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AT THE
UNIVERSITY OF GHANA, LEGON

FEMALE ADOLESCENT SEXUALITY, CONTRACEPTIVE
USE AND REPRODUCTIVE HEALTH IN THE CENTRAL
REGION OF GHANA: A CASE STUDY OF CAPE COAST AND
MANKRONG

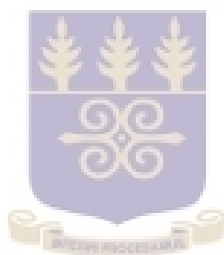


STEPHEN OWUSU KWANKYE

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ACCEPTANCE

Accepted by the Faculty of Social Studies, University of Ghana, Legon, in fulfilment of the requirement for Degree in Ph.D (Population Studies).

Supervisors of Thesis:



E.O. Tawiah

Dr. E.O. Tawiah

22-04-2004

Date

J.K. Anarfi

Prof. J.K. Anarfi

22/4/04

Date

John S. Nabila

Naa Prof. John S. Nabila

22/4/04

Date

DECLARATION

I hereby declare that, except for references to other people's work which have been duly acknowledged, this work is the result of my own research and that it has neither in part nor in whole been presented elsewhere for another degree.



.....
Stephen Owusu Kwankye

21st APRIL 2004

.....
Date



DEDICATION

I dedicate this thesis to my very understanding children, Kwame, Akos, Nana and Mercy.



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A number of individuals and institutions have contributed a great deal to ensure the completion of this thesis. In fact, it has first and foremost been the abundant grace of God that has seen me this far. Doing a Ph.D on part-time in Ghana while a full-time lecturer is not easy and but for God's provision of good health, I might not have completed the thesis. To God be all the glory, honour and thanksgiving.

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I must, however, emphasize that I am solely responsible for any errors and criticisms that may arise as a result of this study.



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S.O. Kwankye

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ABSTRACT

The study on Adolescent Sexuality, Contraceptive Use and Reproductive Health was undertaken as part of the ongoing effort at understanding some of the problems that confront adolescents in Ghana. With a general objective of examining the magnitude of reproductive health-related problems pertaining to adolescent sexuality and contraceptive use, the study used a sample of 1,828 female adolescents aged 12-24 years (1,503 from Cape Coast and 325 from Mankrong) in the Central Region of Ghana as a case study. This was with the primary purpose of comparing the situation in an urban vis-à-vis a rural area. The two study areas are far apart: Cape Coast at the coast while Mankrong is located in the interior of the Central Region.

It uses simple techniques including cross-tabulations as well as multiple regression analysis to examine quantitative and qualitative data collected from structured questionnaire and focus group discussions held separately among male and female adolescents and adults in Cape Coast and Mankrong.

Among other things, the study found that the proportion of adolescents ever having sex increased with higher age of the adolescent with higher proportion having sex in Mankrong compared to Cape Coast. The mean age at first sex was, however, almost the same at 16.9 years in Cape Coast and 17 years in Mankrong. Mean age at first sex also increased with higher age of adolescents, implying plausibly of a declining age at first sex at the two study areas.

Furthermore, there were suggestions to indicate that females become sexually active earlier than their male counterparts on account of the fact that at first sex most females were much younger than their male partners at the time. However, it was deduced that due to the fact that first sex usually may occur with persons who may be sexually more

experienced and older, it may not always be easy to determine whether or not it is the female who enters into sex earlier if one depended on responses exclusively from the male or female.

Generally, the adolescents did not approve of pre-marital sex but gave the indication of the possibility to indulge in it for financial reasons. What people approve of may thus, be different from what they may practise depending on the issues at stake. Peer pressure and lack of knowledge were the main reasons that provided grounds for a large proportion of the adolescents entering into sex for the first time.

Again, although most of the adolescents did not approve of abortion, the report on abortion among them showed a possibility of an underestimation, suggesting a situation of a much higher abortion rate among the sexually active adolescents than was reported. Abortion rates were found to be higher in Cape Coast relative to Mankrong.

Also important was the finding that adolescents who used contraception at first sex had a higher age at pregnancy. Similarly, adolescents who practised contraception had a relatively lower number of children ever born in contrast with those who did not practise contraception at first sex. There was also a lower number of children ever born with higher education of the woman.

Results from the multiple regression analysis confirmed most of the observations made in the cross-tabulations. These included a declining age at first sex at 100 per cent level of confidence. Besides, financial considerations were found to contribute more to the reduction of an adolescent's age at first sexual activity.

The study confirmed at 95 per cent level of confidence, four of the five hypotheses, namely, that:

- i) There is an inverse relationship between age at first sexual intercourse and childbearing among adolescents;

- ii) There is an inverse relationship between adolescent childbearing and contraceptive use at first sex;
- iii) There is an inverse relationship between education and childbearing among adolescent females; and
- iv) There is a direct relationship between contraceptive use at first sex and age at first sexual activity among adolescent females.

However, the hypothesis that contraceptive use is directly related to the level of education of the adolescent could not be analysed due to the very small sample of adolescents who were reported to be contracepting at the time of the survey. It is therefore, recommended that future research should consider a much larger sample of adolescents to facilitate such an analysis. In addition, future research should probe into the educational level of adolescents as at the time of their first sexual act for incorporation into the analysis. Similarly, future research should consider collecting information on the educational aspirations of adolescents as a proxy in analysing the timing of first sex among adolescents.

The study further recommends intensive and sustained public education against criminal abortion, highlighting the short and long-term health implications to the adolescents while underscoring the fact that abortion is not a family planning method. It also calls for a review of the educational policy in Ghana with a possibility of making Family Life Education (FLE) a completely separate subject from Social Studies and be taught at earlier stages of the primary school education possibly at Primary Class Four. Besides, to ensure that teachers who are well trained in FLE teach pupils, FLE should be a compulsory component of the curricula of teacher training colleges in the country.

A call is also made for the establishment of District Youth Centres throughout the country to offer education and counselling on all issues pertaining to the adolescents, especially their sexual and reproductive health.

The study concludes by calling on government and civil society to put adolescent sexuality and reproductive health as a national development priority and to show the maximum commitment in addressing the various dimensions of the problem principally as critical components of the efforts at addressing the HIV/AIDS epidemic in Ghana. This is borne out of the realisation that the adolescents offer a window of opportunity and hope in the fight against HIV/AIDS among the entire population of Ghana.

INTRODUCTION

1.1 Background to the Study

Adolescent sexuality and reproduction are issues that are attracting worldwide recognition as social problems of development. In many sub-Saharan African countries, teenage/adolescent pregnancy has been relatively high although declines in overall fertility are being recorded in most developing countries. For example, between 1988 and 1993, overall fertility in Ghana is reported to have declined by almost one child per woman from 6.4 to 5.5 according to the 1993 Ghana Demographic and Health Survey (Ghana Statistical Service, 1994) and a further decline to 4.6 in 1998 as per the 1998 Ghana Demographic and Health Survey (GDHS). In most developing countries, it appears that reduction in fertility among younger women would be achieved mainly through the postponement of marriage. With age at marriage in Ghana steadily rising, the risk of out-of-wedlock pregnancy among individual adolescent women is likely to increase as pre-marital sex continues with little or no contraceptive use.

Rapid urbanization in Ghana has been the result of natural population increase as well as inter- and intra-regional movements, which in recent times, appear to be dominated by adolescents and the youth in search of jobs particularly in the cities and large towns. Separation of adolescents from their parents obviously is likely to result in the steady breakdown of traditional and parental controls on the lifestyles of the adolescent migrants. Because of difficulty in getting jobs in their places of destination, many female adolescents may be tempted to take to commercial sex as a matter of survival and, in the process may begin childbearing earlier than anticipated.

In many parts of Ghana, especially in the cities, defilement of female adolescents is increasing and has attracted much concern. Apart from its criminal nature, adolescent female

defilement or rape carries with it long term reproductive, psychological and health implications for the female adolescent victim of sexual abuse.

The issues of adolescent sexual activity and reproduction are likely to become increasingly more important in Africa in the near future due to urbanization and the dramatic growth in secondary schooling (Cherlin and Riley, 1986). This observation is equally valid for Ghana and a source of worry particularly because contraceptive use among adolescents in Ghana is not acceptable by some sections of the adult population.

A situation of this nature requires that a research is carried out to find out what really exists on the ground. To achieve this purpose, the Central Region is chosen as the study area with a focus on Cape Coast, the regional capital located at the coast and Mankrong, a rural settlement in the interior of the region.

It is hoped that results from the study covering the two settlements will provide plausible bases for making conclusions to guide adolescent policy programmes aimed at reducing the magnitude of adolescent reproductive health problems in the Central Region in particular and Ghana as a whole.

1.2 Statement of the Problem

Rapid population growth has been one of the thorny problems most African countries have had to contend with in their socio-economic development efforts. Ghana is no exception and, as far back as 1969 a comprehensive National Population Policy was adopted. Over 25 years have passed but the indications are that the nation's efforts at reducing population growth have achieved modest results.

In recent times, the population problem has been assuming different dimensions, which should attract research. This is in the area of adolescent fertility, which is the result of early age at sexual experience especially for females in Ghana. This constitutes a serious problem considering

that most of these sexual activities are taking place outside wedlock and without contraceptive use.

As a result, teenage pregnancies and their accompanying child delinquency and poor development of the female adolescent victim are unfolding problems that Ghana will have to contend with.

The foregoing situation is made worse by the cultural environment within which adolescent sexuality is taking place. In Ghana, it is felt in many circles that it is culturally unwelcome to discuss sexual issues with the adolescent. Again, sections of the society and even some family planning service providers frown upon the provision of family planning services to these youngsters. For example, according to the 1994 Situation Analysis of Family Planning Service Delivery Points in Ghana, 40 per cent of service providers expressed their unwillingness to provide family planning services such as intra-uterine device (IUD) and injectables to unmarried adolescents and 25 per cent of them would not administer the pill under the same conditions (GSS, 1994). Contraceptive advertisements on the television that use adolescents to present the messages have been criticised by a section of the populace to constitute an introduction of the adolescents to sexual promiscuity. Thus, although it is clear that adolescent sexuality is a common phenomenon of Ghana's social life, adolescents are not encouraged to find out what methods there are for their use to avoid any untimely pregnancies should they choose to have sex. Not quite surprisingly, some girls continue to have their future development permanently impaired through early practice of sex and subsequent pregnancy.

The conditions are again made fertile for criminal abortion to thrive in Ghana. Data are not readily available on abortion in Ghana, but in a society where adolescents are increasingly indulging in sex with little or no family planning practices, it is obvious that abortion will be resorted to by many of the girls who become pregnant. The possibility of increasing unsafe abortion contributing to high maternal mortality ratios cannot be underestimated.

Furthermore, adolescent sexuality, apart from having the tendency to cause unplanned pre-marital pregnancies, carries another more serious problem of the infection and spread of sexually

transmitted infections (STIs), including HIV/AIDS. The extent of AIDS prevalence in Ghana is often shrouded in mystery and people do not even want to hear about it. Yet, data obtained from the National AIDS Control Programme for the period 1986-2000 suggest that AIDS prevalence is increasing in Ghana and that a higher proportion of its contraction takes place during adolescent ages of 15-19 years. This is because available data on reported AIDS cases by age indicate that for both males and females, almost 75 per cent of AIDS cases were reported among persons aged 20-39 years and 4 per cent among adolescents aged 15-19 years. The implication is that considering that the incubation period of the disease ranges between 5 and 12 years or more, it is possible that many of the reported cases in the age group 20-39 must have been contracted within adolescent ages.

Adolescent childbearing rates in Ghana have been found to be highest in the Central Region, at least in 1993 (Ghana Statistical Service, 1994). In the 1993 Ghana Demographic and Health Survey (GDHS), 33.3 per cent of female adolescents aged 15-19 years in the Central Region had begun childbearing as against 21.6 per cent for the entire country. In the 1998 GDHS however, the region recorded a relatively lower percentage of adolescents having begun childbearing (18.7 per cent) to place third after Eastern Region (21.2 per cent) and Ashanti (19.6 per cent) compared to a national average of 14.1 per cent. The Central Region also has many fishing communities, which tend to have relatively low levels of education. This situation suggests that adolescent reproduction within the region may be perpetuated for a long time to come if concrete efforts are not made to combat it.

In the 1998 GDHS, it was found that 13.8 per cent and 40.1 per cent of women aged 15-19 and 20-24 years respectively were sexually active in the last four weeks preceding the survey. However, overall, 37.8 per cent and 91.4 per cent had ever had a sexual activity respectively among women of 15-19 and 20-24 years. Meanwhile, only 6.5 per cent of women 15-19 years and 42.4 per cent of women aged 20-24 years were enumerated as married (i.e., in a formal union).

This suggests a relatively high sexual activity among young women including the never married in Ghana.

Linked to the high sexual activity among young women is their low contraceptive use. For example, current contraceptive use for modern methods in 1993 was 5.0 per cent and 8.3 per cent among women of 15-19 and 20-24 years respectively compared to 9.3 per cent among all women in Ghana (Ghana Statistical Service, 1994). The corresponding figures for 1998 were 4.8 per cent and 10.4 per cent among women of 15-19 and 20-24 years respectively as against 10.7 per cent among all women in Ghana. The implication is that low contraceptive use among adolescent and young women may foreclose education and employment opportunities to many of them as they expose themselves to risks of unplanned pregnancies.

In addition, social and health problems that arise from early motherhood for both mother and child are not in the interest of the nation's manpower development. For example, teenage pregnancies are contributing to school dropouts, a phenomenon which is impeding the nation's efforts at empowering women through increasing female education.

In view of the foregoing social, health and economic problems that are the result of adolescent sexual behaviour, the relevant questions that this study seeks to answer include the following:

- (i) At what age does sexual activity begin among female adolescents in the Central Region in particular and Ghana as a whole?
- (ii) What peculiar factors are contributory to the adolescents' decision to enter into sexual activity?
- (iii) What are the fundamental barriers that prevent most sexually active female adolescents from practising contraception considering the high level of unmet needs of 48 per cent for family planning among adolescents in Ghana?

- (iv) In what ways could adolescents be well educated and better informed about negative reproductive health consequences that result from their early entry into sexual activity to ensure either safer sex practices or outright sexual abstinence considering the Ghanaian cultural perception that sexual issues need not be discussed openly especially with children or adolescents?

It is clear then that the issue of adolescent sexuality as it relates to contraceptive use and reproductive health is a complex one and will require a comprehensive research such as the current study in order to resolve the intriguing questions that surround it.

1.3 Rationale of the Study

The study is considered both important and timely for a number of reasons. The first consideration is the acknowledgment that adolescent reproductive health issues have become problems of national interest and concern. In line with this reasoning, the National Population Policy (Revised Edition) of Ghana (National Population Council, 1994), unlike the 1969 Ghana Population Policy, highlights adolescent reproductive health as one key area that requires critical attention in the nation's population programmes. The Revised Population Policy therefore calls for increased efforts at empowering women through increasing female education. A research of this nature is thus relevant in bringing to the fore the various dimensions of adolescent sexual and reproductive health problems to attract increased government attention and funding. The importance of a study of this magnitude can therefore not be underestimated.

The Adolescent Needs Assessment Study carried out in Ghana by Nabila et. al., (1997) recommended among other things, that research facilities should be established to study the extent to which early childbearing increases health risks and also, to educate the people on the consequences of early marriage and childbearing. The current study is in response to this need to provide a

relatively more detailed analysis of the dimensions of adolescent sexual and reproductive health problems with respect to the Central Region of Ghana.

The Central Region which is the study area is also appropriate in the sense that it benefited from the pilot survey conducted by the Ghana Population Agenda Project, a World Bank/UNFPA sponsored project which sought among other things, to integrate family planning education and awareness including adolescent reproductive health, with development projects at the community level through community mobilisation. Cape Coast, the regional capital of the Central Region, benefited from the pilot survey. The current study therefore offers an opportunity to examine adolescent sexual and reproductive health situation in at least one of the towns (Cape Coast), which benefited from the activities of the Ghana Population Agenda Project to guide future programmes that are focused on adolescents. The choice of the Central Region is also relevant as it has one of the highest adolescent childbearing rates in Ghana (it had the highest adolescent childbearing rate in the 1993 GDHS and the third according to the 1998 GDHS).

The study is also timely on account of efforts by the National AIDS Control Programme (and in recent times, the Ghana AIDS Commission) and other related organisations in forestalling an AIDS epidemic in the country. This is because, since STIs and AIDS infection appears to be occurring mostly among adolescents, a research of this nature could assist a great deal in offering concrete recommendations for the implementation of family planning programmes with special reference to adolescents as well as AIDS control in Ghana.

It is also important to indicate that the 1993 GDHS did not collect detailed information on adolescent reproductive health to permit an in-depth study of adolescent sexuality and reproductive health. On the other hand, although the 1998 GDHS collected some data on adolescent reproductive health, the information was not detailed enough, on account of its national character, to permit a thorough analysis of the problem particularly with reference to Cape Coast and Mankrong, the areas

which, this study focuses attention on. The GDHS studies covered only adolescents of 15-19 years and not those below 15 years, a research gap which, the current study attempts to fill.

The relationship that exists between adolescent sexuality, contraceptive use and reproductive health is not only complex but has received limited rigorous research attention in Ghana. This is another important research gap, which this study attempts to fill and hence, makes the study not only timely but also very much justified.

The study concentrates on female adolescents as against males because even in situations where an adolescent female is impregnated by an adolescent male, it is the female that usually drops out of school. Any complications that occur during childbearing also affect women and not men. Biologically too, reproductive health problems are more grave when women are involved compared to men. The bias of the study towards women is also justified within the context of on-going efforts at improving the socio-economic plight of women especially adolescents in Ghana.

1.4 Objectives

The general objective of the study is to examine the magnitude of reproductive health-related problems associated with adolescent sexuality and contraceptive use for the purpose of evolving effective strategies and programmes to combat unplanned childbearing among adolescents and its negative implications for development in the Central Region in particular and Ghana as a whole.

The specific objectives are to:

- i) Estimate the age at first sexual activity among female adolescents in the Central Region of Ghana,
- ii) Investigate the factors that influence female adolescents' early entry into sexual intercourse,

- iii) Discuss the variation of childbearing among the female adolescents in respect of differences in their socio-economic characteristics,
- iv) Estimate the level of knowledge and use of contraception among sexually active female adolescents and their implications for fertility in the two study areas,
- v) Find out the means by which the sexually active female adolescents who practise family planning obtain information and services,
- vi) Analyse the barriers that inhibit sexually active adolescents from practising contraception,
- vii) Examine the reproductive health consequences of early entry into sexual activity,
- viii) Evolve appropriate modes of informing adolescents about sexually related issues as a way of breaking the cultural myth that has surrounded the discussion of sexual matters with adolescents in Ghana,
- ix) Make recommendations to guide policies that are geared towards addressing sexuality and adolescent reproductive health problems in Ghana.

1.5 Literature Review

Adolescent reproduction has attracted much research throughout the world in recent times. This stems largely from the increasing incidence of adolescent pregnancies, unrecorded criminal abortions and their effects on the socio-economic development of the individual adolescent and the wider society. The literature review seeks to bring to the fore relevant issues that are related to adolescent reproduction that have been raised in studies on the magnitude of adolescent fertility, its determinants, contraceptive knowledge and use, the health implications and consequences of early age at sexual intercourse and reproduction.

1.5.1 Adolescent Fertility

The magnitude of adolescent fertility has varied widely within and between developing countries. The Pan American Health Organisation (PAHO, 1988) estimates that 83 per cent of the world's adolescent population is found in developing countries. According to the PAHO study, adolescent fertility rates in developing countries are for the most part, higher than those of developed countries. For example, age specific fertility rates for women aged 15-19 recorded by the PAHO study varied from as low as four births per 1,000 women in Japan in 1981 to as high as 302 births per 1,000 women in Mauritania in 1981. The study observes further that although the proportion of adolescent births to total births is declining with time, the proportion of out-of-wedlock births has increased.

In Ghana, the three demographic and health surveys report that the contribution of adolescents to overall fertility has been around 10 per cent between 1988 and 1998. Deductions from the GDHS reports on the age specific fertility rates among women 15-49 years showed that women within 15-19 years contributed 9.7 per cent of total fertility in 1988, 10.8 per cent in 1993 and 9.9 per cent in 1998. On the other hand, the contribution of women aged 20-24 years to total fertility could be computed as 20.2 per cent in 1988, 21.0 per cent in 1993 and 21.1 per cent in 1998 (Ghana Statistical Service, 1989, 1994 and 1999). It is clear that while the contribution of adolescents 15-19 years has remained almost constant around 10 per cent, that of their counterparts of 20-24 years has shown only one percentage point increase during the ten-year period of 1988-1998. In spite of the observed decline in the contribution of adolescents to total fertility, out-of-wedlock births may be quite common in the country considering that a large proportion of the sexually active adolescent women are not married.

Proceedings from the International Forum on Adolescent Fertility indicate that over 15 million adolescents of 15-19 years give birth every year. Most of these births are said to be to women in developing countries and many are not desired (Centre for Population Options, 1992).

The proceedings of the forum further estimate that between one million and 4.4 million abortions take place among adolescent women each year in the developing countries. What makes the problem more serious, according to the Centre for Population Options, is that adolescents make up a high percentage of abortion-related complications and a significant percentage of deaths due to botched abortions. In Ghana, the magnitude of abortion among adolescents is not known. However, occasionally, cases of complications having developed from abortions undertaken under unsafe conditions including self-inducement, seeking help from traditional healers, chemists, shopkeepers and other non-medical personnel are reported. In Ghana, abortion can be procured under certain conditions including situations of threat of life of the mother and pregnancy being the result of incest or rape.

Analysis of the Adolescent Fertility Survey data for Kampala, Uganda, also suggests high rates of sexual activity among adolescents (Adjei and Epema, 1990). The study reveals that 85 per cent of both male and female adolescents were sexually active with mean age at first coitus being 15.7 years for males and 15.3 years for females. It was also found that by age 17 years, 30 per cent of the women had one or more pregnancies. Similar findings were recorded in Ghana from the 1993 GDHS, which showed that by the age of 20 years, more than 85 per cent of adolescent females had ever had sex and that 45 per cent had already begun childbearing. Moreover, the 1993 GDHS reports that by age 19 years, five per cent of the adolescent females had already had two or more children. These show that in many sub-Saharan African countries, sexual activity and childbearing are taking place among a reasonable proportion of the adolescent population and are thus, exposed to various health risks and consequences.

Furthermore, in a study on adolescent fertility and reproductive behaviour in Ghana, with special reference to Accra and Kumasi, Nabila and Fayorsey (1996) examined the ages and conditions which affected the first sexual exposure among adolescent boys and girls, the socio-economic and other determinants of adolescent fertility, the health and other consequences of

adolescent fertility and the social policies and programmes dealing with adolescent sexuality in Ghana.

This study showed that an unspecified proportion of adolescents start practising sexual activity very early in life. For example, the researchers reported that some of the adolescents (number not specified) began sexual activity as early as 10 years and although the mean age at first sexual experience was 16 years, by age 15 years, about 58 per cent of the adolescents had already experimented with sex for the first time. Again, 11.2 per cent of all female adolescents were found to have been pregnant once while 4.4 per cent had been pregnant two times. A significant finding, however, was that, while about 17 per cent of the female adolescents had ever been pregnant, only 8.3 per cent had ever had children. This implies that about half of the pregnancies among the female adolescents were lost through either miscarriages or induced abortion, a situation, which could have lasting negative impacts on the reproductive health of those involved.

Singh (1998), in a global review of adolescent childbearing in developing countries examines current levels and recent trends in adolescent childbearing rates, the timing of first births as well as births to unmarried women for 43 developing countries. This study which is based on nationally representative fertility surveys, demonstrates among other things, that substantial declines in adolescent fertility have been recorded in countries of North Africa and Asia although levels are still considered high in some countries. According to this study, declines are beginning to occur in sub-Saharan Africa. In spite of this, the proportion of births to unmarried adolescents is increasing in some countries especially in Niger and Mali where recorded age specific fertility rate during the 1980-90s was recorded as 215 (in 1992) and 206 (in 1987) per 1,000 adolescent women aged 15-19 years respectively compared to a low of 51 in Burundi in 1987. It was further reported that a higher proportion of rural and less educated women had a child before age 20 years compared to urban and higher educated women.

1.5.2 Determinants of Adolescent Sexuality and Reproduction

Many studies have focused on the determinants of adolescent reproduction. One such study examines the problem from the biological perspective (Becker, 1993). The biological factors that are highlighted to affect adolescent fertility include the probability of non-ovulatory cycles and foetal loss which tend to be more common among adolescents than women in their twenties. This suggests that most adolescents may be under the conviction that on account of their relatively young ages, it is unlikely that they would be pregnant. Most of them therefore resort to unprotected sex and eventually may become victims of unplanned births.

On the other hand, in a study in Kenya, Kiragu (1991), reports that substance use could predispose an adolescent to be sexually active. For example, he shows that males and females reporting substance use are four and two times respectively, more likely to be sexually active and consequently, be at risk of unplanned pregnancy. This view is supported by Moore (1984), in a study showing that substance use may ensue as a consequence of early sexual or pregnancy experience. He adds that the possibility exists that early sexual activity, pregnancy, abortion, adoption or parenthood, all increase the risk of becoming a drug user. The study further posits that studies on adolescent fertility would be enhanced by the inclusion of drug use as a possible causal variable.

Kiragu's 1991 study also acknowledges the important role of peer pressure in introducing adolescents into sexual activity. His finding, which is also supported by the findings of Nabila and Fayorsey (1996) in Ghana, suggests that in Kenya socialising with sexually active peers results in males and females being seven and three times respectively more prone to being sexually active. Other factors, which are cited by Kiragu to predispose an adolescent to sexual activity include residence in rural areas, attainment of puberty, unstable family environment and boarding school attendance particularly for males.

Nabila and Fayorsey's (1996) study on Accra and Kumasi using focus group discussions and structured interviews also emphasised poverty, peer pressure, lack of parental control as the main factors determining adolescent sexuality and their reproductive behaviour in both Accra and Kumasi. These findings are also supported by a Population Impact Project (PIP, 1995) study on Adolescent Fertility and Reproductive Health in Ghana which further underscores the fact of an unmet need of about 48 per cent of family planning among adolescents.

The PIP (1995) study examined the problem of adolescent fertility in the country using 1993 GDHS data. The PIP study listed the determinants of adolescent fertility to include early age at menarche and marriage, premarital sexual experience, lack of economic incentives, lack of knowledge of reproduction and contraception and low use of modern family planning methods. These, according to the study, operate in various ways to affect the sexual and reproductive health of adolescents in Ghana.

The problem of poor knowledge of a woman's reproductive cycle and its relationship with pregnancy occurrence among adolescents has been cited as contributing to increasing adolescent fertility in Africa. Ajayi et. al. (1991) record that in Kenya, one in 10 adolescents recognised the fertile or ovulatory cycle and only 50 per cent of them knew that pregnancy could occur at first sexual intercourse. This is an important consideration for, if adolescents are unaware that a first sexual intercourse could produce a pregnancy, they may not even consider the use of contraception if even they have knowledge of any.

Other studies have focused attention on the limited access of most adolescents to contraception and abortion services as a principal cause for high incidence of adolescent fertility in most countries. For example, McGrath (1979) found that among the factors in the etiology of unintended early childbearing, the single most important factor amenable to policy intervention is lack of teenage access to contraception and abortion services. This observation is as valid today in many countries in Africa as it was almost two decades ago. In a study in Kenya and Nigeria, Barker

and Rich (1990) state that in Kenya for example, there is much reluctance by church and government officials to provide family planning services to adolescents. Similarly, the Centre for Population Options urges that adult discomfort with adolescent sexuality is a major obstacle to providing the youth with needed family planning information and services.

There has been one comprehensive study in Ghana by Nabila et. al. (1996) to assess the reproductive and health needs of adolescents. It also reviewed relevant legislations and policies that affected the reproductive health of adolescents. In addition, the study assessed the roles and capabilities of major government and non-governmental agencies in the area of adolescent reproductive health in the country. It also provided an inventory of all non-governmental organisations and other institutions that were involved in reproductive health activities with the youth and identified potential settings where youth services can be integrated with current activities. In addition, the obstacles inhibiting the provision of adolescent reproductive health services throughout Ghana were examined. The obstacles include socio-cultural, legislative, medical and economic barriers. Finally, the researchers recommended programme interventions for advocacy, policy formulation and research on issues pertaining to the reproductive health of adolescents.

In another study on Adolescent Sexuality in Southern Africa, Meekers and Ahmed (1997) examine patterns of male and female adolescent sexual behaviour among the Tswana in Botswana. The researchers use data obtained from the 1995 Botswana Adolescent Reproductive Health Survey in addition to focus group interviews among University students. One striking finding of this study was that at younger ages (15-16 years), a higher percentage of males (41 per cent) as against females (15 per cent) were sexually experienced. However, at later ages (17-18 years) the differences between the sexes disappear. Although level of education was found not to affect the likelihood of females being sexually active, the proportion of sexually active females was lower

among females enrolled in school. On the other hand, males with higher levels of education were found to be more likely to be sexually experienced than their counterparts with lower levels of education.

Furthermore, they observed that incidence of casual sex was quite common among the adolescents interviewed because both males and females were likely to have one or more casual sexual partners. This was in spite of the fact that both males and females were aware of the potential negative consequences of sexual activity including stigma, pregnancy or STIs. At the same time, while 33 per cent of the females saw sexual activity as having no advantages, information from the focus group interviews showed that female sexual activity is often motivated by economic gain. Finally, the study showed that adolescents do not consider parents as ideal sources of information about sex and related matters although they were included among peers and siblings as having the strongest influences on female reproductive health attitudes.

Another study in Nigeria by Olawoye (1995) on adolescent sexuality indicates that parents and the media are blamed for the change in sex behaviour. However, adolescents studied pointed to a situation of overcrowded living conditions that allow children to observe parental sexual intimacy as an influencing condition for early involvement of adolescents in sexual activity. Respondents were also reported to having multiple sexual partners although many of them were aware of the dangers of sexually transmitted infections. A high incidence of unreported rape and of unplanned pregnancy was noted with adolescents rarely seeking modern medical advice.

Gage (1998), in a study that focuses mainly on literature from sub-Saharan Africa, discusses non-marital sexual activity, contraceptive use including condom use. This study explores adolescents' perceptions of the costs and benefits of engaging in these behaviours, their assessment of their susceptibility to the potential consequences of their actions and the role of family, peer and dynamic factors in shaping their reproductive decisions. Among other things,

Gage shows that cultural values regarding sexuality and gender roles, the power dimensions of adolescents' lives, and economic disadvantage exert powerful influences on the decision making process. Besides, decisions to engage in unprotected sex may also be based on insufficient knowledge and distorted judgements of the risks of becoming pregnant and acquiring sexually transmitted infections. The study also finds that perceptions about what adolescent peers are doing and what is accepted in their peer groups may be more strongly related to their motivations to engage in sexual activity or risk-taking than perceptions about the opinions of parents and other family members. Again, motivations for engaging in certain types of sexual behaviour such as offering sex for money or having intercourse as a result of force or coercion appear to be more common among teenagers than among adults.

Zelaya et. al. (1997), sought to examine gender and social differences in adolescent sexuality and reproduction in Nicaragua through an investigation of age at first coitus and pregnancy. The study uses data from a 1993 cross-sectional, community-based survey of a representative sample of 7,789 households in the municipality of Leon. In all, 10,867 women of 15-49 years were studied while more detailed analysis was done on a random sub-sample of 388 men and 413 women. Among other things, Zelaya et. al. found that although the median age at first coitus was higher for females (17.8 years) than males (16.2 years), women had a lower median age (19.6 years) at delivery of first child than males (21.2 years). Another significant finding was that one in four persons engaged in coitus before age 15 years, a situation suggesting quite an early sexual activity among the Nicaraguan population.

Zelaya et. al. also found that lack of formal education increased the risk of earlier pregnancy for adolescents by 2.5 times but no increased risk was found to occur between persons of rural as against urban residence. Furthermore, the study underscores the fact that earlier pregnancy occurred among women who did not live with their biological fathers during their childhood and period of

adolescence. On the other hand, living with a stepfather was found to increase the risk of early coitus and delivery even more.

1.5.3 Adolescent's Reproductive Health Knowledge, Attitudes and Practices

A study on attitudes and practices regarding pre-marital sex among adolescents has been carried out by Adomako-Ampofo (1991). This study was based on a sample of adolescents drawn from Sunyani, Kumasi, Hohoe, Cape Coast, Aburi and Accra. It examined issues including the age at which young people begin to have a clear understanding of reproductive related issues, their main sources of reproductive information, the age at which they become sexually active, the duration of adolescent sexual relationships and the frequency of sexual intercourse. The study also investigated the knowledge and use of contraceptives as well as the incidence of pregnancy and abortion among the adolescents.

In the analysis, Adomako-Ampofo found 13.5 years as the average age at which adolescents begin to have a clear understanding of reproductive related issues. It was also shown that only 7 per cent of the boys and 22 per cent of the girls that were studied demonstrated that they had an accurate knowledge of when in the reproductive cycle it is most likely that a woman will become pregnant if she indulged in sex, i.e., the woman's fertile period.

Another fundamental finding from Adomako-Ampofo's study was that 32 per cent of the adolescents had ever had a sexual intercourse, the youngest age at sexual intercourse being eight years. For some female adolescents therefore, sexual activity could start very early in Ghana. On the use of birth control, half of the sexually active adolescents reported to have ever used some form of contraception. Furthermore, among the sexually active adolescent girls who had ever been pregnant, 10 per cent were reported to have ever had an abortion. Adomako-Ampofo further found that among 61 per cent of adolescent boys who had ever made a girl pregnant, the girl concerned was reported to have had an abortion. This suggests that abortion, although officially

outlawed in Ghana, appears to be a practice among some sexually active adolescents in the country.

In their study of adolescent reproductive behaviour in Ghana, Ampofo and Gyepi-Garbrah (1986), explained among other things that the pronatalist beliefs of the Ghanaian society, often result in early marriage of females, coupled with a desire to prove their fertility during the first year of marriage. In addition, improvements in health and nutrition conditions, have resulted in the early physical development of adolescents who are easily drawn into sex and in the process become pregnant. The study further examined extracts of antenatal attendance at the Korle-bu Teaching Hospital and reported that 18.4 per cent and 19.3 per cent of the women who reported to the clinic for services were adolescents of 15-19 years in 1983 and 1984 respectively. Although the sample used in this study is not representative of the situation in Ghana, it may suggest quite fairly that the contribution of adolescents to childbearing in Ghana could be quite substantial.

Another study by Agyei and Hill (1997), entitled “Sexual Behaviour, Reproductive Health and Contraceptive Use among Adolescents and Young Adults in Ghana”, found that one in three sexually active but unmarried adolescents had been pregnant at least once, with some variation between the rural and urban areas. For example, the study showed that 47.1 per cent of adolescents aged 15-19 years in the rural areas had ever been pregnant compared to 23.6 per cent and 36.7 per cent of their counterparts in Accra and peri-urban areas respectively. According to the study therefore, adolescents in rural areas are also twice as likely to become pregnant relative to their friends in Accra. It must however, be noted that the sample used in the study was quite small and hence it would be unrealistic to make valid conclusions based on this study especially of rural and urban areas in Ghana in addition to making realistic comparisons between rural and urban areas in Ghana as the study sought to do.

In another study covering a sample of 1,356 adolescent residents in high population density areas in Accra, including Chorkor, James Town, Nima, Madina, Maamobi, La, Korle-Gonno and

Teshie-Nungua, Kumekpor (1997) observed that almost one in four of the partners of teen mothers was a teenager himself, who depended on his parents for his welfare. According to Kumekpor, this is the main reason why most of them deny responsibility for the pregnancies they have caused. The study however, also shows that adults rather than adolescents were responsible for a relatively higher proportion of the pregnancies among adolescents. What was clear in the study was that as high as 90 per cent of the adolescent females who had ever become pregnant did not intend or had no plans to become pregnant at the time they engaged in sexual intercourse. While such a situation results in untold hardships in respect of the maintenance of children of these teenage mothers, it suggests that most of them could be helped to avoid the pregnancy in the first place through education on either outright abstinence or use of pregnancy preventive methods if they cannot abstain.

In a study on knowledge and attitude of adolescents towards reproductive health, carried out at Okponglo, near Legon, Peprah (1998) observed that 80 per cent of the sexually active adolescents were not using contraceptives. Another finding from this study was that 44 per cent of the adolescents responded that they knew of a friend who had ever had an abortion. This is interesting, since they themselves scarcely admit openly to have undertaken an abortion but are happy to report on friends they know have had an abortion.

On his part, Anarfi (1997) studied 1,147 street children aged between 8 and 19 years who usually congregated or slept around four major markets in Accra. In this study, Anarfi found that 53 per cent of them had ever had a sexual experience. It was also found that sexually active adolescents had had two or more sexual partners, a situation which obviously has many implications for their reproductive health as far as sexually transmitted infections are concerned. Thus, a little over 7 per cent reported that they had contracted one kind of STI or another while only 18 per cent of those who had ever contracted an STI went to a hospital for treatment. Self-medication was therefore, found to be quite common among the adolescents with respect to STIs.

It was also established that majority of the street children are aware of the risk of contracting HIV/AIDS, but they are not doing much to protect themselves from HIV infection. This situation, according to Anarfi, is partly explained by the kind of misconceptions they have about the disease.

Ankomah and Ford (1993), also interviewed 400 never married females aged 18-25 years who live in Cape Coast and found a high level of premarital sexual experience amongst them. The researchers also found that 86 per cent of the respondents had engaged in sexual intercourse at least once, the median age at first sexual intercourse being 16 years which is about one year below the average of 16.9 years among women 20-24 years according to the 1993 GDHS.

A number of studies have been done on adolescents elsewhere in other countries in the world. One of these studies done in the United States of America was by Johnson et. al. (1999). This study examines adolescent attitudes, knowledge and values on sexuality and sexually transmitted infections. It covered a sample of 170 students from one rural high school. Hypotheses that formed the basis of the analysis included the following: a higher value of an exciting life has a higher attitude toward sexual intercourse scores; a higher knowledge score on sexual intercourse will have a lower attitude toward sexual intercourse scores and a higher knowledge score about AIDS/STIs will have a higher attitude toward condom use scores.

Using the Rotter's Social Learning Theory, the study by Johnson et. al., made significant findings. The adolescents were found to have higher accurate knowledge on sexual intercourse and STIs. They also found among the adolescents a positive attitude toward condom use and sexual intercourse with the girl/boy friend. They also found that health values have a positive correlation between an exciting life and the knowledge and attitude about sex and condom use, and a negative correlation towards sex. The findings of minimal impact of knowledge of sexual intercourse and STIs on sexual behaviour and attitudes among adolescents, were considered consistent with earlier studies. The limitation of the study however, was its small sample size, which may not be reliable in making generalizations.

1.5.4 Knowledge of HIV/AIDS and STIs Among Adolescents

In a survey among 1,553 adolescents, McCombie and Anarfi (1991), sought to collect baseline data to evaluate the impact of mass media campaign on AIDS and assist the Ministry of Health in planning future AIDS prevention efforts. From the analysis, it was shown that the most important source of information on AIDS so far has been the radio (88.7 per cent), friends (78.7 per cent) and television (75.3 per cent). The researchers also revealed in this study that misconceptions and negative attitudes as far as the disease is concerned were quite high. One finding in this study was that less than 40 per cent of the respondents in the study mentioned AIDS as one of the three most dangerous diseases in Ghana while a quarter of them thought that most young people did not need to worry about the disease. Interestingly too, 46 per cent of the people interviewed believed that AIDS could be cured. Such thinking creates problems for the nation in its fight against HIV/AIDS since it gives some false hope that may, however, not be realized in the foreseeable future.

In another study carried out among adolescent students of second cycle institutions in the Greater Accra Region, Asamoah-Odei et. al. (1992) probed into the knowledge of students about HIV/AIDS as a disease. The findings of this study included a high knowledge of HIV/AIDS among all segments of the sample interviewed irrespective of their sex, educational level and religious affiliation. Knowledge about the modes of HIV transmission was equally found to be high with 90 per cent of the students having knowledge about the three main modes of transmission, namely, sexual contact, intra-venous drug abuse and blood transfusion. Misconceptions about some aspects of the disease were, however, found as in the case of McCombie and Anarfi's study of 1991. For example, 20.5 per cent of the students reported that, AIDS virus could be transmitted by living together with an AIDS patient; 33.1 per cent stated that one could be infected with the virus through an insect bite and 26 per cent were of the opinion that

one could contract the disease by merely kissing someone. These are misconceptions, which HIV/AIDS educational programmes should aim at correcting.

On the whole, adolescents in Ghana face a lot of reproductive health problems most of which stem from their early entry into sexual activity without adequate knowledge about the dangers or risks they subject themselves to. Contraceptive use has been generally low among them and although many of them are aware of the transmission of many STIs including HIV/AIDS through sexual activity, many of them do not abstain from sex or have protected sex. The Health Systems Development Unit (1998) in a study on Adolescent Sexuality and Reproductive Health presents a summary of research findings of the Adolescent Sexual and Reproductive Health Programme in addressing adolescent sexual and reproductive health issues and needs in the Northern Province of the Republic of South Africa. The study uses interviews and focus group discussions among school-going adolescents in respect of their knowledge, attitudes, and behaviour on sexual and reproductive health. The views of teachers and health workers were also sought.

Major findings from the South African study included the observation that majority of the adolescents were sexually active by age 15 years with only a few using preventive methods against sexually transmitted infections and pregnancy. Many of those who were infected with STIs failed to consult a health worker, a problem that the study attributes to the lack of reproductive health knowledge, inaccurate or unreliable information, inaccessible reproductive health services and negative perception of health services. It therefore recommends an adolescent health programme that places emphasis on the significant roles of the youth, health care workers, teachers and the community in addressing the observed problems.

1.5.5 Contraceptive Education and Practice

Ruusuvaara (1997) provides a review of family planning literature and concludes that little concern is shown in most of the articles reviewed about promoting the idea of more communicative, pleasurable, and egalitarian sexual relations among teenagers because the focus is on avoiding behaviours that are defined as “high risk”. The review also notes that in the United States of America, there is little evidence that contraceptive-based sex education programmes have resulted in reduced sexual activity, diminished teenage-pregnancy rates, or increased effective contraceptive use. Similarly, in Canada, Ruusuvaara notes that the clinical evidence is that existing prevention strategies are not working. However, it is acknowledged that countries where sex education has been accepted, combined with widely spread family planning services and abortion on demand, have the lowest pregnancy and abortion rates in the world.

The Centre Francais sur la Population de le Development (CEPED) has carried out a study of adolescent sexuality in five Sahel countries, namely Burkina Faso, The Gambia, Mali, Niger and Senegal (CEPED, 1997). According to this study, strong taboos on discussing sexuality have led to most studies on reproductive health in the Sahel Region in Africa to pay little attention to adolescents, who constitute over one-fifth of women in the reproductive ages. Consequently, awareness of problems in adolescent reproductive health is limited. The study also found that knowledge of sexually transmitted infections is limited among girls and most of them do not know that seemingly healthy persons can be HIV seropositive. While friends and the media were identified as the most common sources of information about sex, health agents, family members and teachers were among the least frequent sources.

According to the Sahel Adolescent Sexuality Study, much older respondents agreed that premarital sexual activity has increased in the recent past. From the point of view of the adolescents themselves, the disapproving attitude of health workers prevents them from seeking contraception and other needed reproductive health services. This suggests that attitude of service

providers is quite important in encouraging adolescents to patronize reproductive health services to forestall most of the reproductive health problems that most of them are faced with.

Lunin et. al. (1995) conducted a study on adolescent sexuality in Saint Petersburg, Russia with the objective of describing adolescent knowledge, attitudes and behaviour relevant to sexuality and the prevention of AIDS. The study focused on 185 female and 185 male students who completed a self-administered questionnaire with a response rate of 94 per cent. The study comes out with interesting findings. For example, only 25 per cent of females and 34 per cent of males believed that condoms should be used just once, 38 per cent of each sex believed that if washed, condoms could be used multiple times. Clearly, the study reported gross misinformation and unwarranted attitudes towards condom use and hence the need for rigorous sex education programmes for Russian youth who, the study found to have a strong support for sex education especially among females, with most respondents seeing sex education as improving sexual pleasure. Accordingly, the study recommends that sex education should be introduced at an early age so that children could be taught how to reduce the risks of sexual abuse, HIV infection, and other STIs as well as improve their sexual experiences as responsible adults.

Goddard (1995) sought to present the facts in respect of adolescent sexuality in Nigeria. In his account, 22 per cent of Nigeria's 1991 population of 96 million is aged 10-19 years. According to this study, adolescent women experience first sexual intercourse at the median age of 16 years with 80 per cent of them having sexual intercourse by age 20 years. In spite of this high level of sexual activity among the adolescents in Nigeria, Goddard's (1995) study shows that 60 per cent of the adolescents that were surveyed were unaware that pregnancy can result from first sexual intercourse. It was also found that nationwide, contraceptive use among women 15-19 years was low with less than 1 per cent using condoms, foaming tablets, or inter-uterine device (IUD). The study also acknowledges that early, unprotected sexual intercourse, leads to many unintended

pregnancies, unsafe abortions, and abortion-related complications. It also cites the practice of male genital mutilation (FGM), vesico-vaginal fistula, early female marriage, and low educational status among women as relevant factors that complicate adolescent development in Nigeria.

Kilbourne-Book (1998) reports that worldwide, about 15 million people of 15-19 years give birth, as many as 4 million obtain abortions, and up to 100 million become infected with curable STIs. He further reports that 40 per cent of all new HIV infections occur among people aged 15-24 years old. The study underscores the fact that adolescents encounter many obstacles to securing the reproductive health care services they need. However, the study declares that it takes programmes that satisfy the information and service needs of adolescents to make a real difference towards solving adolescents reproductive health problems in most countries of the world.

Blanc and Way (1998) provide an overview of sexual behaviour and contraceptive knowledge and use among adolescent women across a large number of developing countries. The results of this study indicate that in almost all of sub-Saharan Africa and in majority of countries in other regions, there has been an increase between age at first sexual intercourse and age at first marriage. This suggests that between age at first sexual intercourse and marriage, the adolescent is exposed to so many risks that are associated with non-stable sexual relationships. The study also found that in sub-Saharan Africa, current contraceptive use among sexually active but unmarried teens is higher than among their married counterparts. On the other hand, the reverse is true in Latin America and the Caribbean. Overall, however, adolescents were found to have a high probability of not practising contraception the first time they have sexual intercourse.

1.5.6 Adolescent Pregnancy Risks and Consequences

Adjei and Ampofo (1986) carried out a study to assess some of the social and medical problems associated with adolescent pregnancy in Ghana. Among other things, the researchers concluded that more than 50 per cent of pregnancies to girls under 20 years were reportedly unwanted or unplanned. Similarly, the study found up to 50 per cent of their partners not wanting the pregnancy.

In a survey of teenage pregnancy and substance abuse in Ablekuma Sub-District of Accra, carried out by the University of Ghana Medical School (UGMS) in 1990, the findings were that, 9 per cent of the teenagers were pregnant at the time of the survey and that among them, 27 per cent had complications such as general weakness, bleeding and anaemia. A further 21.5 per cent said that they would opt for termination of the pregnancy if they found out that they were pregnant. Besides, even though 89 per cent of the teenagers stated that abortion was bad, 20 per cent were reported to have actually visited a health institution within the sub-district to terminate their pregnancy just prior to the survey.

Liskin et. al. (1993) also concluded that young women are especially ill-prepared to respond to reproductive health risks including HIV/AIDS, STIs and unwanted pregnancies. The study showed that in spite of the fact that adolescent females under 18 years had the least knowledge about family planning and AIDS from such sources as friends or peer groups, partners, health care providers, parents as well as the media, a large proportion of them were sexually active and only a few used contraceptives. The implication is that many of them could either become pregnant and or contract sexually transmitted infections (STIs) including HIV/AIDS.

The dimensions and implications of adolescent fertility in sub-Saharan Africa have been studied in Nigeria, Kenya, Liberia, Sierra Leone and Botswana (Gyepi-Garbrah, 1985). In all these studies, it is emphasised that with increasing age at marriage as a result of increasing education, births to adolescents, which hitherto have been mainly within marriage, are likely to be conceived

out-of-wedlock. The findings also point to a situation of increasing use of illegal abortion in cases of unplanned pregnancies and a growing incidence of sexually transmitted infections due mainly to unprotected sex. Adolescent childbearing therefore, is gradually becoming a major problem in the sub-Saharan African Region.

One other focus of the 1995 PIP study was the reproductive health consequences of adolescent fertility among adolescents themselves. The major reproductive health consequences of adolescent fertility were identified in this study to include sexually transmitted infections, health risks of early pregnancy and abortion. There was however, lack of reliable data on abortion rates in Ghana to make relevant conclusions. Finally, the study recommended certain policy intervention measures that could be taken to curb the incidence of adolescent sexuality. These include family life education, the setting up of youth counselling centres, encouraging girls to pursue educational opportunities to the highest levels by substantially subsidising female education and making available family planning services to all adolescents regardless of marital status. The other policy intervention strategies suggested by the study were improving reproductive health care, involving adolescents in the design of programmes that seek their welfare and evolving policies to protect young girls from sexual harassment and rape.

The study by Nabila and Fayorsey (1996) also found that the high knowledge that adolescents showed about sexually transmitted infections (STIs), HIV/AIDS and possible incidence of pregnancies through sexual activity was not translated into practically wanting to use any contraceptives at their first sexual intercourse. The finding was that 51.2 per cent and 70.1 per cent of the adolescents did not practise any form of contraception during their first sexual intercourse in Kumasi and Accra respectively. It was also found that unplanned teenage pregnancies were largely responsible for most cases of females that dropped out of school especially in the peri-urban and rural areas that were covered in the study. This suggests that if adolescents are able to avoid unplanned pregnancy, most of them can complete their education to a

large extent. Caution should however, be exercised in the interpretation of the results from such studies since their representativeness is not easy to determine.

According to Kumekpor's (1997) study, early pregnancy has either interrupted or led to outright cessation of all socio-economic activities that the girls were engaged in before getting pregnant. For example, 39.3 per cent of school girls were reported to be in school or awaiting their examination results before they got pregnant and obviously had to abandon their education in order to become mothers.

Buvinic (1998) has reviewed results from studies done in Chile, Barbados, Guatemala and Mexico. The review looks at the costs of adolescent childbearing in the four countries. It addresses questions including whether early childbearing contributes to perpetuating poverty that has been found to plague the Latin American and Caribbean countries. It also answers questions regarding the social and economic impacts of adolescent childbearing on mothers and children.

One important observation in Buvinic's review is that the disadvantages of early parenthood may be only transitory and that adolescent mothers may overcome these disadvantages over time. It is argued that the negative outcomes of early childbearing may be a result of associated conditions, such as women's poverty and that these mothers may fare poorly even if they delay childbearing.

For example, Buvinic shows that little evidence exists in the four countries to demonstrate that early childbearing has negative consequences on the marriage options of young women. Adolescents who bore children were no more or less likely than adult mothers to be married in the subsequent years according to the Barbados, Chile and Guatemala studies. This was in sharp contrast to the finding in the United States of America that adolescent childbearers spend nearly five times more of their young adult years as single parents than do later childbearers (Marynard,

1996). It was however, illustrated that a high proportion of the adolescent mothers are more likely than adult mothers to pass on their adolescent motherhood and poor life prospects to their daughters in a hereditary fashion. Furthermore, women who gave birth at early ages were found to be more likely than their counterparts who gave birth at adult ages to earn incomes, hence emphasising the poor economic opportunities that may be the lot of adolescent mothers compared to adult mothers. Early childbearing among women is therefore likely to contribute to the creation and perpetuation of poverty among women.

The Family Care International, a Safe Motherhood Inter-Agency Group (1998) presents findings from the analysis of data on adolescent sexuality and childbearing. This study focuses on adolescents of 10-19 years and finds that adolescent pregnancy is common in many countries in the world. It also reports that adolescents aged 10-19 years give birth to 15 million children every year worldwide and consequently, subject themselves to considerable health risks during pregnancy and childbirth. Specifically, the study shows, among other things, that pregnant adolescents are two times as likely to die from childbirth than women in their twenties. Again, pregnancy-related complications were identified as the main causes of death among adolescent girls of 15-19 years worldwide due to the prevalence of early childbearing. Recommendations made in this study include the institution of programmes for the removal of legal, regulatory and cultural barriers towards family planning service provision to adolescents in addition to providing appropriate, accurate sexual and reproductive health education; and the development of sensitive and confidential reproductive health services to protect the sexual and reproductive health of adolescents.

In Yaunde, Cameroon, Kamtchouing et. al. (1997), in their adolescent sexuality study in a school environment, covering 574 students made up of 233 males and 341 females aged 12-19 years in five randomly selected secondary schools, reported undesired pregnancy as a major cause

for dropping out of school among adolescent females in Cameroon. Other findings of this study include the observation that 41 per cent of the 53 per cent who reported to be sexually active used a contraceptive method during the most recent sexual encounter. While most of these contraceptive users (54 per cent) used condoms, close to a third of them relied on periodic abstinence. Consequently, 24 per cent of them reported a pregnancy ending in either delivery or abortion. The major source of information on STIs and contraception was also reported to be the mass media for 54 per cent of the adolescents, school for 21 per cent, friends for 16 per cent while parents constituted just 9 per cent. The study recommends that sex and family planning education should be offered through youth organizations and schools while teaching parents to discuss sexual topics with their children in order to prevent STIs, unwanted pregnancies, illegal abortions and their medical and psychological consequences.

From the literature review, a few research gaps have come out. First, many of the studies on adolescent sexual and reproductive health used data whose representativeness is quite suspect. Example is the 1998 GDHS, which used data on women of 15-19 years to describe adolescents who, by definition, include persons of 10-14 years as well. Secondly, each of the studies focused on certain aspects of the subject matter of adolescent sexual and reproductive health leaving out the comprehensive analysis of the subject. Besides, many of the studies used actual birth performance i.e., children ever born to measure adolescent childbearing, thus, clouding the role of abortion in understanding adolescent reproductive health. This is a gap that the current study attempts to fill by focusing on the number of pregnancies ever had by the adolescents.

Finally, the complex relationship that exists between adolescent sexuality, contraceptive use and reproductive health has not been comprehensively studied, a gap the current study attempts to fill in its combination of both quantitative and qualitative methods of analysis.

1.6 Conceptual Framework

Several relationships have been revealed in the available literature on adolescent sexuality and reproductive health. While many studies focus on the determinants of the phenomenon, others draw attention to the impact of the problem on the individual adolescent. It is clear however, that one cannot fully discuss the phenomenon of adolescent sexuality and reproduction without considering some intermediate variables. Yet, on account of the small age group (12-24), which is the target in this study, the relationships may not be as straight forward as the case may be in a situation where one is considering all women of reproductive ages. Variables have therefore been selected to suit the purpose and interests of the study.

Figure 1.1 illustrates the general interrelationships that are conceived in the conceptual framework with respect to adolescent sexuality, contraceptive use and reproductive health. It shows the main factors that have come up in the literature to influence adolescent childbearing all over the world.

In the framework shown in Figure 1.1, the age at first sexual activity and knowledge and use of contraception are presented as the main intermediate variables, which directly influence adolescent childbearing defined as the number of pregnancies ever had by adolescents. Number of pregnancies is used in order to measure plausibly the proportion of pregnancy wastage as a result of either abortion or miscarriage.

