescents, even before they experience puberty. While the contents cover a wide range of topics, it has become apparent that some issues, such as respect for individual as well as sexual and reproductive health rights, need to be included. This may help to reduce defilement and rape cases. Furthermore, teachers teaching the subject should be supported and provided with the appropriate materials and resources to enable them teach family life education properly.

Younger adolescents (aged 12–14 years) need information suitable to their age, especially information about puberty before they experience the event. Also, due to their vulnerability, younger adolescents need to be given more attention and monitored in homes and in the community.

- *Abortion.* Although respondents in rural and urban areas alluded to abortion as a problem, there appears to be minimal information on its scope. There is the need

for comprehensive and innovative studies on the problem throughout the country. The drop in total fertility from 6.4 children in 1988 to 4.4 in 2003 cannot be fully explained by relying on three of the four proximal determinants of fertility—levels and trends in marriage, infecundability and contraceptive use.⁴⁷ But the fourth determinant—abortion—cannot be adequately accounted for. Thus, understanding the magnitude of abortion may help to explain this dramatic decline in births within the 15-year period and also provide information on the level of unsafe abortion taking place among young people, who are considered to account for about a quarter of unsafe abortions in the country.

- *Gaps in communication and programmes.* Both young people and adults reported gaps in communication on sexual and reproductive health: Young people indicated that their parents did not talk to them, and parents acknowledged that they were unable to discuss sexual and reproductive health issues with their adolescent children. Youth-serving organizations, religious leaders and community leaders should take up the responsibility to develop area-specific programmes to address this gap.

There are also gaps between good intentions and actual results in addressing adolescent sexual and reproductive health needs. While adults recognize the need to provide adolescent sexual and reproductive health information, some of them are unable to do so for various reasons, including cultural inhibitions and attitudes. Therefore, programmes should target adults to sensitize them to youth concerns and enable them to engage in constructive discussion with young people and/or provide youth-friendly services.

The major problem identified by adults was adolescent pregnancy. Yet, the main focus of adolescent reproductive health interventions in the country is HIV/AIDS. While HIV/AIDS is certainly worthy of much attention, this mismatch between concerns and programmes should be resolved. This can be done through an integrated sexual and reproductive health programme that includes pregnancy and HIV/AIDS related services. To be in line with the existing perceptions, pregnancy should be used as the conduit for addressing a wide range of sexual and reproductive health issues.

- *Shared responsibilities.* Meeting the sexual and reproductive needs of young people is a shared responsibility. Therefore, there should be consensus building among all stakeholders. As indicated in Chapter 6, the roles and responsibilities of various entities should be

identified and their efforts nurtured as part of the process of meeting the needs of young people. A supportive atmosphere at home, in the community, in the school system and in the country will help provide holistic family life education to young people.

- *Rape, defilement and incest.* Rape, defilement and incest, especially among young people aged 12–14, constitute one of the hidden adolescent sexual and reproductive health problems. Because these crimes are rarely reported, their magnitude is not known. Therefore, this should be flagged for further studies and also given priority in the implementation of the Domestic Violence Law.

- *Need for more and long-term data on young people.* Although it has provided valuable information, the Protecting the Next Generation project is only a snapshot of the situation of young people in Ghana. This is a group in transition and, therefore, a prospective study is needed to unravel the various stages of their transition—education, work, family formation, citizenship and healthy living. This will help to collect and collate adequate and reliable data to inform policies and programmes on young people. Ghana, like the other three African countries involved in the study will need to invest in data collection on young people.

Conclusion

Targeting adults who create the environment for, design, implement and assess sexual and reproductive health programmes for young people is important for three reasons. First, adults have to be brought on board, alongside young people, to design and implement adolescent sexual and reproductive health programmes. Secondly, as gatekeepers, adults need to be sensitized to understand and create the necessary environment and support for adolescent reproductive health programmes. Thirdly, they themselves need to be educated in order to become effective partners in the delivery of adolescent sexual and reproductive health policies and programmes.

Ghana has many of the elements necessary for addressing the sexual and reproductive health needs of young people. There are laws, regulatory mechanisms and agencies currently working on improving adolescent sexual and reproductive health. Adults constitute an important element in this equation and understanding their perceptions and attitudes will contribute immensely to the development of programmes that meet the needs and aspirations of young people.