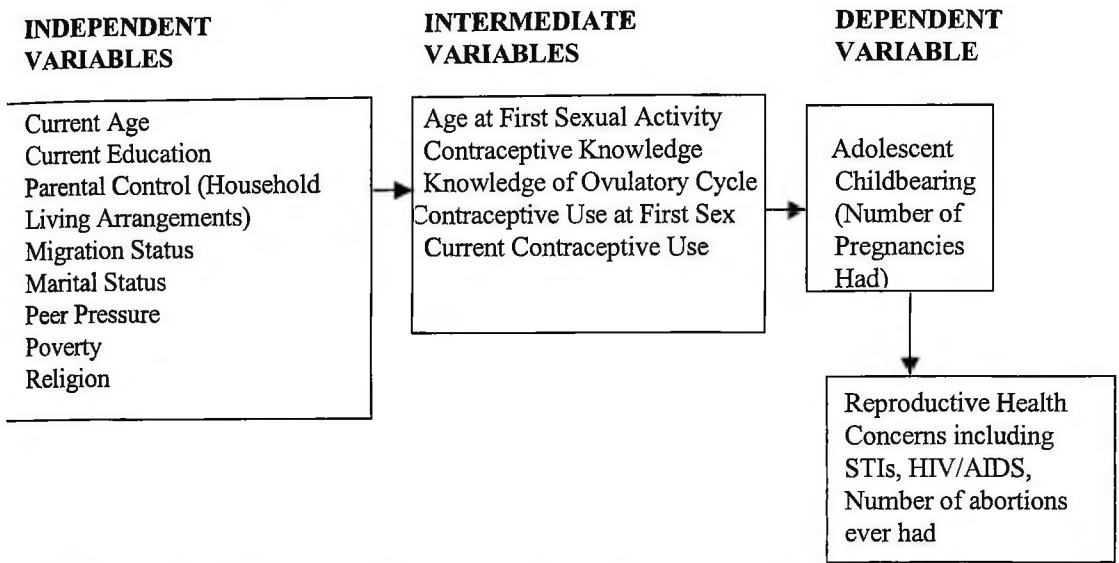
Age at first sexual intercourse is conceived to be influenced by peer pressure, parental control, poverty and migration status of the adolescent. Parental control is defined in terms of whether the adolescent is staying with both parents, one of the parents or none of them. Poverty is also included to find out adolescents who indulge in sex for monetary considerations. On the other hand, migration status (i.e., whether the adolescent is born in the study area or has moved to stay there from another area outside the district in which the study area is located) is considered in view of the current wave of migration of adolescents into the cities and large towns in Ghana. This is

conceived to be particularly important in the case of Cape Coast, the regional capital. The study is also interested in finding out how much knowledge adolescents have about the ovulatory cycle as an explanatory factor for the incidence of adolescent childbearing.

Age is an important demographic variable that is put in the model to examine the variation of the adolescents in their contraceptive knowledge and use, sexual behaviour patterns and childbearing experience. Education is also included as a major social variable that influences the fertility behaviour of people. Similarly, religion is used to examine the extent to which it influences an adolescent's knowledge and use of contraception and hence influences her reproductive behaviour.

Furthermore, the conceptual framework seeks to explore the consequences of adolescent sexuality and childbearing. Issues like the contraction of sexually transmitted infections, abortion, sterility and death as well as other fertility associated health concerns are qualitatively considered. These are, however, explored from the point of view of the adolescent's knowledge of these as consequences of adolescent reproduction. The perception of the adolescents (male and female) and adults on the consequences of adolescent sexuality, contraceptive use and childbearing are also analysed from the focus group discussions that were conducted. The reproductive health issues are thus, more descriptive and exploratory.

Figure 1.1. Conceptual Framework Showing the Interrelationships between Adolescent Sexuality, Contraceptive Use and Childbearing



Source: Adapted from Bongaarts' (1978) idea of intermediate variables in understanding fertility.

The study acknowledges that adolescent childbearing affects their reproductive health. On account of data limitations however, the reproductive health concerns are not statistically analysed but discussed from the point of view of the respondents who participated in the focus group discussions. The direct reproductive health effects of adolescent childbearing pertaining to the data collected from adolescents in this study are therefore not analysed quantitatively.

1.7 Hypotheses

The following hypotheses have been examined in the study.

- i) There is an inverse relationship between age at first sexual intercourse and childbearing among adolescents;
- ii) Contraceptive use is directly related to the level of education of the female adolescent;

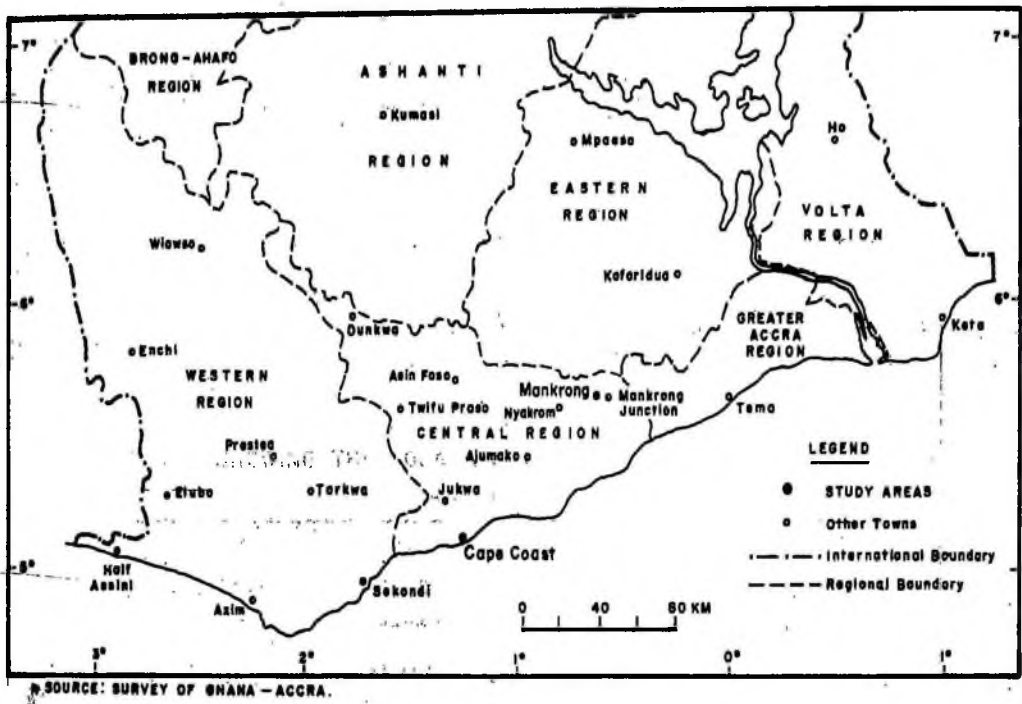
- iii) There is an inverse relationship between female adolescent childbearing and contraceptive use at first sex;
- iv) There is an inverse relationship between education and childbearing among adolescent females;
- v) There is direct relationship between contraceptive use at first sex and age at first sexual activity among adolescent females.

1.8 Sources of Data and Methodology

1.8.1 Sources of Data

The main source of data for the study is primary. The data have been collected in a survey undertaken in Cape Coast, the regional capital, and Mankrong, a rural area in the Central Region. The two study areas were chosen purposely for comparing adolescent sexual and reproductive health situation in an urban vis-à-vis a rural area. Figure 1.2 shows the geographical location of the two study areas.

Figure 1.2. Map Showing the Location of the Study Areas, Cape Coast and Mankrong



The main instrument for data collection was a structured questionnaire. Respondents were females aged 12-24 years in the two study areas. Secondary sources including the Ghana Demographic and Health Surveys as well as information gathered from focus group discussions were also used.

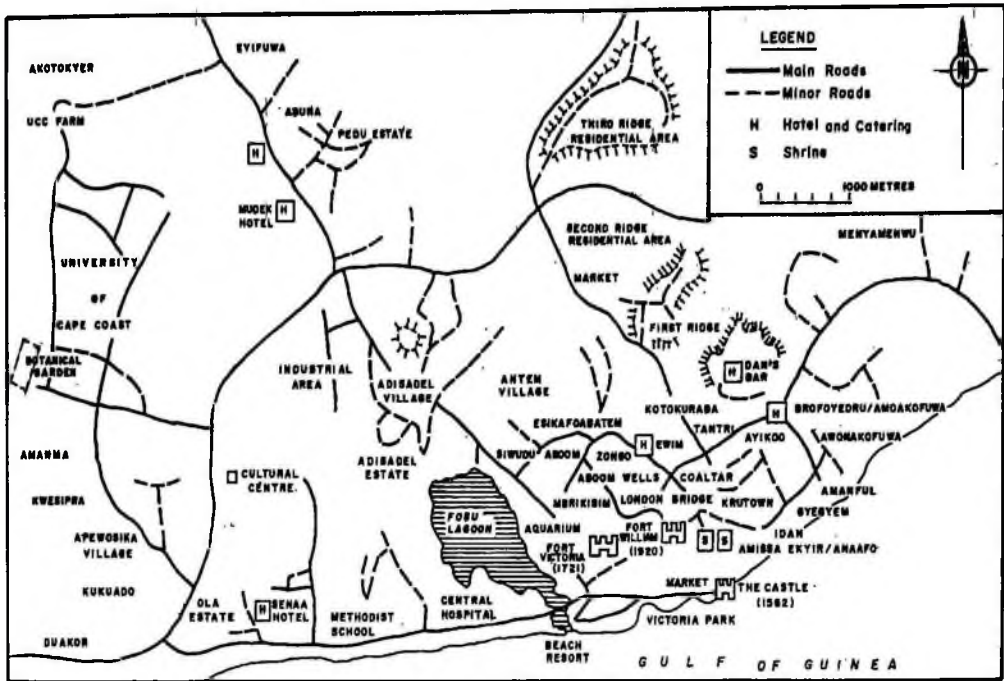
As earlier explained, the study excludes male adolescents because the magnitude of adolescent sexuality and reproductive health problems especially with respect to school drop out, affects female adolescents more than their male counterparts. The focus on adolescent females therefore, is for the sake of drawing more attention to the critical problems female adolescents face regarding their sexuality and reproductive health. However, it does not limit adolescent sexual and reproductive health problems to females only.

1.8.2 Sample Design

The selection of the sample for the study in Cape Coast was carried out in two stages. First, Cape Coast was divided into 34 clusters made up of 15 low-income, 11 middle-income and 8 high-income residential areas to form the sampling units. These were the existing clusters made by the Town and Country Planning Department (TCPD) in the town. The selection of the clusters for the study was done by simple random sampling, taking into account their geographical location such that clusters that were eventually selected were spread across the Cape Coast township as well as cutting across all socio-economic groups. With this at the background, three clusters were each selected from the high and middle-income residential areas and four from the low-income residential areas. In all, 10 residential clusters were purposively selected for enumeration in Cape Coast. Figure 1.3 shows the residential clusters in Cape Coast from which the sample was generated.

At the second stage, the survey aimed at a sample of 150 female adolescents aged 12-24 years from each of the 10 randomly selected residential clusters such that in Cape Coast 1,500 adolescent respondents were targeted based on the assumption that it will constitute a relatively large sample to facilitate the analyses that were envisaged in the study. The survey was therefore targeted purposively at households that had females of 12-24 years who were subsequently selected for interview with the individual questionnaire. On the contrary, considering the small size of Mankrong (made up of Mankrong and Mankrong Junction) and to avoid suspicions of selectivity, total enumeration of all households was undertaken and females aged 12-24 years selected for the individual questionnaire. Overall, the survey achieved a sample of 1,828 female adolescents (i.e., 1,503 in Cape Coast and 325 at Mankrong) of 12-24 years in both Cape Coast and Mankrong instead of 2,000 as was initially envisaged.

Figure 1.3. Map Showing the Residential Clusters in Cape Coast



Two sets of questionnaire were therefore administered: a household questionnaire and an individual questionnaire for eligible females aged 12-24 years. Collecting information from females aged 12-24 years facilitated a comparison between females aged 15-19 years and 20-24 years as well as adolescents below 15 years of age.

Apart from the structured questionnaire, the study conducted focus group discussions among some selected male and female adolescents on one hand, and some male and female adults on the other in respect of their views on the magnitude, causes and impact of adolescent sexuality on the reproductive health of female adolescents as pertains to each of the study areas. These sources of data enabled us answer some fundamental sociological questions about adolescent reproduction in these study areas. The focus group discussions were conducted in Fanti, the main local language of the Central Region. The qualitative data collected from the focus group discussions were transcribed

and translated from Fanti into English. These data were analysed and used to beef up the explanation for the results obtained from the quantitative analysis as they were considered appropriate. The qualitative data thus, provided additional information to strengthen the results of the quantitative analysis throughout the thesis.

1.8.3 Techniques of Analysis

Simple techniques of analysis, including cross tabulations, rates, ratios and proportions were employed. Path analysis was intended to be used to examine the direct and indirect effects of the socio-economic and demographic variables on adolescent sexuality and childbearing. However, due to the small size of the sample of female adolescents who had ever become pregnant at the time of the survey, this technique could not be employed. A multiple regression analysis was however, done to attempt a statistical explanation for some of the relationships. The validity of the hypotheses was determined at 95 per cent level of confidence. The analysis was also intended to be done separately for each study area to enable comparisons to be made before adding them together to find out the situation for all the study areas in the Central Region. However, this was not possible due to the small sample size for the women who were eligible for this kind of analysis particularly in Mankrong. The Statistical Package for Social Sciences (SPSS) was used for data processing and analysis.

1.9 Definition of Concepts

Adolescent: The World Health Organisation defines adolescents as persons aged 10-19 years using chronological age. In this study however, an adolescent is defined to include all persons aged 12-19 years. This is because persons of 10 and 11 years are considered too young to have much knowledge about sexual matters let alone to have a sexual experience. Persons aged 10-11 years who have ever had a sexual experience would be very few and hence would not facilitate any statistically

meaningful analysis. The study therefore did not collect any information on persons of 10 and 11 years old. Persons of 20-24 years are however, included in the analysis not necessarily as adolescents but to allow a comparison between them and the adolescents (12-19 years). The emphasis therefore is more on the adolescents of 12-19 years although throughout, the study examined all categories of respondents i.e., 12-24 years. In the study, teenagers are used interchangeably with adolescents. On account of the small sample size however, while in most cases adolescents less than 20 years have been compared with the youth of 20-24 years, in some cases, the analysis puts all the respondents (12-24 years) together.

Reproductive Health: The study adopts the International Conference on Population and Development (ICPD) broad definition, which has been adopted by the Ministry of Health (MOH) of Ghana together with its implications as spelt out in the Ministry of Health's National Reproductive Health Service Policy and Standards (Ministry of Health, 2000). Reproductive health is therefore defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its functions and processes" (MOH, 2000). The implication here according to the MOH (and which is adopted in this study) is that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Adolescent Reproductive Health: All aspects of reproductive health that pertain to adolescents who are the subject of investigation in this study.

Adolescent Sexuality: According to the Sex Information and Education Council of the United States (SIECUS) whose main goal is to promote education about sexuality, "the concept of sexuality refers to the totality of being a person" and includes "all the aspects of the human being that relate specifically to being a boy or girl, woman or man, and is an entity subject to lifelong dynamic change" (Greenberg et al., 1992). For the purpose of this study however, adolescent sexuality is defined as the knowledge, perception, beliefs and behaviour that are related to sexual relationships

between the opposite sexes, at least one of whom should be an adolescent. In other words, it is used to include any human behaviour that has the potential to affect the reproductive health of the adolescent.

Sexually Active Adolescents: This study defines sexually active adolescents broadly to include all adolescents who had ever had sex prior to the survey. These adolescents are therefore conceived in this study to have the potential to engage in sex at some regular interval and hence are identified as being sexually active.

Socio-Economic Status: This is used to describe the average standard of living of the respondents. The selection of the sample of adolescents in Cape Coast was based on three socio-economic residential groups defined by the Department of Town and Country Planning in Cape Coast as High Class, Middle Class and Low Class residential areas. Persons living in these residential areas are therefore classified respectively as high, medium and low socio-economic status groups. **High socio-economic status** is used to describe persons in households with ownership of basic facilities including means of transport, access to potable supply, electricity, radio, television and, in addition, are above the upper poverty line of ₵900,000.00 per capita as defined in the Ghana Living Standards Survey (GLSS) of 1992. **Medium socio-economic status** persons are those from households who are above the upper poverty line but do not own all the basic household facilities. The **low socio-economic status** persons however, refer to persons conceived to be below the upper poverty line. The limitation of these definitions based on the determination of the poverty line, which is in turn dependent on the non-stable nature of the local currency is however acknowledged by the study.

1.10 Limitations of the Study

The first limitation of this study is its restriction to two settlements in the Central Region i.e., Cape Coast and Mankrong although the goal was to study adolescents in the Central Region. The sample is to this extent, limited in that it is not representative of the population of adolescents in the

entire Central Region. This however, does not seriously affect the findings in the sense that the study seeks to principally compare adolescents in one rural community in the hinterland of the region to their counterparts in the capital town, Cape Coast. This must be borne in mind in the interpretation of the analysis throughout the study in order to be cautious in making generalizations based on the analysis in the study for the whole of the Central Region.

The second limitation, which has also been emphasised in the analysis, is with respect to the effect of education on the sexual practices of the adolescents. In the analysis, current education of the adolescents is used instead of their level of education at the time of first sexual activity which could be of more relevance in understanding the variation of adolescents in terms of the timing of their first sexual intercourse, their contraceptive use at their first sexual activity, etc., as far as their education is concerned. This is because the survey failed to collect information on the level of education of the respondents at the time of their first sexual experience.

Finally, not much rigorous statistical analysis could be done on account of the small proportion of adolescents who had ever had a sexual activity among the total sample. In view of this, results of focus group discussions held separately among adolescents and adults at the study areas have been used to give further explanation to some of the key findings. The study in this respect, introduces qualitative dimensions to the analysis thus, providing readers the opportunity to assess the relationships that have been investigated in the study from two perspectives i.e., the use of quantitative and qualitative data collection processes.

1.11 Organisation of the Study

The study is organized into nine chapters. The first chapter, which is the introduction, provides the background to the study by defining the research problem, the rationale for the study and the key objectives. In addition, it presents the conceptual framework against the background of

available literature on the topic, while describing the sources of data and the methodology as well as the techniques used in the analysis.

Chapter two examines the household characteristics of the study areas emphasising the differences that exist between them. This is to assist in understanding possible sexual behaviour differences between adolescents in the two study areas. On the other hand, Chapter three discusses the socio-economic characteristics of the adolescents in the two study areas with respect to their age, education, marital status, migration status, religious affiliation, ethnicity, occupation and living arrangements.

Chapter four also examines adolescent sexuality and marriage with respect to their age at first sexual activity and marriage as well as the reasons behind the timing of both first sexual activity and marriage. In Chapter five, analysis is done about adolescent childbearing and their reproductive knowledge under which issues including age at first pregnancy and birth were looked at. Other issues examined in this chapter include adolescent fertility, pregnancy wastage and the timing of first pregnancy and as to whether it led to the interruption of their formal education.

Adolescents' knowledge and use of contraception are the subjects of investigation in Chapter six. Efforts are made to analyse the adolescents' use of contraceptives at first sexual activity, current contraceptive use as well as the perception of the adolescents regarding the use of contraceptives by unmarried adolescents and whether the provision of family life education among adolescents could lead to sexual promiscuity among them. Chapter seven focuses attention on the knowledge of adolescents about reproductive health problems as well as the incidence and prevention of sexually transmitted infections including HIV/AIDS.

The study also attempts to examine the possible relationships between adolescent sexuality, contraceptive use and reproductive health in Chapter eight using statistical techniques involving multiple regression analysis. Finally, Chapter nine provides a summary of the key findings of the study and makes relevant recommendations and conclusions.

CHAPTER TWO

HOUSEHOLD CHARACTERISTICS OF THE STUDY AREAS

2.1 Introduction

The behaviour of people is conditioned by a number of circumstances that surround their socialisation process from infancy to adulthood. Sociologically, the household constitutes the primary institution within which the child begins his/her process of socialisation. The household characteristics and the socio-demographic and economic environment within which the child is brought up is therefore crucial in patterning the behaviour of the child including her sexuality. This chapter seeks to examine the demographic as well as socio-economic background characteristics of the households within which the female adolescents have, and are being socialized. This is to find out to what extent the socio-economic conditions in the households have influenced the sexual and reproductive behaviour of the adolescents.

2.2 Age and Sex Distribution of Household Members

A total of 5,209 persons were listed as household members from 759 and 215 households from Cape Coast and Mankrong respectively. It could be computed from Table 2.1 that the distribution of household members was 4,083 or 78.4 per cent for Cape Coast and 1,126 or 21.6 per cent for Mankrong.

Table 2.1. Age and Sex Characteristics of Household Members, Cape Coast and Mankrong

Age	Cape Coast				Mankrong			
	Male		Female		Male		Female	
	Number	%	Number	%	Number	%	Number	%
0-4	84	2.1	80	2.0	37	3.3	47	4.2
5-9	128	3.1	123	3.0	85	7.6	57	5.1
10-14	193	4.7	479	11.7	54	4.8	130	11.5
15-19	197	4.8	721	11.7	41	3.6	110	9.8
20-24	165	4.0	472	11.6	34	3.0	115	10.2
25-29	80	2.0	97	2.4	24	2.1	27	2.4
30-34	41	1.0	94	2.3	17	1.5	40	3.6
35-39	38	0.9	145	3.6	23	2.0	36	3.2
40-44	88	2.2	132	3.2	20	1.8	37	3.3
45-49	100	2.4	141	3.5	23	2.0	23	2.0
50-54	99	2.4	99	2.4	13	1.2	22	1.9
55-59	58	1.4	39	0.9	9	0.8	18	1.6
60-64	46	1.1	39	0.9	8	0.7	11	1.0
65-69	13	0.3	23	0.6	11	1.0	9	0.8
70+	30	0.7	39	0.9	21	1.9	24	2.1
Total	1,360	33.3	2,723	66.7	420	37.3	706	62.7

Source: Compiled from Cape Coast-Mankrong field survey, Aug-Sept. 1997

For both Cape Coast and Mankrong, 65.9 per cent of the household members were females compared to 34.1 per cent males (figures not shown in table). This shows a big bias in favour of females. This is also true when we compare Cape Coast to Mankrong. In Cape Coast, 66.7 per cent of the household members were females as against 33.3 per cent males. Similarly, there were 62.7 per cent females and 37.3 per cent males in Mankrong. This huge bias could be due to the high interest the survey placed on female adolescents. For example, the interviewers were under instruction to interview only households which had at least one female between the ages of 12 and 24 years. This could probably have been misinterpreted leading to possible non-inclusion of some male members of some of the households. This is more pronounced in the ages 10-24 (Table 2.1). The sample bias for females, however, did not affect the results of the analysis since the main focus of the study is on female adolescents of between 12 and 24 years.

Again, the total household members could be broken down as 26 per cent male and 52.3 per cent female from Cape Coast as against 8.1 per cent male and 13.6 per cent female from Mankrong. It is also clear that the age distribution in both Cape Coast and Mankrong is significantly skewed in favour of females within the ages 10 to 24. This is clearly in support of the earlier explanation that both enumerators and household heads were perhaps more interested in listing their female members within the ages of 12 to 24 years upon prior information that they formed the primary basis of the study.

The analysis further shows that more than two-thirds and four-fifth of the household members in Cape Coast and Mankrong respectively were born within the Central Region (Table 2.2). It confirms results of the 1960, 1970 and 1984 Population censuses that the Central Region is not home to many migrants from other regions of Ghana. The sample is thus, more of a homogeneous group by virtue of where they were born.

Table 2.2. Distribution of Household Members by Region of Birth, Cape Coast and Mankrong

Region of Birth	Study Area			
	Cape Coast		Mankrong	
	Number	%	Number	%
Western	178	4.4	19	1.7
Central	2,866	70.2	993	88.2
Greater Accra	232	5.7	29	2.6
Eastern	173	4.2	34	3.0
Ashanti	233	5.7	16	1.4
Brong Ahafo	81	2.0	1	0.0
Volta	130	3.2	19	1.7
Northern	61	1.5	11	1.0
Upper West	17	0.4	2	0.2
Upper East	14	0.3	0	0.0
Outside Ghana	96	2.3	2	0.2
Not Stated	2	0.1	0	0.0
Total	4,083	100.0	1,126	100.0

Source: Compiled from Cape Coast-Mankrong field survey, August/September, 1997.



2.3 Household Headship

There were in all 974 households comprising 759 or 77.9 per cent in Cape Coast and 215 or 22.1 per cent in Mankrong. The distribution of the households is presented in Table 2.3.

Table 2.3. Distribution of Households by Sample Area

Sample Area	Number	%
1. Cape Coast		
University Community	81	8.3
Eyifuwa	85	8.7
Third Ridge Residential Area	53	5.5
North Ola/Ola Estate	75	7.7
Aboom	115	11.8
Pedu Estate/Medical Village	85	8.7
Kotokroba Zongo	90	9.2
Brofoyedru/Amoakofuwa	55	5.7
Idan/Amissa Ekyir/Anafo	35	3.6
Adisadel Village	85	8.7
Total	759	77.9
2. Mankrong	215	22.1

Source: Compiled from Cape Coast-Mankrong field survey, August/September, 1997.

The socialization process of household members would vary in accordance with whether the household head is a male or female. In most cases, where the head of household is a female, it may be that she is living as a single parent as a result of the death or out-migration of her husband. In that case, children in a female-headed household may not benefit from training from both parents, a situation which does not regularly occur in most male-headed households.

Overall, 62.1 per cent of the total number of households that were captured in the survey were headed by males as against 37.9 per cent female-headed households. The female

headship rate is slightly higher in Mankrong, almost 42 per cent as against 37 per cent in Cape Coast as shown in Table 2.4.

Table 2.4. Sex Composition of Household Heads in Cape Coast and Mankrong

Study Area	Male		Female		Total	
	N	%	N	%	N	%
Cape Coast	480	63.2	279	36.8	759	77.9
Mankrong	125	58.1	90	41.9	215	22.1
Total	605	62.1	369	37.9	974	100

Source: Compiled from Cape Coast-Mankrong field survey, August/September, 1997.

The relatively higher proportion of female-headed households in Mankrong may be attributed largely to male out-migration, which came out strongly during the focus group discussions with a section of the adult members of the community. This could have negative implications for the upbringing of children in general and their sexual behaviour in particular.

The age distribution of the heads of household for the two study areas has also been examined. Overall, it shows that about 10 per cent of all household heads were less than 35 years and about 59 per cent were within the middle ages of 35-54 years. However, there is some significant variation between Cape Coast and Mankrong. For example, from Table 2.5, it can be observed that Mankrong has almost two times the proportion of heads of household who are less than 35 years as in Cape Coast (15.9 per cent versus 8.2 per cent). Thus, while almost 62 per cent of the heads of household in Cape Coast are between 35 and 54 years, in Mankrong, the proportion for the same age group is 46 per cent. Conversely, Mankrong has a higher proportion of older heads of household (i.e., 55 and over) compared to Cape Coast.

In sum, Mankrong has higher proportions of younger and older heads of household compared to Cape Coast. The reason could be that Mankrong being a rural area which experiences high out-migration tends to lose most of the young and economically active men to the bigger towns perhaps including Cape Coast, leaving their equally young spouses as heads of household back at home. The larger proportion of household heads, who are more than 55

years in Mankrong in comparison with Cape Coast may be plausibly explained by a relatively higher out-migration of the economically active young persons in Mankrong for economic opportunities in towns close by. This is however, not to discount the practice in most rural households in Ghana where the oldest person in the household is often regarded as the head of household irrespective of his or her economic ability to take care of the household.

Table 2.5. Age Distribution of Heads of Household in Cape Coast and Mankrong

Age	Cape Coast		Mankrong		Total	
	Number	%	Number	%	Number	%
20-24	11	1.4	10	4.7	21	2.2
25-29	21	2.8	8	3.7	29	3.0
30-34	30	4.0	16	7.5	46	4.7
35-39	75	9.9	25	11.6	100	10.3
40-44	124	16.3	22	10.2	146	15.0
45-49	136	17.9	31	14.4	167	17.0
50-54	135	17.8	22	10.2	157	16.1
55-59	70	9.2	14	6.5	84	8.6
60-64	71	9.4	15	7.0	86	8.8
65-69	29	3.8	18	8.4	47	4.8
70+	54	7.1	32	14.9	86	8.8
Not stated	3	0.4	2	0.9	5	0.5
Total	759	100	215	100	974	100

Source: Compiled from Cape Coast-Mankrong field survey, August/September, 1997.

2.4 Household Size

According to Nabila and Fayorsey (1996), most female adolescents in Accra and Kumasi explained, during focus group discussions that they indulge in sexual activities for economic rewards. This is usually the case when parents are either irresponsible or are economically not in a position to take adequate care of their children. It should however, be noted that reward is an intrinsic part of the traditional *mpena* (consensual sexual union) relationship in Ghana. In Ghana, where incomes are generally low, one's economic capability in providing adequately for the needs of his/her children or dependents largely depends on the size of his/her household. Thus, granted that economic incentives are crucial in understanding

an adolescent's sexual behaviour, the size of the household is important in investigating into the sexual practices of female adolescents.

Table 2.6 shows the average household sizes for the study areas. The results in the table are quite contrary to expectation. Overall, the average household size for both Cape Coast and Mankrong is 5.3. However, while Mankrong, which is a rural area has average household size of 5.2, Cape Coast, an urban settlement has a relatively higher household size of 5.6. The variation could be explained with reference to high rates of out-migration from Mankrong as compared to Cape Coast. This view was supported by participants in the focus group discussions in Mankrong who attributed this to the limited number of economic opportunities in that area apart from farming activities, which the youth are not very much interested in. On the other hand, it could be due to differences arising from the sample selection.

It is also significant to note that within Cape Coast itself the variation in household size is such that areas defined as first class residential areas and of high socio-economic status tend to have a higher household size than the low socio-economic status areas. For example, the average household size for the University Community, Eyifuwa and Third Ridge Residential areas supposed to be first class, high status areas is 6.8 on the average compared to 4.6 for the middle class made up of North Ola and Ola Estates, Aboom and Pedu Estate/Medical Village. On the other hand, the very low socio-economic status areas made up of Kotokoraba Zongo, Brofoyedru and Amoakofuwa, Idun/Amissa Ekyir/Anafo and Adisadel Village have an average household size of 5.4.

Table 2.6. Average Household Size by Study Area

Area	Average Household size
University Community	6.7
Eyifuwa	6.9
Third Ridge Residential Area	6.9
North Ola/Ola Estate	5.7
Aboom	4.8
Pedu Estate/Medical Village	3.4
Kotokoraba Zongo	4.2
Brofoyedru/Amoakofuwa	6.4
Idun/Amissa Ekyir/Anafo	6.9
Adisadel Village	4.1
Average for Cape Coast	5.6
Mankrong	5.2
Total	5.3

Source: Compiled from Cape Coast-Mankrong Field Survey, Aug-Sept., 1997.

The pattern of variation in household size among the study areas is probably indicative of the more attraction of the high-class areas to migrants from family relations in the rural areas and not necessarily due to natural population increase. In any case, the pattern of household size variation is more progressive in as much as the relatively higher income areas have more household members to cater for compared to areas with relatively lower incomes. In line with this reasoning, it may not be very common to find most adolescents citing monetary gains as the major reason for indulging in sexual activities in Cape Coast and Mankrong.

2.5 Household Conditions

Household conditions include the type of material used in constructing outer walls and roofing, availability of electricity and piped water in household for its use. Analysis of these characteristics is in conformity with the status of Cape Coast as an urban settlement and Mankrong as a rural community.

With respect to the type of material used in constructing the outer walls of household premises, almost 85 per cent of the household structures were of cement blocks in Cape Coast

while at Mankrong, 76 per cent were of mud (*Table 2.7a*). This is to be expected in most rural settlements in Ghana although in recent times the situation is changing.

Table 2.7a. Type of Main Material Used in Constructing Outer Walls of Household Premises, Cape Coast and Mankrong

Type of Material	Cape Coast		Mankrong	
	Number	%	Number	%
Cement blocks	642	84.6	33	15.3
Mud	111	14.6	163	75.8
Other*	6	0.8	19	8.9
Total	759	100.0	215	100.0

* Includes wood and bricks

Source: Compiled from Cape Coast-Mankrong field survey, Aug-Sep., 1997

On the other hand, as shown in *Table 2.7b*, while almost 44 per cent of the household buildings in Cape Coast were roofed with iron sheets, about 17 per cent with concrete and 37 per cent with slate, almost every house in Mankrong was roofed with iron sheets. Thus, although a rural area, Mankrong does not appear to be too poor to use modern roofing materials.

Table 2.7b. Type of Material Used in Roofing Household Premises, Cape Coast and Mankrong

Type of Material	Cape Coast		Mankrong	
	Number	%	Number	%
Iron Sheets	332	43.7	198	92.1
Concrete	126	16.6	0	0.9
Asbestos Sheets	283	37.3	0	0.0
Roofing Tiles	7	0.9	0	0.0
Other*	11	1.5	17	7.9
Total	759	100.0	215	100.0

* Includes wood and bricks

Source: Compiled from Cape Coast-Mankrong field survey, Aug-Sept., 1997.

Investigation was also made into the availability of electricity and piped water within the household premises. For electricity, only 3 per cent of the households in Cape Coast did

not have supply unlike Mankrong where although the settlement is connected to the national electricity grid, just about half of the households have electricity connected to their houses for their use (Table 2.7c). In a similar vein, while 79.1 per cent of the households in Cape Coast reported that they had pipe borne water within their premises, none of the households in Mankrong has that facility because the village has not been provided with pipe borne water facility. Mankrong therefore depends mainly on the Ayensu River, which lies close by and a bore hole for its household water requirements.

Table 2.7c. Availability of Electricity Within Household Premises, Cape Coast and Mankrong

Study Area	Available		Not Available	
	Number	%	Number	%
Cape Coast	736	97.0	23	3.0
Mankrong	107	49.8	108	50.2
Total	843	86.6	131	13.4

Source: compiled from Cape Coast and Mankrong field survey, Aug-Sept. 1997.

2.6 Socio-Economic Status of Households

The heads of household were asked about their ownership of the structure in which they were housed and certain household facilities which are often considered to be associated with socio-economic status. These included the possession of radio, television, means of transport (i.e., vehicle, bicycle, motor cycle, etc.,) and refrigerator. In addition, they were also asked about their own perception of their socio-economic status and their responses are analysed in this section.

Analysis of the household data suggests that in Cape Coast a large number of the household premises (54 per cent) were rented while at Mankrong, the large proportion of the premises (43 per cent), were rather owned by the household members themselves. Table 2.8a shows that the proportion of households living in family houses varied from 21 per cent in Cape Coast to 27 per cent in Mankrong. This is to be expected because in a regional capital

such as Cape Coast it is common to find many households in rented premises than in Mankrong, a rural area where a relatively large proportion of the households are likely to be in their own houses or family houses. It is however, difficult to compare the two study areas in respect of their socio-economic status based on this evidence, since the value of the structures varies considerably between the two areas.

Table 2.8a. Ownership of Household Premises, Cape Coast and Mankrong

Ownership Status	Cape Coast		Mankrong	
	Number	%	Number	%
Owned	191	25.2	92	42.8
Rented	410	54.0	62	28.8
Family House	157	20.7	57	26.5
Not stated	1	0.1	4	1.9
Total	759	100.0	215	100.0

Source: compiled from Cape Coast and Mankrong field survey, Aug-Sept. 1997.

Availability of radio and television facilities on the other hand, suggests that female adolescents in Cape Coast may have more access to information including that on their reproductive health than their counterparts at Mankrong. The evidence is that almost 90 per cent and 82 per cent of households in Cape Coast responded to having a radio and a television respectively. On the contrary, one in three and one in five households respectively owned a radio and television at Mankrong (Table 2.8b).

It is however, possible that households which have no radio and, or television at Mankrong could have access to them from other households which have, considering the practice of sharing that is a common feature in most rural areas in Ghana.

Table 2.8b. Availability of Radio and Television to Households in Cape Coast and Mankrong

Study Area	Radio				Television			
	Available		Not Available		Available		Not Available	
	N	%	N	%	N	%	N	%
Cape Coast	673	88.7	86	11.3	626	82.5	133	17.5
Mankrong	71	33.0	144	67.0	43	20.0	172	80.0
Total	744	76.4	230	23.6	669	68.7	305	31.3

Source: compiled from Cape Coast and Mankrong field survey, Aug-Sept. 1997.

Ownership of refrigerating facility and means of transport also shows a similar pattern between Cape Coast and Mankrong. While 71 per cent of the households in Cape Coast indicated their ownership of a refrigerator, less than one in 10 households in Mankrong owned one. This is to be expected considering the non-universality of electricity to all households at Mankrong. Similarly, about 30 per cent of households in Cape Coast reported to own a means of transport (i.e. a vehicle) compared to less than 2 per cent at Mankrong. This suggests that adolescents in Cape Coast generally are from households that are of a relatively higher socio-economic status than their counterparts at Mankrong. This is consistent with the Ghana Living Standards Survey (GLSS 4) finding of a relatively higher rural poverty than the urban in Ghana (Ghana Statistical Service, 2000).

Finally, the household heads were asked how they perceived their households with respect to socio-economic status. The results presented in Table 2.8c clearly indicate that in Cape Coast most of the households perceived themselves as belonging to a medium socio-economic status (89.3 per cent) while at Mankrong, majority considered themselves to be in the low socio-economic status. It is revealing to observe that none of the households at Mankrong reported to be in the high socio-economic class.

Table 2.8c. Perception of Household About their Socio-Economic Status, Cape Coast and Mankrong.

Study Area	Socio-Economic Status							
	High		Medium		Low		Not Stated	
	N	%	N	%	N	%	N	%
Cape Coast	31	4.1	678	89.3	43	5.7	7	0.9
Mankrong	0	0.0	46	21.4	169	78.6	0	0.0
Total	31	3.2	724	74.3	212	21.8	7	0.7

Source: compiled from Cape Coast and Mankrong field survey, Aug-Sept. 1997.

The results in Table 2.8c should however, be interpreted with caution since many people particularly in the rural areas associate anything such as incomes that are related to their socio-economic status with a possibility of payment of high rates of taxes. Many people would therefore, wish to be associated with either low or medium status groups in order not to attract high taxation.

On the whole, however, one can fairly conclude that the households in Cape Coast are of a relatively higher socio-economic status than those at Mankrong. Access to information on sexuality and reproductive health may equally be more available to adolescents in Cape Coast than at Mankrong considering the more availability of radio, television and electricity to respondents in Cape Coast, which has the advantage of being the regional capital as against Mankrong.

CHAPTER THREE**DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS
OF FEMALE ADOLESCENTS****3.1 Introduction**

The sexual and reproductive health behaviour of female adolescents may depend on their demographic and socio-economic characteristics. This chapter therefore devotes attention to examining the characteristics of the adolescents who were interviewed to facilitate a better understanding of their sexuality and reproductive health behaviour and practices. Comparisons are made in the analysis between Cape Coast as an urban area and Mankrong as a rural settlement.

3.2 Age Distribution of Adolescents

The eligible respondents in the individual questionnaire numbered 1,828 in all: 1,503 (82.2 per cent) in Cape Coast and 325 (17.8 per cent) at Mankrong. Although the distribution is biased in terms of the numbers for Cape Coast, proportionally, considering the population of the two study areas, that is to be expected.

The distribution of the adolescents by age does not show too much variation between adolescents in Cape Coast and their counterparts at Mankrong. The two most remarkable variations, however, can be observed at ages 12 and 20 years where Mankrong recorded a much higher proportion of respondents than in Cape Coast. It is also clear that the proportion of respondents for ages 21 and above is smaller than that for younger ages especially between 15 and 20 years for either Cape Coast or Mankrong. As is shown in Table 3.1, the drop in proportion from age 20 to 21 is very remarkable especially for Mankrong. This could be a result of most of the respondents who were older than 20 years preferring to report their ages at 20, i.e. at digit zero. It also suggests a situation of age misreporting among the respondents.

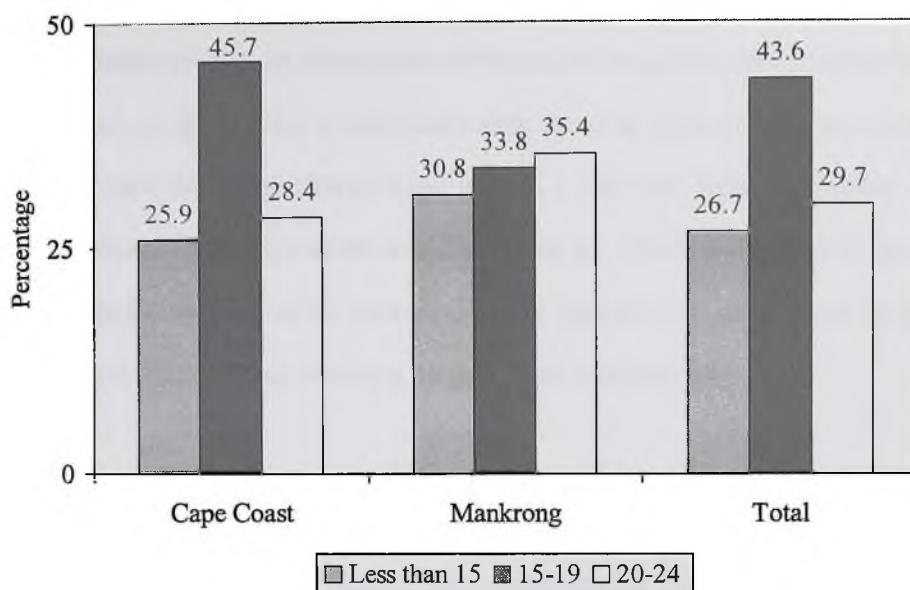
At the same time, the explanation that both interviewers and respondents were under the impression that the survey was mainly focusing attention on females aged 15-19 years appears to be valid here. Thus, overall, in Figure 3.1 when ages are grouped, the concentration is clearly within the age group 15-19 years.

Table 3.1. Distribution of Female Adolescents by Single Years of Age, Cape Coast and Mankrong.

Age	Cape Coast		Mankrong		Total	
	Number	%	Number	%	Number	%
12	115	7.7	38	11.7	153	8.4
13	125	8.3	31	9.5	156	8.5
14	149	9.9	31	9.5	180	9.8
15	145	9.6	28	8.6	173	9.5
16	154	10.3	29	8.9	183	10.0
17	131	8.7	14	4.3	145	7.9
18	144	9.6	22	6.8	166	9.1
19	113	7.5	17	5.2	130	7.1
20	129	8.6	43	13.2	172	9.4
21	83	5.5	22	6.8	105	5.7
22	81	5.4	19	5.9	100	5.5
23	60	5.0	18	5.6	78	4.3
24	74	4.9	13	4.0	87	4.8
Total	1,503	82.2	325	17.8	1,828	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Figure 3.1. Distribution of Female Adolescents by Age Group, Cape Coast and Mankrong



3.3 Education

The survey asked questions about the level of education of the adolescents in order to investigate into how it varies in respect of their sexual behaviour and the role education could play. Table 3.2 shows the proportion of the adolescents by age and current level of education for Cape Coast and Mankrong. Overall, adolescents from Cape Coast tend to have relatively higher levels of education than those at Mankrong. This is supported by the evidence that while just about 6 per cent of the female adolescents in Cape Coast had no formal education, the corresponding proportion at Mankrong was 16 per cent. Similarly, almost 26 per cent of the respondents in Cape Coast had Secondary/Senior Secondary School (SSS) education compared to about 5 per cent at Mankrong. Besides, at least 5 per cent of the respondents in Cape Coast had some Post-Secondary or higher education but no adolescent at Mankrong had had any Post-Secondary or higher form of education. It is however, instructive to observe that most of the adolescent girls had attained a Middle or Junior Secondary School (JSS) level of education

(45 per cent in Cape Coast and almost 50 per cent at Mankrong). The distribution across all the ages tends to follow this pattern.

The implication of the above pattern of education among the adolescents at this stage is that with most of the females in both study areas pursuing formal education at least to the Middle or Junior Secondary School level, there is a relatively higher probability that their knowledge about reproductive health would be enhanced. This is in the light of the generally observed relationship that exists between level of education of women and their fertility behaviour worldwide (Ghana Statistical Service, 1988, 1994 and 1999).

Table 3.2. Percentage Distribution of Female Adolescents by Age and Current Level of Education, Cape Coast and Mankrong.

Age	No Education		Primary		Middle/JSS		SSS/Secondary		Post-Secondary	*Other	Total Number	
	CC	MK	CC	MK	CC	MK	CC	MK	CC	CC	CC	MK
12	6.1	5.3	63.5	81.6	30.4	13.1	0.0	0.0	0.0	0.0	115	38
13	6.4	9.7	39.2	38.7	53.6	51.6	0.8	0.0	0.0	0.0	125	31
14	4.7	9.7	17.4	32.3	73.8	58.1	4.1	0.0	0.0	0.0	149	31
15	10.3	3.6	13.1	25.0	60.7	67.8	15.9	3.6	0.0	0.0	145	28
16	4.5	13.8	12.3	0.0	42.2	75.9	39.6	10.3	0.0	1.3	154	29
17	3.1	14.3	17.6	14.3	42.0	64.3	37.4	7.1	0.0	0.0	131	14
18	5.5	22.7	8.3	13.6	35.4	59.1	49.3	4.6	1.4	0.0	144	22
19	3.5	47.0	7.1	29.4	40.7	11.8	42.5	11.8	5.3	0.9	113	17
20	8.5	32.6	8.5	27.9	34.9	39.5	35.7	0.0	10.9	1.5	129	43
21	2.4	13.6	3.6	22.7	30.1	54.6	36.2	9.1	27.7	0.0	83	22
22	4.9	15.8	9.9	10.5	34.6	63.2	29.6	10.5	21.0	0.0	81	19
23	6.7	16.7	15.0	11.1	46.7	55.5	16.7	16.7	13.3	1.6	60	18
24	4.1	15.4	8.1	30.8	44.6	53.8	25.7	0.0	17.6	0.0	74	13
<15	5.7	8.0	38.0	53.0	54.5	39.0	1.8	0.0	0.0	0.0	389	100
15-19	5.5	18.2	11.8	15.4	44.4	59.1	36.7	7.3	1.2	0.4	687	110
20-24	5.7	21.7	8.7	21.7	37.2	50.4	30.2	6.1	17.6	0.7	427	115
Total	5.6	16.3	17.7	29.2	45.0	49.9	25.7	4.6	5.5	0.5	1,503	325

Notes: C.C. refers to Cape Coast and MK represents Mankrong

*Represents Arabic

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

3.4 Marital Status

An analysis of sexual behaviour patterns among female adolescents requires some knowledge about their marital status at the time of the survey considering the different reproductive health risks that each marital status presents. Table 3.3 presents the distribution of the adolescents according to age and three main marital status groups i.e. never married, currently married and formerly married comprising the divorced, separated and widowed.

Table 3.3. Percentage Distribution of Female Adolescents by Age and Current Marital Status, Cape Coast and Mankrong.

Age	Never Married		Currently Married		Formerly Married		Total Number	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
12	100.0	100.0	-	-	-	-	115	38
13	100.0	100.0	-	-	-	-	125	31
14	100.0	100.0	-	-	-	-	149	31
15	100.0	100.0	-	-	-	-	145	28
16	100.0	100.0	-	-	-	-	154	29
17	99.2	100.0	0.8	-	-	-	131	14
18	99.3	95.5	0.7	4.5	-	-	144	22
19	92.9	47.7	7.1	47.0	-	5.9	113	17
20	88.4	55.8	10.8	34.9	0.8	9.3	129	43
21	94.0	68.2	6.0	27.3	-	4.5	83	22
22	81.5	57.9	17.3	42.1	1.2	-	81	19
23	88.3	38.9	10.0	58.8	1.7	-	60	18
24	62.2	28.6	36.5	64.3	1.3	5.5	74	14
Total N	1,423	260	76	58	4	7	1,503	325
%	94.7	80.0	5.0	17.9	0.3	2.1	82.2	17.8

Note: - means no one belongs to that cell

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept. 1997.

From the table, it can be observed that a high proportion of the respondents were never married at the time of the survey, i.e., 94.7 per cent in Cape Coast as against 80 per cent at Mankrong. Thus, a small proportion of adolescents (5.0 per cent) from Cape Coast reported to have ever married compared to 20 per cent at Mankrong. However, when the two sets of

sample are considered together, 8 per cent of the female adolescents had ever been in a marital union as at the time of the survey.

The youngest age at which a female adolescent reported to be in a marital union was 18 years for Mankrong and 17 years for Cape Coast. The overall proportion of adolescents reporting to have formerly been in marriage was also small: 0.3 per cent in Cape Coast and 2.1 per cent at Mankrong. It is clear that majority of the young girls particularly in Cape Coast are not married and hence are likely to have the opportunity to continue their education. However, contrary to the United Nations' (1989) assertion that adolescent childbearing in developing countries takes place in marriage and hence teenage fertility is not a problem, sexuality and reproductive health may not necessarily depend on whether or not one is married but most importantly, the timing of one's entry into sexual activity and the kinds of sexual practices one may be involved in.

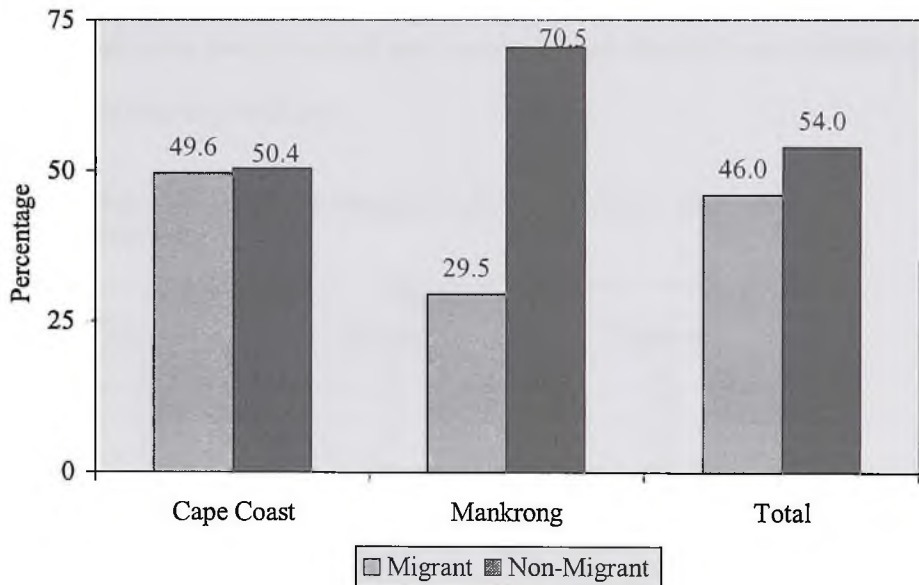
3.5 Migration Status

One emerging problem especially in the cities and urban centres is the issue of *streetism*, particularly among the adolescent migrants from the rural areas. According to Nabila and Fayorsey (1996), migration of many teenagers into cities in Ghana in recent times, has led to many young girls being drawn into sexual relations purely as a matter of survival. Media reports have also indicated a number of these female street adolescents having frequently fallen prey to sexual abuse by some men. Most often, the victims of such sexual abuses are migrant adolescents who have no regular homes in their places of destination and hence are forced to fend for themselves on the streets.

On the basis of the foregoing background, the survey asked questions to find out the migration status of the respondents in order to assess their sexual behaviours. The analysis presented in Figure 3.2 shows that overall, 46 per cent of the female adolescent respondents

were migrants born outside their current place of residence and enumeration. However, there is a variation between those in Cape Coast and Mankrong. For Cape Coast, it is almost 50 per cent migrants and 50 per cent non-migrants compared to only about 30 per cent migrants for Mankrong. This is expected because on account of Cape Coast's position as the regional capital, an urban area as well as an educational centre, more persons are likely to be attracted there than rural Mankrong especially considering the adolescent population that is involved and their need for education.

Figure 3.2. Distribution of Female Adolescents by Migration Status, Cape Coast and Mankrong



It was also considered relevant to look at the distribution of the migrants by their region of birth. This is shown in Table 3.4a. One observation that stands out clearly in the table at both Cape Coast and Mankrong is that a high proportion of the adolescents classified as migrants were born in the Central Region. This shows that most of the migrants were short distance ones. It can thus, be inferred that the migrants were geographically homogeneous in that majority were from the Central Region. In other words, there is more intra-regional

mobility than inter-regional as far as adolescent migrants in Cape Coast and Mankrong are concerned.

It is also observable that limiting the discussion to inter-regional migrants, 13 per cent of them, were from the Greater Accra Region with respect to adolescents in Cape Coast and 11.5 per cent from Eastern Region when one considers adolescents at Mankrong. While Cape Coast recorded a very small proportion of its adolescent migrants to have been born in the Northern, Upper East and Upper West regions, at Mankrong, none of the adolescent migrants was reportedly born in any of the three Northern regions in the country as is depicted in Table 3.4a. It is also significant to add that for all the respondents, while only 10 per cent of those in Cape Coast said they were born in a rural area, almost 87 per cent of those at Mankrong reported to have been born in a rural area.

Table 3.4a. Distribution of Adolescent Migrants by Region of Birth, Cape Coast and Mankrong.

Region of Birth	Cape Coast		Mankrong		Total	
	Number	%	Number	%	Number	%
Western	60	8.0	9	9.4	69	8.2
Central	318	42.7	61	63.5	379	45.1
Greater Accra	99	13.3	8	8.3	107	12.7
Eastern	56	7.5	11	11.5	67	8.0
Ashanti	73	9.8	2	2.1	75	8.9
Brong Ahafo	31	4.2	0	0.0	31	3.7
Volta	35	4.7	4	4.2	39	4.6
Northern	14	1.8	0	0.0	14	1.7
Upper West	5	0.7	0	0.0	5	0.7
Upper East	5	0.7	0	0.0	5	0.6
Outside Ghana	49	6.6	1	1.0	50	5.9
Total	745	100.0	96	100.0	841	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug. - Sept., 1997.

Considering the reasons given by the migrant adolescents for moving into their current place of residence, Table 3.4b shows that the main reason cited by majority of the adolescent migrants for moving to stay at either Cape Coast or Mankrong was the decision of their parents to move. In fact, in the case of adolescents in Cape Coast in particular, many of the

respondents indicated they had to move together with their parents who were on job transfer to the regional capital. Clearly, most of them had no personal control over their decision to migrate. This is not strange considering their young ages and their dependence on their parents for their livelihood. In that case, the problem of street living by many adolescents in the cities in Ghana appears to be non-existent in the two study areas. The evidence that only 1.3 per cent and 11.0 per cent of the adolescent migrants in Cape Coast and Mankrong respectively reported that it was their personal decision to voluntarily move to settle where they were enumerated supports this reasoning.

Table 3.4b. Distribution of Adolescent Migrants by Reason for Migrating, Cape Coast and Mankrong.

Reason	Cape Coast		Mankrong		Total	
	Number	%	Number	%	Number	%
Employment	37	5.1	9	11.1	46	5.7
Move with parents	415	57.0	55	67.9	470	58.1
Marital reasons	16	2.2	10	12.4	26	3.2
Learn a trade	78	10.7	1	1.2	79	9.8
Educational	128	17.5	4	5.0	132	16.3
Involuntary	10	1.4	0	0.0	10	1.2
Voluntary	10	1.4	1	1.2	11	1.4
Work as house-help	18	2.5	0	0.0	18	2.2
Other	16	2.2	1	1.2	17	2.1
Total	728	100.0	81	100.0	809	100.0

Note: 17 adolescents in Cape Coast and 15 in Mankrong did not give any response and were excluded from the analysis in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept.1997.

It is again significant to note that the proportion of adolescents citing educational reasons for migrating into Cape Coast is quite substantial (17.5 per cent). At the same time, about 11 per cent had gone to stay in Cape Coast in order to learn a trade. It is also important to observe that although not a high proportion (2.5 per cent), some of the adolescents went to Cape Coast mainly to be employed as house help. It is also noted that 5 per cent of adolescents in Cape Coast and 11 per cent at Mankrong migrated to seek jobs. Marital reasons including movement with spouse, joining spouse or getting married were relatively more important for

adolescent migrants at Mankrong than those in Cape Coast. This is to be expected considering that a relatively higher proportion of adolescents at Mankrong were currently married compared to those in Cape Coast (See Table 3.3).

During focus group discussions, the views of participants regarding the migration of adolescents into Accra and the major cities in Ghana in recent times were probed into. Those in Cape Coast felt that Cape Coast, unlike other cities like Accra-Tema and Kumasi, does not receive many adolescent migrants and hence, they did not consider it as a big problem in the regional capital and so did not comment on it. To them, Cape Coast does not have many economic opportunities for adolescents and hence many of them are not attracted to the town.

In Mankrong however, participants made it clear that, there are no jobs apart from subsistence farming especially in coconut cultivation in the village. Hence, after JSS, most adolescents move out of the village to continue their education at the SSS level elsewhere. Those who fail to qualify to continue at the SSS level, on the other hand, join their relatives in towns and cities especially in Accra in an attempt to find a job to do. The small number of young persons of 12-24 years in the village was confirmed during the survey carried out for this study, which had to be extended to Mankrong Nkwanta (Junction), due to the failure to attain quite a substantial number of adolescents from Mankrong village for the study.

The movement of adolescents, particularly, young girls to the large cities, however, has been found to impact negatively on the reproductive health of most adolescents who make such movements. For example, an article in the “Junior Graphic” edition of August 22-28, 2001 recounts the experiences of many teenage girls who migrate to Accra to become what has come to be known as *kayayei* i.e., female head porters. In an article authored by Nuhhu-Billa (2001), the “Junior Graphic” narrates the painful initiation rites that many of the *kayayei* (who mainly hail from the Northern regions of Ghana) go through before they are given places to lay their heads.

According to Nuhhu-Billa (2001), most of the girls who “are between 14 and 18 years old are forced to engage in commercial sex to make more money, in addition to what they earn from carrying loads during the day to be able to survive”. In the article, Nuhhu-Billa quotes one of the *kayayei* to have recounted her experience for example that “sleeping outside is not easy, but with time you become used to it since there are hundreds of us sleeping at the same place. Though some men sometimes take advantage of us by abusing us sexually, we cannot complain since no one sympathises with us”. Another young lady was also reported to have said that she had been raped three years ago by a driver’s mate and has since not set eyes on him. This lady, according to the “Junior Graphic” report, has a two-year-old daughter in respect of whom she pays ₵ 1,000.00 (one thousand cedis) a day to a nanny to take care of while she goes about her business of carrying load for money. These *kayayei* sleep anywhere they find comfortable, notably “Accra Central, Kantamanto, Kinbu and Agbogloshie markets, verandas in front of stores, kiosks and the mosque at Tudu”. These areas are all open to both human and natural disasters including sexual harassment, flooding and air-borne infections.

Most of the adolescent girls who are going through all forms of harassment, i.e., both economic and sexual, are lured into the cities often with the collaboration of their parents. For example, Nuhhu-Billa provides the account of why one young lady had to come to Accra when she says “a relation returned from Accra to the village with lots of items as a result of her work in the city”. Without finding out how that relation managed to get all those items, her parents asked her to also come down to seek a fortune. It is thus clear that some parents themselves push their own children to find fortunes in the cities. Unfortunately, many of them eventually suffer a lot of socio-economic hardships, get raped and are subjected to all sorts of sexual relationships as survival strategies, which often lead many of them into all kinds of reproductive health problems.



3.6 Religious Affiliation

The survey asked about the religious affiliation of the adolescents in both study areas in order to assess the possible impact of their religious beliefs on their sexual behaviour and reproductive health. The breakdown of their responses is presented in Figure 3.3.

Figure 3.3. Distribution of Female Adolescents by Religious Affiliation, Cape Coast and Mankrong

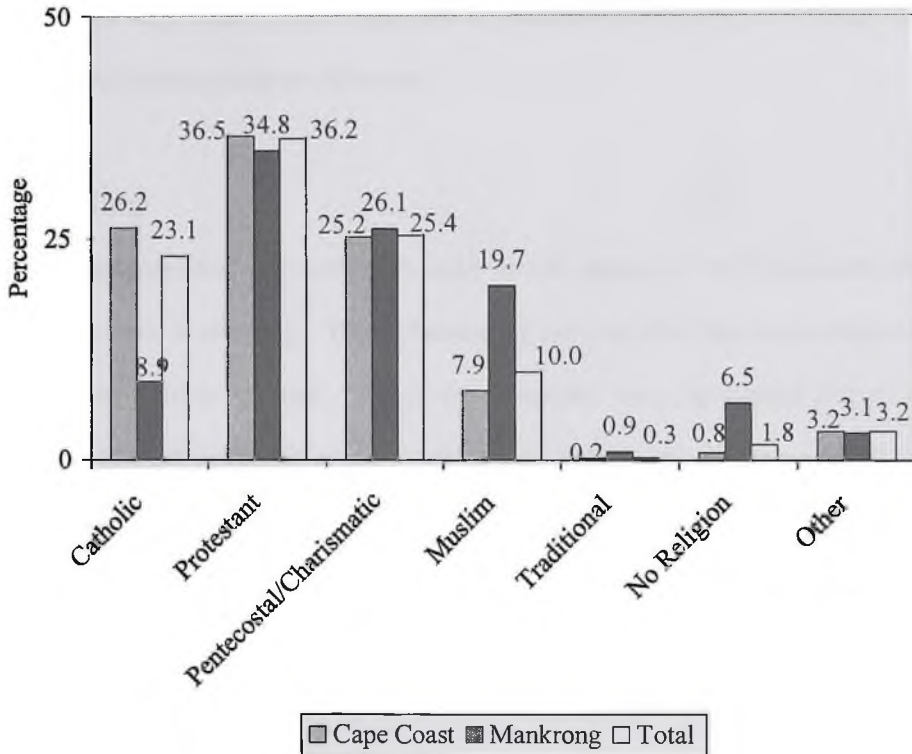


Figure 3.3 shows that a large proportion of the adolescents were Protestants. At least, one in every three adolescents in either study area was a protestant by religion. On the other hand, one in four persons, was a Pentecostal/Charismatic in either area. The major differences between the two study areas are in respect of the Catholic and Islamic religions. For example, while Catholics were made up of at least 26 per cent of the adolescent respondents in Cape Coast, they were just about 9 per cent at Mankrong. On the contrary, there were almost 20 per

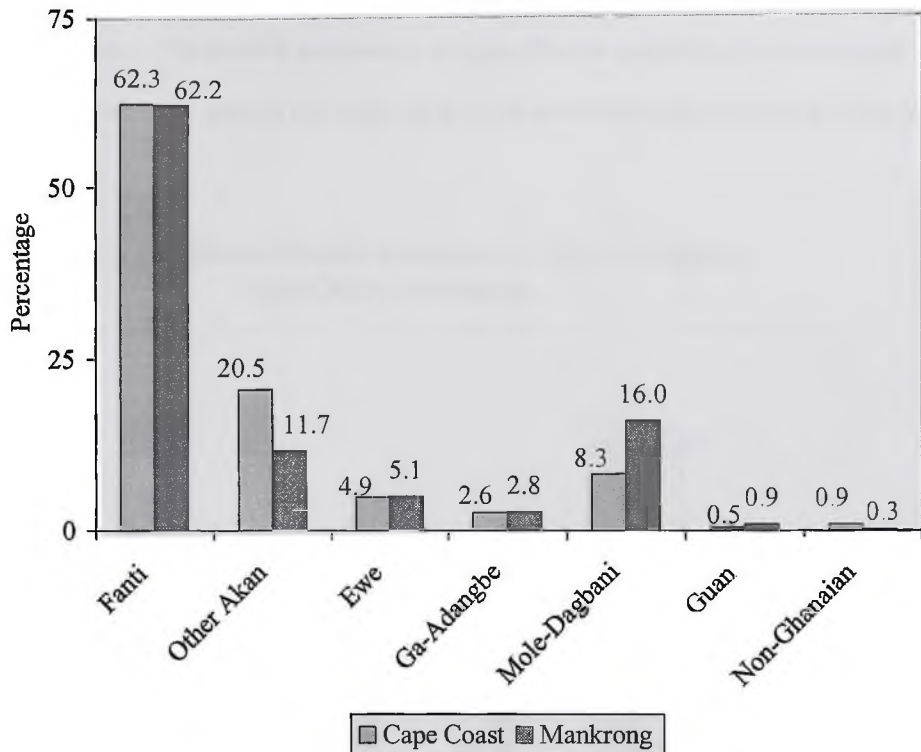
cent Muslims at Mankrong as against just about 8 per cent in Cape Coast. Similarly, there was a higher proportion of adolescents who said they had no religion at Mankrong than their counterparts in Cape Coast.

Traditional religion and other religions including the Jehovah's Witnesses and Hinduism were not found to show significant differences between the two study areas. In sum, with the exception of the Catholic and Islamic religions, the respondents from the two study areas may not vary much in their sexual and reproductive health beliefs and practices as may be determined by their religious affiliation.

3.7 Ethnicity

Respondents from the two study areas do not appear to vary remarkably from each other on the basis of ethnicity. This is because 62 per cent of all the respondents in the two study areas reported to be Fanti. This is to be expected since the Central Region is mainly peopled by the Fanti as the indigenous ethnic group. In the same vein, the proportion of Ewe, Ga-Adangbe, Guan and Non-Ghanaian in each area is not widely different. For example, in Cape Coast, these ethnic groups were found to be 4.9 per cent (Ewe), 2.6 per cent (Ga-Adangbe) and only 0.5 per cent (Guan) with 0.9 per cent as non-Ghanaians (Figure 3.4). The corresponding figures for Mankrong were 6.1 per cent (Ewe), 2.8 per cent (Ga-Adangbe), 0.9 per cent (Guan) and 0.3 per cent non-Ghanaians. The only exceptions though are the Other Akan and Mole-Dagbani categories. Here, while the proportion of Other Akan (made up of Asante, Kwahu, Akwapim, Akyem, Brong) in Cape Coast is nearly twice that in Mankrong, the reverse is the case regarding the Mole-Dagbani ethnic group.

Figure 3.4. Distribution of Female Adolescents by Ethnicity, Cape Coast and Mankrong



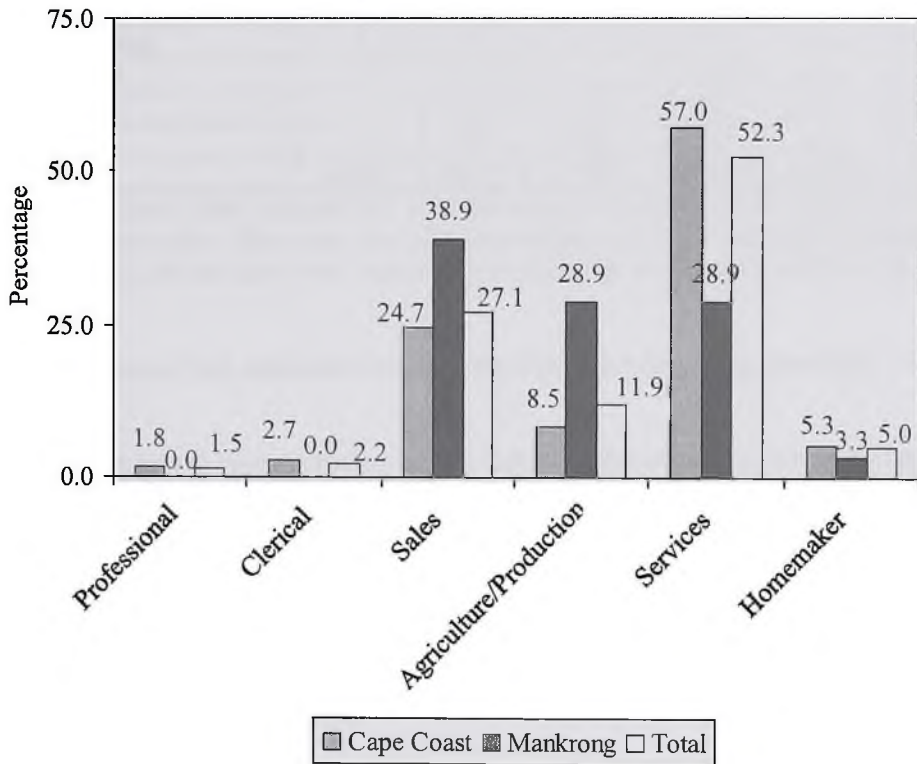
In conclusion, the variation of the adolescents in sexuality and reproductive health may depend on the extent to which adolescents in each of the study areas put the cultural beliefs of each ethnic group about reproduction into practice. In any case, no ethnic group in Ghana openly supports sexual activity among adolescents especially if they are not married, although age at first marriage has been found in the past to vary between the ethnic groups in Ghana with the lowest recorded among the Mole-Dagbani (Rockson, 1994).

3.8 Occupation and Economic Activity

The respondents were first asked about their occupation and then the economic activity they were actually involved in. These are presented in Figure 3.5 and Table 3.5. In Figure 3.5, it is seen that of those who were employed, the highest proportions in Cape Coast were in the

services industry followed by those engaged in sales. The reverse is the case for Mankrong where the highest proportion of those who were working was in sales followed by services and agriculture/production. The relative importance of agriculture in employing young women in Mankrong is to be expected judging the rural status of the settlement with farming as the main economic activity.

Figure 3.5. Distribution of Female Adolescents by Type of Occupation, Cape Coast and Mankrong



It should be noted that 57.0 per cent (856 adolescents) in Cape Coast and 38.5 per cent (125 adolescents) in Mankrong were students. At the same time, 13.2 per cent (197 adolescents) in Cape Coast and 33.8 per cent (110 adolescents) in Mankrong reported to be unemployed. These two categories were not included in Figure 3.5.

Table 3.5. Distribution of Female Adolescents by Type of Economic Activity, Cape Coast and Mankrong

Economic Activity	Cape Coast		Mankrong		Total	
	Number	%	Number	%	Number	%
Fishmonger/food seller	109	25.7	23	26.1	132	25.8
Learning Trade	28	6.6	7	8.0	35	6.8
Hair dresser/seamstress	140	33.0	6	6.8	146	28.5
Seller of Cosmetics/other	52	12.3	15	17.1	67	13.1
Teaching	12	2.8	13	14.8	25	4.9
Iced Water Seller	9	2.1	0	0.0	9	1.8
Secretary	11	2.6	2	0.6	13	2.5
National service	9	2.1	0	0.0	9	1.8
Bread Baking	4	0.9	1	0.3	5	1.0
House help	38	9.0	1	0.3	39	7.6
Farming	1	0.3	0	0.0	1	0.2
Other	11	2.6	20	22.7	31	6.0
Total	1,503	28.3	325	27.0	1,828	28.1

Notes: Adolescents who reported to be students with regard to their occupation were not included in the table. There was also (25 adolescents in Cape Coast and 2 adolescents in Mankrong who did not state their economic activity and hence are not included in the analysis in this table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

A comparison between Figure 3.5 and Table 3.5 shows that the two tables appear to be consistent with each other. It is quite clear that the service sector receives a large percentage of the adolescents in Cape Coast while in Mankrong, it is the agriculture/production sector (Figure 3.5). There are however, some inconsistencies regarding the proportion of adolescents indicating agriculture/production as occupation in Figure 3.5 as against farming in Table 3.5. Another inconsistency is with reference to the homemaker category in Table 3.5 and the house help group in Table 3.5. These inconsistencies could be due to misreporting in the data. It is significant to state that, during the survey it was found that although many of the adolescents were students, they nonetheless, were involved in some kinds of economic activities for which they received some income. They were however, not included in the analysis since in reality students are not supposed to have an economic activity. Specifically, although by definition some of the adolescents were students at the time of the survey, they were perhaps engaged in

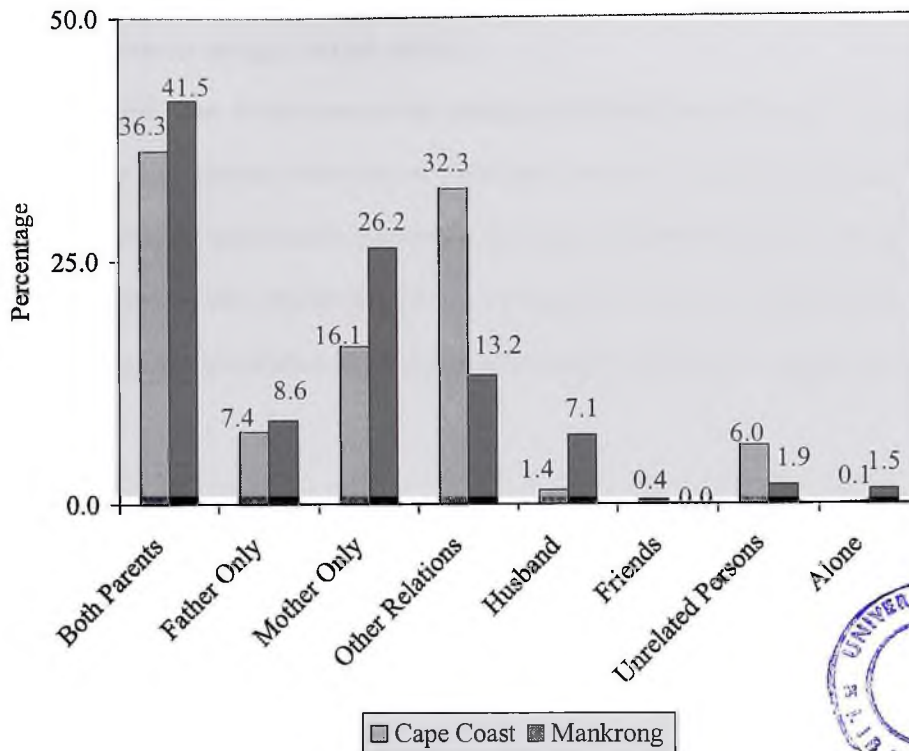
some kind of economic activity such as the sale of iced water and other food items whenever they were at home. This is a practice, which is common in most urban areas and goes a long way to support the household income.

On the whole, it is relevant to state that considering a situation where some adolescents who are supposed to be in school are, at the same time, involved in some kind of economic activities, an interest would be to find out how their introduction to the money economy would influence their sexual behaviour earlier than would otherwise be expected.

3.8 Living Arrangements

Many adolescents are dependent on their parents or guardians. In that sense, the person(s) with whom these young girls live are of importance in understanding their sexual behaviour patterns. The female adolescents were therefore asked about the persons with whom they were living and the results are presented in Figure 3.6.

Figure 3.6. Distribution of Female Adolescents by Living Arrangements, Cape Coast and Mankrong



From Figure 3.6, it is observable that just about one in three adolescents in Cape Coast were living with both parents compared to two in five adolescents in Mankrong. This suggests that supervision of a dolescents by b oth p arents in r espect o f t heir s exual b ehaviour may b e relatively higher at Mankrong than in Cape Coast. Thus, in Cape Coast almost one-third of the female adolescents said they were living with other relations and not necessarily their parents. In Mankrong, a little over one in four adolescents were living with their mothers only compared to about one in six in Cape Coast. While the relatively high proportion of female adolescents living with their mother only could be due to possible out-migration of their fathers, one should not lose sight of the concern that this situation poses. This is because mothers may find it more difficult to supervise or guide their daughters than perhaps the case

may be with “fathers only”. This is especially problematic when mothers are unable to provide for the needs of these young girls, a factor which was raised by many adolescents in the focus group discussions for taking to sexual activity.

In general, over 60 per cent of the female adolescents were living with either one of their parents or with persons who were not their direct parents. The sexual behaviour of these young girls would, to some extent, depend on the kind of relationship that may exist between them and the persons with whom they live, i.e., the concern the latter may show in the former in providing the right information and a right sense of direction as well as supervision.

CHAPTER FOUR

ADOLESCENT SEXUALITY AND MARRIAGE

4.1 Introduction

From the literature, it has been demonstrated that sexual activity is not limited to marital unions but also among unmarried adolescents. In this chapter, the analysis looks at the variation among the female adolescents with respect to their sexual behaviour taking key background characteristics including current age and level of education into consideration. The reasons provided by the adolescents for commencing sexual activity and deciding to marry at the time they did are also examined.

4.2 Age at First Sex

The reproductive health status of female adolescents anywhere in the world may be assessed and understood first and foremost on the basis of how early in age they start practising sexual intercourse and circumstances within which sexual activity takes place. Against this background, this chapter examines female adolescents in Cape Coast and Mankrong as to what proportion of the sample interviewed had ever had a sexual intercourse and the environment or conditions within which their first sexual activity may be understood.

The survey asked the adolescents whether or not they had ever had a sexual intercourse. Table 4.1 shows that overall, the percentage of adolescents who have ever had sex increases with age. This is very much clear when the results of age groups less than 15, 15-19 and 20-24 years are considered. There is, however, a relatively higher percentage of adolescents who had ever had sex in Mankrong than in Cape Coast, except at ages less than 15 years where the result is to the contrary.

Table 4.1 also shows that for the entire sample, 37 per cent responded to have ever had a sexual intercourse. On the other hand, the 1993 GDHS recorded that by the age of 15, only 12 per cent of the respondents had ever had sexual relations. However, by age 20, more than

85 per cent of women had had sexual intercourse at the time of the survey for the whole of Ghana. The corresponding figure for women aged 20-24 years in the 1998 GDHS was 81.4 per cent. The 1998 GDHS also found that 62 per cent of women of 15-19 years had never had sex. This finding compares with that of the current study where 69 per cent of women of age 15-19 years (not shown in table) had never had sex at the time of the survey. When we compare Cape Coast to Mankrong, it is clear from Table 4.1 that the proportion having ever had sexual intercourse in Mankrong was higher than Cape Coast by almost 10 per cent.

One other significant deduction that could be made from Table 4.1 is that by the age of 20 years, 70.3 per cent (i.e., 121 of 172 adolescents) of the adolescents had ever had sex for the entire sample compared to more than 85.0 per cent and 81.4 per cent reported in the 1993 and 1998 GDHS respectively for Ghana. When this is broken down by study area, we have 79.1 per cent (i.e., 34 of 43 adolescents) in Mankrong as against 67.4 per cent (i.e., 87 of 129 adolescents) in Cape Coast (See Table 3.1a for number of adolescents aged 20 years). These figures suggest some improvement on the 1993 recorded figure for Ghana.

It is also noted that the distribution of the respondents who have ever had sexual intercourse is higher at age 20 compared to all other ages. This is valid for both Cape Coast and Mankrong although the figure for Mankrong is much higher (almost 24 per cent) compared to Cape Coast (16 per cent). This is difficult to explain as the proportions relate to the total number of persons who had ever had sexual intercourse for the entire sample as against the proportion within individual ages. In spite of this, caution should be exercised when interpreting the results of the analysis considering the possibility of some adolescents not providing accurate information concerning whether or not they have ever had sex.

Table 4.1. Percentage Distribution of Adolescents Who Have Ever Had Sex by Current Age, Cape Coast and Mankrong

Current Age	Cape Coast		Mankrong		Total	
	N	%	N	%	N	%
12	1	0.2	0	0.0	1	0.1
13	2	0.4	0	0.0	2	0.3
14	3	0.6	0	0.0	3	0.4
15	9	1.7	5	3.5	14	2.1
16	23	4.3	6	4.2	29	4.3
17	40	7.5	7	4.9	47	6.9
18	70	13.0	13	9.1	83	12.2
19	61	11.4	13	9.1	74	10.9
20	87	16.2	34	23.8	121	17.8
21	63	11.7	19	13.3	82	12.1
22	59	11.0	16	11.2	75	11.1
23	51	9.5	17	11.8	68	10.0
24	67	12.5	13	9.1	80	11.8
<15	6	6.0	0	0.0	6	1.2
15-19	203	29.5	44	40.0	247	31.0
20-24	327	76.6	99	86.1	426	78.6
Total	536	35.7	143	44.0	679	37.1

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

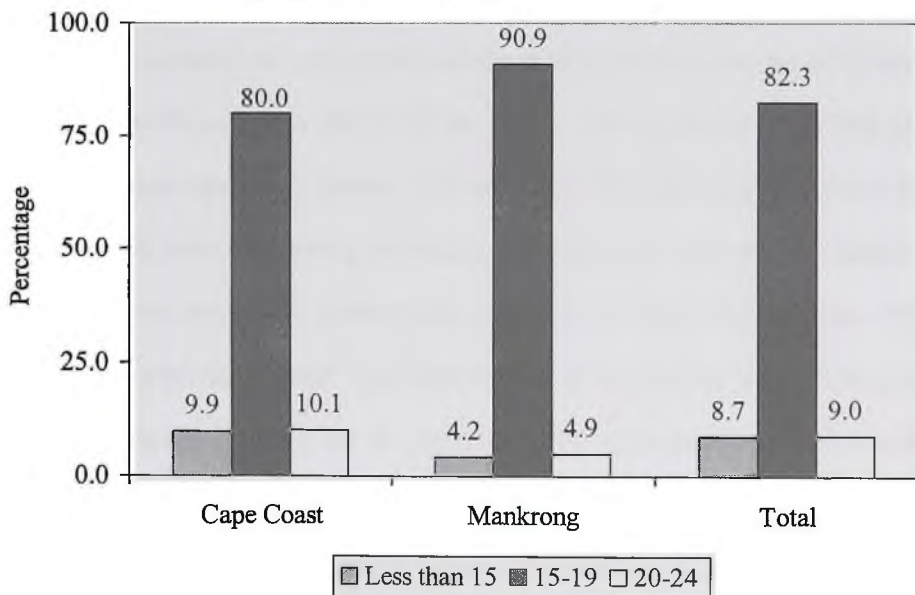
Again, it is of interest to know the timing of first sexual activity among the adolescents. This has been investigated and the results are presented in terms of percentage distribution and mean age at first sexual intercourse in Figure 4.1 and Table 4.2 respectively.

In Figure 4.1, the overall situation is that the peak period of first sexual activity is within 15-19 years where as high as 82 per cent of the respondents indicated having had sexual intercourse for the first time. This is true for both study areas although it is higher in Mankrong (91 per cent) as against Cape Coast (80.0 per cent). Conversely, a relatively higher proportion of the respondents in Cape Coast had their first sexual experience earlier (i.e. less than 15 years) than their counterparts in Mankrong: almost 10 per cent had sexual intercourse at ages less than 15 years in Cape Coast compared to 4 per cent in Mankrong. There is also a higher proportion of respondents in Cape Coast initiating sexual intercourse at ages between 20 and 24 years (10 per cent) than in Mankrong (a little less than 5 per cent). This suggests that

although a relatively higher proportion of adolescents start sexual intercourse earlier in Cape Coast than at Mankrong, at later ages (20-24 years) one is likely to find a relatively higher proportion of them yet to be initiated into sex in Cape Coast compared to their counterparts in Mankrong.

The foregoing finding may be due to the fact that in the rural areas, adolescents who attain age 20 years without continuing their education, are likely to have entered into sexual activity during their teen ages. Thus, during 20-24 years, a relatively fewer proportion of adolescents may be left yet to initiate sexual intercourse compared to adolescents in urban areas, most of whom may continue their formal education. One could however, not rule out possible misstatement of age at first sex by the adolescents in Mankrong.

Figure 4.1. Percentage Distribution of Female Adolescents Ever Having Sex by Age at First Sex, Cape Coast and Mankrong



In terms of the mean age at first sexual intercourse, adolescents from the two study areas are almost the same. While in Cape Coast, the mean age at first sexual intercourse was found to be 16.9 years it was 17.0 years in Mankrong. This finding is quite inconsistent with

the expected situation of a much lower mean age at first sexual intercourse in a rural area than in an urban area in Ghana. However, as was observed earlier, the distribution of the respondents who had ever had sex suggests that a relatively higher proportion of the respondents were sexually active by age 19 years in Mankrong (rural area) compared to Cape Coast (urban area).

On the other hand, the pattern of distribution of mean age at first sex (Table 4.2) suggests a possible decline in the age at first sexual intercourse for respondents in both study areas. This is because as current age increases, mean age at first sex also generally increases. So far, none of the respondents aged 12-14 years in Mankrong responded to have ever had sexual intercourse. In spite of this, it was found that mean age at first sex for respondents aged 15-19 years was 16.1 as against 17.4 for those aged 20-24 in Mankrong. Similarly, it was 12.8, 15.9 and 17.5 respectively for respondents aged 12-14, 15-19 and 20-24 years in Cape Coast. It is to be noted that the proportion of persons becoming sexually active by the age of 20 years in Ghana declined from 59 per cent in 1993 to 38 per cent in 1998 according to the 1993 and 1998 GDHS results (Ghana Statistical Service, 1994 and 1999). It is also underscored that the incidence of first sexual intercourse among adolescents who had ever had a sexual experience (measured by age at first sex) in the current study does not vary from the 1993 and 1998 GDHS records of 16.9 years in 1993 and 17.5 years in 1998 among females aged 20-24 years (the GDHS did not compute age at first sex for adolescents of 15-19 years due to small sample size).

Early age at sex exposes adolescents to reproductive health risks. In Zimbabwe, it has been explained that, “stereotyped sexual norms and peer pressure encourage young males to prove their manhood and enhance their social status by having sex” (Kim et. al., 2001:11). On the other hand, according to Kim et. al., young women are socialized to be submissive and not to discuss sex, thereby leaving them to be unable to refuse sex or insist on condom use.

Table 4.2. Mean Age at First Sex of Adolescents by Current Age, Cape Coast and Mankrong

Current Age	Mean age at first sex - Cape Coast	Mean age at first sex - Mankrong
12	12.0	
13	12.0	
14	13.7	-
15	14.8	15.0
16	15.0	15.5
17	15.2	16.3
18	15.9	16.5
19	16.7	16.3
20	16.9	17.2
21	17.4	17.7
22	18.2	17.1
23	17.4	18.3
24	18.3	17.1
< 15	12.8	
15-19	15.9	16.1
20-24	17.5	17.4
Total	16.9	17.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

4.2.1 Living Arrangements

The study again sought to find out whether or not the persons the adolescent girls live with have any impact on the timing of their first sexual intercourse. This was defined broadly as the living arrangements within which the female adolescent found herself. The results, which portray little variation among the adolescents from each study area, are presented in Table 4.3.

Table 4.3. Mean Age at First Sex of Adolescents by Living Arrangements, Cape Coast and Mankrong

Living Arrangements	Mean age (years)		Total
	Cape Coast	Mankrong	
Both parents	16.9	16.9	16.9
Father only	17.2	17.4	17.3
Mother only	17.1	17.1	17.1
Other relations	16.5	17.0	16.8
Husband	16.6	16.7	16.7
Friends	17.0		17.0
Unrelated person	17.2	17.8	17.5
Alone	18.0*	16.8	17.4

*Note: * Represented by one person.*

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Overall, there is some evidence to show that adolescents who were currently living with their husbands had the lowest mean age at first sexual intercourse. This is quite understandable since many of them might have been married at very young ages, which meant that sexual activity could start shortly after marriage even in situations where the young girl had never had sex before marriage. It is also possible that having indulged in early sex that might have resulted in a pregnancy, marriage became a matter of course for most of the young girls. It is plausible that while early marriage could lead to early age at a woman's introduction to sexual intercourse, at the same time, early age at sexual intercourse could result in early marriage.

This category of adolescents (i.e. those living with their husbands) was followed, with respect to the timing of first sexual intercourse, by those who were living with other relations apart from their own parents and then those who were living with both parents. What is quite unexpected is that adolescents who were living with both parents (where one expects to have better care and supervision) tended to show not much difference in respect of their mean age at first sexual intercourse as their counterparts who lived with either parent or with unrelated persons. Accordingly, comparing Cape Coast to Mankrong, Table 4.3 does not reveal any

uniform pattern that could suggest any possible impact of these living arrangements on the timing of first sexual intercourse of the adolescent females. It should be noted that in rural areas in Ghana, communal type of living is still common but was not investigated in this study and therefore, does not appear in the table.

4.2.2 Level of Education

Another dimension of one's initiation into sexual intercourse is the role of education. In line with this, the respondents were asked about their level of education at the time of the survey. Table 4.4 presents the mean age at first sexual intercourse by the level of education of the adolescents.

The results in the table show that overall, there is a general increasing age at first sexual intercourse with increasing level of education. The only inconsistency is with respect to those with primary level education who unexpectedly showed a lower mean age at first sex compared to their counterparts with no education. This is the result of the general lack of consistency in the pattern exhibited by respondents in Mankrong. It is also possible that adolescents with primary education might have dropped out of school as a result of a pregnancy and hence could have a lower age at first sexual intercourse compared to their counterparts with no education. In Mankrong, results in Table 4.4 do not show much difference in mean age at first sexual intercourse by level of education. In fact, the relatively highest mean age at first sexual intercourse (17.3 years) was recorded among adolescents with no education. This however, may have arisen due to possible misstatement of ages at first sexual intercourse by the adolescents with no formal education. On the other hand, when the discussion is limited to respondents in Cape Coast, it is clear that mean age at first sexual intercourse increases with rising level of education of the female adolescent.

The foregoing finding appears to be inconsistent with Zabin and Kiragu's (1998) observation that seems to suggest that schooling may actually encourage sexual onset especially as it tends to remove young people from the supervision of traditional caretakers. This explanation may tend to support the finding in this study of a lower mean age at first sex among adolescents of primary level education relative to others with no education. This could also be the result that adolescents with primary level education might have dropped out of school at the primary level due to a pregnancy.

In spite of the foregoing observation, no conclusion on the impact of education on a female's entry into sexual intercourse can be made. This is because, the stated levels of education relate to the time of the survey and not the timing of the first sexual experience when their level of education might have been different and perhaps lower. This is a limitation the current study is unable to address.

Table 4.4. Mean Age at First Sex of Adolescents by Current Level of Education, Cape Coast and Mankrong

Education Level	Mean age (years)	Mean age (years)	Total
	Cape Coast	Mankrong	
No Education	16.0	17.3	16.7
Primary	16.1	17.1	16.4
Arabic	17.0		17.0
JSS/Middle	16.8	16.9	16.8
SSS/Secondary	17.1	17.1	17.1
Post-Sec./Higher	18.0		18.0
Not stated*	18.0		18.0

Note: *Represented by one person.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

4.2.3 Religion

Religion has been found to have a big influence on family life and reproductive health and rights (Familusi, 1999). In the current study however, the effect of religious differences among the respondents on their mean age at sexual intercourse does not show any marked

consistency between the two study areas (Table 4.5). There are no significant differences in the mean age at sexual intercourse between the various religious groups. With the exception of the traditional religious group, which has the lowest mean age at sex of 14.5 years (possibly due to the very small number of women involved), the rest fall between 16 and 17 years with the Muslim, Catholic and Pentecostal/Charismatic being slightly higher compared to the Protestant and No religion categories. Considering the two study areas, the highest mean age at first sex was recorded among the Muslim group at Mankrong but in Cape Coast, it was among the Catholic and Pentecostal/Charismatic groups followed closely by the Muslim group.

Table 4.5. Mean Age at First Sex of Adolescents by Religious Affiliation, Cape Coast and Mankrong

Religion	Mean Age at First Sex				Total	
	Cape Coast		Mankrong			
	N	Years	N	Years	N	Years
Catholic	125	17.0	11	16.7	136	17.0
Protestant	196	16.8	53	16.8	249	16.8
Pentecostal/Charismatic	142	17.0	39	17.1	181	17.0
Muslim	55	16.9	25	17.6	80	17.1
Traditional	2	14.5		-	2	14.5
No religion	9	16.1	12	17.1	21	16.7
Other	7	15.9	3	15.3	10	15.7
Total	536	16.9	143	17.0	679	16.9

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

4.2.4 Frequency of Sexual Intercourse

The study again looked at the frequency of sexual intercourse during the month preceding the survey among respondents who had ever had sexual intercourse (Tables 4.6a and b).

Table 4.6a. Percentage Distribution of Sexually Active Adolescents by Frequency of Sexual Activity During the Past Month, Cape Coast and Mankrong

Study Area		Number of Times						Not stated	Total
		0	1	2	3	4	5+		
Cape Coast	N	300	79	81	23	18	6	29	536
	%	59.2	15.6	16.0	4.5	3.5	1.2	5.4	100.0
Mankrong	N	72	15	28	12	8	6	2	143
	%	51.1	10.6	19.8	8.5	5.7	4.3	1.4	100.0

Note: The category "Not Stated" was not included in the computation in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 4.6b. Percentage Distribution of Sexually Active Adolescents by Age and Frequency of Sexual Activity During the Past Month, Cape Coast and Mankrong

Age	Number of Times Having Sex in the Past Month						
	Cape Coast					Total	
	0	1-2	3+	Not Stated	N	%	
<15	25.0	50.0	25.0	33.3	6	100.0	
15-19	64.8	29.5	5.7	4.9	203	100.0	
20-24	56.1	32.6	11.3	5.2	327	100.0	
Total %	59.2	31.5	9.3	5.4		100.0	
N	300	160	47	29	536	100.0	
Mankrong							
<15			-	-			
15-19	48.8	25.6	25.6	2.3	44	100.0	
20-24	52.0	32.7	15.3	1.0	99	100.0	
Total %	51.1	30.5	18.4	1.4		100.0	
N	72	43	26	2	143	100.0	

Note: The category "Not Stated" was not included in the computation in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Results from Tables 4.6a and b show that more than half of them stated that they did not have any sexual intercourse during the month preceding the survey (59.2 per cent in Cape Coast and 51.1 per cent in Mankrong – Table 4.6a). The table should however be interpreted with caution. This is because, the question as to the number of times a person (who is not

married) has had sexual intercourse is so sensitive that the tendency to understate the frequency may be quite high particularly among females in Ghana.

Nonetheless, after controlling for current age of adolescents (Table 4.6b), one key observation is that the frequency of sexual intercourse during the past month preceding the survey, appears to be relatively higher among younger adolescents compared to the older ones. For example, as is shown in the table, in Cape Coast, while the proportion having sexual intercourse three times or more is 25.0 per cent among adolescents of less than 15 years, the corresponding figures for adolescents aged 15-19 years and 20-24 years are 5.7 per cent and 11.3 per cent respectively. Similarly, 25.6 per cent of adolescents of 15-19 years in Mankrong reported to have had three times or more of sexual intercourse during the month preceding the survey compared to 15.3 per cent among their counterparts of 20-24 years. This finding is not a positive one as far as the sexual and reproductive health of these adolescents is concerned especially as majority of them are not married and may be engaging in unprotected sex with its negative health consequences.

It was also considered important in this study to examine the distribution of the sexually active female adolescents in relation to the age at which they had their first sexual intercourse and whether or not they had identifiable sexual partners at the time of the survey. A look at the results presented in Table 4.7 shows that, on the whole, about three-quarters of the respondents who had ever had sex had identifiable sexual partners at the time of the survey in either Cape Coast (75 per cent) or Mankrong (74.1 per cent).

In either case, there is a high concentration within ages 15-19 suggesting that most of the sexually active females had their first sexual experience within ages 15-19 years irrespective of whether or not they had sexual partners at the time of the survey. Overall, while less than 10 per cent of the first sexual activities took place at either less than 15 years or 20 years and over, as high as 82 per cent of first sex occurred within 15-19 years. The table also

suggests that the timing of adolescents' first sexual activity does not appear to influence their decision to have sexual partners. This is due to the observation in Table 4.7 that among either respondents with sexual partners or those without, the pattern of distribution according to the timing of first sexual intercourse does not vary remarkably from each other.

Table 4.7. Percentage Distribution of Sexually Active Female Adolescents With or Without Regular Sexual Partners by Age at First Sex, Cape Coast and Mankrong

Study Area	Age at First Sex			Total	
	<15	15-19	20+	%	Number
<u>Has Sexual Partner</u>					
Cape Coast	9.5	79.7	10.8	75.4	404
Mankrong	4.7	89.6	5.7	74.1	106
<u>Has no Sexual Partner</u>					
Cape Coast	11.4	80.9	7.6	24.6	132
Mankrong	2.7	94.5	2.7	25.9	37
Total	8.7	82.3	9.0	100.0	679

Source: Computed from Adolescent Survey, Cape Coast and Mankrong Aug.-Sept., 1997.

In sum, the adolescents in Cape Coast do not vary substantially from their counterparts in Mankrong with respect to age at first sexual intercourse. It is also clear that most of them tend to have their first sexual experience within the ages of 15-19 years i.e., the peak of their adolescence irrespective of their place of residence, whether rural or urban.

4.3 Characteristics of Sexual Partners of Adolescents

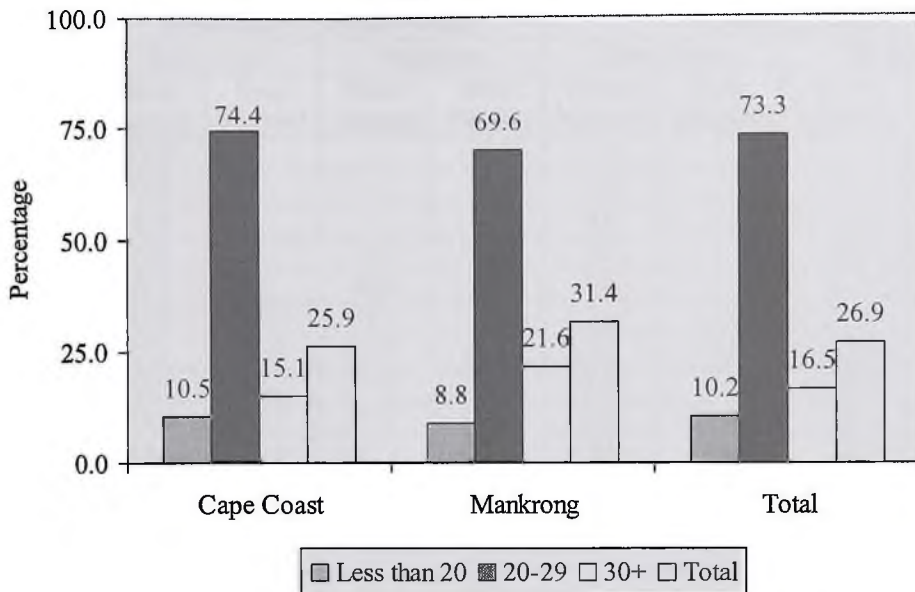
Sexual activity always takes place between two persons. It is therefore not enough to limit the discussions to the characteristics of the sexually active females without examining the demographic and socio-economic characteristics of their sexual partners. This section accordingly examines possible age variations between the females and their sexual partners both currently and at the time of their first sexual encounter. Characteristics such as the

education and occupation of male sexual partners are also looked at as a way of finding out what category of males are usually picked as sexual partners of the female adolescents.

The age distribution of all male sexual partners of the female adolescents is shown in Figure 4.2. The Figure shows that overall, a higher proportion of adolescents in Mankrong (31.4 per cent) reported having sexual partners compared to Cape Coast (25.9 per cent). With respect to age, more than two-thirds of the male sexual partners were reported by their female partners to be within 20-29 years. About 16 per cent of them were 30 years and over while just about 10 per cent were less than 20 years.

For the two study areas, the results do not vary much. However, it is observable that a slightly higher proportion of the male sexual partners at Mankrong were older (21.6 per cent of them aged 30 years and over) relative to their counterparts in Cape Coast (15.1 per cent). Correspondingly, a slightly smaller proportion of the male partners in Mankrong were aged less than 20 years compared to that of Cape Coast. What is quite conclusive on the pattern of age distribution of the male sexual partners is that for both Cape Coast and Mankrong, only a small proportion of them could be said to be the age mates of their female counterparts. This becomes clearer when the table is considered against the background of the ages of the female adolescents under study ranging between 12 and 24 years.

Figure 4.2. Percentage Distribution of Sexual Partners of Female Adolescents by Age, Cape Coast and Mankrong



The mean age distribution of the male sexual partners is again examined in comparison with the female to compute the actual variations at each of the ages. These are presented in Table 4.8. It should be noted that the information in the table was collected from females who reported as having sexual partners at the time of the survey. Again, the results pertain to whom the adolescent female considered as her sexual partner irrespective of whether or not she had more than one sexual partner.

As is shown in the table, about 96 per cent of the female adolescents who had ever had a sexual experience stated that they had regular sexual partners at the time of the survey. What is not clear is whether the remaining 4 per cent had sexual partners who were not considered to be their regular sexual partners or did not have a sexual partner at all at the time of the survey.

Table 4.8. Mean Age of Regular Sexual Partner by Current Age of Female Adolescent and Marital Status Cape Coast, Mankrong

Current Age of Woman	Mean Age of Sexual Partner				Variation (Years)			
	Cape Coast		Mankrong		Cape Coast		Mankrong	
	Never Married	Ever Married	Never Married	Ever Married	Never Married	Ever Married	Never Married	Ever Married
12	13.0	-	-	-	1.0	-	-	-
13	13.0	-	-	-	0.0	-	-	-
14	20.0	-	-	-	6.0	-	-	-
15	17.0	-	18.3	-	2.0	-	3.3	-
16	20.1	-	22.0	-	4.1	-	6.0	-
17	20.6	14.0	19.7	-	3.6	-3.0	2.7	-
18	23.1	20.0	21.5	19.0	5.1	-2.0	3.5	1.0
19	22.9	24.3	23.0	25.0	3.9	5.3	4.0	6.0
20	24.4	26.3	27.8	26.3	4.4	6.3	7.8	6.3
21	24.6	28.0	22.1	24.4	3.6	7.0	1.1	3.4
22	26.1	26.8	26.0	27.3	4.1	4.8	4.0	5.3
23	27.3	28.6	26.0	31.2	4.3	5.6	3.0	8.2
24	28.1	31.2	25.0	31.3	4.1	7.2	1.0	7.3
<20	21.8	22.7	20.7	24.3	-	-	-	-
20-24	25.7	28.8	25.3	28.2	-	-	-	-

Note: Variation for the age groups was not computed due to their wide ranges

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Information presented in Table 4.8 shows that contrary to observations that most sexual partners of adolescents are themselves adolescents, the age variations between the females and their male sexual partners clearly paint a different picture. It is observable that at all ages except age 13 years where the only female in Cape Coast had the same age as her sexual partner, the male sexual partners were on the average older than their female counterparts. Another exception is found at age 17 years where one married adolescent in Mankrong is reported to have a sexual partner three years younger than she was at the time of the survey. This is not normal especially in a situation where the male sexual partner was reported to be as young as 14 years. This suggests a clear case of misstatement of age by the adolescent female. The results as presented here should therefore be interpreted with caution. This is because the analysis is based on information provided by female adolescents who may not be accurate on

the age of their sexual partners. Misstatement of age of sexual partners may therefore have been introduced into the analysis.

Comparing ever married female adolescents to the never married, Table 4.8 shows that the sexual partners of the never married are relatively younger than those of their ever married counterparts except at ages 17 and 18 in Cape Coast and, 18 and 20 in Mankrong where the finding is to the contrary. This finding is clearer when the two age groups of less than 20 years and 20-24 years are considered. Here, the mean age of male sexual partners of ever married female adolescents is higher than that of the never married in either Cape Coast or Mankrong.

There is however, no clear consistency when the situation in Cape Coast is compared to Mankrong. While for some of the ages, the variation in age between the females and their male partners was much higher in Cape Coast than in Mankrong, a look at other ages reveals a contrary picture. This is the case for either the ever married or never married.

At this stage, the study is equally interested in the difference in age between the sexual partners at the time of the first sexual encounter of the female adolescent who was interviewed in the survey. In the survey, the female respondents were asked about how old they were at the time of their first sexual encounter as well as the age of the persons with whom they had their first sexual activity.

In Table 4.9, the ages of the females at the time of the first sexual activity are compared with those of their male partners at the time of the act. The comparison shows that on the whole, the females were younger than their male partners at their first sexual activity. This suggests that the females have first sex earlier than the males. Agyei and Epema (1990) have documented a similar finding in Kampala, Uganda where mean age at first sexual intercourse was recorded as 15.7 years for adolescent males and 15.3 years for adolescent females. This is however, contrary to Nabila and Fayorsey's (1996) finding in their study of Accra and Kumasi, Ghana with mean age at first sexual intercourse recorded as 15.8 years among the adolescent

males and 16.2 years among the females. For all the ages reported for first sexual activity to have taken place, the variation clearly depicts the males to be older, the only exception being at 21 years where the females were older than their male counterparts by just 0.3 years on the average.

From the foregoing analysis, it could be concluded quite plausibly that females become sexually active earlier than males contrary to findings recorded by researchers such as Nabila and Fayorsey (1996). However, it could be argued that when males are interviewed about differences in ages between them and the female counterparts, they might appear to have been younger than their female partners at the time of the first sexual act. What perhaps is the situation is that anyone who engages in first sexual activity does so normally with a more sexually experienced partner who is more likely to be older. Therefore, the question as to which of the sexes enters into sexual activity earlier would depend on whether the responses are from males or females. What may bring out a more reliable result would be when males are interviewed separately from the females and their ages at first sex compared instead of resorting to the differences in age between persons who are sexual partners both of whom may not necessarily have their first sexual activity with each other at the same time.

Table 4.9. Mean Age of Sexual Partner by Age of Adolescent at First Sex, Cape Coast, Mankrong

Age at First Sex	Mean Age of Sexual Partner		Variation (Years)	
	Cape Coast	Mankrong	Cape Coast	Mankrong
8	16.0	-	8.0	-
11	12.0	-	1.0	-
12	14.5	16.5	2.5	4.5
13	17.9	15.0	4.9	2.0
14	19.1	17.3	5.1	3.3
15	19.4	19.6	4.4	4.6
16	21.1	22.1	5.1	6.1
17	21.2	20.7	4.2	3.7
18	23.2	22.0	5.2	4.0
19	23.0	21.4	4.0	2.4
20	23.7	27.7	3.7	7.7
21	20.7	27.0	-0.3	6.0
22	26.6		4.6	
23	25.7	-	2.7	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

It came out in the focus group discussions that often it is wealthy adults who entice unsuspecting adolescents into sexual relationships. The adolescents were therefore asked in the focus group discussions as to their views about the appropriateness of such sexual relationships between an adult and an adolescent. In the discussions they confirmed that this goes on i.e., “sugar daddy” (older man and adolescent girls) and “sugar mammy” (older ladies and adolescent boys). Some of the adults in Mankrong were of the opinion that the discussions should not focus on only perceived wealthy older men taking advantage of young girls but also older rich women who engage young boys for sex. They consequently, condemned this kind of sexual relationship as, to them, it breeds disrespect between the young and the elderly.

However, one male adult narrated a case where he said he overheard two young females having a chat, alluding to the fact that it is better to have a sexual relationship with an elderly person than with their age mates. According to him, the young women argued that “the young men are not responsible enough and are always ready to deceive and disappoint you

while the elderly people will not on account of their experience”. From his view, it therefore appears that it depends on the impression the individual has but it is not a good thing.

The views expressed by most of the adolescents were interesting. Although they all invariably did not endorse such a relationship, it appeared that for financial reasons, they seemed to accept it if they were in a position to benefit from the relationship. For example, while some said “it is not good to have someone as old as your father as your sexual partner as it could lead to disrespect”, there were others who argued that it could be acceptable because “some of them take good care of the girls”. For financial reasons therefore, some of them felt it was good. As one girl remarked, “it is good to have a rich man who will take care of the girl and her boyfriend as well”. What this intervention implied was that some of the girls who befriend older men have boyfriends of their age and hence, get funds from the older persons to take care of themselves and their young sexual partners as well. Clearly, this is a recipe for the spread of sexually transmitted infections (STIs) including HIV/AIDS.

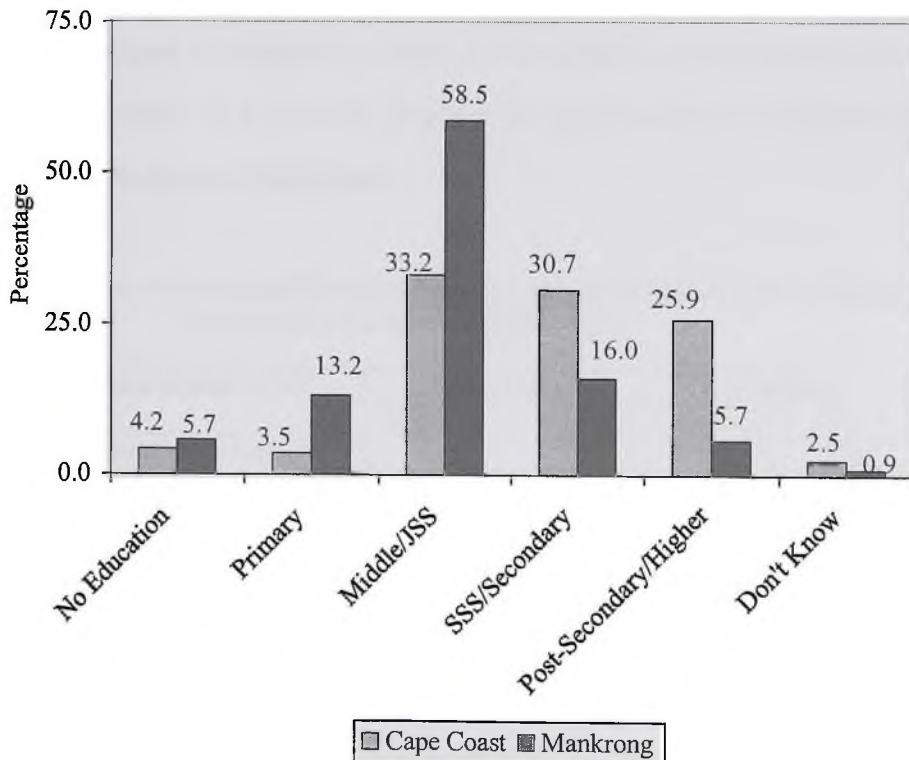
The bottom line of all this as further explained by one adolescent female in Mankrong is money. She argued that if the young girl is well catered for at home by her parents or is working and is able to cater for her basic needs, most young girls would not give in to sexual offers by older persons. However, some give in to sexual offers by older persons. Some of them even were of the opinion that some parents do encourage their young girls to go into such sexual relationships with rich but older men because of financial gains they (the parents) hope to benefit from rather than seeking the interest of their daughters.

The female respondents were also asked about the educational levels of their male sexual partners. Figure 4.3 shows that more than half of the respondents in Mankrong indicated that their sexual partners had Middle/JSS level of education compared to about one-third in Cape Coast in this educational category. It is also observed that, close to a third of the sexual

partners in Cape Coast were reported to have SSS/Secondary level of education, while a quarter of them had post-secondary and higher level of education.

On the other hand, comparatively smaller proportions of the sexual partners in Mankrong had higher than Middle/JSS level of education. This shows that the sexual partners in Cape Coast were of a relatively higher level of education than their counterparts at Mankrong. This is quite understandable considering the status of Cape Coast as an urban area while Mankrong is a rural settlement. Another observation is that for both areas the proportion of the sexual partners who had no education was quite small indicating that most adolescent females tend to have sexual partners from among persons who have had some form of formal education.

Figure 4.3. Percentage Distribution of Sexual Partners of Female Adolescents by Level of Education, Cape Coast and Mankrong



With respect to the type of occupation these sexual partners were engaged in, 1.8 per cent and 26.3 per cent of the total number of adolescents (with sexual partners) in Cape Coast and Mankrong respectively reported that their sexual partners were unemployed while 21.7 per cent in Cape Coast and 2.1 per cent in Mankrong indicated that their sexual partners were students. This information is not shown in Table 4.10 due to the fact that students and unemployed persons are not considered to constitute occupational groups.

This suggests that for Mankrong in particular, economic incentives may not play too much of a leading role in the adolescent female's decision to have a sexual partner. A similar conclusion may be drawn for Cape Coast with respect to the one-fifth of the adolescents with sexual partners who may not have much money to induce their female partners. There is however, quite a substantial proportion of the sexual partners in both Cape Coast and Mankrong who were employed in professionally related jobs as well as in the service sector, which may suggest the importance of financial inducement in sexual relationships involving adolescent females. It is, however, clear that the sexual partners of adolescent females are from diverse employment backgrounds.

Table 4.10. Percentage Distribution of Sexual Partners of Female Adolescents by Occupation, Cape Coast and Mankrong

Educational Level	Cape Coast		Mankrong	
	Number	%	Number	%
Prof/Technical/Admin.	64	21.4	12	17.6
Clerical	19	6.4	4	5.9
Sales	34	11.4	13	19.1
Agricultural/Production	49	16.4	15	22.1
Services	113	37.8	19	27.9
Manual	16	5.3	5	7.4
Other	4	1.3	0	0.0
Total	299	100.0	68	100.0

Notes: 13 adolescents in Cape Coast and 11 in Mankrong did not state the occupation of their sexual partners and were therefore not included in the analysis in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In sum, one striking observation about the male sexual partners is that they are much older than their female counterparts, suggesting perhaps that the male partners may not be mostly adolescents. This is not conclusive since the method of data collection adopted in this study does not in the strict sense permit a comparison between males and females as to which of them on the average was likely to enter into sexual activity earlier. This is especially the case when females who may not know the exact ages of their male counterparts supplied the information on the sexual partners. The foregoing suggests that it would be more instructive in future research to have a control group of male adolescents studied alongside the females. It is however, quite clear that the male sexual partners cut across various economic and educational backgrounds in Cape Coast and Mankrong.

4.4 Reasons for Adolescents' Initiation into Sexual Activity

Various reasons are often given in response to the question as to why female adolescents take to sexual relationships. Accordingly, the survey asked the female adolescents from both study areas as to what they considered as their reasons for engaging in their first sexual act.

The responses are presented in Table 4.11 with a control for age although it has earlier been established in section 4.2 that majority of the sexually active adolescents had their first sexual activity when they were between 15-19 years (80 per cent in Cape Coast and 90 per cent in Mankrong).