References

1. United Nations (UN), *World Population Prospects: The 2002 Revision, Vol. II*, New York: UN, 2003.
2. Ghana Statistical Service (GSS), *2000 Population and Housing Census of Ghana*, Accra, Ghana: GSS, 2002.
3. Ibid.
4. Ghana Health Service, Facts and Figures, Accra: Ghana Health Service, 2005; GSS, 2002, op. cit. (see reference 2): and Ghana Statistical Service. *Poverty trends in Ghana in the 1990s*. Accra, Ghana: Ghana Statistical Service, 2000.
5. GSS, Noguchi Memorial Institute for Medical Research (NMIMR) and ORC Macro, *Ghana Demographic and Health Survey 2003, ORC Macro*, Calverton, MD, USA, 2004.
6. Ibid.
7. Ibid.
8. Ghana AIDS Commission, *2005 Annual Report*, Accra: Ghana AIDS Commission, 2006.
9. Ghana Health Service and National AIDS/STI Control Programme, *Report on AIDS Situation in Ghana, 2005*, Accra: Ghana Health Service and National AIDS/STI Control Programme, 2006.
10. Ibid.; and GSS, NMIMR and ORC Macro, 2004, op. cit. (see reference 5).
11. Ghana Health Service and National AIDS/STI Control Programme, 2006, op. cit. (see reference 9).
12. World Bank, *World Development Report 2007: Development and the Next Generation*, Washington, DC: World Bank, 2007.
13. The first three phases of the project have been published as Guttmacher Occasional Reports Nos. 13, 22 and 30.
14. Awusabo-Asare K, Interpretations of demographic concepts: the case of Ghana, *Population and Development Review*, 1988, 14(4):675–687.
15. For a full description of the selected districts, see Kumi-Kyereme A, Awusabo-Asare K and Biddlecom A, Adolescents' sexual and reproductive health: qualitative evidence from Ghana, *Occasional Report*, New York: Guttmacher Institute, 2007, No. 30.
16. The Assembly and Unit Committees are the lowest administrative structures in the country. The Unit Committees represent people in a neighborhood and a set of unit committees elect a member to represent them at the Metropolitan/Municipal/District Assembly.
17. Thumbprinting is the method adopted in Ghana for endorsing documents due to low adult literacy rates; it is also used for voting.
18. Bronfenbrenner U, *The Ecology of Human Development*, Cambridge, MA: Harvard University Press, 1979.
19. The official policy is that such girls should be admitted back into their old school or assisted to enter another school. But invariably, most of such girls do not return to school due to a number of factors, including their new status as mothers, and the shame associated with premarital pregnancy.
20. This means that they look like poor, shabbily dressed housemaids who are helping to take care of their employer's baby.
21. Bleek W, Avoiding shame: the ethical context of abortion in Ghana, *Anthropological Quarterly*, 1981, 54(4):203–209.
22. Ghana AIDS Commission, *National HIV/AIDS Strategic Framework II: 2006–2010*, Accra: Ghana AIDS Commission, 2005.
23. Akwara PA et al., *An In-Depth Analysis of HIV Prevalence in Ghana: Further Analysis of Demographic and Health Surveys Data*, Calverton, MD, USA: ORC Macro, 2005.
24. Awusabo-Asare K, Anarfi JK and Agyeman DK, Women's control over their sexuality and the spread of STDs and HIV/AIDS in Ghana, *Health Transition Review*, 1993, 3(Suppl.):69–84.
25. Awumbila M and Ardayfio-Schandorf E, The gendered face of poverty: female porters in Accra, Ghana, in Awusabo-Asare K, Agyei-Mensah S and Jorgensen SH, eds., *The Changing Face of Poverty in Ghana*, Proceedings of NTNU Workshop, University Cape Coast, Cape Coast, Ghana, 2005; and Tanle A, Rural-urban migration of females from the Wa district to Kumasi and Accra: a case study of the kaya yei phenomenon, unpublished M. Phil. thesis, University of Cape Coast, 2003.
26. Awusabo-Asare K et al., Adolescent sexual and reproductive health in Ghana: results from the 2004 National Survey of Adolescents, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 22.
27. Even now that premarital pregnancy no longer attracts punitive measures, among the Akan, a man who is involved in a premarital pregnancy is made to pay a fine to the parents of the woman involved. The fine is referred to as domfre, which literally means "fine for taking what does not belong to you".
28. Sarpong PK, *Girls' Nubility Ashanti Rites*, Tema: Ghana

Publishing Corporation, 1977.