Table 4.11. Percentage Distribution of Female Adolescents by Reason for First Sexual Encounter and Age at First Sex, Cape Coast and Mankrong

Reason	Age at First Sex					
	Cape Coast			Mankrong		
	<15	15-19	20+	<15	15-19	20+
Had the urge	0.0	6.3	9.3	33.3	36.2	71.4
Insistence from boyfriend	7.5	10.5	9.3	0.0	0.0	0.0
Peer pressure	11.3	9.6	13.0	16.7	14.6	28.6
Curiosity	9.5	11.0	5.5	0.0	5.4	0.0
Mutual consent	3.8	4.9	13.0	0.0	0.0	0.0
Seduction	22.7	14.4	5.5	33.3	5.4	0.0
Thought was of age	0.0	3.5	13.0	0.0	0.0	0.0
For fun	5.7	2.7	3.7	16.7	0.0	0.0
Expression of love	7.5	4.9	5.5	0.0	9.2	0.0
Was raped	7.5	0.9	0.0	0.0	3.1	0.0
Financial reasons	11.3	8.2	3.7	0.0	14.6	0.0
Convinced/Promises by partner	5.7	7.2	11.1	0.0	3.1	0.0
Can't tell	7.5	9.1	5.5	0.0	3.8	0.0
Not stated	0.0	6.8	1.9	0.0	4.6	0.0
Total %	9.9	80.0	10.1	4.2	90.0	4.9
N	53	429	54	6	130	7

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

When we compare the responses in Cape Coast to those in Mankrong, no clear-cut pattern is observable across the three age categories in respect of the reason for first sex among the adolescents. It is, however, noticeable that for both Cape Coast and Mankrong, sexual activity that took place at ages less than 15 years was mainly the result of seduction by perhaps their unsuspecting much older and more experienced male partners. It suggests that most of the young adolescent females might have responded out of ignorance.

Another important observation from the table is that peer pressure appears to be a relatively strong driving force behind many female adolescents' entry into first sex. For example, as part of peer pressure, some girls may have no choice but to submit to the sexual demands of boyfriends who threaten to abandon them if they refuse to comply with the boys' sexual advances (Goldstein, 1993, Preston-Whyte, 1994). From Table 4.11, peer pressure and financial reasons are the second major reasons cited among the adolescents who had their first

sexual intercourse under 15 years in Cape Coast and the third in Mankrong. This means, they only followed their peers without much independent assessment of the costs and benefits of sexual intercourse at that early age. There is therefore the need for education on sexual issues at early ages both at the household and school levels to avoid these peer pressures, much of which could be quite negative to the future development of the adolescents.

On the other hand, a large proportion of the respondents in Mankrong in particular said their first sexual activity was in response to what they termed an urge they had (perhaps naturally) for sex. Even at ages less than 15 years, one in three adolescents reported to have had sexual intercourse because they had the urge. This is quite interesting since one wonders what kind of sexual urge one would have at these tender ages of female adolescents. This, nonetheless, indicates the earlier sexual development of the sexual sensibilities of young persons in recent times.

There is also some considerable proportion of the adolescents suggesting their first sexual activity to be due to financial reasons, an observation which is consistent with Nabila and Fayorsey's (1996) finding that many adolescents in Accra and Kumasi indulged in sexual activity due to poverty-related circumstances. In reality, poverty among parents could predispose their adolescent children to having sex in order to earn some money to support themselves. In a similar vein, Olawoye (1995) reports that adolescents point to overcrowding living conditions that allow children to observe parental sexual intimacy and to the prevalence of rape. This, to a large extent, is the result of poverty making adolescents take to sex for financial reasons. A small number of them (less than 10 per cent), however, indicated that their first sexual encounter was actually an expression of love. Unfortunately, some of them (7.5 per cent of adolescents in Cape Coast whose first sex occurred at ages less than 15 years for example) said they were raped which puts such female adolescents at risk of becoming pregnant or contracting sexually transmitted infections including HIV/AIDS since rapists

usually do not have protected sex with their victims. It also suggests that many rape cases take place in Ghana than is reported.

As a follow up to the foregoing array of reasons given by the sexually active female adolescents as to why they had their first sexual activity, the study was interested in finding out the views of these young women on pre-marital sex. They were simply asked to state whether they considered pre-marital sex to be acceptable or otherwise.

From the responses presented in Table 4.12, it is observed that a large majority of the adolescents were not in favour of pre-marital sex. While over 80 per cent of those in Cape Coast condemned pre-marital sex, a little over half of their counterparts in Mankrong did so. Only a small proportion of them in either study area thus, supported pre-marital sex. However, it must be noted that about one in three of the respondents in Mankrong could not decide as to whether pre-marital sex was acceptable or not and hence responded simply that they did not know. This suggests that they may not be able to resist any temptation to engage in pre-marital sex i.e., there appears to be a high sense of indifference towards pre-marital sex among this category of persons.

When age is grouped, it is quite clear that the proportion perceiving pre-marital sex as acceptable is higher at higher ages especially with respect to Cape Coast. Across all age groups, a higher percentage of adolescents considered pre-marital sex as unacceptable except at ages less than 15 years in Mankrong where majority of the adolescents could not decide as to whether pre-marital sex is acceptable or otherwise. Similarly, at single ages, the perception that pre-marital sex is unacceptable was found to be higher among the adolescents except at ages 12 and 13 years in Mankrong where majority of them had no specific answer.

On the whole, however, what is difficult to explain is that with such a high sense of indignation against pre-marital sex among the respondents, one would have thought that this would be translated into a corresponding proportion of them abstaining from sex until they

were married. Yet, from Table 4.1, it was observed that about 36 per cent of them in Cape Coast and 44 per cent in Mankrong responded to have had sexual activity as against 8.3 per cent in Cape Coast and 13.2 per cent in Mankrong stating that pre-marital sex was acceptable in Table 4.12. This is however, consistent with the finding of Ajayi et. al. (1991) that in Kenya 60-65 per cent of adolescents disapprove of pre-marital sexual relations and yet, 51 per cent of them reported sexual activity with a mean age at sex as low as 13 years. The deduction from this is perhaps that young females enter into sexual activity before they realise that it is unacceptable to do so.

Table 4.12. Percentage Distribution of Female Adolescents by Current Age and Perception of Pre-Marital Sex

Current Age	Perception of Pre-Marital Sex					
	Acceptable		Unacceptable		Don't know	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
12	0.0	0.0	67.8	31.8	32.2	63.2
13	0.8	0.0	80.0	48.4	19.2	51.6
14	1.4	0.0	87.9	50.0	10.7	50.0
15	2.1	21.4	89.6	42.9	8.3	35.7
16	3.2	6.9	92.2	62.1	4.6	31.0
17	11.4	35.7	86.3	42.9	2.3	21.4
18	5.5	4.5	91.7	54.5	2.8	40.9
19	14.1	41.2	84.1	41.2	1.8	17.6
20	17.8	9.3	80.6	62.8	1.6	27.9
21	12.1	22.7	84.3	63.8	3.6	13.6
22	16.1	42.1	80.2	52.6	3.7	5.3
23	21.7	21.1	73.3	68.4	5.0	10.5
24	22.9	7.7	78.6	84.6	4.3	7.7
<15	0.8	0.0	79.4	44.4	9.8	55.6
15-19	6.8	19.1	89.1	50.0	4.1	30.9
20-24	17.6	19.0	79.2	64.6	3.3	16.4
Total	8.3	13.2	83.8	53.5	7.9	32.9

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Further investigation was again made into what specific responses were given by the adolescents who perceived pre-marital sex to be acceptable as against their counterparts who were of a contrary opinion. The two groups of adolescents gave a number of reasons. Their responses are presented in Tables 4.13a and b. The information in both tables does not include

those who responded "Don't Know" in the question as to their perception of pre-marital sex recorded in Table 4.12.

From Table 4.13a, no uniform pattern is shown between respondents from the two study areas. For Cape Coast, one observes that the most important consideration for supporting pre-marital sex by the female adolescents was premised on real love expressed by one's sexual partner. They did not see how one could avoid having sex with a partner who has demonstrated a high sense of love.

Next in the order of importance was a reason to practise pre-marital sex in order to gain experience before marriage. It is however, not clear as to what kind of experience is needed to gain through pre-marital sex before finally getting married. Yet, this suggests that this category of female adolescents may consider sexual practice as one important area one needs to have experience in before getting formally married. A large proportion of them may as such overlook the reproductive health risks involved in gaining such an experience. The other reasons that were given for supporting pre-marital sex were of less importance as can be observed from Table 4.13a.

In contrast to the views expressed by the group of female adolescents from Cape Coast, it is noticeable that respondents from Mankrong considered financial considerations as the most important in supporting pre-marital sex. About 42 per cent of Mankrong adolescents actually named financial reasons as very critical in their support for pre-marital sex. The next major reason that was supported by about a third of this category of female adolescents in Mankrong was a determination to know partner better followed by the possibility of gaining some kind of experience before entering marriage. Programmes that are aimed at educating the adolescents on their reproductive health, should be evolved against the backdrop of these major considerations by the female adolescents for supporting pre-marital sex.

Table 4.13a. Percentage Distribution of Female Adolescents Who Perceive Pre-Marital Sex to be Acceptable by Reason, Cape Coast and Mankrong

Reason	Cape Coast		Mankrong	
	N	%	N	%
If loved by partner	43	34.4	0	0.0
Gain experience before marriage	33	26.4	7	16.3
Societal norm	9	7.2	2	4.6
Psychological reasons	6	4.8	0	0.0
Could lead to marriage	6	4.8	1	2.3
When convinced of marriage	3	2.4	0	0.0
Financial reasons	1	0.8	18	41.9
Know partner better	6	4.8	14	32.6
Don't know	12	9.6	1	2.3
Other	6	4.8	0	0.0
Total	125	100.0	43	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Turning attention to the female adolescents who were in the majority and did not support pre-marital sex, it is clear from Table 4.13b that for both Cape Coast and Mankrong, the major reason was based on religious prohibitions. About 54 per cent of female adolescents in Cape Coast supported this reason while the figure for Mankrong was 41 per cent. Ironically, however, it appears that many adolescents who quote these reasons to support their views on pre-marital sex do not heed these religious inhibitions against pre-marital sex, otherwise we would find a much lower percentage of female adolescents ever having sexual intercourse than it was recorded in Table 4.1.

Quite a sizeable proportion (20.3 per cent) in Cape Coast but a smaller percentage of 10.9 in Mankrong were also of the view that sex is for the married. This somehow corroborates Nguyen and Hoang's (1999) finding that in Vietnam most adolescents believe that sexual intercourse should be reserved for the married. The question however, is whether such beliefs are put into practice.

It must also be pointed out that the fear of becoming pregnant at a time one is not prepared for childbearing ought to have been given as one of the main reasons to avoid pre-

marital sex. Contrarily, not a high proportion of the respondents indicated this as their main consideration for not supporting pre-marital sex. At the same time, only a small proportion (3.3 per cent in Cape Coast and 2.3 per cent in Mankrong) said pre-marital sex could result in their contraction of sexually transmitted infections. Again, possible consequences on their education were equally not thought to be relevant considerations. These suggest that a lot of sensitisation is required for female adolescents to understand what the practical implications of pre-marital sex especially the unprotected type are to their personal socio-economic development.

Table 4.13b. Percentage Distribution of Female Adolescents Who do not Perceive Pre-Marital Sex to be Acceptable by Reason, Cape Coast and Mankrong

Reason	Cape Coast		Mankrong	
	N	%	N	%
Religious reasons	675	53.6	72	41.4
Sex is for the married	256	20.3	19	10.9
Partner may not marry you	16	1.3	0	0.0
Could contract STD/AIDS	42	3.3	4	2.3
Could be pregnant	125	9.9	20	11.5
Not mature	30	2.4	8	4.6
Just bad	24	1.9	19	10.9
Could affect one's education	8	0.6	1	0.6
Partner would not respect you	6	0.5	0	0.0
No mutual trust	6	0.5	3	1.7
Against parents' and elders' advice	17	1.4	4	2.3
Financial reasons	2	0.2	5	2.9
Don't know	49	3.9	6	3.4
Other	3	0.2	13	7.5
Total	1,259	100.0	174	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In the focus group discussions, most of the discussants, adults and adolescents, thought it was not good for unmarried persons to have sexual relationships. Various reasons were given in support of this opinion. A few of them, however, thought otherwise, with apparent reference to the circumstances many adolescents find themselves in most cases.

One female adult in Cape Coast, was emphatic that most of the unmarried adolescents are actually dragged into sexual activity by adults. In other words, many adolescents would stay without practising sex until marriage but for the role of older persons. In her own words, “the elderly men are responsible for the current sexual activity of most of the adolescents. In cases where adolescents refuse such sexual advances of adult men, they are accused of being disrespectful”.

The others explained the situation within the context of so-called modernisation of the Ghanaian society, which has glorified sexual relationships involving unmarried adolescents as a modern practice. According to them, this is a marked departure from what prevailed several years ago when it was societally abominable for sexual relationships to precede marriage.

The sentiments expressed by adults in Mankrong during the focus group discussions were similar to those of their counterparts in Cape Coast. For example, most of them were emphatic that the only acceptable thing is that the adolescent should get married first before having a sexual activity.

On the part of many of the adolescents in Cape Coast, sex before marriage was generally not considered good but acceptable if that is the only means by which they could survive. Here, it was a question of monetary gains. According to one of them, this usually happens when parents are unable to provide for the needs of their children. In this case, if under such a situation a gentleman will have sex with a female and provide the money to support her, she did not see anything wrong with it since it is a matter of one’s survival. In her own words, “there are young girls who desire to have some money to trade but their parents refuse to give it to them. At the same time, even when they see their friends with new clothes, they also yearn for such items. In the circumstance, if they find a man who is willing to provide these items, they yield to their sexual advances”.

One adolescent on the other hand, linked it to peer pressure. To her, when they see their friends practising sex, they consider it to be fashionable and so join it. There were, however, some adolescents who condemned it out-rightly on account of the hardships it may bring to innocent children who may be born through such pre-marital sexual relationships. On the contrary, one adolescent was convinced that “pre-marital sex is good and acceptable since that is the only way one could prepare and get the experience about marriage before entering the marriage institution itself”.

At Mankrong, one female adolescent was of the opinion that sex before marriage was normal since one could not stay without sex if not married. She added however, that it is left to the individual to decide considering her own circumstances as to whether or not she can stay without sex until she gets married. This was however, disagreed to by her other colleagues who thought at that stage, she would not be in a position to take care of children who may possibly come out of this practice. Another female adolescent was also not happy about sexual activity before marriage because “there are attempts most often to abort pregnancies that usually result from such a practice and this could lead to the premature death of the girl involved”.

From the foregoing, it could be concluded that majority of the respondents in the focus group discussions, whether adults or adolescents, do not seem to agree that adolescents should have pre-marital sex. Yet, it is clear from the analysis that pre-marital sex has become quite unavoidable among some adolescents in Ghana. It therefore appears that given the option, many adolescents will choose abstinence but are unable to do that for financial reasons as well as pressure from their peers as some of the adolescents openly expressed. Since the inability of parents to provide for the needs of their female adolescents was cited as a major reason, the role of parents in the attainment of this goal of sexual abstinence before marriage becomes quite critical.

Furthermore, the respondents (adults and adolescents in the focus group discussions) were asked specifically to give factors that they thought contribute to the early entry of adolescents into sexual unions. Most of the responses among the adults in either study area were mixed in the sense that while some of them blamed the development on the inability of most parents to either meet the needs of their children or instil discipline and moral values in them, others thought it was due to the inability of some adolescents to abide by parental guidance. They all invariably agreed that sexual activity involving adolescents is quite early. In fact, one adult male indicated that “it is being done openly at Victoria Park in Cape Coast” and hence there is no secrete about it.

In either Cape Coast or Mankrong, there was some consensus among the adults that many parents are going through economic hardships and hence, are unable to discharge their financial obligations to their children. For example, some parents have no jobs and cannot cater for their wards. Another dimension of the problem was also explained in terms of the absence of one or both parents from home most often in search of money to keep the household running. They are therefore not always at home to keep an eye on their children in order to provide the needed guidance. However, they thought that the demands of some adolescents are insatiable considering the poor financial status of most of their parents. The inability of parents to satisfy the many material desires of their children therefore often draws them into relationships that may end up in sex at early ages in life.

The issue of broken homes was also cited as a major contributory factor during the focus group discussions. Many of the adults explained for example that, in broken homes, most often, neither the father nor mother is in control. In the process, some children are left to care for themselves leaving them with no option than to enter into sexual relationships for financial gains. According to some of them, the situation is made worse when the children have to live with their mothers as single parents, who, most often do not have much control over the

children. Some of the adolescents made similar arguments. On the other hand, misunderstanding between parents especially when they are not in agreement regarding how their children should be disciplined, could pre-dispose the children to practise sexual activity at early ages. For example, one male adult explained that, “some mothers stand behind their daughters any time their fathers discipline them about their sexual habits. Some mothers could even team up with their daughters against the father who, may be considered as being harsh and in the process, push the poor daughter into sexual relationships, the consequence of which, she will realise only when it is too late to make amends”.

There were still others who attributed the development to the thinking of some adolescents that their parents are old-fashioned and hence would not take the wise counsel they are provided. Reference was also made to programmes that are shown on the television, which they considered to have both positive and negative influences on the sexual behaviour of adolescents. This is because some of the adolescents are unable to distinguish between the positive and negative things that are screened on the television. As one of them said, most of the films especially the foreign ones are full of sexual episodes which some adolescents try to copy without understanding what they all mean.

Some also blamed early sex among adolescents on some of the cultural practices that are taught in schools, which they felt have sexual underpinnings. The adolescents in Cape Coast in particular made references to the practice of many of their counterparts in imitating certain foreign cultures such as dressing which tends to expose their bodies, making them fall prey to the lustful desires of some unscrupulous men.

The adolescents were to some extent in agreement with their adult counterparts in explaining that both parents and adolescents are to blame. About the role of the parents, they said some of them are not responsible enough as to take care of the needs of their children. Majority of them were however, of the opinion that it was mainly the result of peer pressure

that makes some of them follow their friends blindly without actually understanding why they behave the way they do. In the words of one adolescent in Mankrong “there is no work here apart from selling coconut. So when a female adolescent finds a friend to be wearing a new dress and realises that she has a boyfriend who sells coconut, she will also be desirous to take a boyfriend who sells coconut in order to be bought a new dress like her other friend”.

From the foregoing, it is quite clear that whether it is parental irresponsibility or peer pressure, the bottom line most often is that of material or financial benefits that will be derived from the sexual relationships. This should be viewed against the background of many of the respondents stating that pre-marital sex is unacceptable.

4.5 Adolescents’ Knowledge About Sexuality

One fundamental factor that has been identified to affect female adolescent fertility is their poor knowledge in sexuality and reproductive health in general. Thus, many of the young girls enter into sexual relationships without adequate knowledge about what they are in for. They are therefore limited as to how they can either avoid being pregnant or protecting themselves from contracting an STI including HIV/AIDS.

Against this background, this study looked at the level of knowledge of the female adolescent respondents in sexuality and reproduction. They were first asked as to the source from which they had their knowledge about sexuality. The purpose for asking this question was to find out the most common source(s) from which most adolescents get information on sexuality. This is to enable reproductive health programme managers fashion out their programmes to equip and strengthen these sources to be able to provide the right information and education to the adolescents in order to make informed decisions on their sexuality and reproductive health.

The sources that included parents, siblings, teachers and friends are presented in Table 4.14. In the table, age has been controlled for. However, it appears that age has little role to play in determining the source from which sexuality knowledge is gained among the adolescents. This is because the sources that are considered important do not vary between the three broad age groups.

Overall, it appears that friends (i.e., peers) of adolescents happen to be the most regular source of information on sexuality issues among the adolescents in both Cape Coast and Mankrong. While 40 per cent of the respondents in Cape Coast named friends as their source of sexuality information, almost half of their counterparts in Mankrong gave the same response. In fact, in the case of Mankrong, close to half of the respondents indicated they did not know the source from which they had knowledge about sexuality.

It is again observable from Table 4.14 that teachers were the second major source of knowledge of sexuality issues to female adolescents in Cape Coast. This is especially the case for those who were aged less than 20 years. One would have thought that parents being the first point of contact for adolescents would constitute a major source of information about sexuality. Yet, information presented in the table portrays a contrary picture where just about 9 per cent of the respondents from Cape Coast named parents as their source of knowledge about sexuality. In the case of Mankrong, none of the respondents mentioned parents as their source of sexuality information. This suggests the low level of parent-daughter communication on reproductive health as far as the respondents in this study are concerned.

Table 4.14. Percentage Distribution of Female Adolescents by Current Age and Source of Knowledge About Sexuality, Cape Coast and Mankrong

Source of Knowledge	Age Group							
	Cape Coast				Mankrong			
	<15	15-19	20-24	All Ages	<15	15-19	20-24	All Ages
Parents	11.6	8.4	8.6	9.3	0.0	0.0	0.0	0.0
Siblings	7.0	5.8	7.7	6.6	0.0	0.9	0.0	0.3
Teachers	36.3	35.7	17.1	30.5	3.0	1.8	1.7	2.5
Friends	30.4	37.6	53.6	40.3	45.5	45.5	55.7	48.9
Family Planning Nurses	0.5	1.6	0.0	0.9	0.0	0.0	0.0	0.0
Newspapers	2.3	2.3	5.2	3.1	0.0	0.0	0.0	0.0
First sexual partner	4.9	3.6	2.6	3.7	7.1	0.9	0.9	2.8
Don't know	7.0	5.0	5.2	5.6	44.4	50.9	41.7	45.5
Total %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	389	687	427	1,503	99	110	116	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The analysis is further extended to finding out the views of the female adolescents under study regarding whether or not one could be pregnant the first time she engages in sexual intercourse. It is seen in Table 4.15 that female adolescents in Cape Coast had a relatively higher knowledge about possible pregnancy occurrence at first sexual intercourse than their counterparts in Mankrong. This is explained by the fact that while about two-thirds of those in Cape Coast were convinced they could become pregnant at their first sexual intercourse, less than half of their counterparts in Mankrong had this awareness. Thus, while just about a quarter of the respondents in Cape Coast thought they would not be pregnant at first sexual intercourse, as high as 47 per cent of their friends in Mankrong shared a similar opinion. The implication of this observation is that the respondents in Mankrong are more likely to indulge in unprotected sex (as far as pregnancy is concerned) compared to their counterparts in Cape Coast. The above two proportions are lower than the finding of Goddard's (1995) study in Nigeria which pointed to a high proportion of 60 per cent of persons 12-24 years not aware that pregnancy could result from first sexual intercourse. At the same time, Ajayi et. al. (1991)

record that half of adolescents in Kenya did not know that first sexual intercourse could produce a pregnancy.

Table 4.15. Percentage Distribution of Female Adolescents by Current Age and Knowledge as to Whether a Girl can be Pregnant at First Sexual Intercourse, Cape Coast and Mankrong

Current Age	Cape Coast					Mankrong				
	Yes	No	Don't know	Total		Yes	No	Don't know	Total	
				N	%				N	%
12	33.0	43.5	23.5	115	100.0	18.4	79.0	2.6	38	100.0
13	34.4	56.0	9.6	125	100.0	12.9	83.9	3.2	31	100.0
14	59.1	30.9	10.0	149	100.0	20.0	73.3	6.7	30	100.0
15	56.6	31.7	11.7	145	100.0	46.4	42.9	10.7	28	100.0
16	66.2	26.0	7.8	154	100.0	48.3	44.8	6.9	29	100.0
17	70.2	22.1	7.6	131	100.0	64.3	28.6	7.1	14	100.0
18	77.8	18.7	3.5	144	100.0	45.5	50.0	4.5	22	100.0
19	80.5	15.9	3.6	113	100.0	88.2	11.8	0.0	17	100.0
20	81.4	14.7	3.9	129	100.0	69.8	27.9	2.3	43	100.0
21	89.2	8.4	2.4	83	100.0	50.0	45.5	4.5	22	100.0
22	90.1	8.7	1.2	81	100.0	63.2	26.3	10.5	19	100.0
23	86.7	8.3	5.0	60	100.0	84.2	15.8	0.0	19	100.0
24	90.5	8.1	1.4	74	100.0	84.6	15.4	0.0	13	100.0
<15	43.4	42.7	13.9	479	100.0	17.2	78.8	4.0	99	100.0
15-19	69.7	23.3	7.0	687	100.0	55.4	38.2	6.4	110	100.0
20-24	86.9	10.3	2.8	427	100.0	69.0	27.6	3.4	116	100.0
Total N	1,019	370	114	1,503	100.0	158	152	15	325	100.0
%	67.8	24.6	7.6		100.0	48.6	46.6	4.6	-	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

A further look at Table 4.15 illustrates the fact that with the exception of a few cases particularly in respect of respondents in Mankrong, knowledge that pregnancy could result from any first sexual intercourse shows a general tendency to increase with increasing age of the respondent. Specifically, less than half of the respondents at ages less than 14 years in Cape Coast and less than 17 years and at age 18 years in Mankrong were aware that a pregnancy could result from a first sexual intercourse.

Comparing the two study areas by age group, there is evidence in Table 4.15 to suggest that knowledge that first sexual intercourse could result in a pregnancy increases with the age of the adolescent with obviously higher knowledge in Cape Coast than Mankrong. In each age

group however, particularly in ages less than 20 years, the proportion not knowing that first sexual intercourse could produce a pregnancy, is quite substantial. A much higher proportion of adolescents with no knowledge that first sexual intercourse could result in a pregnancy has however, been found in Kenya where 50 per cent of adolescents did not know that first sexual intercourse could produce a pregnancy (Ajayi et. al., 1991). The need for more sexuality education at early ages for adolescents can, therefore, not be over-emphasised.

In sum, it can be concluded that adolescents are limited in the sources of knowledge of sexuality i.e., from their friends (who may not even have the right information) and teachers. Accordingly, quite a substantial proportion of them are not aware that they could be pregnant at their first sexual encounter, a situation that could result in unprotected sexual activity.

Further information gathered from the focus group discussions also showed that both adults and adolescents were very much aware of the problems that tend to be associated with early entry into sexual unions. Among the adults in Cape Coast, the concern was with respect to problems of poverty, poor physical development of the child that may be born out of such a sexual relationship together with his/her teenage mother. They also mentioned poor parental care of such children and its associated problem of school dropouts among young girls who become pregnant. Besides, they were concerned that pre-marital sex could result in the production of bastards, a situation they considered as a shameful development. They added for example that, there have been instances where people have had to sell all their belongings in order to buy food to feed both mother and child. In such circumstances, according to them, some of the girls go to the extent of abandoning their children, an instance of which they cited to have occurred behind the Anglican Mission in Cape Coast some time ago.

In the case of the adolescents themselves, most of them mentioned unplanned pregnancy, which could result in the termination of the education of the young girl. Besides, they were aware that sexual relationships at early ages could lead to the contraction of sexually

transmitted infections. Like their adult counterparts, the adolescents were aware of problems of poor career development of young girls who get pregnant through pre-marital sex as well as abortion related complications and death in extreme cases.

Both adults and adolescents in Mankrong expressed similar sentiments as their counterparts in Cape Coast. Of special mention though is the observation by one adult respondent that pre-marital sexual relationship could lead to the actors involved contracting HIV/AIDS. They were also more worried about the impact of a pregnancy that may result from a sexual relationship especially when both partners are adolescents who may have no jobs and hence no income to support the upkeep of themselves and their child. In such a situation, the burden would fall on their poor parents, who may be forced to withdraw them from school to the detriment of the adolescent mothers. It is also important to note that most of the adolescents in Mankrong emphasised on the possibility of the contraction of STIs since, according to them, adolescents who indulge in pre-marital sexual practices tend to have either casual sex or engage multiple sexual partners.

With such a high knowledge of the possible problems that could result from early sexual practices among the adolescents in particular, it is quite worrisome that many adolescents practise sexual activity as if there is nothing at stake. It is therefore clear that in sexual issues among adolescents, knowledge is not the problem but how they can be empowered practically to either fully abstain or practise safer sex, which may involve contraception against either unplanned pregnancy or STI or both.

4.6 Age at First Marriage

It has already been established in Section 3.3 that only a small proportion (5.3 per cent in Cape Coast and 20.0 per cent in Mankrong) of the respondents had ever been married. A higher proportion of the few who had ever been married were also between 20 and 24 years.

This section attempts a comparative analysis of the average ages at first marriage of the females that were interviewed during the survey and the ages of their partners at first marriage in order to see the variation in age between them. The average age at marriage is also considered against the background of persons who influenced the decision of the adolescents to marry.

The general pattern depicted in Table 4.16 is that for both study areas, mean age at first marriage increases with age. This may suggest that among those who had ever married, there appears to be a declining age at marriage over the years. Yet, it must be noted that some of the marriages were pregnancy-induced and hence the expected age at marriage could be distorted. As has already been established in Section 3.4, a large proportion of the respondents especially the young ones were still not married at the time of the survey. The tendency for them to postpone marriage cannot therefore be in doubt.

A comparison of the respondents in the two study areas, on the other hand, shows that those in Mankrong had a relatively lower overall mean age at marriage than their counterparts in Cape Coast. The difference between them is, however, negligible. The finding is considered normal in view of Mankrong's status as a rural area, the residents of which are more likely to marry earlier than their colleagues who are domiciled in urban areas such as Cape Coast.

Table 4.16. Mean Age at First Marriage by Current Age of Female Adolescents, Cape Coast and Mankrong

Current Age	Mean age at first marriage		
	Cape Coast	Mankrong	Both
17	17.0*	-	17*
18	18.0*	15.0*	16.5
19	17.9	18.1	18.0
20	18.6	18.4	18.5
21	19.6	18.6	19.0
22	19.7	19.4	19.7
23	19.3	21.2	20.5
24	20.9	21.3	21.0
Total	19.7	19.4	19.5

Note: *Only one person is involved

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Most participants in the focus group discussions felt that the ideal age for a woman to marry is between 20 and 25 years. There were a few who thought it was ideal to marry between 18 and 20 years. No one however, favoured marriage below 18 years, and this is quite supportive of the minimum age at marriage in Ghana, which is fixed at 18 years. However, evidence from Table 4.16 shows some inconsistency with views gathered from the focus group discussions. This is because although during the discussions, both adults and adolescents were all unanimously not in favour of any marriage below 18 years, there were some adolescents who had already been married below 18 years.

In Table 4.17, the female respondents have been compared with their partners at the time they married for the first time to establish the extent to which they varied from each other in terms of their ages. The analysis should be interpreted against the background that the ages of the male partners were provided by their female partners and not the male partners themselves. The small cell sizes do not provide strong support for making any valid conclusions.

Table 4.17. Mean Age of Sexual Partner by Age at First Marriage of Female Adolescent, Cape Coast and Mankrong

Age at First Marriage	Mean Age of Partner				Variation (years)	
	Cape Coast		Mankrong		Cape Coast	Mankrong
	N	Mean	N	Mean		
14	1	23.0	-	-	9.0	-
15	1	21.0	2	19.5	6.0	5.5
16	2	22.0	4	26.5	6.0	10.5
17	6	21.5	5	22.4	4.5	5.4
18	9	23.5	12	24.2	5.1	6.2
19	14	25.4	12	26.3	6.4	7.3
20	23	26.5	16	29.2	6.5	9.2
21	10	27.5	3	33.0	6.5	12.0
22	10	29.1	4	28.5	7.1	6.5
23	4	27.6	4	28.0	4.6	5.0
24	-	-	3	30.0	-	6.0
<20	33	23.8	35	24.7	-	-
20-24	47	27.4	30	29.4	-	-
Total	80	25.8	65	26.8		

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

One observation from the table is that at all ages at marriage, the males were older than their female partners. A similar observation is made comparing age at first marriage within ages less than 20 years and 20-24 years, the marriage partners of female adolescents in Mankrong having relatively higher ages than their counterparts from Cape Coast. This is quite normal since in Ghana there is always a higher tendency for males to marry women who are younger than they are.

It is also clear that the male partners in Mankrong were on the average one year older than their male counterparts in Cape Coast. This is supported by the observation that with the exception of women who married at age 22 years, the variation in age was higher for males in Mankrong than those in Cape Coast at all the ages at first marriage. The variation found here is consistent with the earlier observation when the ages of the females and those of their male partners at the time of first sexual intercourse were examined. This however, does not overlook possible misstatement of ages of male sexual partners by adolescent females who were interviewed in the survey.

Another dimension that is investigated in this study is the variation in age at first marriage among the respondents who had ever married with respect to the person who influenced them to marry. Before this is examined, however, it is important to look at the percentage distribution of the respondents according to the person who influenced the adolescent to marry. To address this issue, the female adolescents were asked to indicate persons they considered to have influenced them to marry at the time they did.

The results in Table 4.18 indicate that for the majority of the marriages, the adolescents themselves took their own decisions to marry (54 per cent in Cape Coast and 60 per cent in Mankrong). Apart from the adolescents themselves, male partners were reported to be an important group of people behind the decision of female adolescents to marry (22.5 per cent in Cape Coast and 12.3 per cent in Mankrong). Also of some relative importance is the role of both parents of the female adolescent (8.8 per cent in Cape Coast as against 12.3 per cent in Mankrong). Other persons like friends and other relations were on the other hand said to play less influential roles in this respect.



Table 4.18. Percentage of Ever Married Female Adolescents by Person Who Influenced them to Marry for the First Time, Cape Coast and Mankrong

Person	Cape Coast		Mankrong	
	No	%	No	%
Both parents	7	8.8	8	12.3
Mother only	2	2.5	0	0.0
Father only	2	2.5	5	7.7
Other relations	6	7.5	1	1.5
Partner	18	22.5	8	12.3
Friends	2	2.5	4	6.2
Self	43	53.7	39	60.0
Total	80	100	65	100

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In Table 4.19, it is shown that overall, apart from the situation where the decision to marry was said to have been influenced by both parents, mean age at first marriage is lower in Mankrong than in Cape Coast irrespective of the person supposed to have influenced the adolescent to marry. It is also striking to observe that in either Cape Coast or Mankrong, female adolescents who said their decision to marry at the time they did was influenced by their friends portray a higher tendency to marry earlier than their counterparts who cited other persons other than their friends to have influenced their decision to marry. It is also shown that mean age at marriage is highest among women whose first marriages were said to have been influenced by other relations of theirs in Cape Coast. On the other hand, among respondents in Mankrong, the highest mean age at marriage was recorded in respect of marriages said to have been influenced by their own partners. The caution though is that the numbers are too small to allow valid conclusions to be made.

Table 4.19. Mean Age at First Marriage of Female Adolescents by Person Influencing Her to Marry

Person influencing the marriage	Mean age at Marriage	
	Cape Coast	Mankrong
Both parents	19.3	19.6
Mother only	19.0	-
Father only	20.0	19.0
Other relations	20.5	19.0
Partner	20.1	19.8
Friends	18.0	17.5
Self	19.6	19.5
Total	19.7	19.4

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

To sum up, it has been established that although a small proportion of the adolescents in both Cape Coast and Mankrong had ever married, marriage is earlier in Mankrong than in Cape Coast. Again, the adolescents who had ever married were younger than their male partners at the time of first marriage, the variation in age being higher in Mankrong than in

Cape Coast. Finally, as much as possible women should be educated to be circumspect in yielding to the influence of their friends in their decision to marry since that practice has shown a tendency for young women to marry earlier when the influence is from their friends rather than their parents, other relations or male partners. Peer pressure such as from friends or age mates thus, seems to play a contributory role in bringing about early marriages among adolescent females in Ghana.

4.7 Decision to Marry

The decision to marry is considered an important component of the analysis in this study. In this section therefore, attempts are made to establish to what extent marriages among female adolescents are pregnancy-induced. In other words, do they marry because of a pregnancy at a time they were not married? Again, a look is taken at what proportions of the marriages were under other influences in order to identify target audiences for reproductive health educational programmes that particularly pertain to marriages among adolescents. Thereafter, the actual reasons provided by these ever-married female adolescents for deciding to marry at the time they did are also examined.

Table 4.20 presents information on the status of the first marriages of the ever-married female adolescents in respect of whether it was as a result of a pregnancy. From the table, it is observed that many adolescent marriages are the result of unexpected pregnancies. It therefore means that many of them might not have married at the time they did but for the pregnancy they had. There is, however, a variation between respondents in Cape Coast and Mankrong. Overall, more than half of the young females ever marrying in Mankrong said their first marriages were pregnancy-induced. This compares to a relatively smaller proportion of about 43 per cent of those in Cape Coast stating that their marriages were pregnancy-induced.

Table 4.20. Percentage of Female Adolescents in Respect of Whether their Marriages were Pregnancy-Induced by Age at First Marriage, Cape Coast and Mankrong

Age at Marriage	Cape Coast				Mankrong			
	Pregnancy induced		Not pregnancy induced		Pregnancy induced		Not pregnancy induced	
	N	%	N	%	N	%	N	%
14	-	0.0	1	100.0	-	0.0	-	0.0
15	1	100.0		0.0	1	50.0	1	50.0
16	2	100.0	-	0.0	2	50.0	2	50.0
17	1	16.7	5	83.3	5	100.0	-	0.0
18	4	44.4	5	55.6	8	66.7	4	33.3
19	5	35.7	9	64.3	8	66.7	4	33.3
20	10	43.5	13	56.5	7	43.8	9	56.3
21	4	40.0	6	60.0		0.0	3	100.0
22	4	40.0	6	60.0	-	0.0	4	100.0
23	3	75.0	1	25.0	2	50.0	2	50.0
24	-	0.0	3	100.0	3	100.0	0	0.0
<20	13	39.4	20	60.6	24	68.6	11	31.4
20-24	21	42.0	29	58.0	12	40.0	18	60.0
Total	34	42.5	49	57.5	36	55.4	29	44.6

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The pattern across the individual ages at first marriage does not suggest any uniformity between the two study areas. It is clear, however, that with the exception of a few cases, the proportion of the marriages said to be pregnancy-induced is quite substantial particularly for Mankrong. It is therefore not surprising that Ajayi et. al. (1991) report in their study in Kenya that age at birth of first child tends to parallel age at first marriage. It is also noteworthy to state that comparing marriages at less than 20 years to those at 20-24 years, the proportion of the marriages reported to be pregnancy-induced in Cape Coast was relatively higher among marriages at 20-24 years (42.0 per cent) than at less than 20 years (39.4 per cent). This is however, in sharp contrast to the situation in Mankrong where the figures were 68.6 per cent among marriages at less than 20 years and 40.0 per cent among those taking place between 20 and 24 years. The observation made in Table 4.20 regarding pregnancy-induced marriages suggests that if unwanted or unplanned pregnancies and first births among the adolescents

could be avoided, marriages could be delayed or postponed till later ages when it would be physiologically ideal to participate in childbearing. The analysis, however, does not lose sight of the small number of respondents that are involved which could introduce some biases.

The female adolescents who had ever married were further asked whether with their experience in marrying they would advise their daughters to marry at the same age they got married for the first time. From the responses presented in Table 4.21, it is clear that majority of them (about 78 per cent in Cape Coast and 69.2 per cent in Mankrong) would not because they thought they married too early, a practice, which they did not find to be good for their daughters.

Table 4.21. Percentage of Adolescent Females by Reasons Given as to Whether or Not they would Advise their Daughters to Marry at the Same Age they got Married for the First Time, Cape Coast and Mankrong

Reason	Cape Coast				Mankrong			
	Yes		No		Yes		No	
	N	%	N	%	N	%	N	%
Economic reasons	2	11.1	19	30.6	3	15.0	18	40.0
Must be matured			9	14.5	-	-	16	35.6
Educational reasons	-	-	17	27.4	-	-	6	13.3
Time married was ideal	11	61.1			14	70.0		
Decide for themselves	1	5.6	7	11.3	1	5.0	1	2.2
Other	4	22.2	3	4.8	2	10.0	1	2.2
Not stated			7	11.3			3	6.7
Total	18	22.5	62	77.5	20	30.8	45	69.2

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

It is also observed that among those who indicated they would advise their daughters to marry at similar ages as themselves, majority of them (61 per cent in Cape Coast and 70 per cent in Mankrong) thought the age at which they married was ideal. On the other hand, in the case of those whose response was in the negative, the major reasons given in support of their response were for Cape Coast, economic, educational and the need to attain some physical

maturity in order of importance. Similarly, adolescent respondents in Mankrong indicated economic, physical maturity and educational pursuits in order of importance as their basis for not wanting to encourage their daughters to marry at early ages.

On the issue of whether parents should decide for their wards as to whom to marry, the adults in the focus group discussions, unanimously thought the situation in the past was that it was fashionable for parents to decide on whom their children should marry but this practice has changed with time. In other words, the situation in the past when parents single-handedly decided who their children should marry has changed. In spite of this development, they thought some parental guidance as to who to marry is often helpful. The views of the adolescents in both study areas supported this view. Some even felt it is right for parents to direct their children as to which families they should or should not marry from because they (the parents) have had long periods of experience and know what is good. They however, thought that it should not be an imposition such that the views of the children were not respected.

On the other hand, according to Familusi (1999), in matters pertaining to reproductive health of adolescents, boys and girls alike as well as women (as mothers) should take more blame than men. Familusi argues for example, that most men believe that it is the woman's natural responsibility to guide and counsel their children on sexual activity. Thus, men adopt a sit and watch attitude only to come out snorting and cursing when things go wrong in the lives of the children. From Familusi's analysis therefore, women occupy a central position and must play a vital role in all matters related to adolescent sexuality and reproductive health problems. It is, however, the conviction of this study that a more collaborative effort on the part of both men and women would be more productive in providing reproductive health education to children while exercising some cautious guidance when it comes to marriage decisions.

The conclusion that may be drawn from this analysis is that majority of the female adolescents are not in favour of early marriages. Yet, it appears that many of them learn mainly by experiencing the events before advising themselves to the contrary. It is obvious that to forestall this practice, young adolescents should not be denied reproductive health education from both parents and teachers. Again, the views of parents regarding whom to marry should not be imposed on the adolescents. Instead, adolescents should be guided to make the right decisions. This is consistent with the views expressed by both adults and adolescents in the focus group discussions.

CHAPTER FIVE

ADOLESCENT CHILDBEARING AND REPRODUCTIVE KNOWLEDGE

5.1 Introduction

Childbearing begins with one's entry into sexual activity, pregnancy and birth. In the preceding chapter, a look was taken into sexuality issues and marriage, the latter being with reference to those who had ever been married. Yet, while repeated sexual activity might precede a pregnancy, each birth is traceable to only one particular pregnancy. It should however be mentioned that for each childbirth that occurs, the mother may have had earlier pregnancies which did not necessarily end in a birth. Thus, this chapter, apart from informing us about how early pregnancies and childbearing are taking place among the adolescents under study, will shed light on possible pregnancy losses either through miscarriage or abortion, which are often shrouded in secrecy in the country.

5.2 Age at First Pregnancy

The interest in this section is not just the age at first pregnancy but the number of times an adolescent has become pregnant. Throughout therefore, an attempt has been made to control for the number of times the adolescents have ever become pregnant. Two sets of analysis have been made in Table 5.1a. The first is to find out the distribution of the adolescents who have had a particular number of pregnancies by age in single years. The second is to compare all adolescents less than 20 years relative to their counterparts of 20-24 years to find out the proportion of each group that has had a number of pregnancies at the time of the survey.

As has been presented in Table 5.1a, a small proportion of the adolescents reportedly had ever become pregnant at the time of the survey. It was 11.7 per cent among respondents in Cape Coast as against a quarter (25.5 per cent) of their counterparts in Mankrong. Overall, it

appears that approximately two in three of the respondents who had ever had a pregnancy reported to have had only one pregnancy in either Cape Coast or Mankrong although the proportion is slightly higher in Mankrong. Higher pregnancy rates have however been recorded in a study by Agyei and Epema (1990) in Kampala, Uganda where, by age 17 years, 30 per cent of the women had one or more pregnancies with one in six of them found to be currently pregnant in addition to an average of 2.15 pregnancies among all adolescents. The caution, however, is that of data representativeness of the Kampala study.

Compared to the foregoing finding in Kampala, the incidence of pregnancy in Cape Coast and Mankrong is on the low side. The proportion having had two or three pregnancies is on the other hand, slightly higher in Cape Coast (27.4 per cent and 12.0 per cent respectively) compared to 21.7 per cent and 10.8 per cent respectively in Mankrong. This shows that although a relatively higher proportion of the respondents in Mankrong had ever become pregnant, the proportion having more than one pregnancy is higher in Cape Coast than in Mankrong. This finding is quite contrary to expectation because in urban areas, although adolescents could be pregnant at an early age, opportunities including easier access to information on contraception in urban areas may reduce the number of subsequent pregnancies relative to the rural areas.

It is, however, important to note that in either study area, some of the respondents reported to have had up to three or more pregnancies. Yet, it is clear that many of those who have had several pregnancies were relatively older, i.e., more than 19 years. In Mankrong for example, apart from age 19 years, all the respondents who had ever become pregnant at ages younger than 20 years had had one pregnancy only except one person at age 19 years who had had two pregnancies. In Cape Coast, although some of the adolescents below 20 years had had more than one pregnancy, none, except at age 19 years had had up to three pregnancies.

In the second part of the analysis, it is observed that among either adolescents less than 20 years or within 20-24 years, a high proportion of them had had one pregnancy only. This is especially the case among adolescents less than 20 years (79 per cent in Cape Coast and 92 per cent in Mankrong). In the case of the youth of 20-24 years, the proportion having one pregnancy only reduces in either study area while that for second and third pregnancies increases in comparison with their counterparts less than 20 years. This is expected since at these ages, many of them may be married and hence it may not be uncommon for many of them to have more than one pregnancy. For example, while 16.4 per cent of women 20-24 years in Cape Coast were ever married, close to half (47.4 per cent) of their counterparts in Mankrong were ever married. Accordingly, the proportion of adolescents that have ever been pregnant within age 20-24 years in Mankrong is higher (84.3 per cent) than the case is in Cape Coast (75.6 per cent). This suggests that the observed higher proportion of adolescents ever becoming pregnant in Mankrong is largely among the youth aged 20-24 years. From Table 5.1a, while about one in four of the adolescents ever becoming pregnant in Cape Coast, was aged less than 20 years, the corresponding figure for Mankrong was one in six adolescents.

Table 5.1a. Percentage of Female Adolescents by Current Age and Number of Times Pregnant, Cape Coast and Mankrong

Age	Number of Times Pregnant									
	Cape Coast					Mankrong				
	1	2	3+	Total		1	2	3+	Total	
				N	%				N	%
16		100.0	-	1	0.6	100.0	-	-	1	1.2
17	87.5	12.5	-	8	4.5	100.0	-	-	1	1.2
18	80.0	20.0	-	15	8.6	100.0	-	-	2	2.4
19	79.0	10.5	10.5	19	10.9	88.9	11.1	-	9	10.9
20	60.7	28.6	10.7	28	16.0	74.1	18.5	7.4	27	32.5
21	58.4	33.3	8.3	12	6.3	70.0	20.0	10.0	10	12.0
22	64.3	28.6	7.1	28	16.0	72.7	9.1	18.2	11	13.0
23	39.1	34.8	26.1	23	13.1	50.0	41.7	8.3	12	14.5
24	47.6	35.7	16.7	42	24.0	30.0	40.0	30.0	10	12.0
15-19	79.1	16.3	4.6	43	24.4	92.3	7.7	0.0	13	15.7
20-24	53.4	32.3	14.3	133	75.6	62.9	24.3	12.8	70	84.3
Total %	60.6	27.4	12.0	-	100.0	67.5	21.7	10.8	-	100.0
N	105	50	21	176	-	56	18	9	83	-

Note: *11.7 per cent had ever become pregnant in Cape Coast compared to 25.5 per cent in Mankrong.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The adolescents have also been compared on the basis of their marital status in respect of the number of times they have been pregnant. This is due to the understanding that ever married women would normally have higher frequency of pregnancies compared to the never married due largely to differences in pregnancy risk exposure among the two groups. In Table 5.1b, it is observed that in either Cape Coast or Mankrong, a relatively higher proportion of the ever married adolescents have had more pregnancies compared to the never married among whom a large proportion have had one pregnancy only. However, it is equally worthy of note that among the never married adolescents, there are some who have had three pregnancies or more. One thing which stands out in Table 5.1b and corroborates the results in Table 5.1a is that among never married and ever married adolescents, the overall percentage ever becoming pregnant is higher among persons aged 20-24 years relative to those of less than 20 years.

Table 5.1b. Percentage of Female Adolescents by Age Group, Marital Status and Number of Times Pregnant, Cape Coast and Mankrong

Marital Status	Age and Number of times pregnant									
	Less than 20 years					20-24 years				
	1	2	3+	Total		1	2	3+	Total	
				N	%				N	%
Cape Coast										
Never Married	75.8	21.2	3.0	33	100.0	57.7	31.0	12.3	71	100.0
Ever Married	90.0	0.0	10.0	10	100.0	48.4	33.9	17.7	62	100.0
Total	79.1	16.3	4.6	43	100.0	53.4	32.3	14.3	133	100.0
Mankrong										
Never Married	100.0	0.0	0.0	4	100.0	80.0	20.0	0.0	20	100.0
Ever Married	88.9	11.1	0.0	9	100.0	56.0	26.0	18.0	50	100.0
Total	92.3	7.7	0.0	13	100.0	62.9	24.3	12.8	70	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 5.2 also looks at the mean age at first pregnancy among the adolescents. Once again, the number of times an adolescent has become pregnant has been controlled to facilitate a comparison of age at first pregnancy according to the number of times pregnant.

Table 5.2. Mean Age at First Pregnancy of Female Adolescents by Number of Times Pregnant, Cape Coast and Mankrong

Number of times pregnant	Cape Coast		Mankrong	
	N	Mean (years)	N	Mean (years)
1	105	19.2	56	19.0
2	49	18.0	18	18.4
3+	21	17.3	9	18.7
Total	175	18.6	83	18.8

Note: One person from Cape Coast having had two pregnancies did not state her age at first pregnancy and hence was not included in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The overall observation is that the mean age at first pregnancy is relatively lower in Cape Coast (18.6 years) compared to Mankrong (18.8 years). What this means is that although in the towns, more adolescents do not get pregnant relative to what pertains in the rural areas, yet pregnancies when they occur could be relatively earlier in the towns as against the villages. This is however, contrary to expectation and could be the result of possible age misreporting

among the adolescents in Mankrong in respect of age at first pregnancy. In 1996, Nabila and Fayorsey found that adolescent pregnancies and impregnation among a sample of adolescents in Accra and Kumasi begin as early as age 13 but the mean age at first pregnancy was found to be 17 years which is a little over a year lower than the current result from Cape Coast and Mankrong.

Again, it is recognisable especially in respect of respondents in Cape Coast that there appears to be an inverse relationship between mean age at first pregnancy and the number of times pregnant. This means that the earlier an adolescent becomes pregnant for the first time, the more likely she is to have more subsequent pregnancies. Thus, if first pregnancy is postponed, it is possible that the number of pregnancies that may occur to them in their adolescent ages could be reduced. This finding is to a large extent consistent with a Guatemalan study where there was an observed association between early childbearing and higher completed fertility (Buvinic, 1998). This is however, based on the assumption that most of the pregnancies would end in a birth. On the other hand, no such association was found in studies in Chile and Mexico (Buvinic, 1998). This observation is not too straight forward as regards adolescents in Mankrong. Yet, it is obvious from Table 5.2 that the mean age at first pregnancy for persons having had two or more pregnancies is comparatively lower than their counterparts who have had only one pregnancy.

Another important area of interest is the role of education in the incidence of pregnancies among the female adolescents. The limitation of the current data, however, is that the educational levels of the respondents do not relate to the time of the occurrence of the pregnancy. Yet, it is observable from Table 5.2 that, the minimum mean age at first pregnancy among the adolescents occurred after the age of 17 years (i.e., 17.3 years) at which time, those who might have gone to school would, all things being equal, have completed at least Junior Secondary School and even could be in the Senior Secondary School. To some extent

therefore, the data presented here could shed some light on the role of education in the incidence of pregnancies among adolescent females.

From Table 5.3, it can be observed that some form of education is important in reducing the repeated incidence of pregnancies during the period of adolescence. The evidence from the table is that with the exception of educational categories with few cases, adolescents with no education show signs of higher number of pregnancies compared to their counterparts with any level of formal education. For example, while almost 32 per cent (Cape Coast) and 25 per cent (Mankrong) of the adolescents with no education have had up to three or more pregnancies, the proportion pertaining to other educational categories is less than 10.0 per cent. This observation is reinforced by the fact that the proportion of adolescents who have only one pregnancy is lowest among adolescents who have no education compared to their counterparts of other levels of education. The implication of this, as is shown in Table 5.3 is that among adolescents with no education, relatively higher proportions have had two or more pregnancies than adolescents of other educational categories. In this regard retention of young adolescents in school could reduce incidence of both first and repeated pregnancies.

Table 5.3. Percentage of Female Adolescents by Number of Times Pregnant and Level of Education, Cape Coast and Mankrong

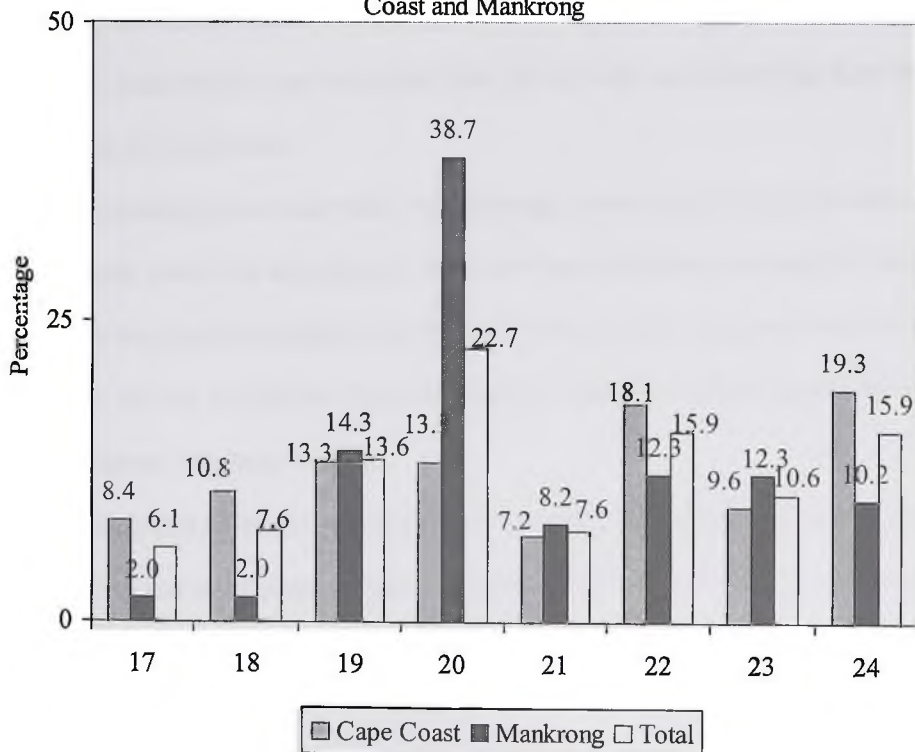
Education	Number of pregnancies							
	Cape Coast				Mankrong			
	1	2	3+	Total	1	2	3+	Total
No education	36.8	31.6	31.6	100.0	58.3	16.7	25.0	100.0
Primary	60.6	30.3	9.1	100.0	66.7	23.8	9.5	100.0
Arabic*	66.7	33.3	-	100.0	-	-	-	100.0
Middle/JSS	63.4	26.9	9.7	100.0	71.4	25.7	2.9	100.0
SSS/Secondary	61.5	30.8	7.7	100.0	100.0	-	-	100.0
Post-Secondary/Higher*	50.0		50.0	100.0				-
Total Number	105	50	21	176	56	18	9	83

Note: * Less than 5 cases involved.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The study also examined the pregnancy situation among the adolescents during the last 12 months before the survey. The results indicate that only about 5.5 per cent of the adolescents in Cape Coast reported to have been pregnant in the last 12 months compared to 15.1 per cent among their counterparts in Mankrong. Overall, however, 27.3 per cent of the pregnancies occurred to adolescents below 20 years. The breakdown by study area also shows that the proportion of the pregnancies occurring to adolescents less than 20 years was higher in Cape Coast (32.5 per cent) compared to Mankrong (18.3 per cent). These are however, not shown in Figure 5.1. It is also to be noted that although overall pregnancies are lower in Cape Coast, the evidence in Figure 5.1 suggests that the proportion of pregnancies to persons less than 20 years (where reproductive health risks are much higher), is higher in Cape Coast, a bigger town as against a small settlement, Mankrong.

Figure 5.1. Percentage of Female Adolescents and the Youth Ever Becoming Pregnant in the Past Twelve Months by Current Age, Cape Coast and Mankrong



In sum, although the overall pregnancy occurrence is higher in the rural settlement of Mankrong, pregnancy incidence appears to be much earlier in Cape Coast. This is a problem that should not escape the attention of policy makers although possible age misreporting in respect of first pregnancies cannot be ruled out.

The adolescents were also asked in the focus group discussions about what they thought should be the attitude of parents towards young girls who become pregnant while in school. The responses were almost the same whether they were adults or adolescents. Most of the adults were concerned about the possibility that when one is not patient with the pregnant girl, she could even commit suicide or attempt an abortion and in the process may lose her life. For example, one adult in Cape Coast advised that parents “should be patient with school girls who get pregnant and assist the male partner who is responsible for the pregnancy to take care of her in order not to drag her to take her life”. There were also suggestions that when parents are patient with the pregnant adolescents, they could be encouraged to go back to school. However, one female adult in Mankrong, citing the case of her own sister, explained that some of them would refuse to go to school, after giving birth notwithstanding how lovingly their parents would handle them.

According to one male adult in Mankrong, he was angry with a man who impregnated his daughter some time ago and that led to the man absconding, leaving the whole burden of caring for his pregnant daughter and the child falling on him even long after the delivery. He therefore, felt that the attitude of parents should be humane to reduce the burden of taking care of the pregnant daughters on them.

In support of the position of most of the adults, one female adolescent in Mankrong was of the view that when pregnant girls are not handled with care and love, it could affect their health and that of the babies they give birth to. To her, part of the high infant mortality among

adolescents is the result of the negative attitude of some parents towards their daughters when they disappointingly become pregnant.

One female adolescent in Cape Coast was, however, of the opinion that the adolescent girl who gets pregnant while in school should be reprimanded to serve as deterrent to her other sisters. This is because, in her view, when they are “pampered” during their period of pregnancy, most of them do not learn any lessons and get pregnant again still without husbands, bringing more burden to their parents.

On the whole, however, it looks like it is quite a delicate situation when a young girl gets pregnant while at school. Hence, since many parents are constrained by such delicate situations to handle pregnant teenage daughters with care and love, it does not become deterrent enough to others not to follow the footsteps of their friends or sisters.

5.3 Age At First Birth

The timing of first births is crucial in determining possible fertility levels. This is because, when people give birth quite early in life there is a high tendency for them to have subsequent births in quick succession especially when the first births are not the result of marriage. It is against this background that the two study areas are compared in this section which also attempts to compare reported first births to first pregnancies between the two study areas.

In Table 5.4, the evidence points to almost the same mean age at first birth in Mankrong (19.4 years) and Cape Coast (19.5 years). This is quite unexpected because, with a much lower mean age at first pregnancy in Cape Coast, it should have followed that mean age at first births should accordingly be lower in Cape Coast than in Mankrong. The inconsistency could therefore be attributed to possible misstatement of either age at first pregnancy or first births between the two areas. It should, however, be noted that since not all the reported

pregnancies might end in a birth those inconsistencies are likely to occur. This is based on the understanding that some of the first births could actually be the products of second and third pregnancies rather than first pregnancies in view of possible pregnancy losses.

Table 5.4. Mean Age at First Birth Among Female Adolescents and the Youth by Current Age, Cape Coast and Mankrong

Study Area	Current Age								Total
	17	18	19	20	21	22	23	24	
Cape Coast	16.0*	17.1	18.0	18.2	18.8	20.4	19.4	21.1	19.5
Mankrong	17.0*	16.0*	18.1	18.8	19.3	20.3	20.9	20.2	19.4
Total	16.3*	17.0	18.0	18.5	19.1	20.4	20.1	20.9	19.5

Notes: *Less than 5 cases involved.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Note must again be taken of the fact that 22.5 per cent of the adolescents in Mankrong had had a birth in comparison with 7.5 per cent in Cape Coast (not shown in the table). Among those who had ever had a birth in Cape Coast, 18.6 per cent were aged less than 20 years, the remaining 81.4 per cent falling within 20-24 years. In contrast, it was 13.7 per cent for those aged less than 20 years in Mankrong and 86.3 per cent in respect of those who were more than 20 years. This again supports the earlier observation with regard to pregnancy incidence that actual adolescent births (i.e. less than 20 years) are comparatively higher in Cape Coast than in Mankrong, their urban and rural statuses notwithstanding.

With reference to Table 5.4, there is a general observation that mean age at first birth increases with higher age of the adolescent except at age 23 years for Cape Coast and 24 years for Mankrong where there appears to be non-conformity to the overall observation. This suggests possible decline in the age at first birth with time, a situation which does not present healthy signals to the development of the adolescents although on the whole the proportion that reported to have ever had a birth is quite small.

5.4 Adolescent Fertility and Pregnancy Wastage

The study investigated into actual childbearing performance among the adolescents. It first, in Table 5.5, looks at current childbearing experiences i.e., within the last 12 months before the survey. From the table, it is to be noted that only 3.6 per cent (54 adolescents) of all the respondents in Cape Coast had given birth within the 12 months preceding the survey compared to 12.3 per cent (40 adolescents) in Mankrong. There were also two persons in Cape Coast who reportedly were pregnant at the time of the survey but were not included in the table. The table shows a relatively higher childbearing performance in Mankrong than in Cape Coast. It, on the other hand, supports the earlier observation of a higher proportion of childbearing contributed by adolescents of less than 20 years in Cape Coast (18.6 per cent) than their counterparts in Mankrong (13.7 per cent). In each study area, childbearing is obviously higher among older adolescents 20-24 years compared to their younger counterparts who are less than 20 years. This is to be expected because a higher proportion of women of 20-24 years were found to be married relative to adolescents of 15-19 years (Table 3.3).

Table 5.5. Percentage of Female Adolescents Having Births in the Past Twelve Months Before the Survey by Current Age, Cape Coast and Mankrong

Study Area	Current Age								Total	
	17	18	19	20	21	22	23	24	N	%
Cape Coast	1.8	9.3	11.1	16.7	5.5	22.2	9.3	24.1	54	100.0
Mankrong	2.5	-	15.0	42.5	5.0	15.0	10.0	10.0	40	100.0
Total	2.1	5.3	12.8	27.7	5.3	19.1	9.6	18.1	94	100.0

Note: The percentage is of the total number of respondents in Cape Coast and Mankrong respectively.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 5.6 shows the proportion of the adolescents according to current age and the number of children ever born. Overall, more than two-thirds of adolescents who had ever had a birth at the time of the survey had had only one birth, the proportion being slightly higher in Mankrong (75.4 per cent) than in Cape Coast (72.8 per cent).

Table 5.6. Percentage of Adolescents by Number of Children Ever Born and Current Age, Cape Coast and Mankrong

Current Age	Number of Children Ever Born					
	Cape Coast			Mankrong		
	1	2	3+	1	2	3+
17	2.4		-	1.8	-	-
18	7.2	4.0		1.8	-	
19	12.1	4.0	16.7	12.7	8.3	
20	18.1	16.0	16.7	36.5	33.3	16.7
21	7.2	8.0		14.5	8.3	
22	15.7	20.0	16.7	14.5	-	33.3
23	8.4	16.0	33.2	12.7	16.8	16.7
24	28.9	32.0	16.7	5.5	33.3	33.3
Total %	72.8	21.9	5.3	75.4	16.4	8.2
N	83	25	6	55	12	6

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

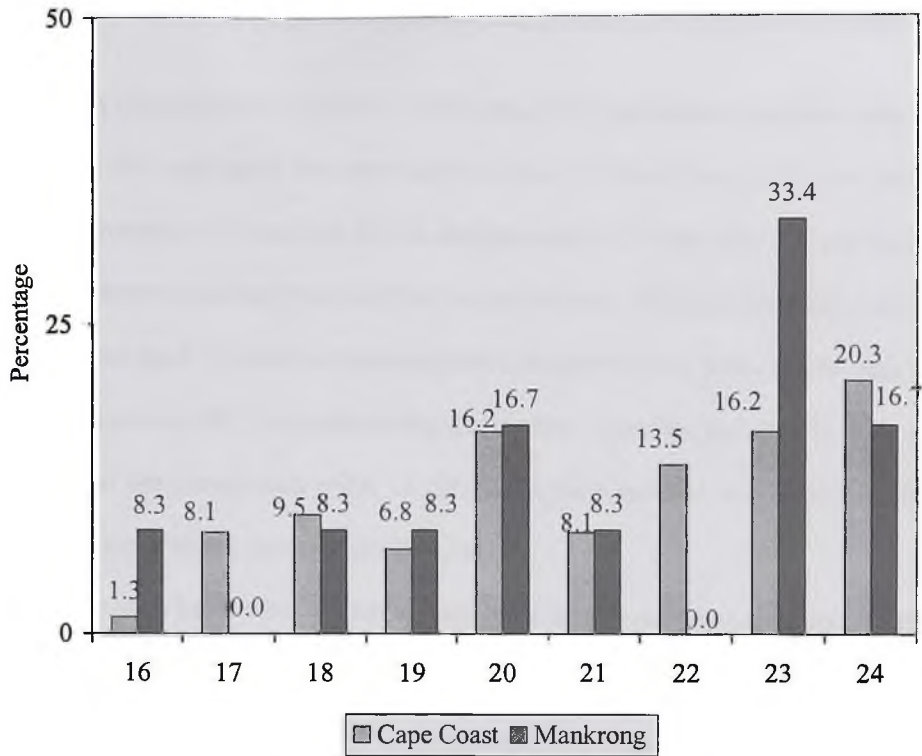
On the other hand, a higher proportion (21.9 per cent) of the respondents in Cape Coast had had two births compared to 16.4 per cent in Mankrong. In contrast, a slightly higher proportion of the respondents had had up to three or more births in Mankrong (8.2 per cent) as against Cape Coast (5.3 per cent). It is significant to observe that only four of the respondents who were less than 20 years had had two or more births, three in Cape Coast and one in Mankrong. Thus, for each category of births, the highest proportions were between 20 and 24 years whether in Mankrong or Cape Coast. However, it will still be healthier if no adolescent gives birth at any age less than 20 years to ensure that they all attain the highest level of education as possible.

Investigation was also made into pregnancy wastage due to induced abortion. The adolescents were asked about whether or not they had ever had an abortion. The results show that 4.9 per cent or 74 adolescents from Cape Coast reported to have ever had an abortion. However, this number formed 42.0 per cent of the adolescents in Cape Coast who had ever

been pregnant. Obviously, this is on the high side suggesting that pregnancy wastage as a result of induced abortion is quite high among adolescents.

In contrast, 12 adolescents from Mankrong made up of only 3.7 per cent of all the respondents interviewed in Mankrong and 14.5 per cent of those who had ever been pregnant in the village reported to have had an abortion. This shows a higher abortion rate in Cape Coast compared to Mankrong. This may be due to the availability of more health facilities and personnel in Cape Coast (an urban area) that facilitate the provision of relatively smooth abortion services in contrast to Mankrong (a rural area). It could also be the result of differences in accuracy of reporting which may be better in Cape Coast than in Mankrong. It is also possible that the idea of menstruation regulation using local herbs is more likely in rural Mankrong than Metropolitan Cape Coast. The proportion of female adolescents who reported ever having an abortion by single ages is shown in Figure 5.2.

Figure 5.2. Percentage of Female Adolescents Ever Terminating a Pregnancy by Current Age, Cape Coast and Mankrong



At the same time, reported cases of abortion whether in Cape Coast or Mankrong were among adolescents of at least 16 years old. From Figure 5.2, a relatively higher proportion of reported abortion occurred to persons aged between 20 to 24 years than among those less than 20 years.

It was also observed in Table 5.7 that some of the adolescents had had more than one abortion. In the same table, the observation is that for Cape Coast, 67.6 per cent of ever pregnant adolescents who had ever had an abortion had had it once while 23 per cent and 9.4 per cent respectively had had it two and three or more times. On the other hand, only one ever pregnant person aged 24 years in Mankrong had had abortion two times, all the other 11 ever pregnant adolescents, (91.7 per cent) having had it once. It is also important to draw attention to the fact that one person each at 16, 17, 18 and 19 years reported to have had abortion two times, a situation, which is not good for their health.

On the other hand, when adolescents aged less than 20 years are compared to others 20-24 years, Table 5.7 shows that the proportion having had one abortion only was higher among adolescents less than 20 years (73.7 per cent) in Cape Coast than their counterparts aged 20-24 years (65.5 per cent). This suggests that relatively higher proportions of the youth aged 20-24 years have had two or more abortions than their younger counterparts of less than 20 years. In the case of Mankrong however, with the exception of one adolescent aged 24 years, all adolescents who reported ever having abortion have had it only once.

Table 5.7. Percentage of Female Adolescents by Current Age and Number of Times Ever Terminating a Pregnancy, Cape Coast and Mankrong

Current Age	Number of Times of Pregnancy Terminated				
	Cape Coast			Mankrong	
	1	2	3+	1	2
16		5.9		9.1	-
17	10.0	5.9	-	-	-
18	12.0	5.9	-	9.1	-
19	6.0	5.9	14.3	9.1	-
20	12.0	29.4	14.3	9.1	-
21	10.0		14.3	18.2	-
22	16.0	5.9	14.3	-	-
23	16.0	11.7	28.5	36.3	-
24	18.0	29.4	14.5	9.1	100.0
16-19	73.7	21.0	5.3	100.0	0.0
20-24	65.5	23.6	10.9	88.9	11.1
Total %	67.6	23.0	9.4	91.7	100.0
N	50	17	7	11	1

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

However, it may be that people are always not keen at reporting to have embarked on abortion. With this at the background, Table 5.8a presents a matrix of the number of pregnancies and births among the adolescents in Cape Coast. From Table 5.8a, a total of 278 pregnancies were reported to have occurred among all the adolescents. Out of this number, there were 151 births (54.3 per cent of the pregnancies) with 127 (45.7 per cent) ending in pregnancy wastage. This suggests that the 42.0 per cent reported abortion observed earlier in Figure 5.2 is relatively on the low side and hence it is possible that some other adolescents might have carried out abortion but failed to report as such. This is, however, not to discount the possibility of a few pregnancies resulting in miscarriages without any direct and deliberate inducement on the part of the persons carrying the pregnancies.

Table 5.8a. Percentage Distribution of Female Adolescents (15-24 Years) by Number of Births and Pregnancies Ever Had, Cape Coast

Number of Births	Number of Pregnancies							Total
	0	1	2	3	4	5	6	
0	100.0 (1,327)	41.9 (44)	26.0 (13)	20.0 (3)	33.3 (1)	-	100.0 (1)	92.4 (1,389)
1		58.1 (61)	34.0 (17)	20.0 (3)	33.3 (1)	50.0 (1)	-	5.5 (83)
2	-	-	40.0 (20)	20.3 (3)	33.3 (1)	50.0 (1)		1.7 (25)
3	-			40.0 (6)	-			0.4 (6)
Total	88.3 (1,327)	7.0 (105)	3.3 (50)	1.0 (15)	0.2 (3)	0.1 (2)	0.1 (1)	1,503 (100.0)

Notes: Brackets represent number of cases

Total number of pregnancies = 278; 151 births = 54.3 per cent and 127 wastages = 45.7 per cent

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Similarly, in Table 5.8b, 120 pregnancies were reported to have occurred among the female adolescents in Mankrong. However, 98 (81.7 per cent) of the total number of pregnancies ended in births while the remaining 22, constituting 18.3 per cent of the number of pregnancies could be deduced to have been pregnancy wastages including abortion. Again, this is about 3.8 per cent higher than the reported abortion rate of 14.5 per cent observed in Table 5.7, i.e., among adolescents who have ever become pregnant.

Table 5.8b. Percentage of Female Adolescents (15-24 Years) by Number of Births and Pregnancies Ever Had, Mankrong

Number of Births	Number of Pregnancies					Total
	0	1	2	3	4	
0	100.0 (242)	16.1 (9)	5.6 (1)	-	-	77.5 (252)
1		83.9 (47)	44.4 (8)	-	-	16.9 (55)
2		-	50.9 (9)	37.5 (3)		3.7 (12)
3	-	-		62.5 (5)		1.6 (5)
4	-	-	-	-	100.0 (1)	0.3 (1)
Total	74.5 (242)	17.2 (56)	5.5 (18)	2.5 (8)	0.3 (1)	100.0 (325)

Notes: Total number of pregnancies = 120 made up of 98 births (81.7 per cent) and 22 wastages (18.3 per cent).

Brackets represent number of cases

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

From the foregoing analysis, it is valid to state that the abortion rate could be higher than was reported by the adolescents. On the other hand, the reported higher abortion rate in Cape Coast compared to Mankrong is again supported by these further analyses and deductions. The limitation here, however, is that it is not possible to calculate the number of pregnancy wastage due to miscarriage from those that were the result of intentionally induced processes.

Information on abortion among adolescents is difficult to elicit from respondents due to the fact that the 1960 Criminal Code, Act 29 (58-63) makes abortion illegal in Ghana. The exceptions however, are under conditions of rape, incest or maternal health. According to Nabila and Fayorsey (1996), most adolescent females have developed a social network system which tends to keep abortion incidence as secret as possible. From this observation therefore,

the reported abortion rates could be an underestimation of what the situation may be on the ground.

At this stage, it is relevant to find out the reasons given by the adolescents for terminating the pregnancies at the time they did. In Table 5.9, it appears that there were three major considerations for deciding on an abortion. In the case of adolescents in Cape Coast, the major reason was that they were not ready at the time of the pregnancy to have a child (39.2 per cent) and secondly, a desire to complete their education (28.4 per cent). In contrast, among adolescents in Mankrong the most cited reason for embarking on an abortion was that the male partner was either not working or had proved to be financially irresponsible and hence incapable of taking care of both mother and baby (41.6 per cent). The reason of wanting to complete one's education was the second most cited consideration given by one in four of those ever undertaking an abortion in that community. What is worth appreciating is the fact that at least, one out of every four adolescents had the desire to complete their education before entering into childbearing.

Table 5.9. Percentage of Female Adolescents by Reason for Terminating Pregnancy, Cape Coast and Mankrong

Reason	Cape Coast		Mankrong	
	N	%	N	%
Not ready at the time	29	39.2	2	16.7
Wanted to complete School	21	28.4	3	25.0
Partner not working/irresponsible	4	5.4	5	41.6
Previous child not old enough	5	6.7	-	
Financial reasons	8	10.8		-
Other	7	9.5	2	16.7
Total	74	100.0	12	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Another area of importance in respect of pregnancy wastage is the place or person from whom the abortion service was sought. The responses of the adolescents are shown in Table 5.10. It is observable from the table that almost three out of every four abortions in Cape

Coast were carried out by trained medical personnel as against slightly more than half the number in Mankrong. Although it is the view of this study that abortion should not be resorted to except in situations where the pregnancy is the result of incest or rape or where the health of the mother is at a serious risk, whenever it becomes necessary to undertake an abortion, then it has to be done at the right place and by medically trained persons to avoid or reduce complications or deaths. It is therefore a welcome observation that a higher proportion of the abortion cases were reportedly sought from or carried out by either a trained medical doctor or nurse.

Yet, in the case of Mankrong, one in every three cases of abortion was reported to have been assisted by a friend who obviously may not be a qualified medical professional. Some were also reported to have been by self-inducement, i.e., 13.5 per cent in Cape Coast and 8.3 per cent in Mankrong. At the same time, two adolescents also indicated to have had an abortion service from a traditional healer in Cape Coast. In these cases, the use of herbs which may have negative and often, disastrous consequences on the reproductive and physical health of the person on whom the abortion was carried out cannot be ruled out.

Table 5.10. Percentage Distribution of Female Adolescents Ever Terminating a Pregnancy by Person Providing the Service, Cape Coast and Mankrong

Person	Cape Coast		Mankrong	
	N	%	N	%
Doctor	48	64.8	7	58.4
Nurse	7	9.5		-
Friend	7	9.5	4	33.3
Traditional Healer	2	2.7		-
Self	10	13.5	1	8.3
Total	74	100.0	12	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In sum, reported number of abortions has been shown to fall short of the actual cases of abortion that may have taken place among the adolescents who had ever been pregnant. This

has however, been consistent with earlier studies in Ghana as a result of the fact that abortion is illegal in the country in addition to the stigma that goes with it in the Ghanaian society (see Nabila and Fayorsey, 1996). Given the opportunity however, it is clear that many of the adolescents becoming pregnant would avoid the pregnancy in order to complete school. Yet, it appears these adolescents lack both information and services that could save them from first becoming pregnant and hence not to contemplate on an abortion which could have long term and at times irreversible negative impacts on their health.

There is always some kind of stigmatisation attached to abortion in Ghana. No one wants to be associated publicly with an abortion. Yet, many people may resort to abortion any time they find it necessary to do so. There are still others who feel that abortion is a family planning method. For example, many sexually active adolescents who were interviewed in Kumasi and Accra as to why they do not practise contraception, said that they could go for an abortion any time they become pregnant (Kwankye, 1999).

To this extent, the participants in the focus group discussions were asked about their views as to whether they would agree that a girl who has an unplanned pregnancy should go for an abortion and why they support it. In the discussions, it was found that almost all of them disagreed that it is advisable to embark on abortion no matter the situation. Many of the reasons that were given in support of their opinions touched on the fear that abortion could lead to complications such as sterility or death to the victim. For example, some of them indicated that an abortion could cause barrenness to the girl in future and evidence suggests that in situations of this nature, “some of the victims turn round to blame their mothers (who might have encouraged them to go for the abortion) for bewitching them and being behind their inability to give birth in future”. According to them, such a development should be discouraged since it destabilises whole families and households.

The adolescents were all unanimous in their suggestion that young girls who become pregnant should be encouraged to give birth and thereafter, be assisted to continue their education. To many of them, “any form of abortion is tantamount to murder”. However, two adolescents in Cape Coast were of a different opinion. One of them argued that “abortion is good if it is upon the advice of a doctor”. To another, “it may be good if there is no hope to care for the child”.

With respect to the health-related problems of abortion, almost all of them mentioned the possibility of death occurring or becoming sterile. For example, one male adult in Mankrong cited a case in point and argued that there is always a possibility that the future birth performance of an abortion victim would be negatively affected. In the example he cited, “a lady had undertaken an abortion contrary to all advice. Later on, she could not give birth again”. Their concern, in this respect, was expressed more in the context of the Ghanaian culture, which makes childlessness more of an abomination than abortion having any health effects on the individual who goes for it. It is therefore important that people are sensitised on the health effects of abortion rather than the cultural underpinnings when future births are curtailed as a result of abortion carried out in the past.

Judging from the views expressed in the focus group discussions, one would have thought that abortion would not be a problem in Ghana but the reality is to the contrary. In this study it has earlier been established that in spite of the small proportion of adolescents who reported to have ever had an abortion, the analysis points to perhaps a higher proportion than was reported. It thus, seems quite clear that when it is a question of abortion, what people believe in and talk about is quite different from what they practise.

5.5 Incidence of Pregnancy and School Attendance

The most negative impact of an adolescent’s pregnancy on her development is felt when it finally leads to the dropping out of school of the adolescent. For example, Ajayi et. al.

(1991) report that early untimely pregnancy results in expulsion from school at the rate of 10 per cent annually in Kenya. In the light of this, the study asked the adolescent females that had ever become pregnant whether their first pregnancies occurred when they were in school and what happened thereafter.

The distribution of incidence of pregnancy and school attendance is presented in Tables 5.11 and 5.12. In Table 5.11, the occurrence of first pregnancy is related to the current age of the female adolescents while in Table 5.12, the analysis uses the age at first pregnancy. In the case of Table 5.11, i.e., with respect to current age, no uniform pattern is observed except that a relatively higher proportion of the pregnancies that occurred while the adolescents were in school was among adolescents of less than 20 years compared to those of 20-24 years. This is the case for either Cape Coast or Mankrong. On the other hand, in Table 5.12, it is noted that in both Cape Coast and Mankrong, among those who reported to have been pregnant while in school, relatively higher proportions were reported to be at younger ages at first pregnancy (i.e., less than 20 years) compared to older ages (i.e., 20-24 years). As it is shown, in Cape Coast, about 28 per cent of the pregnancies occurred in school among adolescents of less than 20 years compared to 16.0 per cent among those of 20-24 years. The corresponding figures for Mankrong are about 17.0 per cent among adolescents of less than 20 years as against just 4.0 per cent among their counterparts of 20-24 years. This is in line with the fact that it is usually at younger ages that most of the women are likely to be in school especially in the urban compared to the rural areas.

What is perhaps more important is the finding (not shown in the tables) that out of 42 female adolescents in Cape Coast who became pregnant while in school, 16 of them (38.1 per cent) dropped out of school compared to nine (81.8 per cent) of the 11 female adolescents in Mankrong who became pregnant while attending school. This finding is also consistent with the earlier observation that a relatively higher abortion cases were reported in Cape Coast than

in Mankrong. It is possible then that many of the pregnant women who otherwise would have dropped out of school in Cape Coast may have resorted to abortion making it possible for them to continue with their education compared to their counterparts in Mankrong many of whom may have no ready access to safe abortion services. This reasoning is again in line with Ajayi et. al.'s (1991) report that although abortion is not approved by adolescents in Kenya, it appears it is used in order to stay in school.

Table 5.11. Percentage of Female Adolescents Ever Becoming Pregnant by Current Age and Whether First Pregnancy Took Place While in School, Cape Coast and Mankrong

Age	Cape Coast		Mankrong	
	Yes	No	Yes	No
16	0.0	100.0	100.0	0.0
17	50.0	50.0	100.0	0.0
18	46.7	53.3	0.0	100.0
19	31.6	68.4	0.0	100.0
20	21.4	78.6	3.7	96.3
21	18.2	81.8	20.0	80.0
22	28.6	71.4	18.2	81.8
23	21.7	78.3	8.3	91.7
24	9.5	90.5	30.0	70.0
16-19	39.5	60.5	18.2	81.8
20-24	18.9	81.1	12.9	87.1
Total %	24.0	76.0	13.3	86.7
N	42	133	11	72

Note: One person of age 21 years did not state whether her first pregnancy occurred while she was in school or not and is not included in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 5.12. Percentage of Female Adolescents Ever becoming Pregnant by Age at First Pregnancy and Whether First Pregnancy Took Place While in School, Cape Coast and Mankrong

Age at First Pregnancy	Cape Coast		Mankrong	
	Yes	No	Yes	No
12	100.0	0.0	-	
14	50.0	50.0		
15	44.4	55.6	100.0	0.0
16	41.2	58.8	25.0	75.0
17	29.4	70.6	11.1	88.9
18	28.2	71.8	18.8	81.2
19	9.4	90.6	11.5	88.5
20	17.4	82.6	0.0	100.0
21	33.3	66.7	0.0	100.0
22	6.7	93.3	16.7	83.3
23	0.0	100.0	0.0	100.0
24	0.0	100.0	0.0	100.0
< 20	27.7	72.3	16.7	83.3
20-24	16.1	83.9	4.3	95.7
Total %	24.0	76.0	13.3	86.7
N	42	133	11	72

Notes: One person did not state her age at first pregnancy and is not included in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Suggestions were sought from participants in the focus group discussions as to how adolescents who get pregnant could be encouraged or helped to go back to continue their education after childbirth. Opinions were made to the effect that it is good for the girls to go back to school after birth but their parents should support them to go back to school. They however, acknowledged that it is often difficult for them to go back to their former school. In that case, it is advisable for them to be sent to completely new schools where it may not be known by her school mates that she has given birth before while her baby is taken care of by her parents or relatives.

However, some of the adults were of the view that it is usually dull female students who become pregnant at school and hence, it becomes quite difficult for them to be encouraged to go back to school after birth when the academic capacity of their minds would have been

further reduced after their long stay at home. They therefore argued that it usually depends on the young girl's preparedness to go back to school otherwise it will just be an exercise in futility.

The other dimension was also with respect to financial considerations. In fact, according to one female adult in Mankrong, in situations where parents are struggling to pay the fees of their wards at school, it may even be unthinkable for them to consider further education of the girl after giving birth especially where the burden of the pregnancy and child care falls on the parents. As one of the male adult discussants in the focus group discussions put it, "the parents of the young girl may even be so much disappointed and indeed annoyed with the young girl that going back to school may not even be considered as an option in such peculiar situations".

The adolescents were also of a similar opinion with the adults when they argued that it depends on whether someone will be willing to take custody of the baby to allow her go back to school. At the same time, they thought it would largely depend on whether or not the young girl wants to go back to school and whether the parents have financial resources to send her back to school.

There are clear indications from the analysis that although adolescents who become pregnant while in school are not barred from going to school in Ghana after they have given birth, the socio-economic and cultural environment often is not conducive for the adolescent mothers to go back to school. There are therefore high social costs of adolescent childbearing especially when it leads to school drop-out. For example, Mohamud (1996) reports that in 1988, 8,000 girls dropped out of primary school in India because of pregnancy. The social costs of adolescent childbearing would obviously be reduced if young girls who become pregnant while in school could be assisted to go back to school after the delivery of their babies.

5.6 Desired Fertility Among Adolescents

In most cases, the desire of persons in childbearing has the likelihood of affecting their overall fertility. In this light, all the respondents were asked the number of children they would like to have. The responses are presented in Tables 5.13a and 5.13b. The two tables depict marked differences between female adolescents in Cape Coast and Mankrong. Comparing the two tables, it is consistent with earlier findings that both desired fertility and actual fertility are both higher in rural as against urban areas in Ghana (See GDHS, 1993 and 1998).

The evidence in the two tables is that in Cape Coast desired fertility of between two and four children attracted relatively higher proportions of the respondents (Table 5.13a). Among them, less than one-fifth could not make any specific decision and hence were prepared to have any number of children as determined by God. It must be noted that in Ghana persons who would respond this way would obviously desire large number of children hence making them pro-natalist in their childbearing practices. Comparing the adolescents by age groups, there is not much observed difference between them except that the proportion who thought it depends on “God’s will” tends to rise with decreasing age of the adolescent, i.e., 8.9 per cent among the youth 20-24 years, 14.4 per cent among adolescents 15-19 years and 30.3 per cent with respect to those 12-14 years. This suggests that adolescents are more likely to indicate their desired fertility to coincide with as many children “as God gives” compared to the youth 20-24 years possibly as a result of ignorance.

In contrast, almost half of the respondents in Mankrong indicated their desire for large number of children in accordance with “God’s will” (46.2 per cent) as shown in Table 5.13b. At the same time, more than half of the adolescents less than 20 years gave such a response compared to about 30 per cent of their counterparts of 20-24 years. With such a thinking, many of them are not likely to practise any form of contraception. These pro-natalist sentiments therefore appear to be exhibited particularly among adolescents less than 20 years

especially in Mankrong compared to their counterparts aged 20-24 years. Here again, there is a high tendency for the younger adolescents to leave a decision of the number of children desired to "God's will". In either case, the proportion of adolescents desiring to have only one child is negligible, 1.6 per cent (Table 5.13a) and 0.6 per cent (Table 5.13b) respectively in Cape Coast and Mankrong.

Table 5.13a. Percentage of Female Adolescents by Current Age and Number of Children Desired, Cape Coast

Age	Number of Children Desired						As God grants	N.S.	Total Number
	1	2	3	4	5+				
12	0.9	30.4	13.0	11.3	2.6	38.3	3.5	115	
13	4.8	27.2	24.0	11.2	1.6	26.4	4.8	125	
14	1.3	26.2	25.5	13.4	3.4	27.5	2.7	149	
15	2.1	33.1	26.2	13.8	2.7	20.0	2.1	145	
16	1.2	27.3	29.9	15.6	3.9	19.5	2.6	154	
17	2.3	24.4	32.1	18.3	5.3	11.5	6.1	131	
18	2.1	26.4	32.6	23.6	2.1	11.1	2.1	144	
19	1.8	27.4	31.8	23.9	5.3	8.9	1.8	113	
20	1.5	24.8	32.6	21.7	7.0	10.1	2.3	129	
21	-	30.1	37.3	12.0	7.2	8.4	4.8	83	
22	-	37.0	32.1	21.0	-	6.2	3.7	81	
23	-	31.7	36.7	21.7	3.3	6.6	-	60	
24	-	17.5	37.5	29.7	1.4	12.2	1.4	74	
<15	2.3	27.8	21.3	12.1	2.6	30.3	3.6	389	
15-19	1.9	27.8	30.4	18.8	3.8	14.4	2.9	687	
20-24	0.4	27.9	34.9	21.1	4.2	8.9	2.6	427	
Total %	1.6	27.8	29.3	17.7	3.6	17.0	3.0	100.0	
N	24	418	441	266	54	255	45	1,503	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 5.13b. Percentage of Female Adolescents by Current Age and Number of Children Desired, Mankrong

Age	Number of Children Desired							Total Number
	1	2	3	4	5+	As God grants	N.S.	
12	-	5.4	8.1	2.7	-	83.8		37
13	-	9.7	19.4	9.7	6.4	54.8	-	31
14	-	3.2	19.4	-	6.5	67.7	3.2	31
15	3.6	3.6	28.6	17.8	-	42.8	3.6	28
16		10.3	17.2	17.2	3.4	51.7		29
17	-	-	35.7	14.3	21.4	28.6	-	14
18		13.6	13.6	18.2	4.6	50.0		22
19		5.9	47.1	17.6		29.4		17
20	-	7.0	25.6	27.9	9.3	30.2	-	43
21		9.1	22.7	22.7	4.8	40.9		22
22	-	10.5	21.1	36.8	10.5	21.1	-	19
23	5.3	5.3	36.8	26.3	5.3	21.0	-	19
24	-	15.4	7.7	38.4	7.7	30.8		13
<15	0.0	6.1	15.2	4.0	4.0	69.7	1.0	99
15-19	0.9	7.3	26.4	17.3	4.5	42.7	0.9	110
20-24	0.9	8.6	24.1	29.3	7.8	29.3	0.0	116
Total %	0.6	7.4	22.2	17.5	5.5	46.2	0.6	100.0
N	2	24	72	57	18	150	2	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Furthermore, it has been found that education has much influence on a person's desired fertility and actual childbearing performance. Thus, in Tables 5.14a and 5.14b, an attempt has been made to control for the education of the female adolescents in both study areas.

The results indicate that overall, desire for children, tends to decrease with increasing education of the female adolescent. For example, in Table 5.14a, desire for children up to four or more is 28.6 per cent among the adolescents with no education compared to just 8.4 per cent for those with Post-Secondary/Higher education. One observation, which is quite outstanding in respect of those who left the decision to God is that the proportion responding this way was highest among women with Primary education (23.7 per cent) as against 19.0 per cent among their counterparts with no education. This could, however, be due to age differences where

women with primary education are relatively younger than those with no education and hence may be undecided on how many children they would want to have.

Although the proportions in Table 5.14b are different in sizes, the overall pattern is not much different from the women in Cape Coast (Table 5.14a). Here, it must be highlighted that the proportion of women with Primary and Middle/JSS education who were undecided in the number of children they desired and hence relied on God was higher than that for their counterparts with no education. The role of age differences among different educational groups can again not be discounted here.

Table 5.14a. Percentage of Female Adolescents by Number of Children Desired and Level of Education, Cape Coast

Level of Education	Number of Children Desired							Total		
	1	2	3	4	5+	As God grants	N.S.	N	%	
	No education	3.6	14.3	27.4	17.9	10.7	19.0	7.1	83	100.0
Primary	2.2	28.2	22.6	13.5	6.0	23.7	3.8	266	100.0	
Arabic		14.3	28.6	28.6	14.3	14.3	-	7	100.0	
Middle/J.S.S.	1.6	27.1	26.3	20.3	3.2	19.1	2.4	676	100.0	
S,S.S./Sec	1.0	28.4	37.7	18.4	1.0	10.1	3.4	387	100.0	
Post Sec./Higher		44.6	38.6	6.0	2.4	7.2	1.2	83	100.0	
Not Stated		-				100.0		1	100.0	
Total	%	1.6	27.8	29.3	17.7	3.6	17.0	3.0	-	100.0
	N	24	418	441	266	54	255	45	1,503	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 5.14b. Percentage of Female Adolescents by Number of Children Desired and Level of Education, Mankrong

Level of Education	Number of Children Desired									
	1	2	3	4	5+	As God grants	N.S.	Total		
								N	%	
No education		9.4	26.4	20.8	5.7	37.7		53	100.0	
Primary	1.1	7.4	12.6	12.6	3.2	61.1	2.1	95	100.0	
Middle/JSS	0.6	6.8	23.5	17.9	7.4	43.8		162	100.0	
S,S.S/Sec		6.7	53.3	33.3		6.7		15	100.0	
Total	%	0.6	7.4	22.2	17.5	5.5	46.2	0.6		100.0
	N	2	24	72	57	18	150	2	325	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

It has been shown in this section that there is not much variation between adolescents from urban areas represented here by Cape Coast and others from the rural area, i.e., Mankrong with respect to their respective desire for number of children except that the proportion whose response was in accordance with whatever God gave them was higher among adolescents in Mankrong (46.2 per cent) in comparison with those in Cape Coast (17.0). On the other hand, the influence of education on an adolescent's desired fertility has been demonstrated whether it is in Cape Coast or Mankrong area.

Participants in the focus group discussions were also asked about ways by which people could be encouraged to have smaller family sizes. The responses pointed to the need for family planning adoption by everyone. However, they felt that it would need a lot of education as some of them have diverse views about childbearing. For example, one adolescent argued that there are people who refuse to stop childbearing because according to her, "they think God has enjoined them to give birth as many as the sand at the beach and so unless God naturally stops them, they would not listen to any counsel on small family sizes". Some of the adolescents in Cape Coast suggested that nurses should embark on house-to-house education

on the advantages of small family sizes and how it could be attained since when one has many children over and above his or her capability to take care of, it is the children who “although did not take part in the decision to be born, suffer most”.

It was also explained by some adults in Cape Coast that often the desire to strike a sex balance between a couple’s children contributes to many births. They suggested during the focus group discussions that efforts at retaining small family sizes should in this sense, seek to educate people on the fact that, as an adult married male member of the focus group discussions put it, “whatever a boy can do, a girl can equally be trained to do it and vice versa”. To them therefore, it is not enough to talk about family planning without necessarily addressing the misconceptions people have such as the need for such sex balance among one’s children.

5.7 Reproductive Knowledge Among Adolescents

The surest way to avoid pregnancy is abstinence from sexual activity. In situations where the adolescent women would not abstain from sexual activity, it may still be possible to avoid unwanted pregnancy if they have a very good knowledge about their ovulatory cycle to the extent that they are able to predict the onset of ovulation and hence when they are most likely to be pregnant.

The adolescent females under study were asked about their knowledge of the timing of ovulation. Table 5.15 shows that more than half of the adolescents had no knowledge as to when in their menstrual cycle they were likely to be pregnant if they engaged in sexual activity. While 41.5 per cent of the adolescents in Cape Coast know when ovulation was likely to take place, only about a quarter of their counterparts in Mankrong had this knowledge. This means that a larger proportion of the adolescents interviewed may not be able to avoid being pregnant if they engaged in sexual activity without contraception. This finding is consistent

with other studies including that by Ajayi et. al. (1991) in Kenya which found that one in 10 adolescents recognized the fertile cycle and hence the timing of ovulation.

Examining the distribution by age, it is quite evident from Table 5.16 that knowledge is generally higher among the youth aged 20-24 years except in a few cases in Mankrong. This is more evident when comparison is made of adolescents by age group. For example, while in Cape Coast, 65 per cent of the youth aged 20-24 years had knowledge about the ovulatory cycle, smaller proportions of 13 per cent and 43 per cent of adolescents less than 15 years and 15-19 years respectively had this knowledge. Similarly, almost 39 per cent of the youth aged 20-24 years in Mankrong knew about the ovulatory cycle compared to about 25 per cent and 11 per cent respectively among adolescents less than 15 years and 15-19 years. Clearly then, knowledge of the ovulatory cycle tends to be higher with higher age of the adolescent. It is also seen that knowledge of the ovulatory cycle is lower among the adolescents in Mankrong in each of the age groups compared to their counterparts in Cape Coast. With the relatively low knowledge of the ovulatory cycle particularly among the adolescents less than 20 years, there is a possibility of a high incidence of pregnancy in the absence of sexual abstinence or contraception. This is quite critical in view of the fact that this is the period when majority of them would be in school. The evidence from Table 5.15 also suggests that many of the young women do not receive sexuality education either at home from their parents or at school from their teachers, a situation which does not augur well for their reproductive health.

According to Kim et. al. (2001), traditionally, aunts, uncles and other extended family members provided sexuality-related information to young people. With urbanization, the distance between family members has increased and hence, parents are taking greater responsibility in offering sexuality education to their children. However, many parents feel uncomfortable in this unaccustomed role. Meanwhile, health care providers have not filled the void either because many of them share the overall societal bias against adolescent sexuality.

Many also lack the skills needed to communicate with young persons about sensitive topics such as sexuality and reproductive health. For example, according to Kim et. al. (1997), 72 per cent of service providers believe that contraceptives should not be offered to people aged 16 years or younger.

Table 5.15. Percentage of Female Adolescents by Knowledge of the Timing of Pregnancy in the Ovulatory Cycle and Current Age, Cape Coast and Mankrong

Current Age	Knowledge of the Ovulatory Cycle					
	Cape Coast			Mankrong		
	Yes	No	Total N	Yes	No	Total N
12	8.7	91.3	115	10.5	89.5	38
13	9.6	90.4	125	6.5	93.5	31
14	18.1	81.9	149	16.7	83.3	30
15	28.3	71.7	145	21.4	78.6	28
16	33.8	66.2	154	13.8	86.2	29
17	45.8	54.2	131	57.1	42.9	14
18	51.4	48.6	144	13.6	86.4	22
19	61.1	38.9	113	41.2	58.8	17
20	58.9	41.1	129	34.9	65.1	43
21	71.1	28.9	83	18.2	81.8	22
22	60.5	39.5	81	52.6	47.4	19
23	65.0	35.0	60	68.4	31.6	19
24	75.7	24.3	74	23.1	76.9	13
<15	12.6	87.4	389	11.1	88.9	99
15-19	43.1	56.9	687	25.5	74.5	110
20-24	65.3	34.7	427	38.8	61.2	116
Total %	41.5	58.5	100.0	25.8	74.2	100.0
N	624	879	1,503	84	241	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The analysis is again done to examine the possible role of education in knowledge of the incidence of ovulation. It is seen in Table 5.16 that in either Cape Coast or Mankrong, knowledge of the incidence of ovulation increases generally with higher education. There is, however, some inconsistency among the adolescents in Cape Coast where adolescents with Primary education have the smallest proportion with knowledge of the timing of ovulation even when compared to their counterparts with no education. This is not strange since

currently, sexuality education is likely to be offered (if at all) at educational levels that are higher than Primary. This therefore puts persons with Primary education in similar positions as their counterparts with no education.

Table 5.16. Percentage of Female Adolescents by Knowledge of the Timing of Pregnancy in the Ovulatory Cycle and Level of Education, Cape Coast and Mankrong

Level of Education	Knowledge of the Ovulatory Cycle			
	Cape Coast		Mankrong	
	Yes	No	Yes	No
No Education	28.9	71.1	18.9	81.1
Primary	20.7	79.3	22.1	77.9
Arabic	42.9	57.1		-
Middle/JSS	34.3	65.7	26.5	73.5
SSS/Sec.	63.6	36.4	66.7	33.3
Post Sec./Higher	75.9	24.1	-	
N.S.	100.0	0.0	-	
Total	41.5	58.5	25.8	74.2
%				
N	624	879	84	241

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In sum, it has been shown in this section that the overall knowledge of the adolescents regarding the incidence of pregnancy in the ovulatory cycle is low especially among adolescents less than 20 years in Mankrong. The need for more sexuality education both at home and at school can therefore not be over-emphasised.

CHAPTER SIX

CONTRACEPTIVE KNOWLEDGE AND USE

6.1 Introduction

Knowledge of adolescents about family planning has been high but use has been low. The implication is that many of the sexually active adolescents are subjecting themselves to reproductive health risks. This chapter therefore examines the female adolescents to find out their variation in contraceptive knowledge and use as it possibly affects their reproductive health. The views of the adolescents regarding whether or not contraceptive knowledge and use could affect them positively or negatively and the need to address reproductive health problems of adolescents through the establishment of youth counselling centres have been analysed. Throughout the analysis, comparisons are made between urban Cape Coast and rural Mankrong.

6.2 Contraceptive Knowledge

Knowledge of any method of family planning has been found to be important in determining an individual's practice of contraception. For example, Agyei and Epema (1990) report adolescents as citing their lack of knowledge of contraceptive methods as one main reason for not using any method of family planning. On the basis of this, the respondents were asked about their knowledge of any method of family planning.

The results presented in Table 6.1 show that there is higher knowledge among the female adolescents in Cape Coast (78 per cent) than their counterparts in Mankrong where just about one in three of the adolescents indicated to have heard of any method of contraception. Although a relatively low level of knowledge in family planning is expected in Mankrong on account of its rural status in comparison with Cape Coast, an overall contraceptive knowledge of 31 per cent and, 36.4 per cent among female adolescents of 15-19 years, appears to be on a

low side considered against a high knowledge of 84.2 per cent and 66.7 per cent reported among female adolescents in the rural sample in a study among adolescents of the same age group in Accra and Kumasi respectively (Nabila and Fayorsey, 1996, p.79).

On the other hand, contraceptive knowledge of 82.8 per cent found among female adolescents 15-19 years in Cape Coast (Table 6.1) is comparable to the recorded figures of 75.9 per cent and 86.9 per cent respectively among urban-resident female adolescents (15-19 years) in Accra and Kumasi and 84.2 per cent and 66.7 per cent in rural areas in Accra and Kumasi respectively reported by Nabila and Fayorsey (1996). Again, it is supported by a finding of a high contraceptive knowledge of 92.9 per cent among all women in Ghana of any method of contraception in 1998 according to the GDHS (Ghana Statistical Service and Macro International Inc., 1999).

Table 6.1. Percentage of Female Adolescents by Contraceptive Knowledge and Current Age, Cape Coast and Mankrong

Current Age	Knowledge of Contraception							
	Cape Coast				Mankrong			
	Yes	No	Total		Yes	No	Total	
			N	%			N	%
12	43.5	56.5	115	100.0	0.0	100.0	38	100.0
13	52.0	48.0	125	100.0	3.2	96.8	31	100.0
14	62.4	37.6	149	100.0	3.3	96.7	30	100.0
15	69.7	30.3	145	100.0	32.1	67.9	28	100.0
16	78.6	21.4	154	100.0	13.8	86.2	29	100.0
17	84.0	16.0	131	100.0	21.4	78.6	14	100.0
18	90.3	9.7	144	100.0	54.5	45.5	22	100.0
19	94.7	5.3	113	100.0	70.6	29.4	17	100.0
20	90.7	9.3	129	100.0	39.5	60.5	43	100.0
21	96.4	3.6	83	100.0	40.9	59.1	22	100.0
22	90.1	9.9	81	100.0	68.4	31.6	19	100.0
23	95.0	5.0	60	100.0	73.7	26.3	19	100.0
24	100.0	0.0	74	100.0	53.8	46.2	13	100.0
<15	53.5	46.5	389	100.0	2.0	98.0	99	100.0
15-19	82.8	17.2	687	100.0	36.4	63.6	110	100.0
20-24	94.1	5.9	427	100.0	51.7	48.3	116	100.0
Total %	78.4	21.6		100.0	31.4	68.6	-	100.0
N	1,178	325	1,503		102	223	325	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 6.1 shows that generally knowledge of contraceptives is higher among persons of older ages. This is especially so among adolescents in Cape Coast compared to Mankrong where less than half of the respondents aged 20 and 21 years had knowledge in a method of family planning. Considering the adolescents by age group, knowledge about contraception increases with higher age of the adolescent in either Cape Coast or Mankrong. It is also significant to observe that particularly for Mankrong, contraceptive knowledge is almost non-existent at ages less than 15 years. This suggests that any sexual activity that takes place at these ages is not likely to involve the use of any method to prevent a pregnancy or an STI and, or HIV/AIDS infection.

With respect to contraceptive knowledge and the level of education of the adolescents, the pattern shows a general increasing knowledge with higher level of education among the adolescents particularly in Cape Coast. In the case of Mankrong however, although there is a tendency for contraceptive knowledge to increase with higher level of education, there is, contrary to expectation, a higher level of knowledge among respondents with no education than those with Primary and Middle/JSS levels (Table 6.2), a situation which could be the result of inaccurate reporting particularly among adolescents with no education. It is also clear that unlike respondents in Cape Coast, less than half of the respondents in Mankrong expressed knowledge in any contraceptive method at all educational levels except at the Secondary/SSS levels.

Table 6.2. Percentage of Female Adolescents by Contraceptive Knowledge and Level of Education, Cape Coast and Mankrong

Level of Education	Knowledge							
	Cape Coast				Mankrong			
	Yes	No.	Total		Yes	No	Total	
			N	%			N	%
No Education	53.0	47.0	83	100.0	41.5	58.5	53	100.0
Primary	57.5	42.5	266	100.0	22.1	77.9	95	100.0
Arabic	85.7	14.3	7	100.0	-			100.0
Middle/JSS	78.1	21.9	676	100.0	31.5	68.5	162	100.0
Secondary/SSS	94.3	5.7	387	100.0	53.3	46.7	15	100.0
Post-Sec./Higher	97.6	2.4	83	100.0		-	-	100.0
Not stated	100.0	0.0	1	100.0		-	-	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The study was also interested in comparing the knowledge of contraceptives among unmarried adolescents as against their married counterparts. It is clear in Table 6.3 that contraceptive knowledge is higher among persons who have ever married compared to those who have never been married. The level of knowledge is especially low among never married adolescents in Mankrong with only one in four persons having known a method of contraception.

This situation is not good enough in that women who are never married should think more about avoiding unwanted births. With this reasoning therefore, if three in every four young women do not have knowledge about the methods they can use for safer sexual activity, it would be difficult to avoid either unintended pregnancy or sexually transmitted infections any time they become sexually active.

Table 6.3. Percentage of Female Adolescents by Contraceptive Knowledge and Current Marital Status, Cape Coast and Mankrong

Current Marital Status	Cape Coast			Mankrong		
	Yes	No	Total No.	Yes	No	Total No.
Never Married	77.6	22.4	1,423	25.4	74.6	260
Currently Married	92.1	7.9	76	56.9	43.1	58
Separated/Divorced/Widowed	100.0	0.0	4	42.9	57.1	7

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The study is also interested in the most common methods of family planning known by the adolescents that expressed some knowledge of a contraceptive method. The results are presented in Tables 6.4a and b for Cape Coast and Mankrong respectively.

Table 6.4a. Percentage of Female Adolescents by Knowledge of Family Planning Method and Current Age, Cape Coast

	Contraceptive Method										Total No.
	Pill	IUD	Injectable	Vaginal Foaming Tablets	Condom	Norplant	Female Sterilization	Rhythm	Withdrawal	N.S	
12	54.0	-	12.0	-	34.0	-	-	-	-	-	50
13	61.6	-	9.2	-	23.1	3.1	-	1.5	-	1.5	65
14	62.4	-	3.2	1.1	28.0	-	2.1	1.1	-	2.1	93
15	54.4	2.0	6.9	2.0	30.7	-	1.0	2.0	1.0	-	101
16	52.9	2.5	5.8	2.5	32.2	0.8	0.8	-	-	2.5	121
17	56.4	1.8	4.6	2.7	29.1	-	1.8	3.6	-	-	110
18	54.6	1.6	7.7	3.8	28.5	-	-	3.8	-	-	130
19	57.0	1.9	4.7	2.8	29.0	-	-	2.8	0.9	0.9	107
20	51.3	1.7	6.8	2.6	30.8	0.8	-	5.2	-	0.8	117
21	61.3	2.5	3.7	5.0	21.3	-	-	6.2	-	-	80
22	49.3	-	12.3	2.7	21.9	1.4	-	11.0	1.4	-	73
23	57.8	-	10.5	1.8	24.6	-	-	5.3	-	-	57
24	60.8	-	4.1	2.7	25.7	-	-	6.7	-	-	74
≤15	60.0	0.0	7.2	0.5	27.9	1.0	1.0	1.0	0.0	0.0	208
15-19	55.0	1.9	6.0	2.8	29.9	0.2	0.7	2.5	0.3	0.7	569
20-24	55.6	1.0	7.2	3.0	25.4	0.5	0.0	6.7	0.3	0.3	401
Total %	56.1	1.3	6.6	2.5	28.0	0.4	0.5	3.6	0.3	0.7	100.0
N	661	15	78	29	330	5	6	43	3	8	1,178

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 6.4b. Percentage of Female Adolescents by Knowledge of Family Planning Method and Current Age, Mankrong

Current Age	Pill	IUD	Injectable	Vaginal Foaming Tablets	Condom	Rhythm	Withdrawal	Total No.
12	-	-	-	-	-	-		0
13	-	-	-	-	100.0	-		1
14	100.0	-		-	-		-	1
15	44.5		11.1	11.1	33.3	-		9
16	50.0		25.0	-	25.0			4
17	66.7	-					33.3	3
18	66.7	8.3	8.3		16.7			12
19	58.4	8.3		-	33.3	-	-	12
20	88.2	-	5.9	-	5.9			17
21	77.8			11.1	11.1			9
22	38.4	7.7	15.4	7.7	23.1		7.7	13
23	50.0	-	21.4		14.3	14.3		14
24	71.4		28.6					7
<15	50.0	0.0	0.0	0.0	50.0	0.0	0.0	2
15-19	57.5	5.0	7.5	2.5	25.0	0.0	2.5	40
20-24	65.0	1.7	13.3	13.3	11.7	3.3	1.7	60
Total %	61.8	2.9	10.8	2.9	17.6	2.0	2.0	100.0
N	63	3	11	3	18	2	2	102

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In both tables, the evidence is that of a higher percentage of the adolescents having knowledge in the pill (56 per cent in Cape Coast as against almost 62 per cent in Mankrong), followed by the condom (28 per cent in Cape Coast and 17.6 per cent in Mankrong). This is consistent again with Nabila and Fayorse's (1996) finding for Accra and Kumasi that the pill was the mostly known method of contraception among adolescents. The other methods, apart from injectables which, were known by 6.6 per cent and 10.8 per cent of the respondents in Cape Coast and Mankrong respectively, were known by only negligible proportions of the adolescents in either study area. The situation does not change when the adolescents are considered according to age group. Among the three age groups i.e., less than 15, 15-19 and 20-24 years, the pill is the most well known family planning method, followed by condom, except among age group 20-24 years in Mankrong where injectables were second to the pill in terms of the proportion that had knowledge of them.

Across all ages, the pattern is the same, implying that the pill, condom and perhaps the injectables are better known among the female adolescents in both study areas. This may be due to the fact that radio and television advertisements on these three methods in Ghana are more frequent compared to the other methods. The overall observation where the two study areas do not vary much from each other, is however contrary to expectation. Adolescents in Cape Coast as an urban area, were expected to have a much higher knowledge in the modern methods compared to their counterparts in Mankrong, a rural area. It must be explained however, that although Mankrong is a rural area, it is served with electricity which makes it possible for many of them to have access to radio and television advertisements on modern family planning methods.

It was also considered important to find out the major sources of knowledge of the family planning methods among the adolescents. Table 6.5a shows that in Cape Coast, the most important sources were the television (45.9 per cent), the school (24 per cent) and friends (12.3 per cent). On the other hand, in Mankrong, the hospital (21.6 per cent) emerged as the second most commonly quoted source of knowledge of family planning methods after the television (43.1 per cent) with the school taking the third position with 18.6 per cent (Table 6.5b). The foregoing observation does not change in respect of the pattern across single or grouped ages in the two study areas except to state that there is a decline in the proportion of adolescents having the television as their source of family planning information as age increases. The suggestion is that television as a major source of family planning information is of a relatively recent development in the two study areas. Surprisingly, the radio, which is likely to be available in almost every home in both study areas, is not a common source of contraceptive knowledge to most of the adolescents. It implies that the most reliable medium of information-flow regarding contraceptives among young women is the television.