29. Awusabo-Asare K et al., Adolescent sexual and reproductive health in Ghana: a synthesis of research evidence, *Occasional Report*, New York: The Alan Guttmacher Institute, 2004, No. 13.
30. Bleek W, 1981, op. cit. (see reference 21).
31. Abortion is only legal if the pregnancy threatens the physical or mental health of the mother or the unborn child, or if it is the result of rape of a minor or a person with mental disability (Act 29).
32. Ghana AIDS Commission, 2005, op. cit. (see reference 23).
33. There have been newspaper reports on conflicts between teachers and parents. See, for example, Aklorbortu MK, Teacher humiliated before pupils, *The Mirror*, July 21, 2007, p. 31.
34. See, for instance, UN Population Fund (UNFPA), *Investing in People: National Progress in Implementing the ICPD Programme of Action, 1994–2004*, New York: UNFPA, 2004.
35. Awusabo-Asare K et al., 2006, op. cit. (see reference 27).
36. Kumi-Kyereme A, Awusabo-Asare K, Biddlecom A and Tanle A, Influence of social connectedness, communication and monitoring on adolescent sexual activity in Ghana, *African Journal of Reproductive Health* 2007, 11(3):133-147
37. Awusabo-Asare K et al., 2006, op. cit. (see reference 27).
38. Ghana News Agency, Northern Region is short of doctors, Feb. 13, 2007, <<http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=119092>>, accessed May 16, 2008.
39. Katz K and Naré C, Reproductive health knowledge and use of services among young adults in Dakar, Senegal, *Journal of Biosocial Science*, 2002, 34(2):215–231.
40. Erulkar AS, Onoka CJ and Phiri A, What is youth-friendly? adolescents' preferences for reproductive health services in Kenya and Zimbabwe, *African Journal of Reproductive Health*, 2005, 9(3):51–58.
41. Awusabo-Asare K et al., 2006, op. cit. (see reference 27).
42. Speizer IS, Magnani RJ and Colvin CE, The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence, *Journal of Adolescent Health*, 2003, 33(5):324–348.
43. Awusabo-Asare K et al., 2006, op. cit. (see reference 27).
44. Bronfenbrenner U, 1979, op. cit. (see reference 18).
45. Kumi-Kyereme A, Awusabo-Asare K and Biddlecom A, Adolescents' sexual and reproductive health: qualitative evidence from Ghana, *Occasional Report*, New York: Guttmacher Institute, 2007, No. 30.
46. Jeejeebhoy SJ and Bott S, *Non-consensual Sexual Experiences of Young People: A Review of Evidence from Developing Countries*, New Delhi: Population Council, 2003.
47. Blanc AK and Grey S, Greater than expected fertility decline in Ghana: untangling a puzzle, *Journal of Biosocial Science*, 2002, 34(4):475–495.

Appendix I

In-depth Interview Study Design

Distribution of Respondents	Expected	Interviewed
<i>Health care providers (HCP): 20 interviews</i>		
Rural (females)		3
Rural (males)		7
Urban (females)		6
Urban (males)		4
<i>Teachers: 16 interviews</i>		
Rural (females)		0
Rural (males)		8
Urban (females)		3
Urban (males)		5
<i>Parents/Adult community leaders: 24 interviews</i>		
Rural (females)		6
Rural (males)		6
Urban (females)		5
Urban (males)		7

Field team

Name	Sex	Age	Education	Languages Spoken
<i>Southern Sector</i>				
Akua K. Damphey	F	22	Graduate Student	Akan, Ga, English
Kobina Essiah-Donkor	M	26	Graduate Student	Akan, Ga, English
<i>Northern Sector</i>				
Haruna Alidu	M	25	Undergraduate	Mamprulli, Dagbani, Akan, English.Hausa
Samata Gifty Bukari	F	26	Undergraduate	Mamprulli, Dagbani, Akan, English.Hausa
<i>Supervisors</i>				
Augustine Tanle	M	38	Graduate	Akan, Dagare, English
A. Kumi-Kyereme	M	36	Graduate	Akan, English

Appendix II

In-depth Interview Study Design

A. Background Characteristics

1. Are you married?

- How old are you?
- How long have you lived in this community?
- What kind of work do you do to make a living?
- What level of education have you completed?
- Just to confirm: what are the ages of your children?
 - Do they live with you?
- What do you talk about with your children/the children you advise?
- What kind of personal things do you talk about?
- Apart from your children/the children you advise, in what other ways do you interact with adolescents?

This study is primarily interested in your experiences with and opinions about the sexual and reproductive health of adolescents in your community. When I say adolescent sexual and reproductive health, what I mean is sexual relationships among adolescents whether they are married or not. I'm also talking about the consequences of sexual behavior among adolescents and whether they're using protection to prevent pregnancy, sexually transmitted infections and HIV when they have sex.

B. Community Perceptions

2. What do you think are the major sexual and reproductive health issues for adolescents in your community? If not mentioned, ask: HIV/AIDS? Unintended pregnancy? Probe fully.

- What are some of the reasons why you see these as important issues?
- How do these issues differ for girls compared to boys?

- How do these issues differ for younger girls and boys (less than 15 years old) compared to older adolescents?
- How do these issues differ for young women and men who are married compared to those who are still not married?

C. Personal Experiences

3. What are some of the sexual and reproductive health issues that you have discussed with your children/adolescents of the community? If not mentioned, ask: HIV/AIDS? Unintended pregnancy? Probe fully.

- In what ways does what you talk about differ for girls compared to boys?
- In what ways does what you talk about differ for younger girls and boys (less than 15 years old) compared to older adolescents?
- In what ways does what you talk about differ for young people who are married compared to those who are not married?
- Which, if any, of these conversations have adolescents initiated with you?

4 As a [PARENT/GUARDIAN/COMMUNITY LEADER], what is the most difficult adolescent sexual and reproductive health issue you have encountered?

- Did you face any barriers in dealing with the situation in the way that you wanted to?
- What is the source of these difficulties?
 - How did you or have you been able to cope with them?
 - How have others been able to cope with these difficulties?
 - Is there another difficult adolescent sexual or reproductive issue that you have encountered? What was that issue? Continue with probes above.