Table 6.5a. Percentage of Female Adolescents by Source of Knowledge of Family Planning Method and Current Age, Cape Coast

Current Age	Source										Total N
	School	Friends	Books	Parents	Radio	Television	Hospital	Drug Store	Other	N.S.	
12	10.0		2.0	2.0	2.0	80.0	2.0	-	-	2.0	50
13	12.3	1.5	1.5	3.1	6.2	75.4	-			-	65
14	29.0	4.3	1.1	2.0	1.1	60.2	1.1		-	1.1	93
15	29.7	6.9	1.0	2.0	3.0	51.5	1.0	-	1.0	3.9	101
16	29.7	10.7	4.1	1.7	1.7	45.4	3.3		1.7	1.7	121
17	26.4	13.6	2.7	5.5	-	44.6	3.6	-	1.8	1.8	110
18	32.3	10.0	3.1	0.7	0.7	43.2	7.7	-	2.3		130
19	19.6	15.0	4.7	4.7	1.9	44.8	7.5	0.9		0.9	107
20	26.5	22.2	3.4	-	4.3	31.6	8.5	-	2.6	0.9	117
21	25.0	11.3	2.5	1.2	1.2	38.8	12.5	2.5	1.2	3.8	80
22	17.8	21.9	5.5	2.7	1.4	37.0	9.6	-	2.7	1.4	73
23	12.4	26.3	5.3	-	5.3	26.3	19.3	1.7	1.7	1.7	57
24	17.6	13.5	6.8	1.3	-	33.9	24.3		1.3	1.3	74
<15	19.2	2.4	1.4	2.4	2.9	69.7	1.0	0.0	0.0	1.0	208
15-19	27.8	11.2	3.2	2.8	1.4	45.7	4.7	1.4	0.2	1.6	569
20-24	20.9	18.9	4.5	1.0	2.5	33.7	14.0	0.7	2.0	1.7	401
Total %	24.0	12.3	3.3	2.1	2.0	45.9	7.2	0.3	1.4	1.5	100.0
N	282	145	39	25	24	540	85	4	16	18	1,178

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 6.5b. Percentage of Female Adolescents by Source of Knowledge of Family Planning Method and Current Age, Mankrong

Current Age	Source									Total N
	School	Friends	Books	Parents	Radio	Television	Hospital	N.S.		
12					-		-			
13	-	-				100.0	-			1
14		-	-	-	-			100.0		1
15	33.3			11.1	11.1	44.5				9
16	25.0	-	25.0	-	-	50.0	-	-		4
17	33.3	-	-	-	-	33.3		33.3		3
18		16.7	8.3		-	50.0	25.0			12
19	8.3	16.7	-	-	-	41.7	33.3	-		12
20	11.8	11.8	-		-	58.8	17.6	-		17
21	22.2			-	-	55.6	22.2			9
22	23.1	-		-	7.7	23.1	38.4	7.7		13
23	42.9	7.1	-	-		50.0	-			14
24	-		-	-	28.6	-	71.4			7
<15	0.0	0.0	0.0	0.0	0.0	50.0	0.0	50.0		2
15-19	15.0	10.0	5.0	2.5	2.5	45.0	17.5	2.5		40
20-24	21.7	5.0	0.0	0.0	5.0	41.7	25.0	1.7		60
Total %	18.6	6.9	2.0	1.0	3.9	43.1	21.6	2.9		100.0
N	19	7	2	1	4	44	22	3		102

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The analysis of the source of contraceptive knowledge with the educational levels of the adolescents has again reinforced the observations in Tables 6.5a and 6.5b. In Tables 6.6a and 6.6b, at almost all levels of education, the most common sources of knowledge of family planning are the television, school and friends in Cape Coast while in Mankrong it is still the television, hospital and the school as already shown in Tables 6.5a and 6.5b.

It is however, not too clear as to why many adolescents in Mankrong quoted the hospital as their main source of knowledge of contraceptives considering the fact that Mankrong has not got a clinic. Data reliability problem can therefore not be ruled out. Considering the location of Mankrong which is not too far from Agona Swedru, it is possible that some of the adolescents might have heard about family planning methods from hospitals and clinics in Agona Swedru.

It was also learnt from the focus group discussions in Mankrong that the HABITAT Non Governmental Organization (NGO) has been involved in family planning education in the village. Yet, none of the adolescents interviewed mentioned HABITAT as their source of family planning knowledge. It could mean that adolescents are not the primary target of HABITAT's family planning education, a practice which tends to exclude adolescents from family planning campaigns and hence increases their reproductive health risks.

Table 6.6a. Percentage of Female Adolescents by Source of Knowledge of Family Planning Method and Level of Education, Cape Coast

Level of Education	Source										Total N
	School	Friends	Books	Parents	Radio	Television	Hospital	Drug Store	Other	N.S.	
No Education		27.3		2.3	2.3	38.6	22.7		6.8	9.1	44
Primary	7.2	20.9	1.3	2.6	3.3	53.6	7.8			3.3	153
Basic	-	16.7			-	66.6	16.7	-	-	-	6
Middle/JSS	18.9	12.1	0.9	1.9	2.3	52.7	8.0	0.4	1.1	1.7	528
Sec./SSS	41.4	7.4	6.6	1.9	1.1	34.2	4.7	0.5	1.4	0.8	365
Post Sec./Higher	23.5	12.3	-	3.7	2.5	40.7	3.7		2.5	1.2	81
S.				-		100.0			-		1

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997

Table 6.6b. Percentage of Female Adolescents by Source of Knowledge of Family Planning Method and Level of Education, Mankrong.

Level of Education	Source								Total N
	School	Friends	Books	Parents	Radio	Television	Hospital	N.S.	
Secondary Education	-	9.1	-		4.5	50.0	27.3	9.1	22
Primary		9.5			-	52.4	33.3	4.8	21
Middle/JSS	23.5	7.9	3.9	2.0	5.9	39.2	17.6	-	51
Sec./SSS	75.0	-	-	-	-	25.0	-	-	8

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

6.3 Contraceptive Use at First Sexual Intercourse

Contraceptive use at first sexual intercourse is indicative of efforts by individuals to adopt safer sex practices on the onset of sexual activity. This is, of course, dependent on the knowledge people have about contraception and reproduction in general. Since sexual activity among women tends to take place early, it is important that first sexual activities take place within safe and protected circumstances so far as unplanned pregnancy and sexually transmitted infections are concerned.

The analysis looks at the proportion of the sexually active adolescents who practised contraception at their first sexual encounter. The purpose is to find out how safe female adolescents are at their first sexual encounter. In Table 6.7, the responses among sexually active female adolescents as to whether or not they practised contraception are presented with a control for age at first sexual intercourse.

The results indicate that overall, about 29 per cent of sexually active adolescents in Cape Coast practised contraception at first sexual intercourse as against 15 per cent among those in Mankrong. This shows that for 71 per cent and 85 per cent of sexually active female adolescents their first sexual activity was without contraception, a situation that could expose them to both early pregnancy and sexually transmitted infections. However, the pattern across age shows that in the case of Cape Coast, there is a relatively higher chance of practising safe

sex through contraception when first sexual activity is delayed. This is quite evident when the three age groups are compared, particularly for Cape Coast where there is a rise in the proportion practising contraception as age at first sexual intercourse increases. On the other hand, no definite pattern is shown by the results for Mankrong perhaps due to the relatively small number of cases involved.

One other observation that is worthy of note is that about 40 per cent of the respondents in Mankrong did not give a response to the question as to whether or not they used any contraceptive method at first sexual activity. The corresponding figure for Cape Coast is 7.6 per cent. It is, however, possible that those who did not give any definite response might not have used any contraceptive method at first sex.

It must be noted that the use of contraception at first sexual intercourse does not always mean that it would be used at subsequent sexual encounters. For example, according to Felton (1996), 22 per cent of adolescents studied in South Carolina, USA, used contraception at first coitus but did not at most recent sexual intercourse. Yet, the use of contraception is quite important because it usually takes place at a time when the young girl may be very young and ignorant of most of the reproductive health implications of the sexual act and hence, may be at a relatively higher risk than with subsequent acts which may take place later in life at which time they may have acquired more knowledge and experience.

Table 6.7. Percentage of Sexually Active Female Adolescents by Contraceptive Use at First Sexual Intercourse and Age at First Sex, Cape Coast and Mankrong

Age at First sex	Cape Coast				Mankrong			
	Yes	No	N.S.	Total N.	Yes	No	N.S.	Total N.
8	-	100.0	-	1	-	-	-	-
11	-	100.0	-	1	-	-	-	-
12	-	100.0	-	2	-	-	100.0	2
13	17.6	76.5	5.9	17	-	-	100.0	1
14	21.9	71.9	6.2	32	-	67.7	33.3	3
15	33.7	57.0	9.3	86	23.5	35.3	41.2	17
16	24.7	62.4	12.9	93	12.5	40.6	46.9	32
17	38.8	57.3	3.9	103	17.9	46.4	35.7	28
18	33.7	56.1	10.2	98	17.1	45.7	37.1	35
19	26.5	63.3	10.2	49	16.7	61.1	22.2	18
20	38.8	55.6	5.6	36	-	50.0	50.0	6
21	42.9	57.1	-	7	-	-	100.0	1
22	42.9	42.9	14.2	7	-	-	-	-
23	50.0	50.0	-	4	-	-	-	-
<15	18.9	75.5	5.6	53	0.0	33.3	66.7	6
15-19	32.2	58.7	9.1	429	16.9	45.4	37.7	130
20-23	40.7	53.7	5.6	54	0.0	55.6	44.4	7
N. S	3.4	96.6	-	59	-	2	-	2
Total %	31.7	59.9	8.4	100.0	15.2	45.5	39.3	100.0
N	170	378	45	536	22	64	57	143

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The next stage of the analysis then looks at the relationship between contraceptive use at first sexual activity and current age of the respondents. The analysis here considers only those who answered either "Yes" or "No" in Table 6.7. Its purpose is to find out whether over the years, contraceptive use at first sexual intercourse is increasing or decreasing.

The overall results (Table 6.8) are not too different from those shown in Table 6.7 in that contraceptive use at first sexual contact is still low, i.e., less than one-third. Across the ages, no clear pattern can be observed particularly among adolescents in Cape Coast where the number of respondents makes it possible to make conclusions. There is an indication that females 15-19 years are not different from their older counterparts 20-24 years in respect of contraceptive use at first sexual intercourse. There is however, a clear evidence of low contraceptive use among adolescents below the age of 15 years. For example, contraceptive

use among this age group is 16.7 per cent in Cape Coast compared to 32.5 per cent and 31.5 per cent among their counterparts of 15-19 and 20-24 years respectively. This is in spite of the fact that a relatively higher proportion of young females have some form of education in comparison with their older generation. The good thing, however, is that adolescents below the age of 15 years are less likely to indulge in sexual activity compared to 15-19 and 20-24 year olds.

Table 6.8. Percentage of Sexually Active Female Adolescents by Contraceptive Use at First Sexual Intercourse and Current Age, Cape Coast and Mankrong

Current Age	Cape Coast			Mankrong		
	Yes	No	Total N	Yes	No	Total N
12	0.0	100.0	1	0.0	0.0	0
13	50.0	50.0	2	0.0	0.0	0
14	0.0	100.0	3	0.0	0.0	0
15	11.1	88.9	9	20.0	80.0	5
16	26.1	73.9	23	16.7	83.3	6
17	37.5	62.5	40	14.3	85.7	7
18	37.1	62.9	70	30.8	69.2	13
19	29.5	70.5	61	38.5	61.5	13
20	32.2	67.8	87	2.9	97.1	34
21	42.9	57.1	63	21.1	78.9	19
22	28.8	71.2	59	18.8	81.2	16
23	21.6	78.4	51	5.9	94.1	17
24	29.9	70.1	67	7.7	92.3	13
<15	16.7	83.3	6			0
15-19	32.5	67.5	203	27.3	72.7	44
20-24	31.5	68.5	327	10.1	89.9	99
Total %	31.7	68.3	100.0	15.4	84.6	100.0
N	172	321	550	22	121	143

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The possible impact of a person's level of education on contraceptive use at first sexual intercourse is investigated by relating the use of contraception at first sex to the level of education of the adolescents. The results as shown in Table 6.9 suggest that on the whole, contraceptive use at first sex increases with education. This is evident for Cape Coast in particular although contraceptive use is relatively lower at the Post-Secondary level compared to the SSS-Secondary educational level. In the case of adolescents in Mankrong, although the

pattern is not definite, it is quite observable that the highest proportion of adolescents using contraception at first sexual activity occurred among adolescents at the Secondary/SSS level, which happens to be the highest educational level in Mankrong.

Table 6.9. Percentage of Sexually Active Female Adolescents by Contraceptive Use at First Sexual Intercourse and Level of Education, Cape Coast and Mankrong

Level of Education	Cape Coast			Mankrong		
	Yes	No	Total N	Yes	No	Total N
No Education	8.8	91.2	34	14.3	85.7	35
Primary	17.9	82.1	67	20.0	80.0	30
Arabic	0.0	100.0	5	-	-	-
Middle/JSS	25.3	74.7	241	11.9	88.1	67
SSS-Secondary	51.4	48.6	146	27.3	72.7	11
Post Sec./Higher	45.2	54.8	42	-	-	-
N.S.		100.0	1	-	-	-
Total %	31.7	68.3	100.0	15.4	84.6	100.0
N	170	321	536	22	121	143

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The foregoing results in Table 6.9 should, however, be interpreted with some caution. This is because the pattern is with respect to current education and not the educational level of adolescents at the time the first sexual act took place, an important information which is not available for this study. It is hence not possible to examine the extent to which one's educational level will be of influence in her practice of contraception at the time the sexual act takes place. However, the finding could indicate a girl's aspiration to move up the educational ladder and consequently may have a mind and determination to postpone first sex till later ages.

Another significant observation is with regard to the most common family planning methods that were used by the small proportion that used contraception at first sex. The analysis (not included Table 6.9) shows that majority of the adolescents (75.7 per cent) in Cape Coast used the condom with smaller proportions practising other methods including the pill (7.9 per cent), vaginal foaming tablets (5.1 per cent), rhythm (5.1 per cent) and withdrawal (6.2 per cent). On the other hand, the pill was mentioned as the most commonly used method at

first sex (43.4 per cent) followed by condom and vaginal foaming tablets (21.7 per cent each) with the injectable, rhythm and withdrawal methods each being used by 4.4 per cent of the adolescents in Mankrong. It is thus, clear that in relative terms, at first sex, adolescents in Cape Coast seem to be better protected from other sexually transmitted infections including HIV/AIDS in addition to pregnancy by the use of the condom by a large proportion of them compared to their counterparts in Mankrong.

Another relevant issue is the knowledge of the adolescents as to the possibility of a pregnancy occurring at first sexual intercourse. As can be seen in Table 6.10, more than two-thirds of the adolescents in Cape Coast and Mankrong answered in the affirmative irrespective of whether or not they practiced contraception or not at first sex. Yet, we do not have similar proportion indicating use of any method of family planning during their first sexual activity as already discussed in this section. There is however, a relatively lower proportion of adolescents who have had a sexual intercourse responding that one could become pregnant at first sexual intercourse. This is perhaps due to the fact that some of them may not know much about sexual activity and its aftermath. In spite of this reasoning, a higher proportion of these adolescents (who had never had sex) in Cape Coast knew that a first sexual activity could result in a pregnancy. The corresponding result in Mankrong is however, to the contrary. There is therefore a gap between the relatively higher knowledge about pregnancy occurrence at first sexual contact and contraceptive use at that same time.

Table 6.10. Percentage of Sexually Active Female Adolescents by Contraceptive Use at First Sexual Intercourse and Knowledge of Pregnancy Occurring at First Sexual Intercourse, Cape Coast and Mankrong

Contra- ceptive Use at First Sex	Possibility of Pregnancy Occurring at First Sexual Intercourse									
	Cape Coast					Mankrong				
	Yes	No	Don't Know	Total		Yes	No	Don't Know	Total	
				N	%				N	%
Yes	84.7	12.9	2.4	170	100.0	68.2	31.8	-	22	100.0
No	79.8	18.3	1.9	366	100.0	76.9	22.3	0.8	121	100.0
Total %	81.3	16.6	2.1	-	100.0	75.5	23.8	0.7	-	100.0
N	436	893	11	536	-	108	34	1	143	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The respondents who did not practise any contraception at first sex were also asked about the reasons why they did not do so. The results covering only those who gave some answer are provided in Table 6.11.

The results in Table 6.11 show that lack of knowledge of family planning methods at the time of first sexual intercourse is the major reason why most adolescents do not practise contraception at first sex i.e., 57.8 per cent in Cape Coast and 76.5 per cent in Mankrong. Other minor reasons quoted in both Cape Coast and Mankrong include disapproval by partner, lack of personal interest, sex having taken place spontaneously without any prior planning and a feeling of no possibility of becoming pregnant from the first sexual encounter. There were at the same time some of them who said their contraceptive non-use at first sexual activity was due to the fact that they were raped (2.3 per cent in Cape Coast as against 4.7 per cent in Mankrong). The reasons given here do not deviate from others cited elsewhere in Kampala which include the belief that contraceptives were unsafe, objections from male partners or insufficient knowledge (Agyei and Epema, 1990).

Table 6.11. Percentage of Female Adolescents by Reason for Non-Use of Contraception at First Sexual Intercourse, Cape Coast and Mankrong

Reason	Cape Coast		Mankrong	
	N	%	N	%
Lack of knowledge	177	57.8	49	76.5
Partner disapproved	18	5.9	5	7.8
Not interested	18	5.9	1	1.6
Felt would not be pregnant	20	6.5	2	3.1
Did not plan for sex	18	5.9		-
Was raped	7	2.3	3	4.7
No reason	20	6.5	1	1.6
Other reasons	28	9.2	3	4.7
Total	306	100.0	64	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In sum, contraceptive use at first sex has been low in either Cape Coast or Mankrong suggesting that many of the adolescents are subjected to much reproduction risk at first sex. This is in direct contrast to the fact that majority of them were aware that first sexual activity could result in a pregnancy. There is also an indication of an increase in contraceptive use when first sex is delayed. This is quite evident when a comparison is made of contraceptive use among the three age groups, namely less than 15 years, 15-19 years and 20-24 years.

6.4 Current Contraceptive Use

Contraceptive use among adolescents in Ghana has generally been low. The result is that many otherwise preventable pregnancies and STIs become unavoidable among some of the sexually active adolescents especially the unmarried.

Against this background, it was necessary to examine the level and pattern of contraceptive use among the adolescents in both study areas. Table 6.12 examines current contraceptive use among the sexually active respondents by age at the time of the survey.

Table 6.12. Percentage of Sexually Active Female Adolescents by Current Contraceptive Use and Age, Cape Coast and Mankrong

Age	Cape Coast			Mankrong		
	Yes	No	Total N.	Yes	No	Total N.
12	0.0	100.0	1	-	-	-
13	0.0	100.0	2			-
14	33.3	66.7	3			-
15	22.2	77.8	9	40.0	60.0	5
16	26.1	73.9	23	33.3	67.7	6
17	40.0	60.0	40	14.3	85.7	7
18	37.1	62.9	70	30.8	69.2	13
19	32.8	67.2	61	38.5	61.5	13
20	35.6	64.4	87	29.4	70.6	34
21	50.8	49.2	63	26.3	73.7	19
22	32.2	67.8	59	43.8	56.2	16
23	29.4	70.6	51	23.5	76.5	17
24	44.8	55.2	67	30.8	69.2	13
<15	16.7	83.3	6			
15-19	34.5	65.5	203	31.8	68.2	44
20-24	38.8	61.2	327	30.3	69.7	99
Total %	36.9	63.1	100.0	30.8	69.2	100.0
N	198	338	536	44	99	143

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

On the whole, current contraceptive use is higher in the two study areas compared to a low of 2.3 per cent and 7.2 per cent recorded among female adolescents of 10-19 years in Accra and Kumasi respectively (Nabila and Fayorsey, 1996). Current contraceptive use in Cape Coast and Mankrong is also higher than the 1998 recorded figure among female adolescents of 15-19 years in Ghana (Ghana Statistical Service, 1999). As expected, contraceptive use among the respondents in Cape Coast (i.e. 36.9 per cent) was 6 percentage points higher than that for their counterparts in Mankrong (i.e. 30.8 per cent). This is in conformity with the finding that contraceptive use among women tends to be lower in the rural areas than in the urban centres in Ghana (See 1998 GDHS). At the same time, there is higher contraceptive use with higher age of the adolescent especially in Cape Coast when we compare the three age groups shown in Table 6.12. Similar results of higher current contraceptive use with higher age of adolescents were found in Bangladesh in 1989. In the Bangladesh Fertility

Survey, 15.3 per cent married women of under 20 years were currently using contraception compared to 34.4 per cent of respondents 20 years of age and older (Mahmud and Islam, 1995).

In many studies on adolescents, the finding often is that of a high knowledge but low use of contraception. Ajayi et. al. (1991) report that Kenyan adolescents' knowledge of at least one modern method of family planning was as high as 75 per cent. However, while majority of them approved of the use of contraceptives, ever use among sexually active adolescents was just 10 per cent.

Reasons for low contraceptive use among adolescents could be the result of certain perceptions some women have. For example, in a study in Burkina Faso (Gorgen et. al., 1993), it was noted that the reluctance to use modern methods stemmed from a fear that use might produce damaging side effects, and that forgetting to take the pill for example, was considered a serious risk.

The analysis on the type of contraceptives currently used by adolescents (not in table) was quite consistent with results pertaining to contraceptive methods used at first sex. The condom and the pill were the most commonly mentioned methods currently used by sexually active female adolescents in this study. In Cape Coast, 67.5 per cent of the sexually active adolescents were using the condom as against 15.2 per cent for the pill. On the other hand, in Mankrong, it was 40.9 per cent for the condom and 34.1 per cent for the pill. The use of the condom by relatively higher proportions of sexually active female adolescents (especially in Cape Coast) at this stage when majority of them are not married is a good development since in addition to preventing unplanned pregnancy, it also could safeguard them against STIs including HIV/AIDS.

In Table 6.13, the analysis investigates the variation of contraceptive use among the sexually active adolescents by their level of education. In the case of Cape Coast,

contraceptive use tends to be directly related to the level of education of the female adolescent. The results of the current study support Mahmud and Islam's (1995) study in Bangladesh where for example, 29 per cent of adolescents with a higher secondary and above level of education were practising contraception compared to 10.3 per cent among those with less education. The situation in Mankrong as shown in Table 6.13, however, deviates from the above pattern although the highest proportion currently practising contraception is found among adolescents with the highest level of education i.e., Secondary/SSS.

Table 6.13. Percentage of Sexually Active Female Adolescents by Current Contraceptive Use and Level of Education, Cape Coast and Mankrong

Level of Education	Cape Coast			Mankrong			
	Yes	No	Total N.	Yes	No	Total N.	
No Education	5.9	94.1	34	22.9	77.1	35	
Primary	25.4	74.6	67	40.0	60.0	30	
Arabic	0.0	100.0	5	-	-	-	
Middle/JSS	36.1	63.9	241	28.4	71.6	67	
Sec./S.S.S.	47.9	52.1	146	45.5	54.5	11	
Post Sec./Higher	50.0	50.0	142		-	-	
Not Stated	100.0	0.0	1	-			
Total	%	36.9	63.1	100.0	30.7.3	69.2.7	100.0
	N	198	338	536	44	99	143

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In the focus group discussions, factors which militated against the use of contraceptives by sexually active adolescents, were investigated. Most of the male adults in Mankrong were not wholly in agreement that most sexually active adolescents do not practise contraception. They rather differentiated between relationships that involved adolescents and older men and others involving adolescents only. To them, the older men who have sex with adolescents would always want to prevent a pregnancy in order that they would not be found out since many of them are married. Their thinking therefore was with reference to those relationships with young boys who are as ignorant and irresponsible as their young female counterparts and hence, would most often not use any method of contraception during sexual activity.

As to why the adolescents do not practise contraception, some of the adults in Cape Coast explained that “sex between them is usually not planned. It is done along street corners and hence using contraceptives may waste time”. In this sense, sex is done without any thought of the consequences thereafter. This shows that many of the sexual relationships are founded on ignorance.

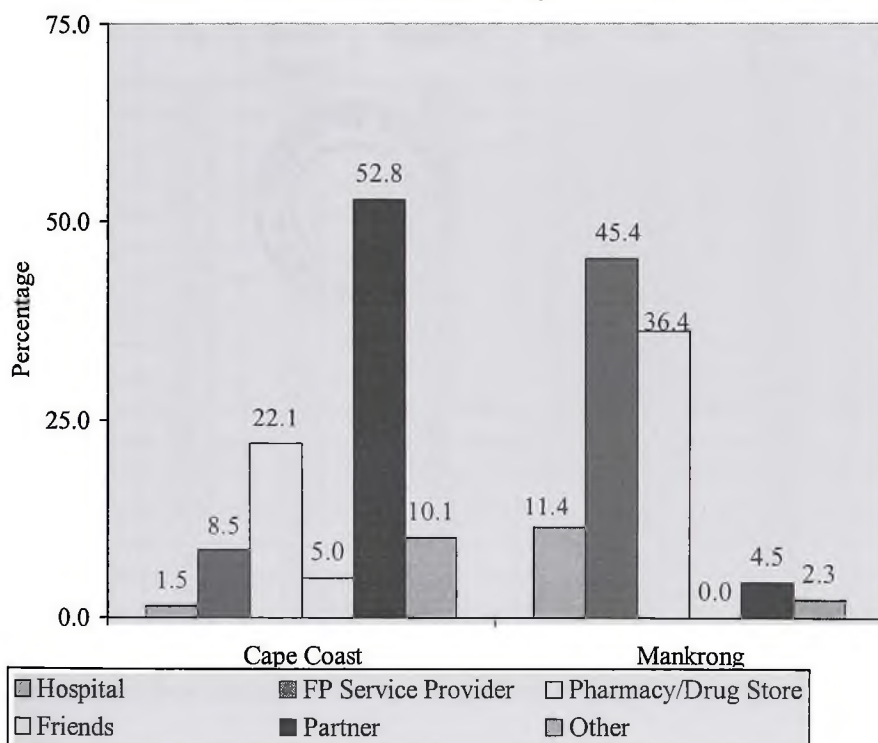
On the part of the adolescents, the reasons were listed to include the fact that most sexual partners disapprove of use of contraception. Specifically, they explained that some of the girls do enjoy better without condom. To others, each of the contraceptives has the possibility of failure and hence they have no confidence in using them. There were others who thought the use of contraception such as condoms “does not mean true love to one’s sexual partner”. Besides, they considered it “biblically wrong to practise contraception”. It is strange that the same adolescents who use the Bible to support their non-use of contraception do not realise that the same Bible is against sexual practise among all unmarried persons including adolescents (See The Holy Bible – 1st Corinthians 5:9 where it is stated “I have written to you in my letter not to associate with sexually immoral people”).

At this stage, it is relevant to find out the most common source of contraceptive supply among the adolescents who were practising any form of contraception. This is shown in Figure 6.1. Here, there is no uniformity between the two study areas. In Cape Coast, the highest proportion of contraceptive users (52.8 per cent) indicated their partners as their source of supply, followed by the pharmacy or drug store, cited by 22.1 per cent of the adolescents currently using contraceptives in Cape Coast.

In contrast, family planning service providers were the main source of contraceptive supply in Mankrong, constituting 45.4 per cent and followed by drug stores taking 36.4 per cent. These family planning service providers in Mankrong were most likely to be from HABITAT. It is also worth noting that although there is no hospital in Mankrong, a higher

proportion of the adolescent contraceptive users (11.4 per cent) cited the hospital as their source of supply compared to only 1.5 per cent among their counterparts in Cape Coast. All things being equal therefore, it is possible that more than 50 per cent of the contraceptive users in Mankrong would benefit from counselling services from the sources of their contraceptive supply in comparison with their Cape Coast counterparts.

Figure 6.1. Percentage of Sexually Active Female Adolescents by Current Contraceptive Use and Source of Supply of Method, Cape Coast and Mankrong



The adolescents were again asked about their views on whether they considered it necessary for them to seek the consent of their parents before practising contraception. The results are summarised and presented by age in Table 6.14.

In Table 6.14, the overall observation is that 36.4 per cent and 27.4 per cent of the adolescents in Cape Coast and Mankrong respectively thought that it was not necessary to seek any consent from one's parents before contracepting should they decide to do so. At the same

time, a considerable proportion of the adolescents especially in Mankrong were not sure as to whether or not parental consent was necessary. Across the single years of age, the pattern is not very definite for either study area. Similar observation is apparent when the ages are grouped.

Table 6.14. Percentage of Female Adolescents by the Need to Seek Parental Consent Before Using Contraception and Current Age, Cape Coast and Mankrong

Age	Cape Coast				Mankrong			
	Yes	No	Don't Know	Total N.	Yes	No	Don't Know	Total N.
12	34.8	12.2	53.0	115	-	13.2	86.8	38
13	30.4	17.6	52.0	125	9.7	6.4	83.9	31
14	40.9	16.8	42.3	149	6.7	13.3	80.0	30
15	41.4	20.7	37.9	145	17.8	28.6	53.6	28
16	37.0	35.1	27.9	154	17.2	24.1	58.6	29
17	39.7	37.4	22.9	131	28.6	42.8	28.6	14
18	28.5	59.0	12.5	144	22.7	31.8	45.5	22
19	34.5	47.8	17.7	113	23.5	53.0	23.5	17
20	30.2	49.6	20.2	129	20.9	44.2	34.9	43
21	33.7	51.8	14.5	83	4.5	27.3	68.2	22
22	34.6	48.1	17.3	81	31.6	31.6	36.8	19
23	28.3	50.0	21.7	60	21.1	36.8	42.1	19
24	32.4	52.7	14.9	74	23.1	23.1	53.8	13
<15	35.7	15.7	48.6	389	5.1	11.1	83.8	99
15-19	36.2	39.6	24.2	687	20.9	33.6	31.8	110
20-24	31.8	50.4	17.8	427	19.8	35.4	44.8	116
Total %	34.9	36.4	28.7	100.0	27.4	27.4	56.9	100.0
N	524	548	431	1,503	51	89	185	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The adolescents were then asked about the reasons supporting their views in Table 6.14. The results are divided into two for those supporting the need to seek parental consent (Table 6.15a) as against others who reasoned to the contrary (Table 6.15b).

In Table 6.15a, one major reason which stands out both in Cape Coast and Mankrong is that adolescents need advice from their parents (64.1 per cent in Cape Coast as against 78.4

per cent in Mankrong). Other minor reasons but worth mentioning include the fact that parents will always get to know as well as that parents need to know whatever their children do.

Table 6.15a. Percentage of Female Adolescents Who Consider it Necessary to Obtain Parental Consent Before Contraception by Reason, Cape Coast and Mankrong

Reason	Cape Coast (%)	Mankrong (%)
For their advice	64.1	78.4
Parents are their caretakers	7.3	0.0
Parents will always get to know	10.5	5.9
Parents need to know	9.0	3.9
Other reasons	9.1	11.8
Total Number	524	51

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In contrast to the reasons supporting the need for parental consent on contraceptive use by adolescents, three major reasons are prominent in support of why parental consent need not be sought. The first major reason supported by higher proportions of adolescents in both study areas is the fact that a request of this nature will obviously annoy parents. This was supported by 32.8 per cent of the adolescents in Cape Coast compared with 38.2 per cent in Mankrong. This reason was followed in order of importance by the fact that adolescents are shy to ask of their parents' consent in respect of contraception among adolescents in Cape Coast. Correspondingly, the second major reason given by adolescents in Mankrong is that contraceptive use is an issue that should be left for sexual partners to decide rather than parents of sexual partners.

Table 6.15b. Major Reasons Given by Female Adolescents in Cape Coast and Mankrong Who Consider it Unnecessary to Obtain Parental Consent Before Contraception

Reason	Cape Coast (%)	Mankrong (%)
Too shy to ask for parents' consent	25.7	3.4
Parents will be angry	32.8	38.2
Should marry before	5.3	0.0
Should be left between partners	6.4	36.0
Parents will not consent	0.0	12.4
No specific reason given	13.4	6.6
Other reasons	16.4	3.4
Total Number	548	89

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

With respect to possible influence by a person's educational level in response to whether or not parental consent is required before practising contraception, Table 6.16 shows that in the case of Cape Coast, there appears to be an increase in the proportion supporting the need to seek parental support with higher education of the adolescent up to Secondary/SSS level of education and then declines. This is however, contrary to expectation since with higher education one would be better placed to make critical analysis of issues and take decisions without necessarily seeking consent from parents. On the other hand, it is possible that adolescents with higher education are in a position to discuss all issues including contraceptive use with their parents. In the case of adolescents in Mankrong, no clear pattern appears to show by education perhaps on account of the small sample size for the area.

Table 6.16. Percentage of Female Adolescents by the Need to Seek Parental Consent Before Using Contraception and Level of Education, Cape Coast and Mankrong

Level of education	Cape Coast				Mankrong			
	Yes	No	Don't know	Total N.	Yes	No	Don't know	Total N.
No education	22.9	32.5	44.6	83	17.0	35.8	47.2	53
Primary	32.3	23.3	44.4	266	10.5	26.3	63.2	95
Basic	0.0	71.4	28.6	7	-	-	-	
Middle/JSS	33.9	37.3	28.8	676	16.0	24.1	59.9	162
Secondary/SSS	42.4	41.6	16.0	387	40.0	40.0	20.0	15
Post Sec./Higher	31.3	48.2	20.5	83	-	-		
Total	0.0	100.0	0.0	1	-	-	-	

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

To recapitulate, it has been found that current contraceptive use has been higher in both study areas than the recorded figure for the Central Region according to the 1998 GDHS report. However, the older adolescents are using contraception more than the younger ones. Education generally is affecting the contraceptive use of the adolescents positively, emphasising the need for increased female education. Finally, many of the adolescents do not think it is right for them to seek their parents' consent before practising contraception for reasons mainly of being shy and the fear of incurring the displeasure and anger of their parents on an issue which to some of them should be left to them and their sexual partners.

6.5 Unmarried Persons and Contraception

In Ghana, low contraceptive use among sexually active adolescents is often explained in terms of the perception even among some family planning service providers that contraception is for married persons only. The Ghana Situation Analysis Report of 1995 for example showed that some 40 per cent of service providers would not provide family planning services such as IUD and injectables to unmarried adolescents while a quarter of them would not provide the pill under similar circumstances (Ghana Statistical Service, 1995). Against this

background, this study sought to find out the thinking of the adolescents themselves on contraceptive use by unmarried adolescents.

The views of the female adolescents from the two study areas regarding whether or not they considered it right for unmarried but sexually active adolescents to practise contraception are presented in Table 6.17. From the table, it is observed that slightly more than half of the adolescents (54 per cent) in Cape Coast were of the opinion that unmarried sexually active adolescents should practise contraception. The corresponding figure for Mankrong is 45.8 per cent. A study in Kampala, Uganda, however, recorded a higher proportion of 69 per cent of adolescents agreeing that unmarried people could use contraceptives (Agyei and Epema, 1990).

Although some proportion of the adolescents in either study area (7.5 per cent in Cape Coast and 11.4 per cent in Mankrong) indicated their inability to provide a specific answer, the table shows clearly that at least 38 per cent and almost 43 per cent of the adolescents respectively in Cape Coast and Mankrong thought unmarried sexually active adolescents should not practise contraception. In this case, exposure to the risks of unintended pregnancy and sexually transmitted infections including HIV/AIDS is high. Incidentally, some females become sexually active long before they are married.

Table 6.17. Percentage of Female Adolescents by Views on Whether it is Right for Unmarried Sexually Active Persons to Practise Contraception and Current Age, Cape Coast and Mankrong

Age	Cape Coast				Mankrong			
	Yes	No	Don't Know	Total N.	Yes	No	Don't Know	Total N.
12	20.9	56.5	22.6	115	7.9	71.1	21.0	38
13	24.8	59.2	16.0	125	12.9	71.0	16.1	31
14	38.2	46.3	15.4	149	16.7	66.6	16.7	30
15	40.7	51.0	8.3	145	39.3	50.0	10.7	28
16	49.3	44.2	6.5	154	37.9	48.3	13.8	29
17	59.5	37.4	3.1	131	64.3	28.6	7.1	14
18	67.3	29.2	3.5	144	59.1	27.3	13.6	22
19	73.5	23.9	2.6	113	76.5	17.6	5.9	17
20	68.2	27.9	3.9	129	67.4	25.6	7.0	43
21	73.5	26.5	0.0	83	54.6	40.9	4.5	22
22	64.2	33.3	2.5	81	73.7	10.5	15.8	19
23	86.7	11.7	1.6	60	78.9	21.1	0.0	19
24	78.4	18.9	2.7	74	76.9	23.1	0.0	13
<15	28.8	53.5	17.7	389	12.1	69.7	18.2	99
15-19	57.2	37.8	5.0	687	51.8	37.3	10.9	110
20-24	72.8	24.8	2.4	427	69.0	25.0	6.0	116
Total	54.3	38.2	7.5	1,503	45.8	42.8	11.4	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

A look at the results by age suggests that in either study area, the proportion accepting that unmarried sexually active adolescents should practise contraception tend to increase with higher ages of the adolescents. This observation is clearer when age is grouped. For example, while the right of unmarried sexually active persons to use contraceptives is supported by 28.8 per cent and 12.1 per cent of adolescents of less than 15 years in Cape Coast and Mankrong respectively, the figures for age group 20-24 years are 72.8 per cent and 69.0 per cent in Cape Coast and Mankrong respectively. In all age groups, the proportion supporting unmarried sexually active adolescents' use of contraception is higher in Cape Coast than it is in Mankrong. The finding shows that ignorance plays a big role in directing the thinking of the adolescents especially at younger ages as far as the use of contraceptives among unmarried adolescents is concerned.

The major reasons provided by adolescents supporting contraceptive use by unmarried sexually active adolescents were the need to avoid pregnancy and STIs including HIV/AIDS. In contrast, non-supporters of contraceptive use by the unmarried in Cape Coast cited the reason that sex is for married persons only, followed by health concerns to support their claim. What they seek to portray is that at these young ages, they should abstain from sex altogether. While this is the best thing to do, yet, it fails to recognise the fact that there are some unmarried adolescents who are sexually active.

In the case of adolescents in Mankrong not supporting the use of contraceptives by the unmarried sexually active adolescents, religious reasons were cited as their main reasons. At the same time, however, quite a sizeable proportion of them could not find any reason to support their views probably, suggesting that they are just echoing a thinking of other people but may not necessarily understand these views.

The analysis further compares the results to examine the possible role of education. In Table 6.18, it is observed that the proportion of adolescents agreeing to the use of contraceptives by unmarried sexually active adolescents steadily increases with increasing education of the adolescents. This is mainly the case in Cape Coast. A similar pattern appears to manifest itself in Mankrong apart from the unexpected observation of a higher proportion of adolescents with no education responding in the affirmative compared to those with Primary and Middle/JSS levels of education. This could be the result of the small sample of adolescents with no education relative to those with Primary and Middle/JSS level of education.

Table 6.18. Percentage of Female Adolescents by Views on Whether it is Right for Unmarried Sexually Active Adolescents to Practise Contraception and Level of Education, Cape Coast and Mankrong

Level of Education	Cape Coast					Mankrong				
	Yes	No	Don't know	Total		Yes	No	Don't know	Total	
				N	%				N	%
Below education	34.9	38.6	26.5	83	100.0	56.6	32.1	11.3	53	100.0
Primary	36.1	49.2	14.7	266	100.0	28.4	60.0	11.6	95	100.0
Jr High	57.1	14.3	28.6	7	100.0	-	-	-	-	100.0
Middle/JSS	54.3	39.1	6.6	676	100.0	47.5	40.1	12.4	162	100.0
Secondary/SSS	65.6	33.5	1.0	387	100.0	100.0	0.0	0.0	15	100.0
Post Sec./Higher	78.3	20.5	1.2	83	100.0	-	-	-	-	100.0
Total Stated	100.0	0.0	0.0	1	100.0	-	-	-	-	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The focus group discussions probed into the opinions of the adolescents, vis-à-vis their adult counterparts in respect of whether they would recommend that adolescents who are sexually active be given contraceptives and why. The views varied among the adults and adolescents in the two study areas. Among the adults in Cape Coast, the general feeling was for the adolescents to be taught about problems that are associated with early sexual practices in order to encourage them to simply abstain rather than give them contraceptives. Many were of the conviction that contraception could fail to protect one from either a pregnancy or a sexually transmitted infection (STI) and hence there is no point encouraging its use among adolescents. Besides, in situations where adolescents are convinced about the use of contraceptives, their sexual partners, who may be much older and often financially responsible for their upkeep, may refuse their use of contraceptives.

In contrast, the adults in Mankrong reached a consensus that since many of the early sexual relationships result in pregnancies, which bring untold hardships on the adolescents and their children as well as the parents of adolescent mothers, there is nothing wrong about

providing sexually active adolescents with contraceptives that can protect them from both conception and STIs. They therefore commended the HABITAT Non-Governmental Organisation, which, according to them was in the village teaching people about family planning among the general population. To them, the interest is how frequent births among the adolescents could be curtailed in such a way that the few children one gives birth to would be properly taken care of.

Among the adolescents in Mankrong, there was a general disagreement about the use of contraceptives by adolescents. For example, while some of them thought contraception could lead to future reproductive problems because of the perceived side effects, others felt contraception is meant only for married persons. Adolescents who were quite liberal in their thinking expressed their agreement about adolescents' use of contraceptives only in situations when a doctor has certified that the adolescent could practise it. When this view is examined critically however, it amounts to saying that adolescents cannot use contraceptives since many adolescents would not find it comfortable to seek approval from a doctor before practising contraception.

On the contrary, in Cape Coast, some of the adolescents were in agreement while others were not in favour of the use of contraceptives by sexually active adolescents. Those in agreement cited the need to prevent unplanned pregnancies and births as well as STIs. On the other hand, many of those who did not support contraceptive use by sexually active adolescents were convinced it would lead to sexual promiscuity. This was however, not accepted by the others one of whom argued for example that "there will always be bad nuts who may abuse the use of contraceptives and in the process become promiscuous, but it is good to have contraceptives available for use by the responsible ones".

To sum up, it has been found that although some of the adolescents would not support contraceptive use by unmarried sexually active adolescents, there are others who think

otherwise, recognising the pregnancy and STI risks such persons would be exposing themselves to. Thus, on how sexually active adolescents could be encouraged to practise contraception, most participants in the focus group discussions put the onus on parents. For example, there was a suggestion by an adolescent that parents should, with the on-set of menarche, begin teaching their children their reproductive cycle so that they would be knowledgeable enough to protect themselves. Yet, many parents do not do it because they fear that such education would push their daughters to be promiscuous which may not be the case.

However, the question is whether parents themselves have adequate knowledge and skill to offer such education to their teenage children. This became evident when some adults in Cape Coast suggested the need for parents to be taught about family planning so that they could, in turn, teach their children. There were yet other adults who rejected the teaching of adolescents anything about family planning because to them, this could be counter-productive. They instead, insisted on the need for parents to teach their children more about moral uprightness, which they believed, could be the solution. What such suggestions overlook is the reality on the ground that there are still other adolescents who, in spite of all the on-going moral education, are practising sexual activity and are not protecting themselves either from unplanned pregnancy or STIs including HIV/AIDS.

There were suggestions by some adults and adolescents about the work of teachers in schools in teaching sexuality issues including contraception to encourage sexually active adolescents to use some family planning methods to protect themselves. However, one adolescent faulted this by arguing that often when teachers teach such reproductive health issues at school, some students do not take them serious while others giggle and even ridicule such teachers thinking they are bad morally.

There is consistency in both the results of the analysis of the data collected from the structured questionnaire and views gathered in respect of many of the issues from the focus

group discussions. The role of education in assisting the adolescents think most practically about such issues has also been demonstrated. The important thing is to educate these adolescents on the issues involved through both the formal and informal means and opportunities that may be open at any given time.

6.6 Family Life Education and Adolescent Sexual Promiscuity

There have been mixed feelings about the introduction of adolescents to family life education (FLE) where sexuality issues are taught at young ages. This is mainly because culturally, sexuality matters are often shrouded in secrecy and hence are not discussed especially between adults and adolescents. The most cited reason among adults is the fact that such early education would lead to sexual promiscuity among the young adolescents who would want to experiment with the knowledge so gained. Unfortunately, society does not pause to find out the views of the adolescents themselves on this thorny subject matter although it is they who are directly affected. Yet, it has been found that sexuality education and adolescent contraception have been the answer to the problem of adolescent fertility in developed countries of the world (United Nations, 1989).

In line with the foregoing, it was necessary to find out from the adolescents in the study areas as to what their position is on the issue. The views that were expressed are presented in Table 6.19.

Table 6.19. Percentage of Female Adolescents by Views on Whether Family Life Education Promotes Sexual Promiscuity and Current Age, Cape Coast and Mankrong

Age	Cape Coast					Mankrong				
	Yes	No	Don't Know	Total		Yes	No	Don't Know	Total	
				N	%				N	%
12	8.7	43.5	47.8	115	100.0	7.9	15.8	76.3	38	100.0
13	12.0	52.0	36.0	125	100.0	16.1	22.6	61.3	31	100.0
14	14.1	61.1	24.8	149	100.0	13.3	16.7	70.0	30	100.0
15	21.4	53.1	25.5	145	100.0	7.1	42.9	50.0	28	100.0
16	23.4	61.0	15.6	154	100.0	13.8	27.6	58.6	29	100.0
17	20.6	64.9	14.6	131	100.0	21.4	42.9	35.7	14	100.0
18	19.4	68.8	11.8	144	100.0	18.2	27.3	54.5	22	100.0
19	29.2	61.9	8.9	113	100.0	11.8	58.8	29.4	17	100.0
20	25.6	64.3	10.1	129	100.0	23.3	41.9	34.9	43	100.0
21	34.9	59.0	6.0	83	100.0	9.1	18.2	72.7	22	100.0
22	33.3	54.3	12.4	81	100.0	10.5	52.6	36.9	19	100.0
23	23.3	56.7	20.0	60	100.0	26.3	31.6	42.1	19	100.0
24	37.8	52.7	9.5	74	100.0	23.1	15.4	61.5	13	100.0
<15	11.8	53.0	35.2	389	100.0	12.1	18.2	69.7	99	100.0
15-19	22.1	61.9	15.6	687	100.0	13.6	38.2	48.2	110	100.0
20-24	30.7	58.3	11.0	42.7	100.0	19.0	34.5	46.5	116	100.0
Total %	22.1	58.5	19.4	100.0	100.0	15.1	30.8	54.1	100.0	100.0
N	332	880	291	1,503	100.0	49	100	176	325	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

From the results in Table 6.19, one sees that the argument of family life education having the possibility of resulting in adolescent sexual promiscuity is not supported by majority of the adolescents. This is the case at all ages in either Cape Coast or Mankrong. Only a small proportion of 22 per cent and 15 per cent of the adolescents respectively in Cape Coast and Mankrong agreed that family life education could lead to sexual promiscuity. In Cape Coast for example, almost 60 per cent of the adolescents reasoned to the contrary. In all three age groups, only a small proportion of the adolescents thought family life education (FLE) could lead to sexual promiscuity. It is, however, worthy of note to state that more than half of the adolescents in Mankrong did not know whether or not family life education could lead to promiscuous lifestyles among the adolescents. This smacks of a high level of ignorance

among the adolescents in Mankrong. On the other hand, it could be due to the fact that most of them have not benefited from such education and hence are not sure what could result thereafter. A contrary picture is shown among adolescents in Cape Coast where the proportion who were definite that FLE does not lead to sexual promiscuity was more than half of the adolescents in each age group.

Furthermore, opinions expressed during focus group discussions regarding whether or not the teaching of adolescents about family life education leads to sexual promiscuity were mixed. In Cape Coast, one female adult was of the opinion that “family life education could lead some of the adolescents to experiment with sex when they know how to avoid pregnancies”. On the other hand, others especially the males thought it could be beneficial when it is taught properly with the dangers involved explained. Similar mixed opinions were expressed among the adults in Mankrong. For example, some of them felt that given the fact that the family life education will assist the adolescent in knowing when in her reproductive cycle she could become pregnant, there is a possibility that many young girls will be promiscuous since they could go on and avoid being pregnant.

In the case of the adolescents, particularly in Cape Coast, the consensus was that family life education does not lead to sexual promiscuity. Their explanation was that the education would present adolescents with all the information about sexuality and reproduction including the dangers involved in unprotected sex. In this case, the adolescent is likely to make a choice of abstinence as against any sexual experiment. This view was largely supported by adolescents in Mankrong who thought that FLE would provide adolescents with the needed guidelines to be protected from any sexual practices that would ruin their lives both now and in the future. This is consistent with the finding of Lunin et. al. (1995) in Saint Petersburg, Russia, of a strong support especially among adolescent females for sex education. It was the view of the researchers that sex education should be introduced at an early age so that children can be

taught how to reduce the risks of sexual abuse, HIV infection and other STIs as well as improving their sexual experiences as responsible adults. However, one male adolescent in the focus group discussions in Mankrong was convinced that once teachers teach it, “their students will, by all means take to sex and feel they are protecting themselves or avoiding unwanted pregnancies”.

The understanding of the exchanges was that it depends on the approach, most especially the expertise of the person doing the teaching. This is because it became quite clear from the discussions that if family life education is not taught well especially by persons who are, themselves, sexually disciplined, it could arouse the sexual instincts of adolescents who may be pushed into something they are being counselled to avoid.

The views expressed by majority of the adolescents on family life education and sexual promiscuity are in line with the reasoning of Ehrhardt (1996). According to Ehrhardt’s study, the widely held belief that sex education would promote sexual promiscuity has resulted in less than 10 per cent of American children receiving comprehensive sex education. This situation is described by Ehrhardt as a deficiency that has contributed to rates of teen pregnancy in the USA that exceed those in other countries with comparable cultures and economies. This is an indication that family life education would be more beneficial in reducing unsafe sexual activity among young persons when the right approach is adopted to its implementation. In Ghana however, its implementation should take note of the cultural sensitivities of the Ghanaian society.

For those who were not in favour of teaching adolescents family life education, suggestions pointed to the need to simply encourage them to study to achieve laurels so as to close their minds from sex and all that it entails. One suggestion by the female adults in Cape Coast was with reference to what pertained in the past when mothers would wait till their daughters were of age before they were cautioned to be careful about how to conduct

themselves in matters of sex. However, it is thought that as an adolescent, she is of age and hence, beginning to caution her at this stage about the dangers of sex may be too late since she would already be far ahead in practising sex and hence, the earlier they are taught about their reproductive health in general, the more beneficial it would be to them.

With respect to education, Table 6.20 presents inexplicable results that seem to suggest especially in the case of Cape Coast that the chances that an adolescent would believe in the proposal of family life education resulting in promiscuity appear higher with increasing education of the adolescent. This is quite difficult to explain since ideally a higher education would broaden a person's scope to think that family life education would rather do away with promiscuous lifestyles once one is exposed to the dangers involved. On the other hand, the results in respect of Mankrong, although not very definite, point to a relatively lower probability that a more educated adolescent would accept that family life education would lead to sexual promiscuity among young women.

Table 6.20. Percentage of Female Adolescents by Views on Whether Family Life Education Promotes Sexual Promiscuity and Level of Education, Cape Coast and Mankrong

Level of education	Cape Coast				Mankrong			
	Yes	No	Don't know	Total N.	Yes	No	Don't know	Total N.
Primary	18.1	38.5	43.4	83	20.1	32.1	47.2	53
Elementary	18.0	48.5	33.5	266	21.1	24.2	56.9	95
Basic	0.0	57.1	42.9	7				
Middle/JSS	21.9	58.6	19.5	676	11.1	30.9	58.0	162
Secondary/SSS	24.8	69.5	5.7	387	13.3	66.7	20.0	15
Post Sec./Higher	28.9	60.2	10.9	83	-			-
Total Stated	100.0	0.0	0.0	1		-		
Total %	21.1	58.5	19.4	100.0	15.1	30.8	54.1	100.0
Total N	332	880	291	1,503	49	100	176	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

For those who were sure family life education could lead to promiscuity, their main reasons were that once family life education helps the beneficiaries to know how to avoid pregnancy, they are likely to have frequent sex and in the process become promiscuous. In

contrast, those who did not share this view thought that family life education is a basic requirement for all persons since it would expose adolescents to all the dangers involved in early and unprotected sex. By so doing, many of them would be so scared that they would avoid sexual activity until they are married. What this means is that when adolescents are taught well about their sexuality and its dangers well explained to them, they would either avoid sexual intercourse outrightly or practise safer sex, which is a better option.

6.7 Provision of Counselling on Contraception for Adolescents

It has earlier been stated that in Ghana, sexuality issues are not freely discussed between adults and adolescents. In fact, in most cases, parents either have no time or find it difficult to talk to their growing-up children about sexuality matters especially when they reach adolescent ages. The need then arises as to whether the establishment of counselling centres with trained personnel to provide counselling services on contraception and reproductive health would not play a supplementary role to that of parents. To clarify issues concerning reproductive health counselling centres, the adolescents were asked whether there was the need for these counselling centres and if so, who is the best person to provide these counselling services?

In Table 6.21, the responses of the adolescents regarding the need for counselling centres according to age are shown. The results no doubt point to a large proportion of the adolescents supporting the idea. The support is, however, more overwhelming in Cape Coast (86 per cent) than in Mankrong (54 per cent). Across the ages, the evidence is that of massive support for the establishment of counselling centres especially among the adolescents in Cape Coast where the proportion expressing support for this cause ranges from 62.6 per cent at age 12 years to a high of 93.8 per cent at age 19 years. Similar support is also shown for this need among the adolescents in Mankrong particularly at older ages above 16 years. When

considered by age groups, the results indicate a higher support for family planning counselling centres by higher age of the adolescent. It must be noted however, that the proportion supporting family planning counselling centres is quite low among adolescents less than 15 years in Mankrong (26.3 per cent) relative to their counterparts in Cape Coast (73.8 per cent).

Table 6.21. Percentage of Female Adolescents by the Need for Health and Family Planning Counselling Centres and Current Age, Cape Coast and Mankrong

Age	Cape Coast				Mankrong			
	Yes	No	Don't Know	Total N.	Yes	No	Don't Know	Total N.
12	62.6	10.4	27.0	115	18.4	5.3	76.3	38
13	75.2	4.0	20.8	125	29.0	12.9	58.1	31
14	81.2	6.0	12.8	149	33.3	13.3	53.4	30
15	82.8	6.9	10.3	145	53.6	17.8	28.6	28
16	88.3	6.5	5.2	154	37.9	27.6	34.5	29
17	90.8	4.6	4.6	131	85.7	14.3	0.0	14
18	91.0	5.5	3.5	144	68.2	13.6	18.2	22
19	93.8	4.4	1.8	113	70.6	5.9	23.5	17
20	93.0	4.7	2.3	129	69.8	9.3	20.9	43
21	91.6	6.0	2.4	83	72.7	0.0	27.3	22
22	91.4	4.9	3.7	81	73.7	10.5	15.8	19
23	93.3	1.7	5.0	60	78.9	5.3	15.8	19
24	90.5	8.1	1.4	74	76.9	0.0	23.1	13
<15	73.8	6.7	19.5	389	26.3	10.1	63.6	99
15-19	89.1	5.7	5.2	687	59.1	17.3	23.6	110
20-24	92.0	5.2	2.8	427	73.3	6.0	20.7	116
Total %	86.0	5.8	8.2	100.0	54.1	11.1	34.8	100.0
N	1,292	87	124	1,503	176	36	113	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In terms of education, a similar pattern is shown in Table 6.22 with the proportions of the adolescents calling for the establishment of counselling centres being higher at higher levels of education of the adolescents. Although this is mainly the case among the adolescents in Cape Coast, the situation among the adolescents in Mankrong is not different apart from a recorded higher proportion among those with no education compared to the Primary and Middle/JSS adolescents.

Table 6.22. Percentage of Female Adolescents by Views on Whether there is the Need for Health and Family Planning Counselling Centres by Level of Education, Cape Coast and Mankrong

Level of Education	Cape Coast				Mankrong			
	Yes	No	Don't Know	Total No.	Yes	No	Don't Know	Total No.
No education	71.1	8.4	20.5	83	60.4	15.1	24.5	53
Primary	77.8	4.9	17.3	266	43.1	7.4	49.5	95
Arabic	85.7	14.3	0.0	7	-	-	-	-
Middle/JSS	85.6	6.4	8.0	676	54.3	13.0	32.7	162
Secondary/SSS	93.3	4.9	1.8	387	100.0	0.0	0.0	15
Post Sec./Higher	95.2	4.8	0.0	83	-	-	-	-
Not Stated	100.0	0.0	0.0	1	-	-	-	-
Total %	86	5.8	8.2	100.0	54.1	11.1	34.8	34.8
N	1,292	87	124	1,503	176	36	113	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

On the issue of the person considered to be the most appropriate to provide family planning counselling, Table 6.23 presents the views of the adolescents who called for the establishment of these counselling centres. Among the adolescents in Cape Coast, clinical nurse was considered the best, followed by parents with teachers as the third consideration. On the other hand, among adolescents in Mankrong, community-based distribution workers were considered second to clinical nurses with parents as third although a negligible proportion of the adolescents in that community supported the view that parents should be the best persons to provide counselling services to adolescents on reproductive health matters (Table 6.23).

Table 6.23. Percentage of Female Adolescents Who Accept Family Planning Counselling by Person Considered Best Positioned to Provide it, Cape Coast and Mankrong

Person to provide service	Cape Coast		Mankrong	
	N	%	N	%
CBD Workers	142	11.0	48	27.3
Clinical Nurse	570	44.1	107	60.8
Teacher	199	15.4	7	4.8
Priest/Pastor	26	2.0	2	1.1
Peer	22	1.7	1	0.6
Parents	286	22.2	11	6.2
Married Persons	3	0.2		
Don't know	44	3.4		
Total	1,292	100.0	176	100.0

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Furthermore, in the focus group discussions, those who supported family life education were asked about which persons they considered better placed to handle it. In both study areas, there was some consensus about the need to involve parents (especially mothers), nurses and teachers. What many of them lost sight of is whether most parents have the knowledge and the art to impart this knowledge at ages early enough to help the young persons make the right choices as they grow into responsible adulthood.

Some of them were, however, not happy about the involvement of teachers because they thought that some teachers are to blame for making young girls in their schools pregnant. Those who argued vehemently against the use of teachers suggested that trained female nurses in family life education should be attached to the schools to offer the training since according to them, they have had several experiences of teachers impregnating their own students.

On the whole, the analysis in this section has revealed relevant results. These include relatively higher contraceptive use among the sexually active adolescents in the two study areas. There have also been much positive views expressed on issues that pertain to the reproductive health of adolescents. In both the focus group discussions and the main analysis, the role of nurses, parents, and teachers in the provision of family life education to adolescents,

has been upheld by most of the respondents. These views could therefore guide policies and programmes that principally focus attention on the sexuality and reproductive health of adolescents in Ghana.

CHAPTER SEVEN**KNOWLEDGE, INCIDENCE AND PREVENTION OF REPRODUCTIVE
HEALTH PROBLEMS AMONG ADOLESCENTS****7.1 Introduction**

This chapter examines the knowledge of the adolescents about sexually transmitted infections and their incidence among the adolescents. In addition, their knowledge about how the infections could be avoided has also been analysed against the background of their characteristics. Principal among the sexually transmitted infections that are investigated is HIV/AIDS, which poses considerable degree of threat to adolescents especially those who engage in unprotected sex.

7.2 Knowledge of Sexually Transmitted Infections (STIs)

A person's knowledge of the existence of a disease or infection and its mode of transmission is one step ahead in avoiding its contraction or infection. This is especially the case with reference to sexually transmitted infections (STIs) and the need to practise safe sex if one cannot abstain from it. Based on this premise, the female adolescent respondents in Cape Coast and Mankrong were asked about their views on whether they were aware they could contract some infections through sexual activity.

Table 7.1. Percentage of Female Adolescents by Knowledge as to Whether or Not Infections can be Contracted Through Sex and Current Age, Cape Coast and Mankrong

Age	Knowledge of Contraction of Infection					
	Cape Coast			Mankrong		
	Yes	No	Total N	Yes	No	Total N
12	60.9	39.1	115	13.2	86.8	38
13	72.0	28.0	125	19.4	80.6	31
14	81.2	18.8	149	26.7	73.3	30
15	86.2	13.8	145	57.1	42.9	28
16	90.3	9.7	154	55.2	44.8	29
17	92.4	7.6	131	78.6	21.4	14
18	96.5	3.5	144	72.7	27.3	22
19	98.2	1.8	113	82.4	17.6	17
20	90.7	9.3	129	72.1	27.9	43
21	100.0	0.0	83	81.8	18.2	22
22	96.3	3.7	81	78.9	21.1	19
23	98.3	1.7	60	89.5	10.5	19
24	97.3	2.7	74	76.9	23.1	13
<15	72.2	27.8	389	19.2	80.8	99
15-19	92.4	7.6	687	66.4	33.6	110
20-24	95.8	4.2	427	78.4	21.6	116
Total %	88.2	11.8	100.0	56.3	43.7	100.0
N	1,325	178	1,503	183	142	325

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

From Table 7.1, it is evident that overall, a higher percentage of the respondents in Cape Coast than in Mankrong were aware that they might contract some infections if they engaged in sexual activity. While close to 90 per cent of the respondents in Cape Coast expressed such an awareness, a little more than half (56.3 per cent) of their counterparts in Mankrong responded that they could contract an infection through sexual activity. This is to be expected between the two study areas because of a higher knowledge about STIs in urban than rural places of residence. For example, the 1998 GDHS reported that for all types of STIs, knowledge among women was relatively higher in urban areas than in rural areas. It is however, clear that knowledge of STIs in the current study is quite high with 82.5 per cent of all respondents being aware that they could contract some infections through sex (not shown in Table 7.1). A high knowledge of STIs has also been reported by Olawoye (1995) among

adolescents in Nigeria although according to the study, many of them reported having multiple sexual partners.

In terms of the distribution of the responses by age, evidence in Table 7.1 shows that although in either study area, the pattern is not uniform, it is observed that generally, higher proportions of the respondents at higher ages know of a possibility of contracting an STI through sexual activity compared to their relatively younger colleagues. The situation is more vivid in Mankrong at ages less than 15 years where less than 30 per cent of the respondents in these ages knew of such a possibility. Comparing the age groups for example, 19.2 per cent of the adolescents of less than 15 years in Mankrong knew that one could contract some infections through sex compared to 72.2 per cent of adolescents of the same age group in Cape Coast. There is also a clear evidence of increase in knowledge of the contraction of infections through sex as adolescent's age increases in either Cape Coast or Mankrong.

The implication is that should the young adolescents engage in sex at these early ages, they may not consciously do anything to protect themselves against the possible contraction of these diseases. It should also be added that with over 40 per cent of the respondents in Mankrong not aware of such possible contraction of infections through sex, many of them may be put at higher health risk in relation to their colleagues in Cape Coast, should they engage in sex. This is because their apparent lack of such a knowledge may not encourage them to consciously protect themselves during sex.

Table 7.2 examines the knowledge of female adolescents about the contraction of STIs by level of education. As is shown in the table, particularly in Cape Coast, such a knowledge tends to increase with increasing education of the respondent. It ranges from a low of 63.9 per cent among respondents with no education to 97.9 per cent among those with SSS and Secondary level of education. In fact, all the 83 respondents who had attained Post-

Secondary/Higher education indicated that they knew of such a danger of contracting an infection through sex.

Table 7.2. Percentage of Female Adolescents by Knowledge as to Whether or Not Infections can be Contracted Through Sex and Level of Education, Cape Coast and Mankrong

Level of Education	Knowledge of Contraction of Infection					
	Cape Coast			Mankrong		
	Yes	No	Total N	Yes	No	Total N
No Education	63.9	36.1	83	69.8	30.2	53
Primary	69.2	30.8	266	41.1	58.9	95
Arabic	100.0	0.0	7	-	-	-
Middle/JSS	91.4	8.6	676	56.8	43.2	162
SSS/Secondary	97.9	2.1	387	100.0	0.0	15
Post Sec./Higher	100.0	0.0	83		-	
Note Stated	100.0	0.0	1	-		

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997

In contrast to the situation in Cape Coast, there is no definite pattern among the respondents in Mankrong. Apart from the 15 respondents with SSS/Secondary level of education, all of whom responded to having knowledge of contraction of some infections through sex, the proportion answering same was higher among those with no education (almost 70 per cent) compared to 41 per cent and 57 per cent respectively among females with Primary and Middle/JSS levels of education. Clearly, this is unexpected and could be due either to misstatement by adolescents with no education or the relatively smaller sample size of the “No education” category, compared to the other educational groups. However, with all the 15 persons having the highest level of education (SSS/Secondary) expressing knowledge of the possibility of acquisition of some infections through sex, it may be concluded that the role of education could be positive even in Mankrong to let the more educated become knowledgeable in infections that may be contracted through sexual intercourse.

Furthermore, as a proof of their knowledge of the infections that could be contracted through sex, the respondents were asked to name diseases they knew could be contracted through sex. Each person was allowed to name as many diseases as she knew. The results as shown in Table 7.3 are, therefore, multiple responses. Two kinds of information are shown in the table. These are (i) the percentage of the total number of respondents who had a knowledge that sexual intercourse could result in the contraction of a disease mentioning a particular disease and (ii) the percentage of the total number of multiple responses that mentioned a particular disease in relation to all others mentioned by respondents in each study area. The denominator is therefore different in either case and is indicated below Table 7.3. The interpretation of the table should, therefore, be done bearing in mind these differences in information and how each was arrived at.

Table 7.3. Percentage of Female Adolescents by Type of Infection that can be Contracted Through Sex, Cape Coast and Mankrong

Infection	Cape Coast			Mankrong		
	Number Of Responses	% of total No. having knowledge of an STI*	% mentioning infection in relation to other infections**	Number of Responses	% of total No. having knowledge of an STI*	% mentioning infection in relation to other infections**
Gonorrhoea	829	62.6	29.5	125	68.3	24.6
Phillys	448	33.8	16.0	40	21.9	7.9
HIV/AIDS	1,286	97.1	45.8	175	95.6	34.5
Herpes	19	1.4	0.7	13	7.1	2.6
Malaria	21	1.6	0.8	6	3.3	1.2
Gonorrhoea	7	0.5	0.2	2	1.1	0.4
Cholera	28	2.1	1.0	-	-	-
Chicken Pox	168	12.7	6.0	146	79.8	28.8
Diabetes	1	0.1	0.0	-	-	-
Total	2,807		100.0	507	-	100.0

Notes: * Percentage of the total number of respondents who replied 'Yes' to knowing a disease that could be contracted through sexual intercourse i.e. 1,325 in Cape Coast and 183 in Mankrong.

** Percentage of total number of multiple responses i.e. 2,807 in Cape Coast and 507 in Mankrong, mentioning a particular disease as against all other diseases mentioned in the study area.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Overall, and as shown in Table 7.3, nine infections were named by the respondents as likely to be contracted through sexual intercourse. These include non-STIs as malaria, cholera, chicken pox and diabetes. This is a clear case of ignorance and misinformation, a situation which suggests that a number of the adolescents are actually confused as to what is an STI and what is not. For example, it is noted that almost 80 per cent of the adolescents interviewed in Mankrong who were convinced they knew one could contract a disease through sex named chicken pox as one disease that could be the outcome of sexual intercourse. The corresponding figure for Cape Coast was 12.7 per cent. At the same time, 3.3 per cent and 1.6 per cent of the adolescents in Mankrong and Cape Coast respectively, named malaria as a sexually transmitted disease. This is also surprising since persons who have never had sexual intercourse before also do fall sick of malaria.

It is also strange for some of the adolescents in Cape Coast (though a relatively small number) to mention cholera and diabetes as being caused by sexual intercourse. Perhaps, the mention of cholera and chicken pox might have resulted from the association of the appearance of shingles (called “ananse” in Akan) which is like rashes and hence chicken pox, and extreme diarrhoeal conditions with AIDS patients most of whom in Ghana are known to have contracted the AIDS virus through sexual intercourse.

By far, however, in either Cape Coast or Mankrong, the disease that appears most commonly known by the adolescents as an STI is HIV/AIDS, followed by gonorrhoea and syphilis. The common knowledge of HIV/AIDS among adolescents is not surprising because apart from the fact that many people are obviously scared of it and that it still has no known cure in Ghana, public education during the last five years has been stepped up in Ghana on how its infection could be avoided. Knowledge of persons regarding sexual intercourse as the principal mode of transmission of HIV/AIDS is almost universal in Ghana. This, the 1998 GDHS attests to.

The pattern is not too different when we consider the percentage of the total number of multiple responses that mentioned a particular disease as against all other diseases named in the study. The most commonly known STIs in Cape Coast are still HIV/AIDS (45.8 per cent of the responses), gonorrhoea (29.5 per cent) and syphilis (16.0 per cent). There were also 6.0 per cent of the respondents who ignorantly named chicken pox as one of the STIs known. On the other hand, almost 29 per cent of the responses in Mankrong ranked chicken pox as second to HIV/AIDS (34.5 per cent) with gonorrhoea (24.6 per cent) taking the third place in the order of how common the infection is known. Syphilis also ranked fourth attracting only 8 per cent of the responses.

What is important is for those who have a good knowledge of STIs to translate such knowledge into good sexual behaviour and to practise safer sex whenever the need arises. Unfortunately, most often this does not happen as has been shown even in this study in Chapter Six. This explains why many adolescents fall victims to the contraction of STIs although most of them have adequate knowledge that they can be infected if they engage in unprotected sexual intercourse.

7.3 Incidence and Treatment of STIs

Apart from knowing the extent to which adolescents are exposed to reproductive health risks, the study also ascertained how many of the adolescents have ever fallen victims to STI infection. It has to be stated at the outset, however, that an investigation of this nature is usually fraught with inaccurate responses. This stems from the stigma that often accompanies STI infection. As it often happens, sexually transmission infected persons scarcely willingly disclose in public that they have ever in the past or at present been infected by an STI. It is, therefore, not uncommon to have STI infected persons resorting to

self-medication to avoid being stigmatised even by some professionally trained health personnel.

In line with the foregoing observation, it was found that only nine adolescents in Cape Coast and three in Mankrong admitted ever contracting an STI. This may be an understatement of the true picture. They listed the STIs they have ever contracted to include gonorrhoea (contracted by five persons in Cape Coast and two persons in Mankrong), Chlamydia (two persons in Cape Coast), Syphilis (one person in Mankrong) and HIV/AIDS (one person in Cape Coast). Even, it is doubtful if the person mentioning HIV/AIDS actually understood this question since it is unlikely for someone with HIV to openly declare such a status to an enumerator in a survey considering the extreme form of stigmatisation that is currently associated with such a health condition in Ghana. Interestingly, one person in Cape Coast named malaria as the STI she had in the past contracted. This obviously suggests ignorance of what constitutes an STI.

On the other hand, when they were asked whether they knew of other persons who have ever contracted an STI, 104 (made of 6.9 per cent of the respondents in Cape Coast) and seven (i.e., 2.2 per cent of respondents in Mankrong) replied in the affirmative. Clearly then it is like when it is an STI, other people can have it but not the one who is being interviewed. It is also suggesting that when someone contracts an STI, other persons are likely to know of it and not the person carrying the infection. This shows the extent to which the contraction of STIs is stigmatised in Ghana. It could also be the result of non-disclosure by the sexual partners of these ladies when they become infected for them (females) to also know they may be infected to enable them seek early treatment since for females, STIs are not easy to detect at the early stages. There is however, the need to exercise circumspection in interpreting the results from such an investigation.

The low reporting rate of STI contraction among the adolescents is however, consistent with studies done in Ghana by Awusabo-Asare and Anarfi (1995) and, Nabila and Fayorsey (1996). The latter study for example, reported 28.5 per cent of male adolescents and 4.6 per cent of female adolescents ever contracting an STI in the study in Accra and Kumasi. This shows that report about STI incidence among females has usually been lower compared to their male counterparts due to the fact that STIs among females are not easy to detect unlike in males.

In spite of the perceived inaccuracies in the reporting of the incidence of STIs, the few who admitted having ever been infected with an STI were asked about where they sought treatment. Out of the nine persons in Cape Coast, two adolescents said that they sought treatment from the hospital, one was assisted by a friend (suggesting some kind of self-medication), three used local herbs and the other three failed to state how they got treatment. In the case of the three persons in Mankrong, two sought treatment from the hospital with the third person not stating her source of treatment. Obviously, no meaningful conclusions can be drawn here on account of the very small number of cases that are involved in the analysis.

It is however, not uncommon for adolescents who contract STIs to fail to seek treatment from recognised health institutions as demonstrated by the adolescents who either resorted to self medication or relied on local herbs the effectiveness of which can often not be pre-determined. This reasoning is consistent with findings from a study by the Health Systems Development Unit of the Hlatlolanang Health and Nutrition Education Centre (1998) that many adolescents who become infected with STIs fail to consult a health care worker due to lack of reproductive health knowledge, inaccurate or unreliable information, inaccessible reproductive health services and negative perceptions of health services.

On the other hand, when we consider the responses of the respondents in Cape Coast who claimed to know of persons to have ever contracted an STI in respect of where treatment was sought, it can be observed that close to half of the 104 persons involved sought treatment outside the modern health delivery system. The breakdown shows that 57 persons (54.8 per cent) sought treatment at the hospital, 15 of them (14.4 per cent) resorted to self-medication with seven (6.7 per cent) using so-called local herbs the efficacy of which it was not possible for this study to determine. There were also 15 of them (14.4 per cent) who indicated that the infected persons died due to the fact that no treatment was sought while 10 persons (9.6 per cent) did not state the kind of treatment those persons they knew to have contracted an STI sought. In the case of Mankrong no meaningful analysis could be made of the information since only seven cases were involved among which three were alleged to have sought treatment from a hospital setting, the rest possibly outside the hospital.

In spite of the limitation on the validity of the analysis that can be made in respect of the incidence and treatment of STIs among the adolescent females due to the small number of persons offering some information, one thing is quite conclusive. That is, apart from the difficulty in getting the adolescents to admit to having ever contracted an STI, some of the few known to have ever contracted any such infections do not have the modern health facilities as regular centres of call for treatment. This is not a healthy observation since that could pose a threat to the proper treatment of these infections, a situation which could in future have irreparable consequences not only on the infected female adolescent but also on her sexual partner and children.

It is, however, again being emphasised that the rather low reporting of persons ever contracting an STI among the females could be the result that many of them may not be aware that they are infected if they are not told by their sexual partners since the anatomy of

the female does not facilitate relatively early detection of an STI infection by the female herself compared to the male. It, therefore, goes without saying that many sexually active adolescents may be exposed to many risks of STI infection, which do not guarantee their sound reproductive health.

7.4 Knowledge of HIV/AIDS Transmission and its Avoidance

The study did not ask about the knowledge of the adolescents about HIV/AIDS as a disease but rather its mode of transmission. In any case, it has already been established in this study (Table 7.3) that HIV/AIDS is the most commonly known disease that could be contracted through sex by the adolescents. The 1998 GDHS reports that 97 per cent of women have heard of HIV/AIDS nationwide, 97.8 per cent in the Central Region and 96.5 per cent and 97.5 per cent respectively among women aged 15-19 years and 20-24 years in Ghana. Clearly, knowledge of female adolescents about HIV/AIDS is almost universal in Ghana. On the basis of this perceived high knowledge of the adolescents about HIV/AIDS in this study, they were asked about what they considered as the modes of its transmission. It should be noted that each respondent was allowed to mention as many modes of transmission she possibly was aware of. The analysis therefore is based on the multiple responses they gave.

The responses as provided by the respondents in Table 7.4 show that overall, 3,557 responses were given by the 1,503 adolescents interviewed in Cape Coast compared to 627 responses by the 325 adolescents in Mankrong. The analysis looks at two scenarios. The first scenario is the percentage of all the multiple responses mentioning a particular mode of transmission in relation to others in each study area. In the second scenario, the analysis examines the percentage of the total number of respondents in each study area mentioning a particular mode of transmission. The denominators for computing the percentages in each

scenario is, therefore, different as indicated in Table 7.4. The two scenarios do not, however, contradict each other but are in harmony.

In the first scenario, Table 7.4 shows that almost 85 per cent of the respondents in Cape Coast knew that HIV can be transmitted through sexual intercourse which ranked as the mode of HIV transmission well known to the adolescents. This compares with 51 per cent of the respondents in Mankrong with knowledge of sexual intercourse as a conduit of HIV transmission. This shows that in Ghana knowledge of HIV transmission is higher in the urban as against the rural areas, a fact which is supported by the results in Table 7.4. It is evident, however, that among the adolescents in Mankrong, the most well known means of HIV transmission is from mother to child (88.6 per cent) which ranked third among adolescents in Cape Coast. Other important modes of HIV transmission mentioned by the adolescents include sharing of blades, the use of unsterilised needles (usually for injection) and blood transfusion when it is already infected with the virus.

Table 7.4. Percentage of Female Adolescents by Knowledge of Modes of HIV/AIDS Infection, Cape Coast and Mankrong

Mode of transmission	Cape Coast			Mankrong		
	Number of Responses	% of total number mentioning a particular mode of transmission *	% mentioning mode of transmission in relation to others**	Number of Responses	% of total number mentioning a particular mode of transmission *	% mentioning mode of transmission in relation to others**
Sexual Intercourse	1,276	84.9	35.9	166	51.1	26.5
Sharing of Blades	829	55.2	23.3	74	22.8	11.8
Use of unsterilised Needles	506	33.7	14.2	57	17.5	9.1
Blood transfusion	289	19.2	8.1	37	11.4	5.9
Mosquito or Other insect bites	31	2.1	0.9	1	0.3	0.2
Kissing	39	2.6	1.1	4	1.2	0.6
When Parents are infected (Mother to Child)	584	38.9	16.4	288	88.6	45.9
Sharing of brassiere	3	0.2	0.1			
Total	3,557	-	100.0	627	-	100.0

Notes:

* Percentage of total number of respondents mentioning a particular mode of transmission i.e., 1,503 in Cape Coast and 325 in Mankrong. These figures constituted the respective denominators in the computation of the results in these columns.

** Percentage of total number of multiple responses i.e. 3,557 in Cape Coast and 627 in Mankrong, mentioning a particular mode of transmission in relation to others.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

One significant observation is that the proportion of the adolescent females mentioning perceived modes of transmission like mosquito and other insect bites, kissing and sharing of clothing such as brassieres (which have not medically been proved to be true) is quite small (i.e. less than 3 per cent in each case). This suggests that earlier notions held

by many people about the transmission of HIV through these medically unsupported means in Ghana are gradually fading away.

There are, however, some of the adolescents i.e., 15 per cent and 49 per cent respectively in Cape Coast and Mankrong who never mentioned sexual intercourse as a possible means of HIV transmission. For almost half of the adolescents interviewed in Mankrong, therefore, any attempt to consciously avoid or prevent HIV/AIDS infection may not include sexual intercourse as a first consideration. The adolescents' knowledge base should be broadened since to date about 80 per cent of HIV/AIDS infections are attributable to sexual intercourse, i.e., whether heterosexual or homosexual (Ministry of Health, 2001).

As has been stated earlier, the observations in the second scenario, which take cognisance of all multiple responses do not run counter to those in the first scenario. For example, sexual intercourse still ranks first as the most commonly known mode of HIV transmission in relation to all other modes among the adolescents in Cape Coast and mother-to-child transmission among adolescents in Mankrong. The analysis here is limited by the fact that the sources of information about HIV transmission were not investigated during the survey and hence is not analysed.

Following the responses regarding the modes of HIV transmission, the adolescents were further asked how they would avoid being infected with the AIDS virus. The responses are presented in Table 7.5. The results indicate that in each study area, a higher proportion of the total number of respondents mentioned complete sexual abstinence as one main means of avoiding HIV/AIDS. The figures show 52.4 per cent in Cape Coast and 43.7 per cent in Mankrong. The next two ways considered important in the avoidance of HIV/AIDS infection are also sexually related, namely; keeping one sexual partner only (mentioned by 44.6 per cent of the adolescents in Cape Coast and 28.6 per cent in Mankrong) and using condoms during sex (38.3 per cent in Cape Coast and 28.6 per cent in Mankrong). This is

quite instructive considering that a relatively high proportion of the female adolescents considered the prevention or avoidance of HIV/AIDS infection more with respect to sexual intercourse relative to other preventive measures. For example, it can be deduced from Table 7.5 that as high as 81 per cent and 62 per cent respectively of the total number of multiple responses in Mankrong and Cape Coast named a sexually related HIV/AIDS preventive means (i.e., sexual abstinence, maintenance of one sexual partner and the use of condoms).

Table 7.5. Percentage of Female Adolescents by Knowledge About how to Avoid HIV/AIDS Infection, Cape Coast and Mankrong

Means of avoiding HIV/AIDS	Cape Coast			Mankrong		
	Number of Responses	% of total number mentioning a particular means of HIV/AIDS avoidance*	% mentioning means of HIV/AIDS avoidance in relation to others**	Number of Responses	% of total number mentioning a particular means of HIV/AIDS avoidance	% mentioning means of HIV/AIDS avoidance in relation to others**
Abstinence from sex	787	52.4	24.1	142	43.7	35.0
Maintain only one sexual partner	671	44.6	20.5	93	28.6	22.9
Use condoms	575	38.3	17.6	93	28.6	22.9
Avoid use of unsterilised needles	481	32.0	14.7	34	10.5	8.4
Do not share blades	571	38.0	17.5	33	10.2	8.1
Avoid someone with HIV/AIDS	62	4.1	1.9	6	1.8	1.5
Spray mosquitoes	3	0.2	0.1			
Maintain clean environment	120	8.0	3.6	5	1.5	1.2
Total	3,270		100.0	406		100.0

Notes:

* Percentage of total number of respondents mentioning a particular means of avoiding HIV/AIDS i.e. 1,503 in Cape Coast and 325 in Mankrong. These figures therefore formed the respective denominators in the computation of the results in these columns.

** Percentage of total number of multiple responses i.e. 3,270 in Cape Coast and 406 in Mankrong, mentioning a particular mode of transmission in relation to others.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In addition to the foregoing analysis, the views of participants in the focus group discussions, were sought regarding how adolescents could be helped to avoid contracting STIs and HIV/AIDS. The responses from adults from Cape Coast suggested the need for intensified public education. This is because, although many adolescents are aware of HIV transmission through sexual activity, a considerable number of them are sexually active. In their view therefore, education should stress faithfulness in sexual partnerships. The need for intensified education was stressed in view of the fact that there are many people who do not see anything frightening about AIDS as they see it as “one of the many ways by which death comes”.

Among the adolescents in Cape Coast, there were suggestions of the need to avoid multiple sexual partners and discouragement of sharing of unsterilised blade and needles. However, one person suggested that as much as possible, one should “avoid mosquito bites since with time, it could lead to the contraction of HIV/AIDS”. This is again an indication that there are people who still consider mosquito bites as possible ways by which one could get infected with HIV/AIDS.

One adolescent from Mankrong during the focus group discussions, expressed her helplessness in the prevention or avoidance of HIV/AIDS infection. To her, when one is about to marry, one cannot tell from the face of the suitor as to whether he has HIV or not and so could contract the virus even when one marries if even she stayed virgin throughout her life before marriage. Another, however, offered a solution by suggesting the need for persons to call for hospital investigation through HIV tests to ascertain one’s HIV status before deciding either to accept a sexual or marriage proposal from any person. This would, however, depend on the self-discipline of everyone since before this idea of a test one might have already started engaging in sex. Perhaps, it would be helpful if all “Stop AIDS” campaigns shall embody in them the need for would-be sexual partners to first request for

HIV test prior to any sexual act between them. The focus of such campaigns should be focused particularly on adolescent males and females, many of whom may be indulging in sexual activity for the first time.

However, what is relevant is not what these young women think or know could help them avoid being infected with the AIDS virus but rather how to translate this good knowledge into practice. As can be observed from Table 7.5, there are still some of the young women (although quite few) who think spraying mosquitoes and keeping a clean or neat environment could help them avoid HIV/AIDS infection. Obviously, this is a clear case of ignorance, which could form a basis for exposing some young women to the risk of HIV/AIDS. The need for intensified public education on HIV/AIDS especially in the area of its avoidance can therefore not be over-emphasised.

CHAPTER EIGHT**RELATIONSHIP BETWEEN ADOLESCENT SEXUALITY, CONTRACEPTION AND REPRODUCTIVE HEALTH****8.1 Introduction**

A number of relevant findings have been made in the preceding chapters through the bi-variate analysis. This chapter attempts to statistically examine the relationship (if any) between adolescent sexuality, contraceptive use and reproductive health. The key variables in the relationship are first examined as a prelude to the multi-variate analysis using multiple regression analysis. It must however, be noted that in view of the small sample size as a result of the fact that not a large proportion of them had ever had a pregnancy, many of the variables originally considered could not be included in the regression analysis which, on account of the stated limitations, is considered as exploratory. In spite of this, the qualitative information gathered from the focus group discussions does not contrast the kind of relationships observed in the analysis.

8.2 Adolescent Sexuality and Contraceptive Use

This section attempts to look into a little more detail adolescent sexual behaviour with respect to contraceptive use when variables including current age, education, age at first sexual intercourse and the number of times having had sexual intercourse during the past month have been controlled for. Only adolescents who had ever had a sexual intercourse have been considered here. This reduces the total sample to about 37.1 per cent i.e., 36 per cent for Cape Coast and 44 per cent for Mankrong. Although the reduction in sample size constitutes some limitation, some useful insights into the sexual behaviour of sexually active adolescents regarding their use of contraception, both currently and at the time of their first sexual activity can be gleaned. Considering the relatively smaller sample size that is involved in the analysis

both current age and age at first sexual intercourse have been recategorised as less than 15 years, 15-19 years and 20-24 years.

In Table 8.1, the percentage of female adolescents who used any method of contraception at their first sexual intercourse has been presented. The table shows that overall, the proportion of females practising any form of contraception at first sexual intercourse (31.7 per cent in Cape Coast and 25.6 per cent in Mankrong) is comparable to Nabila and Fayorsey's (1996) finding of 29.9 per cent among female adolescents in Accra but lower than 48.8 per cent among female adolescents in Kumasi from the same study. Yet, it appears that there is a higher probability that a woman would practise some form of contraception when first sexual intercourse is delayed. For example, it is evident in the table that among the respondents in Cape Coast (where the number of cases in each cell is relatively adequate to permit some generalisation), overall contraceptive use at first sexual intercourse rises from 18.9 per cent at less than 15 years to 32.2 per cent at 15-19 years and 40.7 per cent at 20-24 years.

Table 8.1. Percentage of Sexually Active Female Adolescents by Contraceptive Use at First Sexual Intercourse, Current Age and Age at First Sex, Cape Coast and Mankrong

Current Age	Age at First Sexual Intercourse							
	<15		15 – 19		20 - 24		Total	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
<15	16.7 (6)	–	–	–	–	–	16.7 (6)	–
15-19	14.8 (27)	0.0 (2)	35.2 (176)	28.6 (42)	–	–	32.5 (203)	27.3 (44)
20-24	25.0 (20)	0.0 (4)	30.0 (253)	11.4 (88)	40.7 (54)	0.0 (7)	31.5 (327)	10.1 (99)
Total	18.9 (53)	0.0 (6)	32.2 (429)	16.9 (130)	40.7 (54)	0.0 (7)	31.7 (536)	25.6 (143)

Notes: The percentages were calculated out of the total number of eligible adolescents which are in brackets

– means there are no respondents in cell.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

One other significant observation is that without a control for age at first sexual intercourse, there appears to be a relatively higher proportion of female adolescents aged 15-19 years who practised some form of contraception at first sex compared to their older counterparts of 20-24 years in the sense that while 31.5 per cent of the older age group (20-24) from Cape Coast practised contraception at first sexual intercourse, 1 per cent more (i.e. 32.5 per cent) of the younger group (15-19) practised same at first sexual intercourse. In the case of Mankrong, it was 10.1 per cent among those currently aged 20-24 compared to 27.3 per cent among those aged 15-19 years. While it is important to encourage adolescents who indulge in sex to practise contraception even at first sexual intercourse, it is significant to conclude that the longer first sexual intercourse is delayed, the higher the chance that the actors would be exposed to public education on the need to avoid unwanted pregnancy and hence guaranteeing their willingness to practise contraception.

In Table 8.2, the effect of education in the use of contraception at first sexual intercourse has been analysed while controlling for age at first sexual intercourse.

Table 8.2. Percentage of Sexually Active Female Adolescents by Contraceptive Use at First Sexual Intercourse, Level of Education and Age at First Sex, Cape Coast and Mankrong

Level of Education	Age at First Sexual Intercourse					
	<15	15-19		20-24	Total	
	Cape Coast	Cape Coast	Mankrong*	Cape Coast	Cape Coast	Mankrong
No Education	0.0 (8)	11.5 (26)	14.3 (35)	-	8.8 (34)	14.3 (35)
Primary	8.3 (13)	20.8 (48)	20.0 (30)	16.7 (6)	17.9 (67)	20.0 (30)
Arabic	0.0 (1)	0.0 (4)			0.0 (5)	-
Middle/JSS	41.7 (17)	24.8 (202)	11.9 (67)	25.0 (24)	25.3 (241)	11.9 (67)
Sec./SSS	36.4 (11)	52.1 (119)	27.3 (11)	56.3 (16)	51.4 (146)	27.3 (11)
Post Sec./Higher	0.0 (3)	44.8 (29)		60.0 (10)	45.2 (42)	
Not Stated		0.0 (1)			0.0 (1)	

Notes: The percentages were calculated out of the total number of eligible adolescents, which are in brackets. Due to the very small size of cases in the cells for Mankrong the results for all the adolescents of all ages have been put together under 15-19, the age group that contained the largest number of eligible adolescents in the analysis in the table.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The information presented in Table 8.2 shows that with few exceptions and particularly for Cape Coast, the general situation is that contraceptive use at first sexual intercourse increases with higher education at each age at first sex. There is, however, no consistent observation as to whether within each educational category, contraceptive use at first sex increases with increasing age at first sex as the case was when current age was controlled for in Table 8.1. In the case of Mankrong, no definite pattern is evident although the higher

educational levels generally have relatively higher proportions contracepting at first sexual intercourse than those with lower educational levels.

Perhaps, it has to be reiterated that the influence of education is not so much the type of impact one would expect at the time the sexual act took place. The reason is that one's educational level at the time of first sexual intercourse may not necessarily be the same as at the time of the survey. The exceptions that were observed could perhaps be due to some possible changes that might have occurred between the time of the first sexual intercourse and the time of the survey. Once again, the aspiration of the girl for higher education and hence the quest for postponing first sex cannot be downplayed. Unfortunately, as earlier explained, no information on the level of education of the adolescents at the time of first sexual activity was collected.

Another aspect of contraceptive use that was considered worthy of investigation was the current use of contraception with respect to the current age and education while controlling for the number of times the woman had sexual intercourse in the past one month preceding the survey. The analysis here and the conclusions however should be taken with some caution on account of the fact that people normally would not give accurate information when it comes to the frequency of sexual activity. In other words, there is a tendency for them to reduce the number of times they have had sexual activities.

Table 8.3 looks at current contraceptive use and current age with a control for frequency of sexual activity in the past one month. The information suggests that in Cape Coast and Mankrong, current contraceptive use is relatively higher compared to the situation at the time of first sexual intercourse. Yet, about two in every three sexually active female adolescents in either Cape Coast or Mankrong are not practising any form of contraception.

Table 8.3. Percentage of Sexually Active Female Adolescents by Contraceptive Use, Current Age and Number of Times Having Sexual Intercourse During Past Month, Cape Coast and Mankrong

Current Age	Number of Times Having Sexual Intercourse in Past Month							
	0		1 – 2		3+		Total	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
<15	0.0 (1)		0.0 (2)		33.3 (3)		16.7 (6)	-
15-19	28.0 (125)	23.8 (21)	52.6 (57)	45.5 (11)	23.8 (21)	33.3 (12)	34.5 (203)	31.8 (44)
20-24	27.6 (174)	19.6 (51)	60.4 (101)	37.5 (32)	34.6 (52)	50.0 (16)	38.8 (327)	30.3 (99)
Total	30.5 (272)	20.8 (72)	61.9 (147)	39.5 (43)	36.4 (66)	42.9 (28)	36.9 (536)	30.8 (143)

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

A further look at Table 8.3 reveals that overall, there is increasing contraceptive use with higher frequency of sexual intercourse among the female adolescents in Mankrong. On the contrary, the highest contraceptive use among the respondents in Cape Coast is recorded among those who had sexual intercourse between one and two times (61.9 per cent) followed by those who had sexual intercourse for three or more times. This pattern is also valid among persons aged 15-19 and 20-24 years among whom there is adequate number of respondents to make relatively valid conclusions. This is also applicable to respondents aged 15-19 years in Mankrong compared to their counterparts aged 20-24 years among whom the evidence suggests a higher current contraceptive use with increasing frequency of sexual intercourse. It is, however, clear that current contraceptive use is lowest among women who reportedly had no sexual intercourse over the past one month prior to the survey. This is to be expected especially with some of the short-term contraceptive methods, which are only used at the time of sexual activity. This, notwithstanding, the majority of the young women are exposing

themselves to the risk of pregnancies some of which might not be wanted at the time they might occur.

With respect to education, the presentation provided in Table 8.4 suggests an increasing contraceptive use with higher education particularly among adolescents in Cape Coast. The same picture is again generally valid after controlling for the frequency of sexual intercourse among the females in Cape Coast. The effect of education in encouraging current contraceptive use is clearly evident here.

Table 8.4. Percentage of Female Adolescents by Contraceptive Use, Level of Education and Frequency of Sexual Intercourse During Past Month, Cape Coast and Mankrong

Level of Education	Frequency of Sexual Intercourse in Past Month							
	0		1 - 2		3+		Total	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
No education	4.8 (21)	6.7 (15)	14.3 (7)	36.4 (11)	0.0 (6)	33.3 (9)	5.9 (34)	22.9 (35)
Primary	21.0 (32)	33.3 (18)	29.2 (24)	62.5 (8)	27.3 (11)	25.0 (4)	25.4 (67)	40.0 (30)
Arabic	0.0 (4)		0.0 (1)				0.0 (5)	
Middle/JSS	27.3 (139)	24.2 (33)	56.5 (69)	27.3 (22)	30.3 (33)	41.7 (11)	36.1 (241)	28.4 (67)
Sec./SSS	35.4 (82)	0.0 (6)	72.7 (44)	100.0 (2)	45.0 (20)	100.0 (3)	47.9 (146)	45.5 (11)
Post Sec./Higher	36.4 (22)		78.6 (14)		33.3 (6)		50.0 (42)	
Not Stated	-		100.0 (1)	-		-	100.0 (1)	

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In the case of respondents from Mankrong, not much consistency is shown although generally there is a tilt towards higher current contraceptive use with increasing education of the female adolescent. The absence of a consistent pattern among the females in Mankrong

could be the result of the relatively small number of cases that are involved after controlling for frequency of sexual intercourse.

In sum, what adolescents need to know is that the higher the frequency of sexual intercourse without contraception, the higher the risk of exposure to pregnancy and hence the need to contracept to avoid any unplanned pregnancy.

8.3 Adolescent Sexuality and Childbearing

Sexual activity, without any form of contraception, apart from the immediate satisfaction the actors may derive from it, tends to involve one of four possible outcomes. These are the contraction of a sexually transmitted infection, a pregnancy, abortion or childbearing. Yet, many young persons enter into sexual relations with only the quest for satisfying one's sexual desires in mind. Hence, they ignore or overlook the possibility of occurrence of any of the four outcomes listed above each of which has both short and long term consequences for the socio-economic and personal development of the players involved.

This section therefore analyses the relationship between sexuality and childbearing among the female adolescents in both Cape Coast and Mankrong. Childbearing is defined to include pregnancies and actual number of deliveries a woman has ever had. In this respect, the mean age at first pregnancy and number of children ever born to each female adolescent are the focus of the analysis with a control for age at first sexual intercourse, current age and level of education.

Table 8.5 examines the mean age at first pregnancy controlling for current age and age at first sexual intercourse. The rationale is to find out to what extent the incidence of first pregnancy is a function of the timing of a woman's first sexual activity.

Table 8.5. Mean Age at First Pregnancy Among Female Adolescents by Current Age and Age at First Sexual Intercourse, Cape Coast and Mankrong

Current Age	Age at First Sexual Intercourse							
	<15		15-19		20-24		Total	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
15-19	15.2 (9)	17.5 (2)	17.4 (34)	17.4 (11)			16.9 (43)	17.4 (13)
20-24	17.0 (12)	17.5 (4)	19.0 (103)	19.5 (59)	21.5 (17)	20.4 (7)	19.1 (132)	19.1 (70)
Total	16.2 (21)	17.5 (6)	18.6 (137)	18.8 (70)	21.5 (17)	20.4 (7)	18.6 (175)	18.8 (83)

Note: None of the respondents age less than 15 years had ever become pregnant.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The evidence in Table 8.5 suggests that age at first pregnancy appears to vary directly with the timing of first sexual activity. In this respect, early timing of first sexual activity means early occurrence of first pregnancy among the female adolescents and vice versa. This observation is valid for adolescents in either Cape Coast or Mankrong.

It can also be observed in Table 8.5 that the total mean age at first pregnancy is slightly higher among female adolescents in Mankrong than their counterparts in Cape Coast, a situation which runs counter to the usual finding of a lower age at first pregnancy among rural as against urban residents. On the other hand, it is possible that the relatively lower mean age at first pregnancy in Cape Coast (an urban area) may be due to the anonymity, which urban areas offer in relation to rural areas such that adolescents can indulge in sexual relationships without being noticed in an urban environment in contrast to the closed society which rural areas present.

At the same time, it appears that for both Cape Coast and Mankrong, mean age at first pregnancy is decreasing since in the case of either Cape Coast or Mankrong, it is noted that mean age at first pregnancy is lower among adolescents aged 15-19 years compared to those

aged 20-24 years. This is also contrary to the expectation that with time adolescents have gained more knowledge about how to protect themselves against unplanned pregnancies compared to their older counterparts who might not have benefited from the kind of information that is today available to younger adolescents. On the other hand, the role of modernisation, coupled with the kinds of films that are shown on the television screens many of which demonstrate sexual interrelationships, contribute to the decline in the age at first pregnancy in Ghana. However, the small sample for the analysis at this stage could equally be an underlying factor in the apparent decline in mean age at first pregnancy among the adolescents.

The analysis further examines education as one key factor that influences the timing of first pregnancy. It must be noted that the study did not collect information on the education of the adolescents at the time of first pregnancy, which would have been the most important variable to use to assess the effect of education in determining the timing of first pregnancy among the adolescents. On account of this data limitation, the current level of education of the adolescents is used as a proxy in the analysis in Table 8.6 with the acknowledgment that its contribution may not be much felt due to possible changes in a person's education between the time of first pregnancy and the time of the interview.

Table 8.6. Mean Age at First Pregnancy Among Female Adolescents by Level of Education and Age at First Sexual Intercourse, Cape Coast and Mankrongo

Level of Education	Age at First Sexual Intercourse							
	<15		15-19		20-24		Total	
	Cape Coast	Mankrongo	Cape Coast	Mankrongo	Cape Coast	Mankrongo	Cape Coast	Mankrongo
No Education	16.2 (6)	-	18.0 (12)	18.2 (23)		21.0 (1)	17.4 (18)	18.3 (24)
Primary	16.3 (6)	17.0 (3)	18.3 (24)	18.2 (15)	20.3 (3)	19.7 (3)	18.2 (33)	18.2 (21)
Arabic			19.7 (3)	-		-	19.7 (3)	
Middle/JSS	18.0 (3)	18.0 (2)	18.5 (78)	19.4 (30)	21.6 (12)	21.0 (3)	18.9 (93)	19.5 (35)
Sec./SSS/ Higher	15.3 (6)	18.0 (1)	19.4 (20)	20.5 (2)	23.0 (2)		18.7 (28)	19.7 (3)

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrongo, Aug.-Sept., 1997.

In spite of the limitation already highlighted above, the general pattern, which is depicted in Table 8.6, is that of increasing mean age at first pregnancy with higher education. This observation should be appreciated based on the fact that girls who become pregnant may often not get the opportunity to go further in education. There are, however, some exceptions, which are likely to be the contribution of small sample sizes in some of the cells in the table. In any case, the importance of education in postponing first pregnancies as well as reducing fertility among females has been noted in many studies including the 1988, 1993 and 1998 GDHS reports.

Having examined first pregnancies, the pregnancies that actually resulted in births are further analysed. Similar to the analysis of mean age at first pregnancy, current age and education have been controlled for to examine the extent to which actual childbearing is contributed to by the timing of first sexual intercourse. These have been analysed in Tables 8.7 and 8.8.

In Table 8.7, the general observation is that of an inverse relationship between the timing of first sexual intercourse and mean number of children ever born among the adolescents. The exceptions are in respect of adolescents in Mankrong which are largely the result of small sample sizes of some of the categories. Delaying of first sexual intercourse has therefore the built-in potential in reducing childbearing among female adolescents to enable them continue their education to higher levels.

Table 8.7. Mean Number of Children Ever Born Among Female Adolescents by Current Age and Age at First Sexual Intercourse, Cape Coast and Mankrong

Current Age	Age at First Sexual Intercourse							
	<15		15-19		20-24		Total	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
<15	0.0 (6)				-		0.0 (6)	
15-19	0.30 (27)	0.50 (2)	0.10 (176)	0.24 (42)			0.12 (203)	0.25 (44)
20-24	0.75 (20)	0.75 (4)	0.39 (253)	0.83 (88)	0.24 (54)	1.57 (7)	0.39 (327)	0.88 (99)
Total	0.43 (53)	0.67 (429)	0.27 (429)	0.64 (130)	0.24 (54)	1.57 (7)	0.28 (536)	0.69 (143)

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

One other important observation from Table 8.7 is that the overall mean number of children ever born is higher among adolescents in Mankrong compared to their counterparts in Cape Coast. This is in contrast to the observed relatively lower mean age at first pregnancy among adolescents in Cape Coast compared to those in Mankrong in Table 8.5. This therefore reinforced the earlier finding (Chapter five) of a higher abortion rate and contraceptive prevalence among adolescents in Cape Coast compared to their counterparts in Mankrong. Yet, abortion, apart from being illegal in Ghana, is not a recognised family planning method in the country and hence it cannot be encouraged.

In Table 8.8, similar relationships between age at first sexual intercourse and childbearing can be observed when level of education of the adolescent is controlled for. The results in the table do not show consistency across all levels of education. While for Secondary and Higher levels of education, there appears to be an inverse relationship between age at first sexual intercourse and mean number of children ever born, the situation is to the contrary among adolescents with Primary level of education in Mankrong and Middle/JSS level in Cape

Coast. This unexpected pattern could be the result of the small number of cases in some of the cells. It is also noted that at each category of education, the mean number of children ever born is higher among adolescents in Mankrong than those in Cape Coast, an observation which is very much expected.

Table 8.8. Mean Number of Children Ever Born Among Female Adolescents by Education and Age at First Sexual Intercourse, Cape Coast and Mankrong

Level of Education	Age at First Sexual Intercourse							
	<15		15-19		20-24		Total	
	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong	Cape Coast	Mankrong
No education	1.0 (8)		0.62 (26)	1.06 (34)		3.0 (1)	0.94 (34)	1.11 (35)
Primary	0.54 (13)	0.67 (3)	0.50 (48)	0.75 (24)	0.50 (6)	1.67 (3)	0.79 (67)	0.83 (30)
Basic	0.0 (1)		0.25 (4)				0.20 (5)	
High/JSS	0.18 (17)	0.50 (2)	0.32 (202)	0.45 (62)	0.41 (22)	1.0 (3)	0.32 (241)	0.48 (67)
Sec./SSS	0.18 (11)	1.0 (1)	0.08 (119)	0.10 (10)	0.06 (16)		0.08 (146)	0.18 (11)
Post Sec./Higher	1.0 (3)		0.0 (29)		0.0 (10)		0.07 (42)	
Not Stated	-		0.0 (1)				0.0 (1)	

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

In sum, the importance of delaying first sexual intercourse among female adolescents cannot be over-emphasised. This is evident throughout the analysis in delaying first pregnancies as well as lowering number of children ever born when current age and education of the woman have both been controlled.

8.4 Contraception and Childbearing

Contraception is one of the key proximate determinants of fertility. It is therefore important to find out the extent to which it has contributed to delaying both first pregnancy and actual childbearing among the adolescents that are being studied. Variables used in the analysis include current contraceptive use and contraceptive use at first sexual intercourse while controlling for current age and level of education.

Table 8.9 examines the possible relationship between contraceptive use at first sexual intercourse and the timing of first pregnancy among the adolescents. The table compares the mean age at first pregnancy between adolescents who practised contraception at first sexual intercourse and those who did not.

Table 8.9. Mean Age at First Pregnancy Among Female Adolescents by Current Age and Contraceptive Use at First Sexual Intercourse, Cape Coast and Mankrong

Current Age	Contraceptive Use at First Sex			
	Yes		No	
	Cape Coast	Mankrong	Cape Coast	Mankrong
15-19	17.3 (6)	18.0 (5)	16.9 (37)	17.0 (8)
20-24	20.1 (22)	19.0 (2)	18.9 (110)	19.1 (68)
Total	19.5 (28)	18.3 (7)	18.4 (147)	18.8 (76)

Notes: No one less than 15 years has ever been pregnant. Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

From the table, it is noted that adolescents who practised contraception at first sexual intercourse have a relatively higher mean age at first pregnancy. This observation is valid especially among adolescents from Cape Coast within the two age groups shown in the table. The situation among the respondents in Mankrong, however, appears to contradict this position perhaps due to the small number of cases that are involved especially those who practised some contraception during first sexual intercourse. It is, therefore, in the interest of

adolescents to be provided with adequate information about contraception so that those who are unable to abstain completely from sex at these early ages can protect themselves from early pregnancy through effective contraception even at first sex.

With respect to the nature of the relationship when education is considered in the analysis, Table 8.10 shows no clear consistent pattern. While in some cases, persons who did not contracept at first sex have higher mean age at first pregnancy among some of the educational categories (especially in Mankrong), in other cases mainly in Mankrong the reverse is true. Similarly, there is no clear-cut pattern as to whether education increases or reduces age at first pregnancy among the adolescents as there is not much consistency in the relationship. However, as has been explained earlier, the education being used here is current education and not education of the women at the time of first sexual intercourse, a limitation which could contribute to some of the distortions. Besides, in several instances, not many cases are involved especially those who practised some contraception at first sexual intercourse. It is in this respect difficult to make any valid conclusions although one would expect contraceptive use at first sexual intercourse and increasing education to both affect the occurrence of first pregnancy positively.

Table 8.10. Mean Age at First Pregnancy Among Female Adolescents and Contraceptive Use at First Sexual Intercourse, Cape Coast and Mankrong

Level of Education	Contraceptive Use at First Sexual Intercourse			
	Yes		No	
	Cape Coast	Mankrong	Cape Coast	Mankrong
No Education	17.0 (1)	18.7 (3)	17.4 (17)	18.3 (21)
Primary	19.5 (4)	17.5 (2)	18.0 (29)	18.3 (19)
Arabic			19.7 (3)	
Middle/JSS	19.1 (15)	18.0 (1)	18.9 (78)	19.5 (34)
SSS/Sec.	20.4 (7)	19.0 (1)	18.4 (19)	20.0 (2)
Post Sec./Higher	21.0 (1)	-	12.0 (1)	

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The next stage of the analysis looks at mean number of children ever born among all adolescents who have ever had sexual intercourse by contraceptive use both currently and at the time of first sexual act. In the first stage, Table 8.11 presents information on mean number of children ever born controlling for both contraceptive use at first sex and current age.



Table 8.11. Mean Number of Children Ever Born Among Female Adolescents by Current Age and Contraceptive Use During First Sexual Intercourse, Cape Coast and Mankrong

Current Age	Contraceptive Use at First Sexual Intercourse			
	Yes		No	
	Cape Coast	Mankrong	Cape Coast	Mankrong
<15	0.0 (1)		0.0 (5)	
15-19	0.02 (66)	0.42 (12)	0.18 (137)	0.19 (32)
20-24	0.23 (103)	0.20 (10)	0.46 (224)	0.96 (89)
Total	0.15 (170)	0.32 (22)	0.34 (366)	0.75 (121)

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

From the table, the observation is that overall, a definite pattern is established suggesting that in either Cape Coast or Mankrong, adolescents who practised some contraception at first sex have lower mean number of children ever born in comparison with their counterparts who did not. This is also true for each of the age groups with the exception of adolescents aged 15-19 years from Mankrong where for reasons of perhaps small sample size, those who did not contracept have a relatively lower mean number of children ever born than their counterparts who contracepted at first sexual intercourse.

Considering education, evidence in Table 8.12 is largely in support of a relatively lower mean number of children ever born among adolescents who practised contraception at first sex compared to their counterparts who did not although there are, as usual, some exceptions. Similarly, the contribution of education in lowering fertility is largely demonstrated in Table 8.12. Here, apart from adolescents from Mankrong who practised contraception at first sex, in all cases, there is some inverse relationship between education and mean number of children ever born.

Table 8.12. Mean Number of Children Ever Born Among Adolescent Females
By Level of Education and Contraceptive Use at First Sexual
Intercourse, Cape Coast and Mankrong

Level of Education	Contraceptive Use at First Sexual Intercourse			
	Yes		No	
	Cape Coast	Mankrong	Cape Coast	Mankrong
No Education	1.0 (3)	0.80 (5)	0.68 (31)	1.17 (30)
Primary	0.42 (12)	0.33 (6)	0.53 (55)	0.96 (24)
Arabic		-	0.20 (5)	-
Middle/JSS	0.23 (61)	0.0 (8)	0.35 (180)	0.54 (59)
SSS/Sec.	0.04 (75)	0.33 (3)	0.13 (71)	0.13 (8)
Post Sec./Higher	0.00 (19)		0.13 (23)	
Not Stated			0.00 (1)	-

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

The analysis again, examined the relationship between mean number of children ever born and current contraceptive use controlling, as usual, for current age and education. The results are shown in Tables 8.13 and 8.14.

Table 8.13. Mean Number of Children Ever Born Among Female Adolescents
by Current Age and Current Contraceptive Use, Cape Coast and
Mankrong

Current Age	Current Contraceptive Use			
	Yes		No	
	Cape Coast	Mankrong	Cape Coast	Mankrong
<15	0.0 (1)		0.0 (5)	
15-19	0.06 (70)	0.21 (14)	0.16 (133)	0.27 (30)
20-24	0.27 (127)	0.63 (30)	0.46 (200)	0.99 (69)
Total	0.19 (198)	0.50 (44)	0.33 (338)	0.77 (99)

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

Table 8.14. Mean Number of Children Ever Born Among Adolescent Females
by Level of Education and Current Contraceptive Use, Cape Coast
and Mankrong

Level of Education	Current Contraceptive Use			
	Yes		No	
	Cape Coast	Mankrong	Cape Coast	Mankrong
No Education	0.0 (2)	0.75 (8)	0.75 (32)	1.22 (27)
Primary	0.65 (17)	0.83 (12)	0.46 (50)	0.83 (18)
Arabic	-		0.20 (5)	
Middle/JSS	0.23 (87)	0.32 (19)	0.37 (154)	0.54 (48)
Sec./SSS	0.10 (70)	0.0 (5)	0.07 (76)	0.33 (6)
Post Sec./Higher	0.0 (21)	-	0.14 (21)	
Not stated	0.0 (1)	-		

Note: Number of cases in brackets.

Source: Computed from Adolescent Survey, Cape Coast and Mankrong, Aug.-Sept., 1997.

From both tables (8.13 and 8.14), although relatively more adolescents were found to be currently contracepting in either Cape Coast or Mankrong, the pattern of the relationship is similar to what was earlier observed when considering contraceptive practice at first sexual intercourse. It must, however, be noted that the mean number of children ever born is different in size between the two scenarios. For example, the overall means recorded in Table 8.13 (when current contraceptive use is considered) are relatively higher compared to the figures in Table 8.11 (when contraceptive use at first sex was the focus).

In conclusion, it has been established that with a few exceptions, contraceptive use at first sexual intercourse largely delays first pregnancy and reduces mean number of children ever born among female adolescents when current age and education have been controlled for. It would, however, have been more instructive to find out the role of education at the time of first sexual intercourse, an analysis which was not possible on account of lack of data in that respect.

8.5 Multiple Regression Analysis of the Relationship

The analysis so far has examined individual independent variables as they affect other dependent variables. In a real world situation however, a number of variables interact to impact on other phenomena. It is therefore important to apply an analysis, which sees a number of independent variables as working together in an interrelated manner to explain variations in the dependent variables, if any.

Multiple regression analysis is hereby used to examine the entire structure of linkages between independent variables including age of the woman, current education, household living arrangement, marital status and the reason for having sexual intercourse for the first time, etc., on one hand and each of the dependent variables on the other.

The equation of the analysis is as follows:

$$Y = A + B_1X_1 + B_2X_2 + \dots + B_kX_k + E_i \text{ where}$$

Y is the dependent variable under consideration at a point in time and $X_1, X_2 \dots X_k$ the independent or explanatory factors that have been included in the analysis. On the other hand, $B_1, B_2 \dots B_k$ represent the regression co-efficients for each of the explanatory variables. At the same time, 'A' is a constant when all the explanatory variables are assumed to be non-operative and E_i an error term.

The interest of the study was to carry out a separate regression analysis for the entire sample and separately for each of the study areas i.e., Cape Coast and Mankrong. However, the sample for Mankrong as explained earlier in the study was too small to facilitate such separate study area-specific analysis. As a result, the analysis is carried out for the whole sample i.e., both study areas put together instead of separate analysis for each study area as originally considered.

Originally, three main dependent variables were identified for the multiple regression analysis. These were the age at first sexual intercourse, the number of times ever becoming pregnant and contraceptive use at first sexual activity. The study was interested in finding out the factors that affect the age at first sexual intercourse among the female adolescents. In other words, what are the contributory factors that predispose a female adolescent to having sexual intercourse earlier or later? On the other hand, the factors that help to explain the incidence of pregnancies among the young females were quite important. Here, the actual number of children ever born was not used since many of them had not had any births as at the time of the survey. Besides, the rationale was to be able to capture all pregnancies that might have been aborted. In the case of the third dependent variable, the interest was to find out how adolescents who take to sexual practices could be encouraged to practise contraception during their first sexual act and subsequent ones.

However, the option of the contraceptive use at first sexual intercourse as a dependent variable was abandoned due to the fact that the number of persons who practised contraception was so small that no meaningful results and interpretation could be made of the regression analysis that was attempted. After running the model, it was found that while many of the variables were statistically insignificant, the standard errors were too large as to make the results meaningful. Consequently, the hypothesis that contraceptive use is directly related to the level of education of the adolescent could neither be validated nor rejected.

At the same time, only few variables were run on the remaining dependent variables i.e., age at first sexual intercourse and number of pregnancies ever had for similar reasons. Here too, not many variables were found to be statistically significant. In spite of these limitations, the analysis provides some explanation to some of the questions posed in the statement of the problem. The results are, however, supported by more qualitative information gathered from the focus group discussions.

In Table 8.15, the analysis examines possible factors that could explain the age at first sexual intercourse among adolescent females. The variables considered are the current age of the respondent, household living arrangements (i.e., person(s) with whom the adolescent was living), current education of the respondent, knowledge of the ovulatory cycle and of contraception, contraceptive use at first sex, marital status and reasons given by the adolescents for practising sex at the age they did.

The study acknowledges that many of the variables used are statistically insignificant for reasons of small sample size, considering that just 37 per cent of the respondents had ever had a sexual encounter. When this is further broken down to variable categories, it reduces the statistical significance of the analysis, thus contributing to the large standard errors shown in the table. In spite of this limitation, the results as presented in Table 8.15 are quite useful as

they provide some plausible guide to understanding the relationships. The interpretation of the results should however, be done against the background of the foregoing stated limitations.

Table 8.15. Results of Multiple Regression Analysis on Age at First Sexual Intercourse by Selected Background Variables

Variable	B	S.E	Beta	Sig. F
Age	.4227	.0286	.5366	.0000
Household Living Arrangements				
Both Parents	RC			
Husband	-.9313	.3171	-.1176	.0034
Father Alone	.2128	.2728	.0272	.4356
Mother Alone	.2123	.1907	.0435	.2659
Alone	-1.252	.6939	-.0601	.0718
Other Relation	-.1401	.1700	-.0336	.4068
Unrelated	.3438	.2785	.0439	.2175
Friends	-.1553	.6821	.0075	.8199
Education				
No Education	RC			
Primary	-.2917	.2534	-.0524	.6691
Middle/JSS	-.1033	.2168	-.0264	.6339
Secondary/SSS	.1089	.2548	.0236	.6691
Post Secondary/Higher	.2521	.3489	.0312	.4703
Contraceptive Use at First Sex				
Yes	RC			
No	-.3830	.1498	-.0974	.0108
Knowledge of Ovulatory Cycle				
Yes	RC			
No	.2121	.1354	.0533	.1179
Knowledge of Contraception				
Yes	RC			
No	.0522	.2227	.0093	.8149
Marital Status				
Never Married	RC			
Currently Married	-.1011	.1975	-.0207	.6086
Previously Married	-.5221	.5084	-.0338	.3049
Reasons for First Sex				
Had the Urge	RC			
Mutual Consent	-.3189	.2310	-.0475	.1679
Was of Age	1.0943	.3713	.0994	.0033
Curiosity	-.3040	.2320	-.0449	.1906
Financial Reasons	-.4957	.2325	.0727	.0334
Peer Pressure	.1767	.2245	.0272	.4315
Seduced	-.4107	.2103	-.0683	.0513
Don't Know	.2461	.3048	-.0268	.4197
Constant	8.7152	.6162	-	.0000

R Squared = .3298 F = 13.41

Adjusted R = .3052 RC = Reference Category

Signif. F = .0000

Overall, the variables included in the analysis explained just about one-third (31 per cent) of the variation in the age at first sexual intercourse among the young women under discussion. Although this is quite low, it is understandable in view of the limitations already stated which did not make the inclusion of other variables that were listed in the conceptual framework, which could offer some additional explanation.

At the individual variable level, some observations are worth highlighting in spite of the lack of statistical significance of many of the variables. The first relevant observation is the effect of current age of the adolescent, which suggests that a unit increase in the current age of the female adolescent tends to increase the age at first sexual activity by 0.42 units. In other words, it shows that there has been a decline in the age at first sex over the years. This means that young women are entering into sexual practices earlier in recent times than their older counterparts. This was found to be statistically significant at 100 per cent level of confidence and hence leaves no one in doubt as to what the situation is. This finding is quite consistent with the results shown in Table 4.3 (Chapter four), which shows a general increasing mean age at first sex with higher current age of the adolescent particularly in Cape Coast.

With reference to the views expressed by both adults and adolescents in the focus group discussions, the observed declining trend in age at first sexual activity is not unexpected. While most of the adults condemned the involvement of unmarried adolescents in sexual practices, many of the adolescents, although generally did not support sexual practice by adolescents, nonetheless justified it on the grounds that parents are unable to provide them with their basic needs. It is therefore abundantly clear that if parents would live up to their responsibility towards their children and wards, sexual activity may not be an immediate consideration among many adolescents.

Besides, it has already been established in Table 8.1 that contraceptive use at first sex tends to generally increase with higher age at first sex. This means that when adolescents are

properly taken care of and are able to postpone first sex, it is possible that when they do start at a much older age they may practise contraception which would not only protect them from unwanted pregnancies but also STIs including HIV/AIDS.

The analysis further shows that although the household living arrangements (i.e., the person(s) with whom the adolescent is staying) does not show an overall statistical significance in the results, they nonetheless, provide useful lessons. Of all the categories of living arrangements shown in Table 8.15, the results are statistically significant among adolescents who were staying with their husbands at 99.7 per cent level of confidence and at 92.8 per cent level of confidence among adolescents who were staying alone. The relevant lessons from the results obtained from the analysis of living arrangements are first, adolescents who live all by themselves tend to have first sexual activity the earliest i.e., 1.25 years earlier than their counterparts who live with both of their parents. They are followed by adolescents who stay with their husbands who have 0.93 years earlier entry into sexual activity than their colleagues who live with both parents.

At the same time, females who live with their friends also have 0.15 years of entering into sexual activity earlier than their counterparts staying with both parents although the result is not statistically significant. There is no significant difference between adolescents who live with their fathers alone and those who are with their mothers only. What is not usual is that these two categories of adolescents appear to enter into first sexual activity 0.21 years later than those with both parents.

One would have thought that one of the main factors leading to a young girl staying with only one of the parents is the incidence of broken homes which, in itself has the tendency to lead young children into immoral ways. The reason is that often the care for children in broken homes is not adequate especially when the children are most often forced to depend on

the low income of one of the parents. This, however, cannot be overstretched since the results are not statistically significant.

In terms of education, although none of the categories showed statistically significant results, yet a clear direct relationship appears to emerge between level of education and age at first sexual activity. This implies that the pursuit of higher education is likely to increase the age at which females begin sexual activity. The caution here however, is that the timing of the first sexual activity occurred at a point in time when the educational attainment of the woman might not have been the same as the current educational level (i.e., at the time of the survey).

Another relevant finding, which is also statistically significant at 99 per cent level of confidence is the relationship between contraceptive use at first sex and age at first sex. As is shown in Table 8.15, adolescents who do not practise contraception at first sex are likely to have an earlier sexual practice than their counterparts who use any form of contraception at first sexual activity. Here, adolescents who do not practise contraception at first sex tend to reduce their age at first sexual encounter by 0.38 years in comparison with their counterparts who practise contraception at first sex. The suggestion is that late incidence of first sex is associated with contraceptive use among females. This confirms the hypothesis that there is a direct relationship between contraceptive use at first sex and age at first sexual activity among adolescent females. It is therefore important that first sexual activity is delayed to ensure that when it does take place, the sexual act will reduce the risk of the partners to either unwanted pregnancy or STI or both. Incidentally, the results in respect of knowledge of contraception and the ovulatory cycle are to the contrary although statistically not significant.

Furthermore, while the results appear to show that previously married (divorced, widowed and separated) and currently married females have 0.52 and 0.10 years reduction in their age at first sexual practice, the results are statistically not significant. This may be due to

the fact that as already shown in chapter three, only about 8 per cent of the respondents had ever been in a marital union by the time of the survey.

The reason for one's first sexual practice was included in the multiple regression analysis to find out whether it was important in influencing the timing of the first sexual act. From the results, three reasons namely, a consideration that one was of age to practise sex, financial consideration and the issue of education showed a high level of statistical significance. Among these, financial consideration so far appears to contribute more to reduction in a woman's age at first sexual activity. As shown in Table 8.15, adolescents, who quoted financial reasons for their first sexual encounter have almost 0.50 years reduction in their age at first sex compared to their counterparts who reported that their first sexual practice was based on their conviction that they had the urge to do so. This is quite consistent with the views expressed in the focus group discussions all of which suggested the possibility of young females succumbing to a sexual proposal when financial gains are likely to be the reward. Thus, poverty cannot escape blame in any effort at explaining early sexual practices by adolescents in recent times.

In the second multiple regression analysis, the number of pregnancies ever had by the respondents was the dependent variable on which selected variables were run. These variables were the current age of the adolescent, current level of contraceptive use at first sex, knowledge of the ovulatory cycle and of contraception, age at first sex and marital status. The living arrangements and reasons given by the adolescents for first sexual activity were excluded in the second model as they were statistically shown to have little or no relationship with the number of pregnancies the adolescents had ever had.

The results presented in Table 8.16 show relatively lower standard errors, with all but one variable, namely knowledge of the ovulatory cycle being statistically significant at 95 per

cent level of confidence. Overall, the variables included in the analysis explained 39 per cent (R Squared) of variation in number of pregnancies among the female adolescents.

From the results shown in Table 8.16, age appears to relate positively with number of pregnancies ever experienced by the adolescent females. This is to be expected since older adolescents are likely to have a longer period of sexual exposure relative to their younger counterparts. Besides, a relatively higher proportion of the youth of 20-24 years were found in Chapter three to have ever been married. Thus, since marriage exposes women to a higher risk of pregnancy, it follows as a matter of course that pregnancy incidence will increase with increasing age of the woman especially in a society where contraceptive use particularly among adolescents is quite low.

Table 8.16. Results of Multiple Regression Analysis on Number of Pregnancies Ever Had by Selected Variables in Respect of Adolescent Females in Cape Coast and Mankrong

Variable	B	S.E	Beta	Sig. F
Age	.1363	.0140	.3723	.0088
Education				
No Education	RC			
Primary	-.2711	.1094	-.1048	.0135
Middle/JSS	-.3998	.0935	-.2198	.0000
Secondary/SSS	-.5369	.1084	-.2500	.0000
Post Secondary/Higher	-.8626	.1474	-.2295	.0000
Contraceptive Use at First Sex				
Yes	RC			
No	.1817	.0646	.0994	.0050
Knowledge of Ovulatory Cycle				
Yes	RC			
No	-.0990	.0586	.0536	.0917
Knowledge of Contraception				
Yes	RC			
No	.2491	.0949	.0959	.0088
Age at First Sex	-.1054	.0164	-.2268	.0000
Marital Status				
Never Married	RC			
Currently Married	.7685	.0772	.3378	.0000
Previously Married	.5858	.2190	.0817	.0077
Constant	-.2492	.2935	-	.3960

R Squared = .4010

Adjusted R = .3912

F = 40.60

Signif. = .0000

R.C. = Reference Category

In terms of education, Table 8.16 shows clearly that the educational level of the adolescent relates inversely with the number of pregnancies she will ever had. In other words, the possibility of childbearing relates indirectly with an adolescent's level of education. This finding therefore validates the hypothesis that there is an inverse relationship between education and childbearing among adolescent females. The results are statistically significant at 100 per cent level of accuracy for almost all levels of education. For example, Post-Secondary/Higher level of education of the adolescent reduces number of pregnancies ever had by 0.86 compared to adolescents who have no education.

The results further show that contraceptive use at first sex appears to relate indirectly with childbearing risks, i.e., number of pregnancies ever had. Quite clearly, female adolescents who did not practise contraception at their first sexual activity had 0.18 unit increase in number of pregnancies ever had compared to others who practised contraception at first sexual intercourse. This is statistically significant at 100 per cent level of confidence, and hence, validates the hypothesis that there is an inverse relationship between adolescent childbearing and contraceptive use at first sex. Similar results are observed in respect of the relationship between contraceptive knowledge and number of pregnancies ever had. Here, at about 99 per cent level of confidence, adolescents who had no knowledge about any method of contraception showed a 0.24 unit increase in the number of pregnancies ever had compared to their counterparts who had some knowledge of contraceptive methods.

While these findings point to positive developments, they do suggest that more public education should be done among the general population in Ghana particularly among the adolescents. This is on account of the apparent misconceptions among many adolescent and adult respondents during the focus group discussions as to whether unmarried sexually active adolescent females should use contraception. Incidentally, their views, particularly in Cape Coast, that the exposure of adolescents to contraceptive knowledge and use by the sexually

active among them would lead to sexual promiscuity and negative reproductive health impacts on the adolescents are not supported by the regression analysis, the results of which are presented in Table 8.16.

On the other hand, knowledge of the ovulatory cycle, i.e., when in a woman's reproductive cycle she is likely to be pregnant, does show a contrary relationship with pregnancy incidence. The observation in Table 8.16 shows that female adolescents who had no knowledge of the ovulatory cycle have 0.10 unit reduction in the number of pregnancies ever had in comparison with their counterparts who indicated knowledge of the ovulatory cycle. This is significant statistically at 90 per cent level of confidence. This is unexpected since ideally, knowledge of when a woman could be pregnant during her reproductive cycle could be an important asset if she wants to avoid an unwanted pregnancy. It is however, possible that girls who have ever become pregnant learnt of when a woman could be pregnant during her ovulatory cycle as a matter of experience. Further research in respect of this relationship would therefore be useful.

The relationship between age at first sexual activity and number of pregnancies ever had among the female adolescents clearly confirms the hypothesis of an inverse relationship between age at first sexual intercourse and childbearing among adolescents. Here, increasing age at first sexual intercourse produces declining number of pregnancies among the female adolescents. Specifically, a unit increase in age at first sex result in 0.10 unit reduction in the number of pregnancies ever had (and for that matter childbearing risks) at 100 per cent level of confidence. This supports the observation that substantial delay in first sexual practice among females is likely to contribute largely to higher reduction in unplanned pregnancies.

Finally, as expected, the analysis shows quite clearly that marriage among adolescents has the tendency to increase number of pregnancies. The evidence is that currently married female adolescents had 0.76 unit increase in number of pregnancies ever had compared to their

counterparts who had never married. The increase in respect of adolescents who were previously married was 0.58 unit in comparison with those who have never married. These results are statistically significant at 100 per cent and 99 per cent level of confidence respectively among currently married and previously married female adolescents (Table 8.16).

In sum, most of the statistically significant results obtained in the multiple regression analysis do not vary from those arrived at in the cross tabulation analyses earlier made in this chapter. It has been established from the cross-tabulations that early sexual activity is likely to produce early first pregnancies among the female adolescents studied. Similarly, the regression analysis found an inverse relationship between age at first sex and number of pregnancies ever had. In other words, early first sex could lead to early and frequent pregnancies.

Furthermore, it was found from the cross-tabulations that with few exceptions, contraceptive use at first sex largely delays first pregnancy and reduces mean number of children ever born. This was partly confirmed in the regression analysis, which concluded that contraceptive use at first sex tends to reduce number of pregnancies ever had among the females. At the same time, a declining age at first sex and increasing number of pregnancies with age of the adolescents have also been underscored as key findings while number of pregnancies ever had has also varied inversely with the woman's current level of education.

On the whole, the major explanatory factors for the variation in age at first sexual intercourse among the female adolescents in the two study areas (based on the level of significance) have been the adolescents' current age, contraceptive use at first sex and financial reasons. These factors therefore, form the basis for a female adolescent's involvement in first sexual activity. In addition to these factors, a young woman's age, contraceptive knowledge, marital status and current level of education have been found as the most important factors in understanding the variation in number of pregnancies ever experienced among the female adolescents.

SUMMARY, RECOMMENDATIONS AND CONCLUSION

9.1 Summary of Findings

The study of Adolescent Sexuality, Contraceptive Use and Reproductive Health was borne out of the increasing concern expressed about the magnitude of problems that adolescents face. These have mainly resulted from their early entry into sexual activity at a time when majority of them do not have adequate knowledge about sexuality and reproductive health. The knowledge of many adolescents about reproductive health issues is also hampered by the socio-cultural environment in Ghana, which does not embrace open discussions of sexuality issues not only with adolescents but the entire population as a whole.

The study therefore sought to provide answers to research questions including age at sexual activity among females, peculiar factors that are contributory to adolescents' decision to enter into sexual activity; the fundamental barriers in the way of adolescents with respect to contraceptive practice; and ways by which adolescents could be positively influenced to either abstain completely from sex or practise safer sex which would save them from unplanned pregnancies and, or sexually transmitted infections including HIV/AIDS.

The overall objective of the study was to examine the magnitude of reproductive health related problems that pertain to adolescent sexuality and contraceptive use as a basis for evolving strategies that are effective enough in combating the incidence of adolescent childbearing in the Central Region in particular and Ghana as a whole. The choice of Cape Coast and Mankrong in the Central Region as the study areas was informed by the reported highest rates of adolescent fertility in the Central Region in comparison with other regions with reference to the 1993 GDHS report. Cape Coast, the regional capital and Mankrong, a village in the hinterland of the region

were chosen to facilitate a comparison between a rural settlement and the regional capital. The two study areas in the Central Region were therefore purposively selected.

Structured interviews with female adolescents and focus group discussions (especially for adolescents and adults separately in either study area) were conducted in the two study areas. The analysis is therefore both quantitative and qualitative. A sample of 1,828 adolescents (1,503 in Cape Coast and 325 in Mankrong), aged 12-24 years were interviewed. In addition to simple statistical techniques including proportions and means, multiple regression analysis was employed to study the interrelationships that were identified in the conceptual framework. Five hypotheses were examined in the study.

The study acknowledges a limitation of its restriction to Cape Coast and Mankrong and hence making its findings not truly representative of the whole of the Central Region. Besides, information on the education of the adolescents at the time of their first sexual practice was not collected and hence made it quite difficult to understand the impact of education especially on the sexual behaviour of adolescents pertaining to their initiation into sexual practice.

The analysis was based on data collected from the households and individual adolescent women. In the household analysis, it was found that Mankrong had higher proportions of female-headed households compared to Cape Coast. At the same time, Mankrong had relatively higher proportions of younger and older heads of household than in Cape Coast. This situation was attributed to high rates of out-migration of the economically active males in their middle ages from Mankrong, a rural community, to Accra and other towns for white-collar economic opportunities.

The average household size for the two study areas was found to be 5.3. Cape Coast, however, had a higher household size of 5.6 compared to 5.2 in Mankrong. This was again

attributed to possible out-migration from Mankrong, relative to Cape Coast. Within Cape Coast, however, it was evident that areas classified as having high socio-economic status were found to have relatively higher household sizes, in comparison with areas of low socio-economic status. By region of birth, however, the study population was found to be more homogeneous by virtue of the fact that more than two in three persons were born within the Central Region. Migrants from other regions of the country were therefore in the minority in the sample.

The analysis of data pertaining to the socio-economic status of the households showed that female adolescents in Cape Coast were from relatively higher socio-economic status households compared to their counterparts in Mankrong. This is largely in respect of their possession of basic household facilities including electricity, means of transport, radio, television and refrigerator. Quite consistently, majority of the household heads perceived their households to belong to the medium status class while in Mankrong, the perception was more of a low status class. Access to sexuality and reproductive health information could therefore be more available to adolescents in Cape Coast than in Mankrong.

Examining the background characteristics of the adolescents showed that majority of them had Middle or Junior Secondary School level education. Overall, however, adolescents in Cape Coast had relatively higher education than their counterparts in Mankrong. On the other hand, a large proportion of them were never married especially in Cape Coast where only 5 per cent had ever married compared to 20 per cent in Mankrong. At the same time, half of the adolescents in Cape Coast were migrants compared to 30 per cent in Mankrong where the situation was more of out-migration than the reverse. A high proportion of those classified as migrants were reported to have been born in the Central Region, and hence constituted intra-regional migrants. According to majority of the adolescent migrants, they moved with their parents and hence, did not at any time

make any personal decisions to migrate. On account of this, and as was suggested from the focus group discussions, streetism, as far as adolescents are concerned is not a problem in either study area.

In terms of religion and ethnicity, there was not much variation found among the adolescents. Majority of them were Protestant by religion. For the other religions, the only major difference between the two study areas was that while about one in four of them was Catholic in Cape Coast as against just 9 per cent in Mankrong, one in 8 of them in Mankrong was a Muslim compared to eight per cent in Cape Coast. With respect to ethnicity, close to two-thirds of the adolescents were Fanti. At the same time, majority of the adolescents were students at the time of the survey. However, among those who were employed, many of them were in services in Cape Coast as against sales in Mankrong, in spite of Mankrong being a farming community. With reference to the household living arrangement, it was found that while one in three of the adolescents was living with both parents in Cape Coast, the situation in Mankrong was two in five adolescents.

The analysis on adolescent sexuality found that the proportion of adolescents ever having sex increased with higher age of the adolescent with the higher proportions having sex in Mankrong vis-à-vis Cape Coast. On the other hand, although mean age at first sex was found to be almost the same in the two study areas (16.9 years in Cape Coast and 17.0 years in Mankrong), a relatively higher proportion of the adolescents in Cape Coast start sexual intercourse earlier than their counterparts in Mankrong. It was also found that mean age at first sex increased with higher age, suggesting plausibly that there has been a decline in age at first sex among the adolescents over the years.

A look at mean age at first sex with reference to the household living arrangements also showed that adolescents who were living with their husbands tended to have the earliest age at first sex and were followed by others who were living with other relations other than their own parents. Yet, the kind of person the adolescent was living with did not appear to show any defined pattern with respect to the timing of first sex among the adolescents.

On the other hand, there was increasing age at first sex with higher education of adolescents except that in Mankrong no clear pattern was shown, adolescents with no education having the highest mean age at first sexual intercourse compared to other educational categories. Differences among the adolescents in Mankrong by education were however small.

Religion was also found to have no consistent pattern of influence on the timing of first sex among the adolescents. While in Mankrong, Muslim adolescents recorded the highest mean age at first sex, in Cape Coast, it was among the Catholic and Pentecostal/Charismatic adherents.

In terms of recent sexual activity (i.e., within the past one month preceding the survey), the study found that half of the adolescents who had ever had sex reported to have had no sex during the past month preceding the survey. Frequency of sexual activity was, however, found to be higher among younger adolescents compared to older ones. At the same time, three in four sexually active adolescents had regular sexual partners with a higher proportion in Mankrong as against Cape Coast. However, the timing of first sex did not seem to have anything to do with whether or not an adolescent had regular sexual partner. This is because the current regular sexual partner might not have been the one with whom she first had sex. As high as 82 per cent of first sex took place when the adolescents were 15-19 years.

Again, the male sexual partners were reported to be much older than the adolescents although the sexual partners of the never married adolescents were much younger compared to

those of the married. Besides, at first sex, it was found that the male partners were older than the females, suggesting that females become sexually active earlier than their male counterparts. While this was contrary to earlier findings such as Nabila and Fayorsey (1996), it was explained that whether it is the male or female, first sex usually may occur with persons who are sexually more experienced and hence much older. It is, therefore, not easy to determine whether it is the male or female who first has sex in these circumstances.

Generally, although the adolescents did not approve of pre-marital sex, especially with what they called “sugar daddies”, some of them felt that there is nothing wrong with it if it is for financial gains. Some of them also felt that they have sexual relationships with older and rich persons in order that the rich persons would take care of them (the girls) and their boy friends. This suggests that many of the young women who sexually befriend older men also have other sexual partners (preferably of their age), a situation which prepares fertile grounds for the transmission of sexually transmitted infections.

Some of the adolescents blamed some parents for encouraging their daughters to have sexual affairs with richer but older men for financial gains not only to the girl but to the parents as well. Clearly, the high indignation expressed by the adolescents against pre-marital sex was not translated into abstinence by many of them. Among the major reasons cited by the adolescents for entering into sexual intercourse for the first time included ignorance particularly at younger ages less than 15 years and peer pressure, although a relatively larger proportion of the adolescents in Mankrong said they had a natural urge for sex at the time they did it for the first time.

On the specific reasons why pre-marital sex is going on in spite of the expressed condemnation of it by majority of the adolescents, many of the adolescents were quite clear that older men drag adolescents into it. They also thought it was for financial reasons especially in

situations where parents are unable to take care of their adolescent children. Some of them, particularly in the focus group discussions, blamed the situation on modernisation of the Ghanaian society, which with reference to some of the films shown on the television screens, tends to glorify sexual relationship involving unmarried adolescents as a modern practice. In addition, peer pressure was cited as a big force. Besides, while some of them felt one could not stay without sex if not married, others thought that pre-marital sex is a way by which one could gain some experience before marriage.

The main regular source of sexuality information among the adolescents was from friends and, to a lesser extent, teachers. This demonstrates the role of peer pressure, which may lead to wrong information, which in turn, may produce wrong outcomes. There was, however, evidence to suggest that knowledge that first sex could result in a pregnancy increased with the age of the adolescent. Yet, quite a substantial proportion of them (a quarter in Cape Coast and almost half in Mankrong) were not aware that first sexual act could result in pregnancies.

They were, however, very much aware that sexual activity could bring about problems such as unplanned pregnancy which could lead to school drop out and sexually transmitted infections including HIV/AIDS. Thus, although knowledge about these problems were high among the adolescents, many of the sexually active were not practising safe sex.

Analysis of marriage among the adolescents also showed that although over 80 per cent of them were not married at the time of the survey, analysis of age at first marriage among the few that were ever married showed possible decline in age at marriage with not much difference between mean age at first marriage at Mankrong (19.5 years) and Cape Coast (19.7 years). In spite of this, majority of them thought the ideal age at marriage should be between 20-25 years although some of them were reported to have been married at less than 18 years. Furthermore, the

analysis showed that while overall, adolescents who reported that their decision to marry at the time they did was influenced by friends married the earliest, in Cape Coast, the earliest marriages were among those whose marriages were influenced by other relations. In Mankrong, the earliest age at marriage was among first marriages found to have been influenced by the male partners.

One important finding in the study was that more than half of the marriages in Mankrong and 43 per cent in Cape Coast were pregnancy-induced. There were, however, higher proportions of such marriages within ages 20-24 years compared to less than 20 years in Cape Coast while in Mankrong, the situation was to the contrary. This is an indication that, but for the occurrence of a pregnancy, many of the adolescents might not marry at the time they did. Given the opportunity therefore, many of them would like to postpone their marriages to later ages.

Age at first pregnancy was also analysed among the adolescents and was found that overall, the incidence of pregnancy was low. However, it was relatively higher in Mankrong than in Cape Coast although the proportion with higher number of pregnancies was higher in Cape Coast than in Mankrong. Proportionally, however, higher number of pregnancies occurred among adolescents of 20-24 years than their counterparts of less than 20 years. An inverse relationship between age at first pregnancy and number of times ever pregnant was also noted. On the other hand, high education appeared to reduce the incidence of pregnancy among the adolescents.

Age at first birth was also found to be relatively lower in Mankrong than Cape Coast in spite of the fact that age at first pregnancy was lower in Cape Coast than in Mankrong. Again, with age at first birth increasing with higher age, the possibility that age at first birth has declined over the years was noted.

With respect to actual childbearing, it was found that births in the 12 months preceding the survey were higher in Mankrong than in Cape Coast. However, childbearing within ages less than 20 years was higher in Cape Coast than in Mankrong.

Furthermore, information analysed on births ever had and number of times ever becoming pregnant showed that report on abortion was an understatement. In spite of this, reported abortion rate was higher in Cape Coast than in Mankrong. Reasons given on why some of the adolescents resorted to abortion included their desire to complete their education especially in Cape Coast in addition to the fact that the male partner was not working or was financially not responsible. However, a higher proportion (74.3 per cent) of the reported abortion cases was said to have been carried out in health facilities and by qualified medical personnel especially in Cape Coast. In Mankrong, however, one in three of the cases was reportedly, assisted by friends and 8.3 per cent by self-inducement.

The views of the adolescents particularly in the focus group discussions pointed to a total disagreement on abortion for fear that it could result in the death of the girl or confer on her, life-long health and childbearing consequences and complications. The adolescents instead agreed that pregnant girls should be assisted to go back to school after delivery. The few who indicated they might consider abortion thought that it may be good if there is no hope to care for the child.

Another important finding was that a higher proportion of the pregnancies among the adolescents occurred while they were in school at ages less than 20 years. Yet, while in Cape Coast, only 38 per cent of the adolescents who became pregnant while in school dropped out of school, as high as 81 per cent of their counterparts in Mankrong could not continue school on account of the pregnancy. The consensus among the adolescents was that when girls become

pregnant while in school, they should be assisted to return to a new school to avoid embarrassment while there is someone at home to take custody of the baby.

It was also found that the desire for children decreases with higher age of the adolescent. The proportion of adolescents who desired number of children in accordance with what they termed the “will of God” was, however, higher among adolescents with primary education (23.7 per cent in Cape Coast and 61.1 per cent in Mankrong) compared to those with no education (19.0 per cent in Cape Coast and 37.7 per cent in Mankrong). Apart from this, there was a tendency for them to desire fewer number of children with rising level of education.

In the assessment of the knowledge of reproduction, it was found that more than half of them did not know when pregnancy could occur in a woman’s ovulatory cycle. While about 42 per cent of adolescents in Cape Coast knew this, only a quarter of their counterparts in Mankrong had this knowledge. Overall, knowledge of the ovulatory cycle was higher with higher age of the adolescent. Again, with the exception of a rather low knowledge of the ovulatory cycle among adolescents with Primary education as against no education, knowledge of the timing of pregnancy in a woman’s menstrual cycle increased with higher education.

The investigation into the knowledge of the adolescents about contraception also showed that overall, knowledge increased with higher age of the adolescent with adolescents in Cape Coast having a higher knowledge of contraception, adolescents with no education reported a relatively higher knowledge than their counterparts with Primary and Middle/JSS level of education. The pill happened to be the most commonly known contraceptive method, followed by condom in either Cape Coast or Mankrong. This was consistent with earlier studies including that of Nabila and Fayorsey (1996) in Accra and Kumasi.

On contraceptive use, the finding was that of low use at first sexual intercourse. There was, however, a tendency for use to increase with higher age at first sex. Similarly, there was higher contraceptive use at first sex with higher education of the adolescent especially in Cape Coast. Furthermore, while condom was the most commonly used method of contraception at first sex in Cape Coast, for their counterparts in Mankrong, it was the pill. Quite importantly, there was a gap between knowledge of possible pregnancy occurrence at first sex and contraceptive use at first sex, suggesting a case of an unmet need for contraception. The major reasons cited by the adolescents for non-use of contraception, however, were lack of knowledge of contraception and partner disapproval.

It is noteworthy to state that with reference to current use of contraception, a much higher use was found among the sexually active adolescents of 15-19 years than the 1998 GDHS reported in Ghana for same age group of female adolescents. From the focus group discussions, it was explained that the non-use of contraception among many adolescents is because for many of them sex is unplanned and hence the spontaneity of the act precludes the thought of any use of contraception.

Responses about the need for adolescents to consult with their parents on contraceptive use were mixed. One fundamental reason cited by those who did not think it was prudent to consult with one's parents, however, was that matters of contraception should be left entirely to the two sexual partners. It was also found that half of the adolescents in Cape Coast and close to half in Mankrong were in agreement that sexually active adolescents should have access to contraception. Such an agreement was also found to increase with higher age and education of the adolescent. Yet, about 40 per cent of them were in disagreement, many of them supporting their disagreement with the reasons of religious prohibition and that sex is only for married persons.

Furthermore, it was found that majority of the adolescents did not think that teaching adolescents family life education (FLE) would make them sexually promiscuous. Contrary to expectations, it was found, especially among adolescents in Cape Coast, that the perception that the teaching of FLE could lead to sexual promiscuity tended to increase with higher education of the adolescent. However, in the focus group discussions, the opinions were mixed, with males particularly in support of teaching of family life education among adolescents. The consensus that appeared to permeate the discussions was that it would depend on the approach used in teaching FLE as well as the expertise of the person doing the teaching. For example, some of them felt teachers are not the best persons to teach FLE because normally their students do not take them seriously. Most of them therefore recommended that trained nurses should be equipped to teach FLE in schools.

The analysis further showed an overwhelming support for the establishment of counselling centres on contraception and reproductive health for adolescents, many of them citing clinical nurses as the best persons to undertake family planning counselling to adolescents. Others thought it would be useful to involve parents and Community-Based Service Providers. Teachers were considered as the third in order of preference especially in Cape Coast as the best persons for family planning counselling. While in the focus group discussions, the need to involve parents, nurses and teachers in counselling was endorsed by the adolescents, it was recommended that trained nurses should be attached to schools to offer this kind of counselling services to the pupils.

Another important finding was that there was high knowledge among the adolescents that they could contract some STIs if they engaged in unprotected sex. Such a knowledge also increased with both higher age and education of the adolescent. HIV/AIDS was noted as the most commonly known sexually transmitted infection, followed by gonorrhoea that one could contract

through sex. Some of them, however, mentioned STIs to include diseases such as cholera (2.1 per cent), chicken pox (12.7 per cent in Cape Coast and 79.8 per cent in Mankrong), diabetes (0.1 per cent in Cape Coast) and malaria (1.6 per cent in Cape Coast and 3.3 per cent in Mankrong). There is therefore some confusion and misconception in the minds of some of the adolescents with respect to what are STIs.

On the other hand, only nine adolescents in Cape Coast and three in Mankrong reported ever contracting an STI. This was considered to be due to either the difficulty of many people to openly report on their STI experience or the inability of females to detect an STI infection in the early stages of infection until their attention is drawn to it by their sexual partners. On the contrary, a relatively higher percentage of them (6.9 per cent in Cape Coast and 2.2 per cent in Mankrong) claimed to have known other persons who have ever contracted an STI. The results on where these persons sought treatment indicated that close to half of them reportedly sought treatment outside the main health delivery system, a situation, which suggests some kind of self-medication or not seeking treatment at all.

HIV/AIDS was singled out as a major STI and investigated as to the knowledge of the adolescents on its transmission and how to avoid being infected. The results showed that there was high knowledge among the adolescents that HIV/AIDS could be contracted through sex. Other modes of transmission such as kissing were mentioned by a small proportion of the adolescents (2.6 per cent in Cape Coast and 1.2 per cent in Mankrong). Yet, 15 per cent and almost half the adolescents in Cape Coast and Mankrong respectively, never mentioned sexual intercourse as a possible mode of HIV/AIDS transmission. With respect to how to avoid its infection, however, sexual abstinence, keeping one sexual partner and condom use were the most commonly mentioned means.

Furthermore, it was found that there is a higher probability for females to use contraception at first sex if first sex is delayed. There was also an increasing contraceptive use with higher frequency of sexual intercourse particularly in Mankrong. At the same time, a higher contraceptive use was found with increasing level of education of the adolescent.

As regards childbearing, it was found that age at first pregnancy tends to vary directly with the timing of first sexual activity. There also appeared to be a decline in age at first pregnancy in either study area. Age at first pregnancy was, however, slightly higher in Mankrong than in Cape Coast. There was also a higher age at first pregnancy with higher education as well as an inverse relationship between the timing of first sex and children ever born among the adolescents except in Mankrong where at all levels of education, children ever born was higher than in Cape Coast.

The analysis on contraception and childbearing also showed that adolescents who used contraception at first sex had a higher age at first pregnancy especially in Cape Coast. The small sample size in Mankrong, however, appeared to contradict the situation. The relationship between level of education and incidence of first pregnancy also did not show any consistency. There was, however, smaller number of children ever born with higher education. At the same time, adolescents who practised contraception had a relatively smaller number of children ever born in contrast with those who did not practise contraception at first sex. Similarly, sexually active adolescents who currently practised contraception had a smaller number of children ever born relative to those currently not using any form of family planning.

The results of the multiple regression analysis showed that overall, the selected variables explained 31 per cent and 39 per cent respectively of the variations in age at first sexual intercourse and number of pregnancies ever had. At the individual variable level, there was found to be declining age at first sex over the years at 100 per cent level of confidence. This situation

was explained by most adolescents in the focus group discussions to be due to poor parental care for adolescents. It was also found that adolescents who live all by themselves have the earliest age at first sex followed by others who live with their husbands.

Furthermore, the analysis confirmed the hypothesis that there is a positive relationship between contraceptive use at first sex and age at first sexual activity among the female adolescents. This means that persons who use contraception at first sex are also likely to delay the ~~timing~~ timing of first sexual activity. Besides, financial considerations contributed more to the reduction in an adolescent's age at first sexual activity, a finding which was consistent with the views expressed by the adolescents in the focus group discussions.

With respect to the number of pregnancies ever had, the multiple regression analysis showed that number of pregnancies increased with increasing age of the adolescent. An inverse relationship between level of education and number of pregnancies ever had was also found, thus validating the hypothesis of an inverse relationship between level of education and childbearing. Again, at 100 per cent level of confidence, the analysis confirmed the hypothesis that there is an inverse relationship between adolescent childbearing and contraceptive use at first sex. Knowledge of any method of contraception was also found to relate to lower number of pregnancies ever had.

Another major finding which was quite unexpected was that persons who reported to have knowledge of the ovulatory cycle had a higher number of pregnancies relative to their counterparts without this knowledge. It was, however, explained that it is possible that girls who become pregnant might have learnt about the ovulatory cycle as a matter of experience.

Analysis of the relationship between age at first sexual activity and number of pregnancies ever had confirmed the hypothesis of the existence of an inverse relationship between age at first

sexual intercourse and childbearing among the adolescents. Again, as expected, the analysis showed that marriage tends to increase number of pregnancies ever had as the currently married adolescents were found to have the highest number of pregnancies compared to their counterparts who were never married at 100 per cent level of confidence.

On the whole, the results of the multiple regression analysis did not contradict those of the cross-tabulations. At the same time, they were supported in various ways by views expressed during the focus group discussions either in Cape Coast or Mankrong.

9.2 Policy Implications and Recommendations

The study has come out with relevant findings, which have policy implications for the socio-economic and reproductive health development of adolescents not only in Cape Coast and Mankrong in the Central Region but Ghana as a whole. This section highlights the major policy implications and relevant recommendations made to address them.

9.2.1 Abstention From Sex

The results of the study have shown quite clearly that although majority of the adolescents do not approve of pre-marital sex, many of them are unable to abstain from sex and by so doing subject themselves to avoidable risks of teenage pregnancy and STIs including HIV/AIDS. The policy challenge therefore is how to equip young girls to be able to abstain from sex until they eventually get married or are in a position to practise safe sex. At the same time, many parents are unable to educate their children on sexual matters as effectively as possible. There is therefore an unmet need for sexuality education.

This study therefore recommends that the country's educational policy should be re-examined and modified to address the observed unmet need. The Ministry of Education, Youth and Sports and the Ghana Education Service should consider making Family Life Education a separate subject and detached from the Social Studies course as a way of giving it a priority. Besides, teaching of this course (FLE) should begin quite early possibly at primary class four since the current wave of information technology is subjecting children to all kinds of information including sexual issues at very early ages.

The foregoing recommendation would be more effective if family life education is also made a compulsory or core subject in the curricula of the teacher training colleges so that teachers would come out already equipped to teach the subject effectively. The guidance and counselling co-ordinators of the various schools should also be made to attend sexual and reproductive health counselling training in order for them to play their respective roles more effectively. It should therefore be made a policy that new guidance and counselling co-ordinators should have adequate training in sexual and reproductive health particularly as pertains to adolescents. Alternatively, as was recommended by the adolescents in the focus group discussions in the study, qualified clinical nurses with reproductive health counselling training should be attached to the schools to offer counselling support particularly on reproductive health to the guidance and counselling co-ordinators of the schools. This is because according to many of the adolescents in the study, teachers who teach family life education in schools are not taken seriously by students.

The media should also be targeted with accurate information through seminars and workshops on reproductive health pertaining to adolescents in order that media practitioners would be in the right position to address adolescent sexual and reproductive health issues in their day-to-day programmes whether in the print or electronic media.

9.2.2 Abortion

Another finding that has policy implications is related to abortion, which clearly was under-reported in the study. Although almost all the adolescents were not in support of abortion, the evidence pointed to possible high rates of abortion among the sexually active adolescents particularly in Cape Coast. In response to this, it is recommended that intensive and sustained public educational campaigns should be mounted against induced abortion in Ghana. This should be done by educating adolescents about the short and long term health implications of criminal abortion on the female. The educational campaign should also disabuse the minds of some adolescents that a bortion is a family p lanning m ethod. T his is b ecause as already noted in this study (section 5.4), some sexually active adolescents in Ghana do not practise contraception because of their thinking that they could always go for an abortion any time they become pregnant. This perception ought to be discouraged in all reproductive health programmes that target adolescents in Ghana.

Additionally, public education campaigns against HIV/AIDS should include the dangers of abortion as it affects the health of abortion victims. The campaign on condom use should equally emphasize abstinence as the surest way to avoid HIV/AIDS as well as STIs. Perhaps, it is about time the Ministry of Education encouraged the formation of Virgin and Secondary Virgin Clubs in schools and colleges as a way of bringing the dignity and virtues of virginity to the fore as one national objective. Guidelines for the formation of these clubs countrywide should however be carefully discussed and evolved by the Ministry of Education and the Ghana Education Service in collaboration with religious bodies in the country. A reward and incentive system should also be built into the organisation of these virgin clubs not only for girls but boys as well.

Girls need to be empowered to abstain from sex. This calls for special training. In Ghana, there is the thinking among males that when girls say no to sex, they don't mean it. The girls must therefore be taught how to use both verbal and body language to let their no be no, and yes be yes.

9.2.3 Youth Counselling Centres and Family Planning Education

There was a high degree of interest expressed by the adolescents in the role of youth centres in equipping them in avoiding sexual and reproductive health problems. While a few of the youth centres particularly of the Planned Parenthood Association of Ghana (PPAG) are doing well, it is recommended that the National Population Council (NPC) and other population implementation agencies should lobby Parliament to consider passing a law that would enjoin all District Assemblies to establish District Youth centres where all young persons could go for recreation and counselling on all issues including sexual and reproductive health. This is considered very important in view of the finding that parents are unable to effectively counsel their children on sexual issues. The Central Government should however, support the District Assemblies by increasing the District Assembly Common Fund to ensure that the District Assemblies would have the resources to establish these youth counselling centres and make them.

With respect to the observation made by many of the adolescents to the effect that they take to sex especially with older persons for financial considerations, (especially as parents are unable to meet their needs) it is recommended that the campaign on having the number of children one could possibly take care of should be intensified throughout the country. Alongside these campaigns, Government should find measures to address the issue of low wages and salaries of workers in Ghana so that they (workers) could in turn adequately take care of their children in order that they would not take sex as an alternative to meet their needs. Yet still, some parents are

just not responsible and hence existing policies or laws that are to ensure that parents particularly fathers shoulder their responsibilities especially to their children should be strengthened and implemented to achieve more positive results.



9.2.4 Future Research

In terms of future research, one limitation of this study was that it failed to collect information on the education of the adolescents at first sexual intercourse. Thus, it could not relate very well the effect of education on a person's timing of first sexual activity. Future research should therefore take note of this need and include it in the data collection stage to facilitate such an important analysis. Future research should additionally collect information on adolescents' future aspirations pertaining to education as a proxy which when related to current educational level of the adolescent could offer plausible answers to the relationship between adolescents' education and the timing of their sexual activity.

Furthermore, the relationship between contraceptive use and childbearing among the adolescents could not be analysed because of the small number of persons who were practising contraception at the time of the survey. Future research should consider a much larger sample of adolescents to be able to have adequate number of cases to facilitate more statistically robust analysis.

Finally, there is a need for a national comprehensive study that focuses on both male and female adolescents to be able to compare the relevant factors that affect adolescent sexual and reproductive health in the various regions. Such a national research would also have the advantage of understanding the socio-cultural ramifications, of the problem from the regional perspectives.

9.3 Conclusion

Female adolescent sexual and reproductive health is a subject with several dimensions. The evidence at least from this study shows that it is not a matter for one ministry or body to handle. It is also quite clear that one sure way of reducing the incidence of sexual and reproductive health problems is the provision of the right information at an age early enough for children to grow along with.

The study, though limited to the Central Region and to only Cape Coast and Mankrong, has relevant lessons for addressing the various dimensions of adolescent sexual and reproductive health problems throughout Ghana. What is required however is the acknowledgement of society of the magnitude of the problem and the commitment of all sectors particularly government and parents to make adolescent sexual and reproductive health, a matter of top national concern and priority and be motivated to find the resources to address it. It also requires the commitment of adolescents themselves to determine to live their lives to overcome the challenges of sexuality as they grow into adulthood.

As the world tries to find the antidote for the HIV/AIDS epidemic, adolescent sexuality and reproductive health cannot be relegated to the background. The young persons widely constitute a big window of opportunity and hope in the fight against HIV/AIDS if properly addressed. Addressing adolescent sexual and reproductive health problems should therefore be critical components of efforts at reducing the incidence and spread of HIV/AIDS which has the potential to undermine the manpower resources and hence the socio-economic growth and development of Ghana.

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**APPENDIX A: QUESTIONNAIRE FOR DATA COLLECTION DURING THE
ADOLESCENT SURVEY ON ADOLESCENT SEXUALITY, CONTRACEPTIVE USE
AND REPRODUCTIVE HEALTH, 1997**

SECTION A: HOUSEHOLD QUESTIONNAIRE

Name of Study Area: 1. Cape Coast 2. Mankrong

Cluster No. House No. Household No.

Summary Count Males Females Total

No. of Eligible respondents (Females 12 –24 years)

Q1 Serial No.	Names of Household Members (Begin with HHH)	Q2 Relationship to Head of Household*	Q3 Sex 1. Male 2. Female	Q4 Age	Q5 Region of Birth **	Q6 How Long has x been living here	Ti ck all women 12-24 years
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							

* Codes for Q2

1. Head of Household 2. Spouse 3. Son/Daughter 4. Brother/Sister
5. Grandson/Daughter 6. Other Relations 7. Unrelated

** Codes for Q5

01. Western 02. Central 03. Gt. Accra 04. Eastern 05. Ashanti 06. B/Ahafo
07. Volta 08. Northern 09. U/West 10. U/East

Q7. State type of material used in constructing household building

1. Blocks 2. Mud 3. Wood 4. Grass 5. Other

Q8. State type of material used in roofing of house

1. Iron Sheets 2. Wood 3. Grass 4. Tiles 5. Concrete
6. Slate 7. Other

Q9. Is household premises owned or rented?

1. Owned 2. Rented 3. Family House

For the following questions, indicate which of the following facilities/amenities are enjoyed or owned by household.

Q10. Electricity 1. Yes 2. No

Q11. Pipe borne water in the house 1. Yes 2. No

Q12. Radio 1. Yes 2. No

Q13. Television 1. Yes 2. No

Q14. Refrigerator 1. Yes 2. No

Q15. Bicycle 1. Yes 2. No

Q16. Motor Cycle 1. Yes 2. No

Q17. Vehicle 1. Yes 2. No

Q18. Tractor 1. Yes 2. No

Q19. Horse/Cart 1. Yes 2. No

Q20. How does household regard itself socio-economically?

1. High Status 2. Medium Status 3 Low Status

Q30. What is your current occupation?

01. Prof/Tech/Admin/Manag. 02. Clerical
 03. Sales 04. Agric/Production
 05. Services 06. Homemaker/Unemployed
 07. Manual 08. Student 09. Other (specify)

Q31. What is your economic activity?

Q32. What is your ethnicity?

1. Fanti 2. Other Akan 3. Ewe
 4. Ga-Adangbe 5. Mole Dagbani 6. Other (specify)

Q33. What is your religion?

1. Catholic 2. Protestant 3. Pentecostal/Charismatic 4. Muslim
 5. Traditional 6. No religion 7. Other (specify)

Q34. Do you listen to the radio at least once a week?

1. Yes 2. No

Q35. Do you read the newspaper at least once a week?

1. Yes 2. No

Q36. Do you watch the television at least once a week?

1. Yes 2. No

SECTION B2: SEXUAL PRACTICES

Q37. At what age did you have your first menstrual period?

88. Not yet menstruated

Q38. Have you ever had sexual intercourse?

1. Yes 2. No (skip to Q47)

Q39. At what age (in completed years) did you have sexual intercourse for the first time?

Q40. How old (in completed years) was the person with whom you had sexual intercourse for the first time?

Q41. About how many times over the past month have you had sexual intercourse?

Q42. Do you have a regular sexual partner?

1. Yes 2. No (skip to Q46)

Q43. How old (in completed years) is your regular sexual partner?

Q55. What is his current occupation?

- 01. Prof/Tech/Admin/Manag.
- 02. Clerical
- 03. Sales
- 04. Agric/Production
- 05. Services
- 06. Homemaker/Unemployed
- 07. Manual
- 08. Student
- 09. Other (specify)

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Q56. Was your first marriage as a result of a pregnancy?

- 1. Yes
- 2. No

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Q57. How many times have you been married?

--

Q58. For how many years have you been married altogether?

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Q59. Who influenced you to get married for the first time at the age you did?

- 1. Both parents
- 2. Father only
- 3. Mother only
- 4. Other relations
- 5. Partner
- 6. Friends
- 7. Myself

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Q60. Would you advise your children to marry at the age you did?

- 1. Yes
- 2. No

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Q61. Why?.....

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SECTION B4: PREGNANCY AND FERTILITY HISTORY

Q62. How many times have you been pregnant?

- 00. Never been pregnant (skip to Q76)

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Q63. How old were you when you became pregnant for the first time?

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Q64. Were you in school when you became pregnant for the first time?

- 1. Yes
- 2. No (skip to Q68)

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Q65. Did you drop out of school as a result of the pregnancy?

- 1. Yes
- 2. No

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Q66. Did you go back to school after you had the baby?

- 1. Yes (skip to Q68)
- 2. No

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Q67. Why did you not go back to school?

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Q68. How many pregnancies did you have during the past 12 months?

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Q69. How many births did you have during the past 12 months?

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Q70. How many births have you had altogether?

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Q71. How old were you when you first had a birth?

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- Q88. If No in Q84, why are you not using contraception?
 01. Not sexually active
 02. Currently pregnant
 03. Don't think I can be pregnant
 04. Lack of knowledge
 05. Don't know where to get contraceptives
 06. Health concerns
 07. Want to have a baby
 08. Partner disapproves
 09. Afraid parents will find out
 10. Cost too much
 11. People will think I am a spoilt girl
 12. Religious reasons
 13. Currently breastfeeding
 14. Other (specify)
- Q89. Do you think it is right for unmarried persons to use contraception if they choose to have sexual relations? 1. Yes 2. No
- Q90. Why?
- Q91. Do you think adolescents need parental consent before obtaining or using Contraceptives?
 1. Yes 2. No 3. Don't Know
- Q92. Why?
- Q93. Do you think giving adolescents family life education in school or at home will Lead them to become sexually promiscuous?
 1. Yes 2. No 3. Don't Know
- Q94. Why?
- Q95. Do you think there is the need for health/family planning counselling for Adolescents?
 1. Yes 2. No 3. Don't Know
- Q96. Who is the best person to provide counselling at the health/family planning Clinic?
 1. CBD Workers 2. Clinic Nurse 3. Teacher 4. Priest
 5. Peer 6. Parents 7. Other (specify)

SECTION B6: REPRODUCTIVE HEALTH

- Q97. Do you know you can contract some infections through sexual intercourse?
 1. Yes 2. No (skip to Q105)
- Q98. Name the infections that you know can be contracted through sexual intercourse
 1. Gonorrhoea 2. Syphilis 3. HIV/AIDS 4. Herpes 5. Malaria
 6. Chlamydia 7. Other (specify)

Q99. Have you ever contracted any of these STIs?

1. Yes 2. No (skip to Q105)

Q100. Which of the STIs have you ever contracted?

1. Gonorrhoea 2. Syphilis 3. HIV/AIDS 4. Herpes
5. Chlamydia 6. Other (specify)

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Q101. How did you treat the STI you contracted?

1. Hospital/Doctor/Nurse
2. Self-medication (Drugs from drug store)
3. Friends
4. Used local herbs
5. Other (specify)

Q102. Do you know of any friend who contracted any STI?

1. Yes 2. No (skip to Q104)

Q103. How did he/she treat the STI he/she contracted?

1. Hospital/Doctor/Nurse
2. Self-medication (Drugs from drug store)
3. Friends
4. Used local herbs
5. Other (specify)

Q104. In what ways can you contract HIV/AIDS? (Impute 0 for no response)

1. Sexual intercourse
2. Sharing of shaving sticks/blades
3. Use of unsterilized needles
4. Transfusion of improperly screened blood
5. Mosquito and other insect bites
6. Avoid kissing
7. Other (specify)

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Q105. How would you avoid contracting HIV/AIDS and other STIs?
(Impute 0 for no response)

1. Stay away from sex until one marries
2. Keep to one faithful sexual partner
3. Use condoms during sex
4. Avoid using unsterilized needles and/or improperly screened blood
5. Do not share shaving sticks/blades with others
6. Don't have anything to do with someone with AIDS
7. Other (specify)

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**APPENDIX B: QUESTIONNAIRE INSTRUMENT FOR FOCUS GROUP DISCUSSIONS
DURING THE ADOLESCENT SURVEY ON ADOLESCENT SEXUALITY,
CONTRACEPTIVE USE AND REPRODUCTIVE HEALTH, 1997**

1. Is it wrong for adolescents who are not married to be sexually active? Why?
2. What are the factors which are contributing to the early entry of adolescents into sexual unions?
3. What are the problems that are associated with this early entry into sexual unions by adolescents?
4. Are there any cultural, religious or traditional practices (e.g. puberty rites) which you think are encouraging young girls to have sexual partners at very early ages? Explain.
5. Would you recommend that adolescents who are sexually active be given contraceptives and why?
6. Would you agree that a girl who has an unwanted pregnancy should go for an abortion and why?
7. What do you see as some of the health-related problems of abortions?
8. Do you think teaching adolescents family life education (including contraception) will lead them to sexual promiscuity? Why?
9. If No, what do you recommend instead?
10. If Yes, who is the right person(s) to teach adolescents family life education and Why?
11. How would you ensure that teenagers who drop out of school due to an untimely pregnancy go back to school?
12. Do you think parents should decide for their wards as to whom to marry and why?
13. Is it right for an adult to have sexual partnership with an adolescent? Why?
14. Why do many adolescent girls decide to have sexual partners among wealthy but married adults?
15. What do you consider as the factors that do not encourage sexually active adolescents to practise contraception?
16. At what age do you consider ideal for a woman to marry?
17. How many children do you consider as ideal for every couple in Ghana today and why?

18. In what ways do you think people can be encouraged to have small family sizes?
19. What do you consider as reasons for the migration of adolescent girls to the main cities and regional capitals to work as “kayaye”?
20. How can we stop this movement of young girls into the cities and large towns?
21. In what ways can we help adolescents to avoid contracting sexually transmitted infections and HIV/AIDS?
22. What should be the attitude of parents towards their unmarried adolescent daughters who become pregnant?
23. What is the best way to provide family planning services to adolescents?
24. What role should the religious bodies play to assist adolescents to avoid unwanted pregnancies and sexually transmitted infections?